City of York Suicide Audit

- a review of deaths by suicide within the city of York between 2010 and 2014

CITY OF YORK COUNCIL

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Executive Summary

The York five year suicide audit reviewed 60 deaths which took place between 2010 and 2014. Files reviewed related exclusively to coroner's inquest conclusions of suicide and so did not include deaths by 'accident or poisoning of undetermined intent' which are included in the wider definition of suicide by the Office of National Statistics. The audit was conducted in line with national guidance in order to enable better understanding of the pattern of suicide in the local area. Findings will inform suicide prevention plans and activities to be used to develop the local aspiration for York to become an accredited 'Suicide-Safer Community'.

There has been an increasing trend in suicides within the last decade in England and this has been replicated in York with some years seeing comparatively high levels of suicide, particularly in men.

An audit template was used to record information obtained from coroner's files which contain evidence and information relevant to individual deaths by suicide. Data and thematic analysis was carried out on this information which highlighted that across those 60 people who died by suicide in York during the time period:

- 83 % were male
- The average age at death was 42.8 years
- Approximately three quarters of people were single, divorced or separated.
- 44% lived alone
- There was a higher proportion of death by suicide among people living in more deprived areas notwithstanding the fact that suicide affects people from a wide range of backgrounds
- 48% had a physical or sensory health condition at time of death; 47% had a history of substance misuse; 40% had a history of self-harm, 37% had a diagnosed mental illness; and 25% had previously attempted suicide
- Hanging was the most common method of suicide
- the majority of incidents took place in the deceased's own home or other private premises whilst seven incidents took place on the railway.
- Around 50% of people left some form of suicide note
- 22 out of 60 people (37%) had consumed alcohol prior to their death, 14 were over the drink drive limit and seven of these were heavily intoxicated at the time of death
- For over half of the people who died there were warning signs or evidence of risk prior to their suicide e.g. suicide intent, suicidal thoughts or significant behavioural change
- A thematic analysis identified the main themes linked to the suicides to be: history of self-harm/ suicide attempts, diagnosed mental health problems, loneliness and isolation/lack of engagement, undiagnosed mental ill health/emotional distress, family/relationship difficulties and substance misuse

- In the year prior to death, 63% had a recorded visit to their GP, 52% had taken up psychiatric treatment, 40% had contact with specialist mental health services and 28% had attended the Emergency Department at hospital
- 32% of the people had either declined some form of psychiatric treatment or shown a lack of adherence to their medication/ treatment plan in the year prior to death
- Whilst 28 people had a history of substance misuse only four had a treatment record in York, suggesting a possible lack of engagement with substance misuse services
- 13 people (22%) were clients of City of York Council as either housing tenants or having been subject of Adult Social Care records (open or closed) at the time of death.
- 43 people had previous contact with the police as victims, persons reporting a crime or incident, suspects, offenders, witnesses or subjects (e.g. 'concern' for safety or missing person). 37 of these had contact in the 12 months prior to their death
- 51 out of 60 people (85%) had some recorded contact in the 12 months prior to their death with at least one agency or organisation, leaving nine people (15%) who had no recorded contact. The average age of the people who died who had had no contact with services was 32.3 years which is noticeably younger than the average age of those who had been in contact with some agency(44.6 years of age).

Recommendations

- Work towards achieving formal 'Suicide Safer Community' accreditation for the city of York with Living Works.
- Develop a suicide prevention framework for York and an accompanying multi-agency 'Framework' of objectives, risks actions and outcomes.
- Ensure that recommendations contained in the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (October 2016) are considered, implemented and embedded into the policies and practices of local commissioned mental health services.
- Undertake a regular programme of suicide audits, including a wider scope to cover 'deaths by accident/poisoning of undetermined intent' to be used to inform suicide prevention priorities and development needs
- Develop 'suicide surveillance' and real time 'early alert' processes to improve the multi-agency response, lower and mitigate suicide risk and reduce the number of completed suicides and attempts.
- Provide more responsive support arrangements to those affected by suicide. Include people who are bereaved through suicide, recently or historically, those experiencing suicidal ideation or caring for others and those who have been otherwise touched by suicide through loss of an acquaintance or presence at the scene of a related incident.
- Ensure that those people who are affected by suicide are able to have their views and experiences heard and the opportunity to contribute to suicide prevention activity.
- Raise awareness around which groups are at 'high risk' or 'vulnerable' to suicide amongst front-line staff ensuring that those staff receive training to enhance their skills in communicating with and protecting someone who may be at risk.
- Develop a communication plan for the city to include awareness raising, encourage help-seeking, open and non-judgemental approaches and dialogue between those at risk and those in contact with those at risk.

Introduction

In 2013, the leading cause of death for 20-34 year olds in England and Wales was suicide (including deaths through injury/poisoning of undetermined intent). Suicide remains the leading cause of death for men aged 35-49 accounting for 13% of all deaths. Every 40 seconds, someone somewhere in the world dies by suicide (WHO, 2014). Across the world, suicide is the second leading cause of death among young people aged between 15-29 years (after road related deaths).

Between 2006-2015, 136 City of York residents died by suicide. A further 46 people died through accident or poisoning in cases where the coroner could not establish, beyond reasonable doubt, that they had died by suicide.

The numbers of suicides occurring within a timeframe or locality are usually calculated as a rate. Hence the suicide rate is based on how many people out of every 10,000 or 100,000 people in the population are recorded as having taken their own life or died through accident or poisoning of undetermined intent.

The suicide rate in York for 2013-2015 was 14 suicides per 100,000 of population and this is significantly higher than the national and regional rates (10.1 and 10.7 per 100,000 respectively). In 2013-15 York had the highest suicide rate when compared to other local authority areas that have similar levels of deprivation. Deprivation has been used as a comparison because death by suicide is more common among people who live in deprived areas.

In 2013, one of the peak years for suicides in York, the age adjusted suicide rate for males of working age (18-64) was the fourth highest in England.

Every life lost to suicide is a tragedy and is likely to have a significant effect on the emotional health and wellbeing of those touched by it. For some people that may be during the immediate aftermath or over the following months. For others the experience of that loss or simply the knowledge that a loved one such as a parent, partner, sibling or child took their own life, can stay with them forever and undermine their long-term ability to thrive.

The unexpected death of a family member or close friend through any cause can be the most significant traumatic event in a person's life. A loss through suicide can be completely shattering, intensifying feelings and responses associated with bereavement and leaving people with enduring emotions and questions with which they often never fully come to terms. Research suggests it may even render them more at risk of suicide themselves at some time in the future (BMJ Open 2015) Whilst the full human cost is impossible to quantify or measure, it is also difficult to place a financial cost on any individual suicide or on the incidence of suicide generally. In 2013, Public Health England estimated the average cost per suicide to be £1.7 million. Placing a monetary value on the loss of life may be considered insensitive by some, whilst others may question what factors and timeframes should be included in the calculation. What is indisputable is that the economic burden of suicide falls upon everyone in a society and that it is significant.

This report primarily relates to the audit and subsequent analysis of 60 suicides which occurred within the city of York over a period of five years between 2010-2014. It makes reference to the audit of 227 suicides during the same time period in the North Yorkshire County Council area.

The two audits were almost identical in their methodology and objectives and were conducted consecutively over the autumn and winter of 2015/16 with the majority of team members being involved, to some degree, in both. The geographical proximity of the two audit areas and the collaborative approaches to suicide prevention that partner agencies across both local authority areas have, enabled shared learning and consideration of joint approaches to reducing suicide across the county as a whole.

The York audit considered deaths of people across a wide range of ages, backgrounds, status, stages of life and living circumstances.

The audit included people with diagnosed mental ill-health conditions who were receiving treatment from mental health services which were, in some cases, endeavouring to manage a known risk of suicide on a weekly or even daily basis.

It included people who had previously received such treatment but were no longer in touch with services and people whose mental or physical ill-health was currently being managed and treated by primary care services. Significantly the audit also included cases where the deceased had not had any contact with health professionals for a considerable time and some cases where there had been no prior indication whatsoever to anyone of suicidal ideation or emotional turmoil.

All causes of avoidable, premature death are deserving of attention and resources to prevent unnecessary loss of life. Relatively few people die in York through suicide when compared with the leading causes of death. However when the number of 'years of life lost' is considered rather than simply the number of lives lost, the impact of suicide is particularly poignant.

Average life expectancy in York is currently 80.1 years for men and 83.5 years for women. The average age of the York audit cohort was 42.4 for men and 47.8 for women. A calculation based on these figures shows that those sixty people taken together were deprived of 2,249 'years of lost life', around 37 years per person, as a result of suicide.

It is anticipated that that this report will be read by stakeholders and partners who have the desire, influence and resources to affect change. It is hoped that it will provide an insight into the common situations, stresses, risk factors and catalysts which led those who took their lives to the conclusion that suicide was their only option. It is also hoped that this work will highlight any potential gaps in services in terms of their availability, profile, accessibility and credibility amongst people who may benefit from using them.

The audit team members who undertook this audit recognise the very sensitive nature of the information reviewed and their privileged position in being granted access to intimate details of peoples' lives and deaths. The coroner, in supporting this research, sought strong reassurances in relation to confidentiality of personal information and the anonymity of individuals when that information was subsequently collated and presented. The audit team has endeavoured to respect that need in reporting its findings. Whilst case studies used within this report are based on information found within the audit the names of individuals and some of the details have been changed to avoid possible identification of specific cases and further distress being caused to loved ones.

This report does not attempt to express a view or position on the ethicality of suicide. It is not a crime in UK law to take one's own life and has not been since 1961. Throughout the report we have avoided the term 'to commit' suicide in favour of phrases such as 'complete' or 'die by' suicide or 'take one's own life. This reflects guidance from Samaritans and other national support charities based on feedback and preferred terminology of those people directly affected by suicide.

[1] Suicides are reported by the year in which they were registered rather than the year in which the death occurred. The ONS definition of suicide includes deaths given an underlying cause of intentional self-harm or an injury/poisoning of undetermined intent.

Part (i) Context-Suicides in York over the last decade

Numbers of suicides in York 2006-2015

A total of 182 deaths by suicide among York residents were registered in the 10 year period 2006-2015. 136 of these had a clear coroner's outcome of suicide and a further 46 were from accident / poisoning of undetermined intent[1].

Table 1: Number of Suicides in York 2006-2015

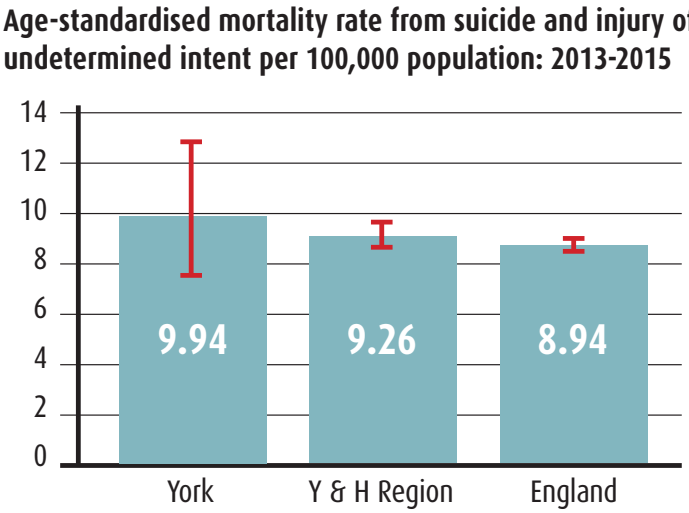
	Year of Registration										
Intent	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total
Intentional	7	9	22	10	15	11	10	21	13	18	136
Undetermined	4	4	1	4	3	7	1	9	3	10	46
Total	**11**	**13**	**23**	**14**	**18**	**18**	**11**	**30**	**16**	**28**	**182**

Source: Primary Care Mortality Database (PCMD)

Suicide Rates in York

Published suicide figures are calculated as rates per 100,000 of population and are adjusted to take into account differences in the age breakdown of different areas. The latest published rates are for the three year period 2013-2015. The rate in York is 14 suicides per 100,000 of population and this is significantly higher than the national and regional rates (10.1 and 10.7 per 100,000 respectively). (Public Health England, 2016a).

Figure 1: York suicide rates compared to Region/England 2013-2015

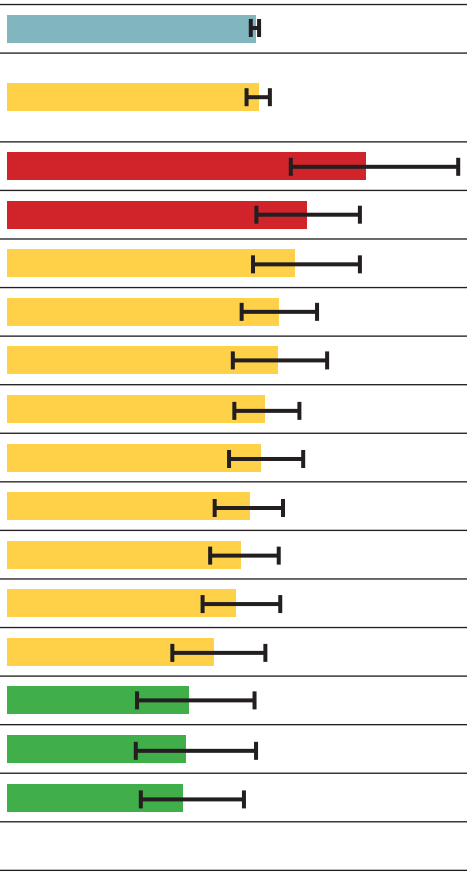


Source: Public Health Outcomes Framework (2016)

In 2013-15 York had the highest suicide rate when compared to other local authority areas that have similar levels of deprivation. Deprivation has been used as a comparison because death by suicide is more common among people who live in deprived areas.

Figure 2: York suicide rate compared to Local Authority areas with similar levels of deprivation 2013-2015

Area	Count	Value	95% Lower CI	95% Upper CI
England	14,429	10.1	10.0	10.3
Second least deprived decile (IMD2010	1,661	9.8	9.3	10.3
York	74	14.0	10.9	17.6
Warwickshire	175	11.8	10.2	13.7
Cheshire East	115	11.4	9.4	13.7
Gloucestershire	171	10.6	9.0	12.3
Dorset	117	10.6	8.7	12.7
West Sussex	220	10.1	8.8	11.5
North Yorkshire	164	10.0	8.5	11.6
Leicestershire	164	9.3	7.9	10.9
Cambridgeshire	155	9.1	7.7	10.6
Wiltshire	116	9.0	7.4	10.8
Bromley	68	8.1	6.3	10.3
Sutton	36	7.0	4.9	9.8
Merton	37	7.0	4.8	9.8
Harrow	45	7.0	5.1	9.4
City of London	4		-	-



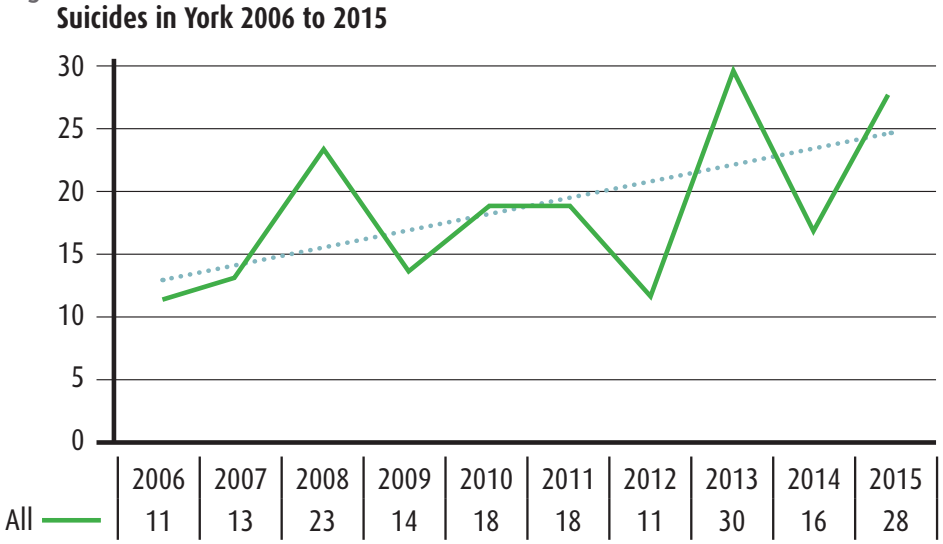
Source: Public Health Outcomes Framework (2016)

In 2013, one of the peak years for suicides in York, the age adjusted suicide rate for males of working age (18-64) was the fourth highest in England.

Suicide Trends in York 2006-2015

There has been an increasing trend in suicides in York the last 10 years. There have been sharp peaks in some years e.g. 2008, 2013 and 2015.

Figure 3: Trend in suicides in York 2006 to 2015

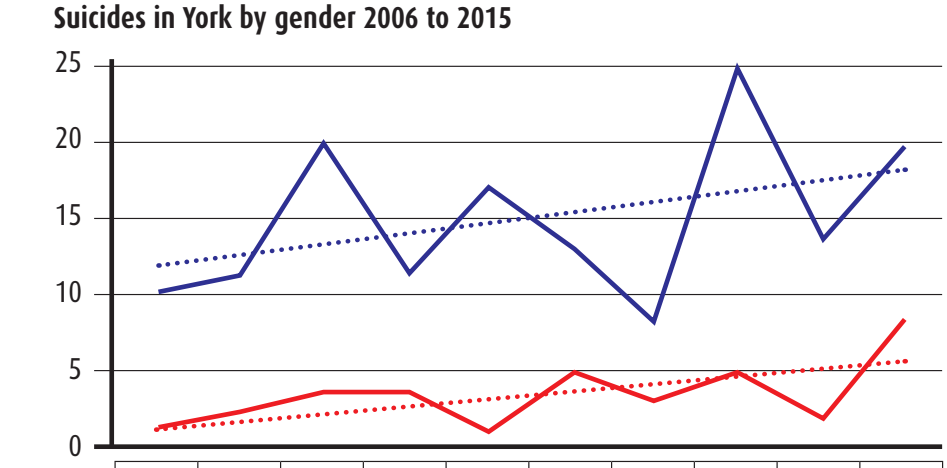


	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
All	11	13	23	14	18	18	11	30	16	28

Source: primary care mortality database

The trend has been increasing for both males and females in York over the last 10 years. The 'peak' years tend to be due to sharp increases in male suicides, however in 2015 there were more female suicides (8) than in previous years.

Figure 4: Trend in suicides in York by Gender 2006 to 2015



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
M	10	11	20	11	17	13	8	25	14	20
F	1	2	3	3	1	5	3	5	2	8

Source: primary care mortality database

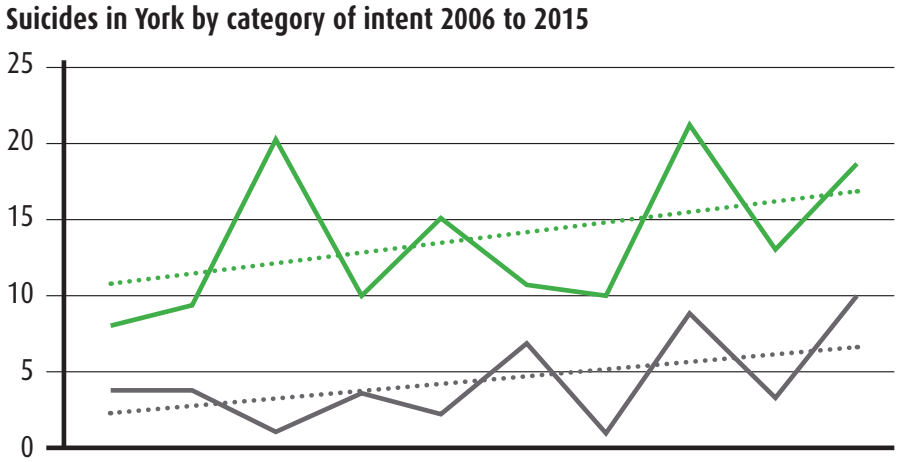
Published figures about death by suicide are calculated based on how many deaths occurred that were classed as one of two groups of ICD 10 codes:

- Intentional self-harm (X60-X84) – Conclusion of suicide
- Event of undetermined intent (Y10-Y34) – Open conclusion.

ICD 10 codes are used within health care services to classify what conditions or injuries people receive treatment for or die from.

If these are analysed separately it can be seen that the 2008 peak was due to intentional self-harm whereas in 2013 and 2015 there was also an increase in deaths with 'undetermined intent'.

Figure 5: Trend in suicides in York by category of intent 2006 to 2015



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Intentional	7	9	22	10	15	11	10	21	13	18
Undetermined intent	4	4	1	4	3	7	1	9	3	10

Source: primary care mortality database

Suicide Prevention Profile for York

Public Health England produced a suicide prevention profile highlighting risk factors for each local authority (Public Health England, 2016b).

For many of the risk factors, York had a significantly lower value compared with the national average. For example York has lower levels of unemployment, less homelessness and fewer alcohol related hospital admissions. There were, however, some risk factors where York had a significantly higher value than the national average:

- The percentage of people with a high anxiety score
- The percentage of children aged 10-18 years who have formally entered the youth justice system
- The percentage of households occupied by a single person aged 65 or over.
- The percentage of emergency hospital admissions for intentional self-harm.

Part (ii) York Five Year Suicide Audit 2010-14

Background and drivers

The Government's 2012 document 'Preventing suicide in England, a cross-government outcomes strategy to save lives' highlighted the need for local authorities and other statutory, voluntary and private sector organisations to work in partnership with local communities to reduce the incidence of suicide and to provide better support for those affected by it.

Government strategy supports the view that suicide is not inevitable for anyone and that appropriate interventions at the right time and for the right people can, and do, save lives. It provides clear direction to local authorities and other stakeholders, highlighting the benefits of much closer partnership working, improvements to information sharing and data gathering and sharing and replication of best practice initiatives. A key message is the concept of the problem of suicide and its causes being 'owned' by and responded to jointly by partners and communities.

In 2014, in response to this guidance, a North Yorkshire and York multi-agency Suicide Prevention Task Group was created to consider and seek to address the issue of suicide across the local authority areas of North Yorkshire and the City of York. Chaired by the Director of Public Health, the group has representation from a wide range of stakeholders including police, NHS, clinical commissioning groups, mental health services, substance misuse services, Network Rail, higher education institutions, Samaritans, other voluntary sector organisations and community members - some of whom are themselves personally affected by suicide.

One of the six key objectives within the government strategy is to 'support research, data collection and monitoring'. A large amount of research has been conducted world-wide to identify causes, risk factors and interventions aimed at reducing suicide and in the UK research at a national level has been under-way for several years. The strategy, however, stresses the need for local research to be conducted and developed to better inform stakeholders responsible for service delivery within local authority areas. Its message is that it is imperative for those seeking to take action to reduce suicide locally to have more precise and up to date information regarding trends, high risk groups, prevalent methods, location hotspots and triggers which resulted in recent deaths within the communities they serve.

A priority for the task group was therefore the completion of a five year county-wide suicide audit. A holistic study of suicide within the local area had not been previously conducted and it was apparent that there were clear gaps in the knowledge and understanding about the pattern of suicide across the area.

Aims

The aims of the audit were to:

- Compare local, regional and national data and trends
- Identify local risk factors, groups at 'high' or 'raised' risk and localities of higher incidence
- Establish the extent and nature of contact with various services by those who subsequently completed suicide
- Provide an insight into common situations, stresses and triggers which led to suicide
- Inform future prevention strategies in conjunction with a review of the evidence base for them
- Provide a bench mark of evidence to inform future audits and evaluate prevention strategies
- Develop a sustainable system for future data collection
- Explore opportunities to intervene, provide support and address gaps in service in order to reduce or mitigate further risk

Method

The most relevant single source of information relating to individual suicides is the records and evidence collated during coroners' inquests. The Coroner responsible for conducting inquests into deaths occurring in City of York agreed to an information sharing protocol and granted the suicide audit team access to case files. The cases examined were identified from information provided by the Coroner's office, linked to Office of National Statistics (ONS) data and cross-referenced with data about deaths from the Primary Care Mortality Dataset.

Each individual file was read by a member of the audit team and information entered onto a generic electronic template. This template included multiple choice or free text boxes for recording demographic information, facts relating to the death such as date, place and cause of death, medical history and details of contact with various services. A free text box was used to include general notes in relation to particular circumstances, lifestyle, significant events or history which were believed to have resulted in or contributed to the suicide. After reading the complete file the reviewer returned to a list at the top of the template to indicate which 'triggers' for suicide appeared to be the most relevant to that individual death.

Analysts from City of York Council's Strategic Business Intelligence Hub analysed both the quantitative and qualitative data that was collected. Quantitative data was analysed to identify the range of socio-demographic and lifestyle characteristics, patterns and trends among individuals who had taken their own life that are discussed throughout this audit report.

Qualitative data supplied to the audit was grouped into a range of themes to facilitate identification of common issues impacting on the day to day lives of individuals who had chosen to end their lives. The outcome of the qualitative analysis was considered alongside the findings from quantitative analysis to provide a wider, richer intelligence based insight into the common characteristics and antecedents of individuals who had chosen to complete suicide, and identify socio-demographic groups which may be at raised risk.

Audit scope

The York suicide audit considered:

- Deaths recorded between 2010 and 2014 where inquests were held in York and which resulted in the coroner recording the cause as 'suicide.'
- Death of people who resided outside of York who died by suicide within the city.
- Cases where individuals died by suicide outside of England and the body was repatriated to the city as the location of their residence or family home.
- Cases in which the deceased resided in York and died in the North Yorkshire County Council area (as those files were also available to the audit team).

The audit did not consider:

- Deaths which were recorded as 'accidents or poisoning of undetermined intent'.
- Deaths of people who resided in York and who died elsewhere in England (other than in North Yorkshire as above) as those investigations fell under the jurisdiction of the coroners for those other areas
- Incidents of attempted suicide or serious self-harm not resulting in death. However, between the start of the audit process and the publication of the findings, a real-time surveillance process has been established which allows a faster response to identification of risk factors associated with local suicide. The intention is to further develop this method to be better able to identify and respond to risk factors in cases which did and did not result in death in an attempt to reduce future suicide attempts and death by suicide.
- A number of cases which were not available for review due to on-going proceedings or other reasons.

58 of the 60 people considered within the scope of this audit were York residents (or had their family home in York) at the time of death. The other two people lived outside York but completed suicide in the city.

Limitations and challenges of data collection

Whilst the information contained within coroners' files proved invaluable as a source of evidence regarding suicide it should be noted that such files do not include all material necessary to provide a comprehensive and complete picture of its character and causes.

The objectives of a coroner's enquiry and those of a suicide audit differ markedly, most significantly in relation to individuals' motivation to complete suicide. It is a coroner's responsibility to establish 'how' someone came about their death rather than 'why' someone chose to die by suicide.

Whilst how someone died i.e. the method was of clear interest and value to the audit team, the reasons why someone completed suicide were considered to have most significance to the research.

A coroner's enquiry only collates evidence and information which is made available through a police investigation or provided by services and organisations which hold information relevant to a death.

Some information regarding deceased individuals, their lifestyles or health history or recent stresses is not available within such files –or known even to those closest to them -and in many cases only the deceased themselves knew the true causes or catalysts of their suicide.

A number of case studies are used in the following audit element of this report. These scenarios are based on circumstances faced by those who died and provide an insight into the common antecedent history and life stresses encountered by them. However, to avoid possible identification of individuals, changes have been made to names, age, gender or living circumstances.

York Suicide Audit Findings

Demographics

Of the 60 people in the York sample, 50 (83%) were men and 10 (17%) were women. This is the same as the gender breakdown in the North Yorkshire audit which considered 227 deaths of which 83% were male. This also reflects the position in England (78%) and internationally where data shows that men account for more than three quarters of people worldwide who complete suicide. The national strategy provides the following explanation for this:

> "Men are at greater risk for a number of reasons. Many of the clinical and social risk factors for suicide are more common in men. Cultural expectations that men will be decisive and strong can make them more vulnerable to psychological factors associated with suicide, such as impulsiveness and humiliation. Men are more likely to be reluctant to seek help from friends and services. Linked with this, providing services appropriate for men requires a move away from traditional health settings. Men are also more likely than women to choose more dangerous methods of self-harm, meaning that a suicide attempt is more likely to result in death."

Case study

Brian, who was in his late forties, had recently been through an acrimonious divorce, the settlement of which had left him with significant debts. He struggled with depression which he attributed to his marriage break-down and a long term ill-health condition, arthritis which was worsening, but he had not discussed his mental health with his doctor. He had not previously self-harmed and he did not drink alcohol to excess. He took his own life whilst staying at his friend's address. He left a note in which he said he could no longer cope with the prospect of bankruptcy , reduced contact with his children and unmanageable physical pain.

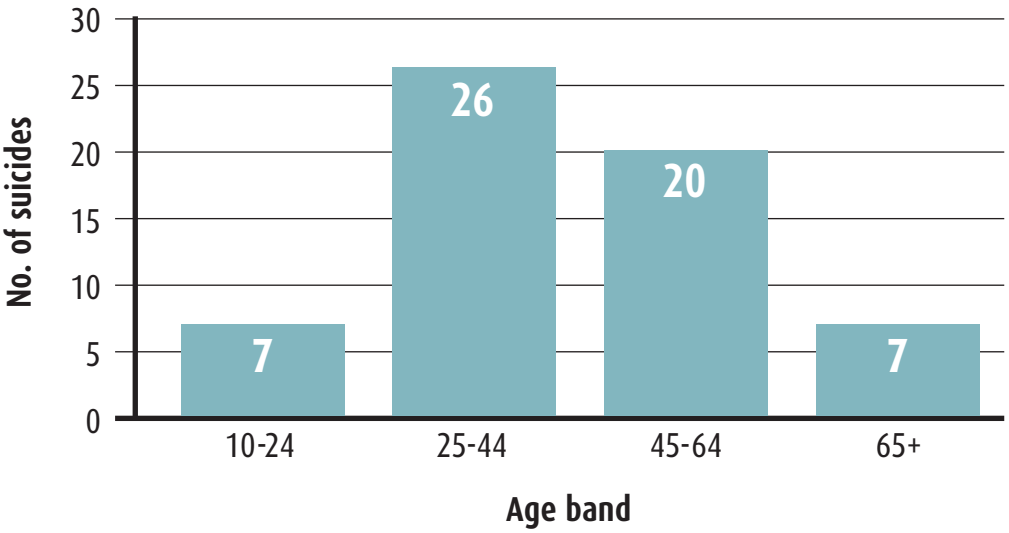
Age at Death

Death by suicide occurred in a wide range of people aged anywhere between those in their teenage years to those in their eighties.

The average age at death was 42.8 years overall (41.9 years for men and 47.4 years for women).

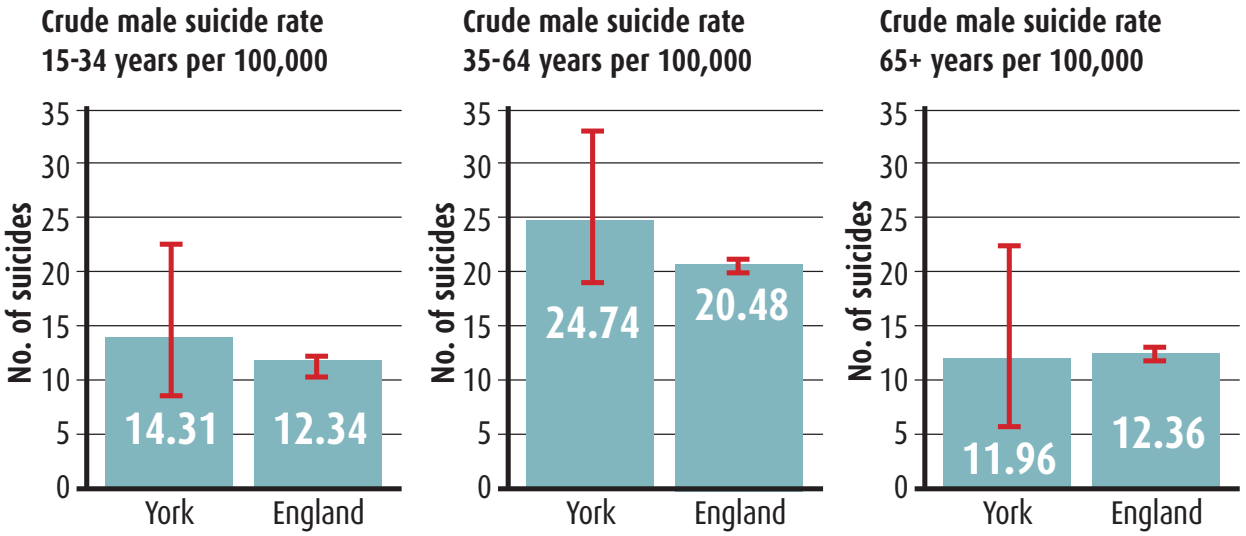
The most common age group for people to take their own lives (overall and for men only) was 45-54. For women, the most common age group was among women aged between 25-34.

Figure 6: Age at which people took their own lives



Age specific male suicide rates are available for York for the period of the audit (Public Health England, 2016). These are shown in the figure below for the period 2010-2014. It can be see that rates in York for the three age bands (15-34, 35-64 and 65+) are not significantly different from the national averages.

Figure 7: Age specific male suicide rates: York v England: 2010-2014



Based on the age at death of each person in the York cohort and the average life expectancy in York, the sixty people who died were deprived of a total of 2,249 years of lost life as a result of suicide.

Case study

Liam, who was in his forties, was struggling at work. He didn't feel he was capable of the tasks expected of him and didn't receive support from managers or colleagues. It was a very male dominated environment and no one ever discussed personal issues. He became increasingly anxious and reluctantly booked an appointment with his GP. During his consultation he found it difficult to describe the extent of his anxiety and feelings of low self-worth. A close friend had taken her own life a few weeks earlier and this had hit Liam very hard. He suffered episodes of low mood but had not previously self-harmed, used drugs or drunk to excess. He took his own life one afternoon without having given his partner any indication that he was feeling so desperate. He had sent her a text apologising and explained that he could no longer bear the stress but didn't go into any detail. The post-mortem revealed that he had drunk alcohol that day but not a substantial amount.

Ethnicity

Ethnicity was recorded for 48 people in the York sample. 47 people (98%) were identified as White or White British.

It is recognised nationally that there are gaps in the way that data is collected in relation to ethnicity and this was also apparent during the York audit, with ethnicity data missing from 12 of the 60 files. The national strategy suggests that Travellers, and in particular, Gypsy and Traveller men are more at risk of suicide and mental ill-health when compared to the general population.
The audit did not indicate that this was the case in York during the period considered and there was

no suggestion that a higher risk of suicide was associated with any particular ethnic minority group. The largest proportion by far of death by suicide was of people from White or White British ethnicity (90.2% of York's population are White British based on the 2011 Census).

Sexuality

Sexuality was recorded for 37 people in the York sample, 35 people (95%) were recorded as Heterosexual and 2 people (5%) as Homosexual.
National data indicates that people who are lesbian, gay, bi-sexual or transgender are more susceptible to mental ill-health, self-harm and bullying and are, as a result, at greater risk of suicide.

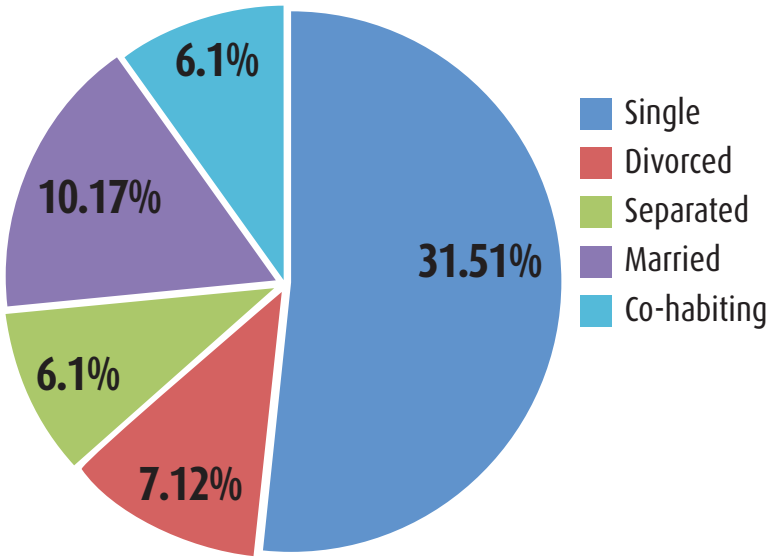
Definitive data collection in relation to sexuality is not possible from coroners' files and the audit only provides an indication of the likely sexuality profile of just over half of the cohort where it was specifically referenced or could be reasonably assumed.

There was no evidence in the audit of sexuality or bullying related to sexuality or gender identity being factors which contributed to completion of suicide within this specific cohort

Marital status

Approximately three quarters of people in the York sample were either single, divorced or separated (44 out of 60 people, 73%). The detailed breakdown by marital status is shown in the chart below.

Figure 9: Marital status



'Marital status' in itself does not provide clear clues in relation to vulnerability to suicide particularly as legal marital status of those in the cohort was often at variance with their actual domestic arrangements at the time of their death.

However, relationships in general and breakdown in intimate relationships in particular featured as a significant contributory factor in the deaths considered through this audit.

Whilst some of those who completed suicide were in stable, loving relationships or had supportive extended family there was a common theme of recent relationship breakdown or estrangement from family.

In some cases, particularly where this was linked to other risk factors such as mental ill-health or alcohol misuse the breakdown of a relationship or the perception that the relationship was ending proved to be the catalyst which triggered suicide.

There were also instances of acrimonious divorce proceedings – either recent or historical – often leading to significant debt or estrangement from children which appeared to compromise individuals' emotional resilience. This, combined with other factors such as mental ill-health in the form of depressive illness or anxiety, appeared to generate feelings of mental anguish, guilt, hopelessness or despondency resulting in eventual suicide.

Housing status

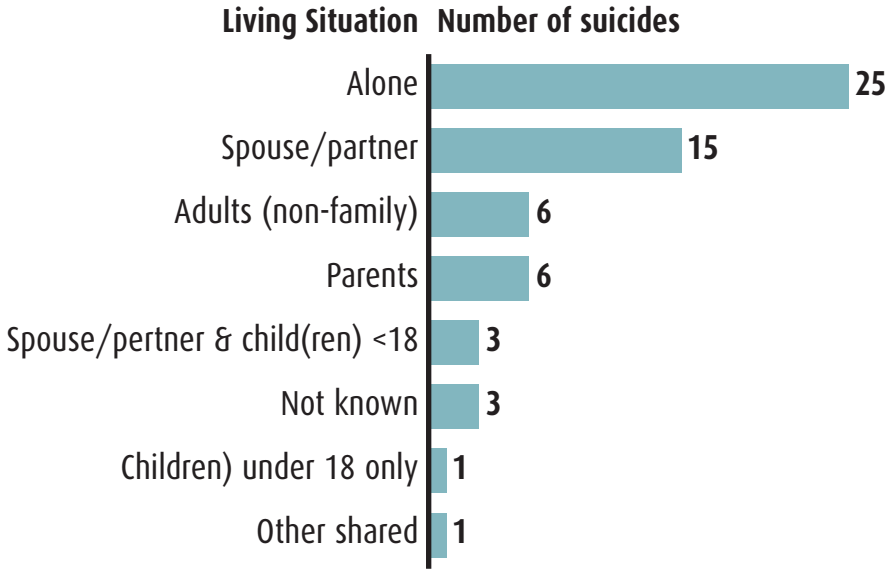
Housing status was recorded for only 40 of the 60 people in the York sample. 18 out of 40 people (45%) were owner occupiers, 16 (40%) were private renters and 6 (15%) were council tenants. National data suggests that homelessness can be a significant risk factor for both mental ill-health and suicide. The cohort did not include anyone who could be considered a 'rough sleeper' i.e. living on the city's streets and there was no one who was a resident or temporary resident at a homeless hostel.

There were, however, several people whose accommodation was unstable including people housed under very temporary arrangements; such as staying with friends or employers or where rent arrears or other difficulties were likely to result in imminent eviction.

Living situation at time of death

Living situation at the time of death was recorded for 57 of the 60 people in the York sample. 25 out of 57 (44%) were living alone at the time of taking their own life.

Figure 8: Living Situation at the time of death



Whilst living alone does not necessarily indicate social isolation it is noteworthy that almost half of the cohort were such at the time of their death. Generally the presence of supportive relationships within a home environment-family, friends or house-mates can be considered a protective factor perhaps because someone who is vulnerable has the opportunity to talk through difficulties or worries or to reduce feelings of loneliness. Conversely, where there is a lack of or limited human contact within the home or absence of interaction with people elsewhere then vulnerable people can lose a sense of perspective and the ability to rationalise or problem solve, creating a significant risk factor (Mental Health Foundation and Campaign Again Living Miserably).

In a minority of cases reviewed , the individual lived a reclusive lifestyle with little or virtually no contact with other people or services. Others became more reclusive in the days or weeks prior to their death often as a result of deteriorating mental health or drug or alcohol dependency. In the majority of cases where social isolation was considered a factor in the suicide, it was apparent that it was not an individual's deliberate lifestyle choice. Instead it was a situation brought about by circumstances beyond their control and which was clearly detrimental to their quality of life and emotional wellbeing.

There were examples in the cohort of the breakdown of a personal relationship or relationships which contributed to an absence of regular contact with family, friends or neighbours. This lack of interaction appeared to aggravate mental ill-health or feelings of loneliness or hopelessness, perpetuating seclusion and leading to suicidal ideation. The fact that in some cases the body of the deceased was not discovered for several days or even weeks after their death is a clear indication that people can live isolated, reclusive lives in a city and this negatively impacts both personal and community resilience.

Case Study

Diane, who was in her forties, had no previous history of mental health although she did self-harm on one occasion some years ago when a relationship had ended. She was not known to local services and had not seen her GP for some time. Diane was prone to periods of low mood and she frequently self medicated by drinking alcohol at levels well above recommended limits whilst not actually being dependent on alcohol. She had been in a stable relationship but her partner called an end to it unexpectedly, partly due to her drinking. Diane took this very hard and increased her alcohol intake substantially. Around a week after the relationship ended she drank excessively and completed suicide without leaving a note.

Place of birth

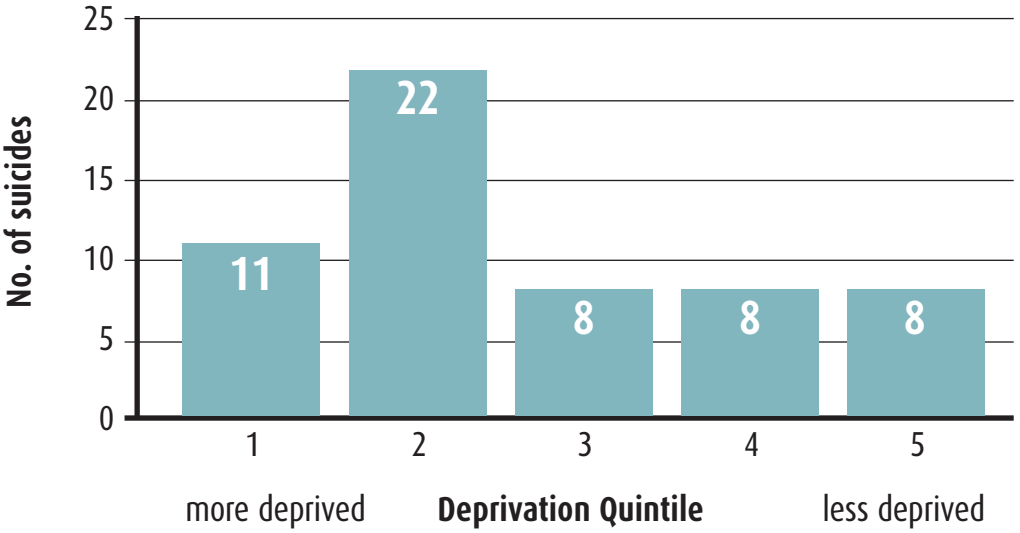
Place of birth was recorded for 58 of the 60 people in the York sample. 29 people (50%) were born in York, 25 (43%) were born elsewhere in the UK and four people (7%) were born outside the UK.

Socio-Economic Status

Deprivation is acknowledged as a factor that increases risk of suicide. The audit team considered whether the level of deprivation that a person experienced was a defining factor in local deaths by suicide and it can be shown that there was over-representation in suicides among people living in more deprived areas. However, due to the small number of cases reviewed, we cannot draw a clear conclusion from this data that locally, deprivation is a statistically significant risk factor.

- Almost 60% of people dying by suicide (33 out of 57) lived in the most deprived 40% of York.
- Almost 40% of all people dying by suicide (22 out of 57) lived in the second most deprived quintile

Figure 9: Number of suicides by deprivation quintile (York residents n= 57)



There are, however, some differences identified as part of the analysis that are worth noting. There was a difference in the age at death between those who were financially poorer when compared to those who were better off. People who died by suicide and were from poorer backgrounds, tended to die at an earlier age than those who were wealthier.

Age	Higher Deprivation	Lower Deprivation
45 and under	61%	50%
46+	39%	50%

The method of suicide seemed to differ slightly too, with people from poorer backgrounds being slightly more likely to use poisoning or hanging as methods and less likely to jump or lie before a train than people with higher incomes.

Method	Higher Deprivation	Lower Deprivation
Self-poisoning	27%	17%
Hanging/Strangulation	55%	42%
Jumping/lying in front of a train	6%	21%

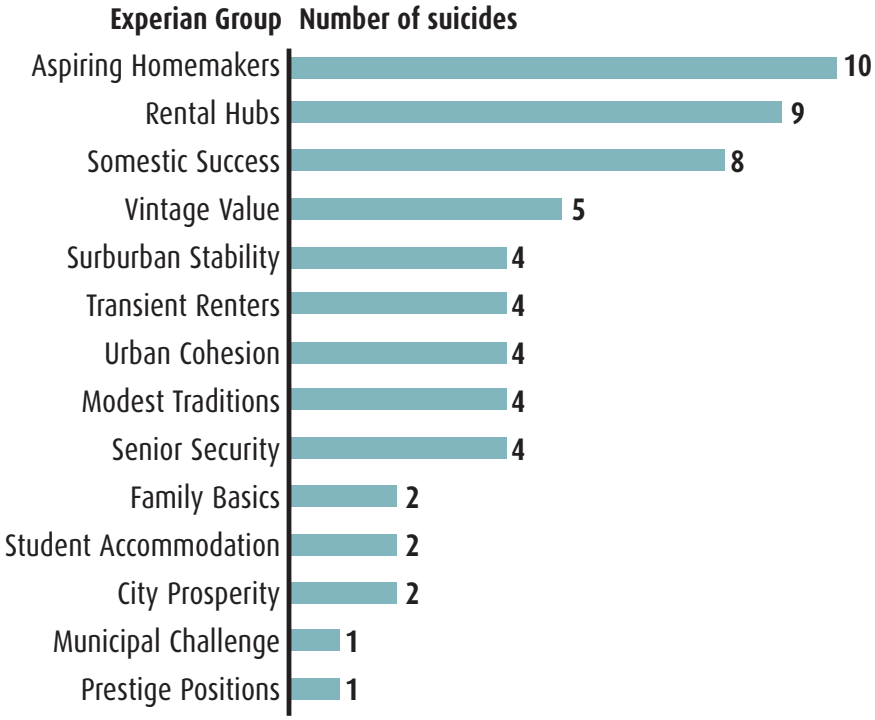
One impact of deprivation is that it contributes to negative impacts on the health and wellbeing of those who are from poorer areas. The Marmot review into health inequalities identifies deprivation as a factor in contributing to reduced mental health and wellbeing. Whilst the important negative impact that deprivation has on the health and wellbeing of York residents is acknowledged, there were no statistically significant findings as part of this audit that highlight this.

Experian Household Segmentation

The Mosaic/Experian segmentation classification divides all households into 16 high level 'groups' and 66 lower level 'types' based on a range of socio-demographic data. The postcode of residence for people in the York sample can be used to identify the household groups and types in which people lived.

Fourteen of the sixteen household groups are represented in the York sample. The household groups seen most frequently in the sample are 'Aspiring Homemakers' (10 people), 'Rental Hubs' (9 people) and 'Domestic Success' (8 people).

Figure 10: Number of suicides by Experian Household Group



Brief descriptions of the most frequently seen household groups are shown below.

- Aspiring Homemakers: Younger households settling down in housing priced within their means
- Rental Hubs: Educated young people privately renting in urban neighbourhoods
- Domestic Success: Thriving families who are busy bringing up children and following careers.

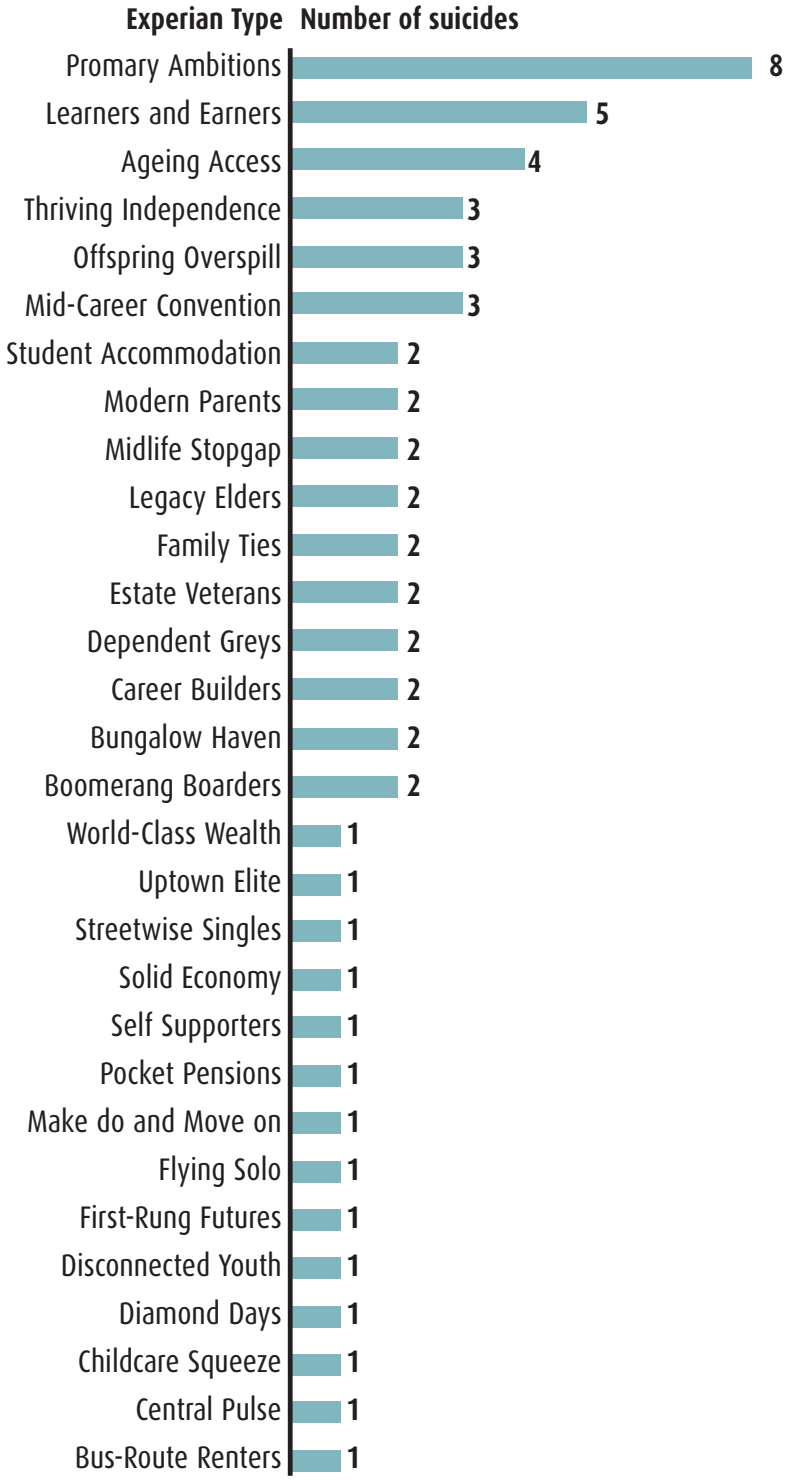
This data highlights the broad impact that suicide has across the full range of society and that suicide can affect people regardless of their socio-economic status, ethnicity or background.

Thirty of the 66 household types are represented in the York sample. The household types seen most frequently in the sample are 'Primary Ambitions' (8 people), 'Learners and Earners' (5 people) and 'Ageing Access' (4 people).

Brief descriptions of the most frequently seen household types are shown below.

- Primary Ambitions: Forward-thinking younger families who sought affordable homes in good suburbs which they may now be out-growing
- Learners and Earners: Inhabitants of the university fringe where students and older residents mix in cosmopolitan locations
- Ageing Access: Older residents owning small inner suburban properties with good access to amenities.

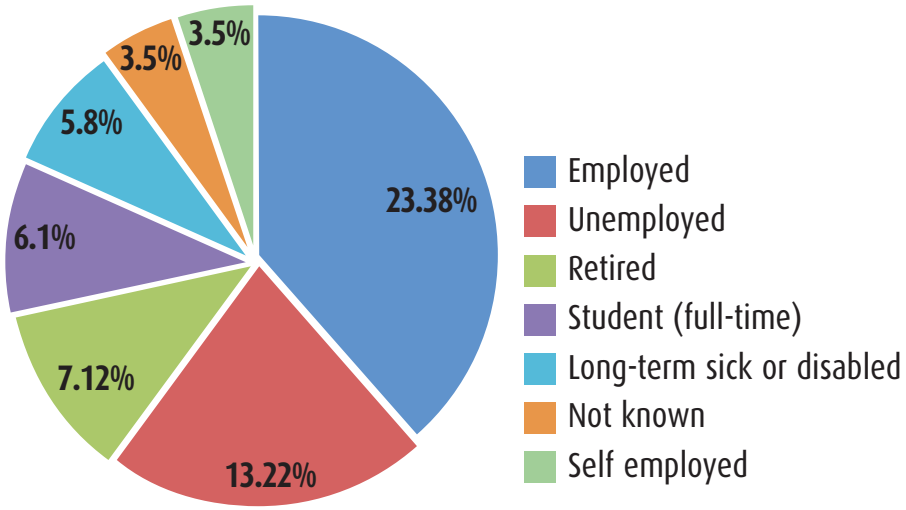
Figure 11: Number of suicides by Experian Household Type



Employment status

Employment status at the time of death is shown in the chart below. 26 people (43%) were in employment at the time of death, 13 (22%) were unemployed and six (10%) were students.

Figure 13: Employment Status

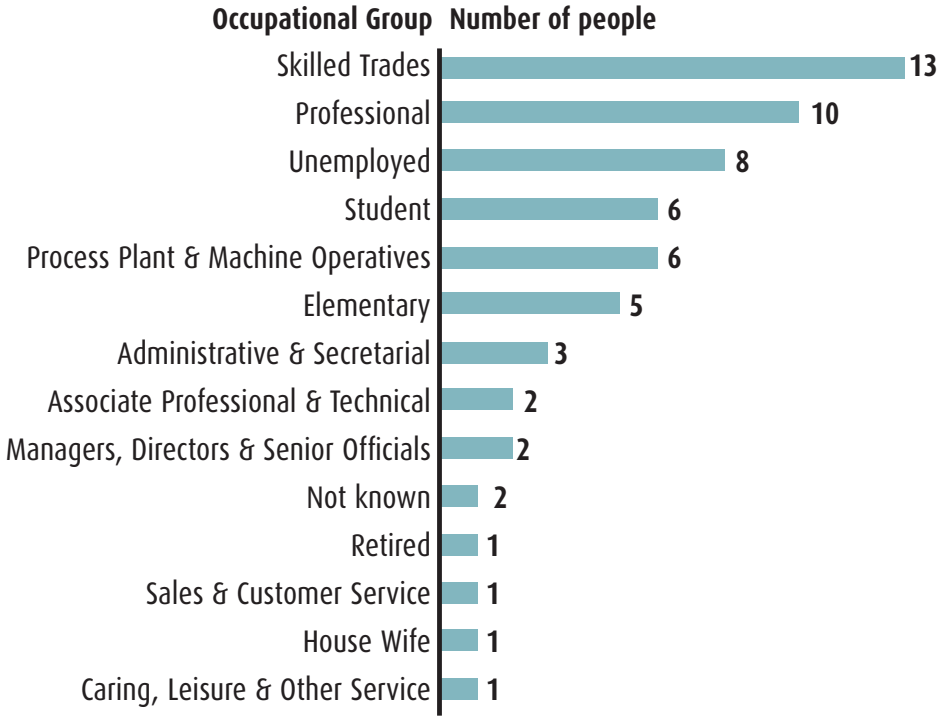


Retired people were comparatively under-represented in the York city audit. York's population in 2014 was 204,439 and people aged 65 and over accounted for 18% (36,459) of the overall population. However, a lower proportion of retired people completed suicide compared with the percentage of retired people within the general population.

By contrast in the North Yorkshire audit almost 25% of the cohort were retirees which more closely reflects their representation within the general population (People 65 and over make up 23% of the total population (137,356 of 601,536 people).

Occupation

Figure 14: Occupation groups



A wide variety of occupations and positions were represented within the cohort and no specific careers or jobs featured to indicate clear occupational risk. This demonstrates how suicide can affect people across a range of social, class, wealth and professional backgrounds.

Almost a third of the cohort were employed in jobs of either 'process, plant and machine operatives' or 'skilled trade occupations'. Whilst the sample is too small to reach clear conclusions there may well be a correlation between skilled or semi-skilled work, involving an element of manual dexterity, and suicide. This indicates a possible link to 'practical' people favouring methods of suicide which have a high lethality e.g. suicide by hanging.

It also perhaps suggests a link to traditional male orientated roles where workplace settings promote a more machismo culture thereby reducing employees' inclination to show apparent weakness or seek – or have access to - support during periods of emotional vulnerability.

There were instances in both the York and North Yorkshire audits which identified links to workplace stresses in some of the people who completed suicide.

In some cases the individual believed they were struggling with work pressures, were not well regarded or were being considered for dismissal or redundancy, often despite evidence and reassurance to the contrary.

There were instances of employees being subject to poor performance or disciplinary and misconduct proceedings which had a considerable effect on their emotional and mental health.

Some people were suspended from work and were directed not to have any contact with colleagues during an investigation (thereby perhaps causing or contributing to social isolation and reducing access to support networks). Others received notice of risk of redundancy, reduction in pay or other unfavourable work related news through formal correspondence or management contact in circumstances where support and assistance was either not offered or was declined.

It was apparent that those subject of such procedures often anticipated calamitous outcomes from them – envisioning loss of long held career opportunities, employment, financial security or status with potentially serious implications to other aspects of their life and lifestyle.

History of self-harm/previous attempt(s)

24 out of 60 people in the York sample (40%) had a history of self-harm. For fourteen of these people (23%) the self-harm had occurred within a year prior to death.

15 out of 60 people (25%) had a previous suicide attempt recorded. For seven of these people, the attempt had been made within a year prior to death.

Five people had two or more self-harm incidents within the year prior to death.

The nature of self-harm can differ markedly and is not necessarily linked to suicidal ideation or attempts. Some self-harm, even that which causes serious injury, can be conducted for reasons other than suicide.

Mental health professionals recognise that such behaviour sometimes acts as a way to prevent suicide or manage extreme psychological distress. However, it is generally accepted and highlighted in the national strategy that people who self-harm are significantly more vulnerable to suicide at some stage and the underlying causes of that harm may be similar to those which prompt suicide.

Clearly, previous suicide attempts also indicate that someone is at serious, heightened risk and it is important that such behaviour is not disregarded, rationalised or dismissed by professionals, family or friends, even if the person exhibiting the behaviour does so themselves.

Prior intimation of suicide/ideation

From the cases analysed, 52% (31 people) were known to have previously had suicidal thoughts. This was made up of: 14 people who were recorded as having expressed suicidal thoughts; 13 people who had stated suicide intent to their GP; and four people who exhibited significant behavioural

change prior to death.

There are many examples in the audit where the deceased had exhibited very clear suicidal ideation and self-harm behaviour in the days, weeks, months or years prior to their death. Some of those people had been diagnosed with significant mental health conditions, many of which were associated with suicidal ideation, and were in the care of mental health services. Those services were often aware of the general risk that the service user presented to themselves and risk management plans were in place aimed at maintaining regular contact and endeavouring to keep the person safe. Despite the efforts of services, family or friends to manage identified risk some of those community based patients made apparently spontaneous decisions to complete suicide.

In other cases, there was an apparent lack of engagement or disclosure by the patient with medical professionals where the deceased either denied or downplayed any suicidal ideation or previous attempts. The true reasons why the deceased felt unable to disclose their distress or talk about their feelings was known only to themselves although it may be speculated that this was through embarrassment, stoicism, self-denial or fear of the consequences. They might have suspected that full disclosure could lead to them being detained under the Mental Health Act or even recognised that professionals would prevent them taking the path to suicide which they had decided upon.

Social stigma in relation to suicidal thoughts can contribute to the risk by discouraging people from seeking help. It can prevent disclosure of suicidal thoughts through individuals' fear of being judged or of being detained in a mental health institution. The issues of stigma are similar to those seen in relation to mental ill-health generally and present significant challenges to those seeking to reduce risk and encourage more open communication.

Medical Conditions/Diagnoses

22 people out of 60 in the York sample (37%) had received a diagnosis of a mental illness within a year prior to their death by suicide. At the time of death, the range of diagnoses included: depressive illness (21 people, 35% of the sample), anxiety/phobia/panic disorder/OCD (15 people, 25%) and alcohol misuse (8 people, 13%).

29 out of 60 people (48%) had a physical and/or sensory disabling condition (non-psychiatric) at the time of death. 10 people were taking non psychiatric medication at the time of death.

Substance misuse history

28 out of 60 people (47%) had a history of alcohol or drug misuse (or both). For 23 of these people, the alcohol or dug misuse had occurred within a year prior to death.

20% of the deaths by suicide considered within this audit had some description of history of drug misuse recorded within the information contained in the coroner's files but only two people had been

known to substance misuse treatment services in York.

Within the information reviewed as part of the audit, a large number of people who had died by suicide had some reference to misuse of either drugs or alcohol. Alcohol use was much more commonly recorded than drug use.

Some case files clearly identified that a person had had alcohol dependency but none were currently in receipt of support from drug and alcohol services.

It is apparent that substance dependency or near dependency featured as a prevalent factor in their lives and contributed to the challenging conditions they found themselves in.

Alcohol consumption in particular appeared to present as a significant risk factor to many. This was either seen in the way it resulted in or aggravated other stresses (such as mental ill-health problems, loss of employment or relationship breakdown) or the effect that heavy consumption had on an individual's cognitive functioning and decision making immediately prior to their death which precipitated their suicide.

Both long term alcohol misuse and 'binge drinking' sessions presented significant risk and many of the deaths appear to be directly or indirectly related to alcohol use in some way.

Of particular significance is the fact that so many people would in all likelihood have been diagnosed with an alcohol use disorder by a medical professional had they engaged with services and disclosed their alcohol use.

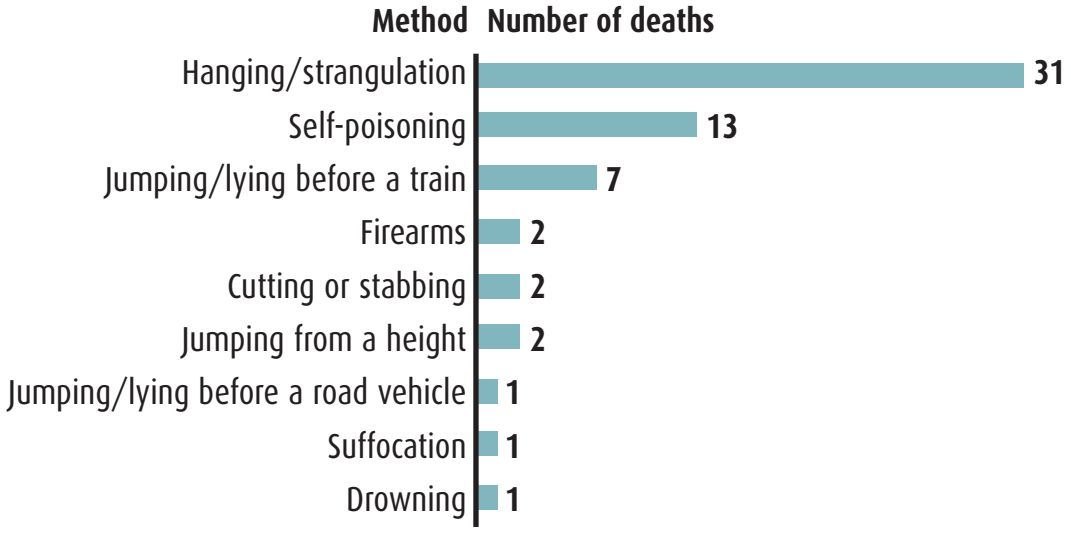
From the evidence considered as part of the audit process, many of those who died had what was likely to be a daily alcohol intake which could indicate some level of possible alcohol dependency. The actual level of alcohol use might often only be known to close family members, friends or the person themselves. Some however had been diagnosed with alcohol use disorder by their GP and were either attempting to manage it with treatment or had disengaged, declined or discontinued treatment. Whilst the long and short term health risks associated with excessive alcohol consumption are well known to medical professionals and widely publicised to the public the strong correlation between alcohol use and suicide may not be as widely recognised.

Suicide Event

Method

The most common methods of suicide in the York sample were hanging/strangulation (31 people, 52%) self-poisoning (13 people, 22%) and jumping/lying before a train (7 people, 12%). The methods did not vary between men and women.

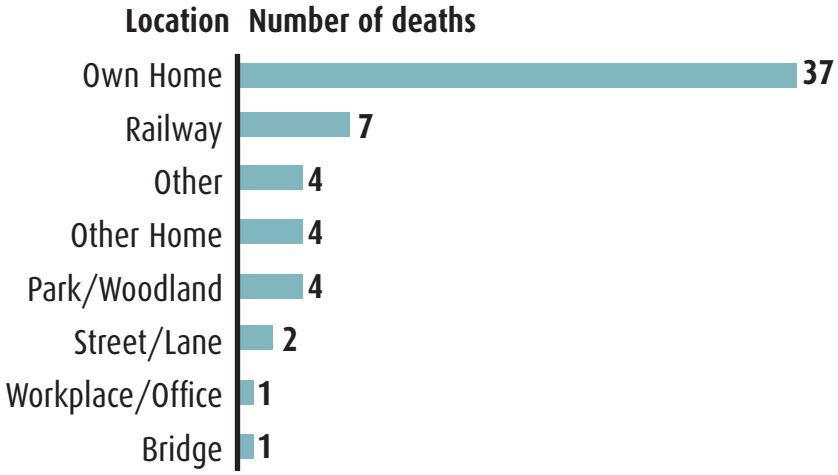
Figure 12: Method of suicide



Incident/event location

The majority of suicide incidents took place in the person's own home (37 incidents, 62%). Seven incidents took place on the railway (12%).

Figure 13: Incident/Event Location



One of the most effective means of reducing suicide is to 'reduce access to the means'. This is one of the key areas for action in the national strategy and includes initiatives such as:

- Limiting the volume of tablets or medicine available on prescription or for sale over the counter and curtailing the availability of certain drugs which have identified links to suicide
- Erecting signs or posters at public hotspot locations such as bridges which encourage help seeking or increase the likelihood of third party intervention
- Encouraging individuals disclosing suicidal ideation to relinquish the tools with which they have contemplated using such as knives, poisons or ropes
- Reducing ligature points in hospital wards, prisons or police cells and securing doors, windows or structures which facilitate access to heights
- Reducing the availability of pro-suicide websites and books or instructional literature which provides sources of information on methods of suicide.

A significant challenge in relation to this approach is presented by the fact that 'hanging and strangulation' is by far the most prevalent method of suicide nationally and this was reflected in the cases considered for York.

Reducing access to the means of hanging and strangulation within the home is particularly difficult in view of the range of commonly available implements which can be used and the likely levels of privacy which reduce the chances of third party intervention. The situation is intensified by general public perception, re-enforced by portrayals in the media and on television and film drama that hanging is the most efficient, effective and relatively pain free method of completing suicide.

This may well be untrue and there are common reports of significant physical injury or brain damage arising from unsuccessful attempts at suicide by hanging which cause long term disability, life-limiting or capacity limiting effects.

At a national level the need to change public perception in relation to the effects of hanging is recognised. Local suicide prevention plans needs to acknowledge and be realistic about the likelihood of direct influence in this specific area and that the emphasis should be about endeavouring to ensure people are less inclined to complete suicide and therefore not need to consider effective methods of doing so.

This demonstrates that an effective prevention strategy considers all areas of positive action at both an individual level by seeking to prevent individual deaths and at a population level by improving general levels of resilience and support service provision.

Case Study

Marco was in his thirties and from Eastern Europe. His wife remained in their home country with their child and he sent money back for them. He worked as a joiner and shared a house with some work colleagues from a variety of countries. Marco became increasingly withdrawn and took time

off work claiming to be sick. His housemates noticed that he began to behave very much out of character and appeared paranoid that neighbours and the landlord were entering the property and removing things from the house. He began locking himself in his room for several days at a time and came out only occasionally to eat or to receive a delivered package. He ordered a book online which detailed various ways in which to complete suicide. During an occasion of his self isolation, he took his own life whilst in his room using one of the methods described in the book. He left a note in his native language which was jumbled and incoherent saying that he'd been told he had to die by voices in his head.

Suicide note

A suicide note was left by 32 of the 60 people who died (53%). 26 of these notes were handwritten and the remainder were sent by text (2), computer/email (2) and social media (2). 56% of men (28/50) left a suicide note compared to 40% (4/10) of women.

Whilst the majority of suicide notes were hand written their nature, content and length varied considerably. A number of notes were written well in advance of the completed suicide, some lengthy and clearly considered, demonstrating a clear, long-held commitment to that course of action. Typically these related to people with long term mental ill-health problems who had struggled with suicidal ideation for some time but it also included people more recently diagnosed with terminal or life-limiting illness.

Others contemplated the difficulties associated with increasing old age, illness or disability and stated their desire to avoid the worsening impact on themselves or the burden on their loved ones. Many of the notes, short or long, gave some indication of the triggers for suicide in messages to family, friends, employers or neighbours.

Some cited specific reasons such as relationship breakdown, bereavement, long term or acute illness or physical pain whilst others simply suggested an inability to tolerate further mental anguish, stress or difficult circumstances without further explanation.

The section below provides an indication of the level of alcohol consumption amongst the cohort at the time of death and many of the notes left appeared to be written whilst their authors were under the influence of alcohol. Many were short, apparently hastily written notes which often offered an apology or sought forgiveness either for the suicide itself or for the deceased's previous behaviour or perceived failures. Friends, families and professionals were frequently thanked for their love or support by individuals who insisted that suicide was the only choice available to them.

The fact that someone did or did not leave a suicide note and the general contents of those notes do not in themselves provide a greater insight of how to prevent suicides.

What perhaps is indicated though is the extent of apparent pre-planning in comparison with those events which appeared to be relatively spontaneous.

Many people had clearly previously or regularly considered suicide and some may have intimated this to others. It seemed that for many people though the final decision to die by suicide was made on the spur of the moment, at a time when they were affected by alcohol or drugs or when they had simply lost a sense of perspective on the issues they were facing.

People completed suicide during periods and even particular times when their resilience was at its lowest level and when accompanied or combined with other short term risk factors such as heavy alcohol or drug consumption which, if experienced separately, might have had a different outcome. There is a view that people who are prone to more spontaneous behaviour as opposed to those who ruminate may be at more risk of completing suicide and there were indications of this in the audit.

Alcohol/non prescribed drugs taken at the time of death

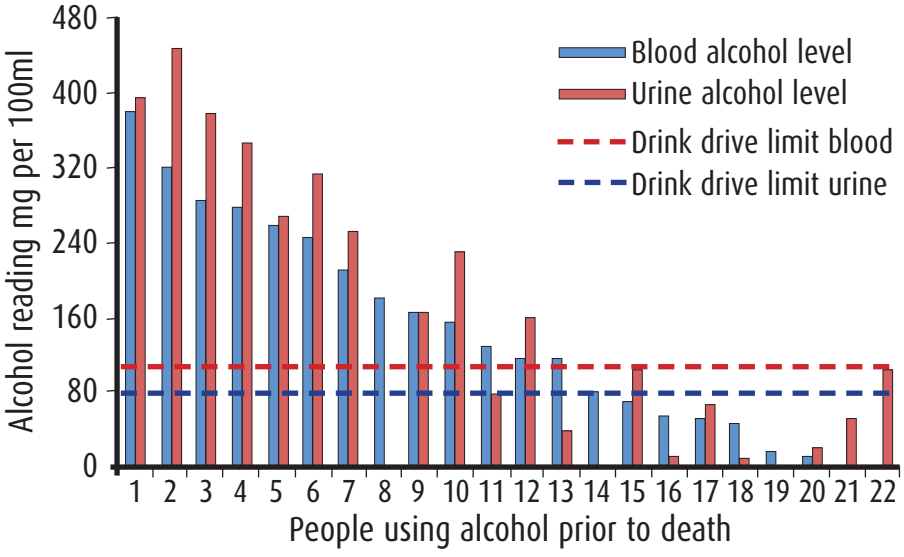
22 out of 60 people in the York sample (37%) had taken alcohol prior to their death based on information in the coroner's file. Blood and/or urine alcohol levels for these 22 people are shown in the chart below. 14 people were over the drink drive limit and seven of these were heavily intoxicated at the time of death[2].

[2] In the UK the drink driving limit is: 35 micrograms of alcohol in 100 millilitres of breath; or 80 milligrams of alcohol per 100 millilitres of blood; or 107 milligrams of alcohol per 100 millilitres of urine.

Table 2: Alcohol levels for those who had taken alcohol prior to death

Person	Blood alcohol level	Urine alcohol level	Level of alcohol
1	n/a	52	below the drink drive limit
2	n/a	20	
3	18	n/a	
4	49	10	
5	51	68	
6	55	13	
7	71	104	
8	n/a	105	
9	82	n/a	over the drink drive limit
10	115	38	
11	116	160	
12	130	78	
13	156	231	
14	165	166	
15	182	n/a	
16	210	252	significantly intoxicated
17	246	313	
18	258	268	
19	278	347	
20	285	378	
21	321	448	
22	380	395	

Figure 14: Alcohol levels for those who had taken alcohol prior to death



In addition to blood analysis results, tests indicated that five people had taken non prescribed drugs prior to death. This included cannabis, opiates, stimulants and pain killers.

The number of people where alcohol was a contributing factor in the death compared to drug use was far more common.

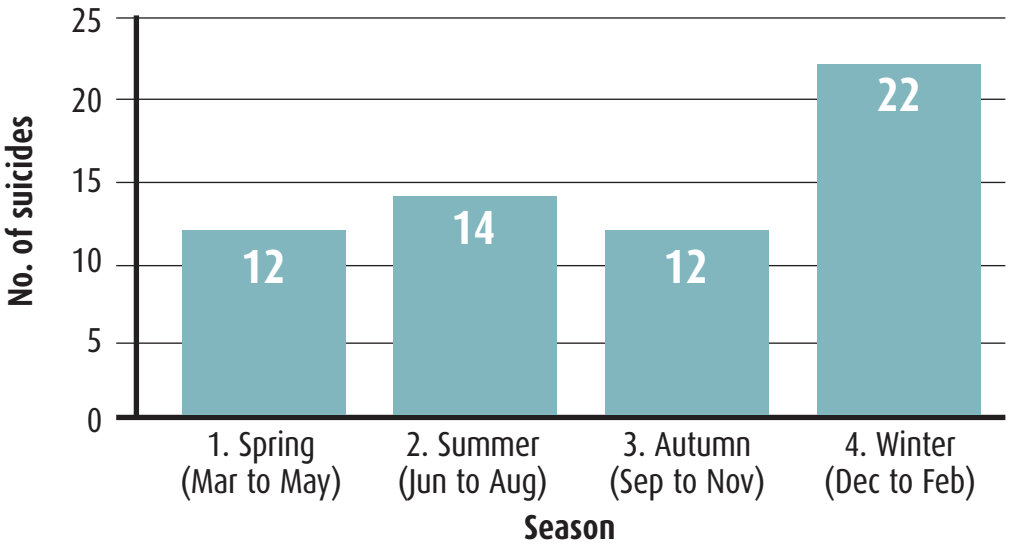
Case Study

Janine's daughter was killed in a road collision three years earlier and she had struggled to overcome her grief. She began to drink excessively which aggravated her depressive moods. Janine was in her fifties when she lost her job as a result of her drinking and sickness record and was referred to alcohol treatment services by her GP due to the amount she was drinking. She attended some talking therapy sessions to support her mental ill-health which helped. One day though she drank excessively and took her own life at home leaving a note to say she was sorry but could not cope with life without her daughter

Suicide event by time of year

Suicide events in the York sample took place fairly evenly throughout the calendar year but the highest number occurred in the winter months (December to February).

Figure 15: Season of Suicide Event



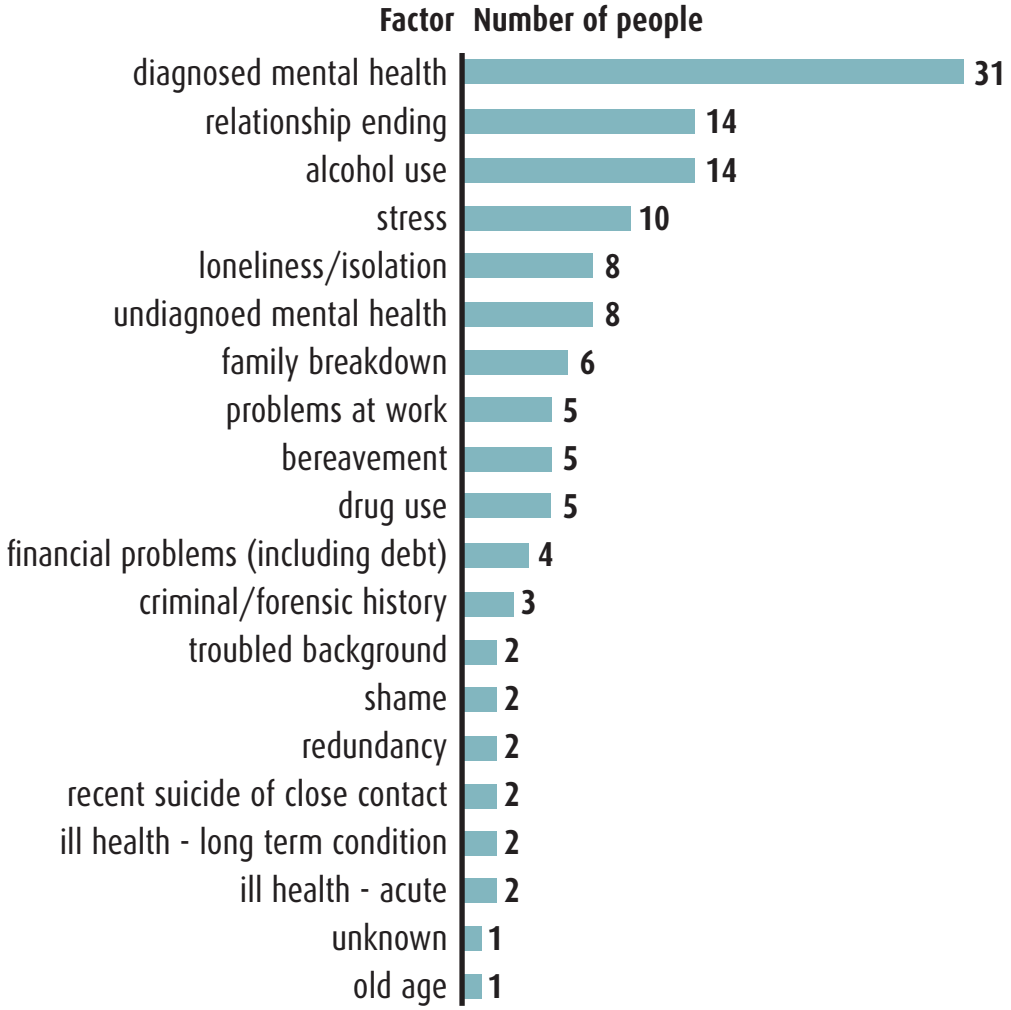
Prior intimation of suicide/ideation

For over half of the York sample (31 people out of 60, 52%) there were warning signs/evidence of risk prior to suicide. 13 people were recorded as having explicitly stated suicide intent, 14 people were recorded as having expressed suicidal thoughts and four people had significant behavioural change recorded prior to death.

Triggers/ factors contributing to suicide

Based on the contents of the coroner's file, the key factors contributing to the suicide were identified by the auditor, using a pre-determined list. An average of two factors per person was identified. The main factors were: diagnosed mental health condition (31 people, 52% of cases); relationship ending (14 people, 23% of cases), alcohol use (14 people, 23% of cases); stress (10 people, 17% of cases); loneliness/isolation (8 people, 13% of cases) and undiagnosed mental health (8 people, 13% of cases).

Figure 16: Risk Factors contributing to suicide



The most common combination of risk factors were: diagnosed mental health with loneliness and isolation (5 people); with stress (4 people); with bereavement (4 people); and with alcohol use (4 people).

Table 3: Common combinations of risk factors

Combinations of risk factors	No. of people with this combination
Diagnosed mental health / Loneliness - isolation	5
Diagnosed mental health / Stress	4
Diagnosed mental health / Bereavement	4
Diagnosed mental health / Alcohol use	4
Diagnosed mental health / Relationship ending	3
Undiagnosed mental health / Alcohol use	2
Undiagnosed mental health / Stress	1

Thematic Analysis

A separate process of identifying themes contributing to suicide was undertaken using the notes section of the audit template.

This process enabled the audit team to identify a more complete range of themes based on the full range of written information contained within the files.

This process allowed the audit team to identify common themes in the case files for each person and identify the potential risks or contributing factors in a much more comprehensive way that allowed more detailed consideration about whether risk factors were recurring themes for a person or how several independent risk factors might be combined together. This identified a greater number of risk factors than the method of using a pre-defined list to assess risk factors and allowed instances of a theme to be identified multiple times. This process also identified a different combination of risk factors being more prevalent.

The themes identified are shown in the table below.

Table 4: Themes contributing to suicide.

Theme	No.
History of self-harm/suicide attempts	48
Mental ill health (diagnosed)	43
Loneliness and isolation/lack of engagement	31
Mental ill health (undiagnosed)/emotional distress	29
Family/relationship problems	28
Substance misuse	25
Criminality	18
Bereavement	17
Work issues	15
Physical health problem	16
Behaviour change	9
Financial problems	8
Carer	3
Sexuality	1
Veteran	1

Table 5: Combination of themes contributing to suicide

Combination of Themes	No.
History of self-harm/suicide attempts and Mental ill health (diagnosed)	19
History of self-harm/suicide attempts and Family/relationship problems	16
Mental ill health (diagnosed) and Loneliness and isolation/lack of engagement	15
History of self-harm/suicide attempts and Substance misuse	14
Mental ill health (diagnosed) and Mental ill health (undiagnosed)/emotional distress	14
History of self-harm/suicide attempts and Mental ill health (undiagnosed)/ emotional distress	11
Mental ill health (diagnosed) and Family/relationship problems	11
Mental ill health (diagnosed) and Substance misuse	8
History of self-harm/suicide attempts and Physical health problem	5

Using this method of analysis, the most common risk factor is identified as history of self-harm or previous suicidal attempt.

A detailed breakdown of what was included within each theme is provided below.

Table 6: List of Themes and Sub-Themes

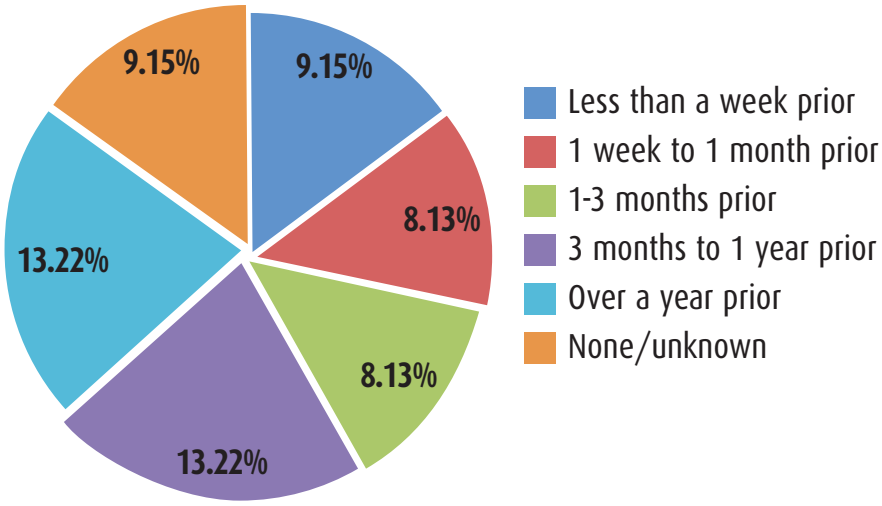
Theme	Sub-Themes
Family/ relationship problems	Childhood experience of being in care, childhood experience of abuse, experience of domestic abuse, spouse suffered mental ill-health, no family support network, plans to end relationship, recent divorce, relationship problems, family problems, family history of mental ill-health, relationship ended, relationship breakdown, ex-partner entered new relationship, childhood experience of family breakdown
Behaviour change	Not coping with change to circumstances, Accusations of inappropriate behaviour, Behaviour change prior to suicide, Change in circumstances
History of self-harm/suicide attempts	Previous suicide attempt, risky behaviours reported, previous threat of self-harm, previous suicidal ideation, safeguarding and vulnerability concerns, history of self-harm, threatened suicide, planned suicide in advance, poor Self-care, threatened suicide, lack of self-care, previous suicide attempt – multiple, suicidal thoughts, at risk of suicide, lied about herself, thoughts of self-harm, recent self-harm
Bereavement	Suicide of friend, Recent miscarriage, Bereavement, Suicide of partner, Suicide of family member, Loss
Mental ill-health (diagnosed)	Accessing telephone support, history of detention under mental health act, history of mental ill-health, history of mental ill-health – anorexia, history of mental ill-health – anxiety, history of mental ill-health – depression, history of mental ill-health - low mood, history of mental ill-health - specific disorder, history of mental ill-health – ocd, history of mental ill-health – schizophrenia, mental ill-health – anxiety, mental ill-health - depression and anxiety, mental ill-health - low mood, mental ill-health - social anxiety/agoraphobia, mental ill-health, mental ill-health - depression
Mental ill-health (undiagnosed)/ emotional distress	End suffering, ex-partner entered new relationship, feelings of guilt, felt unloved, identified as not coping, low mood, low self-worth, perception that 'let people down', poor quality of life, problems coping with feelings of guilt, problems coping with perceived failure, stress, suicide followed argument, suicide was a response to perceived social shame, unable to cope with bereavement, unable to cope with change in circumstances, unable to cope with loss, unable to cope with redundancy, unable to cope with relationship ending, undiagnosed mental ill-health, worried about lack of success/failure
Financial problems	Debt, experience of poverty/deprivation, financial problems, gambling addiction

Carer	Carer
Work issues	Employment problems, long-term sickness absence from work, loss of employment, recently started new job, redundancy, relationship problems – colleagues, resigned from job, sickness absence from work, suspension from work, work related stress
Substance misuse	Alcohol addiction, alcohol dependency, alcohol misuse, gambling addiction, history of alcohol dependence, history of binge drinking, history of drug use, history of drug use – cannabis, history of substance misuse, relapse from drug recovery, substance misuse

Prior contact with services: Primary care

The chart below shows the most recent contact with primary care prior to death by suicide amongst the 60 people. 38 people (63%) had a recorded visit to the GP in the year prior to death. 25 people (42%) had a recorded visit less than three months prior to death and 17 of these people saw their GP in relation to mental health. Nine people saw their GP in the week prior to death (7 for mental health).

Figure 17: Breakdown of most recent contact with primary care prior to death by suicide



22 people had seen their GP for mental health problems in the year prior to death and seven of these people had attended five or more times in that period.

For two people, clear suicide intent or suicide plans were documented by the GP. For another 12 people the GP had documented that thoughts and ideas about suicide had been expressed but without intent or plans.

24 people (40%) from the 60 self-harmed. 13 of those people (22%) were treated in hospital due to their injuries within the year prior to death.

Mental Health Services

31 people (52%) had taken up psychiatric treatments in the 12 months prior to death. The broad types of treatment were: prescribed medication (28 people); talking therapies (11 people) and social interventions (2 people).

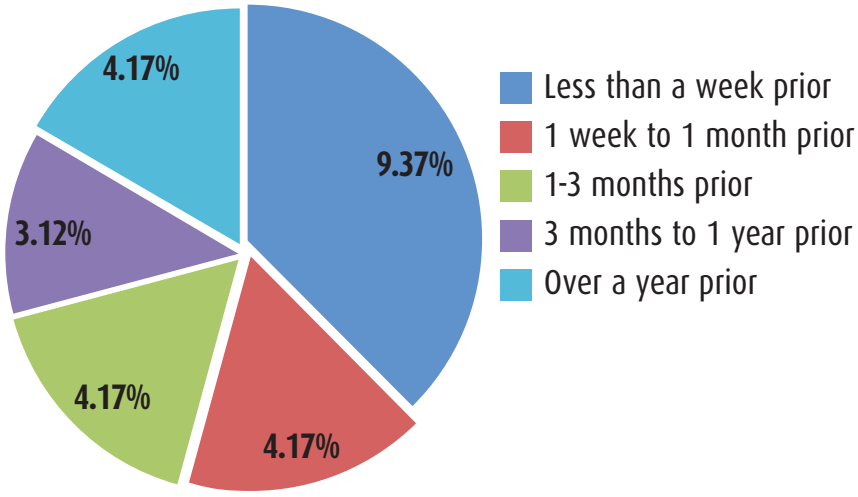
11 people were recorded as having declined some form of psychiatric treatment in the year prior to their death. Information on adherence to medication/treatment plans in the year prior to death was recorded for 21 people and 17 of these did not adhere to their plan.

24 people (40%) had contact with specialist mental health services in the year prior to death and nine of these had contact in the week prior to death. A further three people were referred but not seen. The majority of people (17) had contact as part of ongoing treatment but seven people had a one off contact. The majority of contacts were community based or outpatient appointments.

Case study

Dora who was in her late 20s was diagnosed with Bi-polar disorder some years ago and had previously been detained under the Mental Health Act. She had a history of self-harm by cutting some of which was severe. She was in a long-term, stable relationship and had an active social life with a good job arising from strong academic attainment. She did not take drugs or drink alcohol to excess. Dora had recently been admitted to a mental health hospital as a voluntary patient having expressed suicidal thoughts after her beloved Collie dog has been knocked down by a car. As a result of appearing to respond well to treatment and providing reassurance that she was no longer contemplating suicide Dora was permitted a short period of home leave. She took her own life in a public place not far from her home when she was left alone briefly by her partner. She did not leave a note.

Figure 18: Breakdown of most recent contact with specialist mental health services prior to death by suicide.



Emergency Department

17 people (28%) had attended the Emergency Department in the year prior to death and 12 of these had attended in the three months prior to their death. This figure may be higher in view of the potential for treatment or episodes to be omitted from Coroners' files. Whilst some of those seeking treatment may have been known to mental health services or primary care with identified suicidal ideation or self-harm, others may not.

The Emergency Department visit, particularly if in connection with a suicide attempt, self-harm or mental health crisis may have been the first and perhaps only indication of the patient's vulnerability to suicide.

The attendances were for a mixture of physical and mental health reasons. Six people were admitted to hospital following the emergency department attendance. Seven people had elective hospital admissions in the year prior to death and two of these were for mental health issues.

There is insufficient information available to identify any patterns in relation to reasons for attendance or outcome. However, 11 of the 60 people attending had a history of self-harm and 31 of the 60 had a diagnosed mental health condition.

Emergency Departments have an important role to play in identifying and responding to risk when people present in distress, with mental health conditions or due to self-harming injury.

Other Agencies Involved

The Coroner files indicated that 17 people were involved with other agencies in the 12 months prior to their death. The main services recorded were substance misuse services (6 people), social services (4 people) occupational health (4 people) and the faith community (3 people).

Cross referencing with other data sets

To obtain further information for the audit, the details of the York cohort were cross checked against local client databases for substance misuse, adult social care and council house tenants. North Yorkshire Police also checked the details of the York cohort against their records and provided an aggregated summary of contact history with the criminal justice system.

Substance Misuse

Four people from the case files reviewed had a substance misuse treatment record. None were in treatment at time of death, having been discharged between five and 18 months previously. In three cases alcohol/drug use was already flagged in coroners file (although known drug was not referenced in one case). In one case, alcohol/drug use was not recorded in the Coroners file despite being known to be an issue to at least one other service.

This does indicate some discrepancies between the information known to local services and that which was known to the Coroner.

Previous analysis showed that 28 out of 60 people (47%) had a history of alcohol or drug misuse (or both) and that for 23 of these people, the alcohol or drug misuse had occurred in the 12 months prior to death. However, only four people had a substance misuse treatment record which suggests a lack of engagement with treatment services but those people who may well have benefited from such treatment.

Adult Social Care

20 people had a record on the York Adult Social Care database (as customers rather than as carers). 10 people had open episodes prior to their death which means they had some form of need identified by Social Care Services. These were: disabled blue badge (5); mental health services (3); safeguarding (2); occupational therapist (1); warden call (1) and telecare (1).

Seven of the 10 people were identified with specific support needs that showed six people were classed as having a physical disability, frailty or sensory impairment and the other person was classed as 'vulnerable'.

City of York Council Housing Tenants

Three people from the cohort were City of York Council housing tenants at the time of their death and three more had previously been tenants some years prior to their death.

Overall, 13 people were current customers of City of York Council at the time of death as either tenants or Adult Social Care customers.

'The extent and nature of contact by Adult Social Care with the deceased varied considerably from individual to individual. The majority involved cases which had been 'closed' some time prior to the death. Of those, four cases involved assessment of individuals where following assessment –in some instances by an Approved Mental Health Professional- it had been determined that no further action was necessary at that time. One case involved a recent social care assessment where no further action was taken as a result of a transfer to a care facility. Another related solely to a disability Blue Badge application.

Of those cases where the status was still classed as 'open' at the time of death one involved a person who was in receipt of a health related service albeit there had been no indication of safeguarding or mental health concerns. Two cases involved referral to mental services- one very recent and at allocation stage –without ongoing involvement of social care.

Contact with the police

43 people (72%) had previous contact with the police as victims, persons reporting, suspects, offenders, witnesses and subjects (e.g. concerns for safety or missing person). 37 of these had some form of contact with the police in the 12 months prior to their death.
The table below shows that the main types of police contact were subject of concern for safety/ person (18 people); arrest (13) and victim (8).

Table 7: Type of Police Contact for York Cohort

Type of Police Contact	No.
Subject - concern for safety/missing	18
Arrest	13
Victim	8
Suspect	4
Warning	3
Witness	3
Detained under s.136 Mental Health Act	1
Person reporting	1
Stop and Search	1

13 people came to the attention of the police in the week prior to their suicide and six of these were reported as missing from home and categorised as high risk.

Two people were arrested within the 24 hours prior to their deaths and for another person, an arrest was imminent but not carried out due to their suicide. One person had also been arrested in the week prior to their suicide and another person had been arrested a few weeks prior to their suicide. Four people were due to appear in court within two weeks of their suicide, including two who were due in court on the day of their death.

13 people had 'police markers' which highlight information that should be brought to the attention of officers when dealing with those individuals. The most frequently occurring markers were 'ailment' (9 people); 'suicidal' (5); 'drugs' (5); 'weapons' (5) and 'mental disorder' (4).
In addition to the five people with suicide 'markers' eight other people had previously come to the attention of the police as suicidal, including previously attempting suicide.

Case study

Callum had a good job some savings and was in a new relationship which was going well. He had a close circle of friends and was considering buying a house because he had been offered a promotion. He'd never suffered with any mental ill-health or substance abuse issues and had never been in trouble with the police. One day he was arrested at work on suspicion of downloading indecent images of children. The police seized his personal laptop and his mobile phone after searching his home address. Whilst in police custody Callum was offered the chance to speak with a doctor but he declined. He also said he didn't want anyone informed of his arrest. The police established that Callum's niece was temporarily staying at his home address and so he had to find an alternative place to stay on his release from custody on bail. He spoke with a friend and explained that this was all a misunderstanding and that he was not being charged. The friend agreed for him to be bailed to his address. Callum left the police station and did not have the means to contact anyone as the police had his phone. He was aware of the images that the police would find on his laptop and that it would lead to a prison sentence. He realised that his new relationship would end and that his parents would insist he left their house. That evening, he wandered around the city for several hours and drank excessively in a pub. He took his life that night after booking into a hotel.

General contact with agencies

Taking into account information obtained from the coroner's files and cross referencing with other client databases, 51 out of the 60 people (85%) had some recorded contact in the 12 months prior to their death with at least one of the following: GP, psychiatric treatment services, emergency department, , adult social care, City of York Council housing team, elective hospital admission, criminal justice system and substance misuse treatment services or 'other support services' Nine people (15%) had no recorded contact with any of the above. This was a slightly younger cohort with an average age at death of 32.3 years compared with the age of those who had been in contact with some agency in the last year (44.6 years).

Conclusions

This analysis of York suicides is based on a relatively small sample of deaths over a five year period and this inevitably places some limits on the number of clear conclusions that can be drawn from the audit. Whilst findings from this audit do not necessarily reflect the full picture of suicide past and future in York, they do allow a comprehensive analysis of suicide, the risks and contributory factors that led to the death of those 60 people between2010-2014.

National research suggests some groups are at higher risk of suicide when compared to the general population but these were not notably represented within the local audit e.g. people who are lesbian, gay, bi-sexual or transgender or those going through a period of uncertainty or questioning about their sexuality.

The city is also home to others at recognised raised risk such as offenders recently released from prison and ex-forces personnel, particularly early leavers.
Guidance discusses emerging issues such as the influence of social media and so called 'cyber-bullying', which whilst not revealed as prominent issues by the audit are clearly very current, influencing factors within our communities, particularly amongst the younger generation and potentially those groups which are at higher risk.

In addition to the range of risk factors that Public Health England identify, this audit identified that the presence of a diagnosed mental health problem or undiagnosed mental distress combined with a history of self-harm or previous suicide attempts is a common combination of risk factors for the people in York who died by suicide. Alcohol was also identified as a risk factor and when used at a time of emotional distress it might have the effect of impairing judgement and influencing a decision towards suicide.

Whilst the sample in the York audit was relatively limited there are clear themes and commonalities in the lifestyles and risk factors amongst those who chose to complete suicide.

Those at highest risk appear to be:

- Men approaching and in middle age, particularly those aged between 40-55 years old
- People with diagnosed mental ill-health particularly that which is:
  - Border-line Personality Disorder (BPD) schizophrenia, Depressive illness, acute anxiety, Post Traumatic Stress Disorder(PTSD)
  - Untreated
  - Recently diagnosed and so not yet subject to effective treatment
  - Inconsistently treated due to lack of or limited engagement by the patient with services and/or non-compliance with medical/treatment plans
  - Recurring, having been previously treated but not recognised or responded to by the sufferer or services
  - Considered mild depressive illness or anxiety, managed by primary care where the patient may not fully disclose the severity of their low mood or suicidal ideation

- People with symptoms of undiagnosed mental ill health, particularly depressive illness and anxiety which is not recognised, disclosed or managed by the person affected and which leaves them vulnerable in the event of compounding life stresses
- People who have previously self-harmed, attempted suicide or experienced suicidal ideation
- People who are drug or alcohol dependant or who regularly use substances, particularly at times of combined life stresses or linked with mental ill-health (dual diagnosis). This includes people who may not be dependent drinkers or drink regularly to excess but who on occasion 'binge drink' particularly if linked to or brought on by periods of low mood/depressive episodes precipitating a spontaneous, alcohol fuelled decision to complete suicide
- People experiencing multiple life stresses either simultaneously or successively over a long, medium or short time frame particularly if linked to or aggravated by mental ill-health. Such stresses include bereavement or other significant loss, breakdown of intimate relationships, particularly if acrimonious, unwanted estrangement from family or children, unmanageable debt, business failure, insecure accommodation or employment, workplace stress particularly related to performance issues or disciplinary action, loneliness and social isolation, behaviour and mood changing addictions including gambling
- People who have experienced or witnessed significant trauma such as sexual abuse, domestic violence, others' suicide or violent death including those who come into professional contact with victims or such incidents
- People who have been in recent contact with the police, particularly where an arrest, charge or conviction is likely to have catastrophic consequences to their lifestyle, relationship, status, employment or liberty. At particular risk are those arrested or charged and granted bail in relation to offences concerned with Indecent Images of Children (IIOC)
- People who have long term, acute or debilitating physical health conditions particularly if linked to an onset of depressive illness, diagnosis of terminal illness or if the condition causes a significant change to quality of life or perception of what the future holds.

Whilst there might be a belief that professionals including GPs, social workers, health visitors, police officers, nurses and other public sector workers are those who will be best placed to identify people at risk of suicide, there are still people who complete suicide who did not have any contact with these professionals or services.

Approximately 15% of the deaths considered by this audit were of people who had no known contact with any services or public sector workers in the weeks and months prior to their deaths. This makes it important to consider how we can work with people and communities to better identify and support those who might be at risk of suicide.

Risk factors are wide ranging but often include significant life changes such as new or recurring mental health problems or emotional distress, family or relationship problems, new or recurring substance misuse problems, bereavement, work related problems, or physical health issues. The Faculty of Public Health's "Better Mental Health for All" report identifies that experiencing two or more adverse life events in adulthood can be associated with developing mental health problems and for some this can have a cumulative effect following on from adverse life experiences in childhood.

There is a growing body of evidence which identifies that communities can act as assets in many ways and can help to support individuals' positive health and wellbeing through factors such as social inclusion and positive social networks. The 'Fair Society, Healthy Lives' Marmot review into health inequalities identified the important role of communities in supporting physical and mental health and that physical and social characteristics of communities and how able a community is to support and promote healthy behaviours can have an impact on wellbeing related inequalities.

It is very difficult to predict which individuals affected by significant or multiple life stresses or exhibiting consequential harmful behaviours will be the ones who attempt or complete suicide. Many people experiencing one or more of those life stresses and engaging in harmful behaviour may be included in an identifiable 'suicide high risk group' but may never contemplate taking their own life. Others affected may not behave out of character, continue to present as they always have despite their inner turmoil and then unexpectedly die by suicide. Any strategy or action plan which aims to reduce suicide must consider a more holistic approach by seeking to find ways to mitigate the effects of common life stresses affecting the wider population whilst at the same time seeking to support those who are known to be at higher risk.

Recent Developments

By the time this audit was undertaken all of those deaths reviewed had occurred between eighteen months and five and a half years previously.

Some of the incidents had been subject to serious incident review processes by services which had some level of contact with, or responsibility for the deceased prior to their death.

Hence in some cases the coroner's files included reports detailing formal investigations into the circumstances of individual deaths produced internally by service providers or by national bodies such as the IPCC or the Health and Safety Executive.

In the majority of cases those reports contained 'lessons learned' recommendations which were subsequently, and for the most part, introduced and embedded into the policies and operating procedures of the organisations concerned.

As a result, some of those policies and procedures or lack of such which may have been identified through the audit as gaps or areas of increased organisational risk may well have now been addressed.

Similarly, national or local policies or initiatives specifically relating to mental health and suicide prevention or improved support have been introduced by a number of organisations in direct response to the recognised risk and the effects of suicide amongst certain groups or sections of the population.

These include initiatives such as:

- Emergency Psychiatric Liaison Service: Support arrangements available to people presenting to the emergency department in emotional distress.
- Co-ordinated, collaborative working between Samaritans, Network Rail and BritishTransport Police to reduce incidents of suicide on the national rail network.
- Facing the Future: A national three year pilot of collaborative working between Samaritans and Cruse Bereavement Support to provide peer support counselling sessions to people bereaved through suicide. One of the pilot areas is York
- Ways to Wellbeing Social Prescribing Pilot: A pilot programme that provides social prescribing interventions through York CVS to patients referred from some GP practices in York
- YorWellbeing Service: A service under development which will support people to improve physical and mental health and wellbeing which aims to prevent ill-health – both physical and mental.
- Firearms Licensing: In April 2016, the Home Office and British Medical Association introduced national updated guidance to ensure that GPs are cognisant of the fact that a patient may be a shotgun or firearms certificate holder and therefore have access to weapons. GPs are advised to liaise with the local police service to ensure that issues in relation to substance misuse or relevant mental ill-health difficulties are brought to the attention of the Firearms Licensing Department

- University of York Student Mental Health Task Group
- Mental Health and Substance Misuse Dual Diagnosis Network
- Coroners' Court Support Service
- York Mental Health Forum
- North Yorkshire and York Suicide Prevention Task Group
- North Yorkshire and York Crisis Care Concordat
- York Community Covenant (to support military personnel, their families and military veterans).

Each of the above undertakings represents real progress and recognition by some agencies that innovative and proactive approaches are crucial in order to prevent unnecessary loss of life through suicide. Findings from the audit clearly demonstrate that suicide is a very complex issue. Work to significantly reduce it over the long term must be similarly multifaceted and effectively co-ordinated. Effective suicide prevention plans must have the full commitment of all relevant stakeholders at strategic level, ensuring that this issue is considered, and demonstrated to be, a priority within their individual organisations and in collaborative, partnership working.

In considering a meaningful, strategic and multi-agency approach the Director of Public Health for York has recently announced an ambition for York to become a 'Safer Suicide Community'. Such 'status' is awarded to communities which demonstrate clear commitment by 'Living Works' a Canadian company which has operated within the field of suicide prevention for several decades.

The below explanation is taken from Living Works' website:

> "The Suicide-Safer Communities designation honors communities that have implemented concerted, strategic approaches to suicide prevention. The nine pillars in this designation reflect the core elements of suicide prevention strategies around the world. The designation celebrates and acknowledges those communities who have made significant progress in reaching their suicide-safer goals, and helps others understand what strategic steps they can take to prevent suicide on a community level".
>
> In acquiring an official "Suicide-Safer Community" designation, communities will be recognized for their efforts as leaders in formulating and implementing suicide prevention initiatives on a sustainable and ongoing basis over time. Those that seek and prepare for designation engage in an opportunity to identify their community strengths and opportunities for improvement in the area of suicide prevention.

Suicide-Safer Communities are passionate in their belief that suicide is preventable and that suicide prevention is a shared responsibility where every person from policy makers to individual community members has the potential to make a difference and save a life. It is a community that believes that everyone has a fundamental right to a life lived with dignity with the supports and resources accessible to ensure a future filled with hope and possibility.

The designation of "Suicide-Safer Community" is a prestigious honor awarded to a community where multi-sectoral entities, in agreement that suicide is a serious community health problem, are engaged with individuals, organizations and stakeholders collaboratively to strategize, create, implement, and sustain efforts around nine 'pillars of action' ".

Recommendations

The following recommendations reflect information and apparent gaps in service revealed by the York suicide audit together with national suicide prevention guidance and recognised best practice:

- Work towards achieving formal 'Suicide Safer Community' accreditation for the city of York with Living Works.
- Develop a suicide prevention strategy for York and an accompanying multi-agency 'Framework' of objectives, risks actions and outcomes.
- Ensure that recommendations contained in the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (October 2016) are considered, implemented and embedded into the policies and practices of local commissioned mental health services.
- Undertake a regular programme of suicide audits, including a wider scope to cover 'deaths by accident/poisoning of undetermined intent' used to inform suicide prevention priorities and development needs
- Develop 'suicide surveillance' and real time 'early alert' processes to improve the multi-agency response, lower and mitigate suicide risk and reduce the number of completed suicides and attempts.
- Provide more responsive support arrangements to those affected by suicide. Include people who are bereaved through suicide, recently or historically, those experiencing suicidal ideation or caring for others and those who have been otherwise touched by suicide through loss of an acquaintance or presence at the scene of a related incident.
- Ensure that those people who are affected by suicide have the their views and experiences heard and the opportunity to contribute to suicide prevention activity
- Raise awareness around which groups are at 'high risk' or 'vulnerable' to suicide amongst front-line staff ensuring that those staff receive training to enhance their skills in communicating with someone who may be at risk.
- Develop a communication plan for the city to include awareness raising , encourage help-seeking, open and non-judgemental approaches and dialogue between those at risk and those in contact with those at risk.

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http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci

Appendix

Glossary of Terms

Alcohol dependence is a previous psychiatric diagnosis in which an individual is physically or psychologically dependent upon drinking alcohol. In 2013 it was reclassified as alcohol use disorder (alcoholism) along with alcohol abuse in DSM-5.

ASIST a two day programme which offers 'suicide alertness' training. Delegates are taught how to recognise when a person may have thoughts of suicide, to communicate effectively with them and to connect them to suicide intervention resources to keep them safe in the short term. It is effectively suicide prevention first aid.

Cohort a group of subjects who shared a particular event during a particular time span. In this context the term relates to the sixty individuals whose deaths through completed suicide were considered by the audit.

CMHT Community Mental Health Team.

Cyber-bullying is any form of bullying which takes place online for example via social networking or gaming sites or through messaging apps.

Dual diagnosis (also called co-occurring disorders, COD) in this context is the condition of suffering from a mental illness and a co-morbid substance abuse problem.

IHTT Intensive Home Treatment Team (Mental Health Service).

IAPT Improving Access to Psychological Therapies a national NHS programme introduced with the aim of increasing the provision of evidence-based treatments for anxiety and depression via primary care.

IPCC Independent Police Complaints Commission.

MHFA Mental Health First Aid.

Experian designed to improve the reporting of small area statistics built up from groups of output areas (OA).

Office of National Statistics is the UK's largest independent producer of official statistics and is the recognised national statistical institute for the UK.

Protective factors lifestyle influences which serve to improve an individual's resilience and thereby make them less susceptible to suicide such as good mental health, supportive family and friends, stable employment or accommodation.

Risk Factors lifestyle influences which increase an individual's vulnerability to suicide such as poor mental health, lack of support or close relationships, bereavement through suicide, drug and alcohol dependency, unstable employment, housing or financial position. These should not be considered suicide indicators, however.

Safetalk a three hour condensed version of ASIST training aimed at raising awareness of suicide indicators and enhancing the confidence and skills of delegates in communicating effectively with someone at risk.

Self-Harm The National Institute for Health and Care Excellence (NICE) Guidance definition is used in this report: any act of self poisoning or self injury carried out by a person, irrespective of their motivation. This commonly involves self poisoning with medication or self injury by cutting. Self harm is not used to refer to harm arising from overeating, body piercing, body tattooing, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself.

Social Prescribing is a way of linking patients in primary care with sources of support within the community. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and wellbeing.

Suicide is the act of intentionally causing one's own death.

Talking Therapy a method of treating psychological disorders or emotional difficulties that involves talking to a therapist or counsellor, in either individual or group sessions

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