ITEM 6 - LATE REPORT

Health and Wellbeing Board
North Yorkshire

# Suicides in North Yorkshire

## An audit of deaths due to suicide in North Yorkshire between 2010 and 2014

## Report Authors


| | |
|---|---|
| Clare Beard | Public Health Consultant |
| Stephen Miller | Public Health Intelligence Analyst |
| Claire Robinson | Health Improvement Manager |
| Andy Chapman | Senior Suicide Prevention Co-ordinator |
| Dr Victoria Turner | Speciality Registrar in Public Health |
| Dr David Bagguley | Speciality Registrar in Public Health |


## Acknowledgements


Business Support Service North Yorkshire County Council

Coroner's for North Yorkshire (East) and North Yorkshire (West)

North Yorkshire Police

North Yorkshire County Record Office

Leeds City Council, Public Health

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

The Partnership Commissioning Unit (PCU)


## Table of Contents

## Glossary

| | |
|---|---|
| **Suicide** | is the act of intentionally causing one's own death |
| **ASIST** | Applied Suicide Intervention Skills Training |
| **Cyber-bullying** | is any form of bullying which takes place online or through smartphones and tablets. Social networking sites, messaging apps and gaming |
| **Binge drinkers** | the definition of binge drinking used by the NHS and National Office of Statistics usually refers to drinking lots of alcohol in a short space of time or drinking to get drunk |
| **Alcohol dependency** | this group are drinking above recommended levels, experiencing an increased drive to use alcohol and feel it is difficult to function without alcohol |
| **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 |
| **Peer advocacy** | provide information, representation or support to solve a problem |
| **Mental Health First Aid** | Mental Health First Aid is an educational course which teaches people how to identify, understand and help a person who may be developing a mental health issue |
| **Safe Talk** | is a programme that offers "suicide alertness" training. It teaches you to recognise when a person may have thoughts of suicide, and to connect them to suicide intervention resources |
| **Office of National Statistics** | is the UK's largest independent producer of official statistics and is the recognised national statistical institute for the UK |
| **Middle Super Output Areas** | designed to improve the reporting of small area statistics and are built up from groups of output areas (OA) |
| **Legal Highs** | Legal Highs are substances which produce the same or similar effects, to drugs such as cocaine and ecstasy, but are not controlled under the Misuse of Drugs Act. "Legal highs" refers to a broad category of unregulated psychoactive compounds or products containing them that are marketed as legal alternatives to well-known controlled drugs |

## List of Tables

## Executive Summary

**In 2012 Public Health England (PHE) estimated the average overall cost of someone of working age taking their own life to be £1.7million. This takes account of lost output of the individual and their relatives in the months and years following the death, the police investigation, inquest and funeral.**

In response to national guidance and recognised best practice, a North Yorkshire and City of York multi-agency Suicide Prevention Task Group was created in 2014. This group developed a suicide implementation plan and identified that an audit of suicides within the County should be prioritised. This report is based on information relating to individual suicides from the records and evidence collated during coronial enquiries, examined during inquests and retained by coroners. The coroners agreed to an information sharing protocol and granted the suicide audit team access to those files.

## Summary of findings

**Of those taking their own life in North Yorkshire:**

- 82% were male
- 25% were in the 40 to 49 age group
- 45% were employed at the time of their death
- 60% were single (including individuals who were widowed divorced or separated)

**Place:**

- There was some variation by both district and Clinical Commissioning Group (CCG), although not significantly so
- The majority of incidents occur at the home postcode (131 out of 200 incidents which could be mapped, 65.5% of incidents)

**Figures for risk factors are:**

- 53% identified mental health issues as a contributory factor
- 41% were recorded as suffering with a chronic, long term illness or medical condition. In those aged 70 the proportion rose to almost 80%. This was typified by a growing despondency about the future and reduction in quality of life.
- 40% of cases identified emotional loss as a contributing factor
- 36% of all cases had a history of self-harm and was more common in females than males
- 33% had alcohol present at time of death
- 19% had relationship problems
- 15% had expressed suicidal ideation which was documented by their General Practitioner (GP)

**Method:**

- 56% died by hanging/strangulation
- 11% died by self-poisoning

**Contact with services:**

- 51% had contact with their GP in the four weeks leading up to death
- 48% cited mental health issues as a reason for contact

- Of the 49 individuals with information on accident and emergency attendance, 23 individuals had made contact in the four weeks leading up to death and 19 of these related to mental health issues

## Recommendations

This analysis of North Yorkshire suicides is based on a relatively small sample of deaths (227) over a five year period. It would be imprudent to assume that its findings necessarily reflect the full picture of suicide past and future in North Yorkshire, or to rely on it exclusively to identify those groups at most risk or the most significant contributing factors.

National research for example suggests some high risk groups which were not notably represented within the local audit but which are known to have a presence within the county population, for example people who are lesbian, gay and bi-sexual or transgender or offenders or ex-forces personnel. Guidance discusses emerging issues such as the influence of social media and so called 'cyber-bullying', which are not revealed as a prominent issue by the audit but are clearly very prominent and influencing factors within our communities, particularly amongst the younger generation and potentially those groups which are at higher risk.

This report must be read in conjunction with national strategy guidance and be mindful of emerging national trends and social factors which may not yet have materialised within our County. The following recommendations are therefore set within the context of that national guidance whilst primarily reflecting the evidence and learning arising from North Yorkshire suicides:

1. **Reduce the risk of suicide across the North Yorkshire population, particularly targeting high-risk groups**
2. **Recognising that 'multiple stresses multiply risk': enhance service provision in relation to common stressors**
3. **Improve support for those affected by suicide in North Yorkshire in the days, months and years after a death.**
4. **Further develop data collection and monitoring**
5. **Training and Awareness**

## Introduction

The topics of suicide prevention, assisted suicide and voluntary euthanasia have for many years been subject to much public and political debate and media attention. Readers of this report may hold different positions in relation to the ethics and morality of suicide and indeed in their own personal attitude towards those who take their own life. This report does not purport to express a view or stand-point on the ethicality of suicide. It is not a crime in English law to take one's own life (hence avoidance throughout this report of the term 'commits suicide').

This report reports on the number of deaths due to suicide and aims to provide a more accurate picture of local trends. It is anticipated that this report will be read by key stakeholders who are able to influence resources and effect 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. It is also hoped that this work will highlight potential gaps in services in terms of their availability and accessibility amongst people who may benefit from using them.

## Aims

This audit aimed to:

- Compare local suicide data and trends with those identified nationally and regionally
- Highlight local risk factors, triggers or localities of higher incidence
- Identify key "at risk" groups and if possible develop generic subject profiles for these key groups
- Describe the suicide cohort in terms of size, rates, local/national benchmarking and description of most common ages, methods, days etc
- Consider the nature and extent of recent or previous contact between the deceased with primary or secondary care services, with other support organisations or with criminal justice services
- Identify possible opportunities, interventions and any apparent gaps in service
- Triangulation of data to establish key patterns or trends, including commonalities across demographic groups - for example, is there a particular cause of death more prevalent in specific age groups?
- Inform future audits and prevention strategies in conjunction with a review of national evidence

## National and local strategies supporting suicide prevention work

In recent years the government has consistently stated its ambition and intention to improve the mental health of the UK population. Several strategies have been implemented in response. Those most closely linked to suicide prevention and the corresponding local strategies or publications are cited below:

### No Health without Mental Health (2011)

This cross-government mental health outcomes strategy for people of all ages outlines six principles which all closely relate to suicide prevention:

- More people will have good mental health
- More people with mental health problems will recover

- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

The Suicide Prevention Strategy for England **'Preventing Suicide in England: a cross-government outcomes strategy to save lives 2012'**[1] (updated 2014) sets out two overall objectives:

- A reduction in the suicide rate in the general population in England; and
- Better support for those bereaved or affected by suicide.

The strategy and its 2014 update support 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 urges a multi-agency response to suicide and its causes demonstrating the benefits of partnership working, data analysis and sharing and highlights various evidence best practice adopted in specific localities. Six key areas for action are outlined in the strategy.

These areas, in brief are:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

**National Suicide Prevention Alliance (2013)**[2]

A cross-sector England-wide coalition committed to reducing the number of suicides in England and improving support for those affected by suicide.

**Public Health Outcomes Framework 2013-2016**[3]

This Framework (PHOF) includes indicators on suicide rate (the three year rolling average age standardised mortality rate from suicide and injury of undetermined intent) and mortality rate of people with mental illness.

Other key strategies include:

- Future in mind 2012[4]
- Mental Health Crisis Care Concordat 2014[5]
- North Yorkshire Joint Health and Wellbeing Strategy 2013-2018[6]
- North Yorkshire Mental Health Strategy 2015- 2020
- North Yorkshire Joint Alcohol Strategy 2014 - 2019

## Audit Scope

Information considered by the audit was collated exclusively from coroners' files and evidence relied upon on during inquests in North Yorkshire during the period 2010-2014.

The audit included:

- Residents of North Yorkshire who died within the County and whose deaths were determined by the coroner as 'suicide'

- People who resided outside of North Yorkshire who died by suicide within the County
- Residents of North Yorkshire who took their lives outside England in cases where the body was repatriated to the County

The audit did not include:

- Deaths subject of an 'open' or 'narrative' inquest outcome, significantly those classed as 'accident or poisoning of undetermined intent'
- Deaths of people who resided in North Yorkshire and who died elsewhere in England (as those investigations fell under the jurisdiction of the coroners for those other areas)
- Cases of suicide which at the time of the audit had not been concluded at inquest
- Deaths determined as suicide which occurred within the City of York (subject of a separate audit and report)
- The report does not include any child death under the age of 17 years of age. Analysis of those less than 17 years was not deemed appropriate due to the small numbers

This report details key findings from the audit. An in-depth analysis and lessons learnt report are available at; **www.nypartnerships.org.uk/suicideprevention**

## Method

Files for review were identified from information provided by the two North Yorkshire Coroners' offices and linked to Office of National Statistics (ONS) data, where the death was determined as suicide. These records were pulled by county records staff from their archives.

Each individual file was reviewed by a single member of the audit team and information ascertained entered onto a generic computer based template. This template (Appendix 1) included multiple choice or free text boxes for recording demographical 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 'notes' 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.

Staff involved in undertaking this audit took part on a voluntary basis and had training in advance about reviewing records and completing the proforma. Staff took part voluntarily and were encouraged to discuss any emotional issues arising from participation at audit team meetings.

An analyst from the Public Health Intelligence Team analysed both the quantitative and qualitative data collected to inform the audit. Quantitative data was cross-tabulated and triangulated to facilitate identification of socio-demographic and lifestyle characteristics, patterns and trends among individuals who had taken their own life. Where location data was available, geographic analysis was undertaken to facilitate analysis at middle super output area (MSOA), district and clinical commissioning group. Analysis was also undertaken using customer insight segmentation and the 2015 indices of multiple deprivation to ascertain if there was any correlation to specific types of communities or levels of deprivation.

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 of individuals who had chosen to take their own life, and identify socio-demographic groups who may be at raised risk.

## Data Analysis

### National and regional comparisons using ONS data

The rate of suicide in North Yorkshire (as measured by ONS) is marginally lower than that observed nationally, regionally or across comparator shire authorities. Mirroring the national profile, the rate among males is much higher than among females. For the period 2012-14 the suicide rate in North Yorkshire was 8.7 persons per 100,000 population, compared to the national average of 8.9 persons per 100,000. However, it should be noted that throughout the period 2003-05 to 2011-13 the suicide rate in North Yorkshire was marginally above the national figure, on average by 0.7 persons per 100,000.

Table 1: Suicide rate North Yorkshire v England v Regional authorities 2012-2014 - ONS data

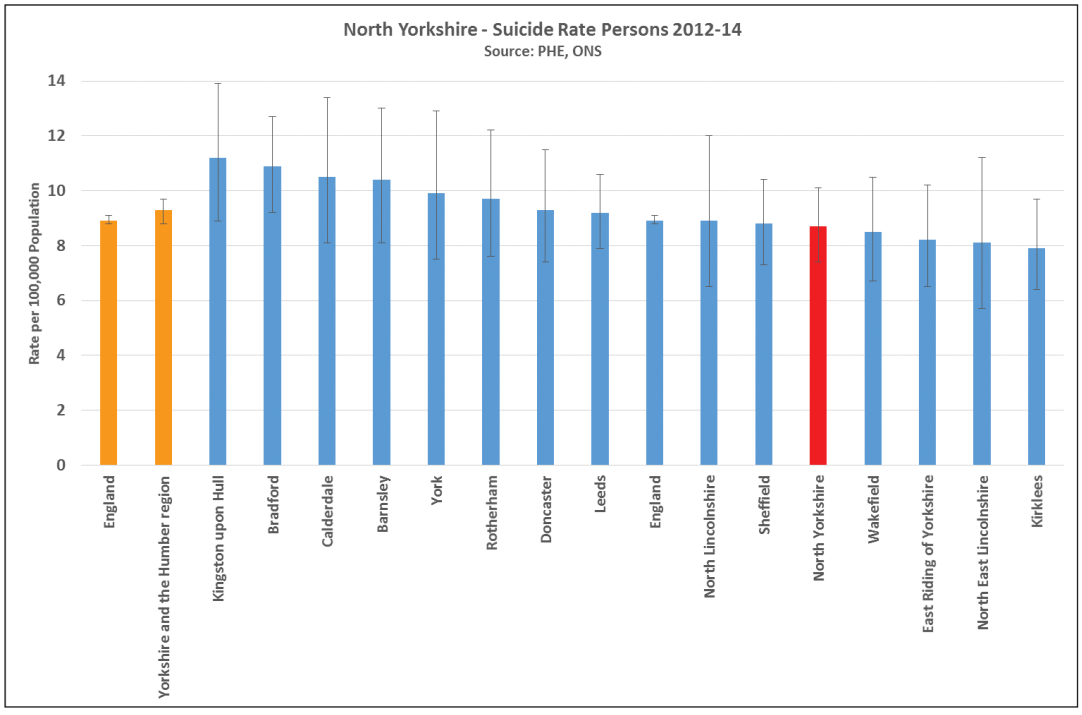
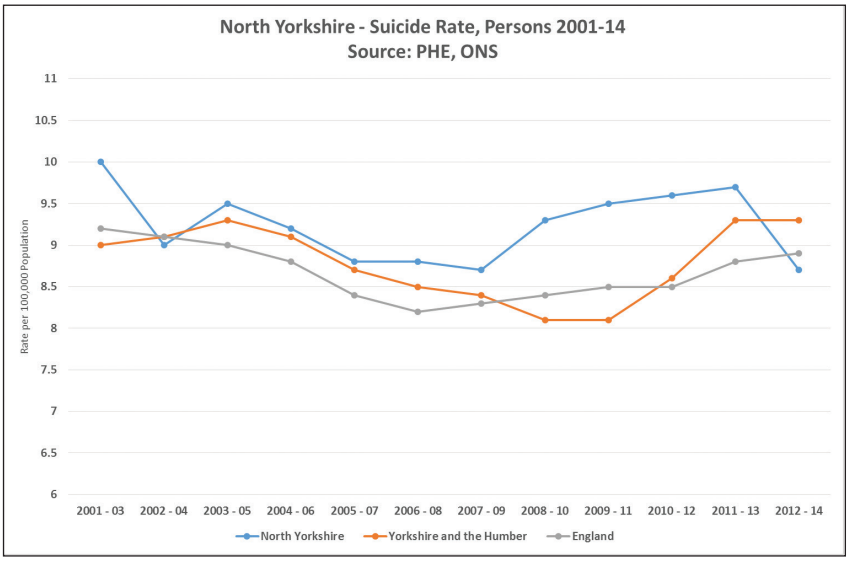
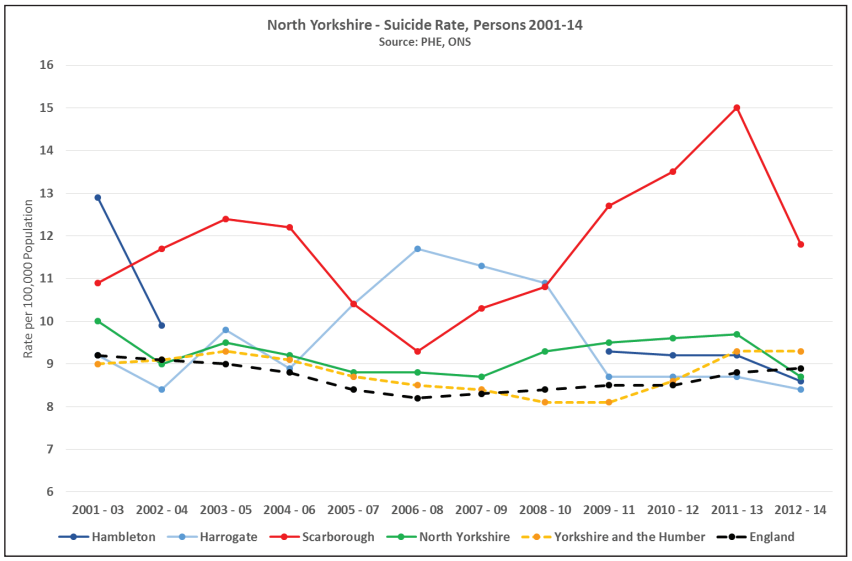


**Table 2: Suicide rate in North Yorkshire v England v Yorkshire and Humber 2001-2014 - ONS data**




The suicide rate (three-year average) in North Yorkshire exhibited an upward trend from 2007-09 to 2011-13, mirroring similar trends observed regionally and nationally.

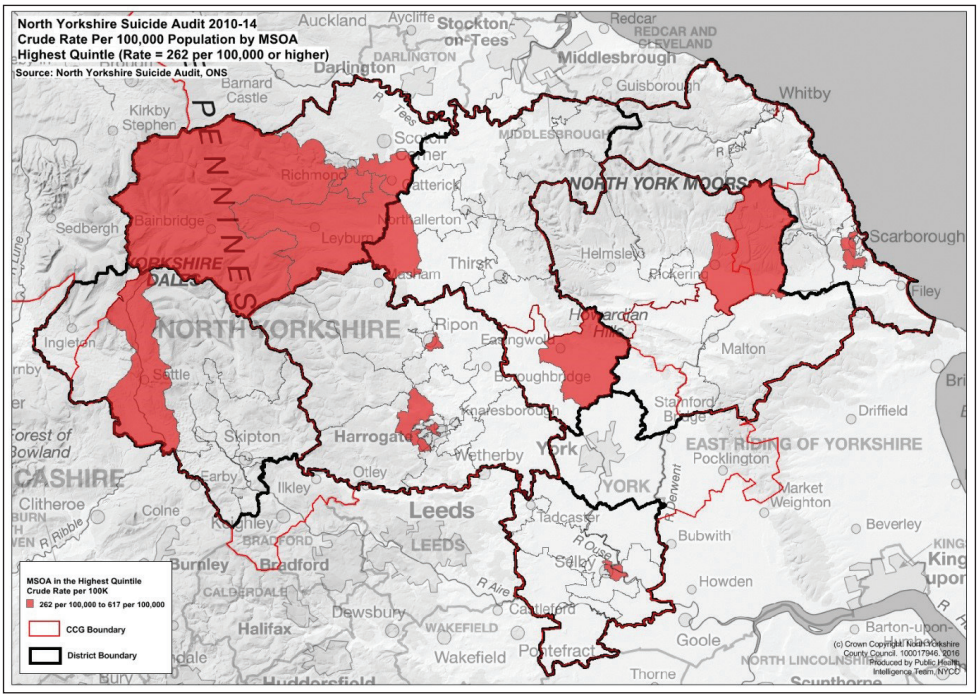
**Table 3: Suicide rate 2001-14 Harrogate, Scarborough, Hambleton, v England, Yorkshire and the Humber**




When broken down to district level, the suicide rate appears noticeably higher for Scarborough than for the other districts (rates specified for Scarborough, Hambleton and Harrogate below; data from other districts suppressed due to low volume of incidents).

The North Yorkshire audit data does suggest a number of potential hotspots across the County, illustrated in the following map based on home postcode data.

**Table 4: North Yorkshire Suicide 2010-14 - Hot spots map**




The map illustrates potential hotspots in every district, ranging from more urban areas in the towns of Harrogate, Scarborough and Selby to very rural areas in Craven, Richmondshire and Ryedale. Across the 16 MSOA highlighted in the map the number of incidents of suicide in the period 2010-14 averaged 4.81 per MSOA. This compares with an average of 1.65 incidents per MSOA across the remaining 60 MSOAs across the County.

Although the map highlights much of Richmondshire as a potential hotspot, this should be considered in the context of other data - for example, around 11% of all incidents of suicide captured by the audit involved a Richmondshire resident, and these accounted for 20 of the 176 incidents that could be mapped to an address within North Yorkshire.

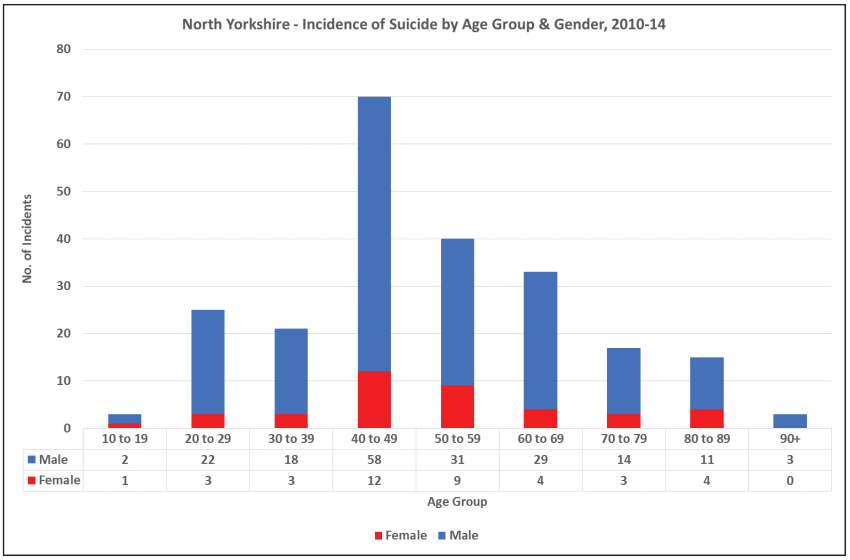
## Basic Demographics

### Age and Gender

In keeping with national trends, suicides in North Yorkshire are much more common in males compared to females. Of the 227 incidents recorded as part of the audit (2010-2014), 188 involved males (82.8%), with the highest number of incidents (58) recorded in males aged 40 to 49. This comprises 25.5% of all local suicides, despite this age/gender group accounting for just 7% of the North Yorkshire population.

Overall, incidents involving males in the 40 to 70 age range account for just over half of all incidents (51%, 118 incidents). When expressed as a crude rate, the rate of suicide in males aged 40 to 49 over the five year period was 132.8 per 100,000; double the crude rate for the male population as a whole (65.7 per 100,000).

Table 5: North Yorkshire Suicide Audit 2010-14 by age including gender




The incidence among women is also highest in the 40 to 49 age group, followed by the 50 to 59 age group. The incidence in other female age groups is too small to provide further meaningful differences.

## Marital status

Based upon provided marital status information, around 60% of individuals were single (including individuals who were widowed, divorced or separated), and 40% were cohabiting or married. The proportion of single females was slightly higher (66%) and the overwhelming majority of individuals in the 20 to 29 age group were classified as single (90.9%, 20 out of 22 individuals).

## Housing Status

Housing status at time of death could not be determined in 94 incidents (41.4%). Where housing status could be determined, around half of all individuals owned their home (rising to 66.7% of females). Six per cent (all males) were either homeless or in bed & breakfast accommodation.

## Employment

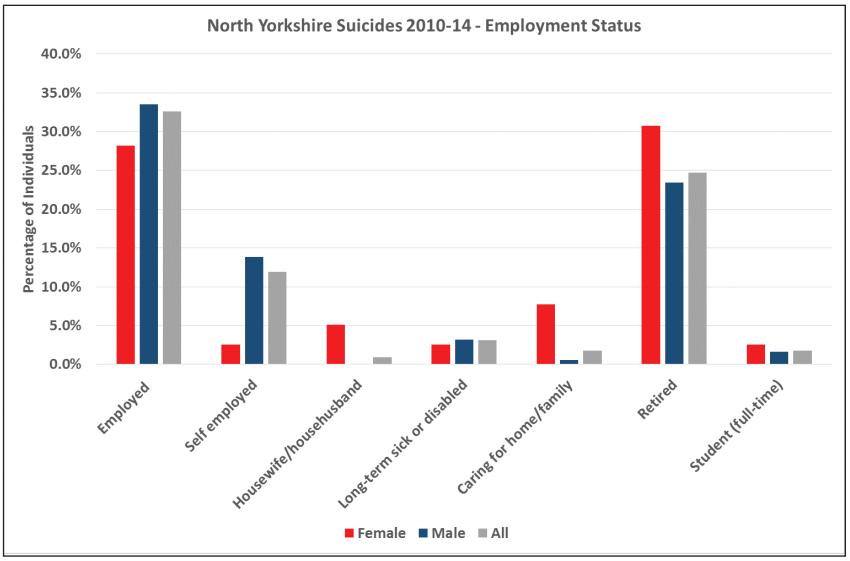
Overall, almost half of all individuals (44.5%, 101 individuals) were employed at the time of their death, of which a significant minority were self-employed (11.9%, 27 individuals). Individuals who were self-employed were almost exclusively male (26 out of 27 individuals), of which approximately 60% (15 individuals) were aged between 40 and 59.

Almost one in four individuals were retired at the time of death, whilst around 16% were unemployed.

Type of employment could be determined in 87% of cases (197 cases), including those where a previous occupation was given but current employment status was either “unemployed” or “retired”. Of these, 40.5% (92 cases) were in skilled occupations (e.g. engineer, fitter, secretary, technician), with 23.8% (54 cases) from professional occupations (e.g. company director, teacher, doctor). Around 5% of cases (11 cases) involved an individual employed in

farming. The proportion of individuals from professional occupations was higher in the over-50s (and highest in the over 70 age group), whilst the proportion of individuals in semi-skilled or unskilled occupations was highest in the under 30 age group.

Table 6: North Yorkshire Suicide Audit 2010-14 employment status by gender




## Impact of Deprivation and Analysis of Customer Insight Data

Of the 227 records examined, 200 could be geo-coded and mapped (based upon home postcode data), equating to 88% of records.

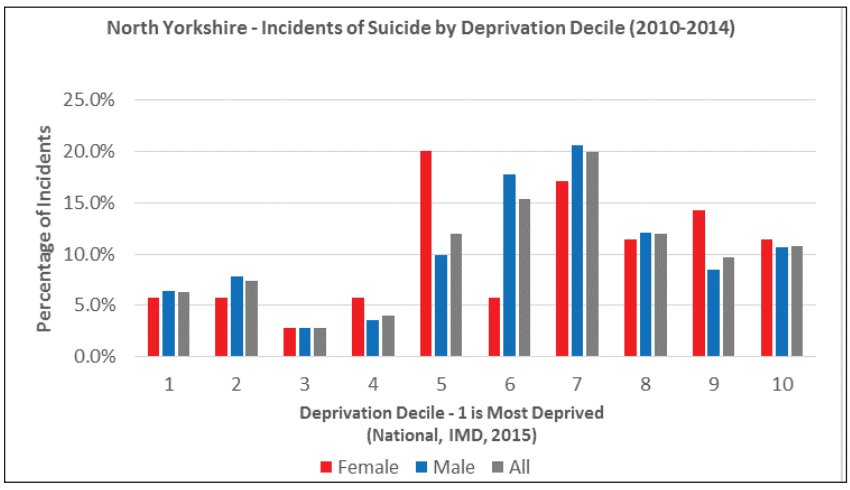
### Indices of Multiple Deprivation

Based on the available data, there is some evidence of a link between deprivation (as measured by IMD) and incidence of suicide. In 1 in 5 incidents[1] (20.5%, 36 incidents) the home postcode was in an area among the 20% least deprived nationally, whilst in only 13.6% of incidents (24 incidents) was the home postcode among the 20% most deprived areas.

This chart demonstrates some differences across genders, with a higher proportion of females coming from less deprived areas than males.

Of the 36 incidents involving an individual resident in the 20% least deprived areas of the county, 9 were females (25%). This is higher than the proportion of females across the cohort as a whole (17.2%). Examination of the difference across age groups highlights that among the most at risk age group (those aged 40 to 49) the proportion of individuals from the 20% most deprived areas rises to 24.5% overall and 25.6% for males.

Table 7: North Yorkshire Suicide Audit 2010-14 by deprivation decile




1 Where home postcode was in North Yorkshire and could be mapped

### Customer Insight data

The highest proportion of individuals who died by suicide was from insight group 4A (12.5%). This is slightly higher than the proportion of the overall North Yorkshire population from this insight group (10%). Insight group 4A tends to comprise older, more affluent individuals, often living in large houses in commuter villages, with good levels of general health and education. Employment is often in managerial or professional occupations; self-employment is higher than average but so are levels of retirement.

Males were most likely to be from insight group 4A (12.8%) and 9A (9.9%) and 2B (9.9%). Group 9A is typified by families living in semi-detached or terraced housing, where employment tends to be in semi-skilled or unskilled occupations, whilst group 2B is typified by married couples in the 45 to 64 age group working in managerial, professional or skilled trades occupations, often within the agricultural sector. Females were most likely to be from insight group 4A (11.4%), 7 (17.1%) and 9B (11.4%). Group 7 is typified by younger communities living in lower quality terraced housing and higher levels of benefit dependency, whilst group 9B is typified by families living in social housing where unemployment levels are higher and those in work tend to be employed in either unskilled or semi-skilled occupations.

Among the most at risk 40 to 49 age group, the most common insight groups were group 7 (16.3%), 4A (14.3%) and 9B (12.2%). Further details on the characteristics of individual insight groups can be found in Appendix 4.

## Details of suicide event

### Method of suicide

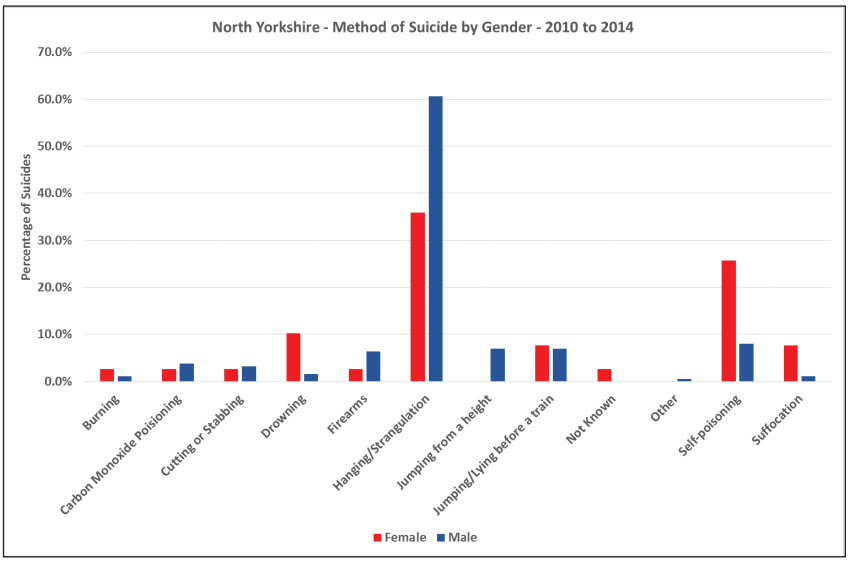
The five most common means by which individuals died by suicide were:

| | | | |
|---|---|---|---|
| **Hanging/Strangulation** | **-** | **128 incidents** | **(56.4%)** |
| **Self-poisoning** | **-** | **25 incidents** | **(11.0%)** |
| **Jumping/Lying before a train** | **-** | **16 incidents** | **(7.0%)** |
| **Jumping from a height** | **-** | **13 incidents** | **(5.7%)** |
| **Firearms** | **-** | **13 incidents** | **(5.7%)** |

Just over half of all suicides analysed involved hanging or strangulation. This method of suicide was more common among males, particularly males under 60, in comparison with females (60.6% of male suicides, 35.9% of female suicides). It is much more prevalent among individuals aged under 40 (77.6% of under-40s compared to 50.6% of over-40s). The second most common method of suicide was self-poisoning, and this method accounted for a higher proportion of suicides in females than males (25% of female suicides, 8% of male suicides).

The majority of incidents where a firearm was used involved males (12 out of 13 incidents). However, it is possible that this simply reflects the gender balance of the population that hold a firearms/shotgun licence, and therefore have ready access to firearms and ammunition.

Table 8: North Yorkshire Suicide Audit 2010-14 Method of suicide by gender




Analysis of incidents involving self-poisoning suggests opiates (including opiate-based pain medication) or sedatives (such as barbiturates) were the most commonly-used substances. Where prescription medication was used, there was only one instance identified involving medication which had been prescribed for another individual.

## Location of incident

Almost two thirds (63.4%) of incidents occurred at the individuals' home address (144 incidents). This was consistent across most age groups, with this highest proportion found in the 70 to 79 age group (76.5% of individuals in this age group). Data quality issues precluded further geographic analysis of locations other than the home.

All incidents involving suffocation (five incidents) and the overwhelming majority of incidents involving cutting/stabbing (six out of seven incidents) occurred at the individual's home address. Both of these methods involved a typically older demographic, which may to a certain extent reflect their mobility (both in terms of method and location). A high proportion of deaths involving hanging/strangulation (76.9%) or firearms (76.6%) were also recorded at a home address.

## Suicide Notes

A suicide note was left by the deceased in 103 incidents (45.4%). Females were slightly less likely to leave a note (41.0%) than males (46.3%). Suicide notes provided further insight into the reasons a person chose to end their own life.

The majority of suicide notes were hand written (70.0%, 87 of 103 incidents), with little variation by gender. The second most common media was text message (14.6%, 15 out of 103 incidents), with a further five incidents (4.9%) relating to files or e-mails on a computer. Younger age groups were more likely to leave a text message note; however, with the exception of the 10 to 19 age group a handwritten note was the most common form of note across all ages.

## Drugs, Alcohol and Criminal Justice involvement

### Use of alcohol and drugs at time of death

Whilst not an explicit cause of death, alcohol was identified as present in one third of incidents (75 incidents). Of this group, 61 were male (32.4% of all males) and 14 were female (35.9% of all females). Overall, 43 individuals (57% of individuals with recorded blood alcohol level) had a recorded blood alcohol level above the prescribed drink drive limit in England (80mg per 100ml blood). Among males aged 40 to 49, alcohol was present in 52.9% of incidents and was found to be in excess of 80mg per 100ml in 35.3% of incidents.

The average recorded blood alcohol level was 156.3 micrograms per 100ml of blood. This is almost double the prescribed drink drive limit in England and, in a 40 year old male weighing 75kg, would equate to over a bottle of wine consumed.

Alcohol was most commonly present in incidents of hanging/strangulation (49 incidents, 38.3% of all hanging/strangulation incidents) and self-poisoning (14 incidents, 56% of all self-poisoning incidents.

Non-prescribed drugs were found to be present in 29 incidents (12.7%). The majority of incidents involved males, although the proportion was broadly similar to the overall cohort (i.e. over 80% male). The most common drug found to be present was cannabis (eight incidents, 27.6%), followed by paracetamol (where paracetamol was identified it was not determined whether this was prescribed or non-prescribed) (six incidents, 20.7%). However, in a total of seven incidents (24.1%) a combination of at least two drugs were found to be present.

The presence of non-prescribed drugs was most common in cases of hanging/strangulation (18 incidents, 62.1%). Non-prescribed drugs were found to be present in 15 males who had died by hanging/strangulation, equating to 12.7% of all male deaths involving hanging/strangulation. There was no specific age group where this behaviour was more prevalent.

During the audit the use of new psychoactive substances (NPS) so called ‘legal highs’ was apparent in some cases however there was not significant evidence that these ‘legal highs’ contributed to suicides across North Yorkshire. National evidence is increasing about the effects of legal highs on an individuals’ health and evidence suggest that taking legal highs could lead to a range of different side effects, for example people taking their own life or becoming paranoid. It will be the requirement of the Suicide Prevention Task Group to monitor this growing evidence base and implement recommendations.

### Previous involvement with the criminal justice system

Forty-five individuals (19.8%) were recorded as having previous involvement in the criminal justice system, of which 21 (46.6%) had an involvement in the 12 months prior to death. The overwhelming majority of individuals with previous involvement in the criminal justice system were male (43 individuals, 95.5%), of which 17 (38.5%) were aged 40 to 49. In total, around 30% of the male cohort aged 40 to 49 had previous involvement with the criminal justice system. This rose to 40.1% in males in the 20 to 29 age group and 44.4% in males in the 30 to 39 age group. A much lower proportion of

older males (age 50 and over) had previous involvement with the criminal justice system.

This suggests that males under 50 with historic criminal justice service involvement are at an elevated risk of suicide; however, it important to note that correlation does not necessarily equate to causation and historic criminal justice service involvement will not have directly driven an individual to suicide in every case. Review of qualitative data supplied to the audit does highlight two circumstances in which criminal behaviour can quickly escalate to a suicide attempt:

a. (White collar/professional males arrested and/or charged with possession of indecent imagery of children.

b. (Blue collar individuals, particularly males aged 40 to 60, who are alleged to have committed theft from the workplace (typically petty/ low value theft of goods).

In both instances individuals appear to perceive catastrophic loss as a direct consequence, including loss of employment, family, social status and an overwhelming sense of shame. The timeframe between being made aware of an allegation/investigation and suicide attempt was often remarkably short; in some cases less than 24 hours.

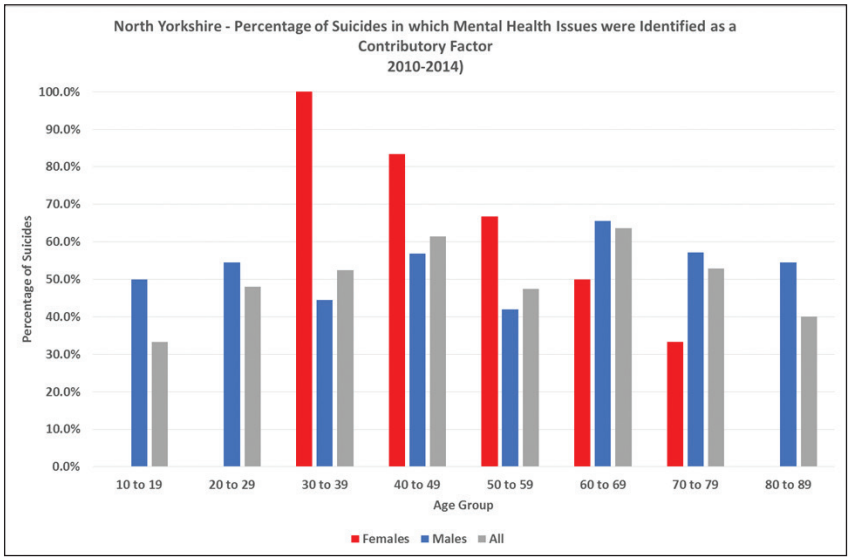
## Prevalence and impact of health issues

### Mental Health

Mental health issues were identified as a contributory factor in 52.7% of incidents (122 incidents), with the proportion of males and females broadly similar. In 74 cases the mental health issue had been diagnosed within the twelve months prior to death.

The highest proportions of individuals with mental health issues were found in the 40 to 49 age group (61.4%) and the 60 to 69 age group (63.6%). (N.B. although 100% of females aged 30 to 39 had identified mental health issues, this equated to only three incidents).

**Table 9: North Yorkshire Suicide Audit 2010-14 where mental health is a contributory factor by age group**




Treatment for mental health issues received in the preceding 12 months included selective serotonin reuptake inhibitor (SSRI) antidepressants, tetracyclic antidepressants, antipsychotics and benzodiazepines, sometimes in conjunction with talking therapies (including IAPT (Improving Access to Psychological Therapies), Cognitive Behavioural Therapy and counselling). Over half of cases (where treatment received was documented) received medication without simultaneous talking therapy.

Approximately 35 individuals were referred to other mental health services. During the audit these were not defined. This

equates to around half of the individuals with a diagnosed mental health issue.

The qualitative information gathered suggests that the prevalence of mental health issues is likely to be higher than that indicated by diagnosed cases. The qualitative data indicated evidence of current or historic mental health issues in around 105 cases, of which approximately two thirds were supported by a diagnosis. This is corroborated by the analysis of the underlying/contributory factors identified in each case, which highlighted that around half of all individuals who died by suicide had a mental health issue (either diagnosed or undiagnosed). The qualitative data suggests that in many instances, mental health issues focused towards the less complex cases and were typified by mild to moderate depression, either at the time of the suicide attempt or at some point in the individuals' history. This suggests a hypothesis that those at raised risk of suicide are typically individuals with some recorded history of mild to moderate depression/anxiety who has recently been subject to at least one significant life stressor.

The data suggests that individuals with mental health issues (either diagnosed or undiagnosed) are at elevated risk of suicide, and this is particularly true among the 40 to 49 age group.

## Suicide Ideation

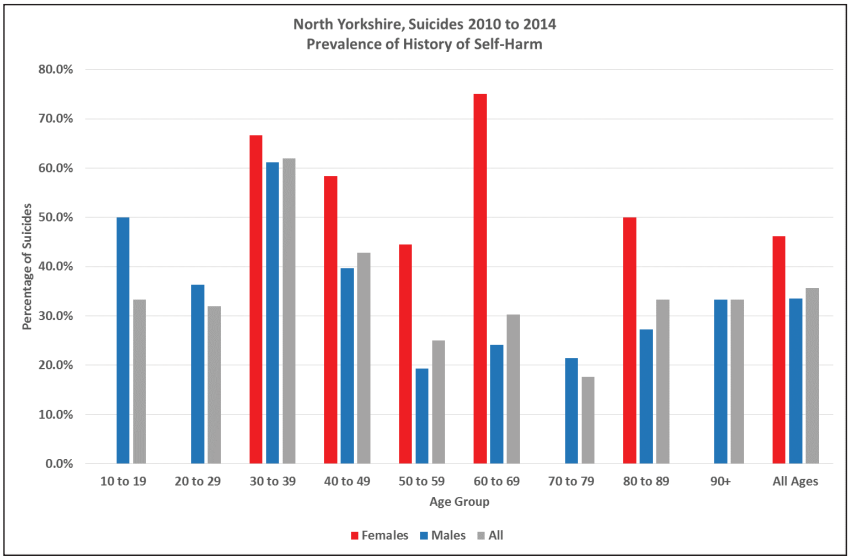
Suicidal ideation was identified and documented by a GP in 15.4% of instances (35 cases). Of this group of individuals, 51.4% (18) had contact with primary care services in the four weeks leading up to death. In 57% of cases where ideation was documented (20 cases), ideation was limited to thoughts and ideas rather than a clear expression of suicidal intent.

Overall, documented ideation was more common in females (23.1%, 9 cases) compared to males (13.8%, 26 cases). Documented ideation was also more common in the 50 to 59 age group (22.5% of cases in this age group) compared to other ages.

## History of Self-harm and Previous Suicide Attempts

A significant minority of individuals had a history of self-harm (81 cases, 35.7% of all cases). Self-harm was more common in females (46.2%, 18 out of 39 cases) than in males (33.5%, 63 out of 188 cases).

**Table 10: North Yorkshire Suicide Audit 2010-14 history of self- harm and previous suicide attempts**




Of the individuals identified with a history of self-harm, 54.3% (44 cases) had experienced a self-harm episode within the 12 months leading up to death, whereas for 41% (35 cases) the most recent self-harm attempt was more than 12 months prior to death. In 5% of cases it

could not be established when the most recent self-harm attempt had occurred. This suggests that self-harm, whether recent or historic, places individuals at an elevated risk of suicide.

Almost one in five individuals had attempted suicide on at least one previous occasion (18.5%, 42 cases). Of these individuals, 40 out of 42 had a documented history of self-harm. The proportion was slightly higher in females (25.6%, 10 cases) compared to males (17.0%, 32 cases). A higher proportion of individuals in the 30 to 39 age group had a history of previous attempts (38.1%, eight cases) and this was also true of the 40 to 49 age group (22.9%, 16 cases).

### Chronic Health Issues

A significant minority of individuals (41.0%, 93 individuals) were recorded as suffering from chronic medical conditions. In those aged over 70 the proportion rose to almost 80% of individuals, compared to around 20% in those aged under 40. Among the over 70 age group multiple conditions were common, with more than one illness/chronic condition evident in 16 of all 35 cases in this age group (45.7% of cases in the over 70 age group). There were no specific trends identified in terms of disease prevalence, although those associated with older age groups were common (e.g. osteoporosis, arthritis, heart disease etc.). Among those aged under 60 were much more likely to be suffering from only one chronic condition. Again, there were no common themes in terms of the type of illness/condition.

Among older individuals it was possible to identify a thematic group, typified by a growing despondency about the future as consequence of increased frailty, amplified by long term health issues (either diagnosed or perceived as future risks by the individual), resulting in a perceived reduction in quality of life. This seemed to be exacerbated in those individuals who had, until recently, been leading active, busy lives, but whose ability to remain active had diminished.

### Other Contributory Factors

Significant life stressors (including family/relationship breakdown, loss of employment, housing concerns etc.) were common contributory/risk factors and present in over a third of cases. In some instances there were a number of life stressors present; for example, relationship breakdown may be accompanied by concerns about housing. The top six contributory factors are listed below; for a full list see Appendix 5.

| Contributory Factor | Total Number of Incidents[3] | Percentage of Total Incidents[4] |
|---|---|---|
| Diagnosed mental health | 94 | 41.4% |
| Relationship ending | 42 | 18.5% |
| Bereavement | 39 | 17.2% |
| Stress | 31 | 13.7% |
| Debt | 30 | 13.2% |
| Undiagnosed mental health | 28 | 12.3% |
| Ill health - long term condition | 25 | 11.0% |

Diagnosed mental health issues were the most common contributory factor for individuals who choose to take their own lives. However, whilst there was often evidence of historic mental health issues, it was not always clear if mental health issues were of themselves triggers to other stressors, or if

3 Total exceeds 227 incidents as more than one contributory factor could be identified in the case of most incidents
4 Percentages expressed as a proportion of the 227 incidents recorded

significant life stressors precipitated further episodes of depression and anxiety among individuals with lower resilience and perhaps a propensity for lower mental wellbeing.

Bereavement was found to be a significant contributory factor in a fifth of cases. A review of these cases highlighted two particular themes:

a. Recently bereaved individuals often aged over 60, who had lost a spouse in the 12 months leading up to the suicide attempt. Within this group, suicide could occur in a relatively short timeframe following the bereavement, and instances were identified in which there was clear suicide ideation in the immediate aftermath of the loss of a spouse. The impact of the loss of a spouse could be amplified if the individual experienced further bereavement involving other family members or close friends. This may suggest a lack of bereavement support (perceived or real) for older individuals, although hesitancy to seek out support in older males must also be considered.

b. Individuals who had experienced a significant bereavement more than 12 months ago, but who had struggled to come to terms with the loss. Within this group there was a sense that whilst the bereavement was a significant contributory factor, it was often a second subsequent contributory factor that finally persuaded the individual to take their own life. Examples include subsequent decline in health or loss of mobility/ independence, concerns about money, or in one case, the loss of a cherished pet.

Debt and financial worries were a final common theme, and again this could often be woven into a web of other contributory factors. Financial issues included self-employed individuals who were facing loss of their business/livelihood, individuals facing divorce and in a small number of cases, older individuals facing an uncertain financial future.

Analysis of case-level contextual information highlights that often a number of circumstances would transpire, which ultimately would result in a suicide attempt. For example, an individual would experience a significant life stressor, such as loss of employment, which would in turn lead to financial difficulties, which in turn would precipitate a depressive episode. Two or more contributory factors could be identified in over 50% of cases. Clearly, there were also a significant minority of cases in which only one contributory factor could be identified, and such cases included individuals suffering recent bereavement (particularly of a spouse or partner), or individuals suffering from painful or degenerative long-term medical conditions.

The qualitative data also illustrated that a third of individuals had experienced significant life stressors, such as relationship breakdown and divorce, carer responsibilities or significant stress at work. Emotional loss in some shape or form could be identified in over 40% of cases, and highlights the elevated risk of suicide that individuals with low resilience and/ or poor access to support networks may face in times of severe emotional stress.

In a number of cases, there was evidence of potentially chaotic lifestyles where a number of life stressors (such as frequent relationship breakdown, unstable accommodation) were present along with some evidence of substance misuse (typically alcohol and/or cannabis) and underlying mental health issues.

The data supports the hypothesis that individuals can be at elevated risk of suicide as a result of experiencing loss (either real or perceived) as a result of bereavement, family breakdown/relationship problems, debt and ill health. For example, emotional loss in the form of bereavement, family breakdown or the end of a relationship was identified in 42.7% of incidents. It can be hypothesised that in a significant minority of incidents, a perception of loss (for example, either emotional as a result relationship breakdown or physical as a result of reduced mobility arising from illness) is leading individuals with lower resilience/mental wellbeing to take their own lives. The data suggests that it is plausible that such circumstances account for at least between one in five suicides in North Yorkshire, and the true figure may be higher.

## Contact with Services

### Last Contact with Primary Care Services

The most recent primary care contact was recorded in 162 instances (71.4%). Around half of these (77 cases) had contact in the month prior to death, of which 32 were in the seven days leading up to the incident. However, in 32% of cases (52 incidents) there had been no contact with primary care services for at least three months, which included 26 cases in which there had been no contact for over a year.

Where documented, the reason for primary care contact was mental illness in 77 cases and physical illness in 76 cases.

### Last Attendance at Accident & Emergency Services

The most recent A&E attendance was recorded in 49 instances (21.6%). Of this group, 23 people had attended A&E in the month prior to death, of which nine were in the seven days prior to death. Of the 23 individuals who attended A&E in the four weeks leading up the suicide attempt, 19 attendances were in relation to mental health issues. Ten of these attendances resulted in admission.

The proportion of males and females attending A&E as a consequence of mental health issues in the four weeks before death was broadly similar to the overall cohort. However, when considered by age group, almost half of this group (nine out of 19 attendances) were by individuals aged 40 to 49, of which most (six out of nine) had also seen their GP in the same four week period. This equates to almost one in ten of those people aged 40 to 49 who died by suicide, who also saw their GP and attended A&E in the lead up to the suicide attempt. Overall, 17% of individuals in the 40 to 49 age group had attended A&E in the four weeks leading up to death.

### Contact with Other Services

Other agencies had a confirmed involvement in 51 instances (22.5% of all cases). The most commonly involved agencies were alcohol-related services (11 instances) and accommodation services (10 instances). The most common demographic group to have involvement with other services were males aged 40 to 49 (14 cases). Among this demographic group one in four had an involvement with other agencies, although there was no clear pattern or trend in terms of the agencies involved.

## Conclusions

This analysis of North Yorkshire suicides is based on a relatively small sample of deaths (227) over a five year period. It would be imprudent to assume that its findings necessarily reflect the full picture of suicide past and future in North Yorkshire, or to rely on it exclusively to identify those groups at most risk or the most significant contributing factors.

National research for example suggests some high risk groups which were not notably represented within the local audit but which are known to have a presence within the county population, for example people who are lesbian, gay and bi-sexual or transgender or offenders or ex-forces personnel. Guidance discusses emerging issues such as the influence of social media and so called 'cyber-bullying', which are not revealed as a prominent issue by the audit but are clearly very prominent and influencing factors within our communities, particularly amongst the younger generation and potentially those groups which are at higher risk.

## Recommendations

This report must be read in conjunction with national strategy guidance and be mindful of emerging national trends and social factors which may not yet have materialised within our County. The following recommendations are therefore set within the context of that national guidance whilst primarily reflecting the evidence and learning arising from North Yorkshire suicides:

1. **Reduce the risk of suicide across the North Yorkshire population, particularly targeting high-risk groups**

- Raise awareness of suicide and those at highest risk as identified from the audit and those other communities considered by national research to be at greater risk
- Promote help seeking and engagement with services amongst high risk groups
- Tailor approaches to improve mental health in specific communities
- Explore innovative, non-traditional ways to engage the seldom-seen, seldom heard
- Highlight the concept that 'past behaviour in an indicator of future behaviour' in raising awareness of risk to those who have previously attempted suicide or seriously self-harmed
- Explore the support available to those with increased frailty and long term health issues. Working with CCGs and social care to identify those at risk and for staff to be aware of the options available to support those with increased frailty

2. **Recognising that 'multiple stresses multiply risk': enhance service provision in relation to common stressors**

- Key services include: debt counselling (including gambling), bereavement support, relationship counselling, advice and support in relation to alcohol and drug use to highlight the suicide risk amongst binge drinkers and those close to a dependency threshold
- Target and develop 'talking therapy' and 'peer advocacy schemes' to provide support to the socially isolated or specific occupation groups

**3. Improve support for those affected by suicide in North Yorkshire in the days, months and years after a death**

- Consider experiences and views, where possible of people bereaved or otherwise affected by suicide in activity planning and awareness raising
- Improve advice and support available to those concerned about suicidal ideation of family members, friends or colleagues including children and young people
- Consider the importance and recommendations of Future in Mind

**4. Further develop data collection and monitoring**

- Ensure national guidelines assimilated into NY policies
- Maintain up-to-date suicide prevention strategy
- Repeat suicide audit bi-annually
- Encourage on-going relationship with coroner, police to support improved data collection
- Consider expanding the scope of future audits to include likely suicides amongst deaths by accident/poisoning of undetermined intent, and the availability of partner agency information in relation to suicide attempts and serious self-harm incidents including children and young people
- Report to and/or attend the York and North Yorkshire Safeguarding Adults Boards as required to update the boards periodically and to raise any emerging concerns connected to the adult safeguarding agenda

**5. Training and Awareness**

- Promote the delivery of suicide prevention training to professionals in regular contact with people most at risk of suicide. Consider bespoke on-going training for primary care and other clinically trained staff who are most likely to routinely encounter individuals with suicidal ideation
- Support the delivery of recognised suicide prevention and mental health awareness courses
- Consider adopting a target of 1% of the County population to be trained e.g. ASIST, Mental Health First Aid or Safe Talk by 2020 in accordance with ‘No Health without Mental Health’ and ‘Parity of Esteem’

## Appendix 1

**Audit Proforma**

## Factors contributing to death

| Category | | ✓ |
|---|---|---|
| 1 | Undiagnosed Mental Health | |
| 2 | Diagnosed Mental Health | |
| 3 | Ill Health - acute | |
| 4 | Ill health - long term condition | |
| 5 | Stress | |
| 6 | Drug use | |
| 7 | Alcohol use | |
| 8 | Bereavement | |
| 9 | Recent suicide of close contact | |
| 10 | Family Breakdown | |
| 11 | Loneliness/isolation | |
| 12 | Relationship ending | |
| 13 | Retirement | |
| 14 | Redundancy | |
| 15 | Financial problems (including debt) | |
| 16 | Shame | |
| 17 | Criminal/forensic history | |
| 18 | Troubled background | |
| 19 | Old age | |
| 20 | Problems at work | |
| 21 | Disability benefits stopped | |
| 22 | Blackmail | |
| 23 | Unknown | |

## Section 1: Demographic details

(Data likely to be available from Coroner initially but also other sources)

| | | | |
|---|---|---|---|
| 1.1 | Date of birth | | |
| 1.2 | Date of death | | |
| 1.3 | Age | years | |
| 1.4 | Sex | ☐ Male | ☐ Female |
| 1.5 | Sexual orientation | ☐ Heterosexual | ☐ Homosexual |
| | | ☐ Bi-sexual | ☐ Not known |
| 1.6 | Resident's postcode | | |
| 1.7 | Ethnicity | | |
| | ☐ White British | ☐ White Irish | ☐ Any other White background |
| | ☐ Mixed White and Black Caribbean | ☐ Mixed White and Black African | ☐ Mixed White and Asian |
| | ☐ Any other mixed background | ☐ Indian | ☐ Pakistani |
| | ☐ Bangladeshi | ☐ Any other Asian background | ☐ Caribbean |
| | ☐ African | ☐ Any other Black background | ☐ Chinese |
| | ☐ Any other ethnic group | ☐ Not known | |
| 1.8 | Place of birth (if known) | | |
| 1.9 | Marital status | | |
| | ☐ Single | ☐ Married | |
| | ☐ Divorced | ☐ Widowed | |
| | ☐ Separated | ☐ Co-habiting | |
| | ☐ Civil partnership | ☐ Not known | |
| | ☐ Other (please specify) | | |
| 1.10 | Living situation at time of death | | |
| | ☐ Alone | ☐ Spouse/partner | |
| | ☐ Spouse/partner & child(ren) <18 | ☐ Child(ren) under 18 only | |
| | ☐ Child(ren) over 18 | ☐ Parents | |
| | ☐ Other family | ☐ Adults (non-family) | |
| | ☐ Other shared | ☐ Not known | |
| | ☐ Other (please specify) | | |
| 1.11 | Occupation at time of death | | |
| 1.12 | Employment status at time of death | | |
| | ☐ Employed | ☐ Self Employed | |
| | ☐ Sheltered work | ☐ Unemployed | |
| | ☐ Long-term sick or disabled | ☐ Caring for home/family | |
| | ☐ Student (full-time) | ☐ Student (part-time) | |
| | ☐ Retired | ☐ Housewife/husbehusband | |
| | ☐ Not known | | |
| | ☐ Other (please specify) | | |

| | | |
|---|---|---|
| 1.13 | Housing status at time of death | |
| | ☐ Council/housing association | ☐ Owner-occupier |
| | ☐ Privately renting | ☐ Bed & breakfast/lodgings |
| | ☐ Homeless/no fixed abode | ☐ NHS/SSD/voluntary/ independent care provider |
| | ☐ Supervised hostel | ☐ Unsupervised hostel |
| | ☐ Prison or young offenders institution | ☐ Not known |
| | ☐ Other (please specify) | |
| 1.14 | Any previous involvement in the criminal justice system? | |
| | ☐ Yes | ☐ No/unknown |
| | ☐ Young Offenders Institution | ☐ Police arrest |
| | ☐ Police caution | ☐ Police conviction |
| | ☐ Imprisonment | ☐ Probation service |
| | When was the most recent involvement? | |
| | ☐ Within 12 months of death | ☐ More than 12 months prior to death |
| | Other comments: | |

## Section 2: Coroner related information

| | | | | |
|---|---|---|---|---|
| 2.0 | Brief description of incident | | | |
| 2.1 | Was there a suicide note? | ☐ Yes | ☐ No | ☐ Not Known |
| | If yes: | ☐ Handwritten note | ☐ Text message | |
| | | ☐ Social media | ☐ Computer/email | |
| 2.2 | Location of event: | | | |
| | ☐ Own Home | ☐ Other Home | ☐ Hospital | |
| | ☐ Prison | ☐ Railway | ☐ Bridge | |
| | ☐ Park/woodland | ☐ Quarry/wasteland | ☐ Field | |
| | ☐ Workplace/office | ☐ Street/lane | ☐ Not stated | |
| | ☐ Other (please specify) | | | |
| 2.3 | Location postcode (where possible) | | | |
| 2.4 | Method of death (if more than one, please give direct cause) | | | |
| | ☐ Self-poisoning | ☐ Carbon monoxide poisoning | | |
| | ☐ Hanging/strangulation | ☐ Drowning | | |
| | ☐ Firearms | ☐ Cutting or stabbing | | |
| | ☐ Jumping from a height | ☐ Jumping/lying before a train | | |
| | ☐ Jumping/lying before a road vehicle | ☐ Suffocation | | |
| | ☐ Burning | ☐ Electrocution | | |
| | ☐ Not known | | | |
| | ☐ Other (please specify) | | | |
| 2.5 | If self-poisoning, specify substance (tick all that apply) | | | |
| | ☐ Method not self-poisoning | ☐ Anti-psychotic drug | | |
| | ☐ Tricyclic anti-depressant | ☐ SSRI/SNRI anti-depressant | | |
| | ☐ Lithium/other mood stabiliser | ☐ Benzodiazepine/other hypnotic | | |
| | ☐ Paracetamol | ☐ Paracetamol/opiate compound | | |
| | ☐ Salicylate | ☐ Opiate (heroin, methadone, etc.) | | |
| | ☐ Other poisons (e.g. weedkiller) | ☐ Not known | | |
| | ☐ Other drug (please specify all substances or drugs not identified above) | | | |
| 2.6 | Where did the self-poisoning substance referred to above come from? | | | |
| | ☐ Method not self-poisoning | ☐ Prescribed for the subject | | |
| | ☐ Prescribed for someone else | ☐ A combination of substances prescribed for more than one person | | |
| | ☐ Not known | | | |
| | ☐ Not prescribed (please specify) | | | |

| | | | | |
|---|---|---|---|---|
| 2.7a | Was alcohol taken at time of death? | ☐ Yes | ☐ No | ☐ Not Known |
| 2.7b | If yes, please detail the level of alcohol | mg/l (blood) | mg/l (urine) | |
| 2.8a | Were other non-prescribed drugs taken at the time of death? | ☐ Yes | ☐ No | ☐ Not Known |
| 2.8b | If yes, please specify | | | |
| 2.9 | Was there any history of Alcohol Misuse?<br>☐ Yes (within last 12 months)<br>☐ Yes (more than 12 months previously) | ☐ No/not known | | |
| 2.10 | Was there any history of Drug Misuse?<br>☐ Yes (within last 12 months)<br>☐ Yes (more than 12 months previously) | ☐ No/not known | | |
| 2.11 | Were there any warning signs/evidence of risk prior to suicide? | | | |
| | ☐ No | ☐ Expressed suicidal thoughts | | |
| | ☐ Explicitly stated suicide intent | ☐ Behavioural change | | |
| | ☐ Other (please specify) | | | |

## Section 3: Medical History (Including Psychiatric)

| | | |
|---|---|---|
| 3.1a | Last Primary Care Contact:<br>☐ Less than a week prior ☐ 1 week to 1 month prior<br>☐ 1-3 months prior ☐ 3 months to 1 year prior<br>☐ Over a year prior ☐ None/unknown | |
| 3.1b | Nature of appointment: ☐ Mental Health ☐ Physical illness | |
| | Further details: | |
| 3.1c | Date of last contact with General Practitioner (if known) | |
| 3.2a | Physically and/or sensory disabling condition (non-psychiatric) at the time of death (please state if the condition is chronic or temporary) | |
| 3.2b | Medication (non-psychiatric) taken at time of death | |
| 3.3 | Number of consultations with the GP for mental health problems during the previous 12 months | |
| 3.4 | Diagnosis of any mental illness made in 12 months prior to suicide ☐ Yes ☐ No ☐ Not Known | |
| 3.5 | Current and/or on-going diagnoses (tick all that apply)<br>☐ Adjustment disorder/reaction ☐ Alcohol misuse<br>☐ Anxiety/phobia/panic disorder/OCD ☐ Bipolar affective disorder<br>☐ Dementia ☐ Depressive illness<br>☐ Drug misuse ☐ Eating disorder<br>☐ Head injury ☐ Learning disability<br>☐ Personality disorder ☐ Schizophrenia & other delusional disorders<br>☐ No mental disorder ☐ Not known | |
| | ☐ Other (please specify) | |
| 3.6 | Documentation of suicide risk by GP<br>☐ No thoughts, plans or intent of suicide documented<br>☐ Thoughts and ideas about suicide documented but no intent or plans<br>☐ Clear suicide intent or suicide plans documented | |

| | | | |
|---|---|---|---|
| 3.7a | Psychiatric treatments taken up in last 12 months prior to death (tick all that apply) | | |
| | Treatment | Specify treatment requested | Referred to |
| | ☐ Social interventions | | |
| | ☐ Talking therapies | | |
| | ☐ Prescribed medication | | |
| | ☐ Other (please specify) | | |
| | ☐ No treatment offered ☐ Treatment declined | | |
| 3.7b | Did the patient adhere to their medication/ treatment plan in the 12 months prior to death? ☐ Yes ☐ No ☐ Not known | | |
| 3.8a | History of self-harm ☐ Yes ☐ No ☐ Unknown ☐ Suicide attempt ☐ Other | | |
| | ☐ Within last 12 months ☐ More than 12 months previously | | |
| 3.8b | Number of known previous self-harm/suicide attempts in the 12 months prior to death | | |
| 3.9 | Other agencies involved in 12 months prior to suicide | | |
| | ☐ Accommodation services ☐ Alcohol services<br>☐ Employment service ☐ Faith community<br>☐ Occupational health ☐ Probation service/youth justice<br>☐ Social services ☐ Substance misuse services<br>☐ Voluntary sector services ☐ Not known | | |
| | ☐ Other (please specify) | | |

## Notes

# Appendix 2

## Data tables

| Gender | Count |
|---|---|
| Male | 188 |
| Female | 39 |
| Total | 227 |

| Age Group | Count |
|---|---|
| 10 to 19 | <5 |
| 20 to 29 | 25 |
| 30 to 39 | 21 |
| 40 to 49 | 70 |
| 50 to 59 | 40 |
| 60 to 69 | 33 |
| 70 to 79 | 17 |
| 80 to 89 | 15 |
| 90+ | <5 |
| Total | 227 |

| Sexual Orientation* | Count |
|---|---|
| Bi-sexual | <5 |
| Heterosexual | 68 |
| Homosexual | <5 |
| Not known | 154 |
| Total | 227 |

| Marital Status* | Count |
|---|---|
| Co-habiting | 18 |
| Married | 66 |
| Divorced | 23 |
| Separated | 21 |
| Single | 68 |
| Widowed | 25 |
| Not known/Other | 6 |
| Total | 227 |

| Living Situation at Time of Death* | Count |
|---|---|
| Adults (non-family) | <5 |
| Alone | 99 |
| Child(ren) over 18 | <5 |
| Child(ren) over18 only | <5 |
| Child(ren) under 18 only | <5 |
| Other (please specify) | <5 |
| Other family | <5 |
| Other shared | 5 |
| Parents | 15 |
| Spouse/partner | 48 |
| Spouse/partner & child(ren) <18 | 28 |
| Not known | 13 |
| Total | 227 |

| Ethnicity* | Count |
|---|---|
| Any other white background | 7 |
| Mixed white & black Caribbean | <5 |
| White British | 185 |
| White Irish | <5 |
| Not known | 32 |
| Total | 227 |

| Place of Birth | Count |
|---|---|
| Craven District | <5 |
| Hambleton District | 10 |
| Harrogate District | 19 |
| Richmondshire District | <5 |
| Ryedale District | <5 |
| Scarborough District | 20 |
| Selby District | <5 |
| Cumbria | <5 |
| Darlington | <5 |
| East Yorkshire | 7 |
| Hartlepool | <5 |
| Lancashire | <5 |
| Middlesbrough | 8 |
| Not Known | 12 |
| Other Australasia | <5 |
| Other Europe | 9 |
| Other UK | 45 |
| South Yorkshire | 11 |
| Stockton-on-Tees | <5 |
| Tyne & Wear | 5 |
| West Yorkshire | 46 |
| York | 16 |
| Grand Total | 227 |

| Place of Residence by District | Count |
|---|---|
| Craven | 16 |
| Hambleton | 21 |
| Harrogate | 53 |
| Richmondshire | 20 |
| Ryedale | 14 |
| Scarborough | 37 |
| Selby | 15 |
| Outside North Yorkshire | 24 |
| Unknown | 27 |
| Total | 227 |

| Employment Status* | Count |
|---|---|
| Caring for home/family | <5 |
| Employed | 74 |
| Housewife/househusband | <5 |
| Long-term sick or disabled | 7 |
| Other (please specify) | <5 |
| Retired | 56 |
| Self employed | 27 |
| Student (full-time) | <5 |
| Unemployed | 36 |
| Not known | 14 |
| Total | 227 |

| Manner of Death | Count |
|---|---|
| Burning | <5 |
| Carbon Monoxide Poisioning | 8 |
| Cutting or Stabbing | 7 |
| Drowning | 7 |
| Firearms | 13 |
| Hanging/Strangulation | 128 |
| Jumping from a height | 13 |
| Jumping/Lying before a train | 16 |
| Other | <5 |
| Self-poisoning | 25 |
| Suffocation | 5 |
| Not Known | <5 |
| Total | 227 |

| Day of Week* | Count |
|---|---|
| Monday | 39 |
| Tuesday | 32 |
| Wednesday | 31 |
| Thursday | 35 |
| Friday | 29 |
| Saturday | 35 |
| Sunday | 26 |
| Total | 227 |

| Location | Count |
|---|---|
| Bridge | 8 |
| Farm Building | <5 |
| Field | <5 |
| Hospital | <5 |
| Not Stated | <5 |
| Other | 19 |
| Other Home | 10 |
| Other Public Space | <5 |
| Own Home | 143 |
| Park/woodland | 8 |
| Quarry/wasteland | <5 |
| Railway | 16 |
| Road, street or lane | <5 |
| School | <5 |
| Workplace | 6 |
| Grand Total | 227 |

| Poison Substance | Count |
|---|---|
| Benzodiazepine/other hypnotic | <5 |
| Opiate(heroin,methadone etc) | <5 |
| Other poisions(e.g. weedkiller) | <5 |
| Paracetamol | <5 |
| Paracetamol/Opiate compound | <5 |
| SSRI/SNRI anti-depressant | <5 |
| Tricyclic anti-depressant | 5 |
| Other drug | 6 |
| Not Known | 5 |

| History of Self-Harm* | Count |
|---|---|
| Yes - Within last 12 months | 44 |
| Yes - More than 12 months previously | 35 |
| No/Not Known | 148 |
| Total | 227 |

| Previous History of Suicide Attempts* | Count |
|---|---|
| Yes | 42 |
| No/Not Known | 185 |
| Total | 227 |

| History of Drugs and/or Alcohol* | Count |
|---|---|
| Alcohol - Within the last 12 months | 30 |
| Alcohol - More than 12 months previously | 10 |
| Drugs - Within the last 12 months | <5 |
| Drugs - More than 12 months previously | 22 |

| Reasons for Attempt* | Count |
|---|---|
| Alcohol use | 20 |
| Bereavement | 39 |
| Criminal/forensic history | 9 |
| Debt | 30 |
| Diagnosed mental health | 94 |
| Drug use | 13 |
| Family breakdown | 16 |
| Ill health - acute | 15 |
| Ill health - long term condition | 25 |
| Loneliness/isolation | 12 |
| Old age | 7 |
| Problems at work | 19 |
| Recent suicide of close contact | 10 |
| Redundancy | 5 |
| Relationship ending | 42 |
| Retirement | <5 |
| Shame | 15 |
| Stress | 31 |
| Troubled background | <5 |
| Undiagnosed mental health | 28 |
| Unknown/Other | 21 |

N.B. total is greater than 227 as multiple reasons could be identified in many instances

| Contact with GP - Time* | Count |
|---|---|
| More Than a Year | 60 |
| Within previous 3 to 12 months | 30 |
| Within Previous 3 Months | 32 |
| Within Previous Month | 36 |
| Within Previous Week | 34 |
| None/Not Known | 35 |
| Total | 227 |

| Contact with A&E - Time* | Count |
|---|---|
| More Than a Year | 7 |
| Within previous 3 to 12 months | 9 |
| Within Previous 3 Months | 10 |
| Within Previous Month | 14 |
| Within Previous Week | 9 |
| None/Not Known | 178 |
| Total | 227 |

| Contact with A&E - Reason* | Count |
|---|---|
| Mental Health | 30 |
| Mental Health & Physical Health | 5 |
| Overdose | <5 |
| Physical Health | 13 |
| Not known | 178 |
| Total | 227 |

| Contact with Specialist MH Services* | Count |
|---|---|
| More Than a Year | 22 |
| Within previous 3 to 12 months | 12 |
| Within Previous 3 Months | 11 |
| Within Previous Month | 18 |
| Within Previous Week | 23 |
| None/Not Known | 141 |
| Total | 227 |

| Contact with Other Services* | Count |
|---|---|
| Accomodation services | 10 |
| Alcohol services | 7 |
| Employment Service | 5 |
| Faith community | <5 |
| Occupational Health | 5 |
| Probation service/Youth Justice | <5 |
| Social services | 6 |
| Substance misuse services | <5 |
| Voluntary sector services | <5 |
| Other | 8 |
| None/Not Known | 177 |
| Total | 227 |

* data/ conclusions are subject to the limitations of the information available within coroners' files.

## Appendix 3

The evidence base for suicide prevention strategies

Areas of the country where a suicide audit has been completed have conducted evidence reviews and included this within the audit report. Leeds and Bradford both included evidence reviews of suicide trends and the effectiveness of interventions to reduce suicide. As these reviews were conducted in 2008 and again in 2015 we have approached Bradford Council and Leeds City Council to ask their permission to include the literature search as a link to the North Yorkshire Suicide Audit.

The full literature review is available at
**www.nypartnerships.org.uk/suicideprevention**

# Appendix 4

## Characteristics of Customer Insight Groups

| Group | Description |
|---|---|
| **1** | Typically young families living in owner-occupied detached or semi-detached houses. This is a mostly rural group. The adults are more than likely to be aged 30-44 and there are high numbers of dependent children aged 0-15. Likely to be educated to degree level and working full-time. |
| **2A** | This group is located in rural areas of the county near the main road corridors. The population density is the third lowest of all the groups. Many households are married couples aged 45-64 living in their own detached homes |
| **2B** | Many households are married couples aged 45-64 living in their own large detached homes. |
| | Residents in this group are more likely than average to work in the agricultural sector and to have managerial, professional or skilled trades' occupations. There is a very high incidence of self-employment, home working and degree level education. |
| **2C** | Residents are three times more likely than average to work in agriculture with skilled trades occupations common. Self-employment is twice the county average and home working levels are high. The age profile is older than the county average but health levels are good. Typified by very rural locations. |
| **3A** | Many group 3A residents are retired older people aged 75 or more, living in purpose built flats and communal establishments. Many are living on their own, often widowed. |
| **3B** | More likely than average to be aged 65 - 84, retired and living in detached properties that they own. Many are living as a married couple although single person households are also common. Households usually have one car and are located close to settlements and are particularly found in the Scarborough area. Economic activity levels are low. |

| Group | Description |
|---|---|
| **4A** | Group 4A are often older residents (aged 45-74) living in large, owner occupied detached housing. This group has a high incidence of degree level education. Self-employment is higher than average but so are levels of retirement. Those who work often do so as managers or in professional occupations. |
| **4B** | Group 4B's age profile and household composition matches the county average closely. Residents are the most highly qualified group with just under half being educated to degree level or above. There are many managers, directors and professionals. |
| **5A** | Group 5A are often married residents aged 45-74 living in owner-occupied detached or semi-detached housing. |
| **5B** | Group 5B are often married residents with an older than average age profile. Administrative and sales occupations are common, self-employment and home working less so. |
| **6A** | Often single residents, aged 16 to 29 and living in high density urban flats rented privately or socially. Unemployment and other benefit levels are very high. Almost a third of residents have no qualifications. Those in work often work in elementary occupations and the accommodation and food service industries. This group is almost exclusively composed of residents in the Scarborough district. |
| **6B** | Mostly single residents with a high proportion aged 25 to 44. This group often work in service, sales or elementary occupations in the accommodation and food services sector or in wholesale and retail trades. A fifth of residents were born outside of the UK and do not have English as a main language. |

| Group | Description |
|---|---|
| **7** | Group 7 residents typically live in urban areas occupying rented or owner-occupied terraced housing The age profile is younger than that found elsewhere. Marriage levels are lower than average and adult residents are often co-habiting or living on their own with more than average numbers in lone parent households. Economic activity levels are high but benefit claimant levels are also high. |
| **8A** | More likely to be aged over 65 and living in privately or socially rented flats and in town. ESA and incapacity benefit claimant levels are high. |
| **8B** | Often aged 65 - 84 and living in socially rented properties, many of these semis or flats in urban areas. The proportion of residents aged 85+ is almost three times the county average |
| **9A** | A mainly urban group often comprised of families living in semi-detached or terraced housing that they own although some rent socially. There is a higher proportion of residents aged 0-15 than seen elsewhere. Residents are likely to be employed but qualification levels are lower than average and semi-skilled and unskilled occupations are common. |
| **9B** | Often families or lone parents living in socially rented semi-detached and terraced housing in urban areas. The group has a young age profile.<br><br>More likely to be unemployed or looking after home and family than other groups, a high proportion of households have no adults in employment. A third have no qualifications |
| **10** | Mostly young married couples or young families, living in privately rented semi-detached or terraced housing or single people in large communal establishments. A fifth are aged 16 to 24.<br><br>Economic activity is high. Likely to work full-time, particularly in public admin and defence (military). Many have level 2 or level 3 qualifications and few have none |

In addition to the identified key most at risk groups, a number of other key groups could be identified as demonstrated by the following 'generic subject profiles' which use fictitious names and do not relate to specific cases:

**1. Older individuals coming to terms with increasing frailty**

Norman was 82 and lived alone in the house he had shared with his wife until her death around two years ago. They had been married for over 40 years and whilst Norman initially struggled to come to terms with his loss, he had a good network of friends in the local area who helped support him through his grief.

After working for over 35 years Norman retired from his job as an electrical engineer in his early 60s and enjoyed an active retirement, socialising with friends and playing more than just an occasional round of golf.

Norman had enjoyed relatively good health throughout his life, although he had arthritis in some of his joints. However, over the last year, the arthritis had become progressively worse, limiting his mobility and he'd had to give up his golf about six months ago. Although he was experiencing increasing pain, he was reluctant to see his GP. Norman was starting to become more and more concerned for his independence, and although he could still climb the stairs at home, it was becoming a real challenge which was starting to leave him feeling tired and breathless.

His friends noticed that Norman was becoming less outgoing, less sociable and smile less than he had previously. Although they were concerned, they thought he might start to bounce back once he got over having to hang up his golf clubs for good.

However, Norman became increasingly convinced that the time would soon come when he'd have no option other than to sell his house and move into some kind of care setting. The pain from the arthritis was getting worse, intolerable on a bad day, and he didn't want to end up seeing out his days in pain in a care home.

**2. Erratic and turbulent lifestyles**

Jeremy was 39 and lived on his own in a small rented flat. He'd tried his hand at a number of jobs, but never for very long and at the time of his death he was unemployed.

Since his early 20s Jeremy had struggled with depressive episodes and this had caused problems with relationships. He'd been in two long-term relationships and had a five year-old daughter, although his ex-partner had moved out of the area, which meant he'd lost contact with his daughter.

After splitting up with his ex-partner Jeremy found himself turning to alcohol, and although he wouldn't see himself as an alcoholic his drinking was starting to affect his health.

Following the end of a relationship Jeremy found it difficult to build stability into his life, and this manifested itself in difficulties keeping a job and problems paying rent. This led to Jeremy moving from job to job and flat to flat, often leaving debt behind him.

Jeremy had recently started a new relationship and although there was sometimes talk of moving in together, Jeremy became concerned that his new girlfriend was seeing other men. This led Jeremy to become increasingly depressed and drink more heavily, which in turn led to his new girlfriend ending the relationship.

### 3. Impact of Criminal Behaviour

Arrest for possession and/or distribution of indecent images of children, or allegations of sexual offences where the victim was a child.

Adam was 47 and worked as an accountant for a business based in Leeds. He had been married for around 20 years and had two children, the eldest of which was at University.

He and his wife both led busy lives but found time to relax together and were both members of a local badminton club, and true to his profession, Adam acted as club treasurer.

Early one morning Adam awoke to a knock at the door to discover the police on his doorstep with a warrant to search the house. The police arrested Adam on suspicion of possession of indecent images of children, seized Adam's personal and work laptop, his smartphone, his wife's tablet and smartphone.

Adam was taken to a local police station where he was interviewed under caution and then released on bail pending a decision about whether to charge Adam with any offences. Adam knew that the police would find either images or visits to websites that would lead to him being charged, and saw his life unravelling in front of him. He knew that he'd have to explain to his wife and family what had happened, tell his employer he'd been arrested and face suspension from work.

### 4. Theft from the workplace - typically low value theft

Katie was 34 and lived alone in a flat she rented. She had been on her own since splitting up with her boyfriend two years ago. Katie found the end of the relationship difficult to deal with, but she was persuaded to see her GP who diagnosed mild to moderate anxiety and Katie responded well to treatment.

Up until last year, Katie had enjoyed her job as a team leader in a busy office for a local company. However, the company had needed to make cutbacks and Katie was made redundant.

Although she'd been initially positive about finding a job, Katie had found it difficult to find something that had paid as well as her old job and she was now working as a sales assistant in a local shop. The redundancy payment she had received from her previous employer had been spent and now Katie was really starting to struggle with bills. She was a month behind with her rent and would have struggled to pay the current month's rent without the gas bill that had recently arrived.

Katie was becoming increasingly anxious about her financial situation and felt as if she had nowhere to turn. When she received a reminder for her gas bill she panicked and took £100 from the till at the shop she worked at. When the shop manager reconciled the day's sales she noticed that the takings were £100 short. She asked Katie if she knew anything about it and Katie confessed that she'd taken the money. She apologised and offered to pay the money back but she was immediately dismissed.

With no job and no earnings Katie couldn't see a way forward. She'd found it hard enough to find a job, without having to tell prospective employers that she'd been dismissed from her last job for theft. Already behind with her rent and unable to pay the gas bill became convinced that she would face eviction from her home and would be homeless very soon.

# Appendix 5

## Contributory Factors

| Contributory Factor | Total Number of Incidents[6] | Percentage of Total Incidents[7] |
|---|---|---|
| **Diagnosed mental health** | **94** | **41.4%** |
| **Relationship ending** | **42** | **18.5%** |
| **Bereavement** | **39** | **17.2%** |
| **Stress** | **31** | **13.7%** |
| **Debt** | **30** | **13.2%** |
| **Undiagnosed mental health** | **28** | **12.3%** |
| **Ill health - long term condition** | **25** | **11.0%** |
| Unknown/Other | 21 | 9.3% |
| Alcohol use | 20 | 8.8% |
| Problems at work | 19 | 8.4% |
| Family breakdown | 16 | 7.0% |
| Ill health - acute | 15 | 6.6% |
| Shame | 15 | 6.6% |
| Drug use | 13 | 5.7% |
| Loneliness/isolation | 12 | 5.3% |
| Recent suicide of close contact | 10 | 4.4% |
| Criminal/forensic history | 9 | 4.0% |
| Old age | 7 | 3.1% |
| Redundancy | 5 | 2.2% |
| Troubled background | 4 | 1.8% |
| Retirement | 3 | 1.3% |

6 Total exceeds 227 incidents as more than one contributory factor could be identified in the case of most incidents

7 Percentages expressed as a proportion of the 227 incidents recorded

## References

1. Suicide Prevention Strategy for England
**https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england**

2. National Suicide Prevention alliance **http://www.nspa.org.uk/**

3. Public Health Outcomes Framework **http://www.phoutcomes.info/**

4. Future in mind **https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf**

5. Mental Health Crisis Care Concordat
**http://www.crisiscareconcordat.org.uk/about/#the-concordat**

6. North Yorkshire Joint Health and Wellbeing Strategy 2013-2018
**http://www.nypartnerships.org.uk/jhws**

## Contact us

**Suicide Prevention www.nypartnerships.org.uk/suicideprevention**

Claire Robinson: Health Improvement Manager
Public Health, Health and Adult Services, North Yorkshire County Council, County Hall
Northallerton, North Yorkshire. DL7 8DD

Direct Line 01609 534919  Mobile 07773156288

**North Yorkshire County Council, County Hall, Northallerton, North Yorkshire, DL7 8AD**

Our Customer Service Centre is open Monday to Friday 8.00am - 5.30pm
(closed weekends and bank holidays). Tel: **01609 780 780**
email: **customer.services@northyorks.gov.uk** web: **www.northyorks.gov.uk**

If you would like this information in another language or format please ask us.
Tel: **01609 780 780** email: **customer.services@northyorks.gov.uk**

64323 03/16