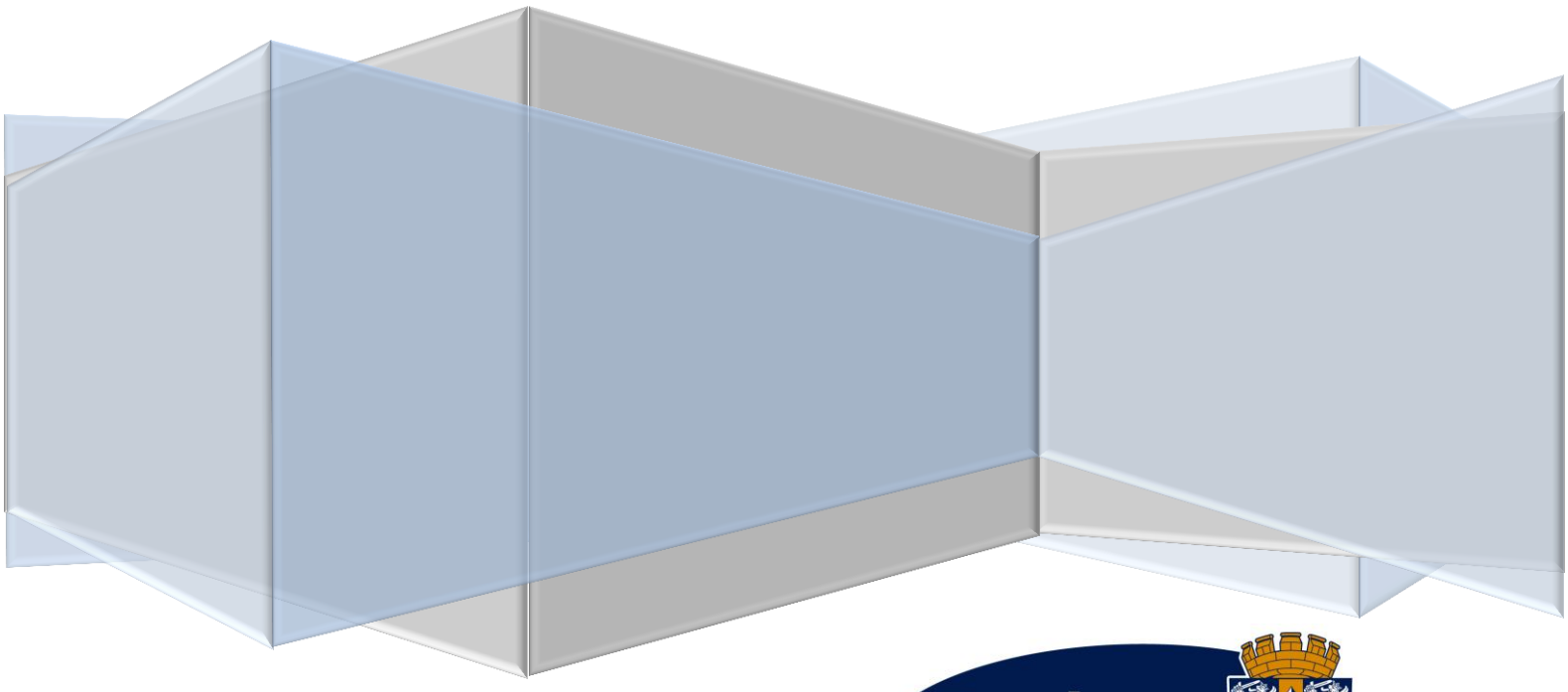
Self-harm and Suicide Audit 2012-14

County Durham

Authors: Kirsty Gail Wilkinson and Keith Allan



Durham County Council

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1. Purpose

This report presents the analysis of deaths by suicide and undetermined injury that occurred in the County Durham area from 2012 to 2014. This report covers 3 years and provides a bridge between the previous audit undertaken by Tees, Esk and Wear Valleys NHS Foundation Trust and the last full calendar year (2014).

Whilst providing the analysis of recent cases the report will also make recommendations for future prevention work.

2. Background

In 2013 suicide prevention became a local authority responsibility. Suicide prevention cannot be undertaken in isolation by the local authority but requires working in partnership with the police, clinical commissioning groups (CCGs), NHS England, Coroners and the voluntary sectors to be effective. The rate of suicide per 100,000 population is a performance indicator in the Public Health Outcomes Framework (PHOF).

Public Health England, in its 2014 Guidance for developing a local suicide prevention action plan identified local suicide audits as being an effective way for authorities to identify and respond to high risk groups in their areas, as well as reveal hot spots.

An audit of suicides through the systematic collection and analysis of local data on suicides can provide valuable information to learn lessons and inform suicide prevention plans.

3. Methodology

This report is based on data collected locally as part of the locally established audit and prevention scheme. Following a Coroner's report of suicide, open verdict or narrative verdict information was collated by the Public Health Team drawing together information from a variety of partners including primary care, social care, substance misuse, hospital and mental health services.

4. Summary

There were 198 deaths by suicide or undetermined injury in County Durham between 2012 and 2014. Eight of these deaths were non-County Durham residents and therefore have not been included in the analysis. The analysis is therefore based on 190 deaths.

Of the 190 deaths 75% were male (142) and 25% were female (48).

67% (128) of all cases were people under the age of 50.

Just over a third of cases were employed at the time of death 33% (63), a further 31% (59) were unemployed, 11% (21) were retired and 7% (14) were long-term sick or disabled.

In 34% (65) of cases the person lived alone at the time of death.

Hanging/strangulation was the most common method of suicide and occurred in 68% (129) of cases. In a further 22% (42) of cases the method was self-poisoning. In 66% (126) of cases the location was home.

Toxicology reports indicate that 32% (61) cases had alcohol in the blood at the time of death. Of these cases 64% (39) were over the legal driving limit of 80 milligrams of alcohol per 100 millilitres of blood.

51% (97) of cases had been known to the police prior to their death, 25% (24) had been in contact with the police in the three months preceding their death.

5% of all cases (9) were prisoners at the time of death. A further five people died within a year of being released from prison.

A date of last contact with a GP was known for 125 cases, of which 80 (65%) had been seen by a GP within three months of their death.

95 (50%) of cases were recorded as being known to mental health services at some point prior to their death, of these cases 7 (4%) had been referred to mental health services but were never seen. 54 cases (57%) had been seen by mental health services in the three months prior to death.

Themes were identified for 158 of the 190 cases. The most common single theme was relationship problems/breakdown which features solely in 22 of the cases. This also featured in a further 16 cases where there were multiple themes. 24% of all cases (38) featured relationship problems/breakdown. Financial/debt featured in 13% (20) of cases and bereavement in 12% (19).

5. Public Health Outcomes Framework: Suicide Rates

According to the Public Health Outcomes Framework (PHOF) County Durham has a suicide rate of 13.3 per 100,000 population for the 2012-14 aggregated data. This remains above the suicide rate for the North East (11.0 per 100,000 population) and significantly higher than the suicide rate for England (8.9 per 100,000).

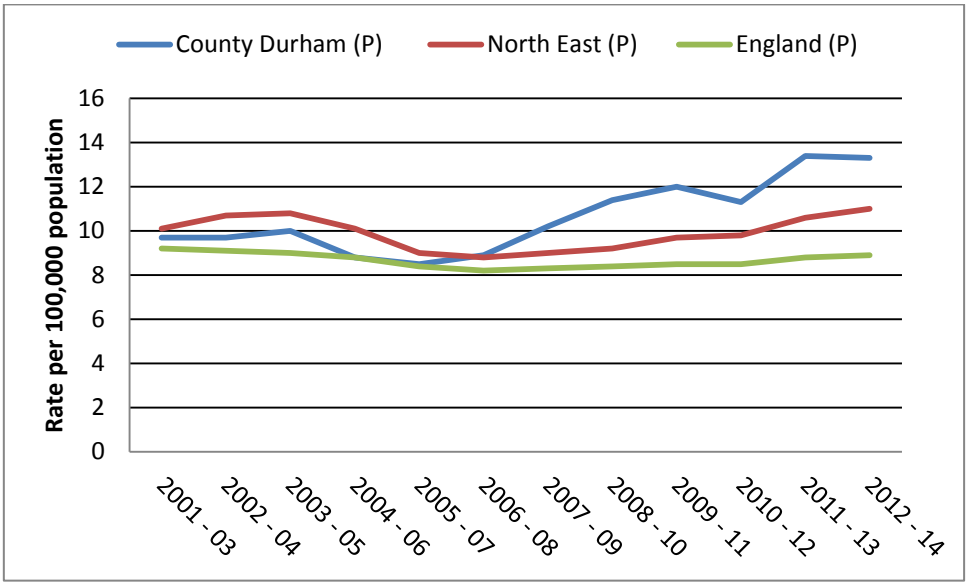

Figure 1: Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (Persons)

Suicide rates for males in County Durham are continuing to increase. In 2012-14 they stood at 20.6 per 100,000 population. The suicide rates for males are higher than those in the North East (17.9 per 100,000 population) and England (14.1 per 100,000 population).

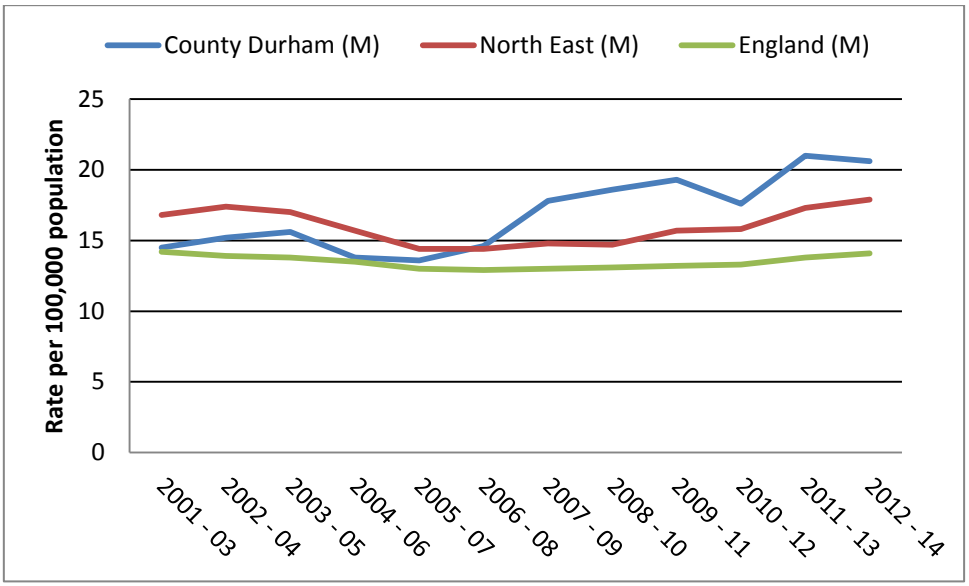

Figure 2: Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (Males)

Suicide rates for females in County Durham are increasing. In 2012-14 they stood at 6.1 per 100,000 population. The suicide rates for females are significantly higher than those in the North East (4.5 per 100,000 population) and England (4.0 per 100,000 population).

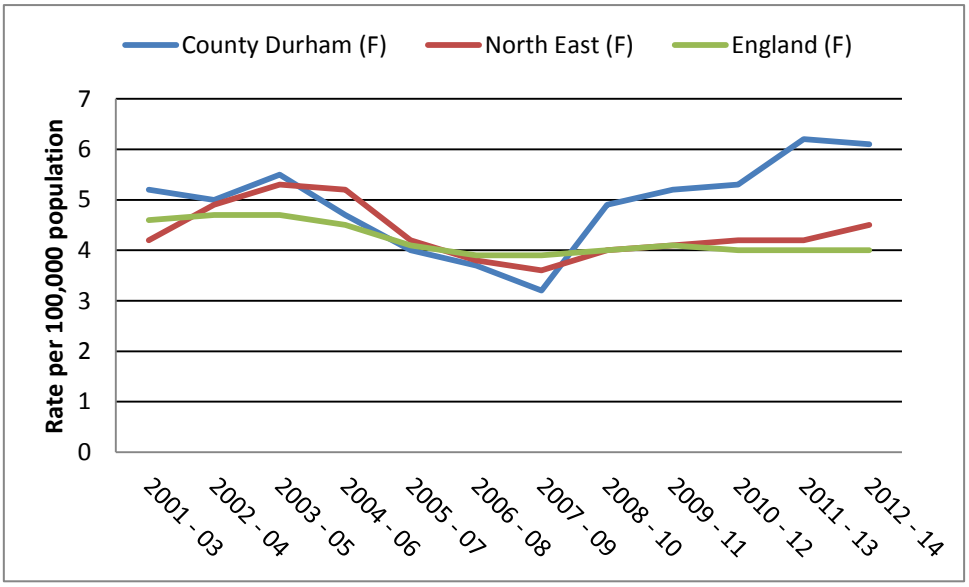

Figure 3: Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (Females)

The suicide rate reported in the PHOF data is recorded by date of registration of death rather than date of death. This means there are minor discrepancies between the rates reported nationally and the local audit data.

6. Self-harm rate of admission

Certain forms and sustained patterns of self-harm may be a risk factor for dying by suicide. Recording of self-harm is highly problematic however. The term can be used to describe a wide variety of behaviour from self-cutting to attempted suicide. An added complication is that the intent behind the action is often not known. Furthermore data is only routinely available for cases which result in admission to hospital. Most incidences of self-harm will not result in an attendance at hospital and of those that do only a proportion will actually be admitted rather than treated and sent home. Therefore the reported statistics may be the tip of an iceberg in terms of incidence and prevalence and consequently risk.

Figure 4 below demonstrates the differences in self-harm admission rates between genders and age groups. In males, across the date range, the highest rates are seen in those aged 25 to 34. In females the rates tend to be higher in females in general with a peak amongst 15 to 24 year olds.

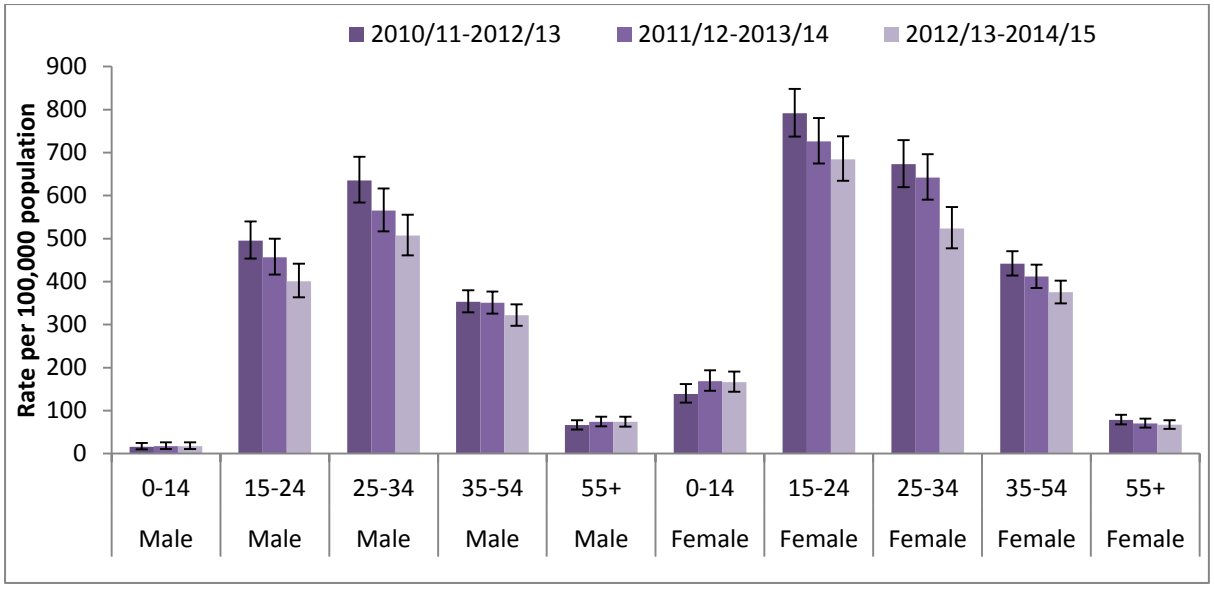

Fig. 4 Rate of admissions for self-harm by age and sex per 100,000, County Durham, 2010/11-2012/13 to 2012/13-2014/15

Figure 5 below that the majority of admissions for self-harm are in people who live in more deprived areas.

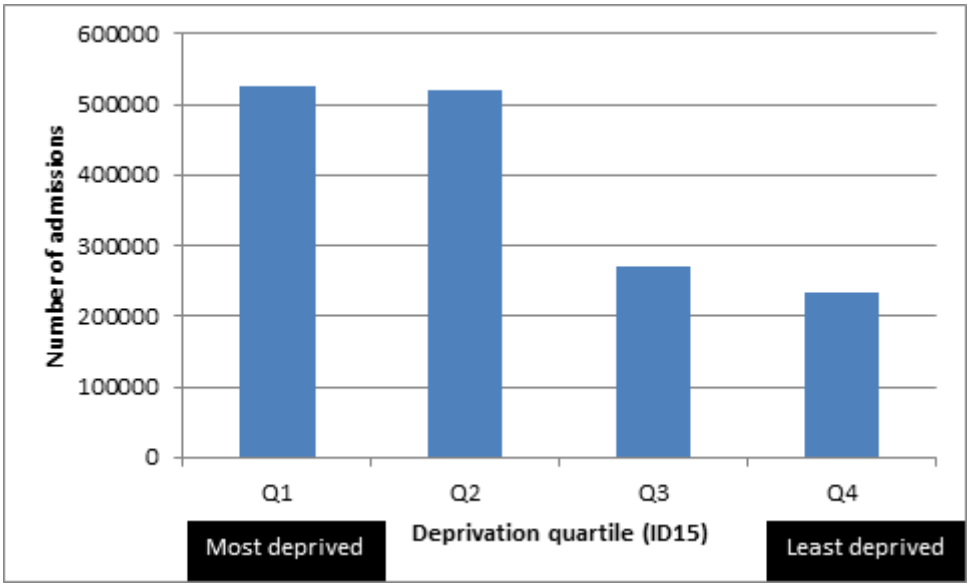

Fig. 5 Number of admissions for self-harm by deprivation quintile, County Durham, 2010/11-2012/13 to 2012/13-2014/15

7. Local Audit Suicide Rates

The following information is based on the local audit findings, which is presented by date of death rather than registration of death. The audit includes the deaths of County Durham residents where the coroner has reached the verdict of suicide or misadventure as well as open and narrative verdicts.

The suicide rate taken from the local audit data stood at 11.13 per 100,000 population in 2014 which had reduced from 13.5 per 100,000 population seen in 2013.

Year of Death	Female	Male	Total	Population	Rate per 100,000 population
2012	13	50	63	515,578	12.22
2013	21	48	69	518,330	13.50
2014	14	44	58	521,202	11.13

Table 1: Suicide numbers & rates per 100,000 population in County Durham 2012-14

The geographical breakdown of numbers of suicides reveals Durham and Derwentside areas as areas with high numbers of suicides between 2012 and 2014. Removing the cases where the death has occurred in prison identifies the former Derwentside and Durham areas as having the highest numbers and rates across the three years. Elvet ward, which includes Durham Prison and University student accommodation, was identified as experiencing the highest numbers of deaths by suicide in 2012-14. Coxhoe ward featured the second highest numbers of deaths by suicide.

Former local authority area	2012 rate per 100,000 (n)	2013 rate per 100,000 (n)	2014 rate per 100,000 (n)	Population (2013 mid year)
Durham	14.5 (14)	16.5 (16)	15.5 (15)	96,680
Derwentside	16.3 (15)	16.3 (15)	14.1 (13)	92,146
Easington	11.6 (11)	7.4 (7)	7.4 (7)	95,153
Sedgefield	8.0 (7)	12.6 (11)	8.0 (7)	87,537
Chester Le Street	Suppressed (no. less than or equal to 5)	12.9 (7)	11.1 (6)	54,228
Durham Dales	12.2 (11)	14.4 (13)	11.1 (10)	90,213

Table 2: Suicide rates & numbers by former lower level local authority area 2012-14

8. Local Analysis

8.1 Demographics

There were 198 deaths by suicide or undetermined injury in County Durham between 2012 and 2014. Eight of these deaths were non-County Durham residents and therefore have not been included further in the analysis. The analysis is therefore based on 190 deaths.

Of the 190 deaths recorded in County Durham between 2012 and 2014 75% (142) were male and 25% (48) were female. The number of male suicides has decreased year on year since 2012. There was a peak in female suicides in 2013.

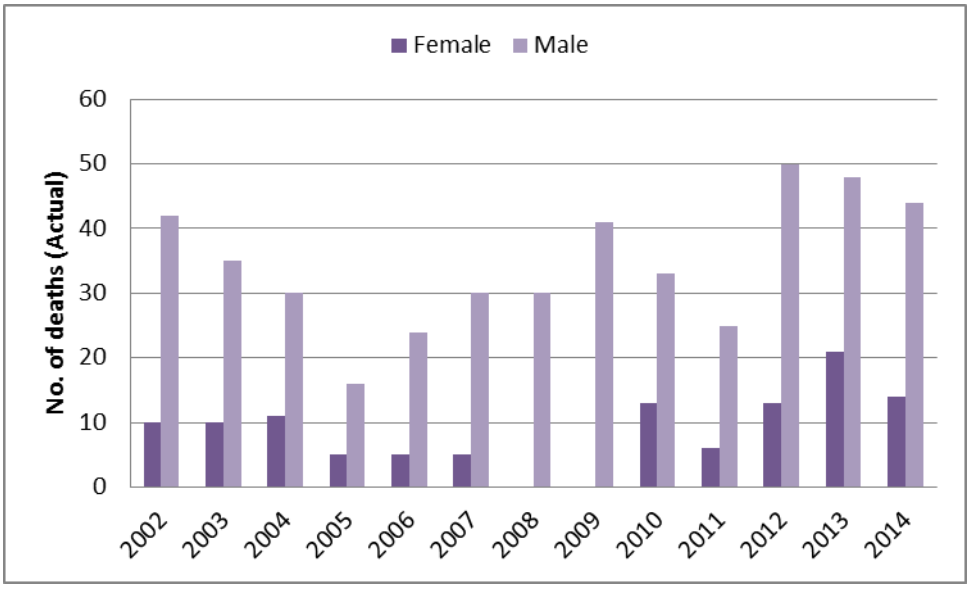

Figure 6: County Durham deaths by suicide and undetermined injury by gender 2002-2014 (N.B. numbers of deaths in females for 2008 and 2009 have been suppressed due to low numbers)

Of the suicides and undetermined injuries 67% of both male and female cases were of people who were under the age of 50 at time of death. The greatest numbers of deaths were seen in those aged 40 to 49 (in part due to the age structure of the county). There was however relatively high numbers of deaths by suicide in those aged 20 to 59, with higher numbers seen in males. Whilst suicide is relatively rare in children and young people there were nine deaths recorded in those 19 and younger. At the other end of the age distribution there were eight deaths by suicide or undetermined injury in those aged 70 years or more.

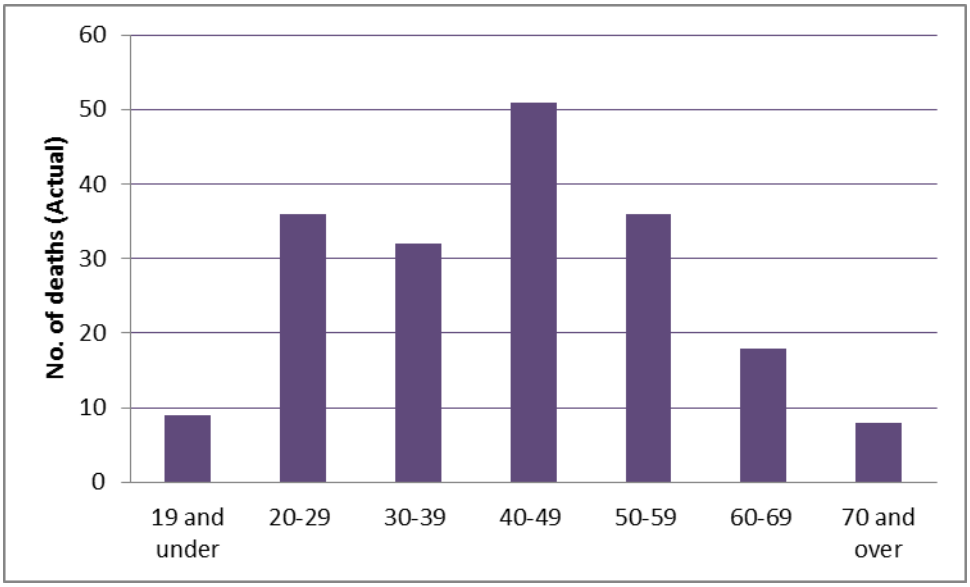

Figure 7: Deaths by suicide and undetermined injury by age cohort 2012-14

Table 3 below shows the living arrangements of those who are suspected of dying by suicide. The largest group was those living alone (34%) however the majority of people who died were thought to have lived with other people. A total of 32 people who lived alone (49% of those living alone) also had contact with mental health services. This may be an issue as social isolation and some forms of mental health problems are known to be associated with increased suicide risk.

Lived with	Cases (n=190)
Alone	65
Spouse/partner	41
Spouse/partner and children under 18 years	22
Parents	21
Other or not known	13
Other family and other shared	12
Prison	8
Children	8

Table 3: status at time of death 2012-14

In 2012-14 the employment status in most cases at time of death was employed or unemployed. There were also higher numbers of retired, long-term sick or disabled and students than the 2011-13 audit.

Employment Status	Cases (n=190)
Employed	63
Unemployed	59
Retired	21
Long-term sick or disabled	14
Student (full time)	12
Other	6
Self Employed	Suppressed (no. less than or equal to 5)
Unknown	Suppressed (no. less than or equal to 5)
Caring for home/family; Housewife / househusband; Employed part-time	Suppressed (no. less than or equal to 5)

Table 4: Employment status at time of death 2012-14

In the 2012-14 period covered by this audit, 68% (129) of the cases the method of death was by hanging/strangulation with 22% (42) through self-poisoning. This mirrors the pattern seen in previous years. The substances used for self-poisoning were identified in 38 cases, this was most commonly an opiate or opioid analgesic (14 cases), followed by the use of multiple substances in 10 cases.

In 61 cases (32%) toxicology indicates alcohol in the blood at time of death. One in five of all cases of suicide had more than the drink drive limit in their blood at time of death (80 milligrams of alcohol per 100 millilitres of blood).

The most common suicide location was the home with 66% (126) accounting for this location.

Location	Cases (n=190)
Home	126
Wooded Area	18
Hospital	11
Prison	8
Other	17
Other Address (including friends or family)	10

Table 5: Location of suicides 2012-14

More suicides occurred on a Sunday than any other day across the three-year audit period with one in five occurring on this day.

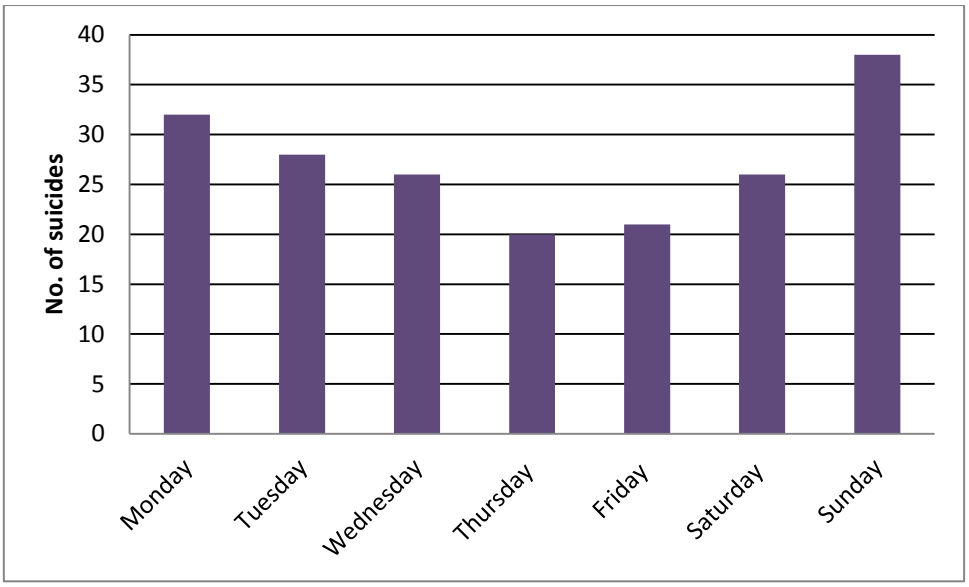

Figure 8: Death by suicide by day 2012-14

The months of February, March, April, July and October experienced higher than average numbers of deaths by suicide across the three years.

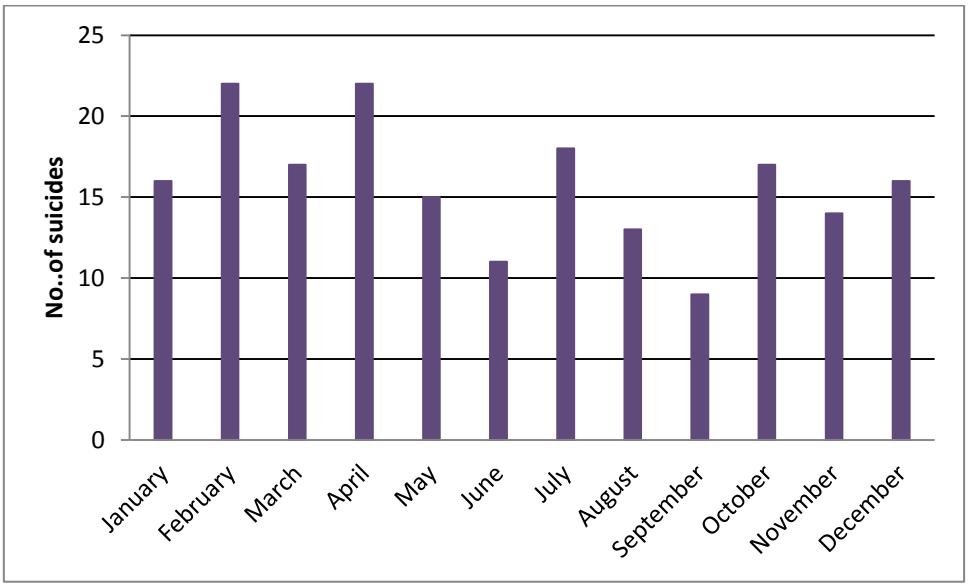

Figure 9: Death by suicide by month 2012-14

8.2 Minority groups

Nationally Gay, lesbian and bisexual adolescents are at higher risk for mental health problems and associated risk behaviours including suicidal behaviour (Blake et al, 2001). The risk appears to be greatest during adolescence and early adulthood, diminishing as people age (Cochran, 2001).

There are a number of environmental factors such as victimisation experiences, social isolation and the use of substances to cope with associated stress which may explain this increased risk (Blake et al, 2001).

Whilst sexual orientation is a field within the audit data it tends to be poorly recorded. There is usually only data available where this has been raised within the Coroner's investigations. Within the current data sexuality was not known for the majority of cases, 'heterosexual' was given as the next largest group. It seems unlikely that the number of people who would have identified as homo- or bisexual who died from suicide would be as few as recorded in the dataset (fewer than five).

Suicide risk has also been linked to being part of a minority ethnic group or being a recent immigrant to a country (McKenzie et al, 2003). Again while ethnicity is recorded within the dataset it does not provide fine grain description, therefore we are limited in the inferences that may be drawn from the available information. The current data shows that 125 of the deaths were in people who were identified as being 'white British'. In 57 cases ethnicity was not known. The remaining deaths were amongst people of 'other ethnic groups'.

8.3 Contact with Criminal Justice Services

Between 2012 and 2014 there were 9 deaths from suicide in prison. A further five suicides took place within a year of release from prison.

Only a minority of 14% (27) of cases had ever been known to the Probation Services. Eight people had their last contact with the probation service within three months prior to their death and a further four people had contact a year prior to their death.

A small majority of cases (51%, 97) were known to the police prior to death. A quarter (24) had their last police contact within three months of death. A further 18% (17) had their last contact with the police within a year of their death.

8.4 Contact with GP Services

A date of last contact with GP services was known in 125 cases. Of these cases 64% (80) were seen within three months of their death. The majority of these consultations may not have been directly related to suicidal ideation or mental health. In nine cases a suicide risk was noted in GP records, with a further 19 people having multiple risks noted. Previous attempted suicides were recorded in eight cases.

8.5 Contact with Acute Services

There were 39 cases which had contact with A&E/hospital services in the year prior to their death. While 10 were associated with overdose (of which we do not know the proportion which were intentional or indeed attempted suicide), the majority were from a range of conditions not necessarily associated with suicidal ideation or mental ill health.

Treatment for general medical conditions was the next most common cause of an A&E/hospital contact (six cases) followed by gastrointestinal (five cases). There were fewer than five cases per each of the remaining categories, including contact for reasons of mental illness or alcohol problems. 6 cases were known to have a psychological assessment prior to discharge.

8.6 Contact with Mental Health Services

Fifty percent of cases (95) had been referred to or were known to mental health services at some point in their lives. Of these individuals 63 had been seen in the 12 months prior to their death, with the majority (54 people, 57%) being seen in the three months prior to death. Of those referred to mental health services seven cases had never been seen.

Where cases had been seen by mental health services in the six months prior to death (57) a known diagnoses were:

Mental Health Diagnosis	Cases
Multiple diagnosis	7
Depressive illness	6
Bipolar affective disorder	Suppressed (less than or equal to 5)
Other (including personality disorder; Schizophrenia & other delusional disorders; Adjustment disorder/reaction; Anxiety/phobia/panic disorder/OCD; and drug misuse)	19

Table 6: Mental Health Diagnosis 2012-14

Other and multiple diagnoses include:

- Depression, pathological jealousy, bi-polar and emotionally unstable personality disorder
- Alcohol and drug misuse
- Anxiety and Depression
- Bipolar Affective Disorder & Emotionally Unstable Dependant Personality Disorder
- HIV, Mental and Behavioural Disorder due to multiple drug use & use of other psychoactive substances
- Mixed anxiety, depressive disorder and schizophrenia
- Mixed anxiety and depression

- Alcohol dependence, suicidal idealisation, severe depressive disorder
- Psychotic depression, differential OCD
- Schizoaffective disorder, Personality Issues, Polydrug misuse
- Moderate depressive episode with somatic symptoms, low mood & anxiety
- Autism spectrum disorder (ASD) & Attention deficit hyperactivity disorder (ADHD)
- Mixed Anxiety and Depressive disorder
- Social anxiety & low mood

8.7 Themes

Themes were identified in 158 cases. Most cases were identified as displaying multiple themes. The most common single theme was relationship problems/breakdown. Relationship problems/breakdown was also mentioned most in the multiple themes followed by financial/debt problems (although it is unclear if relationship break-up triggered suicide or if mental illness, poor coping strategies and suicidal ideation contributed to relationship break-up).

Themes	Cases (n=158)
Multiple themes	42
Relationship problems/breakdown	22
Mental Health Diagnosis	16
Ill-health/Illness	13
Bereavement	9
Financial/debt problems	6
Emotional distress	Suppressed, 5 or fewer
Family problems/breakdown	Suppressed, 5 or fewer
Court Hearing pending	Suppressed, 5 or fewer
Under Police Investigation	Suppressed, 5 or fewer
Depression	Suppressed, 5 or fewer
Drug misuse	Suppressed, 5 or fewer
Alcohol misuse	Suppressed, 5 or fewer
GP – Mental Health diagnosis	Suppressed, 5 or fewer
Other	25

Table 7: Identified themes

9. Conclusion

The pattern of suicide in County Durham mirrors the national picture with young males making up a significant proportion of deaths by suicide in County Durham. In County Durham for 2012-14 the greatest number of cases of deaths by suicide was in males age 40-49. While there are often multiple possible triggers or themes associated with a death by suicide we can see that a sudden change in

circumstances, be that financial or social, was associated with a significant number of the recorded deaths.

10. Beyond the Audit

The early alert and review process, from which the information for this audit was drawn, is only one part of the suicide prevention and wider wellbeing work carried out in the county. A number of activities which seek to minimise onward risk of those people exposed to suicide and to support individuals

10.1 Support following suicide

Suicide postvention support is offered in County Durham via 'If U Care Share' (a local charity), which is based on the American model, where support is facilitated by people who themselves have been bereaved by suicide. The team offers outreach to those bereaved by suicide within two days of receiving a referral, with family members being offered practical and emotional support by responding officers.

10.2 Welfare Rights

Durham commissions a dedicated welfare rights service targeted through the Men's, and Women's Sheds programme (locally known as CREEs). Welfare rights and financial issues can impact on suicide rates especially in periods of economic recession.

Evidence suggests that family support and debt relief programmes may be beneficial to those who are at risk of suicide due to financial worries and should therefore be incorporated into any suicide prevention strategy.

Participants identified as being bereaved by suicide are eligible for support from a welfare rights worker who provides them with a wide range of services.

10.3 Relationship support

Relationship breakdown was identified by the County Durham suicide audit as a risk factor in someone taking their own life, therefore it is important to offer relationship support and advice to those who may be socially isolated, or find it difficult to maintain meaningful relationships.

A national charity within County Durham, RELATE is commissioned to offer counselling, support and information for all relationships including couples and family therapy.

10.4 Men's, Women's and Young People's Sheds (CREEs)

The Durham CREE programme is based on the Australian Men in Sheds model to reach out to people who may be isolated and vulnerable in the community. There are a number of CREEs across County Durham that can offer community based support

and reduce social isolation. Welfare rights support is also available through the CREEs:

http://www.suicidesaferdurham.uk/get-involved/

10.5 On-line support

Durham has also developed an on line support for people who may be at risk of suicide and for people who are concerned about others. This contains a range of information, links to CREE programme, and telephone support lines:

http://www.suicidesaferdurham.uk/i-need-help/

10.6 Wellbeing support (WBfL)

The WBfL service is managed and delivered by a consortium of voluntary sector and public sector organisations. The service provides 'one to one' support, group activities, volunteering opportunities and community development approaches. One of the main outcomes of the wellbeing for life programme is to reduce social isolation and work to enable people to connect with others in their communities:

http://www.wellbeingforlife.net/

10.7 Others sources of support and help:

http://www.suicidesaferdurham.uk/i-need-help/

11. Recommendations

It is recommended that:

- A focus should be put on upstream interventions designed to support mental health and wellbeing in residents of County Durham.
- Prevention of deaths amongst the high risk group identified in the audit should remain a priority.
- Support for those self-harming, possibly targeted towards the at risk group of young females identified in the audit, should be a priority. This may take the form of work to support mental resilience within school age children (to provide lifelong skills which will promote mental wellbeing) and/or the collating of available services in an easy to access portal.
- The Suicide Prevention Alliance continue to review the most up to date data available.
- Additional work with criminal justice agencies should be undertaken to support staff in considering suicide risk when an individual has been in contact with the police or wider criminal justice system.

- Work to support access to welfare and benefits should continue and be supplemented with access to debt management advice as financial problems were a theme identified in a significant proportion of cases.
- Consider opportunities to reduce social isolation (especially in those known to mental health services) within the population.
- Work with partners to promote appropriate access to out of hours and weekend crisis support.

12. References

Blake, S.M., Ledsky, R., Lehman, T., Goodenow, C., sawyer, R., Hack, T., 2001. Preventing Sexual Risk Behaviors Among Gay, Lesbian, and Bisexual Adolescents: The Benefits of Gay-Sensitive HIV Instruction in Schools. American Journal of Public Health, 91 (6), pp. 940-946.

Cochran, S.D., 2001. Emerging issues in research on lesbians' and gay men's mental health: does sexual orientation really matter? Am Psychol, 56 (11), pp. 931-947.

McKenzie, K, Serfaty, M., Crawford, M., 2003. Suicide in ethnic minority groups. The British Journal of Psychiatry, 183 (2), pp. 100-101.