Health and Wellbeing Board

16 March 2017

Self-Harm and Suicide Audit 2012-14

Report of Gill O'Neill, Interim Director of Public Health, Adult and Health Services, Durham County Council

Purpose of the Report

1 This report is to update the Health and Wellbeing Board regarding deaths by suicide and undetermined injury that occurred in the County Durham area from 2012 to 2014, the full Audit report is attached at Appendix 2. This report covers three 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 cases the report will also make recommendations for future prevention work.

Background

2 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 sector to be effective. The rate of suicide per 100,000 of the population is a performance indicator in the Public Health Outcomes Framework (PHOF).

3 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.

4 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. In order to draw together meaningful numbers while still preserving the anonymity of those involved, a three year pool of data is used. This audit uses information from 2012 to 2014. The next will use 2013 to 2015 data and will be written this year.

5 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.

6 Over the last few months Durham County Council's Overview and Scrutiny have undertaken a detailed review of suicide. The information received is currently being analysed and a number of recommendations will be produced. The recommendations will be integrated with the new County Durham Mental Health Strategy. This is to be an overarching mental health strategy amalgamating children, adults, and suicide into one document. Underneath the overarching strategy will be a dedicated suicide prevention plan on a page. It is important to note that County Durham's Local Safeguarding Children Board (LSCB) have taken a specific interest

in self harm through a dedicated work stream. There is a standalone Self-Harm Action Plan being progressed. For the remainder of this report suicide will be the focus.

7 There are a number of activities which seek to minimise onward risk of those people exposed to suicide and to support individuals. These are highlighted below:

Suicide Prevention Interventions in County Durham

8 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.

9 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.

10 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.

11 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.

12 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.

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

14 Reducing social isolation is a priority for County Durham and loneliness has an association with suicide. Joint working has progressed with Area Action Partnerships, partners such as fire and rescue and other commissioned services to deliver effective and evidence based community interventions which engage vulnerable people into services and become an active member of their community.

15 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 (**Link**).

16 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 the CREE programme, and telephone support lines (**Link**).

17 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 (**Link**).

18 Other sources of support and help are detailed on the Suicide Safer Durham webpages (**Link**).

19 Further work is planned with the Criminal Justice System (CJS) to ensure pathways of support are seamless for people going through probation or are being released from prison. Partnership working is being progressed with Durham prison services.

20 The CCGs in County Durham have been leading on improvements in mental health crisis care. The Mental Health Partnership Board are approving plans and the Health and Wellbeing Board will receive for further discussion and ratification.

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;
- There were 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;
- 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 65% (80) had been seen by a GP within three months of their death;

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

Recommendations

21 The Health and Wellbeing Board is requested to accept the audit and the following recommendations:

- 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 groups 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. This will be covered in the children's mental health plan on a page and LSCBs work on self-harm;
- The Suicide Prevention Alliance continues 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.

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Appendix 1: Implications

Finance
Suicide prevention response had a financial implication as a number of the services put in place are paid for from the Public Health grant.

Staffing
Currently suicide prevention is part of the portfolio of a PHSMT member and also a suicide co-ordinator role is paid for. This is in addition to procured programmes and services.

Risk
No implications

Equality and Diversity / Public Sector Equality Duty
Risk of suicide may be higher in some minority groups. It is therefore necessary to understand this local risk.

Accommodation
No implications

Crime and Disorder
No implications

Human Rights
No implications

Consultation
No implications

Procurement
The Public Health team procures a number of services to reduce the risk of suicide within the county.

Disability Issues
Risk of suicide may be higher in some minority groups. It is therefore necessary to understand this local risk.

Legal Implications
In 2013 suicide prevention became a local authority responsibility.