

Suicides Audit in North Yorkshire 2016

Enter

Contents

Report Authors	2
Acknowledgements	2
List of Tables	3
Summary of findings	3
Introduction	4
Aims	4
Data analysis	6
Recommendations	14

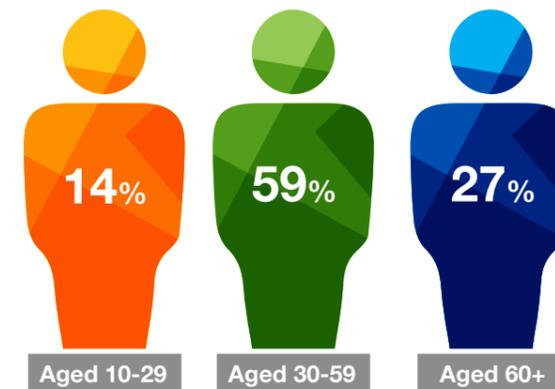
Report Authors

Claire Robinson Health Improvement Manager
 Emel Perry Public Health Intelligence Analyst
 Clare Beard Public Health Consultant

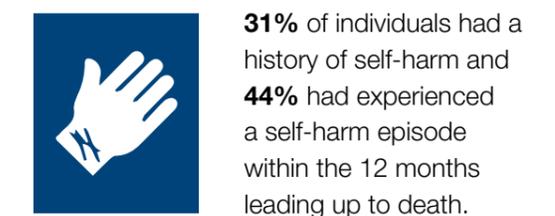
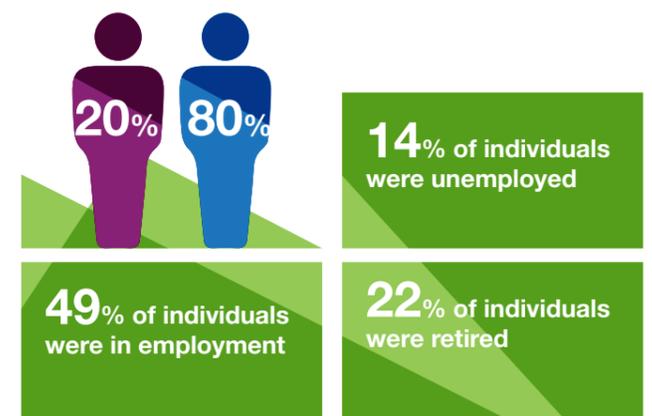
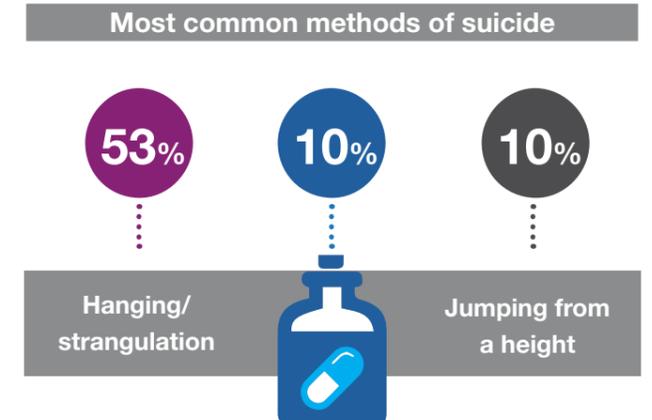
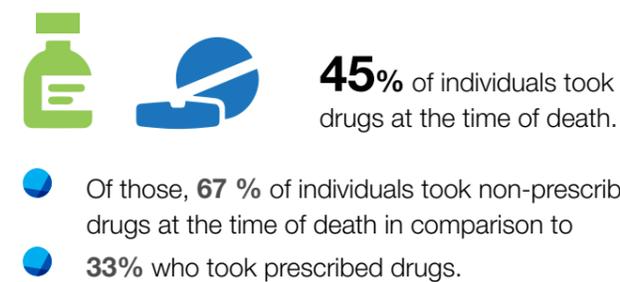
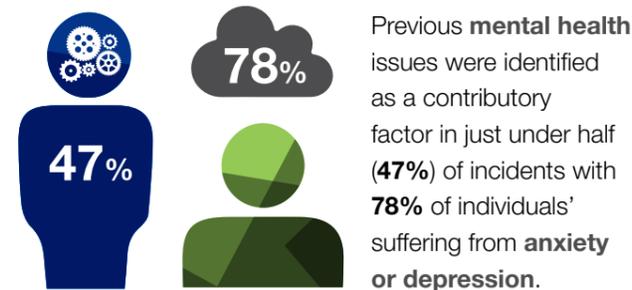
Acknowledgements

Coroners for North Yorkshire
 North Yorkshire Police
 North Yorkshire County Record Office

Summary of Findings



- The average age of the deceased was **50**.
- 24%** of individuals who died by suicide were aged between **50** and **59** and;
- 18%** of individuals were aged between **40** and **49**.



Introduction

The Five Year Forward View for Mental Health set out clear recommendations on suicide prevention and reduction, and made a commitment to reduce suicides by 10% nationally by 2020/21. Alongside this, Secretary of State Jeremy Hunt announced a zero suicide ambition for mental health inpatients in January of this year.

This report pulls together data about deaths by suicide in North Yorkshire collected exclusively from coroners' files and evidence relied upon during inquests in North Yorkshire for the period 2016, and reflects changes in groups or risk factors which have emerged.

The North Yorkshire 2016 audit of suicides is based on a small number of deaths (N=49) over a one year period and comparisons will be made with data collated from the 2015 audit. This report provides a refresh of the 2015 North Yorkshire Suicide Audit report.

Audit Scope

The audit included:

- Residents of North Yorkshire who died within the County where there was a coroner's conclusion of suicide
- All age deaths with a conclusion of suicide
- People who resided outside of North Yorkshire who died by suicide in the County.
- Residents in 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 to an 'open' or 'narrative' inquest outcome
- 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)
- Deaths determined as suicide which occurred within the city of York

Aims

The 2016 annual audit aimed to:

- compare local data and suicide trends with those identified nationally and regionally
- reflect changes in groups or risk factors which have emerged since 2015
- identify opportunities to influence the work of the North Yorkshire Suicide Prevention Strategic Group

Key Findings

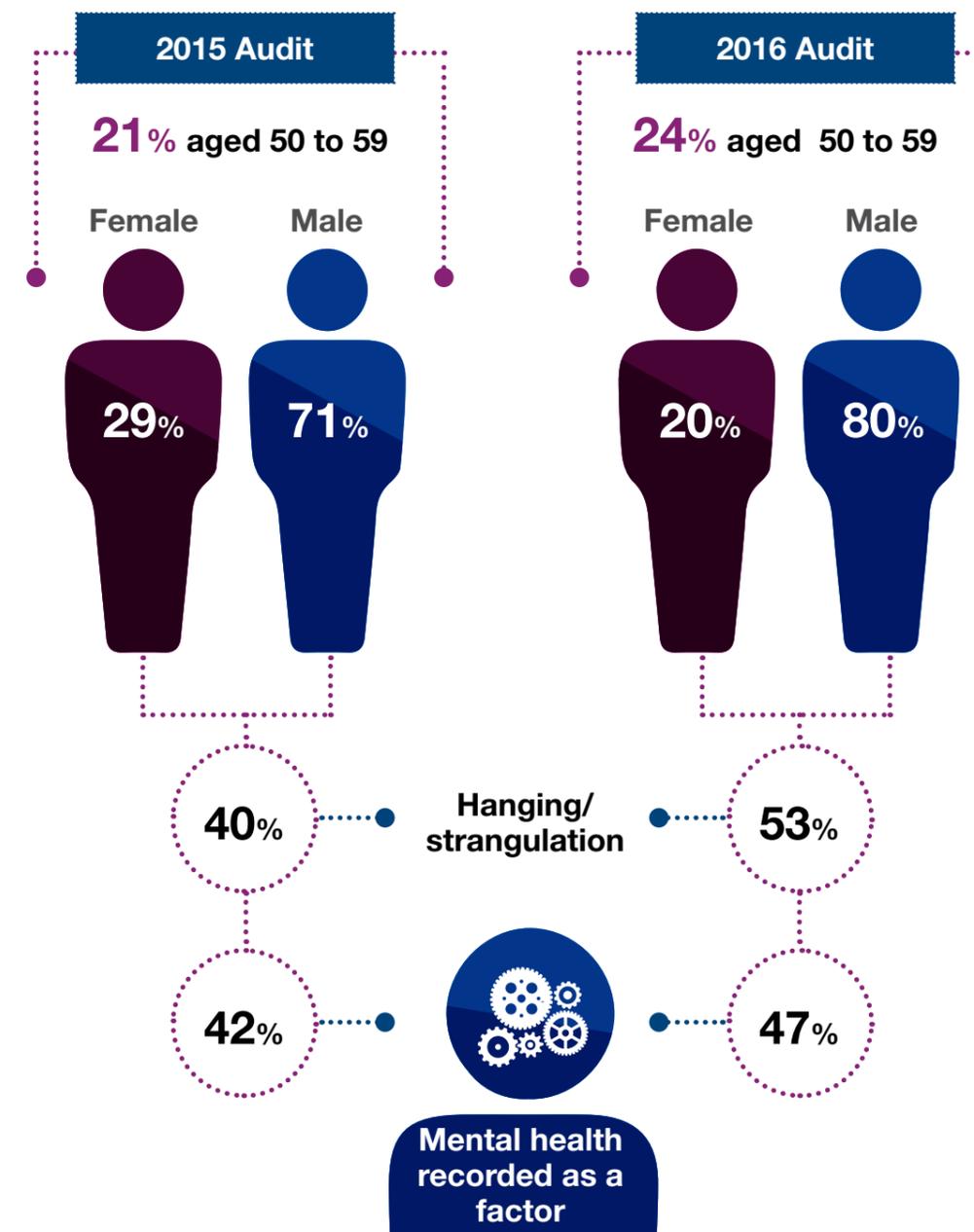
The 2015 audit highlighted an increase in the proportion of female suicides; however the 2016 audit shows a reduction in the proportion of female suicides.

The age profile of those most likely to take their life by suicide has remained the same in 2016, highlighting that those aged 50 to 59 are most at risk.

Furthermore, a high proportion of those aged 40 to 49 (18%) were also at risk.

Hanging or strangulation remains the most common means of suicide. There is a higher proportion of males than females taking their life by hanging or strangulation (19% female and 81% male).

Based on coroner's records, the proportion of individuals taking their own life who had a mental health issue (diagnosed and undiagnosed) has increased between 2015 and 2016; however, this is not statistically significant.



Data Analysis

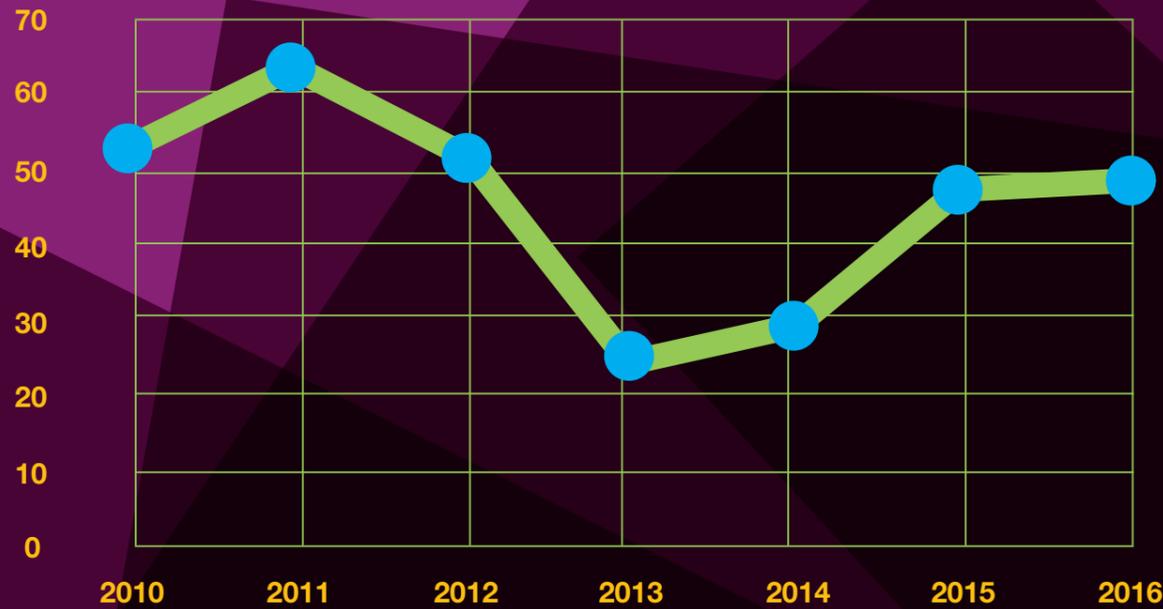
National and regional comparisons using ONS data

In **2016**, there were **4,941** deaths recorded as suicide in England and Wales; however, there are much larger numbers of people who consider taking their own lives. In the same year, Samaritans volunteers had more than **770,000** contacts from people who expressed suicidal feelings. This included people thinking about suicide, making plans, or actively attempting it.

In England and Wales, fewer deaths were reported as suicide in 2016 than in each of the previous three years.

The chart below highlights the number of suicides across North Yorkshire between **2010** and **2016**. Although the number of suicides decreased in North Yorkshire between **2010** and **2013** the number has slowly risen between **2014** and **2016** and North Yorkshire has a slightly higher suicide rate when compared to the national average (**10.1 locally v 9.9 nationally per 100,000 population**).

Number of Suicided in North Yorkshire, 2010-2016 Source: Coroner files



Age and Gender

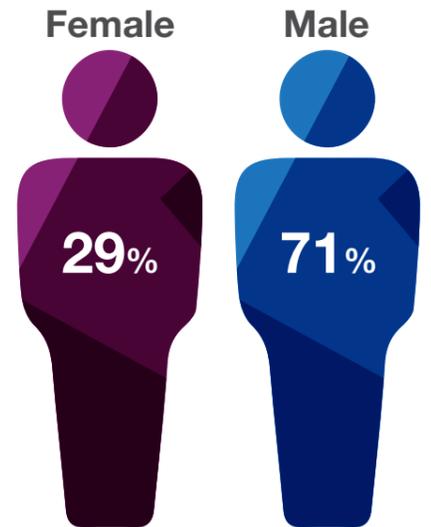
A research report by the Samaritans¹ found that men aged between 35 and 44 who are from disadvantaged backgrounds are more likely to die by suicide.

One reason that men are more likely to take their life by suicide is because they are less likely than women to ask for help or talk about depressive or suicidal feelings. Statistics show that 72% of people who died by suicide between 2002 and 2012 had not been in contact with their GP or a health professional about these feelings² in the year before their suicide³.

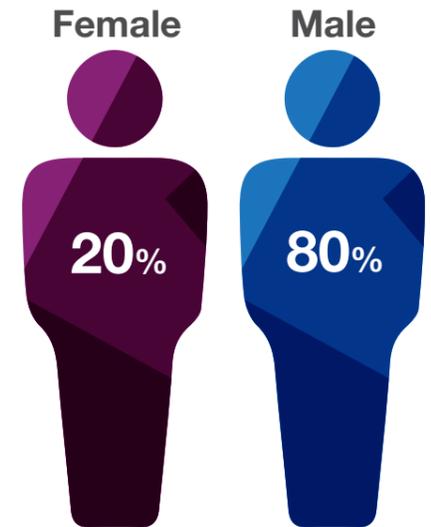
The 2016 audit highlights that suicide remains more common amongst males than females. Between 2015 and 2016 there has been an increase (9.0%) in the proportion of male suicides.

This is in line with national trends as recent data from the Office for National Statistics (ONS) highlights that men are at much greater risk of suicide and the rate of suicide for males in North Yorkshire is **15.8 per 100,000 population (2014-16)**, slightly higher than the **England average (15.3 per 100,000 population)**.

2015 Audit



2016 Audit



¹ <https://www.samaritans.org/about-us/our-research/research-report-men-suicide-and-society>

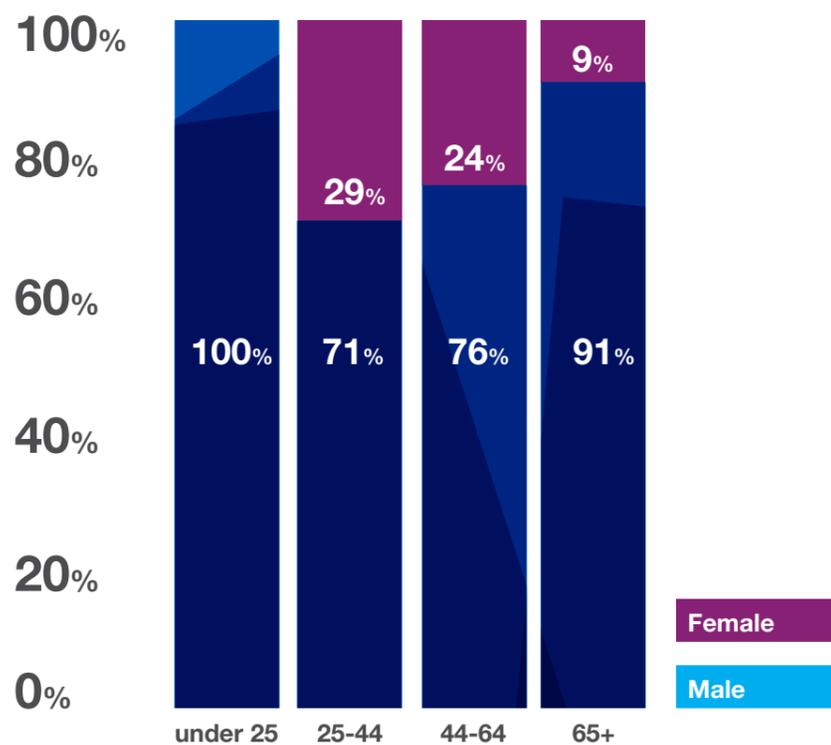
² Wylie, C. et al. (2012). 'Men, Suicide and Society.' Samaritans Research Report.

³ Hewlett, E. & Horner, K. (2015). Mental Health Analysis Profiles: OECD Working Paper No. 81

Of the 49 suicides recorded as part of the 2016 audit, 80% involved males, with the highest number of incidents recorded in men aged 50 to 59 the same as the 2015 audit. This trend differs when compared to the national trend. Across England men aged 40 to 44 are more likely to die by suicide a rate of 23.7 deaths per 100,000 population⁴.

However, in contrast to men, the number of incidents among women in North Yorkshire is highest in the 40 to 49 age group, followed by the 30 to 39 age group. This trend differs when compared to the 2015 audit where the number of incidents among women was highest in those aged 65+; however this is not statistically significantly different.

North Yorkshire - Incidence of suicide by age and gender 2016



⁴ ONS, 2016

Details of suicide event

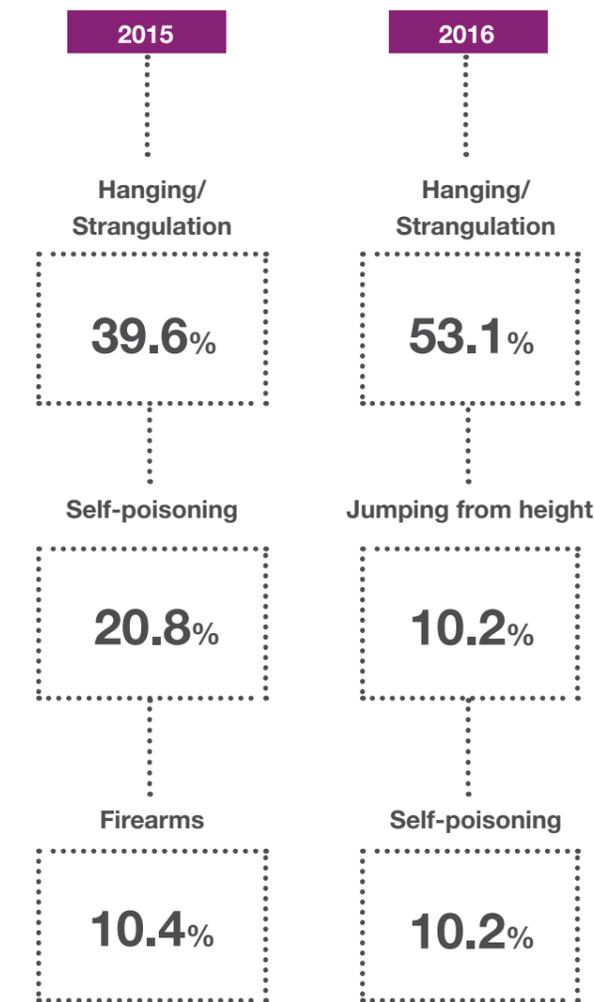
Method of suicide

The 2016 audit shows that the most common means of suicide was hanging or strangulation (53.1%) which is an increase of 13.5% when compared to the 2015 audit. This method was more common with men, with 80.8% of males taking their life by hanging or strangulation in comparison to 19.2% of females.

The second most common method of suicide was jumping from height (20.8%), however when compared to the 2015 audit the second most common method was self-poisoning. Jumping from height accounted for a higher proportion of suicides among males than females.

The third most common method of suicide was self-poisoning and this method was most common amongst females. Of those who self-poisoned, 60% of individuals were diagnosed with a mental illness at the time of death.

The three most common means by which individuals died from suicide



Location of incident

In 2016 more than half of incidents (63%) occurred at the individuals' home address the same as the 2015 audit (62.5%). The 2016 audit highlighted that men (71%) were more likely to take their own life at home in comparison to women (29%). The most common age group to take their life at home were aged between 45 and 54 (32%).

54.8% of incidents of hanging or strangulation took place at the individuals' home address and 12.9% of self-poisoning also took place at the individuals' home address. A similar trend was seen in the 2015 audit with 53.3% of deaths involving hanging or strangulation taking place at the individuals' home address. The 2015 audit highlighted that over half of individuals who used these methods were aged over 50 (58.3%) which may to a certain extent reflect their mobility-related limitations both in terms of method and location.

This trend is not seen in the 2016 audit; instead 62% of individuals aged under 50 are using hanging or strangulation or self-poisoning to take their own life.

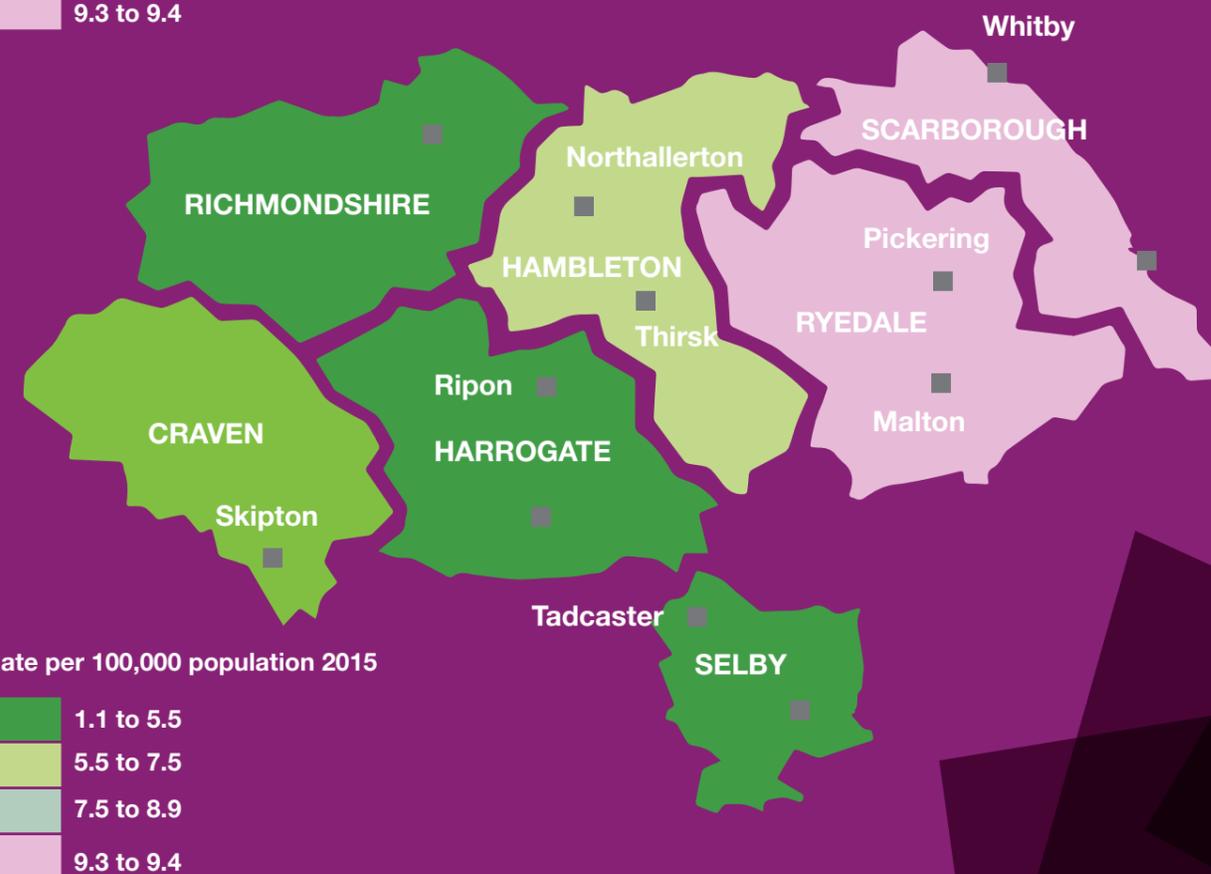
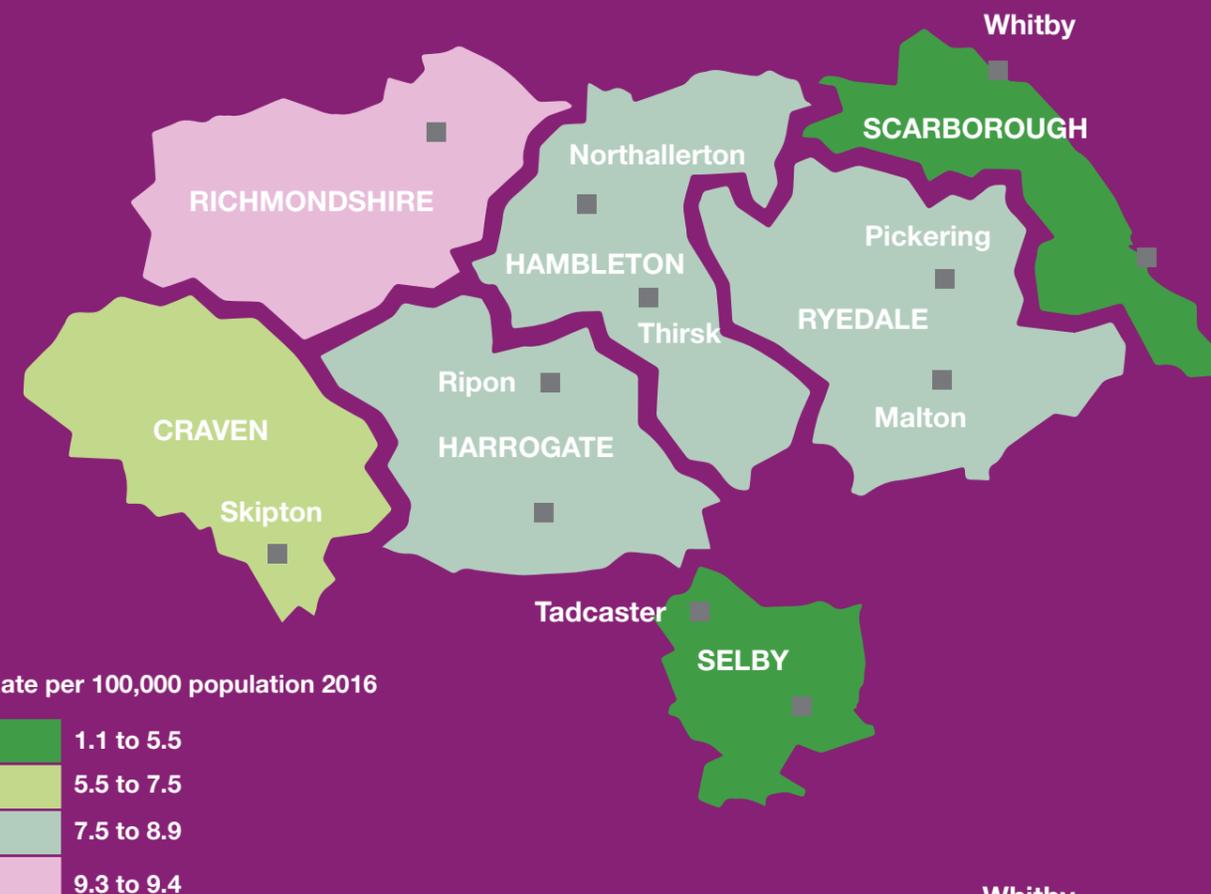
The maps to the right highlight the proportion of suicides in 2016 compared to 2015. Richmondshire district has the highest rate of suicide (9.3 per 100,000 population) in 2016 in comparison to Selby district which has the lowest rate of suicide (1.2 per 100,000 population).

In 2016 there has been a decrease in the number of suicides in Scarborough district, however this decrease is not statistically significant when compared to 2015.

The number of suicides have increased in Harrogate district between 2015 and 2016, however the increase is not statistically significantly different.



63% of incidents occurred at the individuals' home address



Use of alcohol and drugs at time of death

Whilst not an explicit cause of death, alcohol was identified in 32.7% cases with the majority of alcohol found in males (93.8%). This trend mirrors that of the 2015 audit. Furthermore, alcohol was most commonly found in those aged 50 to 59 (31.3%), however the 2015 audit highlighted those aged 40 to 49 were more likely to take alcohol at time of death.

Alcohol was most commonly present in incidents of hanging or strangulation (31.3%) and jumping from height (18.8%) in contrast to the 2015 audit where alcohol was most commonly present in incidents of hanging or strangulation (52.9%) and self-poisoning (41.2%).

44.9% of individuals took drugs at the time of death; this is an increase (9.5%) compared to the 2015 audit. Of this, 18.2% of individuals took non-prescribed drugs. The majority of individuals who took non-prescribed drugs were male. The most common drug found to be present was cocaine. The presence of non-prescribed drugs was most commonly found in incidents of hanging or strangulation (50%).



Alcohol was identified in **32.7%** of individuals

Drugs were identified in **44.9%** of individuals

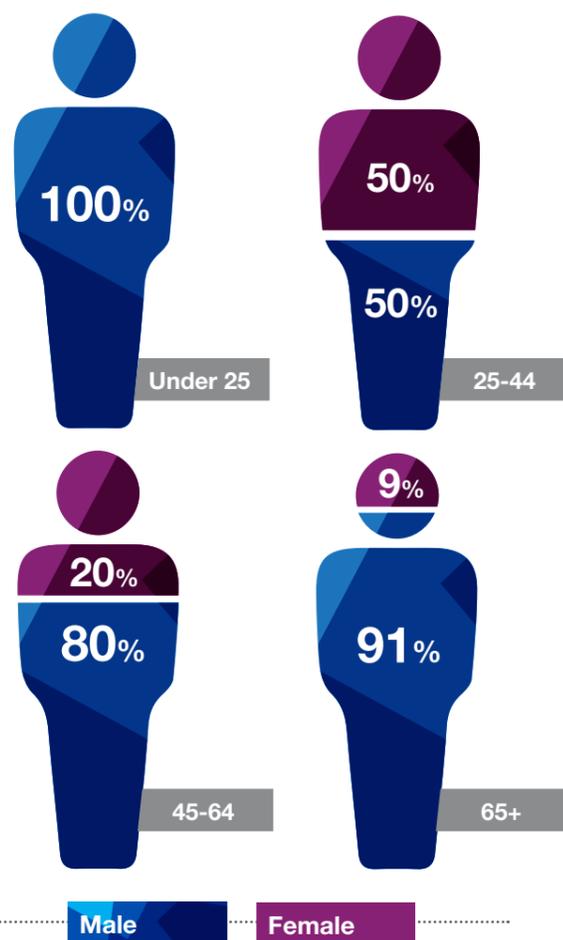
Prevalence and impact of Mental Health

Mental health issues were identified as a contributory factor in just under half of incidents with a high proportion of individuals suffering from anxiety or depression and under half of individuals had contact with mental health services one week to one month prior to their death. This trend is the same as the 2015 audit.

The highest proportions of individuals with mental health issues were found in the 30 to 39 and 50 to 59 age groups with males suffering more from mental health issues than females.

69.6% of individuals who died by suicide in 2016 with a history of mental illness received treatment for mental health issues in the preceding 12 months with 52.2% of individuals taking prescribed medication.

North Yorkshire - incidence of suicide where mental health was a contributory factor (2016)

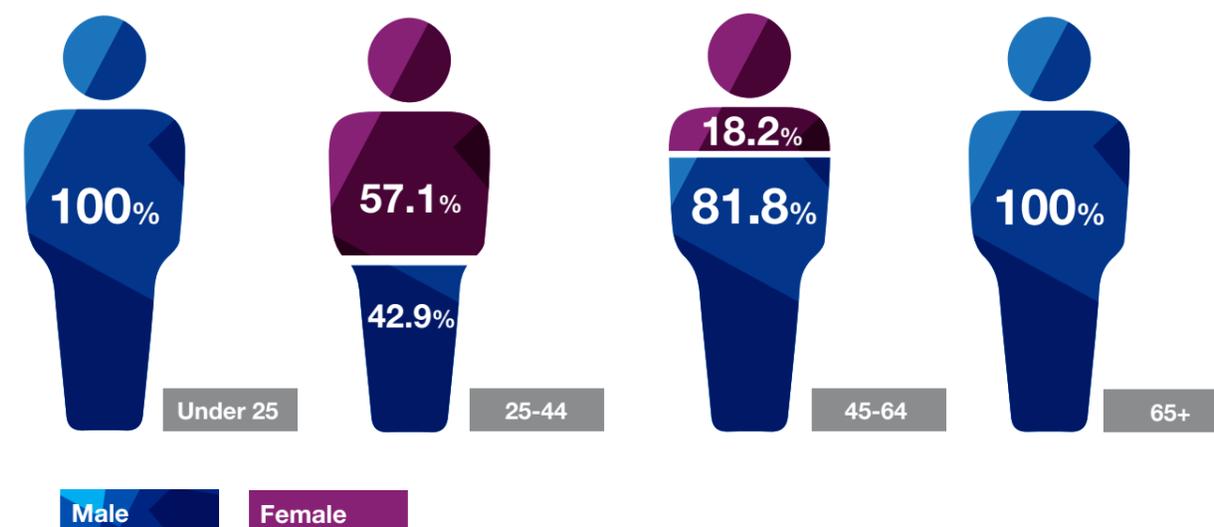


History of self-harm and previous suicide attempts

In 2016, a significant minority of individuals had a history of self-harm (30.6%), similar to 2010-15. Self-harm was more common in males than female and cases of self-harm were more common in those aged 30 to 34.

Individuals with a previous suicide attempt on at least one occasion, with a history of self-harm accounted for 40%. Of those individuals, the proportion was slightly higher in males (26.7%) than females (13.3%).

North Yorkshire-number of suicides where a history of self-harm was present (2016)

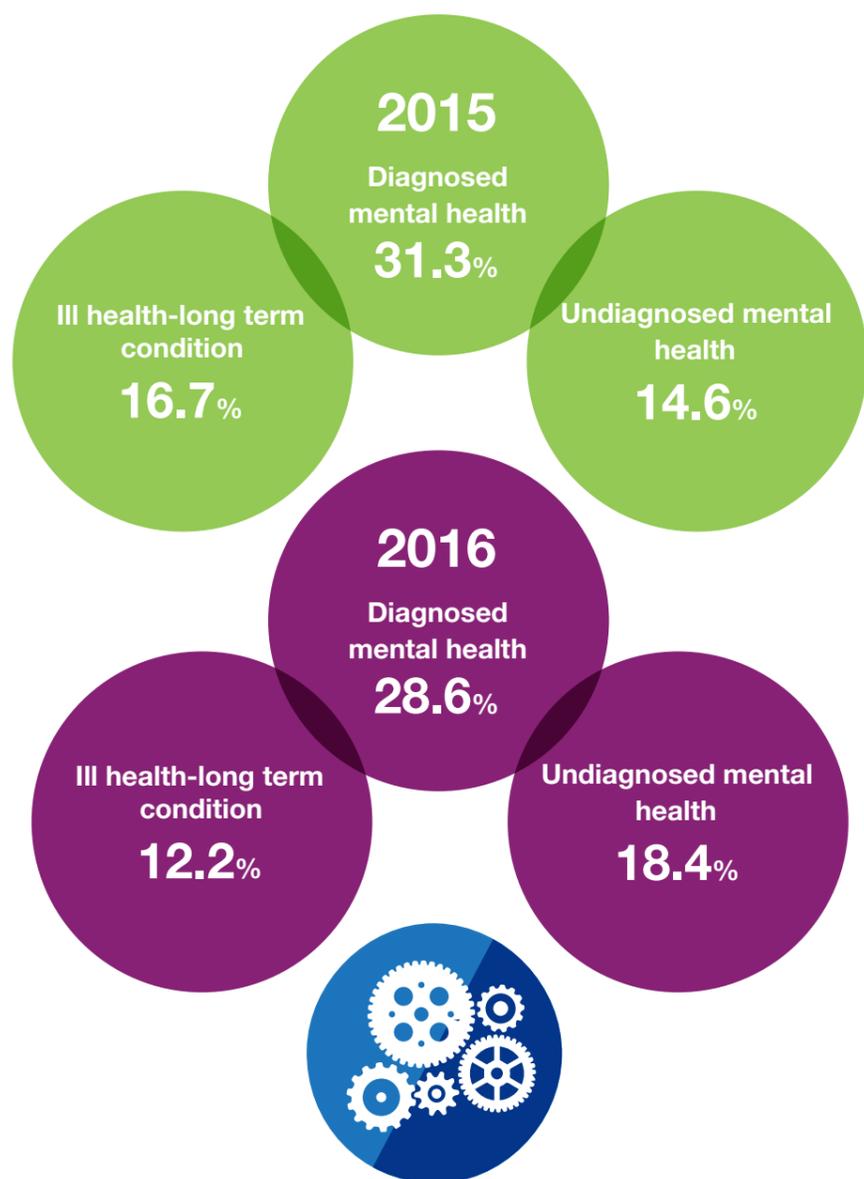


Other contributory factors

Diagnosed mental health issues were the most common contributory factors for individuals who choose to take their own life. 28.6% of individuals who were diagnosed with mental health conditions were in the care of their GP and 42.9% of individuals had contact with mental health services one month prior to their death. It is not always clear if mental health issues were of themselves triggers to other stressors, or if significant life stressors precipitated further episodes of depression and anxiety among individuals with lower resilience and perhaps a propensity for lower mental wellbeing.

Recommendations

The information contained in this report will be used to ensure the priorities within the North Yorkshire Suicide Strategic Plan reflect the needs of individuals and their families in North Yorkshire.



Suicides Audit in North Yorkshire 2016

Contact us

W: www.northyorks.gov.uk E: customer.services@northyorks.gov.uk
T: 01609 780 780 (Monday to Friday 8.00am - 5.30pm closed weekends and bank holidays)
North Yorkshire County Council, County Hall, Northallerton, North Yorkshire, DL7 8AD

You can request this information in another language or format at www.northyorks.gov.uk/accessibility