Introduction

Suicide remains one of the leading causes of premature mortality among men under 50 and across North Yorkshire between 50 and 100 adults choose to take their own life every year. In addition to the emotional impact upon the families and communities affected by suicide there is significant economic impact, and in 2012 Public Health England (PHE) estimated the average cost of someone of working age taking their own life to be £1.7 million. Suicide links to a range of other public health issues, including mental health and physical wellbeing.

In response to national guidance and recognised best practice a North Yorkshire & York Suicide Prevention Task Group was established in 2014. One of the actions driven forward by the group has been an audit of deaths which received a verdict of suicide at coronial inquest between 2010 and 2014. The audit aimed to improve understanding of the incidence of suicide among adults in North Yorkshire, and examined socio-demographic data, geographic data, risk factors and contact with services. A copy of the final report of the audit can be accessed here.

In response to the audit suicide surveillance and early alert protocols have been established and embedded into the work of the North Yorkshire and York Suicide Prevention Task Group. The purpose the surveillance activity is to monitor incidents deemed to be probable incidents of suicide by North Yorkshire Police to identify emerging patterns, trends or issues at the earliest opportunity and implement interventions in a timely manner.
1. Key issues

Although suicide in North Yorkshire devastates the lives of families and friends, it must be remembered that the actual number of people taking their own life remains relatively low. For example, across the five year span considered within the audit, a total of 227 individuals were identified from coroner records, from an adult population of around 500,000.

The rate of mortality from suicide was slightly lower in North Yorkshire (10.0 per 100,000) in 2013-15 than that reflected nationally (10.1 per 100,000), regionally 10.7 per 100,000) and across comparator authorities (average of 10.1 per 100,000). However, suicide surveillance data points to an increase in the rate of suicide in the adult population in North Yorkshire. Whilst difficult to quantify this increase the data suggests that the rate in North Yorkshire may rise above that observed nationally in coming years.

Mirroring national trends, suicide is much more common in males than females and, in North Yorkshire, males account for 8 out of 10 individuals who take their own lives.

Men in middle age (40-70) have been identified at the most at-risk group. Whilst the audit identified males aged 40-49 as the key at-risk demographic group, early indications from surveillance data suggest that the demographic of the key at-risk group may be shifting towards men in the 50’s. This supports a hypothesis put forward in the audit that it is males born between 1960 and 1975 that are most at risk and the key at-risk group will age as this cohort of men grow older.

Most incidents of suicide take place in the home, a trend that is also observed nationally. Hanging and self-poisoning are the most commonly used methods, both in North Yorkshire and across England as a whole.

Mental health problems were the most commonly identified contributory factor, with a third of individuals diagnosed with mental health problem in the 12 months leading up to the suicide attempt and were typified by mild/moderate anxiety or depression. Qualitative data suggests the true proportion (including undiagnosed mental health problems) is much higher.

The impact of chronic long term illness is also evident, particularly among older individuals who took their own lives. This may be exacerbated in the future as a result of the aging nature of the North Yorkshire population, and as the “baby boomer” generation move into older age.
Self-harm could be identified as a potential marker for future suicidal behaviour, particularly among women aged 40-69, whilst at 1 in 5 individuals was known to have attempted to take their own life at least once in the past.

2. Commissioning priorities are recommended

The audit made the following recommendations, which are being implemented through the work of the North Yorkshire & York Suicide Prevention Task Group:

- Reduce the risk of suicide across the North Yorkshire Population, particularly among high-risk groups
- Recognising that multiple stressors multiply risk, enhance service provision in relation to common stressors such as bereavement support, access to talking therapies and substance misuse
- Improve support for those affected by suicide in North Yorkshire in the days, months and years after a death
- Further develop data collection and monitoring
- Training and awareness, including supporting roll out of ASIST and Mental Health First Aid

3. Who is at risk and why?

The data gathered for the audit provided a valuable and privileged insight into the lives of people from North Yorkshire who had chosen to take their own lives, and their stories were often as varied as the wide range of communities in which they lived and died.

Nevertheless, there are a number of themes and commonalities that have emerged, and these are summarised below:

1. Individuals who had experienced emotional loss, which they had perceived as at least significant, and at worst catastrophic
2. Lower levels of resilience, coupled with higher susceptibility to episodes of mild to moderate depression, anxiety and other common mental illness
3. A perception that existing support networks could not help, or had been taken away, or a reluctance to engage with people who could help
4. Individuals who would have benefitted from additional help and support from agencies, but often don’t meet interventions thresholds (e.g. access to tier 2 “targeted” services and above)
The most “at risk” group indicated by the data were males aged 40 to 49. There was some evidence of significant life stressors, ranging from family/relationship breakdown to bereavement or financial difficulties, combined with reduced emotional resilience or history of mild to moderate depressive episodes, triggering a suicidal response in individuals. This may have been coupled with other symptoms, including alcohol use (typically at hazardous rather than harmful levels).

In addition to this key at risk group, a number of other key groups could be identified:

1. **Older Individuals Coming to Terms with Increasing Frailty**

   A common theme among older individuals who took their own life was a despondency brought about by increased frailty, often as a result of existing long term medical conditions, which resulted in a perceived lack of 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.

   A number of older individuals had also experienced bereavement following the loss of either a spouse or close friends/other relatives in the 12 to 24 months leading up to the suicide attempt.

2. **Complex Lifestyles**

   In a number of instances, there was evidence of potentially complex 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.

   In particular, qualitative data suggested that within this group issues such as poor mental health, substance misuse or accommodation issues did not necessarily meet thresholds to gain access to specialist services. For example, alcohol misuse may have been an issue for the individual, but had not yet reached a point where routes to treatment were open. Similarly, there may have been a history of mental health issues, but not at the level where an individual reached crisis. It can be hypothesised that although small in number, there are an important minority of individuals at elevated risk of suicide who are falling “between the gaps” in services.

3. **Impact of Criminal Behaviour**

   There were a small number of instances where suspected criminal activity was identified as a significant contributory factor. This was most commonly the case among individuals, particularly males, who had no criminal history and were well respected by friends and family members alike.
Criminal activity (proven or suspected) tended to fall into two categories:

1. Arrest for possession and/or distribution of indecent images of children, or allegations of sexual offences where the victim was a child. Qualitative data suggested that typically, this group involved males aged 40 to 69 from a white collar background. In particular, the data suggests that where such an individual is arrested and/or charged with possession of indecent images of children for the first time, that individual can go on and take their own lives within a very short space of time.

2. Theft from the workplace – typically very low value theft (such as small quantities of fuel, petty cash or goods) but nonetheless perceived by the individual to likely result in dismissal from employment. The data suggested that individuals in this group tended to be middle-aged males in blue collar or unskilled employment

In both sets of circumstances, the individuals concerned perceived catastrophic impacts that would arise from this activity, including financial difficulties, loss of social status for the individual and family members and an overwhelming feeling of shame. There was a further, and smaller, subset within this group, which involved self-employed (or employed within a family-run business) who had fraudulently taken money from the business.

Looking to the future, the aging population may present new challenges as a generation used to enjoying generally good health and active lives begin grow older and have to come to terms with increasing frailty and the possibility of long term illness.

Although the data highlights that over the last five years almost a third of suicides involved someone in their 40’s, it is not clear if it is people in their 40’s generally who are at risk or this specific generation of people aged 40 to 49. Trends in suicide in the coming years will need to be examined to determine if the 40 to 49 age group remains a key “at risk” group, or if it is the generation born between the mid-1960’s and mid-1970’s who remain at most risk as they grow older.

A third of individuals had been diagnosed with mental health issues in the 12 months leading up to the suicide attempt, and qualitative data suggests the true proportion (including undiagnosed mental health issues) could be around 50% of the cohort. Mental ill-health was also identified as a contributory factor in around half of all incidents. 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.

A significant minority of individuals were also suffering from chronic, long term illness or medical conditions, and the proportion rose to 80% in those aged over 70. 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.

Over a third of individuals had a history of self-harm, although not always in an individual’s recent past. Overall, this trait was more common in females than in males, particularly in the 40 to 69 age group.

At least one previous suicide attempt was recorded in almost 20% of cases, of which almost all individuals also had a history of self-harm. The proportion of individuals who had previously attempted suicide was higher in the 30 to 39 and 40 to 49 age groups.

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.

Bereavement was found to be a significant contributory factor in a fifth of cases. Whilst there was evidence of the immediate impact of bereavement (particularly of a spouse), there was also some evidence of the impact of bereavement over a longer time period. This coupled with a recent life stressor or declining health could lead that individual to take their own life.

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.

4). What is the level of need in the population?

In the period 2013-15, the rate of mortality from suicide is slightly lower in North Yorkshire (10.0 per 100,000) than that reflected nationally (10.1 per 100,000), regionally 10.7 per 100,000) and across comparator authorities (average of 10.1 per 100,000).
The mortality rate among males in 2013-15 in North Yorkshire was above that recorded nationally (16.6 per 100,000 locally compared with 153.8 per 100,000 nationally). Although this represents an increase on the rate recorded in 2012-14 (16.3 per 100,000) the increase is not statistically significant.

Mirroring the findings of the North Yorkshire Suicide Audit, the mortality rate among females was much lower than in males in 2013-15 (3.9 per 100,000 locally) and is lower than that recorded nationally (4.7 per 100,000).

When considered by age group and gender, mortality rates across the 15-34 and 35-64 age groups were similar in North Yorkshire in 2013-15 to that recorded nationally. However, among males aged 65 and over, the mortality rate in North Yorkshire was higher than across England (15.9 per 100,000 locally compared with 12.4 per 100,000 nationally), although the difference is not statistically significant.

5). What services are currently provided?

There is a range of bereavement support currently offered in North Yorkshire, primarily in a community-based setting through voluntary and charity organisations such as Cruse and by hospices, as well as smaller local organisations. There are around 17 organisations in North Yorkshire that offer specific bereavement support services. Clinical counselling is also provided through CAMHS and the mental health trusts for adults. There is a jointly funded (NYCC and NHS) mental health helpline specific to North Yorkshire which can be called for further information and support, and in a crisis.

There is a range of community-based group support on offer across the county, some of which are targeted at specific individuals e.g. those bereaved by cancer. Cruse is the largest and most well-known provider of community based bereavement support with group and one to one support provided in York, Harrogate, Ryedale and Skipton. Telephone and online support are also available. Five hospices (Just B; Martin House; St Catherine’s Hospice; St Leonard’s Hospice and Heriot Hospice Homecare) across the county offer bereavement support, with some offering outreach support including one-to-one counselling (some home based), telephone support and group support. There is also a large amount of remote support available via phone lines, email support and online forums. Due to the nature of this type of support it can be accessed by anyone in North Yorkshire who has access to a telephone or internet, regardless of geographical location.
6). What is the projected level of need/service use in the medium- and long-term?

Analysis of the overall rate of suicide in North Yorkshire indicates a relatively stable position over the course of the period 2001-03 to 2013-15. Throughout this period the rate has remained within the range of 11.2 per 100,000 and 9.7 per 100,000. This broadly mirrors the position nationally, and indeed there has been no statistically significant difference in the overall rate locally in comparison with the national picture.

Suicide surveillance data across 2016 suggests that the incidence of suicide across North Yorkshire may be increasing, with a crude rate of 13.0 per 100,000 recorded. However, it is important to note that this is based upon data collected at the time of death by the police and not the same data used by ONS for official statistics. It is therefore likely that the “official” overall suicide rate in North Yorkshire will rise from around 10 per 100,000 in the short/medium term but would be expected to remain below 13 per 100,000.

Data published by PHE suggests that although rates of suicide in men in North Yorkshire remain stable and statistically similar to those observed nationally, there is evidence emerging that the rate of suicide in women in the 35-64 and 65 band above age groups is rising, and that speed with which the rate in these groups is rising is faster than that observed nationally. Although a concern, this emerging trend needs to be considered against the background of 3 times as many men as women choosing to take their own lives in these age groups.

It is well recognised that North Yorkshire has an older population than other parts of the England, and that our population is expected to grow older in coming years. A combination of different factors can account for this change, including outward economic migration of younger people and inward migration of older individuals wishing to retire in the Dales or on the coast. Population projections indicate that this will be exacerbated in coming years as post war “baby boomers” of the 1950s move into their 70s and 80s whilst the current population “bulge” in the 40 to 50 age group moves with time into the 55 to 65 age group. In the context of analysis of future trends in suicide there are a number of factors to consider:

1. The older population is healthier than it’s ever been, but there are likely to be an increasingly large number of people either coming to terms with chronic, long term conditions as they age, or a fear of developing such conditions in the near future
2. The “baby boomer” generation has (in general terms) grown up in much better health than previous generations and are typically used to being able to lead active, on affluent, busy lives, both up to retirement and beyond.
3. Increased discussion within society around euthanasia and the wider “right to die” debate
4. The extended family has become increasingly fragmented as a consequence of a more mobile population. This can lead to reduced access to familial support for older individuals.

5. The data supplied to the audit suggests that a small but significant number of older people struggle to come to terms with becoming frail as they age, linked to fears around loss of independence and in some cases financial concerns or insecurities.

It can be hypothesised that the number of individuals aged over 65 who take their own life may rise, particularly among those in their seventies who are diagnosed with a chronic, long term condition and where family support is not close to hand.

7). What needs might be unmet?

Analysis undertaken to inform the audit pointed to evidence individuals at risk of suicide falling “between the gaps” in services. This was particularly true at the lower end of the need spectrum, where a service was required that was greater than that available universally or at tier 1 of need, but did not meet the threshold for the next stage of specialist support. Examples included mental health services and substance misuse services.

The at risk group of men aged 40 to 70 are perceived nationally as particularly hard to reach and this was reflected in the North Yorkshire data, suggesting that services and interventions need to proactively target this gender group.

8). What evidence is there for effective intervention?

PHE has published a range of information and guidance describing best practice and evidence based interventions:

**Suicide prevention: developing a local action plan** – advises local authorities and partners how to develop a multi-agency suicide prevention partnership, make sense of local and national data and to develop a suicide prevention strategy and action plan.

**Suicide prevention: identifying and responding to suicide clusters**: provides guidance on the identification of suicide clusters, suggestions for who may be at risk of suicidal acts due to the influence of other people’s suicidal behaviour, the mechanisms involved in suicide clusters, the effects of suicide on other individuals and best practice guidance on how to evaluate responses to a cluster, and on using the experience to improve further suicide prevention measures.
**Suicide prevention: suicides in public places**: provides a step-by-step guide to identify hotspot locations and a framework for identifying and implementing preventative actions and interventions.

**Support after a suicide**: a guide to providing local services: provides guidance on commissioning and delivering support after a suicide (otherwise known as postvention support), as part of a wider suicide prevention strategy.

9). **What do people say?**

N/A

10). **Is any additional needs assessment required?**

Needs assessment on the mental health and wellbeing of the population of North Yorkshire complements the information contained in this report.

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References:
Local strategies and plans with dates:
National strategies and plans with dates:
Other references with dates: