Preventing Suicide in Somerset

Audit Report 2014

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Contents

Executive Summary

On average around 50 people have died each year by suicide in Somerset in the period between 2011 and 2013.

The suicide and undetermined death rate for Somerset is currently reported by the Public Health Outcomes Framework (PHOF)[i] as 9.8 per 100,000 for the period 2011 – 2013. The England average for the same period was of 8.8 per 100,000 and the South West average was 10.1 per 100,000.

Rates of mortality from suicide and undetermined death for both females and males are highest for those aged 35 to 64.

Around 75% of deaths are male. This reflects the pattern nationally.

The most common method of death was hanging, a method known to have a high lethality. This is similar to elsewhere in the country.

The most common place of death is at home. Over half (59%) of all suicides and undetermined deaths took place at home. This is similar to elsewhere in the country.

There is a strong association between suicide rates and levels of deprivation. The rate for suicide and undetermined death, for residents living in the 20% most deprived areas in the county, is significantly higher than for Somerset as a whole.

Although there is variation across the districts, this is not statistically significant.

The reported suicide rate can vary, depending on the years reported or the age groups included. This does not mean the actual numbers have changed, but that a different method of calculation has been used.

In this report we have used two sources of data the Public Health Outcome Framework (PHOF) and the Health and Social Care Information Centre[ii] (HSCIC). At the point of publishing this report data is available up to 2013 for PHOF and up to 2012 for HSCIC.

Introduction

On average around 50 people have died each year by suicide in Somerset in the period between 2011 and 2013.

Across England as a whole, one person dies every two hours as a result of suicide. The effect of a death resulting from suicide on family and friends is devastating. Others who knew the person through work or education, or who were involved in providing support and care will feel the impact profoundly.

Not all suicides are inevitable. Around a quarter of all deaths are people in contact with specialist mental health services[iii], a much higher proportion may have had contact with their GP or other health service. Suicide can be the end point of a complex history of risk factors and distressing events; and action to prevent suicide has to address this.

The health strategies of many countries include targets to reduce suicide rates. In England, Preventing Suicide in England – a cross governmental strategy to save lives[iv], was launched in 2012. This is the second national suicide prevention strategy and it sets out six key priority action areas to be progressed both at national and local level:

- Reduce risk of suicide in high risk groups
- Tailor approaches to mental health support in specific groups
- Reduce access to the means of suicide
- Provide information and support to individuals bereaved by suicide
- Support the media to report appropriately on incidents of suicide
- Implement research, data collection and monitoring

Local responsibility for coordinating and implementing work on suicide prevention became, from April 2013, an integral part of local authorities' new responsibilities for leading on local public health and health improvement. Included in these responsibilities is the establishment of a local suicide prevention partnership, the implementation of a process for local suicide audit and the delivery of local action to prevent and reduce suicide.

The Somerset Suicide Prevention Advisory Group is the multi-agency forum which leads this work locally. The Suicide Prevention Advisory Group is responsible for the delivery of the Somerset Suicide Prevention Strategy and Action Plan, which focusses on the local areas for action.

This report provides information on suicide rates and trends for Somerset in comparison with the national picture. These are, by their nature, retrospective by at least two years. In 2015 the trend report will be supplemented by information drawn from a newly established case audit system, which will provide a more real time view on themes, issues and action.

Understanding Suicide Statistics

Definition

Official suicide statistics in the UK are based upon coroners' verdicts. In the case of a suspected suicide an inquest will be held. For a death to be recorded as a suicide intention to die by suicide must be proven. If not proven, such deaths are most likely to receive open verdicts and be classified in national statistics as deaths of undetermined intent.

Research indicates that over three-quarters of deaths given open verdicts by coroners are likely to be suicides. Therefore, in an attempt to provide a more accurate estimate of the true levels of suicide, the data reported in this analysis presents figures for both suicide and undetermined deaths. A significant number of deaths receive death by misadventure, accidental death or, increasingly, narrative verdicts, and so will not appear in official suicide statistics. There is growing evidence that differences between coroners in their use of narrative verdicts across the country is making comparison of suicide statistics between areas less reliable.

Timeliness

The coroner's verdict may be given some time after the time of death. For this reason, the analysis of suicide trends is always retrospective by a period of two years. The case audit system which is being implemented locally will provide more timely information on deaths, prior to the coroner's verdict, which are likely to the consequence of a suicide.

Reliability

Due to the relatively low number of deaths by suicide within a local area, numbers can fluctuate. For this reason it is considered good practice to undertake analysis of trends in three year periods. It is important to look at the time period when comparing data, as an analysis of a different year grouping will produce slightly different rates.

Understanding published suicide rates

In January 2012 a new indicator measuring suicide rates was introduced in the Public Health Outcomes Framework (PHOF 4.10). This is indicator reports age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population. This indicator includes deaths by suicides for people of all ages but only undetermined death for people aged 15+[1] in line with the ONS definition. Historically the NHS/Health and Social Care Information Centre (HSCIC) indicator portal has published data on suicides and undetermined death for people of all ages and for those aged 15+. However, from 2009-2011 onwards the all-ages indicator has been suppressed and is no longer published.[2]

[1] Public Health England (PHE): Public Health Outcomes Framework
[2] Health and Social Care Information Centre (HSCIC) Indicator Portal, 2014

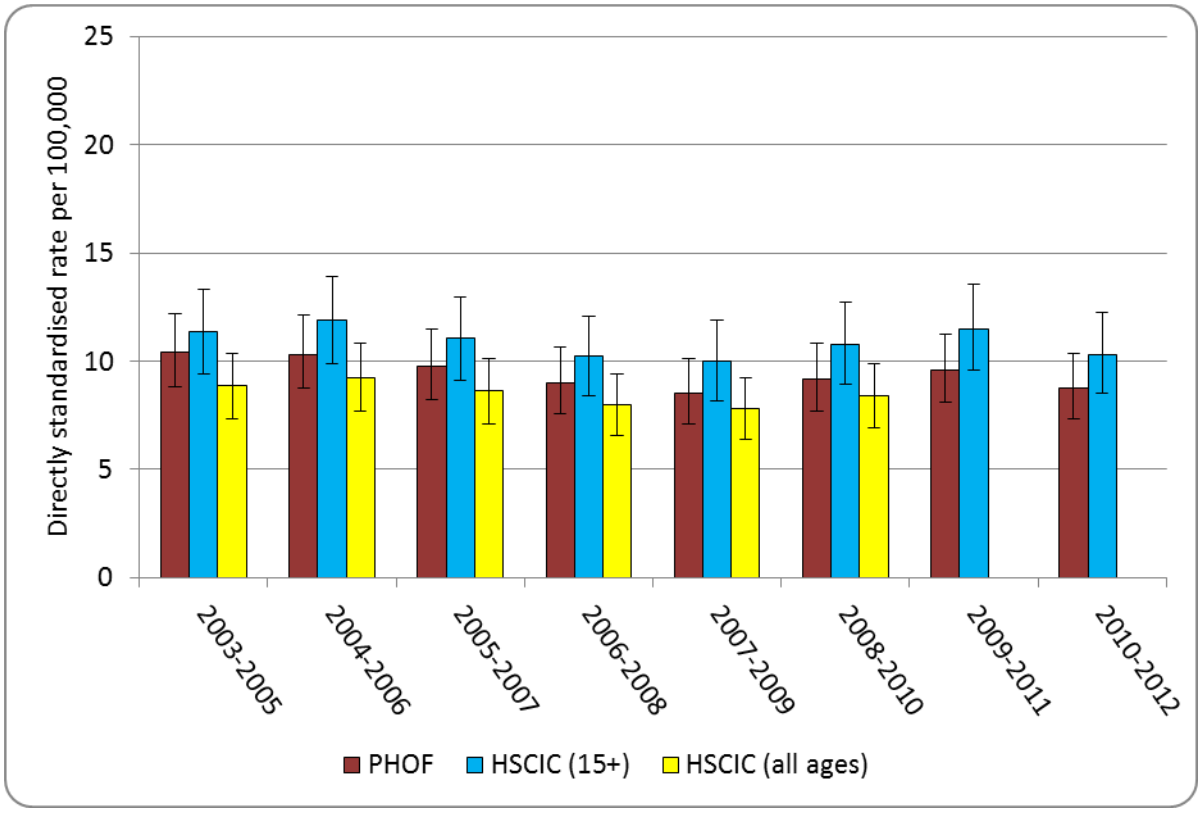
Table 1 below provides a summary of the different indicators on suicide and the way that the information is collected and analysed.

Table 1: *Cohorts used in the calculation of HSCIC and PHOF indicators.*

Indicator	Suicides	Undetermined death
HSCIS (15+)	15+	15+
HSCIC (All Ages) (obsolete)	All ages	All ages
PHOF	All ages	15+

Source: Health and Social Care Information Centre (HSCIC) Indicator Portal, 2014.
and Public Health Outcome Framework 2014

Figure 1:*PHOF indicator 4.10 and the HSCIC rolling three-year average rates of mortality from suicide and undetermined death in Somerset, 2003-2005 to 2010-2012, directly standardised rates per 100,000.*



Source: Health and Social Care Information Centre (HSCIC) Indicator Portal, 2014 and Public Health Outcome Framework 2014

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There have not been any statistically significant differences between the HSCIC and PHOF measures between 2003-2005 and 2010-2012. There have also not been any significant changes over time in the rates of suicide and undetermined deaths for either indicator since 2003-2005.

Suicide and undetermined death rates for Somerset

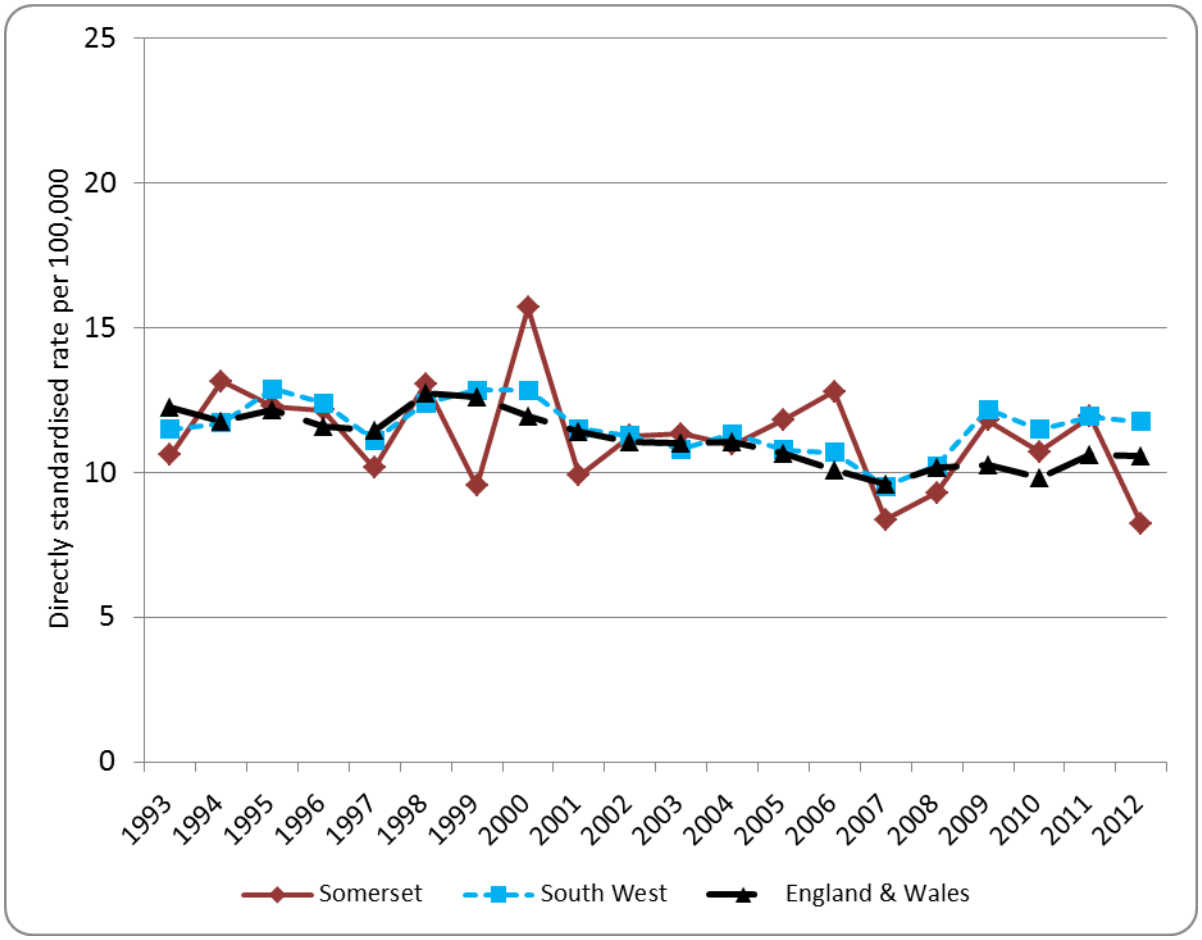
An overview

The suicide and undetermined death rate for Somerset is currently reported by the Public Health Outcomes Framework is 9.8 per 100,000 for the three year period 2011 – 2013. The England average for the same period was 8.8 per 100,000 and for the South West 10.1 per 100,000.

This is a slight, but not statistically significant increase on the period 2010 – 2012 when the rate for suicide reported for Somerset was 8.8 per 100,000 (PHOF) which was statistically similar to the England rate of 8.5 per 100,000.

The annual rates of mortality from suicides and undetermined death have generally declined in the past 20 years in England & Wales. Rates in the South West have remained fairly static and this was also the case in Somerset between 1993 and 2011. Rates in individual years can fluctuate widely due to the small numbers; however, the Somerset rate in 2012 was notably lower than the previous year.

Figure 2: *Annual trends in mortality from suicide and undetermined death in Somerset, the South West and England & Wales, 2003-2005 to 2010-2012 for people aged 15 and over, directly standardised rate per 100,000.*



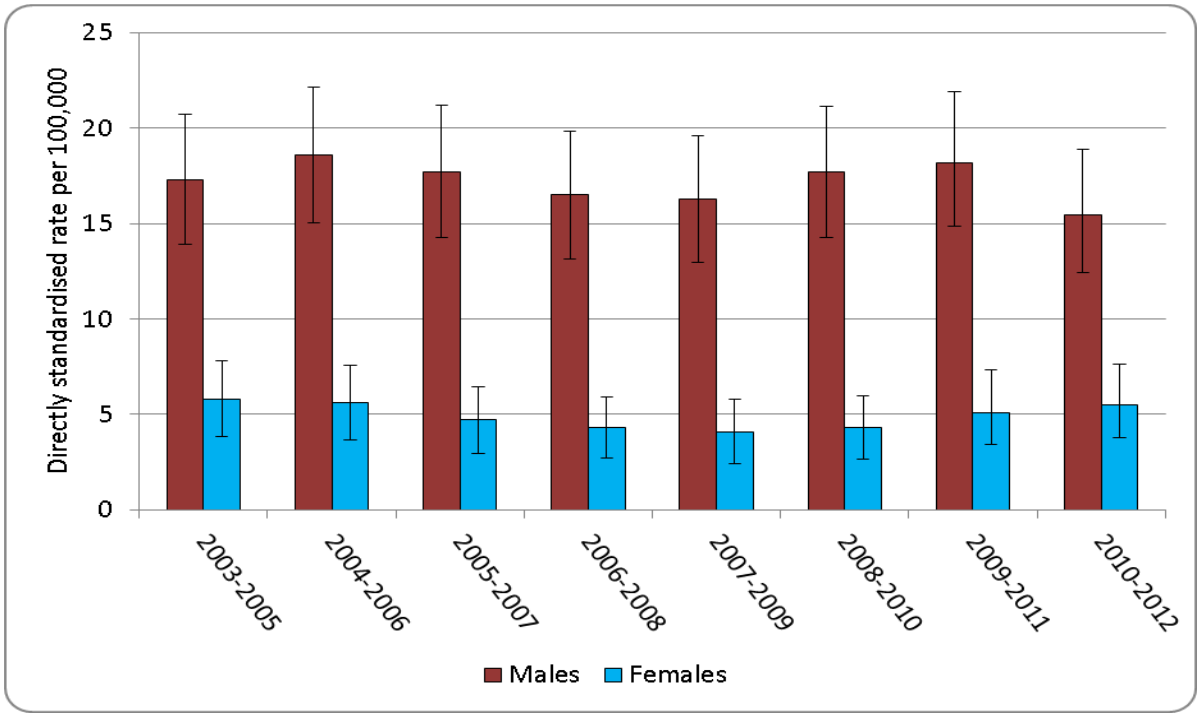
Source: Health and Social Care Information Centre (HSCIC) Indicator Portal, 2014.

Sex and Age

There have not been any significant changes in the rates of suicide and undetermined death for females or males aged 15 and over between 2003-2005 and 2010-2012. 74% of suicides and undetermined death in Somerset during 2010-2012 were of males, this reflects the picture in England and Wales (76%).

Although the rate for females, appears to have been increasing since 2007-2009. The rates for males have been significantly higher than for females throughout this period. In the 2010-2012 period the mortality rate from suicide and undetermined death for males was almost three times higher than for females.

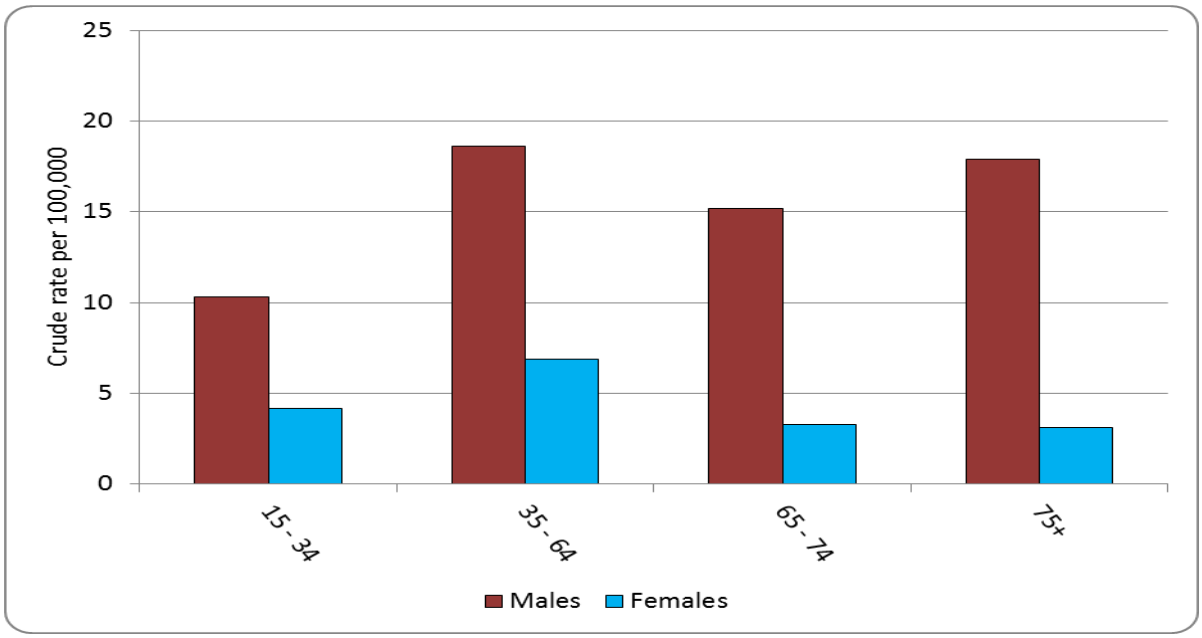
Figure 3: *Rolling three year trends in mortality from suicide and undetermined death in Somerset for males and females aged 15 and over, directly standardised rate per 100,000.*



Source: Health and Social Care Information Centre (HSCIC) Indicator Portal, 2014.

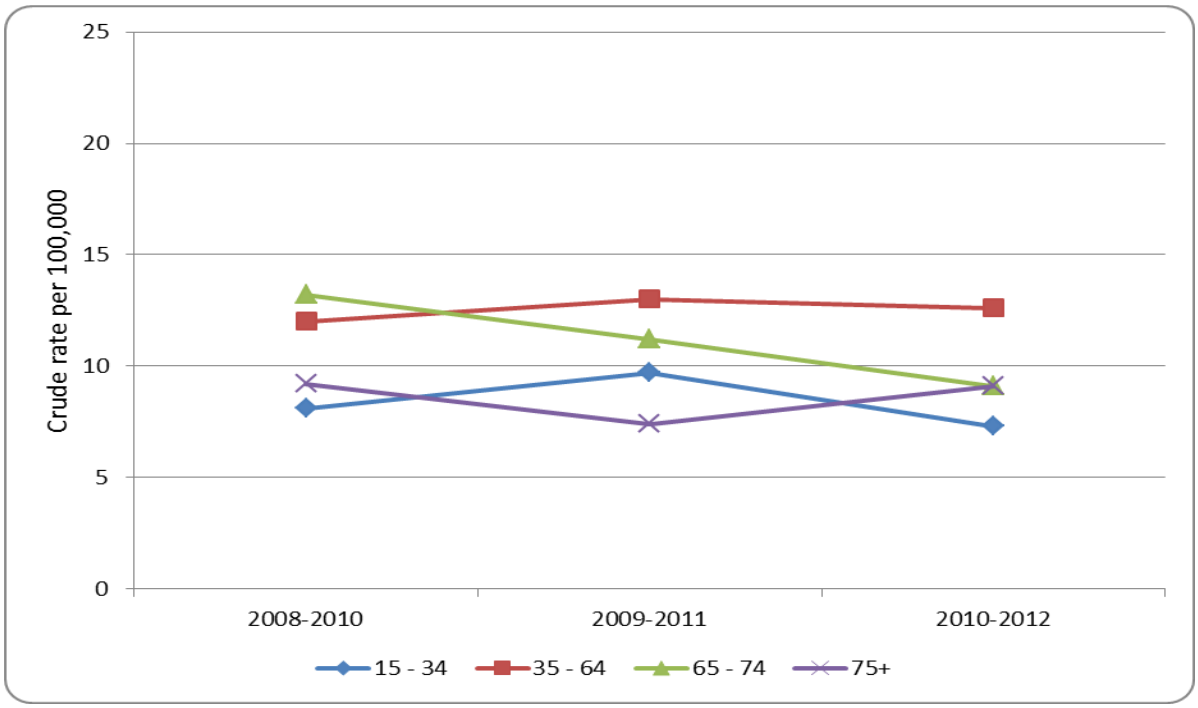
The age profile of suicide deaths has changed over time. Figure 4 shows that the rates of mortality from suicide and undetermined death for both females and males have been highest for those aged 35 to 64. The rate for males aged 65-74 and 75 and over are also relatively high. While the rate for males aged 15-34 is the lowest it is also higher than the rates for any of the female age bands. Figure 5 illustrates how these patterns have changed, with a seeming decline in deaths in the 65 – 74 age band between 2008- 2010. However, these trends should be viewed with some caution due the low numbers in the analysis, and the absence of confidence intervals.

Figure 4: Male and Female *rates of mortality from suicide and undetermined death in Somerset for males and females aged 15 and over by age band, per 100,000 for the period 2010 - 2012.*



Source: Health and Social Care Information Centre (HSCIC) Indicator Portal, 2014.

Figure 5: ***Age band*** *rates of mortality from suicide and undetermined death in Somerset for people aged 15 and over by age band, 2008-2010 to 2010-2012, crude rates per 100,000.*



Source: Health and Social Care Information Centre (HSCIC) Indicator Portal, 2014.

Geographical patterns across the county

Although there have been variations in the suicide rates across the districts, this has not been statistically significant, which means that the variation is likely to be due to chance. However, we felt that it would be useful to provide this information to complete the picture for Somerset.

Between 2007-2009 and 2009-2011, Mendip had the lowest rate in the county. However this was only significantly lower than the Somerset average in 2008-2010. The rate in 2010-2012 has been roughly similar to the Somerset average.

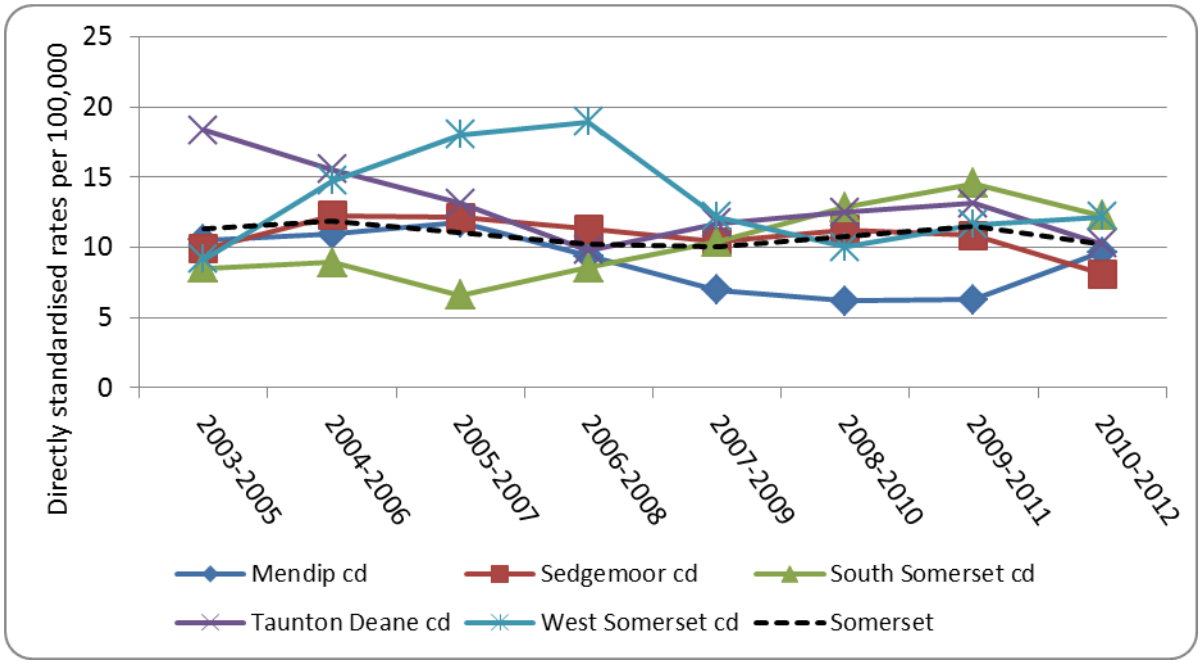
The directly standardised rate in Sedgemoor has been roughly in line with the Somerset average between 2003-2005 and 2009-2011. However, the rate has decreased in 2010-2012, and was actually the lowest in the county, but is not significantly lower than the Somerset average.

In South Somerset the rate steadily increased between 2005-2007 and 2009-2011. However, this is not a statistically significant difference.

Taunton Deane's rate of mortality from suicide and undetermined death has been roughly in line with the Somerset average throughout the whole period.

In West Somerset there was an increase in the rate from 2003-2005 to a peak in 2006-2008 but this change was not statistically significant. Neither was the rate in the district significantly different to the Somerset average throughout this period. The rate since 2007-2009 has been roughly in line with the Somerset average.

Figure 6: Somerset's districts *rolling three year trends in mortality from suicide and undetermined death of people aged 15 and over, directly standardised rate per 100,000.*



Source: Health and Social Care Information Centre (HSCIC) Indicator Portal, 2014.

Socio-economic factors

There is a strong association between suicide rates and levels of deprivation. The rate for suicide and undetermined death, for residents living in the 20% most deprived areas in the county is significantly higher than for Somerset as a whole.

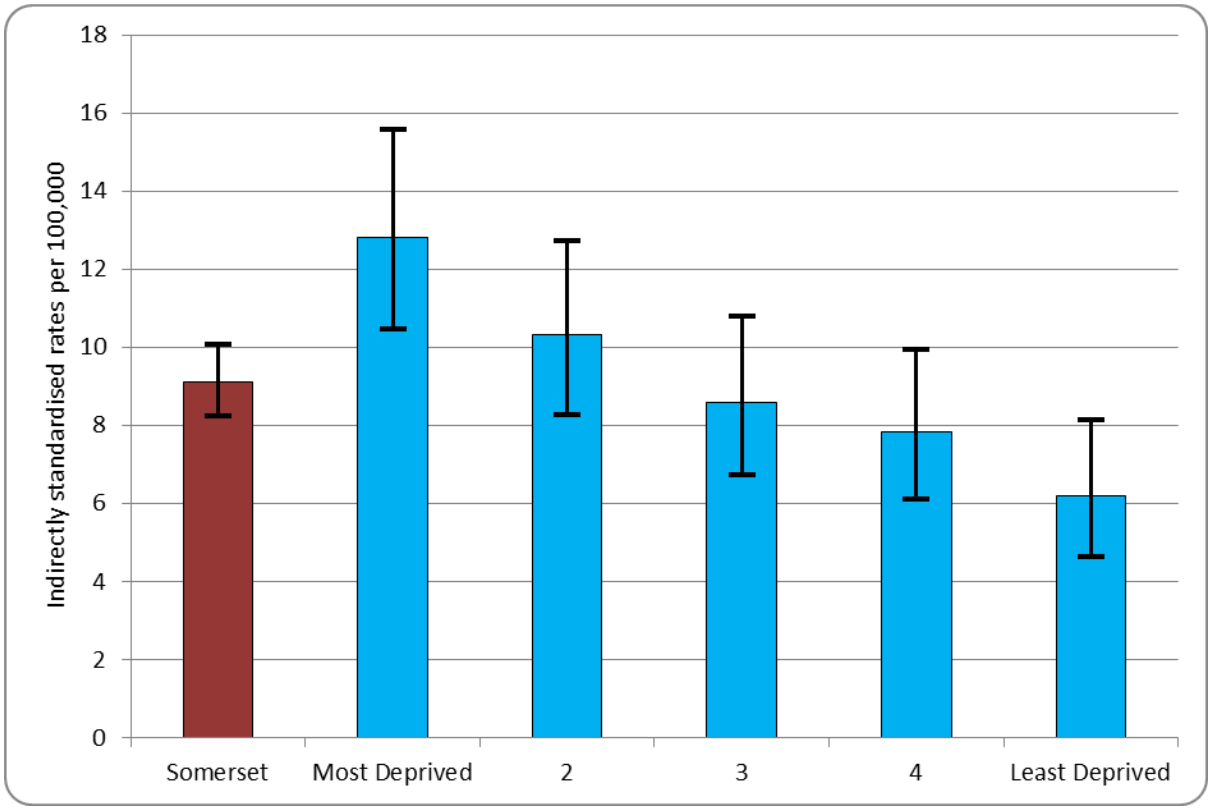
In line with national patterns, Somerset residents living in the 20% least deprived areas have a significantly lower suicide rate than the county average.

Table 2: Percentage of suicides and undetermined death between 2006 and 2013 for people of all ages by Somerset deprivation quintile.

Deprivation Quintile	Percentage
Most Deprived	26.7%
2nd Quintile	22.7%
3rd Quintile	19.1%
4th Quintile	17.6%
Least Deprived	13.4%
Somerset	**386**

Source: ONS Primary Care Mortality Database , 2014

Figure 7*: Suicides and undetermined death in Somerset, between 2006 and 2013 for people of all ages by deprivation quintile, indirectly standardised rates per 100,000.*



Source: ONS Primary Care Mortality Database , 2014.

Method of death

Over half (54%) of all causes of mortality from suicide and undermined deaths over the period between 2006 and 2013 have been caused by hanging and nearly a quarter (24%) some form of poisoning. This is similar to elsewhere in the country.

Methods, such as hanging carry a high lethality, that is are most likely to succeed. Poisoning, the second most common means, can be less lethal, with a greater potential to survive. Providing support following a deliberate self-harm incident is recommended best practice in preventing suicide. Evidence also suggests that reducing access to means by erecting barriers, publicising helplines and restricting access to poisons are effective interventions.

Table 3: **Method** *of suicides and undetermined death in Somerset between 2006 and 2013 for people of all ages*

Cause	%
Hanging	54%
Poisoning	24%
Other	6%
Firearms	4%
Jumping (including before moving objects)	3%
Drowning	3%
Smoke/fire	3%
Sharp object	2%

Source: ONS Primary Care Mortality Database , 2014.

Place of death

The most common place of death is at home. Over half (59%) of all suicides and undetermined deaths took place at home, a quarter (27%) took place elsewhere and 14% were recorded as taking place in hospital. However it should be noted that for the most part the event and injury would have occurred elsewhere. A small number, less than >2% took place in either a nursing/care home or a hospice.

Table 4: Place of death for *suicides and undetermined death in Somerset, between 2006 and 2013 for people of all ages*

Place of Death	%
Home	59%
Elsewhere	27%
District Hospital	9%
Other Hospital	5%
Care/nursing Home	<2%

Source: ONS Primary Care Mortality Database , 2014.

Next steps for suicide audit in Somerset

This report will be produced annually, with the existing tables and figures updated, and with further analysis of deaths in contact with mental health services and the criminal justice system.

We will also be publishing the outcomes of the new suicide case review. This will look in more depth, and in a more timely manner at themes and potential action.

Progress on the Somerset Suicide Prevention Strategy and Action Plan is currently reported directly to the Suicide Prevention Advisory Group. We will include a summary report on this work in next year's audit report.

If you would like more information about the Somerset Suicide Prevention Advisory Group please contact:

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References

[i] http://www.phoutcomes.info/

[ii] http://www.hscic.gov.uk/

[iii] http://www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci/

[iv] https://www.gov.uk/government/publications/suicide-prevention-strategy-launched