



Preventing Suicide in Somerset

Audit Report 2015

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Executive Summary

This annual report presents an analysis of deaths by suicide in Somerset based on a three year rolling period, currently 2012 – 2014.

Also included in this report is a summary of the findings from the first full year's case audit, for the year 2014.

Numbers of deaths vary from year to year and therefore the suicide rate is usually calculated based on a three year period, not on any individual year.

On average, around 50 people died each year by suicide in Somerset in the period 2012 – 2014.

The current rate of 9.4 per 100,000¹ is a decrease on the previous rate of 9.8 (2011 – 2013), but this is not statistically significant and in effect demonstrates no particular change.

The rate for Somerset (9.4) although higher, remains statistically similar to the rate for all of England (8.9 per 100,000). The rate for Somerset (9.4) although lower, remains statistically similar to the rest of the South West (10.1 per 100,000).

Rates of mortality from suicide and undetermined death are highest for males aged 75+ and for females aged between 35 and 64. During the 2012- 2014 period there were deaths in all age groups, from 15 to 75 +.

Deaths by suicide of children under 15 years old are, fortunately, a rare occurrence and these, as with all unexpected deaths of children under 18 years, will prompt a strategy meeting between health, social care and the police to identify any safeguarding concerns relating to this child, or other children within the household.

Around 70% of deaths are male. This reflects the pattern nationally.

The most common method of death is 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 (60%) 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 of 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 annual case audit, established in 2014, provides a more timely and in-depth view of deaths in Somerset, enabling preventative action.

Introduction

Across England as a whole, one person dies every two hours as a result of suicide. On average, around 50 people died each year by suicide in Somerset between 2012 and 2014. 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.

Suicide is often the end point of a complex history of risk factors and distressing events. Action to prevent suicide has to address this. Issues of depression, self-harm and substance misuse are all common factors, with relationship breakdown or loss of employment being common triggers in Somerset, as elsewhere.

Somerset level data from the Health and Social Care Information Centre (HSCIC) for 2012 – 2014 suggests men are two-and-a-half times more likely to die by suicide than women and suicide remains the cause of most life years lost for men.

Nationally, around 30% of all deaths are people in contact with specialist mental health servicesⁱⁱ. However, the Somerset Case Audit suggests that in Somerset this is around 50%. This indicates opportunities for suicide prevention within mental health services and for ensuring support for people living in recovery. It also serves as a reminder that many people who go on to complete suicide have no previous history of mental illness.

'Preventing Suicide in England' – a cross-governmental strategy to save livesⁱⁱⁱ – was launched in 2012. This is the second national suicide prevention strategy and it sets out six key evidence-based priority action areas to be progressed both at national and local level:

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

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

This report addresses the action around research, monitoring and data collection and 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. 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. 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 open verdicts.

In this report we have used two sources of data: the Public Health Outcome Framework (PHOF) and the Health and Social Care Information Centre^{iv} (HSCIC). At the point of publishing this report, data is available up to the end of the 2014 financial year. Detailed local analysis has been completed using the Primary Care Mortality Database (PCMD) provided by HSCIC on behalf of the Office for National Statistics (ONS).

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.

Due to the retrospective nature of the official statistics, a local case audit system has been implemented to provide more timely information on deaths. This looks at cases prior to the coroner's verdict, which are likely to be the consequence of suicide. The case audit seeks further information on the circumstances surrounding each death, from GPs and other agencies. This year's annual report includes a summary of the findings from the in-depth case audit for the year January to December 2014. The case audit comes under the oversight of the Suicide Audit Group, which meets a minimum of twice a year to consider in-depth learning, initiate action and make recommendations to the Suicide Prevention Advisory Group.

Somerset Suicide Prevention Strategy

Somerset Suicide Prevention Strategy 2013-2016 is based on the current national strategy, *'Preventing Suicide in England: a cross-government outcomes strategy to save lives'* 2012. The strategy is reviewed and monitored by the Somerset Suicide Prevention Advisory Group. This is a multi-agency group from across statutory and third sector organisations, co-ordinated by Public Health and chaired by Somerset Partnership. The group has been in existence since 2008.

The overall aim of the 2013-2016 Somerset Strategy is to achieve a reduction in the suicide rate in the general population in Somerset and better support for those bereaved or affected by suicide. There are six overarching areas of action. Below is a summary of action taken in the last year.

Action area one: Reduce the risk of suicide in high risk groups

National and international research has identified particular groups who are at greater risk. These include people in the care of mental health services, young and working aged men, people with an established history of self-harm, people in contact with the criminal justice system and some specific occupational groups, locally this includes farmers in Somerset. Local action is tailored to the specific needs of each group taking account of recommended good practice and NICE guidelines.

This year our focus has been on men and on people in the care of mental health services. A bespoke 'Putting men into mental health' conference was held in conjunction with the national organisation Men's Health Forum. The day was chaired by the medical director of Somerset Partnership with over ninety participants, seventy per cent of whom were men. A Men's Mental Health Interest group has been formed and further actions are being developed across a range of settings.

Somerset Partnership is leading work to address the needs and risks of people in contact with mental health services. An extensive Somerset Partnership Suicide Prevention Action Plan has been developed managed by an Operational Group. Patient and carer representatives are involved in developing the pathway for people bereaved by suicide, including links to the existing Suicide Bereavement Support Service. Advanced risk assessment training courses have continued to be delivered and ASIST suicide prevention courses are being arranged for carers. Guidance for the management of patients who refuse treatment is also being developed as this is recognised as a potential risk factor to someone being in crisis.

Action area two: Promote mental health and wellbeing in the population

As well as targeting high-risk groups, a key element of work is to improve the mental health of the population as a whole. A Somerset Positive Mental Health Strategy has been approved by the Health and Wellbeing Board. This includes action to help build individual and community resilience, promote mental health and wellbeing and challenge health inequalities. This year there has been a strong focus on promoting the mental health and wellbeing of children and young people through the dissemination of the Emotion

Coaching programme, the development of a web based mental health toolkit and working with young people to develop resources to promote emotional health. Resources to help tackle self-harm are in development.

Public Health continues to invest in Applied Suicide Intervention Skills Training (ASIST). The course is known to increase knowledge and confidence to respond to a person at risk and intervention skills are retained over time and are put to use to save lives. Seven courses were delivered and two new ASIST trainers were trained thanks to Health Education England SW for a grant given to the SW Public Health Workforce Steering Committee.

Action area three: Reduce access to the means of suicide

This involves a partnership approach led by Somerset Partnership Foundation Trust, emergency services and Somerset County Council. The revised national guidance on the identification and management of suicide hotspots has been reviewed and is awaiting publication. The audit process will further enable us to monitor and take action in relation to reducing access to means.

Action area four: Provide better information and support to those bereaved or affected by suicide

Somerset's bespoke Suicide Bereavement Support Service has continued to provide emotional and practical support to those bereaved by suicide. Fifty seven people contacted the helpline this year, thirty people received Cruse suicide bereavement support and there were over eighty attendees to the Peer Support Group. This service is delivered through a partnership between Mind in Taunton and West Somerset, Cruse and the Samaritans.

Action area five: Support the media in delivering sensitive approaches to suicide and suicidal behaviour

This year Advisory Group members worked on a series of suicide prevention radio features. Ben McGrail from BBC Somerset, won the Mind Media Award for the best factual radio programme. Monitoring local media reporting and disseminating the national Suicide Reporting Guidelines continues to be part of our action plan and our communication leads will follow up on any inappropriate local reporting.

Action area six: Support research, data collection and monitoring

The Somerset Public Health Department is responsible for the audit process. The Somerset Suicide Prevention Audit Group meets quarterly throughout the year to review progress and initiate action. This report is the annual summary of this process. Learning and recommendations from the audit process are fed back to the advisory group for consideration and, if appropriate, inclusion in the forward action plans.

A Suicide Prevention Awareness Workshop is held annually.

Somerset Case Audit Report: January – December 2014

As reported in the annual audit report '*Preventing Suicide in Somerset*' (Dec. 2014), in addition to the annual audit of trends, an in-depth case audit of deaths by suspected suicide in Somerset has been established.

The case audit process looks at deaths within the year in which they have occurred, for which the most probable cause is suicide. Further information about the circumstances surrounding the death is then sought from the GP and other agencies who may have had contact with the deceased person. This process takes place prior to the coroner's verdict, which in some cases, where there is an inquest, can be given some considerable time after the death. The case audit allows the audit group to have a more timely view of incidents, spot any emerging patterns and to take prompt action.

The first full year of the case audit has been completed for January – December 2014. During this period the audit group considered 39 deaths of Somerset residents and two further deaths that were recorded within the county, but were not of Somerset residents. Overall the pattern in terms of gender, location and means reported in the broader analysis, and of trends, was reflected in the case audit.

The case audit confirms that in Somerset, as in the rest of England, a long history of self-harm, substance misuse, unemployment and emotional / mental health problems are common features in those who go on to complete suicide. The most common place of death was the home.

Overdose information was looked at in detail where it was available, but no particular pattern was found on which to base preventative action.

There were four railway deaths during the year; three of which were in or near Taunton and the other occurring in or near Wellington. No particular pattern was found in relation to deaths in public places.

The case audit did not find any specific direct associations with physical health problems during the year in question, either in individual cases or as part of a wider pattern.

Alcohol and drug related problems were a known factor in 18% of deaths in this period.

The findings of the case audit support local on-going action in terms of a focus on:

Men's mental health: enabling men to develop emotional resilience and to find safe and appropriate ways to manage and share feelings should remain a high priority. In Somerset two-and-a-half times more men than women go on to complete suicide and it remains the cause of most life years lost for men.

Self-harm support and prevention: particularly for women, and recognising that there are a significant number of people engaged in self-harming behaviour who are not in contact with mental health services. During 2014 around 35% of all of those who died were identified as having a history of self-harm.

Contact with mental health services: during the audit period (January – December 2014) 50% of Somerset residents who died were known to mental health services. Further work between the audit group and the mental health trust is recommended to identify the nature of the contact and to ensure that all lessons are learned.

Preventing Railway deaths: on-going work with Network Rail and the Samaritans to provide information at stations and training for railway staff is highly recommended. Support for affected staff should also be considered by Network Rail and the train companies.

GPs: on-going support training and resources for GPs in mental health and suicide prevention is supported by this audit, with approximately 25% of those who went on to die by suicide having had more than 6 visits to their GP in the previous 12 months. This work should focus on the resources needed to support GPs with identifying and managing emotional distress within a highly pressured clinical setting.

Understanding Published Suicide Rates

The Public Health Outcomes Framework (PHOF 4.10) reports age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 head of 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 Office for National Statistics (ONS) definition. The Health and Social Care Information Centre (HSCIC) publishes data on suicides and undetermined death for those aged 15+.

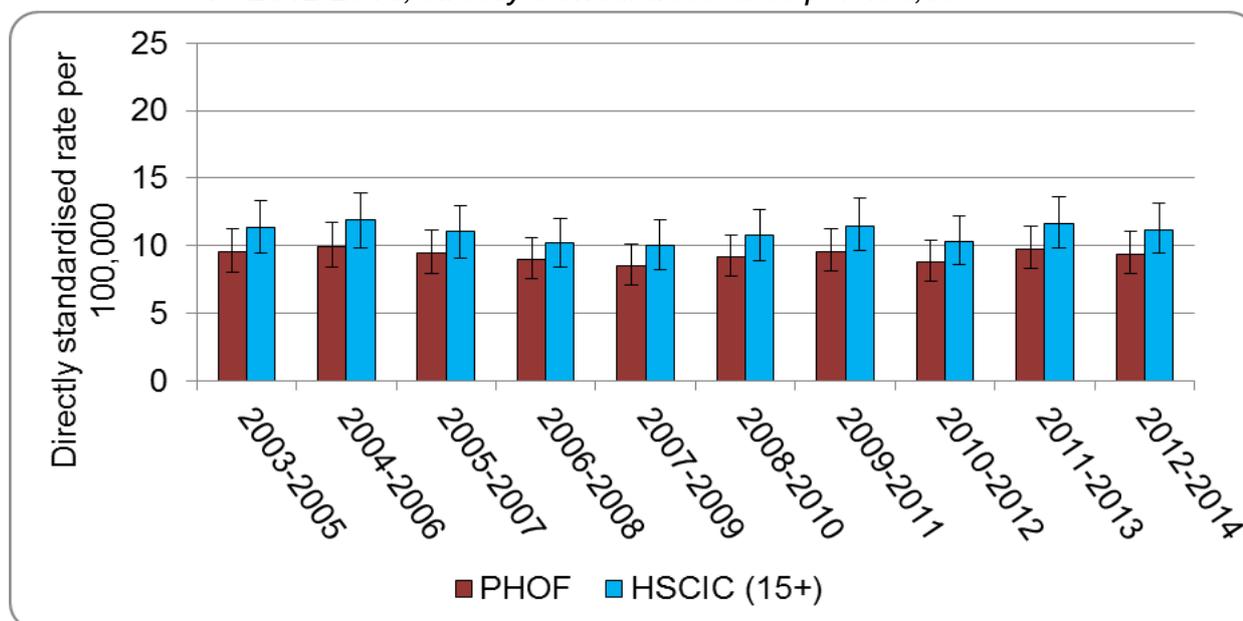
Since 2003-2005 there have not been any statistically significant differences between the HSCIC and PHOF measures, nor have there been any significant changes over time for either indicator. Table 1, below, provides a summary of the current indicators on suicide and the way that the information is collected and analysed. In most years the number recorded by HSCIC and PHOF are identical (because there were no suicides recorded for 0-14 year olds). The HSCIC rates tend to be higher as they do not include 0-14 year olds in the denominator for suicides.

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

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

Sources: Health and Social Care Information Centre (HSCIC) Indicator Portal, 2014
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 2012-2014, directly standardised rates per 100,000



Sources: Health and Social Care Information Centre (HSCIC) Indicator Portal, 2015
Public Health Outcome Framework, 2015

¹ Public Health England (PHE): Public Health Outcomes Framework

Trends In Suicide And Undetermined Death Rates For Somerset

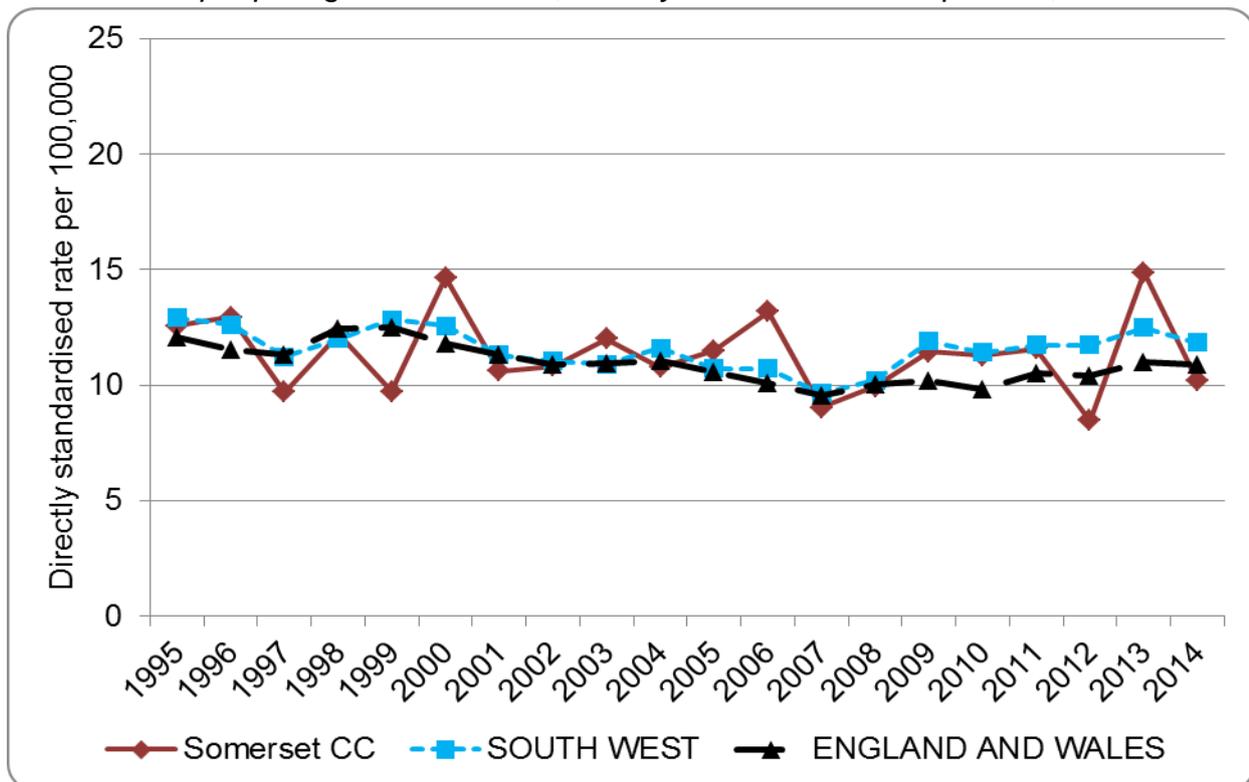
An Overview

The suicide and undetermined death rate for Somerset, currently reported by the Public Health Outcomes Framework, is 9.4 per 100,000 for the three year period 2012 – 2014. This was statistically similar to the England (8.9 per 100,000) and South West (10.1 per 100,000) averages. This is a slight, but not statistically significant, decrease on the period 2011 – 2013 when the rate for suicide reported for Somerset was 9.8 per 100,000 (PHOF) which again was statistically similar to the England (8.8 per 100,000) and South West (10.1 per 100,000) rates.

The annual rates of mortality from suicides and undetermined death, reported by the Health and Social Care Information Centre (HSCIC) for people aged 15 and over, have generally declined in the past 20 years in England and Wales. However, rates for both England and Wales and the South West have been fairly static since 2009.

Individual years can fluctuate widely due to the small numbers involved; however, there was a notable spike in the rate for Somerset in 2013.

Figure 2: *Annual trends in mortality from suicide and undetermined death in Somerset, the South West and England & Wales, 1995 to 2014 for people aged 15 and over, directly standardised rate per 100,000*



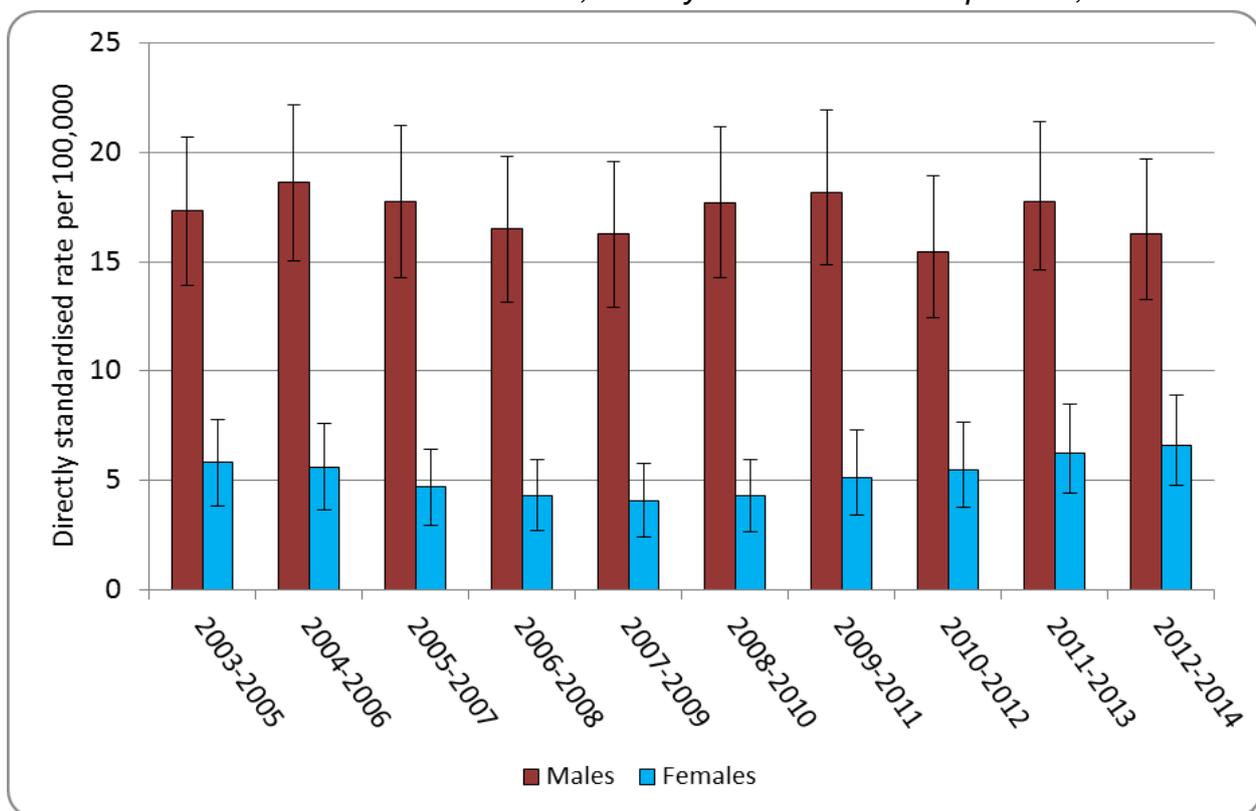
Source: *Health and Social Care Information Centre (HSCIC) Indicator Portal, 2015.*

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 and 2014. During 2012-2014, 71% of suicides and undetermined death in Somerset were of males; this reflects the picture in England and Wales (77%).

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. During the 2012-2014 period, the mortality rate from suicide and undetermined death for males was almost two-and-a-half 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 between 2003-2005 and 2012-2014, directly standardised rate per 100,000*

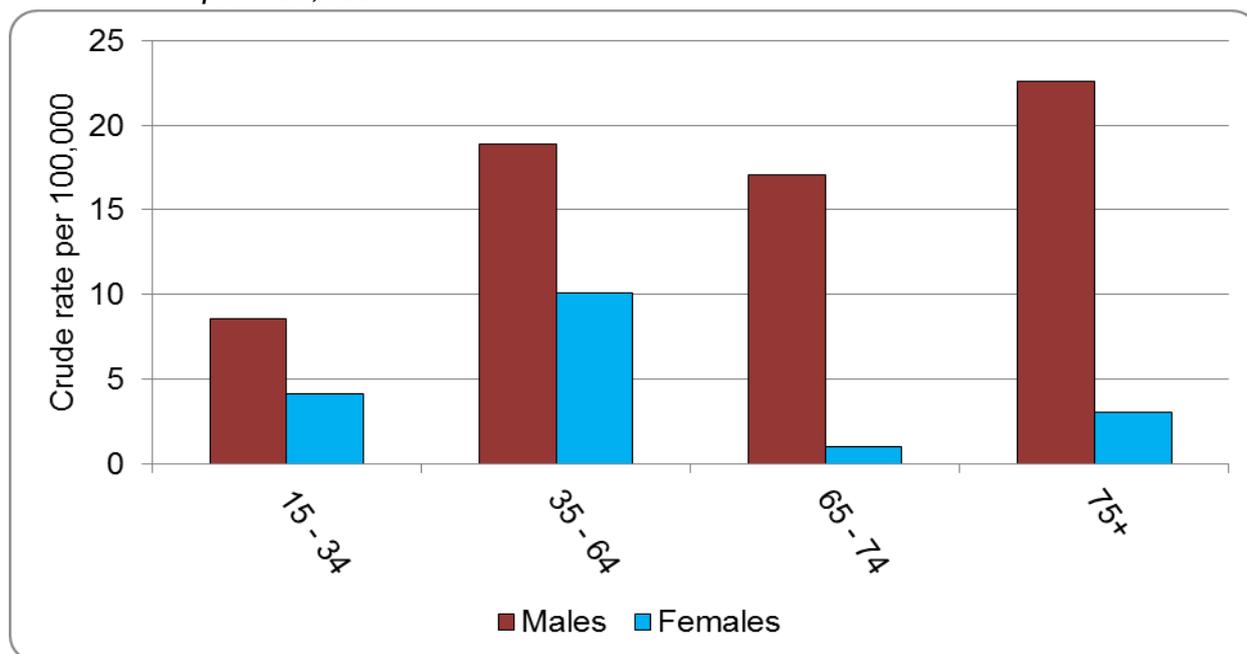


Source: *Health and Social Care Information Centre (HSCIC) Indicator Portal, 2015*

Figure 4, below, shows that the rates of mortality from suicide and undetermined death for females have been highest for those aged 35 to 64. The rates for males were highest in those aged 75 and over, although the rates for males aged 35-64 and 65-74 were also relatively high.

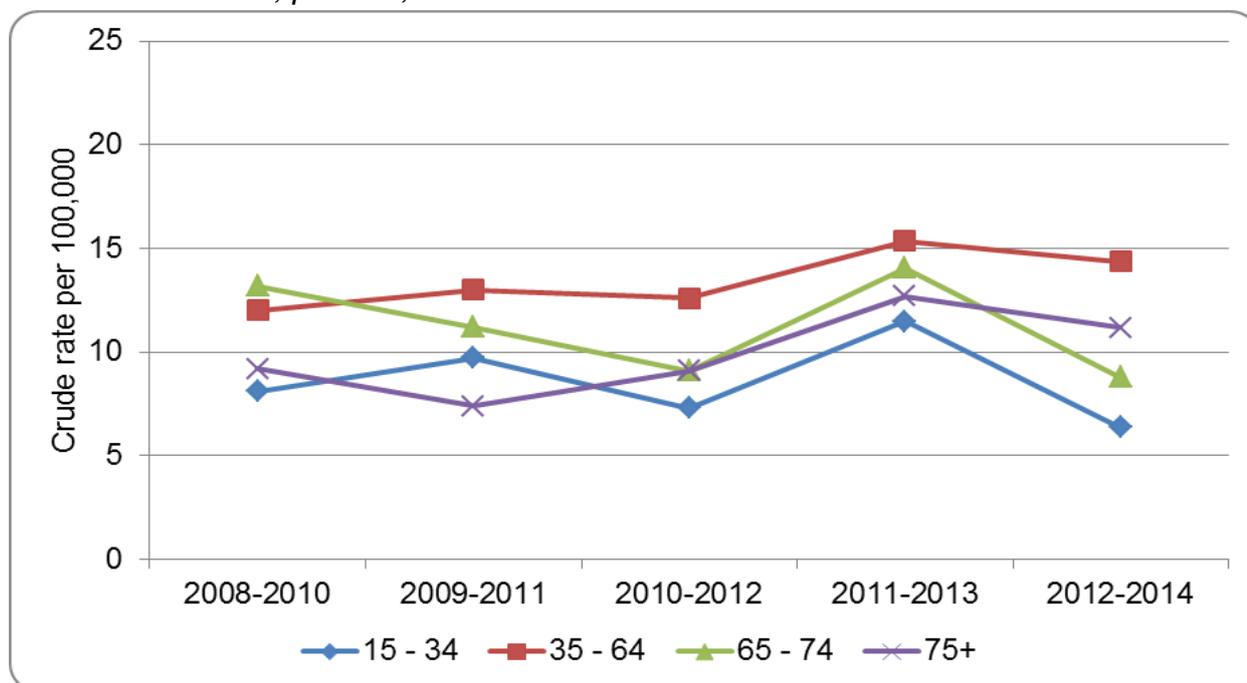
Figure 5, also below, illustrates how these patterns have changed since 2008-2010. However, these trends should be viewed with some caution due the low numbers in each age band and the absence of confidence intervals.

Figure 4: 2012 – 2014 rates of mortality from suicide and undetermined death in Somerset for males and females aged 15 and over by age band, per 100,000



Source: Health and Social Care Information Centre (HSCIC) Indicator Portal, 2015

Figure 5: (2008-2012) to (2011-2014) rates of mortality from suicide and undetermined death in Somerset for people aged 15 and over by age band, per 100,000.



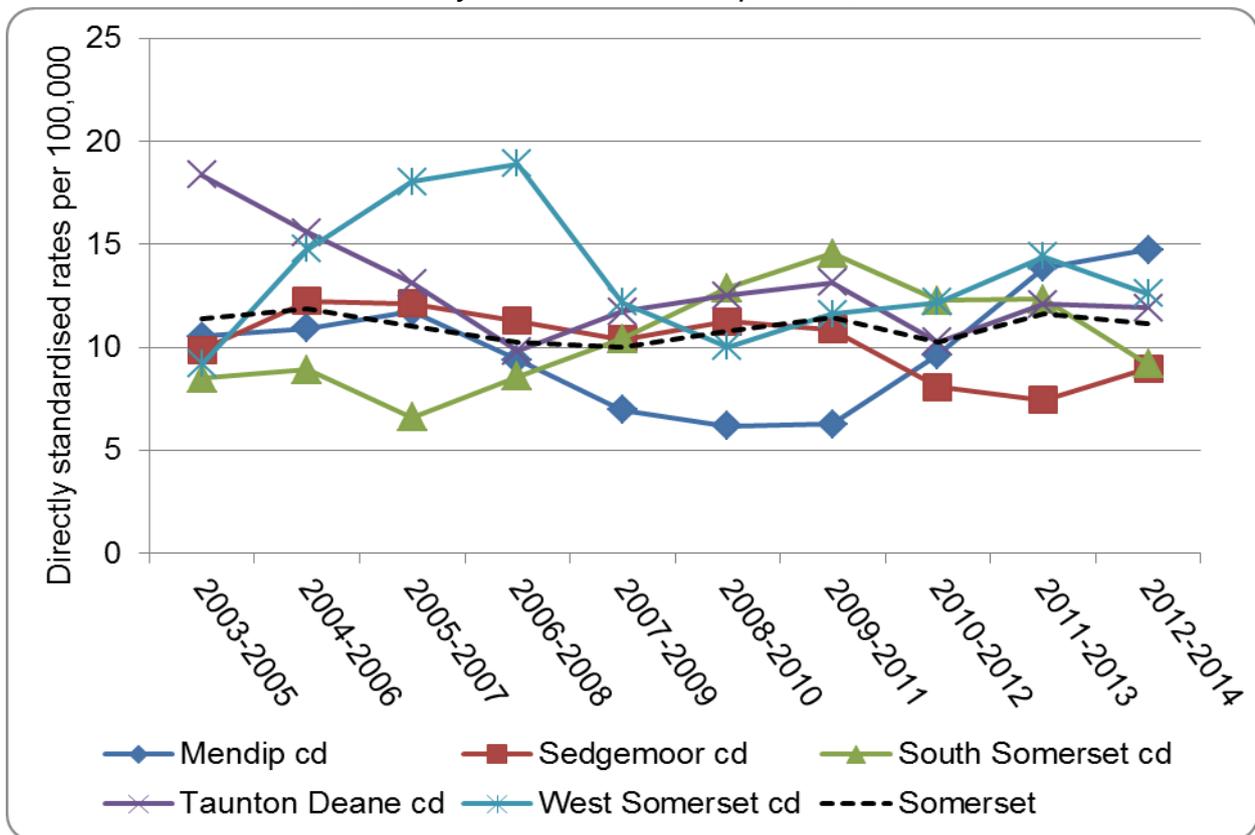
Source: Health and Social Care Information Centre (HSCIC) Indicator Portal, 2015.

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.

Although not statistically significant, the rate in Mendip has consistently increased from the lowest rate of any district in 2009-2011 to the highest in 2012-2014. Conversely, rates in South Somerset were the highest of any district in 2009-2011, but have been falling and are now joint-lowest, with Sedgemoor.

Figure 6: Somerset's districts rolling three year trends in mortality from suicide and undetermined death of people aged 15 and over between 2003-2005 and 2012-2014, directly standardised rate per 100,000



Source: Health and Social Care Information Centre (HSCIC) Indicator Portal, 2015

Socio-economic Factors

There is a strong association between suicide rates and levels of deprivation. The rate of 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.

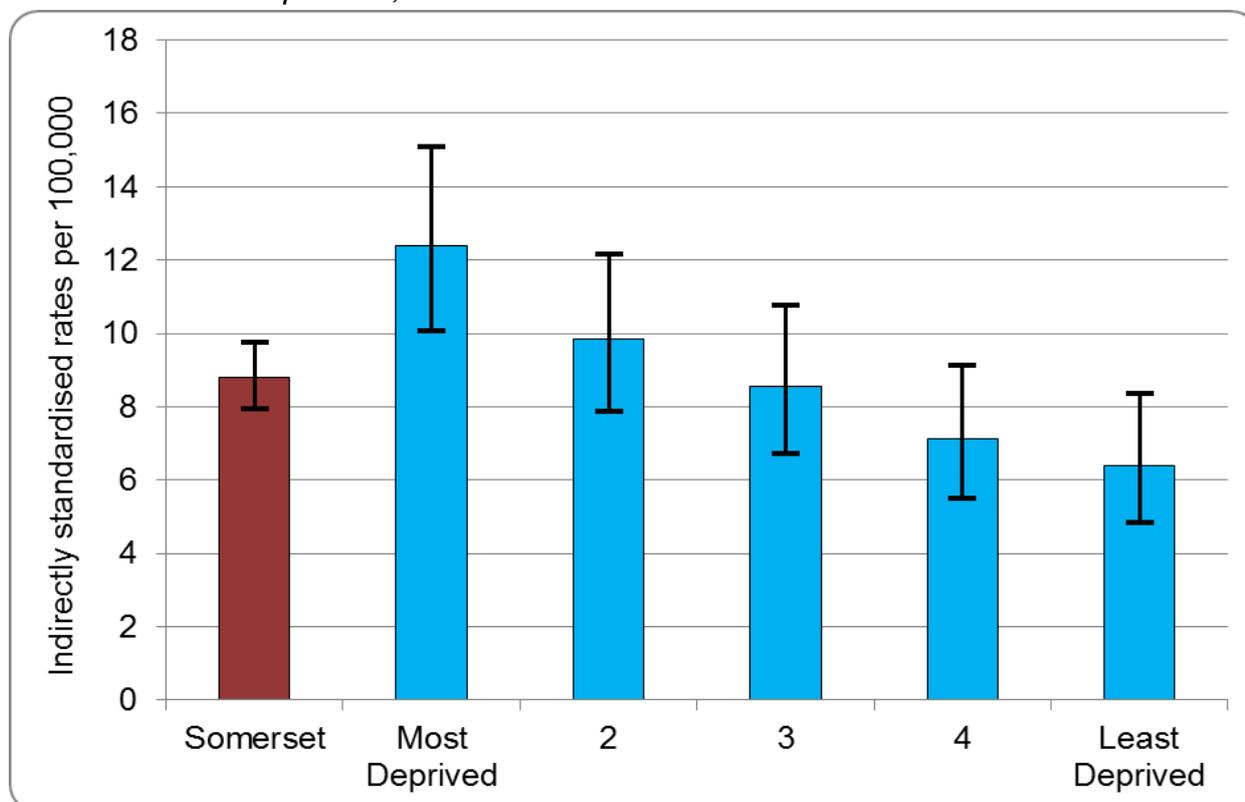
In line with national patterns, residents living in the 20% least deprived areas of Somerset have a lower suicide rate than the county average and this difference was statistically significant.

Table 2: *Percentage of suicides and undetermined death between 2007 and 2014, for people of all ages by Somerset deprivation quintile*

Deprivation Quintile	2007-2014
Most Deprived	28.1%
2nd Quintile	19.0%
3rd Quintile	20.6%
4th Quintile	17.6%
Least Deprived	14.7%
Somerset	374

Sources: ONS Primary Care Mortality Database, 2015
Index of Multiple Deprivation, 2015

Figure 7: *Suicides and undetermined death in Somerset between 2007 and 2014 for people of all ages by deprivation quintile, indirectly standardised rates per 100,000*



Sources: ONS Primary Care Mortality Database, 2015
Index of Multiple Deprivation, 2015

Method Of Death

Over half (56%) of all causes of mortality from suicide and undermined deaths during the period between 2007 and 2014 were caused by hanging and a quarter (25%) by some form of poisoning. This is similar to elsewhere in the country.

Methods such as hanging carry a high lethality; that is, they are most likely to succeed. Poisoning, the second most common method, 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 2007 and 2014 for people of all ages*

Method of Completion	Percent
Hanging	56%
Poisoning	25%
Other	5%
Jumping (including before moving objects)	4%
Firearms	3%
Smoke/Fire	3%
Drowning	3%
Sharp object	2%

Source: ONS Primary Care Mortality Database, 2015

Place Of Death

The most common place of death is at home. Three in five (60%) of all suicides and undetermined deaths took place at home, a quarter (27%) took place elsewhere and 13% were recorded as having taken place in a hospital. However, it should be noted that for the most part the event and injury would have occurred elsewhere.

Table 4: *Place of death for suicides and undetermined death in Somerset, between 2007 and 2014 for people of all ages*

Place of Death	Percent
Home	60%
Elsewhere	27%
Somerset District Hospitals	9%
Other Hospitals	4%

Source: ONS Primary Care Mortality Database, 2015.

Conclusion And Recommendations

This audit confirms that in Somerset, as in the rest of England, a lifetime history of self-harm, substance misuse, unemployment and emotional / mental health problems are common features in those who go on to complete suicide. Men are two-and-a-half times more likely to die by suicide than women and the most common place of death is the home. Overall, rates in Somerset have remained stable and in line with the rest of England. The audit findings support an on-going emphasis for suicide prevention in the following areas:

Men's mental health: enabling men to develop emotional resilience and to find safe and appropriate ways to manage and share feelings should remain a high priority.

Self-harm support and prevention; particularly for women, and recognising that there are a significant number of people engaged in lifelong self-harming behaviour who are not in contact with mental health services.

Contact with mental health services: Further work between the audit group and the mental health trust is recommended to identify the nature of the contact and to ensure that all lessons are learned.

Preventing Railway deaths: On-going work with Network Rail and the Samaritans to provide information at stations and training for railway staff is highly recommended. Support for affected staff should also be considered by Network Rail and the train companies.

GPs: On-going support training and resource for GPs in mental health and suicide prevention is supported by this audit. This work should focus on the resources needed to support GPs with identifying and managing emotional distress within a highly pressured clinical setting.

Districts and localities: Given the link between 'people' and 'place' there are opportunities for districts and localities to have a greater understanding of the role that they can play in both building community resilience and in implementing direct suicide prevention initiatives, such as signage, safe havens and local participation in the multi-disciplinary training ASIST programme.

Contact Details

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

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References

ⁱ Public Health Outcomes Indicator (2012 – 2014)

ⁱⁱ <http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/>

ⁱⁱⁱ <https://www.gov.uk/government/publications/suicide-prevention-strategy-launched>

^{iv} <http://www.hscic.gov.uk/>