Leeds CITY COUNCIL

Executive Summary

Audit of Suicides in Leeds

2014 – 2016

September 2019

Acknowledgements

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The full Audit report for Suicides in Leeds 2014-2016 can be found on the Leeds Observatory website (https://observatory.leeds.gov.uk/wp-content/uploads/2019/09/Leeds-Suicide-Audit-2014-2016-Full-Report.pdf).

This report is dedicated to the individuals in this audit and all those affected by their deaths.

Executive Summary

Overview

Suicide is a high priority public health issue for Leeds. Alongside this audit looking back at deaths over a three year period, we use information from the Office of National Statistics (ONS) to give us a broad picture of suicide deaths in Leeds, comparisons to other areas and trends over time. The numbers are not exactly identical to our audit data, due to slightly different methodologies, but together this gives us a detailed picture for suicide deaths across the city. The most recent Office for National Statistics data was received at the time of writing this report (3rd September 2019) and covers the period 2016-18.

This most recent information shows that Leeds has a similar suicide rate to England as a whole, although male deaths from suicide are relatively higher. The overall suicide rate in Leeds has remained relatively level over the last 5 years, with a slight fall in the rate from 11.8 to 10.9 per 100,000 people in the last 3 year period (2016 – 18). In 2018, there were 74 deaths attributed to suicide in Leeds. We know that the gap between deprived Leeds and the city as a whole remains a challenge.

Leeds' rates remain slightly higher than those for the English Core Cities, in particular when compared to Birmingham and Sheffield (both 8.1). However, it should be noted than most Core Cities have lower suicide rates than the England average, with the highest rates being outside the major cities. Leeds has a rate similar to the average in Yorkshire and Humber (10.9 compared to 10.7 per 100,000 people).

The audits in Leeds are a public health approach to suicide prevention, and enable us to understand patterns, trends and risk factors for suicide within our population. The audit is a key tool in engaging the wider public health workforce and provides a focus for delivering effective suicide prevention interventions. This then shapes our priorities in the form of the Leeds Suicide Prevention Action Plan. Disseminating findings from the audit is an important element of this work and enables key messages to be shared across the city. Partners own the audit findings and understand their role in preventing suicide in local communities.

The suicide audit process would not be possible without a close and collaborative working relationship with the West Yorkshire Eastern Coroner's Service, who allow us full access to every sudden death inquest in the interest of preventing future deaths. The inquests are formal proceedings that determine a cause of death, using evidence gathered from witnesses, family and friends, healthcare and other service providers and usually a post-mortem report. Combined, the information from these sources creates a rich source of intelligence we can extract and present to the public in this audit report.

Key Findings

Trends

The 2014-16 audit revealed 205 suicides by Leeds residents and 11 suicides occurring in Leeds by non-Leeds residents. By comparison, the 2011-13 audit showed 213 deaths from suicide by Leeds residents and 179 in the 2007-10 audit.

The rate of deaths from this suicide audit was 8.8 per 100,000 residents, a small decrease from the rate of 9.5 per 100,000 residents in the previous audit (2011-13). This rate is lower than the official ONS rate which includes undetermined intent.

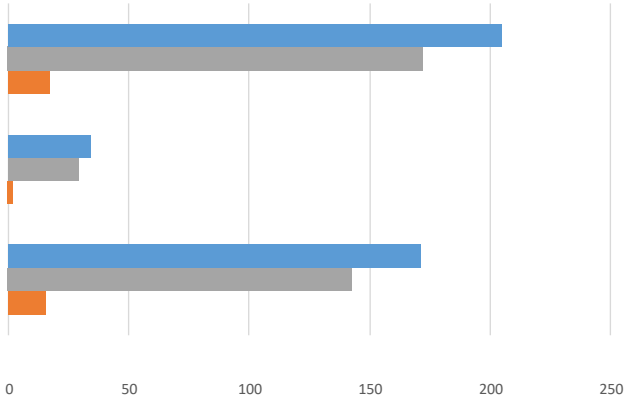
The most common age group was those aged 40-49 for males and 30-39 for females, similar to previous audits.

83% of cases were male and there continues to be a 5:1 ratio of males to females dying from suicide in Leeds, in stark contrast to the national ratio of 3:1.

Deaths from Suicide 2014-16

Leeds City residents by gender and ethnicty, count

	2011-13 Audit Count	2014-16
Count Male		
Overall	176	171
White British/Other	145	143
BAME	25	15
Female		
Overall	37	34
White British/Other	28	29
BAME	6	2
Persons		
Overall	213	205
White British/Other	173	172
BAME	31	17



* 'overall' includes suicides where ethnicity was unknown

Figure 1: Suicide counts by gender and ethnicity

78% of the cases were White British. This is a figure that is consistent for males and females, but more pronounced in older people: 69% of those aged 40 and under were White British versus 84% of those aged 41 and older. Given that the minority ethnic background population in Leeds is 12.7% of the total population (PHE, 2016), the suicide rate amongst those with non-White ethnicities was 5.8 per 100,000.

The breakdown in Table 1 shows that White males are at the highest risk of suicide followed by Black, Asian and Minority Ethnic (BAME) males.

	Overall (including unknown ethnicity)	BAME	White British and White Other
Persons	8.8	5.8	8.5
Female	2.8	1.3	2.8
Male	15.0	10.4	14.4

Table 1: Suicide rate per 100,000 population by gender and ethnicity

Deprivation and Geography

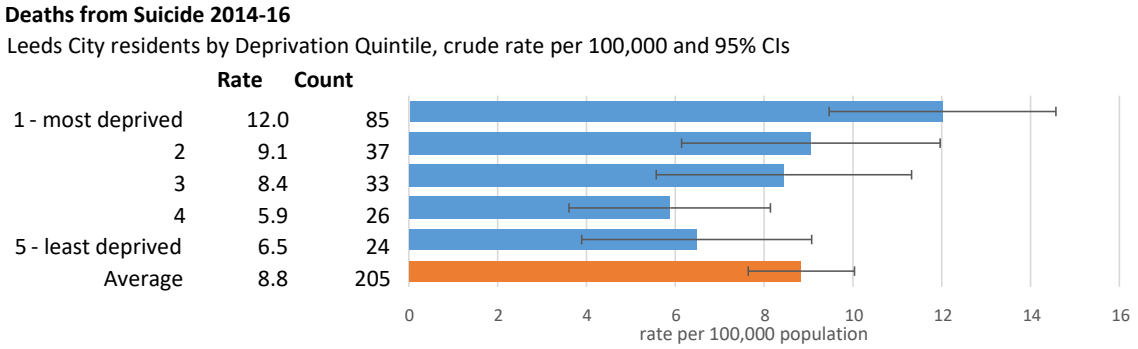


Figure 2: Suicide rate by deprivation quintile

30% of all suicides in Leeds occurred amongst residents in the most deprived 20% of the city. Two out of three suicides were in the most deprived half of the city. This is consistent with previous audits and national trends in suicides.

Of the 31 postcode areas where suicides were recorded in Leeds, half of all individuals lived in just seven: LS6, LS8, LS9, LS11, LS12, LS15, and LS28. An additional seven postcode areas capture 80% of all suicides: LS13, LS14, LS16, LS17, LS19, LS25, and LS27.

Social Isolation

75% of the audit population were either single, divorced, separated or widowed and 41% lived alone. This reflects the previous audit's findings, although there has been a slight increase in the percentage of those experiencing problems with a personal relationship (53% in the 2011-13 audit compared to 60% in the current audit).

Employment and Finances

38% of the individuals in the audit aged 16-64 were employed compared to 71% in the Leeds population over the same time period. 7.3% of the audit population were on long term sick and 5% were students.

From the limited information available in the Coroner's records, it was apparent that approximately one third (35%) were experiencing a level of financial difficulty, with 6% recently being made redundant. Overall, half (47%) of those that died from suicide had some level of worklessness. This pattern is consistent across gender, though as expected financial difficulty was concentrated amongst the most deprived areas.

Contact with Primary Care and other Services

15% of those in the audit (31 individuals) had contact with their GP within one week of their death and 43% within one month prior to death. Half of those presenting within a month prior to death presented with a mental health issue.

Consistent with previous audits, 24% of people had current contact with a specialist mental health service (defined as contact within the previous three months). 42% of the audit population had never been in contact with a specialist mental health service, although 78% had a documented history of a mental health diagnosis (up from 70% in the 2011-13 audit). The prevalence of self-reported long-term mental health problems in the general Leeds population is 18.2% and the GP recorded prevalence of those with severe mental illness is 1% (PHE, Mental Health and Wellbeing JSNA, 2017/18).

Risk Factors

Individuals in the audit had an average of six observed risk factors. This finding was consistent across geography, deprivation, gender and ethnicity. The audit highlights what we already know from practice: those that die from suicide often have chaotic lives and experience compounding risks. No single risk factor stands out as causal in isolation, though some are more observed than others.

In general, the audit revealed that recent changes in individuals' lives were potential triggers for suicide. We particularly noted redundancy, relationship breakdown, a recent health diagnosis, bereavement and the accusation of a sexual offence.

Conversely, the audit also identified risk factors that are potentially present for a long time before a suicide death: adverse childhood experiences, mounting financial difficulty, substance misuse and a history of mental illness were all noted.

Recommendations

The following recommendations are based on the findings of this audit, national policy, and a review of current evidence. They are structured according to the six areas for action suggested in the 2012 National Suicide Prevention Strategy (HM Government) and its refresh in 2017 (HM Government).

Area for action 1

Reduce the risk of suicide in key high-risk groups:

This audit has identified that those at the highest risk of suicide within Leeds are:

- Aged 40 to 65
- Male
- Born locally and predominantly living in deprived areas of Leeds
- Living alone
- Single/ separated/ divorced
- Experiencing worklessness
- Experiencing relationship problems
- Have a history of self-harm or previous suicide attempt(s)
- History of a mental health diagnosis
- Have a history of drug/ alcohol misuse

Recommendation 1
Engage partners from a wide range of organisations, ensuring key suicide prevention work is undertaken by skilled people who have access to the groups identified as most at risk. Support partners to embed effective actions within their own action plans across the city that link to the Leeds Strategic Suicide Prevention Plan.

Recommendation 2
Target interventions towards those identified as most at risk. Every agency working to prevent suicide should consider how their work promotes resilience and good mental health, whilst reflecting the needs of the local population.

Recommendation 3
Actions to reduce risk for people in contact with the criminal justice system to include points of transition, first contact, early days of custody and the pre- and post-release period. Link the suicide prevention agenda to other plans in the city where criminal justice work is being prioritised.

Area for action 2

Tailor approaches to improve mental health in specific groups.

Specific groups which the audit shows to be at a high risk of suicide are:

- Those who have a history of drug or alcohol abuse
- Adverse childhood experiences
- Domestic violence (both victims and perpetrators)
- Contact with the criminal justice system
- Accused of an offense, especially those with stigma attached (i.e. sexual offenses)

- Those in ill physical health, particularly those experiencing chronic pain
- Those who have poor mental health

Recommendation 4

Work with primary care to increase the recognition of those at risk of suicide. This audit shows that half of the people had contact with primary care within three months of their death. Clinical Commissioning Group partners to work collaboratively with Leeds City Council, frontline services and the voluntary sector, ensuring acute and community services are better joined up, avoiding gaps in support during transitions and improving access for those that need it most.

Recommendation 5

Appropriate management of poor mental health at an early stage, including swift access to care, with family and friends involved in care planning where appropriate. Research shows that those with depression and other mental illnesses can benefit from a range of interventions both pharmacological (Zalsman, et al., 2016; Reinstatler & Nagy, 2015; Cipriani, Hawton, Stockton, & Geddes, 2013) and psychosocial (Zalsman, et al., 2016; Donker, et al., 2013) and these can reduce the risk of suicide. Ensure healthcare strategies are aligned and embed relevant recommendations from the latest Leeds Suicide Prevention Action Plan.

Area for action 3

Reduce access to the means of suicide.

The audit shows that Leeds does not have a defined geographical area at which multiple suicides take place. The majority of deaths occur within the home. The evidence on suicide prevention interventions however is particularly strong around reducing access to the means of suicide (Zalsman, et al., 2016; Pirkis, et al., 2015).

Recommendation 6

Continue to develop real time surveillance including data from partners to tailor specific activity around reducing the means of suicide. Partners should include West Yorkshire Police along with the transport and rail sector to inform future local action.

Recommendation 7

Continue to work with the local media to dispel myths around any high-frequency locations (should they arise) as an effective means of suicide prevention.

Area for action 4

Provide interventions and support to those bereaved or affected by suicide.

The audit shows that 10% of those included in the audit had been bereaved by suicide. Leeds City Council has commissioned the Leeds Suicide Bereavement Service, an innovative peer-led postvention service that offers support to those bereaved by suicide.

Recommendation 8
Continue to prioritise postvention interventions that are aimed towards those who are bereaved by suicide, and ensure that the Leeds Suicide Bereavement Service receives timely referrals from local organisations.

Recommendation 9
Engage with partners who are most likely to be in early contact with those who are bereaved by suicide (e.g. Accident and Emergency departments, West Yorkshire Police, Coroner's office) to ensure early access to appropriate services.

Area for action 5

Support the media in delivering sensitive approaches to suicide and suicidal behaviour.

There is evidence suggesting that adverse media coverage can be a risk factor for suicide (Pirkis, et al., 2015) and there are concerns that some media coverage can contribute to the 'contagion' effect of suicide (PHE, 2015).

In partnership with the National Union of Journalists, Leeds City Council have developed guidelines for the media to aid journalists when reporting on a death by suicide (Stack, 2003). These guidelines have been well received nationally.

Recommendation 10
Continue to work with colleagues in the media and promote the use of the national guidelines developed in Leeds in partnership with the National Union of Journalists.

Area for action 6

Support research, data collection and monitoring.

The Leeds Suicide Audit continues to be cited as an example of good practice. As discussed in the Introduction, the audit process is part of a comprehensive approach to intelligence on suicide in Leeds.

Recommendation 11
Continue to undertake a suicide audit at regular intervals to gather detailed knowledge about the epidemiology and risk factors of those taking their own life in the city.

Recommendation 12
Continue to inform partners on suicide intelligence using the audit, real time surveillance and Office for National Statistics mortality statistics, so that relevant organisations can develop coordinated responses to both emerging risks and clusters should they arise.