

# Joint Strategic Needs Assessment

## **Suicide audit in Cornwall and Isles of Scilly**

A report prepared for Cornwall and Isles of Scilly Suicide Audit Group, Cornwall Council and partners in Cornwall and Isles of Scilly

April 2015

Public Health Cornwall & Isles of Scilly

# Suicide audit in Cornwall and Isles of Scilly

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## **Executive summary**

The rate of death by suicide and injury of undetermined intent in Cornwall and Isles of Scilly (which is the recommended measure for suicide research and includes open verdicts) continues to be higher than the national average.

Suicide rates for males fell locally and nationally from 1998 onwards, but have been increasing since 2007. The female suicide rate (which is considerably lower than the male rate) fell slightly until 2007 and then remained fairly static.

In 2013 there were 65 deaths by suicide and injury of undetermined intent registered for residents of Cornwall and Isles of Scilly. This equates to an annual rate of 13.99 per 100,000 population, compared to a national rate for the same year of 10.98 per 100,000. Of those 65 recorded deaths, 49 were males and 16 were females (a ratio of 3:1).

Nationally, the risk is reported to be highest among males aged 35-64. Locally, the highest rates are seen among males aged 35-64 and 75+. The suicide rate for males aged over 74 has risen in Cornwall over the most recent published four year period but has remained fairly static in England and Wales.

Although suicide 'rates' are relatively high in Cornwall in the older male population, actual 'numbers' are highest among middle aged (45-59 year old) males because there are more people in those age groups. Although rates and numbers are relatively low for young people, suicide is a more significant cause of death at a younger age, when compared to other causes. This is because death by other causes is uncommon, becoming increasingly likely with increasing age.

The most commonly used methods are 'hanging, strangulation and suffocation' by males and 'poisoning by drugs/alcohol' by females.

The proportion of local deaths by suicide that are of people who have been in recent contact with specialist mental health services is lower than the national average, suggesting safer care by these services.

The results of this audit will be used to influence priorities in the local suicide prevention strategy.

## **Acknowledgements**

Thanks are due to the following for their contribution to suicide audit in Cornwall & Isles of Scilly:

HM Coroner for Cornwall and staff of the Coronial Service  
General Practitioners in Cornwall & Isles of Scilly  
Cornwall Foundation Trust  
Outlook South West  
Members of the Suicide Audit Group  
Public Health admin staff at Cornwall Council

## 1. Introduction

This report updates the suicide audit report published in 2012<sup>1</sup> and the Suicide Audit Group update (annual trend data) in 2014. It presents the latest available information about suicides in Cornwall and Isles of Scilly, and of residents of Cornwall and Isles of Scilly.

Descriptive statistics are presented to describe the local picture and compare it with the national one. Numbers of deaths by suicide at a local level are small in statistical terms so changing trends and patterns can be hidden by random fluctuations or may only become evident after several years. Nevertheless, some conclusions can be drawn from these data. It has also been found worthwhile to examine information about individual suicides in order to be alerted to factors that might influence the suicide rate. Individual cases and small numbers that might lead to the identification of individuals cannot be reported here for reasons of confidentiality, but individual cases are reviewed to inform themed discussions by the Suicide Audit Group (see appendix 1 for terms of reference of the Suicide Audit Group).

The purpose of suicide audit is to identify factors that influence suicide risk, so that these can be addressed in a timely manner to prevent suicides. These annual audit reports will be used to influence regular revisions of the suicide prevention strategy for Cornwall and Isles of Scilly<sup>2, 3</sup>.

## 2. The practice of suicide audit

We have conducted annual audit in Cornwall and Isles of Scilly since 2007, and have followed the guidance published by Peninsula Medical School in 2006<sup>4</sup>. This has proved to be a resource intensive exercise and the relative value has been questioned. There have been benefits, in that partner organisations have come together to examine and interpret the information and then propose action to reduce suicide risk. Action has been largely through the dissemination of information to alert primary care staff to risk factors. It is also believed that communication about a suspected cluster was made easier by having a known network of individuals contributing to audit.

Before the transfer of Public Health from the NHS into Local Authorities we surveyed all Primary Care Trusts to find out how suicide audit was being conducted across the country as we were keen to ensure that we continued to follow best practice. We found a common narrative that described an enthusiasm to learn from audit but a struggle to commit the resources and to identify local learning that adds significantly to generic policy and guidance<sup>5</sup>. Christabel Owens from Exeter University helped to analyse our findings and proposed a useful model (figure 1), describing the essential elements of, and necessary conditions for, the suicide audit process. We are aiming to achieve these conditions but we still not achieving the desired 'complete and timely data set' that directly influences local action, and are not using all the data collected in the lengthy audit questionnaires.

The All Party Parliamentary Group on Suicide and Self-Harm Prevention has recently published the results of an inquiry into local suicide prevention plans in England. This took note of the concerns expressed in our paper and recommends that:

- A long term aim should be for coroners to collect and digitalise a wider range of suicide data which is automatically made available to public health teams
- In the short term, Public Health England (PHE) should issue guidance on what data should be collected locally and how it can be used. This should include the provision of an updated suicide audit tool/template.
- The Chief Coroner should issue guidelines to Senior Coroners on enabling free access to public health teams to all necessary records and data.
- PHE should also consider how suicide data could be pooled over wide geographical areas in order to better identify trends.

Further guidance will be welcomed. In the meantime we will continue to strengthen the partnership system that we have in place. The launch of the Zero Suicides collaborative, which will support the delivery of local suicide prevention strategies, can only increase the appetite for locally relevant information.

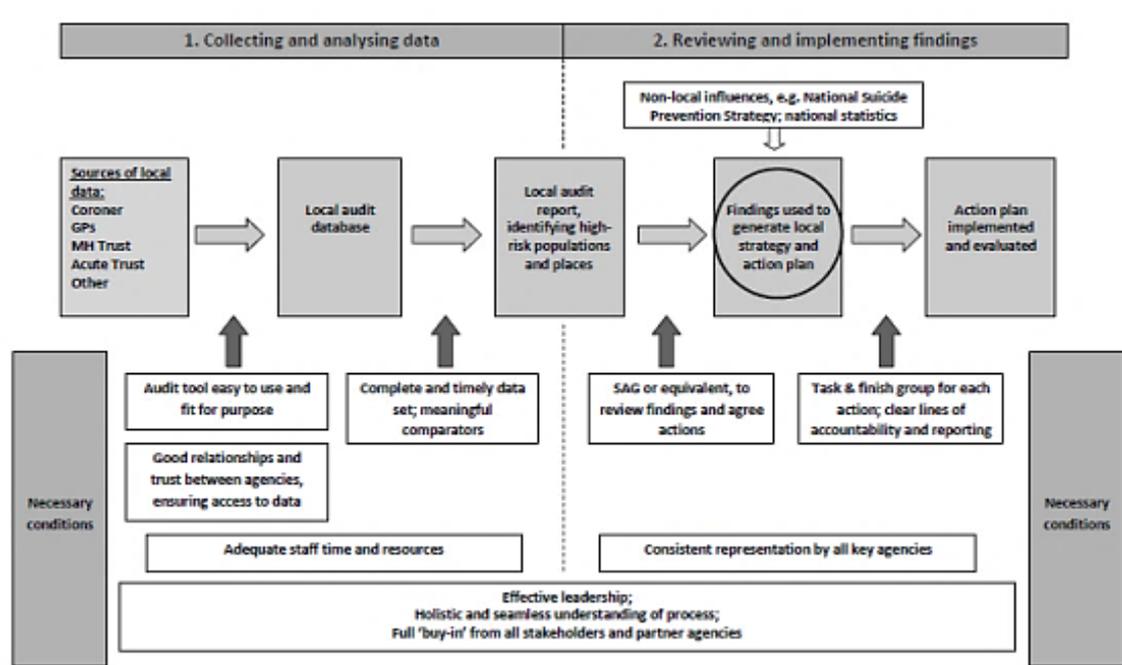


Figure 1. Essential elements of, and necessary conditions for, the suicide audit process.<sup>5</sup>

### 3. Data sources

The Office of National Statistics has changed suicide data reporting in two respects that will affect comparisons between this report and those of previous years:

- Data is published at the level of local authorities whereas previously PCT level data was available. This means that Cornwall level data will be

reported in our annual audit report rather than pooled information for Cornwall & Isles of Scilly. Data from the Isles of Scilly contains extremely small numbers (most years there are no suicides).

- Data sets that were created to monitor progress towards the Saving Lives: Our Healthier Nation target to reduce suicides by 20% by the year 2010 are no longer being updated. These included deaths at all ages. The remaining data sets only report suicides and deaths by injury of undetermined intent for people aged 15 years and over.

The following data sources have been used for this report:

1. Health and Social Care Information Centre (HSCIC) indicators<sup>6</sup>. This reports deaths by year of registration; data up to and including the year 2013 has been included in this report.
2. Office for National Statistics Primary Care Mortality Files. This dataset includes resident's deaths regardless of where they died and non-resident deaths occurring in Cornwall and Isles of Scilly. Deaths occurring during 2011-2013 have been included in this report.
3. Local suicide audit database (only available for deaths registered in 2005 onwards). This data set has been collected following the methodology set out in 'Suicide audit in PCT localities (2006)<sup>4</sup>.

The definition used for inclusion in the ONS and HSCIC files is "death from suicide or injury of undetermined intent", classified according to ICD 10 (The International Classification of Disease 10<sup>th</sup> revision) codes X60-84 and Y10-34 (excluding Y33.9)<sup>7</sup>.

The local suicide audit database includes information collected from the Coroner for Cornwall, the deceased person's GP, Cornwall Partnership Foundation Trust (for those cases that have been in contact with mental health services) and occasionally from the police. This provides information about the circumstances around the incident and the contact that the individual had with services prior to the event. The information is reviewed by an expert suicide audit group (appendix 1). The data set is not complete as it relies on voluntary reporting rather than a mandatory requirement to report, as is the case with death registration.

## 4. Suicide audit results

### 4.1 The incidence of mortality due to suicide or injury of undetermined intent

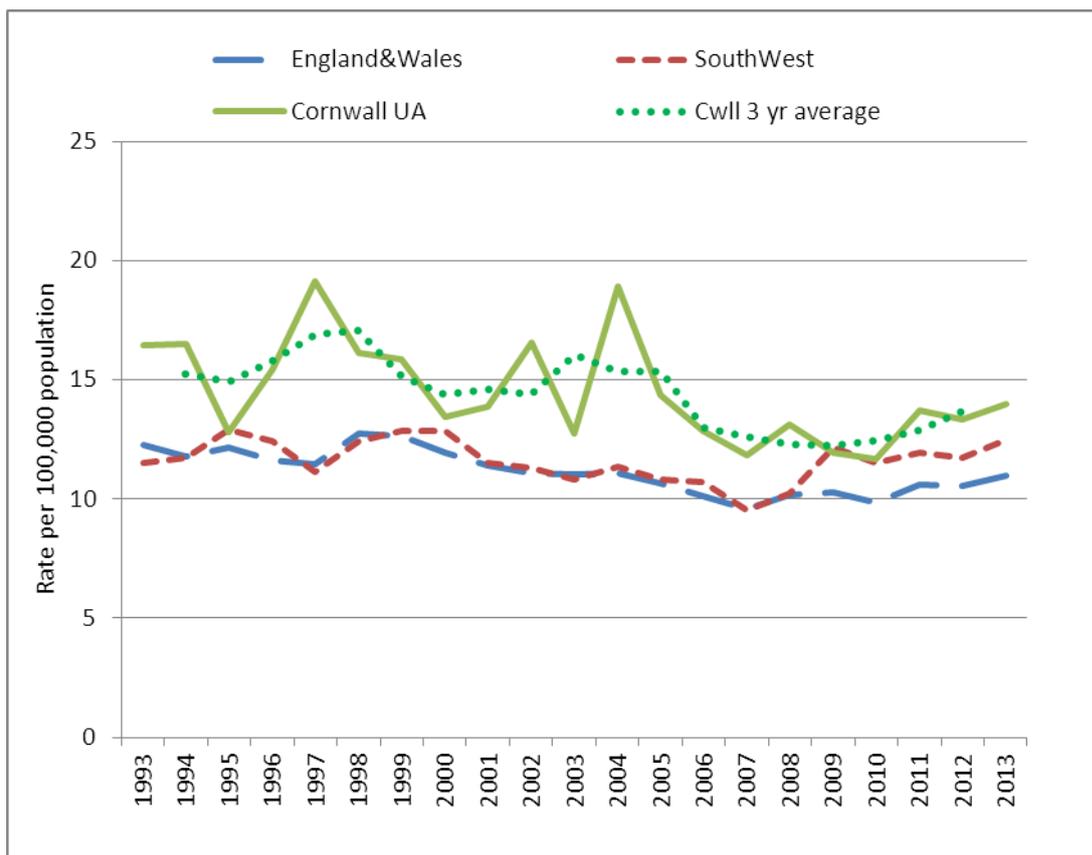
The local rate has been consistently higher than the national rate since 1993 (when data collection in its current form began). Figure 2 shows the death rates by suicide and undetermined intent for Cornwall, compared with the South West and England and Wales.

In Cornwall there have been between 50 and 80 deaths per year as a result of suicide or self-injury of undetermined intent since 1993. They are shown in the chart as a rate per 100,000 population. In Cornwall the rate is subject to larger fluctuations than it is at a regional or national level. This is because the

actual numbers are smaller so they are subject to wider random yearly variation. A line showing the three year moving average for Cornwall is included in the chart to smooth out the variation and avoid drawing undue attention to year on year fluctuations instead of the underlying trend.

The most recently published data at local authority level describes deaths up to the end of 2013. In 2013, there were 65 deaths by suicide and injury of undetermined intent in Cornwall which equates to an annual rate of 13.99 per 100,000 population compared to the national rate for the same year of 10.98 per 100,000. Forty nine of the people who died were males, and 16 were females.

The incidence of suicides fell steadily at a local and national level between 1998 and 2007. Since then the rate has steadily increased. This coincides with a period of national economic recession.



**Figure 2: Trends in mortality from suicide and death by injury of undetermined intent in Cornwall & Isles of Scilly, and England & Wales: 1993 - 2013**

Source: HSCIC Indicators

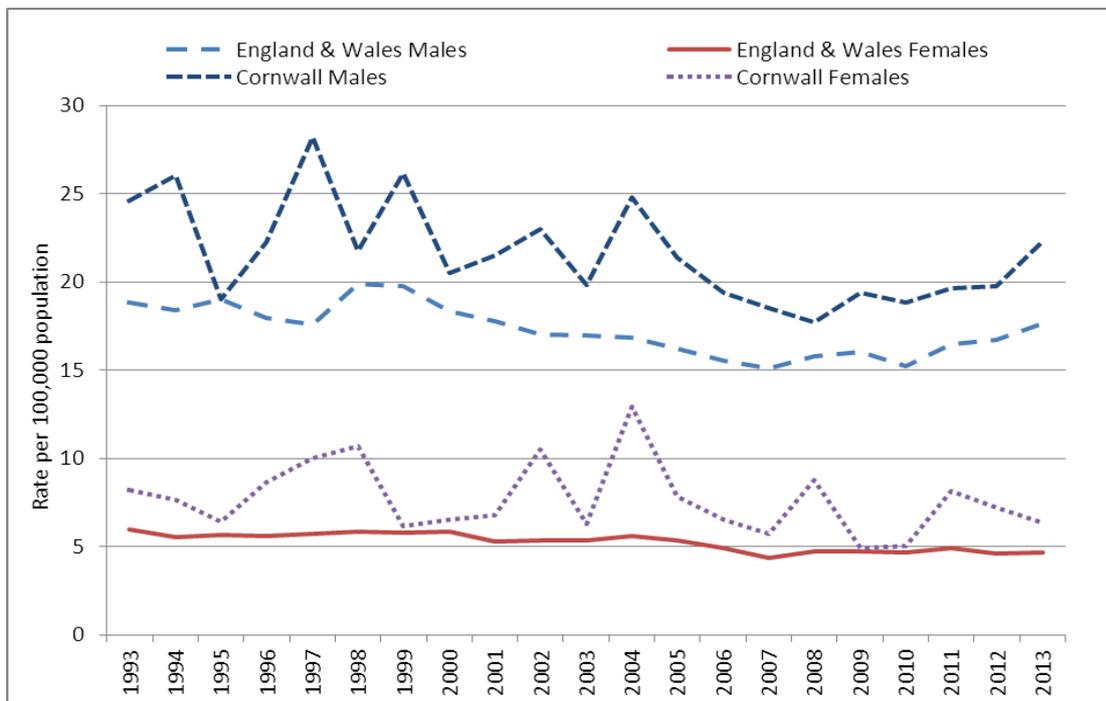
#### 4.2 High risk groups

This box summarises the high risk groups identified at a national level. These are likely to be relevant at a local level.

- Males
- Older people
- People with a family history of suicide
- Women during pregnancy and after childbirth
- People from ethnic groups – women born in Sri Lanka and the East African Commonwealth are approximately 50% more likely to die by suicide than the general population as a whole
- Certain occupational groups – unskilled occupations, doctors, nurses, vets, farmers
- Sentenced and remand prisoners and ex-prisoners recently released into the community
- People who have been discharged from inpatient psychiatric services within 4 weeks
- People with a history of self harm
- People with alcohol and/or drug problems
- People with mental health problems, especially depression, schizophrenia and personality disorders (many may not be in contact with secondary mental health services, especially people with depression)
- People with serious physical illnesses
- Divorced people
- People recently bereaved
- Lesbian, gay and bisexual people

### **4.3 Age and sex**

Men are more likely to die by suicide than women; this is evident nationally and locally (Figures 3&4). Time trends from 1993 to 2013 show that both males and females in Cornwall have consistently higher rates of suicide compared to the national rates. The increase in the suicide rate since 2007 evident in figure 2 is revealed here to be due to an increase in the suicide rate of males over this period.

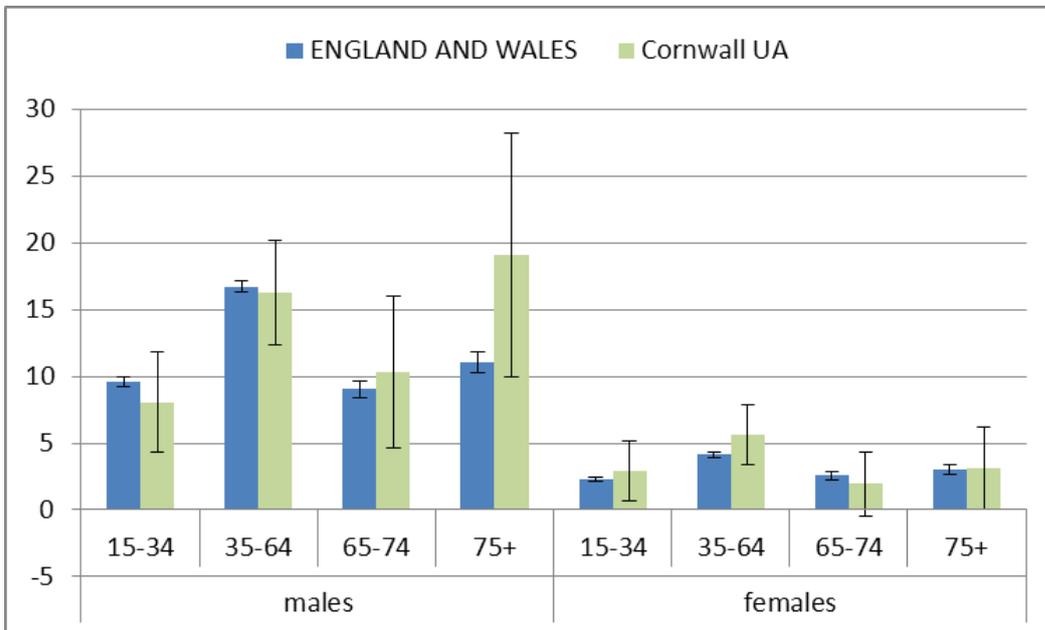


**Figure 3: Time trends in mortality from suicide and injury of undetermined intent in Cornwall and England & Wales: males and females: 1993 – 2013**  
 Source: HSCIC Indicators

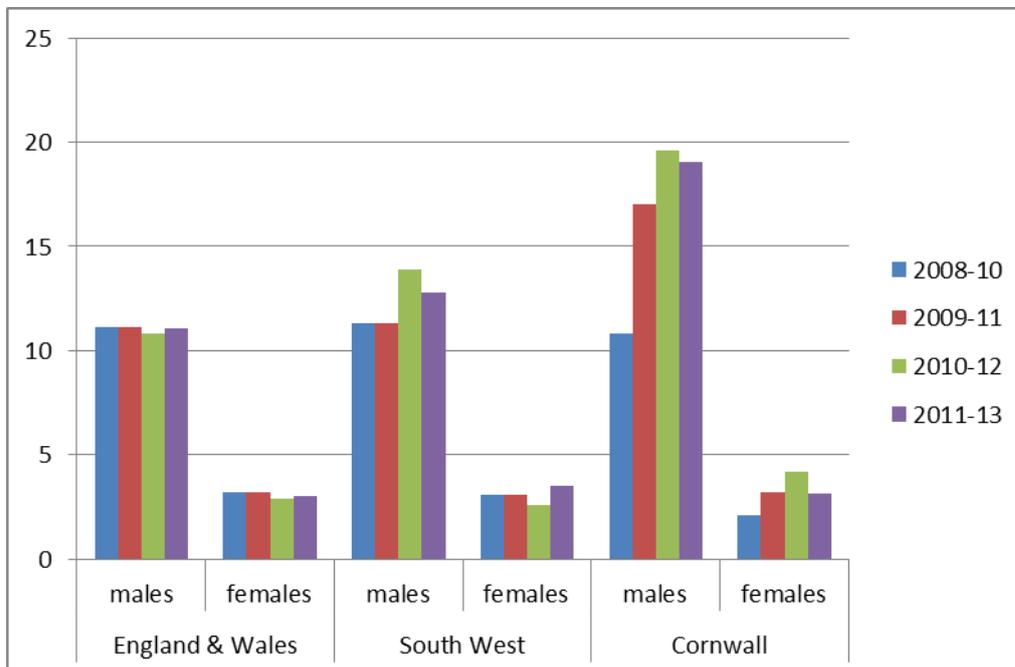
In 2011-13 the highest mortality rate for both males and females at a national level is observed in the 35-64 year age group (figure 4). This group also has a relatively high rate locally. As has been observed previously, the suicide rate among older males is higher in Cornwall than in England and Wales. Some variation is expected as a result of chance, so 95% confidence intervals have been added to the bars. Where these bars do not overlap we can be more confident that the differences are not due to random variation

Suicide rates for people over 75 years appear to have risen in Cornwall in recent years, but remained fairly static at a national level (figure 5).

Although rates are relatively high among older males, actual numbers are higher for middle aged males, as can be seen in figure 6. To assess the relative importance of tackling suicide risk at different ages, the rates, numbers and potential number of years of life lost can all be considered. Rates and numbers are relatively low for young people. However, deaths by other causes are also uncommon so suicide is more significant as a cause of death among young people; suicide and injury/poisoning of undetermined intent were the leading cause of death for 20-34 year olds in England and Wales in 2012, for 26% of men and 13% of women<sup>8</sup>.



**Figure 4. Suicide rates by age and sex. 2011-13 pooled.**  
Source: HSCIC Indicators



**Figure 5. Suicide rates for people aged over 74 years. 2009-10 to 2011-13.**  
Source: HSCIC Indicators

NB. Suicide is defined as deaths given an underlying cause of intentional self harm or injury/poisoning of undetermined intent, as stated on page 6. It has been customary to assume that most injuries and poisonings of undetermined intent are cases where the harm was self inflicted but there was insufficient evidence to prove that the deceased deliberately intended to kill themselves. This cannot be assumed in children due to the possibility that these deaths were caused by unverifiable accidents, neglect or abuse. Therefore suicide data is not published for children and young people under the age of 15 years.

#### 4.4 Method of suicide

Three conditions are necessary in order for a suicide attempt to take place. The individual must:

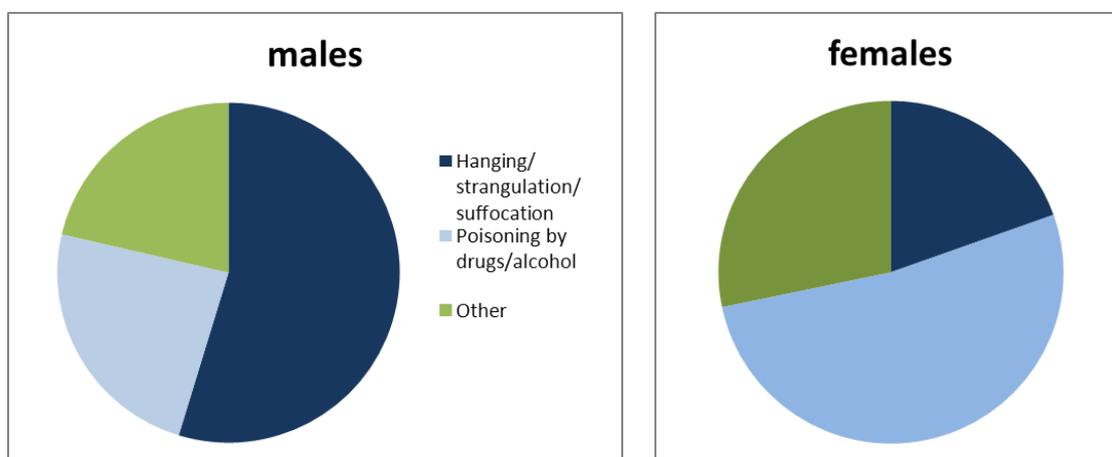
- Resolve to die or give up on life
- Decide on a method (e.g. hanging, overdose, jumping from a height)
- Obtain the means by which to carry out the plan (e.g. rope, tablets, jumping site)

There is general agreement that it is possible to interrupt the suicidal process by making it difficult for people to obtain the means by which to kill themselves. By identifying frequently used methods and locations it may be possible to plan interventions that could reduce suicides that are impulsive acts or are the result of an acute or temporary crisis.

The 'underlying cause of death' listed in the primary care mortality files indicates the method of suicide. The majority of male suicides are by hanging whereas the majority of female suicides are by self-poisoning with drugs (figure 6). The 'other' category includes poisoning by gases and chemicals, falling/jumping from a high place, drowning, impact with or crashing a moving vehicle, fire and/or smoke, fire arms and injury with a sharp or blunt instrument.

It is interesting to note that hanging had become a more common method of suicide for females than self-poisoning in the previous period (2007-2011) examined, although self-poisoning had been the most common method for females prior to 2007.

Regional analysis by the South West Public Health Observatory in 2011<sup>9</sup> revealed that most suicides by self-poisoning with drugs were due to overdose of prescribed drugs. Over the last decade there has been a considerable fall in the number of suicide deaths due to poisoning by gases, fire and smoke, probably due to the introduction of catalytic converters in vehicles.

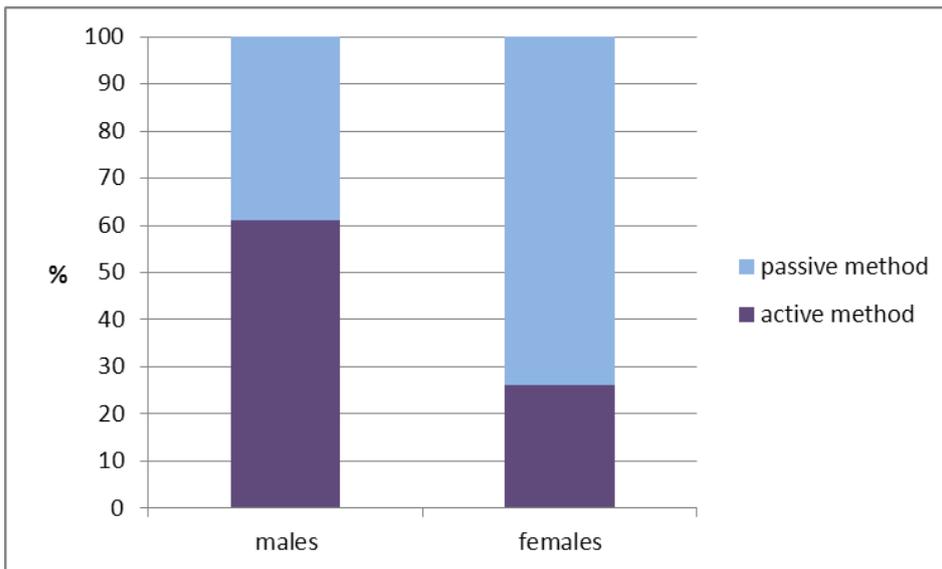


**Figure 6. Underlying cause of death. 2011-2013.**

Source: ONS Primary Care Mortality Files

Methods can be described as 'active' or 'passive'. A passive method allows some time to reconsider, to call for help, the possibility of being discovered and for someone to intervene. In general, males and older people are reported

to be more likely to use active methods that indicate greater determination to end life. In Cornwall and Isles of Scilly, 61% of men and 26% of women used an 'active' method of suicide between 2011 and 2013 (Figure 7).



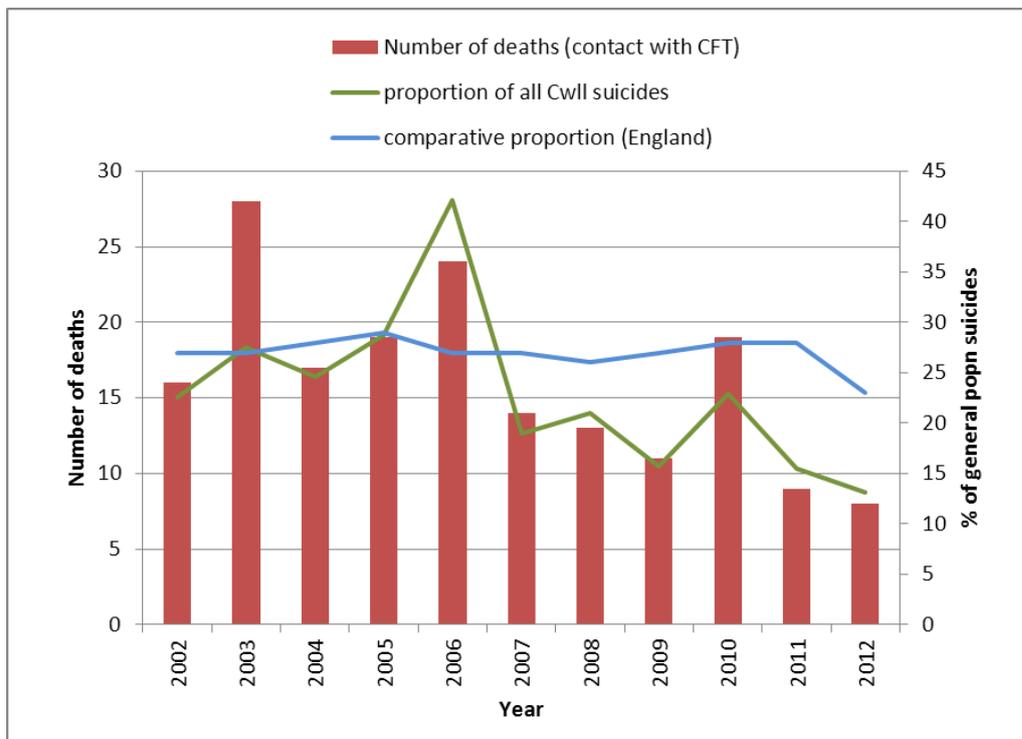
**Figure 7: Methods of deaths by suicide or injury of undetermined intent classified as 'active' or 'passive: 2011-13**

Source: ONS Primary Care Mortality Files

#### 4.5 Contact with mental health services

Figure 8 shows the number of deaths by suicide of people in contact with Cornwall Foundation Trust within the previous 12 months, over an eleven year period (2002-2012). With some fluctuations (higher numbers in 2003 and 2010), a general rising then falling trend is evident. There was an increasing trend between 2002 and 2006 and then a fall to 2012. In 2012 there were eight deaths by suicide of people in recent contact with CFT mental health services. This is the lowest annual number of suicides within this group in the eleven year period.

In 2003 and 2010 there were also peaks in the number of suicides in the general population in Cornwall, so it is also useful to see these 'CFT contact' deaths presented as a proportion of the total number of deaths by suicide in Cornwall. A comparable figure for England is also presented. In England, an average of 27% of all deaths by suicide over this eleven year period has been of people in contact with specialist mental health services. There has been little variation although there appears to be a fall in 2012. In contrast, the proportion in Cornwall does vary. Some fluctuation would be expected as a result of small numbers, but there appears to have been a downward trend below the national average from 2007 onwards.



**Figure 8. Suicides by people in contact with mental health services (CFT) (in the 12 months prior to death). 2002-2012.**

Source: National Confidential Inquiry into Suicide and Homicide by people with mental illness.

The data includes people referred and assessed but not taken on by the service. This result indicates safer care in Cornwall. In support of this interpretation is the finding that inpatient suicides are also lower (as a proportion of all suicides) than the national average (7% for CFT in Cornwall and 10% in England). There is also evidence that patient suicide rates are lower for those Trusts that have implemented at least seven of nine key service recommendations by the National Confidential Inquiry into suicide and homicide<sup>10</sup>.

#### 4.6 Geographical locations

163 cases were identified from primary care mortality files listing C&IoS residents, whose deaths occurred between 2011 and 2013. Fourteen additional cases were identified that died by suicide in Cornwall but were resident out of county, eleven males and three females (table 1). Out of county residents do not feature in the trend data described in section 4.1., but the suicide location for out-of-county residents dying in Cornwall is relevant to efforts to prevent suicide in Cornwall. Not surprisingly, out-of-county residents were less likely than residents to die in a residential setting. Numbers are small but it is notable that three of the out-of-county resident's deaths took place in coastal settings yet countryside (fields and woods) settings did not feature. It is possible that the coast attracts people who have previously visited on holiday or that people might travel here to access the means to die by jumping from a height or drowning.

	Cornwall residents		Out of county residents	
residential address	108	includes 7 at residential addresses not their home address.	5	
hospital*	25	including one hospital out of county	3	
coastal	7	including 3 in one resort but different beaches	3	Including one at the same resort
countryside	10	including 6 fields (1 out of county) and 4 woodland		
road	2	1 'A' road, 1 rural lane	1	
railway	1	foot crossing over railway		
car parks	4	including 1 out of county	1	
rivers	0			
holiday park or accommodation	1		1	
parks/sports fields	1			
quarry	2			
Total	161	For two additional cases the location was unclear.	14	

**Table 1. Place of death.**

Source: ONS Primary Care Mortality Files

\* If the individual was found prior to death and subsequently died in hospital, the hospital will have been recorded as the place of death and the location of the act is not known. There were 25 deaths in hospital of C&IoS residents, one of which occurred in a hospital outside Cornwall & Isles of Scilly. There were no deaths by suicide of Cornwall Foundation Trust inpatients in this time period.

67% of deaths by suicide (108 cases) occurred at home or in a private residential setting. The remainder occurred in public places. None of the identified locations were used more than once in this three year period.

## 4.7 Local audit database

As stated on page 6, this is not a complete data set so quantitative findings must be treated with caution. It provides some useful qualitative information to inform debate about particular issues and can highlight novel methods, areas of concern, possible links between cases and developing trends.

The number of cases recorded in the database are shown below (table 2). The proportion of total suicides (as recorded by ONS) that have been recorded in the local suicide audit database was low in the first year (2005) as the system was being developed. It has never achieved 100% completeness but peaked at 94% in 2010 and has fallen in 2011-13. Deaths during 2014 and 2015 would not be expected to be completely recorded yet, due to the time taken for the inquest process (hence they are shaded grey in the table).

Year	Deaths by suicide and injury of undet. intent recorded by ONS	Complete records in the suicide audit database	Incomplete records in the suicide audit database	Total cases in the suicide audit database	Proportion of audit database records that have been completed	Proportion of ONS recorded cases recorded in audit database
2005	62	15	0	15	1.00	0.24
2006	51	43	0	44	0.98	0.86
2007	55	48	1	49	0.98	0.89
2008	54	43	2	44	0.98	0.81
2009	50	41	3	45	0.91	0.90
2010	50	34	15	47	0.72	0.94
2011	63	14	21	33	0.42	0.52
2012	61	27	33	40	0.68	0.66
2013	65	25	31	39	0.64	0.60
2014	n/a	5	34	39	0.13	
2015	n/a	0	3	3	0.00	
<b>totals</b>	511	295	143	398	0.74	0.78

**Table 2. Completeness of the suicide audit database.**

Of those files on the database, information is collected from a number of sources before being marked as complete. If any one source fails to complete the questionnaire or to record whether or not the person was in contact with the service then the record is marked 'incomplete' and is not included in subsequent analysis. Work is being carried out by Public Health, Cornwall Partnership Foundation Trust and the Coroner for Cornwall, to identify incomplete records and bring the database up to date so that the results of analysis will be more meaningful and representative of the study population.

### 4.7.1 Ethnicity, age and gender of the database population (completed records)

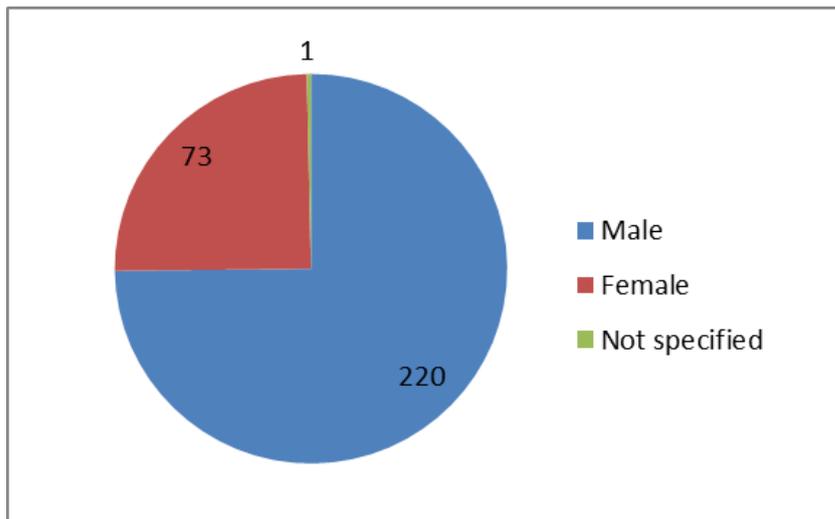
The ethnic profile of the cases recorded on the database is as follows:

Ethnicity	Audit database Number (%)	Wider population in Cornwall & Isles of Scilly (%)
White British	247 (94.6%)	(97%)
Other white background, including Irish	10 (3.8%)	(1.9%)
Other ethnic group including Caribbean, African, Chinese	4 (1.5%)	(1.0%)
Sub-total	261 (100%)	(100%)
Not known or missing data	33	
Total	294	

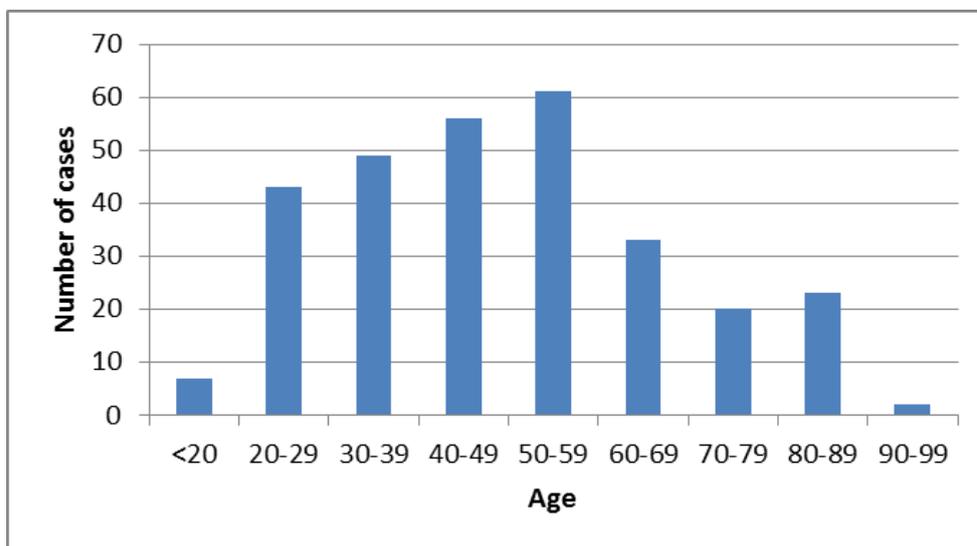
**Table 3. Ethnicity.**

The population of Cornwall & Isles of Scilly is 97% White British, 1.9% other White background and 1% other ethnic group, including African, Caribbean and Chinese. There is a higher than average representation from the minority ethnic population in the suicide audit database records.

The age and gender profile of the cases recorded in the database are as shown in figures 9 and 10. These reflect the age and sex profile of the more complete ONS data set.



**Figure 9. Number of cases in the suicide audit data base that are 'male', 'female' or 'not specified'.**



**Figure 10. Number of cases in the suicide audit database by age.**

#### **4.7.2 Suicide Audit Group analysis and narrative**

The suicide audit group meets approximately three times per year and discusses the cases described by completed records in the database. The discussion explores emerging themes and potential scenarios as well as the actual facts of a case, to build a narrative about the complex and interacting factors involved in suicide risk. Some of the themes identified from these discussions are described below.

##### **4.7.2.1 Loneliness/isolation**

This is identified from the case reports as ‘living alone’ or ‘bereavement’ or by other descriptions, indicating that the person lacked social connections. Loneliness and isolation can become more common with age but can affect people of all ages. We have witnessed cases where young people have reacted badly to rejection, middle aged men have lost their place in the family as a result of divorce, carers have experienced sudden isolation when the person they cared for dies, and older people have lost lifelong partners to dementia or death. The loss of a pet can also have a significant impact for a person living alone. This would be an interesting topic for further investigation.

Protective factors could include staying in contact with loved ones (technology can help), community involvement - including volunteering, getting out and about and developing and following interests. Initiatives like the Pioneer programme may help isolated older people to become more connected to services and the community. Age UK befriending programmes and CRUSE bereavement care can also play a valuable role.

Analysis of the completed records shows that the people listed commonly lived alone and/or were single, divorced, separated or widowed (see figures 11 and 12)

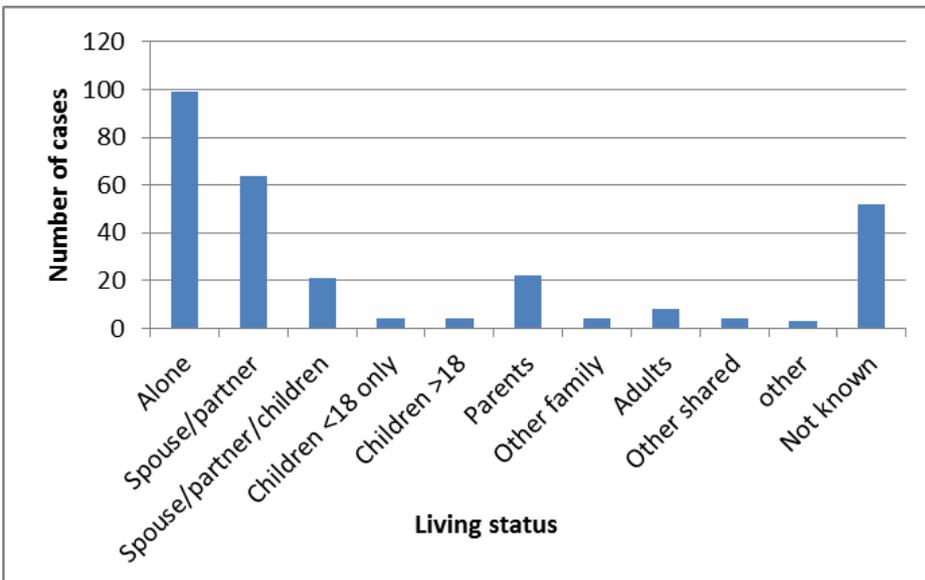


Figure 11. Number of cases in the suicide audit database by living status

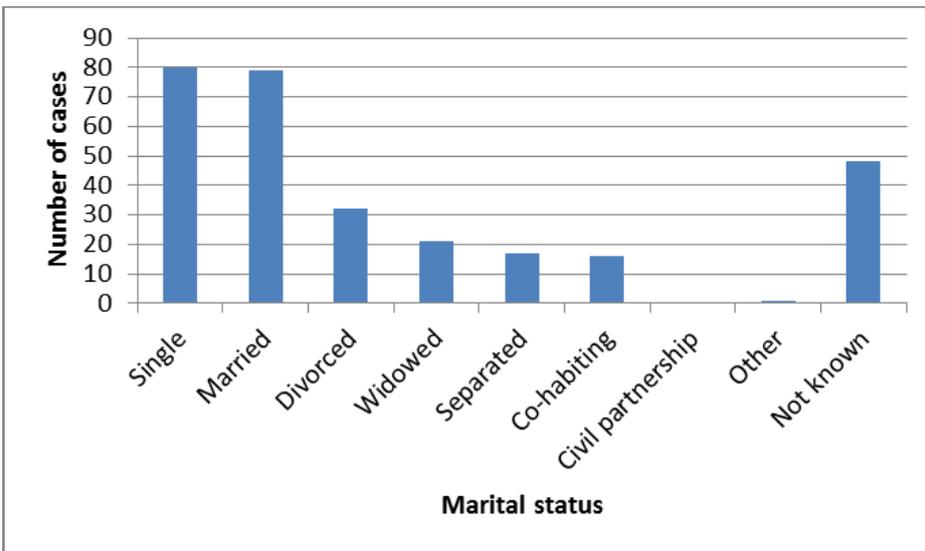


Figure 12. Number of cases in the suicide audit database by marital status.

#### 4.7.2.2 Mental illness

High quality, accessible mental health services are essential to preventing suicide. This includes access to psychological therapies as well as more specialised mental health services. In addition, more could be done to encourage help-seeking behaviour, including tackling the stigma that can act as a barrier to people admitting to suffering mental health problems and hence to them receiving effective treatment.

Depression is a well-known risk factor for suicide. This was recognised in Detroit, where the Zero Suicide initiative achieved success in preventing suicides by aiming to deliver 'perfect depression care'. This has prompted the clinical collaborative in the south west region (and also in Merseyside and East of England) to aspire to achieving zero suicides locally.

We hear it reported that occasionally the suicide of someone with depression takes people by surprise because it happened at a time when they appeared to be feeling better. Sadly, a seemingly more positive outlook might be a sign that the person has decided on a course of action to end their suffering. Or it may be that a person doesn't have the energy to act on suicidal thoughts while in a deep depression but is able to do so when the depression starts to lift. A period of improved health after a psychotic event, or the period shortly after diagnosis, can be a time of increased risk as the patient contemplates the potential future impact of mental illness on their life.

Patients with mental health problems who fail to make or attend follow up appointments with the GP may be at increased risk. Follow up is especially important after prescribing and this could be by the GP or practice nurse following a simple protocol, offering advice related to the expected effects at timed intervals after starting medication.

#### **4.7.2.3 Chronic illness/pain**

The development of progressive and debilitating health problems can increase suicide risk. Patients may find the pain difficult to manage, or be devastated by the loss of an active or social lifestyle. The prospect of losing an independent life in one's own home and moving into a strange and somewhat controlled environment in a residential or nursing home could be an additional risk factor. Becoming dependent on family members can be perceived as 'becoming a burden'.

People with chronic conditions often have lawful access to supplies of drugs that could be taken in fatal doses.

Effective pain management, mental health assessment for patients with chronic physical illness and providing better support for carers could all help.

#### **4.7.2.4 Consequences of criminal activity/disciplinary proceedings**

The group has looked at several cases where the person was subject to criminal investigation or awaiting trial. Fear of the consequences (public knowledge/ condemnation and sentencing) could be a significant risk factor for suicide. The courts are aware of this and 'harm to self' is a reason to refuse bail. The criminal justice/mental health liaison team has a role to play in signposting to available support services. The Samaritans might be a useful service in this situation, as people can speak to them anonymously without fear of judgement.

Disciplinary proceedings at work can also cause great stress. Workplaces can help to mitigate this by providing support.

#### **4.7.2.5 Financial problems**

The recent rise in the suicide rate at a local, national and global level has been attributed to the global financial crisis. Although the UK economy is now recovering, individuals may still be vulnerable due to their social and economic circumstances.

Some occupations pose particular risk, as a consequence of financial threats, work-induced stress and access to the means by which to take one's own life. Farming can be a particularly challenging occupation as a consequence of social isolation, falling income and the demanding paperwork required to receive subsidies.

Gambling can cause rapidly escalating debts. Little is known about the extent of gambling as a suicide risk factor locally, but the easy access to gambling provided by internet sites may be creating a growing, but largely hidden, problem.

Citizens Advice Bureau provides free online debt advice at <https://cornwall.cabmoney.org.uk/> . Links could be made between debt advisors and GP practices and other settings that are used by vulnerable people, such as courts. Benefits staff could signpost to help lines such as Samaritans, CALM and Nightlink.

#### **4.7.2.6 Males**

Males are at greater risk of suicide for a number of reasons. Depression is less likely to be diagnosed and treated because men are more likely to be reluctant to admit to problems or to seek help. Cultural expectations for men to be decisive and strong can cause men to suffer low self-esteem and lead them to hide their perceived 'weaknesses' or to feel humiliated when they are exposed<sup>11</sup>. Men often find their emotional support from a female partner and feel the loss very strongly when a relationship breaks down, whereas females tend to get additional emotional support from friendship groups.

The risk among men can only be completely overcome by achieving cultural change. However, steps can be taken to reduce stigma and make services more accessible. CALM (Campaign Against Living Miserably) is a programme that is designed to meet the needs of men, particularly young men. Although based outside Cornwall, it is now a national charity and the help line service is available to all.

#### **4.7.2.7 Older people**

A detailed study<sup>12</sup> undertaken a few years ago in Cornwall showed that depressive illness, physical illness and bereavement were the most commonly identified risk factors for older people. Warning signs included previous self-harm or attempted suicide, suicide ideation or plans, behavioural changes and researching euthanasia.

There were some gender and age-related differences in suicide rate, risk factors, method and location. Older males were at greater risk of suicide than females, but physical health problems appeared to be a larger contributing factor to suicide in females. Male suicides were more likely to occur in a public place and use more violent methods including jumping, hanging or strangulation and firearms. The 'oldest old' appeared more likely to take their lives at home by suffocation.

#### **4.7.2.8 Young people**

Despite higher suicide rates in older age groups, the problem of young suicides deserves particular attention. This is justified by the number of years of life lost to each individual and the lost opportunities to fulfil their aspirations. The death of a young person can be viewed as particularly tragic and wasteful, as that person may have lacked the maturity to fully understand the consequences of their suicidal actions, or to appreciate that symptoms of depression and feelings of hopelessness can be temporary and may abate given time and appropriate support. Another issue of concern that is particularly relevant to young suicides is the phenomenon of contagion or ‘copycat’ suicide.

In England and Wales suicide is a leading cause of death in young people aged 15-24, as it is globally. Statistics show that, on average, two young people in England and Wales take their own lives every day. This equates to around seven per year in Cornwall and Isles of Scilly.

Action to reduce the risk of suicide among children and young people includes promoting positive mental health from a young age, via family, education and care settings. Mental health problems often begin at a young age so early prevention and intervention is vital. Personality factors can play a part in individual responses to difficult situations; it has been noted that some people who have had a lifetime of trauma and self-harm may be picked up and put back on their feet, but it would not take much to destabilise them. Building resilience during childhood is important as a preventive action.

#### 4.7.2.9 Alcohol and drugs

One of the factors that increase the likelihood a person will take his or her own life is the abuse of substances such as alcohol and drugs. Alcohol and some drugs can result in a loss of inhibition, may increase impulsive behaviour, can lead to changes in the brain that result in depression over time, and can be disruptive to relationships—resulting in alienation and a loss of social connection. Furthermore, excessive acute drug and/or alcohol ingestion could result in death.

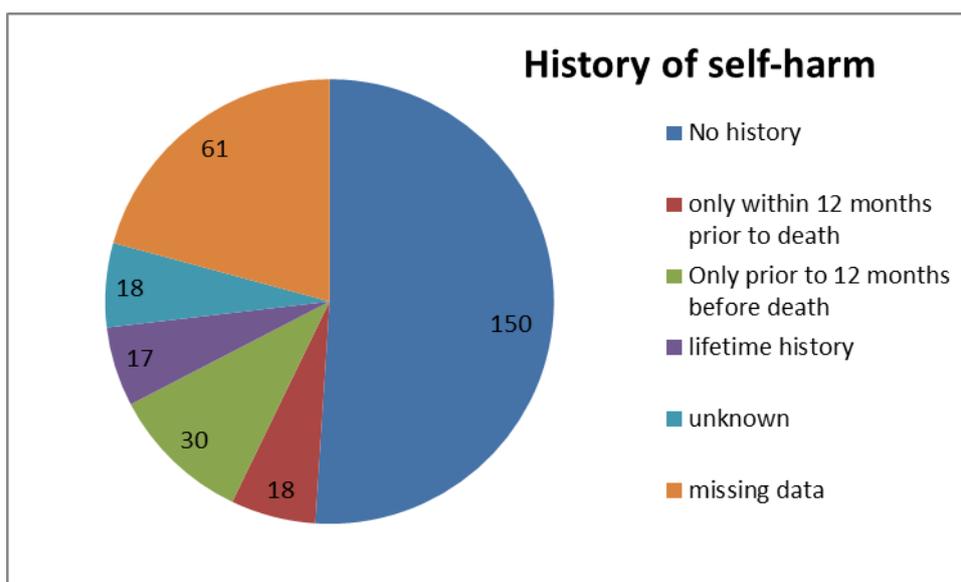
Local data collected from the Coroner, GPs and Mental Health services can provide an indication of the role of alcohol and drugs. Unfortunately in many cases the relevant questions about history of alcohol or drug misuse on the audit forms have not been answered. With regard to whether alcohol or drugs were taken at the time of death, the proportion of unknown or blank answers is lower, as this is less likely to be a hidden factor. The results are shown below.

<p>Was alcohol taken at the time of death?          Yes: 71          No: 118          Not known or left blank: 105</p> <p>24% of all suicide cases were reported to have taken alcohol at the time of death. However, this was equivalent to 38% of those for whom the information was provided.</p>	<p>Were other non-prescribed drugs taken at the time of death?          Yes: 25          No: 154          Not known or left blank: 115</p> <p>8.5% of all cases were reported to have taken non-prescribed drugs at the time of death. However, this was equivalent to 14% of those for whom the information was provided.</p>
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The incidence of alcohol and drug use at the time of death is fairly high. The intention behind their use is not known, but the act would be likely to reduce inhibitions and increase impulsive behaviour.

#### 4.7.2.10 Self harm

Of all the cases listed in the suicide audit database, 51% (150) had no known history of self-harm and 22% (65) had a known history of self-harm (figure 14). 6% (18) had harmed themselves in the 12 months before death; 10% (30) had harmed themselves but only prior to the 12 months before death; 6% (17) had a lifetime history of self-harm. These results might underestimate the true prevalence of self-harm because 21% of cases (61) had no recorded response to this question.



**Figure 14. History of self-harm prior to death (numbers)**

Good management of self-harm is an essential part of the suicide prevention strategy. Self-harm is not always an indicator of suicide risk. Some people harm themselves as a means of coping with distress and will not become suicidal. However, at a population level people who have a history of self harm are at increased risk. Self-harm increases the likelihood that the person will eventually die by suicide by between 50- and 100-fold above that of the rest of the population.

There will be some blurring of boundaries between suicide and self-harm statistics. A non-fatal suicide attempt would be classified as self-harm in hospital statistics and a fatal act of self-harm may be classed as suicide if the intention is undetermined.

Self-harm among young people in Cornwall & Isles of Scilly has been examined during 2014, to provide the background information for a self-harm strategy<sup>13</sup>.

It is estimated that between 7,000 and 17,000 young people in Cornwall & Isles of Scilly have deliberately harmed themselves by the age of 25 years. Approximately 6,300 regularly self-harm as a way of coping with emotional

problems. Around 270 young people each year are admitted to hospital as a result of self-harm each year, some of them more than once. Analysis of self-harm among adults will be carried out when the children and young people's strategy is completed.

Male and female behaviour differs with respect to both suicide and self-harm. As reported earlier in this document, males are more likely to die by suicide and are likely to use more lethal or faster acting methods than females do. Females are three times more likely than males to admit having harmed themselves (and this is reflected in rates of hospital admissions). However, young men may be harming themselves in other ways that may not be recognised as self-harm, such as by alcohol misuse and violent behaviour.

## 5. Conclusions

The increase in suicide rates since 2007 is likely to be a consequence of the recession. The association between unemployment rates and the suicide rate of working aged males has been demonstrated over many years. It is also known that job insecurity and the fear of unemployment can increase the risk.

The results of this audit highlight the need for action to protect some high risk groups, including males, older people and people who self-harm or misuse drugs and/or alcohol.

It should be recognised that the factors leading to suicide are complex and each case is unique, but there are a number of factors that are known to increase the statistical risk of suicide. Among those that have stood out in Suicide Audit Group discussions are depression, long-term limiting illness, lack of social connections (including loss through relationship breakdown or bereavement) and being subject to criminal investigation. Attention should be drawn to these risk factors when promoting partnership action to prevent suicides.

The findings will be reported in May 2015 to an inter-agency partnership to prevent suicides under the banner of Zero Suicides. This is a Cornwall & Isles of Scilly collaborative, acting within a regional programme that aims to achieve zero suicides by October 2018<sup>14</sup>.

This report will be filed within the Joint Strategic Needs Assessment for Cornwall.

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April 2015

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## Appendix 1. Suicide Audit Group

### **Cornwall & Isles of Scilly health community Suicide Audit Group Terms of reference. Revision January 2015.**

A suicide audit group was formed in 2005 to oversee the development of a system to gather individual case audits in Cornwall and Isles of Scilly, following a toolkit developed by the Peninsula Medical School. Once the system was established the group disbanded. There remained a need for a suicide audit advisory group, but with slightly different roles and responsibilities. A new group formed in February 2008. The terms of reference agreed at the formation of that group have been revised several times, most recently in January 2015.

#### **Terms of reference**

The roles of the group will be:

- To identify lessons emerging from audit that could help to prevent suicides in future. The sharing of information about suicides is to be encouraged; it is not intended to apportion blame in any way.
- To examine summary reports of individual case audits and provide expert comments about issues of risk, e.g. considering the following questions:
  - Did the individual appear to have received appropriate interventions by NHS or other services?
  - Does the case highlight training needs for any particular staff group, or a need to raise awareness of particular issues?
  - Are current systems and processes adequate, or does the case report indicate gaps in service provision or the need to develop patient pathways?
  - Does the case raise an issue that could/should be investigated further or more widely (through audit or research)?
- To share results of other audits and research relevant to suicide prevention
- To act as a consultation group for the annual suicide audit report (produced by Public Health)
- To make recommendations to the Mental Health Programme Board, based on the results of audit.
- To facilitate training, as influenced by the outcome of the audit process.
- To meet on average four times a year on an ongoing basis.
- To review progress annually

More detailed analysis of individual cases should be carried out through Serious Untoward Incident processes (in CFT), Significant Event Audit (in GP practices) and inquests (Coroner services). The Suicide Audit Group is not responsible for carrying out these reviews. However, some lessons emerging from these processes are appropriate to share more widely and should feed into the audit process through the open questions in the audit questionnaires. (These questionnaires are sent to CFT, GPs and the Coroner.)

**The group will report to the Mental Health Programme Board.**

## Membership

Suicide audit requires a range of skills and knowledge, so the group should include:

	Member during 2014/15:
▪ Public Health - analysis of data, and reporting of results. Links to suicide prevention strategy.	Sara Roberts, Cornwall Council
▪ Secondary Care representatives –expert knowledge of mental health conditions and treatments, secondary care processes and systems. (& links to suicide prevention strategy through OS).	Ellen Wilkinson and/or Quinn Scobie, Consultant Psychiatrists, CFT
▪ GP representative – expert knowledge of primary care, patient presentations and systems	Tom Hotton, GP Becky Osborne, ST4, while on zero suicides placement.
▪ DAAT – expert knowledge of drug related deaths	Sid Willett, Drug-related deaths coordinator, Cornwall Council
▪ Police Drugs liaison	Steve Dredge, Devon & Cornwall police.

Additional specialist advice and interpretation will be sought for specific topic areas, e.g. self-harm (psychiatric liaison team), older adults & chronic ill health (community matron), debt (CAB), bereavement (suicide liaison workers).

A flow chart showing the route that audit information will take is shown on the following page.

**Chart showing information flow for suicide audit and prevention**  
 (SAG role shaded in grey)

CFT = Cornwall Foundation Trust  
 PH = Public Health  
 SAG = Suicide Audit Group  
 SEA = Significant Event Audit  
 SIR = Serious Incident Review

