North Tyneside Council

North Tyneside Suicide Health Needs Assessment

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3 Abbreviations

ADPH	Association of Directors of Public Health
CCG	Clinical commissioning group
CYP	Children and young people
DH	Department of Health
DWP	Department for Work and Pensions
GP	General practitioner
ICS	Integrated care system
ICP	Integrated care partnership
JSNA	Joint strategic needs assessment
LGA	Local Government Association
LGBTQ+	Lesbian, gay, bisexual, transgender, queer +
NHS	National Health Service
NHSE	NHS England
NICE	National Institute of Health and Care Excellence
NSPSAG	National Suicide Prevention Strategy Advisory Group
ONS	Office for National Statistics
PHE	Public Health England
RTSS	Real-time suicide surveillance
WHO	World Health Organisation

4 Executive summary

Introduction

Suicide is a global public health problem that contributes to years of life lost and has devastating wider impacts on society. Suicide is not inevitable; it is a preventable cause of death that, due to its complex contributory factors, requires a multiagency approach to prevention.

Local authorities have a key role in suicide prevention in their communities, working with other stakeholder organisations such as the police, clinical commissioning groups (CCGs), National Health Service (NHS), coroners, and voluntary sector organisations. The Government recommends that each local authority has a suicide prevention action plan in place.

This needs assessment aims to generate further understanding of suicide in North Tyneside to inform suicide prevention activity in the borough. It is a needs assessment of suicides in the borough of North Tyneside, as defined by the Office for National Statistics (ONS).

Definition of suicide

Suicide is defined by the ONS as:

> ***"all deaths from intentional self-harm for persons aged 10 and over, and deaths caused by injury or poisoning where the intent was undetermined for those aged 15 or over".***

Key findings of Suicide Needs Assessment

- There has been a significant increase in suicide nationally since 2017
- Despite the recent increase in suicide rates at a national level, suicide rates have remained the same in the equivalent years in North Tyneside.
- The current North Tyneside suicide rate is 12.6 per 100,000 which is similar to the England rate (10.8 per 100,000) and similar to the rate of the other 11 North East local authority areas
- Early analysis of national real-time suicide surveillance (RTSS) and monitoring of local RTSS indicates that there is no evidence of a large rise in suicides as a consequence of the COVID-19 pandemic and subsequent lockdowns, but this is based on early data and could change with time
- Male suicides account for approximately 75% of all suicides both nationally and in North Tyneside
- Suicides peak in middle-age both nationally and in North Tyneside
    - In North Tyneside the age groups with the highest suicide rates are the 41-50-year-old age group for males and the 41-60-year-old age group for females
    - There is some evidence to suggest that North Tyneside has a higher rate of suicide in males over 65 than England and the North East region and that the suicide rate in this age group is increasing in the borough

- 'Hanging, strangulation, and suffocation' is the most common method of suicide in both males and females, followed by poisoning both nationally and in North Tyneside
    - In North Tyneside suspension accounts for 48% of all suicides in males and 39% of all suicides in females
    - Self-poisoning also accounts for 39% of all suicides in females in North Tyneside
- Most suicides occur in areas of the borough with high levels of deprivation
- An in-depth audit of 92 case files highlighted that:
    - in North Tyneside around 59% of cases have no record of a previous suicide attempt;
    - around 59% of cases in North Tyneside have never had any contact with specialist mental health services;
    - the most reported contributing factor to suicides in North Tyneside is relationship or family problems (29%); and
    - other important factors include physical illness or disability, being single, divorced, separated, or widowed, living alone, being unemployed, bereavement, and alcohol consumption.
- North Tyneside has a higher rate of emergency hospital admissions for self-harm than the national rate, but this must be considered in the context of the limitations of self-harm data

<u>Risk factors for suicide</u>

Multiple risk factors and circumstances often contribute to somebody taking their own life, evidence suggests that the key groups at highest risk of suicide are:

- men;
- people who self-harm;
- people who misuse alcohol and drugs;
- people in the care of mental health services;
- people in contact with the criminal justice system; and
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers, and agricultural workers.

Other at-risk groups include:

- those in middle-age;
- people in the lowest socio-economic group;
- people who are unemployed;
- people with physical health problems, including chronic pain;
- people living alone;
- people who are unmarried;
- people in contact with the criminal justice system; and
- people with a mental illness.

Action to address suicide

There is a significant volume of suicide prevention work happening at a local and regional level across multiple sectors. Local action by North Tyneside council includes, but is not limited to:

- Annual meetings of the North Tyneside Suicide Prevention Task Group
- Annual updates of the North Tyneside suicide prevention action plan
- An audit of suicides and undetermined deaths 2012-2015
- An audit of under-18 suicides on behalf of the North of Tyne Child Death Overview Panel
- Monitoring and responding to real-time suicide surveillance
- Working closely with the regional and sub-regional suicide prevention groups
- Suicide awareness training courses covering different topics for a wide range of stakeholder groups in North Tyneside
- Grassroots funding for the local voluntary sector to deliver suicide prevention activity during COVID-19 lockdown
- A wide range of activity across organisations within the voluntary sector including mental health promotion and suicide prevention
- Mapping of current bereavement services and gaps in provision
- Awareness raising of the 'If U Care Share' suicide bereavement service and 'Help is at Hand'
- Awareness raising of campaigns and key messages throughout the year
- Outreach work within specific settings such as workplaces and sports clubs.

Regional action includes:

- The inclusion of the 'Zero Suicide Ambition' as one of the workstreams within the North East and North Cumbria Integrated Care System (ICS)
- The North Integrated Care Partnership (ICP) has a suicide prevention coordinator, a real-time suicide surveillance system, a data analyst, and works with multiple agencies including grass-root organisations to provide a wide variety of suicide prevention work across the North ICP patch

Recommendations

The recommendations generated by this needs assessment are:

1. When delivering suicide prevention in North Tyneside local action should address national strategy and guidelines whilst tailoring this to the needs of the local population, as identified by this needs assessment

2. The North Tyneside suicide prevention plan should be updated using learning from this needs assessment and the well-established and successful multi-agency approach to suicide prevention in the borough should continue

3. This needs assessment should be used to prepare and present a report on suicide in North Tyneside for scrutiny by the Adult Social Care Health and Wellbeing Sub-Committee

4. The impact of the COVID-19 pandemic on health inequalities in the borough should be considered when planning suicide prevention activities, and the borough must continue to be vigilant and responsive to changes or emerging patterns in suicide as a consequence of the pandemic

5. North Tyneside Council should continue to work closely with the established regional and sub-regional suicide prevention groups in the North East and North Cumbria where sharing of good practice, learning, and resources has the ability to benefit both local and regional suicide prevention work

Next steps for North Tyneside

The recommendations and learning from this needs assessment will be used to update the 2021-2022 North Tyneside suicide prevention action plan and to prepare and present a report on suicide in North Tyneside for scrutiny by the Adult Social Care Health and Wellbeing Sub-Committee.

The findings and action plan will be further disseminated to all partners across the system in North Tyneside for discussion and further action.

The North Tyneside Public Health Team will continue to monitor suicide in their local area using real-time suicide surveillance, ONS, and PHE data and work within the regional system on suicide prevention work. As the borough starts to recover from the COVID-19 pandemic it is important that the impact of the pandemic on suicide is considered and opportunities for suicide prevention work are incorporated into this recovery process.

5 Introduction

5.1 Suicide as a public health problem

Suicide is a major, global, public health problem (World Health Organisation [WHO], 2021). Suicide is not inevitable; it is a preventable cause of death and a leading cause of years of life lost (WHO, 2021). Suicide has a devastating impact on both those close to the person who died and their wider community (Department of Health [DH], 2012). The Samaritans Chief Executive describes suicide as

"*a rock thrown into the water with the ripples spreading outwards, covering family, friends, soaking work colleagues, acquaintances, the wider community*" (Sutherland, 2018).

Globally, an estimated 703,000 people die as a result of suicide each year (WHO, 2021). In England, one person dies every two hours as a result of suicide and we know that some groups in our society are at greater risk than others (DH, 2012). Suicide is a complex public health problem. Multiple risk factors and circumstances often contribute to somebody taking their own life (DH, 2012). Prevention of suicide must therefore reflect this complexity and requires a multiagency approach (DH, 2012).

Local authorities have a key role in suicide prevention in their communities, working with other stakeholder organisations such as the police, clinical commissioning groups (CCGs), National Health Service England (NHSE), coroners, and voluntary organisations (Public Health England [PHE], 2014). The Government recommends that each local authority has a suicide prevention action plan in place, establishes ways to monitor trends and map suicide hot spots, engages with media, and takes action to improve mental health in their area (PHE, 2014).

This needs assessment aims to generate understanding of suicide in North Tyneside in order to inform suicide prevention in the borough. It is a needs assessment of suicides in North Tyneside, as defined by the Office for National Statistics (ONS) (see section 6). It therefore does not cover suicides in children aged under 10 years of age, or deaths caused by injury or poisoning of undetermined intent in children aged under 15 years of age.

5.2 National suicide policy, strategy, and publications

This section summarises the policy, strategy, and other publications relevant to local authority suicide prevention work.

5.2.1 The National Suicide Prevention Strategy

The National Suicide Prevention Strategy 'Preventing suicide in England: A cross-government outcomes strategy for saving lives' was published by the Department of Health (DH) in September 2012 and is the key driver of suicide prevention work in

England (DH, 2012). The strategy sums up the local public health approach to suicide prevention as:

> ***"An effective local public health approach is fundamental to suicide prevention. This will depend on effective partnerships across all sectors including health, social care, education, the environment, housing, employment, the police and criminal justice system, transport, and the voluntary sector" (DH, 2012).***

It emphasises that suicide prevention is most effective when it is combined with wider work addressing population health, the social determinants of health, and their link with health and wellbeing (DH, 2012). It emphasises that services should be of high quality and accessible to all (DH, 2012).

This strategy sets out two overarching objectives:

1. **a reduction in the suicide rate in the general population in England; and**
2. **better support for those bereaved or affected by suicide (DH, 2012).**

This strategy identified six key areas for action to support these overarching objectives (DH, 2012). A seventh was added in 2016 (HM Government, 2017). These seven key areas can be seen in Table 1.

Table 1: National Suicide Prevention Strategy: seven key areas for action

Key area	Definition of key area	Further information
1	Reduce the risk of suicide in key high-risk groups	Key high-risk groups include: • young and middle-aged men • people in the care of mental health services • people with a history of self-harm • people in contact with the criminal justice system • some specific occupational groups including doctors, nurses, veterinary workers, farmers, and agricultural workers.
2	Tailor approaches to improve mental health in specific groups	These specific groups include: • children and young people • survivors of abuse or violence • veterans • people living with long-term physical health conditions • people with untreated depression • people who are especially vulnerable due to social and economic circumstances • people who misuse drugs or alcohol • lesbian, gay, bisexual, and transgender people • Black, Asian and minority ethnic groups • Asylum seekers.

3	Reduce access to the means of suicide	The national guidance suggests tackling: • hanging and strangulation in psychiatric inpatient and criminal justice settings • self-poisoning • those in high-risk locations • those on the rail and underground networks.
4	Provide better information and support to those bereaved or affected by suicide	It is important to: • provide effective and timely support of the families bereaved or affected by suicide • have a place effective local response to the aftermath of a suicide and provided information and support for families, friends, and colleagues who are concerned about someone who may be at risk of suicide.
5	Support the media in delivering sensitive approaches to suicide and suicidal behaviour	The government wants to promote the responsible report of suicide in the press, support the online industry to remove content that encourage suicide, and provide ready access to suicide prevention services.
6	Support research, data collection and monitoring	The government has pledged to continue to support high-quality research on suicide, suicide prevention and self-harm through the National Institute of Health Research and the Policy Research Programme. Work will also continue regarding data monitoring and National Framework Public Health indictors.
7	Reduce rates of self-harm as a key indicator of suicide risk	The strategy was expanded in 2017 to include self-harm, recognising that self-harm is a key indicator of suicide risk and addressing the increasing levels of self-harm is a key issue for all partners.

Key advice/recommendations within the national suicide prevention strategy relevant to local authority work and that will help refresh North Tyneside's local action plan are to:

- build both individual and community resilience;
- support vulnerable people;
- use known suicide resilience factors to plan interventions;
- adopt cost-effective, evidence-based approaches;
- educate those working in the community who come into contact with vulnerable groups in the context of suicide, such as:
    - care leavers
    - those at risk of sexual exploitation
    - middle-aged men
    - those in the lowest socioeconomic groups
    - those in contact with the criminal justice system
    - domestic and sexual violence survivors
    - those with disabilities and long-term health conditions
    - older people
    - those with social or economic difficulties
    - those who misuse drugs and alcohol misuse
    - the lesbian, gay, bisexual, transgender, queer + (LGBTQ+) community
    - minority ethnic groups

    - children and young people;
- ensure effective information dissemination on suicide in communities;
- reduce access to methods of suicide, and be vigilant to new or unusual suicide methods;
- provide effective and timely emotional and practical support for those bereaved;
- ensure families/friends are aware of how to contact services if they are worried someone is at risk of suicide;
- work with local media;
- specifically consider suicide prevention at Health and Wellbeing Boards; and
- work with regional or sub-regional multi-agency suicide prevention groups (DH 2012).

5.2.2 Prompts for local leaders on suicide prevention

In accompaniment to the National Prevention Strategy, the Government published Prompts for Local Leaders on Suicide Prevention. This document provides a list of prompts to facilitate understanding of what is happening at a local authority level in the context of suicide.

5.2.3 Must know: Suicide prevention

In March 2020 The Local Government Association (LGA) and the Association of Directors of Public Health (ADPH) published a guide for local authorities and their partners which includes an update on suicides in England and guidance on how to provide effective suicide prevention.

5.2.4 Preventing suicide in England: Fifth progress report

The Government publishes progress reports detailing steps taken to reduce deaths from suicide each year. The Fifth progress report is the most recent report, published in March 2021.

The fifth report seeks to understand trends in suicide between 2016 and 2019 and, as it was written mid-COVID-19 pandemic, also considers the impact that the pandemic and its associated restrictions may have had on suicide (HM Government, 2021). The report outlines the steps that have been taken in response to changing trends in suicide and emphasises that the pandemic has presented unprecedented suicide prevention challenges that must be tackled proactively by multi-disciplinary, cross-sector working (HM Government, 2021).

5.2.5 ONS statistical update

The ONS publishes an annual statistical update on suicides in the UK. Their most recent statistical update was published in September 2020 and presents 2019 data.

5.2.6 Cross-Government Suicide Prevention Workplan

The Cross-Government Suicide Prevention Workplan was published in 2019. This workplan sets out action to be taken by the Government to reduce the incidence of suicide and ensure people get the help they need. It details actions to be taken at both national and local government levels and by other sectors such as the National Health Service (NHS) and the criminal justice system, providing timescales for these actions.

Implementing this workplan in local government

This workplan sets out two key actions that are particularly relevant to local government organisations:

1. ensure the effectiveness of every local authority suicide prevention plan; and
2. improve data collection at local and national level, and harness technology to identify those most at risk of suicide and self-harm.

This workplan emphasises the central role of local government organisations in reducing suicide and its impact on communities. It outlines the importance of a multidisciplinary approach and the sharing of good practice in embedding local authority suicide prevention plans to ensure their effectiveness.

Updates to the workplan in response to the COVID-19 pandemic

The Cross-Government Suicide Prevention Workplan has been expanded and updated to include new actions in response to the COVID-19 pandemic. This updated workplan can be found as Annex A within the Fifth progress report. The actions listed in this updated workplan aim to protect the groups most impacted by the pandemic in the context of suicide, including previously vulnerable groups whose risk may have been exacerbated by the pandemic (HM Government, 2021). These groups can be found in section 8.2.

5.2.7 PHE local suicide prevention planning

PHE have worked with the National Suicide Prevention Alliance to develop the document: Local suicide prevention planning: a practice resource. The aim of this document is to help local authority public health teams work with the wider system to implement suicide prevention plans.

5.2.8 PHE Suicide prevention profile

The PHE Suicide prevention profile (commonly known as the Suicide Prevention Fingertips tool) presents publicly available, routine suicide data to facilitate understanding and encourage an intelligence led approach to suicide prevention nationally, regionally, and locally.

5.2.9 Real-time suicide surveillance

When a person dies unexpectedly in England, Wales, and Northern Ireland, a coroner's inquest is held to determine the cause of death. A coroner's inquest can take months to years which causes a registration delay, with a median delay of 6 months between a suicide death occurrence and its subsequent registration (ONS and fifth progress report). This means many deaths appear in the statistics of a year later than they occurred.

Real-time suicide surveillance (RTSS) is used by organisations involved in suicide prevention to track suspected suicide deaths, recognising that a time lag exists between unexpected deaths being reported and the outcome of a coroner's inquest in England. By providing organisations with real-time data, RTSS enables them to

identify clusters, changing trends, or areas where action could be taken to prevent suicides in their local area in a timely manner (RCPYSCH, 2021).

The North East and North Cumbria Integrated Care System (ICS) has recently put a RTSS system in place.

5.2.10 National Institute for Health and Care Excellence Quality Standard 189

In 2019 the National Institute for Health and Care Excellence (NICE) issued Quality Standard 189: Suicide Prevention. This Quality Standard considers ways to reduce suicide and help those bereaved and affected by suicide.

6 Definition of suicide

The ONS defines suicide as:

> ***"all deaths from intentional self-harm for persons aged 10 and over, and deaths caused by injury or poisoning where the intent was undetermined for those aged 15 or over".***

Notable change to this definition
In January 2016, the definition of suicide was expanded to include deaths from intentional self-harm in children aged 10 to 14 years (ONS, 2019). Deaths from an event of undetermined intent in 10 to 14-year-olds are not included because it is deemed inappropriate to assume that harm resulting in death in this age group is self-inflicted (ONS, 2019).

Notable change to the standard of proof
Prior to July 2018, the "criminal standard" was used by coroners in England and Wales to determine whether a death was caused by suicide, meaning the coroner required evidence that a death was caused by suicide "beyond all reasonable doubt". Since July 2018, the "civil standard" has instead been applied, changing the requirement of evidence to show a death was caused by suicide "beyond all reasonable doubt" to on the "balance of probability". This does not impact processes in Scotland and Northern Ireland (ONS, 2018).

The impact of this change has been investigated by the ONS and has not resulted in any significant change to the reported suicide rate in England and Wales; the increasing trend we are currently seeing in suicide started before this legal change occurred (ONS, 2020).

7 Prevalence of suicide

Data presented here have been taken from the ONS statistical update, the suicide prevention profile, and an Audit of suicides and undetermined deaths undertaken by North Tyneside council's Public Health Team. The most up to date data have been presented which are 2019 data and therefore are pre-COVID-19 pandemic.

Where age-standardised suicide rates are presented they have been standardised to the 2013 European Standard population, unless otherwise stated.

Limitations of these data can be found in Appendix One and should be considered when interpreting the findings.

7.1 The impact of the COVID-19 pandemic on suicide

The impact of the COVID-19 pandemic on suicide has generated understandable concern. Professor Appleby (chair of the National Suicide Prevention Strategy Advisory Group) *et al*. have produced a report that is referenced in the Government's Fifth progress report titled Suicide in England since the COVID-19 pandemic – early figures from real-time surveillance. This report used Real Time Suicide Surveillance (RTSS) data from different areas of England, giving a total population covered of nine

million (Appleby et al., 2020). The impact of the pandemic on RTSS data was examined by comparing data from before lockdown (January-March 2020) and after lockdown (April-August 2020) (Appleby, 2020). This report found no evidence of a large national rise in suicides as a consequence of the lockdown in the areas included (Appleby et al., 2020). However, this conclusion was caveated with the facts that:

1. RTSS provides early figures therefore the numbers could change with time;
2. only some areas of the country were included in the comparison; and
3. it is too soon to capture the full long-term impact of the pandemic and its associated economic adversity on suicide in England (Appleby, 2020).

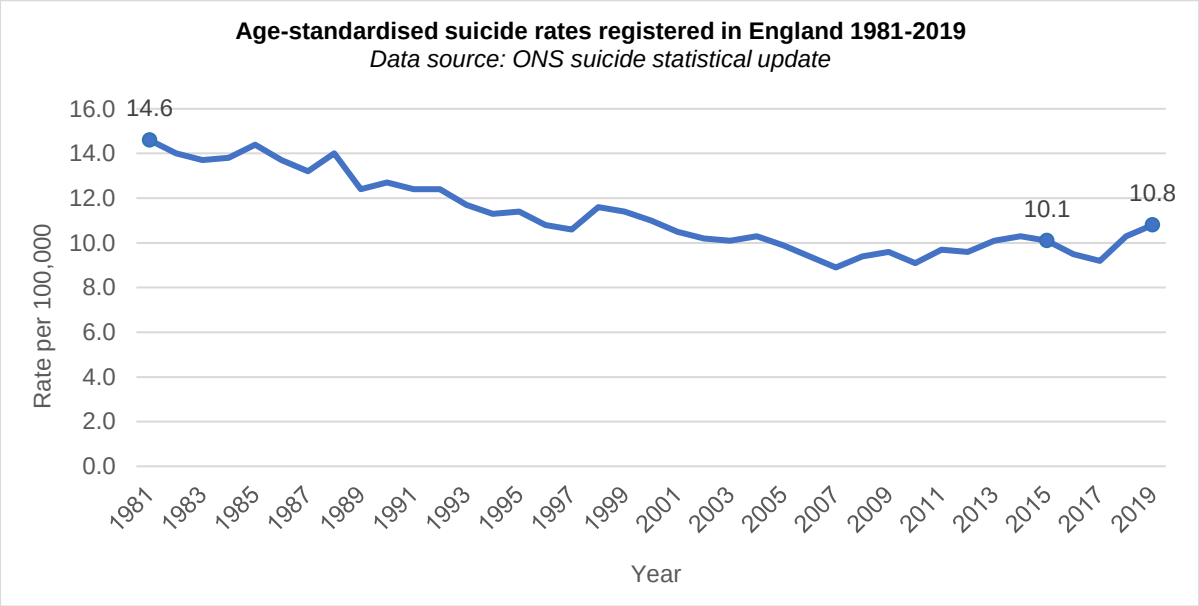
Data from North Tyneside RTSS do not indicate an increase in suicides over the pandemic. From April 2020 – August 2021 there were 31 suspected suicides. However, as with national data this is early, indicative data and this finding could change with time.

7.2 Suicides in England

7.2.1 Overall rates

Following a downward trend in suicides between 2014 and 2017, there have been statistically significant increases in recent years (HM Government, 2021). Figure 1 shows the trend in suicide rates in England from 1981 to 2019.

Figure 1: Age-standardised suicide rates registered in England between 1981 and 2019



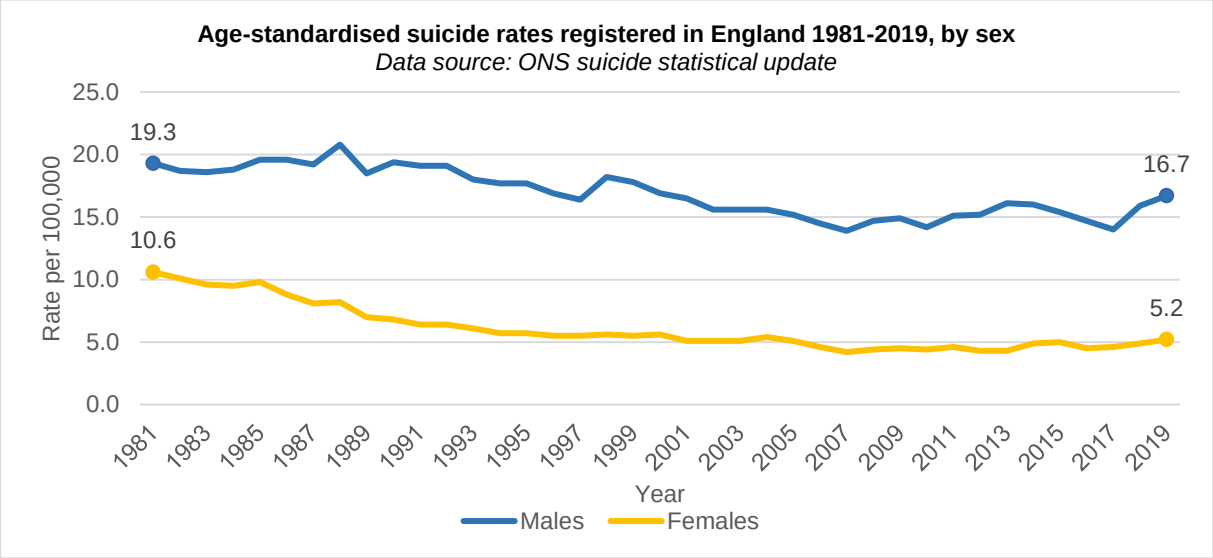
In 2019 there was a total of 5,316 suicides registered in England, giving an age-standardised rate of 10.8 deaths from suicide per 100,000 population. This rate is similar to the 2018 rate of 10.3 per 100,000 but is the highest rate since 2000.

7.2.2 Patterns by sex

In England in 2019 there was 4,017 suicides in men and 1,299 suicides in women. This means 75% of suicides were in men and 25% were in women, demonstrating that

suicides are not evenly distributed by sex. This sex distribution has remained similar since the mid-1990s (ONS, 2020). Figure 2 shows the trend in sex distribution of suicides in England from 1981 to 2019.

Figure 2: Age-standardised suicides rates registered in England from 1981 to 2019, by sex



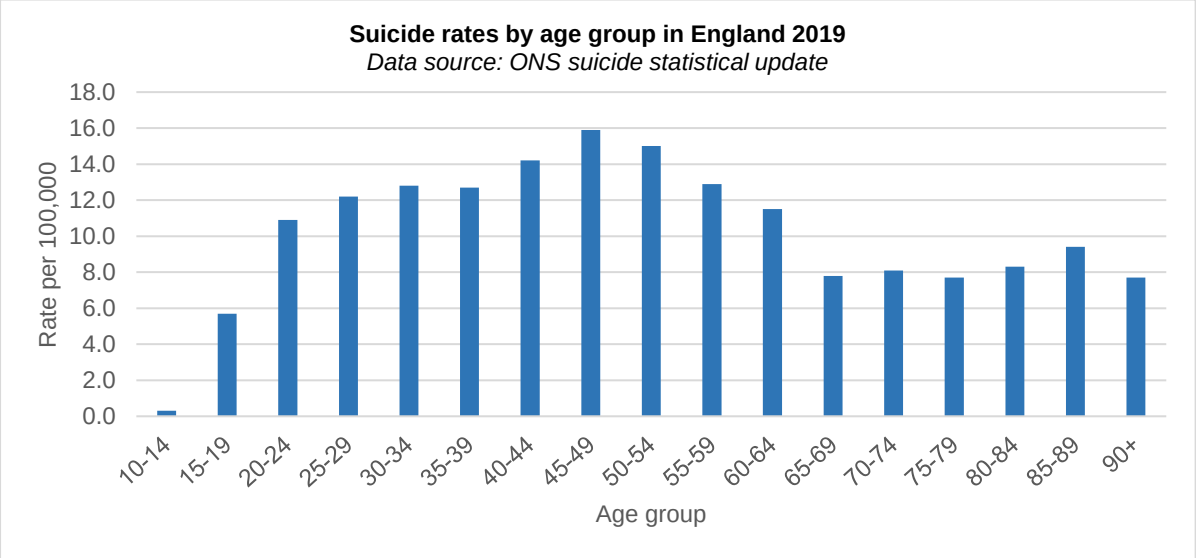
The suicide rate for men in England in 2019 was 16.7 per 100,000 and for women was 5.2 per 100,000. The 2019 rate for men is the highest in England since the year 2000, and the 2019 rate for women is the highest since the year 2004.

7.2.3 Patterns by age

Since the mid-1980s, suicide rates have increased with age, peaking in middle-age at around 45-54 years old (ONS, 2020). It has also been a consistent pattern that, following a decline after the middle-age peak, rates increase again in the 80-89-year-old age group (ONS, 2020).

Figure 3 shows suicide rates by 5-year age groups in England in 2019.

Figure 3: Suicide rates by 5-year age group in England in 2019

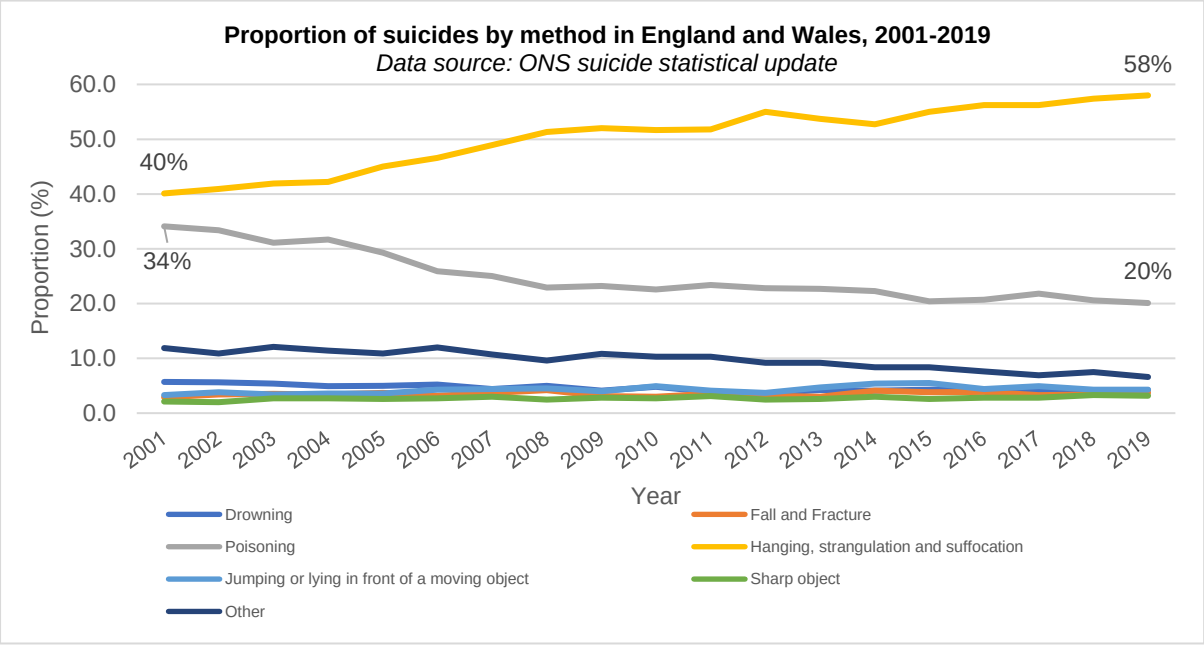


This figure highlights the increase in suicide rates with increasing age and the peak in rates in the middle-age groups. It also shows the second small peak in the 80-89-year-old age group. In 2019, the age-group with the highest rate of suicide in England was the 45-49-year-old age group for men, and the 50-54-year-old age group for women (ONS, 2020).

7.2.4 Patterns by method

Data for suicide patterns by method include both England and Wales data. 'Hanging, strangulation, and suffocation' has been the most common method of suicide in England and Wales for some time, and the proportion of suicides caused by these methods is increasing with time (ONS, 2020). The trends in suicide method can be seen in Figure 4.

Figure 4: Proportion of suicides by method in England and Wales from 2001-2019



This figure demonstrates the increasing trend in the proportion of suicides caused by hanging, strangulation, and suffocation. It also indicates that the proportion of suicides caused by poisoning and drowning is decreasing. The other methods displayed have remained relatively stable in their proportions and are all below 10%.

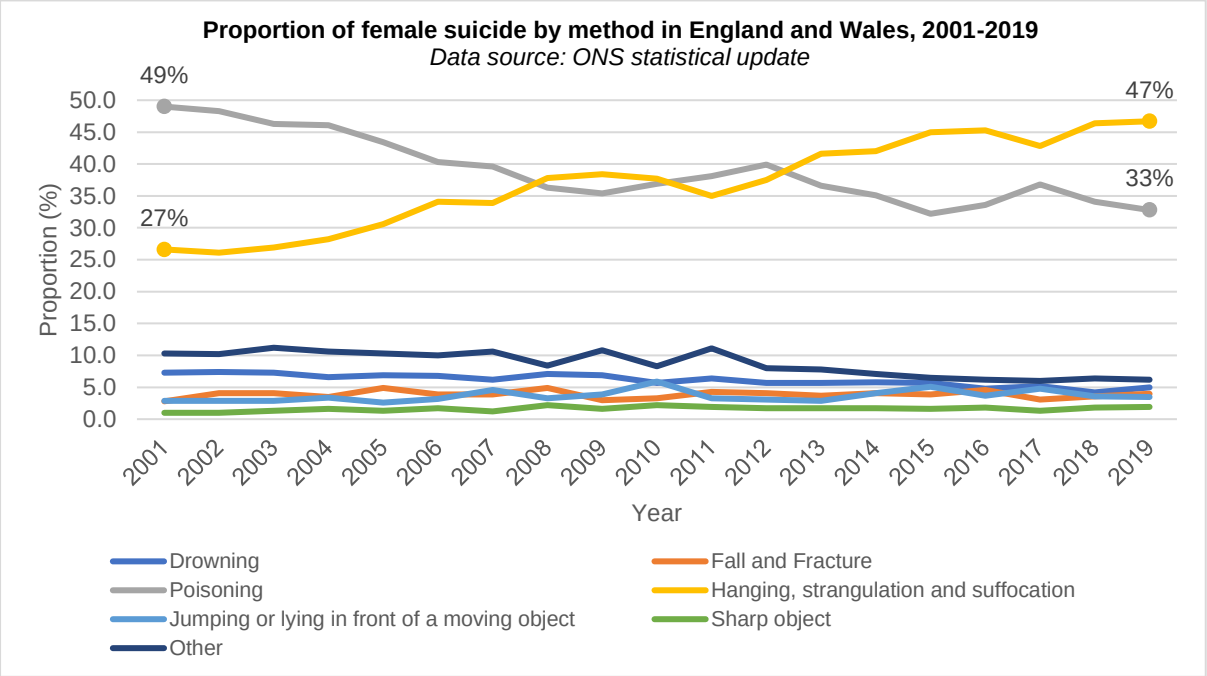
Method of suicide in males

When method of suicide is broken down by sex, the patterns for methods used by males is almost identical to that for both sexes seen in Figure 4 above. In 2019, the most common method of suicide for males in England and Wales was hanging, strangulation, and suffocation, accounting for 61.7% of all suicides (ONS, 2020). This is an increase from 44.5% in 2001 (ONS, 2020). The second most common method for males in 2019 was poisoning but, in-keeping with the overall trend, this method is becoming less common over time (ONS, 2020).

Method of suicide in females

The trends seen in method of suicide in females in England and Wales can be seen in Figure 5.

Figure 5: Proportion of female suicides by method in England and Wales from 2001-2019



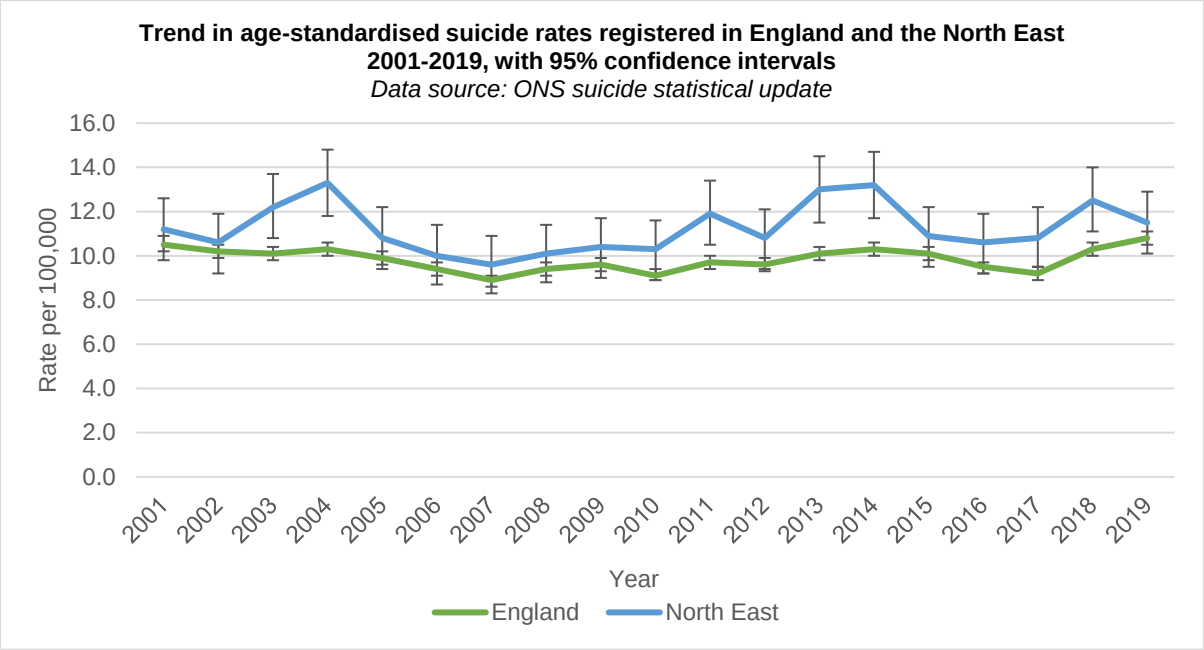
This indicates that the most common method of suicide in females in England and Wales from 2001-2008 was poisoning, but since 2013 has been hanging, strangulation, and suffocation. The proportion of suicides caused by drowning has decreased, while other methods have stayed relatively stable and below 10%.

7.3 Suicides in the North East region

In 2019, the North East region had the third highest age-standardised suicide rate for males out of the nine regions in England at 19.1 per 100,000 and a rate higher than the national male rate (16.7 per 100,00). However, the North East region had the lowest age-standardised suicide rate for females out of the nine regions in England at 4.1 per 100,000, and a rate lower than the national female rate (5.2 per 100,000) (ONS, 2020).

Figure 6 compares the trend in age-standardised suicide rates for all persons in England and the North East region from 2001-2019.

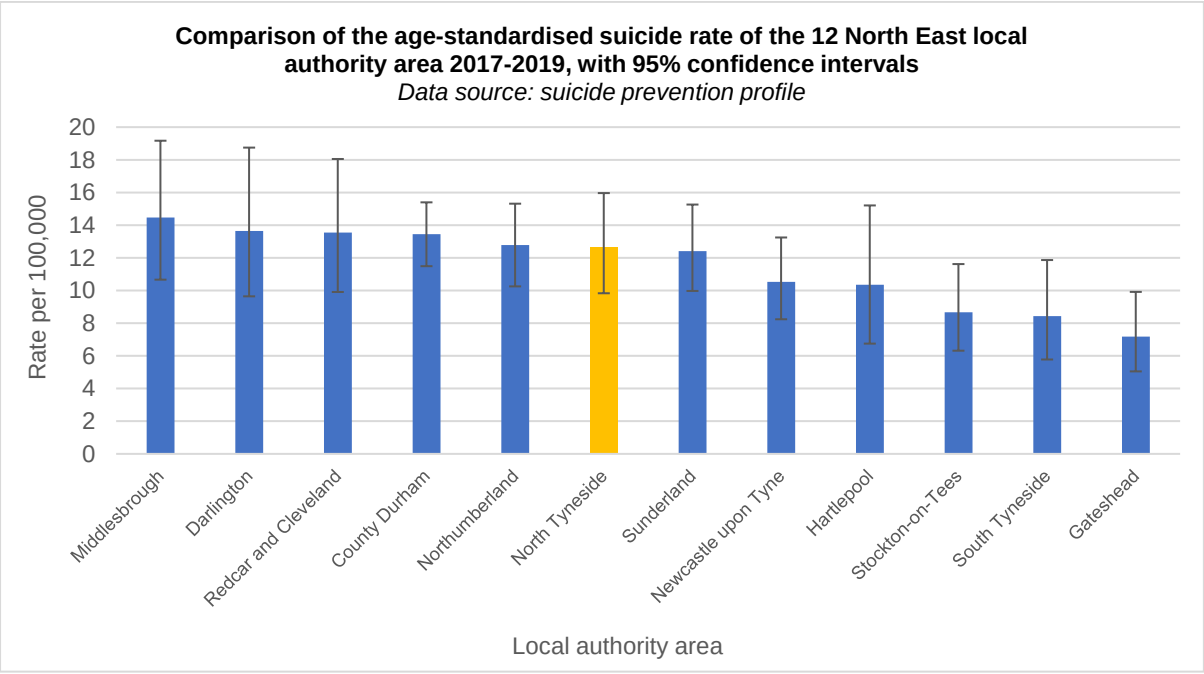
Figure 6: Trend in age-standardised suicide rates registered in England and the North East from 2001-2019, with 95% confidence intervals



This indicates that, generally, the North East region has an suicide rate higher than the national rate. This graph indicates that the North East region had a signifcantly higher suicide rate than the national rate in the years 2003, 2004, 2011, 2013, 2014, and 2018.

Figure 7 compares age-standardised suicide rates of the 12 North East local authority areas for the years 2017-2019.

Figure 7: Comparison of the age-standardised suicide rate of the 12 North East local authority areas 2017-2019, with 95% confidence intervals



The 95% confidence intervals for all 12 local authority areas overlap, indicating that there is no significant difference between their suicide rates. This means that North Tyneside has a similar suicide rate to the other 11 North East local authority areas.

7.4 Suicides in North Tyneside

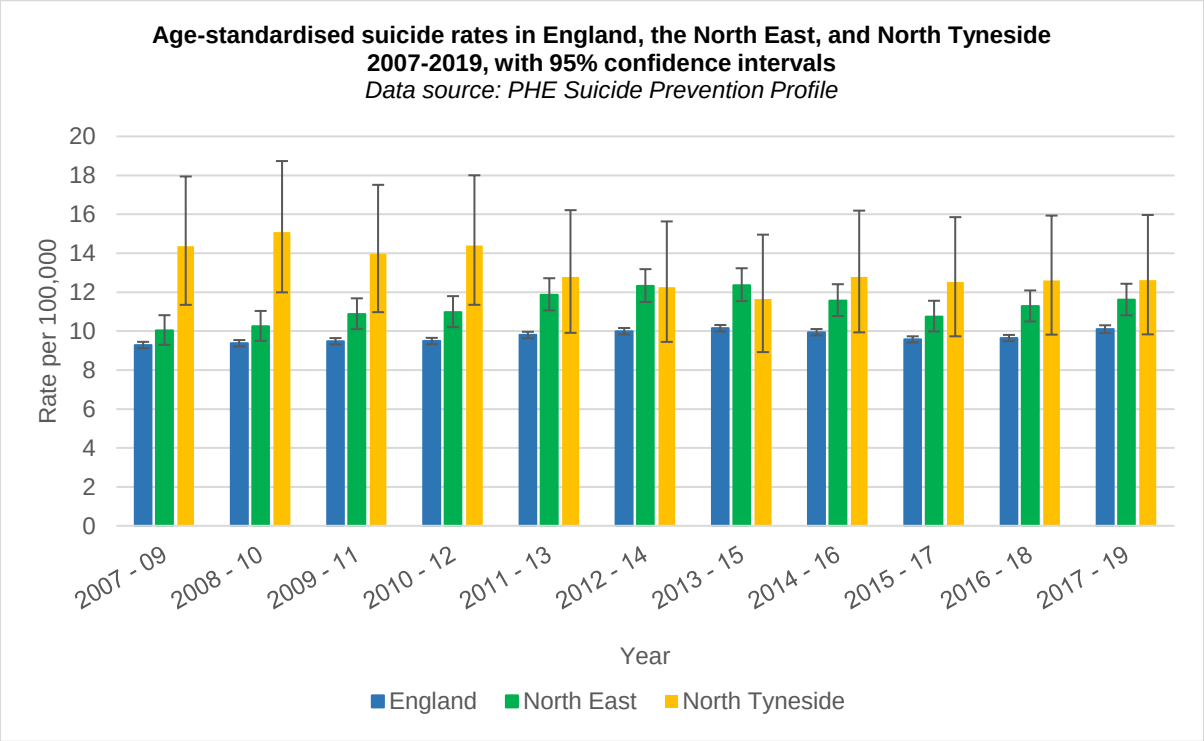
To minimise the impact of fluctuations due to small numbers, local authority level suicide rates are presented as aggregated data for 3-year periods (ONS, 2019).

7.4.1 Suicide prevention profile data

The current (2017-19) suicide rate in North Tyneside is 12.6 per 100,000 population. The national suicide rate is 10.1 per 100,000 and the North East rate is 11.6 per 100,000 (data source: suicide prevention profile).

Figure 8 compares the age standardised suicide rates nationally, regionally, and locally by 3-year periods from 2007-2019.

Figure 8: Age-standardised suicide rates in England, the North East, and North Tyneside 2007-2019, with 95% confidence intervals



The 95% confidence intervals for North Tyneside are wide and since 2011 have overlapped with regional and national confidence intervals, suggesting that there are no significant differences between the three geographical areas.

This means that the suicide rate in North Tyneside is similar to the national and regional rates.

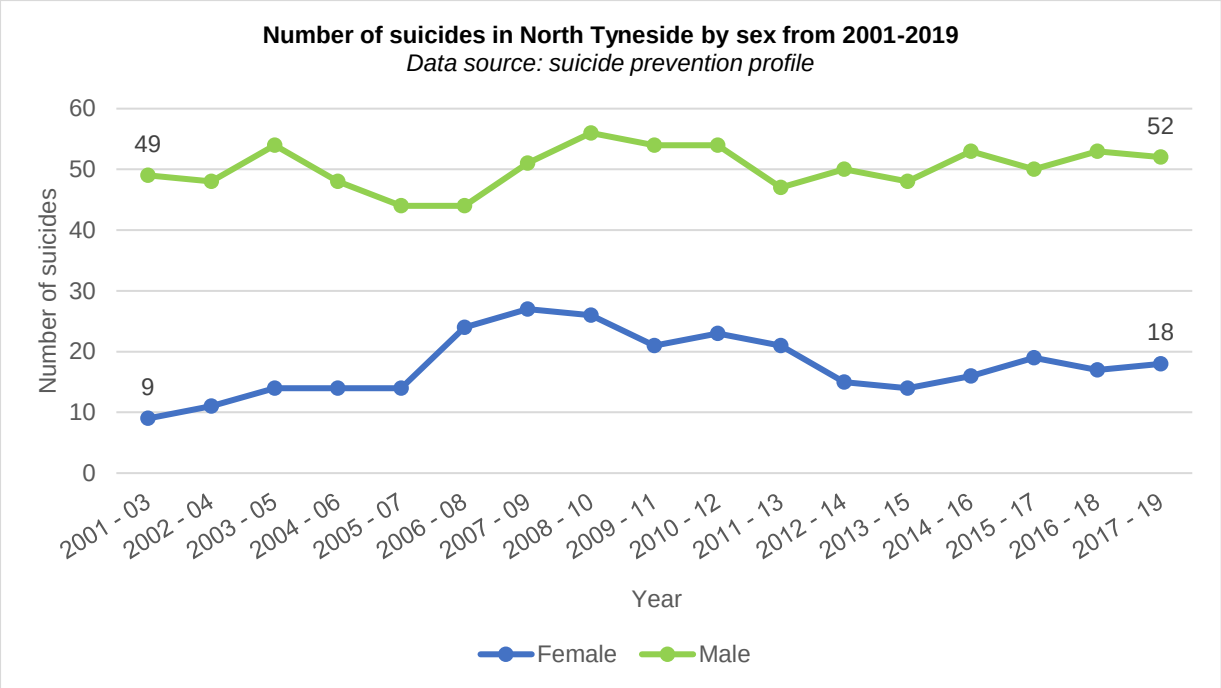
Table 2 shows the numbers and rates of suicides in North Tyneside.

Table 2: Numbers and rates of suicides in North Tyneside from 2009-2019

	Age-standardised rate			Number (in 3-year period)		
Year	Female	Male	Persons	Female	Male	Persons
2009 - 11	7.5	20.9	14.0	21	54	75
2010 - 12	8.2	20.8	14.4	23	54	77
2011 - 13	7.4	18.2	12.8	21	47	68
2012 - 14	5.3	19.4	12.3	15	50	65
2013 - 15	5.1	18.7	11.7	14	48	62
2014 - 16	5.7	20.8	12.8	16	53	69
2015 - 17	6.6	19.4	12.5	19	50	69
2016 - 18	5.9	20.5	12.6	17	53	70
2017 - 19	6.2	19.6	12.6	18	52	70
* Rates not calculated due to small numbers						
Data source: Suicide prevention profile						

Figure 9 shows the number of suicides by sex in North Tyneside.

Figure 9: Number of suicides in North Tyneside by sex from 2001-2019



This indicates that the number of deaths caused by suicide in males in North Tyneside ranges from between two to three times the number of deaths caused by suicide in females in the borough.

Table 3 shows suicides in North Tyneside in males and females, as a proportion of total suicides in the borough.

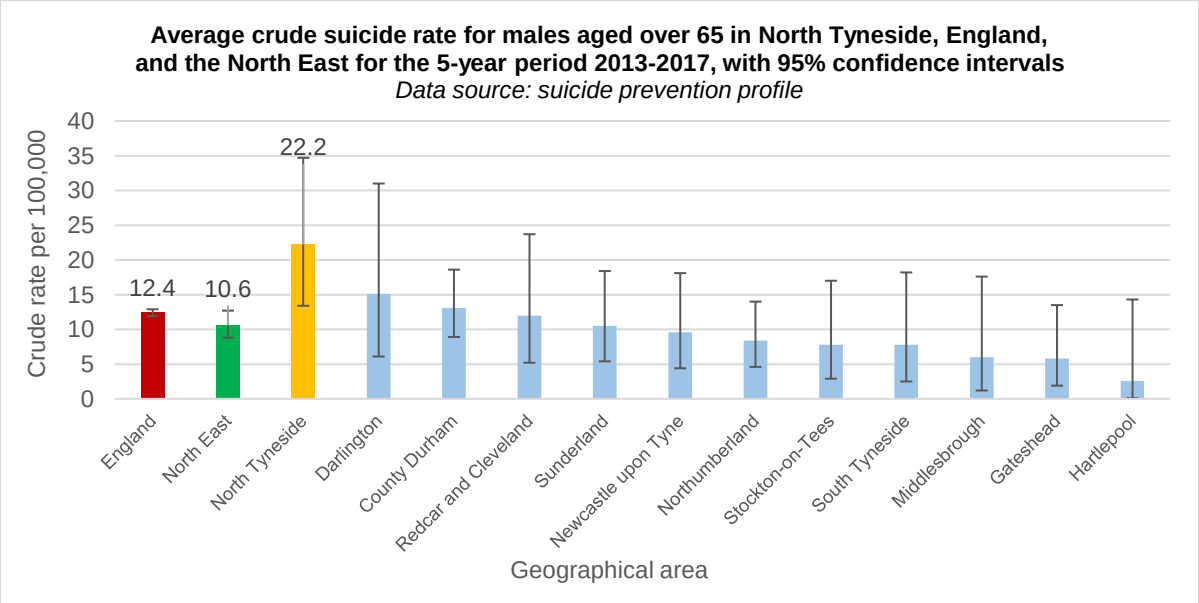
Table 3: Suicides in North Tyneside by sex as a proportion of total suicides from 2009-2019

	Number (in 3-year period)			Proportion (%)	
Year	Female	Male	Persons	Female	Male
2009 - 11	21	54	75	28.0%	72.0%
2010 - 12	23	54	77	29.9%	70.1%
2011 - 13	21	47	68	30.9%	69.1%
2012 - 14	15	50	65	23.1%	76.9%
2013 - 15	14	48	62	22.6%	77.4%
2014 - 16	16	53	69	23.2%	76.8%
2015 - 17	19	50	69	27.5%	72.5%
2016 - 18	17	53	70	24.3%	75.7%
2017 - 19	18	52	70	25.7%	74.3%
Data source: Suicide prevention profile					

These data indicate that the ratio of male to female suicide deaths is similar to the national ratio of 3:1; male suicides make up around 75% of all suicides in North Tyneside.

A dataset that stands out in the Public Health England (PHE) suicide prevention profile is the suicide rate in males over 65 years old. Figure 10 compares the average crude suicide rate in males over 65 years old in England, the North East, and each of the 12 North East local authority areas for the five-year period of 2013-17. It is important to note that crude rates are not adjusted for the age of the underlying population. Furthermore, crude rates are presented as averages for a five-year period to minimise the risk of random variation that occurs with small numbers (PHE, 2018). The following figures must be interpreted in the context of these data limitations. These limitations are explained further in Appendix One.

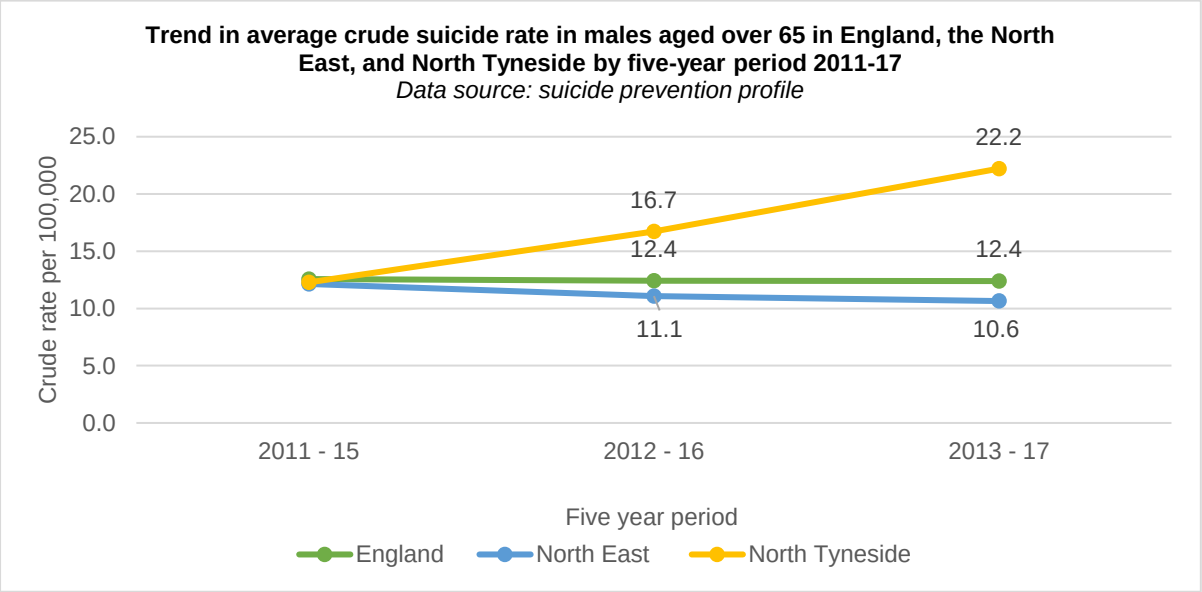
Figure 10: Average crude suicide rate for males aged over 65 in England, the North East, and each North East for the five-year period 2013-2017, with 95% confidence intervals



This indicates that, in the five-year period of 2013-2017, North Tyneside had a significantly higher crude rate of suicide in males over 65 than England and the North East region as a whole, but this rate is similar to other North East local authority areas.

Figure 10 compares the trend in the average crude suicides rate in males over the age of 65 in England, the North East region, and North Tyneside by five-year period from 2011-2017.

Figure 11: Trend in average crude suicide rate in males aged over 65 in England, the North East, and North Tyneside by five-year period from 2011-2017



This indicates that, whilst the national and regional crude suicide rates in males aged over 65 have remained stable between 2011 and 2017, the North Tyneside rate has increased.

7.4.2 The North Tyneside Audit of suicides and undetermined deaths 2012-2015

It is important to supplement national data with more local intelligence as timely information is essential to identify trends, clusters, or potential high frequency locations. Working with the local coroner the North Tyneside Council Public Health team completed an in-depth suicide audit, analysing all 92 cases of suicide in over 18s from January 2012 to 31st December 2015. The audit is only a small sample of suicides from a fixed time period, but the findings do appear to corroborate similar findings from national studies.

Although the circumstances of every death are unique, there are some common themes across cases. Some key findings from the audit include:

- 75% of suicides were among men
- The highest number of suicides was in men aged 41-50 years old
    - This age group represented 23% of male suicides in this time period
- The highest number of suicides in women was in the age group of 41-60 years old
    - This age group represented 52% of female suicides in this time period

- The usual place of residence was in North Shields (25%), Wallsend (17%), and Whitley Bay and coastal area (16%)
- 61% of cases were single, divorced, separated, or widowed
- 51% of cases lived alone
- 41% of cases were unemployed
- 62% of cases died in their own home, 8% in hospital, and 8% by a railway or metro
- The most common method of suicide for men was suspension (48%) and for women was suspension (39%) self-poisoning (39%)
- 59% of cases had no record of a suicide attempt
    - 25% had attempted suicide in the last year
    - 16% had attempted suicide more than one year ago
- 9% of cases had self-harmed within the last year and 13% had self-harmed more than a year ago
- 33% of cases left a written note
- 40% of cases had consumed alcohol at the time of their death
    - But only 17% of females had consumed alcohol at the time of their death
- The top reported contributing factor (29%) was relationship or family problems
    - The second most reported was physical illness or disability (13%)
- 21% of cases had contact with specialist mental health services at the time of their death
    - However, 59% of cases had never had any contact with specialist mental health services

Four case file summaries presented in this audit can be found in Appendix Two. These case files add real-life context to the data presented here and highlight bereavement as a consideration when considering factors relating to suicides in North Tyneside.

7.5 Self-harm in North Tyneside

Self-harm is ‘when somebody intentionally damages or injures their body’ (NHS, 2020). It therefore includes different acts, for example ingestion to harm the body, or externally damaging the body. Some of the reasons people may self-harm include a cry for help, a way to relieve unbearable tension, or a way to cope with or express emotional distress (NHS, 2020).

Self-harm is an indicator relevant to suicide prevention as previous self-harm episodes are the strongest identified predictor of suicide (PHE, 2020). Reducing rates of self-harm as a key indicator of suicide risk was added as a seventh key priority to the National Suicide Prevention Strategy in 2016 (PHE, 2020). It is therefore important that self-harm is understood at a local level when working to prevent suicide.

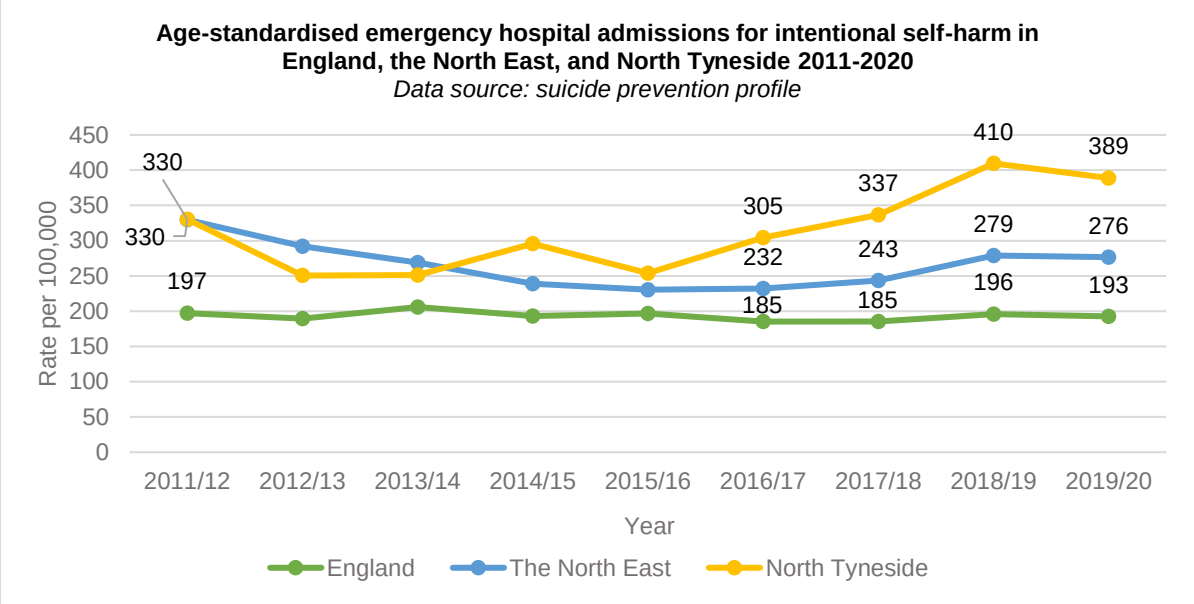
Figure 12 shows compares the age-standardised rates of emergency hospital admissions for intentional self-harm nationally, regionally, and locally. When interpreting the following data, it is important to note that variation exists between geographical areas in the context of emergency hospital admissions for self-harm. Variations include:

- how many people who self-harm seek medical attention; and
- the threshold/policy for admitting people who self-harm in secondary care settings.

It is also important to note that hospital admissions only represent a very small proportion of the episodes of self-harm and only the tip of the iceberg of the impact of self-harm and do not fully represent the prevalence of self-harm (PHE, 2021).

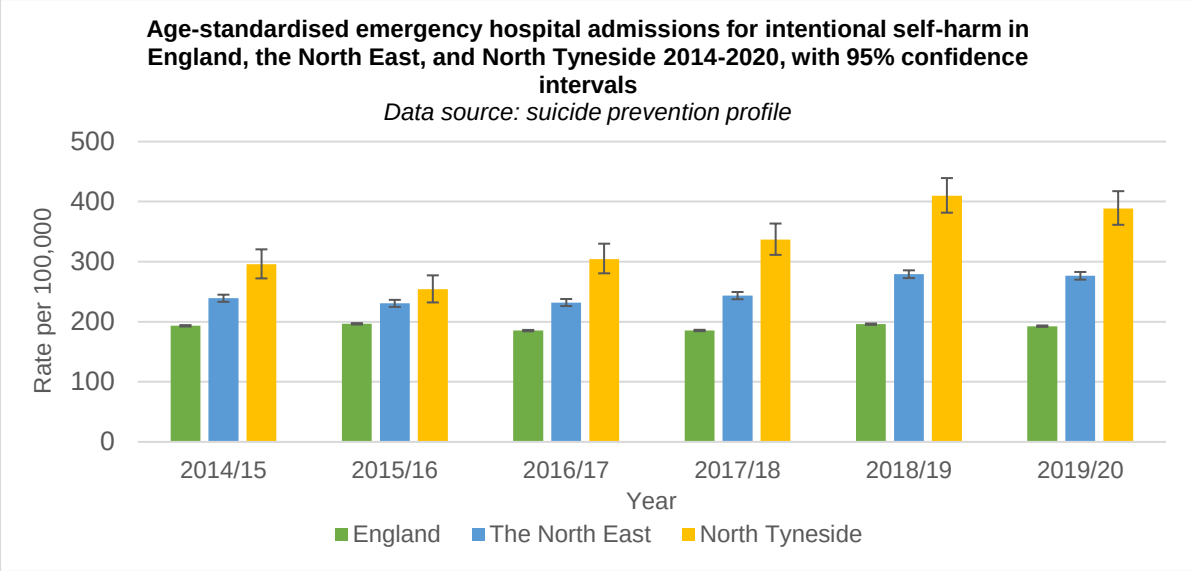
These caveats and causes of variation should be considered when interpreting self-harm admissions data.

Figure 12: Age-standardised rates of emergency hospital admissions for intentional self-harm in England, the North East, and North Tyneside from 2011-2020



This indicates that the borough of North Tyneside has had a higher rate of emergency hospital admissions for intentional self-harm than national and regional rates since the financial year of 2014/15. Figure 12 shows the 95% confidence intervals of the age standardised rates from 2014/15 onwards.

Figure 13: Age-standardised emergency hospital admissions for intentional self-harm in England, the North East, and North Tyneside from 2014-2020, with 95% confidence intervals



This indicates that North Tyneside has had a rate of emergency hospital admissions for self-harm significantly greater than the national rate since 2014/15. It also suggests that the borough's rate has also been significantly greater than the regional rate every year except 2015/16. Data from the suicide prevention profile show that North Tyneside had the third highest rate of emergency hospital admissions for intentional self-harm in the North East region in 2019/20.

7.6 Overall key findings

The key findings from these data are:

- There has been a significant increase in suicide nationally since 2017, however suicide rates have not significantly increased in the equivalent years in North Tyneside.
- The North East region has had a significantly higher suicide rate than the national rate in six of the last 18 years
- The North Tyneside suicide rate is 12.6 per 100,000 which is similar to the England rate and similar to the rate of the other 11 North East local authority areas
- Early analysis of national real-time suicide surveillance (RTSS) and monitoring of local RTSS indicates that there has been no evidence of a large rise in suicides as a consequence of the COVID-19 pandemic and subsequent lockdowns, but this is based on early data and could change with time
- Male suicides account for approximately 75% of all suicides both nationally and in North Tyneside
- Suicides peak in middle-age both nationally and in North Tyneside
    - Nationally, the age groups with the highest suicide rates are the 45-49-year-old age group for males and the 50-54-year-old age group for females
    - There is a second small peak in the 80-89-year-old age group
    - In North Tyneside the age groups with the highest suicide rates are the 41-50-year-old age group for males and the 41-60-year-old age group for females
    - There is some evidence to suggest that North Tyneside has a significantly higher crude rate of suicide in males over 65 than England and the North East region as a whole, and that the suicide rate in this age group is increasing in the borough

- 'Hanging, strangulation, and suffocation' is the most common method of suicide in both males and females, followed by poisoning both nationally and in North Tyneside
    - Nationally, hanging, strangulation, and suffocation accounts for 58% of all suicides and poisoning accounts for 21%
    - In North Tyneside suspension accounts for 48% of all suicides in males and 39% of all suicides in females
    - Self-poisoning also accounts for 39% of all suicides in females in North Tyneside
- Most suicides occur in areas of the borough with high levels of deprivation, however
- An audit of 92 case files highlighted that:

  - in North Tyneside around 59% of cases have no record of a previous suicide attempt;
  - around 59% of cases in North Tyneside have never had any contact with specialist mental health services;
  - the most reported contributing factor to suicides in North Tyneside is relationship or family problems (29%); and
  - other important factors include physical illness or disability, being single, divorced, separated, or widowed, living alone, being unemployed, bereavement, and alcohol consumption.

- North Tyneside has a higher rate of emergency hospital admissions for self-harm than the national rate, but this must be considered in the context of the limitations of self-harm data

8 Risk factors for suicide

8.1 Risk groups

Some groups in our society are at increased risk of suicide. The key groups at highest risk of suicide as identified by the National Prevention Strategy are:

- men;
- people who self-harm;
- people who misuse alcohol and drugs;
- people in the care of mental health services;
- people in contact with the criminal justice system; and
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers (DH, 2012).

Other at-risk groups include:

- those in middle-age;
- people in the lowest socio-economic group;
- people who are unemployed;
- people with physical health problems, including chronic pain;
- people living alone;
- people who are unmarried;
- people in contact with the criminal justice system; and
- people with a mental illness (Samaritans, 2012; Harding, 2019; PHE 2020).

The group at greatest risk of suicide is men, in the lowest socioeconomic group, in middle-age (Samaritans, 2012). The Samaritans describe suicide in this group as a social issue with the following factors playing a role in suicide risk in this group:

1. personality traits;
2. masculinity;
3. challenges of mid-life;
4. relationship breakdown;

5. emotional illiteracy;
6. socioeconomic factors (Samaritans, 2012).

The Samaritans outlines a list of recommendations for policy makers and practitioners to tackle suicide in this group in their summary report 'Men and Suicide: Why it's a social issue'.

The Suicide Prevention Strategy highlights the following additional groups as vulnerable groups:

- care leavers
- those at risk of sexual exploitation
- those in the lowest socioeconomic groups
- domestic and sexual violence survivors
- those with disabilities and long-term health conditions
- older people
- those with social or economic difficulties
- the lesbian, gay, bisexual, transgender, queer + (LGBTQ+) community
- minority ethnic groups
- children and young people

The fifth progress report outlines four vulnerable groups in the context of suicide to be prioritised to reduce suicides to as low as possible. These four groups are:

1. middle-aged men;
2. people who self-harm;
3. children and young people; and
4. people with a mental illness (HM Government, 2021).

8.2 Risk groups following the COVID-19 pandemic

The COVID-19 pandemic is likely to have exacerbated existing risk factors for suicide, as well as generating new at-risk groups. This potential impact is recognised within the fifth progress report by the National Suicide Prevention Strategy Advisory Group (NSPSAG) (HM Government, 2021).

Within the NSPSAG there is a COVID-19 subgroup studying suicide trends during the pandemic (HM Government, 2021). This subgroup has identified groups of people who may be disproportionally affected by the pandemic, and therefore at greater risk of suicide (HM Government, 2021). These groups are:

- people who are economically vulnerable;
- people with mental health problems;
- people who are disproportionally impacted by lockdown or restrictions;
- Children and Young People;
- NHS and social care staff; and
- people in contact with the criminal justice system (HM Government, 2021).

However, as noted above there is no evidence to date that suicide rates have increased during the COVID-19 pandemic.

9 Local and regional action to address issues of suicide

9.1 Local action

In 2014 under the leadership of the Director of Public Health the North Tyneside Suicide Prevention Task Group was established. This Task Group includes representation from North Tyneside Council, North Tyneside CCG, Northumbria Healthcare NHS Foundation Trust, Northumberland Tyne and Wear Mental Health Trust, Northumbria Police, HM Coroner, Samaritans, Tyneside and Northumberland Mind, and the Department for Work and Pensions (DWP). This group meets annually and oversees the annual suicide prevention action plan.

The North Tyneside Suicide Prevention Task Group has also carried out a large number of pieces of suicide prevention work in North Tyneside including the audit of suicides and undetermined deaths 2012-2015 and an audit of current services and gaps in provision. In 2018 the North Tyneside Public Health Team undertook an under-18 suicide audit on behalf of the North of Tyne Child Death Overview Panel. The Public Health Team also continues to monitor and respond to RTSS and work closely with the regional and sub-regional suicide prevention groups.

Other local actions include, but are not limited to:

- In 2020-21 suicide awareness training has been delivered by the North Tyneside Public Health Team and Tyneside and Northumberland Mind to a wide range of stakeholder staff groups across North Tyneside.
- Grassroots funding was obtained for the local voluntary sector to deliver suicide prevention activity during COVID-19 lockdown
- Much work being undertaken by the voluntary sector includes suicide prevention activity and mental health support including LaunchPad North Tyneside, VODA Good neighbours project, Age UK's social prescribing, VODA's 'little boxes of hope', Helix Arts grants, and promotion of the regional work around targeting men through football and the 'Be a Game Changer' Campaign
- Ongoing awareness raising of the 'If U Care Share' suicide bereavement service
- The Active North Tyneside Sports Coaches have been trained as Mental Health First Aiders and offer support and disseminate a range of awareness messages and signposting.
- Training has been delivered to the North Tyneside Recovery Partnership (NTRP) to ensure drugs and alcohol services are aware of suicide risk in clients
- Outreach work has been undertaken in work-based settings to encourage help seeking behaviour in men in the borough though the Better Health at Work Programme
- Key messages, campaigns and awareness raising takes place throughout the year and around World Suicide Prevention day on 10th September

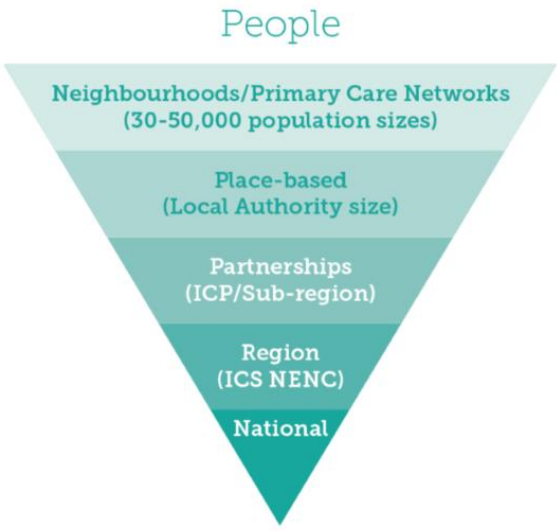
- The 'Help is at Hand' resource is continuously promoted through the Coroner's office and via Northumbria Police and other partners.

9.2 Regional action

There is also a large volume of suicide prevention work happening at a regional level. A North East and North Cumbria Suicide Prevention Network exists that includes multiple agencies, such as the North East and North Cumbria ICS, sub-regional Integrated Care Pathways (ICP), PHE, local authorities, the NHS, social care, the police, and third sector organisations.

The Network structure is seen in Figure 12.

Figure 14: North East and North Cumbria Suicide Prevention Network structure



(Taken from the North East and North Cumbria Suicide Prevention Network website)

This network aims to generate cross boundary collaboration in order to share best practice, learning, and resources, identify and address gaps, and ensure the effectiveness and efficiency of suicide prevention work in the North East and North Cumbria. Detailed information, resources, support, and reports can be found on their website.

At an ICS level, mental health is one of six priorities and Priority 5 in the mental health workstream is the 'Zero Suicide Ambition'. Sitting just below and supported by the ICS are three sub-regional ICPs; the South ICP, the North Cumbria ICP, and the North ICP. North Tyneside local authority area is a member of the North ICP which also includes the boroughs of Northumberland, Newcastle Upon Tyne, Gateshead, South Tyneside, and Sunderland.

The North ICP brought their suicide prevention plans together to identify commonalities and gaps. Identified gaps included:

- formal training;
- bereavement support;

- self-harm work; and
- grass-roots projects.

The identified gaps are being addressed through projects being delivered across the ICP through NHS England funding. The work being undertaken includes, but is not limited to, training delivered through Mind, grass-roots projects such as the Newcastle United Foundation and Sunderland's Foundation of Light 'be a game-changer' campaign to get men talking about suicide, and a local schools programme.

A North ICP suicide prevention co-ordinator post has been successfully filled which is hosted by Northumbria Police as they cover the six local authority areas of the North ICP. The suicide prevention coordinator brings together all six local authorities, crisis teams, and charities, with the aim of providing help to those most in need (Northumbria Police, 2019). The coordinator also offers and arranges postvention support to those affected by suicide.

RTSS has also been established in the North ICP which is controlled by the suicide coordinator. In addition, a data analyst post has been filled. A weekly summary of suspected suicide data is generated from the RTSS and provided to each of the six local authorities. Due to the success of this, the dashboard used has also been adopted by the ICS and the next aim is to include near-miss data in order to undertake evidence-based suicide prevention work.

10 Conclusion

Despite the recent increase in suicide rates at a national level, suicide rates have remained the same in the equivalent years in North Tyneside. It is reassuring that the rate is not currently increasing locally, but it is still of huge importance that work is undertaken to reduce this rate as low as possible; of course, ideally to zero.

Patterns in suicides in North Tyneside are similar to national patterns with the highest risk group being middle-aged men, and the most common methods of suicide being hanging, strangulation, suspension, and suffocation, and poisoning.

Other findings that have been identified when looking at those who have died by suicide in North Tyneside are being single, divorced, separated, or widowed, living alone, being unemployed, experiencing relationship or family problems, bereavement, and consuming alcohol. Again, these findings are also found at a national level.

The COVID-19 pandemic may have exacerbated existing risk factors for suicide and generated new risk factors. The full impact of the pandemic is likely to be seen over the coming year/years as national level data become available and recovery work is undertaken. It is essential that those working to prevent suicide stay alert and responsive to changes that may occur in suicide risk and suicide rates in the borough while the full picture is understood.

National policy emphasises the complex nature of suicide prevention and therefore the importance of a multiagency approach and effective partnerships across all sectors (DH, 2012). There is a large volume of multi-agency suicide prevention work being

done both regionally and locally and there is momentum behind this workstream in the North East region and the North ICP with recent investments in regional RTSS, the generation of cross-sector suicide prevention roles, prioritisation of mental health and suicide prevention by the ICS, and funding for interventions such as training of front-line staff.

11 Recommendations

The recommendations as a result of the findings of the needs assessment are:

1. When delivering suicide prevention in North Tyneside local action should continue to address national strategy and guidelines whilst tailoring this to the needs of the local population, as identified by this needs assessment

2. The North Tyneside suicide prevention plan should be updated using learning from this needs assessment and the well-established and successful multi-agency approach to suicide prevention in the borough should continue

3. This needs assessment should be used to prepare and present a report on suicide in North Tyneside for scrutiny by the Adult Social Care Health and Wellbeing Sub-Committee

4. The impact of the COVID-19 pandemic on health inequalities in the borough should be considered when planning suicide prevention activities, and the borough must continue to be vigilant and responsive to changes or emerging patterns in suicide as a consequence of the pandemic

5. North Tyneside Council should continue to work closely with the established regional and sub-regional suicide prevention groups in the North East and North Cumbria where sharing of good practice, learning, and resources has the ability to benefit both local and regional suicide prevention work

11.1 Next steps for North Tyneside

The recommendations and learning from this need assessment have been used to update the North Tyneside suicide prevention action plan for 2021-22 and to prepare and present a report on suicide in North Tyneside for scrutiny by the Adult Social Care Health and Wellbeing Sub-Committee.

The findings and action plan will be further disseminated to all partners across the system in North Tyneside for discussion and further action.

The North Tyneside Public Health team will continue to monitor suicide in their local area using RTSS, ONS, and PHE data and work within the regional system on suicide prevention work. As the borough starts to recover from the COVID-19 pandemic it is important that the impact of the pandemic on suicide is considered and opportunities for suicide prevention work are incorporated into this recovery process.

12 Acknowledgements

I would like to thank Rachel Nicholson (Senior Public Health Manager at North Tyneside Council) for her support as supervisor for this piece of work.

I would also like to thank Michelle Stamp at (Consultant in Public Health at Newcastle City Council and chair of the North ICP suicide prevention group) and Julie Daneshyar (PHE Health and Wellbeing Programme Manager North East) for their help in understanding the suicide prevention systems that exist and the work being undertaken in the North East region and by the North ICP.

Thank you to the members of the North East Public Mental Health Network and the Northern Sub-Regional Suicide Prevention Group for allowing me to attend their meetings.

Thank you to Mary Hall (Public Health Portfolio Lead, Adults and Partnerships at Darlington Borough Council) and Diane Foster (Suicide Prevention Coordinator at Durham County Council) for sharing their suicide prevention plans to facilitate the update of the North Tyneside suicide prevention plan.

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Finally, I would like to thank Paul Murphy (Public Health Information Specialist at North Tyneside Council) and Wendy Burke (Director of Public Health at North Tyneside Council) as authors of the previous suicide health needs assessment in 2015, which this document is an update of.

13 Appendices

13.1 Appendix One: Data limitations

Due to the complexity of suicide data, it is important to be aware of their limitations. Section 6 on the definition of suicide explains the limitations in suicide data as a result of changes to the definition and difficulties in classifying deaths in children.

13.1.1 ONS data limitations

Limitations stated by the ONS include:

1. Death registration delays
    a. When a person dies unexpectedly in England, Wales, and Northern Ireland, a coroner's inquest is held to determine the cause of death. A coroner's inquest can take months to years which causes a registration delay, with a median delay of 6 months between a suicide death occurrence and its subsequent registration (ONS and fifth progress report). This means many deaths appear in the statistics of a year later than they occurred.
2. Age-standardised rates are not calculated for years when there are fewer than 10 deaths in this age group
3. The accuracy of statistics is dependent on the quality of the underlying data. In the context of suicide this is the information supplied when a death is registered, for example a clinician's accurate completion of a death certificate. The accuracy of underlying data can result in under-reporting of suicides which must be considered during interpretation.
4. Non-resident deaths are included in the figures for England and Wales combined but are excluded for England and Wales when these countries are presented separately (ONS, 2019).

13.1.2 PHE Public Health Profiles data limitations

PHE Public Health Profiles data are sourced from the ONS meaning the above limitations apply.

Additional data limitations for suicide rate data stated in the Public Health Profiles include:

1. From 2014 the ONS changed the software used to code cause of death.
2. From January 2014 the ONS introduced a new version of ICD-10 (version 2013).

To ensure consistency, a revision of data was undertaken (PHE, 2020).

Limitations of males over 65 crude suicide rates:

1. Due to the relatively small numbers of suicides in this age group, the numbers reported will be subject to random variation. Comparisons across years and between areas should therefore be undertaken with care (PHE, 2018).
2. Suicide deaths over five years have been pooled and averaged to reduce the impact of random variation, however rates based on numbers of deaths fewer than 10 may be too unstable to interpret accurately (PHE, 2018).

3. Based on revised underlying population estimates, comparison of rates from 2011-15 will not be directly comparable to previous time periods.
4. Crude rates are not adjusted for the age of the underlying population. This means they are influenced by the underlying age distribution of the population and therefore any differences seen may be due to differences in the age of the underlying population, rather than true differences in their rates of suicide in males over 65 years of age.

Limitations of self-harm emergency hospital admissions data include:

1. Self-harm admissions data use Hospital Episode Statistics (HES) and are therefore reliant on coding and admission thresholds. Errors may occur during coding and variation may exist between trusts and areas in how self-harm episodes are coded.
2. It must be noted that that variation exists between geographical areas in the context of emergency hospital admissions for self-harm. Variations include:
    a. how many people who self-harm seek medical attention; and
    b. the threshold/policy for admitting people who self-harm in secondary care settings.
3. Hospital admissions only represent a very small proportion of the episodes of self-harm and only the tip of the iceberg of the impact of self-harm and do not fully represent the prevalence of self-harm (PHE, 2021).

13.2 Appendix Two: Case file summaries

Please read the following case file summaries with care as they contain upsetting information.

These cases have been anonymised but please continue to treat these cases with confidentiality.

13.2.1 Case file summary 1

Summary
• Female in late 40s, working full time, separated from her husband, and lived alone. • The Police were called to the deceased's address by a neighbour who was concerned. • After receiving no answer at the front door, the Police entered the address and found the deceased hanging by the neck. • This lady had suffered depression since the death of her child. • Heavy drinker intoxicated with alcohol at the time of death. • Child died in the same circumstances. • A note was found at the address. • No known involvement of any services.
Key issues
• Bereavement • Depression • Involvement of alcohol • History of suicide in family • Living alone

13.2.2 Case file summary 2

Summary
• Male in early 70s • Retired • Widowed • Lived alone • Family visited every day • No alcohol/drug problems • Note referred to feeling very lonely
Key issues
• Bereavement • Loneliness

13.2.3 Case file summary 3

Summary
• Male in late 50s, working full time as a manual worker. • Lived with his long-term partner. • The deceased was found hanging in his own home. • Intoxicated with alcohol at the time of death. • The deceased had anger issues and had threatened to hang himself however never made any previous attempts nor self-harmed. • The deceased regularly drank alcohol. • A note was found at the address. • No known involvement of any services
Key issues
• Threat of suicide was made previously • Alcohol involved

13.2.4 Case file summary 4

Summary
• Male in mid 20s, unemployed and lived alone. • The deceased was found in his own home having suffocated himself. • There was no note found at the address. • In contact with Mental Health Services (Crisis Team) at time of death and section several times and discharged within a month of death. • The deceased had an extensive history of suffering from mental health issues, namely depression from an early age and was still suffering up to death. • The year before his death, the deceased's close relative died, and the deceased took this badly. • Previous suicide attempts in the year before death.
Key issues
• Extensive contact with Mental Health Services • Depression • Bereaved • Lived Alone • Early drug use • Alcohol involved • Relationship difficulties • Previous suicide attempts

14 References

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