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SUICIDE ON THE ISLE OF WIGHT

AUDIT REPORT 2013-2014

1 Document Information

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3 Introduction

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

Not all suicides are inevitable. Around a quarter of all deaths are people in contact with specialist mental health services (The University of Manchester, 2016), a much higher proportion may have had contact with their GP or other health service. Suicide can be the end point of a complex history of risk factors and distressing events; and action to prevent suicide has to address this.

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

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

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

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

This report provides information on suicide rates and trends for the Isle of Wight in comparison with the national picture. These are, by their nature, retrospective by at least two years. In this report we have used three sources of data the Public Health Outcome Framework (PHOF), the Health and Social Care Information Centre (HSCIC) and coroners' records from inquest proceedings. The inquest proceedings provide wealth of information about the who, how and where of suicides and tell us more about the motivations and causes of suicide.

3.1 Understanding suicide statistics

Definition

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

Research indicates that over three-quarters of deaths given open verdicts by coroners are likely to be suicides. Therefore, in an attempt to provide a more accurate in depth understanding of suicide on the Isle of Wight, the data reported in this analysis comes from a variety of sources, Office for National Statistics (ONS), Public Health England Suicide Prevention Profile and the HSCIC. A significant number of deaths receive a verdict of death by misadventure, accidental death or, increasingly, narrative verdicts, and so will not appear in official suicide statistics. There is growing evidence that differences between coroners in their use of narrative verdicts across the country is making comparison of suicide statistics between areas less reliable.

Timeliness

The coroner's verdict may be given some time after the time of death. For this reason, the analysis of suicide trends is always retrospective by a period of two years.

Reliability

Due to the relatively low number of deaths by suicide within our local area, numbers can fluctuate. For this reason it is considered good practice to undertake analysis of trends in three year periods. It is important to note that for the purpose of this audit and to ease access and impact on the coroner's officers we have only considered those cases who have a verdict of suicide. We have not considered cases of open or narrative verdict. It is important to look at the time period when comparing data, as an analysis of a different year grouping will produce slightly different rates. However, for this audit and its use with shaping future service provision for mental health through the Vanguard New Models of Care for the Isle of Wight a period of only two years has been covered.

3.2 Understanding published suicide rates

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

3.3 Suicide and undetermined death rates for the Isle of Wight

The suicide and undetermined death rate for the Isle of Wight currently reported by the Public Health Outcomes Framework is 11.9 per 100,000 for the three year period 2012-2014. The England average for the same period is 8.9 per 100,000 and for the South East 9 per 100,000. Although the rate for the Isle of Wight is higher this is not significant. However the rate for males on the Isle of Wight is 20.2 which is significantly higher than the England average of 14.1 per 100,000. A rate for female suicide on the Isle of Wight cannot be calculated because the number of cases is too small; the England average however is 4 per 100,000.

It must be highlighted that three year rolling averages are generally used for monitoring purposes, in preference to single year rates, in order to produce a smoothed trend from the data and to avoid drawing undue attention to year on year fluctuations instead of the underlying trend.

4 Isle of Wight Suicide Profile

The information for this report has been gathered using coroner's reports and reading inquest data from the Coroner's Office. As stated earlier the availability of data searches and the changes in the reporting of coroner's verdicts has limited the information available for this report. Therefore, the decision was made to only explore verdicts of suicide.

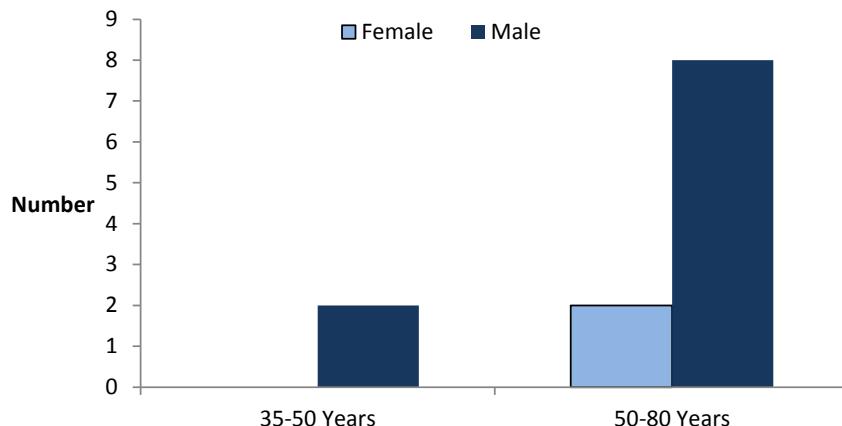
The following charts have been generated from the suicide audits carried out in 2013 and 2014; they aim to provide a risk profile of people who have taken their own life on the Isle of Wight.

4.1 Gender and age

Figure 1 shows age and gender breakdown, male gender is a known risk factor with more males than females taking their own life on the Isle of Wight; this pattern is the same for rest of the UK. The audits show that for the Isle of Wight the majority of suicides have occurred in males aged fifty and over.

Figure1:

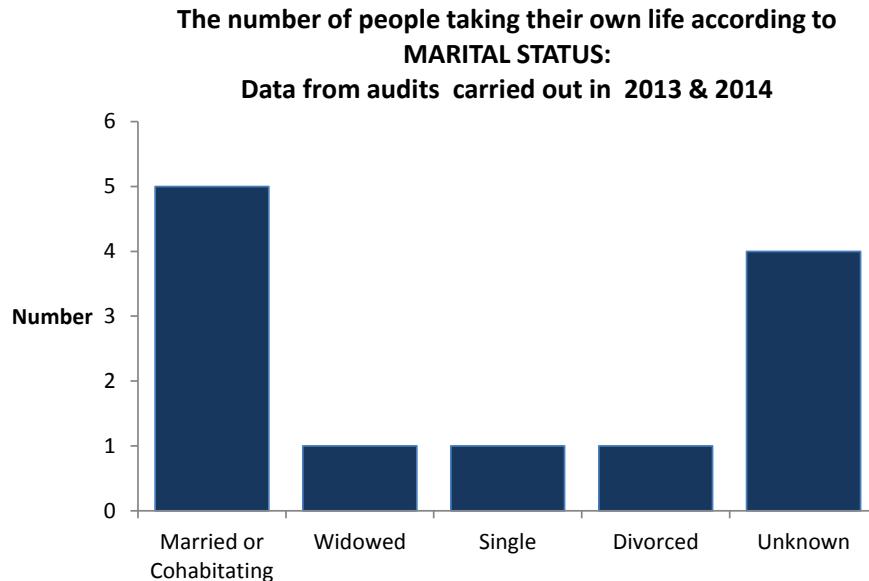
**The number of people taking their own life according to
AGE GROUP & GENDER:
Data from audits carried out in 2013 & 2014**



4.2 Marital status

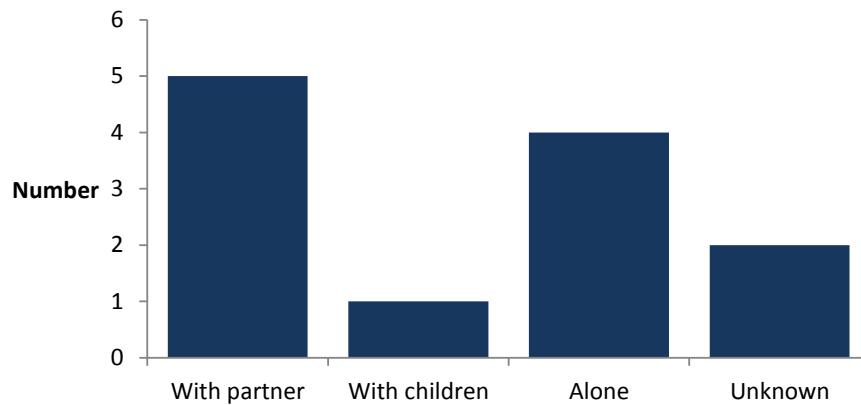
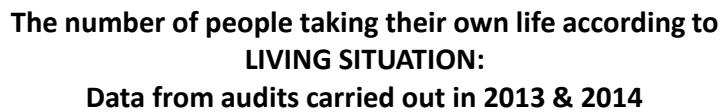
Marital status is associated with an increased risk of suicide for those who are single, divorced or widowed; however this relationship could be because those with poor mental health are less likely to marry and if married to divorce, or it could be economic, that being married gives access to a greater net income (ONS, 2008).

Figure 2 shows the marital status of those that took their own life on the Isle of Wight, however in four of the cases the marital status was not known making it difficult to analyse the effect of marital status on suicide locally.

Figure 2:

4.3 Living situation

Living alone is another known risk factor in suicide, figure 3 shows that one third of those that took their own life lived alone, this figure could be higher but in two cases the persons living situation was not known. It should be noted that half either lived with their partners or with children.

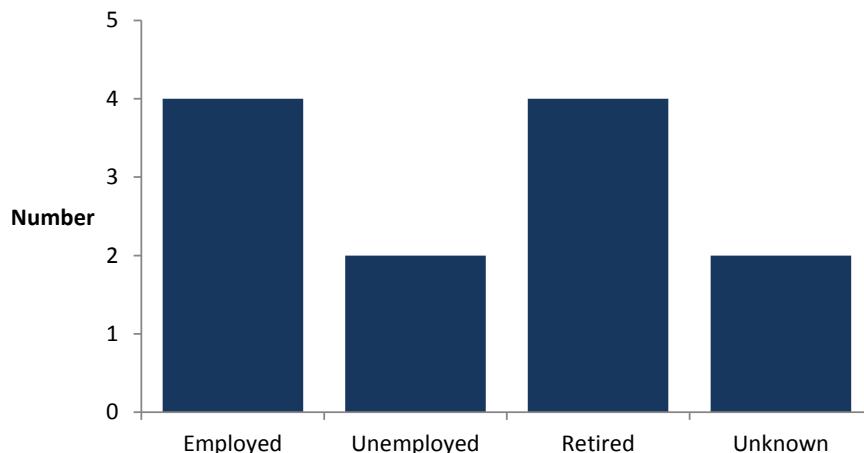
Figure 3:

4.4 Employment status

Evidence shows that employment status can be a factor in suicide; figure 4 shows four people were in employment against eight who were unemployed, retired or the status unknown.

Figure 4:

**The number of people taking their own life according to
EMPLOYMENT STATUS:
Data from audits carried out in 2013 & 2014**

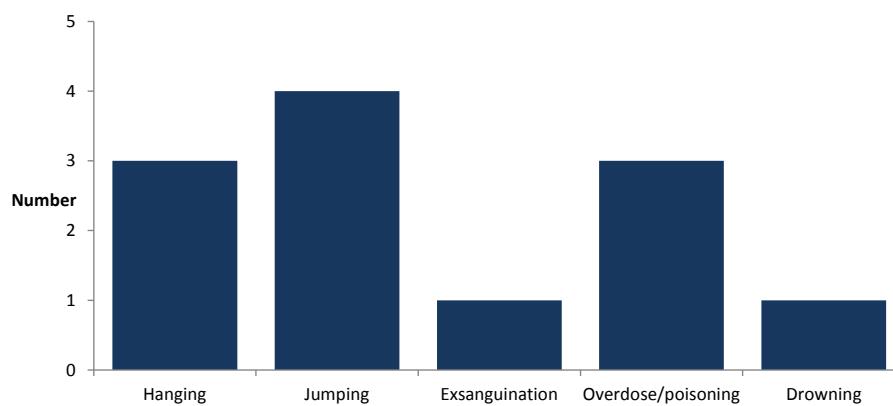


4.5 Method of suicide

The latest ONS suicide report (February 2016) shows that the two most common methods of suicide among men are hanging followed by poisoning; this is the same for women (ONS, 2016). Figure 5 shows the methods used by those taking their own life on the Isle of Wight; the local picture is slightly different from the national in that jumping features as the most recorded method, whereas nationally this method is much less common and is well below hanging and poisoning. It is possible that the geography of the Isle of Wight is a factor which makes this method more accessible.

Figure 5:

**The number of people taking their own life according to
METHOD:
Data from audits carried out in 2013 & 2014**

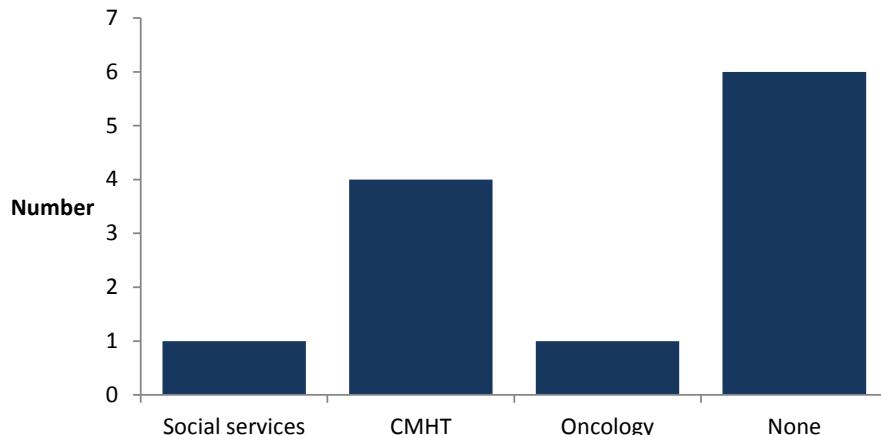


4.6 Contact with services

Figure 6 shows that half of those who took their own life on the Isle of Wight were in contact with a service and one third were in contact with a specialist mental health service. As mentioned before, nationally around a quarter were in contact with a specialist health service.

Figure 6:

The number of people taking their own life who were in contact with services:
Data from audits carried out in 2013 & 2014



CMHT refers to the Community Mental Health Team

Data from the audit also shows that eight of the twelve people that took their own life had a diagnosis of mental illness and one person had a history of substance abuse. Some of the reasons recorded for people taking their own life were work stress, bereavement, terminal illness and debt; there were a number of cases where the reason was not recorded.

5 Suicide attempts

Further discussion within the suicide prevention group highlighted the availability of information and data collected from ambulance paramedic staff on possible attempted suicide call outs. This data has been separated into 18 and over and under 18 data. For the purpose of this audit the data for those aged over 18 has been reviewed. Multiple call outs for the same person have been removed from the data.

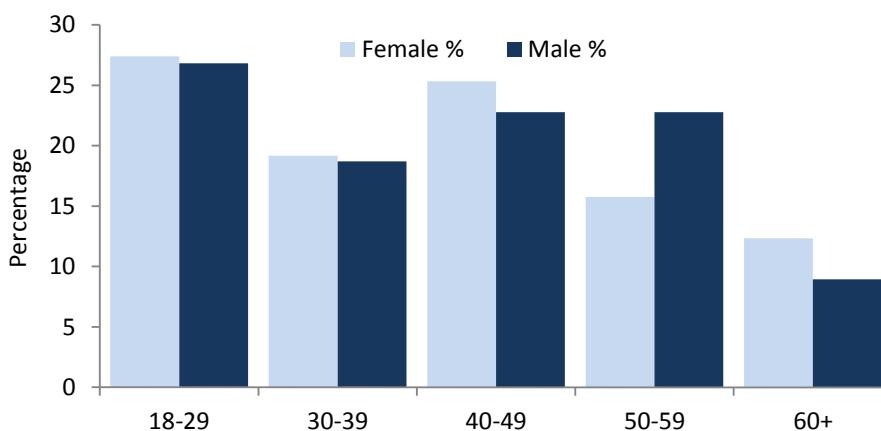
This data can be used to begin to develop prevention work and to assist in the planning and regulation of future development of the night time economy. The following charts highlight the key findings from this data.

5.1 Gender and age

Figure 7 shows that those attempting to take their own life are highest in the 18-29 and 40-49 age groups for both male and female, but male self-harm exceeds female in the 50-59 age group.

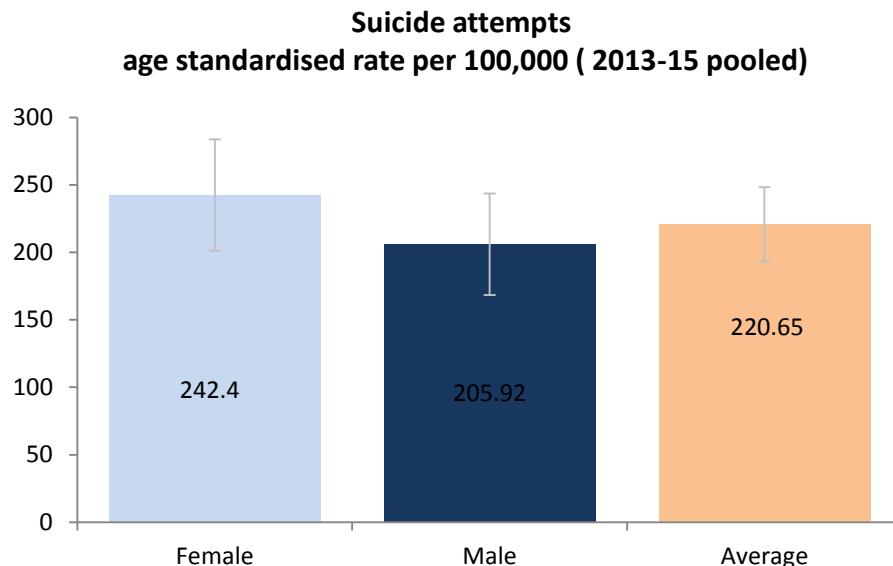
Figure 7:

Suicide attempts by gender and age group
2013-2015 (pooled)



Source: Local audit

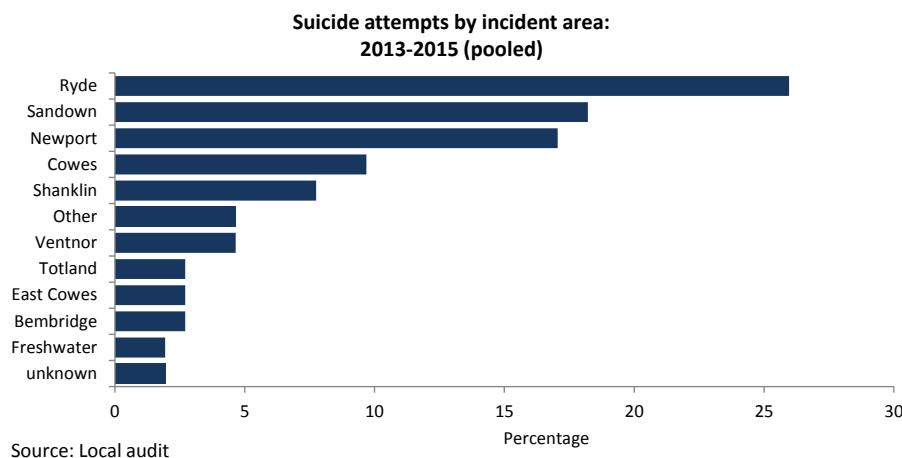
Overall 146 women and 123 men attempted taking their own life for the pooled period 2013-2015. Figure 8 shows the age standardised rate for suicide attempts, age-standardisation adjusts rates to take into account how many old or young people are in the population being looked at. When rates are age-standardised, this enables the differences in the rates to be monitored over time or compared between geographical areas and does not simply reflect variations in the age structure of the populations. The chart also shows there is no statistical significance between the males and females attempting suicide.

Figure 8:

Source: Local audit

5.2 Incident area

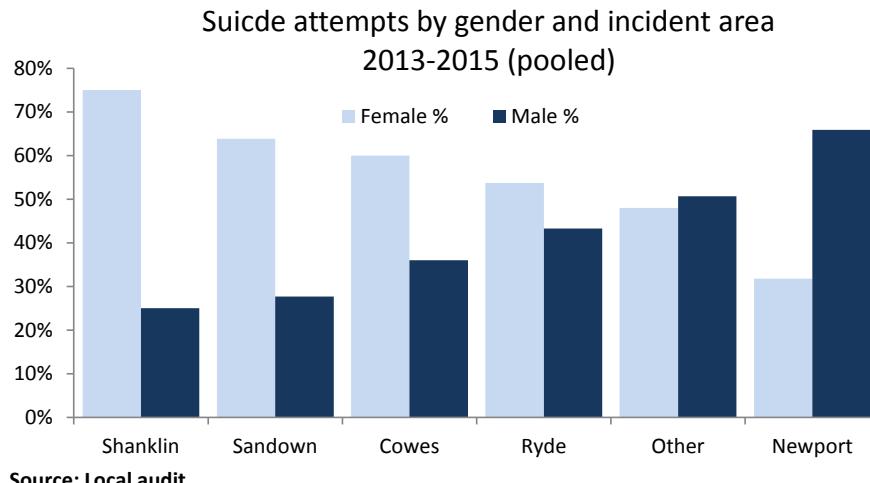
Over a quarter (26%) of all attempted suicides with ambulance attendance are in Ryde, with just under 20% in both Sandown (18.2%) and Newport (17.1%). This is likely to reflect both the population size and also the size of the night-time economy in these areas.

Figure 9:

Source: Local audit

Overall there were 54% female and 46% male attempted suicides, and the pattern of more women than men was repeated across most areas, with the exception of Newport with 66% male and 32% female, see figure 10.

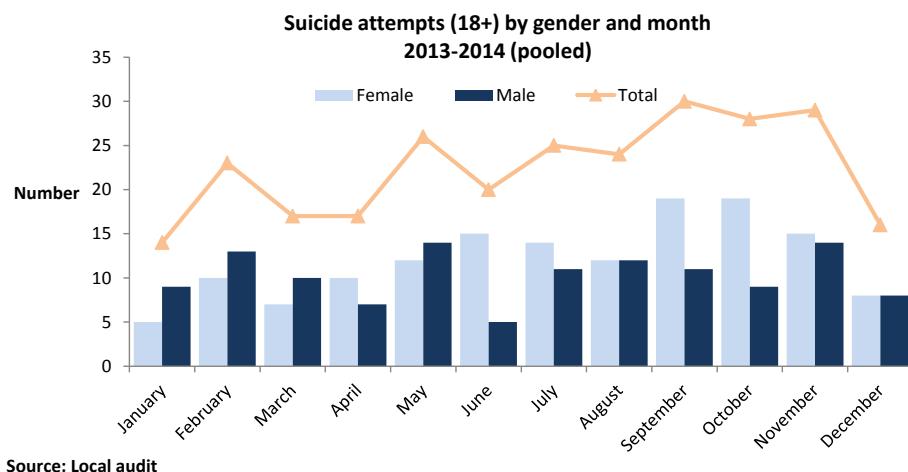
Figure 10:



5.3 Time of the year

Analysing the attempted suicides by months (figure 11) shows the highest numbers are from September to November, dropping sharply in December and January with peaks in February and May. There is no clear association between men attempting to take their own life and the month, however women seem more likely to attempt to take their life in June, July, September and October. There is some coincidence with the Isle of Wight festival and the Bestival.

Figure 11:



6 Next steps for suicide prevention on the Isle of Wight

The practice of “suicide audit” refers to the systematic collection of local data on suicides in order to learn lessons and inform suicide prevention plans. The Isle of Wight Public Health team have invested a huge amount of time and effort in conducting this local audit of death by suicide and have worked hard to overcome procedural obstacles. It is the aim of this audit to make sure that these findings are translated effectively into action. Appendix A shows a proposed method of both the audit process and how best to review and implement the findings and can be used as a framework to support the ongoing suicide prevention action plan.

Focussing on the six identified key priority areas from the Preventing Suicide in England document the following local actions have been highlighted from this audit:-

- **Reduce risk of suicide in high risk groups**

The audit indicates that males aged 50 or over with a diagnosis of a long term condition or a terminal illness, which live alone are considered to be a high risk vulnerable group. This should be considered within all areas where diagnosis is delivered and high level intervention of support should be offered to this group.

- **Tailor approaches to mental health support in specific groups**

Offer additional support to residents who have a long term condition or terminal illness. Offer increased mental health support to those identified with financial difficulties. Increase follow up from those patients who are conveyed to hospital with a possible suicide attempt.

- **Reduce access to the means of suicide**

Measures are in place to limit the amount of over the counter medications that can be purchased. Increased support for community pharmacy staff for help in supporting patients and their families with a long term condition and terminal illness.

Availability of Samaritans Help Line and Freephone number and key locations

Regular police presence at identified hot spots

- **Provide information and support to individuals bereaved by suicide**

Increase availability and knowledge of appropriate bereavement support so that wider support groups can refer or offer support to those affected.

- **Support the media to report appropriately on incidents of suicide**

Continue to develop the good working relationship with local media agencies. Provide up to date briefings on data and findings from audit and other sources.

- **Implement research, data collection and monitoring**

A revised audit process and the interdependencies highlighted within both the prevention group and wider stakeholder groups, such as paramedics callout information, has clearly shown that there is a need for wider collaboration to prevent suicide. An outcome of this audit is to continue to develop these relationships and use the information and intelligence gathered to support and shape the prevention strategy and enable guidance to other agencies such as the night time economy. This

process will be developed using the guidance suggested from Owen, Roberts and Taylor (2014) and can be found in Appendix A.

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

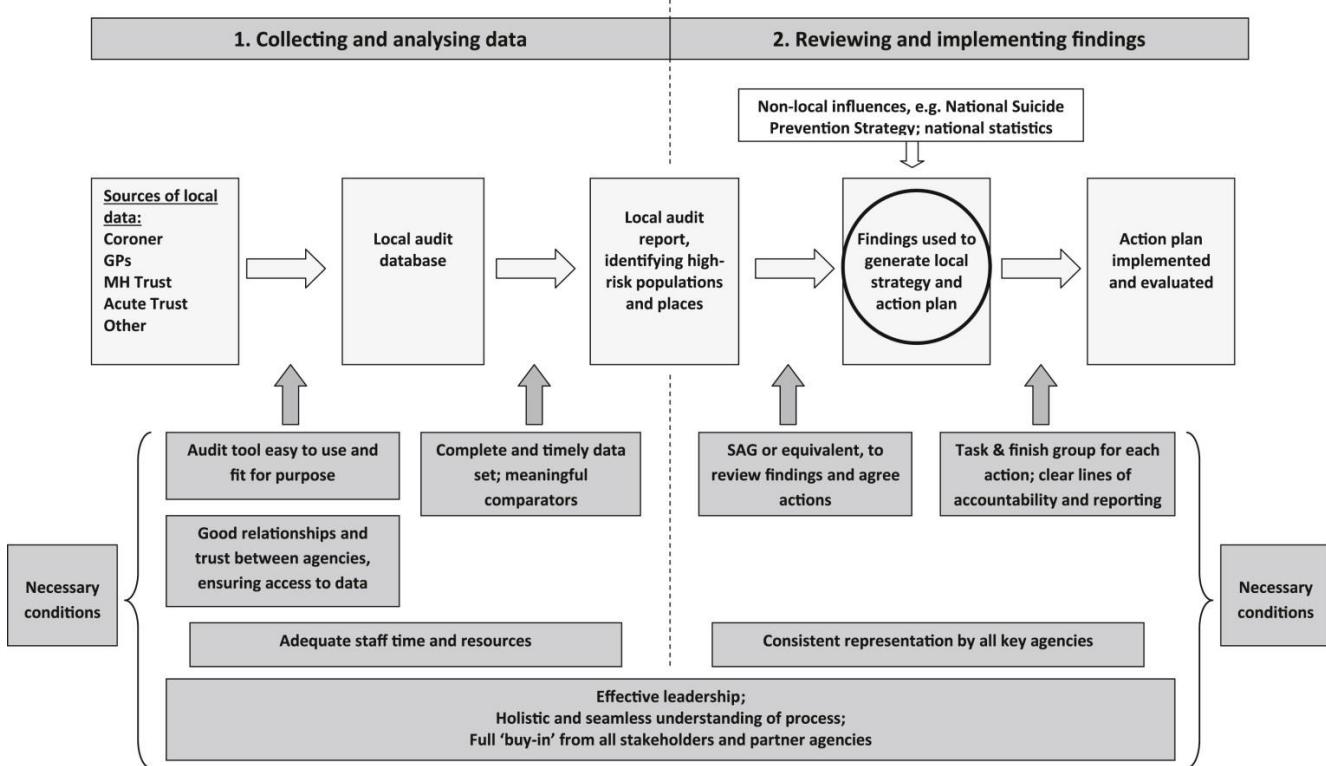
Progress on the Isle of Wight Suicide Prevention Strategy and Action Plan is currently reported directly to the Suicide Prevention Group. We will include a summary report on this work in next year's audit report.

If you would like more information about the Isle of Wight Suicide Prevention Group, The Isle of Wight Suicide Prevention Strategy or any elements of this audit report please contact:

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7 Appendix A

7.1 Proposed suicide audit process



(Owens, Roberts, & Taylor, 2014)

8 References

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