A framework of the suicide audit 2019-2021 findings and recommendations for Bradford, Calderdale and Kirklees: these are reported against the national strategy recommendations, which includes additional local findings.

Please note that this version of recommendations has been created at the end of the 2019-2021 reporting and analysis suicide audit cycle, which dates to April 2024. It is intended to be shared and used as a working document at local level, therefore this document may evolve and develop over time. If you would like to enquire about the most recent version, please contact the suicide audit representative from the relevant local authority:

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Framework

National strategy	Sub domain	Key recommendation areas	Bradford, Calderdale and Kirklees Local finding 2019-2021	Recommendation – so what does this mean for our practice? Call to action- (add to this when tested with local suicide prevention groups). Overall recommendations.	What my team do, or what are my team doing that would support this recommendation?
Overarching	National		While overall the current suicide rate is not significantly higher than in 2012 (when the last national suicide prevention strategy was produced), the rate is not falling.	National aims: (2023) • Reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner. • Continue to improve support for people who self-harm • Continue to improve support for people bereaved of suicide • The WY HCP aims to achieve a minimum 10% reduction in the suicide rate across West Yorkshire over the next five years. (22-27)	
	Bradford, Calderdale, Kirklees		• Since 2014, ONS data shows suicide rates in Kirklees have remained higher than the England average but lower than the Yorkshire and Humber average rate. However, in recent years rates for Kirklees appear to show a longer-term gradual increase, having recently reached 11.9 per 100,000 in 2020-2022.	Bradford, Calderdale and Kirklees are working towards the aims set out in the National and West Yorkshire Suicide Prevention strategies to reduce suicide rates over the next 5 years. Each place has its own suicide prevention group and the findings from this audit should be used to refresh and inform the action plans of those groups to prioritise and target effective suicide prevention interventions.	
	Covid		• There was no observed increase in the number of	Due to the unique circumstances people experienced during the pandemic a separate in-depth analysis of this data has been undertaken. The findings have been	

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			deaths by suicide during these years. • Of those who died by suicide during this time period, it does not appear that testing positive for covid, having symptoms of covid or suffering from long covid were significant contributors to suicide. • However, 28.8% of deaths of those who died by suicide between 2020 and 2021 had reported covid as a wider contributary factor to death.	included in a distinct section of the summary report for this audit	
Tailored, targeted support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.	National strategy high risk groups	Children and young people	• The rate of suicide for those under 26-year-olds is 5.1, which is significantly lower than the overall rate for all ages. In total there were 37 people under the age of 26 years old who died by suicide. Fewer than 5 of these people were under 18 years old. • The mean age of those who died by suicide (46.2) has gone up since the last audit (44.5). The age range was between 14 and 94 years old. • 22% of those who died by suicide had suffered Adverse Childhood Experiences (this is likely to be under-recorded). There was some indication this was higher in young	• Ensure services providing support children and young people experiencing mental health problems or distress are easily accessible. • Improve understanding and challenge stigma around suicide and self-harm in settings where children and young people spend their time. • Where possible, support work under the national suicide prevention action plan: Review relationships, sex and health education (RSHE) guidance to consider the inclusion of suicide and self-harm prevention as an explicit part of the curriculum • Where possible, support the work of the higher education mental health implementation taskforce which aims to improve mental health support and suicide	

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			people than adults who died by suicide, but this may be due to reporting rather than individual circumstances.	prevention in higher education as set out in the national strategy. • Ensure data and evidence from child death overview panels and the National Child Mortality Database are harnessed to support learning and future interventions.	
		Middle-aged men	• Nearly 4/5 of those who died by suicide were male, which is similar to trends in previous years. • The suicide rate for 46–55-year-old males is significantly higher than the suicide rate for males of all ages across the total audit population, however there were some variances noted across each local authority. • There were higher proportions of males (compared to females) who died by suicide whose files recorded they had previous contact with the criminal justice system or were a perpetrator of abuse.	• Continued focus on men; men aged 46-55 years in-particular. • Consider further analysis of this age group. • See recommendation below in relation to the Criminal Justice System (CJS).	
		people who have self-harmed	• Of those who died by suicide 46.1% had a history of suicidal ideation; 45.8% had a history of suicide attempts; 21.3% had a history of self-harm. • Females (35.4% of audit population) are more likely to have a history of self-harm	• Ensure that people who self-harm and/or have made a previous attempt of suicide have access to supportive services who are well equipped to provide skilled care and safety planning. • Challenge stigma around mental health problems, self-harming and suicidal ideation and ensure access to support services is available to those who need it.	

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			than males (17.7% of audit population). • Those under 36 years were more likely to have a history of previous self-harm. • Those aged 65 years and over were less likely to have a history of previous suicidal intent or suicide attempts.		
		People in contact with mental health services.	• Having a mental health condition was the biggest risk factor for suicide. 64.6% of the audit population had a diagnosed mental health condition. This is higher in females than in males. A further 10.5% had a suspected undiagnosed mental health condition. • 51.6% of people who died by suicide had a record of a referral to Specialist Mental Health (SMH) services at some point in their lifetime; 19.5% within the 3 months preceding death and 25.9% were within the month preceding death. • Of those with a SMH referral record, 32% were actively under care at the time of death. • Approximately 1/5th (17.8%) of people who died by suicide were referred to talking therapies. People who were	• The findings of this audit should be shared with mental health professionals. • Encourage suicide prevention training for staff in mental health services and other services that might support people in a mental health crisis. • Mental health services should be keenly represented at the Kirklees suicide prevention action group to support and identify localised prevention opportunities and systemwide working. • Professionals referring people into mental health services should be encouraged to consider making the referral themselves, rather than signposting and encouraging self-referral routes.	

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			referred, as opposed to sign-posted, were much more likely to make contact with services.		
		People in contact with the criminal justice system (CJS)	• Of those who died by suicide, 25.8% had previous contact with the criminal justice system across their lifetime. • 14.3% of people had police contact as a form of help within 3 months before death.	• Work with the Police Mental Health Engagement officer and other services who work with people accessing the criminal justice system to promote staff training, awareness and effective leaning following serious incidents.	
		Autistic people	• Of those who died by suicide 4.7% of people from the total audit population were diagnosed as being neurodiverse (this includes autism and ADHD). Another 2.9% of people had spoken to someone about being neurodiverse (professional or family member) before their death but hadn't received a formal diagnosis (includes Autism and ADHD). • *We know that the UK estimated prevalence (all age) of Autism is between 1 and 1.7% and the global estimated prevalence of ADHD for adults is between 3 and 4% and 5% in children (NICE guidance on autism & ADHD as applied to the census 2021 populations). This makes*	• Improve awareness and promote suicide prevention training to people working with those neuro-diverse. • Draw learning from the Learning from Lives and Deaths - people with a learning disability and autistic people (LeDeR) programme to identify areas for improvement to prevent suicides. • Work in partnership with other organisations to share data and learning to improve our understanding of risk and signs of distress and identify opportunities to prevent future deaths via the suicide prevention groups and local autism partnership board.	

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			drawing any real conclusions difficult. There is however a growing research to suggest there is a higher risk of suicide in neurodiverse people. (PAPYRUS, National Autistic Society, Journal of the American Medical Association).		
		Pregnant women and new mothers	There are no specific findings to report from this audit for pregnant women or women who had been pregnant within 2 years of their death. Numbers for women that had been identified as dying by suicide within two years of a pregnancy were fewer than 5 (figure supressed). However, we do know from national data that this can be a period of increased risk of suicide for females.	• More in-depth review of the data to obtain further insight into the risk factors for women and suicide Actions to prevent female suicide should be determined locally through the Suicide prevention groups. • Raise awareness of the risks of suicide and support services available, particularly amongst professional groups who work with women.	
	High risk groups identified locally.	Those who identify as gay and lesbian	• Where sexual orientation was recorded the suicide rate for gay and lesbian people was significantly higher than the rate for all people who died by suicide.	• Ensure targeted work is reaching this group. • Consider further analysis of this data for this group of people.	
		Those living in our most deprived communities	• There was no clear pattern in terms of deprivation and the IMD quintile in which those who died by suicide lived.	• Prevention interventions that are geographical in nature should be determined locally and be further informed by the suspected suicide data and cluster monitoring and response policies.	

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		Those economically inactive/ currently unable to work and occupation.	• Just over half of people who died by suicide were economically inactive, which is significantly higher than the proportion of the BCK population who were economically inactive. • The rate of those who worked in skilled trade occupations who died by suicide was significantly higher than the rate for all occupations at 36.7 people compared to 13.7 people (per 100,000).	• Consider the use of public campaigns to raise awareness, reduce stigma and encourage help seeking behaviour amongst those who are economically inactive or have an occupation associated with a higher risk of suicide. • Ensure prevention interventions including awareness and training is reaching: - those who work with people who are economically inactive - those who are economically active and at higher risk of suicide, especially in skilled trade work.	
		Women	20.7% of the audit population were female. • Females who died by suicide in this audit population were more likely to have been in contact with professional services prior to their death than males in this audit population.	• To share findings of this report especially to people working in services with females.	
Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.	National strategy common risk factors	Physical illness	• Having a physical health problem could be a risk factor for suicide. Of those who died by suicide 57% had at least 1 physical health condition; 19% had 3+ physical illnesses diagnosed. (We do not have comparator data).	• In the next audit categorise this data to understand the impact this risk factor has to more helpfully inform prevention. • Work with Primary Care services to share current findings and seek input for more effective data collection in the future.	
		financial difficulty and economic adversity	• 15.3% of those who died by suicide had issues with debt: 14% in the year prior to death	• Work with services who offer or signpost people to debt advice and financial support and services who work with people who	

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				may be experiencing financial difficulties such as housing support services and council customer contact centres to promote staff training, including awareness of suicide risk and support services available.	
		harmful gambling	• Data was collected on whether those who died by suicide had a history of gambling - small numbers were recorded. • National data tells us that people who have a history of gambling are at increased risk of suicide.	• Work with services who offer or signpost people to gambling support services to promote staff training, including awareness of suicide risk and support services available.	
		substance misuse	• Of those who died by suicide 48.6% had recorded problematic use of either drugs, alcohol or both at some point in their lifetime. • Males were more likely than females to have history of drug use. Alcohol misuse figures were similar when broken down by gender. • Of those with a history of substance use, 33.6% had been referred or signposted to addiction services.	• Improve referral rates to substance misuse services of those who report substance misuse as problematic. • Work with services who offer or signpost people to drug and alcohol services to promote staff training, including awareness of suicide risk and support services available.	
		domestic abuse	• Of those who died by suicide 14% recorded they were a victim of abuse, either confirmed, alleged or a survivor.	• Work with services who provide support for victims of and perpetrators of domestic abuse services to promote staff training, including awareness of suicide risk and support services available.	

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			• 9% of audit population recorded they were a perpetrator of abuse, either confirmed or alleged.		
		social isolation and loneliness	• 43.6% of people who died by suicide were single; 23.2% were separated or divorces; 42.7% of people lived alone. • 23.2% were recorded as suffering from isolation and loneliness. • Comparing this with the previous audit; -For Calderdale and Kirklees, the proportion of those who are single has increased -For those who died by suicide across all three authorities, the proportion of those who are single has increased from 39.9% (2016-2018) to 43.6%.	• Work with social prescriber link workers and community-based services who to promote staff training, including awareness of suicide risk and support services available.	
	Risk factors identified locally.	A bereavement	• Out of all ALEs of those who died by suicide, bereavement is one of the common factors with 42.4% having a bereavement recorded. • Don't have comparator for general population.	• Ensure a specialist bereavement support offer is in place locally in line with the national strategy and use suspected suicide data to effectively coordinate access to this offer. • Encourage data sharing and learning where possible from services to inform more targeted suicide prevention interventions and coordination of bereavement support.	

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		Those with an adverse childhood experience and abuse	• 22% of those who died by suicide had suffered Adverse Childhood Experiences. • There were higher proportions of females who died by suicide whose files recorded they had suffered adverse childhood experiences, bereavement or had been a victim of abuse. • There were higher proportions of males who died by suicide whose files recorded they had previous contact with the criminal justice system or were a perpetrator of abuse	• Inform local suicide prevention groups to create action plans to prioritise people who may be at higher risk of suicide locally and identify opportunities for prevention.	
Providing effective crisis support across sectors for those who reach crisis point.	Local opportunities	Primary care (GP Practice)	Nearly everyone who died by suicide had been in contact with health services and/ or the police. • 91.4% of those who had died by suicide had a record of a primary care contact. • Of those visiting Primary Care, 7% had disclosed self-harm or were suicidal, at the appointment. • 57.4% had accessed their GP practice within 3 months of death. • 37.3% of those who died by suicide had accessed their GP practice in the month preceding death.	• The findings of this audit should be shared with Primary care professionals. • Encourage suicide prevention training for staff in Primary care. • Primary care services should be keenly represented at the Kirklees suicide prevention action group to support and identify localised prevention opportunities and systemwide working.	

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			• Depression and anxiety were the most frequently cited reason for someone to contact their GP practice in relation to their mental health.		
		Specialist mental health services (SMH)		• See recommendations above in relation to those in contact with mental health services.	
		A&E	• 29.3% of the audit population had accessed A&E within the 12 months preceding.	• Consider further analysis on reason for presenting in A&E. • The findings of this audit should be shared with staff working in A&E departments. • Encourage suicide prevention training for staff in A&E departments. • Staff working in A&E should be keenly represented at the Kirklees suicide prevention action group to support and identify localised prevention opportunities and systemwide working.	
		Non-professional (friend, family, neighbour)	• Over half of those who died by suicide had a record of non-professional support. This includes a spouse, family or friend.	• In line with strategic aims; make suicide prevention everybody's business • Raise awareness of the risks of suicide and support services available to the public and people working in non-professional services.	

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Reducing access to means and methods of suicide where this is appropriate.	Priorities- National common and emerging methods and high-risk locations.	Reduction in access to high-risk locations and methods	• 71.3% of those who died by suicide, died in a private location, as opposed to a public location.	• Be data driven in the identification of existing or emerging high-risk locations. Take necessary action to mitigate identified risks. • Raise awareness with key professionals of the risks of suicide in relation to commonly used or emerging methods to enable effective risk assessment and management. • Use the suspected suicide data to coordinate the bereavement support offer to those who are affected by suicide, such as witnesses or those first to attend the person who has died by suicide, which includes first responders/ witnesses.	
Providing effective bereavement support to those affected by suicide.	Effective and timely bereavement support		• Suicide is devastating for the people it leaves behind and those who are bereaved by suicide are more likely to become at risk of suicide themselves. • 62% of the audit population had children (NB children does not mean minors); this equates to 195 families across the audit population; 9.6% of those who died by suicide, were living with children under 18 at the time of their death; this equates to 62 children under 18, across the 3 local authorities who lost someone that they lived with.	• Ensure a specialist bereavement support offer is in place locally in line with the national strategy and use suspected suicide data to effectively coordinate access to this offer	

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			• 42.4% of those who died by suicide had suffered bereavement; 8% bereaved by suicide		
Improving data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.	Inquest data and other data recorded by partner agencies		Aim to improve recording of demographics and protected characteristics such as: • Ethnicity • Religion • Sexual orientation • Disability • Carer status • Neuro-diversity	• Encourage safe and effective data sharing from partners across the system so that understanding can be improved in relation to some groups of people and risk factors and effective learning can take place and be shared. • The BCK audit team have liaised with the coroner's office to make a specific request in relation to the recording of the ethnicity.	
	Further analysis		Further analysis queries have been considered, collected and recorded throughout the process. Analysis will be completed dependent on time capacity and priority allocation, and at local authority level where appropriate.		
	Future audits		Learning from this suicide audit was collected throughout the process and will be applied to inform the next audit.		