Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group Governing Body Meeting

Date: Tuesday 3rd April 2018

Time: 1.30pm

Location: Vassall Centre, Gill Avenue, Downend, BS16 2QQ

Agenda item: 7.3

Report title: BNSSG Suicide Prevention Report

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Report Sponsor: Deborah El Sayed, Director of Transformation

1. Purpose

To inform the Governing Body about the current work taking place across BNSSG to prevent suicide in the local population.

To ask the Governing Body to approve the recommendations for future priorities for the CCG in this area of work.

2. Recommendations

The Governing Body is asked to

- To note the extensive work that is taking place currently and planned for the future to prevent suicide in our populations in BNSSG

- To consider where systems leadership belongs for this issue across BNSSG and potentially take on this role as a CCG.

- To note the recent national report into suicide in those with a personality disorder and the increased risks for this group of people. Research has shown that around 70 percent of people with Borderline Personality Disorder will have at least one suicide attempt in their lifetime, and many will make multiple suicide attempts.

- To monitor the AWP suicide strategy as part of the CQPM process

- Implement the bid and evaluate to inform future commissioning

- Build on current good practice into other areas

- Use FYFV and green paper to work towards our shared goals

- Support and develop the Bristol Anti Stigma Alliance (BASA) to become a BNSSG wide response to stigma in mental health

- Support the work of Time to Change through the TTC hub in Bristol

- Take an active role in Thrive West programme with the aim of bringing this together by July 2018

- Continue to develop the primary and secondary care interface in mental health promoting where feasible the role of social prescribing
  .
- GPs/Primary care are represented on the Suicide and prevention Groups (SPAGs)

- Medicines management are represented on the SPAG

- Develop a hot spot map that will be supported by the MH data platform help us understand the impacts of any interventions we have implemented around the physical hot spots across the three counties. We will develop this in partnership with providers and Local Authorities.

- Work towards a whole system pooled data resource that will help us to understand the impact of initiatives during May and June 2018

3. Background

Every day in England around 13 people take their own lives. The effects can reach into every community and have a devastating impact on families, friends,

colleagues and others. Each one of these deaths is a tragedy. PHE recommend that every local area, whether its own suicide rate is high or low, should make suicide prevention a priority.

Suicide risk reflects wider inequalities as there are marked differences in suicide rates according to people's social and economic circumstances with those in poorer communities more likely to be affected. Approaches aiming to protect those who are vulnerable in this way - people in debt or homeless, for example - are vital to reducing risk.

Local authorities are well placed to prevent suicide because their work on public health addresses many of the risk factors, such as alcohol and drug misuse, and spans efforts to address wider determinants of health such as employment and housing. There are also important and varied opportunities to reach local people who are not in contact with health services through on-line initiatives or working with the third sector. Across BNSSG public health take the lead in each area on suicide prevention.

However, local authorities cannot do this on their own. Local suicide prevention plans should and do combine actions by local authorities, mental health and health care services, primary care, community based organisations and voluntary agencies, employers, schools, Colleges and Universities, the Police, transport services, prisons and others.

Primary and secondary health care are crucial - they will come into contact with high risk groups such as people who have long-term physical illness or are isolated or depressed. They should be key partners to local authorities and ensure that their work is integral to local suicide audit and action plans.

Local situation

In the latest figures (ONS, 2017), the South West of England had the highest suicide rate for any English region, at 11.2 per 100,000 people, in contrast to London which had the lowest at 7.8 per 100,000 people. Specifically, the age-standardised suicide rate (a three year average covering 2013 – 15) is as follows in each local area:

- In Bristol it is 12.8 per 100,000 people
- In North Somerset it is 8.7 per 100,000 people
- In South Gloucestershire it is 9.2 per 100,000 people

The Bristol figure is particularly high even when compared to other core cities and London which has a much lower rate. It is not entirely clear why this is the case as rates are much lower in other areas where deprivation is a factor e.g. Lewisham 7.2, South Tyneside 7.4 and Trafford 6.8 per 100k.

Who is at risk?

There are particular groups within the population who are more likely to commit suicide which include, males, those in touch with mental health services (there is an AWP suicide prevention strategy which is attached as an appendix to this report), those in debt or struggling financially, women experiencing perinatal mental health problems or who have been the victims of domestic violence, those in prison, people from the LGBT community, young people, particularly student population and those who misuse drug and alcohol. Added to this there are significant risk factors involved as well including, history of self-harm, drug and alcohol misuse, depression, relationship break up and living alone.

The majority (70%) of suicides are committed by males in Bristol and 47% of those who commit suicide live in the most deprived parts of the city. However the suicide rate for young females (10-34) is an outlier in Bristol with one of the highest rates in the country for this group. Around 1 in 5 young people in Bristol has self-harmed.

4. What are we doing to prevent suicide across BNSSG

Five Year Forward View for Mental Health (MH) Deliverables

In the implementation plan for the BNSSG are we have committed to;

- Reduce number of suicides compared to 2016/17 levels in line with national ambition to reduce suicides by 10% by 2020/21: The table below demonstrates what this means in terms of numbers.

- Deliver local implementation support which includes the requirement that all local areas have local multi-agency suicide prevention plans by the end of 2017. All three local authorities led by public health, Bristol, North Somerset and South Glos have developed plans which are attached as appendices to this report.

- Each local authority area has their own multi agency suicide prevention plan which is monitored and delivered by a multi-agency suicide prevention

group including those who have lived experience of mental health services. The CCG is presented at these by MH commissioners.

Suicide: age-standardised rate per 100,000 population (3 year average), STP, all persons 10+

Area Name	Time period	Rate	Lower CI 95.0 limit	Upper CI 95.0 limit	Number	Compared to England value or percentiles	New rate if 10% reduction achieved	New no of suicides if 10%reduction achieved
BNSSG	2011 - 13	10.2	8.9	11.5	245	Same	9.18	220.5
BNSSG	2012 - 14	10.8	9.5	12.2	262	Same	9.72	235.8
BNSSG	2013 - 15	10.7	9.4	12.1	260	Same	9.63	234

Suicide: age-standardised rate per 100,000 population (3 year average), UA, all persons 10+

Area Name	Time period	Rate	Lower CI 95.0 limit	Upper CI 95.0 limit	Number	Compared to England value or percentiles	New rate if 10% reduction achieved	New no of suicides if 10% reduction achieved
Bristol	2013 - 15	12.803	10.74291701	15.13215505	147	Higher	11.5	132.3
North Somerset	2013 - 15	8.722	6.407499135	11.59271317	48	Same	7.8	43.2
South Gloucestershire	2013 - 15	9.1603	7.062816622	11.68366519	65	Same	8.2	58.5
Bristol	2014 - 16	12.651	10.57724548	15.00262805	140	Higher	11.4	126
North Somerset	2014 - 16	10.091	7.574739214	13.16836087	55	Same	9.1	49.5
South Gloucestershire	2014 - 16	7.3114	5.454395952	9.595156253	52	Lower	6.6	46.8

Source: JSNA Mental Health profile
https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna

- As mentioned above Avon and Wiltshire NHS Mental Health Partnership Trust has recently developed a new suicide prevention strategy. This plan is joined up with local suicide prevention plans to ensure a co-ordinated approach.

- A West of England Public Mental Health working group has recently been established under the direction of the West of England Public Health Partnership. This brings together public mental health leads to join efforts for public mental health and wellbeing across the life course, for the benefit of all residents of the West of England.

- Thrive Programme 'Thrive Bristol' is a new ten year programme to improve the mental health and wellbeing of everyone in Bristol, with a focus on those with the greatest needs. It covers all ages and considers mental health in its broadest sense, with initiatives to improve the whole population's wellbeing to interventions for people experiencing mental illness. Thrive' focuses on prevention and early intervention and works by mobilising public, private and third sector collaboration and leadership (and resources) across a city. It also aims to simplify and strengthen leadership and accountability across the whole system. This approach aligns closely with the findings of the Marmot Review (2010) on health inequalities which called on us to address the social determinants of health and the 'causes of the causes'. Drawing on this and existing Thrive models, Thrive Bristol is a programme which aims to bring the city together to:
    - Create a city free from mental health stigma and discrimination
    - Enable individuals and communities to take the lead
    - Maximises the potential of children and young people
    - Create a happy, healthy and productive workforce
    - Become a city with services that are there when, and where, needed
    - Enable people to have enough money to lead a healthy life, and safe and stable places to live
    - Become a zero suicide city

  Although this is currently a Bristol focussed programme discussions are taking place to have a Thrive West programme in place for the wider region

Other areas of Innovation and good practice

- Teams are working across BNSSG (with Bath and North East Somerset) on an Avon-wide Coroner Data Steering Group. This is an innovative approach to align resources to better understand who in our area are taking their lives by suicide, and to work collectively to try and reduce this.

- In 2016-17 academic year, Bristol experienced a 'suicide cluster' within its student population. It worked closely with NHS colleagues, local stakeholders and PHE's regional and national team to respond to it. A 'lessons learned' document has been developed, and public health and university leads are working with PHE's national suicide prevention team to inform its revised national guidance and new guidance for universities.

- A new app to help people who are considering self-harm or having suicidal thoughts launched in Bristol on 30 November 2017. The distrACT app is designed to give easy, quick and discreet access to general health

information and advice about self-harm. Self-harm remains the highest risk factor for completed suicide: those who self-harm and attend hospital are 20 times more likely to end their lives

- Bristol Public health have been working with schools to improve mental health of young people. Each school should have a 'Mental Health Lead' and schools can network together to share ideas about improving mental health and reducing self-harm. For information please contact Jo Williams: jo.williams@bristol.gov.uk

- A lot of work has been done with the media around the reporting of suicide to avoid sensationalising the act and contributing to copycat actions

- "Hot Spots in the region have been identified and work with many organisations to reduce the completion of suicide in these areas e.g. Clifton Suspension Bridge and the Avon Gorge

5. What is planned for the future

- Structures are in place to ensure there is a robust multiagency approach to address suicide prevention across the STP footprint for the next 3 years. This is supported by local suicide prevention plans which have been developed. There will be co-ordinated approach to ensure there are more detailed deliverables set out in early 2018.

- It is expected that each local area will be delivering on the actions highlighted within their own suicide prevention Strategy. The public health leads will also work collectively on a range of other projects. E.g. work has already started on some initiatives for example, a roll out of Applied Suicide Intervention Skills Training (ASIST).

- In addition to suicide prevention plans, each area is developing plans for a mental health and wellbeing strategy. This will fulfil the requirements of the Prevention Concordat as well as include actions for suicide prevention. There will be local actions to meet the requirements of local Health and Wellbeing Boards, but this will be co-ordinated to ensure there is a regional approach.

Suicide Prevention Bid

In January BNSSG STP was invited to submit a proposal for the use of funding allocation from April 2018 for suicide prevention. This transformation funding is intended to support the overall national 10% reduction in suicide rate by 2020/21(see above).

Data analysis from the Mental Health Intelligence Network and Office of National Statistics identified BNSSG STP footprint has a significantly higher suicide rate in middle-aged men and asked that the plan focussed on this group of the population.

The bid was focussed around two areas. The first is the roll out of a pilot tested in Bristol to offer help and support to those in financial difficulties that were self-harming and/ or at risk of suicide in 2017 to BNSSG. The responsibility for this would be given to a lead organisation who would employ the workers and be responsible for delivering the interventions.

The second piece of work focuses on mental health promotion for men and the Public Health teams in each area (BNSSG) would lead the strategic work related to men's health.

Part one of the bid: Suicide and financial downturn

- It is estimated that an 1,000 extra deaths from suicide and an additional 30-40,000 suicide attempts may have occurred from 2008-2010 following the economic downturn, reversing previous trends in Britain where suicide rates among men were falling (Gunnell et al Bristol University 2015).

- The bid therefore mainly focused on tackling debt and financial difficulties. This would be to provide psychological support for those experiencing financial difficulties and to provide debt and financial advice and support to those presenting with psychological difficulties. This would be done by the expansion of the HOPE project across BNSSG.

- The interventions would include but not be limited to benefit advice, employment advice, support to attend appointments relating to financial support and running resilience workshops.

- The proposal is to expand this service to deliver to 200 + people over BNSSG over the course of 18/19 and the table below demonstrates the expected outcomes

Outcome	How Measured
Reduced number of suicides/ attempted suicides	Number of suicidal thoughts and /self-harm reporting Increase wellbeing on PHQ scores
Individuals at risk of suicide but not currently known to services engaged	Number of individuals self-reporting/partner agency reporting
Reduced presentations at primary care/ acute care settings	Number of presentations before and after intervention in primary care - self reporting/partner agency reporting – will need to be through qualitative measure There will be an evaluation of this work by an independent organisation commissioned once the bid has been successful
Reduced presentations at secondary care	Number of presentations where debt or work issues are identified as key precipitant before and after intervention in secondary care - self reporting/partner agency reporting. This will be included in the evaluation as above

Part 2 of the bid

To develop and implement a targeted strategy for the promotion of men's MH as described in the attached suicide prevention strategies.

This would include but not be limited to:

- Working across partnerships to target men who are at risk through the interventions below
- Training the trainers to provide MH awareness training
    - Training 10 people to run training in MHFA (Mental Health First Aid) and 10 to run training in MHFA lite (Mental Health First Aid) ensuring some of this is in male focussed environments e.g. employers where mostly male workforce, sports facilities,
    - Training 10 people to run training in SafeTalk (suicide prevention)as above for MHFA
    - Providing booklets and materials for the above training
    - The above training will mean this is sustainable as once trained the trainer is then able to offer training for up to 12 people at a time. It is anticipated that 10 people offer six sessions per year meaning that 1,440 people would receive MHFA training and 600 people would receive safe talk training as a minimum

- Targeting Workforce education: construction industry as the industry with the highest risk of suicide, and consider local employers such as Airbus, Rolls Royce
- The statistic shows that men are more likely to commit suicide by jumping so training would be targeted for key front line staff in areas which are deemed hot spots for suicide e.g. Suspension Bridge staff, Network Rail, car park attendants and support for these staff after traumatic events would therefore be included.
- Events to target men
    - Development of literature to target males through identified events at e.g. football and rugby clubs and games.
    - Focussed work in areas of greater deprivation under "Thrive West" as this is where men are at most risk. Working with the CALM (Campaign Against Living Miserably)https://www.thecalmzone.net/
    - Warriors of Wellbeing in North Somerset
    - "Time to Change" city hub to focus on raising awareness with men.
    - Movember" sports related MH promotion work including a Time to Change football tournament– to be supported again in 2018.

It is hoped that the implementation of the plans described in this bid will begin in April 2018.

6. Financial/resource implications

There are no additional financial or resource implications identified in this report. One of the desired outcomes of existing and planned programme investment in mental health services will be the reduction in suicide and self-harm as part of the overall national 10% reduction in suicide rate by 2020/2.

7. Legal implications

There are no legal implications identified in this report.

8. Risk implications

There are risks and challenges to delivery

- The ambition to reduce suicides by 10% by 2020 is an ambitious one, given the wider economic and social environment.
- There is increased pressure on the public health budget and the wider local authority budget. This may impact on the ability to deliver on some specific actions.

Mitigation for both of these is making good use of the transformation money that is coming from NHSE along with strong partnership working across all agencies to prevent suicides in the area.

9. Implications for health inequalities

There is an existing weight of empirical evidence that points to a significant association between socioeconomic disadvantage and suicidal behaviour. For example there is a significantly higher risk of suicide among unemployed people, compared to employed people, even after taking into account other possible explanatory factors. The adverse effects of economic recession on suicide and other mental health outcomes are highlighted in a recent review (Gunnell & Chang, 2016). Although increases in job loss contribute to this effect, a range of other stressors such as austerity measures, loss of home, debt, strains on relationships, and changes to mental health and social care services may also contribute.

Those who are already vulnerable, such as individuals who are supported by social welfare or who have pre-existing mental health problems are also at high risk. Similarly here is an inverse relationship between occupational social class and risk of suicide, the higher the social class position, the lower the rate of suicidal behaviour.

10. Implications for equalities (Black and Other Minority Ethnic/Disability/Age Issues)

As noted above, suicide risk increases in conjunction wider inequalities as there are marked differences in suicide rates according to people's social and economic circumstances with those in poorer communities more likely to be affected. Emerging research (Data from NHS Digital's Adult Psychiatric Morbidity Survey) suggests rates of suicide amongst disabled people appear to be increasing and it is suggested that this is due to changes in the benefits regime and the wider impacts of the economic downturn.

11. Consultation and Communication including Public Involvement

There has been no new or specific consultation and communication in regard to this report, however the report is informed by information and testimony received during previous public and service user involvement considering suicide and self-harm.

10 . Appendices

1. Bristol Suicide prevention strategy
2. South Glos suicide prevention action plan
3. North Somerset Suicide prevention action plan
4. AWP Suicide Prevention strategy

Item 7.3, Appendix 1

Bristol Suicide Prevention Strategy

Foreword (Marvin Rees, Mayor of Bristol)

Suicide is a preventable tragedy with a wide ranging and devastating impact. Suicide prevention is a priority across the country, but especially so in Bristol. Our suicide rates are higher than the national average, and the South West has the highest suicide rates of any English region. We know that factors such as self-harm put people at increased risk of suicide, so it's especially shocking that 1/5 of Bristol's young people are self-harming.

This strategy sets out **our vision:**

We want Bristol to be a suicide safe city so that people do not consider suicide to be a solution to the challenges they face, and individuals are supported by friends, colleagues and services at times of crisis.

For this to be achieved, we need partners across the city to play their part. I'm reassured to see this happening, and for this strategy to have been a product of individuals and organisations across Bristol giving their time, expertise and ideas. I'd like to pay particular thanks for the contribution made by those directly affected by suicide for their support, and for the Samaritans, CRUSE, Bristol Independent Mental Health Network and Bristol Mind for their invaluable support.

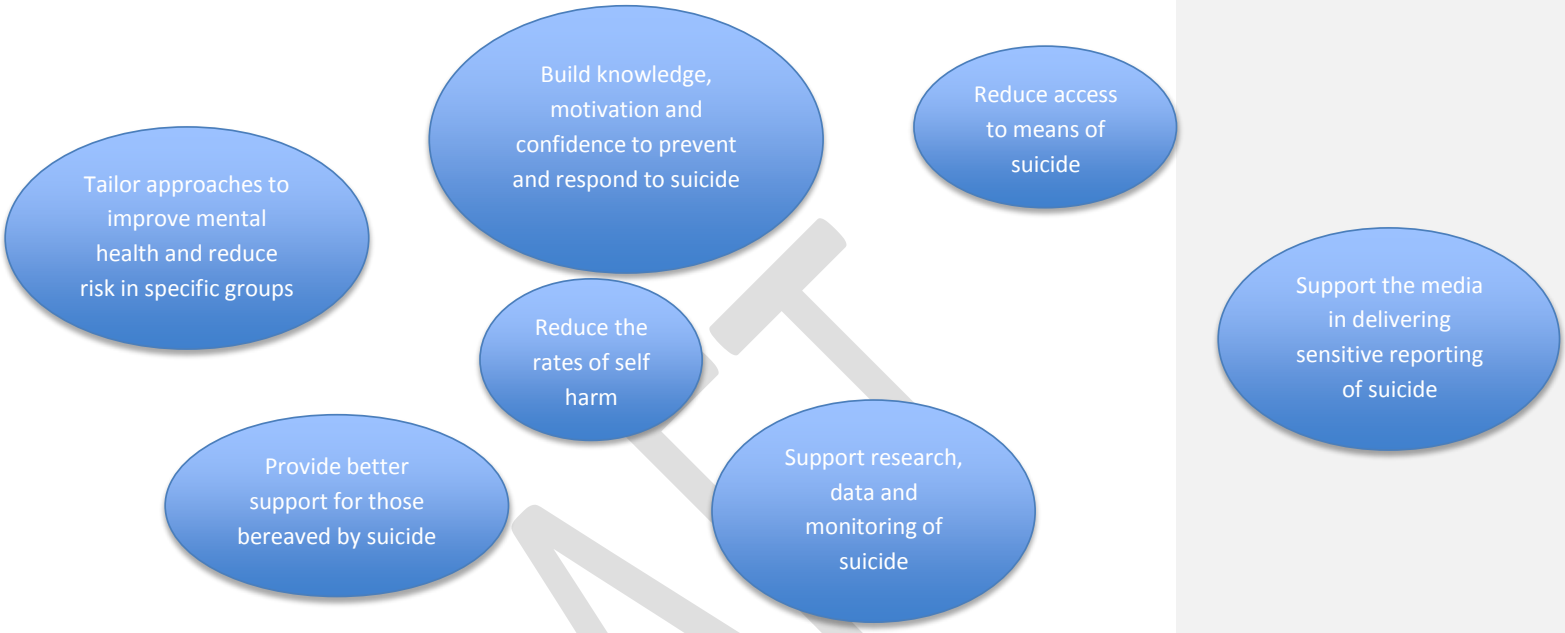
Collectively we have created a strategy which sets out the facts, presents the most evidence based, cost effective measures with realisable, measurable specific commitments. We are clear about what we need to achieve and when action needs to be achieved.

However, we all know that it's one thing to create a strategy and another for its aspirations to be delivered. This is particularly true as we enter a further period of financial restraint and austerity.

We are introducing a robust and transparent process for colleagues and I to be held to account for progress made. We will have an annual public Suicide Prevention Scrutiny Hearing whereby leads from the Health and Wellbeing Board, our Safeguarding Boards and Children and Families Partnership Board will assess how well Bristol is working to tackle suicide. This will be both an opportunity for accountability, but also for us to continue to leverage support and resource from partners to play their role. I also commit to publishing a yearly progress report on how we are meeting the goals set out in this strategy.

Through us aligning strong local partnership working, political commitment and a robust and transparent system of accountability, I believe we can – and will – make the progress so desperately needed to take us closer to preventing suicide in our city.

What are Bristol's Suicide Prevention Priorities?



How the strategy was developed:

Bristol City Council's Public Health Team has developed this strategy in partnership with the Suicide Prevention and Audit Group, in collaboration with a wide range of partners and stakeholders in Bristol. They also sought expert support from national partners, including Public Health England's suicide prevention leads. Central to our strategy are three key elements:

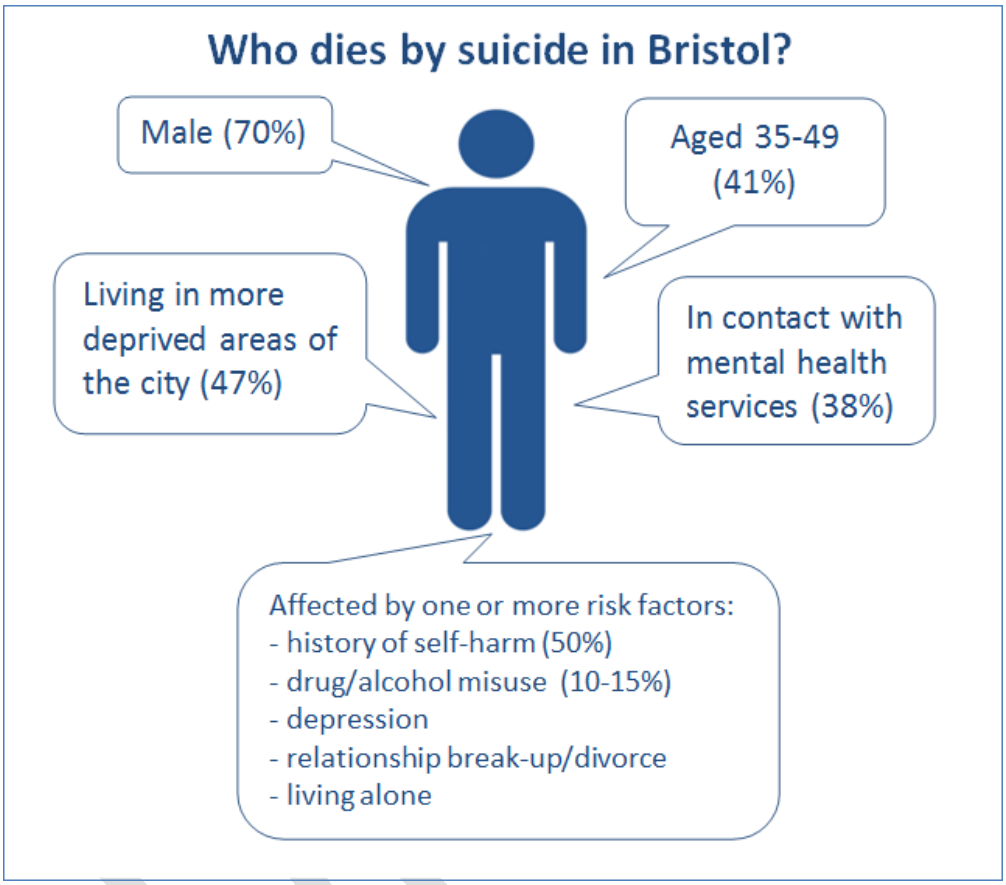
- People involvement
- Research informed evidence base
- Tangible, realisable goals that can be evaluated.

How the strategy will be delivered and accountability mechanisms:

Delivery of the strategy will continue to be informed by working groups, with a focus on implementing our action plan. The Suicide Prevention and Audit Group will meet three times a year with the aim of delivering the action plan: assessing progress and refining actions to meet need. The Health and Wellbeing Board (chaired by Bristol's Mayor and the chair of the Clinical Commissioning Group) is accountable for this work. In addition to this, we are seeking to coordinate and strengthen scrutiny through the introduction of an annual public Suicide Prevention Scrutiny Hearing whereby leads from the Health and Wellbeing Board, Bristol's Safeguarding Boards and Children and Families Partnership Board will assess how well Bristol is working to act on this strategy.
A progress report will be published annually to report on how goals set out in this strategy are being met.

The strategy will be updated in three years (2021) in order to update it based on evaluation and new evidence.

Aims and context



As the Mayor notes, Bristol has high levels of suicide: 12.7 per 100,000 and it is a key and urgent priority for the city to act upon this.

Bristol's long term vision is to become a city with one of the lowest suicide rates in the UK: currently low rates include Lewisham 7.2, South Tyneside 7.4 and Trafford 6.8 per 100k. In the medium term we want our suicide rate to reduce by 25% by 2028: this equates to 12 fewer deaths in Bristol. In the short term we want a clear direction of travel towards our suicide safe city ambition.

Direction of Travel

Public Health England (PHE) has produced three key documents to translate analysis of national trends in suicide into the planning of local services and preventative measures. These inform this strategy and the wider work being undertaken in Bristol.
There also already exists a very varied and representative Suicide Prevention and Audit Group in Bristol. Our local task is to ensure that we have a strong and measurable strategy based on PHE guidance, adjusted to not only meet local need but to reflect and accentuate local resources available.

Our Suicide Prevention and Audit Group (the 'SPAG') formed in 1995 and is a long standing multi-agency group chaired by public health with suicide prevention as its aim. The group's partners are all involved in the creation of the strategy and critically with the action plans to reduce suicide. After a quiet period, the SPAG has in 2017 remobilised and gained new members. It has strengthened commitment and focus to drive improvements across the city, to take forward this strategy's aspirations.

Risks and Challenges

Bristol and the South West have suicide rates greater than many other parts of England. The recession and the experience of austerity - with higher unemployment, cuts to benefits and increased homelessness - have all had a part to play in increased suicide rates. Specific issues that present challenges in our city for suicide prevention are higher than national average levels of: alcohol problems, illegal substance use, and ease of access to the Clifton Suspension Bridge and Avon Gorge.

Opportunities and New Relationships

Over the last year some strong relationships have formed with suicide reduction as their aim. As a response to tragedy, our universities are collaborating closely with public health locally and nationally, service users and mental health leads. This has not happened before in Bristol and presents a major step forward in providing a platform for swifter more effective response to suicides amongst young adults in Bristol, as well as significantly increased prevention work.

Reduction of access to means has a proven evidence base for reduced suicide. The newly formed Avon Gorge Working group chaired by the Clifton Suspension Bridge's Bridgemaster is cementing relationships between health, police, ambulance, fire services, parks and gardens staff and public health around suicide reduction of the high frequency location of the suspension bridge and gorge. As well as making progress on solutions to reducing access to means, the group reviews real-time incidents to learn lessons and provide support. This group shortly intends to expand to include all high use areas: including network rail and car parks in Bristol.

Our city has an established Health Integration Team specifically for self harm: (STITCH) with its own steering group and action plans, including innovative new projects such a self-harm App and a Primary Care Aide Memoire on the assessment and management of self-harm. STITCH, informed by Bristol's self-harm surveillance register, works closely with Bristol's SPAG to monitor the changing incidence of self-harm in Bristol and develop jointly agreed priorities and actions.

Accountability and Governance

Formatted: Highlight

A Joint Strategic Needs Assessment was carried out in 2017 to set the local agenda and benchmark Bristol's with other cities in England (Appendix 3). This strategy builds on the findings of the JSNA and links with other strategies and action plans: mental health and wellbeing, domestic violence, young people, drug and alcohol.
The strategy is signed off by Bristol City Council's Health and Wellbeing Board and the Bristol Suicide Prevention and Audit Group. Bristol's Adults and Children's Safeguarding Boards have supported the development of this strategy.

We are seeking to coordinate and strengthen scrutiny through the introduction of an annual public Suicide Prevention Scrutiny Hearing, whereby leads from the Health and Wellbeing Board, Bristol's Safeguarding Boards and Children and Families Partnership Board will assess how well Bristol is working to act on this strategy. We would also hope to hear from people with lived experience in these sessions to better understand local needs and opportunities to provide greater support.

Annually a progress report will be published to report on how the goals set out in this strategy are being met. To inform and support this, the Suicide Prevention and Audit Group will meet three times a year.

Monitoring and Evaluation

Knowing who dies by suicide and under what circumstances is critical to helping those bereaved, but also for understanding trends, auditing changes and pinpointing areas of highest risk. A key part of our strategy is to bring organisations and services together to improve the timeliness of information.

Bristol Mortality Data
Local suicide deaths are investigated by the Avon Coroner. Local data is shared with the Avon Coroner Monitoring Group, which is formed of public health leads that meet quarterly to audit suicide deaths and analyse trends. The report looks at local data for a three year period so that small fluctuations due random variation as a result of the small number of deaths every year will not overly influence decisions or change.

Bristol Self Harm Surveillance Register
England's Public Health Outcomes Framework requires data to be collected on people who self harm and come to hospital. The Bristol Self Harm Surveillance Register (SHSR), part funded by Bristol City Council, records self harm and both A+E attendance and hospital admission in Bristol. Other monitoring includes local prescribing trends and medicines taken in overdose, trends in suicide under specialist mental health care.

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Why do people die by suicide?
There were 6639 suicides in the UK and the Republic of Ireland in 2015: this equates to 18 deaths per day. There were 112 suicide deaths in Avon in 2016: 2 per week. On average there are 50 deaths annually in the city of Bristol. Suicide is preventable, yet is the leading cause of death in men under 50 and young people. Since the 2008 Global Financial Crisis, and the introduction of austerity measures in the UK, a growing number of vulnerable people have experienced economic hardships; debt and job loss which are important risk factors for suicide.

What is the national picture?
Although suicide rates fell between 1981 and 2007 in England, since then there has been a steady increase up to 2013-2015 (10.1) and a small decrease in the 3 years average rate to 9.9 per 100,000 people aged 10 and over in 2014-2016 (PHE: Suicide Prevention Profile 2017). The male suicide rate is more than three times higher than the female rate, with 15.3 male deaths per 100,000 compared to 4.8 female deaths on average in 2014-2016. Targeted prevention is needed for men, specific BAME groups, people who self harm and those recently discharged from inpatient care. Suicide is the single biggest killer of men aged 20-49 in England and Wales, with 78% of all suicides in that age group in 2016 being men.

What is the current position in Bristol?
The current 3 years average suicide rate in Bristol is 12.7 per 100,000: 28% higher than the national average of 9.9. According to Public Health England there were 140 suicide deaths registered in Bristol in 3 years 2014 - 2016. 69% (97) of those deaths were among males and 31% (43) among females. The suicide rate for women is 7.4 per 100,000: the 10th highest in England's unitary authorities and the highest among the core cities in England. Amongst men aged 35-64 the suicide rate is 27.5 per 100,000 in Bristol: 27 % higher than the national average of 20.8.

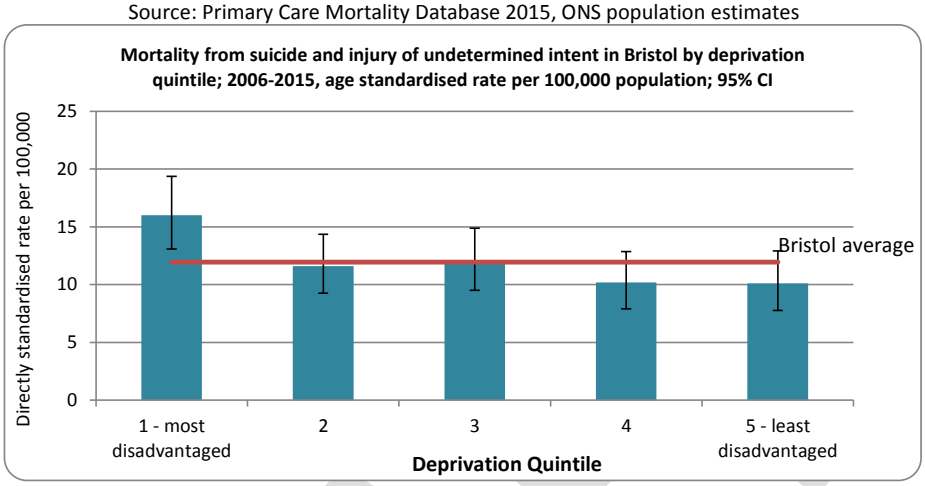
Indicator	Period	Bristol Count	Bristol Rate	SW Region Rate	England Rate	England Lowest	England Range	England Highest
Suicide: age-standardised rate per 100,000 population (3 year average) Persons aged 10+	2014-16	140	12.7	10.8	9.9	6.1		18.3
Suicide: age-standardised rate per 100,000 population (3 year average) Males aged 10+	2014-16	97	18.0	16.0	15.3	8.6		27.7
Suicide: age-standardised rate per 100,000 population (3 year average) Females aged 10+	2014-16	43	7.4	5.9	4.8	3.3		11.3
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) PERSONS	2012-14	131	35.7	35.6	31.9	10.7		62.6
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) MALES	2012-14	95	57.6	52.8	50.2	16.4		101.6
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) FEMALES	2012-14	36	21.2	18.8	13.7	0.0		26.2
Suicide crude rate 10-34 years: per 100,000 (5 year average) MALES	2011-15	49	13.1	10.8	10.5	4.5		25.3
Suicide crude rate 10-34 years: per 100,000 (5 year average) FEMALES	2011-15	22	5.3	4.0	2.9	2.5		5.3
Suicide crude rate 35-64 years: per 100,000 (5 year average) MALES	2011-15	105	27.5	22.2	20.8	8.9		39.7
Suicide crude rate 35-64 years: per 100,000 (5 year average) FEMALES	2011-15	31	8.4	7.1	6.0	5.0		8.4
Suicide crude rate 65+ years: per 100,000 (5 year average) MALES	2011-15	13	10.1	13.6	12.6	2.9		26.2
Suicide crude rate 65+ years: per 100,000 (5 year average) FEMALES	2011-15	9	5.6	5.6	4.4	3.7		5.6

The indicators from the Public Health England Suicide Prevention Profile above show that the situation in Bristol needs urgent attention: in no area do we appear 'green' or better than average. Bristol is worse than the average for England in 8 areas: 3 years average suicide rate among persons and among females; years of life lost due to suicide rates among persons and among females;

suicide rates among females 10-34 years old; suicide rates among males and females 35-64 years old and suicide rates among females aged 65 and older.

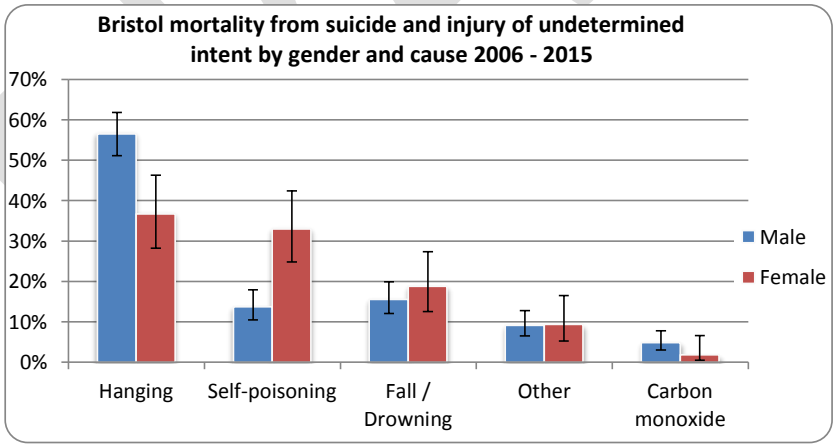
Rate of suicide death is 60% higher in the most deprived areas of the city versus the most affluent:

Source: Primary Care Mortality Database 2015, ONS population estimates



The most common method of suicide for both men and women is hanging (57% of suicide deaths among men and 37% among women) followed by self-poisoning and fall/drowning.

Bristol mortality from suicide and injury of undetermined intent 2006-2015 by gender and cause:

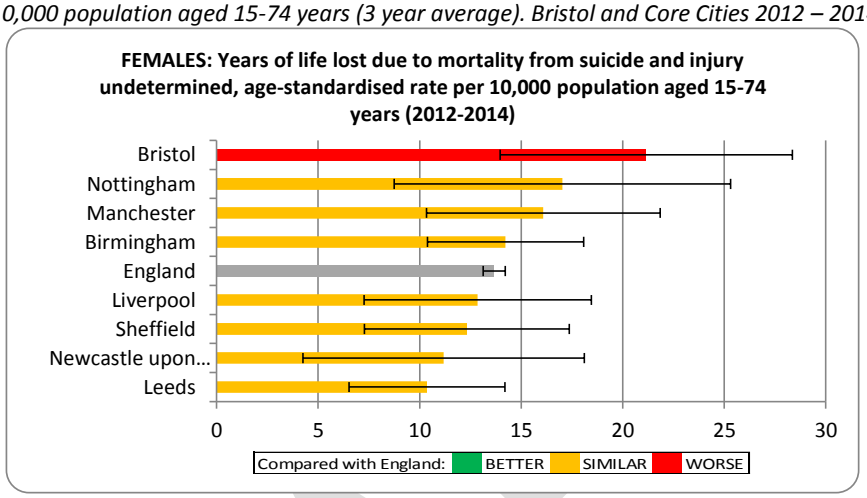


Over 50% of suicide deaths in Bristol happen at home, over 23% in a public place (park, car park, road or railway) and about 14% in Avon Gorge and Cumberland Basin area.

Years of life lost is a measure of premature mortality and gives an estimate of the length of time a person would have lived had they not died prematurely. This is important as it tells us our suicides in young women are greater than other core cities.

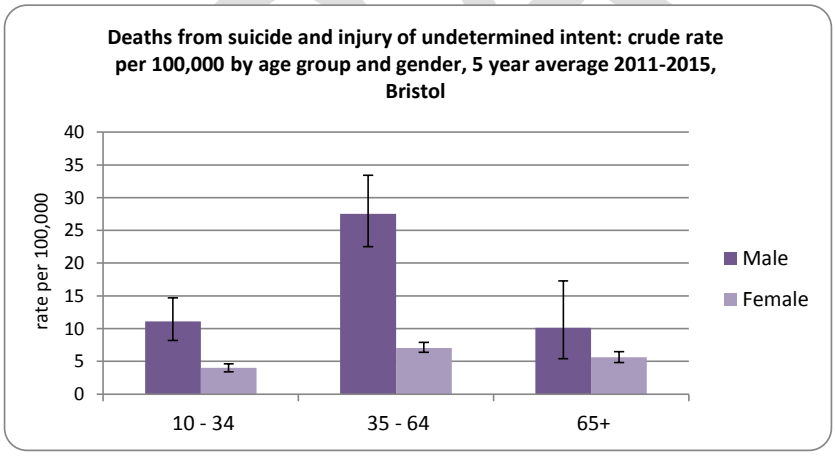
The following charts show the rate of the years of life lost due to suicide in Bristol compared to Core Cities and England's values:

Years of life lost due to mortality from suicide and injury undetermined, age-standardised rate per 10,000 population aged 15-74 years (3 year average). Bristol and Core Cities 2012 – 2014



Source: Health and Social Care Information Centre Indicator Portal

Middle aged men are the highest risk group in Bristol and nationally: this chart shows Bristol deaths by gender:



In Bristol deaths by suicide of those in contact with mental health services is higher than the national average. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

(2016) report estimates that about 28% of general population suicides in England were identified as patient suicides between 2004 and 2014 (i.e. the person had been in contact with mental health services in the 12 months prior to death). In Bristol that number is higher: 38.5% for the same period.

People who self-harm are at increased risk of suicide. Since 2011, 57 people who attended the Bristol Royal Infirmary following self-harm subsequently died by suicide. The emergency hospital admissions for intentional self-harm, directly age standardised rate indicator for 2015/16 in Bristol at 269.2 per 100,000 population is significantly higher than England average: 196.5 per 100,000. There were 1,536 episodes of self harm and presentation the Bristol Royal Infirmary in 2016. Female patients have increased in 2016. Presentations to Bristol Children's hospital remains stable in 2016 – approx. 4-5 presentations per week.

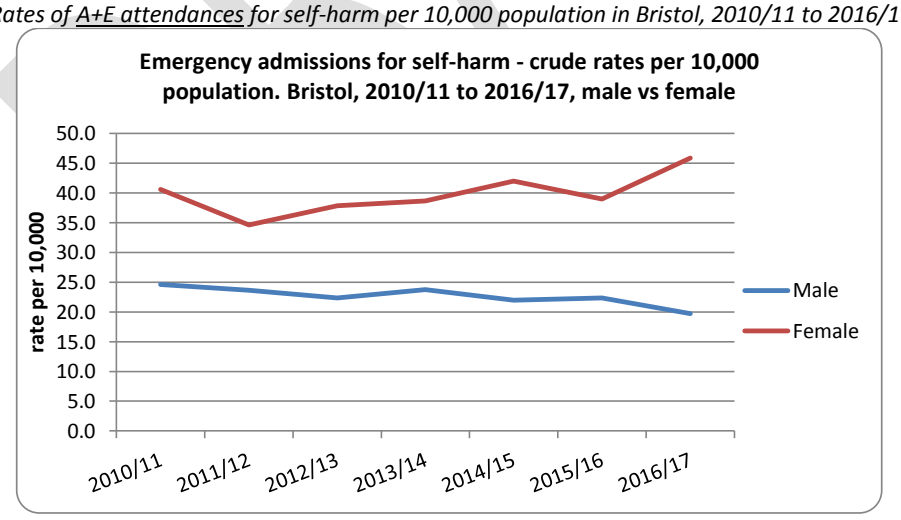
The numbers of hospital admissions for self-harm in Bristol have been steadily rising since 2010/11, mostly among women (similar to national data):

Numbers of hospital admissions for self-harm in Bristol, 2010/11 to 2016/17

Year	Male	Female	Total
2010/11	518	863	1,381
2011/12	505	743	1,248
2012/13	483	820	1,303
2013/14	519	847	1,366
2014/15	485	931	1,416
2015/16	502	876	1,378
2016/17	448	1,040	1,488

Source: SUS admissions data via NHS South, Central and West Commissioning Support Unit ABI database

Rates of A+E attendances for self-harm per 10,000 population in Bristol, 2010/11 to 2016/17



The economic case for action

Suicide must primarily be seen as a traumatic human tragedy. Economists have looked at the costs of suicide death and attempted suicide – self harm. Although the number of studies estimating these

costs remains limited (McDaid, 2016b) costs are substantial. The Bristol economic evaluation found costs of self harm and attendance at hospital to be £700 per patient: this approximates to over £2 million per year in Bristol. Previous work in the UK has estimated that the average cost per completed suicide for those of working age only in England is £1.67m (at 2009 prices) (McDaid, 2016b). This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as lost output (both waged and unwaged), police time and the costs of coroner inquests.

Bristol level data show that there were approximately 62 deaths due to suicide in 2016. Therefore, the total estimated human cost of suicide is **£103.5m (To add).**

What is effective in suicide prevention?

Reducing access to means, such as installing a safety barrier at 'frequent use sites' or restricting sales/ prescribing of high-toxicity medications is effective in preventing suicide (Bennewith, Hawton).

Training of larger groups of people, such as frontline staff, has proven impact in reducing stigma and increasing skills, knowledge and confidence (Walrath et al 2015).

Primary care staff need support in recognising and getting help for those at risk of suicide. NHS England's Five Year Forward View for Mental Health (2016) recommends that by 2020/21 all GP's should receive core mental health training. It would seem appropriate that Bristol GPs are confident in recognising and responding to those at risk of suicide.

There is no evidence of efficacy of any pharmacological interventions, but there is evidence that both psychosocial assessment and CBT as a treatment is effective in preventing repeat self-harm (Hawton, Witt et al 2016).

Whilst we cannot prove that good reporting prevents suicide, we do know poor reporting (especially graphic portrayal of high-lethality methods) leads to rises in suicides – so we continue to work with local media on their reporting and coverage of suicide and mental health issues

People of Bristol: Evidence to support the strategy

No, I haven't told any of them (about self harm). No. It's either a combination of lies about skiing trips or something else. (laughs) I don't do the heart on the sleeve thing. It's just easier for my day to day.

"……..the (mental) illness, lack of job. It was just…enough was enough…I thought that would be better for everybody if I wasn't here anymore because I just saw I was making people suffer."

Mungo, 23 interviewed after hospital admission for suicide attempt

Debbie (37)
Interviewed after suicide attempt
and hospital admission

"…. I felt like I was stuck in a rut and the drugs and the alcohol … I ended up feeling more and more worthless every time you get shot down…… you start to feel defeat yourself and eventually I think I just got to that point where I'd had enough"

Paul (23) Interviewed at home after a suicide attempt

"…I mean obviously through my early childhood he [Dad] *was a bad drinker. …. I'd been beaten so much over the years that I kind of became used to it and it was literally I could sit here and he could punch me and be beating me….*

Jo (31) speaking after a suicide attempt

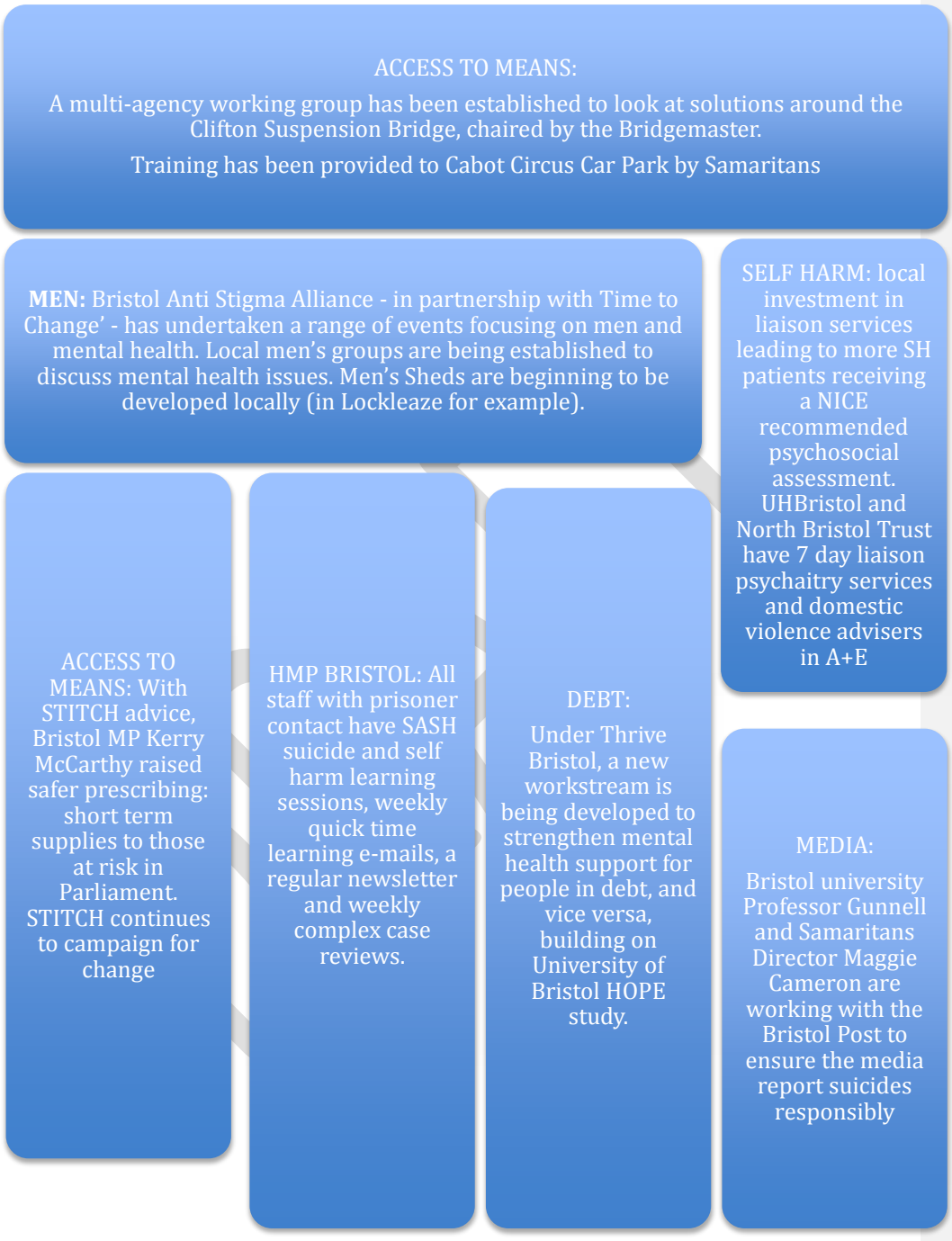
"…and it's really disheartening when you get rejected when you've spent a few hours on an application and then you just get rejected I'd gone to….interview… I was cycling home and I just thought I can't do this, this is too much and I didn't want to live so I took an overdose."

Ellie (23) talking after hospital admission for suicide attempt

"I can't get out due to health problems so it can be …3 days I go without talking to someone… I dread the winter nights….sometimes I need that to get through another pointless day where I feel as if I am a waste of space

Ellen (71) talking about a suicide attempt

Professionals and Services in Bristol: Supporting the Strategy



Bristol Strategy Action Plan (final version will not include named individuals)
Do we need to prioritise? If so which?

Priority	Action	Partners Responsible	Timescale	KPI /outcome Progress and date
1. Monitoring annual review trends in rates and local patterns of suicide (age/sex/method/location)				
Suicide Prevention and Audit Group	Build on existing partnerships; lead work to ensure plans are implemented.	Public Health	Next meeting April 2018	3 meetings a year
Avon Coroner Audit Group	Ensure accurate data on deaths from a) the Clifton Suspension Bridge and b) other parts of the Avon Gorge is collected and shared appropriately to inform priorities for prevention	Coroner/ Public Health	To add	
Self-harm surveillance register	Ensure continued funding for the register to facilitate cross-Bristol surveillance of the changing trends and risk factors for self-harm	Public Health/AWP/UHB/NBT		
Real time surveillance 'Cluster' identification to alert emergency protocol	Develop a model of real time surveillance to ensure that suicides can well responded to and trends monitored and acted upon (including around suicide clusters).	Avon and Somerset Police /emergency services and public health	To develop initial approach by June 2018	
2. Supporting those bereaved by suicide				
Students	Ensure recommendations / lessons learnt from the recent deaths are implemented. Emergency Protocol for emergent high incident patterns signed off. Develop city-wide programme (under Thrive Bristol) to support student mental health and wellbeing, involving universities, FE colleagues and Universities UK (building on recommendations from national Task Group)	University of Bristol/ Public health/UWE Public Health / Universities / FE colleges, Universities UK	First meeting early February	
Public	Coroners and emergency services to have access to resources for bereaved. Group based bereavement support and 1-1 counselling to be available for those affected by suicide Map of support services to be created to assess gaps and reduce	Samaritans / Cruse	To add	

	duplication			
3. Tailor approaches to improve mental health and reduce risk in specific groups				
Men	Bristol Ideas Generation Event: local businesses to understand options. Bristol City FC target for suicide resources Workforce education: construction industry, Airbus, Rolls Royce Focused work in areas of greater deprivation (under Thrive Bristol) to include 'suicide safer zone': with GP surgery information, poster campaigning, leafletting, and other events personal to the chosen area; tie in with existing help and support already available to support the area. Use as a pilot for comparison. Dedicated men's mental health website / resources for Bristol. Time to Change city hub to focus on raising awareness with men.	Public Health Tom Hore Time to Change For discussion For discussion Bristol Anti-Stigma Alliance	April 2018 onwards	
People in contact with Mental Health Services	To report on the actions identified in AWP's 2017 suicide prevention strategy: **In-patients:** Develop and implement an anti-absconding toolkit and resources. **Young people under MHS services:** Develop a plan of work supporting families of young people who self-harm. N.B. CAMHS and Transitions – any actions? **People under the Crisis Teams:** Implement the Collaborative Assessment & Management of Suicidality (CAMS) across all intensive teams for people who are acutely suicidal.	Chris Ellis + AWP suicide prevention group Glenn Townsend: CCG	To add	

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	Perinatal mental health: Identify and develop 'Perinatal Mental Health Champions' within each clinical team across AWP. **Carer involvement:** Develop and implement a trust-wide patient safety initiative and communication 'campaign' aimed at promoting and reinforcing the changes in culture with regard to family and carer engagement that ensures a consistent focus on: - Improved risk assessment: - Effective engagement and collaboration with carers and family members regarding risk assessment and risk management; - Comprehensive risk formulation and risk management plans. **Information Sharing:** Establish a 'Mortality Review Group' to ensure the learning from all unexpected deaths is appropriately identified, reviewed and shared in order to inform learning.			
Debt/financial vulnerability	Thrive Bristol workstream is being developed to strengthen mental health support for people in debt, and vice versa, building on University of Bristol HOPE study. Southmead hospital and other workplaces and agencies to be made aware of Samaritans outreach service: calls made by Samaritans to individuals. A checklist to be shared with organisations to allow this service to be used.	Public Health / debt advice agencies / University of Bristol NBT/UHB/ Samaritans		
Women	NCT/non stat service training re suicide triage/prevention Domestic Violence leads and IDVAs	Bluebell/Paula Bentley/Holly Starkey		

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	to have ASIST training/Safetalk. More needed.			
Criminal Justice/Prison	Improve timely information about prisoners: to investigate Connecting Care ACCT forms to be of high quality as standard and appropriate Identify, record and respond appropriately to all known risk factors of newly arrived prisoners Ensure prisoners are kept safe and supported during their first night in prison and early days in custody and their immediate needs are met • Identify, manage and support prisoners and detainees who are at risk of harm to self, others, and from others • Ensure appropriate responses and investigations to incidents, which promote learning to prevent future occurrences and improve local delivery of safer custody services	Sarah Smith		
LGBTQ+	Ensure improvement in all pubic facing services for monitoring and data collection of LGBTQ+ so that trends/specific issues can be identified. Access to Safetalk/ASIST for frontline staff working with LGBTQ+ people with mental health issues. Greater communication and increased knowledge for services about what LGBTQ+ services are available and to increase those services: Priory to offer group work and transport.	To add		

Children and Young People	As above, universities and FE multiagency group collaboration. *Children:* Develop plan to roll out mental health training to professionals. Family support workers and school teacher mental health leads to be prioritised for ASIST or Safe Talk training and receiving the CFP Newsletter and have access to the Network for support. Ensure information about the 'self harm toolkit' and 'suicide pack' provided to schools is consistent and appropriate for Bristol schools. Ensure all schools, educational schools and other educational settings have the 'Suicide Pack'. To be shaped by the Mental Health Schools Network *Young adults:* Transition specific services staff to be targeted for training. Further development of transition services to be monitored as a focus to enable suicide prevention Emergency protocol for any patterns or any emerging 'suicide cluster' to be developed by the SRT *All:* Data to be collected on all those who have received ASIST, MHFA and Safe Talk training. Ensure agencies are aware and are referring children and young people to commissioned support (Kooth and OTR).	Public health, Fes Public health Public health Public health Public health To add	Spring 2018 Summer 2018 Summer 2018 Summer 2018 (tbc)	
BAME	Consulting Bristol Race Equality Commission			
Alcohol and Drugs	D+A HIT to set actions			
4. Reducing access to means				
High use areas Review and	Avon Gorge Working Group to extend to bring together key	Avon and Somerset		

improve existing safety measures on the Clifton Suspension bridge and around Avon Gorge.	agencies to improve and review all high use areas. PPI, the Downs Committee, Natural England, landowners, climbing groups, the mayor and other Key stakeholders to agree areas which could have protective planting/other barriers to prevent suicide. Business case for funding of barrier projects. Ensure key frontline staff: Bridge staff, network rail, car park attendants have training in suicide prevention and are supported after traumatic events. Network Rail Car Parks	Police Avon Gorge Working Group Avon Gorge Working Group “” Public Health / Avon Gorge Working Group		
2. Reduction of Medication/ prescription tablets used in overdose				
5. Reduce the Rates of Self Harm				
STITCH aims to be actioned, measured and reported on	NICE guidance regarding psychosocial assessment following self harm. Research and the self harm register continue to provide evidence DisTRACT and SASHA to be used by the public and GP’s. Continued and sustained funding for Bristol Self Harm Surveillance Register. Launch and share Self harm App Pilot GP surgeries for self harm aide memoire. Bristol Royal Infirmary (UHB) Southmead (NBT) South Bristol Acute Care (SBCH) and Weston-Super-Mare GH to have agreed standards of care.	STITCH Steering Group/Salena Williams Public Health STITCH Steering Group/Salena Williams BRI / NBT / WSM		
6. **Supporting local news media in reporting suicide and suicidal behaviour**				
To see a measurable	Provide local media with access to the designated suicide prevention	Samaritans / Public Health		The number of editors engaging

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increase in the number of local articles adhering to national guidelines, including mentioning sources of support	lead so they can speak to them prior to running any story work with local media to encourage them to provide information about sources of support and contact details of helplines when reporting mental health and suicide stories Ensure all local press have regular visits to discuss media guidelines on suicide. Samaritans to approach Higher Education Institutes in Bristol that run Journalism courses to offer training input in relation to reporting deaths by suicide.	Samaritans		with the local suicide prevention lead The results of national data showing an improvement in local reporting period
7. Build motivation and confidence in Bristol people to prevent and respond to suicide				
Training	Priority training areas to be identified and agreed, and training targets over next 3 years. Identify key frontline staff to receive suicide awareness training. Monitor training levels across the city and share with SPAG.	Public Health Public Health		100 people in 2018 100 people in 2018

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Conclusion

'We can choose to stand together in the face of a society which may often feel like a lonely and disconnected place, and we can choose to make a difference by making lives more liveable for those who struggle to cope. We believe we can do this because we know that people and organisations are stronger together.'

Samaritans Suicide Statistics Report 2017

The purpose of the strategy has been to outline how partners and individuals across Bristol can prevent suicide, ensuring that the experience of survivors, those bereaved by suicide and people who self harm are at the heart of all that we do in respect to suicide prevention. Individuals, local services and community groups are critical to the success of suicide prevention planning.

England's Five Year Forward View for Mental Health has set the ambition that by 2020/21 the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels. As part of implementation of Avon and Wiltshire Partnership NHS Foundation Trust (mental health service providers) Suicide Prevention Strategy, AWP has mirrored this ambition in its suicide

prevention strategy: committing itself to 'reducing the total number of confirmed suicides by at least 10 per cent from baseline by 2020.' (Appendix 2). As stated, as a city our objective is to reduce suicides by 25% by 2029, and an aim of reducing to the lowest levels in England.

In Bristol our goal is an ambitious one – reducing stigma, improving knowledge, motivation and competence to understand and provide help. We seek to create a city that is a safe, suicide preventative environment; to invest and take action in key areas to allow groups at higher risk to be able to gain streamlined access to support; and – with the support of the Suicide Prevention and Audit Group – to hold decision makers to account to ensure action and significant progress.

Item 7.3, Appendix 1

Appendix 1: Strategy Development Panel

Name	Title	Organisation
Glenn Townsend	Mental health commissioning Patient monitoring and development coordinator	NHS Clinical Commissioning Group
David Gunnell	Professor of Epidemiology	University of Bristol
Tom Hore	Director	Bristol Mind
Tom Renhard	Representation & Accountability Officer	Bristol Independent Mental Health Network
Paula Bentley	Bluebell Buddy	Bluebell
Greg Burgess	Deputy Chief Executive Officer	Papyrus
Martin R White	Public Health Officer	Public Health England South West
Maggie Cameron	Director	Bristol Samaritans
Leonie Roberts	Public Health consultant	Public Health and Commissioning, Bristol City Council
Magda Szapiel	Public Health Practitioner – Epidemiology, data analyst	Bristol City Council, Public Health, Neighbourhoods Directorate
Sarah Smith	Head of Safer Prisons and Equalities	HMP Bristol
Catherine Wevill	Mental Health Programme Manager	Bristol Mental Health Clinical Commissioning Group
Chris Ellis	Nurse Consultant and Joint Suicide Prevention Lead	Avon and Wiltshire Partnership Mental Health NHS Foundation Trust
Salena Williams	Senior Nurse, Liaison Psychiatry	Bristol Royal Infirmary
Project lead		
Victoria Bleazard	Mental Health and Social Inclusion Programme Manager	Public Health, Bristol City Council
Strategy author and project coordinator		
Salena Williams	Senior Nurse, Liaison Psychiatry	Bristol Royal Infirmary

Item 7.3, Appendix 1

Appendix 2: Evidence Considered for this Strategy

PUBLICATIONS

Date	Title	Publisher / Source
2016	The Five Year Forward View for Mental Health	NHS England
2016	Suicides in the UK: 2015 registrations	Office for National Statistics
2016	Guidance for creating a Suicide Prevention Plan	Public Health England
2017	'Preventing Suicide in England: third progress report on the cross-governmental outcomes strategy to save lives'	HM Government
2016	Media Guidelines for Reporting Suicide	Samaritans
2016	National confidential Inquiry into suicide and Homicide by People with Mental Illness	University of Manchester
2015	Inquiry into Local Suicide Prevention Plans in England: APPG for Suicide and Self harm Prevention	HM Government
2015	Preventing suicide in England: Two years on. Second annual report on the cross-government outcomes strategy to save lives	HM Government
2015	Aiming for 'zero suicides': An evaluation of a whole system approach to suicide prevention in the East of England	Centre for Mental Health
2015	Help is at Hand: Support after someone may have died from suicide	Public Health England
2014	Preventing suicide: A Global Imperative	World Health Organisation
2014	Information sharing and suicide prevention: Consensus statement	Department of Health
2012	Preventing suicide in England: A cross-government outcomes strategy to save lives	HM Government
2016	Map of guidance and evidence: interventions to prevent and manage suicide and self harm	Public Health Wales Observatory`
2015	Preventing suicide among lesbian, gay and bisexual young people	Public Health England
2017	Suicide Prevention Profile Perinatal Mental Health Profile Crisis Care Profile	Public Health England
2011	2011 Census	Nomis
2015	Primary Care Mortality Database	Health and Social Care Information Centre
2015	Health and Social Care Information Centre Indicator Portal	Health and Social Care Information Centre
2012 - 2016	ONS mid-year population estimates	Office for National Statistics
2010 - 2016	SUS hospital episodes data via NHS South, Central and West Commissioning Support Unit ABI database	NHS South, Central and West Commissioning Support Unit
2017	GP Patient Survey July 2017 gp-patient.co.uk	NHS England
2015	Annual Population Survey: UK Armed Forces Veterans residing in Great Britain	Ministry of Defence, ONS

Date	Title	Publisher / Source
2017	https://fingertips.phe.org.uk/search/suicide#page/0/gid/1/pat/6/par/E12000009/ati/102/are/E06000022	Public Health England
2016	Safety in Custody Statistics	Ministry of Justice and National Offender Management Service
2010 - 2015	*The 'RaRE Research Report: Risk and Resilience Explored' www.queerfutures.co.uk/wp-content/uploads/2015/04/RARE_Research_Report_PACE_2015.pdf*	PACE
2015 -16	*Bristol Quality of life Survey*	Bristol City Council
2016	*Joint Strategic Needs Assessment (JSNA)*	Bristol City Council
2016	*Nomis Labour Market Profile 2016 for Bristol LA*	Nomis, ONS

Appendix 3: References

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Hawton K Bergen H Dodd S et al. (2013) Long term effect of reduced pack sizes of paracetamol on poisoning deaths and liver transplant activity in England and Wales: interrupted time series analysis British Medical Journal 346: 403

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Walrath et al Am J Public Health. 2015;105:986–993. doi:10.2105/AJPH.2014.302496

South Gloucestershire Suicide Prevention Strategy: action plan*

Date: v.9 – January 2018

Priority actions	Detail	Lead	Timescale
Governance	Provide updates to H&WB Board. Support the development of a BNSSG Suicide Prevention Plan	MH Partnership LG/KA	Ongoing From Feb 18
Individuals who self harm	STORM training covers self-harm and suicide; ICS staff targeted to attend from 2018	Workforce Development/Public Health (Holly Magson/Mark Allen)	From Early 2018
Supporting individuals affected by financial issues/welfare reform	Work across the West of England to develop a joint approach to support people experiencing mental ill health to access or stay in the workplace. Training for CCG/AWP staff on UC/Welfare reform to be rolled out Development of pilot project proposed – to support debt and employment advice in primary care/IAPT	Steve Spiers Lynn Gibbons Kate Archibald In partnership with Bristol PH and South Glos WAP	Ongoing Spring 2018 Spring 2018
Helping those affected or bereaved by suicide	Updating local guide and to include in local wellbeing directory.	Adele Mildon	Feb 2018
Middle-aged men	Include within Healthchecks – use information cards eg Samaritans/MIND. Follow up to confirm information shared Movember – to be supported again in 2018. Discussion with WoE MH Partnership re joint comms Link to debt and employment work (as above)	Steve Spiers Steve Spiers and Lynn Gibbons, MH Partnership	 Nov 18

Children and Young People	From late 2017 Integrated Children's Services staff are the main focus for staff training with STORM course upskilling around self-harm and suicide starting early 2018. Off the Record have a new CYP IAPT workforce working across the system Work with Bristol PH to support universities and FE colleges re prevention and resilience in the student population. Possible link to NHS E bid.	LG/SS	From Feb 18
Older People	Service data suggests that over 70's are not accessing different local interventions as much as working age adults. This needs further investigation.		
Individuals in contact with criminal justice system	PHE leading (with HMPS) on suicide prevention work in prisons, to include Eastwood Park Avon and Somerset Reducing Reoffending Board Strategy to include MH needs of those involved in CJS, and development of Community Orders NHS England Collaborative Commissioning Project BNSSG –Trauma and Recovery Training for 120 Professional who work with CYP at risk of or with involvement with the criminal justice system. Additional BNSSG workforce capacity with YOTs and mental health services to support CYP in this cohort with their mental health needs. Speech and Language Therapy Training (Box training) delivered to YOTs and secure unit staff in BNSSG.	Rachel Campbell, PHE Lynn Gibbons KA	Ongoing Funding ends by March 2021
Working with coroners	West of England Local Authorities joint fund project (delivered by AWP) to access and analyse Coroner's data in real time. The group meets biannually to discuss findings, annual report published.	SB/LG & WoE PH partnership	Ongoing for 2018
Networks	Ensure attendance at AWP suicide leads meeting	SB/LG	Ongoing
Address stigma	Co-ordinate activities and communication linked to key MH days and campaigns: eg, Movember,	MH Partnership	Ongoing

Training Education	GP training particularly around suicide risk assessment – option to produce short information guide for GPs	LG/SS/KA	Ongoing
Adverse Childhood Experiences	Appointment of 1FTE job share to work across South Gloucestershire to support the ACEs approach to working with people with adults and children with trauma.	LG	

COMPLETED OR AMENDED ACTIONS		
Develop a local suicide prevention strategy		COMPLETED – TO BE RENEWED FOR JAN 2019
Develop action plan	Develop, implement and monitor via newly established South Gloucestershire Suicide Prevention Strategy Group which reports to South Gloucs Mental Health Partnership.	COMPLETED NB – now included in MH Partnership, with Action Plan T&F Group
Governance	Ensure reference to suicide prevention group in new MH strategy. Suicide trends and audit data to be referred to within the MH needs assessment and suicide prevention to be integrated within the overall MH Strategy.	COMPLETED
Individuals who self-harm	Ensure primary and secondary care compliant with NICE guidance (June 2013) – AWP work ongoing. Joint commissioners to review documents for 15/16 service specs.	Completed
	Training for acute Trust staff e.g. within ED - self-harm CaMHS team give ad hoc training to ED & annual UHB study day (BCH staff can attend).	Completed October 2015
	Review self-harm register data from UHB & NBT to track local trends and provide surveillance	NBT HIT Update October 2015
	Mental health promotion, prevention and early intervention – review service provision in relation to suicide prevention. Support those in crisis to prevent repetitive cycle of crisis with support after hospital discharge – address via strategy. Address issue re iapt referral to PCLS, GP for info, and crisis team for those generally at risk. AWP to map service provision and service criteria and link	Work done to improve the whole care pathway and in particular primary mental health offer. This aims to give individuals timely support and prevent crisis and therefore is part of a whole population suicide prevention approach.

	to GP comms.	
Supporting individuals affected by the financial crisis	Close working between specialist services, primary care and credit counselling services. Links to be further developed with the following organisations, local information to be developed and shared and specific suicide prevention training to be delivered: Well-being Hubs, DWP, ATOS training, Welfare and Benefits group, workplaces, YISS and job centres	May 2016: JCP staff booked onto ASIST, food poverty network have had a Promoting Positive Mental Health session. JCP staff booked onto ASIST along with VCSE worker supporting long term unemployed. Sept 17: JCP staff have attended PPMH course. Mental Health Awareness Week campaign in JCP Debt advice course part of WBC Employment skills courses part of WBC
	RCGP factsheet on managing suicide risk in primary care – review current information to practices and ensure user-friendly. RCGP factsheet should be tailored with SG audit data and risk groups specific to SG.	Peter Bagshaw, Sara Blackmore When local audit data available
Helping those affected or bereaved by suicide	Cruse provide fortnightly support (Bristol base). Bereavement resources (reading) – NS reading list to be shared with Fiona O'Driscoll, Denise Swain, Martin Burton Information on Prescribing – review options for sharing MH directory with primary care SOBS – ensure information included in directory of services SOBS Gloucester are happy to go in our local guides. Review national resources e.g. 'Help is at Hand'	May 2016: Local Bereavement Guide produced including information about Bereavement by Suicide, signposting postcard available. Sept 17: SOBS group in BANES that can be accessed by SG residents
Middle-aged men	Identify depression early in primary care – mental health needs assessment Include within Healthchecks – use information cards eg Samaritans/MIND.	May 2016: Health Checks do no specific screening around mental health or suicide but do give out a signposting guide at the end and agreed with Joanna Goodred to review mental health information to include crisis support and suicide prevention.

	Community outreach programmes in traditional male environments – identify existing resources (eg Samaritans) and local 'champions'. Possible use of sports role models and promotion via Active Card and sports clubs. Try to find a high profile advocate/champion. Focus for a future strategy group meeting	SS has made links with Brian Gardner and working with sports clubs – resourcing required. Use existing information/help leaflets from Samaritans/MIND. May 2016: Outreach work in rugby club completed but poor result. Evidence is poor for resources and comms eg beer mats or toilet doors . Sept 17: Successful Movember 16 campaign resulted in a number of new male MH champions coming forward. Getting men to access services still a big issue.
Children & young people	Early identification of young people with mental health problems, for example schools – link with SGC survey of schools and children's MH needs assessment. Continue to provide information to schools – tailor to need ie education re cutting, safety, risks. Links re young people in care and those with LDs. Partnership with Lottie Lawson, Brook and PCC. Link to educational sub-group of children's safeguarding Board.	May 2016: CAMHS Transformation plan developing a range of staff training option, awareness campaigns, improved internet content and resilience sessions for CYP re mental Off the record do have 'Harmless' groups to support young people around self-harm September 2017: A lot of work has gone into strengthening the CYP care pathway with Off the Record doing outreach work in schools and the community and peer support sessions developed in primary school.
	CYP IAPT programme – clarify service provision and content ie tier 3 (CaMHS), lower tier (< 16s counselling) etc. 'Off the record' now commissioned for ,16s. Update May 2016	There has also been a big programme of training for CYP staff with other 800 practitioners attending a course in 2016/7 including key work forces such as school nurses and teachers.

	Big increase in Off the Record Capacity (250 up to 1200)	
	Ensure link to CDOP	COMPLETE – South Glos rep on Board, annual report shared
Older people	Link to existing workstreams on social isolation in older people – ensure included in JSNA.	May 2016: Meeting set with Sue Jaques to look at work addressing social isolation in older people. A joint meeting between MH partnership and Older people group is planned for the autumn to look at social isolation.
Individuals in contact with mental health, drug & alcohol services	Link to alcohol and drugs services commissioning/strategy, MH commissioning/strategy & JHWBS. Alcohol needs assessment and substance misuse needs assessments currently being refreshed.	May 2016: ASIST training is being delivered jointly with DAAT and as a result substance misuse practitioners are being targeted. September 2017:New DAAT contract has a target about better join up of work with the mental health system including running sessions in partnership with the Wellbeing College
Individuals in contact with criminal justice system	Work with those recently released Peer mentoring	September 2017: Compass project working with ex-offenders part of the Wellbeing College but number taking part modest.
Specific occupational groups e.g. vets	Vets, GPs, dentists, practice members, Avon C.O.P.E – awareness raising amongst CCG member practices in first instance – via LMC. Develop leaflet/guidance based on local audit data when available.	September 2017: Some Wellbeing work with the fire service at Patchway fire station delivered via Wellbeing College Ambulance service looking a staff wellbeing and suicide prevention
Lesbian, gay, bisexual, transgender and questioning (LGBTQ)	Assess needs assessment & approach Phil Simons for evidence input. Link to schools.	September 2017: LGBTQ network set up March 2017 and mental health is a key focus of the work both in terms of challenging stigma but also raising awareness of supports in the community Event in October 2017 looking at hate crime against LGBTQ community.
Other groups	Eg Individuals with long term conditions, chronic conditions	SB / Jon Evans

	etc – link to chronic disease clinics. Carers registers link BME – make link with January event with Chinese population?	 SB/Denise Swain KA/Paul Frisby Update group Oct 15
Partnerships		
Working with coroners	Close working PH & coroners – develop process to enable real-time survellaince	SB & WoE PH partnership Update group Oct 15
Working with transport	Work with transport and other partners in H&WB Boards on identifying hot spots and taking appropriate actions – identify once local audit data available.	SB / Bob Eveley Update group Oct 15
National guidance	Review DoH 'Prompts for Leaders' and address gaps in knowledge and systems.	Completed
Data monitoring & surveillance		
	Improve access to real-time surveillance data to enable leads to monitor suicide trends, respond to incidents, (to include self harm register workstream). Possible partnership working with VCSE at A&E's Samaritans do this in a number of hospitals possible including RUH in Bath.	WoE LAs joint fund from 2017 (ongoing)
	Review findings of MH needs assessment in relation to suicide prevention notably service provision.	Completed – Mental Health Strategy published
Communications		
	Engage with local media regarding suicide reporting Samaritan have good guidelines available as to how to do this.	Media coverage delivered for World Suicide day on the 10th September September 2017: Via the Wellbeing College we have developed an outreach approach to take wellbeing activities into different workplaces. Big employers like Rolls Royce, Ministry of Defence and GKN and SGC have all had sessions.

		SGC and MOD have both achieved Time to Change accreditation
	Provide information to public eg MIND information 'supporting someone who feels suicidal'	
	Raise awareness of MH and peer support in YP	
	Workplace health promotion and support with local business. Training for frontline staff includes ASIST, Mental Health First Aid, and STORM. PHE's forthcoming national workforce development plan (due autumn 2014) will further assist this work. Suicide Talk and Safe Talk offered as shorter training option than Assist.	ASIST training programme now delivered for over 120 front line staff will receive training during 2016 and 2017. Workforces supporting around key risk factors such as drug and alcohol and debt, unemployment will be targeted.
	Address stigma – identify national resources etc. 'Time to change'	May 2016 : Mental health stigma (but not specifically suicide) addressed during - Mental health awareness week in May. - World Mental Health day in October - Movember for men's mental health in November September 2017: Added CYP mental health week in February to the existing programme with Adult MH week, World mental health day and Movember
Training/education		
	Work with police on mental health literacy	Update group Oct 15: Nick Thorne Workforce Development Lead + multi-agency training forum and link to ASIST training May 2016: The idea of a one minute guide being
	Provide training to relevant healthcare staff GP training particularly around suicide risk assessment and also information sharing with offer of support from Papyrus	

		developed around suicide risk assessment for a range of key staff. ASIST is targeting 120 front line staff but the 2 day commitment is seen as a barrier to some people accessing it. 90 mins or half day alternatives are an option. Sept 2017: Lot of adults 1300 in (2016/7) attending courses including ASIST and safetalk. However little engagement from GPs and briefing paper or quick guide on suicide risk may still be a useful resource

*Priorities based on HM Government February 2014 'Preventing Suicide in England: one year on-first annual report on the cross-governmental outcomes strategy to save lives' and reflecting the needs highlighted in the South Gloucestershire Suicide Prevention Strategy 2015-2018

North Somerset Suicide Prevention Action Plan

Live or ongoing work

Objective	Projects	Milestones	Timescales (complete by)	Lead	Status
Ensure effective implementation of suicide prevention work	Establish a multi-agency suicide prevention group including public health, CCG, Primary Care Providers, voluntary sector organisations, secondary MH, emergency services, CJS.	Review current membership of steering group to ensure appropriate representation from various agencies Monitor attendance at meetings	October 2017 Ongoing	CCG and Public Health	Ongoing
	Work with NHS England to identify work that can be funded through the new suicide prevention fund, estimated to be around £33,000-£66,000 a year.	Contact Mental Health Clinical Network Obtain confirmation from NHS England when funding will be available and what it can be used for	February 2018	CCG	Live
	Ensure the work around the local prevention concordat for better mental health includes the suicide prevention action plan.	Include most up to date data on deaths from suicide and self-harm rates in the mental health needs assessment. Ensure the work of the suicide prevention steering group is considered when developing the prevention concordat action plan. Once priorities from prevention concordat have been identified review whether this stream and the suicide prevention work can be merged	December 2018 December 2019 March 2020	Public Health	Live

Objective	Projects	Milestones	Timescales (complete by)	Lead	Status
Reduce the risk of suicide in high risk groups	Look at pulling together all the different case reviews that have a suicidal element to them and bring the findings to the suicide prevention group to ensure all lessons can be learnt and any common themes picked up	Scope out existing reviews and reporting Agree future process and timetable going forward	Mar-2018 Apr-2018	Public Health/CCG	Live
	Development of a Crisis Card to be used by people in the care of mental health services who transition to the community	Write project plan Approval for project Consult with service users and stakeholders who would use the card Develop card Launch tool	September 2017 December 2017 March 2018 May 2018 June 2018	AWP	Live
Reduce the stigma around mental health and promote wellbeing	Develop mental health awareness raising campaign under the umbrella of Warriors of Wellbeing	Launch Warriors of Wellbeing Run first event for World MH Day 2017 Review lessons learnt Develop timetable of events for 2018 Run events for World MH Day, Mental health Awareness Week and smaller events around time to talk day and World Suicide Prevention Day	August 2017 October 2017 October 2017 December 2017 Ongoing	Public Health, AWP, 1in4 and CCG	Live
	Launch Healthy Schools Healthy Minds project in Secondary schools. Project aims to showcase good practice, raise the profile of mental wellbeing and identify areas that would benefit from further development	Develop a mental health checklist for schools Launch programme with schools Deadline for schools to submit expressions of interest School visits and network meetings set up Schools submit checklists Moderation visits to assess impact Evaluate programme	July 2017 April 2018 April 2018 July 2018 July 2018 July 2019 December 2019	Public Health	live
Supporting workforce	Develop mental health training package for people working and	Pilot Connect 5 training and plan training courses for next twelve months	January 2018	Public Health	Live

Objective	Projects	Milestones	Timescales (complete by)	Lead	Status
	volunteering in North Somerset	Develop further work with GPs and practice staff around suicide prevention training	February 2018	CCG	Live
	Control room and street triage projects	Present business case for proposed control room triage and street triage merger Evaluate service delivery to date Agree funding for services going forward	Ongoing	CCG & AWP	Live
	Review content of NS Online Directory	Review current content Identify any gaps Finalise content	June 2018 June 2018 July 2018	Public Health but all take responsibility to review their services	Live
	Look at developing physical form of a directory of services	Scope existing directories that cover North Somerset Write project plan Seek approval for project Consult with service users and stakeholders who would use the directory Develop directory Pilot directory Finalise directory Launch Scope existing directories that cover North Somerset Write project plan	Apr-18 Jun-18 Aug-18 Nov-18 Feb-19 Feb-19 Mar-19 Apr-19 Apr-19 Jun-19	AWP	Live
Tailor approaches to improve mental health in specific	Work with CCG equalities and diversity lead to further develop local links	Identify key local groups to establish links with e.g. LGBT, BME	June 2018	CCG	Live

Objective	Projects	Milestones	Timescales (complete by)	Lead	Status
groups	Research shows that lesbian, gay, bisexual and transgender people (LGBT) are more likely to suffer from suicidal thoughts than their straight friends, particularly those who are young. As part of our work to improve the mental health of people in specific groups Public Health have funded North Somerset LGBT forum to develop a programme of work.	Pull together a communications package for use at events to publicise the work of LGBT forum Develop a quarterly newsletter to help engagement with individuals in rural areas Run drop in sessions at the following locations for a range of client groups including young people, those in drug and alcohol treatment/recovery, older people, BME groups. Website update	March 2018 January 2018 October 2017 October 2017	LGBT and Public Health	Live
	People with Autism Spectrum Disorders such as Autism and Asperger's syndrome can be prone to depression, which may lead to a risk of suicide in some cases	Working with Bridging the Gap and BASS Autism Services to better understand the work that is undertaken in North Somerset and where the gaps exist.	February 2018	NSCCG	Live
	Financial problems are often a trigger for marital break down, family problems and loss of employment. Research has shown that suicide is considered by nearly half of all people struggling to make ends meet.	Work with Citizen Advice North Somerset and wider West of England Public Health colleagues to develop a programme of work to tackle the mental health issues associated with financial problems.	June 2019	Public Health	Live
Reduce access to the means of	Continue to monitor deaths associated with the railways	Annual report produced about deaths on local railway networks	Annual to be agreed	BTP	Live

Objective	Projects	Milestones	Timescales (complete by)	Lead	Status
suicide	Suicide prevention work with staff and passengers at local priority railway stations	Raising awareness of Samaritans services with railway staff and passengers. Post incident support offered to railway station staff and passengers if there has been a traumatic rail suicide	Ongoing and when needed Ongoing and when needed	Samaritans	Ongoing
	Review suicide audit findings to identify most methods of suicide and identify appropriate interventions	Review findings If identified develop interventions which will reduce access to the means of suicide	March 2018 July 2018	Public Health	Live
Provide better information and support to those bereaved or affected by suicide	Scope potential project to fund a coroner liaison service	Pull together a group of interested parties including CCG, Public Health, A&S Police Identify coroner liaison service in other area and organise visit Develop feasibility plan for North Somerset include outline of costs	December 2017 January 2018 March 2018	Tbc	Live
	Continue to support and run the Weston-super-Mare support group for those bereaved by suicide	Monitor number of attendees Promote service on annual basis	Ongoing	Public Health	Ongoing
Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour	Weston-super-Mare Samaritans Branch to continue monitoring the reporting of potential suicides in the media and working with media outlets when a problem arises	Deliver a presentation to the steering group explaining the Samaritans media guidelines identifying where breaches have occurred locally and what actions have been taken.	Annual to be agreed	Samaritans	Live

Objective	Projects	Milestones	Timescales (complete by)	Lead	Status
Supporting research, data collection and monitoring	Avon coroner audit work. A West of England report looking at suicides across the 4 areas will be produced. Further data analysis including hotspot mapping planned.	Data collection Review annual data report	Ongoing March 2018	Public Health	Ongoing
Reducing rates of self-harm as a key indicator of suicide risk	Self-harm amongst young people	Review healthy minds programme checklists to identify work around self-harm in schools Attend Healthy Minds moderation visits to assess impact Look at developing and supporting interventions in schools which aim to reduce rates of self-harm	December 2018 July 2019 September 2019	Public Health	Live
	Admissions to hospital due to self-harm	Analysis to understand significantly high rates of admissions to hospital	December 2018 onwards	Public Health	Live
	Review adherence to NICE guidance around self-harm	Benchmark current service provision against NICE guidance Understand where gaps exist in service provision	February 2018 March 2018	CCG	Live

Completed actions

Objective	Projects	Milestones	Timescales (complete by)	Lead	Status
Ensure effective implementation of suicide prevention work	Refresh current action plan	Review progress against current plan Consultation Draft plan Final feedback Finalise document	August 2017 September 2017 September 2017 November 2017 January 2018	Public Health	Complete
	Formalise the reporting framework for suicide prevention work in North Somerset	Review existing reporting frameworks within CCG and NSC and agree reporting lines.	November 2017	CCG and Public Health	Complete
Reduce the stigma around mental health and promote wellbeing	Supporting Walking out of Darkness event in September 2017 in Weston-super-Mare which aims to raise awareness around mental health issues.	Engage with local charities organisations to participate in the Mental health festival Promote the walk amongst stakeholders	Ongoing up to event Ongoing up to event	Public Health	Complete
Supporting workforce	Develop mental health training package for people working and volunteering in North Somerset	Plan ASIST training programme for 2018/2019	End September	Public Health	Complete

Avon and Wiltshire Mental Health Partnership NHS Trust

Suicide Prevention Strategy

Board library reference	Document author(s)	Assured by	Review cycle
P147	Anthony Harrison Chris Ellis	Quality and Standards Committee	3 years

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Contents

1. Terminology

In-patient suicide:

Death by suicide of a person who was registered as being an inpatient within a mental health ward/unit/hospital at the time of their death, irrespective of the exact location of their death.

Patient suicide:

Death by suicide of a person who had been in contact with mental health services in the 12 months prior to their death, but excluding IAPT and other primary care based mental health services.

Suicide:

The act of deliberately taking one's own life. Excludes other definitions where the word 'suicide' is also used – eg: 'physician-assisted suicide', 'suicide bomber', etc.

Suicide rate:

Refers to the number of suicides which have been adjusted to take into account epidemiological variations in populations (groups of people) such as age, gender, number of people receiving a service, etc. Nationally and internationally the suicide rate is the number of suicides per 100,000 of the population.

2. Introduction

Suicide is a devastating event; family, friends, and the wider community feel its emotional and practical consequences. This strategy outlines the wide range of work being undertaken across AWP that contributes to the prevention of suicide and describes our plans for the next three years (2017-20). As with our previous strategy (2014), it is consistent with the aims and approach of the national strategy – Preventing Suicide in England 2012 and updated in 2017.

Suicide prevention is a complex and challenging task which requires a co-ordinated approach by a number of different agencies. Research indicates that the prevention (minimisation) of suicide, while feasible, involves a whole series of activities, ranging from the provision of the best possible conditions for bringing up our children and young people, through the effective treatment of mental disorders, to the environmental control of risk factors. Therefore prevention strategies should be directed partly at factors which reduce the risk of suicide occurring (eg: availability of dangerous means for suicidal acts, knowledge and attitudes of the population concerning the prevalence, nature and treatability of mental disorders, and media portrayal of self-harming and suicidal behaviour), and partly at recognised high risk groups (eg: people with mental health problems, people in prison, people with an addiction to alcohol and/or drugs).

In general, national suicide rates have risen since the 2008 recession except in Scotland where there has been a sustained fall. The rate in England now appears to be falling. The highest rate is in Northern Ireland. There is variation also within each country, by geographical area. In England this variation is systematic, with higher rates in the north and south-west, and lower rates in London and adjacent south central areas.

There continues to be wide variation in suicide rates in each country by age and gender, with the highest rates in men in middle age. The highest male to female ratio is in Northern Ireland.

The number of suicides by mental health patients in the UK has risen in recent years, mainly as a result of increases in England. This primarily reflects the large rise in the number of people under mental health care in England. During 2004-14, 28% of suicides in the UK general population were by people under mental health care, a total of 18,172 deaths since 1996.

Data relating to suicide, undetermined death and high risk groups has been obtained from the:

- Office of National Statistics (ONS) – 2015 [This is the most recently published data].
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) – 2016.
- Department of Health (England) – Suicide prevention: Third annual report – 2017.

A target of reducing suicide by 10 percent by 2020, from its 2015 baseline, has been set by the Department of Health. Our strategic aim is to mirror this national target, reducing the total number of confirmed suicides *by at least* 10 percent from baseline by 2020[1].

AWP links with public health colleagues who are responsible for suicide prevention in our local general populations, through our six locality suicide prevention groups, and our two STP areas. Each STP will have its own over-arching suicide prevention strategy, with AWP being an active participant in these networks. At the time of writing, detailed STP-wide suicide prevention strategies have yet to be published.

3. National trends in suicide

The ONS definition of suicide includes all deaths from intentional self-harm for persons aged 10 and over, and deaths where the intent was undetermined for those aged 15 and over. This definition was revised in January 2016.

According to the ONS the most recent data on suicides can be summarised as:

- In 2015 there were 6,188 suicides in the UK, a small increase from 6,122 deaths in 2014.
- In 2015, the suicide rate in the UK rose slightly to 10.9 deaths per 100,000 of the population, up from 10.8 in 2014. This was made up of a decrease in the male suicide rate from 16.8 to 16.6 deaths per 100,000 of the population and an increase in the female rate from 5.2 to 5.4 deaths per 100,000, the highest female suicide rate since 2005.
- Of the total number of suicides (6,188 deaths) registered in the UK in 2015, three-quarters (75%) were males and one-quarter (25%) were females.
- The most common method of suicide amongst males and females in the UK in 2015 was hanging.

4. National trends in suicide in mental health patients

Mental health patient suicides are referred to as 'patient suicides' by the NCISH, and for the purposes of suicide prevention reporting this group of people is defined as those individuals

[1] A separate workplan and annual updates regarding this target will be published as part of our Sign-Up to Safety activities.

who were either in contact with mental health services (including statutory drug and alcohol services) at the time of their death, or had been in contact with services at any point in the 12 months prior to their death (NCISH, 2016). This definition does not currently include people who have only been referred to primary care-based mental health services, such as IAPT.

The number of patient suicides in the UK, driven by figures from England, has risen over the past 20 years. However, the *patient suicide rate* – ie: taking into account increases in the number of people under mental health care, has fallen. The calculation is not straightforward, however, being complicated by inconsistent estimates of total patient numbers, re-organisation and re-provision of mental health services (including new models of care delivery), and a changing clinical population.

Suicide by mental health in-patients (ie: people who were registered as being in a mental health unit at the time of their death) continues to fall, most clearly in England where the decrease has been around 60 percent during 2004-14. This fall began with the removal of ligature points to prevent deaths by hanging, but has been seen in suicides on and off the ward and by all methods. Despite this reduction, there were 76 suicides by in-patients in the UK in 2014, including 62 in England.

The trend in individual settings is clearer. The main setting for suicide prevention is now the crisis team, following a substantial fall in in-patient suicides and a rise in the use of CRHT as an alternative to admission in acute care. The fall in suicides after leaving in-patient care has been less substantial and the post-discharge period, especially the first two weeks, continues to be a time of high risk.

The clinical and social characteristics of patients who die by suicide show a number of changes over the last 20 years. Certain risk factors have become more common as precipitants of suicide - these are the factors that services have to address to reduce risk, including:

- Isolation
- Economic adversity
- Alcohol and drug misuse
- Recent self-harm

Non-adherence to medication in the period leading to suicide has become less common; loss of contact is less frequent than 20 years ago but continues to be a common antecedent.

5. Methods of suicide – general population

The most common methods of suicide among the general population are:

- Hanging and strangulation – 47%
- Self-poisoning (overdose) – 21%
- Jumping and multiple injuries – 11%
- Drowning – 4%
- Gas inhalation (including carbon monoxide poisoning) – 3%
- Cutting/stabbing – 3%
- Firearms – 2%

6. Methods of suicide – mental health patients

Between 2004 and 2014, 13,921 deaths (28 percent of general population suicides) were identified as patient suicides – ie: the person had been in contact with mental health services in the 12 months prior to death, but excluding IAPT and other primary care based mental health services.

The number of suicides in male patients has increased since 2006. For females, there has been a 12 percent rise to 2013 since 2006. The rise in male patient suicides since 2006 is 22 per cent, whereas the general population rise in male suicides is less, at 12 percent from 2006 to 2013.

There was an increase in the number of male suicides in those aged under 25, 45-54, 55-64 and 65+. The rise in male patients aged 45-54 and 65+ has been particularly striking since 2005-06. The number of female suicides did not change overall in any age-group.

The most common methods of suicide by mental health patients were:

- Hanging and strangulation – 43%
- Self-poisoning – 25%
- Jumping/multiple injuries – 15%

The most common types of drugs used in suicide were:

- Opiates - 24%
- Tricyclic antidepressants – 12%
- Anti-psychotic drugs – 11%

- Paracetamol/opiate compounds - 9%
- SSRI/SNRIs antidepressants - 9%

7. Local trends in general population suicide

The suicide rate (number of suicides per 100,000 of the population) for each of our respective STP footprint areas is as follows:

- Bristol, North Somerset & South Gloucestershire 10.0
- Bath, Swindon & Wiltshire 8.9

The highest rate of suicide was in Cornwall and the Isles of Scilly, at 13.8, twice the lowest rate, in South West London, at 6.9. In general the highest rates are in the north and south-west, with the lowest rates in London and the south-central areas.

ONS suicide rates mapped to English local authorities can be found at:
http://fingertips.phe.org.uk/search/suicide

8. National analysis of suicide trends in AWP

The NCISH provide data[2] for suicide rates in respect of all NHS trusts in England; the rates for 2011-13 and 2012-14 (the most up-to-date figures) show that:

- In 2011-13, we had a suicide rate of 11.4 per 10,000 people under mental health care, compared to the median of 7.65 for the rest of England;
- In 2012-14, we had a suicide rate of 8.6 per 10,000 people under mental health care, compared to the median of 7.13 for the rest of England.

National data analysed by Mazars[3] on behalf of NHS England in 2015 identified that our standardised death rate (all causes, including suicide) is higher than the national (England) average and the average for the South West of England.

These data, whilst recording a significant fall in the rate from 11.4 to 8.6 for the most recent years, nevertheless show AWP with a consistently higher rate than the national average for the rest of English NHS trusts. It is possible that our higher rates are, at least in part, explainable by

[2] Summary data in this format have only been supplied by the NCISH since the start of 2016. Given this only covers two whole years, annual fluctuations should be treated with caution as these are not necessarily indicative of particular future trends.

[3] Mazars' data were supplied to AWP (along with other mental health trusts nationally) as a 'one-off' exercise as part of NHS England's (2015) follow-up to the investigation into the failings at Southern Health NHS Foundation Trust.

the fact that total population suicide rates for the South West are higher than the average for the rest of England. It is important to state that in offering a possible explanation, we are not seeking to justify or accept an inevitably high suicide rate.

9. Suicide prevention within AWP

Our approach to suicide prevention is consistent with the Government's current strategy for England (2012), which was expanded in 2017. Additionally, there is an expectation that we include the principles derived from the 'Zero Suicide Program', which originated in Detroit, USA. This is a health systems-wide approach aimed at eliminating all suicides, and has been adapted for implementation in some parts of the UK. The limited UK evaluations of Zero Suicide (Centre for Mental Health, 2015) have yet to demonstrate either complete adherence to the US model, or the ability to successfully achieve zero suicides in the pilot sites. The contested nature of Zero Suicide means that we have adopted a pragmatic interpretation of the approach, focusing instead on 'zero tolerance' of non-implementation of core patient safety activities across all our clinical services – see Action Area 1, below.

Our suicide prevention strategy and associated work plan are part of our broader Sign-Up to Safety actions.

Our strategy addresses seven key areas of suicide prevention activity:

1 Reducing the risk of suicide in high risk groups.

2 Tailoring approaches to improve mental health in specific groups.

3 Reducing access to means of suicide.

4 Providing better information and support to those bereaved or affected by suicide.

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

6 Supporting research, data collection and monitoring.

7 Reducing rates of self-harm as a key indicator of suicide risk.

Core suicide prevention activity within AWP will focus on the domains for which we have primary responsibility. Each of the seven domains has been broken down into areas for action (see below), which inform our detailed 'suicide prevention work plan'.

10. ACTION AREA 1: Reduce the risk of suicide in high risk groups

What we know

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) has highlighted the importance of optimizing service user safety across care pathways. Specific aspects of the mental health care pathway where there is potential for suicide prevention includes:

- Removing and minimising fixed ligatures on inpatient wards reduces suicide;
- The majority of inpatient suicides have a history of absconding from, or not returning to inpatient care;
- Half of all inpatient suicide deaths occur in people who are being observed by less experienced or skilled staff;
- On discharge from hospital, the highest number of suicides occurs in the first three days of leaving hospital; and the first three months remains a significantly high risk period;
- Deaths in the first two weeks after discharge are linked to admissions lasting less than seven days, lack of a care plan on discharge, and adverse life events;
- Eleven percent of suicides occur in people who are discharged from out-of-area units (ie: a unit that is not local to them);
- Three times as many suicides occur in people who are in contact with crisis teams than occur in inpatient settings;
- Nearly half of all suicides among people under the care of crisis teams live alone; 40 percent die within two weeks of leaving hospital, and 33 per cent of crisis team patients have been under the service for less than one week;
- For people classed as 'difficult to engage', assertive engagement and follow-up practices are associated with lower suicide rates;
- Over 60 percent of suicides among people known to mental health services have an alcohol misuse problem, and more than one third have a drug misuse problem;
- The implementation of a dual diagnosis policy and protocols are associated with up to 25 percent fewer suicides;
- Multi-disciplinary incident review, the implementation of learning, and effective information-sharing with families are associated with significant reductions in suicide deaths;

- Depression and other mood disorders are the most common mental health problems associated with suicide; organisations that implement national clinical guidance (eg: NICE depression and self-harm guidelines) are associated with up to a quarter fewer suicide deaths;
- Person-centred risk assessment and management practice is associated with fewer suicide deaths, when compared to standard 'tick-box' screening and assessment;
- More effective engagement and collaborative care with families can significantly reduce suicide risk;
- There are fewer suicides in organisations who have a lower turn-over of clinical staff (excluding doctors);
- A recent episode of self-harm is a well-recognised antecedent to suicide; over half of all children and young people (under 20 years) had self-harmed in the week before taking their own life;
- The number of people who attend the emergency department for self-harm in the three months prior to suicide continues to increase;
- Opiate-based drugs, followed by tricyclic antidepressants are the most commonly used medications in fatal overdose;
- A quarter of people who die by suicide have a major physical illness (44 percent in people aged over 65-years);
- Major depression is linked to an increased suicide risk in people with diagnoses such as heart disease, stroke, chronic obstructive pulmonary disease and cancer;
- The highest suicide rates are in men in middle age. Suicide rates in men aged 45-54 years have increased by 26 percent since 2006; this appears to be more than twice that of the general population.

A summary of the main characteristics of people in contact with mental health services who die by suicide is provided in Table 1.

Table 1: Mental health patients who die by suicide are most likely to:

Demographics:

- Be male
- Be unmarried
- Live alone
- Be unemployed

Priority mental health groups:

- Have been discharged from mental health services within three months
- Have missed last mental health contact within one month of death
- Have not adhered with psychotropic medication in the month before death

Clinical features:

- Have been diagnosed with a mental illness within 12 months of death
- Have had repeated in-patient admissions (>5)
- Have had a final in-patient admission that was a *readmission*

Behavioural features:

- Have a history of self-harm
- Have a history of alcohol misuse
- Have a history of violence
- Have a history of drug misuse

Contact with services:

- Have had their last contact with mental health services within 7 days of death
- Have had recognised symptoms of mental illness at their final contact

What we will do

Action Area 1 is detailed in 6 sections below. Overall however, this strategy launches our Zero Tolerance approach which focuses on 3 vital areas of clinical practice relating to suicide prevention. We will develop and implement an organisation-wide strategy titled First Time, Every Time which will focus on always ensuring the following elements of care are in place:

As an organisation we will not tolerate the absence of:

- Person-focused clinical risk assessment
- Person-focused clinical risk management

- Effective carer/family engagement in risk assessment, management and suicide prevention

First Time, Every Time will be evidenced through every staff member constantly ensuring that both their own and their colleagues' clinical risk assessment, clinical risk management, and carer engagement in suicide prevention is observable as being of a high standard. Staff members will feel confident in their own practice and in appropriately challenging any examples where they consider this is not of a high standard. The aim is to standardise the culture regarding these domains across the whole organisation.

10.1 Inpatient care

10.1.1 Every inpatient ward will undertake regular (minimum annually) fixed ligature assessments to identify and remove (or manage the associated risks) ligature points.

10.1.2 Develop and implement an anti-absconding toolkit and resources.

10.1.3 Review and revise current observation and engagement policies and practice, utilising the most up-to-date evidence.

10.1.4 Review and revise post-hospital discharge policies and procedures to reflect the most up-to-date evidence.

10.1.5 Develop an 'Inpatient Module' for the Clinical Toolkit, which will include up-to-date information regarding all aspects of inpatient suicide risk assessment and management.

10.1.6 Ensure zero out-of-area inpatient placements.

10.1.7 Appoint an 'Out-of-Trust Placements Manager'.

10.1.8 Establish due diligence processes in order to ensure that any non-AWP placement meets CQC quality requirements.

10.1.9 Establish systems which monitor all service users admitted to non-AWP placements.

10.2 Intensive services

10.2.1 Implement the Collaborative Assessment & Management of Suicidality (CAMS) across all intensive teams for people who are acutely suicidal.

10.2.2 Develop and implement the robust use of CAMS measures as a mechanism for assessing and monitoring the appropriateness of home treatment as the preferred service delivery option for people who are at high risk of suicide.

10.2.3 Continue to promote awareness via acute care reviews, service induction, clinical supervision, and professional development (training) of the relative suicide risk for the following:

a) the appropriateness of home treatment as the preferred service delivery option for people who live alone and have little or no social support;

b) the high risk period immediately following discharge from hospital;

c) the relatively high risk period when first taken on for home treatment.

10.3 Improve risk assessment and management processes

10.3.1 Through the First Time, Every Time initiative, implement and promote an organisational culture regarding the importance of focusing on the following core patient safety domains:

- Person-focused clinical risk assessment;
- Person-focused clinical risk management;
- Effective carer/family engagement in risk assessment, management and individual suicide prevention.

10.3.2 Develop, implement and promote the First Time, Every Time initiative and reinforce the essential nature of risk assessment, risk formulation, risk management, and effective carer/family engagement as core patient safety actions.

10.3.3 Undertake a review and revision of the 'risk screen' elements of our current electronic patient record (RiO), ensuring that it reflects current evidence-based practice and good practice regarding the assessment and management of risk.

10.3.4 Integrate a 'risk formulation' section within the revised RiO risk screen, as a way of embedding formulation as a core element of risk management practice.

10.3.5 Undertake a review and revision of the clinical guidance on the assessment and management of risk.

10.3.6 As part of the revised Clinical Toolkit, develop and disseminate resources for practitioners that address:
- Adequate assessment and treatment of underlying condition and presenting symptoms;
- Removal and/or reduction in access to means;
- Modification of risk factors;
- Continued and regular assessment of risk.

10.3.7 Establish an operating standard of 100 percent compliance with completed risk assessment, risk formulation and risk management for eligible service users – ie: First Time, Every Time.

10.3.8 Ensure 'suicide prevention and risk assessment' (e-learning) training remains a mandatory requirement for all clinical (including clinical management) staff.

10.3.9 Provide team-based suicide prevention and risk updating for all clinical teams.

10.4 Family and carer involvement in risk assessment and management processes

10.4.1 Develop and implement a trust-wide patient safety initiative, with associated workplan, aimed at reinforcing and demonstrating consistent practice in relation to:
- Family/carer involvement and collaboration in respect of comprehensive risk assessment;
- Effective engagement and collaboration with carers and family members regarding risk management.

10.4.2 Develop and implement First Time, Every Time, supported by a comprehensive communication campaign aimed at promoting and reinforcing the changes in culture with regard to family and carer engagement that ensures a consistent focus on:
- Person-focused clinical risk assessment:
- Person-focused clinical risk management;
- Effective carer/family engagement in risk assessment, management and suicide prevention.

10.4.3 Revise and update the electronic patient record (RiO) risk screen, ensuring that the core elements of risk assessment, risk formulation and risk management are standardised, all of which provide the necessary administrative structures to prompt and reinforce the requirement to involve carers and family members in risk assessment and management

processes.

10.5 Dual diagnosis

10.5.1 Promote the Dual Diagnosis Strategy across all teams and services and as part of training and professional development in suicide prevention.

10.6 Unexpected death review process

Addressed in ACTION AREA 4.

11. ACTION AREA 2: Tailoring approaches to improve mental health in specific groups

What we know

The national suicide prevention strategy identifies that one way to reduce suicide is to address the mental health of the population as a whole – frameworks and approaches to improved mental health are set out in No Health Without Mental Health and Healthy Lives, Healthy People. These are not necessarily discrete groups, and many individuals may fall into more than one of these groups, for example, some black, Asian and minority ethnic (BAME) groups are more likely to have lower incomes or be unemployed. Lesbian, gay, bisexual, transgender and questioning (LGBTQ) individuals are at increased risk of feeling marginalised and stigmatised.

We know that men are three times more likely than women to take their own life, and that middle aged men are at highest risk, particularly those who are socioeconomically disadvantaged. Men also often find it difficult to engage with mental health services.

We know that women with previous or current mental health problems are at increased risk of suicide during pregnancy.

Young people are vulnerable to suicidal thoughts and their risk may be increased when they identify with people who have taken their own life or when such acts are highlighted and promoted through various social media platforms. Self-injury is becoming increasingly common in this group. Older people are also a potentially high risk group – those who have self-harmed have a more significant level of lethality associated with their actions.

What we will do

11.1 Partnership working

11.1.1 Continue to work collegiately with public health leads and commissioners across all areas on the development and implementation of community-wide suicide prevention plans.

11.1.2 Organise and administer bi-annual meetings with local authority public health/suicide prevention leads and the Bridge Master from Clifton Suspension Bridge.

11.1.3 AWP suicide prevention leads will participate in local suicide prevention strategy/monitoring groups.

11.1.4 AWP suicide prevention leads will participate in the emerging STP-wide footprint for suicide prevention strategies.

11.1.5 AWP will manage the Avon Coroner Suicide Monitoring Project, jointly commissioned by Bath & North East Somerset Council, as a way of monitoring and reviewing local suicide data.

11.2 Children and young people

11.2.1 Engage effectively with young people at risk of suicide.

11.2.2 Develop a plan of work with young people who self-harm.

11.2.3 Develop a plan of work supporting families of young people who self-harm.

11.2.4 Develop a plan of work aimed at promoting resilience in young people.

11.2.5 Develop a primary care training programme aimed at the identification of young people who are high risk of suicide.

11.2.6 Promote CAMHS to LGBTQ groups at increased risk of suicide.

11.2.7 Develop a standardised tool aimed at improving the assessment of suicide risk in young people who present to CAMHS.

11.3 Perinatal mental health

11.3.1 Identify and develop 'Perinatal Mental Health Champions' within each clinical team across AWP.

11.3.2 Implement cross-agency care pathways for pregnant and postnatal women, aimed at facilitating prompt identification, assessment and care planning for women in the perinatal period and ensuring no woman is discharged from mental health services during and immediately after pregnancy.

11.3.3 Ensure senior psychiatric assessment for all pregnant women under mental health services, with care co-ordination or support by Band 6 qualified staff.

11.3.4 Ensure perinatal risks are identified and recorded as part of standard Safeguarding procedures and risk assessment.

11.4 BAME, LGBTQ, and unemployed individuals

11.4.1 We will continue to focus on BAME and LGBTQ individuals and those who are unemployed via our active involvement with community-wide suicide prevention activities in locality public health services and STP footprints. Avon & Wiltshire Mental Health Partnership NHS Trust values and celebrates the diversity of all the communities it serves. We are fully committed to ensuring that all people have equality of opportunity to access our service, irrespective of their age, gender, ethnicity, race, disability, religion or belief, sexual orientation, marital or civil partnership or social and economic status.

12. ACTION AREA 3: Reducing access to means

What we know

Reducing access to lethal or potentially high lethality means is one of the most effective ways of preventing suicide; for example, reducing pack sizes of easily available analgesics has led to a significant reduction in the number of suicide deaths associated with these drugs. Novel or new methods of suicide may occur at any time, for example the inhalation of solvent gas and barbecue fumes. People may attempt to end their life on impulse, and if high lethality means are not readily accessible or easily available, the suicidal impulse may pass.

Learning from previous unexpected death reviews has identified that:

- Many people who take their life have had a history of reluctant compliance or non-compliance with psychiatric medication.
- The risks of prescribing certain psychiatric medications are not always adequately assessed.

The most amenable methods to intervention are removal of potential ligature points in inpatient settings, withdrawal of certain analgesics and limitations in the size of packs that can be purchased, restrictions on the quantities of medications that can be used in overdose being dispensed, and reducing access to areas with easily accessible means of suicide, such as multi-storey car parks and motorway bridges.

What we will do

12.1 Environmental safety monitoring of inpatient areas

12.1.1 Continue to assess, reassess and monitor access to non-collapsible curtain rails, shower rails and cubicle rails in all patient-accessible sites.

12.1.2 Continue with the ligature assessment, monitoring, removal and/or remediation of fixed ligature points such as door ironmongery, window fittings and locks, sanitary ware and bathroom furniture, and bedroom furniture.

12.1.3 Ensure that all inpatient areas undertake an environmental ligature audit using the Manchester Ligature tool on an annual basis, or more frequently if there has been a significant change of use or service redesign.

12.1.4 Implement a ligature monitoring and reduction strategy, informed by regular environmental assessment and review, overseen by the Ligature Reduction Group.

12.2 Supply of medication

12.2.1 Work collaboratively with GPs, community pharmacists and specialist prescribers of medication (eg: HIV medicines) to ensure that there is ratification of prescribed medication (medicines reconciliation) and effective medicines management strategies to highlight non-compliance.

12.2.2 Ensure access to the national Summary Care Record for all clinical staff involved in medicines reconciliation.

12.2.3 Assess the requirement for 'as required' medication and supply accordingly.

12.2.4 Assess, reassess and monitor safety to manage medicines; reduce quantities supplied and/or arrange additional support, where necessary.

12.2.5 Review, rationalise and 'de-prescribe' medications where indicated.

12.3 Proportionate information sharing to reduce the risk of suicide

12.3.1 Share information when necessary with other agencies and professionals – eg: GPs, pharmacists, criminal justice agencies, the police and British Transport Police when we are aware of active suicidal ideation or plans that involve access to means that can be moderated.

12.4 Monitor 'suicide hot-spots'

12.4.1 Collaborate with public health colleagues to identify geographical 'hot-spots', where there have been one or more suicides. This information will be used to inform and intervene in order to improve safety in areas where a high risk area is identified.

13. ACTION AREA 4: Learning from investigations and reviews into unexpected deaths

What we know

The quality and generation of learning from incident reviews – specifically unexpected deaths and suspected suicides – is variable across the NHS, as well as within AWP. Strategies to address this variability have been introduced since 2015; including NHS England's revised

Serious Incident Framework (2015). AWP's own analysis of suicide deaths among people in contact with mental health services has identified consistent themes of variable risk assessment and management, and overall poor quality of engagement with families and carers in the risk management process.

NHS England's report (2015) into failings at Southern Health recommended that all mental health and learning disability providers review their incident management and investigation processes to ensure that:

- There is a robust system for the investigation of all patient safety incidents;
- A system and framework are in place for the review of selected samples of incidents that do not necessarily meet the criteria for a full investigation.

In common with many other NHS providers (CQC, 2016), the implementation of learning following investigations and reviews continues to be a problem. The CQC identified that "too often, opportunities are being missed to learn from deaths so that action can be taken to stop the same mistakes happening again" (2016).

What we will do

13.1 Incident management

13.1.1 Establish an 'Incident Management Review Group' to ensure all incidents are reviewed and assigned the appropriate level of analysis and/or investigation.

13.1.2 Implement a three-tier investigation/review framework for all incidents (including unexpected deaths and suspected suicides), consisting of:

a. Management review
b. Structured judgement review
c. Root Cause Analysis

13.2 Information sharing and learning

13.2.1 Improve the recording, accessing and sharing of anonymised incident data within local networks – eg: suicide 'hotspot' data, etc.

13.2.2 Establish a 'Mortality Review Group' to ensure the learning from all unexpected deaths is appropriately identified, reviewed and shared in order to inform learning.

13.2.3 Publish internal 'Safety Bulletins' on a monthly basis to share summarised learning from reviews of unexpected deaths, suspected suicides and information identified by the Mortality Review Group.

14. ACTION AREA 5: Support for people bereaved or affected by suicide

14.1 What we know

Families and friends bereaved by a suicide are at increased risk of mental health and emotional problems, and may also be at higher risk of suicide themselves. Suicide can also have a profound effect on the local community. It is estimated that typically, six individuals (family and/or friends) are directly affected by every suicide. In addition to immediate family and friends, many others may be affected in some way; they include neighbours, school friends and work colleagues. People whose work brings them into contact with suicide – emergency and rescue workers, healthcare professionals, teachers, police, etc. are also at risk of being adversely affected.

'Postvention' is essential to help and support those affected to cope with their loss.

14.2 What we will do

14.2.1 Provide written information, in accessible formats, for staff to use as an adjunct to support for families and others affected by suicide.

14.2.2 Update the AWP website to include specific information and links to sources of post-suicide support for those affected.

14.2.3 Work with local voluntary agencies and self-help groups to ensure that they are aware of how to access IAPT services for those people who require additional psychological support.

14.2.4 Work with local authority public health colleagues to support the development of dedicated bereavement support for those affected by suicide – eg: SOBS – aiming for a Trust-wide network of specialist postvention support.

14.2.5 Ensure that the importance of postvention and ongoing support for bereaved families/friends is highlighted and emphasised as part of our Incident Management Procedure.

15. ACTION AREA 6: Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour

15.1 What we know

The media have a significant influence on potential suicide behaviour and attitudes; there is compelling evidence that certain types of media reporting and portrayals of suicide can lead to copycat behaviour, especially among young people and those already at risk. There is growing concern about the potential misuse of the internet to promote suicide and suicide methods. However, the internet – particularly social media – also provides an opportunity to reach out to vulnerable individuals who might otherwise be reluctant to seek information, help or support.

As a trust we must promote responsible reporting and the portrayal of suicide and suicidal behaviour in the media.

It is important that we pay attention to the language used in all communications – eg: reports, investigations, training events and public meetings. Terms such as 'committed suicide' and 'commit suicide' have annotations with crime, blame, shame and guilt, and should be avoided.

The Samaritans organisation continues to work with the Independent Press Standards Organisation to implement the Editors' Code for reporting matters on suicide responsibly. Public Health England is committed to looking at ways in which it can strengthen the relationship between Samaritans, Public Health England and the Department of Health to support better monitoring of suicide reporting in the media.

15.2 What we will do

15.2.1 AWP's Communication Team will liaise with local media groups in promoting the Samaritans' code, and challenge irresponsible reporting. This will be done in collaboration with our Public Health and STP colleagues.

15.2.2 Respond positively to requests from regional and national media outlets regarding the promotion of positive messages about mental health and avoiding portraying suicide as the only option for people in emotional distress or crisis.

15.2.3 Improve and develop both the Trust's internet and intranet sites as sources of support for staff, the public, service users, carers and family members.

15.2.4 Participate in and promote relevant national and local campaigns, such as World Suicide Prevention Day and World Mental Health Day.

15.2.5 Host an annual patient safety learning event.

16. ACTION AREA 7: Supporting research, data collection and monitoring

16.1 What we know

The success of the National Strategy is reliant on good quality data at both national and local levels. Improving national data will help to continue monitoring suicide rates and identify emerging trends within high risk groups and new methods of suicide. Improving the quality of local data will be critical in supporting local areas to develop effective multi-agency suicide prevention plans that reflect the issues in their local communities.

Robust data collection and local action plans for suicide prevention should be developed at known 'suicide hotspots' (Public Health England, 2015).

16.2 What we will do

16.2.1 Review our use of the Ulysses incident management system and improve both our real-time and retrospective data intelligence.

16.2.2 Continue the local authority public health collaboration of Coroner data collection regarding suicide deaths, which includes sharing appropriately anonymised intelligence – eg: relating to suicide 'hot-spots', etc.

16.2.3 Develop our knowledge and sharing of suicide hotspots intelligence with STP colleagues and include British Transport Police and Network Rail.

16.2.4 Provide financial and other support to regional and national suicide research through continued links with local university academic research units – ie: University of Bristol.

16.2.5 Provide Research Capability Funding to the University of Bristol to develop future suicide research grant applications.

16.2.6 Host any successful future suicide research project bids.

16.2.7 Work with local commissioners to develop 'Self-Harm Registers' across the acute hospital interface within the AWP area.

17. Organisation of suicide prevention activities across AWP

The AWP Suicide Prevention Group reports to the Quality & Standards Committee. It is chaired by the Suicide Prevention Lead. The group meets quarterly, with separate bi-annual meetings with local authority and STP public health/suicide prevention leads, and CCG mental health leads. Each operational directorate is represented by a relevant senior clinical lead and representatives from the Reduced Ligature Group. Other stakeholders attend the meeting on a regular basis, including:

- Wiltshire Police
- Avon & Somerset Constabulary
- British Transport Police
- Samaritans
- Carers

A workplan for implementation of the Strategy is overseen by the Suicide Prevention Group, with annual reports regarding progress submitted to the Quality & Standards Committee. This is also shared with the Critical Incident Oversight Group (CIOG).

Each local authority public health service has a suicide prevention strategy, supported by an active suicide prevention group. AWP attends each of these groups and regularly participates in joint projects across all of the areas for action identified above.

One of the main ways of sharing information regarding suicide prevention activities and the latest evidence and local intelligence is via the Our Space suicide prevention pages. We aim to publish as widely as possible all relevant information regarding our approach to suicide prevention, as well as information for people at risk of suicide or who have been affected by suicide, on the AWP website.

18. Glossary of abbreviations used in this strategy

AWP	Avon & Wiltshire Mental Health Partnership NHS Trust
BAME	Black, Asian and minority ethnic
CAMS	Collaborative Assessment and Management of Suicidality
CAMHS	Child & Adolescent Mental Health Services
CHRT	Crisis and home treatment team
CIOG	Critical Incident Oversight Group
CQC	Care Quality Commission
IAPT	Improving access to psychological therapies
LGBTQ	Lesbian, gay, bisexual, transgender and questioning
LA	Local authority
NCISH	National Confidential Inquiry into Suicide and Homicide by People With Mental Illness
ONS	Office of National Statistics
SOBS	Survivors of Bereavement by Suicide
STP	Sustainability and transformation partnerships
SNRI	Serotonin-norepinephrine reuptake inhibitors: a group of antidepressant drugs
SSRI	Selective serotonin reuptake inhibitors: a group of antidepressant drugs

19. References

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