worcestershire county council

Worcestershire Health and Well-being Board

Suicide Prevention Plan

2018-2021

<table>
<tr><td>Ambition</td><td colspan="4">The ambition is to reduce the number of suicides and to improve the care of families of those who have died by suicide. Our longer-term ambition is to adopt a ‘zero suicide’ mind set in Worcestershire as we believe suicide is largely preventable</td></tr>
<tr><td>Meeting the challenge</td><td colspan="4">requires a co-ordinated whole system community and partnership approach informed by evidence, best practice and local data</td></tr>
<tr><td>We will focus on</td><td colspan="4">reducing the suicide rate in the general population and to provide better support for those bereaved or affected by suicide.

This plan covers suicide prevention across all age groups but includes a focus on key high risk groups:</td></tr>
<tr><td>Priority Groups</td><td>Young and middle aged men</td><td>People in the care of mental health services</td><td>People in disadvantaged circumstances</td><td>People who self harm</td></tr>
<tr><td>To do this we will</td><td colspan="4">Work together in partnership to prevent deaths as a result of suicide. We will focus our effort on six areas for action:

• reduce the risk of suicide in key high-risk groups
• tailor approaches to improve mental health in specific groups
• reduce access to the means of suicide
• provide better information and support to those bereaved or affected by suicide
• support the media in delivering sensitive approaches to suicide and suicidal behaviour
• support research, data collection and monitoring</td></tr>
<tr><td>Local implementation</td><td colspan="4">To achieve this ambition and to work on the six action areas we will:

• Establish a multi-agency suicide prevention group involving all key statutory agencies and voluntary organisations.
• Complete a local suicide audit to identify high risk groups, trends or issues.
• Develop a local action plan with the multi-agency suicide prevention group based on national strategy and best practice but using local data.</td></tr>
<tr><td>Action Plan Priorities</td><td colspan="4">Our priorities for local action over the next 3 years have been identified from evidence and best practice. Our priorities requiring a co-ordinated whole system approach are:

• Reducing risk in men, especially in middle age.
• Preventing and responding to self-harm
• Mental health of children and young people
• Recognition and treatment of depression
• People in the care of acute mental health care
• Tackling high frequency locations, including working with local media to prevent imitative suicides
• Reducing isolation, for example through community-based support and working with third sector
• Bereavement support, especially for people bereaved by suicide</td></tr>
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Background

Every week in Worcestershire around one person dies as a result of suicide. For every person who dies at least 10 people are directly affected. The death of someone by suicide has a devastating effect on families, friends, workplaces, schools and communities, as well as an economic cost. Suicide is preventable and a whole system approach is required, with local government, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide having a role to play in developing and implementing a local suicide prevention plan.

The need to develop local suicide prevention action plans is set out in national strategy, *Preventing Suicide in England: a cross-government outcomes strategy to save lives 2012* and the NHS *Five year forward view for mental health*. Locally, the Worcestershire Health and Well-being Strategy for 2016-2021 identifies 'Good Mental Health & well-being throughout life (GMHWB)' as one of three areas of priority over the next five years. The Herefordshire and Worcestershire STP has prioritised improving mental health and will drive forward change to address the mental health 5 year forward view.

The case for suicide prevention

Suicide takes a high toll yet it is preventable. Suicide is preventable; it is not an unpredictable, personal, tragedy. Suicide is the biggest killer of men under 50 as well as a leading cause of death in young people and new mothers. On average, 13 people take their own life every day in England, resulting in 4820 deaths in 2015. In Worcestershire there is on average one suicide each week. The death of someone by suicide has a devastating effect on families, friends, workplaces, schools and communities, as well as an economic cost. It is estimated that for every person who dies at least 10 people are directly affected.

There are specific groups of people at higher risk of suicide. Three in four deaths by suicide are men. The highest suicide rates are among middle aged men. In Worcestershire the suicide rate for men is higher than the national average. People in the lowest socio-economic group and living in the most deprived geographical areas are 10 times more at risk of suicide than those in the highest socio-economic group living in the most affluent areas. In Worcestershire suicide rates for those living in the most deprived areas are over double those living in the least deprived.

There are specific risk factors that increase the risk of suicide. Suicide is a major cause of premature death, but there are risk factors, as with any other cause of premature death, we must identify and mitigate those risk factors. The strongest identified predictor of suicide is previous episodes of self-harm. It is estimated that 50% of people who die by suicide had a history of self harm. Mental ill-health and substance misuse also contribute to many suicides. People in the care of mental health services are a high risk group. Evidence shows that 30% of all suicides were by people who had contact with mental health services in the last 12 months. Inpatients, people recently discharged from hospital and those who refuse treatment are at the highest risk. Suicide prevention strategies must consider and link to programmes of early identification and effective management of self-harm, mental ill-health and substance misuse.

Preventing suicide is achievable. Suicide prevention can be achieved through direct intervention, at individual, community and societal level. Evidence demonstrates the delivery of a comprehensive strategy is effective in reducing deaths by suicide through combining a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide. An example is the successful *Zero Suicide approach* first implemented in the US, where a systems approach is adopted within health and care settings to achieve a bold goal of zero suicide rather than planning for incremental progress.

Suicide is everybody's business. A whole system approach is required, with local government, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide having a role to play. Suicide prevention can also be part of work addressing the wider determinants of

health and wellbeing. An example is the *suicide-safer communities* framework which has been adopted in some areas in England where action focuses on building communities that are committed to talking openly about suicide, promoting wellness and mental health and supporting those bereaved by suicide.

Restricting access to the means for suicide works. This is one of the most evidenced aspects of suicide prevention and can include physical restrictions, as well as improving opportunities for intervention. For example the successful control of analgesics in reducing poisoning deaths.

Supporting those people bereaved by suicide is an important part of suicide prevention. Compared with people bereaved through other causes, individuals bereaved by suicide have an increased risk of suicide and suicidal ideation, depression, psychiatric admission as well as poor social functioning. Those who are bereaved by suicide are three times more likely to take their own lives. It is important to have timely information and support provided to those bereaved or affected by a suicide.

Responsible media reporting is critical. Research shows that inappropriate reporting of suicide may lead to imitative or 'copycat' behaviour. This risk increases if the suicide method is described, if the story is placed prominently and if the coverage is sensationalised or extensive.

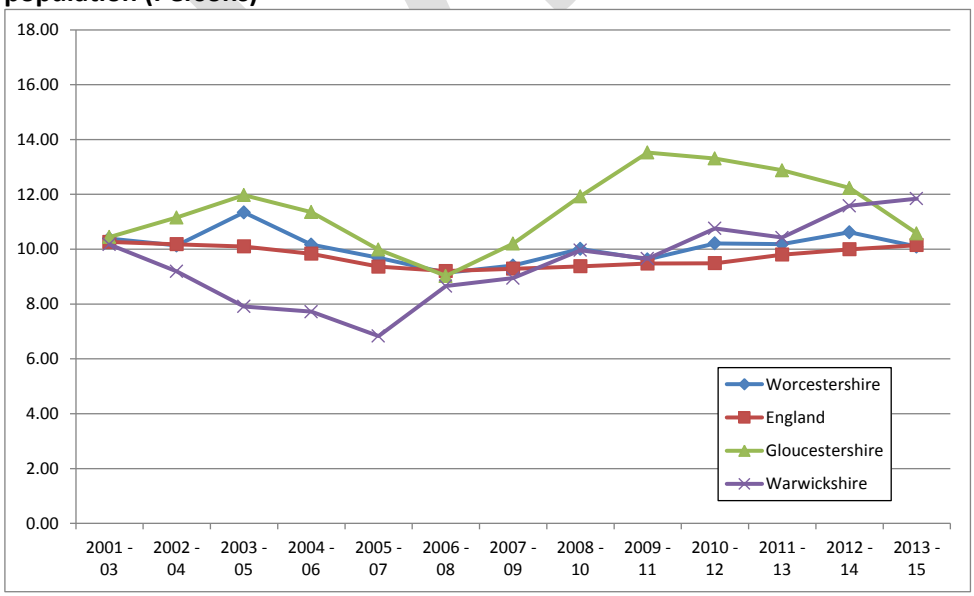
The social and economic cost to suicide is substantial. The economic cost of each death by suicide of someone of working age is estimated to be £1.67 million. This covers the direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering

There is good national evidence available for preventing suicide. This evidence should be used alongside local data and information to ensure local suicide prevention needs are met. Successive reviews, research and guidance identify the need to identify and analyse local suicide data, and to develop an action plan led by a multiagency group.

Suicide in Worcestershire

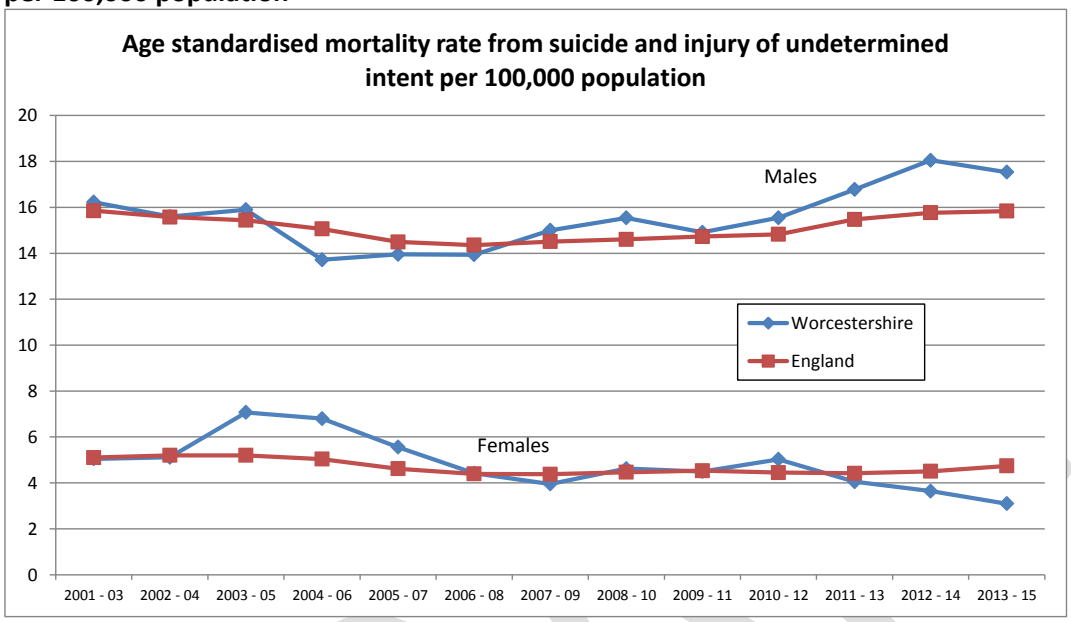
On average one person dies each week as a result of suicide in Worcestershire. There are on average 50 deaths per year and this has been remarkably stable for a number of years. The suicide rate is similar to the England average but lower than statistical neighbours.

Figure 1: Age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (Persons)



Men are three times more likely to commit suicide than women. In Worcestershire, this is similar with men accounting for 76% of all suicide and undetermined deaths since 1995. Figure 2 shows the 3 year age standardised mortality rate, by Males and Females for both England and Worcestershire. There has been an upturn in the rate for males since 2010 which continues to be monitored. In contrast, the female trend appears to be decreasing. They are, however, based on very small numbers. This means that a few deaths could have a marked impact on the rates.

Figure 2: Gender split of age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population



The most common method of suicide in Worcestershire was hanging which has accounted for just over half of all suicides in Worcestershire, as it does nationally. Hanging accounted for 56% of all male suicide registrations between the 10 year period 2006 and 2015. Poisoning remains the more common method for females accounting for 48% of female suicides

Table 1 - Worcestershire Residents – Number and Percentage of Suicide/Undetermined Deaths by Method 2006 – 2015 Registrations (10 years pooled)

	Gender		
Method	Male	Female	Persons
Hanging	213	43	256
Poisoning	76	52	128
Drowning			25
In front of vehicle - train			18
Jumping			17
Cutting			15
Shooting			12
Fire			6
Crashing of motor vehicle			5
Other			10
Grand Total	**383**	**109**	**492**
Hanging	56%	39%	52%
Poisoning	20%	48%	26%

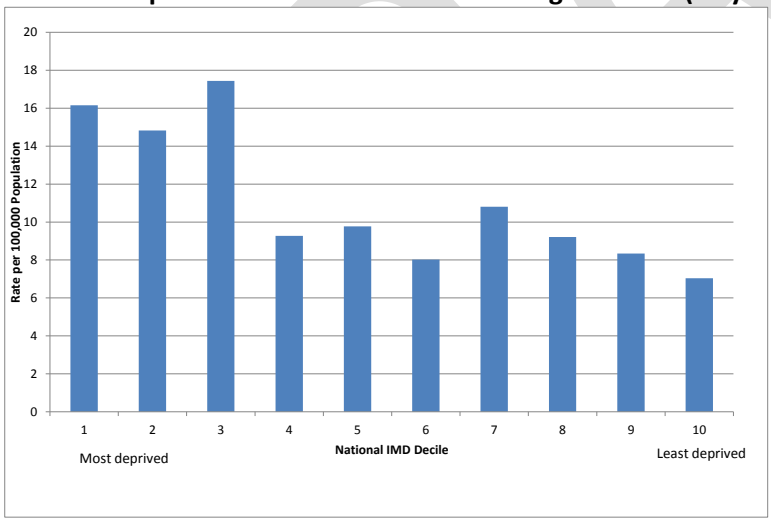
Locally the numbers split by age group are too small to calculate meaningful rates. However, Table 2 provides a view of the overall numbers in the 10 year period by age group along with an age-specific rate per 100,000 population. The highest rate for this period is in the 25-44 age group, however, these rates will have very large confidence intervals.

Table 2 - Worcestershire Residents – Number and Percentage of Suicide/Undetermined Deaths by Age Group 2006 – 2015 Registrations (10 years pooled)

Age Group	10 Year Total	Rate per 100,000 Population
<25	59	7.7
25 – 44	185	15.1
45 – 64	172	12.1
65+	76	7.4
Grand Total	492	11.0

There is a link between deprivation and suicide and people living in the most deprived areas are at ten times more risk. The pattern in Worcestershire has been similar to England and Wales over the last 10 years, with the overall number of suicide/undetermined intent deaths increasing with increasing deprivation (Figure 3). Suicide rates for those living in the most deprived areas were over double those living in the least deprived - 7 per 100,000 population compared with 16 per 100,000 in the more deprived decile (for 10 years pooled data).

Figure 3 - Crude rate of suicide/undetermined deaths per 100,000 population aged 15 and over by National Deprivation Decile:- 2006 – 2015 Registrations (10 years pooled, Worcestershire residents)



Trends by occupation are difficult to analyse due to the small numbers involved, however, a recent ONS analysis identified that males working in the lowest-skilled occupations had a 44% higher risk of suicide than the male national average and the risk among males in skilled trades was 35% higher. Table 3 below gives the numbers and percentages of suicides in Worcestershire between 2006 and 2015 by Occupation Group according to the Standard Occupational Classification 2010 system (SOC2010), along with a comparison of the average percentage employed in each major group over the period.

The group with the highest overall number of deaths is the skilled trades occupations accounting for a quarter of all the suicide/undetermined deaths in the working age group. This group can be further categorised into agricultural trades, metal and electrical trades, construction trades and textiles, printing

and other skilled trades. Of these four groups, by far the greater numbers of deaths were from the construction and building trades. This is a similar result to the national figures, although nationally the elementary trades had the highest rate followed closely by the skilled trades.

Table 3 – Number of Suicide/Undetermined Deaths in Worcestershire by SoC2010 Major Group

Major Occupation Group	Number of Suic/Undet. deaths in working age	% of Suic/Undet. deaths in working age	Average workforce 2006 - 2015
Managers, Directors and Senior Officials	25	7.9%	11.5%
Professional Occupations	37	11.7%	18.8%
Associate professional and technical occupations	21	6.6%	13.0%
Administrative and secretarial occupations	12	3.8%	11.0%
Skilled trades occupations	79	25.0%	12.3%
Caring, Leisure and other Service Occupations	15	4.7%	8.4%
Sales and customer service occupations	12	3.8%	7.4%
Process, plant and machine operatives	57	18.0%	7.2%
Elementary occupations	58	18.4%	9.9%
All occupation groups	316		

There are 2 prisons located within Worcestershire: HMP Hewell located in Bromsgrove Council District and HMP Long Lartin which is based in Wychavon Council District. Over the 10 year period 2006 to 2015 there were 22 suicide deaths of prisoners registered. Of these 22, 8 had a home address outside Worcestershire and do not appear in the Worcestershire numbers but the remaining 14 are attributed to Worcestershire. Of these 12 had the prison as their home address or no fixed abode so were classed as Worcestershire residents.

Our ambition and objectives

National government recommendation is to have a suicide prevention plan in place by the end of 2017 and to reduce the number of suicides by 10% by the year ending March 2021.

Ambition

Our ambition for Worcestershire will be to reduce the number of suicides by at least 10% by March 2021 and to improve the care of families of those who have died by suicide. Our longer-term ambition will be to adopt a 'zero suicide' mind set in Worcestershire as we believe suicide is largely preventable.

Objectives

We shall have two principle objectives:

1. To reduce the suicide rate in the general population
2. To provide better support for those bereaved or affected by suicide.

We will focus effort on six areas for action to achieve this:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide

5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

How will we work together to achieve this

To achieve these objectives and to tackle all six areas of action we shall develop and coordinate a whole system community approach using local intelligence, evidence and best practice. We shall engage a wide network of local stakeholders to help develop and implement a robust and evidence based action plan informed by local data and needs and linked to our other mental health & wellbeing plans across the system. The accountability for the suicide prevention plan will lie with the Health and Wellbeing Board, who will shape and support the plan.

We shall establish a formal multi-agency suicide prevention steering group to understand local patterns of suicide and collate local data and intelligence; to steer the development and implementation of the action plan; to develop and coordinate responses to suicide and activities to reduce suicide; to monitor progress towards reducing suicide rates and to evaluate the impact of actions. The multiagency steering group will include representatives from public health, CCGS, primary and secondary care providers (including mental health), emergency services, police, criminal justice, local authorities, the university and voluntary sector organisations. The steering group will report to the Health and Wellbeing Board.

We shall also develop a wider suicide prevention network or partnership so a wider range of representatives can engage with the work at different levels or for specific projects. For example community groups and networks, task and finish groups to oversee projects or areas of work, suicide prevention champions and those with lived experience and other groups to provide access to at risk groups. We will involve bereaved people and people affected by suicide to help identify issues we are not aware of, to participate in campaign work where appropriate, to highlight gaps between policy and practice and to ensure work is grounded in reality.

We shall collect and use local suicide data to identify high risk groups, patterns and trends, locations or issues of concern to develop our plan and use to monitor our outcomes. We will try to undertake a retrospective suicide audit to provide further local intelligence to our available data to inform the development of the suicide prevention action plan. We will set up a separate suicide audit group to review individual suicide cases to identify preventable factors and mitigate suicide risks. The suicide audit group will report to the suicide prevention steering group. We will work closely with the local Child Death Overview Panel (CDOP) with regard to suicides of young people.

Our priority areas for action

Our priorities for action in the short term have been informed by evidence and best practice using the *Local Suicide Prevention Planning Toolkit* (PHE, 2016) which identifies eight priorities:

- Reducing risk in men, especially in middle age, with a focus on: economic factors such as debt; social isolation; drugs and alcohol; developing treatment and support settings that men are prepared to use
- Preventing and responding to self-harm, with a range of services for adults and young people in crisis, and psychosocial assessment for self-harm patients
- Mental health of children and young people, with joint working between health & social care, schools & youth justice, and plans to address the recent increase in suicide risk between 15 to 19 year olds
- Recognition and treatment of depression
- People in the care of acute mental health care
- Tackling high frequency locations, including working with local media to prevent imitative suicides

- Reducing isolation, for example through community-based support, transport links and working with third sector
- Bereavement support, especially for people bereaved by suicide

Men

Local suicide data indicates a priority group for action are men, particularly younger and middle aged men. Men are at three times greater risk of suicide than women. There are a range of factors associated with suicide that are particularly common in men including depression; alcohol and drug misuse; unemployment; family and relationship problems; social isolation and low self-esteem. Actions to encourage men to seek help and to address the impact of these risk factors are vital to effectively reach men.

People in contact with mental health services

We will focus effort on people in contact with mental health services as they are at a higher risk of death by suicide. 30% of all suicides are by people who had contact with mental health services in the last 12 months. It is important to ensure implementation of the NICE guidance on depression as well as education of doctors, and effective treatment of mental health problems.

Research shows reduced patient suicide rates in those organisations who implemented the National Confidential Inquiry into Suicide and Homicide (NCISH) recommendations. The *Zero Suicide* approach has been shown to be effective within health and care settings particularly in the US. This system approach implements a philosophy and practice of 'perfect depression care' which in turn led to a significant drop in suicides and years without a single suicide.

People in disadvantaged circumstances

Reducing health inequalities is an important component to suicide prevention given that people in the lowest socioeconomic group and living in the most deprived areas are ten times more at risk of suicide than those in the most affluent group living in the most affluent areas. We will work with VCS and housing to provide and promote financial and debt support. We will ensure effective suicide awareness training is available for frontline services. We will also continue to develop and roll out evidence based parenting support.

People who self-harm

Local suicide data is not able to identify the prevalence of specific risk factors in Worcestershire. However, we will prioritise for action, people who have self harmed as the national evidence demonstrating these groups of people at high risk is overwhelming. Through our ongoing local audit activities we will start to collect and monitor local suicide data by demographic and social factors and identify underlying risk factors to better inform our priority groups going forward. Self-harm is the highest risk factor for suicide with around 50% of people who die by suicide having a history of self-harm. The true scale of the problem is not known as many people who self-harm do not attend A&E or seek help from services. It is important to ensure implementation of the NICE Standards and pathways for managing patients who self-harm.

Children and young people

We will prioritise improving the mental health of children and young people, including looked-after children, care leavers and children and young people in the youth justice system to reduce deaths by suicide. Suicide is one of the main causes of mortality in young people and for families its impact is particularly traumatic. A recent UK wide investigation into suicides by people aged under 25 reported themes around the following risks: family mental illness; abuse and neglect; bereavement and experience of suicide; bullying; suicide-related internet use; academic pressures, especially related to exams; social isolation or withdrawal; physical health conditions that may have social impact; alcohol and illicit drugs; mental ill-health, self-harm and suicidal ideas. The report highlights the importance of recognising the pattern of cumulative risk and "final straw" stresses, such as exams, that contribute to suicide in children and young people.

School based awareness programmes have shown promise in reducing suicidal ideation that include gatekeeper training for teachers and staff, a youth mental health awareness programme and professional screening of students considered to be at risk. Whole school and college approaches to promoting emotional health and wellbeing and promoting resilience are effective and shall be promoted. We shall raise awareness of the impact of online bullying.

Specific occupational groups

Unemployment is a risk factor for suicide. Certain occupational groups remain a focus in the national prevention strategy including doctors, nurses, farmers, veterinary and agricultural workers. We will encourage employers to promote mental health and reduce stigma in the workplace through campaigns and evidence based support programmes.

Community-based approaches

We will prioritise system wide community-based approaches. Evidence demonstrates that deaths by suicide can be reduced through combining a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide. Implementing *Suicide Safer* places or environments can be effective where a range of initiatives to enable people to have conversations about suicide and provide life-saving suicide prevention skills, combined with signs or leaflets in appropriate targeted locations or settings and specific support groups or interventions for those at risk.

We will focus on community-based awareness campaigns as they offer the opportunity to improve the mental health of many and to reduce stigma and discrimination. We will prioritise suicide prevention training as training programmes seek to improve the knowledge, skills and ability to intervene and offer support across professionals, frontline workers and community members. Evidence suggests that suicide prevention education for GPs can have an impact as an intervention to prevent suicide.

Reducing access to the means of suicide

Restricting access to means for suicide is one of the most evidenced aspects of suicide prevention and can include physical restrictions, as well as improving opportunities for intervention. We will gather local data from the suicide audits to provide insight into emerging trends with regards to locations and methods.

Working with local media to prevent suicides

Research shows that inappropriate reporting of suicide may lead to imitative behaviour. Best Practice highlights that local media should be adhering to the Samaritans' guidance on responsible media reporting. We will work with the local media to encourage responsible reporting on suicide methods and locations.

Supporting those bereaved or affected by suicide

Evidence suggests that those bereaved by suicide are at a higher risk of depression, suicide attempt, and even suicide. Best Practice highlights that resources should be made available to support those bereaved e.g. *Help is at Hand* cards/booklets via first responders, coroner's, local funeral directors, voluntary sector organisations and within community settings. We will map the current provision of bereavement support services to identify gaps and to help ensure that timely information and support is accessible across the county

Implementation and governance

The detailed actions across the next three years will be further identified and developed by the multiagency steering group and wider suicide prevention network. Where appropriate wider multi-agency task groups will be established to deliver against the priorities outlined above and to improve communication across sectors and geographies.

Progress against the plan's priorities will be reported to the Health and Wellbeing Board through reporting to the Health Improvement Group (HIG) on an annual basis. The key performance indicators associated with the Suicide Prevention plan are;

Performance Indicators for Suicide Prevention Plan	Measurement
Age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population	Public Health Outcomes Framework (PHOF)
Age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (Males)	PHOF
Age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (Females)	PHOF
Emergency Hospital Admissions for Intentional Self-Harm	PHOF
Hospital admissions as a result of self- harm (10-24 years)	PHOF
Hospital admissions as a result of self-harm (all ages)	PHOF