Northumberland Multi-Agency Suicide Prevention Strategy 2017 - 2022

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1. EXECUTIVE SUMMARY

The aim of the Northumberland Multi-Agency Suicide Prevention Strategy is to achieve a 10% reduction in the number of suicides across the County by 2020/21.

Suicide remains a national and local public health priority. It has an immense impact on family, friends, work colleagues and the wider community at both an emotional and economic level. During the three year period 2013 - 2015, 105 people took their own lives in Northumberland.[1] The suicide rate over that period was 12.7 per 100,000 people. This is higher than the England average because Northumberland has a significantly higher suicide rate in males, particularly those aged under 65 years (although not significantly higher than the rate for the North East). For women the number and rate of suicides is much lower and regionally, the rates are not significantly different from the England average.

Suicide is often the end point of a complex history of risk factors and distressing events, but there are many ways in which services, communities, individuals and society as a whole can help to prevent suicides. As our local response, this five year Suicide Prevention Strategy outlines our approach to preventing suicide in Northumberland which will be delivered through the Suicide Prevention Action Plan. As a starting point, a strategic approach to suicide prevention has to be multifaceted in order to secure the best outcomes for the population of Northumberland. This multifaceted approach must describe an agreed and shared ownership of interventions across partners in the County, all of whom will have a contribution to make and are of equal importance. This strategic plan therefore outlines a shared approach to preventing suicide and has a clear ambition to better identify vulnerability in people and across environments; ensure effective collaborative working across agencies; and work alongside related national and local strategies such as the Mental Health Task Force's *Five Year Forward View for Mental Health*[2], the *Northumberland, Tyne and Wear and North Durham Sustainability and Transformation Plan* (STP) and the *Northumberland Mental Health Action Plan*.

In March 2017, the Office of National Statistics (ONS) released a profile of suicide by occupation[3] which highlights which occupations present with higher than average suicide figures. These occupations fall into the categories of nursing and caring professions for women and low skilled and construction work for men. It is essential, in supporting a prevention strategy that vulnerable employment is identified and support given.

The Northumberland Suicide Prevention Strategy reflects the framework of the national cross-government strategy *Preventing Suicide in England. A cross government outcomes strategy to save lives.*[4] It uses the same six priority areas of action outlined in the national strategy. These priority areas have ambitions to:

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[1] PHE (2016). Public Health Outcomes Framework. Suicide prevention profiles.
[2] Mental Health Taskforce (2016). The Five Year Forward View for Mental Health. February 2016.
[3] ONS (2017). Suicide by occupation, England: 2011 to 2015. ONS. 17 March 2017.
[4] HM Government/DH (2012). Preventing suicide in England. A cross-government outcomes strategy to save lives. HMG/DH. 10 September 2012.

1. **Reduce the risk of suicide in high risk groups;**
2. **Engineer 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.**

Using these areas for action, the strategy identifies the main issues we need to understand and manage in order to support vulnerable individuals who are at risk of suicide. The strategic plan will help to secure a whole system approach in identifying, understanding and preventing suicide and self-harming behaviours across high risk groups and improve resilience across populations.

2. INTRODUCTION

"Suicide is often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity." Professor Louis Appleby CBE

What do we mean by suicide?

The National Statistics 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.[5] Throughout the rest of this analysis, these deaths will be referred to as suicides. The differentiation between suicides and injuries of undetermined intent is one of intention; a death is classified as suicide when the intention to commit suicide is made plain, either by methodology or via the leaving of some form of intention (i.e. a note or verbal suggestions that a suicide attempt might be made). Injuries of undetermined intent are deaths due to injuries where the intention to commit suicide is suspected but where there is no evidence of intent. The data also includes those records coded where the cause of death is due to a condition caused by an attempt to self-harm or an injury of undetermined intent.

In England and Wales, all suicides are certified by a coroner following an inquest. The death cannot be registered, and therefore ONS are not notified, until the inquest is completed. Currently, a conclusion of suicide must meet the "higher" standard of proof, that is, that the coroner or jury are sure, to the higher standard, that the person took their own life and intended to do so.

National picture

In England, one person dies every two hours as a result of suicide. The most recent figures from the Office for National Statistics (ONS)[6] state that:

- Deaths from suicide in the UK rose slightly from 6,122 deaths in 2014 to 6,188 deaths in 2015 with a subsequent increase in the rate from 10.8 to 10.9 deaths per 100,000 population. In England, there were 4820 suicides registered in 2015 (45% occurred before 2015). The male suicide rate decreased whilst the female rate increased to its highest rate in a decade.

- The number of people dying by suicide in prison custody in England and Wales annually has varied between 54 and 90 over the period 2008 to 2015 (0.6 to 1.1 per 1000 prisoners).[7]

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[5] In 2016, the suicide definition was revised to include deaths from intentional self-harm in children aged 10 to 14. Deaths from an event of undetermined intent in 10-14-year-olds are not included in suicide statistics, because although for older teenagers and adults it is assumed that in these deaths the harm was self-inflicted, for younger children it is not clear whether this assumption is appropriate.
[6] ONS (2016). Suicides in the UK: 2015 registrations. ONS. 2 December 2016.
[7] Ministry of Justice (2016). Safety in Custody Quarterly Bulletin: December 2016. MoJ. 27 April 2017. Available from: https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-december-2016--2

- England and Scotland saw decreases in the total number of suicides, whilst Wales and Northern Ireland saw increases.

- Of the English regions, Yorkshire and The Humber had the highest suicide rate at 11.6 deaths per 100,000 population and the East of England had the lowest at 9.3 deaths per 100,000. The North East rate was 10.9 deaths per 100,000 population compared to 10.1 deaths per 100,000 population for England. Unlike many mortality statistics, there is no clear north/south divide.

- Across all broad age groups, the rate for males was around 3 times higher than females.

- The most common method of suicide amongst males and females in the UK in 2015 was hanging.

How can we better understand suicide?

A significant factor in prevention is understanding the complex interplay between a person's environment and their vulnerability, the consequence of which could be suicide. Various factors around an individual in relation to how they relate to their own sense of self, their relationships, their community and society as a whole, will influence their behaviours. This interplay is critical in relating the individual to their sense of health and wellbeing in addition to their capacity to ask for and receive help when that is required.

Long term vulnerability can increase the risk of someone having suicidal thoughts and Fig 1 illustrates how circumstances from before birth up to suicide might influence an individual's decision to attempt suicide and the outcome of an attempt.

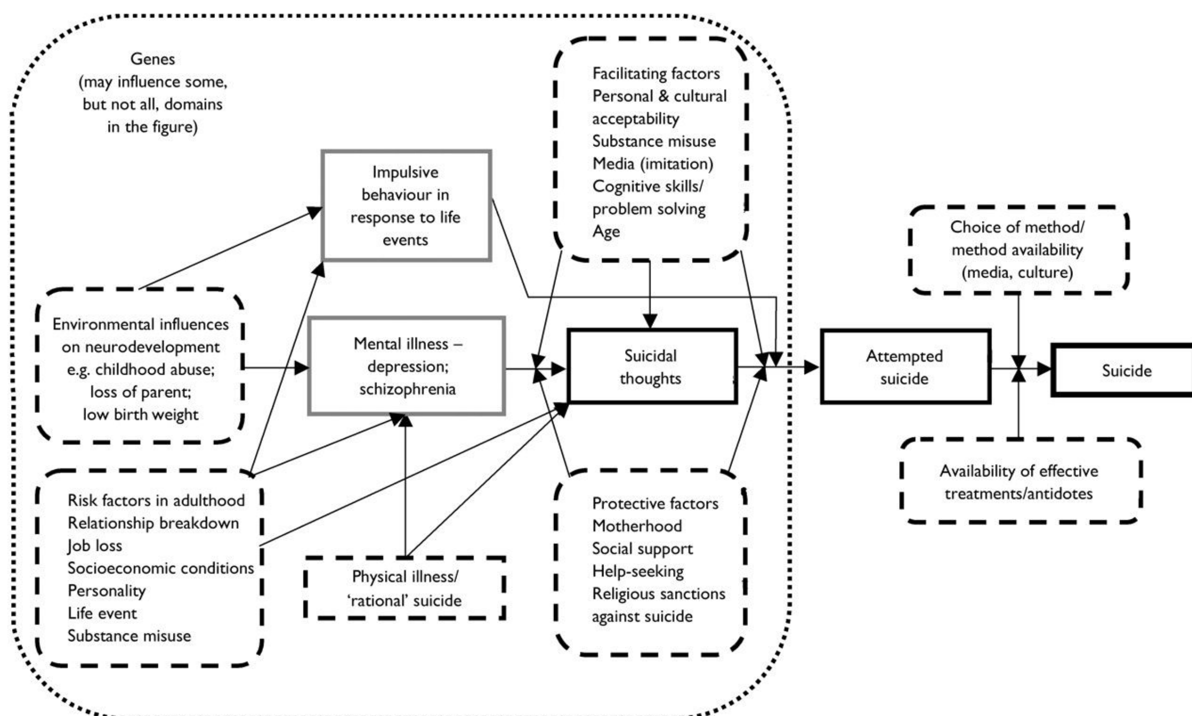


Fig. 1 Influences on suicide over the life course[8]

A collective approach to supporting these individual and broader relationships is pivotal in the context of managing vulnerabilities and behaviours.

3. NATIONAL STRATEGY

In September 2012 the Department of Health produced the national suicide prevention strategy *Preventing Suicide in England: A cross government outcomes strategy to save lives*. This strategy outlined an approach to suicide prevention which recognised a requirement for a multifaceted approach to suicide prevention and described an intention for collaborative cross sector innovations. The strategy offered national objectives and updated 'areas for action' as well as highlighting the responsibility for a local planning approach to be developed to implement work on suicide prevention. Subsequent to the national strategy, Public Health England published guidance on local suicide prevention planning[9] and this local strategic plan reflects the expectations of both documents.

The headline action areas to support the proposed framework for Northumberland follow the six identified headline areas of the National Strategy. These are:

- **Reduce the risk of suicide in high risk groups:** Those individuals who constitute high risk groups are identified as young and middle aged men; people in the care of mental health services (including inpatients); people with a history of self-harm; (although self harm is not necessarily a precursor to suicide); people in contact with the criminal justice system and specific occupational groups (doctors, nurses, veterinary workers, farmers and agricultural workers).

- **Engineer approaches to improve mental health in specific groups:** Specific groups are identified as vulnerable children and young people; survivors of domestic abuse or violence; veterans; people living with long-term physical health conditions; people with untreated depression; people who are especially vulnerable due to social and economic circumstances; people who misuse or have a dependency on drugs or alcohol; people identifying themselves as lesbian gay bisexual transgender questioning (LGBTQ) and people from black and minority ethnic (BAME) groups.

- **Reduce access to the means of suicide:** It is important to collectively work to recognise risky environments or the potential ease of access to means of suicide and effectively manage these risks. The methods of suicide more easily managed through preventative interventions are: hanging and strangulation in psychiatric inpatient and criminal justice settings; self-poisoning; those at high-risk locations; and those on the rail networks. It is also important to be vigilant and respond to new or unusual suicide methods.

[8] Gunnell D, Lewis G. Studying suicide from the life course perspective: implications for prevention. BJ Psych. Sep 2005, 1887 (3) 206-208.
[9] PHE (2016). Local suicide prevention planning. A practice resource. PHE. October 2016

- **Provide better information and support to those bereaved or affected by suicide:** These are identified as those individuals who are directly affected by someone's suicide and as well as people in close relationships with the deceased. This group would also include train (and other vehicle) drivers or people witnessing people who have jumped to their deaths.

- **Support the media in delivering sensitive approaches to suicide and suicidal behaviour:** This would constitute media messages being delivered appropriately and in a measured way which does not over emphasise the details of the death or the exact location.

- **Support research, data collection and monitoring:** This constitutes the need to ensure that all data capture is accurate and timely and is used by the appropriate bodies to deliver informed and interrogated intelligence.

The *Five Year Forward View for Mental Health* challenged areas to reduce suicide by 10 per cent by 2020/21 and reiterated the need for every area to develop a multi-agency suicide prevention plan that demonstrates how they will implement interventions targeting high-risk locations and supporting high-risk groups within their population. This is also reflected in the local STP.

4. LOCAL CONTEXT IN RELATION TO THE NATIONAL OVERVIEW

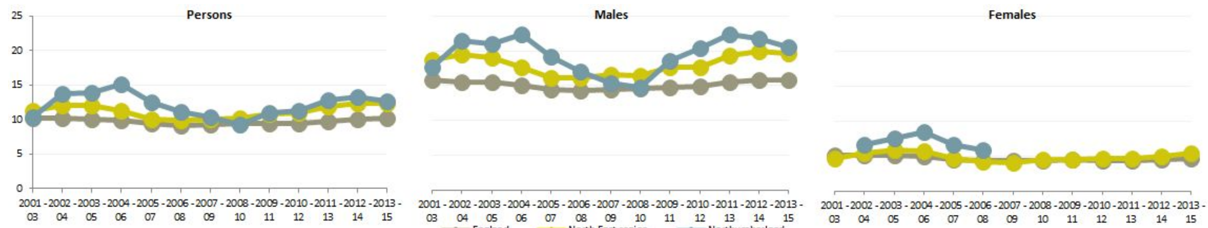
Northumberland is the sixth largest county in the UK with an estimated population of 316,116. The majority of the population is concentrated around the larger conurbation areas of Ashington, Blyth, Cramlington, Morpeth, Anwick, Hexham and Berwick. Whilst there are some areas of significant prosperity in Northumberland, there are also a number of areas that are very deprived and which have the attendant risks to physical and mental health and wellbeing, substance dependency and links to the criminal justice system, which are all risk factors for suicide and self - harm. HMP Northumberland is a Category C prison[10] with an operational capacity of 1348 males; the proportion of offenders supervised by probation services outnumbers those serving a custodial sentence by around 3 to 1.[11] Northumberland also has a secure children's home, Kyloe House which can accommodate up to 12 young people. There are also large tracts of rural areas with small populations but high levels of social isolation and loneliness which are also contributory factors to suicide and self-harm.

Suicide is one of the largest contributors of Potential Years of Life Lost (PYLL) in people under the age of 75 years. During the period 2012-2014, 2995 potential years of life were lost through suicide in Northumberland residents aged 15 - 74 years. This was more than the years of life lost for either respiratory disease (flu, pneumonia and asthma) or

[10] Closed prison - those who cannot be trusted in open conditions but who are unlikely to try to escape
[11] Revolving Doors Agency (2017). Rebalancing Act. A resource for Directors of Public Health, Police and Crime Commissioners, the police service and other health and justice commissioners, service providers and users. Available from:
http://www.revolving-doors.org.uk/sites/default/files/Documents/Rebalancing%20Act.pdf

cerebrovascular (stroke and some other diseases).[12] The rate of suicides for the population of Northumberland was 12.7 per 100,000 people over the three years 2013 to 2015. The actual number of suicides per year is low - on average there were 34 suicides each year in Northumberland between 2002 and 2015 - but because this average can cover substantial annual fluctuations in the data (for example, there were 55 suicides in 2004 and 21 suicides in 2008), suicide data is usually presented as a three year average in order to “smooth out” these fluctuations and enable a trend to be more easily discerned. This rate of 12.7 per 100,000 over 2013 to 2015 represents 105 deaths.

Figure 2. Suicide rate per 100,000 population.



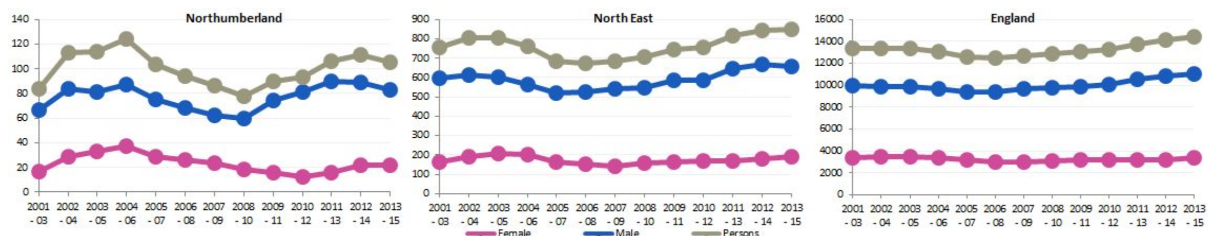
Source: Public Health England - Suicide Prevention Profile.

The left hand chart on Fig 2 shows the trend for the rate of suicides per 100,000 people in Northumberland, the North East, and England. The trend shows a rise in the rate of suicides to 2004-06 then a decline, followed by a slight rise (the latter coincides in time with the aftermath of the global financial crisis that started in 2007/08).

The centre and right hand charts on Fig 2 shows that throughout the country, in the North East and in Northumberland, the rate of suicides amongst males is consistently higher than it is for females - the rate for Northumberland males over 2006 to 2008 was 17.03 per 100,000 males, whereas for females over the same period the rate was 5.92 per 100,000[13], meaning that the rate of suicides amongst males at that point in time was nearly three times as high as the rate amongst females; there is nothing in the regional or national data to suggest that this trend has improved up to 2013 to 2015.

Fig 3 looks at this data from a different perspective (i.e. by geography rather than by sex) and the difference becomes clearer:

Figure 3. Suicide rate per 100,000 population.



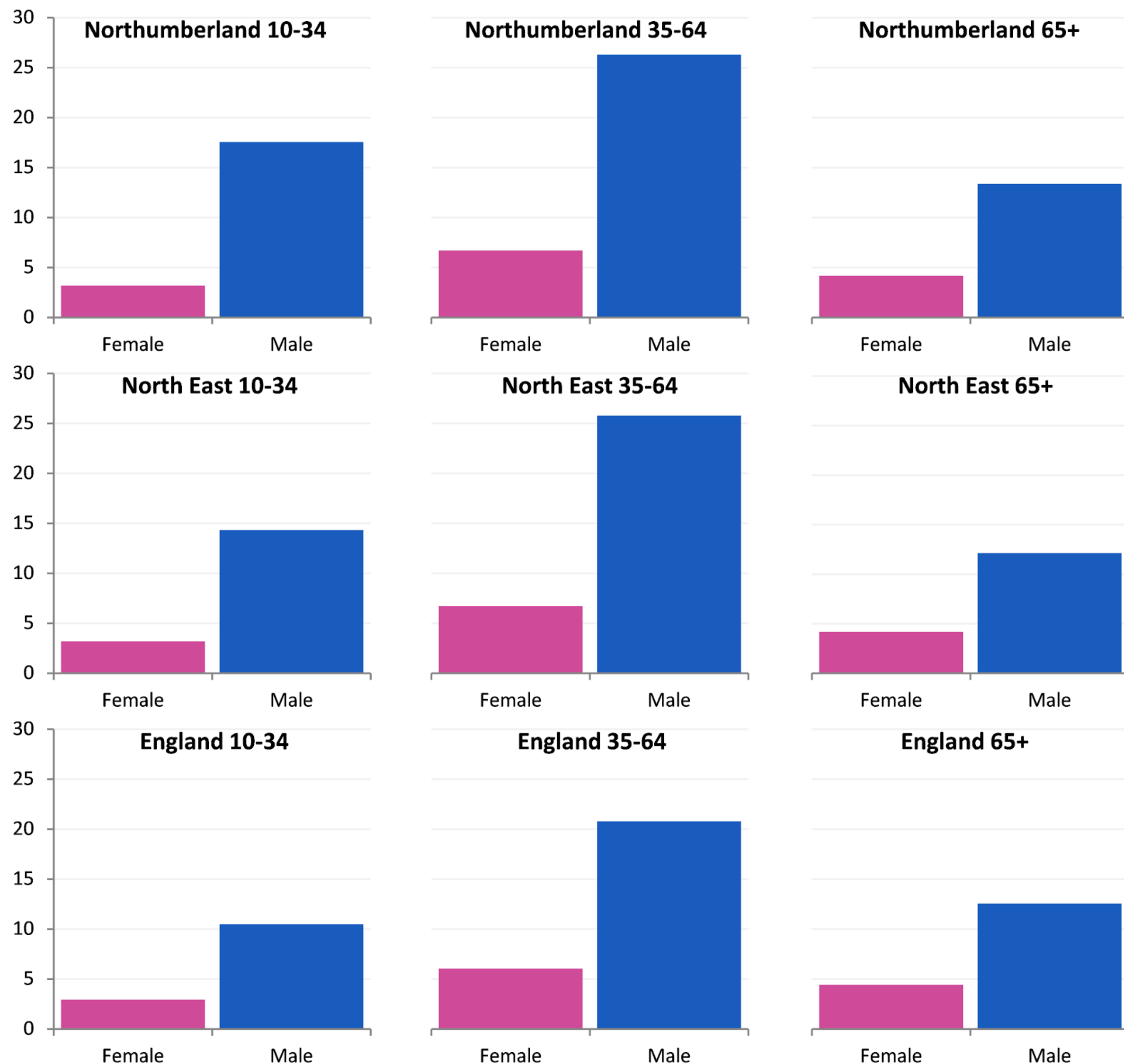
Source: Public Health England - Suicide Prevention Profile

[12] NHS Digital. NHS Indicator portal.

[13] Data is not available for any later three year period because the rate cannot be accurately measured with such low numbers of female suicides .

Northumberland has a significantly higher rate of suicides amongst males under 75 years (Fig 4) when compared with the England rate (17.6 per 100,000 in Northumberland compared to 10.5 per 100,000 in England for 10 - 34 year olds; 26.3 per 100,000 in Northumberland compared to 20.8 per 100,000 in England for 35 - 74 year olds). Rates for the North East for males in these age groups are about the same. Again, the number of suicides in Northumberland is relatively small so the differences outlined above should be seen in that context and interpreted with caution.

Figure 4. Age and gender suicide rates per 100,000 population for the period 2011-15.[14]



Source: Public Health England - Suicide Prevention Profile

The rate of suicides in men aged 35 - 64 in Northumberland is higher than the suicide rate for men aged 10 to 34. However, the lower age range has recently changed from 15 - 34 years to 10 - 34 years; this extension of the age range has had the effect of reducing the rate in this younger population because the proportion of suicides in those aged 10 - 15 years is

[14] Suicide rates in females are shown using the North East value for both Northumberland and the North East (see footnote 10).

very low. This then masks the high risks in younger men. The rate for male suicide amongst the 65+ population in Northumberland has dropped in recent years; the 2011-15 rate is 13.37 per 100,000 whereas the 2009-13 rate was 17.11 per 100,000. Across the North East the highest rate is amongst 35 - 64 year old females and lowest in 10 - 34 year old females.

The Public Health England Suicide Prevention Profile[15] provides a suite of indicators for suicide related risks. The risk factors for suicide are myriad and interrelated, and will be specific to each individual, but the following factors (not an exhaustive list) are known to increase the risk of suicide:

- **Age and sex.** Across all broad age groups, the rate for males was around 3 times higher than females for the UK as a whole. Between 2013 and 2015 there were 105 deaths from suicide registered across Northumberland; 83 were in men. Most at risk of suicide were young men; the crude suicide rate in men aged 15 - 34 years over the five year period 2010-2014 was significantly higher than that for England.

- **Mental ill health.** We know there is a strong association between mental ill health and suicide. During 2004-2014, 13,921 deaths (28% of general population suicides) were identified as patient suicides i.e. the person had been in contact with mental health services in the 12 months prior to death. This represents an average of 1,266 patient suicides per year.[16] The prevalence of depression in Northumberland (as recorded on GP records) is significantly higher than that for England and the North East. The risk of suicide after self-harm may be 49 times greater that the risk of suicide in the general population.[17] During 2014/15, there were 762 admissions for intentional self-harm amongst Northumberland residents; a significantly higher admission rate than that for England and the North East. The rate of maternal death by suicide remains unchanged since 2003 and maternal suicides are now the leading cause of direct maternal deaths occurring within a year after the end of pregnancy.[18] Nationally, there are higher rates of mental ill health and in particular, more severe mental ill health in the prison population and higher rates in offenders on probation and in the community.[19]

- **Substance misuse.** Substance misuse and mental health problems often occur together and there is a complex relationship between the two. The latter can be exacerbated by the former and alcohol and non-prescribed drugs can interact with

[15] Available from: https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide
[16] University of Manchester (2016). National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness. Annual report and 20-year review. October 2016.
[17] Hawton, K., Bergen, H., Cooper, J., Turnbull, P., Waters, K., Ness, J. & Kapur, N. (2015) Suicide following self-harm: findings from the Multicentre Study of self-harm in England, 2000-2012. Journal of Affective Disorders 175, 147-51. DOI:10.1016/j.jad.2014.12.062
[18] Knight M, Nair M, Tuffnell D, Kenyon S, Shakespeare J, Brocklehurst P, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-14. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2016.
[19] Ibid 11 (Revolving Doors Agency).

medicines used to manage mental illness. In Northumberland during 2014/15 there were 4689 alcohol-related admissions[20] and 270 admissions specifically due to intentional self-harm from alcohol.[21] Substance use amongst sentenced prisoners and those on remand is higher than the rest of the population; during 2015/16, 27% of referrals nationally into substance misuse services for opiate addiction originated from the criminal justice system.[22]

- **Social isolation and loneliness**. Social isolation and loneliness can both lead to and arise as a result of mental ill health. Older men, people with a long term disability, those living in more deprived communities, the unemployed, excluded young people, those currently or previously in contact with the criminal justice system and a raft of other groups are likely to experience more social isolation and loneliness. At the last census (2011), there were 19,407 households with a single occupant over 65 years of age. More recent survey data suggests that only 51.5% of adult social care users and only 46.9% of adult carers have as much social contact as they would like.[23]

- **Gender and ethnicity**. We also know that nationally individuals in the LGBTQ groups can be vulnerable to suicide. This is particularly the case for individuals who identify themselves as being transgender, either in treatment for transition or who have recently transitioned. In addition, individuals from BAME communities are also more likely to feel marginalised and disenfranchised from broader societal engagement.

- **Veterans.** Young men (under 24 years) who have left the Armed Forces may be at two to three times higher risk of suicide than the same age groups in the general and serving populations. The risk may be greater in those with a short length of service, and those of lower rank.[24]

- **Prisoners and those in contact with the criminal justice system.** The prison population and people who have been held in a police custody suite in the weeks prior to their suicide are all identified as being at higher risk of suicide than the general population. Provisional data indicates that 3 people died from self-inflicted injuries in HMP Northumberland during 2016. Historically, deaths from self-inflicted injury have generally been been lower and only equalled in 2007.[25] During 2015/16,

[20] PHE (2016). Public Health Outcomes Framework. Suicide prevention profiles.
[21] PHE (2016). Public Health Outcomes Framework. Local Alcohol Profiles for England.
[22] Ibid 11 (Revolving Doors Agency).
[23] PHE (2016). Public Health Outcomes Framework. Suicide prevention profiles.
[24] Kapur, N., While, D., Blatchley, N., Bray, I., & Harrison, K. (2009). Suicide after Leaving the UK Armed Forces —A Cohort Study. PLoS Medicine, 6(3), e1000026. http://doi.org/10.1371/journal.pmed.1000026
[25] MoF (2017). Deaths in prison custody 1978 to 2016. MoJ. 27 Apr 2017. Available from: https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-december-2016--2

there was one death from apparent suicide following police custody in the Northumbria Police Authority; their Local Authority residence is unknown.[26]

Suicides in young people are a rarer occurrence but nationally, rates increase steeply during the late teens. Additional themes in suicide by children and young people include bullying, suicide-related internet use, academic pressures (especially related to exams) and social isolation or withdrawal.[27]

ONS figures for occupational related suicides have highlighted the most vulnerable occupations where the workforce presented with higher than average figures than the general population.[28] The data shows that for women, occupations with a high risk of suicide were nursing (23% above the national average), primary school teachers (42% above the national average) and people who worked within culture, media and sport (69% above the national average). In relation to men, low skilled labourers in the construction industry that had the highest rates of suicide, three times greater than the England average. For both men and women working as care workers the risk of suicide was nearly twice the national average.

The most common method of suicide in 2015 amongst males and females in the UK was hanging. The proportion of deaths from hanging has increased slightly since 2014 (58% in males; 43% in females). In contrast, the second most common method of suicide was poisoning, which has fallen slightly to 18% for males and 35% for females. The proportion of suicides involving drowning, falls and other methods have remained fairly consistent over the past decade.

In terms of the methods used, hanging/strangulation was the most common for males, however in women this was joint with self-poisoning. Alcohol was found to have been taken in 40% of cases. The majority of deaths (62%) occurred at a domestic address while the remainder (38%) occurred in other locations – potential hotspots include multi-storey car parks, railway stations/lines, isolated beauty spots and river courses.

A snapshot audit of the South and North Northumberland coronial records in relation to the numbers and methods of suicide across Northumberland was carried out in March 2017 covering the period August 2015 to January 2017. The coronial records of 16 deaths recorded as suicide across the county were reviewed.[29] The most frequent method used was hanging with only 5 people having been flagged up as at risk of suicide. Experience of members of their own family taking their own lives in the past and a history of previous suicide attempts and self-harm were recurring themes. Ages ranged from 17 and 79 years with the predominant age range being between 43 and 56; most of these individuals were men. These findings reflect national trends.

[26] IPCC (2016). Deaths during or following police contact: Statistics for England and Wales 2015/16. https://www.ipcc.gov.uk/sites/default/files/Documents/research_stats/Deaths_Report_1516.pdf
[27] University of Manchester (2016). National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness. Suicide by Children and Young People in England. May 2016.
[28] Ibid 3.
[29] These were records of those for whom the inquest had been completed during that period, as opposed to the time period during which the suicide took place.

5. NORTHUMBERLAND STRATEGIC PLAN

Current actions relating to preventing suicide in Northumberland relate to promoting positive mental health for people at risk of suicide/self-harm and are part of a broader mental health promotion action plan. A number of initiatives have already been undertaken which support the suicide agenda. These include:

- A consultation with young people in 2016 to secure an overall improvement in their emotional and mental health. The consultation group highlighted a number of issues which impacted on their well being, particularly around their access to health services, with key findings that suggested services missed opportunities to support their emotional health before they reached crisis, particularly at times when they were going through difficult circumstances. They identified a need for information to be provided in a format that was meaningful for them such as the better use of websites and social media, which is their preferred way of accessing information. To this end a resource toolkit is being created, in consultation with young people, to support them with early access to coping mechanisms and self- supporting skills to help them deal more effectively with the challenges they face early on, which could be effective in reducing the risk of escalation into crisis. This work is being formatted to be accessed through digital technology and it is anticipated that this will roll out for use during 2017.

- A significant piece of work done with the British Transport Police (BTP) and Network Rail was undertaken in 2016 as a result of a cluster of suicides on the East Coast line linked back to the closure of a large Berwick-on-Tweed employer. Planned engagement with the 'at risk' workforce and joined up working with BTP and Network Rail to identify areas vulnerable to ingress and ensure fencing was repaired or erected was carried out over a dedicated period of time. Both BTP and the employer believed that without these interventions, there might have been further incidents of suicide and attempted suicide. BTP and Transport for London (TFL) are also delivering an initiative which enables members of the public to feel confident about alerting rail workers where they see individuals behaving in a way which is a cause for concern.

Planning and Governance

As a County, Northumberland needs to action a number of key areas to improve the identification and management of identified risks within the six national framework headlines. Through a new Northumberland Suicide Prevention Partnership, the existing action plan will be reviewed and developed to ensure that all six key areas are addressed, incorporating the actions outlined in the following paragraphs.

The Partnership will, as a minimum, consist of representatives from the following agencies:

- Northumberland County Council Public Health (Chair)
- Northumberland County Council Adult Social Care and Children's Services
- NHS Northumberland CCG
- Northumbria Police
- Northumberland Recovery Partnership
- Northumberland Tyne and Wear NHS Foundation Trust
- Her Majesty's Prison and Probation Service
- Voluntary and community sector
- Coroner's service

It will be accountable to the North Tyneside and Northumberland Safeguarding Adults Board and will report by exception and annually. The Partnership will link closely with the Mental Health Crisis Care Concordat and will ensure that the action plan is integrated with other mental health strategies and action plans in place or in development across the system.

Priority 1 - Reducing the risk of suicide in high risk groups

We have already identified that there are vulnerable groups across society who will be more likely to attempt or succeed in taking their own lives. In recognising these vulnerabilities, Northumberland requires a clear cross organisational commitment to identify individuals at risk and seek assurance that they are recognised and being managed appropriately by the services they are involved in. We will:

- Develop closer links with Her Majesty's Prison and Probation Service (HMPPS) through the regional HMPPS Safer Custody Lead to ensure that there are seamless pathways to support those already identified as being at higher risk of suicide when they transition from a prison to a community setting.

- Using the better Health at Work Awards as one vehicle, provide advice and support to employers on workplace suicide through the promotion of the Prevention toolkit (**http://wellbeing.bitc.org.uk/spret**) and for employers having to manage a traumatised workforce post event, the Postvention toolkit (**http://wellbeing.bitc.org..uk/spostv**) developed by Public Health England, Business In The Community (BITEC) and the Samaritans specifically for employers.

- Identify and exploit opportunities to engage with men (particularly younger men aged 15 - 34 years) in non-clinical settings to encourage them to discuss and seek help/support on the range of factors commonly associated with suicide in men.

- Review recommendations made by the National Confidential Inquiry into Suicide and Homicide in People with Mental Illness and ensure they have been implemented or considered by relevant organisations.

- Ensure that current best practice relating to the identification and management of those who self-harm is being implemented.[30]

- Access and awareness of the many National and regional support organisations are also important and information about these organisations should be available in a highly visible way in an easy read format across all public buildings around the county.

Priority 2 - Engineer approaches to improve mental health in specific groups

The pursuit of parity of esteem, which demands that people who are experiencing mental ill health should be dealt with with the same approach that they would be if they presented to health services with a physical health issue, is a significant driver to the better identification and management of people who may be vulnerable to suicide at the earliest point of intervention. We will:

- Review and monitor the provision of suicide and general mental health awareness and mental health promotion training (particularly mental health first aid training) across the county.

- Focussing on prisons, audit the uptake of suicide prevention, mental health first aid training and contribution to the Assessment, Care in Custody and Teamwork (ACCT) process.

- Support and review the development of a plan by stakeholders involved in the delivery of services to children and young people to develop a coordinated approach to promoting resilience and emotional health and wellbeing in children and young people.

Priority 3 - Strategies for the reduction of opportunity

In order to ensure that there is a strategic approach to ensuring opportunity and access to potential risky spaces is managed, there is a need to consider identified hotspots and potential risk within buildings our vulnerable communities may access. We will:

- Review initiatives to provide safer environments across secure settings and seek assurance that these have been effectively put in place (e.g. removal of ligature points in hospitals, police custody and prison settings).

[30] NICE (2004) - Self-harm in over 8s: short-term management and prevention of recurrence (CG 16); NICE (2011) - Self-harm in over 8s: long-term management (CG133); NICE (2013) - Self-harm (QS 34).

- Maintain links with BTP and Network Rail to support safer rail access; promote a general public awareness raising campaign with respect to the identification of high risk rail side activity.

- Use the suicide audit process to identify any ‘hotspots’ and ensure that mitigating action is put in place where possible and that training is in place for staff in that locality.

Priority 4 - Provide better information and support to those bereaved or affected by suicide:

Bereavement or a close connection with a suicide are themselves risk factors for suicide. It is therefore vital, as part of this suicide strategy, that bereavement and suicide support services are timely and appropriate. We will:

- Map current interventions specifically aimed at reducing suicide and supporting the bereaved and those affected by suicide; review the framework and pathway for service providers and evaluate local bereavement support services.

- Develop a mechanism to promptly identify clusters through closer liaison with Coroners’ services and enable the development of a subsequent Community Action Plan.[31]

Priority 5 - Support the media in delivering sensitive approaches to suicide and suicidal behaviour

It is important that media reporting of suicides is responsible and sensitive so that hotspots are not identified and the narrative is not salacious, likely to influence copycat behaviour and is respectful and non-judgemental of the individual who has died and their family. There is also a need to review and identify the potential risks and benefits that social media presents. We will:

- Ensure the local media are aware of, and following, Samaritans’ guidance on responsible media reporting.

- Review the evidence of the impact of social media on suicide (both positive and negative) to inform future work.

Priority 6 - Support research, data collection and monitoring

A consistent and systematic approach to monitoring suicide incidents and being informed through robust data and research will afford Northumberland the careful thinking time to respond to the management and understanding of suicide events. We will:

[31] PHE (2015). Identifying and responding to suicide clusters and contagion. A practice resource. PHE. Sept 2015

- Develop a suicide audit process to support the regular collection of data, the identification of trends and hotspots, and progress against the aim of the strategy to reduce suicides.

6. MEASURING PROGRESS

Nationally, the **NHS Outcomes Framework,** the **Public Health Outcomes Framework** and the **Adult Social Care Outcomes Framework** all contain high level national indicators which will provide a monitoring framework against which success can be measured.

- Public Health Outcomes Framework for England 2013–2016 identifies four key indicators relevant to this plan: social connectedness (domain 1); hospital admissions as a result of self-harm (domain 2); excess under 75 mortality in adults with serious mental illness (domain 4); and suicide (domain 4).

- NHS Outcomes Framework identifies 2 key improvement areas relevant to this plan: reducing premature death in people with serious mental illness (1.5); and improving outcomes from planned treatments – psychological therapies (3.1).

- Adult Social Care Outcomes Framework indicator of social connectedness (shared with the Public Health Outcomes Framework): proportion of people who use services and their carers, who reported that they have as much social contact as they would like (domain 1) .

Both the Adult Social Care and NHS outcomes frameworks contain safeguarding domains that are relevant to work on suicide prevention (Adult Social Care domain 4 and NHS Domain 5).

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