South Gloucestershire Suicide Prevention Strategy

2015-2018

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Written by
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Acknowledgements
We would like to thank all the people and organisations who have contributed to the development of this strategy.
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Executive Summary

Background and aims

Every suicide death is a tragedy and impacts on friends, family, support services, health care professionals and society as a whole. In England, it has been estimated that one person dies every two hours as a result of suicide.

Nationally, the following groups are identified as having a high risk of suicide compared with the general population: individuals who self-harm, individuals affected by the financial crisis, those affected or bereaved by suicide, individuals in contact with mental health, drug and alcohol services, individuals in contact with the criminal justice system, individuals who identify as Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ), children and young people, older people, people with long term conditions, carers, Black and Minority Ethnic (BME) groups and specific occupational groups (such as vets).

The national suicide prevention strategy, Preventing Suicide in England, published in 2012, identified six priority action areas for suicide prevention: reducing the risk of suicide in key high risk groups, tailoring approaches to improve mental health in specific groups, reducing access to the means of suicide, providing better information and support to those bereaved or affected by suicide, supporting the media in delivering sensitive approaches to suicide and suicide behaviour and supporting research, data collection and monitoring. This local strategy is consistent with the aims and approach of the national strategy, summarises the findings from the Office for National Statistics (for national suicide data) and the most recent suicide audit in South Gloucestershire (for local suicide data). It also describes the suicide prevention action plan for South Gloucestershire over the next three years.

The South Gloucestershire Suicide Prevention Strategy Partnership Group

The South Gloucestershire Suicide Prevention Strategy Partnership Group was set up in early 2014 and meets quarterly. The group reports to the Mental Health Partnership which is in turn accountable to the Health and Wellbeing Board. One of the main responsibilities of the group is to oversee the delivery of the initiatives identified in the local action plan. The group also reviews findings from the local suicide audit which reports annually on suicide and undetermined injury in South Gloucestershire.

Findings from the South Gloucestershire Suicide Audit

Findings from the most recent suicide audit (the 2015 audit includes data from 2002 to 2013) are as follows:

- Suicide rates in males, females and all persons are lower in South Gloucestershire compared to the South West and England.
- Similar to the national picture, there were two to three male suicides for every female suicide in South Gloucestershire.
- Suicide mortality rates in South Gloucestershire have shown an increase from 2004-2006 to 2011-2013. This increase is larger than that observed over the same time period for England.
The highest mortality rates were observed in males aged 65-74 years and those aged 75 years and over; however the largest numbers of suicides were observed in middle aged men (those aged 45 – 64 years) and younger men (those aged 25 to 44 years).
- Suicide rates were highest in the two most deprived quintiles.
- Death by hanging is the most common method of suicide, followed by death by poisoning.
- In children (those aged <18 years), only 1.2% of deaths were due to suicide or deliberate self-inflicted harm.

**Actions going forward**

Suicide prevention activities will be focussed on the groups in South Gloucestershire identified in the most recent suicide audit as having a high risk of suicide compared with the general population (men, particularly older men aged over 65 years and middle aged men (those aged 45-64 years) and people in the two most deprived quintiles) as well as other groups identified nationally as being at high risk (people who self-harm, people bereaved by suicide and the LGBTQ group). Key actions going forward will include:

- Promotion of the new South Gloucestershire Resource List for people bereaved by suicide or sudden death among key agencies.
- Improving data monitoring and real time surveillance of suicides, with particular respect to closer working with coroners. South Gloucestershire is working with other Local Authorities to fund a coroner office audit post to strengthen real time surveillance. The aim is to recruit into this post by the end of 2015.
- Continued support of the Bristol Self-Harm register to obtain surveillance data on hospital attendances for self-harm at the Emergency Department at Southmead Hospital.
- Improving communication activities regarding high risk groups for suicide and suicide prevention activities including engagement with local media, provision of information to the public, raising awareness of mental health issues in young people, addressing stigma and workforce health promotion and support.
- Training and education of staff with particular respect to staff working with offenders, the police and healthcare staff in mental health services to recognise people who may require additional support and improve mental health literacy.
- Continued joint working with the voluntary sector regarding suicide prevention activities and activities to improve general mental health and wellbeing, for example with respect to the Listener Peer Support Service in prisons, provision of support services (including debt counselling, support to reduce social isolation and helplines).

Further details of the South Gloucestershire action plan are included in Appendix E.
Section 1: Introduction

Background

Suicide is one of the leading causes of premature mortality worldwide, with an estimated global burden of between 800,000 and one million deaths annually\(^1\). In England, it has been estimated that one person dies every two hours as a result of suicide\(^2\). In 2013, there were 4727 deaths from suicide, a rise of 214 since 2012\(^3\).

Every suicide death is a tragedy and impacts on friends, family, support services, healthcare professionals and society as a whole. However, suicides are not inevitable and there are many ways in which services, communities, individuals and society can prevent suicides.

The South Gloucestershire Suicide Prevention Strategy Partnership Group was set up in early 2014 and meets quarterly. The group reports to the Mental Health Partnership which is in turn accountable to the Health and Wellbeing Board. The group reviews findings from the local suicide audit which reports annually on suicide and undetermined injury in South Gloucestershire. It also oversees the delivery of the initiatives identified in the local suicide prevention action plan. Further details of the Strategy Partnership Group are provided in Section 4: Preventing Suicide in South Gloucestershire and in Appendix C.

The development of a local suicide prevention strategy to sit alongside the adult mental health and wellbeing strategy was one of the main recommendations from South Gloucestershire’s first adult mental health and wellbeing needs assessment (MHNA). The MHNA was published in July 2015 and is hosted by the Mental Health Partnership. Its findings have been approved by the Health and Wellbeing Board. We recommend that readers of this suicide prevention strategy also take note of the MHNA (and the mental health and wellbeing strategy when this is completed) as improving the mental health of the population is key to suicide prevention. The development of a local suicide action plan was also recommended by the Government in keeping with the 2012 national suicide prevention strategy. Further details of relevant national policy documents are included in Section 3: Preventing Suicide in England.

In this strategy, we aim to outline the approach to suicide prevention in South Gloucestershire. The strategy has been informed by local expertise and experience as well as national research evidence and policy guidance. National and local data (from the most recent suicide audit in South Gloucestershire) are also included. In addition, we highlight the priority actions going forward to reduce the incidence of suicide in South Gloucestershire. These initiatives are included in the local action plan, which is overseen by the Suicide Prevention Strategy Partnership Group and updated on a yearly basis.

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Suicide definition, reporting and risk factors

Suicide is “an intentional self-inflicted act which results in death”\(^4\). In the UK, suicide or attempted suicide is not considered to be a crime. However, suicide deaths are 'determined' by coroners as a coroner’s inquest is required for any death that is violent or unnatural, occurs under police custody, or is sudden and of unknown cause\(^5\). The coroners will only record a suicide verdict if there is indication of suicidal intent beyond reasonable doubt, for example if a suicide note is present. If intent cannot be proven then an accidental or open (undetermined) verdict should be given by the coroner\(^6\). When reporting national suicide statistics, the Office for National Statistics (ONS) usually combines suicides and deaths from undetermined intent\(^7\) to reflect research studies that show that the majority of open verdicts are likely to be suicides\(^8\). In the UK, a coroner may give a verdict of suicide for people as young as 10 years. However, the ONS tends to report suicide statistics for people aged 15 years and over as there is known subjectivity between coroners when classifying children’s deaths as suicide. In addition, the number of these deaths tends to be low in those under the age of 15 years which may reduce overall suicide rates\(^9,10\).

An individual’s risk of suicide is determined by many factors. These include demographic factors such as age and sex, poverty and deprivation, marital status (being divorced or widowed), employment status, seasonal or temporal factors, physical illness (presence of chronic disease), drug and alcohol abuse and psychiatric disorders (depressive illnesses, psychotic illnesses and anxiety disorders)\(^11\). A history of previous self-harm is also strongly associated with increased suicide risk. Self-harm includes behaviours such as intentional self-poisoning or self-injury (for example by cutting, burning or punching) regardless of their severity or the extent of suicidal intent\(^12\).

\(^4\) Maris RW. Suicide. The Lancet 360(9329):319-326. 2002
\(^5\) Chambers DR. The coroner, the inquest and the verdict of suicide. MedSci Law 29: 181. 1989
\(^7\) Department of Health. Statistical update on suicide. February 2015.
\(^9\) Samaritans Suicide Statistics report including data for 2010-2012. 2014
\(^12\) Kapur N. Suicide in the mentally ill. Psychiatry 8: 257-260.2009
Section 2: The national picture

This section describes the current and recent trends in suicide in England.

Trends in suicide in England

Data and figures for this section were obtained from the Department of Health’s statistical update on suicide which was published in February 2015.\(^ {13} \)

**Overall trends**

There was a decreasing trend in suicide rates from 1998 until 2006 although trends have shown a small increase since 2006 (see Figure 2.1). The three year average rate for 2011-2013 for all persons was 8.8 suicides per 100,000 general population (13.8 and 4.0 per 100,000 population for males and females respectively). The 2011-2013 rate was the highest suicide rate in males since 2003-2005; however suicide rates in females have remained more or less steady since 2006-2008.

**Figure 2.1:** Death rates from Intentional Self-Harm and Injury of Undetermined Intent, England, registered in 1995-2013.

![Graph showing death rates from Intentional Self-Harm and Injury of Undetermined Intent from 1995-2013.]

Source: Office for National Statistics

**Sex and age specific suicide rates**

Males accounted for 78% of all suicides in 2013. When compared to women of the same age, men are more likely to take their own lives. However, this difference varies by age. The peak difference occurs in the 25-29 year age group where there are almost five male suicides for every female suicide (see Figure 2.2). In 2013, the highest male suicide rate was seen in men aged 40-44 years; the highest female suicide rate was observed in women aged 45-49 years.

\(^ {13} \) Department of Health. Statistical update on suicide. February 2015.
Figure 2.2 Death rates from Intentional Self-Harm and Injury of Undetermined Intent by five year age band and sex, England, registered in 2013

Age specific death rate per 100,000 population

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Males (%)</th>
<th>Females (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14</td>
<td>25</td>
<td>20</td>
</tr>
<tr>
<td>15-19</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>20-24</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>25-29</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>30-34</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>35-39</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>40-44</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>45-49</td>
<td>25</td>
<td>15</td>
</tr>
<tr>
<td>50-54</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>55-59</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>60-64</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>65-69</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>70-74</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>75+</td>
<td>25</td>
<td>15</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics

Sex and method specific suicides

Table 2.1 shows the percentage of deaths from Intentional Self-Harm and Injury of Undetermined Intent by method and sex in England, registered in 2013. Hanging, strangulation and suffocation was the most common method in males and females, followed by drug poisoning. An increasing trend in the number of deaths mentioning helium poisoning has also been observed; this is concerning as most of these deaths are suicides.

Table 2.1: Deaths from Intentional Self-Harm and Injury of Undetermined Intent by method and sex, England, registered in 2013

<table>
<thead>
<tr>
<th>Method of suicide</th>
<th>Males (%)</th>
<th>Females (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hanging, strangulation and suffocation</td>
<td>57</td>
<td>41</td>
</tr>
<tr>
<td>Drug poisoning</td>
<td>19</td>
<td>47</td>
</tr>
<tr>
<td>All other methods</td>
<td>24</td>
<td>22</td>
</tr>
</tbody>
</table>

Suicides in people in contact with mental health services and inpatient suicides

Figure 2.3 shows the numbers of suicides by people in contact with mental health services (in the 12 months prior to death), England from 2002-2012. In 2012, there were 1272 suicides by people in contact with mental health services in the year prior to death. This is slightly lower than 2010 and 2011 but was higher than that observed in 2006 to 2009.
Figure 2.3 Suicides by people in contact with mental health services (in the 12 months prior to death), England from 2002-2012*

Source: National Confidential Enquiry into Suicide and Homicide by people with mental illness

*The estimate figures provide the most accurate estimate of the number of cases expected. The projected figure may change as data become more complete.

The number of inpatient suicides in England has continued to fall (see Figure 2.4). There were 83 inpatient suicides in 2011 and 50 inpatient suicides in 2012 (note that the figure for 2012 should be viewed with caution as inpatient suicides deaths are more often subject to late notification).

Figure 2.4: Inpatient suicides, England 2002-2012*

Source: National Confidential Enquiry into Suicide and Homicide by people with mental illness

*The estimate figures provide the most accurate estimate of the number of cases expected. The projected figure may change as data become more complete.
**Offenders**

The number of self-inflicted deaths in prison is shown in Figure 2.5. Data are obtained from the National Offender Management Service (NOMS) (see Box below). The number of self-inflicted deaths in prisons remained fairly consistent between 2008 and 2012, ranging from 54 to 60 deaths per year. The numbers of these deaths rose to 74 deaths in 2013 and then again to 80 deaths in 2014.

**Figure 2.5: Self-inflicted deaths* in prison**

![Graph showing self-inflicted deaths in prison from 1998 to 2014.](source)

Source: National Offender Management Service

*Prisoner ‘self-inflicted’ deaths include all deaths where it appears that a prisoner has acted specifically to take their own life. Approximately 80% of these deaths receive a suicide or open verdict at inquest. The remainder receive an accidental or misadventure verdict.

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**The National Offender Management Service (NOMS)**

The National Offender Management Service is an Executive Agency of the Ministry of Justice (MOJ) responsible for the correctional services in England and Wales. Their role is to commission and provide offender management services in the community and in custody ensuring best value for money from public resources. The Service works to protect the public and reduce reoffending by delivering the punishment and orders of the courts and supporting rehabilitation by helping offenders to reform their lives. Offender services are delivered through:

- The National Probation Service which is responsible in the community for carrying out risk assessments of all offenders including management of those offenders who pose the highest risk of serious harm to the public
- Public Sector Prisons
- Community Rehabilitation Companies
- Private Sector prison providers
- Partnerships with police, local authorities, health and education providers and organisations in the voluntary and social enterprise sector
- The Agency is also contracted by the Youth Justice Board to provide commissioned beds for young people (under 18) and by the Home Office to provide places at Immigration Removal Centres and detention spaces in prisons.

Statistics on safety in custody including self-inflicted deaths are published by NOMS every quarter.
Risk factors for suicide

Some groups of people are known to be at higher risk of suicide compared with the general population. The 2012 Suicide Prevention Strategy for England identified the following high risk groups:

- **Men**- Young men (<35 years) were identified as a high risk group in the previous suicide prevention strategy in 2002 (insert ref). Using the most recent data the highest suicide rates were seen in middle aged men i.e. men aged 40-44 years, 45-49 years and 50-54 years. Males aged over 75 years also had high suicide rates.
- **People in the care of mental health services including inpatients**- Inpatients, people who have been recently discharged from hospital and those who refuse treatment have the highest risk of suicide.
- **People with a history of self-harm**- People who self-harm are at increased risk of suicide, although many people who self-harm do not intend to take their own life. Suicide risk is particularly increased in those who repeatedly self-harm and people who have used violent methods of self-harm.
- **People in contact with the criminal justice system**- People at all stages within the Criminal Justice System including people on remand and those recently discharged from custody, are at high risk of suicide. The risk is greatest in the first week of imprisonment.
- **Specific occupational groups**, such as doctors, nurses, veterinary workers, farmers and agricultural workers- These groups are at particularly high risk as they have ready access to lethal means of suicide.

Outside of the high risk groups, there are additional groups of people with particular vulnerabilities or problems with access to services who should also be considered. These groups may have higher rates of mental health problems including self-harm and include as follows (vulnerable groups at high risk of mental ill health identified from the South Gloucestershire Mental Health and Wellbeing Needs Assessment are also highlighted with an asterisk):

- Children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the Youth Justice System.
- Survivors of abuse or violence, including sexual abuse*
- Veterans
- People living with long-term physical health conditions*
- People with untreated depression

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- People who are especially vulnerable due to social and economic circumstances* (in South Gloucestershire this includes the unemployed and people living in Priority Neighbourhoods\textsuperscript{15})
- People who misuse drugs or alcohol*
- Lesbian, Gay, Bisexual and Transgender people*
- Black, Asian and minority ethnic groups and asylum seekers.

Table 2.2 summarises the estimated increased risk for specific groups of people at higher risk of suicide compared to the general population\textsuperscript{15}.

Other vulnerable groups identified in South Gloucestershire’s Adult Mental Health Needs Assessment at high risk of mental ill health include offenders (who as previously described have an increased risk of suicide), people with disabilities, smokers and Gypsies and Travellers.

Table 2.2 Risk of suicide in specific populations compared with the general population

<table>
<thead>
<tr>
<th>Specific population</th>
<th>Estimated increased risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male sex</td>
<td>x2-3</td>
</tr>
<tr>
<td>History of psychiatric illness/Current psychiatric illness</td>
<td>x10</td>
</tr>
<tr>
<td>Previous suicide attempters (≥2 attempts)</td>
<td>x16</td>
</tr>
<tr>
<td>History of childhood sexual or physical abuse</td>
<td>x3</td>
</tr>
<tr>
<td>Family history of death by suicide</td>
<td>x3</td>
</tr>
<tr>
<td>Offenders</td>
<td>x5-20</td>
</tr>
<tr>
<td>Unemployed</td>
<td>x2-3</td>
</tr>
<tr>
<td>Physical illness/physical disability</td>
<td>x2</td>
</tr>
<tr>
<td>Single, divorced or separated</td>
<td>x2-3</td>
</tr>
<tr>
<td>Doctors</td>
<td>x2</td>
</tr>
<tr>
<td>Farmers</td>
<td>x2</td>
</tr>
<tr>
<td>Presence of a suicide plan</td>
<td>x11</td>
</tr>
<tr>
<td>People who have deliberately self-harmed in the past</td>
<td>x10-30</td>
</tr>
<tr>
<td>Alcoholics</td>
<td>x5-20</td>
</tr>
<tr>
<td>Drug misusers</td>
<td>x10-20</td>
</tr>
</tbody>
</table>

\textsuperscript{15} Six localities in South Gloucestershire have been defined as Priority Neighbourhoods as they have the highest socio-economic deprivation, face the greatest health inequalities and have the greatest need. These areas include Cadbury Heath, Filton, Kingswood, Patchway, Staple Hill and West Yate/Doddington.

\textsuperscript{16} BMJ Best Practice Suicide risk management. Available from \url{http://bestpractice.bmj.com/best-practice/monograph/1016/diagnosis.html}
Key points for suicide prevention

- Nationally, up to one quarter of people who die by suicide are under psychiatric care in the year before their death. Therefore 75% of people who die by suicide are not under psychiatric care.

- Up to 50% of people who die by suicide have made previous suicide attempts. Suicide attempters are a high risk group for completed suicide.

- Between 5% and 10% of all suicides occur within four weeks of discharge from psychiatric hospitals. Therefore 4 weeks post discharge should be considered a time of high risk.

- Certain occupational groups are at high risk of suicide, for example doctors, farmers, dentists, pharmacists due to their access to lethal means of suicide. Among women, health workers, in particular doctors and nurses are at highest suicide risk.

Self-Harm

A broader definition of self-harm as ‘self-poisoning or self-injury, irrespective of the apparent purpose of the act’ was adopted by NICE for their Clinical Guideline on self-harm\textsuperscript{17}. As stated previously, people who self-harm are a high risk group for suicide. People who self-poison are more likely to seek help than people who self-injure; about 80% of people who present to emergency departments following self-harm have taken an overdose of a prescribed or over the counter medication. Common drugs taken in overdose include paracetamol, aspirin and other analgesics, antidepressants, benzodiazepines, major tranquillisers and hypnotics/sedatives.

Factors that are associated with self-harm include:

- **socio economic factors** - people who are disadvantaged in socioeconomic terms, single or divorced, are single parents or lack social support
- **negative or adverse life events** - life events such as relationship problems can precipitate an act of self-harm, also self-harm is common in victims of domestic or sexual abuse and people with physical illness
- **the frequency of adverse life events** - there is a strong association between the likelihood of self-harm in an individual and the number of adverse life events experienced by that individual
- **mental illness** - most people who attend an emergency department following self-harm will meet criteria for one or more psychiatric diagnoses at the time of

\textsuperscript{17} NICE CG 16-Self-Harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. 2004
their assessment; depression will be diagnosed in more than two thirds of these individuals. People with certain personality disorders and psychotic disorders including schizophrenia are more than 20 times more likely to report a history of self-harm.

- **alcohol and drug use** - alcohol is commonly associated with self-harm episodes in people who present to emergency departments. Almost 25% of people who self-harm have an additional diagnosis of harmful misuse of alcohol. Men are more likely than women to drink before an episode of self-harm, are more likely to be misusing drugs or alcohol and have higher rates of additional risk factors for suicide.
- **child abuse** - there is a known association between child sexual abuse and self-harm, particularly among people who repeatedly self-harm. Child sexual abuse is also associated with other symptoms of severe mental distress including anxiety, depression, substance misuse, self-destructive behaviour and suicide.
- **domestic violence** - in addition to childhood experiences of abuse, experiences of domestic violence are associated with a wide range of mental disorders, as well as self-harm.

Rates of self-harm are also higher in the prison population than in the general population. This is because:

- Self-harm is sometimes used as a coping mechanism in a difficult situation, which prison is likely to be
- Prison contains a disproportionate number of distressed and vulnerable people who are themselves are at higher risk of self-harm
- Self-harm may be used as a way of communication for people who find it difficult to express their feelings
- Substance misusers are more likely to self-harm
- It is more difficult to hide self-harm in prisons.

Fifty percent of people who die by suicide in prison have a history of self-harm.\(^\text{18}\)

Section 3: Preventing suicide in England

National Suicide Prevention Strategy

A new national suicide prevention strategy for England was published in 2012 with two main objectives, to reduce the suicide rate in the general population in England and to better support those bereaved or affected by suicide. Six priority action areas were identified to support these objectives:

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

Further details of approaches to target the previously listed priority action areas are included in Appendix A.

A key message of the 2012 strategy was that suicide prevention is not the remit of a particular sector organisation. There are many sectors, groups and individuals who can help to reduce suicide.

Annual reports on the Suicide Prevention Strategy

The HM Government Preventing Suicide in England ‘One Year On’ report was published in January 2014 and clarified the role of local authorities regarding suicide prevention following the move of Public Health into Local Authorities. The report clarified the role of Local Authorities as focusing on the following themes:

- Development of a suicide prevention action plan.
- Monitoring of data, trends and hot spots
- Engagement with local media
- Working with transport to may hot spots
- Working on local priorities to improve mental health.

Further details are described in Section 4 of this strategy which focuses on preventing suicide in South Gloucestershire.

The second annual report on the Suicide prevention Strategy was published in January 2015. The Chair of the National suicide prevention strategy advisory group identified the following key messages as follows:

- There has been a rise in the suicide rate since 2008 and the financial crisis; however the rise was not as large as expected

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- Despite improvement in some economic indicators, the suicide rate continues to rise
- The highest suicide rates are observed in the North and South West of England; the lowest suicide rates are observed in London and the South East
- The most rapid increase in suicide rates since 2008 has occurred in middle aged men. As this group are the least likely to seek help, this presents a challenge to services to be more creative about improving access for men in this age group
- In younger men, the fall in suicide rates observed over the previous decade has stalled. Suicide remains a leading cause of death in this group
- Local areas can make an important contribution to saving lives where people are vulnerable due to debt, unemployment and housing problems
- Hanging remains the most common method of suicide. The emergence of new methods of suicide (for example the use of helium gas) is of concern
- There has been a notable rise in the self-inflicted deaths of prisoners
- The Multicentre Study of self-harm has reported recent increases in hospital attendances for self-harm in younger age groups. As self-harm is an important indicator of suicide risk, improving the mental health of young people is key to suicide prevention in the long term.

All Parliamentary Group Report on Suicide and Self-harm

The All Parliamentary Group (APPG) on Suicide and Self-harm prevention published a recent report summarising the ways in which the national suicide prevention strategy has been implemented at local level including details about suicide prevention work in all areas of England. The group identified three main elements for successful local implementation of the government’s national suicide prevention strategy as follows:

Carrying out a suicide audit. This should involve the collection of data about suicides that have occurred locally from sources such as coroners and health

(i) records in order to build and understanding of local factors such as high risk demographic groups
(ii) Developing a suicide prevention action plan setting out the specific actions that will be taken, based on the national strategy and the local data, to reduce suicide risk in the local community
(iii) Establishing a multi-agency suicide prevention group. This group should include all key statutory agencies and voluntary organisations whose support is required to effectively implement the plan throughout the local community.

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22 The All Parliamentary Group (APPG) on Suicide and Self-Harm Prevention-Inquiry into Local Suicide Prevention Plans in England, January 2015
Key national strategies and policies are summarised in the Box below 23,24,25,26,27,28,29,30,31.

<table>
<thead>
<tr>
<th>Key national strategies and policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Healthy Lives, Healthy people: our strategy for public health in England, Department of health 2010</td>
</tr>
<tr>
<td>• Preventing suicide in England: a cross governmental outcomes strategy to save lives, HM Government 2012</td>
</tr>
<tr>
<td>• No Health without Mental Health: a cross governmental outcomes strategy for people of all ages, Department of Health 2011</td>
</tr>
<tr>
<td>• Preventing suicide in England: One year on. First annual report on the cross-government outcomes strategy to save lives, HM Government 2014</td>
</tr>
<tr>
<td>• Preventing suicide in England: Two years on. Second annual report on the cross-government outcomes strategy to save lives, HM Government 2015</td>
</tr>
<tr>
<td>• Statistical update on suicide January 2014, Department of Health 2014</td>
</tr>
<tr>
<td>• Statistical update on suicide February 2015, Department of Health 2015</td>
</tr>
<tr>
<td>• Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: investing in the evidence, Department of Health 2014</td>
</tr>
<tr>
<td>• The National Confidential Enquiry into Suicide and Homicide by People with Mental Illness Annual Report, University of Manchester, July 2014</td>
</tr>
</tbody>
</table>

Further details of South Gloucestershire’s progress against the three elements identified above are described in Section 5.

Public Health England Guidance for developing a local suicide action plan

In September 2014 Public Health England (PHE) published guidance for local authorities on how to write a suicide action plan 32. In addition to this guidance, the document provided advice on how to:

• Monitor data, trends and hot spots
• Engage with local media

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25 Department of Health. No health without mental health. 2011
29 Department of Health. Statistical update on suicide. February 2015
30 Sally Davies. Annual report of the Chief Medical Officer 2013. Public Mental health priorities. 2013
31 National Confidential enquiry into suicide and homicide by people with mental illness. 2014
32 Public Health England. Guidance for developing a local suicide action plan: information for public health staff in local authorities
• Work with transport to map hot spots
• Work on local priorities to improve mental health.

A benchmarking exercise for progress within South Gloucestershire against this national guidance was performed in September prior to the development of the action plan. More details of suicide prevention in South Gloucestershire are provided in Section 5.

The PHE guidance also highlighted the ways in which public health staff in local authorities could work with other organisations to ensure joined up working in response to three main issues:

• The impact of the 2008 economic financial crisis- ensure health services know the options for someone at risk of suicide because of economic difficulties, from debt counselling to psychological therapy
• Self- harm, particularly in young people- ensure there are supports for young people in crisis who are at risk of self-harm
• Men- ensure information about depression and services is available in ‘male’ settings.
Section 4: Suicide in South Gloucestershire

This section summarises information from the most recent South Gloucestershire suicide audit as follows:

- Suicide rates in the South West, South Gloucestershire and other local areas
- Trends in suicide rates according to gender
- Trends in suicide rates according to age
- Deprivation and suicide
- Trends in the methods of suicide

Details of the methodology used to calculate suicide rates are provided in Appendix B. Note that suicide statistics include deaths from suicide as well as deaths from undetermined injury whether deliberate of accidental and include deaths in those aged 15 years and over. Child suicides are described in the last section.

A. Suicide in South Gloucestershire, the South West and England

Trends in suicides in the South West region from 2002 to 2013 are shown in Figure 4.1. Similar to national data, in the South West there were two to three male suicides for each female suicide (see Section 2). There has been a slight increase in male suicide rates in the South West since 2007; female suicide rates have remained consistent.

Figure 4.1: Directly Standardised Rates of suicides and undetermined injury in the South West, 2002-2013

Suicide rates in males, females and all persons for England, the South West and South Gloucestershire are shown in Figure 4.2. There is evidence of an increase in male suicides in South Gloucestershire over the time period. There was annual variation in female suicide rates due to the small numbers involved. However the female suicide
rate in 2013 was similar to the rate in 2002. Male suicide rates in the South West also increased over time (as described previously for Figure 4.1); female rates showed little change. It is important to note the small numbers of suicides in South Gloucestershire and the South West (20 and 450 a year respectively), compared with England (4500 per year).

Figure 4.2: Suicide and Undetermined Injury in England, South West and South Gloucestershire, 2002-2013

Figure 4.3 illustrates three year rolling averages in age standardised suicide rates from 2002 to 2013 in South Gloucestershire, its neighbouring local authorities and England (three year rolling averages smooth out fluctuations that might arise from small numbers). The suicide rates for South Gloucestershire increased from 2004-2006 to 2011-2013; a similar pattern was observed in North Somerset and Bath and North East Somerset (BANES). Suicide rates decreased in England from 2002 to 2004 to 2006-2008 with a small increase afterwards until 2011-2013.
Figure 4.3: South Gloucestershire within a National Context, three year rolling averages

Mortality for Suicide and Undetermined Injury, 3 year rolling averages, England, South Gloucestershire & surrounding areas, 2002-2013

B. Suicide trends by gender

Figure 4.4 shows the directly age standardised suicide rates by sex in South Gloucestershire, the South West and England. The male age standardised suicide rate in South Gloucestershire is lower than the male rate for England and the South West. The findings are not statistically significant as the confidence intervals overlap. There is very little difference in female suicide rates in England, the South West and South Gloucestershire.
C. Suicide trends by age

Trends in suicide rates by age for the years 2002-2004 to 2011-2013 are shown in Figure 4.5. There has been an increase in suicide rates in all age groups from 2007-2009 onwards.

Figure 4.5: Trends in Suicide and death by undetermined Injury by broad age group, three year rolling averages, South Gloucestershire, 2002-2013
Figure 4.6 shows the sex and age specific suicide mortality rates in South Gloucestershire for the years 2009 to 2013 inclusive. In males, the highest mortality rates were observed in the oldest men (those aged 65 to 74 years and those aged 75 years and older).

Figure 4.6: Crude rate of mortality from Suicide and Undetermined Injury by sex and age group, South Gloucestershire, 2009-2013, pooled.

Table 4.1 reports the numbers of suicide deaths by age and sex in South Gloucestershire. Although the oldest age groups reported the highest suicide rates (Figure 4.6), the largest number of suicide deaths was observed in those aged 45 to 64 years followed by those aged 25 to 44 years.

Table 4.1. Numbers of deaths by suicide and undetermined injury, South Gloucestershire, 2009-2013

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age Group</th>
<th>15-24</th>
<th>25-44</th>
<th>45-64</th>
<th>65-74</th>
<th>75+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td></td>
<td>6</td>
<td>21</td>
<td>25</td>
<td>10</td>
<td>7</td>
<td>69</td>
</tr>
<tr>
<td>Females</td>
<td></td>
<td>*</td>
<td>9</td>
<td>7</td>
<td>*</td>
<td>*</td>
<td>26</td>
</tr>
<tr>
<td>Persons</td>
<td></td>
<td>9</td>
<td>30</td>
<td>32</td>
<td>13</td>
<td>11</td>
<td>95</td>
</tr>
</tbody>
</table>

*supressed due to low count <5
D. Deprivation and suicide

Figure 4.7 shows the suicide rates in South Gloucestershire by deprivation. Suicide rates were highest in the two most deprived quintiles. The lowest suicide rate was observed in the 2nd least deprived quintile.

**Figure 4.7: Rate of Suicide and Death by injury of undetermined extent by local deprivation quintile, 2002-2013**

![Graph showing suicide rates by deprivation quintile](image)

E. Suicide methods

Table 4.2 reports the trends in method of suicide in South Gloucestershire. Hanging was the most common method of suicide and the numbers of suicides by this method has increased over time. Poisoning was the second most common method of suicide and there was also an increase in this method over time.

**Table 4.2: Trends in mode of suicide by year in South Gloucestershire, three year rolling averages, 2003-2013**

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<thead>
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<tbody>
<tr>
<td>Sharp object</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Poisoning</td>
<td>8</td>
<td>8</td>
<td>10</td>
<td>10</td>
<td>13</td>
<td>10</td>
<td>14</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>Hanging, strangulation and suffocation</td>
<td>15</td>
<td>18</td>
<td>20</td>
<td>23</td>
<td>25</td>
<td>29</td>
<td>28</td>
<td>27</td>
<td>30</td>
</tr>
<tr>
<td>Drowning</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Falling, jumping and pushed from high place</td>
<td>5</td>
<td>6</td>
<td>9</td>
<td>8</td>
<td>6</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>6</td>
</tr>
<tr>
<td>or before moving object</td>
<td></td>
<td></td>
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</tbody>
</table>
F. Suicide in Children

The West of England Child Death Overview Panel (CDOP) recently undertook a themed review of the deaths of children (those aged <18 years) who had chosen to take their own lives. The West of England panel includes local safeguarding boards in Bath and North East Somerset, Bristol, South Gloucestershire and North Somerset. The numbers of suicide deaths have not been published due to the small numbers of events. It is important to preserve confidentiality to reduce the risk that individuals can be identified. Only 1.2% of deaths were due to suicide or deliberate self-inflicted harm (Figure 4.8).

Figure 4.8 Notifications by category of death, 2010 to 2014 in the West of England
The following themes and learning points were identified by the CDOP:

- Two of the deaths reviewed involved children hanging themselves from bunk beds. The design of bunk beds enables this as the slats on the bottom can be used for the purpose of hanging. This method has been used in child suicides across the country.
- There is concern about the increasing prevalence of “The Choking Game” in children of secondary school age. Videos are available on social media sites.
- Press intrusion following death was identified as a theme in cases of child suicide.
- Often, the child’s friends were more aware than family or professionals of the child’s true feelings/intentions. The CDOP recommends that the use of peer to peer approaches are considered further in the emotional health and wellbeing strategy within each of the CCG areas, with particular consideration to what peers should do if they have concerns about a friend.
- Three of the suicide deaths involved children taking a large amount of medication; in two cases this was found to be the cause of their death. This highlights (i) issues around the amount of medication that can be prescribed to young people at one time and (ii) the wider public health issue of all family members being vigilant about returning or destroying unused medication.
- The Government has removed the statutory nature of the Personal Social Health and Economic (PHSE) programme with the effect that schools are struggling to find the time to keep PHSE in the curriculum now that it is voluntary. The CDOP had a strong belief that the PHSE programme is a valuable avenue to engage with young people on the issues raised by the CDOP review.

Actions taken by the West of England CDOP include:

- Approaching the Royal Society for the Prevention of Accidents (ROSPA) to address the issues of bunk beds. ROSPA have had previous success in changing the design of blind cords following a nationally recognised association with child deaths.
- Writing to the Head of Medicines Management at Bristol CCG regarding the previously described medication issues with a recommendation that these issues are discussed with suicide prevention leads.
- Writing to the Secretary of State for Education regarding the removal of the statutory nature of the PHSE programme.

G. Suicide and self-harm in Prisons

There are three adult prisons in South Gloucestershire, HMP Leyhill, HMP/YOI Eastwood Park and HMP Ashfield. The arrangements for commissioning health and social care in prisons is shown in the Box below.

<table>
<thead>
<tr>
<th>Commissioning health and social care in prisons</th>
</tr>
</thead>
</table>

**Commissioning health care**

From April 2013, NHS England became responsible for commissioning of all health services (with the exception of emergency care, ambulance services and out of hours services and NHS 111 services) for people in prisons (including youth offender institutions) in England. This includes primary care incorporating dentistry and optometry services, preventive and public health services, secondary care, community services, mental health and substance misuse services.

**Commissioning social care**

From 1st April 2015 Local Authorities became responsible for the provision of social care and support to individuals detained in prisons, approved premises, bail accommodation homes and secure training units. Local authorities also have to make sure they are aware of the needs and support required for young people held in secure accommodation as they approach their 18th birthday to ensure that appropriate transition arrangements for care are in place.

In addition, as part of their responsibility to their local population, Local Authorities are responsible for the continuity of care for offenders with packages of care moving into their authority area on release from prison.

The provision of care and support for those in custodial settings is based on the principle of equivalence; therefore, local authorities are required to provide an equivalent level of care and support as provided to the rest of the population, subject to the constraints and circumstances of custodial settings.

HMP Leyhill is an open category prison holding a maximum of 527 prisoners, who are serving the widest range of sentences (in terms of length and offence) than any other Category D establishment in England and Wales. There is no limit on the number of prisoners serving life sentences who can be accommodated at any one time. Prisoners who have no, or very little involvement with drugs are located in a hostel style environment within the prison grounds. Leyhill has a resettlement role, so many prisoners are allowed out of the prison on licence daily. This includes day release, employment purposes or resettlement leave. There have been no self-inflicted deaths in HMP Leyhill between 2004 and 2014. In this time period the number of self-harm incidents has ranged from none (in 2013) to five (in 2006). The instances of self-harm were usually described as being minor.

HMP/YOI Eastwood Park is a closed remand prison for women, holding 362 young offenders (those aged 18 to 21) and adults. It holds prisoners of all ages and categories pending their court appearances in addition to women serving sentences up to 12
months. The prison holds remand and convicted prisoners, from those serving a few days to those serving much longer sentences. Many services are provided, including a mother & baby unit, specialist 24 hour health care, a dedicated resettlement unit, drug recovery service and specialist substance misuse unit. There have been no self-inflicted deaths since 2007 in HMP Eastwood Park. There were >2000 self-harm incidents each year from 2005 to 2008. However the number of self-harm incidents almost halved from 2009 to 2014 ranging from 1261 incidents to 598 incidents. The most prevalent methods of self-harm were cutting and ligature.

HMP Ashfield is a category C adult male establishment that holds 400 convicted prisoners serving sentences for sexual offences. There have been no self-inflicted deaths in custody in HMP Ashfield since it re-rolled as an adult prison in July 2013. However, there was an average of six self-harm incidents per month between July 2013 and October 2014 (with a spike in incidents to 18 and 14 in July and August 2014). The main method of self-harm was a razor blade or a ceramic mug.
Section 5: Preventing Suicide in South Gloucestershire

This section summarises the steps that have been taken in South Gloucestershire to prevent deaths by suicide.

South Gloucestershire Suicide Prevention Strategy Partnership Group

This group was formed in early 2014 and meets at least quarterly. It is chaired by a Public Health Consultant who is based at the Public Health and Wellbeing Division, South Gloucestershire Council. The group consists of a core membership of representatives from Public Health, Adult Social Care, the Clinical Commissioning Group (CCG), Avon and Wiltshire Mental Health Partnership Trust (AWP), Healthwatch, the University of Bristol and the voluntary sector. The group discusses findings from the yearly suicide audit and regularly updates the suicide prevention action plan. The group reports to the South Gloucestershire Mental Health Partnership, which is in turn accountable to the Health and Wellbeing Board. Appendix C includes the current membership and terms of reference for the Suicide Prevention Strategy Partnership Group.

Suicide audit and review process

Findings from the most recent suicide audit have been described previously in Section 4. The suicide audit report is disseminated to the Local Authority, the CCG and AWP. Currently, the four unitary authorities comprising the West of England (Bristol, South Gloucestershire, North Somerset and Bath and North East Somerset (BANES)) are working in partnership with AWP and the University of Bristol to establish a formal link with the Avon Coroner’s office. This project would enable the regular collection of an agreed data set for all cases of suicide among residents in the West of England area. Collected data will include deaths arising in the West of England area that are suspected as being from suicide including those given open verdicts. Accidental deaths where it was clear suicide was not a possibility will be excluded. Data collection will occur prior to the final verdict provided at the coroner’s inquest as the inquest may occur up to a year later than the date of the actual death. Deaths in the West of England area among non-residents will be included to provide information about potential hotspots, such as bridges or multi-storey car parks. The main outcomes of this project will include:

- Regular collection of data on local deaths by suicide from the Avon Coroner’s office and sharing of these data with partner organisations
- Review and interpretation of the data by the four local authorities and AWP to provide recommendations to inform local suicide prevention workstreams
- Review of the data by the University of Bristol to help monitor outcomes of people who have been previously recorded in the self-harm registers (described later in this section) at hospitals in the West of England area
- Improved and streamlined liaison with the Avon Coroner’s office, avoiding duplication and improving the potential for communication
- Media engagement and monitoring in relation to local deaths, to promote good practice and keep track of quality reporting
• Support for families bereaved by suicide. This may include ensuring that bereaved families receive “Help at Hand”, a NHS resource to help people who are unexpectedly bereaved following the suicide or sudden, traumatic death of a friend or a relative and enabling contact with relevant local support groups and help sites. A resource list for people bereaved by suicide or sudden death is included in Appendix C. This list is a modification of a resource originally produced by North Somerset Local Authority.

The Liaison with the Avon Coroner project is estimated to start by December 2015.

**Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)**

AWP’s Suicide Prevention Strategy runs from 2014 to 2017 and has nine main objectives as follows:

1. To focus on fundamental aspects of patient safety- e.g. effective risk assessment and management- as identified by internal learning, research and national guidance.
2. To ensure that lessons learned from unexpected deaths and near misses inform: Service and practice improvements Staff training and development
3. To undertake and publish a three yearly thematic analysis of all unexpected deaths and identify lessons learned.
4. To develop, plan and implement a staff development programme regarding risk assessment and management that specifically addresses the clinical contribution to suicide prevention.
5. To maintain and develop existing relationships with local authority public health services, health and social care commissioners, and other stakeholders in respect of suicide prevention. This includes active participation in local suicide prevention forums.
6. To maintain and develop collaborative relationships with other stakeholders and interested parties, including Samaritans branches, Avon and Somerset police forces, local Mind groups, etc.
7. To support and engage with local and national suicide prevention research.
8. To maintain a zero rate of inpatient suicides using non-collapsible rails (NPSA, 2010).
9. To reduce the rate of inpatient suicides using any other fixed ligature points.

**Bristol Self-Harm Surveillance Register**

The Bristol Self-Harm Surveillance Register is a database maintained in the emergency department of the Bristol Royal Infirmary and has been recording detailed information on patients presenting to hospital for self-harm since September 2010. Data have been collected from Frenchay Hospital from April 2013 to March 2014; in May 2014 services and data collection moved from Frenchay Hospital to the new Southmead Hospital. This change of location resulted in delays in accessing Southmead Hospital Information Systems.
Information recorded on the register enables an assessment of

(i) The incidence of hospital presenting self-harm in Bristol
(ii) Trends in the incidence of self-harm and its management
(iii) The impact of changes in service delivery on patient management and outcomes
(iv) Risk factors for repeat self-harm and suicide
(v) The medicines taken in overdose.

This information contributes to local suicide prevention efforts and identifies research priorities for the Services and Trusts Integrating to Transform Care in Self-Harm (STITCH) Health Integration Team (HIT) of Bristol Health Partners.

Five patients who presented to hospital services following self-harm in 2014 went on to die by suicide. Three patients were male and two were female, with a median age of 43 years. Since the register began, 44 people who attended hospital following self-harm have subsequently died by suicide. The risk of suicide was greater in males compared to females. Also, the risk of suicide in the 12 months after hospital attendance was approximately 0.6%; in the following 2 years it was 1.2%.

Preventing suicide in Prison

The “Safer Custody” Prison Service Instruction (PSI) 64/2011 came into force from the 1st April 2012 and is effective until the 31st January 2016. This instruction states that any prisoner identified as at risk of suicide or self-harm must be managed using the Assessment, Care in Custody and Team-work (ACCT) procedures. A number of elements are included in the ACCT framework such as identifying those at risk, opening an ACCT, Assessment, Review, completing the Care Map, management of the ACCT plan and closing the ACCT. Prisoners with open ACCTs tend to be moved to blocks with higher staffing levels; also plans are in place to provide prisoners who are released from prison with an open ACCT document with discharge packs showing where they can seek help should they need it on release. The prisons also run a Listener Scheme. This is a peer support service which aims to reduce suicide and self-harm in prisons by training prisoners to provide emotional support to other prisoners by becoming ‘Listeners’. Samaritans volunteers select, train and support prisoners to become Listeners. Listeners provide confidential emotional support to their fellow inmates who are struggling to cope.

Role of the voluntary sector

The voluntary sector plays an important role in suicide prevention. Many important support services in the community are provided by the voluntary sector which can reduce people’s risk for developing mental ill health. These include, but are not limited to the following areas: debt counselling, support to reduce social isolation, substance misuse support, bereavement support. Appendix D provides information on local support services for people who are bereaved by suicide. A list of support services which can help people manage their mental health and wellbeing including services and
advice, mental health services, local community support, support for parents, carers, people with long term conditions and helplines can be found in South Gloucestershire’s Mental Health Resource List (Available from http://edocs.southglos.gov.uk/mentalwellbeing/).

South Gloucestershire Suicide Prevention Strategy: Action plan

Details of the action plan and lead agencies can be found in Appendix E. Suicide prevention activities will be focussed on the groups in South Gloucestershire identified in the most recent suicide audit as having a high risk of suicide compared with the general population (men, particularly older men aged over 65 years and middle aged men (those aged 45-64 years) and people in the two most deprived quintiles) as well as other groups identified nationally as being at high risk (people who self-harm, people bereaved by suicide and the LGBTQ group). Key actions going forward will include:

- Promotion of the new South Gloucestershire Resource List for people bereaved by suicide or sudden death among key agencies.
- Improving data monitoring and real time surveillance of suicides, with particular respect to closer working with coroners. South Gloucestershire is working with other Local Authorities to fund a coroner office audit post to strengthen real time surveillance. The aim is to recruit into this post by the end of 2015.
- Continued support of the Bristol Self-Harm register to obtain surveillance data on hospital attendances for self-harm at the Emergency Department at Southmead Hospital.
- Improving communication activities regarding high risk groups for suicide and suicide prevention activities including engagement with local media, provision of information to the public, raising awareness of mental health issues in young people, addressing stigma and workforce health promotion and support.
- Training and education of staff with particular respect to staff working with offenders, the police and healthcare staff in mental health services to recognise people who may require additional support and improve mental health literacy.
- Continued joint working with the voluntary sector regarding suicide prevention activities and activities to improve general mental health and wellbeing, for example with respect to the Listener Peer Support Service in prisons, provision of support services (including debt counselling, support to reduce social isolation and helplines).
Appendix A: Summary of targeted approaches to address the six priority areas identified in the national suicide prevention strategy ‘Preventing suicide in England: a cross-government outcomes strategy to save lives’

<table>
<thead>
<tr>
<th>Priority Area One: Reduce the risk of suicide in key high risk groups</th>
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<tbody>
<tr>
<td>The following high risk groups were identified as priorities for prevention:</td>
</tr>
<tr>
<td>- Young and middle aged men</td>
</tr>
<tr>
<td>- People in the care of mental health services, including inpatients</td>
</tr>
<tr>
<td>- People with a history of self-harm</td>
</tr>
<tr>
<td>- People in contact with the criminal justice system</td>
</tr>
<tr>
<td>- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.</td>
</tr>
</tbody>
</table>

Healthcare professionals who work with men in different settings, especially primary care, should be alert to the signs of suicidal behaviour.

Mental and physical health should be treated with equal importance in the context of suicide prevention.

Accessible, high quality mental health services are fundamental to reducing the suicide risk in people of all ages with mental health problems.

A focus on continuing to improve mental health outcomes for people in contact with the criminal justice system will contribute to suicide prevention, as well ongoing delivery of safer custody.

The statutory sector and local agencies should be alert to the fact that suicide risk by occupational groups may vary nationally and locally. Suicide prevention interventions needed to be adapted accordingly.

<table>
<thead>
<tr>
<th>Priority Area Two: Tailor approaches to improve mental health in specific groups</th>
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<tbody>
<tr>
<td>Another way to reduce suicide includes improving the mental health of the population as a whole.</td>
</tr>
</tbody>
</table>

A tailored approach to the mental health of the following groups is necessary if their suicide risk is to be reduced:

- Children and young people, including vulnerable groups such as looked after children, care leavers and children and young people in the youth justice system.
- Survivors of abuse or violence, including sexual abuse
- 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 drugs or alcohol
- Lesbian, gay, bisexual and transgender people
- Black, Asian and minority ethnic groups and asylum seekers

The importance of children and young people is recognised. Schools, social care and the youth justice system, charities which focus on bullying, low body image and lack of self-esteem, all have an important contribution to make to suicide prevention in this group.

Timely identification and referral of women and children experiencing abuse or violence is required, so that they are able to benefit from appropriate support; this may also help reduce their suicide risk.
The government has made a commitment to improving mental health support for service and ex service personnel through the Military Covenant.

Parity of esteem is expected between mental and physical health. Routine assessment for depression as part of personalised care planning for people with long term conditions can help reduce inequalities and help people to have a better quality of life.

The early identification and prompt effective treatment of depression has a major role to plan in preventing suicide across the whole population.

There are known links between mental ill-health and social factors such as unemployment, debt, social isolation, family breakdown and bereavement. The ability of front line agencies to identify and support (or signpost to support) people who may be at risk of developing mental health problems is important for suicide prevention.

Measures that reduce alcohol and drug dependence are critical to reducing suicide.

It is important for staff in health and care services, education and the voluntary sector to be aware of the higher rates of mental distress, substance misuse, suicidal behaviour or ideation and increased risks of self-harm amongst lesbian, gay and bisexual people, as well as transgender people.

Community initiatives can be effective in bridging the gap between statutory services and Black, Asian and minority ethnic communities, and in tackling inequalities in health and access to services.

**Priority Area Three: Reduce access to the means of suicide**

Reducing access to high lethality means of suicide is one of the most effective ways of preventing suicide. The following suicide methods are most amenable to this intervention:
- Hanging and strangulation in psychiatric inpatient and criminal justice settings
- Self-poisoning
- Those in high risk locations
- Those on the rail and underground networks

Mental health service providers should be continually vigilant with respect to the identification and removal of potential ligature points. Safer cells will complement care for at-risk prisoners.

Safe prescribing can also help to restrict access to some toxic medicines.

Loss of life can be prevented by local agencies when they work together to discourage suicides at high risk locations. Local authority planning departments and developers can include suicide in health and safety considerations when designing structures which have the potential to offer suicide opportunities.

British Transport Police, London Underground, Network Rail, Samaritans and other partners are working together to reduce suicides on the rail and underground networks.

**Priority Area Four: Provide better information and support to those bereaved or affected by suicide**

Every suicide can affect families, friends, colleagues and others. Suicide can also have a profound effect on the local community. It is important to ensure:
- Provision of effective and timely support for families bereaved or affected by suicide
- That effective local responses are in place in the aftermath of suicide
- Provision of information and support for families, friends and colleagues who may be concerned about someone who may be at risk of suicide.

It is essential that effective and timely emotional and practical support for families bereaved by suicide are available to help the grieving process and support recovery.

GPs should be vigilant to the potential vulnerability of family members when another family member takes his/her own life.

Copycat and suicide clusters may be prevented by post suicide community level interventions. These interventions may be adapted for use in schools, workplaces and health and care settings.

People who are concerned that someone may be at risk of suicide should get information and support as soon as possible. Families, carers and friends of individuals under the care of health or social services should know who to contact and be appropriately involved in any care planning. Help is available from the statutory and voluntary sector for people who are not known to services.

Priority Area Five: Support the media in delivering sensitive approaches to suicide and suicidal behaviour

The media have a significant influence on behaviour and attitudes and should be supported by:
- Promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media
- Continuing to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention strategies

Local, regional and national newspapers and other media outlets can provide information about sources of support when reporting suicide. The Press Complaints Commission Editors’ Code of Practice and the Editors’ Codebook recommendations regarding reporting suicide should also be followed.

The government will continue to work with the internet industry through the UK Council for Child Internet Safety to create a safer online environment for children and young people. There is concern about the misuse of the internet to promote suicide and suicide methods; therefore there will be a focus on ensuring that parents have the tools to ensure that their children are not accessing harmful suicide-related content online.

Priority Area Six: Support research, data collection and monitoring

The Department of Health will continue to support high quality research on suicide, suicide prevention and self-harm through the National Institute for Health Research and the Policy Research Programme.

It is recognised that reliable, timely and accurate suicide statistics are essential to suicide prevention. It will be important to consider how to get the most out of existing data sources and options to address the current information gaps around ethnicity and sexual orientation.

Suicide rate is included as an indicator in the Public Health Outcomes Framework to reflect the continuing focus on suicide prevention.
Appendix B- Methodology used to calculate suicide rates

Suicide statistics in England include suicides and deaths of undetermined intent and were identified using International Classification of Disease 10 (ICD-10) codes X60 through X64 and Y10 through Y34, excluding Y33.9. Data were accessed via the Office of National Statistics (ONS) mortality dataset from the Public Health England South West Knowledge and Intelligence Team. Age standardised rates were calculated using the 2013 European Standard population structure. Population data were extracted from the ONS website.
Appendix C Membership and Terms of Reference of the Suicide Prevention Strategy Partnership Group

Current membership (August 2015) includes:

- Sara Blackmore, Consultant in Public Health, South Gloucestershire Council (SGC)
- Steve Spiers, Programme Lead for Mental Health and Wellbeing, SGC
- Kyla Thomas, NIHR Clinical Lecturer in Public Health, SGC and University of Bristol
- Catherine Boyce, Head of Safeguarding, SGC
- Debbie Spaull, Head of Professions and Practice, Avon and Wiltshire Mental health Partnership Trust (AWP)
- Guy Stenson, Partnerships and Commissioning Service Manager, SGC
- Kate Archibald, Lead Commissioner for Mental Health Services, South Gloucestershire Clinical Commissioning Group (SGCCG)
- Katie Harwood, Interim Preventative Services Manager, SGC
- Kenny Braidwood, Service Manager, Adult and Social Care, SGC
- Lindsay Gee, Head of Commissioning Children and Young People and Maternity, SGCCG
- Mark Patterson, Head of Business and Partnership, Public Health England (PHE)
- Peter Bagshaw, Clinical Lead for Mental Health, SGCCG
- Sylvia Chambers, North Bristol Trust
- James Picardo, Project Co-ordinator, The Care Forum
- Michelle Blackler, Children and Adolescent Mental Health Services (CAMHS) Primary Mental Health Specialist, SGC
- Anne Morris, Nurse Director and Head of Quality and Safeguarding, SGCCG

Terms of reference:

- To develop suicide prevention strategy for 2015 – 2018 with associated action plan to be implemented by partnership group member organisations
- To review findings of South Gloucestershire suicide audit 2015
- To review the latest national strategies (‘No Health Without Mental Health’ and ‘Preventing suicide in England: a cross-government outcomes strategy to save lives’)
- To utilise the skills and local knowledge of partnership group members, reflecting on audit findings, Health and Wellbeing Strategy and commissioning priorities, develop a suicide prevention strategy for South Gloucestershire for the period 2015 to 2018 with associated action plan
- To monitor Serious Case Reviews into suicides.
Appendix D Coping with Loss – South Gloucestershire Resource list for people bereaved by suicide or sudden death

Support Groups

Survivors of Bereavement by Suicide
Survivors of Bereavement by Suicide exists to meet the needs and break the isolation of those bereaved by the suicide of a close relative or friend. This is a national helpline.

http://www.uk-sobs.org.uk/
Phone: 0844 561 6855 9am – 9pm 7 days a week

Peer Support Group for those bereaved by suicide
First Thursday of every month 1930-2130h in Taunton. This is a newly formed group already proving valuable to people bereaved by suicide
Parents, siblings, relatives, friends and others emotionally involved in a suicide are welcome to attend.
Meetings are held at Mind TWS, Sussex Lodge, 44 Station Road, Taunton, Somerset, TA1 1NS
Staff members will be in the building, but will not be present in the meetings. The group manages itself.
The group is part of the Somerset Suicide Bereavement Support Service, which is available to anyone in Somerset. The Peer Support Group is open to anyone prepared to travel to Taunton
Tel: 0300 330 5463 email: bereaved@mindtws.org.uk and website: www.mindtws.org.uk/suicide-bereavement

Samaritans
Samaritan volunteers listen in confidence to anyone in any type of emotional distress, without judging or telling people what to do. Samaritans will not offer you advice, but by encouraging you to talk about your feelings will help you explore all the options you have. Samaritans believe that given the time and space to talk through problems or difficulties in confidence, you can find an inner strength and perspective which lets you find your own way forward.

www.samaritans.org
37 St Nicholas St, Bristol BS1 1TP.
Local support line: 0117 983 1000
National helpline 08457 909090

Compassionate Friends – a service led by individuals who have experienced the loss of a child
This charitable organisation provides a service for those bereaved by the loss of a child or children. Compassionate friends are themselves parents who have been bereaved by suicide.
We offer support to all affected by loss of child ie parents, carers, siblings and grandparents. Support is offered both directly to bereaved families and indirectly by fostering understanding and good practice amongst professionals concerned
with child death and by increasing public awareness of this issue. We recognise that many who have suffered the loss of a child feel a bond with others similarly bereaved and wish to extend the hand of friendship.

www.tcf.org.uk
Phone: 0845 123 2304

Campaign Against Living Miserably
The campaign against living miserably (CALM) was set up to reduce the high suicide rate amongst men under 35, currently the single biggest killer of young men in the UK. It is a campaign and charity targeting young men with a helpline, magazine and online community, but CALM listens to anyone who needs help or support.

http://www.thecalmzone.net/what-is-calm/
0800 58 58 58 Saturday to Tuesday 5pm to Midnight

Cruse Bereavement Care, Bristol and District Branch
Bereavement is a major event in our lives and may bring up feelings and issues that are difficult to resolve. Cruse volunteers offer bereavement support and the opportunity to talk to someone, in confidence about your loss.

www.cruse.org.uk
National helpline: 0844 477 9400
Local helpline: 0117 926 4045
Email helpline@cruse.org.uk or bristol@cruse.org.uk

RD4U
A special website for bereaved young people where they can express and share feelings and experiences. This is a CRUSE service.

Young person’s Freephone helpline 0808 808 1677
info@rd4u.org.uk
www.rd4u.org.uk

Papyrus – prevention of young suicide
Suicide prevention support for young people, families, friends and professionals.

http://www.papyrus-uk.org/
HOPELineUK 0800 068 41 41
email: pat@papyrus-uk.org
SMS: 07786 209697
**Winston’s Wish – the charity for bereaved children**

Winston’s Wish was established in 1992 to provide continuing support for children whose parents or siblings had died. The helplines is for anyone concerned about a child who has been bereaved or who is facing the possible death of a family member. The website includes activities for children; Winston’s wish produces excellent publications.

[www.winstonswish.org.uk](http://www.winstonswish.org.uk)

Phone: 08452 030405

**Books to support people bereaved by suicide or sudden loss**

Please find below information on national and local resources and support for people bereaved by suicide.

📖 if you see this symbol the resource is available from the library service.

**Resources**

**Help is at Hand** - A resource for people bereaved by suicide and other sudden, traumatic death. 📖

This NHS guide has been produced to help people who are unexpectedly bereaved following the suicide or sudden, traumatic death of a friend or relative. It also provides information for healthcare and other professionals who come into contact with bereaved people, to help them understand the impact of suicide and how they can provide support.

To obtain a copy call 0300 123 1002 ref: 302314/Help is at hand or download from: [www.orderline.dh.gov.uk](http://www.orderline.dh.gov.uk) or [http://www.nmhdu.org.uk/silo/files/help-is-at-hand.pdf](http://www.nmhdu.org.uk/silo/files/help-is-at-hand.pdf)

**Beyond the Rough Rock** - Supporting a Child who has been bereaved through Suicide 📖

Explaining to a child that someone has died by suicide is possibly one of the most difficult situations that a parent or carer might ever face. This booklet offers practical advice for families in the immediate days and weeks when suicide has been the cause of death. It is a useful booklet aimed at giving parents and professionals the confidence to involve children in discussions about the nature of a death by suicide. It is hoped that children may then begin to understand some of the complexities that often surround suicide. The booklet includes child-friendly activities for you to do as a family as you begin to make sense of what has happened and start to look at ways in which your family can learn to cope.

297mm x 210mm, 44 pages, colour. 9Price: £6.95 Winston’s Wish publication.

[www.winstonswish.org.uk](http://www.winstonswish.org.uk)

Phone: 08452 030405

Acknowledgement- This resource list was originally created by North Somerset Local Authority and has been modified for use in South Gloucestershire.
## Priority actions

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<thead>
<tr>
<th>Priority actions</th>
<th>Detail</th>
<th>Lead Organisation</th>
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<tbody>
<tr>
<td>Develop a local suicide prevention strategy</td>
<td>Develop, implement and monitor via newly established South Gloucestershire Suicide Prevention Strategy Group which reports to South Gloucestershire Mental Health Partnership.</td>
<td>Public Health</td>
</tr>
<tr>
<td>Develop action plan</td>
<td>Provide updates to H&amp;WB Board. 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.</td>
<td>Suicide Prevention Strategy Group</td>
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<tr>
<td>Governance</td>
<td>Training for acute Trust staff e.g. within ED - self-harm CaMHS team give ad hoc training to ED &amp; annual UHB study day (BCH staff can attend). Review self-harm register data from UHB &amp; NBT to track local trends and provide surveillance. 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, crisis team for those generally at risk. AWP to map service provision and service criteria and link to GP communication teams. 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. 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.</td>
<td>Reducing Self Harm Health Integration Team (NBT) Mental Health and Wellbeing Strategy Development Groups-mental health promotion, mental illness prevention and treatment and rehabilitation AWP Public Health CCG Clinical Lead and Public Health</td>
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<tr>
<td>Target populations</td>
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<tr>
<td>Individuals who self-harm</td>
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<tr>
<td>Supporting individuals affected by the financial crisis</td>
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<tr>
<td>Helping those affected or bereaved by suicide</td>
<td>Cruse provide fortnightly support (Bristol base). Bereavement resources (reading) Information on Prescribing – review options for sharing MH directory with primary care SOBS – ensure information included in directory of services Review national resources e.g. ‘Help is at Hand’</td>
<td>Public Health and CCG</td>
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<tr>
<td>Middle-aged men</td>
<td>Identify depression early in primary care – mental health needs assessment</td>
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<td></td>
<td>Include within Healthchecks – use information cards e.g. Samaritans/MIND.</td>
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<td></td>
<td>Community outreach programmes in traditional male environments – identify existing resources (e.g. Samaritans) and local ‘champions’. SS has made links with Brian Gardner and working with sports clubs – resourcing required. Use existing information/help leaflets from Samaritans/MIND.</td>
<td>Public Health</td>
</tr>
<tr>
<td>Children &amp; young people</td>
<td>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 i.e. education re cutting, safety, risks. Links re young people in care and those with LDs. Partnership with relevant partners Link to educational sub-group of children's safeguarding Board.</td>
<td>Public Health and CAMHS</td>
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<td></td>
<td>CYP IAPT programme – clarify service provision and content i.e. tier 3 (CaMHS), lower tier (&lt;16s counselling) etc. ‘Off the record’ now commissioned for &lt;16s.</td>
<td>CCG</td>
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<td>Ensure link to CDOP</td>
<td>Public Health</td>
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<tr>
<td>Older people</td>
<td>Link to existing workstreams on social isolation in older people – ensure included in JSNA.</td>
<td>Public Health</td>
</tr>
<tr>
<td>Individuals in contact with mental health,</td>
<td>Link to alcohol and drugs services commissioning/strategy, MH commissioning/strategy &amp; JHWBS. Alcohol needs assessment and substance misuse needs assessments currently being refreshed.</td>
<td>Public Health</td>
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<tr>
<td>drug &amp; alcohol services</td>
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<tr>
<td>Individuals in contact with</td>
<td>Work with those recently released</td>
<td>Public Health and PHE</td>
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<td>Priority actions</td>
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| criminal justice system | Peer mentoring  
Link with FIF/Troubled Families | |
| 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. | Public Health and CCG |
| Lesbian, gay, bisexual, transgender and questioning (LGBTQ) | Assess needs assessment & review of evidence.  
Link to schools. | Public Health and CCG |
| Other groups | E.g. Individuals with long term conditions, chronic conditions etc. – link to chronic disease clinics.  
Carers registers link BME groups | Public Health and Adult Social Care |
| Partnerships | **Working with coroners**  
Close working PH & coroners – develop process to enable real-time surveillance | West of England Public Health Partnership |
<p>| <strong>Working with transport</strong> | Work with transport and other partners in H&amp;WB Boards on identifying hot spots and taking appropriate actions – identify once local audit data available. | Public Health |
| <strong>Networks</strong> | Ensure attendance at AWP suicide leads meeting | Public Health |
| <strong>Data monitoring &amp; surveillance</strong> | Improve access to real-time surveillance data to enable leads to monitor suicide trends, respond to incidents, (to include self-harm register workstream). | West of England Public Health Partnership |
| | Review findings of MH needs assessment in relation to suicide prevention notably service provision. | MH strategy development – mental illness prevention group |
| <strong>Communications</strong> | Engage with local media regarding suicide reporting | Public Health and CCG |
| | 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 ASSIST, Mental Health First Aid, and STORM. | |
| | Address stigma – identify national resources etc. e.g. ‘Time to Change’ | |</p>
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<tr>
<td>Training/education</td>
<td>Work with police on mental health literacy</td>
<td>Workforce Development Lead + multi-agency training forum and link to ASIST training</td>
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</tbody>
</table>