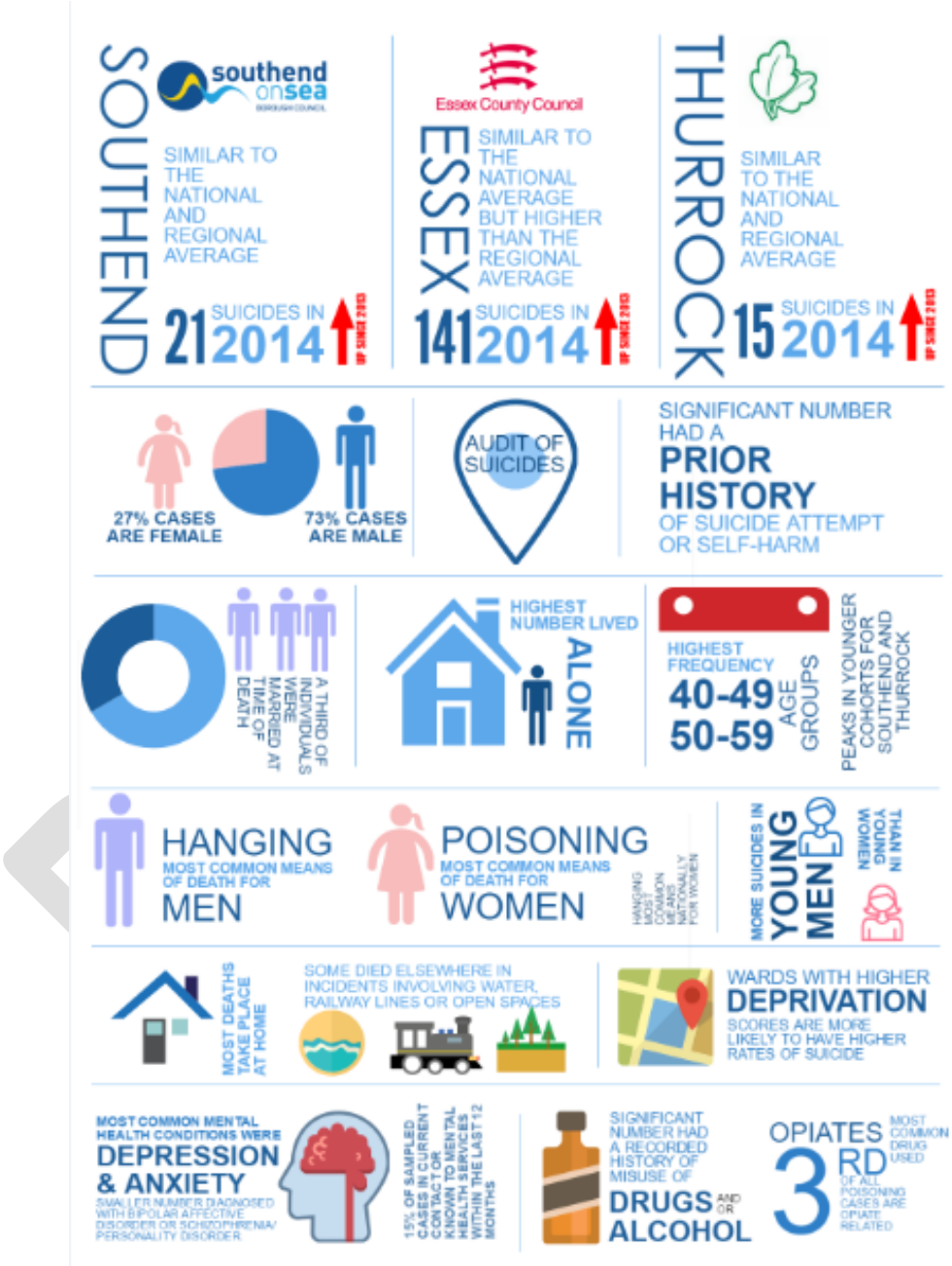
LETS TALK ABOUT SUICIDE

Preventing suicides in Southend, Essex and Thurrock 2017



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Foreword

The impact of any death is profound, affecting loved ones, friends, work colleagues and entire communities. The impact of a death from suicide can be more complex due to often unexpected nature of the death as well as the delays in investigation and conclusion.

The causes of suicide are many. Mental health is a key factor yet the majority of those who take their own life were not in contact with mental health services. In the main, the causes are the everyday pressures of health, relationships, and finances that we may all struggle with. As such, there is no one solution to preventing suicide. Everything we do – as councils and health services, in partnership with many others such as schools and employers – can promote the wellbeing of the population and reduce the risks of suicide. By having a thriving and prosperous local economy, safe communities, a focus on health and wellbeing, and a strong start in life, we can reduce some of those risks.

In 2012, the government of the day published a report entitled *Preventing Suicide in England*, which set a welcome blueprint for local authorities and others. This has since been supplemented with further guidance from Public Health England. The Select Committee has produced its views and recommendations, and it is now seen as a political imperative.

No single organisation can do this alone. We will work through existing agencies and partnerships to build upon and strengthen those actions that we know have an impact.

There are around 175 deaths through suicide each year across Southend, Essex and Thurrock.

We are proud to present this strategy as our first step in tackling this agenda. We hear from those affected by suicidal thoughts and from families and carers that a key part of improving care is to reduce stigma. We are building on some ground-breaking work in other parts of the UK and abroad, where conversations are had about depression, anxiety and suicide. The title "*Lets Talk About Suicide*" reflects the importance of having the conversation whether that is with professionals or simply tackling the stigma of mental health and suicide in particular. The title "*Lets Talk About*" is also used for our Mental Health and Dementia strategies for the same reason.

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Executive summary

Introduction

Suicides are not inevitable. The Southend, Essex and Thurrock partners have agreed to take the ambition of 'Zero Suicide' as the drive for transformational change with optimistic and ambitious expectations. We will build this approach through the branding of ***'Let's Talk About Suicide'***.

National context

In 2012 the Government published its suicide strategy, *Preventing Suicide in England* (DH, 2012). This was in response to rising rates of suicide since 2008. The national rate of suicide is 10.1 per 100,000 persons. We know that men are more likely than women to commit suicide with national rates of 15.8 and 4.7 per 100,000 for males and females respectively. Those known to mental health services are at higher risk, yet more suicides occur in people not under the care of mental health services. The Five Year Forward View for Mental Health (2016) recommends that the Department of Health, Public Health England and NHS England support all areas to have multi-agency suicide prevention plans in place by 2017, and the Secretary of State for Health committed to action to achieve this in his foreword to the Third Progress Report on the national suicide prevention strategy.

Local context

Concerns about suicide rates in Essex were highlighted in the 2016 Joint Strategic Needs Assessment. Locally, suicide rates are similar to the national figures at 10.4, 11.3 and 11.3 per 100,000 persons for Essex, Southend and Thurrock respectively. The trends for person suicide rate are similar to national, although Essex rates are above regional. However, the Essex suicide rate for females tracked as statistically significantly greater than the national average between 2010 and 2014 and should be closely monitored.

The *Southend, Essex and Thurrock Mental Health and Wellbeing Strategy 2017-2021* identifies suicide prevention as a priority for Greater Essex and is intended to drive a range of improvements in mental health services that would be expected to have a positive impact on suicide rates, including improved access to treatment for depression and anxiety, better crisis care and a focus on recovery support following discharge from specialist mental health services.

The Mid and South Essex Sustainability and Transformation Plan (STP) has identified reducing suicide and self-harm as one of three key priorities for mental health. The West Essex and Hertfordshire STP plan identifies taking forward a multi-agency approach to suicide as a priority for

promoting improved mental health. The Suffolk and North East Essex STP plan indicates a whole system approach to the delivery of specific services such as crisis mental health care and suicide prevention.

The Southend, Essex and Thurrock Local Transformation Plan for children and young people's mental health *Open Up, Reach Out* recognises that 'the risk of suicide and self-harm is one of the major concerns of children and young people, families, carers and school staff'.

The Mid-Essex Suicide Prevention Project is one of a group of four pilots led by the East of England Strategic Clinical Network under the 'zero suicide' approach; learning from these pilots should inform local action. These pilots were positively and independently evaluated by the Centre for Mental Health.

A separate report is available on the audit of suicides in 2014/15. Those who died in Southend, Essex and Thurrock were more likely to be male and young to middle aged. Risk factors included drug and/or alcohol problem, previous suicide attempt and/or episodes of self-harm, mental or physical health problems, relationship stress, financial difficulties, involvement in criminal justice system, and recent bereavement. Two thirds died in their own home; rail and coastline are small but significant locations with scope for intervention. Hanging and poisoning were the most common means of death; opiates being the most common cause of poisoning. About one third of people were known to be in contact with or had previous contact with mental health services.

A separate review of suicide in young people found:-

- More likely to occur in boys than in girls
- Most of the young people were not previously known to mental health services.
- Hanging was the means of death for 10 of the 11 young people (poisoning accounting for the other).
- It was not always clear whether death was the intention, or whether accidental or a fatal self-harm episode.

Actions

The action plan set out by the strategy reflects the ongoing and intended work of a multitude of organisations and partnerships, articulated in a range of documents including the SET Mental Health and Wellbeing Strategy, Crisis Care Concordats, safeguarding plans, and the SET Local Transformation Plan for children and young people's mental health.

Preventing Suicide in England identified six key areas for action to support delivery of the objectives

1. Reduce the risk of suicide in key high-risk groups

The majority of action is addressed in the Southend, Essex and Thurrock Mental Health and Wellbeing Strategy 2017-2021 which outlines ambitions and identifies a wide range of outcomes for mental health, supported by implementation plans.

Of the key high risk groups there is little specific mention of targeted action for young and middle aged men, nor specific occupational groups. Current action addresses the key groups of those known to mental health services, people with a history of self-harm, and people in the criminal justice system.

2. Tailor approaches to improve mental health in specific groups

As well as the specific focus on suicide, a broader approach should be taken, looking more at general mental health well-being across the whole population, and recognising the particular needs of specific, often marginalised, groups.

There is a significant amount of work on children and young people as a specific group in Southend, Essex and Thurrock. There is ongoing work addressing veterans, survivors of abuse, people with long term conditions, undiagnosed depression, and dual diagnosis. There is less evidence of targeted work for those vulnerable to social and economic circumstances, LGBT and BME groups.

3. Reduce access to the means of suicide

Hanging is the main means of death and efforts to address this has, as its focus, inpatient and criminal justice custodial settings both of which have been the subject of recent inspections. But within broader community settings some action can be taken to reduce suicide in frequently used locations and managing clusters. There is some mention locally of what may be done re safe prescribing and other methods of minimising self-poisoning. The audit did not show any particular frequently used locations and locally there is continued engagement with National Rail. There was little mention of other action relating to the built environment as a means of suicide e.g. high rise structures.

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

Those left behind face the often intolerable aftermath of a suicide. There is structured support available for some but not all; for example there is support to pupils in schools or occupational

support for staff such as mental health staff, police and prison staff who have dealt with suicide in their job but for others it is more ad hoc with the voluntary sector as the significant source of support.

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

As well as supporting the media to report suicides responsibly, attention must be directed to informal social media, and how suicide is portrayed. Key action is implementation of Editors' code of conduct relating to suicide reporting.

6. Support research, data collection and monitoring

Local, as well as national data and research must be used. Reliable and timely suicide statistics are the cornerstone of any local suicide prevention strategy and ongoing audit is vital.

The key source of information is the proposed mental health strategy for wider Essex. Further work is needed to understand efforts to address the wider social determinants, especially for the majority of people who are not under the care of mental health services.

Prevention group

The geography and organisational structure across wider Essex is complex. Forums are variously organised on local government boundaries and/or pan CCG boundaries. Certain partner agencies, e.g. the police, probation and community rehabilitation, rail etc., cover wider Essex. As such, there is no one forum that encompasses the entirety of the suicide prevention agenda across Greater Essex. Setting up a suicide prevention group – whilst focusing on the specific agenda – would not necessarily have robust governance and would have duplication of membership of existing partnerships.

The approach taken in the strategy is to recommend that the actions are owned by the responsible organisations and partnerships, with regular agenda items on suicide and a nominated champion on each group, with annual oversight by the Health & Wellbeing Boards and an annual summit focused solely on suicide prevention. This approach still allows for local flexibility whilst maintaining a pan Essex overview especially for those partners who cross local boundaries, whether NHS or other.

Recommendations

The full list of recommendations can be found in section 7**.** In short, further work is needed in key areas 3 (addressing the means of suicide), 4 (support for the bereaved), and 5 (working with the media). Key area 6 (information and monitoring) has recommendations about the content and timing of further audits. Much work is in place or intended for key areas 1 and 2 (higher risk groups) but there is a gap around interventions for men, certain occupational groups, LGBT, BME and generally addressing the wider social determinants.

1. Aims

'We need to encourage professionals and communities to be so much more open about mental health and suicidal thoughts. People worry that if you mention "suicide" you could be putting ideas in their head – in fact, the opposite is true'.

Director of Development, Mental Health Provider from *Hope for Better Mental Health*

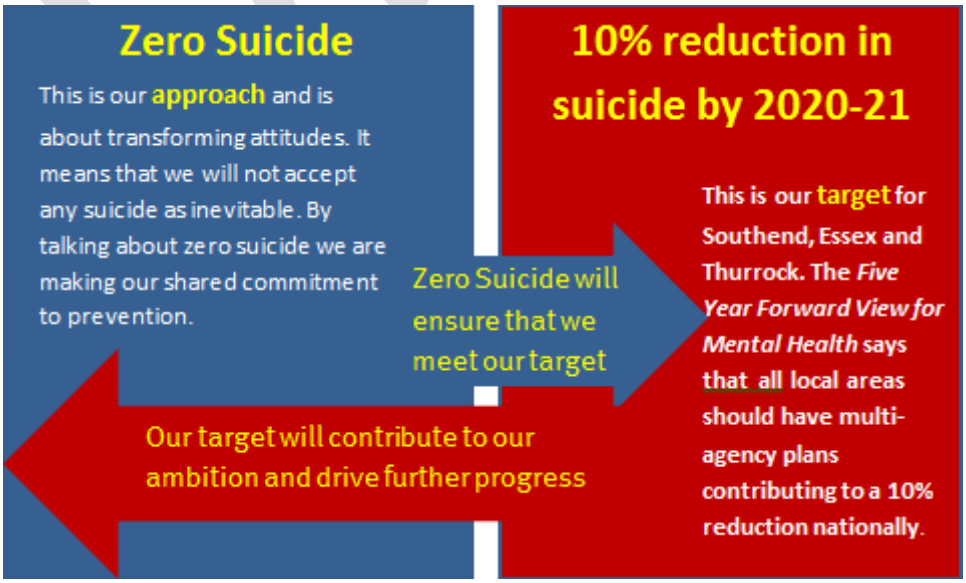
"*For Diane, one of the hardest things to come to terms with was how difficult it is to openly discuss the reasons behind suicide. Being able to meet with others who held similar views and experiences had begun to ease the impact these questions were having on Diane's well-being. Attending her local carers group and forging a network of bereaved Mums were the two outlets she valued most in her own recovery*."

From ECC/Public Office, *Hope for Better Mental Health*

This strategy adapts the Zero Suicide approach that was pioneered in Detroit in the USA and has recently been developed in Mid Essex as one of four pathfinder sites in the East of England.

What does this mean? For us, it means that the starting point for this strategy is our belief that it is not inevitable that anyone in Southend, Essex or Thurrock will take their own life. While we may not be able to prevent every suicide, by making Zero Suicide our ambition we will transform the way that we think about suicide, and prevent more people taking their own lives.

It is not helpful therefore to think of Zero Suicide as a short-term performance measure – it is more a philosophy or mind set. Adopting this approach will enable us to meet (and we hope to exceed) the national requirement for a 10% reduction in suicide rates, by aspiring to prevent every suicide. It will also remind us that we should not accept any level of suicide as inevitable or unavoidable.



Suicide prevention is a useful barometer or vital sign of the success of the local economy as it encompasses health, care and the wider determinants of health. It is important that we view this as a whole society issue not just health care as only about a quarter of suicides occur in people under the care of mental health services.

Taking an outcomes-based approach, we propose that reducing suicide rates is a high level indicator demonstrating success across each of the local authority's key objectives:

- ECC's key strategic aims – inclusive economic growth, help people live healthily & independently and create great places to live & work;
- Southend's key objectives - safe, health and prosperous;
- Thurrock's objectives – learning & opportunity, economic prosperity, respect & responsibility, health & wellbeing;

As well as the CCGs stated objectives about improving the health & wellbeing of their populations.

As we 'turn the curve' of suicide rates, we will know that collectively we are delivering to our full potential. It takes a partnership approach to deliver zero suicide whilst also allowing individual organisations to deliver against specific key performance indicators.

We will build this approach through the branding of '***Lets Talk About Suicide***'. This approach recognises the importance of conversations and safety planning between professional and person at risk, but also notes the need to address the stigma of mental health with the general population. Everybody should have an openness, willingness and the confidence to explicitly talk about suicidal thoughts.

2. National Context

Introduction

1.1. In 2012 the Government published its suicide strategy, *Preventing Suicide in England* (DH, 2012). There have been updates; the most recent being *Preventing Suicide in England: third progress report of the cross government outcomes strategy to save lives* (DH, 2017). Both documents provide useful overviews and information to guide local prevention strategies.

1.2. Suicides are not inevitable. An inclusive society that avoids the marginalisation of individuals and which supports people at times of personal crisis will help to prevent suicides. Government and statutory services [and communities] have a role to play (DH, 2012; p9).

1.3. In 2013 the All Party Parliamentary Group on Suicide and Self-Harm Prevention published its initial deliberations. This was followed by The All-Party Parliamentary Group (APPG) on Suicide and Self-Harm Prevention Inquiry into Local Suicide Prevention *Plans in England 2015*. The main recommendations from the latter were that all local authorities must have in place:

a) Suicide audit work to in order to understand local suicide risk.

b) A suicide prevention plan in order to identify the initiatives required to address local suicide risk.

c) A multi-agency suicide prevention group to involve all relevant statutory agencies and voluntary organisations in implementing the local plan.

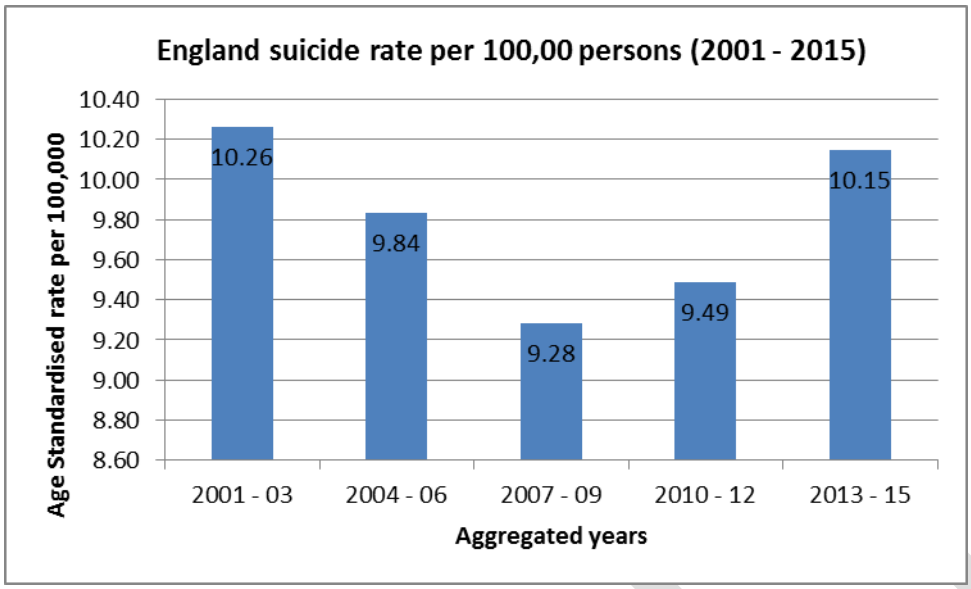
1.4. Definitions of suicide vary and caution is needed when comparing data. Appendix 1: **Suicide definitions** includes more detail of the various definitions used.

Suicide in the general population

Time trends

1.5. In England, there were 14,429 suicides in 2013-15 compared with 13,233 in 2010-12. The trend in the suicide rate dipped between 2005 and 2012 but has since been rising slightly. The three-year average rate for 2013-15 was 10.1 suicides per 100,000 for the general population (PHE, Suicide Prevention Profiles; accessed 20/3/17).

Figure 1: Suicides (Death rates from Intentional Self-harm and Injury of Undetermined Intent), England, 3 year averages, 2001 - 2015

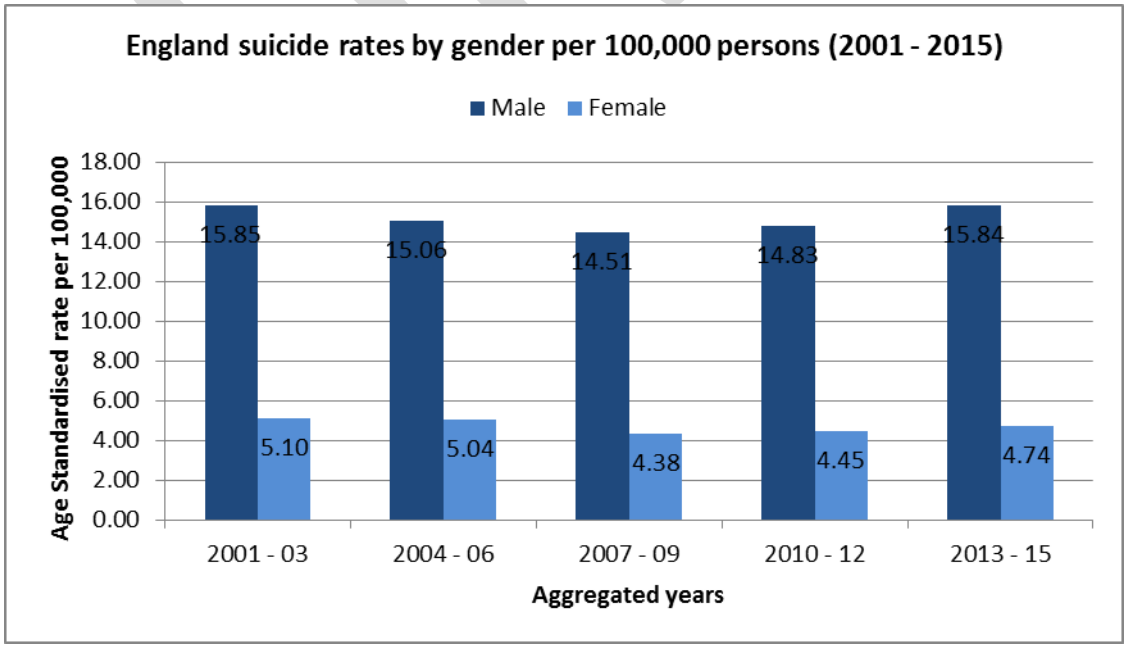


Gender

1.6. In comparison to women, men are more likely to take their own lives, with adult males typically accounting for about three quarters of all suicides. For 2013-15, the three-year average rate for males was 15.8 per 100,000 population; compared with 4.7 females per 100,000 population.

1.7.

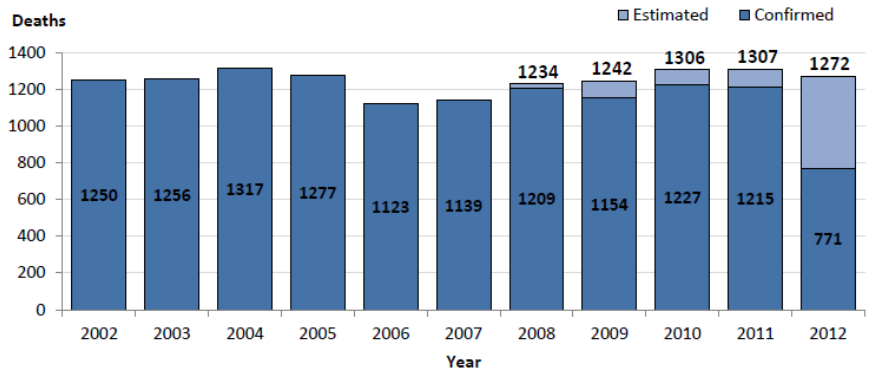
Figure 2: Suicides (Death rates from Intentional Self-harm and Injury of Undetermined Intent by gender, England, 2015



People in contact with mental health services

1.8. The Statistical Update on Suicide records that in 2012 there were 1,272 estimated suicides by people in contact with mental health services in the year prior to death (fig. 3)(DH, 2015; p7). Although for those in receipt of mental health services the actual rates of suicide appear to be falling they are still high. Overall the suicide rate for mental health service users is 87 per 100,000, compared to 8.8 per 100,000 in the general population (National Confidential Inquiry into Suicide and suicide in people with mental illness, 2015, p20). Although people in contact with mental health services are at particularly high risk of committing suicide, most suicides actually occur in people who have not been in contact with mental health services in the previous 12 months.

Figure 3: Suicides by people in contact with mental health services (in 12 months prior to death), England 2002 - 2012*



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

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

Methods of suicide

1.9. Hanging (including strangulation and suffocation) is the most common method of suicide for both sexes, (57 per cent for males; 41 per cent for females).[1] The second most common method for both groups is drug poisoning.

National strategic context

1.10. The Government's *Preventing Suicide in England* strategy sets out six priorities for action:

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;

[1] It has been considered that the gender differences in suicide may have been attributable to the different choice of methods between males and females. With males choosing hanging, this method was more likely to result in death than drug poisoning. With hanging now being the most frequent method of suicide for females (although still less frequent than males), it is unlikely that this fully explains the difference.

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.

The Government produces an annual report to review progress against the strategy, most recently *Preventing suicide in England: Third progress report* (2017).

1.11. The Department of Health and NHS England published *Future in Mind – Promoting, protecting and improving our children and young people's mental health and wellbeing* in March 2015. This identified five themes for the creation of a system that properly supports the emotional wellbeing and mental health of children and young people:
- Promoting resilience, prevention and early intervention;
- Improving access to effective support – a system without tiers;
- Care for the most vulnerable;
- Accountability and transparency;
- Developing the work force.

Future in Mind makes limited direct reference to suicide, but does note the rising numbers of young people presenting with self harm.

1.12. In February 2016, NHS England published the *Five Year Forward View for Mental Health*, following a review by an Independent Mental Health Task Force; this was followed in July 2016 by *Implementing the Five Year Forward View for Mental Health*.

1.13. The *Five Year Forward View for Mental Health* highlights a range of actions that should be taken to reduce suicide:
- Improving the seven day crisis response service across the NHS will help save lives as a major part of a drive to reduce suicide by 10% by 2020/21.
- The Department of Health, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017, reviewed thereafter and supported by new investment (Recommendation 2).
- NHS Improvement and NHS England with PHE should identify what steps services should take to ensure that all deaths by suicide across NHS-funded mental health settings, including out-of-area placements, are learned from, and to prevent repeat events. This should build on insights through learning from never events, serious incident investigations and human factor approaches. The CQC should then embed this information into its inspection regime (Recommendation 57).

1.14. The implementation plan explains that, nationally, a further £25 million will be made available over the period to 2020-21 to support suicide prevention directly (£5 million in 2018-19, £10 million in 2019-20 and £10 million in 2020-21). It also expects the wider investment in mental health to have a positive impact on suicide rates.

1.15. The National Confidential Inquiry published *Making Mental Health Care Safer – Annual Report and 20 Year Review* (2016). It concludes that the number of suicides by mental health patients in the UK has increased in recent years. Suicide by mental health inpatients continues to fall, and there are now around three times as many suicides among patients in contact with Crisis Resolution and Home Treatment Teams (CRHTs). A third of CRHT patients who died of suicide had been under the service for less than one week, a third had been discharged from hospital in the previous two weeks and 43% lived alone.

1.16. The National Inquiry also found that over half of patients who died by suicide in the UK had a history of drug and alcohol problems, 13% had experienced serious financial difficulties in the previous three months, and 5% had been living in the UK for less than five years. Certain risk factors had become more common as antecedents for suicide in the last twenty years, including isolation, economic adversity, alcohol and drug misuse and recent self-harm. Non-adherence to medication is becoming less common as an issue.

1.17. In December 2016, the Health Select Committee published an interim support on suicide prevention to inform government thinking on a refresh of the national suicide prevention strategy. It highlighted five key areas for consideration:

- *Implementation*, arguing that the Government's 2012 strategy had been characterised by inadequate leadership, poor accountability and insufficient action;
- *Services to support people who are vulnerable to suicide,* including wider support for public mental health and wellbeing and targeted support for at risk groups;
- *Adoption of consensus statement on sharing information with families* with better training for professionals;
- *Timely and consistent data,* to enable swift and appropriate responses (e.g., to suicide clusters or new methods of suicide);
- *Media,* including working more effectively with media breaches of reporting guidelines and looking at changes to restrict access to potentially harmful internet sites and content.

1.18. The interim report helpfully distinguishes three groups of people at risk of suicide:

- *Those not in contact with services*, who would benefit from greater emphasis on public mental health and wellbeing, and with a significant role for 'non-traditional' settings and the voluntary sector;
- *People in contact with primary care*, with a need for training and support for GPs;
- *Patients discharged from inpatient mental health care*, who should receive follow up support within three days, and not the current ten.

National guidance and best practice

1.19. Public Health England has recently published a number of resources to support evidence-based practice; see section 8 Resources:

1.20. The National Confidential Inquiry *Annual Report and 20 Year Review* (2016) identifies ten key elements of safer care in mental health services and a further four for safer care in the wider health system.

1.21. The National Institute for Health and Care Excellence (NICE) is currently developing guidance on *Preventing Suicide in Community and Custodial Settings*, with an expected publication date of May 2018.

1.22. The Centre for Mental Health's *Aiming for Zero Suicide* report (2015) provides a review of research evidence on suicide prevention. It concludes: 'there is clear evidence that there are medical and psychological interventions which can be very helpful to individuals who have considered or attempted to end their own lives. However, the evidence of effective interventions designed to reduce the overall suicide rate across a whole population is sparse and largely inconclusive'.

3. Local Context

"A young woman has alcohol dependency, anxiety and depression, and has accessed many services. These included the Cedar ward in Rochford, various rehabs, detox centres, Alcohol & Drug Addiction Service (ADAS) in Harlow, Accident & Emergency departments (A&E), Crisis teams, GPs, medication and various therapies. She has used these therapies fairly recently and has now been sober for several months. She said that she relapses fairly regularly and has previously been sectioned. She feels support is lacking. She says that due to her eye contact and friendly nature she isn't believed and her condition and thoughts of suicide are overlooked."

Case Study from Healthwatch 666 Report

3.12 The geography and organisational structure across wider Essex is complex. There are three local authorities, seven CCGs, two mental health trusts that are in the process of merging into a single trust, three adult safeguarding boards, three children's safeguarding boards, and one police authority, one Police and Crime Commissioner, a category B prison and three Healthwatches. To further complicate the picture, Essex is covered by three NHS Sustainability and Transformation footprints (including two with other county councils).

Sustainability and Transformation Plans

3.13 NHS England now requires every health and care system in England to produce a multi-year Sustainability and Transformation Plan (STP) showing how local services will develop and ensure their sustainability over the next five years. To deliver these plans local health and care systems are divided into 44 STP 'footprints'. The three 'footprints' for Essex are: Mid and South Essex, North Essex and Suffolk, and West Essex and Hertfordshire. STP plans have been produced for each of these areas with more detailed operational plans to follow.

The Mid and South Essex Success Regime STP plan has identified reducing suicide and self-harm as one of three key priorities for mental health given higher than average rates of suicide in the county. The West Essex and Hertfordshire STP plan identifies taking forward a multi-agency approach to suicide as a priority for promoting improved mental health. The Suffolk and North East Essex STP plan indicates a whole system approach to the delivery of specific services such as crisis mental health care and suicide prevention.

Adult Mental Health and Wellbeing

The *Southend, Essex and Thurrock Mental Health and Wellbeing Strategy 2017-2021* was launched in 2017. The strategy includes a chapter on suicide prevention and has included a commitment to reduce suicide rates by 10% against the 2016-17 baselines by 2020-21 in line with the national ambition set out in NHS England's *Five Year Forward View for Mental Health*. It also considers the

particular challenges and opportunities for suicide prevention interventions within particular areas of practice, including perinatal mental health and working with people with personality disorders.

Children & young People's Mental Health and Wellbeing

A new Emotional Wellbeing and Mental Health Service (EWMHS) was launched in November 2015. The new service has brought together the seven Clinical Commissioning Groups (CCGs) and the three local authorities in a single 'collaborative commissioning forum' with responsibility for all targeted and specialist support including a unified crisis response across Southend, Essex and Thurrock, with delivery led by a single provider (NELFT).

The same partners have developed a Local Transformation Plan – *Open up, Reach out* - as part of the national *Future in Mind* initiative to improve the mental health and emotional wellbeing of children and young people. *Open Up, Reach Out* recognises that 'the risk of suicide and self-harm is one of the major concerns of children and young people, families, carers and school staff'.

Priorities for self-harm and suicide reductions includes support with dedicated people in locality teams who have particular skills in suicide prevention and managing self-harm;

Crisis Care Concordat

The 2014 Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

The Concordat focuses on four main areas:

- Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.
- Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.

Although the Crisis Care Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention. Rather than replacing existing guidance, it was designed to provide a framework on which to build further action. The full document can be viewed here: http://16878-presscdn-0-18.pagely.netdna-cdn.com/wp-content/uploads/2014/04/36353_Mental_Health_Crisis_accessible.pdf

Locally, the Crisis Care Concordat agreement is actioned through separate Crisis Concordat Groups across the different health, i.e. CCG geographies.

The North Essex Crisis Care Concordat Action Plan includes a comprehensive set of actions to deliver suicide prevention to primary care, secondary care and the emergency services. It highlights the importance of working with the British Transport Police regarding suicide prevention, including 'daily updates of suspicious activity of identified persons on the railways or near to'.

The SW Essex Crisis Care Concordat Action Plan (2014) highlights the need to involve British Transport Police in suicide prevention projects, and this work has since been taken forward.

The South East Essex Crisis Care Concordat Action Plan (2014) includes a number of actions and outcomes on suicide prevention, including:

- Developing a 'commissioning for prevention' approach with public health;
- Improving early intervention in psychosis services;
- Working with British Transport Police and other relevant agencies to reduce risk.

A Pan Essex System Preparedness Plan has been developed collaboratively by representatives of the 7 Essex CCGs, 3 Local Authorities, 5 Acute Trusts, 2 Mental Health Trusts, Ambulance Service Trust and Essex Police in response to the proposed amendments of the Mental Health Act (1983) by the Policing and Crime Bill (2016).

Safeguarding

Children's Safeguarding

Children's' safeguarding is a mandatory duty for local authorities, covered across Essex by three separate Children's' Safeguarding Boards for Southend, Essex and Thurrock residents. Despite boards being arranged by local authority/ resident geography, SET safeguarding procedures are agreed to provide continuity of systematic process across the greater Essex patch.

A Strategic Child Death Overview Panel for Southend, Essex and Thurrock supported by five local Child Death Review Panels is responsible for reviewing the deaths of any children - including deaths as a result of suicide - normally resident in the Greater Essex area, with a responsibility for: reducing the numbers of deaths; identifying matters of concern affecting the safety and welfare of children; identifying wider public health or safety concerns; and undertaking a co-ordinated agency response to all unexpected deaths of children.

The Essex Safeguarding Children Board has produced a Prevention of Youth Suicide Guidance Toolkit for Schools for use by professionals working with children and young people, which is being

reviewed.[2] As part of the development and roll out of the Toolkit, the ESCB supported workshops with 'Stay Safe' groups on teenage suicide, and quadrant based Case Review Learning Events on suicide among young people. Supplementary self-harm guidance is also currently in development.

Adults Safeguarding

The Care Act 2014 requires that all local authorities establish a Safeguarding Adults Board to oversee the work of agencies within its area to ensure that they are working effectively to prevent abuse and neglect of adults at risk. The aim of the SABs is to ensure the effective co-ordination and delivery of services to safeguard and promote the welfare of at risk adults in accordance with the Care Act 2014 and the accompanying Statutory Guidance.

Adults safeguarding is less formally regulated, since only specific groups of adults are deemed vulnerable. Across Southend, Essex and Thurrock the SABs mirror the functionality of the Children's Boards to optimise safeguarding procedures and share lessons learned around incident review. The SABs has a broad membership including statutory, voluntary and independent organisations.

The SABs meet regularly and receives leadership and support from an Executive Group and Operational Group that have different roles to ensure that abuse and neglect are prevented.

Board members work together to ensure that all organisations that buy services for, or provide services to adults at risk have effective policies and procedures in place to prevent abuse and neglect, and to respond appropriately and quickly when things do go wrong.

All of the Board's decisions and actions are carried out with the Six Safeguarding Principles in mind: Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability.

Mid Essex Suicide Prevention Pilot

The Mid-Essex Suicide Prevention Project is one of a group of four pilots led by the East of England Strategic Clinical Network. It was set up in 2013 and is based on a 'Zero Suicide' approach pioneered by Dr Ed Coffey in Detroit.

The Zero Suicide initiative is one of six programmes of work explored in the ECC/Public Office report, *Hope for Better Mental Health – Exploring Co-Production and Recovery*, which considers initiatives 'in which recovery and co-production are combined with powerful results in the form of radically improved outcomes for service users'.[3]

[2] ESCB (2015), Prevention of Youth Suicide Guidance Toolkit for Schools.
[3] ECC/The Public Office (2015), Hope for Better Mental Health – Exploring Co-Production and Recovery.

Role of the voluntary and community sector

A range of voluntary and community sector organisations provide services to people known to have mental health problems, including those who may be at risk of suicide, as well as individuals and families experiencing other problems that may heighten risk (e.g. drug and alcohol problems or debt). These organisations include the Citizens Advice Bureau (CAB), Depression Alliance, MIND, Open Door, Open Road, Phoenix Futures, and the Samaritans.

The Recovery College http://inclusionthurrock.org/recovery-college/ is a partnership between Inclusion Thurrock (part of the NHS), Thurrock Mind (a charity with a proud tradition of helping those experiencing difficulties with their mental health), and the students of the college. The Recovery College is about providing educational courses to promote mental wellbeing.

Thurrock have a pilot project in conjunction with St Mungo's called Housing First which will look to prevent homelessness in a small referred group of residents who are referred. Prior history of self-harm/suicide attempts form part of the risk criteria to determine whether they are eligible for inclusion onto the pilot.

Local response to *Preventing Suicide in England*

In 2013 the All Party Parliamentary Group on Suicide and Self-Harm Prevention published its initial deliberations. This was followed by The All-Party Parliamentary Group (APPG) on Suicide and Self-Harm Prevention Inquiry into Local Suicide Prevention Plans in England 2015. The main recommendations from the latter were that all local authorities must have in place:

a) Suicide audit work to in order to understand local suicide risk.

b) A suicide prevention plan in order to identify the initiatives required to address local suicide risk.

c) A multi-agency suicide prevention group to involve all relevant statutory agencies and voluntary organisations in implementing the local plan.

In response to these recommendations this document contains:

a) The 2014/15 Southend, Essex and Thurrock Suicide Audit – summary in Section 4: Suicide audit and the full report published alongside this strategy.

b) This report references key actions that have been identified as tackling suicide prevention – see section 5: Actions

c) Recommendations around the governance for actions on suicide prevention – see section 7 of Recommendations.

4. Suicide audit

The full data report can be found in the SET suicide audit 2014/15 report that will be published alongside this strategy. Key findings are presented here.

Demographics

Approximately 73% of suicide cases were male, with approximately 27% being female. Most deaths occur in the age range 40-49 and 50-59 although Southend has a peak in 30-39 and Thurrock in the 20-29year age groups. It is difficult to extrapolate on ethnicity as this was frequently not recorded.

Means of Death

Hanging and poisoning were the most common means of death for men and women respectively; this is slightly contrary to the national picture where hanging is usually most common for both sexes, and locally may reflect the high incidence of poisoning seen in Southend.

Suicide Locations

Place of death is defined by the location where the person was officially pronounced dead. Most deaths take place at home; however, of the audited deaths, a number died elsewhere in incidents involving open water, railway lines, or open spaces such as farm or field, and a few died in hospital after being conveyed there after an episode of injury elsewhere.

We did not explore death by suicide related to deprivation mapping postcode to ward and deprivation score; wards with higher deprivation scores are more likely to have higher rates of death by suicide.

Suicide and access to healthcare

Data completeness in the coroner's report meant that it was not always possible to be sure whether someone had or had not been seen recently by healthcare services such as mental health, GP or A&E.

Where records where available, the local picture is similar to the national in that a significant number are in current contact or known to mental health services within the last 12 months. The most common mental health conditions were depression and anxiety, with a smaller number of people diagnosed with Bipolar affective disorder or schizophrenia/ personality disorder.

In general practice, this contact may have been for reasons of mental health, physical health or simply a routine appointment, and represents an opportunity to recognise and offer support.

Very few had a record of contact with A&E but that may reflect data completeness.

Clinical and social factors

Where available in the record we were able to note factors such as bereavement, financial issues, forensic history, physical illness and disability, and relationship issues. All were prevalent in the deaths reviewed with illness and financial issues the most common. A small but significant number had a recorded history of misuse of drugs and/or alcohol. The highest number lived alone and a number had a shared living situation (living with friends, living in a hostel or another form of house-share).

Suicide in young people

The Southend Essex & Thurrock Strategic Child Death Overview Panel commissioned a review to explore what further actions SCDOP can take to reduce the risk of youth suicide in SET areas. Membership of the Group was made up from representatives of the Child Death Overview Panel and representatives of partner agencies

A summary of each of the 11 cases over the last 3 years was reviewed with a focus on the last 6 cases which occurred over the last 12 months.

Key findings and conclusions:

- Most of the young people were not previously known to services. In some cases the young people had been noted by their family as appearing happy and behaving normally on the day of the suicide. The time between making the decision and carrying out the attempt may be very short, 10 minutes to one hour. Boys, especially, are liable to act impulsively.
- Hanging was the means of death for 10 of the 11 young people (poisoning accounting for the other).
- It was not always clear whether death was the intention, or whether accidental or a fatal self-harm episode.
- Need to build resilience and problem solving strategies for young people
- Online support is key for children and young people. Appropriate support needs to be easy to find but it is difficult to ensure that the right pages appear at the top of the list when using online search facilities.
- Youth champions within schools could be used as young people will often talk about their concerns to peers first, before teachers or professionals.
- The involvement in suicide prevention work by schools who have had experience of supporting staff, children and families following the suicide of a child would be useful. It is felt that the schools involved would be keen to engage.

5. Tackling Suicide prevention in Southend, Essex and Thurrock

'There is a certain attitude amongst professionals that "you can't stop people killing themselves". It's pervasive. There is also a feeling that you shouldn't involve families and carers and that you shouldn't talk openly about suicide because it gives people ideas and makes them more likely to attempt suicide. This just isn't the reality. Doing something is better than doing nothing'.

Strategic Lead, Zero Suicide from ECC/Public Office *Hope for Better Mental Health*

Preventing Suicide in England identified six key areas for action to support delivery of the 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

This section signposts the key partnerships, agencies, strategies and actions which have relevance for suicide prevention across wider Essex. This summary of local action should be read in conjunction with the full strategies and action plans; these include both generic and suicide prevention specific actions from the most relevant strategies and action plans.

There are other actions not noted here that reflect the responsibilities of various agencies on social determinants of suicide risk such as debt, employment & the economy, housing; these actions primarily focus on achieving other outcomes but which have the additional benefit of reducing the risk of suicide.

Southend Essex and Thurrock Mental Health Strategy 2017 – 2021

This strategy has been developed collaboratively by the three local authorities (Southend, Essex and Thurrock) and seven clinical commissioning groups across Greater Essex. The implementation plan is currently in development across key areas of children & young people, perinatal mental health, adults common mental health problems, adults community mental health, adults acute and crisis, health and justice, adult secure pathways, and suicide prevention; there is a supportive piece on communications and engagement. The plans are being overseen by an implementation group.

In addition, the CCGs have quality and performance oversight of Essex Partnership University Trust; this will include their oversight of any CQC inspections including any remedial plans to address suicide risks in inpatient settings.

Under the Crisis Concordat, a Pan Essex System Preparedness Plan has been developed collaboratively by representatives of the 7 Essex CCGs, 3 Local Authorities, 5 Acute Trusts, 2 Mental Health Trusts, Ambulance Service Trust and Essex Police in response to the proposed amendments of the Mental Health Act (1983) by the Policing and Crime Bill (2016).

Collaborative Commissioning Forum for the Emotional Wellbeing and Mental Health of Children and Young People in Southend, Essex and Thurrock *Open Up Reach Out – transformational plan for emotional wellbeing and mental health of children and young people in Southend Essex and Thurrock 2015 - 2010*
https://www.essex.gov.uk/Documents/Full_version_Open_up_Reach_out_v17.pdf
This strategy has been developed collaboratively by the three local authorities (Southend, Essex and Thurrock) and seven clinical commissioning groups across Greater Essex.

NHSE and Chelmsford Prison Health and Social Care Partnership Board is accountable for delivery of care in Chelmsford Prison including response and actions relating to investigations of suicide in Chelmsford Prison.

Southend Essex and Thurrock Domestic Abuse Strategic Board has produced its strategy which aims to assist partnerships and agencies across Greater Essex in delivering appropriate joined up responses to those affected by domestic abuse.
http://dnn.essex.gov.uk/Portals/68/Professionals/Domestic%20Abuse/2015%2009%2024%20Essex%20DA%20Strategy%20(1).pdf

The three local authorities have different discrete treatment systems for the management of drugs and alcohol services; the quality of substance misuse services are governed by PHE.
In Essex, the system operates a 'no wrong door' approach. The key point of contact for all individuals, professional and or public, is the Choices service, provided by Open Road and the Children's Society. Contact details are: 0844 499 1323 and Choices sites are located in all of the key urban centres across Essex.

Network Rail will notify and work with the local authorities where three or more suicidal incidents have occurred at any local stations within 12 months (suicides or injurious attempts). Network Rail has key partnerships with British Transport Police and the Samaritans.
https://www.networkrail.co.uk/communities/safety-in-the-community/suicide-prevention-railway/

The Essex Civilian Military Partnership Board, established as part of the commitment to the Essex Armed Forces Community Covenant, is organised around 5 key pillars -– Health and Wellbeing, Economy and Skills, Safer and Stronger Communities, Education, Children and Young People, and Environment and Infrastructure - each of which addresses key suicide risk factors.

Thurrock has set up a Suicide Prevention Multi-Agency Group (SPMAG). The group will play an active role in developing a local strategy and action plan. The group is comprised of key partner organisations and stakeholders and reports to The Thurrock Health and Wellbeing Board. Emotional health and wellbeing is included in Thurrock Council's Health and Wellbeing Strategy (2016-21).

1. Reduce the risk of suicide in key high-risk groups

The key high risk groups include:

- Young and middle aged men
- People in the care of mental health services, including inpatients
- People with a history of self-harm
- People in contact with the criminal justice system
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers

The audit data (see section 4 above for summary, full report published alongside this strategy) shows a higher than expected risk for young and middle age men with Thurrock and Southend and in older age groups in Essex. The audit showed the expected pattern of in care of mental health services, history of self-harm and contact with the criminal justice system. Data on occupation is available for suicide deaths in Southend, Essex and Thurrock but has not yet been analysed for this report as the focus was predominantly on employment status rather than specific occupations per se; the specific at risk occupations did not present within the audit although this may simply be due to small numbers (unreported data).

The Community Resilience Fund was used to launch the Essex Shed Network facilitated by Maldon CVS https://essexshednetwork.wordpress.com/. Active Essex including, Active Thurrock and Active Southend, are supporting local organisations to bid for funding for young people and disadvantaged communities. Initiatives such as these aim to reach out to men who do not typically engage with health and care services.

The Southend, Essex and Thurrock Mental Health strategy outline the actions and intentions to improve mental health and wellbeing locally. Various chapters of that strategy describe the efforts of the health and care system and wider partners to improve mental health services and outcomes across Greater Essex; these actions will have a positive impact on suicide prevention as a key outcome of success. These chapters outline action to target specific at risk groups as well as general improvements in health and wellbeing across the population. The chapters specifically highlight people in the criminal justice system in addition to the general population. What is less clear is how interventions may need to be further tailored for different groups.

Essex Partnership University Trust (NEP and SEPT trust merger from 1st April 2017) have produced actions in response to CQC inspection recommendations as to environment and safety e.g. addressing ligature risks.

The criminal justice system has a responsibility for risk assessment for those it comes into contact with. The prison, police and the probation / community rehabilitation services have risk assessment processes in place to inform custodial, sentencing and release plans with repeat assessment for significant changes in circumstances. Staff are not specifically trained in mental health although they do have training in safeguarding and core competence in risk assessment and management. There are recommendations in place on safe environments to minimise risk; The Pan Essex

Preparedness Plan addresses place of safety and Chelmsford prison has an action plan in place following recent inspections.

The Essex Rural Partnership is an opportunity to raise the profile of suicide risks in specific occupational groups such as farmers and agricultural workers.

Within the health care system, there are targets and incentives around staff mental health and wellbeing. Local Public Health teams are developing initiatives around healthy workplaces and workforce.

2. **Tailor approaches to improve mental health in specific groups:**

The additional specifically identified groups are:

- 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 including perinatal 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

A new emotional wellbeing and mental health service for children and young people was launched locally in 2015. All targeted and specialist services across wider Essex are now delivered by one organisation with locality-based teams managing local services, as well as working with schools, children centres and the voluntary, community and social enterprise sector (VCSE) on universal support and NHS England on acute services. Risk avert - which is being delivered in 30 Essex schools - supports young people to build resilience, learn skills to manage risk and become more connected at school.

Open up, reach out – Transformation plan for the emotional wellbeing and mental health of children and young people in Southend, Essex and Thurrock includes a specific commitment to work together with the local safeguarding children boards, local authorities and local schools.

The Children and Young People's Plan for Essex launched in 2016 includes a range of further actions to address risk and build resilience, with a particular focus on the most vulnerable http://www.escb.co.uk/Portals/67/Documents/C%20and%20YP/ECC%20Children%20Young%20People%20Plan.pdf

The ECC Children's' Mental Health Commissioner leads the strategic integration of mental health across children's settings on behalf of 7 CCGs and 3 local authorities. Prevention of Youth Suicide Guidance Toolkit for Schools was recently developed which now sits with the Essex Children's'' Safeguarding Board to drive consistent countywide implementation. A supplementary self-harm guidance is also currently in development. New digital resources are being explored to complement the delivery of this agenda across all children's settings, including education.

The Essex Civilian Military Partnership Board, established as part of the commitment to the Essex Armed Forces Community Covenant, is organised around 5 key pillars -– Health and Wellbeing, Economy and Skills, Safer and Stronger Communities, Education, Children and Young People, and Environment and Infrastructure - each of which addresses key suicide risk factors. There is a North Essex Veterans Mental health Network and the existing Veterans First service has been replaced by the newly launched national Veterans' Mental Health Transition, Intervention and Liaison Service.

CCGs are increasingly targeting the provision of IAPT (improving access to psychological therapies) to those with long term physical illness.

The development of a new, integrated 0-19 service provides an opportunity to review and develop the role of health visitors and other key professionals in identifying mothers who may be experiencing perinatal mental health issues. New funding has been secured for mental health midwives.

Ongoing monitoring of drug related deaths/ serious untoward incidents and the associated learning outcomes inform service development to address effective identification and support as part of the suicide prevention agenda. ECC operates a confidential enquiry process into drug related deaths and on a quarterly basis reviews possible trends and root causes to ensure that system-wide learning is disseminated and implemented where required.

The suicide audit showed the expected national trends of the majority of suicides occurring in people not known to mental health services but experiencing everyday pressures of social, personal and financial vulnerability. Agencies such as job centres/ DWP, Citizens advice bureaus, faith groups etc are all key points for a making every contact count approach. Further work may be needed to develop the role of these agencies in the suicide prevention agenda.

There were some noticeable gaps. The suicide audit noted poor recording on some characteristics including ethnicity & sexual orientation, and it is unclear how services account for equality and diversity and the specific needs of those with protected characteristics. It has been noted nationally about immigrants as an emerging risk group; we were unable to determine any local patterns within the audit as the data was insufficient to analyse this characteristic.

In 2013, the East of England Strategic Clinical Network established the 'zero suicide' programme in our region, with Mid-Essex CCG selected to lead the pilot in Essex, one of four across the region. These pathfinder initiatives have had a particular focus on reaching out beyond the 'usual suspects' to engage the widest range of partners in suicide prevention, including coroners, librarians, gym staff, housing association staff, publicans, social care assistants, paramedics, faith groups, Football Association Staff, CCG employees, private security staff and the British Transport Policy. The Mid-Essex pilot had a particular focus on:

- Developing training programmes for third sector and voluntary organisations; and
- Training community nurses, primary care staff, GPs, police, British Transport Police, drug and alcohol staff and paramedics.

3. **Reduce access to the means of suicide:**

The majority of suicides reviewed in the audit were by means of hanging, usually in the home but sometimes in more public places. Jumping, firearms and asphyxiation were rarer means of suicide locally.

Secured placements - including criminal justice custody and mental health inpatient settings – have clear guidance about environmental safety planning. There is a role for environmental planning for the local authorities, and Community Safety Partnerships produce community safety plans which are an opportunity to explore further opportunities to address physical locations as means of suicide.

Network Rail will notify and work with local authorities where three or more suicidal incidents have occurred at any local stations within 12 months (suicides or injurious attempts). Each station will be assessed and physical and psychological barriers to be considered as part of a layered approach to mitigations. Network Rail will increase the opportunity and capacity for interventions e.g. continue to provide 'Managing Suicidal Contacts' training to all staff; increase opportunities for help seeking by suicidal individuals; ensure Samaritans signs are in stations particularly at specific access points with additional posters and cases made available and displayed at stations and Samaritans material displayed within waiting rooms; and seek other opportunities such as digital media. Network Rail are particularly keen to change the public image of such sites and work with local media to ensure they are aware and work within the Samaritans media guidelines (see area action 5 below).

The audit also identified waterways as a chosen location; there is a noticeable lack - nationally and locally - about the role of the Maritime and Coastguard Agency and RNLI, similar to that of Network Rail. The RNLI are keen to explore their community safety role further.

Prescribing for substance misuse is via EPUT or GPs who have to work to national and local guidance; this ensures that new or unstable patients are prescribed the medication as supervised consumption. Whilst most patients would come off supervised consumption after a few months those with more complex needs or lack of housing are kept on supervision to ensure they see a healthcare professional almost daily. All clients coming out of prison are given appointments in the community and put on a supervised consumption prescription. The Take Home Naloxone program has trained those who use drugs and their friends and family in using the injection so that if they see someone overdose they can administer Naloxone which reverses the overdose until a paramedic arrives.

4. **Provide better information and support to those bereaved or affected by suicide:**

It was recognized in the 2012 *Preventing Suicide in England strategy* that bereavement through suicide was an area poorly covered by previous suicide prevention strategies. Bereavement is also itself a risk factor for suicide. In addition, those affected by the loss of a loved one through suicide will have specific needs.

There are several bereavement charities and organisations, some of which specialize in helping those affected by suicide.

The agencies whose staff are most likely in contact with those deaths by suicide offer support to staff through debriefing, professional supervision and occupational health; these may not be comprehensive across all relevant agencies and uptake can be affected by a reluctance to seek help.

5. **Support the media in delivering sensitive approaches to suicide and suicidal behaviour.**
It is known that the reporting of suicides by the media can promote other suicides – particularly using the same method or at the same location and that responsible reporting of suicide or reduced reporting can decrease suicides at frequently locations.

There are media guidelines on the reporting of suicide that set out clear instructions and recommendations on what an article should contain when it reports a death by suicide (see resources section 8).

6. Support research, data collection and monitoring.
The three local authority public health teams have completed an audit of 2014/15 deaths which is summarised in section 3 and full audit report appended to this strategy. Further work is needed locally to schedule more regular audit and surveillance.

Various agencies e.g. Network Rail & BTP, mental health trusts, prison, substance misuse services, undertake regular reviews of deaths within their services to understand root cause.

6. Suicide Prevention Group

In 2013 the *All Party Parliamentary Group on Suicide and Self-Harm Prevention* published its initial deliberations. This was followed by *The All-Party Parliamentary Group (APPG) on Suicide and Self-Harm Prevention Inquiry into Local Suicide Prevention Plans in England 2015*. The main recommendations from the latter were that all local authorities must have in place:
a) Suicide audit work to in order to understand local suicide risk.
b) A suicide prevention plan in order to identify the initiatives required to address local suicide risk.
c**) A multi-agency suicide prevention group to involve all relevant statutory agencies and voluntary organisations in implementing the local plan**.

The intent of this Suicide Prevention Strategy - in this first year iteration – is to collate and cross reference the strategic intent and action plans of the various organisations and partnerships – many mentioned throughout this strategy – that have a role to play in suicide prevention across Essex.

The geography and organisational structure across wider Essex is complex. There are 3 local authorities, 7 CCGs, 2 mental health trusts, 3 adult safeguarding boards, 3 children's safeguarding boards, one police authority, one Police Crimes Commissioner, three Healthwatches, etc. Essex is covered by 3 Sustainability & Transformation footprints (including two with other county councils) which may have implications for how organisations collaborate in the future.

Forums are variously organised on local government boundaries and/or pan CCG boundaries. Certain partner agencies, e.g. the police, cover wider Essex. As such, there is no one forum that encompasses the entirety of the suicide prevention agenda across wider Essex. Setting up a suicide prevention group – whilst focusing on the specific agenda - will not necessarily have robust governance and will have duplication of membership.

The approach taken in the strategy is to recommend that the actions are owned by the responsible organisations and partnerships, with annual oversight by the Health & Wellbeing Boards and an annual summit focused solely on suicide prevention. This recognises the complex geography of Southend, Essex and Thurrock with overlapping boundaries and jurisdictions which require both local and shared approach to suicide prevention.

This approach still allows for local flexibility whilst maintaining a pan Essex overview especially for those partners who cross local boundaries whether NHS or other.

7. Recommendations

In addition to the actions already intended by the relevant organisations and partnership forums, we have identified the following additional recommendations for action.

1: Reduce the risk of suicide in key high-risk groups

1.1 That organisations and forums undertake an impact assessment (similar to equality impact assessment) using the characteristics identified as high risk and apply to their current and intended interventions to ensure that each group has the best evidenced based targeted interventions

1.2 Explore feasibility of equipping people who are most likely to encounter people with mental health issues or suicidal thoughts with the skills and confidence to support them and to enable them to seek professional help (as per Zero Suicide initiative)

2: Tailor approaches to improve mental health in specific groups

2.1 As per recommendations 1.1, 1.2,

3: Reduce access to the means of suicide

3.1 That the intelligence task & finish group (see 6.1) check for possible frequently used locations

3.2Explore further with the Maritime and Coastguard Agency and RNLI about deaths associated with our local waterways.

3.3 Explore further with Community Safety Partnerships actions to address any other frequently used locations.

3.4 Be prepared to convene task and finish group if a cluster of suicide deaths is identified.

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

4.1 Information for those bereaved as a result of suicide should be made available through professionals and other organisations in first & follow up contact with bereaved people (Police Officers, prison staff, ambulance staff, coroners, GPs, death registration professionals and funeral directors etc).

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

5.1 Design and delivery a comprehensive communications plan as part of the existing “Lets Talk About It” branding, with an intelligently mapped timeline (targeting known risk groups at times of high risk such as the start of school/ college terms, linking to national and local partnership campaigns).

5.2.a Ensure all professionals in contact with the media are aware of guidelines for reporting suicide.

5.2.b Liaise with local media to encourage reference to and use of guidelines for the reporting of suicide.

6: Support research, data collection and monitoring

6.1 A Task and Finish Group should be set up to design the audit schedule including the potential value of 'real time' surveillance and analysis of location/means to ascertain if any frequently used locations or emerging clusters.

6.2 Partners should be encouraged to respond to requests from the Office of the Coroner to provide the required data for inquests. In particular, capturing data on ethnicity is gaining importance as some other areas are observing trends in suicides in immigrants/white other categories which may indicate particular risks.

6.3 Organisations that experience deaths directly e.g. prisons, mental health services, rail, should share their thematic analysis of deaths for wider lessons learnt. We would also encourage GPs to review suicides as part of unexpected deaths audit to understand any lessons to be shared.

7: Planning and governance

7.1 That suicide prevention remains the business of the noted partnerships, with regular standing item (at a minimum annually) on suicide prevention

7.2 That each forum with a responsibility for suicide prevention nominates a member of that forum to be a suicide prevention champion

7.3 That we convene an annual summit of all partner agencies to review progress, which will report to the HWBs

7.4 That the Health & Wellbeing Boards hold the accountability for this multi- agency agenda and that they review progress on an annual basis

8. Resources

1. **Reduce the risk of suicide in key high-risk groups**
   - Mental health of adults in contact with the criminal justice system (in development, due march 2017) https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0726
   - Preventing suicide in communities and custodial settings (in development, due 2018) https://www.nice.org.uk/guidance/indevelopment/gid-phg95

2. **Tailor approaches to improve mental health in specific groups:**
   - The Risk Avert website is at http://www.risk-avert.org/
   - The Essex Lifestyle Service website is at http://www.essexlifestyleservice.org.uk/The App can be downloaded at https://itunes.apple.com/gb/app/lifestyle-essex/id967932040?mt=8
   - NICE guidelines (CG16) Self-harm in over 8s: short-term management and prevention of recurrence https://www.nice.org.uk/guidance/CG16
   - NICE guidelines (CG133) Self-harm in over 8s: long- term management , https://www.nice.org.uk/guidance/cg133
   - Department of Health and NHS England Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing
   - NICE guidelines (CG90) Depression in adults: recognition and management
   - North Essex Veterans Mental Health Network http://www.nevmhn.org.uk/
   - Preventing suicide among lesbian, gay and bi sexual young people: a toolkit for nurses; and Preventing suicide among trans young people https://www.gov.uk/government/publications/preventing-suicide-lesbian-gay-and-bisexual-young-people
   - Sources of information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/137640/Sources-of-information-and-support-for-families.pdf

3. **Reduce access to the means of suicide:**
   - Preventing suicides in public places https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/481224/Preventing_suicides_in_public_places.pdf
   - Identifying and responding to suicide clusters and contagion: a practice resource https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459303/Identifying_and_responding_to_suicide_clusters_and_contagion.pdf

4. **Provide better information and support to those bereaved or affected by suicide:**
   - Support after suicide: a guide to providing local services https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/582095/Support_after_a_suicide.pdf
   - Support after suicide: developing and delivering local bereavement support services http://www.nspa.org.uk/wp-content/uploads/2017/01/NSPA-postvention-framework-20.10.16.pdf
   - Help is at hand: support after someone may have died by suicide http://supportaftersuicide.org.uk/help-is-at-hand/

- http://supportaftersuicide.org.uk/
- Guide to Coroners and Inquests and Charter for Coroner Services
- The Inquest Handbook: A guide for bereaved families, friends and their advisors.
- The Road Ahead… A guide to dealing with the impact of suicide, published by Mental Health Matters. www.mentalhealthmatters.com
- Health talk online, a website where people can share experiences of ill health and bereavement, including bereavement by suicide. www.healthtalkonline.org
- If U Care Share, a website and campaign organisation with links to sources of support. www.ifucareshare.co.uk
- Winston's Wish, bereavement support for children and young people. www.winstonswish.org.uk/
- Cruse Bereavement Care http://www.cruse.org.uk/
- Survivors of Bereavement by Suicide, a self-help organisation to meet the needs and break the isolation of those bereaved by the suicide of a close relative or friend. www.uk-sobs.org.uk/
- The Compassionate Friends, support for bereaved parents and their families after a child dies. www.tcf.org.uk/

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

- Samaritans media guidelines for the reporting of suicide and related resource materials http://www.samaritans.org/media-centre/media-guidelines-reporting-suicide

6. Support research, data collection and monitoring.

- Suicide profile https://healthierlives.phe.org.uk/topic/suicide-prevention or http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

References

Bennewith O et al (2007), *Effect of barriers on the Clifton suspension bridge, England, on local patterns of suicide: implications for prevention*, The British Journal of Psychiatry, 190 (3), 266-267.

Department of Health (2012) *Preventing suicide in England, A cross-government strategy to save lives.* London: Department of Health.

Department of Health (2015) *Statistical update on suicide – Prepared by Office for National Statistics.* London: Department of Health.

Department of Health (2015b) *Preventing suicide in England: Two years on. Second annual report on the cross-government outcomes strategy to save lives.* London: Department of Health.

Department of Health (2017) *Preventing Suicide in England: third progress report of the cross government outcomes strategy to save lives.* London: Department of Health

Department of Health/NHS England, *Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing*, London: Department of Health.

Hawton K, Gunnell D&Kapur N (2013) Suicide and self-harm. In *Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence*. p239-250.

Hawton K et al (2013b), Long term effect of reducing pack sizes of paracetamol on poisoning deaths and liver transplant activity in England and Wales, *British Medical Journal*, 346: f403.

HM Government (2013) *The Future of Local Suicide Prevention Plans in England A Report by the All Party Parliamentary Group on Suicide and Self-Harm Prevention*. London: HM Government.

HM Government (2014), *Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis*.

HM Government (2015) *The All-Party Parliamentary Group (APPG) on Suicide and Self-Harm Prevention Inquiry into Local Suicide Prevention Plans in England 2015*. London: HM Government.

Hogan M and Goldstein Grumet J (2016), *Suicide Prevention: An emerging priority for health care' Health Affairs*, June 2016, Vol 85, no. 6 1084 – 1090.

House of Commons Health Committee (March 2017), *Suicide Prevention – Sixth Report of Session 2016-17*.

Leyin A (2015) Suicide: Conceptualisations within a public health framework. Unpublished MS. Lejins Publishing.

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2015: England, Northern Ireland, Scotland and Wales July 2015. University of Manchester.

O'Connor RC (2011) Towards an integrated Motivational-Volitional model of suicidal behaviour. In O'Conner, R.C., Platt S. & Gordon, J. (Eds.) *International Handbook of suicide prevention: Research, Policy and Practice.* John Wiley & Sons Ltd. pp181-198.

Office of National Statistics (2016) Statistical Bulletin (2016) *Suicides in the UK, 2014 Registrations*.

Moulin, L (2015), *Aiming for 'zero suicides' – An evaluation of a whole system approach to suicide prevention in the East of England*, Centre for Mental Health.

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, *Making mental health care safer – Our annual report and 20 year review 2016*.

NHS, ECC, Thurrock and Southend (2015), *Open up, reach out – Transformation Plan for the Emotional Wellbeing and Mental Health of Children and Young People in Southend, Essex and Thurrock*.

Public Health England (2014), *Guidance for developing a local suicide prevention action plan*.

Public Health England (2015), *Preventing suicide among lesbian, gay and bisexual young people*.

Public Health England (2015b), *Identifying and responding to suicide clusters and contagion: A Practice Resource*.

Public Health England (2015c), Preventing suicides in Public Places: A practice resource.

Public Health England (2016) *Suicide Prevention Profile*. http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide [accessed 5/2/17]

Royal College of Psychiatrists (2010), *Self-harm, suicide and risk: helping people who self-harm*.

Samaritans (2015) *Suicide Statistics Report 2015*. Samaritans.

Scott, A and Guo, B (2012), *For which strategies of suicide prevention is there evidence of effectiveness?*, WHO, Europe.

The Scottish Public Health Observatory (2015)*Suicide: key Points*.

http://www.scotpho.org.uk/health-wellbeing-and-disease/suicide/key-points

World Health Organisation (2010) *Towards evidence-based suicide prevention programmes.* Geneva: World Health Organisation.

World Health Organisation (2014), *Preventing suicide – A global imperative*. Geneva: World Health Organisation.

World Health Organisation (2014) *Preventing suicide: A global imperative*. Geneva: World Health Organisation.

Yip, P (2011), *Towards Evidence-Based Suicide Prevention Programes*, Crisis 32 (3): 117-120.

Useful reading

Samaritans (2012) *Men Suicide and Society: Why disadvantaged men in mid-life die of suicide. Research Report*.Samaritans.p57- 72

Samaritans (2017), *Dying from Inequality – Socioeconomic disadvantage and suicidal behaviour*.

Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence.

Appendices

Appendix 1: Suicide definitions

A1.1 Most recent reports[4] draw particular attention to the definition of suicide as currently used by the Office of National Statistics (ONS), which reflects the coding used by the WHO (ICD-10). Thus, the UK definition of suicide now includes death from: (a) intentional self-harm; (b) injury/poisoning of undetermined intent; and (c) as a secondary consequence ('sequelae') of intentional self-harm/event of undetermined intent.

A1.2 This definition will differ from a Coroner's verdict of suicide. Coroners record a verdict of suicide only when there is evidence beyond reasonable doubt that the injury was self-inflicted, and the deceased intended to take their own life (DH, 2015). Research studies tend to show that the majority of open verdicts are most likely suicides, although they do not meet the high legal standard of evidence required for a coroner to record a suicide verdict.

A1.3 In this paper we use the term suicide to refer to deaths from both intentional self-harm and injury or poisoning of undetermined intent (as adopted by the ONS).[5]

A1.4 It should be noted that suicides are recorded following inquest, and that inquests may not be conducted in the year of death. This will have an inevitable impact on the accuracy of statistical returns for any one year but is considered unlikely to have a great impact on the usability of UK suicide statistics.

A1.5 Note: The suicide rates presented by *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (2015) (also used in this report) differ slightly from the ONS data.

[4] Samaritans 2015; DH 2015

[5] Some graphs, from sources other than ONS adopt different criteria (this is specified, where relevant).

Appendix 2: Suicide prevention is everybody's business