Suicide Prevention Strategy

— 2016 —

FOREWORD

The impact of suicide is profound, affecting loved ones, friends, work colleagues and entire communities. Behind each suicide is a tragic set of circumstances, unique to the individual, but with universally devastating consequences for our society.

That suicide prevention is the focus of this strategy is welcome and timely. Not only is improving people's mental health a priority for Suffolk's Health and Wellbeing Board, we also have a mission to support the whole population's health and wellbeing. This is important when you consider that the majority of people who take their lives have not been in contact with mental health services for 12 months.

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 and has achieved a great deal in establishing suicide prevention as a priority.

We are building on these strong foundations with a true partnership approach to preventing suicide in Suffolk. No single organisation can do this alone; the fact that our strategy is endorsed by professionals and partners from the health, public and voluntary sectors, shows the shared commitment and continued strength of partnership working that we have developed in Suffolk.

The vision that we have set ourselves to reduce suicide – currently around 60 people every year in Suffolk – will require a dedicated long-term focus. The subject is complex, which is why our priorities for action are as much about continuing to work together and share the information we have as they are about engaging and involving Suffolk people at each stage.

I am proud to present this strategy as the first, important step in meeting these objectives. The title of this strategy is particularly apt: Suffolk lives matter, which I wholeheartedly endorse on behalf of the Health and Wellbeing Board.

I am committed that we do everything we can to safeguard life, and support everyone who lives and works in our county to enjoy healthy, fulfilling lives.

Tony Goldson

Chairman of the Health and Wellbeing Board and Suffolk County Council Cabinet Member for Health

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EXECUTIVE SUMMARY

Making suicide prevention a priority In Suffolk, the latest data shows that around 62 people die by suicide each year. Behind each death is an individual story of distress and despair, and each death leaves many more people affected by bereavement.

Suffolk County Council is committed to reducing suicide deaths through working with partners across Suffolk; our suicide prevention strategy group will agree a medium-term target for reduction and produce an action plan to achieve this. Through the group, the council will lead the drive to develop our approach in future years to reduce the suicide rate further to as close to zero as possible.

One of the priorities for Suffolk's Health and Wellbeing Board is for "People in Suffolk (to) have the opportunity to improve their mental health and wellbeing." This suicide prevention strategy will contribute to this priority and the action plan will be informed by the content of the document.

Suicide prevention is a local authority-led initiative working closely with other local partners, including the Police, Clinical Commissioning Groups, NHS England, coroners and the voluntary sector. Suffolk County Council has worked together with these key stakeholders to develop this strategy.

WHAT THE DATA TELLS US

Suffolk's rates of death by suicide are similar to the overall England rates: in 2012-14 in Suffolk 8.7 people per 100,000 died by suicide each year, compared with 8.9 per 100,000 in England as a whole. Gender differences are important in suicide as rates of death are much higher in men than in women (13.1 per 100,000 for males in 2012-14 in Suffolk, compared with 4.5 per 100,000 for females). Rates of death by suicide also vary by age, with the highest rates in the age groups between 35 and 59, and low socio-economic status is also an additional risk factor for suicide.

An audit of deaths by suicide in Suffolk found that deaths by hanging account for 40% of suicides and poisoning accounts for 30% of deaths. Most deaths take place in the home but 25% died elsewhere. The audit found that 4% of deaths occurred from falls from the Orwell Bridge and 5% were deaths on railway lines. The audit also found a higher risk of suicide in Suffolk residents who were born in Latvia, Lithuania or Poland.

Nationally, most suicide deaths (72%) affect people who have not been in contact with mental health services in the previous 12 months, and it is important to bear this in mind when considering prevention. However, people with known mental health conditions are at higher risk of suicide and the prevention strategy needs to recognise this as well.

People who have recently been discharged from inpatient care are at the highest risk and there is also an increased risk among those who have deliberately and seriously self-harmed in the past or made previous attempts at suicide. People in contact with the criminal justice system also have a higher risk, as do people who misuse drugs and alcohol.

At present there is no process in Suffolk to identify suicide clusters, and there are many opportunities to improve the gathering and analysis of information on deaths by suicide and suicide attempts to identify and act on clusters and trends.

SUMMARY PRIORITIES FOR SUICIDE PREVENTIONIN SUFFOLK

1

Reducing suicide risk for all (with simple icon showing group of heads together)

We need to ensure that our actions reduce suicide risk for everyone in Suffolk and particular social groups at higher risk. Most deaths by suicide occur in people who have not been in contact with mental health services in the last year, and so we need to look at the whole population. Our information about which groups of people in Suffolk are at increased risk tells us these groups are:

- men, particularly those in mid-life and who are less well-off,
- people who are known to be depressed,
- people who misuse drugs and alcohol,
- people who were born in Eastern Europe.

2

Supporting people at greatest risk

A small number of people are at greater risk of suicide due to severe mental distress, and are in touch with mental health services. We need to make changes designed to prevent suicides in this group of people as they are at such high risk.

3

Taking action together (simple icon to show groups working together)

We will set up a suicide prevention task group with representatives from organisations that are most influential in suicide prevention across Suffolk. The group will agree a medium-term target for reducing the suicide rate and will produce an action plan to achieve this. The group will learn from what works to develop new ways to reduce Suffolk's suicide rate further in future years to as close to zero as possible.

4

Improving how we collect and interpret information

At present there is little information about suicide deaths apart from information from death registrations and reports from the Coroner. Information on attempted suicide is very poor. We need to gather more information and in a more up-to-date way so that we understand more about suicide deaths and attempts locally,

5

Working with people in Suffolk (simple icon)

We will work with key stakeholder organisations, service users and people bereaved by suicide to make sure that the action plan is feasible , to ensure that it is truly effective.

ABOUT THIS STRATEGY

This strategy has been led by Suffolk County Council's Public Health team, working closely with the Suffolk Suicide Prevention Strategy steering group. The steering group consists of representatives of the following interested organisations: Norfolk and Suffolk NHS Foundation Trust (NSFT), Suffolk County Council's Mental Health team, Ipswich and East Suffolk CCG, Samaritans, Healthwatch. Input has also been sought from SOBS (Survivors of Bereavement by Suicide) and the Suffolk User Forum.

Suicide prevention is a local authority-led initiative working closely with other local partners, including the Police, Clinical Commissioning Groups, NHS England, coroners and the voluntary sector. Suffolk County Council has worked together with these key stakeholders to develop this strategy. An associated suicide prevention action plan is in development with input from these stakeholders and also from people bereaved by suicide, mental health trusts, and users of mental health services.

NATIONAL CONTEXT

Every year, around 9 in every 100,000 people in England die from suicide. 1 This rate has stayed fairly steady over the last 15 years. Rates are much higher in men than in women, and nationally it is the single most frequent cause of death in men aged 15-49, as well as the second leading cause of maternal death. 2

In England, **33 years of life per 10,000 people are lost to suicide each year (29 years in Suffolk).** 3 This is one of the highest causes of life years lost because mortality rates from suicide are high in younger age groups.

In September 2012 the Department of Health (under the Coalition Government) produced 'Preventing Suicide in England'. 4 This is a national cross-government strategy that is "intended to provide an approach to suicide prevention that recognises the contributions that can be made across all sectors of our society." The strategy presents national objectives and areas for action, whilst highlighting the responsibility at local level to coordinate and implement work on suicide prevention. The suicide rate is included as an indicator within the national Public Health Outcomes Framework to help track national and local progress towards reducing suicides.

The national strategy identifies six areas for action, which will be reflected throughout this local strategy.

These areas are:

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.**

1) *Age-standardised rate of mortality from suicide and injury of undetermined intent. Data from Public Health England's Suicide Prevention Profile http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide*

2) *Mental Health Taskforce (2016) The five year forward view for mental health.*

3) *Health and Social Care Information Centre. Years of life lost due to mortality from suicide and injury undetermined. Crude rates for 2012-14.*

4) *Department of Health (2012) Preventing suicide in England: a cross-government outcomes strategy to save lives.*

The strategy summarises what is known about high-risk groups at a national level, and this insight will be discussed later along with local data reflecting risk characteristics in Suffolk.

The national All Party Parliamentary Group (APPG) on Suicide and Self-Harm Prevention recently published the findings of an inquiry into local suicide prevention plans in England. 5 The inquiry found that many local authorities did not have a suicide prevention action plan – including Suffolk CC. The APPG recommended that each local authority area should have the following in place:

1. **a regular suicide audit to build understanding of the local picture and risk factors,**
2. **a suicide prevention action plan setting out specific actions to reduce risk in the local community, and**
3. **a multi-agency suicide prevention group involving all key statutory agencies and voluntary organisations whose support is required to implement the action plan.**

Public Health England have published extensive guidance on suicide prevention to support local areas in developing their action plans, and this has been extensively used in developing Suffolk's approach. The guidance recommends that local authorities do the following:

1. **Develop a suicide prevention action plan**
2. **Monitor data, trends and hot spots**
3. **Engage with local media**
4. **Work with transport partners to map hot spots**
5. **Work on local priorities to improve mental health**

Our local Suffolk suicide prevention action plan will be developed in consultation with key partners, based on this strategy and the priorities it identifies.

NATIONAL CONTEXT OF WIDER MENTAL HEALTH ISSUES

The national strategy on suicide prevention should be seen in conjunction with the national mental health outcomes strategy and associated implementation framework ("No health without mental health"). *6* Suicide prevention work should also be seen in the context of ongoing emphasis from the Government around 'parity of esteem' between services for physical and mental health, along with an increased recognition of the importance of wellbeing as well as physical health.

The "Five Year Forward View for Mental Health" report in February 2016 from the Government's independent Mental Health Taskforce called on local areas to develop multi-agency suicide prevention plans. It set out three priorities for the NHS to improve the care of people with poor mental health:

1. **A seven day mental health service - people facing a mental health crisis should have access to mental health care seven days a week and 24 hours a day, just as they can access urgent physical health care,**
2. **An integrated mental and physical health approach - mental health support should be made easily available across the NHS, and integrated services should ensure that health checks and programmes such as smoking cessation are made available for everyone with a severe mental illness**
3. **Promoting good mental health and preventing poor mental health – helping people lead better lives as equal citizens.**

The Chief Medical Officer's report for 2013 focused on mental health, making the important observation that mental wellbeing and mental illness should not be seen as part of the same continuum but should be used as distinct concepts. Measures to improve population wellbeing cannot be assumed to reduce rates of mental illness, and it is possible to have a mental illness but still have high levels of subjective well-being. The report also warns against using suicide rates as an outcome measure in mental health services. The report includes an estimate that a single suicide of a working age adult has an economic impact of over £1.6m.

5) All-Party Parliamentary Group on Suicide and Self-Harm Prevention (2015) Inquiry into local suicide prevention plans in England

6) Department of Health (2011) No health without mental health: a cross-government mental health outcomes strategy for people of all ages

LOCAL WORK ON MENTAL HEALTH AND SUICIDE

Suffolk's rates of death by suicide are similar to the overall England rates: in 2012-14 in Suffolk 8.7 people per 100,000 died by suicide each year, compared with 8.9 per 100,000 in England as a whole. Over this time period, 187 people died by suicide in the county (an average of 62.3 per year). *9* More data on suicide deaths in Suffolk is presented in the next section 'Epidemiology of suicide'.

Mental health is high on Suffolk County Council's agenda. Outcome Four of the Health and Wellbeing Strategy is "people in Suffolk have the opportunity to improve their mental health and wellbeing" and the Mental Health Strategy for Suffolk has recently been adopted by the Health and Wellbeing Board. The strategy implementation plan includes an ambition for Suffolk to achieve a reduction in rates of mental illness and self-harm, and zero suicide across the county. It sets out local proposals for improvements in crisis care, and also requires the development of a local suicide prevention strategy and action plan covering the six areas for action outlined in the national strategy (see above). The Mental Health Strategy aims to improve the health of the population as a whole by increasing individual and community resilience and improving mental health services.

Suffolk signed up to the Mental Health Crisis Concordat in May 2014. Key people from across the county signed up to work together to improve care and support for people experiencing a mental health crisis. The organisations are committed to working together to ensure that people with mental health issues are kept safe and given the support they need, regardless of which service they turn to first and whatever their circumstances. The work around the Crisis Concordat will contribute to the reduction of suicides in Suffolk.

The mental health provider trust for the county is the Norfolk and Suffolk NHS Foundation Trust (NSFT). The Trust has a suicide prevention strategy setting out how the Trust will reduce the likelihood of suicide by service users and monitor progress. *10* Their strategy is currently being refreshed and NSFT is working with both Suffolk and Norfolk County Councils to make sure that the local authority plans and Trust strategy are linked. NSFT are developing a pilot scheme with the Samaritans locally where Trust staff identify people who may benefit from a confidential listening service and refer them on to the Samaritans with contact details and information about the best time to call. The Trust also has a regular meeting to review all deaths of Trust patients to identify themes in deaths and ensure organisational learning.

Across the East of England there is an NHS Strategic Clinical Network for Mental Health which previously had a substantial work programme around reducing suicide in the region. The Network initiated a 'Zero Suicide' programme where CCG areas within the region developed programmes aimed at reducing risk of suicide and self-harm and improving care for people using mental health services. *11* The Network includes mainly NHS staff and organisations and is currently supporting CCGs in implementing plans arising from the Mental Health Crisis Concordat.

Efforts to reduce suicide in Suffolk should also be seen in the context of Suffolk's Emotional Wellbeing Transformation Plan for children and young people. East and West Suffolk CCG areas, together with the County Council, have developed a transformation plan for the services and system supporting emotional wellbeing of children and young people in the area.

12 The relevant priorities include developing a single point of access and assessment, improving crisis care, and investing in workforce development. There will also be an annual universal outcome survey for school age children in Suffolk to monitor children's wellbeing and measure improvements. The impact of parental mental health on children is recognised in the work of Suffolk's 'Hidden Harm' steering group. Some of the actions resulting from this strategy will be relevant to children and young people's mental wellbeing and suicide risk, both directly and via improvements in parental mental health. Suffolk County Council's Public Health team are also taking steps to enhance wider community resilience, including an aim to improve wellbeing across the county.

7) Mental Health Taskforce (2016) The five year forward view for mental health.

8) Annual Report of the Chief Medical Officer (2013) Public mental health priorities: investing in the evidence

9) Data from Suicide Prevention Profiles published by Public Health England – see http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

10) Norfolk and Suffolk NHS Foundation Trust (2013) Suicide Prevention Strategy 2013-15.

11) 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.

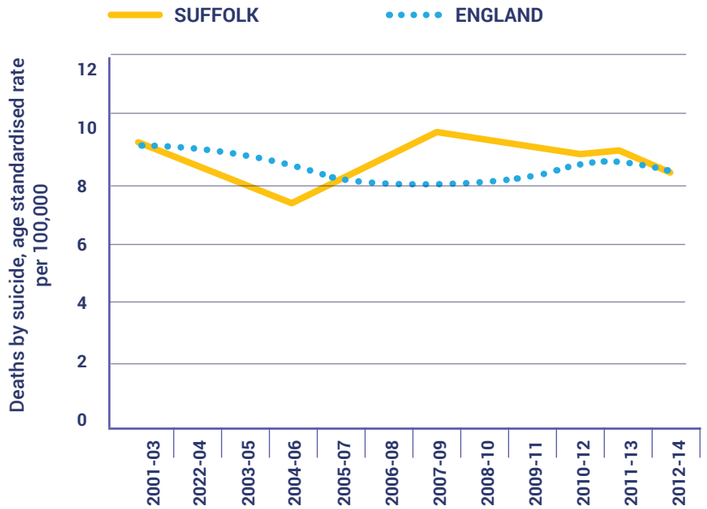
12) There is a separate plan for the Waveney area that is included in the Norfolk transformation plan.

Deaths from suicide are identified from death registrations where the cause is given as from self harm, or from 'event of undetermined intent'.*13* More details on the identification of deaths by suicide can be found in the 'Suicide' chapter of Suffolk's Mental Health JNSA. *14* There will be additional deaths that are not recorded as suicides where the individual has actively contributed to their deaths through their behaviour with some degree of intent.

Although nationally suicide is the most frequent cause of death in men aged 15-49, *15* analysis of the data for Suffolk shows that locally it is in fact the third most frequent cause of death in the county for this group of men. *15*

In the five years from 2010-2014 in Suffolk there were 614 male deaths in this age group; 126 (20.5%) were from cancer, 124 (20.2%) were from accidents, and 107 (17.4%) were from suicide.*16*

Figure 1 shows how rates of suicide in Suffolk (the solid line) compare to national rates (the dotted line) over time. Suicide rates are presented as number of deaths per 100,000 people of all ages, and are given as three-year averages to 'smooth out' variations in the data given the relatively small number of deaths each year. In the most recent years (the three calendar years 2012-14), 187 people in Suffolk died by suicide; an average of 62.3 per year, or 8.7 per 100,000 per year. The rate of suicide in Suffolk is not statistically significantly different from the rate in England as a whole except in one instance where the rate in Suffolk was significantly higher (the peak in 2007-9); it is not known what caused this increase. Rates of death from suicide in Suffolk are also similar to our CIPFA statistical neighbour local authorities (where rates vary from 8.1 to 11.3 per 100,000 in 2012-14). Suffolk rates have remained fairly steady over the period shown in Figure 1, remaining between 7.9 and 10.0 per 100,000. *17*



13) Precise definitions can be found in the 'Definitions' section of the online Suicide Prevention Profiles published by Public Health England – see http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

14) See here: http://www.healthysuffolk.org.uk/joint-strategic-needs-assessment-jsna/reports/NA/MHNA/

15) Mental Health Taskforce (2016) The five year forward view for mental health.

16) Data from the Public Health Mortality Files produced by the Office for National Statistics and made available to local authorities

17) Data from Suicide Prevention Profiles at http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

SUICIDE RATES BY TIME, SEX AND AREA

The overall rate shown in figure 1 hides considerable differences between the rates for men and women in the county. Male suicide rates are nearly three times higher than female rates, and this has been a consistent pattern over the last 15 years in Suffolk and in England as a whole. The latest data gives a rate of 13.1 deaths by suicide per 100,000 men, and for women the rate is 4.5 per 100,000.

The gender differences in suicide are important and need to be considered as part of any strategy to reduce deaths. There have been suggestions that this is due in part to the changing nature of society but records suggest that across England male suicides have been considerably higher than female suicides since the 1860s, with the male to female ratio fluctuating from 4:1 in the 1880s to 1.5:1 in the 1960s. *18*

Figure 2 below shows male and female suicide rates over time for Suffolk and England. Although Suffolk's rate appears higher than the England figures at some points in the graph below, Suffolk's sex-specific rates are not statistically significantly different from the England rates at any point in the period depicted.

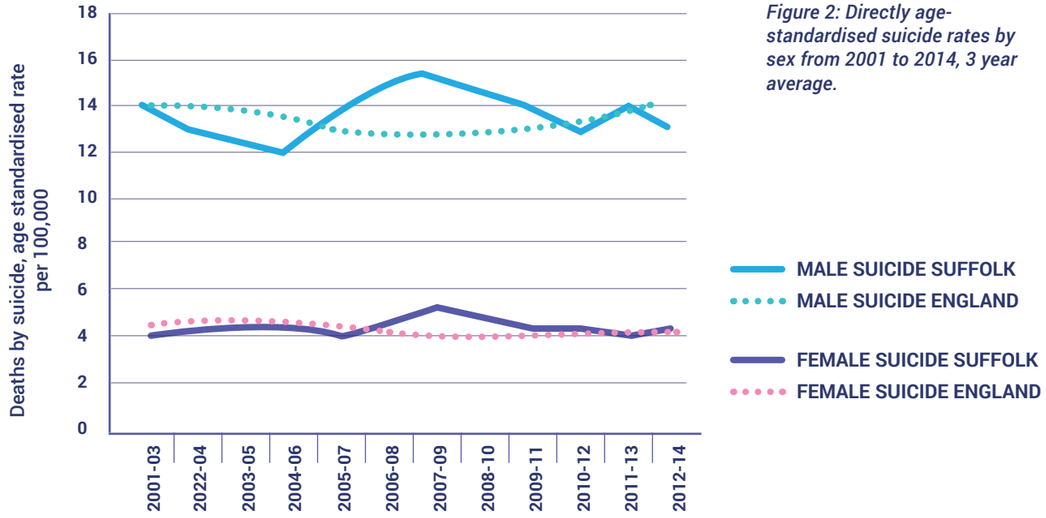


Figure 2: Directly age-standardised suicide rates by sex from 2001 to 2014, 3 year average.

Rates of suicide also vary with age for both men and women in Suffolk and across England. Figure 3a shows that for men in Suffolk the rate of death by suicide climbs from a relatively low rate of deaths in young men aged 15-19 and peaks in the age band 40-44. *19* Deaths from suicide in women are shown in figure 3b and shows rates for the whole of the East of England as numbers in Suffolk are very small once broken down into age bands. *20*

Although nationally suicide is the most frequent cause of deaths in men aged 15-49, in recent years in Suffolk this is not the case.

18) Thomas K and Gunnell D (2010) Suicide in England and Wales 1861-2007: a time-trends analysis. International Journal of Epidemiology, 39, 1464-1475

19) Data from the Public Health Mortality Files produced by the Office for National Statistics and made available to local authorities, combined with mid-year population estimates for 2012.

20) Data from Public Health England's Suicide Prevention Profile http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

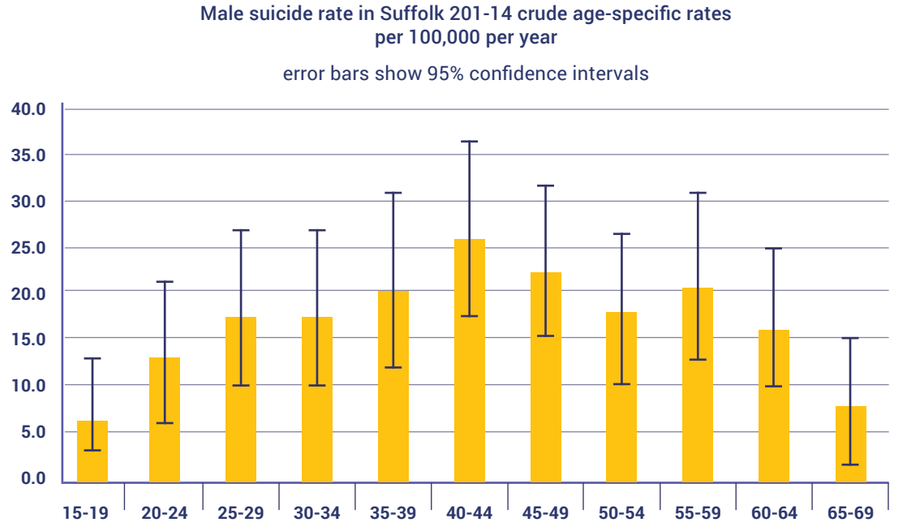


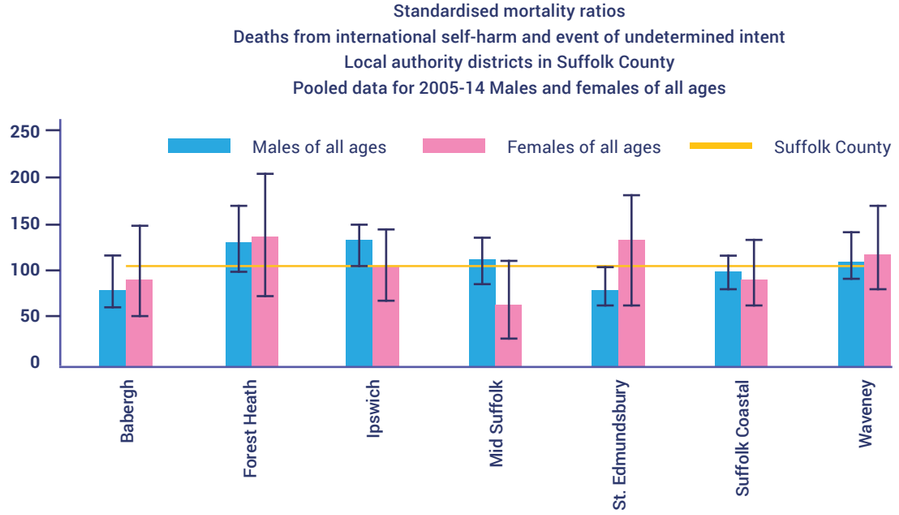
Figure 3a: Crude rates for male mortality from suicide in Suffolk, 2010-14

Deaths from suicide in Suffolk are related to deprivation (as measured by the Index of Multiple Deprivation); wards with higher levels of deprivation are more likely to have a higher rate of deaths from suicide. Figure 4 displays male and female suicide standardised mortality ratios that compare the number of deaths in each local area in Suffolk to the number that would have been expected if the deaths were evenly spread. The relatively low numbers of deaths mean that the confidence intervals around these mortality ratios are wide, and so we cannot say with any statistical confidence that any one district area has significantly more deaths than would be expected for Suffolk. However, St Edmundsbury does have significantly fewer male deaths by suicide than would be expected.

We can also look at how the rates of death by suicide in Suffolk vary by town, and it is notable that over the last ten years, Newmarket appears to have had significantly more deaths by suicide than would be expected for a Suffolk town of that size (roughly twice as many deaths overall). Occupation appears to be a factor in these deaths with a disproportionately high percentage of suicide deaths occurring in people working in occupations relating to the horse racing industry.

These are area-level associations and we also know that at the individual level, lower socio-economic status or unemployment increases the risk of suicide. 21

Figure 4: Standardised mortality ratio for male and female deaths in Suffolk LA districts 2005-14

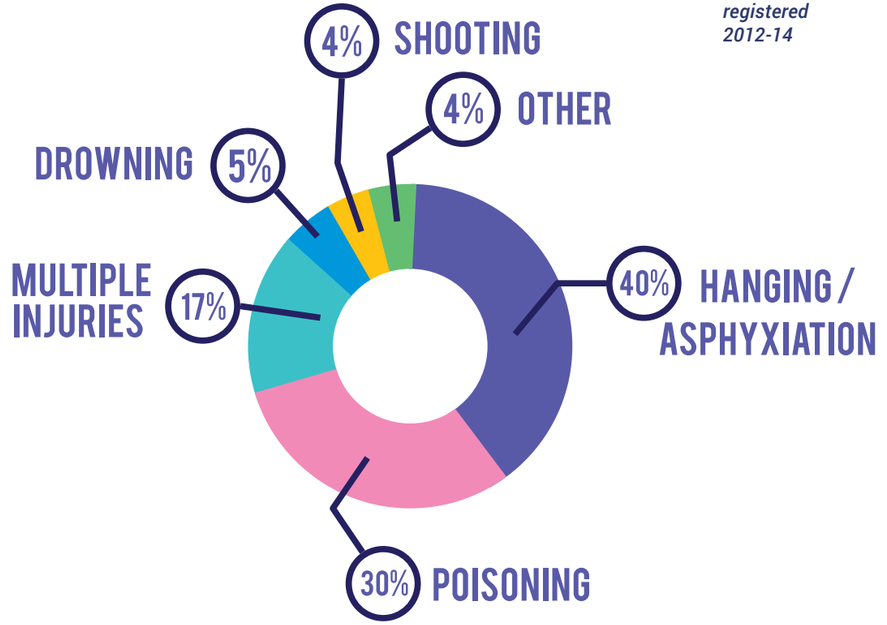


21) Department of Health (2012) Preventing suicide in England: a cross-government outcomes strategy to save lives.

The data that we have on suicide methods in Suffolk comes from the regular 'suicide audit' carried out by the Public Health team. The latest audit reviewed 199 deaths registered between January 2012 and December 2014, following an inquest verdict. Some of these deaths occurred in earlier years. There will also be some deaths which occurred in 2012, 2013 or 2014 that are not included in this data because they were not registered until later (on completion of the coroner's inquest which can take years in complex cases).

The cause of death was given as hanging or asphyxia in 79 inquests. Other causes were poisoning (including carbon monoxide and helium) in 59 deaths, multiple injuries (including deaths on railway lines and falls from the Orwell Bridge) in 33 deaths, and 10 deaths from drowning, 9 from shotgun injuries, and 9 from other causes. The chart below illustrates the causes of death, clearly showing hanging and asphyxiation as the most frequent cause of death.

Figure 5: Cause of death in suicides registered 2012-14



SUICIDE LOCATIONS

Most deaths take place at home. However, of the 199 deaths included in the most recent Suffolk audit, fifty (25%) died elsewhere in incidents involving open water, railway lines, open spaces such as farm or field, and on or near the Orwell Bridge. Several died in hospital after being conveyed there after an episode of self harm or injury elsewhere. In the registrations from 2012-14 included in the audit there were eight deaths at the Orwell Bridge (4% of all deaths from self-harm or undetermined intent), and in the same period there were ten deaths on railway lines (5%).

COUNTRY OF ORIGIN

Examination of the deaths included in the most recent suicide audit report shows a higher than expected death rate among Suffolk residents who were born in some Eastern European countries. Census data shows that around 1% of Suffolk's population were born in Poland, Latvia and Lithuania. However, 7% of Suffolk's suicide deaths in 2012-14 were of people born in these countries.

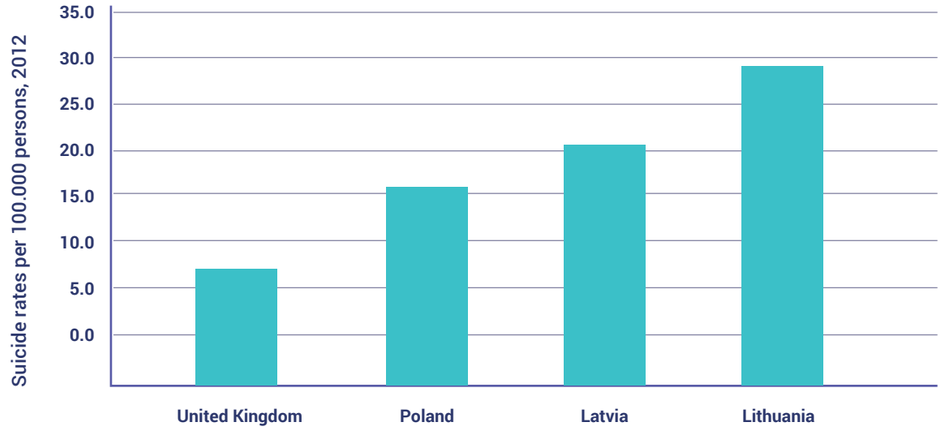
The crude mortality rate from suicide for people born in those countries over the 3 year period was 45 per 100,000 (per person-year), significantly higher than Suffolk as a whole with a crude mortality rate of 8.7 per 100,000.

It seems likely that this is not an issue specific to Suffolk; an increased risk of suicide for men from Lithuania and Poland was also noted in the suicide prevention strategy for Cambridgeshire and Peterborough. Suffolk's audit report also found that the average age at suicide was significantly lower in people born in Poland, Latvia or Lithuania compared to Suffolk as a whole.

The data does not provide an explanation for **why** there is an increased risk for people from certain countries. It may be linked to the social circumstances and disadvantage that many people experience when they migrate. It may also be due in part to cultural differences that people bring with them when they move countries; international statistics show that suicide rates are much higher in these countries of origin than in the UK (Figure 6). *22*

22) OECD data accessed from https://data.oecd.org/healthstat/suicide-rates.htm Please note this shows UK-level data rather than England data, and definitions and recording of suicide may differ across countries

Figure 6: Suicide rates by country, 2012



Complete data is not available to identify how many Suffolk residents who took their own lives were mental health service users. However, there is some data gathered from a review of a small number of GP records for people who died by suicide between January 2010 and March 2011. This considers 46 GP records and found that 29 (63%) had a record of a mental illness that had been treated by the GP, and five (11%) had seen their GP in the month before death. Twenty-two people (47%) had a record of some input from secondary mental health care (the time frame for this was not clear) with nine , or 20%, being seen by secondary mental health care in the month before death. Six people (13%) had a record of a long term medical condition, and 10 (22%) had an alcohol or substance misuse problem noted in their GP record. *23* We should be careful not to over-interpret these findings as the exercise looked at a small number of GP notes and relates to deaths from five or six years ago, but it does suggest that people who died by suicide in Suffolk were likely to have some form of recognised mental distress and/or a substance misuse problem.

More data is available on health care use and suicide from a national perspective, presented overleaf.

23) These numbers add to more than 100% as many people had more than one of these factors.

Data presented above has highlighted the increased risk of suicide in men and in people in the 35-64 age group, and highlighted Eastern Europeans as being of particular local concern. There is also much useful information from national work about additional risk factors that should inform Suffolk's strategy.

SUICIDE AND HEALTH CARE

There is a regular review of suicide by people known to mental health services: the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. *24* The Inquiry report refers to 'patient suicides' as those that occur within 12 months of mental health service contact. The most recent report covers the period 2003-2011 and found that during that period, across England, 28% of all suicides were identified as patient suicides. The report found that, since 2006, male patient suicides have risen in number by 34%, whereas the general population rise in numbers of suicide deaths over that period has been 15%. However, this rise is in absolute numbers of deaths rather than rates. In fact rates of suicide by mental health service users have been declining since 2004, from 118 per 100,000 service users in 2004 to 87 per 100,000 service users in 2013.

Patient suicide methods were most likely to be hanging, as in the wider population (42%) followed by poisoning (26%) and multiple injuries (15%). 17% of patient suicides had a primary diagnosis of schizophrenia and 9% had a primary diagnosis of personality disorder. 45% of patients who died by suicide had a history of alcohol misuse, and 32% had a history of drug misuse. Nine per cent of patient deaths by suicide were of people who were inpatients at the time.

OCCUPATION

The England National Strategy identifies occupational groups at particularly high risk of suicide. Nurses, doctors, farmers / agricultural workers and veterinary workers are at higher risk – the national strategy speculates that this may be partly due to ready access to the means of suicide and knowledge of how to use them. *25*
Data on occupation is available for suicide deaths in Suffolk but has not yet been analysed for this report.

OTHER RISK FACTORS

A higher risk of suicide is associated with a history of self-harm. At least half of people who take their own life have a history of self-harm, and one in four have been treated for self-harm in hospital in the past year. The risk of suicide is highest in people who repeatedly self-harm and who have used violent or dangerous methods. *26*
We do not know the history of self-harm in Suffolk residents who have died by suicide.

People in contact with the criminal justice system also have a higher risk of suicide than the general population. People are at highest risk in their first week of imprisonment. The suicide rate for prisoners in England was 69 deaths per 100,000 prisoners in 2009-11 *27* (compared with 13.2 per 100,000 males for England as a whole in that time period). Suffolk has three prisons (Hollesley Bay, Warren Hill, and Highpoint) and in 2014 there were three self-inflicted deaths (all at Highpoint). *28* No data was available for suicide in other forms of custody in Suffolk. Prison health, including mental health, is the responsibility of NHS England rather than Suffolk clinical commissioning groups or Suffolk County Council.

We should also recognise that other factors and life experiences may place individuals at higher risk of suicide, including:

- chronic pain or disability,
- job loss and unemployment leading to socio-economic disadvantage,
- family breakdown and relationship conflict,
- financial difficulties, and social isolation.

Receiving a diagnosis of a long term health condition, particularly cancer, is associated with a higher risk of suicide. The abuse of drugs or alcohol is strongly associated with suicide risk, particularly in individuals who also experience poor mental health (known as dual diagnosis). A combination of multiple factors is likely to increase suicide risk. Other groups of people who may have higher rates of mental ill-health (although detailed data on suicide rates is lacking) include survivors of abuse or violence, members of minority ethnic groups, and children who are especially vulnerable such as looked after children, care leavers, and children in the youth justice system. *29* Gay men and lesbians are at increased risk of suicide; 3% of gay men and 5% of lesbian or bisexual women say they have attempted to take their own life in the last year. *30*

Deaths from suicide are less common among armed forces veterans than in the general population, apart from in young leavers in their early 20s who may have an increased risk of suicide compared to their peers. *31*

From a psychological perspective, several factors increase the risk of suicidal behaviour: excessive self-criticism, rumination, an inability to generate positive future thoughts, and feelings of entrapment combined with reduced social/emotional problem-solving ability leading to strong feelings of hopelessness. *32*

ESTIMATES OF THE INCREASED RISK OF SUICIDE IN DIFFERENT GROUPS

This data is taken from the suicide prevention strategy for Cambridgeshire and Peterborough.

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

25) Department of Health (2012) Preventing suicide in England: a cross-government outcomes strategy to save lives.

26) Department of Health (2012) as above

27) Department of Health (2012) as above

28) Data from http://www.howardleague.org/suicide-in-prison/

29) Department of Health (2012) as above

30) Stonewall (2012) Mental health: Stonewall health briefing

31) Department of Health (2012) as above

32) Samaritans (2012) Men, suicide and society; why disadvantaged men in mid-life die by suicide.

Table 1: Estimated increased risk of death by suicide by characteristics

GROUP	ESTIMATED INCREASED RISK
Patients in the four weeks following discharge from a psychiatric hospital	X 100 – 200
People who have deliberately self-harmed in the past	X10 – 30
Drug misusers	X 10 – 20
Current or ex-psychiatric patients	X 10
Prisoners and offenders serving non-custodial sentences	X 8 – 13
Alcohol misusers	X 5 -10
Socio-economically deprived (social class IV/V)	X 4
Family history of suicide	X 3 – 4
Unemployed people	X 2 -3
Males (compared to females)	X 2 – 3
Doctors	X 2
Farmers	X 2

PRIORITIES FOR SUICIDE PREVENTION IN SUFFOLK.

The data on suicide deaths informs the first two priorities for Suffolk's suicide prevention strategy:

1. We need to ensure that our actions reduce suicide risk for everyone in Suffolk, particularly social groups at higher risk. Most deaths by suicide occur in people who have not been in contact with mental health services in the last year, and we need to look at the whole population. Our information about which groups of people in Suffolk are at increased risk due to their demographic characteristics tells us these groups are:

   - men, particularly those in mid-life and who are less well-off,
   - people who are known to be depressed,
   - people who misuse drugs and alcohol,
   - people who were born in Eastern Europe.

2. Although it is important to think about everyone in Suffolk, we also know that there are a smaller number of people who are at very high risk of suicide due to severe mental distress, and who are in touch with mental health services. This includes people who have made serious attempts on their own lives in the past, and people who have been recently discharged from inpatient psychiatric care. We also need to make changes designed to prevent suicides in this group of people as they are at such high risk.

SUICIDE IN CHILDREN AND YOUNG ADULTS

Deaths by suicide in children and young people are thankfully rare in Suffolk, although these cases are more likely to receive media coverage. Data for the five most recent years (2010 to 2014) identify eight deaths in people aged 15-19 and 18 deaths in people aged 20-24. Twenty of these 26 deaths were in males (77%). *34* Across England, the suicide rate in teenagers is lower than that in the general population, although self-harm is more common.

34) Data from the Public Health Mortality Files produced by the Office for National Statistics and made available to local authorities.

Data and soft intelligence has not identified any suicide clusters in Suffolk but the possibility should not be ignored. The guidance from Public Health England states: 'The term "suicide cluster" describes a situation in which more suicides than expected occur in terms of time, place, or both. A suicide cluster usually includes three or more deaths; however, two suicides occurring in a specific community or setting and time period should also be taken very seriously in terms of possible links (or contagion), particularly in the case of young people. It is important to establish at a very early stage if there are connections between them.' *35*

The guidance also describes particular groups as being especially vulnerable to clusters / contagion: young people, people with mental health conditions, and prisoners. People who identify psychologically with individuals who have taken their own lives may be affected by contagion, especially if they are already vulnerable. The guidance suggests that the media's role is very important in prompting the development of suicide clusters.

However, it could be considered that suicides by falling from the Orwell Bridge form a cluster, given the number of deaths in one location, and the public and media perception of the bridge as a suicide 'hotspot'.

The Public Health England guidance states that local authority suicide prevention plans should include a suicide surveillance group to identify possible clusters, and a community action plan for responding to clusters. At present Suffolk does not have either of these.

35) Public Health England (2015) Identifying and responding to suicide clusters and contagion: a practice source.

SUICIDE ATTEMPTS

Data on suicide attempts (also referred to sometimes as 'unsuccessful', 'uncompleted' or 'failed' suicide) is hard to come by. On a national level, the 2007 Psychiatric Morbidity Survey found that 5.6% of adults reported attempting suicide at some point in their lives, and it is interesting to note the sex differences in attempts. Contrary to the pattern of deaths from suicides, women are more likely to report previous attempts than men; 7% of women said they had attempted suicide compared with 4% of men. *36*

Admissions and attendance at hospital for self-harm is recorded but this will result from a wide range of actions, many of which were not intended to cause death. There is some information available on police attendance at the Orwell Bridge which recorded 26 police attendances to the bridge due to suspected suicide attempts, *37* and five completed suicides, over a period of one year and two weeks in late 2013 and 2014.

Gathering additional data on suicide attempts may help improve our understanding of risk factors, suicide clusters, and preventive measures. It may also be useful in lowering the risk of people at highest risk of suicide if we can ensure that they are properly identified and followed up after an attempt.

36) Annual Report of the Chief Medical Officer (2013) Public mental health priorities: investing in the evidence

37) The analysis defined attempted suicides as incidents where the subject was observed to have actively made an attempt at suicide i.e. climbing, sitting or standing on the parapet of the Orwell Bridge, as opposed to behaviour that has been interpreted as a potential attempt at suicide, for example, an individual peering over the parapet.

BEREAVEMENT BY SUICIDE

The family and friends of someone who dies by suicide are at increased risk of poor mental health and emotional distress. *38* Partners bereaved by suicide are at an increased risk of suicide themselves, as are mothers who lose an adult child to suicide. Children bereaved by a parent's suicide are at increased risk of depression, alcohol or drug misuse, PTSD, and their own risk of suicide is increased. *39,40* These risks are additional to the risks associated with bereavement from non-suicide deaths. The evidence suggests that specialist bereavement counselling and support can be helpful for people, although the efficacy has not been well demonstrated to date. *41*

The national charity Survivors of Bereavement by Suicide (SOBS) explains how bereavement from suicide is different to other types of loss.*42* Suicide deaths are usually sudden and often unexpected, sometimes violent. Emotional reactions to suicide are likely to be more complicated than to other causes of death, and the bereaved may experience symptoms of post-traumatic stress. The social and cultural stigma around suicide may prevent people from seeking the help and support they need, and others may not offer the support they would for bereavement after other causes of death. There is a lack of privacy around suicide deaths due to the necessity of a coroner's investigation, and there may be media interest as well.

Suicide can also have considerable impacts on many others, including neighbours, work colleagues, and also professionals such as healthcare professionals and emergency workers. Survey data suggests that around 60 people are affected by each suicide death, including close and extended family and friends, colleagues and classmates. *43* Suffolk sees around 62 deaths from suicide each year so this implies that within the county each year around 3,700 people are affected by a suicide death, although clearly the nature and impact of this effect will vary and not all of these people will need additional support.

Within Suffolk, specialist support for suicide bereavement is offered by the Suffolk branch of the charity, SOBS.

38) Department of Health (2012) Preventing suicide in England: a cross-government outcomes strategy to save lives.

39) Penny A and Stubbs D (2015) Bereavement in childhood; what do we know in 2015? Childhood Bereavement Network.

40) Pitman, A., Osborn, D., King, M., & Erlangsen, A. (2014). Suicide 3 Effects of suicide bereavement on mental health and suicide risk. The Lancet Psychiatry, 1(1), 86–94

41) Department of Health (2012) Preventing suicide in England: a cross-government outcomes strategy to save lives.

42) http://uk-sobs.org.uk/for-professionals/how-suicide-bereavement-is-different/

43) Pitman, A et al (2014) as above

EFFECTIVE PREVENTION OF SUICIDE

An awareness of the evidence around effective suicide prevention is important to inform this strategy and the development of the action plan.

The 'Detroit' example is often mentioned in discussions of suicide prevention. 'Perfect' depression care is the aim of the 'zero suicide' approach taken in Detroit, USA.
The programme is aimed at people enrolled in a health insurance plan accepted by the Henry Ford Health System. It screens people for depression when they attend primary care and then ensures patients receive care as appropriate – medication, individual or group therapy, or hospitalisation.
The program did achieve zero suicides in one year in people who were being actively treated for depression or substance abuse; it is no longer zero but is substantially lower than the starting point.

However, it is important to note that this is not a success story about the general population; the results were seen in a group of people who were able to obtain health insurance *44* and who screened positive for depression after a visit to primary care and were subsequently treated. However, there is certainly something to be learned here around improving identification of depression and subsequent care.

Time constraints prevented a full original systematic review of the evidence but there are several relevant recent publications. The information below is drawn from a publication from the World Health Organization *45* and a recent systematic review published in the Lancet Psychiatry. *46* Additional information also comes from the England national strategy on suicide prevention. *47* Evaluating suicide prevention approaches is challenging because suicide is a rare outcome that is affected by many factors, and research often relies on 'proxy' outcomes that are more common, such as suicidal ideation.

RESTRICTING ACCESS TO MEANS

The introduction of firearm control legislation is associated with reduced suicides in some countries. Legislation requiring smaller packets of over-the-counter painkillers has been effective in reducing deaths by suicide in the UK. At sites which have become frequently-used locations for death by jumping, the introduction of barriers is useful and there is little evidence that people substitute this location by jumping from other sites. Restricting the ease of charcoal purchasing may also reduce suicides by carbon monoxide poisoning through charcoal burning, but this is supported by just one study.

PSYCHIATRIC MEDICATION

Evidence from randomised controlled trials shows that lithium is effective in reducing suicide risk in people with mood disorders. Although antidepressants may increase suicidal thoughts, overall there appears to be a benefit for reducing suicide risk in depression. Ketamine and electroconvulsive therapy may also be promising in reducing suicidal thoughts and risk in severe depression but the evidence for this is of lower quality.

THERAPY

Cognitive therapy such as CBT appears to be useful in reducing suicidal ideation and behaviour. Problem-solving interventions appear to reduce self-harm

FOLLOW-UP FOR ATTEMPTED SUICIDE

There is good evidence that the follow-up of people who attempt suicide is effective at reducing future risk.

AWARENESS PROGRAMMES

Evidence from randomised controlled trials suggests that school-based programmes can improve knowledge and attitudes, as well as reducing attempts and ideation. Awareness campaigns directed at the general public may increase calls to helplines but the evidence is lacking regarding whether such campaigns reduce suicide deaths.

PRIMARY CARE EDUCATION AND 'GATEKEEPER' TRAINING

Educating GPs around depression recognition and treatment is an effective intervention to lower suicide rates. 'Gatekeeper' training refers to education aimed at people who are in a position to identify and refer people at risk of suicide – this may include teachers, caseworkers, police, or anyone in a position of trust. Training these people may be effective if there are clear pathways to further support and treatment, although evaluation is difficult as such programmes are usually implemented with other initiatives.

MEDIA REPORTING

Improving the quality of reporting on suicide, or media blackouts, have both been associated with decreased suicidal behaviour

44) 16% of US working-age adults (18-64) have no health insurance coverage. http://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201506.pdf

45) World Health Organization (2012) HEN synthesis report: For which strategies of suicide prevention is there evidence of effectiveness?

46) Zalsman, G., Hawton, K., Wasserman, D., van Heeringen, K., Arensman, E., Sarchiapone, M., Zohar, J. (2016). Suicide prevention strategies revisited: 10-year systematic review. The Lancet Psychiatry

47) Department of Health (2012) Preventing suicide in England: a cross-government outcomes strategy to save lives.

NEXT STEPS FOR SUICIDE PREVENTION IN SUFFOLK

PRIORITIES FOR SUICIDE PREVENTION IN SUFFOLK (CONTINUED).

3. We will set up a suicide prevention 'strategic group' with representatives from organisations that are most influential in suicide prevention across Suffolk. The group will agree a medium-term target for reducing the suicide rate and will produce an action plan to achieve this. The group will learn from what works to develop new ways to reduce Suffolk's suicide rate further in future years, to as close to zero as possible. This group will report to the Joint Commissioning Group on Mental Health and Learning Disability who will monitor and support their work and progress. The organisations represented in this strategic group will need a clear statement of support from their leaders recognising the necessity of tackling suicide deaths in Suffolk.

4. At present there is little information about suicide deaths apart from information from death registrations and reports from the Coroner. Information on attempted suicide is very poor. We need to gather more information and in a more up-to-date way so that we understand more about suicide deaths and attempts locally, and this will help the suicide prevention strategic group to see what prevention efforts are working well and will help us to decide if we need to change our approach.

5. To work with key stakeholder organisations, service users and people bereaved by suicide, to ensure that the action plan is feasible and can be implemented, to ensure that it is supported by stakeholders, and that it is likely to be effective.

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Health and Wellbeing SUFFOLK

Suffolk County Council