The national context and guidance on local plans

The national context

The **National Suicide Prevention Strategy** published in 2012 outlined two objectives: to reduce the suicide rate in the general population in England and better support for those bereaved or affected by suicide.

It called for a partnership approach to implement action in six areas:

1) Reduce the risk of suicide in key high risk groups: young and middle-aged men; people in the care of mental health services, people with a history of self-harm; people in contact with the criminal justice system and specific occupational groups such as doctors, nurses and agricultural workers.
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.

The **All-Party Parliamentary Group on Suicide and Self Harm** (2013) recommended local action to deliver the national strategy is implemented through the establishment of a multi-agency suicide prevention group, completion of a suicide audit and the development of a suicide prevention strategy or plan based on the national strategy and local data.

The **NHS England Five Year Forward View for Mental Health** sets an ambition to reduce suicides by 10% by 2021 and calls upon CCGs to support the development and delivery of local multi-agency suicide prevention plans. From 2018/19, 25m of funding over 3 years will be allocated to CCGs to support this.

The **House of Commons Health Committee** (2017) published a series of recommendations as a result of their inquiry into action on suicide prevention. In January 2017, the Government responded to these recommendations in the 3rd progress report of the cross-government strategy on suicide prevention which committed to strengthening action in the following areas:

- Better and more consistent local planning and action by ensuring that every local area has a multi-agency suicide prevention plan by 2017, with agreed priorities and actions;
- Better targeting of suicide prevention and help seeking in high risk groups such as middle-aged men, those in places of custody/detention or in contact with the criminal justice system and with mental health services;
- Improving data at national and local level and how this data is used to help take action and target efforts more accurately;
- Improving responses to bereavement by suicide and support services; and
- Expanding the scope of the National Strategy to include self-harm prevention in its own right.

Progress on preventing suicide is measured through the **Public Health Outcomes Framework** and the **NHS Outcomes framework** which includes a number of indicators specific to suicide as well as a range of indicators likely to impact on suicide. An overview of how Surrey compares against England and the South East Region is provided in section 3.

National evidence and guidance on the development of local plans

Risk factors for suicide are broad and reducing them involves a wide range of agencies. The World Health Organisation presented a number of risk factors for suicide such as: barriers to accessing health care; access to means; inappropriate media reporting; stigma associated with help-seeking behaviour; trauma or abuse; social isolation; relationship conflict or loss; a previous suicide attempt; being diagnosed with a mental health condition; alcohol abuse; financial loss; chronic pain and a family history of suicide (World Health Organisation, 2014). The prevention of suicide, therefore, requires a multi-agency response involving the NHS; community and acute mental health providers; county; district and borough councils; the police; transport and the voluntary sector.

The evidence of effective interventions and national guidance provides the rationale for action to:

- support people with existing mental health illness; reduce access to methods of suicide;
- collect and share data on attempted and suspected suicides in a timely fashion;
- identify and respond to those vulnerable to suicides who are both within and outside of health services and
- to support those bereaved by suicide.

This evidence is summarised below:

Good practice for mental health providers and the NHS

The NHS and mental health services have an important role to play in identifying and responding to suicide risk. People with poor mental health and wellbeing present at many different services. Lower patient suicide is associated with specialised community teams; lower non-medical staff turnover; implementation of National Institute for Health and Care Excellence (NICE) guidance on depression; and implementation of recommendations made by the National Confidential Inquiry into Suicide and Homicide (NCISH) in particular 24 hour crisis care.

The Zero Suicide approach is a US model based on the concept that suicides in health and behavioural care settings are not inevitable. The approach is recommended by national guidelines and employs strong leadership, training and a data-focused quality improvement approach. A number of areas in England have adopted this approach and it includes activities such as personalised safety plans for service users with a history of self-harm, rapid post-suicide reviews and suicide prevention training.

Effective support for people with coexisting severe mental illness and substance misuse

A history of drugs and / or alcohol use are recorded in 54% of all suicides in people experiencing mental health problems (University of Manchester, 2016). NICE guidance (NG58) identifies that outcomes for people with psychosis and coexisting substance misuse is worse than for people without coexisting substance misuse, partly because the substances used may exacerbate the psychosis and partly because substances often interfere with pharmacological or psychological treatment. Public Health England (PHE) guidance (2017) “Better care for People with co-occurring mental health and alcohol/drug use conditions” supplements NG 58. The guidance provides support for local commissioning and delivery of evidence based pathways of care for people with co-occurring alcohol and/or drug misuse with mental health issues.

Community based approaches

National guidance "Local suicide prevention planning: A practice resource" (PHE, 2016) recommends awareness campaigns to improve mental health and to reduce stigma; signposting and fast-track into effective mental health treatment; and training for primary care doctors in recognising and treating depression.

Tackling high frequency locations

There are four main approaches to tackling suicide in locations where there has been a number of completed suicides:

1) restricting access to means (e.g. through installation of physical barriers);
2) encouraging help-seeking (by placement of signs and telephones);
3) increasing the likelihood of intervention by a third party (through surveillance and staff training) and
4) responsible media reporting of suicides.

There is an evidenced link between media reporting of suicide and imitative suicidal behaviour (PHE, 2016) and therefore local and national action to support the media to respond sensitively to suicide and suicidal behaviour can reduce suicide.

Bereavement support

There is a growing evidence base (PHE, 2016) that individuals and communities need support following suicides to reduce the risk of adverse impacts such as poor social and occupational functioning, depression and suicide. Access to bereavement support and information is cited as an important intervention.

Preventing and responding to self-harm

Whilst the vast majority of people who self-harm do not have suicidal ideation, there is a strong association between attempted suicide, self-harm and completed suicide. One study, concluded that 20-25% of suicides had presented at hospital admission for self-harm in the year previous to death (Foster, 1997).

It is therefore, important to ensure effective follow-up and care through the implementation of NICE standards and pathways for managing people who self-harm.

Economic support services

Suicide, particularly among men, is associated with a lower socio-economic position and unemployment. Almost a third of suicides in Surrey during 2012 and 2013 cited financial problems as a contributory factor. Therefore, working collaboratively with the voluntary sector such as Citizens Advice and the housing associations to train staff in suicide awareness and provide and promote financial support is recommended (PHE, 2016).

Understanding suicides

National guidance urges local suicide prevention groups to collect and analyse suicide data to understand who is at risk and changes in suicide over time to inform action and to monitor and review progress. A number of data sets are available nationally, and it is recommended that this is supplemented by local data from, for example, auditing coroner's suicide reports; sharing learning from Serious Untoward Incidents and monitoring attempted suicides and incidence of serious self-harm.

Appendix 1

Surrey suicide prevention strategy group 2014- 2017
TERMS OF REFERENCE

INTRODUCTION

Between January 2010- December 2011 there were 169 suicides in Surrey; an average of 84 suicides a year. Therefore reducing suicides in Surrey is important.

A new suicide prevention strategy needs to be developed to address this and will aim to reduce suicides and attempted suicides in Surrey. This will be overseen by a new Suicide Prevention Group which is a subgroup of the Emotional Wellbeing and Mental Health Partnership Board.

1. MEMBERSHIP AND PARTNERSHIP RESPONSIBILITY

Membership of the group:

Senior clinicians- CCG leads	Community connections
Commissioners	CAB
Surrey and Borders Partnership NHS Foundation Trust (SABP)	Acute Trusts
Surrey Police	SEC Ambulance trust
Surrey Prisons	Public Health
Surrey University	Virgin Care
Public Health England	First Steps
Virgin Care	IAPT
CAMHS	Safe Havens
Combat Stress	Substance misuse services
Adult social care	Diocese of Guildford
East Surrey Domestic Abuse Service (ESDAS)	Samaritans
Probation	Community connections
Network Rail representative	

Members are asked to attend four meetings a year. All members are asked to provide a brief quarterly update about suicide prevention activities in their organisations at the suicide prevention strategy group. If members are unable to attend and cannot send a representative to the meetings an update should be sent to nanu.chumber@surreycc.gov.uk and this will be included in the minutes of the meeting.

2. AIMS & OBJECTIVES

- Deliver the suicide prevention plan
- Oversee the development of the suicide prevention strategy

- Improve local data on suicide and attempted suicides
- Monitor and 'RAG' rate progress of the strategy every year
- Evaluate the action plan

3. ORGANISATION OF THE GROUP

The suicide prevention strategy group will be chaired by the Surrey County Council Public Health Team. Administrative support to the Group will be provided by Public Health Team. Meetings will be properly minuted and minutes circulated to all participants and nominated others. All members of the group should send agenda items to the public health team two weeks before the meeting.
Meetings will be held bi-monthly for the first four months. There after meeting will be every quarter.
Every quarter specific projects will be invited to present a project update to the group.

The group may delegate sub-groups for specific pieces of work or may delegate to other groups. Specific terms of reference will be established for any new groups and aims and objectives decided for any specific projects

The suicide prevention strategy group may invite representatives from other organisations to attend specific meetings

4. AGENDA ITEMS

The following items will be standing agenda items

- Suicide audit
- Attempted suicide data
- Any subgroups

Members are asked to email agenda items to the meeting coordinator a fortnight before the meeting.

5. ACCOUNTABILITY

- The SPSG will report to the EWMH Partnership Board every quarter
- The SPSG will write an annual progress report. This should be shared will all partners' senior management teams
- The SPSG may organise stakeholder events to consult about its work programme.
- The SPSG will seek regular feedback from service users to gain their views and evaluate the effectiveness of interventions

6. LINKS WITH EXISTING STRUCTURES

Where necessary the SPSG will develop links to other local organisations not listed in the membership.

7. Confidentiality

All members of the group must maintain confidentiality when sensitive data and information is shared.

Data and information from the suicide audit must not be shared until it has been signed off by the group.

8. ARBITRATION

In the event of serious disagreement between the group members the Partnership Board will intervene to resolve the issues.

Appendix 2:

Appropriate Language

1. Suicide numbers are low. Why is it a concern
    - One suicide is one too many
    - Every suicide is preventable
    - For every one suicide there are 6 people intimately affected
    - Suicide affects whole communities

2. Language/ Phases we don't use

Don't use	Use
Committed suicide or successful suicide	Completed suicide or death by suicide
Suicide hotspot or suicide cluster	There has been a number of completed suicides in a location
Unsuccessful suicide	Attempted suicide
Suicide craze	NA
Suicide tourist	NA
Cry for help or attention seeking	NA
Suicide victim	• If family member or significant other: *Bereaved by suicide* • If individual: *completed suicide*

3. Suicide methods:
    - We avoid going into too much detail about suicide methods.

4. Samaritans quick guidance: https://www.samaritans.org/sites/default/files/kcfinder/files/press/10%20things%20to%20remember%20when%20reporting%20suicide.pdf