Report of Director of People and
Director of Public Health

Decision to be taken after:
1 December 2015

NORTH LINCOLNSHIRE COUNCIL

ADULT SERVICES, CHILDREN'S SERVICES AND DEPUTY LEADER INCLUDING REGENERATION AND HEALTH AND STRATEGIC PROJECTS CABINET MEMBERS

NORTH LINCOLNSHIRE SUICIDE PREVENTION STRATEGY

1. OBJECT AND KEY POINTS IN THIS REPORT

To request that Cabinet Members endorse and support the publication and implementation of the North Lincolnshire Suicide Prevention Strategy

2. BACKGROUND INFORMATION

2.1 The Health and Social Care Act 2012 transferred Public Health responsibilities from the NHS to the Local Authority and the Director of Public Health has responsibility for local health improvement and reducing health inequalities. This includes championing mental health including suicide prevention

2.2 Suicide prevention subsequently became a Local Authority led initiative working closely with the Police; Clinical Commissioning Groups (CCGs), NHS England, Coroners and the Voluntary Sector

2.3 The North Lincolnshire Suicide Prevention Strategy reflects the latest national information, evidence and guidance on improving mental health and preventing suicide for the population. The strategy responds to the national suicide prevention strategy 'Preventing Suicide in England' (2012) (Department of Health) which sets out shared objectives for suicide prevention and six key areas for action:

National Strategy Key Objectives and Actions

- Reduce the suicide rate in the general population of England
- Offer better support for those bereaved or those affected by suicide

In order to support suicide prevention, six key areas for action have been identified at a national level:

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.

2.4 The local strategy and an associated action plan have been developed. The local priority actions that form the action plan are:-

Priority Action 1 – Reduce the rise of suicide in key high risk groups (SPECIALIST)

- Identification of high risk groups in North Lincolnshire
- Understand current service provision
- Identify and address any gaps in provision

Priority Action 2 – Tailor approaches to improve mental health in specific groups (TARGETED)

- Consultation with people in high risk groups to understand what would make a difference
- Evidence based and research informed practice

Priority Action 3 – Reduce access to the means of suicide (TARGETED)

- Better understand methods of suicide in North Lincolnshire
- Locally and regionally strangulation has been identified as the main method of suicide.

Priority Action 4 – Provide better information and support to those bereaved or affected by suicide (SPECIALIST)

- Identify current resources for post intervention (support for those bereaved of affected by suicide)
- Understand service availability and accessibility
- Shape and strengthen local postvention services - consultation with those who are bereaved or affected by suicide.

Priority Action 5 – Support the media in delivering sensitive approaches to suicide and suicidal behaviour (UNIVERSAL)

- Adopt good practice from experts in the sector, e.g. Samaritans
- Confirm the key positive messages regarding emotional health and well being

Priority Action 6 – Support research, data collection and monitoring (UNIVERSAL)

- Establish the Suicide Overview and Audit Panel
- Receive intelligence reports from SOAP on trends and issues

3. OPTIONS FOR CONSIDERATION

3.1 To endorse the Suicide Prevention Strategy and support its publication and implementation

4. ANALYSIS OF OPTIONS

4.1 The strategy demonstrates the local commitment to suicide prevention and supports delivery against the Department of Health strategy ‘Preventing Suicide in England’ (2012).

4.2 Suicide prevention forms part of the local authority’s public health responsibilities and the strategy supports the recommendations made in the Director of Public Health Annual Report 2014-15.

5. RESOURCE IMPLICATIONS (FINANCIAL, STAFFING, PROPERTY, IT)

5.1 Finances

5.1.1 Implementation of the strategy will be met from within existing resources

5.1.2 Awareness regarding suicide prevention and the Suicide Prevention Strategy will be supported by a Conference in the New Year. Some funding has been set aside for this, and additional contributions are being sought from partner agencies.

5.2 Staffing

5.2.1 The action plan identifies the need to raise awareness of death by suicide across the workforce and to increase staff members' awareness and confidence in managing this sensitive issue.

6. OUTCOMES OF INTEGRATED IMPACT ASSESSMENT IF APPLICABLE

6.1 The Integrated Impact Assessment indicated that this strategy contributes positively to all the protected characteristics. There is specific relevance for high risk groups included within the following;

- across the life stages
- to both male and female residents
- disabilities and long term conditions,
- gender

6.2 Additionally the strategy highlights the need for support and tailored interventions for a range of higher risk groups including;

- People recently discharged from in patient mental health services
- People who have experienced loss (family break up, death, suicide, unemployment,)
  People who are vulnerable because of poverty or debt problems

7. OUTCOMES OF CONSULTATION AND CONFLICTS OF INTERESTS DECLARED

7.1 The Suicide Prevention Strategy was developed in partnership with the multi-agency Suicide Prevention Group. The draft strategy was presented to the Children and Young People's Partnership and the Adult Partnership as part of the consultation process. The draft strategy was shared with specialist voluntary sector colleagues including The Samaritans, SOBS(a voluntary sector group working with people affected by suicide) MIND and ReThink. Comments and advice received have been incorporated into the final version. No conflicts of interest were identified

8. RECOMMENDATIONS

8.1 That Cabinet Members endorse the Suicide Prevention Strategy and support its publication and implementation

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Date: 13.10.2015



NORTH LINCOLNSHIRE HEALTH AND WELLBEING BOARD
Integrated Working For Better Outcomes

North Lincolnshire

Suicide Prevention Strategy

2015-2018

DRAFT

Safeguard and protect	**Close the gaps**	**Raise aspirations**
Prevention of early deaths	**Enhance mental wellbeing**	**Support independent living**

CONTENTS

FOREWORD

Welcome to North Lincolnshire's first Suicide Prevention Strategy. This strategy sets out our partnership commitment and action to reduce suicide.

Every suicide is a tragedy that has a far reaching impact on individuals, family, friends and the community long after a person has died. This strategy aims to make suicide prevention everyone's business in order to reduce the incidence of suicide locally.

The strategy has considered national learning and also builds on practice, experience and expertise within North Lincolnshire.

The strategy focuses on key areas of work that we believe will make a difference. We want this strategy to be a local call for action in order to better understand the causes, how services can support and intervene and how we can support those affected across all life stages.

We know that prevention works, and by taking a wider approach that builds on positive emotional health and wellbeing will make a difference. This is why activities such as building resilience, promoting positive emotional wellbeing in schools and in the general population; tackling discrimination and stigma are key features of the strategy.

Our Suicide Prevention Strategy and action plan supports the aspirations of our Joint Health and Well-being Strategy vision that;

"*North Lincolnshire is a healthy place to live where everyone enjoys improved wellbeing and where inequalities are significantly reduced*"

This strategy is for the public and the workforce. It enables the public to see what we are doing together to prevent death by suicide and to understand what support is available for those individuals, families and communities affected by suicide.

It enables the workforce to have a shared direction and focus on what needs to be done together and how each professional, agency and service can contribute to reducing suicide.

This strategy mirrors the six areas for action outlined in the national strategy 'Preventing Suicide in England: A cross government outcomes strategy to save lives'. These are identified as:

1. Reduce the risk of suicide in 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.

Together we can make a difference.

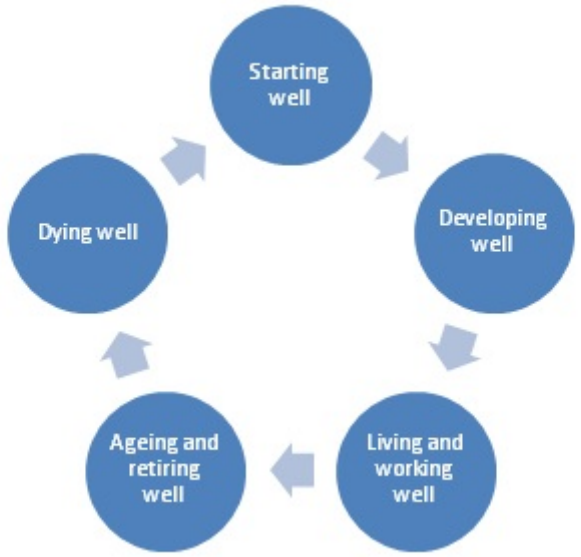
1. INTRODUCTION

Suicide is a major issue for society and a leading cause of years of life lost[1]. (See Appendix I for definitions) After many years of decline, suicide rates in England have risen since 2008 and it is now the biggest single cause of death of young men aged 20-44 in England and Wales[2]. Suicide is not considered inevitable and while numbers are relatively small, the impact of suicide on families, friends and communities is significant. Many others involved in providing support and care will also feel the impact.

In autumn 2012, the government made clear its commitment to suicide prevention by publishing a cross-government strategy for England[3]. The strategy noted that an inclusive society that avoids the marginalisation of individuals and supports people at times of crisis will help to prevent suicides. It made clear that most people who take their own lives have not been in touch with mental health services. A range of agencies across all levels of need and life stages have a role to play in building individual and community resilience, and together can ensure that vulnerable people at risk of suicide are kept safe from preventable harm.

While a whole life approach to suicide prevention will reach all those who might need it, it is recognised that targeted approaches are needed for those with particular vulnerabilities or problems with access to services. This includes people who have experienced abuse and violence, people living with long-term physical health conditions and where social and economic circumstances impact on wellbeing.

The purpose of this Suicide Prevention Strategy is to set out the North Lincolnshire priorities for action for preventing suicide. This strategy applies to all ages from young people to older people and reflects our local life stage approach to improving health and wellbeing and reducing health inequalities.



[1] Source: HM Government (2012). Preventing Suicide in England. A Cross Government Outcomes Strategy to save lives (Page 5)

[2] Source: https://publichealthmatters.blog.gov.uk/2014/12/18/preventing-suicide-theres-a-role-for-all-of-us/

[3] HM Government (2012). Preventing Suicide in England. A Cross Government Outcomes Strategy to save lives

Locally we are committed to enhancing the mental wellbeing of our population and reducing the numbers of people living with preventative ill health and people dying prematurely. We recognise that suicide is a whole population issue and can potentially affect a range of communities across North Lincolnshire. This strategy acknowledges our commitment to suicide prevention and highlights a need to continuously develop our local evidence base and increase our understanding of local suicide data and patterns in order to shape local decisions and priorities around suicide prevention.

Suicide prevention is a cross cutting issue that requires a wider system response in order to develop the right support and services, at the right time, in the right place. It is acknowledged that many people who take their life may not be known to mental health services and that suicide prevention is a complex challenge.

This strategy is intended to outline the North Lincolnshire approach to suicide prevention and recognise the contributions that can be made across all sectors of society. It recognises the strong relationships that have been built across North Lincolnshire with partners, providers and our communities. The aim of the strategy is to ensure that we understand the needs of our population and that in working together, we can develop a local approach to reduce the incidence of suicide now and in the future.

The development of the strategy takes account of the Joint Strategic Assessment (JSA) for North Lincolnshire, the local priorities set out in the Joint Health and Wellbeing Strategy, Local Safeguarding Board Business Plans and our need to respond to national policies. The central purpose of the strategy is to ensure there is a co-ordinated and integrated multi-agency approach to the development and delivery of suicide prevention services that is aligned to local need and driven by involvement and feedback from our communities.

2. VISION AND AMBITION FOR NORTH LINCOLNSHIRE

The North Lincolnshire Health and Wellbeing Strategy sets out a vision for the area that:

"**North Lincolnshire is a healthy place to live where everyone enjoys improved wellbeing and where inequalities are significantly reduced".**

Tackling the wider determinants that affect health and wellbeing is a responsibility for everyone. The Joint Health and Wellbeing Strategy (JHWS) provides the context and structure for how partners across North Lincolnshire can add value by working together differently. This includes collaboration between commissioning authorities, partners, providers and people in need of services. The focus is to improve outcomes for the population across all life stages - *starting well, developing well, living and working well, ageing and retiring well and dying well*.

In response to national drivers and the JSA, the Joint Health and Wellbeing Strategy (JHWS) identifies six priority outcomes all of which underpin a local suicide prevention approach:

1. Safeguard and protect
2. Close the gaps
3. Raise aspirations
4. Prevention of early deaths
5. Enhance mental wellbeing
6. Support independent living

North Lincolnshire has a strong vision and ambition for the area of **aspiring people, inspiring places**. Through effective joint working we are ambitious for the people of North Lincolnshire. We embrace diversity, strive for equality, and seek to raise the aspirations of local people. We challenge ourselves and each other to get it right, to enhance quality of life for our individuals and communities, whilst encouraging economic growth and supporting our existing and new businesses to meet the needs of our population. These principles are central to this suicide prevention strategy.

Our local partnership approach is about reshaping, creating and developing the **right service, at the right time, in the right place** in response to the changing population and changes in population needs. We use this local expertise and experience alongside national research evidence, best practice and guidance to improve the emotional wellbeing of our population while recognising the wider social and economic aspects of suicide. In line with our local Integration Statement, we aim to transform local services so that:

- People have help to look after themselves, develop resilience and be more independent
- People play a part in their community
- People have a choice and receive services when they need them.

3. CONTEXT

In April 2013 public health responsibilities transferred from the NHS and into local government[4]. Suicide prevention consequently became a local authority led initiative working closely with the Police, Clinical Commissioning Groups (CCGs), NHS England, coroners and the voluntary sector. The Director of Public Health has responsibility for locality led improvement, championing mental health including suicide prevention across the whole of the local authority's business and plays a key part in developing local public health approaches.

The local suicide prevention strategy should reflect the latest national information, evidence and guidance on improving mental health and preventing suicide for the population. In addition, the strategy should reflect, support and build upon other local strategies that support mental health and wellbeing across all life stages.

This section provides a summary of the latest national and local publications that shape this strategy.

NATIONAL DRIVERS

Preventing Suicide in England: A cross-government outcomes strategy to save lives (2012)

This strategy responds to the national suicide prevention strategy. 'Preventing Suicide in England' set out shared objectives for suicide prevention and six key areas for action. The strategy supports effective local action by bringing together knowledge about groups at higher risk of suicide, applying evidence of effective interventions and highlighting resources available. While the strategy provides information to support local decision making, it acknowledges that local organisations should decide what works in their area. The strategy provides the foundation for the further development of the current Suicide Prevention Action Plan for North Lincolnshire.

The national strategy is not a standalone document, rather an ongoing set of evolving activities that will influence our local action plan which can be found in Appendix II.

Preventing Suicide in England - key objectives and six key areas for action.

Key Objectives

[4] Health and Social Care Act (2012)

- ***Reduce the suicide rate*** in the general population of England
- Offer better ***support for those bereaved*** or those affected by suicide

Six key areas for action

In order to support the work of suicide prevention locally the six key areas for action from the national strategy have been adopted:

- Reduce the risk of suicide in key high-risk groups
- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour.
- Support research, data collection and monitoring

Future in Mind (Department of Health (2014)) sets out 5 key themes:

These key themes have been used as the framework for action in our work on the emotional health and well-being for children and young people which complements this work on suicide prevention. The work on emotional health and well-being is part of the Transformation Plan for Mental Health.

Identifying and responding to suicide clusters and contagion: Public Health England (2015)

A cluster of suicides is a rare event, but when it happens it can affect more than families and friendship groups. No single agency is likely to have the resources or experience to manage an evolving suicide cluster. It is a complex and under researched area. With modern communications, a potential cluster may not simply be people who live near each other or go to the same school or college: other connections, for example, via social media, may be more important. Preparation is key. The steps that need to be taken at local level to prepare for a suicide cluster are; the development of a community action plan (CAP), including suicide surveillance group (SSG) to review local occurrence of suicides and self-harm, together with a suicide response team (SRT) to deliver the plan. Our Suicide Prevention Strategy action plan addresses these requirements.

Our local work has been informed by a range of national publications and findings from research. There is a brief summary of these in Appendix III.

NATIONAL SUICIDE RATES AND TRENDS

Reviewing nationally available data on suicides is essential in order to place local information on suicides in context. With national reference points that include rates, trends, risk factors, suicide methods and evidence of what works to prevent suicides, a local approach for suicide prevention can be developed.

This section summarises key findings from national data on suicides and is intended to be used as a guide to enable comparisons with local data and information presented in Section 7.

The Office of National Statistics (ONS) Statistical Bulletin - Suicides in the United Kingdom, 2013 Registrations[5] published in February 2015 presents the latest (2013) figures on suicide deaths in the UK for recent years. Key points include:

- 6,233 suicides of people aged 15 and over were registered in the UK in 2013, 252 more than in 2012 (a 4% increase).
- The UK suicide rate was 11.9 deaths per 100,000 population in 2013. The male suicide rate was more than three times higher than the female rate, with 19.0 male deaths per 100,000 compared to 5.1 female deaths.
- The male suicide rate in 2013 was the highest since 2001. The lowest male rate since the beginning of the data series, at 16.6 per 100,000, was in 2007. Female rates have stayed relatively constant since 2007.
- The highest UK suicide rate in 2013 by broad age group was among men aged 45 to 59, at 25.1 deaths per 100,000, the highest for that age group since 1981.
- The most common method of suicide in the UK in 2013 was 'hanging, strangulation and suffocation' which accounted for 56.1% of male suicides and 40.2% of female suicides.
- The highest suicide rate among the English regions was in North East England at 13.8 deaths per 100,000 population, while London had the lowest at 7.9 per 100,000.

Figures presented in this bulletin are for deaths registered in each year, rather than occurring each year. There can be a substantial delay between the date of death and date of registration. Suicide figures in England and Wales are also potentially affected by an increase over time in the use of 'narrative verdicts' by coroners.

For further information on suicide rates and trends see Appendix IV

LOCAL CONTEXT

Health and Wellbeing Board

The Health and Wellbeing Board supports suicide prevention as part of its role in improving population health and wellbeing and reducing health inequalities, prevention of early deaths and enhancing mental wellbeing. Improvements in population health and wellbeing, including mental health will reduce the risks of suicide.

North Lincolnshire Annual Public Health Report 2014 Mindful of Health

The Annual report highlighted the importance of positive mental health to population health and wellbeing, enabling individuals, families and communities, to stay well, navigate their way through life's challenges and fulfil their potential throughout life. The key recommendations from the annual report are to

[5] http://www.ons.gov.uk/ons/dcp171778_395145.pdf

- Promote mental health across the population
- Prevent mental illness and suicide
- Improve the quality and length of life of people with mental illness

This strategy will inform our partnership work to achieve these ambitions.

This strategy aligns with and supports other plans and strategies these include:

- Joint Health and Wellbeing Strategy
- North Lincolnshire Clinical Commissioning Group (CCG) 5-year Strategy
- Vulnerable Adults Strategy
- Children and Young People's Plan
- Commissioning Strategy for Vulnerable Adults
- Commissioning Strategy for Children and Young People
- Local Safeguarding Children Board Business Plan
- Local Safeguarding Adult Board Business Plan

NEEDS ANALYSIS - GENERAL POPULATION DATA

North Lincolnshire covers an area of approximately 85,000 hectares on the southern side of the Humber estuary. At 328 square miles, North Lincolnshire is a relatively large area, with a growing and diverse population. In 2014, an estimated 169,247 people were resident in the authority, including 23% under the age of 20 years, and 20% aged 65+. For a detailed breakdown of population statistics for North Lincolnshire see the North Lincolnshire Data Observatory.

The large urban areas of Scunthorpe and Bottesford, are the main population settlement, employment and shopping centres, and are home to just under half, (48%) of North Lincolnshire residents. The remaining 52% live in the 6 market towns of Barton, Brigg, Crowle, Epworth, Winterton and Kirton Lindsey and in the 80 surrounding villages.

The local Black and Minority Ethnic (BME) population is relatively small compared with other local authorities in the Yorkshire and Humber region, representing an estimated 7.3% of the resident population, compared with 19% nationally. This population is growing and becoming increasingly diverse; the largest growth being amongst White Europeans. Other white Europeans make up more than half of all people from BME communities in North Lincolnshire, the largest being people from Poland.

The nature of North Lincolnshire as a place has been shaped by the local economy over the last few centuries, including agriculture and steel manufacture. A much higher proportion of jobs are in manufacturing compared with IT finance and business services, with significant growth in alternative energy technology, engineering and logistics expected over the next 5 years in the South Humber Bank development. This combined with new housing developments including the 'Lincolnshire Lakes', to the west of Scunthorpe, could potentially change the profile of our population.

In terms of average disposable income, housing quality, and the natural and social environment, North Lincolnshire is an attractive place to live. Average wages for those in full time work are higher than they are regionally, and with lower house prices, and lower than average unemployment rates, falling crime rates, and access to a rich and diverse natural landscape, the quality of life for many of North Lincolnshire residents is very good compared with regional neighbours.

This fact is reflected in local and national surveys, with the vast majority of residents expressing satisfaction with the area, and high happiness scores, highlighting many of North Lincolnshire's attractive physical assets, including close access to the countryside and the coast, low cost of living, strong sense of community and neighbourliness of local people.

LOCAL HEALTH INEQUALITIES

Health and wellbeing profile

Looking at the health and wellbeing of North Lincolnshire's population as a whole, it is improving year on year, and in terms of longer years of life, it has never been so good. Life expectancy at birth is now much closer to the national average, at 78.1 years for men and 82.5 years for women, after lagging behind for many years.

However, healthy life expectancy has not improved quite as fast, which means that for many people these extended years of life are likely to be spent in relatively poor physical and/or mental health.

For more information see Joint Strategic Needs Assessment and Annual Public Health Report.

Health inequalities

We also know that these averages mask significant physical and mental health inequalities in North Lincolnshire, the highest rates of ill health being found in the deprived 10% neighbourhoods.

These inequalities begin early in life and are reflected right across the life course, from maternal and child physical and mental health to quality of life at retirement age, as well as experience of care at the end of life.

Some of these inequalities are narrowing, whilst others have not changed over the last decade. Many of these inequalities are concentrated in the same neighbourhoods, with some population groups, including families and young people, at multiple risk of persistent poverty, low attainment, unemployment, unhealthy behaviours and poor mental health.

For more information on health inequalities see the Health and Wellbeing Evidence pages.

Higher risk groups (National)

The Government strategy Preventing Suicide in England (2012) highlights a number of risk factors which are strongly associated with suicide in the general population and in sub-groups such as young men and people who self-harm.

Public Health England has developed a 'suicide prevention profile' which brings together nationally available data on suicide, risk factors for suicide and service contacts for groups at increased risk of suicide. The data is presented at local level to help develop understanding, and support benchmarking, commissioning and service improvement.

According to these profiles, North Lincolnshire has, compared with the (England average) a higher than average number of people in the following risk groups,

- Opiate and/or crack cocaine use of 15-64 year olds
- Adults with long term illness or disability
- Adults who are separated or divorced

- Older adults living alone

And a lower number of people in the following groups:

- Children and young people in the Youth Justice System
- Children and young people in the Looked After System
- Unemployed adults
- People who are homeless or at risk of homelessness

A local two year audit of death by suicide 2013/2014 demonstrated that there was some correlation with the higher risk groups in relation to substance misuse and long-term illness, although other factors such as isolation and bereavement were also factors.

See appendix V for a detailed breakdown of local high risk groups.

4 NEEDS ANALYSIS – LOCAL SUICIDE TRENDS AND DATA

This section summarises the local rates and trends in the incidence of suicide and undetermined death rate as well as particular risk factors in North Lincolnshire. Some comparisons are made against the national trends.

Number of suicides in North Lincolnshire

The number of deaths from suicide and undetermined injury in North Lincolnshire each year is relatively small. Because of this, a small rise or fall in numbers can result in quite wide fluctuations in suicide rates from one year to the next. The data in the table and graph below are based on the year the death was registered, rather than the year of death. The two figures may not tally due to the time taken for an inquest to be heard. On average, there is a time difference of up to 6 months. However, in very complex cases the time difference may be much longer.

Provisional local data for 2014, suggest that the number of suicides registered in North Lincolnshire in that calendar year was 12, (a rate of 7.7 per 100,000), of which 9 were deaths which had occurred in 2014 and 3 deaths in previous years. There may still be some verdicts pending for deaths which occurred in 2014.

Number of suicides in North Lincolnshire and suicide rate per 100,000 (DSR), 1993-2014

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Number	21	14	9	16	15	17	14	11	14	13	20	11	8	16	13	6	22	20	13	12
Rate	13.86	8.16	5.93	9.62	9.18	11.84	9.78	6.87	8.62	7.27	13.52	6.6	4.62	10.05	7.4	4.02	13.18	11.4	7.4	7.2

Source: ONS and Public Health Intelligence Team, 2014

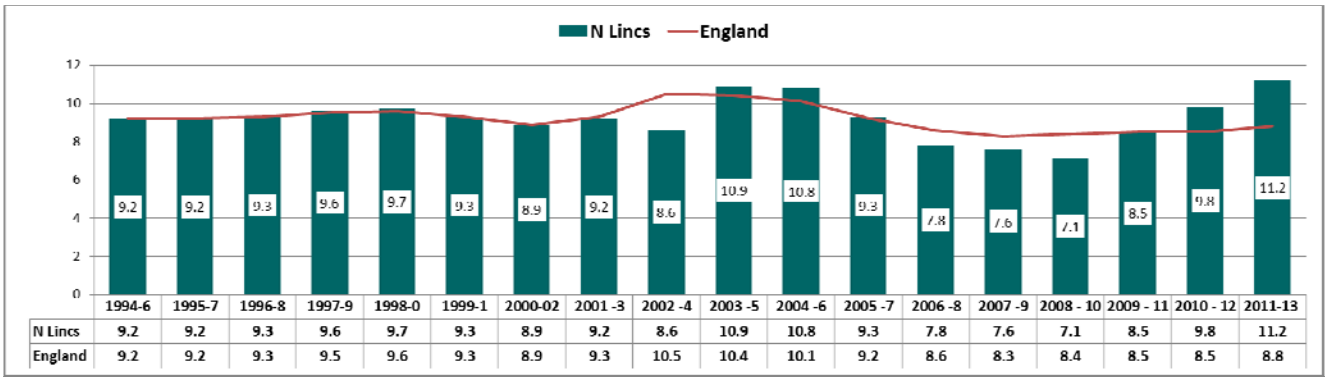
Suicide rates per 100,000 and numbers in North Lincolnshire (based on year of registration)

	2008	2009	2010	2011	2012	2013	2014*
North Lincolnshire rate per 100,000	10.05	7.40	4.02	13.18	11.4	7.4	7.2
North Lincolnshire numbers	16	13	6	22	20	13	12

Source: ONS, and Public Health Intelligence Team, 2015 *Provisional local data

Suicides are generally monitored using three years' worth of pooled data. This shows that local rates rose between 2010 and 2013, and above national rates. However this increase was not statistically significant, and local rates have since fallen back to previous levels. As in previous years, rates remain in line with the national average with no statistically significant differences between the local and national suicide rates.

Death rates per 100,000 from suicide, (DSR) and undetermined injury, England and North Lincolnshire 1994-2013 (latest available published data, rate per 100,000)



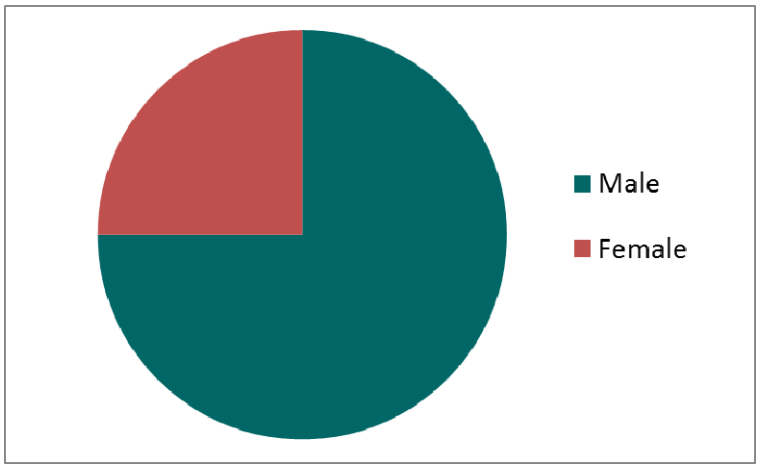
	1994-6	1995-7	1996-8	1997-9	1998-0	1999-1	2000-02	2001 -3	2002 -4	2003 -5	2004 -6	2005 -7	2006 -8	2007 -9	2008 - 10	2009 - 11	2010 - 12	2011-13
N Lincs	9.2	9.2	9.3	9.6	9.7	9.3	8.9	9.2	8.6	10.9	10.8	9.3	7.8	7.6	7.1	8.5	9.8	11.2
England	9.2	9.2	9.3	9.5	9.6	9.3	8.9	9.3	10.5	10.4	10.1	9.2	8.6	8.3	8.4	8.5	8.5	8.8

Source: HSCIC, PHE, PCMD, 2014

Suicides in North Lincolnshire by sex

Nationally, men are at three time's greater risk of suicide than women. Most suicides are amongst working age men, with men aged 35-49 years old being at greatest risk. In the 12 years between 2003 and 2014, there were 164 registered deaths from suicide or undetermined injury in North Lincolnshire; of these 76% were men.

No of Suicides in North Lincolnshire by sex, 2003-2014 (n=164)

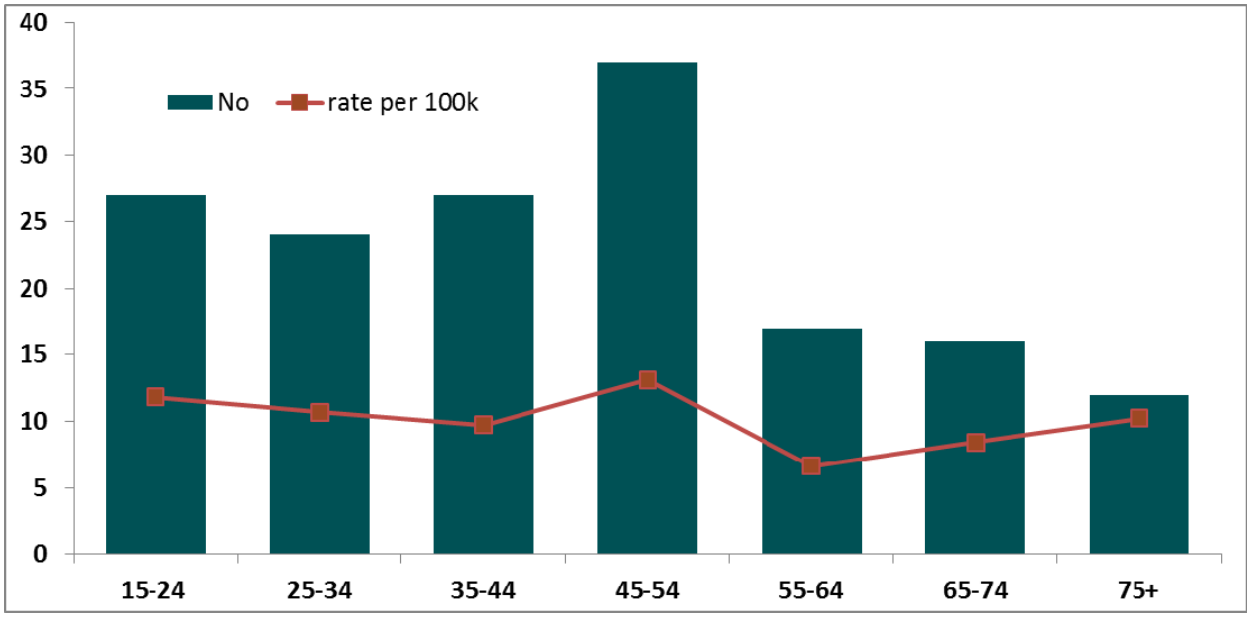


Source: PCMD, Public Health Intelligence Team, 2014

Suicides in North Lincolnshire by age

Men have higher suicide rates than women across all age groups, with the highest number and rates of suicides being amongst people aged 45-54 years. However, other high risk age groups include men under 25 as well as older men aged 75 years and older, who have a higher than average suicide rate per 100,000 men in this age group . This could reflect the impact of social isolation, illness, depression and bereavement in older age.

No of suicides in North Lincolnshire and rate per 100,000 by age group, (2003-2014)



Source: Public Health Intelligence Team (2014)

Suicide by locality

Local data for the period 2006-2014 suggests no rural or urban trend in suicides, with roughly half of all suicides occurring amongst residents of Scunthorpe, and the other half amongst residents of North Lincolnshire's market towns and villages.

Methods of suicide

National data for 2013 suggest that hanging, strangulation and suffocation continue to be the most common methods of suicide for men, along with drug poisoning, which is the most common method amongst women.

In North Lincolnshire, the most common methods of suicide are hanging, followed by drug poisoning, drowning and carbon monoxide poisoning.

Suicide hotspots

Location of suicide is of particular interest in relation to understanding whether 'Hot spots' exist in the area. These are defined as geographical areas where people have repeatedly attempted suicide or completed suicide. This might include bridges, railway lines, cliffs, rivers and woods.

It is recognised that one of the most effective ways to prevent suicide is to reduce access to high-lethality means of suicide. Local agencies can work together to prevent loss of life through discouraging suicides at high risk locations.

Within North Lincolnshire the Humber Bridge has been identified as a local suicide 'hotspot'. There is a need for joint working across a number of agencies to manage this site.

The majority of deaths by suicide in North Lincolnshire are by residential hanging which is difficult to prevent. However, much could be done to raise awareness, recognise distress and support families.

Suicide clusters

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 particularly in the case of young people. It is important to establish at a very early stage if there are connections between them. See Appendix I for a definition of a suicide cluster. Locally no suicide clusters have been identified.

5 WORKING TOGETHER TO PREVENT SUICIDE IN NORTH LINCOLNSHIRE

Suicide prevention is not the sole responsibility of any one sector of society, or of health services alone. The greatest impact is likely to result from a combination of preventative strategies directed at potential suicide determinants, which include:

- The factors which increase the risk of suicidal behaviour in a population; for example, availability of means, knowledge and attitudes concerning the prevalence, nature and treatability of mental disorders, and media portrayal of suicide and suicidal behaviour.

- Recognised high risk groups – e.g. people which recurrent depressive disorders, previous suicide attempts, people who misuse alcohol and/or substances, people who are unemployed, people with certain co-morbid mental and personality disorders and people recently discharged from psychiatric in-patient care.

This suicide prevention strategy has been developed in line with the national Suicide Prevention Strategy for England (2012) and builds on local work. To achieve our goal of reducing death by suicide, we are committed to structuring our local strategy around the six priority areas for action identified in the national strategy.

In order to reduce the local suicide and self-harm rate, we need to work together at each of the identified levels and deliver the stated outcomes.

STRATEGIC LEVEL

In **North Lincolnshire** we aim to:

- Reduce the rate of suicide and self-harm in the North Lincolnshire population
- Reduce excess under 75 mortality in adults with serious mental illness
- reduce the number of people developing mental health problems across all ages and backgrounds
- Reduce the number of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.

We are committed to improving the overall emotional and mental health of the population, treating mental and physical health as equally important.

We will:

- Ensure a multi-agency approach to suicide prevention with a shared commitment to the outcomes identified within this strategy.
- Target high risk groups and improve the mental health of the population as a whole.
- Take a life course approach which recognises that mental health problems often start in childhood, opportunities to promote and protect good mental health arise from pre conception through to old age.

SERVICE LEVEL

At a **service level** we aim to**:**

- Ensure every contact counts, to review Making Every Contact Count (MECC) to ensure it addresses emotional health and wellbeing as well as physical health
- Reduce the stigma associated with mental health, supporting an approach to mental wellbeing
- Increase individual resilience through the life course, building population resilience and social connectedness within communities
- Develop a supported workforce to empower people to seek support and develop resilience across all levels of need
- Align resources to evidence based services and other interventions that contribute to improved outcomes for individuals
- Use data on suicide rates to support the effective targeting of services
- Enhance early help offer and people accessing the right services at the right time in the right place
- Reduce the need for more intensive services
- Better support those bereaved or affected by suicide

INDIVIDUAL LEVEL

Taking a holistic approach to improving outcomes for individuals living in North Lincolnshire we believe that every person living in North Lincolnshire:

- has the right to live and work in a safe and friendly environment
- should have equality of life chances and life expectancy
- should be empowered and have the opportunity to discover their strengths and achieve their potential
- should have a quality of life and be able to contribute positively
- should be empowered to make their own choices and be independent
- is different and their circumstances, background and culture should be recognised, respected and valued
- should be celebrated and promoted
- is unique and has the right to have their individual needs met
- has the right to be involved in plans, interventions and services that affect them

6 WHERE ARE WE NOW?

WHAT HAS BEEN DONE AT A STRATEGIC LEVEL?

Suicide prevention has a strong policy foundation and has clear cross cutting relevance North Lincolnshire. Research, data collection and monitoring is central to the national suicide strategy and local delivery in reducing suicide rates. While nationwide overviews of suicide trends identify at risk groups, for example young men or members of the Lesbian Gat Bisexual and Transgender (LGBT) community, North Lincolnshire needs to apply its expert local knowledge and understanding of communities to develop local strategies to make a real difference in preventing suicides locally.

Suicide Prevention and Audit Group

A multi-agency Suicide Prevention and Audit Group chaired by the Director of Public Health was established in 2014. The group's core function was to ensure that suicides in North Lincolnshire were reviewed, lessons learned and action plans developed and monitored with the purpose of reducing death by suicide in North Lincolnshire. Plans are in place for a new Suicide Overview and Audit Panel (SOAP) to fulfil this role with an extended membership to ensure a better understanding of the issues and greater opportunity to respond at strategic service and individual levels.

Suicide Audit

Audit of suicides and undetermined deaths in North Lincolnshire
January 2011-December 2013

The last local authority wide audit of suicides in North Lincolnshire took place in May 2013 and considered the local coroner's reports of 49 out of 61 North Lincolnshire residents who died during that 3 year period as a result of suicide.

The findings of that audit are in line with national trends about known common risk factors. The highest risk groups emerging from the data are:

- white men aged between 30-50 years of age,
- people experiencing one or more stressful life events, including bereavement/loss, serious financial difficulties, chronic health problems,
- people who have suffered abuse in the past

- people who had previously attempted suicide
- people with serious alcohol or substance misuse problems

The audit was limited to some extent by the source records, which were coroner reports and death registrations. Future audits, informed by more recent national guidance on best practice should enable more information about risk factors from a wider range of sources to be considered.
In the meantime, the audit data below provides some useful information which has guided our local strategic priorities for suicide prevention.

Profile

- 73% were male
- 27% were female
- 55% lived outside the urban areas of Scunthorpe and Bottesford
- 48% were aged 30-50 years
- 10% were from BME communities
- No information was available on residence status

Methods

- 52% died by hanging
- 20% by drug or other poisoning
- 10% by drowning
- 84% died in their own home, with the next most common location being a river, followed by local woods

Risk factors

- Of those of working age, 44% were unemployed, early retired or long term sick or disabled
- 1 in 3 reportedly had an alcohol or substance misuse issue
- 22% were known to have previously attempted suicide or had self-harmed
- 67% had suffered a recent bereavement, separation or divorce
- 35% had at least 1 chronic long term condition
- It is not recorded how many were known to have a diagnosed mental illness at the time of death
- 1 in 12 were known to have been physically or sexually abused in the past
- A similar number were involved with the criminal justice system

REGIONAL FINDINGS

Regionally other local authorities have made similar key findings.

- The male suicide rate is five times higher than the female suicide rate compared to nationally where the male rate is only 3 times higher than the female rate.
- The majority of suicides were in the 35-44 age band whereas nationally it is in the 40-49 age band.
- A higher proportion of suicides were recorded by those who had lived in areas of higher deprivation with those from the two most deprived quintiles accounting for over half of all deaths from suicide.
- Thursday and Friday had the highest proportion of deaths.
- The most common method of suicide was hanging and this proportion was considerably higher than at a national level suggesting that other methods of suicide are not as accessible locally.

Where we are now

Significant development has taken place in North Lincolnshire as outlined above. We have strong partnership engagement including collaboration with the local Coroner.

Nationally, Public Health England is currently piloting real time surveillance of suicide which captures timely data on serious attempts alongside potential suicides i.e. not yet subject to an inquest verdict of suicide. The aim of the real time approach is to enable local areas to:

- Offer timely support to grieving families, friends and communities
- Work within any settings found to be at risk
- Identify any hot spots
- Establish any new methods that may be identified early on

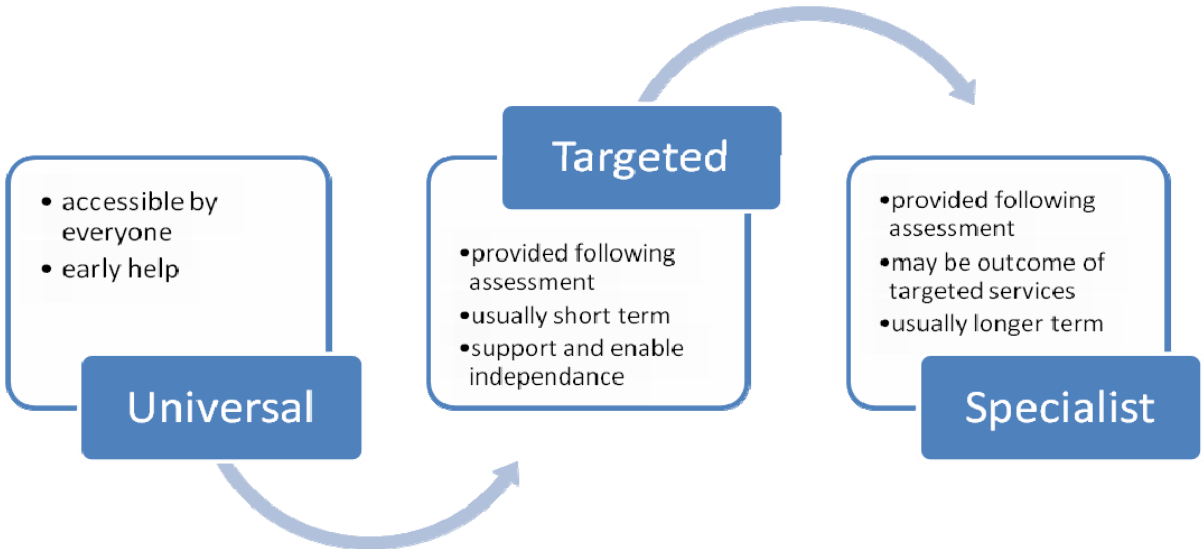
National pilots should be evaluated by March 2015 after which it could be rolled out nationwide. Data from real time surveillance provides a number of opportunities for the future development of a local suicide audit approach.

In response emerging national learning and developments, real time surveillance development, local learning from the initial suicide audit alongside the subsequent publication of 'Guidance for developing a local suicide prevention action plan', we are in a position to review current plans and look to reshape the Audit Group and approach to data capture/monitoring. Reshaping will build on what is working well, lessons learnt / best practice and will seek new opportunities.

7 SUICIDE PREVENTION PRIORITY ACTIONS FOR NORTH LINCOLNSHIRE

This suicide prevention strategy is based on learning of what we know works, what the people who use our services tell us, what our providers and workforce say and what we know from our Joint Strategic Needs Assessment (JSA). Our priorities are also determined by our local priorities (strategic, service, individual), legislation, statute, national and local drivers. This strategy will set out our proposed strategic priorities for North Lincolnshire.

In recognition that suicide should be considered as a whole population, prevention for specific groups and individual issue, our local approach will bridge three levels of need set out in the North Lincolnshire Single Organisational Model (Appendix VI):



This suicide prevention strategy has been developed in line with the national Suicide Prevention Strategy for England (2012) and the six priority areas for action identified within. The strategy also aligns with the themes identified in Futures in Mind (2014), and our local Child and Adolescent Mental Health and Emotional Wellbeing Transformation Plan. Within each of the priority areas we

have identified our local response which will shape our action plan for the people of North Lincolnshire.

Priority action 1

- Reduce the risk of suicide in key high risk groups (SPECIALIST)

- Identification of high risk groups in North Lincolnshire
- Understand current service provision
- Identify and address any gaps in provision

Priority action 2

- Tailor aproaches to improve mental health in specific groups (TARGETED)

- Consultation with people in high risk groups to understand what would make a difference
- Evidence based and research informed practice

Priority action 3

- Reduce access to the means of suicide (TARGETED)

- Understand methods of suicide in NL to inform this work
- In the interim we will look at local information, nationally and regionally, strangulation has been identified as the main method of suicide

Priority action 4

- Provide better information and support to those bereaved or affected by suicide (SPECIALIST)

- Identify current resources for postvention
- Understand gaps in services for postvention
- Shape and strengthen local postvention services Consultation with those who are bereaved to understand the best methods of providing information and understanding the timing

Priority action 5

- Support the media in delivering sensitive apporoaches to suicide and suicidal behaviour (UNIVERSAL)

- Adopt good practice from experts in the sector
- Confirm the key positive messages for use in North Lincolsnhire

- Establish the Suicide Overview and Audit Panel
- Receive intelligence reports from SOAP on trends and issues

What will success look like

The successful delivery of the action plan will ensure

- Fewer people take their own lives
- There is no wrong door for people seeking support
- Staff identify needs early and act swiftly
- Partner organisations understand and prioritse mental health needs
- Organsiations share a collective responsibility and work in partnership
- Organisational commitment to an equipped workforce
- Services meet the needs of indivduals , not individuals fitting into servcie delivery models
- Professionals share the journey with the individual – rather than passing that individual on to other services
- Indivudals are empowered to continue their life's journey – postvention services
- Individuals live in communities that are strong and resilient
- A workforce that is aware of mental health needs and which is trained to support people
- Organisations have support in place for their workforce
- Services are sustainable
- We learn from suicides and suicide attempts
- There is a reduction in stigma

Engaging with the Media

Research shows that inappropriate reporting of suicide may lead to imitative or 'copycat' behaviour. For example, if vulnerable groups such as people with mental health problems and young people are provided with details about the method of suicide used, it can lead to more deaths using the same method. Similarly, a vulnerable person who might not otherwise have attempted suicide could strongly identify with a particular characteristic of a person who has died by suicide, and this may lead them to take their own life.

The Samaritans have worked closely with the media to promote responsible reporting of suicide, and as a result have seen signs of significant progress over the years. One of the ways coverage of suicide can have a positive effect is by encouraging people to seek help. Sensitive coverage can also help reduce the taboo around talking about suicidal feelings as well as challenging stigma. The Samaritans' Media Guidelines for Reporting Suicide (2013) have been produced following extensive consultation with journalists and editors throughout the industry. They provide practical recommendations for reporting suicide across all media. The guidelines are advisory, but evidence shows that following them is likely to reduce the instance of copycat's.

Suicide Overview and Audit Panel

A Suicide Overview and Audit Panel (SOAP) has been established. This will build on the successes and learning of the Child Death Overview Panel (CDOP) which has been operational for a number of years. The primary purpose of Suicide Overview and Audit Panel is to review suicides of North Lincolnshire residents with a view to developing a local evidence base, to gain a greater depth of understanding of local

themes and patterns, understanding reasons and factors contributing to suicide, exploring what we could do differently with a view to learning lessons and developing local strategies to reduce suicide.

The Panel will review high level population data and trends alongside analysis of local suicides. It is not viewed as a case audit or investigation group. The functions will include:

- Reviewing all suicides of people normally resident in North Lincolnshire
- Collecting and collating information on each individual from professionals and where appropriate family members/carers
- Discussing cases at a high level to better understand potential factors contributing to suicide
- Discussing what action could be taken to prevent future suicides
- Making recommendations to relevant bodies such as the SAB, LSCB, HWBB so that action can be taken to prevent future suicides
- Identifying patterns or trends in local data and reporting these to relevant bodies
- Fulfilling the role of the suicide Surveillance Group (SSG)

Aggregated findings from the analysis of suicides should inform/shape local strategic planning and needs assessment such as the JSA, the local suicide prevention strategy/plan, commissioning and service design with the outcome of reducing suicide rates and providing a more timely responses to families.

8 DELIVERING CHANGE

LEADERSHIP

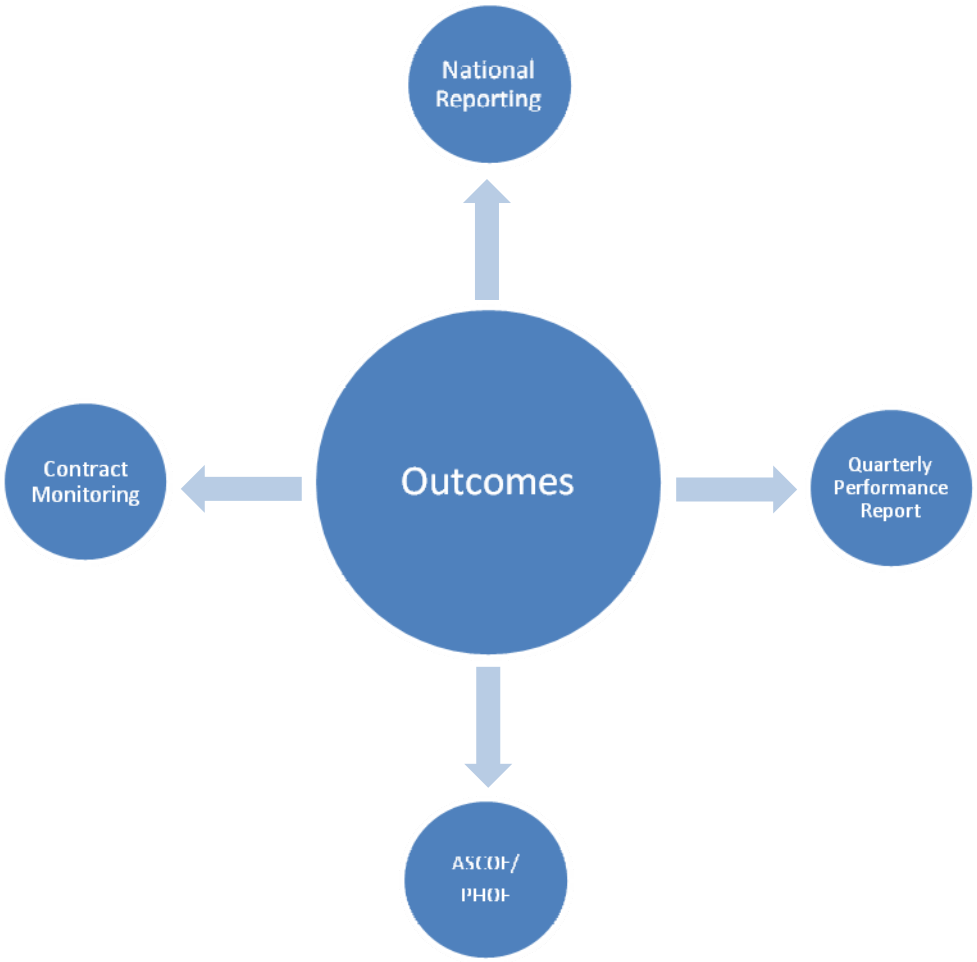
The Suicide Prevention Group will provide leadership for this work in North Lincolnshire, including monitoring of the delivery of the action plan and review of the impact on outcomes which will inform the JSA refresh. This work will contribute to the wider work of transformation being undertaken in North Lincolnshire. See Appendix VII.

GOVERNANCE

Suicide prevention is the statutory responsibility of the Director of Public Health within the Local Authority. Only by working in partnership will the strategy be delivered effectively.
The Suicide Prevention Group has a relationship with the Health and Wellbeing Board and the Suicide Overview and Audit Panel.

IMPLEMENTATION AND MONITORING

The Suicide Prevention Group will be responsible for implementing the action plan and monitoring its progress. Update reports will be presented to the Health and Well-being Board.



SUICIDE OVERVIEW AND AUDIT PANEL

A Suicide and Overview and Audit Panel has been established. This panel is chaired by the Director of Public Health. The purpose of the panel is to identify local trends to increase our understanding locally of factors influencing death by suicide. As outcomes from this audit become available this strategy will be refreshed to take account of the new intelligence. The new responsibility to have a Suicide Surveillance group will be undertaken by the SOAP.

APPENDIX I- DEFINITIONS

What is suicide?

Suicide is defined by the Oxford Dictionary of Law as *'the act of killing oneself intentionally.*' For a Coroner to reach a conclusion of suicide this would need to be proved beyond reasonable doubt. There are difficulties in determining the exact intent of a person who dies thus measuring or estimating the true level of suicide can be complex. However, for the purpose of this strategy the 'suicide rate', will include deaths recorded as follows:

'..as deaths given an underlying cause of intentional self-harm or injury/poisoning of undetermined intent'

In England and Wales, it has been customary to assume that most injuries and poisonings of undetermined intent are cases where the harm was self-inflicted but there was insufficient evidence to prove that the deceased deliberately intended to end their life.

Throughout this strategy suicide cases will be those cases where the Coroner has given a conclusion of suicide or where the injury was of undetermined intent and an open verdict has been given.

However, it should be noted that over the past decade, coroners have increasingly returned narrative verdicts. These record the circumstances of a death rather than providing a 'short form' verdict such as suicide, accident, or natural causes. Prior to 2011, some narrative verdicts were coded as accidental deaths where intent was not specified which may have led to an underestimation of suicide. However, in 2011 guidance was issued to coroners in England and Wales when returning narrative verdicts to provide clearer information on the intent of the deceased. This has led to improvements to the coding of narrative verdicts by the ONS coding team, and some cases which would previously be coded as accidental may now be coded as possible suicide. The impact of these changes, therefore, will potentially increase the number of estimated suicides in 2011, although the anticipated increase is likely to be small.

Office of National Statistics definition

The National Statistics definition of suicide includes deaths given an underlying cause of intentional self-harm or an injury/poisoning of undetermined intent. In England and Wales, it has been customary to assume that most injuries and poisonings of undetermined intent are cases where the harm was self-inflicted, but there was insufficient evidence to prove that the deceased deliberately intended to kill themselves (Adelstein and Mardon, 1975). This convention has been adopted across the UK. However, this cannot be applied to children due to the possibility that these deaths were caused by unverifiable accidents, neglect or abuse. Therefore, only persons aged 15 years and over are included in the suicide figures. Causes of death are coded using the International Classification of Diseases, Tenth Revision (ICD-10) (World Health Organisation, 2010). These are the codes used to define suicide:

What is postvention?

A postvention is an intervention conducted after a suicide, largely taking the form of support for the bereaved (family, friends, professionals and peers). Family and friends of the suicide victim may be at increased risk of suicide themselves.

Updated definition of a suicide cluster (adapted from Larkin and Beautrais)

A series of three or more closely grouped deaths…which are linked by space or social relationships. In the absence of transparent social connectedness, evidence of space and time linkages are required to define a cluster. In the presence of a strong demonstrated social connection, only temporal significance is required.

International Classification of Diseases, Tenth Revision codes used to define suicide in the United Kingdom

ICD-10 code	**Description**
X60–X84	Intentional self-harm
Y10–Y341	Injury/poisoning of undetermined intent
Y87.0 / Y87.22	Sequelae of intentional self-harm / injury / poisoning of undetermined intent

Table notes:
1. Excluding Y33.9 where the coroner's verdict was pending in England and Wales, up to 2006. From 2007, deaths which were previously coded to Y33.9 are coded to U50.9.
2. Y87.0 and Y87.2 are not included for England and Wales.

What is self-harm?

Self-harm is:

'.. self-poisoning or self-injury, irrespective of the apparent purpose of the act'.

The self-harm focuses on those acts of self-harm that are an expression of personal distress and where the person directly intends to injure him/herself. It is important also to acknowledge that for some people, especially those who have been abused as children, acts of self-harm occur seemingly out of the person's control or even awareness, during 'trance –like' or dissociative states. It therefore uses the term 'self-harm' rather than 'deliberate self-harm'.

APPENDIX II – ACTION PLAN

Outcome	Action	Lead	Date	RAG
Priority Action 1 – Reduce the risk of suicide in key high risk groups				
1. Identification of high risk groups in North Lincolnshire	Undertake 5 year suicide audit	PH Intelligence Hub	To commence January 2016 Report January 2017	Green
2. Provision of timely support to young people in right place at the right time by the right people	Undertake an audit of CYP attending NLAG A&E at Scunthorpe General Hospital to understand: • Why they attended • What happened at A&E • What the follow up arrangements were • Missed opportunities for intervening earlier • Recommendations for the future	Partnership with NLAG and RDaSH and HIT	To commence October 2015 – report March 2016	Green
3. Positive messages and campaigns – promote positive self help via safe and reputable organisations and websites	Develop positive messages for CYP and adults Identify most effective communication methodology / media for CYP and adults	CYP – Educational Psychologist Adults – HIT	CYP – July 2015 Adults – October 2015 To be completed December 2015 Reviewed annually	Green
Priority Action 2 – Tailor approaches to improve mental health in specific groups				

Outcome	Action	Lead	Date	RAG
4. Consultation with people in high risk groups to understand what would make a difference.	Work with providers / voluntary sector organisations currently working with high risk groups to include: • People recently discharged from in-patient MH provision. • People currently engaged with MH services in the community. • People engaged with drug and alcohol services. • People who have deliberately self-harmed. • People involved with CJS. • People with complex health needs / life limiting conditions. • Looked after children and care leavers.	Voluntary Sector to lead and undertake this engagement and consultation making use of their expertise and networks .	October 2015 and ongoing dialogue Reported quarterly to SPG	Green
5. Service users already in contact with specialist and targetted providers.	Use existing groups and networks to engage in creative conversations with people from the high risk groups identified to understand what would make a positive difference in their life experiences, and what is working well to sustain their resilience. Increase awareness of workforce about the vulnerability of the people they are working with.	LSCB / LSAB Workforce Groups	September	Green

Outcome	Action	Lead	Date	RAG
	A workforce development programme to increase the knowledge and skills of the workforce to identify and respond to vulnerable people in these high risk groups.	LSCB / LSAB Workforce Groups	2015 – September 2017 September 2015 – September 2017	Green
6. Consultation with people whose circumstances increase their risk to understand what would make a difference.	Work with providers / voluntary sector organisations currently working with these individuals to include: • People who have been bereaved. • People experiencing significant loss (Financial, personal, relationship). • Males in the 35-50 age range. • Children and Young People.	Adults – HIT	December 2015 – June 2016	Green
7. People in contact with universal / primary provision.	For CYP using existing groups and networks to consult with CYP whose circumstances have increased their risks, to understand what support would make a positive difference and what is working well to sustain their resilience.	Educational Psychologist	July 2015 – reporting to SPG 6 monthly	Green
	PLS, ALS and CLS to inform our understanding of the needs of	PH Intelligence Hub	3 yearly cycle, reported	Green

Outcome	Action	Lead	Date	RAG
	CYP. For Adults using the potential of the healthy workplace award scheme to raise awareness and understanding of mental health issues among employers and employees. Increasing the awareness and understanding of the universal CYP and Adult workforce to the implications of self-harm and the signs of suicidal intentions. Increasing the knowledge and skills of the universal workforce to respond supportively to CYP / Adults whose circumstances increase their vulnerability.	 PH Places Team LSCB / LSAB Workforce Groups LSCB / LSAB Workforce Groups	annually. 2016 PLS. April 2015 – 6 monthly report on progress to SPG January 2016 – January 2018 January 2016 – January 2018	 Green Green Green
8. Rasie awareness and increase the knowledge of the local workforce	Deliver a conference for providers and voluntary sector organisations to raise awareness and increase knowledge and understanding of death by suicide	HIT	February / March 2016	Green
9. Evidence based and research informed practice	Desktop review of the current research.	PH Intelligence Hub	June 2015 refreshed annually in line with JSA	Green
Priority Action 3 – Reduce access to the means of suicide				
10. Understand methods of suicide in NL to inform this work	Undertake 5 year suicide audit	PH Intelligence Hub	To commence January 2016 Report Jan 17	Green

Outcome	Action	Lead	Date	RAG
11. Understanding the impact of a local hotspot (The Humber Bridge) and managing the implications of a hotspot	Learn from the work of other local authorities in respect of their management of recognised hotspots, including bridges and railway networks.	HIT	June 2015 – report annually – November 2015	Green
Priority Action 4 – Provide better information and support to those bereaved or affected by suicide				
12. Timely and appropriate support provided form people who have been affected by suicide	Produce and provide written and online information to people affected by suicide Identify current resources and pathways to services delivering postvention	HIT in partnership with The Samaritans, Cruse and SOBS HIT in partnership with CCG	September 2015 – March 2016 TBA	Green TBA
13. Increasing community support to those affected by suicide	Understanding the impact of suicide is included within organisations health and safety policies	PH Places Team	TBA	TBA
14. Consultation with those who are bereaved to understand the best methods of provding information and understanding the timing	Use existing groups and networks to engage in creative conversations with people who have been affected by suicide to understand what would make a positive difference in their life experiences, and what is working well to sustain their resilience.	HIT in partnership with The Samaritans, Cruse and SOBS	January 2016 – report June 2016	Green
15. NLC will be prepared to respond to any identified suicide clusters	Community Action Plan in place. Suicide Surveillance Group is in place (part of SOAP). Suicide Response Team is in	Samaritans DPH / SOAP TBC	October 2015	Green

Outcome	Action	Lead	Date	RAG
	place.			
Priority Action 5 – Support the media in delivering sensitive approaches to suicide and suicidal behaviour				
16. Adopt good practice from experts in the sector	The Samaritans guidance for reporting suicides has been adopted by many national news organisations. Locally, to secure agreement with local media organisations (broadcast, written and online) that they will adopt The Samaritans guidance to inform their reportage. When a person dies by suicide the Samaritans work with local and regional news organisations to support their use of the guidance.	Comms NLC in partnership with The Samaritans	November 2015	Green
Priority Action 6 – Support research, data collection and monitoring				
17. Ensure appropriate Information Governance is in place	Agree information sharing protocol to enable local research and data collection.	PH Intelligence Hub	October 2015	Green
18. Establish local mechanism to enable data collection, trend analysis and monitoring	Establish the Suicide Overview and Audit Panel	DPH	October 2015 Receive intelligence reports from SOAP on trends and issues annually	Green

Evidence Base to support Action Plan

Priority Action 1: Reduce the risk of suicide in key high	Evidence base

risk groups – Best practice guidance/evidence based interventions		
	• Regular suicide prevention and self harm training for 'gatekeepers' ie front line staff working in key public services including those working in schools, colleges, JobCentres, A&E , & other emergency services, primary care, social care environments, criminal and youth justice systems, and the military to ensure that those who work with identified high risk groups are alert to the signs of emotional distress, self-harm and suicide risk and know how to respond effectively • This will include staff who work with high risk men and women who have suffered abuse, have relationship difficulties, alcohol or substance misuse issues, are facing difficult social or economic circumstances, and or have a family history of suicide • This may require a degree of joint work to smooth out referral processes and care pathways where required • School based prevention programmes for adolescents at high risk which focus on developing resilience and enhancing social support • Promoting suicide guidance to the public	National training programmes include: • ASIST • MHFA • STORM • Safe Talk • GP training on the use of the suicide risk assessment tool • Samaritans 'Managing suicidal contacts' is aimed at railway staff • MIND's guidance for the general public 'Suicidal Feelings' and on-line resource 'Supporting someone who feels suicidal' is directed at the general public NICE guidance and national care pathways set out evidence based interventions for working with children, young people and adults who • self harm • suffer from depression or other mental illness • have a long term condition • suffer chronic pain • are terminally ill • are approaching end of life • are at risk of, or are, alcohol dependent • misuse substances Best practice guidelines on preventing suicide amongst mental health patients are identified in '*Avoidable Deaths. The National Confidential Enquiry into Suicide and Homicide by people with Mental Illness' (2013)*
Priority Action 2: Tailor approaches to improve mental health in specific groups		

	• Early identification of children and young people with mental health problems in different settings including schools, ensuring the availability and accessibility of talking therapies - • Developing resilience in all children and young people, and early access to help for children and adults affected by abuse exploitation or neglect • Developing greater internet safety and education tools for parents and children • Focussed mental health promotion and suicide prevention interventions on men, especially those aged 34-49 years. These interventions will need to be targeted through organisations such as Job Centre Plus, as well as other community, workplace and health settings. • Reducing the stigma associated with help seeking behaviour • Invest in campaigns to end loneliness and social isolation • Ensuring that mental health needs are given equal consideration to physical health needs by staff supporting people with a substance misuse issue, a long term condition, or chronic pain, and provide support for self management – • Improving the extent of emotional support offered in workplaces with a significant male workforce, especially those at risk of job loss	• Enhanced early childhood home visits to young low income first time mothers (Family Nurse Partnership Programme) • Early help assessment and pathways to support for children who are already showing signs of social emotional and behavioural problems. • Targeted screening and support for children and young people most at risk (eg children who are looked after). • Mental health screening, assessment and support for new mothers before during and after pregnancy • A whole school approach to emotional wellbeing, including school based resilience, skills building and help seeking programmes (PHE 2015) • Mental health awareness programmes in schools • Anti bullying programmes • Mentoring programmes to enhance connectedness between vulnerable young people and supportive and stable nurturing adults • The Samaritans '*We're in your corner'* campaign is designed to raise awareness of men and suicide and encourage men to seek early help • MIND and Mental Health Foundation's *'Building resilient communities. Making Every Contact Count for Public Mental Health'.* • Wilkins D. and Kemple M. *'Delivering male: Effective practice in male mental health' Mens Health Forum and MIND, (2011, National Mental Health Development Unit* • The Mental Health Foundation Report*, The Lonely Society 2010,* details steps that everyone can take to reduce isolation and loneliness • The 'Campaign to End Loneliness' toolkit focuses on older people • NICE Guidance on workplace health and wellbeing • Lesbian Gay and Bi sexual and Trans Public Health Outcomes Framework Companion Document
Priority Action 3: Reduce access to the means of suicide		

	• Working with local planners and developers to include suicide risk in health and safety considerations when designing structures • Partner agencies ensure safety measures are in place to reduce access to the means of suicide, including barriers, CCTV, signposting and displaying contact details to helplines at known high risk locations, as well as staff training working at or close to 'known hotspots' • Local authorities work with pharmacies to support safe medicine management - • Coroners alert local services to evidence that suggests particular methods/or locations of concern • Ensure partnership work is in place to prevent suicides at high risk locations, including joint training, and communication introducing physical barriers at sites of specific concern and evaluation of efforts to reduce suicides for frontline staff working at or close to key locations and emergency responders • Restrictions on media reporting of suicides at key locations • Ongoing monitoring of events at locations of concern to assess the effectiveness of interventions	• NHS Scotland (2012) *'Guidance on Action to reduce suicides at locations of concern'*
Priority Action 4: Provide better information and support for those bereaved or affected by suicide (postvention)		
	• Formal training and organisational support for emergency service responders, mental health and other involved professionals and those supporting the bereaved, as part of mainstream	• NHS Scotland (2013) *'Supporting people bereaved by suicide. A good practice guide for organisations that respond to suicide'* • (2008) '*Help is at Hand. A resource for people bereaved by*

	professional practice • Ensuring relatives and others bereaved by suicide, (including adolescent friends) have timely access to specialist bereavement counselling and informal support groups, and/or have information about where to get support in the future	*suicide, and other sudden traumatic death'* • Samaritans (2014) *'Help when we needed it most. How to prepare for and respond to suicide in schools and colleges'* Provides core advice to schools faced with a suicide or attempted suicide.
Priority Action 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour		
	• Engaging with local radio, newspaper and TV journalists to promote responsible reporting and portrayal of suicide and suicidal behaviour , following national media guidelines on sensitive reporting • Supporting the local media to reduce stigma and highlight where people can access support • Promote public understanding that suicides are preventable	• The Samaritans '*Media Guidelines for the reporting of Suicide'* (2013)
Priority Action 6: Support research, data collection and monitoring		
	• Local authorities complete a regular multiagency audit of suicides and attempted suicides, gathering evidence from all key agencies to consider local trends and translate into meaningful local intelligence • Local authorities work with the Coroner and police as well as other local agencies to develop an early warning system for early identification of possible repeat or cluster events • Local authorities and key partners regularly monitor and report on the epidemiology of suicide risk	• National Institute for Mental health (NIMHE) 2006. Suicide Audit in Primary Care Trust Localities. A tool to support population based audits of suicides and open verdicts. • There is evidence from other areas that introducing a Self-Harm Register in A&E would allow rates and patterns of self-harm to be monitored locally, including risk factors for repetition and suicide as well as the medicines taken in overdose, thereby informing and supporting local suicide prevention efforts. • All Party Parliamentary Group (APPG) on Suicide and Self harm prevention. Inquiry into local suicide prevention plans in England. (2015).

	• Local authorities with partners ensure the learning from this is shared between primary and secondary care, mental health services, public health, the police, probation, the Coroner, and prison services (where necessary), with clear recommendations for improvements in practice • Local authorities with partners maintain a regular profile of the level of provision, accessibility and quality of local services, and ensure they meet diversity and equality standards • Local authorities and partners share local and national examples of evidence based interventions and best practice tools to support local service developments	

(See Appendix VII for references)

Caveats and health warnings on the evidence

- It should be noted that very few interventions to date have been evaluated by more than a small number of studies and the number of high quality studies is relatively small. However, that is not to say that lack of evidence means that available interventions do not work.
- The evidence of effectiveness presented in this very brief summary of systematic reviews applies to specific groups and specific populations. Other factors such as the cultural, social and socio economic context, can limit the transferability of suicide prevention - interventions.
- Most of the evidence from systematic reviews report on intermediate outcomes, such as risk and protective factors and rates of repeated self harm in certain populations, but not on actual mortality rates
- In the absence of a fully developed evidence base, current recommendations are that practice should focus on those approaches where there is consistent support in the literature and the least evidence of potential harm

APPENDIX III – SUMMARY OF NATIONAL DOCUMENTS

Preventing suicide in England: Two years on (2015)

This document sets out what local areas can consider for the next year.

Guidance for developing a local suicide prevention plan (2014)

In late 2014, Public Health England (PHE) published 'Guidance for developing a local suicide prevention plan'.

Refreshing our local approach to collecting and analysing suicide data is considered a key local priority.

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2014)

The Inquiry report covers deaths by suicide for the period January 2001 to December 2012. Information on all general population suicides (i.e. deaths by intentional self-harm and deaths from undetermined intent) by individuals aged 10 and over is collected from the Office for National Statistics (ONS). Comparisons are made against those identified as patient suicides, i.e. the person had been in contact with mental health services in the 12 months prior to death.

Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis (2014)

The 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.

Preventing suicide in England: One year on (2014)

Published by the Department of Health, One Year On sets out the developments since the launch of the national 'Prevention suicide in England (2012) strategy' and highlights the areas where things need to be done in 2014.

Why children die: death in infants, children, and young people in the UK (2014)

This report recommends national analysis to be completed on young people's suicides and a confirmed a concerted and sustained policy response "to the problem of violence and self-harm among Britain's young people is needed urgently to address the lack of progress in reducing deaths and injuries from these causes."

Public Health Outcomes Framework (2011-2013)

The national PHOF includes suicide rate. (4.10) Age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population: North Lincolnshire 11.2

England average 8.8

No health without mental health: A cross-government mental health outcomes strategy for people of all ages (2011)

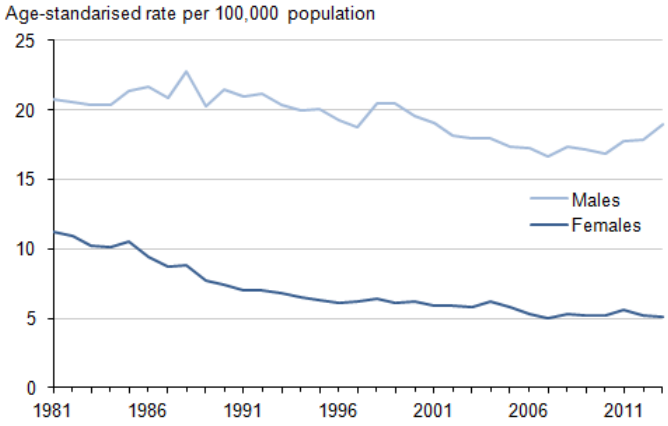
'No Health without mental health' is the government's national strategy for mental health. It describes cross-government actions to support the delivery of the mental health strategy, many of which have direct relevance to suicide prevention.

Healthy lives, healthy people: Our strategy for public health in England (2010)

'Healthy lives health people' is a public health strategy giving parity of esteem to mental as well as physical health. It recognises that self-esteem, confidence, resilience and control have an important impact on our health and behaviour.

APPENDIX IV AGE-STANDARDISED SUICIDE RATES

by sex, deaths registered in each year from 1981 to 2013 (United Kingdom)



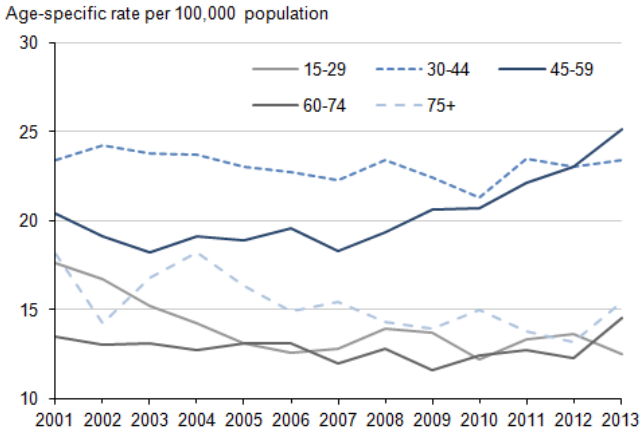
Source: Office for National Statistics, Northern Ireland Statistics and Research Agency, National Records of Scotland[6].

Registered deaths by suicide for females have generally been decreasing year on year and currently sit around 5 per 100,000 population. Rates for males have not fallen in line with the trend for women, and are on the increase, sitting at 19 per 100,000.

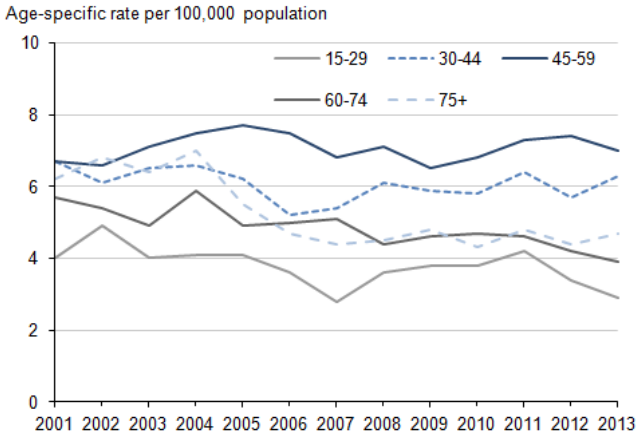
[6] **Graph Notes:**
1. The National Statistics definition of suicide is given in the section 'Suicide definition'.
2. Figures are for persons aged 15 years and over.
3. Rates per 100,000 population, standardised to the European Standard Population (2013). Prior to 1994, the upper age group was 85+ rather than 90+.
4. Deaths of non-residents are included in figures for the UK.
5. Figures are for deaths registered in each calendar year.

SUICIDES BY SEX AND AGE

Age-specific suicide rate, males, deaths registered in each year from 2002 to 2013 (United Kingdom)



Age-specific suicide rate, females, deaths registered in each year from 2002 to 2013 (United Kingdom)

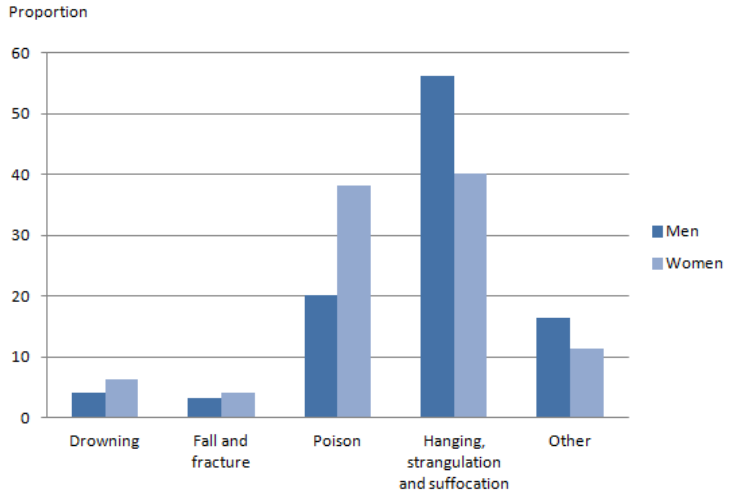


Source: Office for National Statistics, Northern Ireland Statistics and Research Agency, National Records of Scotland[7].

[7] See above.

METHODS OF SUICIDE

Proportion of suicides by method and sex, United Kingdom, deaths registered in 2013



Source: Office for National Statistics, Northern Ireland Statistics and Research Agency, National Records of Scotland[8]

Statistics show for all deaths registered in 2013 death by poisoning, or hanging, strangulation and / or suffocation are significantly higher than other methods for females, both sitting around the 40 mark. For men, hanging, strangulation and / or suffocation is significantly higher than all other methods.

[8] **Notes:**
1. The National Statistics definition of suicide is given in the 'Suicide definition' tab.
2. Figures are for persons aged 15 years and over.
3. Deaths of non-residents are included in figures for the UK.
4. Figures are for deaths registered in 2013.

APPENDIX V – SUICIDE RISK FACTORS

Some groups of people are known to be at higher risk of suicide than the general population. Preventing Suicide in England (2012) identifies those at high risk of suicide as:

- young and middle-aged men
- people in the care of mental health services, including inpatients
- people with a history of self-harm
- physically disabling or painful illnesses including chronic pain
- alcohol and drug misuse
- people experiencing stressful life events:
  - Loss of a job
  - Debt
  - Living alone, or becoming socially excluded or isolated
  - Bereavement
  - Family breakdown and conflict including divorce and family mental health problems
  - Imprisonment
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

Middle-aged men are identified as one of the high-risk groups who are a priority for suicide prevention. A recent report by the Samaritans suggested that middle-aged men, especially those from poorer socio-economic backgrounds are particularly at risk of suicide due to a combination of factors. These include social and cultural changes (for example, rising female employment and greater solo living) that have particularly impacted on the lives of the cohort of men who are now in mid-life).

The following table adapted from information from the 'mental health specialist library' website, lists groups of people identified with higher risk of suicide. The estimated increased suicide risk is given and provides a tool to compare risk between the various groups.

This table highlights the increased risk of suicide in people in the four week period following discharge from psychiatric hospital care with an increased risk of X 100 – 200.

Increased risk of suicide for specific high risk groups compared to the general population (ref: Cambs/Notts Strategies)

High risk groups	**Estimated increased risk**
Males compared to females	X 2-3
People recently discharged from in-patient services	X 10
4 weeks following discharge from psychiatric hospital	X 100-200
People who have deliberately self-harmed in the past	X 10-30
Alcohol misuse and dependency	X 5-20
Drug misusers	X 10-20
Family history of suicide	X 3-4
Serious physical illness disability	Not known/under review (Bazalgette et al., 2011)
Prisoners	X 9-10
Offenders serving non-custodial sentences	X 8-13
Offenders - general	Not known
Doctors	X 2
Farmers	X 2
Unemployed people	X 2-3
Divorced people	X 2-5
People on low incomes (social class IV/V)	X 4

Source: Adapted from information on Mental Health Specialist Library website at www.library.nhs.uk/mentalhealth

Factors associated with increased risk of suicide (reference Notts Strategy)

Suicide is often precipitated by recent adverse events including relationship breakdowns, conflicts, legal problems, financial concerns and interpersonal losses. There is also research into the links between suicide and terminal and/or chronic illness.

The following points are important in terms of developing strategies for suicide prevention.

- In up to half of all suicides there have previously been ***failed attempts***
- A quarter of people (nationally) who die by suicide are ***under psychiatric care*** in the year before their death (i.e. 75% are not)
- 5-10% of all suicides happen in the ***four weeks after discharge from psychiatric*** hospital, making this a time of high risk
- Following a suicide attempt or completion, adolescents are at an ***increased risk of copycat suicides***. Reports indicates that youth suicide can increase two to four times more following exposure to another individual's suicide than among older age groups
- A number of ***occupational groups*** - doctors, farmers, vets, dentists and pharmacists - are at increased risk of suicide, although deaths in these groups make up only 1-2% of all suicides. One important factor influencing the increased risk in these occupations is their access to lethal means of suicide
- A follow-up study of patients at a general hospital, reported a 0.7% risk of adults dying by suicide in the year following self-harm, a 1.7% risk within five years and 2.4% at ten years. The ***risk was far higher in men than in women***
- ***More men die from suicide than women***, but suicidal thoughts and self-harm are more common in women.

Groups who have more frequent thoughts of suicide are:

- Women
- Those aged 16-24
- Those not in a stable relationship
- Those with low levels of social support
- Those who are unemployed.

Mental health services and suicide

The National Confidential Inquiry into mental health services and suicides is being undertaken, information and evidence will be used locally when published, date TBC.

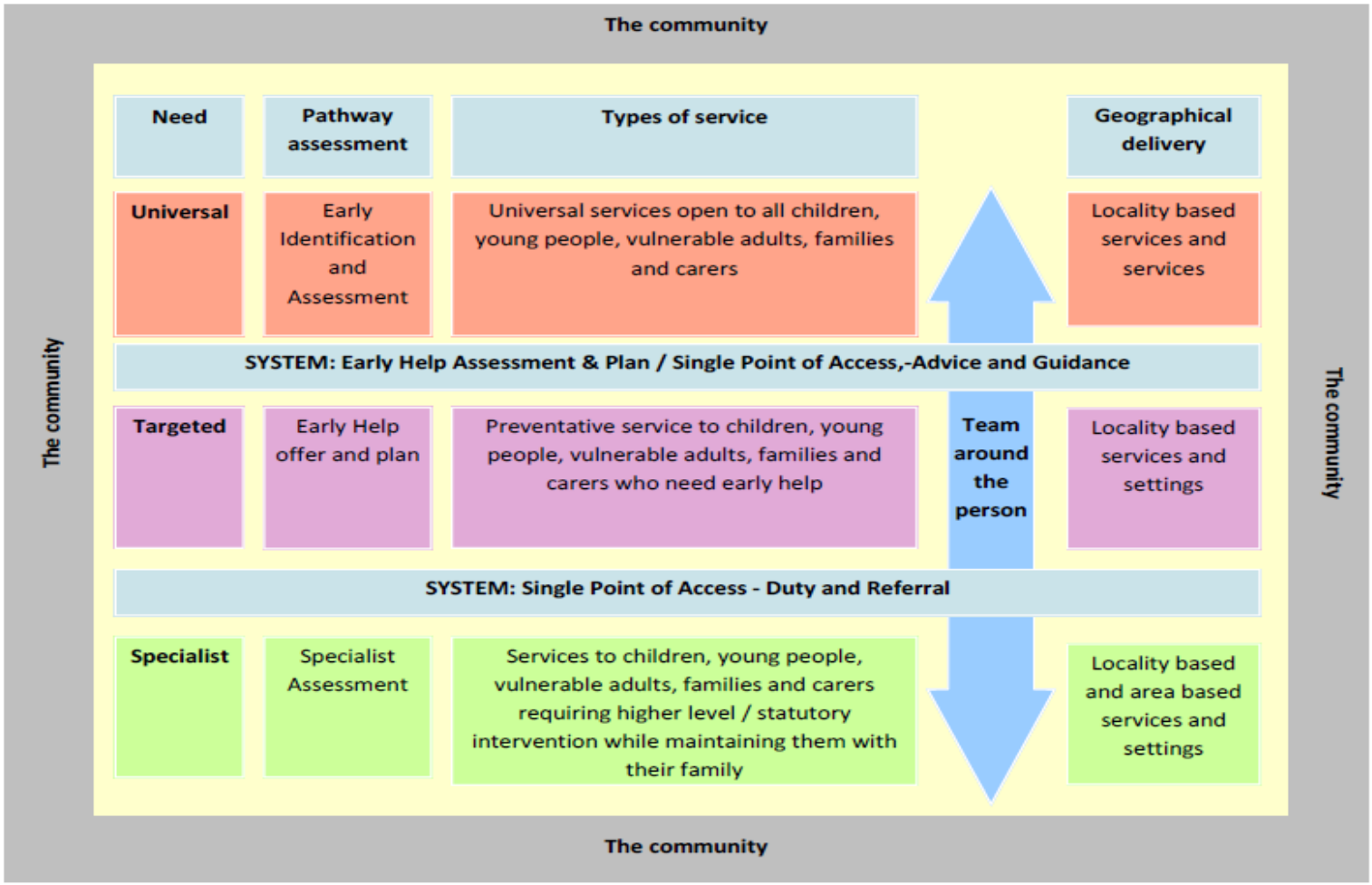
APPENDIX VIa – TRANSFORMING SERVICES THROUGH WHOLE SYSTEM INTEGRATION

The Health and Wellbeing Board's ambition for integration is 'the right service, at the right time, in the right place, with the right management'. In North Lincolnshire we want to commission and transform services so that people use their strengths and abilities to be more independent and caring; people are active citizens and help to build active communities; people are given a choice and can access services when they need them; and services can innovate to improve outcomes and ensure value for money.

Locally we have agreed that the Single Organisational Model will provide the basis on which services can be organised on levels of need and enable integration.

The model represents a framework to describe the level of need that individuals and their families/carers may have and the nature of services that are available at each level. The level of need and service provision will be designed to meet need. The model does not represent a hierarchical pathway. We will actively work to ensure vulnerable adults and their families/carers are as independent as possible with the lowest level of intervention required. However, this will not prevent the right service being offered at the right time, for example, so vulnerable adults may need specialist services from the start.

APPENDIX VIb – NORTH LINCOLNSHIRE SINGLE ORGANISATIONAL MODEL



APPENDIX VII – REFERENCES

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