SUICIDE PREVENTION STRATEGY 2018-2023

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> **Our vision is to make Wakefield a district where no one ever gets to a point where they feel suicide is their only option.**

For further information please contact the public health team. We welcome feedback about our suicide prevention strategy or any of our other documents.

If you have any comments please speak to the Public Health team on:

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This report is available online at **www.wakefield.gov.uk/mentalhealth**

Suicide is the biggest killer of people under the age of 35 and the biggest killer of men under the age of 50. It is the leading cause of death in the UK for 10-19 year olds. They are the result of the ultimate loss of hope and the ultimate loss of meaning of purpose. It devastates families and leaves a lasting impact. However, suicide is not inevitable and is preventable.

Executive Summary

Since a historical low in 2007 the suicide rate in England, Yorkshire and Wakefield District has steadily risen. Over 4,700 people took their own life in England in 2015. Wakefield has a slightly higher rate of suicide than the national average.

During 2014-16 **on average one person took their own life every 12 days in Wakefield District**. Men accounted for 86% of these suicides, compared to 75% nationally. One in five people considers suicide at some point in their lives.

The human cost of death by suicide is high and tends to have an especially heightened and widespread effect for those in the family and beyond. Research suggests that around 135 people may be affected by each person dying by suicide. This can impact on people's ability to work, to continue with caring responsibilities and to have satisfying relationships.

National guidance recommends that every Local Authority carries out a suicide audit, develops a suicide prevention action plan, and establishes a multi-agency group to co-ordinate effective action within the local area.

In line with this guidance, this strategy has been developed by actively engaging local partnerships, using local data and intelligence and with reference to regional and national strategies. A multi-agency governance structure has been developed to manage delivery of the strategy, and monitor how well it is achieving its aims.

Our ambition in Wakefield is consistent with the national suicide prevention strategy for England, the regional West Yorkshire and Harrogate Health Care Partnership (WYHHCP) and South West Yorkshire Partnership Foundation Trust (SWYPFT) suicide prevention strategies in the aspiration of zero suicides.

This work is based on existing provision and resources with no new funding. It is underpinned by the assumption that more can be delivered by improved co-ordination of the many agencies involved, all working to a common aim and plan.

Priorities for Action

1. Reduce the risk of suicide in high risk groups (particularly men aged 30-49, and children and young people).
2. Reduce access to the means of suicide.
3. Provide better information and support to those bereaved or affected by suicide.
4. Develop public campaigns and support the media in delivering sensitive approaches to suicide and suicidal behaviour.
5. Support research, data collection, surveillance and monitoring.
6. Reduce the rate of self-harm and suicide for children and young people.
7. Support and coordinate training to raise awareness and reduce the risk from suicide
8. Develop effective partnerships and collaborative working via multi-agency working

Introduction

The prevention of suicide is both complex and challenging, and no single initiative or organisation can prevent suicide on its own. A comprehensive and co-ordinated approach is required across government and non-governmental organisations, and in partnership with the community.

In 2012 the government, through its national strategy, *Preventing suicide in England: A cross-government outcomes strategy to save lives*, identified six key areas for action to achieve its objectives of reducing the suicide rate, and providing better support for those bereaved or affected by suicide.

The six key areas are:

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

The government has committed to reducing the suicide rate by 10 per cent by 2020/21 (WHO, 2014; The Mental Health Task Force, 2016). To support implementation locally, in 2016 Public Health England (PHE) published Local suicide prevention planning: a practical resource targeted at public health teams within local authorities. However, public health teams are unlikely to affect change in isolation and a co-ordinated multi-agency approach is needed.

In 2017, the national strategy's annual progress report recommended that every local authority carries out a suicide audit, develops a suicide prevention action plan, and establishes a multi-agency group to co-ordinate effective local action. In line with this guidance a multi-agency governance structure is being developed to manage delivery of the plan, and monitor how well it is achieving its aim. A suicide audit has been carried out in Wakefield. The findings from this audit along with the national six key areas for action nationally are being used as the driving objectives for the suicide prevention plan.

Our strategy will be closely aligned to the aims of both the SWYPFT Suicide Prevention Strategy 2016-19 and the West Yorkshire and Harrogate Health and Care Partnership Suicide Prevention Five year strategy 2017-2022, in particular the focus on reducing the impact of social factors on suicide risk, and supporting those who might otherwise not have engaged with services. Wakefield will also implement national guidance with the aim of reducing deaths by suicide and providing greater support for those affected by death by suicide.

A suicide prevention pathway and multi-agency group for children and young people is also being developed. This will link closely to the main action plan but recognise the different risk factors for children and young people (for example exam stress, bereavement) and the opportunities to intervene (for example, through preventative work with schools).

Background

Suicide is the biggest killer of men under 50 and the primary cause of premature death in young people, pregnant women and new mothers (HM Government, 2017). It is the leading cause of death for 10-19 year olds in the UK. The estimated economic cost of every suicide of someone of working age in England is £1.67 million (PHE, 2016). For every completed suicide it is estimated there has been over twenty other attempts (WHO, 2014). Each suicide is a tragedy and can have a far-reaching impact on families, friends and the wider community. For every person that dies at least ten people are directly affected (PHE, 2016), known as the iceberg effect (see Figure 1.). Furthermore, many of these tragic deaths are avoidable.

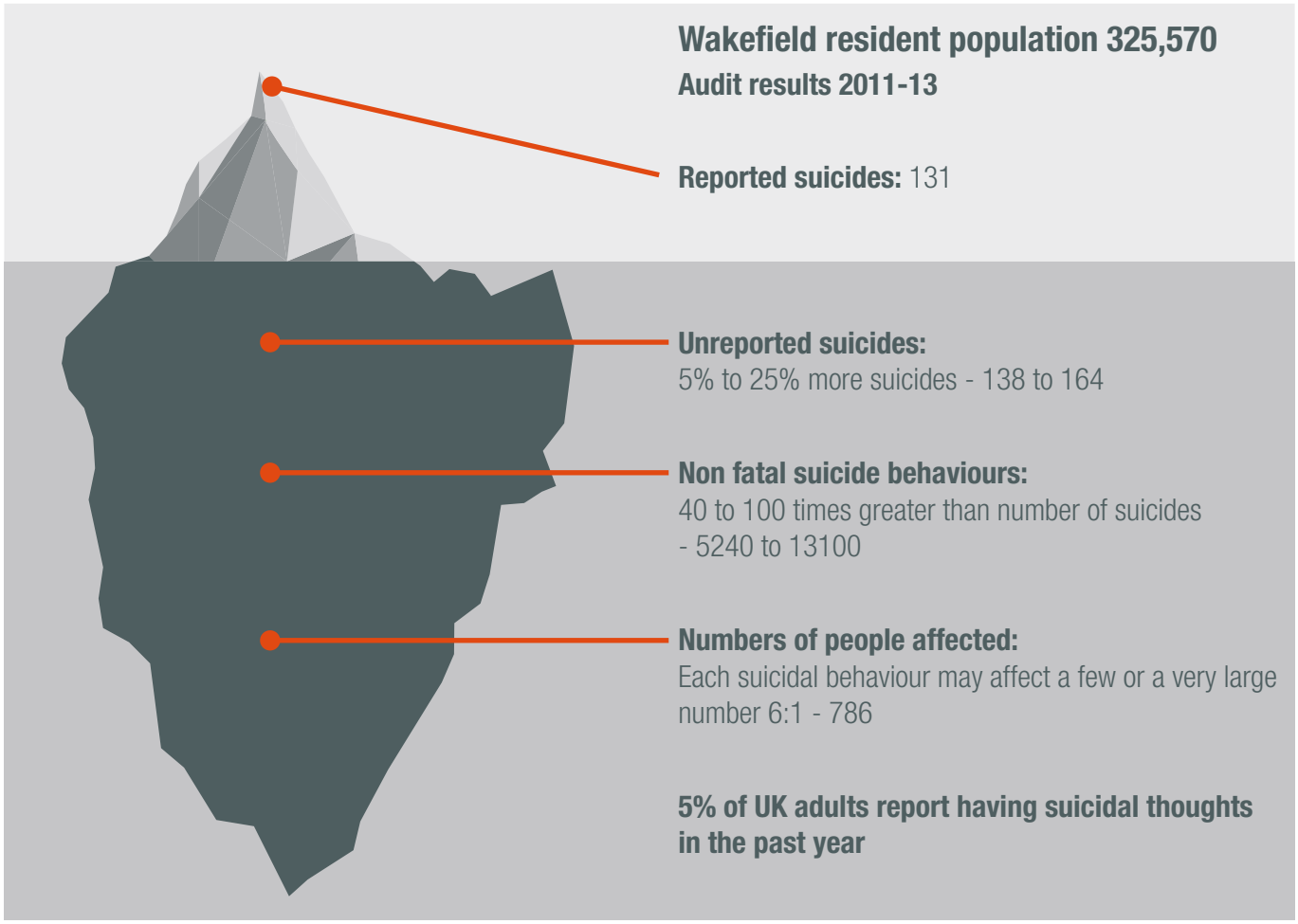
Risk Factors

Often suicidal acts are the result of a culmination of several causes or life stressors rather than one single risk factor. Common risk factors include: alcohol and substance misuse; financial problems; relationship problems; pain and ill-health; mental health problems; isolation and loneliness; violence and abuse (WHO, 2014). The strongest predictor of suicide is previous suicide attempts.

There are also a number of high risk groups including: young and middle-aged men; patients of mental health services; those in the criminal justice system; those with a history of self-harm; certain occupations including doctors, nurses, vets, and farmers (HM Government, 2012).

Figure 1

Iceberg effect for suicides (2011- 2013 Wakefield District data)



Mental ill-health

Depression is one of the most important risk factors for suicide and whilst there is a clear link between suicide and mental ill-health, many suicides are often impulsive acts during periods of crisis. Around a third of people who take their own lives had no contact with health services within the year before their death (House of Commons Health Committee, 2016). Similarly, in a national enquiry into deaths of young people under 25, only 60% of young people who died were known to services and only 42% in recent contact.

Self-harm

People who self-harm are at increased risk of suicide, although many who self-harm do not intend to take their own lives when they self-harm. At least half of those people who take their own life have a history of self-harm and one in four have been treated in hospital for self-harm in the preceding year. There are around 200,000 episodes of self-harm that present to hospital services each year.

In contrast to suicide, the rates of self-harm are highest in girls and women - the highest incidence being among 15-19 year olds. 57% of young people under 24 who took their own life had previously self-harmed. The Confidential Inquiry Report (NCHISH, 2017) describes self-harm as a 'crucial indicator of risk [which] should always be taken seriously, even when the physical harm is minor'. Since thankfully many more young people self-harm than take their own lives, this presents a challenge for services which will be addressed in the children and young people's pathway.

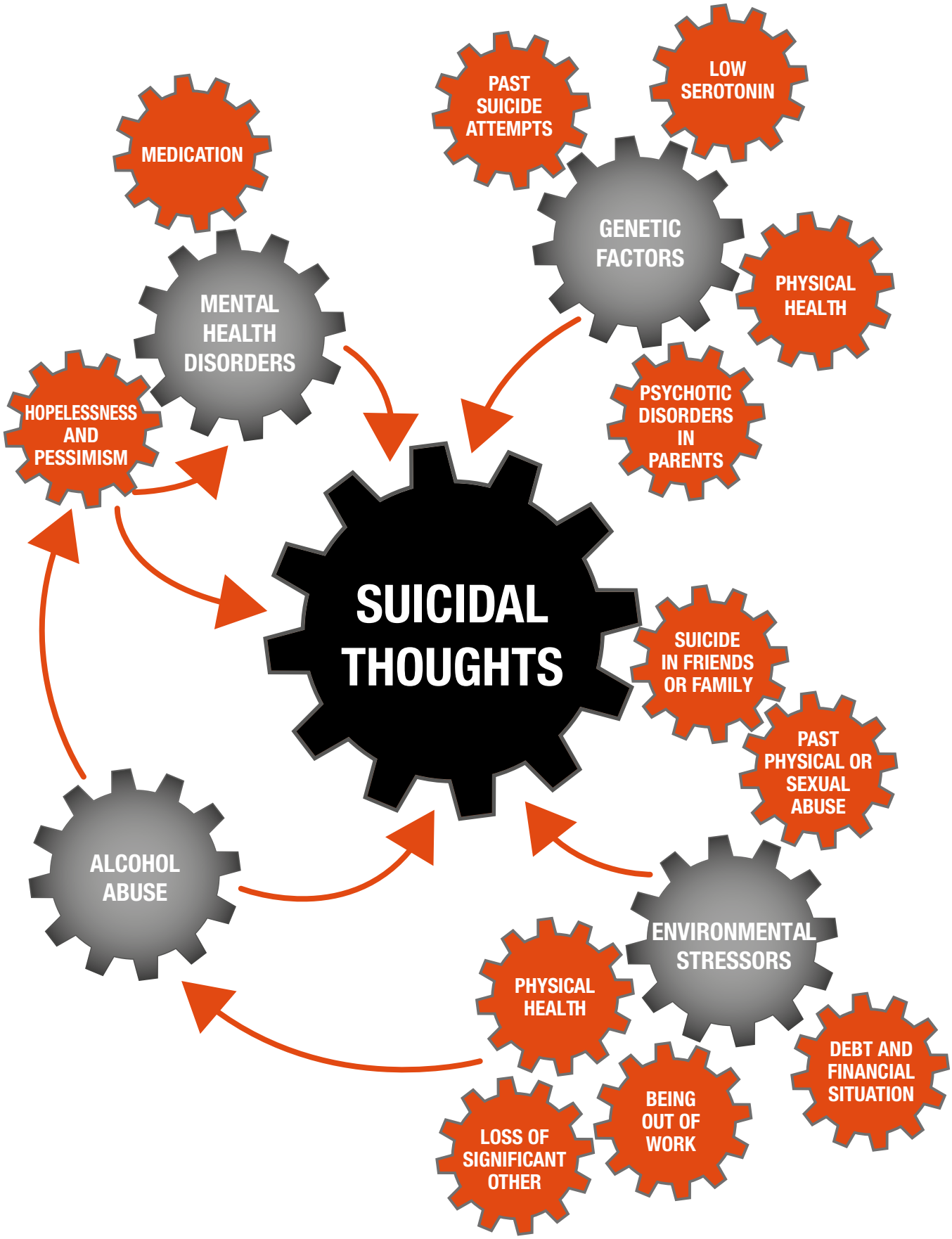
Self-harm occurs in all sections of the population but is more common among people who are disadvantaged in socio-economic terms and among those who are single or divorced, live alone, are single parents or have a severe lack of social support. According to the National Institute for Health and Care Excellence (NICE), risk factors for self-harm include a number of other 'associations' such as: life events; alcohol and drug use; mental disorder; child abuse, domestic abuse and being within the criminal justice system. Within this are special groups such as young people. There are others for whom the evidence is not so well collected such as gay men, lesbians, bi-sexual and transsexual communities.

Inequality

Suicide is also associated with inequality. Those from the lowest socio-economic groups and living in the most deprived areas are at ten times greater risk of suicide than those from wealthier backgrounds living in the least deprived areas (House of Commons Health Committee, 2016). Low income, unmanageable debt, lack of educational qualifications, unemployment, poor housing conditions and homelessness are all features of socioeconomic disadvantage. The risk of suicide is also greater amongst housing tenants compared to home owners, for both men and women (Samaritans, 2017).

The diagram opposite illustrates the complex relationship between the factors which may influence suicidal thoughts. Grey shapes indicate the groups each factor belongs to, based on existing research. Known factors are illustrated in orange and where there is a relationship between different factors these are identified via the arrows.

Figure. 2



Adapted from Pompili et al. (2010)

The National Picture

Rates of Suicide

The rates of suicide have steadily risen in England since 2007 after many years of a declining rate and in 2014 was the highest rate for ten years. In 2015 there was a slight decline in both the overall and male rates of suicide but an increase in the rate for females. Despite this males still accounted for three quarters of all suicides in England (ONS, 2016), a group least likely to seek help (HM Government, 2012).

Rates of suicide in children and young people are lower in the UK compared to other countries, data from the Office for National Statistics (ONS) also indicates overall rates in the UK appear to have been relatively static over the last ten years. Rates of self-harm in young people have also risen significantly in the last fifteen years.

Methods of Suicide

In 2013 hanging (including strangulation and suffocation) was the most common method of suicide for both sexes (male 57%, female 41%). This was the first year it was the most common method for females. Drug poisoning is the second most common method.

Suicide by Occupation

For males, between 2011 and 2015, the suicide rate was highest in the following major occupational groups: elementary; skilled trade; caring, leisure and other services; process, plant and machine operatives. The lowest rates of suicides occurred in professional occupations such as: managers, directors and senior officials. For females, the suicide rate was highest in: process, plant and machine operatives; skilled trade; and unskilled occupations, with the lowest rates of suicides occurring in managers, directors and senior official, administrative and secretarial occupations (ONS, 2017).

Figure 3

WAKEFIELD SUICIDE FACTSHEET

Data from the Adult Psychiatric Morbidly Survey (APMS) 2014

ALMOST DOUBLE

THE NUMBER OF PEOPLE WITH A DRINK PROBLEM HAVE THOUGHT ABOUT SUICIDE COMPARED TO THOSE WHO DON'T

WHO HAVE EXPERIENCED A MAJOR FINANCIAL CRISIS HAVE HAD SUICIDAL THOUGHTS, COMPARED TO 19% OF PEOPLE WHO HAVE MOSTLY BEEN FINANCIALLY STABLE

2 in 3 PEOPLE

ON EMPLOYMENT AND SUPPORT ALLOWANCE (ESA) HAVE CONSIDERED TAKING THEIR OWN LIFE AT SOME POINT, AND 1 IN 3 HAVE SELF-HARMED

OF PEOPLE

WHO HAVE HAD A CHRONIC DISEASE IN THE PAST 12 MONTHS HAVE ATTEMPTED SUICIDE, COMPARED TO 4.5% WHO ARE DISEASE FREE

THE SEVERITY

OF GENERAL MENTAL HEALTH SYMPTOMS IS STRONGLY ASSOCIATED WITH PRESENCE OF SUICIDAL THOUGHTS, SUICIDAL ATTEMPTS AND DELIBERATE SELF-HARM

IN WAKEFIELD

MORE THAN TWICE THE NUMBER OF UNEMPLOYED PEOPLE THAN EMPLOYED PEOPLE SURVEYED HAVE ATTEMPTED SUICIDE

The Local Picture- Suicide in Wakefield

Rates of suicide for Wakefield

As with the national trend, suicide rates in Wakefield have also increased. However, unlike the national trend which has declined over the last 2 years, the suicide rate in Wakefield has continued to increase and its rate is higher than the England average and the highest since before 2001 (Figure 4) and for men (Figure 5) whereas rates of suicide for women have declined slightly (Figure 6). Table 1 compares the latest (2014-2016) rate of suicide for Wakefield and England by age and gender.

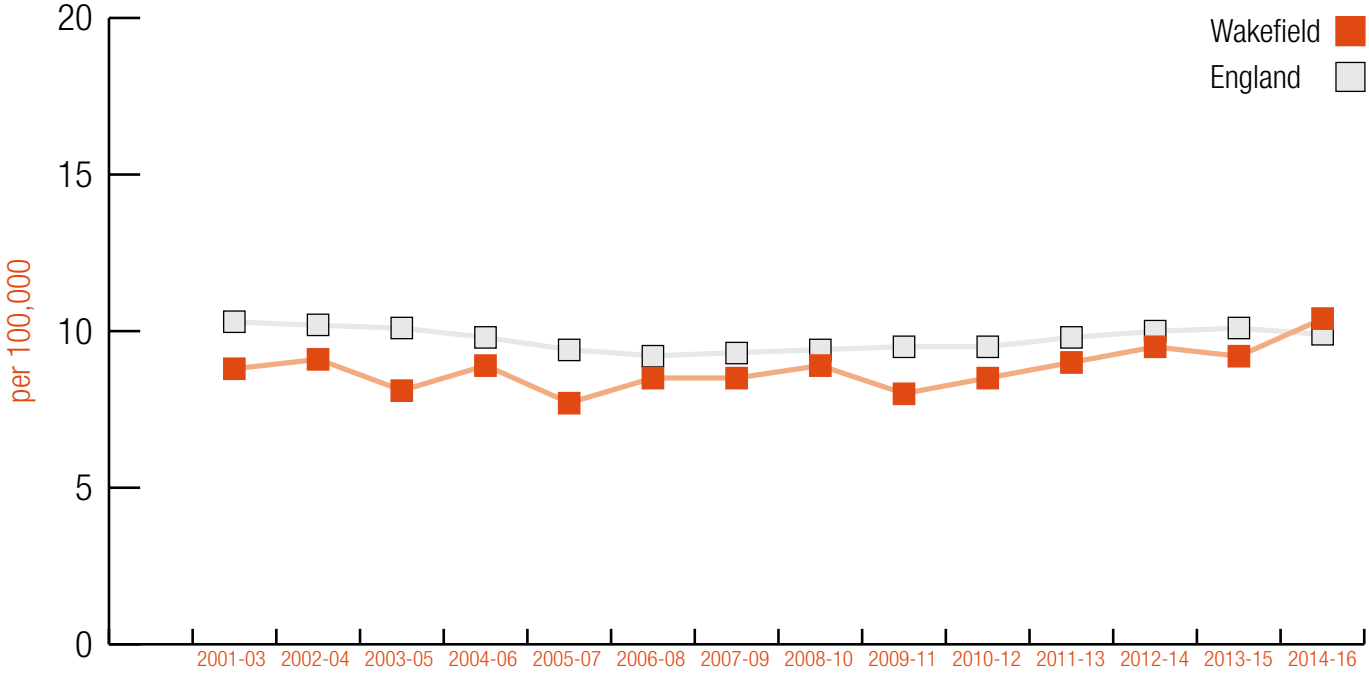
Table 1

Suicide rate	England	Wakefield
All Persons*	9.9	10.4
Male*	15.3	18.5
Female*	4.8	2.9
Male 10-34 years**	10.5	10.7
Female 10-34 years**	2.9	2.7
Men 35-64 years**	20.8	21.3
Female 35-64 years**	6.0	6.1
Male 65+ years**	12.6	8.3
Female 65+ years**	4.4	3.8

*Age-standardised rate per 100,000 population (2014-2016)
**Crude rate per 100,000 population (2011-2015)
Source: Public Health England, 2018.

Figure. 4

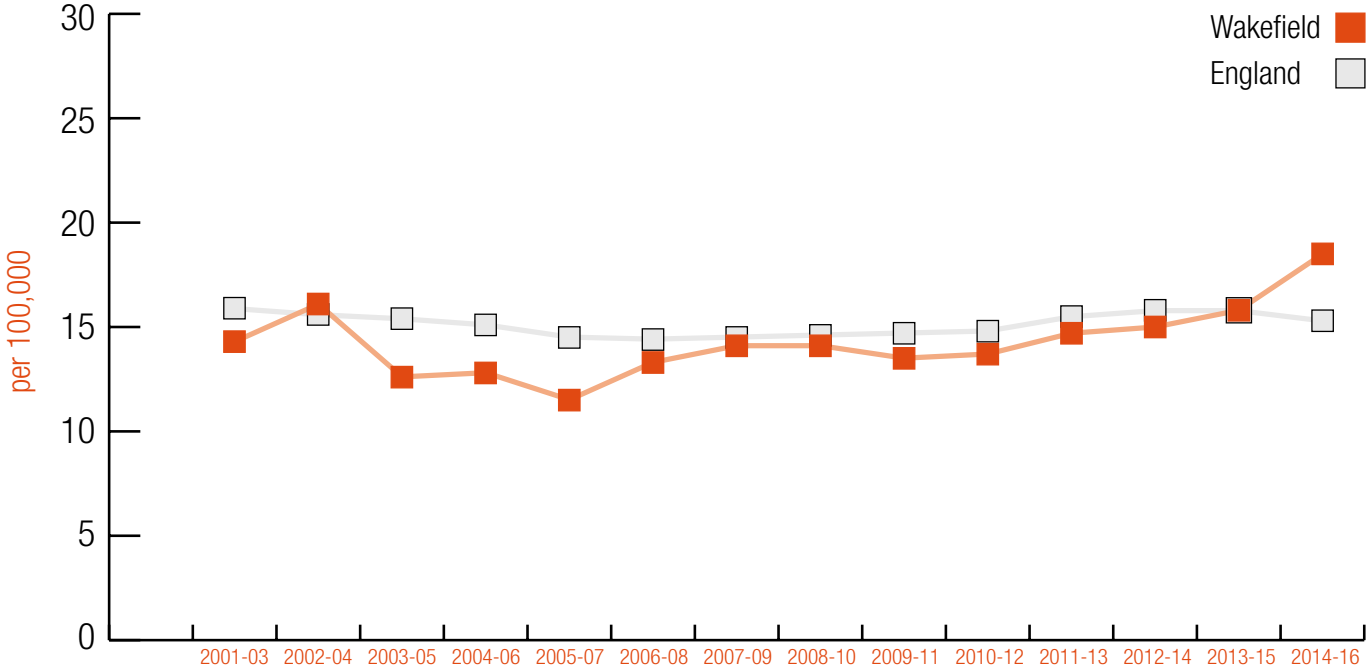
Suicide rate (Persons) - Wakefield



Source: Public Health England, 2018

Figure. 5

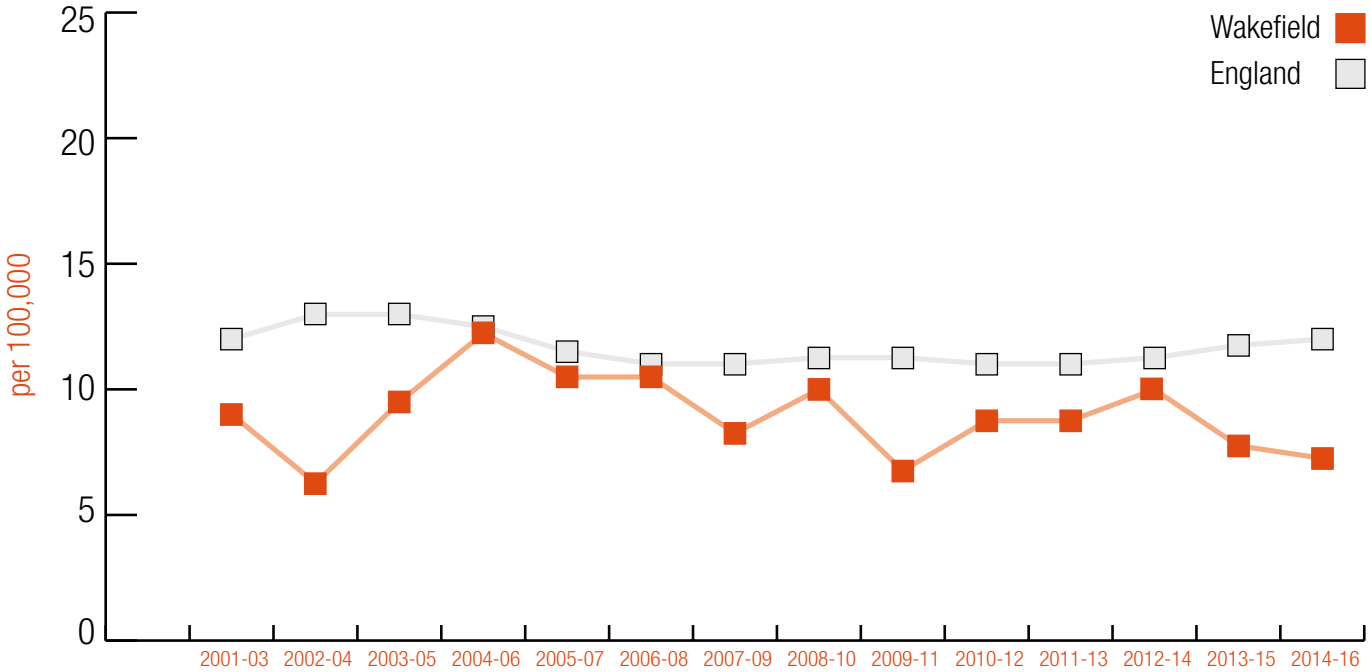
Suicide rate (Male) - Wakefield



Source: Public Health England, 2018

Figure. 6

Suicide rate (Female) - Wakefield



Source: Public Health England, 2018

Rates of self-harm

Emergency hospital admissions for intentional self-harm in Wakefield have seen a dramatic decline over the past two years and for the first time in over 5 years is lower than the national average. Wakefield figures are identified at 185.5 per 100,000 population and the England average being 196.5 per 100,000.

Suicide Audit

In 2014, in response to the increasing trend in suicides locally, Wakefield Council commissioned an audit of deaths by suicide. The aim of the audit was to present data that could be used to inform the development of a local suicide prevention action plan aimed at reducing the number of deaths in the district by suicide. The findings from the audit, which was undertaken between January 2011 and December 2013, found Wakefield was broadly similar to the national picture in terms of demographics, risk factors, methods of suicide, and other factors such as whether people identified were in contact with services. The audit found that:

- Deaths from suicide were slightly lower than the national average.
- 83% of deaths were men. This figure is higher than the national average of 78%.
- 97% of deaths were white British.
- 43% of deaths occurred in the 30 to 49 age range.
- 68% died within their own home.
- Of all 131 deaths, all had visited their GP within the twelve months prior to death.
- 62% of those who died had no current or previous contact with mental health services. Only 17% were engaged with mental health services at the time of death.
- The most common method of suicide was hanging (50%).
- 51% were single.
- 43% lived alone.
- 30% were unemployed.
- 17% had an alcohol problem although only 4% had been in contact with specialist alcohol treatment services.
- 9% had a drug problem (5% were known to specialist substance misuse services).
- 44% were in employment. This may suggest that work stresses or types of employment could also be a risk factor

Given the comparatively low local numbers of suicides (131 suicides in Wakefield 2011-2013) it can be difficult to draw firm conclusions when comparing Wakefield data with the larger populations of Yorkshire and the Humber and England. Also, the data definitions and timescales vary making comparisons more difficult. It is important to recognise that local data may give a useful indication of a possible focus rather than definitive indication of a statistically significant local difference.

Risk Factors in Children and Young People

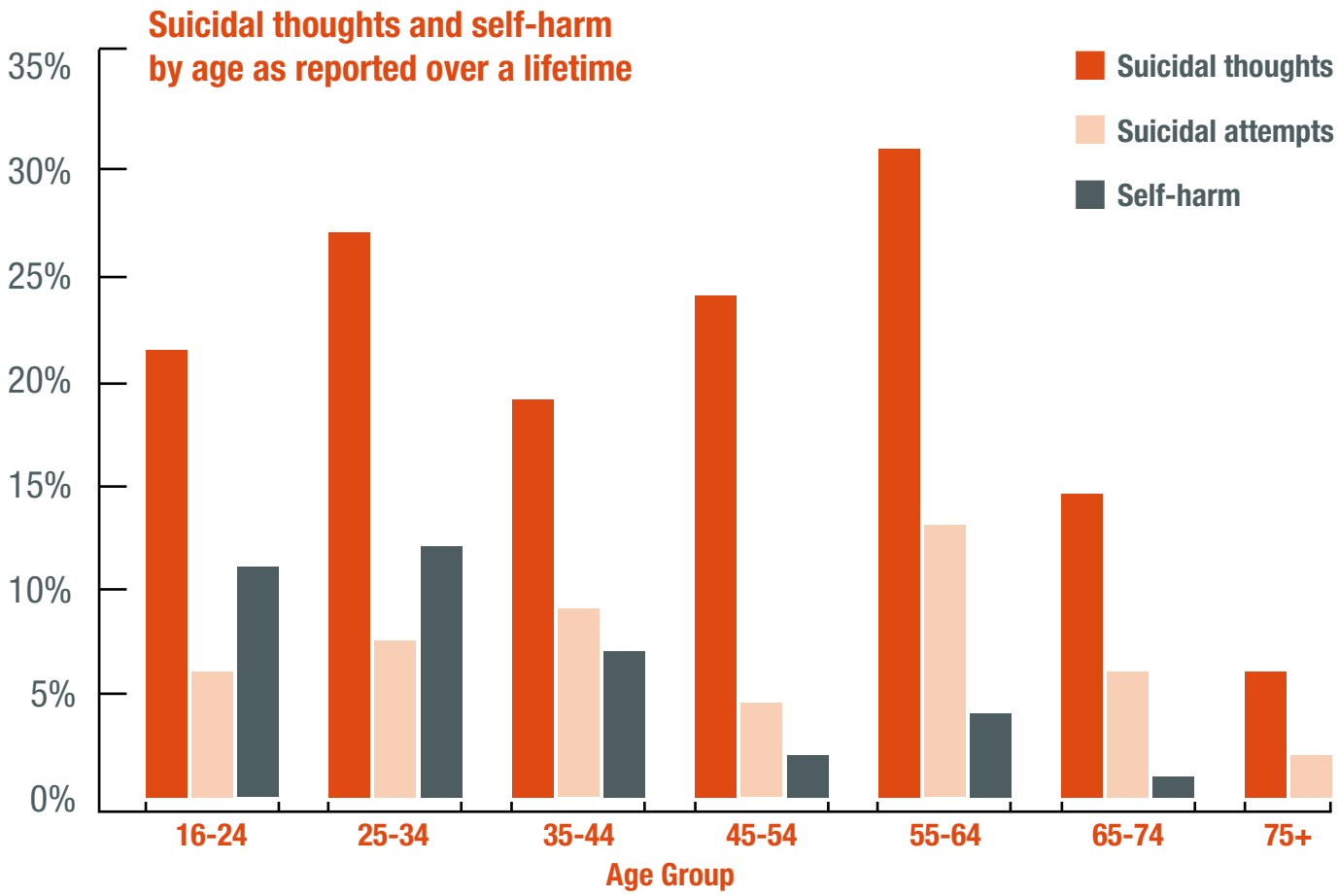
Thankfully, the numbers of children and young people taking their own lives is much smaller than for adults, although each loss is an individual tragedy. This means that it is difficult to identify local risk factors. However, the recent national study (NCHISH, 2017) has identified ten key risk factors in young people under 24, which can form the basis of prevention work in Wakefield:

- Family factors such as mental illness
- Abuse and neglect
- Bereavement and experience of suicide
- Bullying
- Suicide-related internet use
- Academic pressures, especially related to exams
- Social isolation or withdrawal
- Physical health conditions that may have social impact
- Alcohol and illicit drugs
- Mental ill health, self-harm and suicidal ideas

As the report points out, many of these risk factors are commonly encountered in childhood and adolescence, and most children navigate them successfully. The promotion of good mental health and resilience in all children and young people is a key preventative approach.

In addition, we need to address specific risk factors such as self-harm (which is more commonly reported in young people locally) and bereavement, and identify and support young people who may have suffered the cumulative effect of many of these stressors.

Figure. 7



What do we want to achieve?

Our ambition is to prevent and therefore reduce the suicide rate locally and to improve support for those bereaved or affected by suicide. This ambition is consistent with the national suicide prevention strategy for England.

Our vision for Wakefield is that no one ever gets to a point where they feel suicide is their only option.

Our Approach

There is a number of population level or public health targeted measures that can be implemented to help prevent both actual and attempted suicides. There is good evidence about how to reduce suicide rates in mental health care settings. However, there is a lack of high quality evidence about the effectiveness of suicide prevention interventions in the community, to reduce the suicide rate across a whole population. A big part of our approach is therefore aimed at improving the mental health of the population, to reduce the risk of suicide. Improving the mental health of the population as a whole is one way to reduce suicide but a holistic and integrated approach is needed to make the suicide-prevention programme focused and sustainable. Where we do not have the necessary evidence, we must be innovative and implement interventions and rigorously evaluate them. Research has already been undertaken to identify specific interventions evidenced as being effective at reducing the suicide rate, the findings from which will be used to inform the prevention plan.

The approach will:

- Encourage co-ordinated work by all the agencies (private, public and third sector) that may have an influence (however small) on suicide prevention.
- Ensure a detailed plan is developed with clear responsibility for actions.
- Encourage innovation and experimentation with appropriate and proportionate evaluation of the effectiveness of actions.
- Develop a clear pathway for risk identification and suicide prevention in children and young people
- Continue to support the promotion of good mental health, wellbeing and resilience across the whole population, especially in children and young people
- Aim to achieve more using existing resources by taking a more co-ordinated and focused approach.

Governance

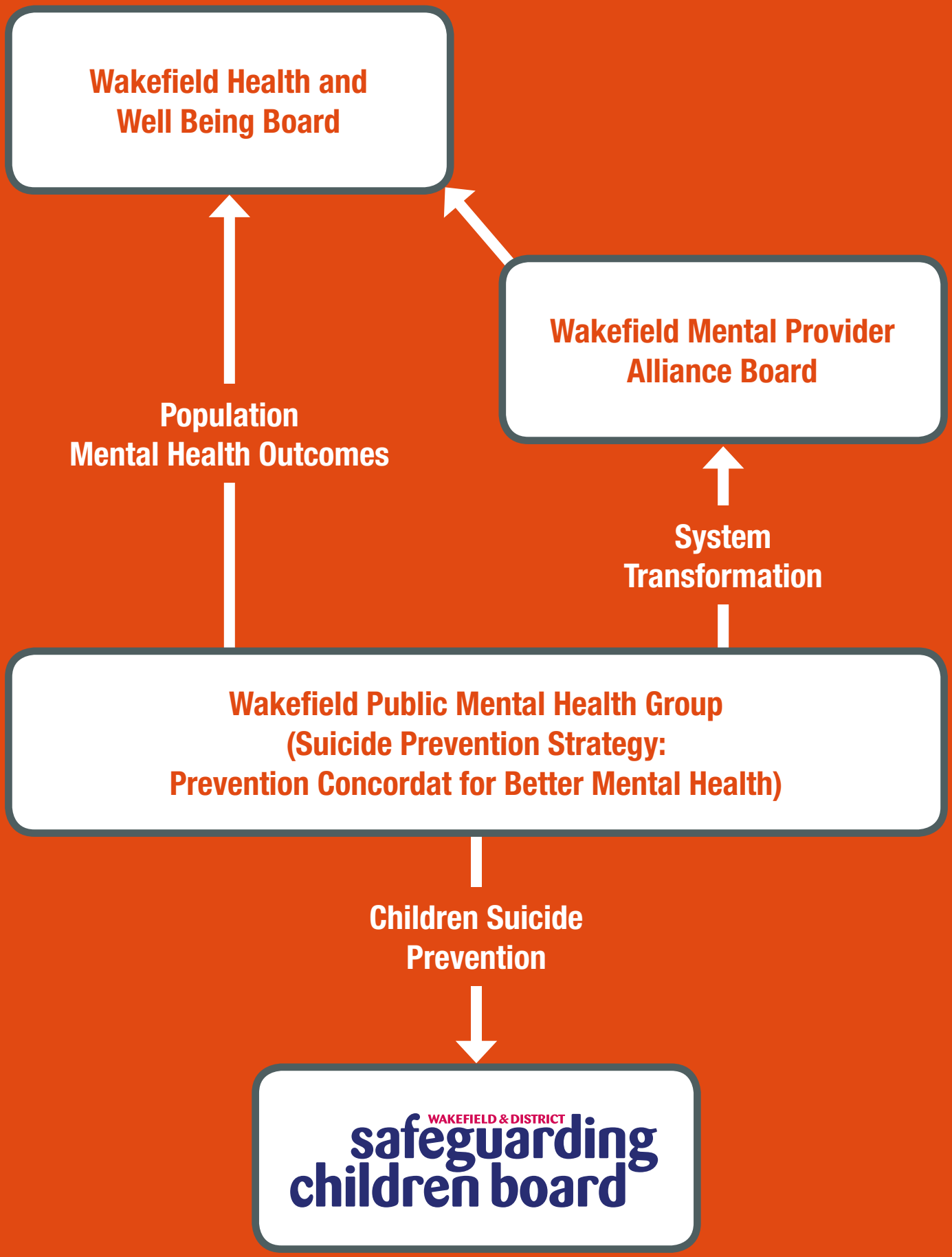
The Wakefield Health and Wellbeing Board will have oversight of the suicide prevention strategy. Responsibility for Implementing the strategy will be via the Wakefield District's Public Mental Health Group (which will also support the Prevention Concordat for Better Mental Health for Wakefield District). To do this it will also report into the newly established Mental Health Provider Alliance Board for Wakefield District (which is driving mental health service transformation). This current governance structure is outlined in Figure 8.

There will be both a national and a regional assurance process for all Local Suicide Prevention strategies in 2018/2019 to strengthen our local planning. The Yorkshire and Humber mental health and suicide prevention network (PHE/ADPH) will be conducting a peer challenge exercise in September to identify any gaps in local planning. Also, in 2018/2019, the LGA (working with ADPH and PHE) will be asking all local authorities to conduct a self-assessment exercise on their local plans for quality assurance and to identify areas of good practice nationally (to support the national strategy).

Suicide Prevention Plan

A suicide prevention plan is being developed based on eight priority action areas. These priorities have been developed via consultation with partners, using intelligence from the local suicide audit and mental health surveys, and with reference to West Yorkshire STP (Sustainability and Transformation Partnership) and national suicide prevention strategy. Below outlines current suicide prevention activity and areas where further work that is required to take our priorities forward. This section forms the basis of an action plan which will be developed with partners over time.

Figure. 8 **Current governance of the suicide prevention strategy (2018)***



** Existing governance structures are under review and subject to change. Regardless of any such changes the Wakefield Health and Wellbeing Board will retain oversight of the strategy*

Priority Action Areas

1. Reduce the risk of suicide in high risk groups (particularly men aged 30-49, and children and young people)

Current activity

- A number of events and workshops aimed at raising awareness around suicide in men have been delivered. For example, Andy's Mans Club and work with Rugby League Clubs.
- The 'luggage for life' scheme is being delivered in schools as part of the Future in Mind programme. The scheme aims to improve emotional literacy and risk and resilience in children.

Further work needed

- Investigate the link between gambling, debt, and benefit reduction with a view to informing future actions.

2. Reduce Access to Means of Suicide

Current activity

- The Samaritans have partnered with Network Rail to train staff to be suicide alert to reduce risks on the railway network.

Further work needed

- Ensure local authority planning departments and developers include suicide in health and safety considerations when designing structures which may offer suicide opportunities.

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

Current activity

- Wakefield Council has funded Wakefield Samaritans to deliver 'Facing the Future', a dedicated post-vention service available to support people bereaved/effected by suicide.

Further work needed

- Strengthen the local post-vention pathway, providing advice and information for people at on-going risk of suicide (working with Suicide Prevention Advisory Network), with dissemination of the 'Help is at Hand' booklet.
- Ensure that co-production with those affected by suicide and poor mental health is embedded within our activities (working with Wakefield Mental Health Provider Alliance).

4. Develop public campaigns and support the media in delivering sensitive approaches to suicide and suicidal behaviour.

Current activity

- A communication plan has been developed and implemented for 2018 using a locally branded 'five ways to wellbeing' campaign to support positive mental health and wellbeing.
- A dedicated website is being developed to provide appropriate information and sign-posting in relation to suicide prevention and mental health support.

Further work needed

- Work with the local media and communications departments to ensure familiar national guidelines for reporting suicide and suicidal behaviour are adopted.

5. Support research, data collection, surveillance and monitoring.

Current activity

- A Mental Health and suicide page is now available on the JSNA website which provides local intelligence about mental health and suicide.
- Monitoring trends in self-harm and suicide, and patterns of suicidal behaviour and methods. For example, via real time surveillance.

Further work needed

- Develop an early alert process (via real-time surveillance) to prompt sharing of appropriate information by the police and coroner's office, referral to support services and multi-agency response.
- Sign off (via West Yorkshire STP) an information sharing agreement to collect and act on real-time information about suicides.

6. Reduce the rate of self-harm and suicide for children and young people.

Current activity

- In collaboration with the Future in Mind Programme's a 'pathway on a page' has been developed for front line staff.

Further work needed

- Complete the multi-agency programme for Suicide and Self-harm Prevention Pathway for Children and Young People in Wakefield District. This includes a self-harm risk assessment tool for professionals; surveillance of self-harming and suicide incidents; rapid response and support for schools; and a local campaign to reduce suicide/self-harm risk in young people.

7. Support and coordinate training to raise awareness and reduce the risk from suicide.

Current activity

- Collaborated with a number of partner organisations and delivered training in conjunction with national campaigns, notably World Mental Health Day and Mental Health Awareness week.
- Specific workshops have been delivered raising awareness of suicide and mental health to front line staff of organisations whom may be faced with people in crisis. For example, 'it's good to talk' male only event and 'Safe TALK' training offered to elected members.
- Investment from the CCG and Local Authority has provided training for staff for Mental Health First Aid with both organisations going on to promote these people in the workplace as mental health champions.

Further work needed

- Train school/college staff in Youth Mental Health First Aid.
- Train more front line staff in SafeTALK, suicide alert awareness
- Support a district-wide training event about suicide prevention for primary care staff.

8. Develop effective partnerships and collaborative working via multi-agency working.

Current activity

- There is an established multi-agency Public Mental Health Group (which covers suicide prevention) and a separate Suicide & Self-Harm Prevention Group for Children and Young People (set up in response to recent suicides in young people).

Further work needed

- Agree a statement of intent, terms of reference and governance structure to support the aims and ambitions of this Suicide Prevention Strategy.
- Provide an annual update to Wakefield's Health and Well-Being Board on the progress of the Suicide Prevention Strategy.
- Actively support the West Yorkshire Suicide Prevention Advisory Network (of West Yorkshire STP).
- Work collaboratively with other partnerships with responsibility for improving mental health and well-being, and encourage the Health and Well Being board to become a member of the National Suicide Prevention Alliance.

200918 Designed and produced by Wakefield Council, Communications **09/18** recycle