Hertfordshire Suicide Prevention Strategy 2017

Our vision is to make Hertfordshire a county where no one ever gets to a point where they feel suicide is their only option

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Executive Summary

Suicide rates within England and the East of England are beginning to rise after a prolonged downwards trend. Over 4,700 people took their own life in England in 2014.

Hertfordshire has lower rates of suicide than the national and regional levels, and the trend is currently broadly stable. But this is no reason for complacency. 56 deaths were recorded as suicides and open verdicts at Coroner's inquests in Hertfordshire between April 2015 and March 2016. 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 in the USA suggests that around 135 people may be affected by each person dying by suicide. The financial cost is estimated to be around £1.5 million per death.

National guidance recommends that every local authority carries out an annual 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, we are working on actively engaging multiple agencies within the private, public and third sectors to help develop and deliver the plan. 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 recently been carried out, and it is intended that this becomes a regular undertaking.

Our ambition of zero suicides in Hertfordshire is consistent with the national suicide prevention strategy for England. It is one of the main aims of this strategy, the other being to improve support for those bereaved or affected by suicide.

This work does not rely on the provision of any extra resource. 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.

Our vision is to make Hertfordshire a county where no one ever gets to a point where they feel suicide is their only option

Introduction

In 2012 the UK Government published *Preventing suicide in England: a cross-government outcomes strategy to save lives.* This identified six key areas for action:

1. Reduce the risk of suicide in key high risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
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

In October 2016 Public Health England published *Local suicide prevention planning: a practical resource"* targeted at public health teams within local authorities.

In January 2015 the All-Party Parliamentary Group (APPG) on Suicide and Self-Harm Prevention reviewed progress and found development of local suicide prevention plans to be patchy across the country. It recommended that every local authority should carry out an annual suicide audit, have a suicide prevention action plan, and put in place a multi-agency suicide prevention group.

This strategy encapsulates how Hertfordshire is implementing national guidance with the aim of reducing deaths by suicide and providing greater support for those affected by death by suicide.

A suicide audit has been carried out in Hertfordshire[1]. The six key areas for action (see above) are being used as the driving Objectives for the suicide prevention plan. This strategy has been developed following consultation with over 30 organisations at a multi-agency suicide prevention event[2]. A multi-agency steering group is being established to oversee implementation of the plan.

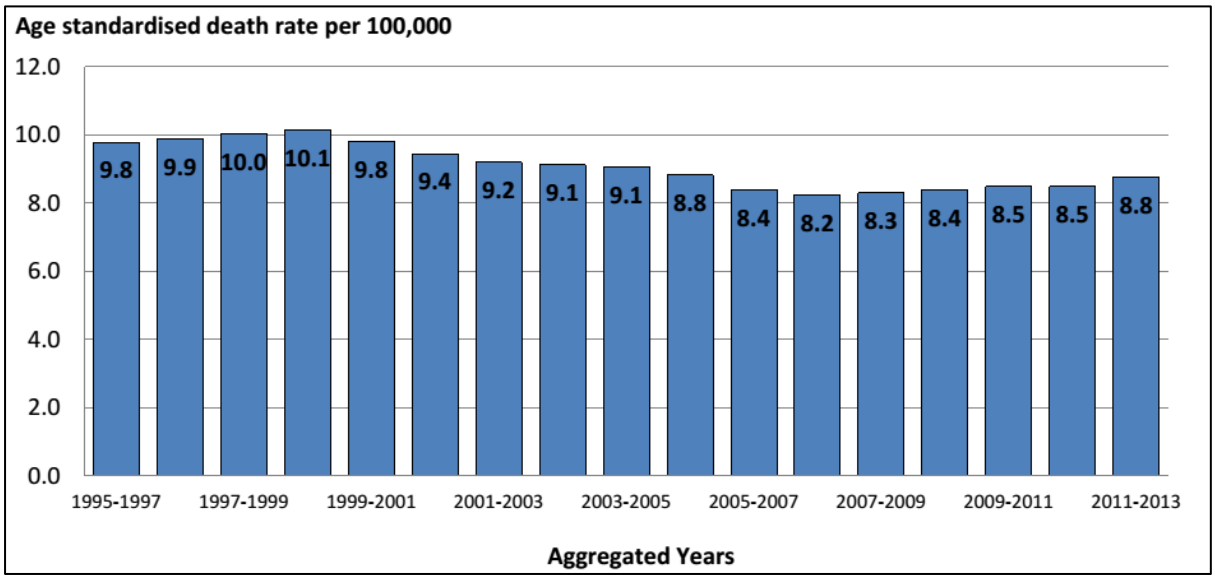
[1] Hertfordshire Suicide Audit 2015/16 October 2016 – analysing suicides in Hertfordshire where the Coroner's inquest took place between April 2015 and March 2016
[2] Hertfordshire Suicide Prevention Event, 9 November 2016

Where are we now? The National Picture

Rates of Suicide[3]

Nationally suicide rates decreased from 1998 until 2008 but have been rising slowly since. The three-year average rate for 2013-2015 was 10.1 suicides per 100,000 general population, the highest since 1998-2000 (see Figure 1).

Figure 1 – Death rates in England from Intentional Self-harm and Injury of Undetermined Intent registered in 1995-2013



Source: Department of Health Statistical update on suicide February 2015

By Age and Gender

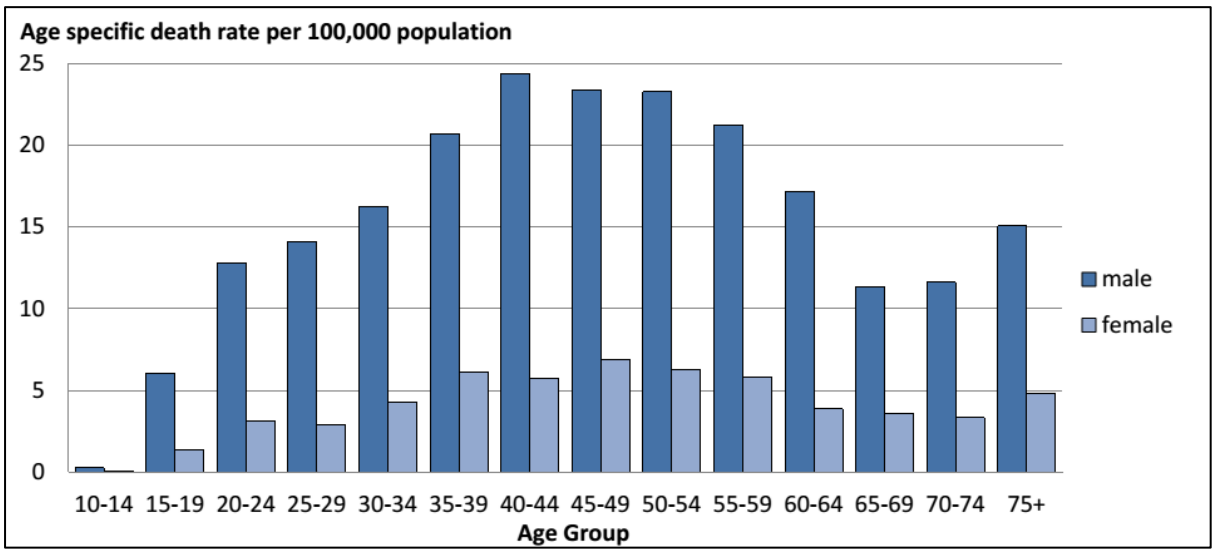
Three quarters of suicides in 2015 occurred in adult males (75%), with uneven distribution across age groups (see Figure 2). In real terms, there were 6,188 suicides in the UK in 2015.

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 (see Figure 3).

[3] Source of data for this section is Department of Health Statistical update on suicide February 2015

Figure 2 – Death rates from Intentional Self-harm and Injury of Undetermined Intent[4] by five-year age band and sex, England, registered in 2013

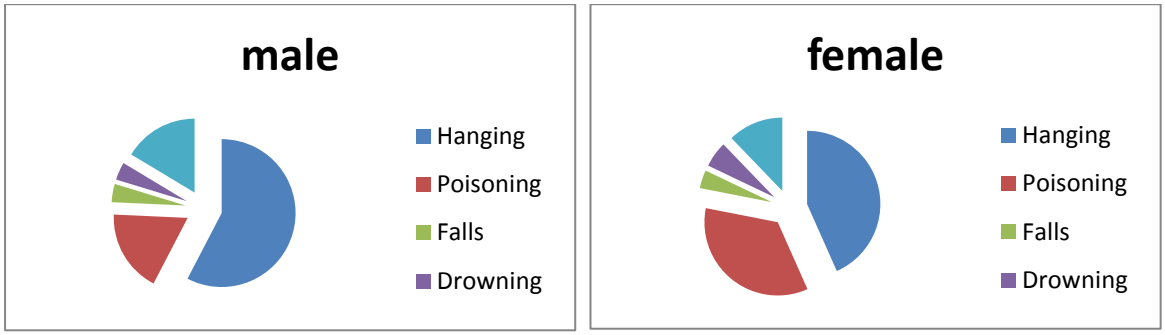


Source: Department of Health Statistical update on suicide February 2015

Suicide by People with Mental Illness [5] [6]

The number of suicides by patients increased between 2003 and 2012, but this is estimated to fall from 2013 (see Figure 4). 28% of the suicides occurred within a year of mental health service contact.

Figure 3 – Deaths from Intentional Self-harm and Injury of Undetermined Intent by method and sex, England, registered in 2015



Source: Department of Health Statistical update on suicide February 2015

[4] Suicide verdicts are not returned for children under 10. Deaths of Undetermined Intent are not included here for 10-14 year olds as they cannot be assumed to be suicide

[5] Patient suicides that occur within 12 months of contact with mental health services

[6] The National Confidential Inquiry into Suicide & Homicide by People with Mental Illness, Oct 2016

The rise in suicide of male patients since 2006 (22%) exceeds the rise in the rate in the general male population (12%).

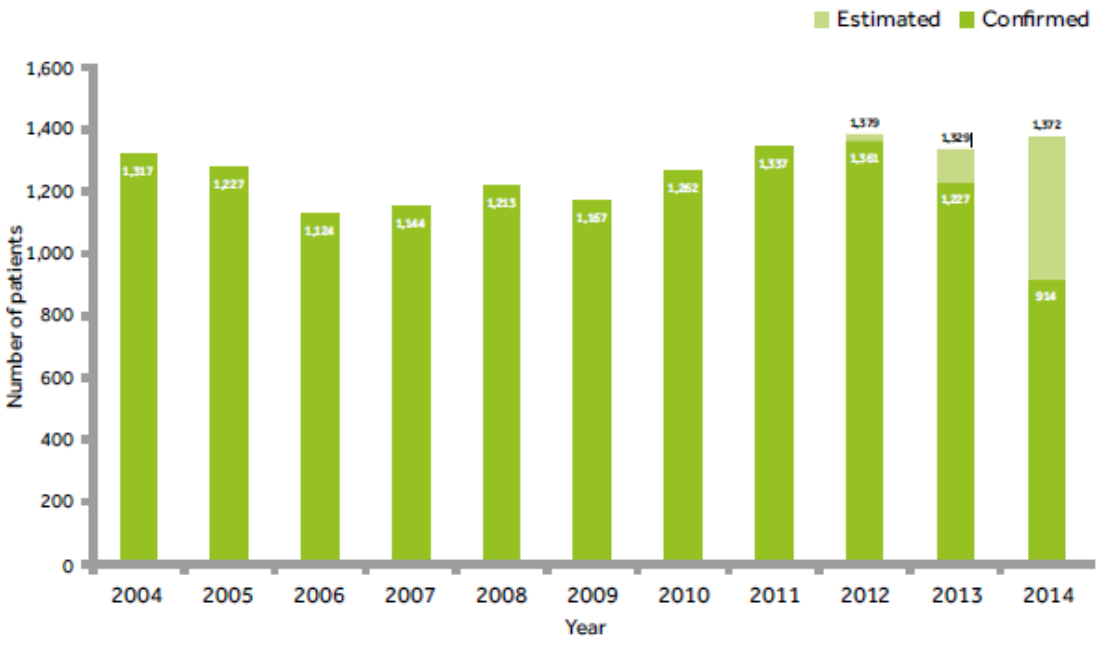
The most common methods of suicide by patients were hanging (43%), self-poisoning (25%) and jumping/multiple injuries (15%). This is roughly in line with the general population.

The substances used in deaths by self-poisoning are:

- Opiates (24%)
- Tricyclic antidepressants (12%)
- Anti-psychotic drugs (11%)
- Paracetamol/opiate compounds (9%)

In-patient deaths by suicide have been falling from 2004 to 2013. Estimates indicate that by 2014 there were three times as many patient suicides under Crisis Resolution/Home Treatment (CR/HT) teams than in in-patient care. In 34% of cases the patient had been discharged from in-patient care within the preceding 3 months. 26% died within a week of discharge. 43% of CR/HT patients who died by suicide lived alone.

Figure 4 – Number of patient suicides, UK – National Confidential Inquiry



Source: The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, Oct 2016

Suicides in Prison & Police Custody

Deaths by suicide (self-inflicted deaths) in prison were trending downwards[7]. However, this has risen markedly during 2016 with over 100 deaths recorded in prisons in England and Wales – an all-time high[8]. This is coinciding with cuts to prison staffing/budgets and an increase in the prison population.

Deaths by suicide in police custody have been reducing (over the period 1998 – 2009)[9]. The majority (77%) of suicides during this period were hangings, dropping in 1999/2000 and remaining at a low level thereafter, probably because of an improvement in cell conditions and the removal of possible ligature points.

[7] Ministry of Justice Safety in Custody Statistics, England & Wales, Update to March 2013. Ministry of Justice Statistics Bulletin

[8] Howard League for Penal Reform, web article, 28 November 2016 (http://howardleague.org/news/suicidesinprison2016/)

[9] Independent Police Complaints Commission Deaths in or following police custody: An examination of the cases 1988/99 – 2008/09

Where are we now? Suicide in Hertfordshire

Suicide Statistics

Hertfordshire suicide statistics are largely lower[10] than those for East of England and England[11]. When compared to England, Hertfordshire has a statistically lower (better) rate for nine out of the 12 indicators and a similar rate for the remaining three (see Figure 5).

The 3 year average suicide rate in Hertfordshire during 2013-2015 was 6.6 per 100,000 compared to 9.3 for East of England and 10.1 for England.

The age standardised suicide rate for England and the East of England is starting to trend upwards. The rate in Hertfordshire remains at a relatively similar level (see Figure 6).

Other Comparisons

Given the comparatively low local numbers of suicides (170 suicides in Hertfordshire 2012-2014) it can be difficult to draw firm conclusions when comparing Hertfordshire data with the larger populations of East of England and England. Also, the data definitions and timescales vary making comparisons more difficult[12]. 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.

Gender - The proportion of males to females is broadly in line with the national picture, albeit with a slightly lower proportion of females. This is consistent with the findings of the 2016 Hertfordshire Suicide Audit[13].

Age - The audit also identified differences in distribution of age ranges for Hertfordshire: females show a steeper curve peaking at 40-49 rather than the steadier rates at national level; males show a peak in the 20-29 age range unlike the national picture where the peak occurs later in life (40-49 years).

Methods – within Hertfordshire the most common method of suicide for males and females was hanging, which is consistent with the national picture.

[10] Indicators where Hertfordshire rates same or greater: Suicide crude rate female 15-34 years 5 year average same for Hertfordshire, East of England and England; Suicide crude rate female 65+ years 5 year average same as East of England lower than England; Adults in treatment at specialist alcohol misuse services 2013/14 same as East of England, lower than England; % bullied in past couple of months slightly higher than England but lower than East of England

[11] PHE Fingertips database 2012-2015

[12] The Hertfordshire Suicide Audit 2015/16 analyses suicides in Hertfordshire where the Coroner's inquest took place between April 2015 and March 2016, whereas the Department of Health Statistical update on suicide February 2015 uses rolling 3 year age standardised rates

[13] Hertfordshire Suicide Audit 2015/16 October 2016 – analysing suicides in Hertfordshire where the Coroner's inquest took place between April 2015 and March 2016

Figure 5 – comparison of key indicators across East of England

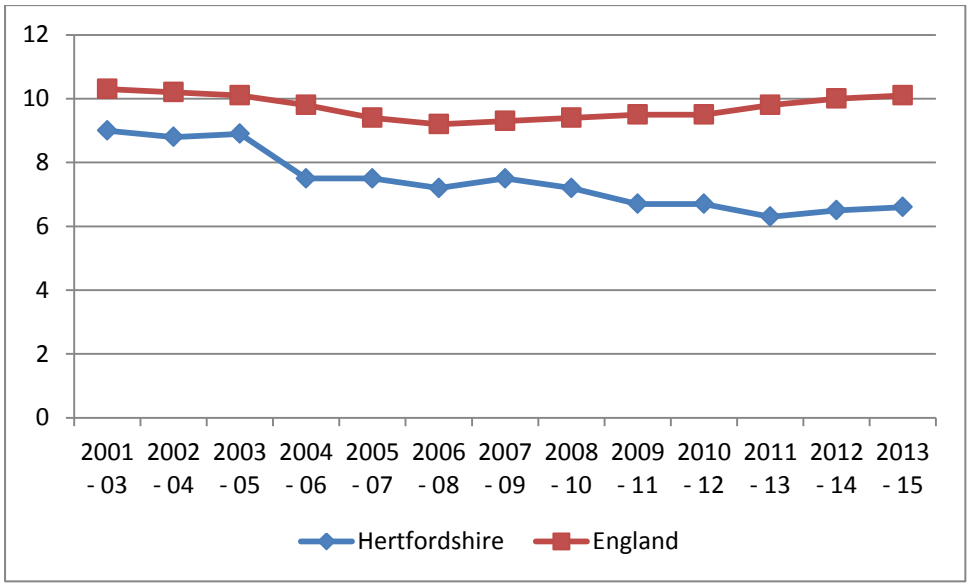
Compared with benchmark: Lower | Similar | Higher | Not compared

Indicator	Period	England	East of England region	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Suicide: age-standardised rate per 100,000 population (3 year average) (Persons)	2013 - 15	10.1	9.3	7.5	9.1	5.6	10.4	6.6	7.7	12.4	8.4	11.3	9.3	11.3
Suicide: age-standardised rate per 100,000 population (3 year average) (Male)	2013 - 15	15.8	14.6	*	14.3	8.5	16.1	10.9	13.1	19.3	11.5	17.8	14.8	15.7
Suicide: age-standardised rate per 100,000 population (3 year average) (Female)	2013 - 15	4.7	4.4	*	4.0	*	5.2	2.6	*	6.1	*	*	4.2	*
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Persons)	2012 - 14	31.9	29.4	29.5	30.6	22.5	33.0	21.2	18.7	37.5	31.8	30.1	30.7	27.2
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Male)	2012 - 14	50.2	45.3	50.5	47.7	35.3	48.3	35.1	32.0	59.5	48.2	48.5	44.6	36.5
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Female)	2012 - 14	13.7	13.6	9.0	12.9	9.8	18.2	7.5	4.8	15.6	15.3	12.0	17.0	18.0
Suicide crude rate 15-34 years: per 100,000 (5 year average) (Male)	2010 - 14	12.3	11.9	11.9	11.7	7.8	12.4	8.6	12.6	14.6	18.7	11.2	13.2	8.6
Suicide crude rate 15-34 years: per 100,000 (5 year average) (Female)	2010 - 14	3.4	3.4	3.4*	3.4*	3.4*	3.4*	3.4*	3.4*	3.4*	3.4*	3.4*	3.4*	3.4*
Suicide crude rate 35-64 years: per 100,000 (5 year average) (Male)	2010 - 14	20.5	18.8	22.5	17.3	17.7	21.7	14.4	12.3	21.5	19.0	16.9	20.3	17.0
Suicide crude rate 35-64 years: per 100,000 (5 year average) (Female)	2010 - 14	5.9	5.6	5.6*	5.6*	5.6*	5.6*	5.6*	5.6*	5.6*	5.6*	5.6*	5.6*	5.6*
Suicide crude rate 65+ years: per 100,000 (5 year average) (Male)	2010 - 14	12.4	11.1	8.5	13.6	6.1	10.6	8.7	10.7	13.1	22.5	8.7	10.3	17.1
Suicide crude rate 65+ years: per 100,000 (5 year average) (Female)	2010 - 14	4.3	3.6	3.6*	3.6*	3.6*	3.6*	3.6*	3.6*	3.6*	3.6*	3.6*	3.6*	3.6*

Source: PHE Fingertips

People with Mental Illness – the proportion of people known to mental health services who died by suicide in Hertfordshire is higher than nationally (44% v 28%) but this must be seen in the context of a small population (25 people in Hertfordshire). The number is too small to derive much significance from further comparison with the picture in England as a whole.

Figure 6: Trend in the age-standardised suicide rate per 100,000 people (3 year average), Hertfordshire & England



Source: PHE Fingertips

Areas on which to focus Hertfordshire-specific plans

Notwithstanding the difficulties in drawing definitive conclusions from the local audit[13] it has highlighted areas which will be used to inform the local suicide prevention plan:

- A greater focus on men in the 20-29 year age range is indicated within Hertfordshire
- There is a need to collect information on the occupation and location of residence of those dying by suicide
- GPs were nearly always the first point of contact for those with mental health issues who subsequently died by suicide. It is clear that GPs have an important role in highlighting the risk of suicide in their patients, which warrants a focus on providing excellent GP support in this area
- Involvement with the criminal justice system increases the risk of suicide so work to minimise this risk needs to be co-ordinated between police, probation and other criminal justice services
- Focus is needed on single men who are not in a relationship
- Co-ordination and communication between primary and secondary mental health care is critical to ensure the best interests of the patient are served.

Where do we want to be?

Zero Suicides

Every death has a wider effect than solely on the person who dies – it affects family and friends, those who are involved in pre-death care (such as medical staff), and those involved in activity arising from the death (such as providing funeral services).

Where the death is by suicide it is more likely to be: premature, unexpected/a shock to others, and sudden. Because it is a deliberate act of self-harm generally it is seen as preventable. It may also feel brutal because of the method used (currently, most commonly hanging). Because of these factors, a death by suicide tends to have a heightened and more widespread effect, both emotionally and environmentally:

- For those affected by the death, complex feelings of grief are intensified, particularly anger and guilt. People with no prior relationship with the deceased may experience shock, depending on the suicide method (for example, the train driver unable to stop the train when someone jumps onto the tracks ahead, or the person out walking their dog who finds someone hanging from a tree).
- Depending on the method used, death by suicide tends to have a wider impact on the environment that death by natural causes. The emergency services will almost certainly be involved. Where the death has taken place outside the home, the area in which it has occurred will be unavailable for some time. This may be relatively low impact (such as part of public park being unavailable) to high impact (such as closing part of the railway network in the case of death by jumping).
- A study in the USA determined that 135 people were affected directly by each person dying by suicide.

Our vision is to make Hertfordshire a county where no one ever gets to a point where they feel suicide is their only option. In practice, this means our ambition is for zero suicides.

The Centre for Mental Health proposes that, as the average age of suicide is roughly the same as the average age of a road fatality, it would be reasonable to use a similar figure for the cost of each suicide[14] (around £1.5 million per case).

Support for Those Affected by Suicide

The ambition of zero suicides in Hertfordshire is consistent with the national suicide prevention strategy for England[15] one aim of which is to reduce the suicide rate in the general population in England. The other main aim of this national strategy is to improve support for those bereaved or affected by suicide, and this stands alongside zero suicides as the other key focus for this strategy.

[14] Centre for Mental Health report "Aiming for zero suicides" published Sept 2015

[15] Department of Health. Preventing suicide in England: a cross government outcomes strategy to save lives. Department of Health 2012

How do we get there?

Our Approach

There is clear evidence about interventions that can help individuals who have considered or tried to end their own lives. However, there is little evidence of effective interventions designed to reduce the overall suicide rate across a whole population. What evidence there is tends to be largely inconclusive. The report on the "Zero Suicide" Programme[16] (set up in 2013 by the East of England Strategic Clinical Network) suggests that "where we do not have the necessary evidence, we must simultaneously implement novel approaches and rigorously evaluate them. A holistic and integrated approach is needed to make the suicide-prevention programme focused and sustainable".

Taking the learnings from the "Zero Suicide" programme, it is evident that we need to carry out a range of actions across a wide area.

We 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
- identify and carry out a range of actions across all fronts adopting a "no change too small" attitude
- aim to achieve more using existing resources by taking a more co-ordinated and focused approach.

The Suicide Prevention Plan

As previously mentioned, the plan is being developed for completion in March 2017 based on the six priority action areas identified in the national strategy. At the suicide prevention event, multi-agency teams provided input to the plan which has been organised into initiatives which can be progressed concurrently, each by its own Task and Finish group. There are more initiatives than can reasonably be delivered in one year, so several have been set aside for 2018. See Appendix A for a list of the initiatives.

Governance

A multi-agency steering group (Suicide Prevention Programme Board) is being established which will be accountable for the implementation of the plan. This will be a small group, comprising a senior representative of Public Health, Hertfordshire Partnership University NHS Foundation Trust (HPFT), Integrated Commissioning (Hertfordshire County Council and

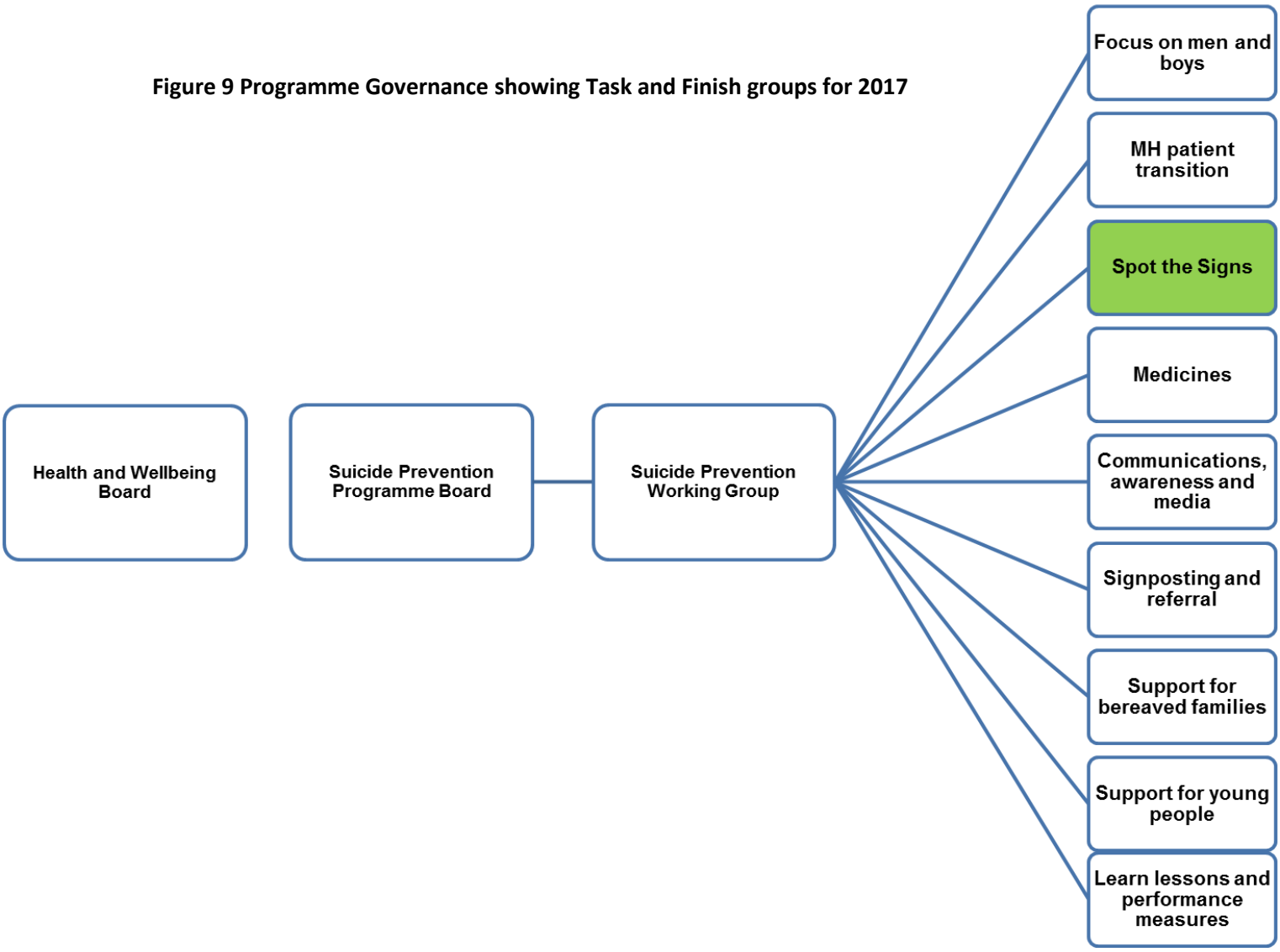
[16] Centre for Mental Health report "Aiming for zero suicides" published Sept 2015

Clinical Commissioning Groups), Hertfordshire Constabulary, the Coroner Service and the voluntary and community sector (Hertfordshire CEO Network). It will operate to a very specific brief around resolving issues escalated by the working group, including barriers to progress.

The working group will oversee the individual initiatives, monitoring progress against the plan. It will report progress to the steering group and escalate any issues requiring steering group attention. The working group will comprise representatives of Public Health, Integrated Commissioning, HPFT (including Community Adolescent Mental Health Services), voluntary sector, and service users. The Task and Finish group leads will attend as necessary. Other representatives of the various agencies involved in delivering the plan may attend if they wish.

Each Task and Finish group will be formed of individuals drawn from agencies with an interest in, and influence on, the specific initiative the group is being formed to deliver. The group will exist only for as long as is required to deliver its objectives. Where there is overlap with existing groups, these will be accommodated within the new governance arrangements. See Figure 9.

Figure 9 Programme Governance showing Task and Finish groups for 2017



Measurement

Part of each initiative is to implement ways of measuring whether it is delivering the intended changes. These outcomes can then be monitored and reported to the steering group to ensure the plan is achieving its aim. Some of these measures will form part of an overall dashboard to be established by the Performance Measures Task and Finish group.

Next Steps

The plan and governance arrangements will be reviewed and approved by the Director of Public Health and the Executive Member for Public Health, Localism & Libraries. The governance structure will be established and the plan shared with the many agencies with an interest in, and influence on, suicide prevention within Hertfordshire. Task and Finish groups will be formed and their scope and deliverables agreed with the working group.

Appendix A – Planned Initiatives

The initiatives outlined below have been identified through and following the Hertfordshire engagement event in November 2016. Their relevance to the six high level objectives below is highlighted at the end of each section.

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

Using the strategy as a framework, each of the task and finish groups will harness the passion and expertise of its membership to create and deliver an action plan that includes delivery dates, expected outcomes and performance measures. The bullet points below, captured from the event in November 2016, provide a starting point.

2017/18 initiatives

Focus on men and boys (Objectives 1 & 2)

- Raise awareness among men aged 20 – 50 (with particular focus on the under 30s) of support available
- Reduce stigma among this age group including finding different language to use and not presuming that men don't want to talk.
- Use pubs, beer mats, gyms, supporters clubs, classic car rallies. Men only groups. Pub discussions with dads.
- Develop links to the current work on *Mental Health Stigma in Boys.*
- Consider including prison population

Improve support for Mental Health patients transitioning between care teams (Objective 1)

- Map current and possible pathways.
- Ensure effective handover protocol at each change in care.
- Ensure appropriate quality standards and ways of measuring.
- Establish monitoring and reporting process.
- Support GPs as first point of contact – training and materials – in identifying patients at risk of death by suicide.

Spot the Signs (Objectives 1, 3, 5)

- Extend more broadly to all front line health and education professionals, sports professionals, emergency services, offender management services, job centre staff, A&E staff (for identifying people who self harm), night club staff, scout and guide leaders, youth leaders.

Access to Medicines (Objective 3)

- Increase awareness of risks of over the counter medicines.

- Improve labels.
- Increase use of blister packs
- Consider whether to look at prescribing for mental health conditions

Communications, Awareness & Media (Objectives 1, 2, 3, 4, 5)

- Determine whether working with media should form a separate Task and Finish group.
- Analysis and development of key messages for awareness.
- Development of branding.
- Analysis of media channels and matching messages to media.
- Use celebrities.
- Use social media, particularly for young people.
- Improve awareness via engaging media campaigns – of support for those at risk, for families where a member is at risk, and for families bereaved by suicide.
- Get personal stories into public domain using as many channels as appropriate.
- Show impact on families and professionals.
- Survivor stories.
- "Self-help" tools.
- Get champions in local media willing to deliver positive mental health stories.
- Talk to local media about having a role. Agree how to handle media enquiries.

Signposting and referral (Objectives 1, 2, 3, 4, 5)

- Map where to signpost to for whom.
- Possibility of creating a single place to signpost, with groups co-ordinated to provide support.
- Signpost/refer via GPs, coroner's office, emergency services (particularly Police).
- Increase awareness of what to look for (like the Samaritans training for railway staff) – staff where "means" of suicide can be purchased (such as rope, knives), car park attendants etc.
- Particular awareness focus on farmers, people being made redundant, people feeling socially isolated (older people, those living on river and canal boats), mental health professionals.

Support for families bereaved by suicide (Objective 4)

- Identify sources of support and any gaps.
- Develop signposting.
- Review tensions between informing family and maintaining patient confidentiality.
- Agree process/boundaries and develop training.

Support for young people (Objectives 1 & 2)

- To be integrated with or linked to existing Child & Adolescent Mental Health Services (CAMHS) groups
- Train those working with young people (youth leaders, scout/guide leaders, night club staff) to pick up signs of those at risk.
- Promote support for children and how to access it (including use of Safe Space, use pop ups on school web sites, use social media).
- Peer support.
- Consider including university students.

Learn Lessons and Performance Measures (Objective 6)

- Develop dashboard of suicide prevention performance measures.
- Monitor and report regularly. Use to inform what data needs to be collected.

- Learn lessons from people who die by suicide via: regular suicide audit (consider frequency), service users who die by suicide.
- Review and interpret data relating to the number of people dying by suicide who have been in contact with mental health services in the preceding year.

Initiatives in Future Years

Support for families (Objectives 1 & 2)

- Develop and promote support for families where family member at risk.

Construction and Design (Objective 3)

- Ensure building design processes include sufficient consultation to minimise risks (such as higher parapets, higher sides on bridges, structures that are hard to climb).
- Reverse engineer high risk locations (multi storey car parks, shopping centres).
- Identify environmental design principles to reduce risk, such as use of open spaces.

Physical signage (Objectives 1, 2, 3)

- Increase signage in high risk areas with signposting information e.g. multi storey car parks, street drinking locations, lifts, back of toilet doors, staircases.

Involvement with Criminal Justice System (including Prison) (Objectives 1, 2, 3)

- Increase signage in high risk areas with signposting information e.g. multi storey car parks, street drinking locations, lifts, back of toilet doors, staircases.