Hertfordshire Suicide Prevention Strategy 2020-2025

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

Contents

Director of Public Health Foreword

The death of someone by suicide can have a devastating effect on families, friends, colleagues, first responders, staff, the wider community and beyond. It has been estimated that around 135 people may be affected by each person dying by suicide.

Hertfordshire has a strong partnership approach to preventing suicide and this dedication is highlighted throughout the work from the 3 years since the previous Hertfordshire Suicide Prevention Strategy was produced.

In developing this all-age suicide prevention strategy for Hertfordshire, we have built on the progress that has been made in reducing the low suicide rates in Hertfordshire, but there is no time for complacency. We continue to face new challenges, particularly in regards to COVID-19 and the health and economic pressures which have, and will continue to impact our population.

Suicide Prevention is a key priority for Hertfordshire County Council and it is now a great opportunity to reflect on the work achieved and build on this.

There are numerous influencers which could lead an individual to take their own life, which makes prevention of suicide complex. We will continue to encourage co-ordinated work by all the agencies (private, public and third sector) that may have an influence (however small) on the agenda. The continued commitment from all partners across the county will be vital. As well as ensuring we engage our local communities and individuals whose lives have been affected by the suicide in some form.

I would like to thank all members of Hertfordshire Suicide Prevention Network for sharing and inputting their knowledge and expertise into the strategy and its implementation.

Tim Hutchings
Executive Member
Public Health and Prevention

Background

There have been several developments in the suicide prevention agenda since the first Hertfordshire Suicide Prevention Strategy published in 2017. These developments have come from both national and local levels to drive the suicide prevention agenda forward and build on the work that has already taken place.

National developments

'Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives' and the 'Cross-Government Suicide Prevention Workplan' were published in January 2019. These set out the Government's plans to improve the implementation and governance of the National Suicide Prevention Strategy. The key areas remain the same, with the addition of an area focusing on reducing self-harm.

The key areas are;

1. Reducing 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
7. Reducing rates of self-harm as an indicator for suicide risk

In May 2019 the Samaritans, working in partnership with the University of Exeter published 'Local Suicide Prevention Planning in England; An independent progress report'[1], commissioned by the Association of Directors of Public Health and the Local Government Association. It was the first of its kind to analyse suicide prevention planning by local authorities across the whole country. This report sets out several recommendations for local authorities including; outcome measures in the monitoring and evaluation processes, targeting training and awareness campaigns to ensure they reach low-income, middle-aged men in high-risk occupations, and ensuring any commissioned suicide prevention training is consistent with national guidelines. The report also highlights good practice across local authorities.

In 2014 NHS England published a Five-Year Forward View and the recently published NHS Long Term Plan in 2019[2]. This plan builds on the policy platform of the Five Year Forward View and addresses mental health and supports the suicide prevention work through objectives focussing on high risk location and high-risk groups, including young people, in local suicide prevention plans and delivering a 10% reduction in suicide rates by 2020/21.

1. Local Suicide Prevention Planning in England (ADPH and LGA, 2019)
2. Five Year Forward View (2014)

This will include a new Mental Health Safety Improvement Programme to reduce suicides in mental health inpatients. Additional funding has allowed for an expansion in mental health crisis services, and suicide bereavement support for families and staff.

The Prevention Concordat for Better Mental Health Programme[3] aims to facilitate local and national action around preventing mental health problems and promoting good mental health. It is part of a public mental health informed approach to prevention, as outlined in the NHS Five Year Forward View. The concordat brings together organisations in a whole system's approach to tackling mental health. Hertfordshire County Council has signed up to the concordat and Public Health lead on this work, establishing what mental health work is being delivered across organisations in the county. This work encompasses all age ranges and covers the suicide prevention agenda.

In July 2019, the standard of proof used by coroners to determine if a death received a conclusion of suicide was lowered to the "civil standard". It is possible that this may result in an increased number of deaths being recorded as suicide in future.

Local developments

On a local level the Hertfordshire Public Health Service Strategy 2017-21[4] stated the need to develop a multi-agency suicide prevention plan. Hertfordshire's Suicide Prevention Network was created, holding its first partnership event in November 2016. A multi-agency approach was agreed with the aim of reducing deaths by suicide and providing greater support for those affected by suicide. Hertfordshire's Suicide Prevention Strategy was published in 2017. With strong partnership links the work of the network has developed over the last five years and achieved positive outcomes.

The Hertfordshire Mental Health Strategy 2016-2021[5] points to a multi-agency suicide prevention strategy and action plan, addressing issues of crisis care for residents of all ages and expansion of the RAID programme. Each of these aids the work of the suicide prevention agenda and helps better support for all, from prevention to crisis.

Hertfordshire Partnership University NHS Foundation Trust (HPFT) published their organisation's suicide prevention plan, 'Preventing Suicide within Mental Health Inpatients Settings and Community Services Action Plan 2019/20' which addresses communications and policy relating to suicide.

The Hertfordshire and West Essex Sustainability and Transformation Plan (STP); A Healthier Future[6] also highlights the importance of having a suicide prevention strategy. As the STP moves to become the Hertfordshire and West Essex Integrated Care System (ICS), work is progressing to ensure that suicide prevention ambitions are aligned on an ICS footprint and there are shared learning and work across the system.

3. The prevention concordat
4. Hertfordshire Public Health Strategy 2017-21
5. Hertfordshire Adult Mental Health Strategy 2016-21
6. Hertfordshire and West Hertfordshire Sustainability and Transformation Plan

In October 2019, Hertfordshire County Council undertook a scrutiny of the suicide prevention work from 2017-2019. The aim of the scrutiny was to review the work of the programme and make recommendations for the direction of the work and to address any obvious gaps. The recommendations were;

- To facilitate further progress the key agencies, including primary care, are involved; that there is proactive collaborative working; joined up collaborative approaches; coupled with effective commissioning of services to deliver the strategy's objectives.
- Embedding awareness of suicide and how it can be prevented is crucial to delivering the seven priority areas of the Strategy. This to be achieved through identification of key stakeholders, partners working effectively together; publicity campaigns; and training.
- To review current bereavement services that support those affected by a suicide and as a preventive approach to ensure that no one ever gets to a point where they feel suicide is their only option.

This is a strong driver for the suicide prevention work and will help to focus the future work of the network.

Impact of COVID-19

Due to the COVID-19 lockdown there will likely be increased issues for people's health and wellbeing. Public Health England have highlighted that due to COVID-19 there has been an increase in the wider factors relating to suicide (including relationship issues, unemployment, debt, housing) and at risk groups including those with chronic physical conditions, Learning Difficulties and autism, the bereaved, health and care staff, in domestic violence during lock down and drugs and alcohol (including new habits and excessive use formed during lockdown).

Mental health problems are also likely to increase, Kooth, the national online counselling service for young people, have shown in their May 2020 report[7] that demand for their services has risen 33%. They have found that young people experiencing suicidal thoughts has increased across the county, alongside several other issues such as loneliness, school worries and sadness.

MIND report[8] on mental health during the pandemic (June 2020), states more than half of adults and over two thirds of young people said that their mental health has deteriorated during the lockdown. One in three adults and more than one in four young people stated they have not accessed support during lockdown because they did not think that they deserved support. A quarter of adults and young people who tried to access support were unable to do so. Not feeling comfortable using phone/video call technology has been one of the main barriers to accessing support. Without accessing appropriate support, more people will end up in crisis, with a possible increase in suicide.

7. Xenzone (2020) Kooth Week 10: How Covid-19 is affecting the mental health of children and young people https://xenzone.com/wp-content/uploads/2020/05/150520_CYP_infographic_D4.pdf
8. Mind (2020) The Mental Health Emergency: How has the coronavirus pandemic impacted our mental health? https://www.mind.org.uk/media-a/5929/the-mental-health-emergency_a4_final.pdf

The national discussions on suicide prevention during this time have focused on the increased risk of the identified high risk groups and the longer term compounding effect of COVID-19. The key recommendation is for all local strategies to continue to focus on their high-risk groups for the foreseeable future. Hertfordshire will continue to review the evidence and analyse trends and patterns of suicidal behaviour in relation to COVID-19 and make changes to programme delivery where and when required.

Suicide Prevention in Hertfordshire

Since 2017 Hertfordshire's Suicide Prevention programme has created strong partnership links with the key stakeholders and the wider network to support the ambition of zero suicide in Hertfordshire. The work was developed through a coordinated approach, which encouraged partnership work and encouraged innovation and experimentation.

This aligned with a focus on key nine priority areas for the county, and these priorities were based on the national strategy, and were as follows:

- Focus on men and boys
- Improve support for Mental Health patients transitioning between care teams
- Spot the Signs
- Access to Medicines
- Communications, Awareness & Media
- Signposting and referral
- Support for families bereaved by suicide
- Support for young people
- Learn Lessons and Performance Measures

A review of the programme was conducted in May 2019, in order to take stock of the work to date and highlight priorities for the partnership to address going forward. These included partnership developments and improving outcome delivery:

- Refresh the suicide prevention strategy for 2020
- Keep the existing programme structure but clarify expectations, roles and responsibilities for members of the various partnership groups that make up the programme
- Review the membership to ensure that it better reflects other sectors - the community and certain businesses for example
- Provide more support to the task and finish groups to ensure that they can deliver their objectives.
- Make time for forward planning and innovation by reviewing the progress and direction of the programme.

Through the task and finish groups partners have worked on various focussed areas of work. Some of the main areas of progress over this time have included the following pieces of work:

- A quality standard kitemark for mental health support and wellbeing in schools.
- An improved data collection and reporting for the suicide audit
- A journalists' charter for sensitive reporting of suicide September 2018
- The "Spot the Signs" suicide awareness training delivered to 2,000 professionals
- Save a Life App was launched within the county
- Bereavement services review and recommendations
- Supporting Just Talk mental health campaign

The National Picture

The latest suicide data for 2018 from the Office of National Statistics shows an increase in registered suicides. Following several years of decline, the latest UK suicide rate has increased to 11.2 deaths per 100,000 population. This is significantly higher than that in 2017 and shows the first increase since 2013.

In 2018 there were 6,507 suicides registered in the UK (11% increase)

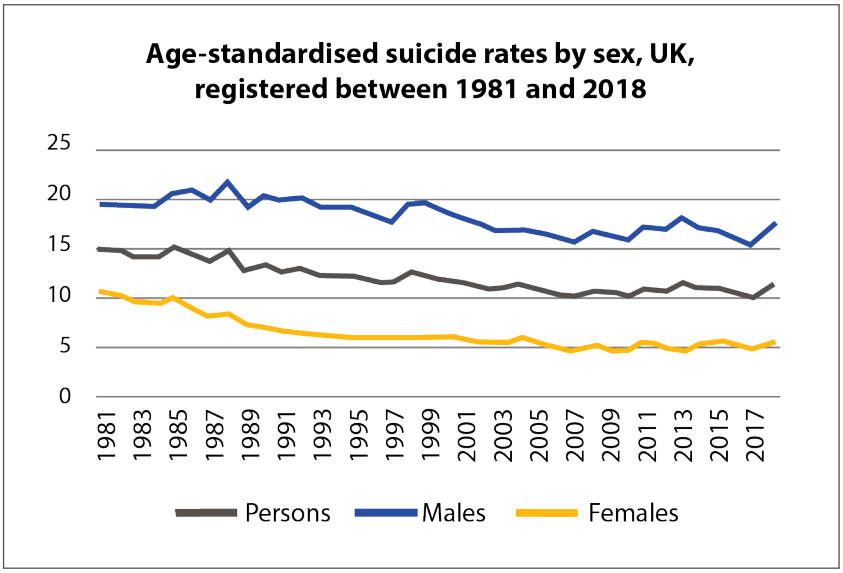
There were 462 suicides in prison custody between 2008-2016. The risk of male prisoners dying by suicide was 3.7 times higher than in the general population.

The most common method of suicide in the UK was hanging, accounting for 59.4% of male suicides and 45.0% of all female suicides.

There were 1,517 suicides by people under mental health care in the UK in 2017.There were 92 suicides by in-patients in the UK in 2017.

In 2018, males and females aged 45 to 49 years had the highest suicide rates than any other age group.

Three quarters of deaths in 2018 were male.



Despite having a low number of deaths overall, rates among the under 25s have generally increased in recent years, particularly 10 to 24-year-old females where the rate has increased significantly since 2012 to its highest level with 3.3 deaths per 100,000 females in 2018.

Comparison of key indicators across East of England

Drawing conclusions can be difficult as Hertfordshire has comparatively low numbers. However, when comparing indicators from the Suicide Prevention Profile, Hertfordshire is generally lower than East of England, using England average as a benchmark.

Data quality: Significant concerns | Significant concerns | Robust

*A note is attached to the value. Hovver over to see more details

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

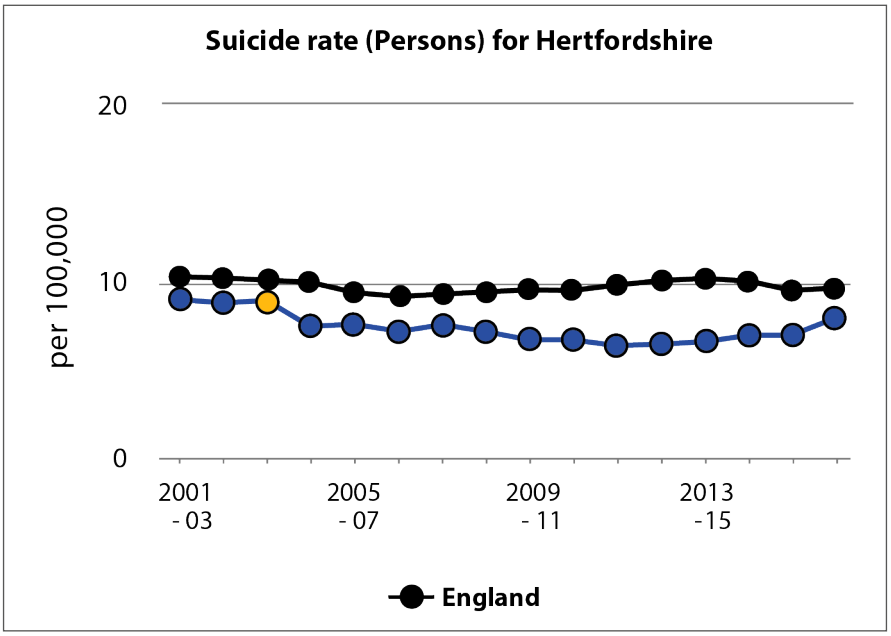
Recent trends: Could not be calculated | Increasing/ Getting worse | Increasing/ Getting better | Decreasing/ Getting worse | Decreasing/ Getting better | No significant change | Increasing | Decreasing

Indicator	Period		England	East of England region	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Suicide rate (male) New data	2016-18	◀▶	14.9	15.3	18.6	13.1	14.5	17.2	12.4	8.5	19.0	18.7	14.5	15.2	12.4
Suicide rate (Persons) New data	2016-18	◀▶	9.6	10.0	12.1	8.8	9.0	11.7	7.9	6.2	11.4	12.2	9.8	9.9	9.0
Suicide rate (Female) New data	2016-18	◀▶	4.7	4.9	5.7	4.5	3.6	6.5	3.7	4.1	4.2	6.0	4.9	4.7	5.6
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	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	-	12.9	-	18.2	7.5	-	15.6	15.3	-	17.0	18.0
Suicide crude rate 10-34 years: per 10,000 (5 year average)	2013-17	◀▶	10.5	9.6*	8.6	10.3	7.6	10.0	7.1	8.9	12.4	9.8	13.0	8.5	11.4
Suicide crude rate 34-64 years: per 100,000 (5 year average)	2013-17	◀▶	20,1	18.7*	18.0	16.6	14.5	21.9	14.1	14.5	22.5	20.6	19.3	20.0	19.0
Suicide crude rate 65+ years: per 100,000 (5 year average)	2013-17	◀▶	12.4	12.6*	9.2	10.5	6.4	14.0	9.9	15.2	17.0	7.9	12.0	12.5	9.7

The Hertfordshire Picture

At local authority level the rates are based on relatively small numbers, changes can often be a result of random fluctuation. The annual number of all age suicides registered in Hertfordshire has fluctuated between 52 and 103 over a 17-year period (2002 to 2018)[10 11]. From 1st January 2017 to 31st December 2019 there were 270 suicides in Hertfordshire.[12]

The 2-year average suicide rate in Hertfordshire during 2016-2018 was 7.9 per 100,000 compared to 9.6 for England[13], showing Hertfordshire has lower rate than the national average.



The suicide rate for males was 12.4 per 100,000. This is lower than the national rate of 14.9. Across the districts the rate ranged from 11.2 in East Herts and 14.8 in Broxbourne.

The suicide rate for females was 3.7 per 100,000. This is lower than the national rate of 4.7. It was not possible to obtain rates for females across the districts as the numbers were too low.

10. Office of National Statistics (2019). Suicides in England and Wales by local authority. www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority
11. ONS report suicides by the calendar year the death was registered in and by the deceased's local authority of usual residence. The coroner's audit is based on the calendar year of the inquest and, in the main, suicides that occur in Hertfordshire. Deaths are usually registered within a few days of the inquest.
12. 2017-2019 Hertfordshire Suicide Audit
13. PHE Fingertips database 2012-2019

Hertfordshire Suicide Audit 2017-19

National guidance recommends that every local authority carries out an annual suicide audit (although they are no longer a statutory requirement).

The audit uses information from files held by the coroner service and has been carried out to a new, more robust and repeatable methodology introduced for the 2017 audit.

270 deaths are included in the audit, with most deaths occurring in 2017 (20.7%), 2018 (26.3%) and 2019 (37.4%).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.

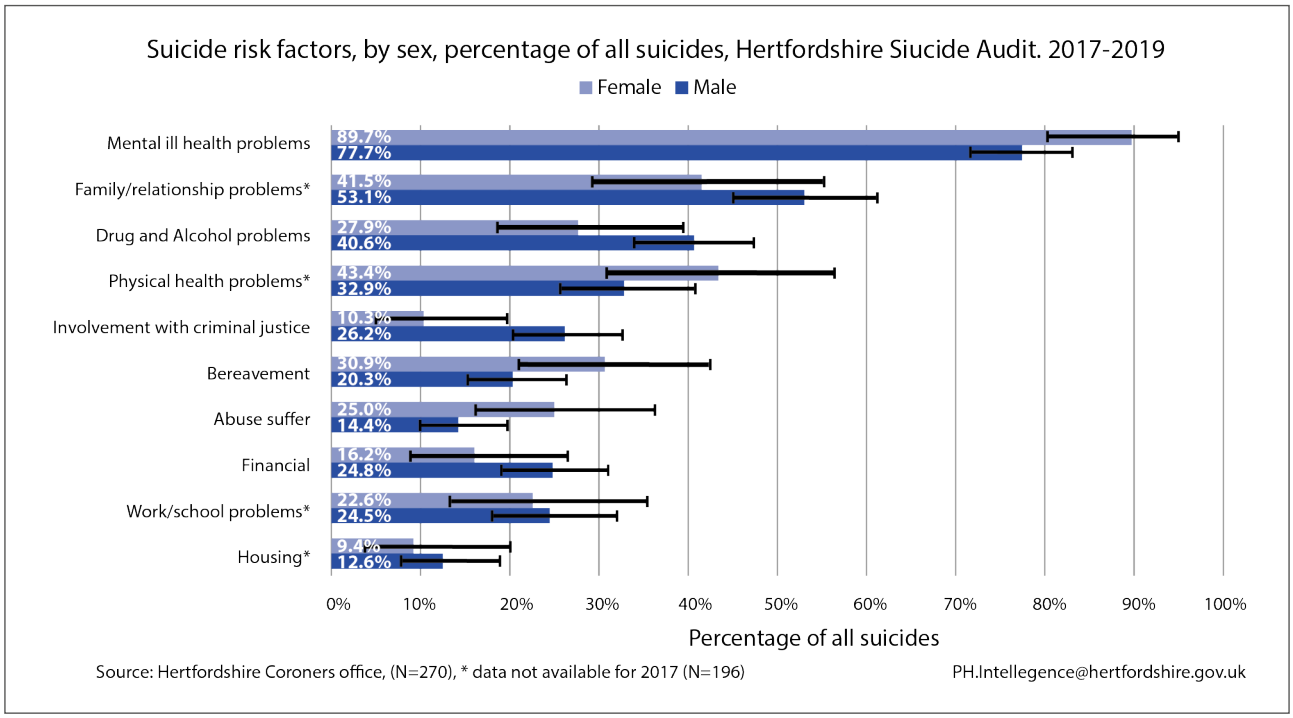
Key demographics

- Of the 270 deaths, 202 were male and 68 were female, showing three quarters of suicides were by males.
- The most common method of suicide was hanging, accounting for 57.8% suicides. The second most common method was self-poisoning (17.8%), followed by deaths on the railway (10.0%).
- 42.2% of people who died by suicide were aged 30 to 49 years old. This is the highest age group.
- Most suicides took place at the individual's home (61.5%). The next most common location was woodland or park (13.7%), followed by the railway (9.6%).
- 34.1% of people who died by suicide were known to a mental health service at the time of death.
- A quarter (25.2%) of people who died by suicide discussed mental health issues with a member of their GP practice in the four weeks leading up to their death.
- 14.4% of people who died by suicide were known to drug and alcohol services at the time of death.

14. https://www.suicidepreventionherts.org.uk/home.aspx
15. Department of Health and Social Care (2012). Suicide prevention strategy for England. www.gov.uk/government/publications/suicide-prevention-strategy-for-england

Key risk factors

The reasons why people take their lives can be complex and consequently can be difficult to establish from the coroners file. The risk factors most frequently mentioned in the coroners' files are listed below.



For women the most pronounced risk factors are mental ill health (89.7%), physical health problems (43.4%) and family/relationship problems (41.5%).

For men the most pronounced risk factors are mental ill health (77.7%), family/relationship problems (53.1%) and drug or alcohol problems (40.6%).

Over a third (38.5%, 104 suicides) of people who died by suicide had a record of a previous suicide attempt. Of these, close to half (46.2%, 55 suicides) had evidence of attempting suicide more than once.

Close to one fifth (17.8%, 48 suicides) of people who died by suicide had a history of self-harm recorded, over half (58.3%, 28 suicides) had reportedly done so on more than one occasion.

The Hertfordshire Approach

Our vision remains 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 ambition of zero suicides in Hertfordshire is consistent with the national suicide prevention strategy for England

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 person out walking their dog who finds someone hanging from a tree). Death by suicide tends to have a wider impact on the environment that death by natural causes. Where the death has taken place outside the home, the area in which it has occurred will be unavailable for some time, which can varying levels of impact, from relatively low impact (part of public park being unavailable) to cause high impact (closing part of the rail network).

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 (around £1.5 million per case).

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. The report on the “Zero Suicide” Programme by the Centre for Mental Health 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”.

Continuing the approach from our previous Suicide Prevention Strategy from 2017, it remains evident that we need to carry out a range of actions across a wide area.

16. Department of Health. Preventing suicide in England: a cross government outcomes strategy to save lives. Department of Health 2012
17. Centre for Mental Health report “Aiming for zero suicides” published Sept 2015
18. Centre for Mental Health report “Aiming for zero suicides” published Sept 2015

We will continue to:

- 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.

Hertfordshire Key Priorities

The Hertfordshire Suicide Prevention Network has continued to grow and expand across the county and has over 200 members since 2016. The strategy has incorporated the input from the members of the network as well as stakeholders, through a variety of mechanisms to develop the priorities. This includes the review of the Suicide Prevention programme in May 2019, HCC Scrutiny of Suicide Prevention Strategy in October 2019 and the annual Hertfordshire Suicide Prevention Network Conference in January 2020. As well as the input from the programme’s working group and eight task and finish groups.

Hertfordshire’s Suicide Prevention Strategy will not be directly addressing self-harm. There is work and progress being made to address self-harm through education and support for those who self-harm across the county. This work will link to suicide prevention work as self-harm is one of the risk factors. It is important that people who self-harm and are being supported by services are given information about where to get help, if they have suicidal thoughts and are given sufficiently effective treatment to minimise the risk of them dying by suicide.

The key priorities remain inline and have mapped across to one or more of the seven key areas as set out in the National Suicide Prevention Strategy (2019).

Communication is a crucial aspect of all the suicide prevention key priorities, and the programme delivery will ensure that a variety of methods of communication are implemented throughout the delivery.

The six key priorities for Hertfordshire are;

- Support for men
- Support for those bereaved by suicide
- Addressing training needs
- Support for children and young people
- Reducing access to means of suicide
- Support research, data collection and monitoring

Priority 1 – Support for Men

Why is it important?

- Suicide is the biggest killer of men under 50 years old and a leading cause of death in young men.
- Men are less likely to seek help or talk about their mental health and can be reluctant to engage with health and other support services[19].
- NICE guidelines recognise the importance of reaching out to males at risk and encouraging help seeking behaviours.

What do we know?

- Of the 270 suicides in Hertfordshire audit 2017-19 74.8% (202) were men and 25.2% (68) were women.
- National findings show males make up three-quarters of suicides in the UK, a proportion which has been mostly consistent since the mid-1990.[20]
- The average age of men who died by suicide over the audit period was 47.0 years.

What are the gaps?

- Lack of awareness of men's mental health issues with frontline staff across all organisations

  Lack of information about mental health aimed directly at men

  Lack of knowledge of where and how to access to support

What are the potential benefits?

- Men being more aware of their mental health needs and possible triggers
- Men being more aware of the support available and how to access it
- Frontline staff acknowledging and understanding mental health needs of men
- Reducing mental health stigma for men
- Enabling earlier intervention for men with mental health issues

19. Men, Suicide and Society. Why disadvantaged men in mid-life die by suicide. (2012) Surrey: Samaritans.
20. ONS suicide statistics (2018)

Priority 2 – Support for those Bereaved by Suicide

Why is it important?

- Every suicide can have a profound effect on families, friends, colleagues and the local community.
- People bereaved by suicide are at greater risk of suicide themselves.[21]
- We must ensure that there is adequate and timely support for those impacted by suicide deaths.

What do we know?

- Research suggests that 10 people will be profoundly affected, and of the wider community 135 people may be affected by each person dying by suicide.[22]
- In Hertfordshire this would mean that there will be 950 people profoundly affected, and 12,825 will be affected in the wider community each year.
- People bereaved by the sudden death of a friend or family member are 65% more likely to attempt suicide if the deceased died by suicide than if they died by natural causes.[23]

What are the gaps?

- Lack of postvention awareness and support.
- No co-ordination of all-age bereavement services.
- Lack of understanding of what bereavement/ suicide bereavement support is available across the system, and at different stages of bereavement.
- Limited availability of family bereavement services.
- Need for assessment pathways and tools for Post-Traumatic Stress Disorder (PTSD) and long-term grief.

What are the potential benefits?

- Reduce the risk of suicides in this high-risk group, by helping people cope better with their loss.
- Better suicide prevention support available.
- Improved assessment pathways and tools for PTSD and long-term grief
- Greater awareness and promotion of the all age bereavement support available across the system.

21. UCL (2016) Bereavement Study https://www.ucl.ac.uk/psychiatry/research/epidemiology-and-applied-clinical-research-department/ucl-bereavement-study
22. Cerel J, Brown M, Maple M et al. How Many People Are Exposed to Suicide? Not Six. Suicide and Life-Threatening Behavior. 2018.
23. UCL (2016) Bereavement Study https://www.ucl.ac.uk/psychiatry/research/epidemiology-and-applied-clinical-research-department/ucl-bereavement-study

Priority 3 – Addressing Training Needs

Why is it important

- Front line services need to be able to support people who are experiencing mental health issues, who are feeling suicidal or those who have been affected by a suicide. Quality assured, appropriate training for staff needs to be available.
- Ensuring the most appropriate training is available for staff, to provide them confidence in helping and supporting people feeling suicidal e.g. signposting them to support.
- Staff working in emergency services are in a high-risk group due to their regular exposure to suicide and suicidal intent.
- Training should also provide staff with information to support their own mental health and wellbeing.
- Ensuring that front line services are aware of how to respond and communicate following a suicide

What do we know?

- There are various suicide awareness training courses available from different providers across Hertfordshire and England.
- The training offer covers online and face to face delivery.
- There are training courses for both professionals and the public to access.
- Over 2,500 people have received suicide prevention training in Hertfordshire.

What are the gaps?

- Lack of clarity and knowledge across the system about the variety of training on offer available.
- Need for better understanding of how the training needs of different groups are being met.
- Limited sustainability of the training offered across the county.
- Limited knowledge and understanding of suicide risk factors and the cumulative effect of these factors

What are the potential benefits?

- Better recognition and understanding of suicidal behaviours and language.
- Better equipped and knowledgeable workforce about suicide, and how they can support their own mental health.
- Improved awareness for professionals on signposting to available services and referral routes.

Priority 4 – Support for Children & Young People

Why is it important

- Early intervention support for children and young people can improve resilience, wellbeing and self-help techniques.
- By tackling mental health issues early, children and young people are more likely to grow into adults with better mental health.
- The death of a child or young person can create an issue of contagion within their school and local community, exposing more young people to suicide and increasing their vulnerabilities.

What do we know?

- Nationally, young people aged 10-24 continue to have the lowest rates of suicide when compared to other age groups, but in recent years they have seen some of the largest increases in their rates.
- While males still have a higher suicide rate than females (all-age), the latest national data shows the suicide rate among 10 to 24-year-old females has increased by 83% since 2012 to its highest recorded level in 2018. Males of the same age saw a 25% increase in their rate from 2017.[24]
- In Hertfordshire there were six suicides by young people aged under 18 in the 2017-19 audit.

What are the gaps?

- A need for additional information and support (or awareness of) for young people during stressful periods in their lives, such as transitions, exams, family separation or family bereavement.
- Inconsistency in accessing support (including specialist mental health services) and knowledge of pathways.
- Further support for young people identified as vulnerable/high risk.
- Access to advice for schools that are concerned about a YP and how to respond

What are the potential benefits?

- Increased resilience in children and young people; reducing the number who cannot cope with life experiences.
- Better access for children and young people who need support for suicidal thoughts and behaviours.
- Increased understanding of the pathways and services available.
- Better equipped and knowledgeable professionals (especially in universal services) about suicide and young people

24. ONS (2019) https://blog.ons.gov.uk/2019/09/10/why-have-suicide-levels-risen-among-young-people-and-what-can-be-done-to-tackle-this/

Priority 5 – Reducing Access to Means of Suicide

Why is it important

- Reducing access to the means of suicide is one of the most effective ways to prevent suicide.[25]
- Sometimes people attempt suicide on impulse, and if the means are not easily available the suicidal impulse may pass.[25]
- If deaths occur in public places it is traumatising for witnesses and increasing impact of the death.[26]
- Monitoring trends in location or other means allows clusters or hotspot areas to be effectively identified.

What do we know?

- The suicide methods that are potentially the most amenable to intervention include: hanging and strangulation in psychiatric inpatient and criminal justice settings; self-poisoning; those in high-risk locations, those on the rail and underground networks.[27]
- In the 2017-19 audit 10% of Hertfordshire's suicides occurred on the Railways.
- Network Rail have a suicide prevention programme in partnership with British Transport Police and Samaritans.[28]
- Highways England developed their suicide prevention strategy in 2017 to help reduce deaths on the highway.[29]

What are the gaps?

- Limited understanding and clarity of local pathways and processes to support postvention after an attempted suicide.
- No system in place for key partners to be alerted when a suicide occurs.
- Lack of information available and shared on high risk locations (geographical and type of location).
- Limited information of deaths on the highway that relate to suicides.
- Lack of evidence around how to prevent suicides in the home.

What are the potential benefits?

- Increase knowledge of high-risk locations and increase ability to manage these risks.
- Stronger partnerships across agencies to tackle suicide prevention.

25. HM Govt (2019) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772184/national-suicide-prevention-strategy-4th-progress-report.pdf
26. Public Health England (2015) Preventing suicides in public places: A practice resource https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/769006/Preventing_suicides_in_public_places.pdf
27. HM Govt (2012) National Suicide Prevention Strategy https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772184/national-suicide-prevention-strategy-4th-progress-report.pdf
28. Network Rail Suicide Prevention on the Railway
29. Highways England (2017) Suicide Prevention Strategy: Our Approach

Priority 6 – Support Research, Data Collection & Monitoring

Why is it important

- Data allows us to make comparisons and provide a more detailed insight into suicides within Hertfordshire, to identify trends and any areas where additional focus or emphasis is required locally versus the national picture.
- Data can provide valuable insight into understanding the reasons why people take their lives.
- Understanding our high-risk groups allows us to provide targeted support and information to these groups.
- Real Time Suicide Surveillance Systems help with timely bereavement support and help to identify clusters.

What do we know?

- We currently collect local data from the coroner's files on an annual basis.
- The 3-yearly suicide audit report (2017-19) allows us to identify possible trends
- Demographic data allows us to compare Hertfordshire with national and regional data sets.
- Real Time Suicide Surveillance Systems can support timely bereavement support for family and friends of the decreased reducing their risk factors.
- Real Time Suicide Surveillance Systems can support the identification of high-risk areas and clusters in a timely fashion, so they can be acted on.

What are the gaps?

- The suicide audit has highlighted a lack of local information on sexuality, gender and ethnicity.
- The coroner's files highlights there is inconsistent information available by different partners across the system.
- Lack of mapping of suicide locations – in relation to hot spots and clusters.
- No Real Time Suicide Surveillance system or structure in place.

What are the potential benefits?

- Ability to capture information on trends, including hot spots and clusters.
- More timely and readily available local data and information.
- A Real Time Suicide Surveillance System would improve access and timely bereavement support, reducing the risk factors for people affected by suicide.

Programme Delivery & Governance

Over the next five years the Suicide Prevention Programme will work to address the six key priority areas outlined. The programme delivery and governance has been restructured into order ensure the programme is well supported and there are mechanisms in place to manage risks and issues as well as having a clear escalation process.

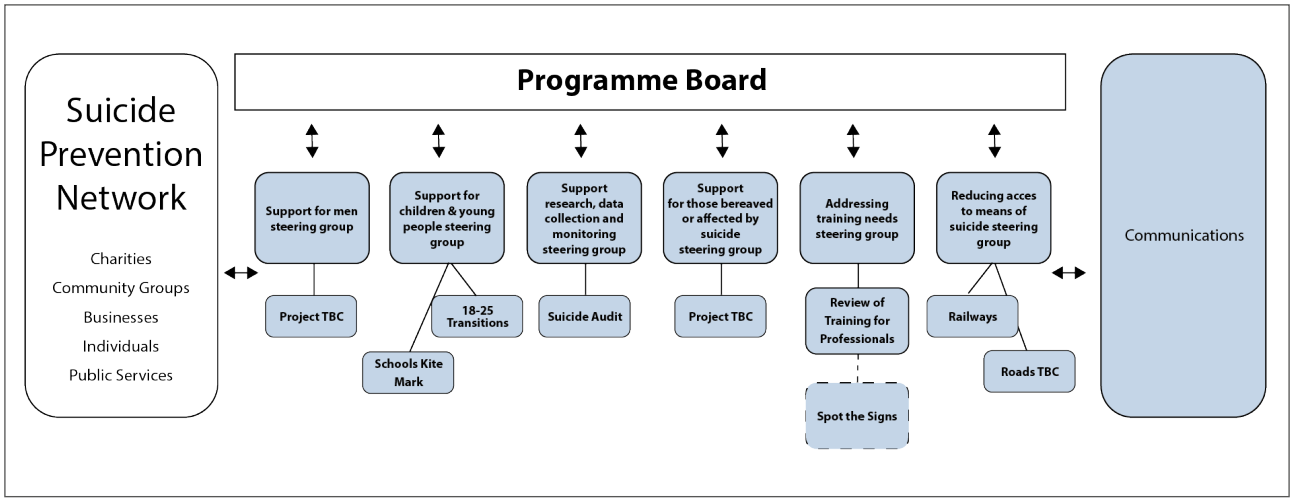


Figure 1: Hertfordshire Suicide Prevention Programme Structure

Hertfordshire's Suicide Prevention Programme Board will provide strategic leadership, accountability and oversight of the suicide prevention strategy programme. The Board will be responsible for ensuring the effective delivery of the projects that are being delivered across partner organisations and will be responsible for escalation and engagement with other key programmes of work. The Programme board will comprise of a senior representative of Public Health, Hertfordshire Partnership University NHS Foundation Trust (HPFT), Integrated Commissioning (Hertfordshire County Council and Clinical Commissioning Groups), Hertfordshire Constabulary, the Coroner Service and the voluntary and community sector, as well as the six chairs of each of the steering groups.

The six priorities form the structure for six steering groups, who will be responsible for that priority. The steering groups will provide oversight, guidance and sign off on a specific priority and agree and take forward specific projects to deliver as well as monitoring their progress and outcomes. The steering group membership will be multiagency to allow all partners to input into the work plan. The steering group will also ensure that completed projects are embedded into the relevant organisation(s) practice and continue as business as usual.

The projects will be defined by the steering group. Some projects have already been agreed and begun delivery. These are shown in the governance structure above (Figure 1.).

Implementation and Monitoring

This strategy has set out the vision and commitments for preventing suicide in Hertfordshire. We will achieve this vision through good collaborative multi-agency working and regular engagement with public, our service users and their carers to ensure the successful development of, implementation and delivery of initiatives and projects.

We will track progress of this strategy through metrics linked to our ambition. These will be monitored through the national Suicide Prevention Profile indicator published by Public Health England. Alongside these indicators we are also developing an outcomes framework linked to the priority areas for action. Progress reviews will take place annually and will be disseminated to network members over the five year life of the strategy.