SOMERSET SUICIDE PREVENTION STRATEGY

2013-2016

Somerset Suicide Prevention Advisory Group

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Document Status:	
Version:	

DOCUMENT CHANGE HISTORY

Version	Date	Comments
1.0	June 2004	Initial Version
1.1	November	2nd Draft following consultation
1.2	January 2005	Joint Executive Team
1.3	January	Joint Strategic Commissioning Board
1.4	March	Final Version
2.0	May 2008	Initial draft following review of Strategy
2.1	October 2009	Revised draft for stakeholder consultation workshop
2.2	February 2010	Version for PEC
2.3	November 2011	Document reviewed and action plan updated
2.4	November 2012	Consultation on refreshing the strategy
2.5	April 2013	Initial draft following review of strategy
2.6	September 2013	Revisions added due to period of transition and staff changes

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To be reviewed by:	April 2015
Document Reference:	

A COLLABORATIVE PREVENTION OF SUICIDE STRATEGY FOR SOMERSET

CONTENTS

1 EXECUTIVE SUMMARY

1.1 Suicide is a major issue for society and a leading cause of years of life lost. During 2010 in Somerset someone died from suicide approximately every 8 days. In the same year in England, as a whole, suicide claimed a life every 2 hours; this equates to over 4,200 deaths [(1)].

1.2 The national suicide prevention strategy is clear that suicide prevention is not the sole responsibility of any one sector or of health services alone. Indeed, only around a quarter of people who die from suicide in Somerset have been in contact with specialist mental health services during the previous year.

1.3 In the most recent national data, there were 4,507 suicides among people aged 15 and over in England in 2012. The age-standardised suicide rate remained static between 2011 and 2012, at 10.4 deaths per 100,000 population. It is interesting to see that when broken down by gender there is an approximate 3:1 ratio of deaths. 3,483 male suicides in 2012 and 1,024 female suicides.

1.4 The overall Somerset rate in 2012 stands at 8.2 deaths per 100,000 compared to England at 10.4 deaths per 100,000. The present overall south west rate is 11.9. The Somerset suicide rate is ranked fifth in the south west (from low to high). Approximately 70% of Somerset suicides were male in 2012. The rate of completed suicide is very similar for all age groups over 35, with the highest rates being in those aged over 75 for both men and women.

1.5 Suicides are not inevitable. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides.

1.6 Suicide affects all age groups and communities in our society. In fact, few people escape being touched by the devastating effects of suicidal behaviour in their lifetime. The emotional, social and practical repercussions of suicide are felt by family members, friends, neighbours, colleagues and people working in a wide range of services and agencies.

1.7 In September 2012, the Government launched the current national policy; *'Preventing Suicide in England: a cross-government outcomes strategy to save lives*'. This replaced the 2010 Strategy following a public consultation on the national strategy which took place between July-October 2011.

1.8 This document represents a second revision of the Somerset Suicide Prevention Strategy, first developed in 2004 and reviewed and revised 2010-2013. This 2013-2016 strategy provides a further update reflecting the progress made, emerging evidence and the current national strategy.

1.9 In Somerset, the specialist suicide prevention activities are monitored by The Somerset Suicide Prevention Advisory Group (see appendix B). It

has brought together all key stakeholders and enabled an increase in joint working such as Samaritan sessions in A&E Departments and liaison with police custody suites. The Distress Cards for professionals have been reported as an innovative programme[5] and the annual suicide prevention awareness workshop and suicide prevention skills training are highly valued.

1.10 The overall aim of the 2013-2016 Somerset Strategy is to achieve:

1. A reduction in the suicide rate in the general population in Somerset

2. Better support for those bereaved or affected by suicide.

1.11 The strategy includes a jointly developed action plan to reduce the incidence of suicide. It follows a similar framework to the National Preventing Suicide in England outcomes strategy and sets out an action plan based on six areas for action:

1.12 Reduce the risk of suicide in high risk groups:

These have been identified as; people in the care of mental health services, young and middle aged men, people with a history of self-harm, people in contact with the criminal justice system and specific occupational groups identified locally which includes farmers in Somerset. Individual plans for each risk group will be developed and includes implementation of good practice guidelines.

1.13 Promote mental health and wellbeing in the population as a whole:

As well as targeting high-risk groups, another way to reduce suicide is to improve the mental health of the population as a whole. In Somerset we will implement the Public Mental Health and Wellbeing action plan to help build individual and community resilience, promote mental health and wellbeing and challenge health inequalities where they exist. This area of action will include continuing to role at suicide prevention skills training and also include tailored measures for groups with particular vulnerabilities or problems with access to services such as; children and young people, unemployed and people who misuse drugs and alcohol.

1.14 Reduce access to the means of suicide:

This will involve a partnership approach being led by Somerset Partnership Foundation Trust, emergency services and Somerset County Council as we look to undertake ligature point auditing, implementing health and safety risks when designing high rise structures and identifying hotspots often found in areas of outstanding natural beauty. The new NICE quality standard on ‘safe prescribing’ as related to reducing self-poisoning will also be promoted and disseminated.

1.15 Provide better information and support to those bereaved or affected by suicide:

Somerset's bespoke Suicide Bereavement Support Service will continue to provide emotional and practical support to those bereaved by suicide, including counselling and a peer support group. This service is delivered through a partnership between Mind in Taunton and West Somerset, Cruse, Barnardos and the Samaritans.

1.16 Support the media in delivering sensitive approaches to suicide and suicidal behaviour:

This will include the development of a communications strategy to help ensure the media understands and supports the need to take a sensitive approach. Monitoring local media reporting and disseminating the national Suicide Reporting Guidelines will be part of the action plan.

1.17 Support research, data collection and monitoring:

The Somerset Suicide Prevention Advisory Group oversees the implementation and monitoring of this action plan. Progress against its objectives will be recorded in the Somerset Audit Report.

1.18 Suicide is often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity. Achieving a reduction in suicide involves all agencies working together to reach more people who may be at risk of taking their own lives; which can only be achieved by understanding which groups of individuals are particularly at risk of suicidal thoughts and behaviours[17].

1.19 The economic impacts of suicide are profound, although comparatively few studies have sought to quantify these costs. In a recent London School of Economics Report[4], it is estimated that the average cost per completed suicide for those of working age only in England is £1.67m (at 2009 prices). This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as lost output (both waged and unwaged), police time and funerals.

1.20 An inclusive society that avoids the marginalisation of individuals and which supports people at times of personal crisis will help to prevent suicides. Statutory and voluntary services have a role to play. We can build individual and community resilience. We can ensure that vulnerable people in the care of health and social services and at risk of suicide are supported and kept safe from preventable harm. We can also ensure that we intervene quickly when someone is in distress or in crisis.

1.21 This strategy is intended to provide an approach to suicide prevention that recognises the need to address these challenges through a

multidisciplinary approach which will share the responsibility of reducing suicides. It draws on local experience, research evidence and the national strategy.

SOMERSET SUICIDE PREVENTION STRATEGY

1 INTRODUCTION

1.1 Suicide is a major public health issue and is a devastating event for families and communities.[1] On average someone dies in England every two hours as a result of suicide. In 2011 there were 4,509 deaths from suicide.[1] Suicide is often the end point of a complex history of risk factors and distressing events. The prevention of suicide therefore needs to address this complexity. This strategy is intended to outline the local approach to suicide prevention and it recognises the contributions that can be made across all sectors of society. The strategy draws on local experience and expertise and national research evidence and guidance.

1.2 The government's mental health strategy *No Health without Mental Health*[5] was published in 2011 to improve mental health outcomes. It is important to acknowledge that suicide prevention starts with better mental health for all.

1.3 In September 2012, the current national policy, *'Preventing Suicide in England: a cross-government outcomes strategy to save lives*' was launched.[1] This replaced the 2010 Strategy on the back of the National Service Framework for Mental Health. This new strategy aims to reduce the suicide rate and improve support for those affected by suicide. The new national strategy emphasises local action and supports this by bringing together knowledge about groups at higher risk of suicide, identifying evidence of effective interventions and highlighting available resources.

1.4 This document represents a second revision of the Somerset Suicide Prevention Strategy, first developed in 2004. This 2013-2016 strategy provides a further update reflecting the progress made, emerging evidence and the current policy climate. The strategy includes a plan which contains six areas for action to reduce the incidence of suicide. It follows a similar framework to the National Preventing Suicide in England outcomes strategy and sets out an action plan based on six goals:

1. Reduce the risk of suicide in high risk groups
2. Promote mental health and wellbeing in the population as a whole
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.

1.5 The Somerset Suicide Prevention Advisory Group oversees the implementation and monitoring of this action plan. Progress against its objectives will be presented to the Safer Somerset Partnership Board and recorded in the Somerset Audit Report.

1.6 Suicides are not inevitable. An inclusive society that avoids the marginalisation of individuals and which supports people at times of personal crisis will help to prevent suicides.[1] Statutory and voluntary services have a role to play. We can build individual and community resilience. We can ensure that vulnerable people in the care of health and social services and at risk of suicide are supported and kept safe from preventable harm. We can also ensure that we intervene quickly when someone is in distress or in crisis.

2 DEFINITION AND TERMS

2.1 This Strategy covers a range of behaviours brought together under the heading "suicidal behaviour". It distinguishes between:

- **'Suicide'**: There is no universally accepted definition of suicide, as there are difficulties in determining the exact intent of a person who dies. However, a broad definition is: *'a fatal act of self-harm with a conscious intent to end life.'*[6] Not all suicides are preceded by suicidal behaviour. Sometimes they are an impulsive act or occur in a state of panic.

- **Deliberate self-harm:** Self-harm is: *'a deliberate non-fatal act whether physical, drug overdose or poisoning, done in the knowledge that it was potentially harmful and in the case of drug overdose that the amount taken was excessive.'*[6]

2.2 Injuring oneself is the objective and not a means to kill oneself. The intent of self-harm may be to stop conscious experience, interrupt conscious experiences, or be an appeal, or request, for help. It may be a way of coping, or surviving. It can take many forms, including poisoning and cutting. For many, it is focused on improving the situation and remains a way of coping with those feelings they cannot express.

2.3 Those who harm themselves in some way may or may not have had a suicidal intent. We are using "deliberate self-harm" as an umbrella term and it would encompass the terms "attempted suicide" and "parasuicide"

2.4 Effective strategies to reduce suicide within a population need to be mindful of the overlap between suicidal behaviour and deliberate self-harm. A proportion of the people who deliberately harm themselves are at increased risk of subsequently completing suicide; Hawton and Fagg suggest that people who self-harm are 20 times more likely to commit suicide within eight years than those who do not self-harm.

2.5 It is crucial that incidents of self-harm are properly recorded and the relevant information elicited. History of deliberate self-harm is a predictor of future injury. Repeated episodes, as distinct from a "one-off" impulsive response to an upsetting event, are a major risk factor for future serious self-harm and suicide. [7]

2.6 However, the relationship between suicide and self-harm is complex:

Some deaths which are classified as suicide may result from acts which were not intended to cause death or where the motivation (suicidal intent) was equivocal.

2.7 Likewise, some acts of deliberate self-harm may have been intended to result in death, but may have been foiled through rescue by others, imperfect knowledge, the choice of method, or some other reason.

2.8 Many acts of deliberate self-harm are not intended to end the person's life. Because of this overlap between the two behaviours, deliberate self-harm needs to be regarded as one of a range of risk factors associated with suicide. It would, however, not be appropriate to regard all deliberate self-harming behaviour as suicidal behaviour. Indeed, the majority of people who self-harm do not go on to take their own life.

2.9 This Strategy includes only those aspects of self-harming behaviour that might be considered as an indication of risk of suicide. It is recognised that there are other dimensions and manifestations of deliberate self-harm that are not covered within the Strategy's scope.

3 NATIONAL CONTEXT

3.1 In September 2012 the Department of Health launched *'Preventing* Suicide *in England: a cross-government outcomes strategy to save lives'.* This strategy aims to reduce the suicide rate and improve support for those affected by suicide and was informed by an earlier consultation on preventing suicide in England. The new strategy outlines six areas for action including: reducing the risk of suicide in key high-risk groups (for example, people in the care of mental health services, people with a history of self-harm, people in contact with the criminal justice system, and men aged under 50); reducing access to the means of suicide; and supporting research, data collection and monitoring.

3.2 There are two further key strategy documents that, in combination with *Preventing Suicides in England,* take a public health approach using general and targeted measures to improve mental health and wellbeing and reduce suicides across the whole population.

3.3 *Healthy Lives, Healthy People: Our strategy for public health in England* (2010)[8] gives a new, enhanced role to local government and local partnerships in delivering improved public health outcomes. The inclusion of suicide as an indicator within the Public Health Outcomes Framework will help to track national progress against the overall objective to reduce the suicide rate[9].

3.4 *No health without mental health: A cross-government outcomes strategy for people of all ages* (2011) is key in supporting reductions in suicide amongst the general population as well as those under the care of mental health services [5]. The first agreed objective of *No health without mental*

health aims to ensure that more people will have good mental health. To achieve this, we need to:

- Improve the mental wellbeing of individuals, families and the population in general;
- Ensure that fewer people of all ages and backgrounds develop mental health problems;
- Continue to work to reduce the national suicide rate.

3.5 *No health without mental health* includes new measures to develop individual resilience from birth through the life course, and build population resilience and social connectedness within communities. These too are powerful suicide prevention measures.

3.6 From April 2013 local responsibility for coordinating and implementing work on suicide prevention became an integral part of local authorities' new responsibilities for leading on local public health and health improvement. Health and Wellbeing Boards will support effective local partnerships and will be able to support suicide prevention as they determine local needs and assets.

3.7 Public Health England, the new national agency for public health, will also support local authorities, the NHS and their partners across England to achieve improved outcomes for the public's health and wellbeing, including work on suicide prevention.[10]

3.8 The impact of stigma associated with mental health problems can also act as a barrier to people seeking and accessing the help that they need, increasing isolation and suicide risk. The need to address this is recognised through the Government and local authorities supporting the national mental health anti-stigma and discrimination Time to Change programme.[11]

3.9 There are a number of other national initiatives and sources including *Avoidable Deaths,* a five year inquiry into deaths from suicide and homicide among people suffering mental illness; studies into self-harm; a revised care planning system for at-risk prisoners; and publication of *Help is at Hand* – a resource for people bereaved by suicide.

4 KEY NATIONAL STRATEGIES

- Preventing Suicide in England: A cross-government outcomes strategy to save lives, HM Government 2012.[1]
- Preventing Suicide in England: Assessment of impact on equalities, HM Government 2012.[14]

- Preventing suicide in England: Prompts for leaders on suicide prevention, HM Government 2012.[15]

- Sources of information for families, friends and colleagues who may be concerned about someone at risk of suicide, HM Government 2012.[16]

- Preventing Suicide in England: Statistical update on suicide, HM Government 2012.[17]

- Public Health Outcomes Framework : Improving outcomes and supporting transparency, 2012.[18]

- No Health Without Mental Health: A cross government outcomes strategy for people of all ages, 2012.

- Healthy Lives, Healthy people: Update and way forward, 2011.[20]

- Avoidable Deaths: Five-year report of the national confidential inquiry into suicide and homicide by people with mental illness.[21]

- Inquiry into suicide and homicide by people with mental illness: Annual report for England and Wales, University of Manchester, 2013

5 NATIONAL SUICIDE RATES & TRENDS

5.1 Suicide rates in England are low compared to those of many other European countries. The latest figures reveal a rate of 10.4 deaths per 100,000 population. In the most recent data available from ONS 2012, there were 4,509 suicides among people aged 15 and over in England and Wales.[1]

5.2 The age-standardised suicide rate has remained static between 2011 and 2012 at10.4 deaths per 100,000 population. It is interesting to see that when broken down by gender there is an approximate 3:1 ratio of deaths. 3,483 male suicides in 2012 and 1,024 female suicides.[1]

5.3 The past five years of data shows a levelling off of suicide rates and a sharp drop in the rate in Somerset. See Figure 1.[1]

5.4 There has been a sustained reduction in the rate of suicide among young men under the age of 35, which reverses the upward trend which began over 30 years ago.[1]

5.5 Currently, around three-quarters of deaths from suicides are men; in 2011 in England, the highest suicide rate was in males aged 45-59 (22.2 deaths per 100,000 population) representing a total of 1,354 suicides. Female suicide rates were also highest in the 45 to 59-year-olds (7.3 deaths per 100,000 population), representing a total of 455 suicides.[1]

5.6 Rates of suicide in men aged over 75 are also relatively high, which is a recent trend; risk factors such as loneliness and physical illness may be contributing factors.[1]

5.7 In 2011 the suicide rate was highest in the North East region at 12.9 deaths per 100,000 population and lowest in London at 8.9 per 100,000 (see Table 1)

5.8 The suicide rate fell in two regions in between 2010 and 2011 (West Midlands and London), and rose in seven regions (South West, South East, North West, East of England, East Midlands, North East and Yorkshire and the Humber). The largest increase was in Yorkshire and the Humber, where the suicide rate increased by 21% in 2011.[13]

Table 1

Number of deaths and age-standardised suicide rate: by sex, country and region, England and Wales, 2011[1],[2],[3],[4],[5]

	Male		Female		Persons	
	Deaths	**Rate**	**Deaths**	**Rate**	**Deaths**	**Rate**
England	3,415	16.1	1,094	4.9	4,509	10.4
North East	218	21.5	55	4.7	273	12.9
North West	525	18.9	148	5.0	673	11.9
Yorkshire and The Humber	359	17.0	104	4.7	463	10.8
East Midlands	281	15.6	84	4.4	365	9.9
West Midlands	324	14.4	106	4.6	430	9.4
East of England	364	15.9	119	4.8	483	10.3
London	427	13.2	156	4.7	583	8.9
South East	525	15.1	198	5.4	723	10.1
South West	392	18.6	124	5.5	516	11.9
Wales	270	22.5	71	5.6	341	13.9

1 The National Statistics definition of suicide is given in the 'Suicide definition' tab.

2 Figures are for persons aged 15 years and over.

3 Age-standardised suicide rates per 100,000 population, standardised to the European Standard Population. Age-standardised rates are used to allow comparison between populations which may contain different proportions of people of different ages.

4 Figures are for persons usually resident in each area, based on boundaries as of August 2012.

5 Figures are for deaths registered in 2011.

Source: Office for National Statistics Office for National Statistics and Department of Health (2010) DH Mortality Monitoring Bulletin (Life expectancy, all-age-all-cause mortality, and mortality from selected causes, overall and inequalities).

5.9 Suicide rates can be volatile as new risks emerge. Previously, periods of high unemployment or severe economic problems have had an adverse effect on the mental health of the population and have been associated with higher rates of suicide[15] Evidence is emerging of an impact of the current recession on suicides in affected countries. A recent study by the University of Liverpool suggests the economic recession is having an impact on suicide rates. Researchers calculated that more than one thousand suicides, between 2008-2010, could be attributed to unemployment.[16] Suicide risk is complex and for many people it is a combination of factors, outlined in figure 7, that determines risk rather than any single factor.

5.10 Understanding some of the issues behind suicide patterns is key to making a difference:

- Up to half of all suicides have previously made failed attempts.
- Only a quarter of people (nationally) who die by suicide are under psychiatric care in the year before their death (i.e. 75% are not). In Somerset in 2011 37% of people who died by suicide were under the mental health services.
- 5-10% of all suicides happen in the four weeks after discharge from psychiatric hospital, making this a time of high risk.
- More men die from suicide than women, but suicidal thoughts and self harm are more common in women.
- Groups who have more frequent thoughts of suicide are:
    - Women
    - Those aged 16 to 24
    - Those not in a stable relationship
    - Those with low levels of social support
    - Those who are unemployed.
- Suicide is often precipitated by recent adverse events. These include relationship breakdowns, conflicts, legal problems, financial concerns, and interpersonal losses. There is also research into the links between suicide and terminal or chronic illness[19]
- Suicide is estimated to be under-reported for reasons of stigma, religion and social attitudes. Many suicides are hidden among other causes of death, such as road traffic accidents and drowning.[19]

6 SOMERSET SUICIDE RATE & TRENDS

6.1 The target is to reduce the death rate. The overall Somerset rate in 2012 stands at 8.2 deaths per 100,000 compared to England at 10.4 deaths per 100,000. The present overall south west rate is 11.8[13] **Figure 1** provides a comparison between the directly age standardised suicide rates in England, South West and Somerset.

6.2 Between 2007-2012 Somerset recorded 269 suicides or open verdicts with an average of 45 deaths per year. The highest number of deaths occurred in 2010 and 2011 at a total of fifty deaths. **Figure 2** provides a breakdown of suicides per year in Somerset since 1993. **Table 2** provides the break down by district related to rates and numbers of suicides since 2007.

6.3 Of the total number of suicides in Somerset, between 2007-12, 76% were Male and 24% were Female. This is consistent with the 3:1 ratio reported nationally. **Figure 3:** provides a comparison of suicide number*s* by gender.

6.4 Men aged 75+ and women aged 75+ were most at risk of completing suicide. **Figure 4** shows the suicide rate by age and gender for 2007-2012 indicating that, while more deaths are in people aged 35-64, there are reasonably similar rates for all age groups above 24.

6.5 The most common means of completing suicide is hanging followed by overdosing. Women use both methods equally often. Hanging is the most common method for men and they tend to use more violent methods such as jumping and the use of firearms **Figure 5** provides details of cause of death by gender.

6.6 **Figure 6** provides details of cause of death by age group. Hanging is the most common method for each age group. Those aged over 75 use a wider variety of methods such as intentional self-poisoning by exposure to unspecified chemicals.

6.7 The data provides an interesting overview to a complex problem. Developing the audit information is essential together with bringing together more narrative surrounding suicide reviews to help build a more detailed picture of trends and patterns that can be used to influence commissioning and service delivery.

Figure 1: Directly standardised suicide rate in England and Somerset

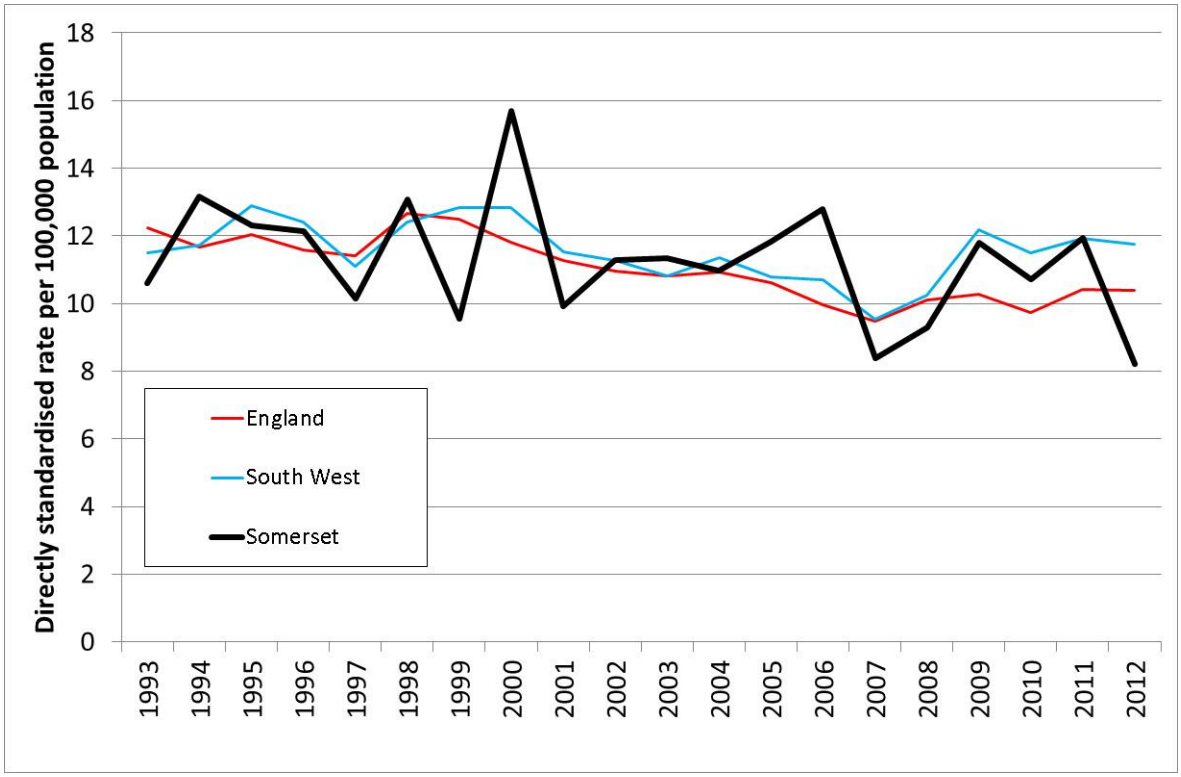


Figure 2

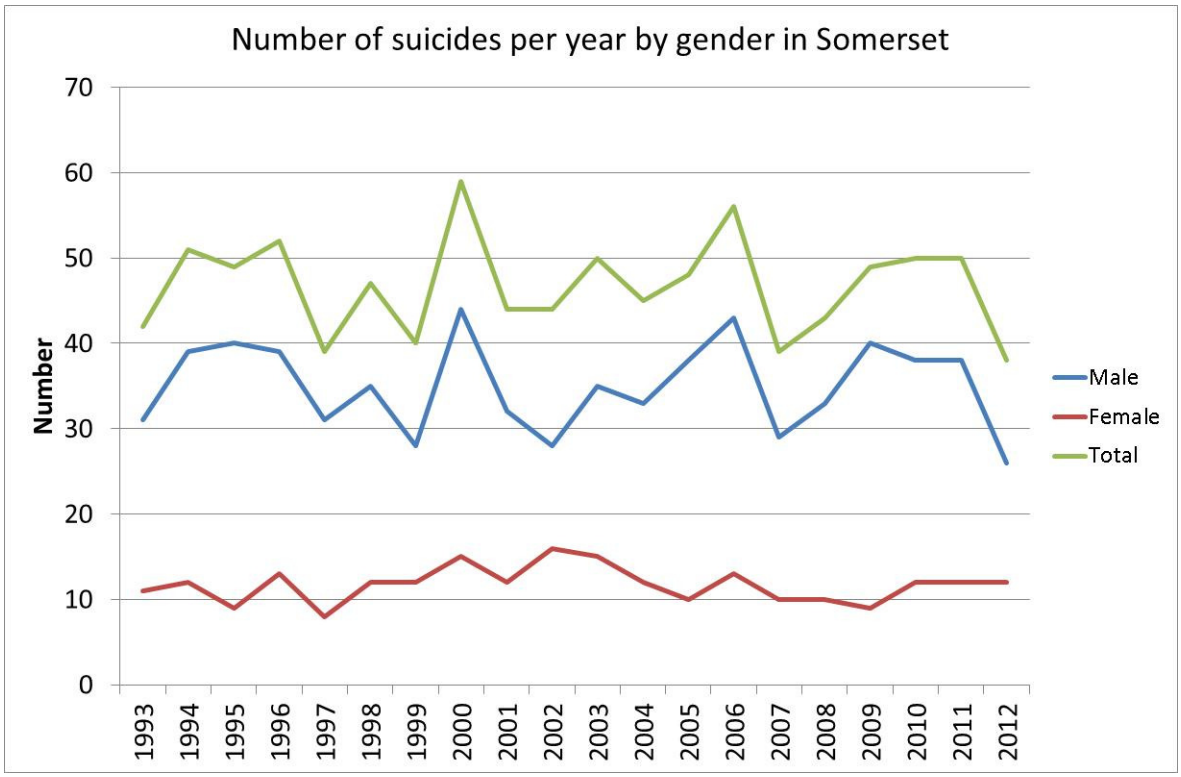


Table 2: Comparison of Mortality from suicide and injury undetermined
(aged15+)

Directly standardised rate per 100,000

Persons	2007	2008	2009	2010	2011	2012
England	9.48	10.11	10.28	9.75	10.42	10.40
South West	9.52	10.24	12.17	11.49	11.94	11.75
Somerset	8.38	9.30	11.81	10.72	11.93	8.21
Mendip	9.41	6.46	4.16	7.72	6.71	14.50
Sedgemoor	9.47	7.62	13.62	12.16	6.79	5.45
South Somerset	5.21	12.30	12.97	12.35	18.30	6.23
Taunton Deane	8.79	8.56	17.53	10.80	11.38	8.54
West Somerset	14.05	15.90	5.45	7.45	22.46	7.02

Numbers

Persons	2007	2008	2009	2010	2011	2012
England	3,988	4,275	4,379	4,193	4,509	4,507
South West	416	441	514	494	516	519
Somerset	39	43	49	50	50	38
Mendip	7	8	3	9	6	14
Sedgemoor	9	9	12	14	6	5
South Somerset	8	16	16	16	22	10
Taunton Deane	9	7	16	9	11	8
West Somerset	6	3	2	2	5	1

Figure 3: Comparison of suicide *numbers* by gender

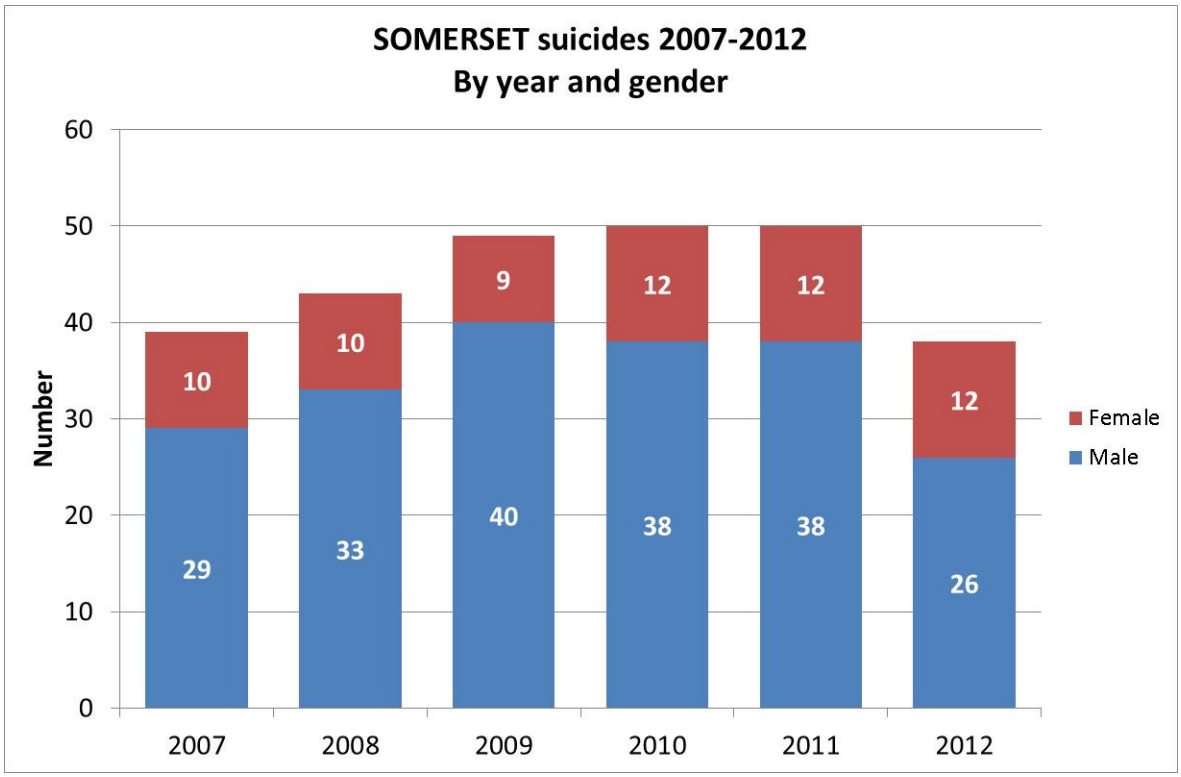


Figure 4: Comparison of suicide *rates* by gender and age group

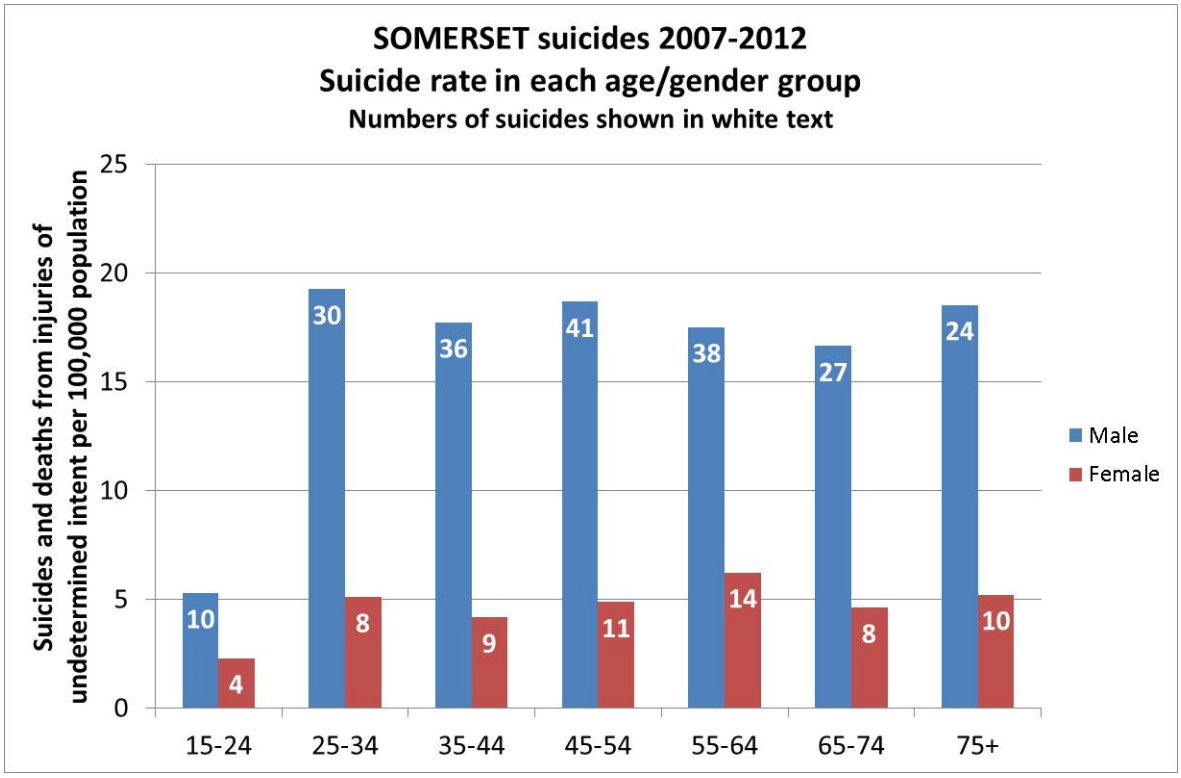


Figure 5: Cause of death by gender

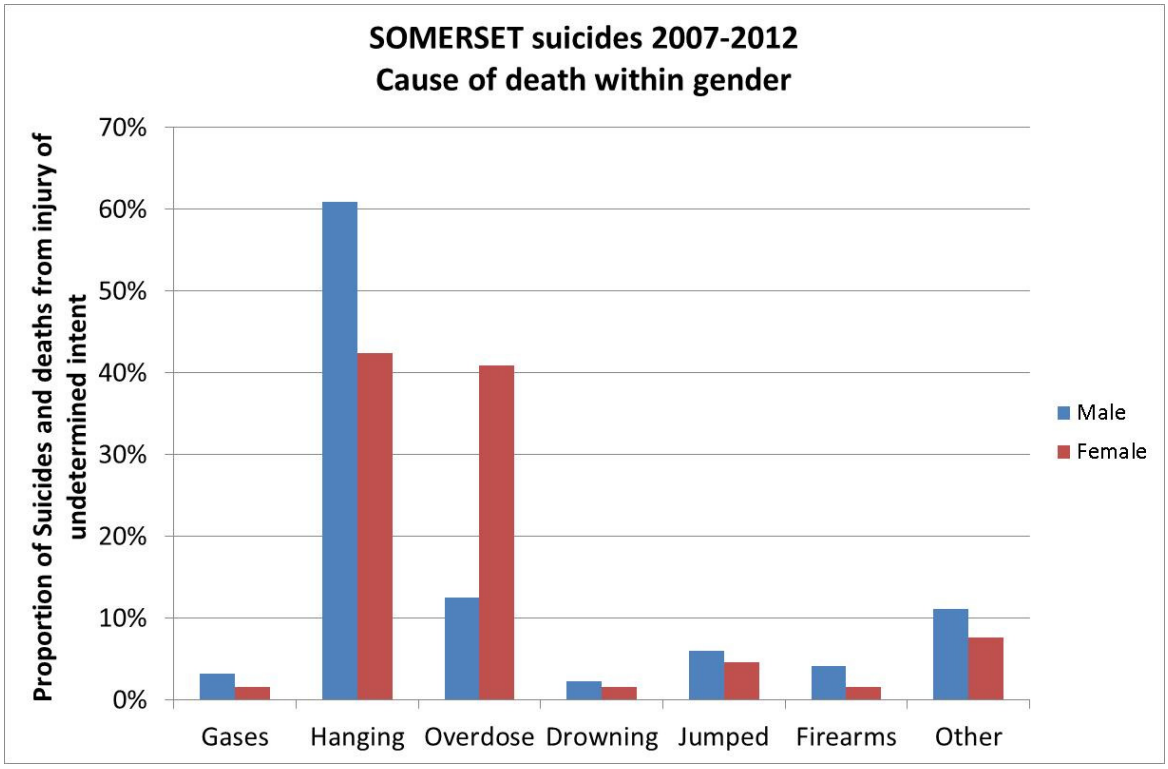
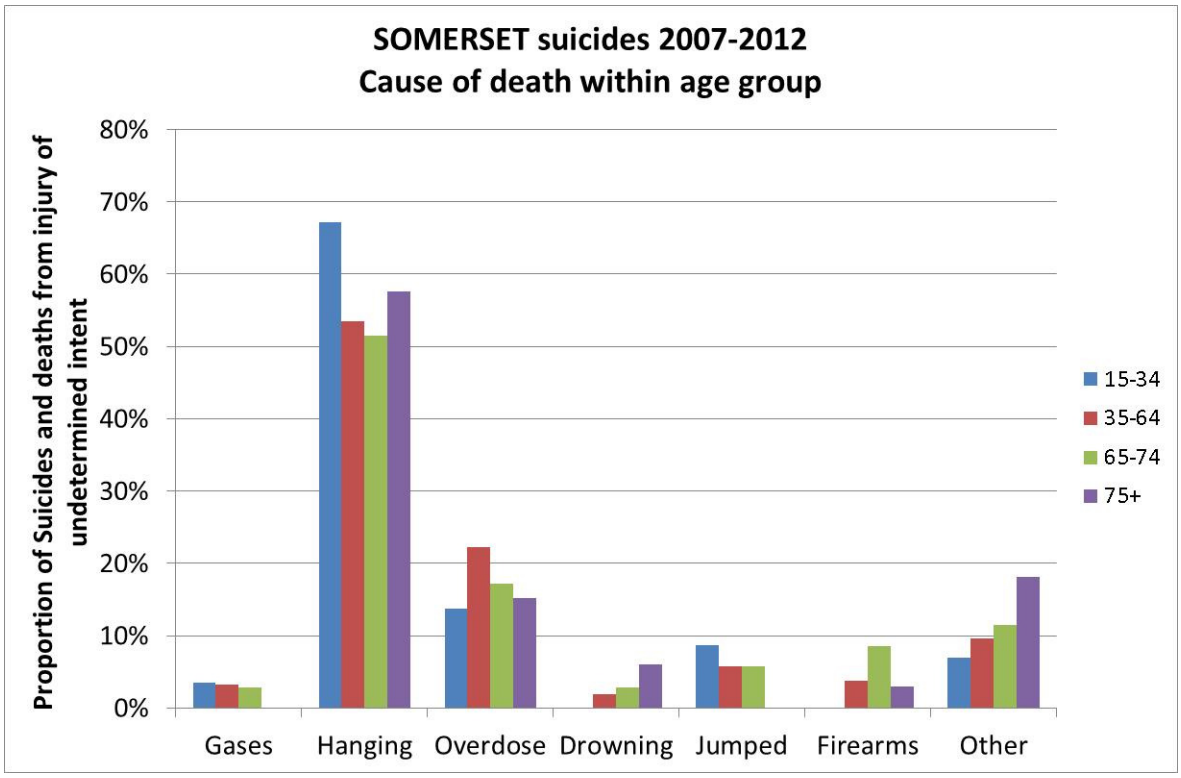


Figure 6: Cause of death by age group



7 LOCAL SUICIDE AUDIT

7.1 The process to collect suicide data began through Somerset Health Authority in 1993. This was initially in line with standard seven of the National Service Framework for mental health which required audits to be undertaken to learn lessons and take any necessary action.[6] This practice also became a requirement under the National Suicide Prevention Strategy.

7.2 In 2003/04, South Somerset Primary Care Trust assumed responsibility for the Somerset Suicide Audit from the Somerset Health Authority function. After the merging of the Primary Care Trusts in 2006, the Public Health and Nursing and Patient Safety Directorates of NHS Somerset took on joint responsibility for the Somerset Suicide Audit. In 2009, the Public Health Directorate appointed a Suicide Audit Coordinator and took on the entire role for suicide audit.

7.3 Audit reports have been produced every three years, with five years data included. An interim one year update was published in 2009, covering the 2006 data period The next full report was published in 2010, including data for the three-year period 2006-2008.

7.4 In April 2013, local responsibility for coordinating and implementing work on suicide prevention was transferred to local authorities' as an integral part of local authorities' new responsibilities for leading on local public health and health improvement. During the transition, co-ordination of the audit was delayed and the next report due out will cover the period from 2009 – 2012. The two year delay is a result of the time taken for inquests to be completed and the suicide audit tool questionnaire being circulated and completed by the professionals involved.

7.5 When the figures are broken down to produce a yearly suicide/ undetermined death rate across Somerset, the numbers are small. This means that small changes in numbers will result in a large variability in the rate. The average rate over three years is more stable than that over a single year, although at a local level even three year averages can be volatile and looking at trends is not helpful.

7.6 In view of the sensitivity of "trends", it is important not to get too "hooked" into the data. Hawton and Van Heeringen comment that it is not necessarily meeting a suicide prevention target that is important…"Rather, it is the role of a target as a guiding beacon that can lead to the problem of suicidal behaviour being taken more seriously and galvanise more active planning of national policy to improve mental health and mental health care.[1]"

7.7 To help develop understanding of effective interventions to reduce suicides, the Somerset Suicide Prevention Advisory group intends to bring together information from the different suicide review processes undertaken and to include these finds as part of the audit report in future years.

8 STRATEGIC APPROACH – THE CHALLENGE OF SUICIDE PREVENTION

8.1 Suicide prevention is not the sole responsibility of any one sector of society, or of the health services alone. Suicide is often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity.

8.2 This strategy is intended to provide an approach to suicide prevention that recognises the contributions that can be made across all sectors of our society. It draws on local experience, research evidence and the national strategy, *Preventing Suicides in England and Wales.*

8.3 A number of factors can increase an individual's vulnerability to suicide. Table 2 highlights common causes and risks to suicidal behaviour from within society, communities, for the individual and the quality of services available to help. For many people, it is the combination of factors which is important rather than one single factor. Figure 7 offers a framework to explore these factors.

8.4 We need to consider ways in which policies and actions to prevent suicide can be made sensitive to the specific circumstances and needs of particular groups on the basis of age, gender, ethnicity, sexual orientation, disability and in particular settings such as schools, workplaces, urban and rural areas.

8.5 The risk factors for suicide:

A number of factors can increase an individual's vulnerability to suicide these include[1]:

- Young and middle-aged men
- People in the care of mental health services, including inpatients and those recently discharged from psychiatric care
- People with a history of self-harm
- People in contact with the criminal justice system
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers
- The following points are also important in terms of suicide prevention.[(10)]
- A number of occupational groups - doctors, farmers, vets, dentists and pharmacists - are at increased risk of suicide, although deaths in these groups make up only 1-2% of all suicides. One important factor influencing the increased risk in these occupations is their access to lethal means of suicide

8.6 The greatest impact is likely to result from a combination of preventative strategies directed at:

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

- Recognised high risk groups - e.g. people with recurrent depressive disorders, previous suicide attempters, people who misuse alcohol, the unemployed, people with certain co-morbid mental and personality disorders and people recently discharged from psychiatric in-patient care

8.7 This Strategy takes a broad approach based on the priority areas for action identified within the National Suicide Prevention Strategy and through discussions locally around unmet needs.

8.8 The Strategy values the importance of general measures to improve the mental health of all, and to address aspects of people's life experiences that may damage their self-esteem and their social relationships. It recognises the need to tackle health inequalities and to combat discrimination against individuals and groups with mental health problems, thereby promoting their social inclusion.

8.9 Achieving a reduction in suicides; the overall vision of this Strategy is:

1. To contribute towards the continued reduction in the death rate from suicide

2. To provide better support for those bereaved or affected by suicide.

8.10 The Strategy works to the themes of:

- **prevention** of suicidal thoughts – promotion of wellbeing and reducing risk factors that can lead to suicidal thoughts

- **provision** of appropriate and effective support and treatment – availability of effective support, treatment and antidotes to enable people to continue with their lives

- **protection** to help keep people safe – related to influences such as the media, culture and reduced availability and lethality of suicide methods

8.11 There are six key priority goals 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.

8.12 To ensure the effective delivery of the Strategy, it will involve contributions from health, social care agencies, local authority and voluntary and private sector organisations. It will need to harness the energy of the voluntary and community sectors and utilise their experience of working with local community interests and networks, alongside those of statutory agencies. The concepts of partnership working and shared responsibility also applies to sharing decisions about the investment and targeting of resources to achieve national and local objectives.

8.13 There is a strong recognition that any suicide prevention strategy has to be grounded in the need to promote mental wellbeing in the wider population. As such, the Somerset Suicide Prevention Strategy will work in partnership with the Public Mental Health action plan as part of the Somerset Mental Health and Wellbeing Strategy that is in draft at the time of writing.

8.14 Improving the mental wellbeing of the general population requires action on three main levels:

Level One: promoting mental wellbeing and reducing the risk factors for poor mental health

Level Two: targeting interventions to those that are at risk of developing mental health problems

Level Three: promoting recovery and better outcomes for people who have mental health problem

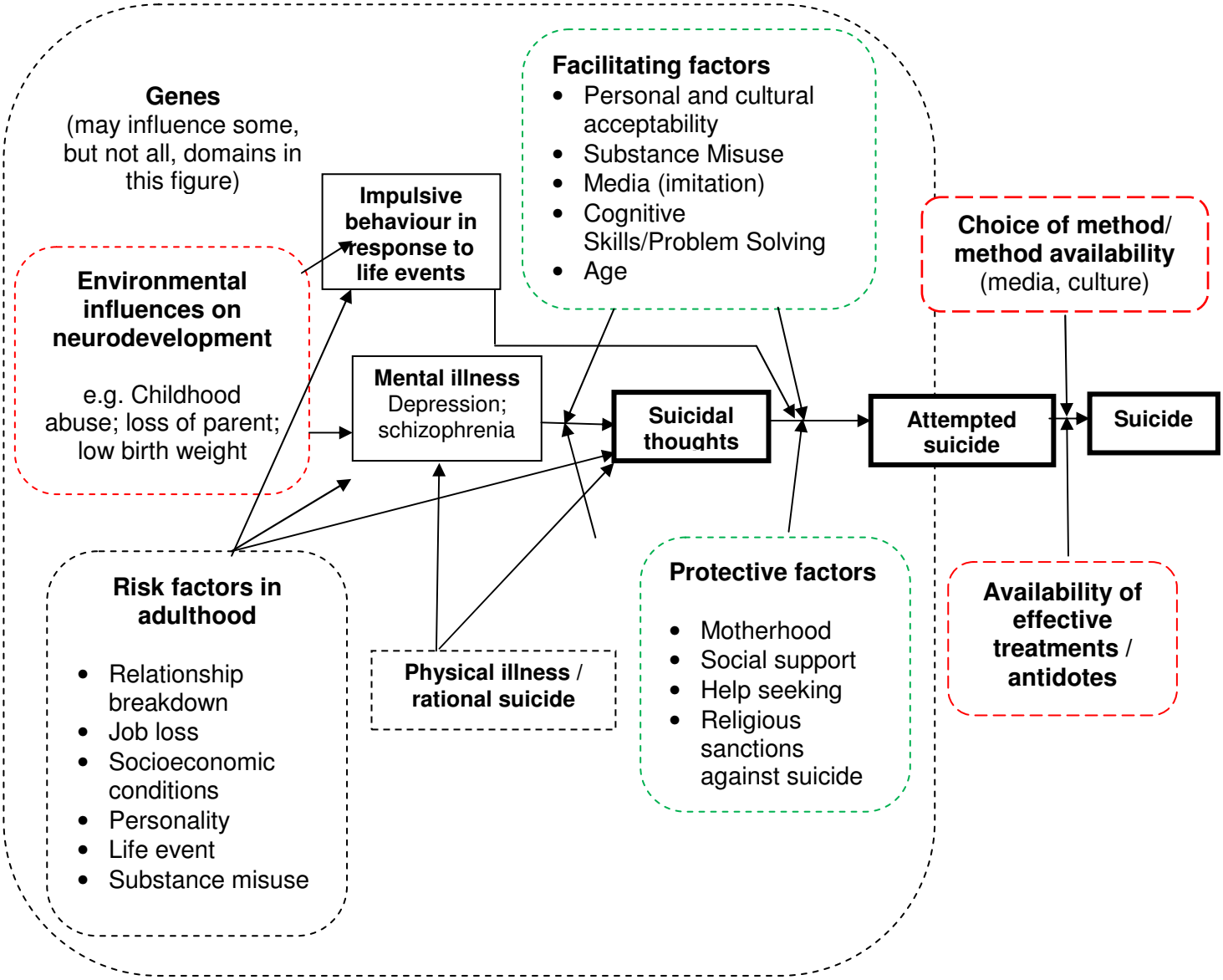
Challenge of Suicide Prevention- Causes and Risks of Suicidal Behaviour

Table 3

Risks and pressures within society	**Risks and pressures within community**	**Risks and pressures for individuals**	**Quality of response from services**
Availability of, and easy access to, methods for suicide	Low level of trust in the community such as poor social cohesion or integration	Inadequate social support such as low levels of practical, emotional and other forms of assistance from family, friends and neighbours	Insufficient focus on the prevention, identification and assessment of needs and provision of care and support by services such as health, social work, education, criminal justice, housing and others.
Changing trends in society such as increase in marital breakdown, divorce and single person households	High level of social exclusion such as neighbourhood poverty and deprivation	Socio-demographic characteristics, such as Age - people aged 35-49 now have the highest suicide rate Gender - males are three times as likely to take their own life as females marital status (non-married), (lower) socio-economic status and (certain types of) occupation	Insufficient focus on the identification of those at risk and assessment of their needs and treatment requirements by health, social care and other services
High prevalence of alcohol problems and substance misuse	Communities which are faced with multiple disadvantages and are low on resources and resilience	Lack of care, treatment and support towards recovery from serious recurring mental illness such as schizophrenia and depression	The treatment and care received after making a suicide attempt
Social values and attitudes to mental illness and mental health, suicidal behaviour, heterosexism, gender stereotyping, racism, domestic	Feelings of fear or lack of safety	Stressful life events including: • the loss of a job; • debt; • living alone, becoming socially excluded or isolated;	

Risks and pressures within society	Risks and pressures within community	Risks and pressures for individuals	Quality of response from services
abuse, stigma, poverty and inequality		• bereavement; • family breakdown and conflict including divorce and family mental health problems; and • imprisonment	
Discrimination and stigma suffered by people with mental health problems	Inadequate access to local services, particularly at times of crisis	Substance misuse and alcohol problems in particular	
Irresponsible reporting and representation of suicidal behaviour by the media	Isolation associated with living in rural areas.	Previous deliberate self-harm	
Adverse labour market conditions such as insecurity of employment		Experience of abuse (sexual and physical) or bullying	
Adverse economic conditions such as level of unemployment and business confidence		Low self-esteem, lack of confidence	
		Low educational qualifications, poor life skills and interpersonal skills	
		Life crises, especially interpersonal loss such as bereavement or divorce, or issues relating to sexual orientation (including experience/fear of societal reaction)	
		Inability to access appropriate services and support at times of need	
		Physically disabling or painful illnesses including chronic pain	

Fig 7: UNDERSTANDING SUICIDE



From a presentation by Professor David Gunnell, University of Bristol 2009 at Raising Hopes, Reducing Fears Conference.

9 IMPLEMENTATION

9.1 The Implementation Plan (Appendix A) has been developed from the Somerset Suicide Prevention Strategy 2010-2013, building on progress to date. To ensure delivery of the objectives, a number of relevant actions have been identified, together with indicators to monitor progress. In order for the Implementation Plan to "work", organisations will need to consider how the strategy impacts on them and to agree and accept responsibility for achieving the relevant outcomes. It has been important to establish realistic timescales for delivery and to monitor progress on a regular basis.

9.2 To further assist in delivery at local level, the Somerset Suicide Prevention Advisory Group (Appendix B) will continue to oversee the delivery of the Implementation Plan.

9.3 The Somerset Health and Wellbeing Board will offer leadership to support suicide prevention as they determine local needs and assets.

9.4 The challenge is in how we make the Strategy relevant and workable to the many people who are at risk. It will involve:

- Shared responsibility - supporting the improved coordination of efforts between and by local agencies

- Continuous Quality Improvement - A strategic approach to suicide prevention has to be informed by drawing on, and developing, better information and evidence of what works. We need to identify outcomes that we can measure and monitor, constantly evaluate progress and make necessary adjustments to confirm that our actions are being effective and take the necessary actions to improve future work

- Shared evidence base - The Suicide Prevention Strategy for Somerset has relied on the National Strategy for examples of evidence and good practice, drawing on published research wherever possible

- Developing and implementing policies and procedures for suicide prevention and intervention

- Encouraging and supporting more innovative local voluntary, community-based and self-help initiatives that address suicide reduction and prevention

- Developing knowledge and understanding - Raising awareness and understanding about suicide across the many stakeholders remains a critical approach within the Strategy. Most people considering suicide share their distress and their intent. Few professionals receive training on how to approach this work. Training can help us

see and respond to these invitations for help, which are often subtle and unexpected

10 CONCLUSION

1.1 A detailed Implementation Plan is outlined in Appendix A. Named organisations or groups have been identified against each action and they will have responsibility for ensuring the implementation of each action identified.

1.2 The Suicide Prevention Advisory Group will take responsibility for collating a yearly monitoring form and will report on progress to Somerset Community Safety Partnership, who will report back to the Health and Wellbeing Board

1.3 Suicides tend to rise at times of unemployment and economic problems. The current recession focuses our thoughts on implementing this Strategy.

1.4 With the arrival of a new national vision for mental health, 'No health without mental health', there is growing support for promoting mental wellbeing. This recognition and interest needs to be harnessed by the Health and Wellbeing Board and Clinical Commissioning Group to assist in the delivery of this Strategy.

1.5 The agreement and implementation of this Strategy will ensure Somerset is well placed to respond to *No health without mental health* and the Public Health Outcomes Framework Domain 4 target to reduce premature death.

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APPENDIX A

Somerset Suicide Prevention Strategy
Draft Implementation Plan 2013-2016

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
1 Action area one: Reduce the risk of suicide in high risk groups						
	1.1 To disseminate and promote the revised suicide prevention strategy to local **stakeholders** including the Community Safety Partnership, Children and Adults' Safeguarding boards and the Clinical Commissioning Group	Consultant in Public Health	Strategy acknowledged by key strategic groups	30 June 2013		
	1.2 To produce, disseminate and evaluate the use of a pocket size 'distress card' to emergency services and people on the frontline supporting vulnerable people	Health Promotion Manager – Mental Health	Distress cards distributed	30 June 2013		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
People in the care of mental health services	1.3 To disseminate and implement NCI checklist of 'Twelve Points to a Safer Service'	Somerset Partnership Suicide Prevention Group	All 12 points have been implemented. and monitored quarterly	Somerset Partnership Suicide Prevention Group to be established by 31 March 2013. Group will develop a plan for dissemination, implementation and monitoring by 31 July 2013.		
	1.4 To implement the NPSA's "*Preventing Suicide: a toolkit* for *mental health services"*	Somerset Partnership Suicide Prevention Group	Monitoring reports produced demonstrating extent Somerset Partnership met the best practice measures on suicide prevention	Reports, including for young people, to be requested from Kay Southway.		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
Young and middle aged men	1.5 To work with the custody and courts scheme to promote access to mental health support as early as possible	Somerset Partnership, Samaritans and Custody Service Working Group		Regular audits on Court Liaison Scheme to be requested from Karen Gough (Forensic Team)		
People with a history of self harm	1.6 To review and disseminate the NPSA Prevention of Suicide: *a toolkit for community mental health*	Somerset Partnership – Community Services	Action plan for reducing gaps in NHS primary care relating to self harm is developed and implemented.	Annually		
	1.7 To identify the options for delivering training and information to GP"s and GP Trainees regarding how to identify signs and talk about suicidal feelings with patients	GP Patient Safety lead	Briefing sheets disseminated to all GP's and training plan developed and implemented	October 2013		
	1.8 Analyse Somerset self-harm data to monitor rates and patterns of self–harm, including risk factors for repetition and data to help with operational plans and medicines taken in overdose.	Reduction in Self Harm Working Group	Self harm data report produced on an annual basis	30 June 2013		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
	1.9 Review existing care pathways and revise to ensure good service provision and practice for all patients attending A&E/acute trusts following self-harm.	Reduction in Self Harm Working Group	Revised care pathways for children and adolescent and adults and older people in place	September 2013		
	1.10 Ensure timely comprehensive psychosocial assessments for patients in acute hospitals following deliberate self-harm	Somerset Partnership Crisis Intervention Teams – East and West	80% of assessments undertaken within 48 hours of referral Somerset Partnership Suicide Prevention Group to evidence performance.	Annually		
	1.11 Review and develop care for 'at risk' patients on discharge., including how the care may vary depending on number of admissions for self harm and the use of social media to offer support	Reduction in Self Harm Working Group	Care pathways implemented, monitored and reported on for at risk patients at discharge	April 2015		
	1.12 To ensure training is available around self harm in line with the NICE	Somerset Partnership Suicide	Self Harm training events offered to a wide range of	On-going		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
	Guidelines on self harm for frontline staff outside of specialist mental health services	Prevention Group	practitioners and courses monitored and evaluated			
People in contact with the criminal justice system	1.13 Ensure Criminal justice system has representation at the Suicide Prevention Advisory Group for both youth and adult services	Somerset Suicide Prevention Advisory Group	Criminal Justice System representative attending Advisory Groups	Karen Gough (Forensic Team) or a representative to be invited to attend the Suicide Prevention Advisory Group		
	1.14 Set up a working group to develop specific actions related to the *offender mental care pathway* for both people involved in the youth and adult offending systems. The actions will also relate to improved access to services and improved recognition and early intervention of mental health problems in criminal justice settings.	Criminal Justice and Somerset Partnership Suicide Working Group	Action plan to improve offender mental health	April 2015		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
Specific Occupational Groups	1.15 To work with the high risk groups locally as identified through the suicide audit ensuring they are involved with the Suicide Prevention Advisory Group and to produce and distribute a list of relevant support agencies.	Somerset Suicide Prevention Advisory Group	Support agencies list distributed to high risks occupational groups	31 March 2016		
	1.16 To liaise with the local Farm Crisis Network to raise suicide awareness and support available	Somerset Suicide Prevention Advisory Group	Suicide awareness and support information disseminated to local farmers networks	Ongoing		
	1.17 Continue support of A & E Samaritans initiative in YDH and explore options for Musgrove A&E	Samaritans	Samaritans run a regular A&E support service	Ongoing		
2 Action area two: Promote mental health and wellbeing in the population as a whole						
	2.1 To implement the mental health and wellbeing strategy to promote mental health and wellbeing	Health Promotion Manager – Mental Health	Strategy endorsed and action plan implemented	April 2014		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
	2.2 To offer suicide prevention skills training through the ASIST programme to improve risk management skills in frontline staff in education, health and social care	Health Promotion Manager – Mental Health	ASIST Training courses are made available and evaluation recorded	Ongoing		
Tailored approach for children and young people	2.3 To promote suicide prevention within the Somerset Health & Wellbeing in Learning programme (SHWiLP) by including appropriate resources and links on the programme's website and via its regular communication with schools	SHWiLP team	Up to date details of suicide prevention work on the website	31 March 2016		
	2.4 To distribute information about suicide awareness to all secondary and further education colleges	SHWiLP team	Information distributed to schools to coincide with World Suicide Prevention Day	Annually		
	2.5 Samaritans to continue its work in Schools and Colleges	Samaritans	Samaritans education information distributed to Somerset Schools	Ongoing		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
	2.6 To develop an action plan to promote *social media safety* around managing the promotion of grooming suicide and self harm sites	Health Promotion Manager – mental health	Social Media Safety Plan developed	March 2014		
	2.7 To set up an emotional health - practitioner group to include key leads within delivery organisations working in and alongside schools; which will include supporting them to promote and develop effective school based suicide prevention strategies	SHWiLP team	Meetings to be held every six months	November 2013		
Identify local actions for high risk groups	2.8 High risk groups identified by the national strategy include: children and young people, survivors of domestic abuse or violence, people living with long term physical health, people with untreated depression, people	Somerset Suicide Prevention Advisory Group	Existing actions reviewed and discussed at Suicide Prevention Advisory Group	31 March 2016		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
	especially vulnerable due to social and economic circumstances, people who misuse drugs and alcohol, lesbian, gay, bisexual and transgender people, Black, Asian and minority ethnic groups and asylum seekers.					
	2.9 Review and identify high risk groups in Somerset to reflect local demographics and larger proportion of older adults in Somerset than the national average consider what further SMART actions can be taken with each group					
World Suicide Prevention Day	2.10 To develop an annual multi-agency campaign to raise awareness on World Suicide Prevention Day 10 September.	Somerset Suicide Prevention Advisory Group	Annual activities planned around World Suicide Prevention Day	Annually		
3 Action area three: Reduce access to the means of suicide						
	3.1 Using the good practice guidelines available,	Somerset Partnership	Ligature point audits undertaken custody	Annually		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
	develop awareness raising training amongst relevant service providers to reduce access to the means of suicide especially ligature points. This will include; custody suites, supported housing providers and acute general hospitals	Suicide Prevention Group	suites, supported housing providers and acute general hospitals across Somerset			
	3.2 After publication, promote and disseminate the new NICE quality standards on 'safe prescribing' as related to reducing self-poisoning	Consultant in Public Health and GP Patient Safety Lead	Safe Prescribing to Reduce Self Poisoning disseminated to stakeholders	31 March 2014		
	3.3 To work with the Somerset Medicines Management Group and Pharmacy Local Professional Network to review and develop local actions to comply with the Commission on Human Medicines review of current guidelines for the management of paracetamol overdose, including the specific	Consultant in Public Health and GP Patient Safety Lead	Action plan developed to implement new guidelines on management of paracetamol overdoses.	31 March 2014		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
	guidelines for the management of paracetamol overdose for young people					
	3.4 To work with relevant local authority departments at both local and county level, to raise awareness of suicide risk in health and safety considerations when designing car parks, bridges, roads and high rise buildings, including guidance on the HSE 'Falls from windows'. Departments will include Planning, Highways and Architectural Liaison	Safer Communities Manager, SCC	Special task and finish group set up to review local planning practices linked to ways to reduce access to means of suicide. Action points included in *Designing out crime and promoting community safety* programme	31 March 2014		
	3.5 To review the *Guidance on action to be taken at suicide hotspots* with local suicide audit data. Consider appropriate steps to improve safety and deter acts of suicide at those locations e.g. providing emergency telephone numbers on	Safer Communities Manager, SCC	Action plan developed and implemented relating to, reducing the means of suicide at local hotspots.	31 March 2014		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
	information boards.					
4 Action area four: Provide better information and support to those bereaved or affected by suicide						
Somerset Suicide Bereavement Service	4.1 To maintain the Somerset Suicide Bereavement Service to provide: • A telephone helpline, linked up to the Samaritans for 24 hour support • Information and guidance for both emotional and practical needs • A peer suicide bereavement support group • Individual face to face bereavement support • Advocacy and support through the inquest process • Work with schools that have experienced a suicide bereavement • Support for children through offering guidance for parents and a special group	Health Promotion Manager – mental Health	Service Annual reports are disseminated to stakeholders.	31 October 2013		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
	support session • A new Bereavement Services Network					
Action area Five: Support the media in delivering sensitive approaches to suicide and suicidal behaviour						
Promote responsible reporting of suicide in the local media	4.2 Monitor local media reporting of suicide and take action to improve reporting.	Public Health and Somerset Partnership Communication Managers	Monitoring of local media recorded within outcomes of the Suicide Prevention Communications Strategy	31 March 2016		
	4.3 Distribute annually the Shift or Samaritans, mental health and suicide reporting guidelines to all local and regional newspapers and radio stations	Health Promotion Manager – Mental Health	Guidelines distributed annually	Annually		
	4.4 To develop a Communications Strategy to address effective ways to raise awareness amongst stakeholder groups and members of the public, e.g. web based information and *art of conversation* guidance	Health promotion Manager – Mental Health and NHS Communications Team	Suicide Prevention Communications Strategy endorsed and implemented	31 December 2013		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
5 Action area six: Support research, data collection and monitoring						
	5.1 To maintain the Somerset multi-agency Suicide Prevention Advisory Group to oversee the implementation of the Suicide Prevention Strategy	Health Promotion Manager – Mental Health	Quarterly meetings held and notes at each meeting are taken	31 March 2016		
	5.2 Produce annual audit report in line with "*Suicide Audit in Primary Care Trust Localities*	Consultant in Public Health & Public Health Audit Coordinator	Annual Audit Report produced	30 September 2013		
	5.3 Organise an annual review of the strategy and audit data	Health Promotion Manager – Mental health & Public Health Audit Coordinator		Annually		
	5.4 To review options to undertake timely learning reviews of suicide deaths that are not known to the secondary services.	Public Health Consultant	Options for timely reviews tabled at Suicide Prevention Advisory group meeting	30 June 2013		
	5.5 Maintain links between the Suicide Prevention Advisory Group and the	Public Health Consultant & Public Health	Relationship between the panel discussed and	30 June 2013		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
	Child Death and the Drug Related Deaths Panel to share information and consider ways to disseminate learning and good practice to prevent future suicides.	Audit Coordinator	actions agreed at Suicide Prevention Advisory group meeting			
	5.6 Disseminate Dr Jason Hepple annual paper reporting local data and trends	Somerset Partnership Suicide Prevention Group	Advisory group members have received the annual Partnership report.	Annually		

Appendix B

TERMS OF REFERENCE
SUICIDE PREVENTION ADVISORY GROUP

1 PURPOSE

1.1 To co-ordinate the planning on suicide prevention in Somerset.

2 AIMS

2.1 Identify priorities and make recommendations for action through the Somerset Suicide Prevention Strategy and Local Area Agreement Frameworks (taking into account any national guidance and priorities for action).

2.2 To monitor the Somerset Suicide Prevention Action Plan.

2.3 To oversee the process of gathering individual case audits and agree the most appropriate format and timescale for the production of audit reports.

2.4 Receive an annual suicide audit update showing trends and progress against targets and ensure these findings influence the development of the Suicide Prevention Strategy.

2.5 Produce and disseminate an annual report on the nature and extent of work taking place in Somerset

3 MEMBERSHIP

3.1 The membership of the group should include the following:

- Public Health Lead - Chair
- Public Health Audit Coordinator
- Two representatives from Somerset Partnership including CAMHS
- Mental Health Promotion Specialist
- Mental Health Commissioning Lead
- GP representative
- County Council representative from vulnerable adults/safeguarding adults domain
- Member of Psychiatric Liaison Team (Somerset Partnership)
- Third sector Involvement
- Accident and Emergency services representative
- Drug and Alcohol Team representative
- Somerset Coroner Service representative
- Police Representative
- SW Development Centre representative
- Involvement of individual Service User or Carer affected by suicide

3.2 Other members may be co-opted as required.

4 QUORUM

4.1 The group is quorate when three members (plus the Chair) are present. If such a quorum is not present within quarter of an hour of the appointed time, or if during the meeting ceases to be present, the meeting will stand adjourned.

5 FREQUENCY OF MEETINGS

5.1 The group shall meet as a minimum on a quarterly basis or more frequently if required.

6 CONDUCT OF MEETINGS

6.1 Meetings will be conducted on an informal basis.

6.2 The Public Health Audit Coordinator will provide the administrative support and keep notes of the meetings.

6.3 The agenda and papers will normally be sent out electronically at least 7 days before the meeting date.

7 ACCOUNTABILITY

7.1 The Suicide Prevention Advisory group will be accountable to the Safer Somerset Partnership.

7.2 The Suicide Prevention Advisory Group will produce an annual Suicide Audit Update and an annual report on the nature and extent of work taking place in Somerset

8 FREEDOM OF INFORMATION/DATA PROTECTION

8.1 These terms of reference have been complied with the requirements of the Freedom of Information Act 2000, which allows a general right of access to recorded information held by Somerset Primary Care Trust, subject to the specified exemptions, including Data Protection and Caldicott Guardian principles.

December 2009
Revised September 2013

APPENDIX C

STATISTICS

1 INTRODUCTION

This appendix contains facts and figures on completed, and attempted, suicides.

2 AMONGST THE GENERAL POPULATION

2.1 In the general population 13% reported suicidal thoughts, 4% attempted suicide and 2% deliberately self-harmed at some time in their lives.

3 PEOPLE WITH EXPERIENCE OF A DIAGNOSIS OF "PSYCHOTIC ILLNESS"

3.1 Over two thirds (70%) of the sample of people with a diagnosis of a psychotic illness had thought about suicide at some time in their lives and 45% had attempted suicide. In addition, 21% had harmed themselves without intending to commit suicide.

4 FACTORS ASSOCIATED WITH SUICIDAL THOUGHTS

4.1 Events or factors for which the prevalence of suicidal thoughts was particularly high include having a major financial crisis (29%), having a problem with the police or a court appearance (27%) and having looked for work for one month or over (23%).

4.2 Higher rates of lifetime suicidal thoughts were found among groups who reported ever having been homeless (48%), running away from home (45%), experiencing violence in the home (44%) and being expelled from school (41%).

4.3 Over half of those who reported experience of sexual abuse also reported having had suicidal thoughts during their lifetime.

4.4 Compared with people who had never experienced a stressful life event, those who reported three or more events were over three times more likely to have had suicidal thoughts and the group who had experienced six or more events were over nine times more likely to have had such thoughts.

5 ATTEMPTED SUICIDE – SOME MAJOR RISK FACTORS

5.1 12% of people who had experienced a problem with the police or a court appearance, 10% of those who had experienced a major financial crisis and 8% of those who had looked for work for one month or more had attempted suicide at some time in their life.

5.2 Around a quarter of people who reported running away from home, being homeless, having experienced sexual abuse and having experienced violence in the home had attempted suicide at some time in their life.

5.3 Women with a severe lack of social support were over five times more likely than those with social support to have attempted suicide in their lifetime (16% compared with 3%) and twice as likely to have attempted suicide than men (8%).

5.4 12% of all respondents with a primary support group of three or less had attempted suicide in their lifetime, compared with only 3% with a social group of nine or more people.

6 SUBSTANCE MISUSE

6.1 In a recent survey (2002) carried out by the Office for National Statistics, 4% of people who were non-alcohol dependent had at one time thought about suicide. This proportion increased to 9% among those moderately dependent on alcohol and rose to 27% of the severely alcohol dependent group.

6.2 Those who were dependent on drugs (other than cannabis) were around five times more likely than the non-dependent group to have ever attempted suicide, 20% compared with 4%.

6.3 Research comparing the relationship between cannabis abuse/ dependence and risk of medically serious suicide attempts indicates that there is a marginally significant association between cannabis abuse/dependence suicide attempt risk. Much of the association arises because: (a) those that develop cannabis abuse tend to come from disadvantaged backgrounds, which independently of cannabis abuse, are associated with higher suicide attempt or (b) because cannabis abuse is co-morbid with other mental disorders which are independently associated with suicidal behaviour.

6.4 Of 332 drug-related deaths in Scotland in 2001, 34 (10%) were as a result of intentional self-poisoning: in a further 52 deaths (16%) it was not clear if the death was accidental or suicide.

7 PEOPLE WHO EXPERIENCE NEUROSIS

7.1 The presence of significant levels of neurotic symptoms, as shown by a CIS-R[#] score of 12 or over, was associated with a four-fold increase in the likelihood of reporting suicidal thoughts at some time. In contrast, having a long-standing psychotic disorder was associated with a decreased likelihood of reporting suicidal thoughts once other factors had been taken into account. High levels of neurotic symptoms were also associated with

[#] CIS-R (Clinical Interview Schedule –revised version) is an instrument designed to measure neurotic symptoms and disorders, such as anxiety and depression

suicide attempts and in this case the number of stressful life events also showed a very strong association.

8 COMPLETED SUICIDES BY PEOPLE IN CONTACT WITH MENTAL HEALTH SERVICES

8.1 Approximately one-quarter of people who completed suicide in England and Wales, Scotland and Northern Ireland had been in contact with mental health services in the year before death; this represents around 1,500 people per year in the UK.

8.2 The commonest methods of suicide were hanging and self-poisoning by overdose.

8.3 Younger people who were in contact with services and who completed suicide more often had a history of schizophrenia, personality disorder, drug or alcohol misuse and violence.

8.4 Most people with schizophrenia who committed suicide were unemployed and unmarried.

8.5 4% of people in contact with mental health services who completed suicide were the lone carers of children.

8.6 Mental health teams in England and Wales regarded 22% of completed suicides as preventable, with lower figures in Scotland (62 cases, 13%) and Northern Ireland (19%) but around three-quarters identified factors which could have reduced risk, mainly improved patient compliance with medication and closer supervision

9 COMPLETED SUICIDES BY PEOPLE IN PSYCHIATRIC IN-PATIENT UNITS

9.1 16% of suicide inquiry cases in England and Wales, 12% in Scotland and 10% in Northern Ireland were psychiatric in-patients.

9.2 In-patient suicides, particularly those occurring on the ward, were most likely to be by hanging, most commonly from a curtain rail and using a belt as a ligature.

9.3 Around one-quarter of in-patient suicides died during the first week of admission.

9.4 Around one-fifth of in-patient suicides in England, Wales and Scotland and almost half of in-patient suicides in Northern Ireland were on agreed leave from the hospital at the time of death.

9.5 Mental health teams more often regarded in-patient suicides as preventable.

10 COMPLETED SUICIDES WITHIN THREE MONTHS OF DISCHARGE FROM A PSYCHIATRIC IN-PATIENT UNIT

10.1 23% of suicide inquiry cases in England and Wales, 26% of cases in Scotland and 30% of cases in Northern Ireland died within three months of discharge from in-patient care.

10.2 Post-discharge suicides were at a peak in the first 1-2 weeks following discharge.

10.3 40% of post-discharge suicides in England and Wales, 35% in Scotland and 66% in Northern Ireland occurred before the first follow-up appointment.

10.4 Compared to all community cases, post discharge suicides were associated with final admissions lasting less than seven days, re-admissions within three months of previous discharge and self-discharge.

11 COMPLETED SUICIDES BY CHILDREN AND YOUNG PEOPLE

11.1 In an analysis of the circumstances of 50 looked-after children who died between 1997 and the end of 2001, 11 were completed suicide.