Report to:	**Health and Wellbeing**
Date:	**25th July 2013**
Title:	**Preventing suicide – a strategy for action in Cornwall and Isles of Scilly.**
Portfolio Holder(s)	**Cllr Judith Haycock CC, Health & Adult Care**
Key Decision:	**Y / N** Approval and clearance obtained: **Y / N**
Author:	**Sara Roberts** Role: **Associate Director of Public Health**
Contact:	**Sroberts2@cornwall.gov.uk**

Recommendations:

1. **The Health and Wellbeing Board is recommended to approve this proposed refresh of the suicide prevention strategy, with its added focus on preventing male suicides and building resilience in the wider population.**

Cornwall Health and Wellbeing Board

1. Executive Summary:

The suicide rate in Cornwall is consistently higher than the national rate and has been treated as a priority for partnership action for several years. The existing strategy was published in 2009. Two developments emerging from that strategy were the introduction of ASIST (Applied Suicide Intervention Skills Training) and a suicide liaison service to support people bereaved by suicide. This paper recommends the continuation of those services and presents a refreshed strategy.

Suicide prevention requires action at three levels:

1. At the level of most acute need this strategy recommends keeping people safe. This might be achieved by reducing access to the means by which someone might take their own life, providing specialised care for serious mental health problems, and creating a safety net of people across the county who are trained to recognise when individuals give out signals of suicidal thoughts, and to respond appropriately.
2. Because it is not always possible to identify individuals who are contemplating suicide, a wider layer of protection is also needed, targeting vulnerable groups. This would include the diagnosis and treatment of depression and the provision of relevant and accessible services for specific high-risk groups.
3. At a universal level there should be action to remove the stigma attached to mental health problems and suicide (to make it easier for people to express concerns and to encourage them to seek help at an earlier stage), to build resilience to cope with stressful and distressing incidents and circumstances through promoting mental wellbeing, and to provide caring services to meet different degrees of need.

The strategy is underpinned by information from audit and research that describes the risk factors, the vulnerable groups and the effectiveness of interventions. The recommendations largely describe ways of working and will be carried out within existing budgets.

The strategy is comprehensive, covering the six goals of the national strategy. However, there could also be benefit from bringing partners together to focus on two wide-reaching, high priority issues:

- Reducing the risk of suicide in men
- Promoting emotional wellbeing in the wider population.

The Health and Wellbeing Board is being asked to consider and approve this proposed approach.

2. Background:

2.1. This suicide prevention strategy supports all three aims of the health and wellbeing strategy:

- Outcome 1 is to 'help people to live longer, happier and healthier lives'. Suicide cuts lives short.

- Outcome 2 aims to 'improve the quality of life', including 'improving the mental wellbeing of people who live in our communities' and tackling loneliness and social isolation.

- Outcome 3 aims for 'fairer life chance for all', to reduce health inequalities and the disadvantages that follow some people through their life course.

Suicide prevention and mental health promotion activities aim to extend life, increase enjoyment of life and give most help to those with the greatest needs.

2.2. Around 50-60 people living in Cornwall and Isles of Scilly die each year by suicide[1]. This figure is higher than expected, based on national average rates. The high rate is cause for concern but every single death can be viewed as a tragic and possibly preventable loss of life. An individual suicide is a devastating event for the person concerned, their family and friends, and the whole community.

2.3. Suicide and its prevention is a difficult and emotive subject to tackle. It requires the involvement of a wide range of independent and public services including for example, health, social care, transport, education, the police and the criminal justice system, alongside community members and advocates.

2.4. A suicide prevention strategy for Cornwall and Isles of Scilly was developed through wide consultation in 2008 and ratified by NHS Cornwall and Isles of Scilly in May 2009[2]. The strategy led to the development of a two new services: a suicide liaison service to support people bereaved by suicide[3] and a suicide first aid training programme (ASIST or Applied Suicide Intervention Skills Training)[4] with open access. It is recommended that these should continue.

2.5.This document is a draft refresh of the previous strategy. It has deliberately been kept fairly brief by summarising the goals in tabular form, and readers seeking more detailed background information are encouraged to consult the previous strategy and the new national strategy, published in September 2012[5]. The recommendations from the national strategy and the results of suicide audit have influenced this document. For local information about suicides see the latest suicide audit report (2012).

---

[1] Suicide audit in Cornwall and Isles of Scilly. S Roberts. NHS Cornwall & Isles of Scilly. 2012

[2] Suicide prevention strategy for Cornwall and isles of Scilly 2008-2013. NHS Cornwall & IoS. 2009.

[3] Suicide liaison service. http://www.outlooksw.co.uk/suicide-liaison-service

[4] Cornwall & Isles of Scilly Health Promotion Service training programmes.

[5] Preventing suicide in England. Department of Health. 2012. http://www.dh.gov.uk/health/2012/09/suicide-prevention/

2.6. Development and implementation of the strategy will be coordinated by the public health suicide prevention lead. From 1st April 2013 the local responsibility for this public health function has transferred from NHS Cornwall and Isles of Scilly to Cornwall Council. Suicide prevention continues to require action from a range of partner organisations and this change in organisational leadership responsibility should not interrupt the efforts of partners to work together to prevent suicides. Once the strategy has been agreed it will be followed by the development of an implementation plan, which will look at how the recommendations will be carried out.

2.7. Since the development of the existing strategy there has been an economic recession and a change of government, bringing in significant changes to the welfare system. It is known that male suicide rates are closely linked to levels of unemployment, and that it is not just job loss but also the fear of unemployment that can cause stress. Suicide rates have started to increase after several years of decline, and this is likely to be linked to the financial climate. In addition to the direct impact on individuals (e.g. of job insecurity, debt and relationship breakdown) the necessity for organisations to cut costs could reduce the availability of support services that address some of the risk factors for suicide (e.g. bereavement counselling, debt advice, relationship counselling and housing support).

2.8. Potentially, welfare reforms could move significant numbers of people into employment and there are health and well being benefits to being in work. However, particular cohorts of the population will be adversely affected by the changes. Research suggests that the following groups are more likely to be adversely affected by the cumulative impacts of the changes.

- Large families
- Disabled groups
- Lone parents
- Low income families
- Working families
- 25s to 35s
- Tenants in private rented accommodation
- Carers
- Those with mental health issues
- The most vulnerable

3. Decision and Supporting Information (Including Options):

3.1. Aims and vision of the strategy

The strategy aims to reduce the suicide rate for residents of Cornwall and Isles of Scilly. Once there is general agreement to the strategy, it will be followed by an implementation plan.

Our vision is …… of a society in which people do not choose to die by suicide. There will be reduced stigma around mental illness and suicide; people will not be afraid to ask for help, or to offer help to those in crisis. Services will be designed to meet the challenging range of needs of the most vulnerable in society; there will be connections between agencies so that people do not 'fall between services'. A pathway of support will be readily available, clearly signposted and easily accessed.

3.2. Goals and objectives for action

This strategy will set a programme of local action to reduce suicide based on the six goals identified in the latest national strategy:

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

For each goal this strategy sets out

a) Why this is important

b) Recommendations

c) Other helpful resources (in addition to the national suicide prevention strategy)

The resources listed under (c) can be used in designing the implementation plan.

It is recommended that action should be taken to meet all goals in this table and the strategy implementation plan will seek to confirm that appropriate action is being taken, or identify gaps for further work. This strategy will result in support being provided at various levels in the population: at a universal level (to build resilience in the wider population) and also in targeted ways to meet the needs of the most vulnerable.

It is recommended that the ASIST programme and Suicide Liaison Service (introduced as a focus of the existing strategy) should continue, and that two new areas of focus for partnership working should be agreed:

- The risk of suicide in men deserves special attention, as male suicide rates are three times those of females. The suicide rate in men is also more likely to be influenced by the economic recession and the threat or reality of unemployment. The strategy recommends exploring the barriers to men accessing help and designing services that better meet men's needs.
- A second issue that could be explored further is the promotion of emotional wellbeing in the wider population. The strategy recommends that this should be informed by the evidence-based 'Five ways to wellbeing' and monitored through the Public Health Outcomes Framework.

Goal 1: Reduce risk in key high risk groups
High risk groups identified in the national strategy are: 1. Young and middle aged men (locally we might add men >75 years) 2. People in the care of mental health services, including inpatients 3. People with a history of self harm 4. People in contact with the criminal justice system 5. Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers
1.1. Young and middle aged (and older) men
a) why this is important Men are at three times greater risk of suicide than women. Most suicides are among men under 50 years old. In Cornwall and Isles of Scilly we also see a relatively high rate among men aged over 75, but the actual numbers are small compared to deaths among working age men. Men appear to be at lowest risk during early years of retirement. Men who are socio-economically disadvantaged are at ten times more risk than those in the most affluent conditions. Risk factors include depression, especially when it is untreated or undiagnosed; alcohol or drug misuse; unemployment, family and relationship problems including marital break up, social isolation and low self esteem. For older men, loneliness, isolation and health problems are more significant.
b) recommendations: • Remove identified barriers to men engaging with services and make sure those from deprived backgrounds have access to a range of support, not just medication alone. • Promote mental health through multi agency partnership in community locations that reach men of different ages. • Support activities that connect people with their community (e.g. time banking)
c) other helpful resources:

- Men, suicide and society. Why disadvantaged men in mid life die by suicide. Samaritans, 2012. https://www.samaritans.org/about-samaritans/research-policy/middle-aged-men-suicide/
- Reaching out. An evaluation of mental health promotion programmes aimed at young men.
- Time banking and health. Volunteer Cornwall.

1.2. People in the care of mental health services, including inpatients

a) why this is important

The number of people in contact with mental health services who died by suicide has fallen nationally between 2000 and 2010. However, people with severe mental illness remain at high risk of suicide, both while in inpatient units and in the community. Inpatients, people recently discharged from hospital and those who refuse treatment are at highest risk.

b) recommendations:

- Provide high quality services, accessible to all.
- For people recognised in primary care to be at risk there should be specialised and caring support available on referral.
- Services to follow best practice guidance, including the National Confidential Inquiry checklist 'Twelve points to a safer service'.
- Mental Health Commissioning plans should be aligned to the suicide prevention strategy

c) other helpful resources:

- No health without mental health: delivering better mental health outcomes for people of all ages.
- Preventing suicide: a toolkit for community mental health. NPSA. 2011.

1.3. People with a history of self harm

a) why this is important

People who self harm are at increased risk of suicide, although many people do not intend to take their own life when they self harm. At least half of people who take their own life have a history of self harm, and one in four have been treated in hospital for self harm in the preceding year. Risk is particularly increased in those repeating self harm and in those who have used violent/dangerous methods of self harm.

b) recommendations:

- Provide good quality care, assessment and follow up of people who attend emergency departments after self harming
- Follow NICE guidance on short and long term management of self harm

- Provide training on suicide and self harm for school and college staff, emergency services, primary care, care environments and the criminal and youth justice systems

c) other helpful resources:

- Self harm in children and young people handbook. 2011. National CAMHS Support Service.
- NICE guidance Self Harm. CG16. http://www.nice.org.uk/cg16
- NICE guidance Self Harm (longer term management) CG 133. https://www.nice.org.uk/guidance/cg133
- Review of self harm in Cwll & IoS. (Public Health Dept., in preparation)

1.4. People in contact with the criminal justice system

a) why this is important.

Cornwall has no prison, but residents of Cornwall are placed in prisons out of county. People at all stages within the Criminal Justice System, including people on remand and recently discharged from custody, are at high risk of suicide.

b) recommendations

- Health and criminal justice organisations to work together to ensure the mental health needs of offenders are recognised and met.
- Raise awareness of the suicide risk of offenders, and the links with drug and alcohol misuse, mental health problems and chaotic lifestyle.

c) other helpful resources

- No health without mental health. 2011. DH. https://www.gov.uk/government/publications/the-mental-health-strategy-for-england
- Cornwall & Isles of Scilly Criminal Justice & Health Liaison Group

1.5. Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers

a) why this is important

Some occupational groups are at increased risk because they have ready access to the means of suicide and know how to use them.

b) recommendations:

- Local agencies should be alert to risk variations by occupational group, e.g. risk among agricultural workers in rural areas.
- Occupational health departments should consider holding an updated list of local and national services for doctors, which should be made available during induction and at initial occupational health assessments.

c) other helpful resources:

- Rural stress helpline Mon-Fr 9am-5pm 0845 094 8286
- Mental health and ill health in doctors. 2008. DH. http://www.em-online.com/download/medical_article/36516_DH_083090%5B1%5D.pdf

Goal 2. Tailor approaches to improve mental health in specific groups

a) why this is important

As well as targeting high risk groups, another way to reduce suicide is to improve the mental health of the population as a whole. For this whole population approach to reach all those who might need it, it should include tailored measures for groups with particular vulnerabilities or problems with access to services. The groups identified are:

- Children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system.
- Survivors of abuse or violence, including sexual abuse
- Veterans
- People living with long term physical health conditions
- People with untreated depression
- People who are especially vulnerable due to social and economic circumstances
- People who misuse drugs or alcohol
- Lesbian, gay, bisexual and transgender people
- Black, Asian and minority ethnic groups and asylum seekers.

b) recommendations:

- As a universal approach: Raise awareness and understanding of mental health and suicide, to remove stigma and improve communication and access to support. Give mental health needs equal consideration to physical health needs. The media and workplace health programmes might contribute to this.
- Promote mental wellbeing by using the evidence-based '5 ways to wellbeing' messages. These five headings can also be used in a strategic framework for promoting wellbeing.
- Use tailored measures to improve mental health in identified vulnerable groups. These might include:
  - Provide PHSE education in schools to help children to recognise, understand, discuss and seek help early for emerging emotional and other problems.
  - Support self management and self care for people with long term health problems and provide routine assessment for depression for people with long term conditions.
  - Provide talking therapies for children and young people, older people and

their carers, people with long term conditions, medically unexplained symptoms and severe mental illness.

- Identify depression early and respond promptly, using effective and appropriate treatments
- A range of frontline agencies can identify and support (or signpost to support) vulnerable people who may be at risk of suicide. Training should be provided.
- Provide public information to signpost people to information, support and useful contacts for debt advice.
- Make links between the suicide prevention strategy and the alcohol reduction strategy – both must respond to the suicide risk associated with alcohol and drug misuse, particularly for men.
- Raise awareness among staff in health care, social services, education and the voluntary sector, of the higher rates of mental distress, substance misuse, suicidal behaviour or ideation and increased risks of self harm in LGB people. Ensure services are LGBT friendly.
-

c) other helpful resources:

- Suicide prevention toolkits. 2011. National Patient Safety Agency.

Mental health services:
https://improvement.nhs.uk/resources/learning-from-patient-safety-incidents/

Community and emergency health care:
https://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Preventing_suicide_011211.pdf

Ambulance services: internet link not maintained
General practice: internet link not maintained

- NICE guidance: Depression with a chronic physical health problem. CG91 (2009)

Depression in adults (update) CG90 (2009)
Depression in children and young people. CG28 (2005)
http://pathways.nice.org.uk/pathways/depression#content=view-info%3Asource-guidance

- Loneliness and isolation. A toolkit for health and wellbeing boards. Campaign to end loneliness. http://www.campaigntoendloneliness.org.uk/toolkit/
- Expert Patient Programme
- ASIST (Applied Suicide Intervention Skills Training) - [Link no longer available]
- Cornwall and IoS Alcohol strategy http://safercornwall.co.uk/what-we-do/alcohol/
- 5 ways to wellbeing [Link no longer available]

Goal 3. Reduce access to the means of suicide

a) why this is important

One of the most effective ways to prevent suicide is to reduce access to the high-lethality means of suicide. This is because people sometimes attempt suicide on impulse, and if the means are not easily available, or if they attempt suicide and survive, the suicidal impulse may pass.

Methods most amenable to intervention are:

- Hanging and strangulation in psychiatric inpatient and criminal justice settings
- Self poisoning
- Those at high risk locations
- Those on the rail and underground networks

b) recommendations:

- Follow best practice in reducing opportunities for suicide in hospital settings and police custody
- Identify local hotpots and take appropriate action, e.g. barriers, Samaritans signage.

c) other helpful resources:

- Guidance on action to be taken at suicide hotspots. (10-10-2006) Devon Partnership NHS Trust and Peninsula Medical School. Department of Health.
- Cornwall & IoS Criminal Justice and Health liaison group
- Drug related deaths panel and annual report. C&IoS DAAT.

Goal 4. Provide better information and support to those bereaved or affected by suicide

a) why this is important

Family and friends bereaved by a suicide are at increased risk of mental health and emotional problems and may be at higher risk of suicide themselves. There may be a risk of copycat suicides in a community, particularly among young people, if another young person or high profile celebrity dies by suicide. People whose work brings them into contact with suicide can also be affected.

b) recommendations:

- Provide effective and timely emotional and practical support for families bereaved or affected by suicide, and raise awareness of the service.
- GPs to be vigilant to the potential vulnerability of family members when someone takes their own life.
- Provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide
- Develop good practice guidelines for head teachers re suicide awareness or in the event of a suicide by a student or staff member (work currently underway by COSS)
- Health professionals and police to distribute 'Help is at hand' and signpost to suicide liaison service.

c) other helpful resources:

- Help is at hand: A resource for people bereaved by suicide and other sudden, traumatic death.
- https://www.gov.uk/government/news/you-are-not-alone-help-is-at-hand-for-anyone-bereaved-by-suicide

- Step by step, post suicide intervention service for schools. Samaritans. https://www.samaritans.org/how-we-can-help/schools/step-step/

- Sources of information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide. http://www.dh.gov.uk/health/files/2012/09/Sources-of-information-and-support-for-families.pdf
- COSS Z-card of services in C&IoS
- Gloucestershire police and 2gether NHS Trust for mental health protocol for disseminating information after a suicide

Goal 5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour.

a) why this is important

The media have a significant influence on behaviour and attitudes. There is already compelling evidence that media reporting and portrayals of suicide can lead to copycat behaviour, especially among young people and those already at risk.

b) recommendations:

- Work with local media outlets to promote the responsible reporting and portrayal of suicide and suicidal behaviour

c) other helpful resources:

- Guidance on reporting suicide. Samaritans. https://www.samaritans.org/about-samaritans/media-guidelines/

Goal 6. Support research, data collection and monitoring

a) why this is important

Reliable, timely and accurate suicide statistics can inform suicide prevention strategies that meet local needs and priorities. Research is essential, to enhance our understanding of the statistics and to develop the evidence base of what works in suicide prevention.

b) recommendations:

- Conduct local suicide audit with multi-agency cooperation and feed results into strategy
- Use audit to identify suicide hotspots clusters of linked suicides and establish a partnership response plan.
- Further suggested topics to explore, include:
    - ‘between service’ suicides, e.g. where a patient is discharged from CFT and signposted to OSW but hasn’t registered with the second service
    - o

c) other helpful resources:

- Suicide audit in PCT localities. 2006. NIMHE and Peninsula Medical School.
- Review of suicide audit in PCTs (Public Health Dept, in preparation)

4. Financial Implications and Budget:

The strategy recommends ways of working to reduce suicide risk, rather than the introduction of new services. It is proposed that the two new areas of focus: reducing the risk among men and promoting mental wellbeing in the wider population, should be delivered within existing budgets and through partnership working. For example, a campaign to promote mental wellbeing and help seeking behaviour among men will be delivered within the public health suicide prevention budget with the support of Samaritans and other agencies.

Delivery of the existing strategy is funded by Public Health (strategic leadership, health promotion and training) and NHS Kernow (suicide liaison service), with the remainder of actions being carried out by partners as part of their routine functions (eg treatment of mental health patients by mental health services and primary care). The ASIST training programme is supported by various agencies by releasing their staff to deliver or attend the training sessions. The cost of venues and training materials is met by Public Health.

5. Other Resourcing Implications:

None identified.

6. Legal Implications:

None identified.

7. Risks:

The suicide rate in Cornwall is higher than the national average and could increase as a result of the recession. No risks are identified as a result of adopting the strategy, which aims to protect the local population from suicide risk.

8. Equality Impact Assessment:

Suicide affects some groups of people disproportionately. For example, suicide rates are highest among lesbian, gay and bisexual people, offenders, people who misuse drugs and alcohol, people with mental health problems, some occupational groups (doctors, vets and farmers), working age men and older men (>75 years).

This strategy, to reduce suicide risk and to reduce the impact of suicide on others, aims to protect and support those who are in greatest need. This should have a positive impact on mental health and wellbeing and on reducing inequalities in health.

Supporting Information

Background Papers:

[under provisions of the Local Government Act 1972]

None.

Approval and Clearance of Report

Guidance: For all reports the following clearances must be obtained by report authors for the report to be classed as final. If you are unsure as to whether or not clearance is applicable please refer to the 'Guidance for Report Authors' for details of how to obtain advice.

Guidance for those clearing reports: Any implications you wish to add to the report should be made under the relevant paragraph in the main body of the report. Always refer such amendments back to the report author for agreement.

All Reports:

Final Report Sign Offs	**This report has been cleared by OR not significant / not required**	**Date**
Finance Required for **all** reports		
Legal (if significant/required)	Not significant/required	
Equality Impact Assessment (if significant/required)	EIA completed	
Human Resources (if significant/required)	Not significant/required	
Property (if significant/required)	Not significant/required	
Procurement (if significant/required)	Not significant/required	
Information Services (if significant/required)	Not significant/required	

Draft Reports Process Checklist:

Guidance: The following section is for use during the drafting of the report. Completion is the responsibility of the report author and it will be removed before publication.

To be completed by report authors prior to submission:

For Cabinet / Individual Decision reports the following checklist should be completed

Process Checklist	**Completed**
Portfolio Holder/Member Champion briefed	**Yes / No**
Corporate Director briefed	**Yes / No**
Head of Service Sign off (draft)	**Yes**
Data Protection Issues Considered	**Yes**
If not on Forward Plan, Overview and Scrutiny offered the opportunity to consider the report	**Yes / No**