TRI-BOROUGH SUICIDE PREVENTION STRATEGY

City of Westminster, London Borough of Hammersmith and Fulham, Royal Borough of Kensington and Chelsea

2013-2018

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This document should be read alongside the tri-borough Suicide Joint Strategic Needs Assessment (2012)

1.0 Summary

1.1 Aims of the strategy

Suicide is a major public health issue. In England, one person dies every two hours as a result of suicide [1]; around 5000 people take their own lives in England every year [2]; at least 0.01% of these are resident in Inner North West London[3]. Suicide has a devastating social, emotional and economic impact. In 2009, the total cost of suicide *per case* in England was estimated as being £1,450,000 per case [4]. The costs of incomplete suicides and/or suicide attempts are also substantial and continue to be a major public health issue particularly in people experiencing mental distress. The National Confidential Inquiry into Suicide and Homicide (2006) shows that many deaths are preventable.

The aim of this strategy is to promote inter-agency working in reducing the numbers of suicides in the Inner North West London boroughs of Westminster, Hammersmith and Fulham and Kensington and Chelsea by 30% by 2018. In actual numbers, this is a reduction of complete suicide events by at least 16, from 55 (in 2012) to 39 (1 event below the number recorded in 2010).

This strategy sets out local priorities for suicide prevention. It is aligned to the national Suicide Prevention Strategy for England (2012). It also contributes to the achievement of outcomes set out in the Public Health Outcomes Framework published in 2012, the White Paper Saving Lives Our Healthier Nation (1999), and reinforced in the National Service Framework for Mental Health (2012) which aims to reduce the death rate from suicide and undetermined injury. It is in line with the joint health and wellbeing strategies of City of Westminster, London Borough of Hammersmith and Fulham and Royal Borough of Kensington and Chelsea. This strategy is a living document that will evolve as new priorities and evidence emerge, and will be subjected to annual review.

The causes and effects of suicide are multi-faceted, with the prevention and management of suicide requiring efforts from different stakeholders. It is therefore recognised that the successful implementation of this strategy requires a coherent approach and active involvement of different agencies. It cannot be an exclusive responsibility of any one organisation or service. The strategy has been developed through a consultative process led by

the suicide prevention working group, involving voluntary, statutory and user groups – including users and survivors of suicide – across the three boroughs.

1.2 Goals of the strategy

Different actions are set out, which are intended to be practical and given to regular monitoring and continual evaluation. These actions are based on four overarching goals:

- Timely communication and information sharing between agencies on identification of at risk individuals and care pathways.
- Public education and awareness on suicide and/or mental health promotion through community outreach, anti-stigma campaigns, etc.
- Promotion of existing suicide prevention resources, interventions and support services like the May tree respite or telephone help lines like those operated by Samaritans or Campaign Against Living Miserably (CALM).
- Priority training for frontline workers (GPs, A&E, and concerned others) through programmes like mental health first aid or applied suicide intervention skills training.

2.0 Background

Suicide and self harm are a broad collection of incidents and actions ranging from self-harming behaviour through to serious self harm. Sometimes there are those people who fully intend to kill themselves and unfortunately, in some cases, succeed in doing so. Though the suicide rate in England and Wales has fallen in recent years, it still remains a great concern. Around 5000 people kill themselves in England and Wales each year (1 in 100 deaths) [1], while at least 10 times that number attempt suicide. Suicide is still the second most common cause of death in men aged 15–44 years, behind accidental death. In relation to men and women of the same age, the peak difference is the 25-44 age groups in which four men die by suicide to each woman[(1)].

Certain factors such as bereavement, previous suicide attempts, substance misuse, economic hardships, social isolation and family breakdown are known to be associated with increased risk of suicide[(3)]. People with a diagnosed mental health problem are known to be at particular risk.

The Government has produced various strategic guidelines for reducing suicide rates. Some of the most recent documents include:

- The public health outcomes framework recently published (2012) which requires local authorities to report on reduction in numbers of people dying prematurely due to suicide.
- Suicide prevention strategy for England (2012) which sets out the need for broad coordinated system-wide approach in self harm prevention and support for families bereaved through suicide
- No health without mental health: a cross-government mental health outcomes strategy for people of all ages (2011)

3.0 Strategic Commitments to Suicide Prevention in Inner North West London

3.1 Local Authorities in the tri-borough area

The joint Health and Wellbeing strategies for City of Westminster (2013-2016), London borough of Hammersmith and Fulham and Royal Borough of Kensington and Chelsea (2012-2015) recognise that good mental health is a critical determinant of quality of life and that it often directly impacts on people's physical health and how they relate to their community. As part of the public health responsibilities transferred to Local Authorities, the three Inner North West London Boroughs of Hammersmith and Fulham, City of Westminster and Kensington and Chelsea have a responsibility to see to the reduction of suicides in the three local authority areas. Some of the expected outcomes in suicide reduction are outlined in the Public Health Outcomes Framework published in 2012. Likewise, the Joint Strategic Needs Assessment documents produced for each of the three boroughs, have as its integral aim, the reduction of health inequalities and improving local health outcomes for the INWL residents.

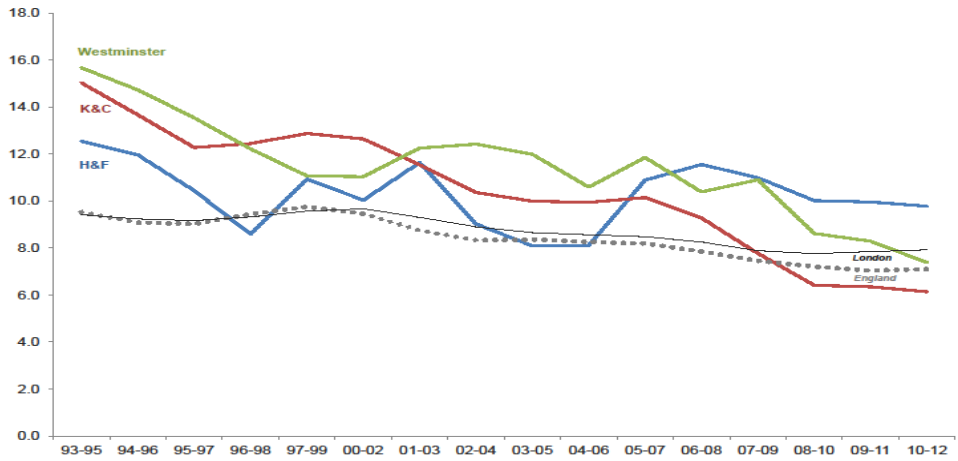
3.2 Suicide Prevention Working Group

A tri-borough multi-stakeholder suicide prevention working group was established in 2011. The group meets quarterly. Membership is drawn from a range of agencies in operating in the area that have a strategic interest in promoting mental wellbeing. These include local mental health trusts, London underground, acute trusts, local authority, public health, police (British transport and metropolitan), clinical commissioning groups, academic institutions, community providers and families bereaved by suicide. The group seeks to promote effective inter-agency working in communicating, managing and preventing suicide incidents in the tri-borough area.

4.0 Epidemiology of suicide – in Inner North West London

According to the Office for National Statistics records (2012), Suicide rates in Inner North West London are relatively higher than London and England average. The chart below shows a directly standardised rate of 3 year combined averages for suicide and undetermined injury for the resident population over time.

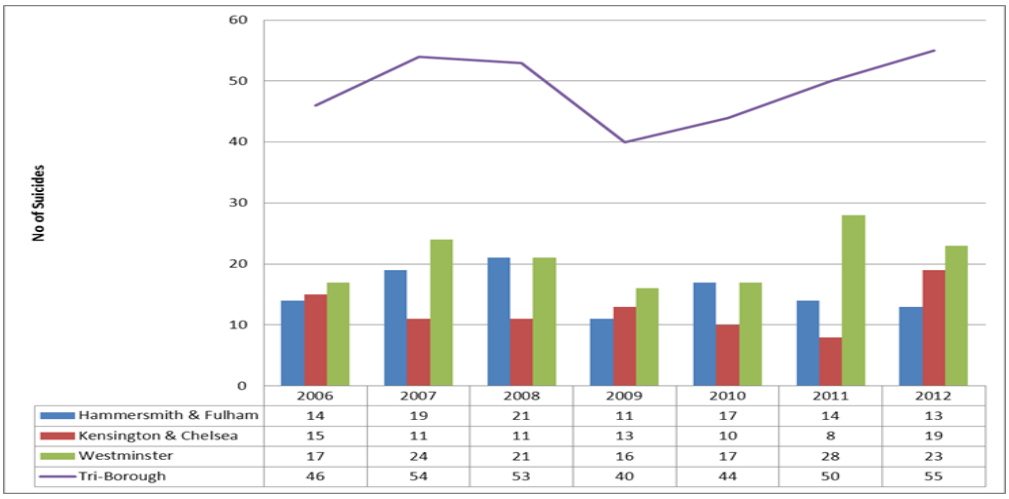
Chart 1: Directly Standardised rate of Suicide and undetermined injuries for the resident population for INWL Boroughs, London and England 1993 – 2012, in 3 year combined averages (HSCIC Indicator Portal)



In summary,

- Kensington and Chelsea is showing a consistent downward trend over time, from one above London and England to one below.
- Westminster is showing a similar downward trend but the rate has generally remained above London and England.
- Hammersmith and Fulham has shown little sign of change and has generally remained above London and England.

The sum of complete suicides across the three boroughs seem declined between 2007 and 2019, from 54 to 40. However, the numbers seem to have started going up steadily from 2010 at 44 deaths to 55 deaths in 2012 (*see figure 2 below).* Complete suicides in the City of Westminster remain higher than the other two boroughs.



	2006	2007	2008	2009	2010	2011	2012
Hammersmith & Fulham	14	19	21	11	17	14	13
Kensington & Chelsea	15	11	11	13	10	8	19
Westminster	17	24	21	16	17	28	23
Tri-Borough	46	54	53	40	44	50	55

Figure 2: Complete suicides in Inner North West London (2006-2012)

4.1 Age and Gender

The gender and age split of completed suicides in Inner North West London mirrors that of England and national average, at 73% (males) and 27% (females) recorded between April 2009 and August 2012. During this time, most male deaths occurred amongst those aged between 20 and 59, and there were 3 deaths recorded for people under 19yrs. The figure below shows the number of complete suicides in young people resident across the three boroughs over the last 10 years (2003-2012). All deaths occurred in young males aged between 15-19 years.

Figure 3: suicides amongst young people (15-19yrs) in INWL – 2003-2012

Borough of residence	03	04	05	06	07	08	09	10	11	12
Westminster	0	0	0	0	0	0	0	0	0	1
Hammersmith & Fulham	1	1	2	0	0	1	0	0	0	1
Kensington and Chelsea	1	0	0	0	0	0	0	0	0	1

4.2 Ethnicity

Very limited data is collected on ethnicity, making it almost impossible to characterise complete suicides by ethnic group. However, inferences can be drawn from place of birth recorded in the Public health mortality files. 57% occurred amongst people born in the UK. Relative to the borough population, suicides from Black and Minority ethnic communities are significantly high at 12% (Eastern Europeans), 11% Western Europeans, 7% Asians and 7% Africans [3]. Research suggests that suicide risk is higher in Asian, Black Caribbean and Black African men.

4.3 Place of death

This is where death was confirmed, not necessarily where the suicide event was initiated. The highest numbers were recorded at home (52.2%), followed by hospital (9.1%), tube stations or on railway network (7.0%), waterways such as the River Thames or Grand Union Canal (4.5%), 'other' include sites such as other residential addresses, hotel rooms and woodland/natural space.

4.4 Cause of death:

Hanging, strangulation and suffocation remains the most common method of suicide for men while drug-related poisoning is the most common method for women.

- **Male:** hanging 33.6%, Intoxication/self-poisoning 19.5%. jumping from a height or in front of moving object 13.3% , asphyxiation 8.8%, Drowning 6.2%, Self-Harm (cutting, etc) 5.3%, Other (e.g. undetermined, multiple injuries) 13.3%
- **Female:** Intoxication 34.1%, hanging 22.7%, Asphyxiation 9.1% jumping from a height /in front of a moving object 4.5% Drowning 4.5% Self-Harm (e.g. cutting) 2.3% Other (e.g. Undetermined, Multiple Injuries) 22.7% .

4.5 At risk Groups

At a national level, the groups identified as being at high risk of suicide are young men, prisoners, people with recent self-harm history and people in contact with mental health services. Evidence suggests that certain occupational groups (such as those with access to means, including medications and chemicals like doctors, nurses, veterinary workers, farmers and agricultural workers) are more likely to commit suicide, as well as those that are unemployed. However, there is no indication to significantly back this up; one of the reasons being that over a third of data is missing in the registration records for suicide. Other groups

with a high risk include young people (especially looked after) and middle-aged men, people in the care of mental health services (including those with a history of self-harm), people from Black and Minority Ethnic communities and people bereaved by suicide.

Locally, a stakeholder engagement activity, suicide audit and a suicide joint strategic needs assessment process highlighted the following groups as high risk: Men (15 to 59 years), older people, black and minority ethnic communities, people with previous suicide attempts and people in crisis (bereaved by suicide, relationship breakdown, loss of employment, etc).

Though the link between suicide and deprivation cannot be significantly proven, it would appear that the rate of suicide per 10,000 people is higher in deprived areas. In England and Wales (199-2003) suicide rates were more than double in the most deprived areas compared to the least deprived areas [3].

5.0 Priority for the Strategy: Reducing suicide in high risk groups

Recent research in the UK has led to the development of 'a cry of pain' or 'entrapment model' which explains suicidal behaviour as an attempt to escape from a feeling of entrapment [5]. The theoretical 'entrapment' model suggests that the focus of therapeutic enquiry should be on key events that can be humiliating, defeating and entrapping and how they are reactivated.

In order to achieve the reduction of suicide events in the local area, five main priority areas are identified to be actioned by a wide range of agencies:

- Timely communication and information sharing between agencies on identification of at risk individuals and care pathways.
- Public education and awareness on suicide and/or mental health promotion – through community outreach, anti-stigma campaigns, etc.
- Promotion of existing suicide prevention resources, interventions or support services (e.g. Maytree respite or telephone help-lines like Samaritans/CALM).
- Training for frontline workers (GPs, A&E, and concerned others) through programmes like mental health first aid training or applied suicide intervention skills training.
- Targeted interventions for at risk groups (bereaved families, people from BME background, people with mental health issues, people known to mental health services, etc).

6.0: Suicide Prevention Action Plan

Goals	Action	Suggested leads	Timescale
Goal 1 Timely communication and information sharing between agencies on identification of at risk individuals and implementation of integrated care pathways **Standards:** ▪ Develop operational inter-agency relationships and referral systems facilitating rapid response and integrated care pathways ▪ All known Mental Health patients with severe and enduring mental health problems (and their carers), who are at high-risk of self-harm or suicide, have their care co-ordinated through Enhanced Care Programme Approach	a) Develop simple multiagency protocol (to be agreed borough by borough) that informs parties on what to do, for example, how to respond to warm transfers between agencies.	**Mind, CNWL, GP MH leads, NWLCSU, BTP CALM**	**12 months** **To be changed to specific dates from sign-off date**
	b) Nominate a member of the clinical team to follow up patients at risk of suicide or with reported suicidal ideation within 7 days of discharge from acute care or contact with mental health services	**GP MH leads, NWLCSU WLMHT, CNWL**	**12 months**
	c) Ensure crisis resolution teams have capacity to effectively follow-up high-risk patients discharged from acute mental health services.	**GP MH leads, NWLCSU WLMHT, CNWL**	**12 months**
	d) Develop and implement comprehensive integrated care pathways for at risk individuals, with a strong emphasis on the psycho-social element of care.	**Mind, CNWL, GP MH leads, NWLCSU, BTP CALM**	**36 months**
	e) Statutory agencies to work effectively in partnership with the voluntary and community sector to support and advice on identification of self-harm issues and ensure rapid responses where appropriate.	**Mind, CNWL, GP MH leads, NWLCSU, BTP CALM**	**36 months**

	f) Multi-agency team to get together for a roundtable workshop demonstration of 3-4 patients - to look at current pathways as well as explore the development of more comprehensive pathways for individuals in care, and those about to enter care	**Mind, CNWL, GP MH leads, NWLCSU, BTP CALM, Public Health, Samaritans, LU, Met Police**	
Goal 2: Public education and awareness on suicide, suicide prevention and mental health promotion through community outreach, anti-stigma campaigns, etc. **Standards** ▪ Public is more aware of wellbeing and is more engaged in activities that increase individual and collective wellbeing. ▪ Children have the best start in life	a) Place suicide prevention messages in local and regional communication medium	**Public Health, MIND, CALM**	**24months**
	b) Develop specific mental health promotion and anti-stigma campaigns specifically targeted at suicide prevention	**Public Health, Mind**	**36months**
	c) Work with the media to promote or include suicide prevention helpline numbers when suicide is reported	**Samaritans, CALM**	**36months**
	d) Promote how people talk about or report suicide using Samaritan guidelines	**Samaritans, Public Health**	**24 months**
	e) Commission community mental health awareness services that promote social inclusion.	**Public Health Service, NWL CSU, CCGs**	**36months**
	f) Introduce curriculum for mental health coping skills, counselling skills and self-harm prevention in schools.	**Education Services, CNWL**	**36months**
	g) Establish mechanisms to ensure support is readily and quickly available for children who are bereaved by	**Children services**	**24months**

	suicide.		
Goal 3 Promotion of existing suicide prevention resources, programmes, interventions or support services such as Maytree, telephone help-lines, etc.	a) Develop, promote and widely distribute a directory of suicide prevention services across the three boroughs	**CALM, Samaritan, MIND**	**24months**
	b) Develop interactive electronic suicide prevention information pool in public libraries and community centres	**CALM, Samaritan, MIND**	**48months**
Goal 4 Priority risk assessment training for frontline workers (GPs, A&E, and concerned others) to better diagnose and/or screen suicide risk, provide better support to vulnerable individuals and improve onward referral - through training programmes like Mental Health First Aid Training or Applied Suicide Intervention Skills Training.	a) Procure and provide training in recognition, screening and case management for Nurse Practitioners, GPs, Police, London Underground, mental health clinical staff - plus key staff in A&E, Ambulance, Social Services, Prison, community workers – who are in contact with patients at risk of self-harm or suicide	**Public Health**	**36months**
	b) Provide approved training in the clinical management of cases of co-morbidity/dual diagnosis to staff providing care to people at risk of suicide.	**Public Health, CNWL, CCGs, WLMHT**	**24months**
	c) Develop and pilot a GP protected learning time pack and encourage take up	**Public Health, CCGs, NWLCSU**	**36months**
	d) Pilot ASIST training to frontline community workers across the three boroughs	**Public Health**	**24months**
	e) Commission and evaluate mental health first aid	**Public Health**	**24months**

	training across the three boroughs		
Goal 5 Targeted intervention for High Risk groups: people bereaved by suicide, black and ethnic minority groups	a) Undertake routine screening in primary and social care for suicide risk due to bereavement, social isolation, dementia or depression	**WLMHT, CNWL, CCGs**	**36months**
	b) Establish effective care plan assessment monitored through clinical governance and multi-agency audit.	**CCGs, CNWL, WLMHT**	**36months**
	c) Establish suicide relief centres for people in crisis	**Claire-Mill Haven, CNWL, WLMHT, CCGs, Public Health, Mind, CALM**	**24months**
	d) Employ a family liaison/integrated care pathway officer to work with named high risk individuals and families bereaved by suicide in developing support plans, link with clinical teams and provide appropriate information promptly following a suicide.	**Public Health, CCGs, Police**	**24months**
	e) Commission peer support activities for people bereaved by suicide	**Public Health**	**12months**
	f) Actively involve community groups in the planning, delivery and evaluation of services to BME communities.	**Public Health**	**12months**

7.0 References

1. Preventing suicide in England A cross-government outcomes strategy to save lives Department of Health (2012:2)
2. National Suicide Prevention Strategy for England, Department of Health (2002:7)
3. Brodie C, Carter S, Lwembe S, Sayers D (2013) Suicide Prevention Joint Strategic Needs Assessment: A review of suicide prevention across Hammersmith and Fulham, Kensington and Chelsea and Westminster Tri-borough suicide Joint Strategic Needs Assessment.
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8.0 Appendices

Appendix 1: Tri-borough Suicide Joint Strategic Needs Assessment

Tri-borough Suicide JSNA 2013.pdf

Appendix 2: Tri-borough BME suicide Needs Assessment

Final Report.docx