Herefordshire Council

NHS

Herefordshire Suicide Prevention Strategy 2019 - 2023

Contents

Foreword

This strategy represents a collective desire across key stakeholders to reduce the number of suicides in Herefordshire. The impact of suicide and suicidal behaviour on the person, their families, friends and communicates is significant and long lasting, yet potentially preventable.

The rate of suicide in Herefordshire is consistent with average rates nationally.

- There were 137 deaths by suicide recorded for Herefordshire between 2010 and 2017.
- In this period the number of suicides in any one year vary, ranging from the lowest number recorded at 12 deaths in 2017 to the highest number at 23 in 2016.
- Herefordshire mirrors the national trend of the numbers of male suicide being significantly higher than female suicide.
- The range of methods of suicide in Herefordshire are similar to those seen nationally.
- Suicide is a significant cause of death in young adults, and is seen asan indicator of underlying rates of mental ill-health.
- Residents of the most deprived areas of Herefordshire are approximately 19% more likely to die as a result of suicide than the county population in general.

A group of Herefordshire suicide survivors has worked together to produce a 'Letter of Hope' which recognises how someone contemplating suicide may feel and how they could overcome their feelings.

"We know it can become more and more difficult to carry on. Indeed, when your experience of life is so grim, it can reach a point where it no longer seems worth making the great effort required just to continue. The silent suffering can become itself too much.

Sometimes we need a helping hand, someone to guide us, someone to be there for us, someone who cares and understands our grief, someone who is good at listening and someone whom we can talk to and confide in."

The Herefordshire suicide prevention strategy commits to recognising and improving local agencies approaches to preventing suicides. To realise fully the aspirations set out in this strategy a collective response is required from statutory bodies, voluntary and faith organisations and the communities of Herefordshire.

Local partners have identified key priority areas for Herefordshire. An action plan will be developed to guide the work required to address the issues raised. It is hoped that during the lifetime of this strategy, more individuals, agencies and groups recognise the value in this work and participate in the implementation of the strategy, its vision and objectives.

The key partners involved in developing this strategy and accountable for ensuring its delivery and implementation are;

- NHS Herefordshire Clinical Commissioning Group (CCG)
- Herefordshire Council
- 2gether NHS Foundation Trust
- Wye Valley NHS Trust
- Samaritans
- Taurus Healthcare
- West Mercia Police
- Hereford and Worcester Fire and Rescue Service

Vision

"Suicide prevention is everybody's business."

Our vision is that Herefordshire is a supportive place to live, work and visit where people receive support when they need it. As a county, we seek to achieve a zero suicide mind set, as suicides are preventable. This includes an ambition of zero suicide for mental health inpatient services.

To achieve this ambition will require a collective commitment by the key partners to develop and action plan to deliver the 'what we can do' sections set out in each key priority area.

Purpose and scope

This strategy seeks to prevent suicides of adults and children in the county by identifying where the key areas for development are and putting these in place through a partnership approach.

The outcome of this work is expected to improve support for people at risk of suicide and those affected by it.

In this strategy, suicide is defined as the act of deliberately killing oneself. In mortality statistics and the work of the coroner there is a variety of terminology used to refer to death by suicide; for example, death categorised as 'suicide' and 'injury undetermined'.

This strategy does not include issues relating to assisted suicide or euthanasia.

Statistical data referred to throughout this strategy has been obtained from the Primary Care Mortality Database and the Public Health Fingertips tool. The deaths recorded statistically for Herefordshire relate to those who had been registered with a Herefordshire GP.

These NHS data sets record deaths using the following International Classification of Diseases (ICD)10 codes:

- X60 – X84 Intentional self-harm
- Y10 – Y34 Injury/poisoning of undetermined intent

It is important to note the difference between these datasets and deaths recorded by the coroner. Coroner conclusions relate to those who have died in Herefordshire, regardless of where they are resident or are registered with a GP. The coroner reaches a conclusion about how the person came about their death. There is no set list that a coroner must use to record their conclusion. They may use short labels such as 'accidental death' or 'suicide.' However, they can also create a new label or write a narrative of the facts of the case. A recent decision in the court of appeal signals a change of approach to the way coroners may reach conclusions around suicide. This may lead to an increase in coroner records of suicides in future years.

The strategy will provide an analysis of available data and how this can be used to identify ways in which to prevent suicide. Limitations in the current data and intelligence are acknowledged and ways in which to address and fill any gaps identified.

Strategic objectives and outcomes

The strategy is intended to achieve the following;

Objective 1

Enhance the prevention of suicide through the effective sharing of knowledge, resources and expertise with related areas of strategy including mental health, domestic abuse, autism, community cohesion, technology enabled living, corporate parenting, migration, equality and dementia.

Outcome

All key people focused strategies to include consideration of suicide prevention.

Relevant findings from Child Death Overview Panel (CDOP), Diagnostic and Outcome Monitoring Executive Summary Report (DOMES) and other relevant mortality programmes used to inform suicide audit.

Objective 2

Maximise the availability, relevance and application of data and other forms of intelligence about suicide and suicide prevention in Herefordshire.

Outcome

Regular reporting and analysis of NHS and ONS data on suicides and an agreed approach to use of real-time data in place.

Objective 3

Address the suicide risk and improve the mental wellbeing of people who have been bereaved by suicide.

Outcome

Routine provision of immediate information and signposting for people bereaved by suicide.

Objective 4

Address the priorities and at risk groups identified in the National Suicide Prevention Strategy, to increase knowledge about them and impact upon them locally.

Outcome

A detailed action plan reviewed annually setting out approaches to the seven priority areas and key at-risk groups.

Objective 5

Help reduce the number and rate of suicides in Herefordshire.

Outcome

Measurable progress towards a five year reduction of the number and rate of deaths by suicide in Herefordshire.

Research and engagement

Preparation of the strategy has drawn substantially on wide ranging research on suicide, nationally and regionally, with advice from the joint regional lead for NHS England and Public Health England. This has been augmented by analysis of local facts and figures. Research and analysis will continue to inform the implementation of the strategy throughout its life.

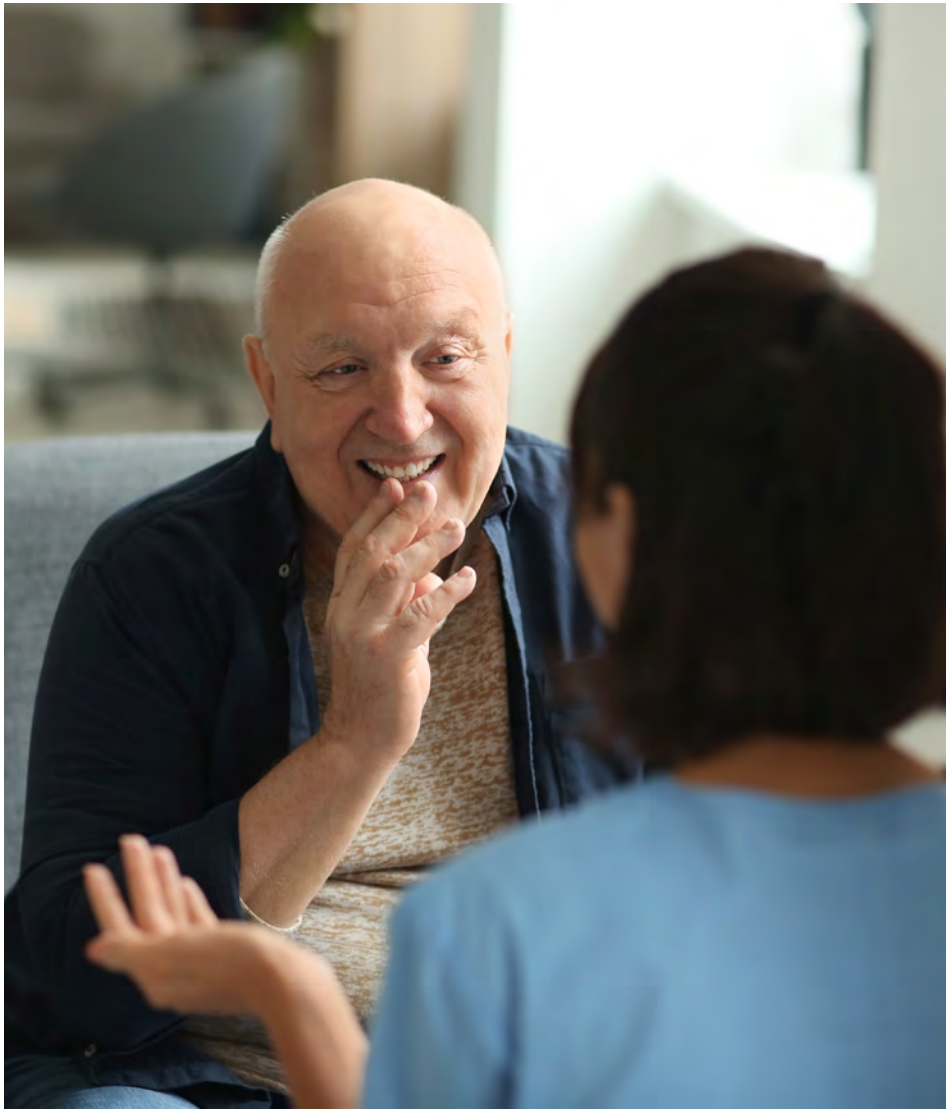
In developing the strategy the council and CCG have engaged with professionals and volunteers across voluntary, community and public sectors and those representing people with mental health needs, including through Herefordshire's mental health partnership board. Continued engagement will be undertaken in support of strategy implementation, including direct engagement with communities. This will be incorporated into development of the Talk Community Plan and Talk Community hubs, along with the development of an updated mental health strategy.

Implementing the strategy

The impact of the strategy will depend on collaborative working by a number of partner agencies and on groups of individuals in Herefordshire communities giving time and energy to helping to prevent suicide.

There will be an expectation that Herefordshire Council and NHS Herefordshire Clinical Commissioning Group will be accountable for the strategic delivery for the strategy, and they will work with other key partners to ensure its implementation. To realise the objectives set out in this strategy key partners and communities will need to commit sufficient time and energy to make the changes necessary to meet the vision of achieving a zero suicide mind set by developing delivering an action plan to address each of the key priority areas. The Mental Health Partnership Board will advise on the action plan and review its implementation. The delivery of the action plan will be reported to the Health and Wellbeing Board, as recommended in national guidance, and the Community Safety Partnership.

Review of progress made in meeting the objectives of the strategy should take place annually in the autumn, to enable the most recent release of data, which is provided in September, to be taken into account. The review should provide opportunity to identify any key changes in data, trends, national guidance, strategy or policy.



Key priority areas

The key areas outlined in this strategy have been identified through analysis of local need and direction set out in the 'Preventing suicide in England; A cross-government outcomes strategy to save lives' (2012) and other relevant national policy and guidance. An action plan will be developed and agreed with partners to realise these key areas.

Key areas;

1. Communities
2. Media
3. Bereavement information and support
4. Reducing means of access to suicide
5. Reducing the risk of suicide in high risk groups
6. Mental health services
7. Self-harm

Key Area 1

Communities

What do we know?

The fourth review of national strategy states, "it is vital that all services within our communities work together to ensure that those who are most challenged and those most at risk of suicide can reach out for support when they need it. After all, suicide prevention is everybody's business."

Most suicides take place in the person's home or nearby, in their local community. Whilst someone is deciding and making plans to take their own life, they are coming and going in their local community, within their family or at their place of work or study. In theory, this provides opportunities for people in the community to provide support or intervene to prevent suicide. In practice, action is needed to realise the potential for community based suicide prevention.

Community offer

The role of the community is of particular importance to those who are not likely to encounter mainstream services, including men. Findings from three mental health projects launched in 2006 highlighted that community outreach programmes and locations, such as job centres and young people-friendly venues, are more successful in engaging with young men than more formal health settings such as GP surgeries.

Herefordshire is particularly rich in volunteering and informal, community based support that provides social and targeted opportunities to maintain wellbeing and reduce vulnerability. The capacity and leadership within communities will play an ever-increasing role in enabling people to stay independent and connected and reduce need for formal health and social care. Through its initiative, Talk Community, Herefordshire Council and its partners is extending and consolidating this community capacity and promoting innovation to ensure that wellbeing and independence are inevitable for more and more people.

Communities of Interest

Communities are not always geographical and there are various communities of interest in Herefordshire that can contribute to suicide prevention. These include support groups/forums for users of mental health services or around certain mental health conditions, such as bi-polar disorder, schizophrenia, depression or anxiety. There is a significant community of interest among serving military personnel, families and veterans that offers substantial support to potentially vulnerable people. There are wider networks of mutual support for carers, disabled people and other groups.

For groups of vulnerable young people, including care leavers there may not be communities of interest established or active enough yet to be able to offer support around suicide prevention. Another community which may not have access to targeted support, are those involved in farming and agriculture. A wider issue is many established communities of interest struggle to engage middle aged and younger men who are a key at-risk group in relation to suicide.

Examples of community activity

There are many examples, locally, regionally and nationally of community and volunteer led groups and activities, which are effective in promoting wellbeing and some of these may contribute to preventing suicide. They include mentoring and buddying schemes, listening services and groups based around social and leisure activities, including groups focused on men.

Some communities of interest may be virtual or online and although these may have no local Herefordshire element, they can potentially offer significant support and protection to people who are vulnerable to suicide.

The Samaritans provides a 24-hour telephone, email and SMS service nationwide and in Herefordshire there is a drop in service when the office is staffed. Samaritans highlights that telephone is the most common form of contact and that their role is often one of listening and providing reassurance that there is someone there who cares enough to take the time to listen. Many other national and local organisations can and do reach out to people and offer support.

There are some excellent examples locally and regionally of people in communities innovating in their own time to reach out to others in ways that will help prevent suicide;

- In Birmingham a woman with lived experience of mental health founded onemillionlovelyletters.com. This project hand-writes personal letters of support, encouragement and affirmation to vulnerable people, nominated by friends or family. Thousands of people around the world have received letters and whilst not focused specifically on suicide, it is apparent that the project has helped prevent deaths.
- A group of local men in the north Golden Valley area got together in 2017/18 to hold drop-in talk sessions in local pubs about suicide. All with professional backgrounds in mental health, they were prompted by the recent suicides of people they knew.

What are the issues?

- People and groups in communities who are willing to help vulnerable people often cannot identify those people who need their help. In relation to suicide, those at risk seldom choose to identify themselves to those around them, whether at home, at work or more widely in the community. Community groups and volunteers will not usually be able to identify people at risk by observation or deduction.
- Just as few people contemplating suicide will talk about it, few people in communities know how to talk about suicide or broach the topic. New ways of communicating about suicide within day to day life are needed which encourage people to seek help and ensure a confident and appropriate response.
- More generally, people who are vulnerable and need help do not know where or how to seek it within their local community. This needs to be made easy and straight forward, including for people thinking about suicide.
- There are many good sources of support in communities, but they are only available in some communities or are in limited supply. Volunteers and groups willing to provide support may need training.
- The government has identified some risk of suicide among children exposed to gangs and this may be a risk for young people in Herefordshire who are more widely at risk of criminal exploitation.
- There is an insufficiency of support and advice in particular for men and for young people, including care leavers, whether around suicide or generally
- There are many people and groups in Herefordshire willing to help vulnerable people and who could contribute to preventing suicide.
- There are also many good ideas in communities about how to help, which need only time or encouragement to put into practice.

What can we do?

Develop new ways of talking about suicide to encourage the seeking and giving of help in communities, including social settings, public signage, open letters, coded language and anonymous help.

Promote awareness of suicide among community groups, including mental health first aid and suicide specific training. Encourage local people with personal experience of suicide to share it appropriately in their communities. Actively promote focus on suicide amongst communities of interest.

Promote information about good practice in mental wellbeing and suicide prevention, including through Talk Community hubs, linking to volunteers trained in Making Every Contact Count (MECC) and mental health first aid. Encourage individuals and groups to develop innovative ideas for tackling suicide in their communities, including through the Talk Community seed fund.

Continue to support informal community groups and social enterprises to grow and provide support to local people. This will include a specific focus on support for mental wellbeing and for young people and men.

Key Area 2

Media

What do we know?

Social media

The media can offer both a positive contribution and negative impact in respect of mental wellbeing and suicidal feelings. Social media provides a platform on which to express thoughts and feelings, open up conversations with those you would not normally connect with, but perhaps have a shared experience or can just demonstrate that they are hearing you. This can be achieved anonymously, creating opportunity to be open and honest where they may not have the confidence to share otherwise. However, it can also bring about a need for constant approval and acceptance, become overwhelming if you cannot keep up with comments or create a feeling of isolation and loneliness if not responded to.

A study examining the exposure to self-harm and suicide on the internet by young people concludes that internet use to view suicide and self-harm related content is common amongst young adults, particularly those with suicidal thoughts and behaviours. The sites accessed provided harmful content that presents potential risk, but a greater proportion of participants had accessed helpful sites that provided opportunity for prevention.

There is national concern about the safety of young people online and protecting them from harmful effects to their mental health. The impact of technology on young people's mental health is due to be explored in a report by the Chief Medical Officer.

Reporting of suicide

The national strategy seeks to expand the work of the Samaritans with support from Public Health England and the Department of Health in improving the monitoring of suicide reporting in the media. Sensitive and responsible reporting in local media will address stigma and reduce copycat behaviours.

The One Herefordshire communications team has a role to undertake in ensuring information provided to the national and local media is correct and used in the right way, signposting to organisations that provide local and national support.

Role and use of the media

Media in all formats provides a platform to raise awareness of suicide prevention with communities. The channels of communication and media coverage have changed significantly with the development of online and social media sources. Bristol University policy briefings on suicide prevention1 highlight clinicians as having a unique position in potentially guiding internet use. They also suggest that by discussing and being aware of internet activity could aid clinicians in identifying high-risk patients and contribute to their clinical decision making, therefore improving the support offered.

1 Priorities for suicide prevention: balancing the risks and opportunities of internet use https://www.bristol.ac.uk/policybristol/policy-briefings/suicide-prevention/

The media has a significant role in reducing stigma and provides opportunity to open up conversations, provide case studies, as well as providing access to information and support. The role of the media extends to challenging the inappropriate use of language such as 'committed' suicide, supporting campaigns such as 'Take a minute, change a life' and responsibly reporting any reported suicides.

In May 2019, the Court of Appeal decided that the criminal civil law standard of proof should be applied to verdicts of suicide, rather than the criminal standard. This means that the coroner only has to be satisfied that it was "more probable than not" that someone had deliberately killed themselves. Whilst many people have already moved towards terminology such as 'death through (or by) suicide' this ruling may help to distance suicide further from being seen/ stigmatised as a crime. The term "commit suicide" should no longer be used.

What are the issues?

- The internet and social media does provide information on methods of suicide and there are some risks and threats in using social media. However, there are also many websites, Apps and social media channels that provide protective support to people at risk of suicide.
- Asking people about internet usage may enable GPs and other professionals to intervene where someone is at risk of suicide.
- Mainstream media coverage can be helpful in promoting awareness of suicide and of support available to people. However, suicide is a complex issue and it may be helpful to encourage positive and constructive media coverage.

What can we do?

Offer suicide prevention awareness training to local media.

Ensure that WISH and other signposting routes clearly direct people to websites and social media that provide support and protection to people at risk of suicide.

Invite local media to participate in this strategy and its key messages and adopt an approach to suicide prevention within the One Herefordshire partnership.

Promotion of World Mental Health Day; Mental Health Awareness Week; and Suicide Prevention Day. (See NHS Employers Calendar of national health and wellbeing campaigns link in resources list for dates).

Develop case studies on people's experience to share suicide prevention messages with the press, linked to local or national events.

Key Area 3

Bereavement information and support

What do we know?

Those bereaved by a suicide are at increased risk of mental health and emotional problems and may be at higher risk of suicide themselves, so receiving the right support is essential. A guide2 has been developed by individuals who have been bereaved by suicide, with support from experts at Public Health England (PHE) and the National Suicide Prevention Alliance (NSPA). This guide seeks to provide more relevant and personal guidance to those bereaved by suicide. In this guide David Mosse, a bereaved father says;

"I think many living with loss know of nothing more powerful, as a force for healing, than to share with others bereaved by suicide and to know that we are not alone."

Herefordshire has a number of local organisations available to provide support, such as Cruse, St Michaels Hospice, Winston's Wish, SOBS – Survivors of Bereavement by Suicide and Herefordshire Samaritans. For many people, their GP or a trusted person in their network can assist in signposting to these local organisations. Yet for other people, access to help can be difficult.

Access to information and support is individualised, in terms of both the sort of help people want and when they want to access it. All organisations in Herefordshire have a role in guiding and aiding people, making sure that grief and loss is recognised. This is wider than family and friends and can affect communities such as schools, employers and neighbours. Educational psychologists can provide additional support for bereaved children and young people in schools.

Support groups provide emotional and practical support to people bereaved or affected by suicide.

The Suicide Prevention National Transformation Programme3 references Cornwall Council's Postvention process, describing the activities developed by, with, or for people who have been bereaved by suicide, to support their recovery and to prevent adverse outcomes, including suicide and suicidal ideation.

What are the key issues?

- People who are bereaved by suicide are at higher risk of suicide themselves and services need to identify this consistently and provide access to appropriate support.
- People who have been bereaved through suicide often value support from people with the same experiences. Personalised support from peers is not available locally at present.
- There are voluntary and community organisations locally and nationally that can provide support to people who are bereaved by suicide. Effective signposting is needed to connect them to the right support at the appropriate time.
- The period of immediate bereavement after a suicide is critical in providing support, advice and signposting. There are challenges for criminal justice agencies in providing this support.

2 Support after a suicide: A guide to providing local services A practice guide by Public Health England https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/590838/support_after_a_suicide.pdf

3 Suicide Prevention National Transformation Programme https://www.rcpsych.ac.uk/improving-care/nccmh/national-suicide-prevention-programme

What can we do?

Ensure that WISH has accurate information on sources of support and information, including local and national organisations.

Offer support from the Samaritans to visit schools and colleges in the event of a child/ young person's suicide.

Raise awareness of the work by bereavement organisations, community and faith based organisations that offer support to those bereaved or affected by suicide.

Review options for immediate bereavement and signposting and support through criminal justice agencies, linked to potential for real time data and learning.

Promote the establishment of a local peer led support group of people who have been bereaved through suicide.

Key Area 4

Reducing means of access to suicide

What do we know?

Those bereaved by a suicide are at increased risk of mental health and Data relating to the period 2010/2017 indicates that;

- Close to half of all suicides in Herefordshire involved hanging/ asphyxiation
- Just over one fifth involved self-poisoning.
- Other methods include drowning and the use of firearms, although no firearm related suicides have been recorded since 2014.
- There are evident patterns indicating that the methods of suicide change with age, with poisoning become more prevalent and hanging/asphyxiation reducing as age increases.
- In 10 out of 13 deaths of those under 25, hanging/asphyxiation was the method used.
- Five of the deaths of under 25's have occurred in areas of natural beauty, three close to the home address.

Location

Consultation with professionals in the emergency services has provided anecdotal evidence that confirms the data available around the method of suicide. Although they also note that there are a number of deaths that may occur at hospital because of trauma following rail associated incidents. Suicides that involve rail incidents occur primarily at platforms and level crossings.

Available data only includes deaths relating to people who are registered with a GP in Herefordshire; this includes seven deaths that have occurred outside of the county. An audit of deaths would include all deaths that have occurred in Herefordshire regardless of where the person was registered with a GP and enable the location of the injuries that led to death where a person has died in hospital to be identified. This would allow further analysis to identify of any frequently used locations and to better understand any significance of the landscape.

Primary Care Mortality Database (PCMD)4 data demonstrates that of the 137 suicides recorded between Jan 2010 and July 2017 the place of death can be broken down as:

- At home = 68 (50%)
- In hospital = 27 (20%)
- Close to home = 23 (17%)
- Elsewhere = 19 (14%)

4 Primary Care Mortality Database https://digital.nhs.uk/services/primary-care-mortality-database

Methods

Of the 68 deaths at home, 43 were due to asphyxiation and 14 poisoning. Whilst a number of the deaths due to drowning occurred in the River Wye, there are no single identifiable 'hot spots' where deaths as a result of suicide have occurred.

Limitations of the data available are that where a death occurred in hospital the data of where the incident that led to the death is not available. There is also no data available on the location of uncompleted suicide locations. Public Health England guidance5 suggest that undertaking suicide audit or real-time surveillance system using data collected from coroners' files. However, this guidance focuses on analysis of particular locations that have been repeatedly used and assessing particular methods at those sites.

Nationally an increase in helium inhalation as a method of suicide has been noted, a recent decrease in suicide by the use of car exhaust has offset the trends in gas inhalation as a method of suicide6. However, this national pattern is not mirrored in the PCMD data for Herefordshire that records seven deaths due to gas inhalation between 2012 and 2016. All of the people who have died as a result of gas have been male, five of whom were aged between 43 and 56 at time of death, the other two in their 20's. Only two of these deaths were due to helium inhalation and both of these were in 2012. All other gas related deaths have been due to carbon monoxide poisoning. The suicide prevention: National Institute for Health Research (NIHR) programme7 will specifically address the emergence of new suicide methods in their research.

What are the key issues?

- Methods of suicide in Herefordshire occurring most frequently are hanging / asphyxiation, self-poisoning, drowning and rail incidents. The particular and growing frequency of hanging as a method may partly be attributed to the easy availability of information via the internet.
- Whilst the natural landscape of Herefordshire does offer opportunities to implement some of these methods, it is not clear whether this has increased the risk or incidence of those methods. Most suicides occur at home or close by.
- There are no locations that are identifiable as particular 'hot spots' for suicides.
- Data recording does not always identify precisely the manner of suicide, particularly where the person has died in hospital or for uncompleted suicides.
- Suicides utilising the rail network locally are most likely to be on platforms or at level crossings, rather than from bridges.

5 Preventing suicides in public places: A practice resource, by Public Health England https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/769006/Preventing_suicides_in_public_places.pdf

6 Suicide by gases in England and Wales 2001–2011: Evidence of the emergence of new methods of suicide, by D. Gunnell, C. Coope, V. Fearn, C. Wells, S.-S. Chang, K. Hawton, N. Kapur https://www.sciencedirect.com/science/article/pii/S0165032714005448

7 Suicide prevention: NIHR programme https://www.bristol.ac.uk/population-health-sciences/projects/suicide-prevention/research/

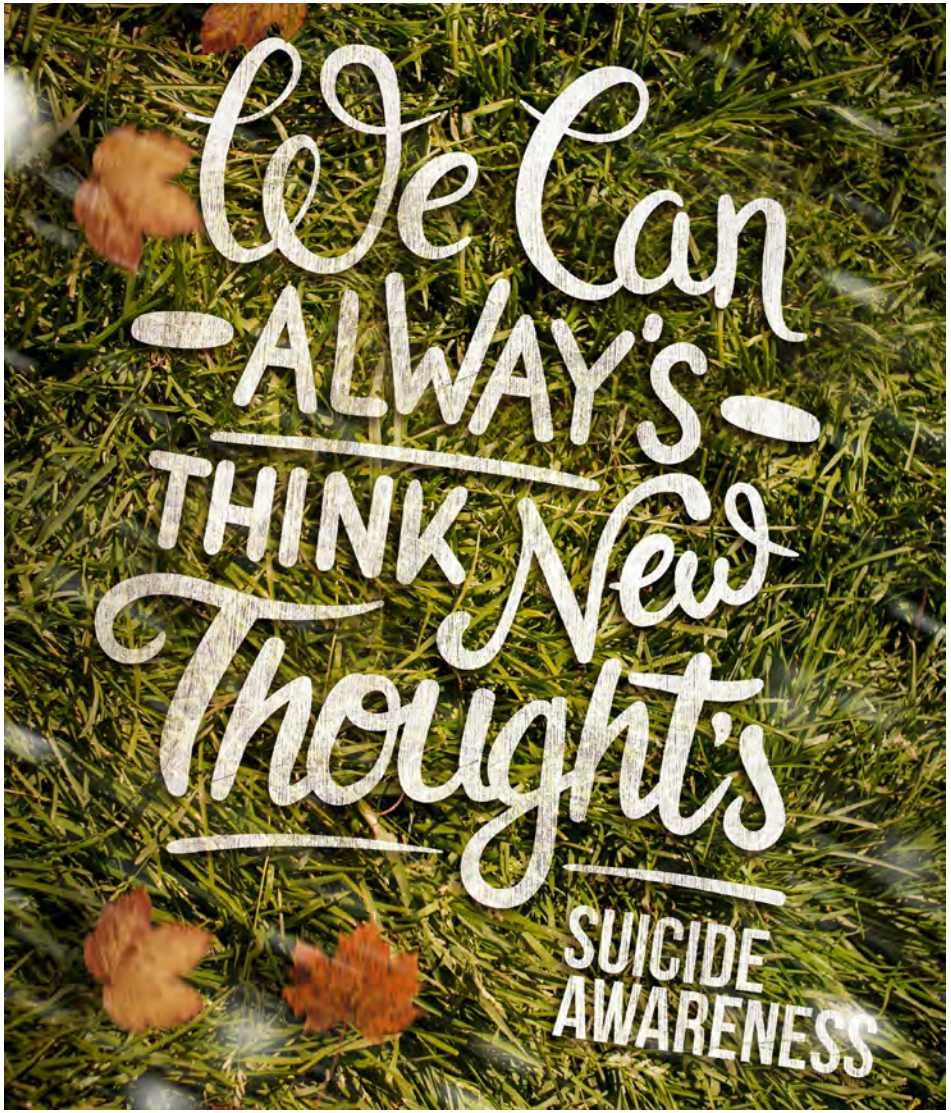
What can we do?

Access to the railway line across Hereford Hospital car park / helipad area will be secured to reduce risk at that location.

Promote an awareness of suicidal risk among property and housing developers, council services and other agencies to aid the designing out risk from new structures and buildings.

Raise awareness with local people, organisations and community leaders of Zero Suicide Alliance training and seek resources to extend its provision.

Establish a suicide audit and real time learning process to inform risk management and development of services and responses across the health, care and criminal justice systems.



Key Area 5

Reducing the risk of suicide in high risk groups

What do we know?

"Preventing suicide in England: A cross-government outcomes strategy to save lives"8 identifies a number of high risk groups of people whereby the risk of suicide is higher. Although these have been adopted for some time, recent data locally and nationally may trigger reflection on these key risk groups:

- Young and middle-aged men
- People under the care of mental health services
- People in contact with the criminal justice system
- Specific occupational groups such as doctors, veterinary workers, and agricultural workers
- People with a history of self-harm

Three particular pre-eminent risk factors are highlighted, based on evidence provided by the National Confidential Inquiry into Suicide and Safety in Mental Health9 (NCISH) about the highest levels of need, these are;

- Middle aged men
- Self-Harm
- People with established mental health needs (especially leaving hospital)

Male suicide

The fourth annual review10 of the national strategy acknowledges recent developments in relation to male suicide;

- There have been some reductions in suicide rates amongst men between 2014 and 2017,
- Men remain the highest risk group, particularly those aged 35-49.
- The male suicide rate in Herefordshire is five times greater than the female rate.
- Factors associated with suicide in men include depression, especially when it is untreated or undiagnosed; alcohol or drug misuse; unemployment; family problems, relationship break-up and divorce; social isolation and low self-esteem.

8 Preventing suicide in England: A cross-government outcomes strategy to save lives (2012) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf

9 National Confidential Inquiry into Suicide and Safety in Mental Health Annual Report 2018 https://sites.manchester.ac.uk/ncish/reports/annual-report-2018-england-northern-ireland-scotland-and-wales/

10 Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives (January 2019) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772184/national-suicide-prevention-strategy-4th-progress-report.pdf

Out of 104 male deaths from suicide in Herefordshire between March 2010 and July 2017;

- 35 were aged 35 – 49,
- 25 were aged 18 – 34,
- 24 were aged 50 – 65,
- 20 were aged 66+

Stigma persists around talking about emotional health and this is an important contributor to reducing suicide, particularly amongst men. The House of Commons health Committee report11 on suicide prevention notes that the role of the community and non-traditional routes, such as "men's sheds" and similar projects may be of specific benefit for people who are unlikely to access mainstream services, particularly young and middle aged men.

In Warwickshire the 'It takes balls to talk' campaign has linked with a wide range of community based organisations to support volunteers to share a simple powerful message that "it's okay to talk about how you feel" at a range of male dominated work and leisure places, such as sporting matches. The volunteers, supported by a clinician to address any immediately presenting significant mental health needs, also encourage the men they engage with to be "A Listening Mate" for someone else.

Self-harm

A number of reports recognise self-harm as a significant indicator of suicide risk. Approximately half of those who go on to complete suicide have previously self-harmed12. It is suggested that one in 25 patients presenting to hospital for self-harm will kill themselves in the next 5 years. The incidence of recorded repeat self-harm and suicide in this population nationally has not changed in over 10 years. Many of those who have self-harmed and go on to complete suicide will have had contact with their GP, A&E or other health professionals in the year before they die. The approach taken in these contacts with health professionals are key in reducing the risk of death by suicide amongst those who self-harm.

11 House of Commons Health Committee, Suicide prevention, Sixth Report of Session 2016-17 https://publications.parliament.uk/pa/cm201617/cmselect/cmhealth/1087/1087.pdf

12 Hospital Presenting Self-Harm and Risk of Fatal and Non-Fatal Repetition: Systematic Review and Meta-Analysis (Robert Carroll, Chris Metcalfe, David Gunnell) https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0089944&type=printable

Mental health

"Many people who take their own lives are not in contact with mental health services and may not necessarily be in contact with a GP, so opportunities for clinical interventions can be limited. Non-clinical interventions, such as telephone or text helplines or volunteer-run face-to-face talking are important to support people with suicidal thoughts and keep them safe."13

The National Confidential Inquiry into Suicide and Safety in Mental Health Annual Report 2018, cites a continued downward trend in the number of inpatient suicides. The report goes on to highlight that the highest risk of suicide for patients who have received inpatient care falls in the 2 weeks following discharge, with suicide most likely to occur on day 3.

Occupation

Analysis of the occupational data available suggests that both agricultural workers and those in the building trade account for local 12 deaths each between 2010 - 2017e. Seven of the deaths in most recent data period (2015 – 2017) relate to the building trade, four are attributed to those working in agriculture. It is noted that these trades are both traditionally associated with male workers and that they may include a high number of self-employed people. Those working in retail account for six deaths between 2010 – 2017, with three of these deaths occurring between 2015 - 2017. Nurses accounted for three deaths since 2010, with the most recent death recorded in 2015. Whilst veterinary workers and doctors are identified as high risk occupations nationally, local data has not recorded any deaths relating to these occupations between 2010 and 2017.

A national analysis of deaths registered in England between 2011 and 2015 was carried out by the Office for National Statistics (ONS) and published in 2017. This showed that males working in the lowest-skilled occupations had a 44 percent higher risk of suicide than the male national average; the risk among males in skilled trades was 35 percent higher. For females, the risk of suicide among health professionals was 24 percent higher than the female national average; this is largely explained by a higher risk of suicide among female nurses.

Criminal justice system

The Probation Healthcare Commissioning Toolkit14 suggests that "rates of suicide and self-harm are higher amongst people in contact with probation than amongst the general population in the UK" Similarly, to those discharged from hospital following care for mental health problems it is during the first few weeks following release from prison that individuals are most at risk. Unlike in the general population, data suggests that the rate of suicides in the criminal justice system in the UK has been increasing, including amongst those in the community.

13 Preventing suicide in community and custodial settings, NICE guideline [NG105] (2018) https://www.nice.org.uk/guidance/NG105

14 Probation Healthcare Commissioning Toolkit: A resource for commissioners and practitioners in health and criminal justice https://cpb-eu-w2.wpmucdn.com/blogs.lincoln.ac.uk/dist/9/8124/files/2019/03/Offender-Health-Commissioning-Toolkit-Full-Version-2h4lln7.pdf

What are the key issues?

- Young and middle aged men are at increased risk of suicide, owing to various factors, including reluctance or stigma associated with talking about mental health or personal/life issues.
- Pathways for people who self-harm may offer limited support options and may not effectively identify or manage risk of escalation to suicide.
- Many people who die by suicide have not been in recent or regular contact with health services, or where they are, the risk of suicide may not be recognised. It is important that people have routes to support through non-health roles or services, including in communities. This may be especially so for young and middle aged men.
- There is a clear increased risk of suicide for people with mental health needs, following discharge from mental health inpatient services and from release from prison. The management of this risk has generally been focused on the first two weeks. Recent developments indicate that the greatest risk occurs during the 48 hours following discharge or release.
- There is apparently increased risk for people working in farming and agriculture or building trades. Given that men continue to make up a great majority of the workforce in those sectors, approaches to the issue could be joined up with strategies for reaching young and middle aged men.

What can we do?

Support criminal justice agencies and 2gether NHS Trust to review how mental health needs are identified and supported for people going through custody and the courts.

Through Talk Community hubs and wider Talk Community initiatives to provide training and resources to enable volunteers, professionals and employers to be confident in talking about and supporting people who are considering suicide.

Promote a focus on managing isolation and loneliness of vulnerable people in rural and farming communities, through the Talk Community plan, hubs and integration of community health and care services.

Herefordshire CCG, Wye Valley NHS Trust, 2gether Foundation and Taurus Healthcare to review clinical recording and responding to people presenting with high risk of suicide, focusing on primary care and accident and emergency.

Key Area 6

Mental health services

What do we know?

Not all of the population are equally affected by the incidents of suicides and yet there is not a discrete group affected. Tailoring approaches will help raise key messages effectively with different parts of the population. Challenging stigma and discrimination around mental health is part of this approach.

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) examines cases of suicide for those people who have been in contact with secondary and specialist mental health services in the previous 12 months. The inquiry has identified that between 2006 and 2016, there were 17,931 suicides by mental health patients, representing 28% of suicides in the UK general population. People who have mental health problems are at particular risk of suicide, although not all people who die by suicide have mental ill health.

Health Education England published the Suicide Prevention and Self-Harm Competency Frameworks15 in October 2018. These frameworks set out the competencies required for effective interventions by clinicians and others working with people of all ages across generalist and specialist settings.

Interest groups

Veterans are highlighted as a group requiring tailored approaches to meet their mental health needs in the national strategy. Whilst the Herefordshire data available does not identify any veteran deaths by suicide between 2010 and 2017, this may be due to the occupation listed being the most recent occupation only. Evidence in the most recent review of the national strategy demonstrates that the overall rate of suicide is not higher for veterans than the general population. It does however suggest that there is an increased risk in male veterans aged below 24, where the rate is 2-3 times the national rate and especially in those who have served a short period in the military, those of lower ranks and those who have attained lower educational achievement. It also identifies that where veterans die by suicide, many have pre-service vulnerabilities.

The mental health and wellbeing of children and young people is seen as a priority across health professionals and schools. However, it is acknowledged that in some cases additional support is only available when a serious issue arises and even then the wait for that support can be long. The 2017 Children and Young People Mental Health Green Paper15 suggests that whilst suicide and self-harm prevention programmes may improve knowledge, attitudes and help-seeking behaviours, there is no robust evidence yet relevant to the UK to suggest that they reduce the number of suicide attempts.

15 Self-harm and suicide prevention frameworks by Health Education England and the National Collaborating Centre for Mental Health https://www.hee.nhs.uk/our-work/mental-health/self-harm-suicide-prevention-frameworks

16 Transforming Children and Young People's Mental Health Provision: a Green Paper (December 2017) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf

In response to the zero suicide ambition for mental health inpatients set out in January 2018, 2gether NHS Foundation have developed a 'Trust Zero Suicide Plan – Inpatient Mental Health Services 2019/20'. This plan builds on a range of inpatient suicide prevention initiatives such as "safe wards" to meet the ambition of "zero suicides" in inpatient settings. The 2gether patient participation group developed the Letter of Hope to provide to patients on discharge from inpatient services.

There is opportunity to improve safety and minimise the risk of completed suicide amongst those with diagnosed mental health problems who have contact with specialist services. The National Confidential Inquiry into Suicide and Safety in Mental Health Annual Report 2018, identifies 10 specific ways to improve safety, these are depicted in the image opposite and expanded upon in the report.

What are the key issues?

- For many people it appears there is still stigma associated with mental health needs and seeking mental health support. This is one factor restricting the numbers with diagnosed mental health needs, so that many people will be living with emerging or escalating needs and not be in contact with services.
- People with diagnosed mental health problems are at increased risk of suicide and this risk is greatest following discharge from a mental health hospital.
- Many people who complete suicide do not have a mental health need and have had no contact with health or care services.
- Where people come into contact with specialist services, there are opportunities to improve safety and reduce the risk of suicide.

What can we do?

Promote the use of the five steps to wellbeing; Connect, Be active, Keep learning, Give to others and Be mindful (https://www.nhs.uk/conditions/stress-anxiety-depression/improve-mental-wellbeing/) and Zero Suicide Alliance training. (http://zerosuicidealliance.com/)

Work with schools, colleges, community, voluntary and faith organisations, including those working with young people, families and veterans, to promote opportunities to support people with mental wellbeing.

Develop employer-based approaches to improve wellbeing in the workplace, targeting the agricultural and building trades.

Ensure that people vulnerable to suicide are provided with a copy of the 'Letter of Hope' on discharge from hospital or on release from prison or custody.

Recognise and review the work by 2gether NHS Foundation in seeking to achieve zero suicide in mental health hospital and review evidence and options around reducing suicide on discharge from hospital.

Key Area 7

Self-harm

What do we know?

Prevention of suicide and reducing the risks associated with suicidal behaviour is a significant area to focus on. 50 per cent of people that self-harm, progress onto suicidal intention. We want the population of Herefordshire to have a good quality of life and healthy lifestyles, reducing the incidents of self-harm and reducing the number of incidents where self-harm progresses to suicide attempts or completion. Bristol health partners identify patients17 who self-harm as being 35 times more likely to end their own lives.

Mental health awareness is fundamental to ensuring that people are given information that helps them recognise the risk of suicide and self-harm in themselves and in others. For every suicide, there are at least ten times more people attempting suicide or self-harming with intent to kill themselves.

Researchers at Bristol University18 have found that predictors of suicide in 16 – 21 year olds include non-suicidal self-harm, Of those at 16 who reported non-suicidal self-harm cannabis and drug use, sleep problems and a less extroverted personality type were the best predictors. The findings of this study suggest that clinicians may be assisted in identifying young people who are most at risk of attempting suicide in the future and informing risk assessments by opening up conversations around substance use, non-suicidal self-harm, sleep, personality traits and exposure to self-harm.

Risk assessment tools or checklists in isolation are considered by clinicians to be limited in their use in predicting suicide19. Rather staff should be comfortable in asking patients about suicidal thoughts and an emphasis should be put on building relationships; and gathering good quality information in the following areas to inform a collaborative approach to risk management;

- Current situation,
- Past history,
- Social factors.

Communities and front-line staff across all organisations shall be aware of self-harm and the link with suicide. Encouraging active listening and communication will increase supportive responses to people. This should include information and support for parents or carers of those who are self-harming.

The NICE guidance on preventing suicide in community and custodial settings states that "suicide and self-harm are major public health problems, with someone who self-harms being at increased risk of suicide" reports the Chief Medical Officer. "Approximately three-quarters of people who die by suicide have not had recent contact with mental health services at the time of their death. However, many may have seen their GP in the year before they died and others may have been seen in A&E or another setting."

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17 Bristol Health Partner, More about the Improving Care in Self-Harm HIT (webpage) http://www.bristolhealthpartners.org.uk/health-integration-teams/improving-care-in-self-harm-hit/more-about-stitch

18 Bristol provides first long-term look at predictors of suicide attempts (online article, March 2019) http://www.bristol.ac.uk/news/2019/march/first-look-at-predictors-of-suicide.html

19 The assessment of clinical risk in mental health services: National Confidential Inquiry into Suicide and Safety in Mental Health http://documents.manchester.ac.uk/display.aspx?DocID=38466

Research by Carrol, R et al20 highlights that there is a significant increase in likelihood of completed suicide where a person has presented at hospital as a result of self-harm, with those who have presented more than once having double the risk. They suggest that hospital admission and discharge in these cases provide an opportunity for suicide prevention.

What are the issues?

- There is no consistently used way of recording self-harm among patients seen by GPs or other health professionals. This impedes identifying and responding to need.
- Pathways and referral options for people who self-harm are limited, so that people may not be enabled to manage risk of escalating needs leading to suicide. However, some people use self-harm to manage their feelings, which can reduce the risk of suicide.
- There is an association between self-harm and diagnoses of personality disorders. Such diagnoses can attract stigma and may not lead to specific or effective treatment.
- There is a need to understand and document the motivation and feelings of people when self-harming and to encourage people to seek support.

What can we do?

Establish agreed ways of recording on the primary care system EMIS, self-harm in patients seen by GPs, including for children. Review recording of self-harm by schools.

Develop a joint local approach in Herefordshire to personality disorders to help improve support for people.

Ensure that adults and young people who self-harm and are in contact with health or social care services have a personal safety or crisis care plan. Encourage individuals and groups to develop innovative ideas for tackling suicide in their communities, including through the Talk Community seed fund.

Promote and encourage formation of a local self-help and mutual support/interest groups for people who self-harm, alongside social media channels. Tackling suicide in their communities, including through the Talk Community seed fund.

Ensure comprehensive information and signposting to national and regional sources of support relating to self-harm.

Partners to explore the pathways and decision making around support for children, young people and adults who self-harm.

20 Hospital Presenting Self-Harm and Risk of Fatal and Non-Fatal Repetition: Systematic Review and Meta-Analysis (Robert Carroll, Chris Metcalfe, David Gunnell)

Local profile and analysis

Facts and figures are a central and complex issue in understanding suicide and seeking to prevent it. There are different sets of data recording different things and reported through different routes. The generally very small numbers for a population such as Herefordshire's and limit the meaning that can be drawn from them and the way they are analysed. The following pages summarise key information locally and nationally. Wider facts and figures about Herefordshire's population, needs and trends can be found on the Understanding Herefordshire website21.

Supporting research, data collection and monitoring

National, regional and county level data is collected and published by the ONS and Public Health England. Partner agencies also have access to the Primary Care Mortality Database (PCMD) to view data on registered deaths. All this data on suicide relates to people who are registered with a Herefordshire GP, although their death may have occurred outside Herefordshire. Deaths recorded by the coroner relate to people who have died in Herefordshire, regardless of whether they are normally resident in the county or not. The two sources of data are therefore not directly compatible.

Factors known to be associated with increased risk of suicide nationally are:

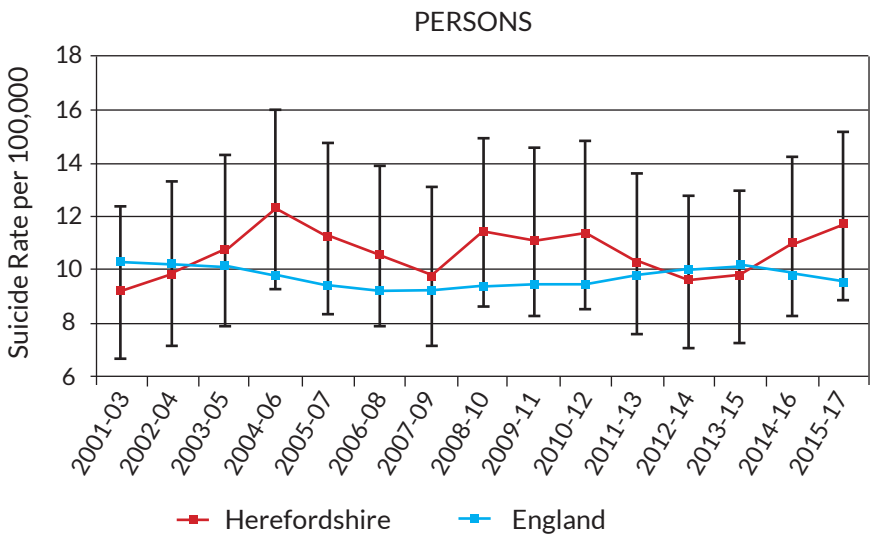
- Drug and alcohol misuse
- History of trauma or abuse
- Unemployment
- Social isolation
- Poverty and debt
- Imprisonment
- Violence
- Family breakdown
- Bereavement
- Parent who has died by suicide
- Previous suicide attempts and self-harming behaviours
- Veterans

21 Understanding Herefordshire – Mental Health https://understanding.herefordshire.gov.uk/health/mental-health/

Local summary

- Between 2001 and 2016, the highest suicide rate was evident in the most deprived quartile of the county where the figure of 12.0 per 100,000 was 40 per cent higher than the lowest rate that was recorded in the least deprived quintile.
- Since 2000, seasonally, the highest number of suicides in Herefordshire were recorded in the spring, while the lowest were recorded across the winter.
- In 2012-14 the Herefordshire directly standardised years lost to life (YLL) rate was 29.0 years per 10,000 population, which was lower than the figures for England and the West Midlands. The male YLL rate for Herefordshire (41.4 years per 10,000) was higher than the female figure (16.8 years per 10,000.
- The Herefordshire suicide rate varies between 9.2 and 12.3 per 100,000 (2001-03 and 2004-6 respectively), the variation over this period is not considered statistically significant. Throughout this period, the Herefordshire rate has not been statistically different from the national rate as the confidence intervals associated with the local figure encompass the corresponding national rate.

FIGURE 1 – Suicide rate 3 year average person's 2001-03 to 2015-17

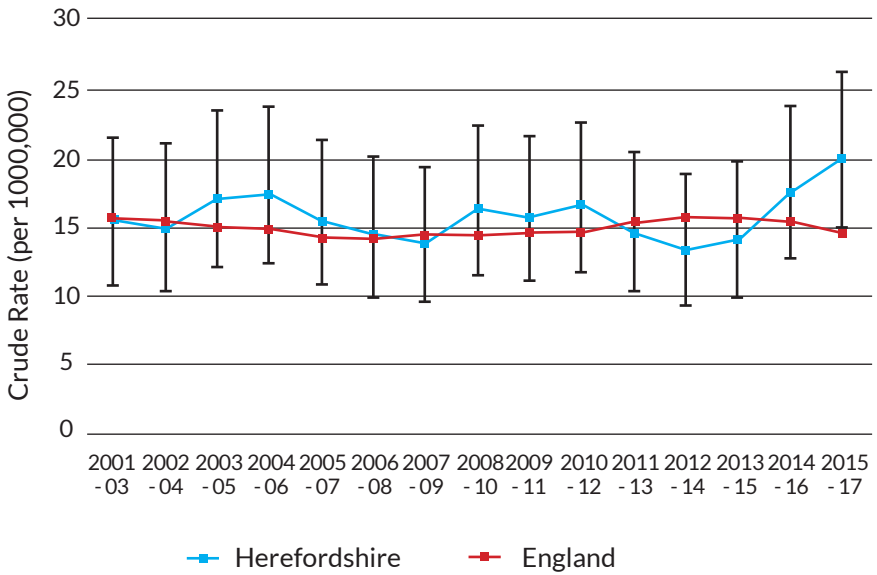


The statistically low numbers of suicides in Herefordshire mean that any differences in annual figures can have a proportionally large influence on associated statistics. Consequently, it is recommended that data should be considered in the wider context and information should be viewed over a greater length of time to better interpret what is going on. When considering whether data is statistically significant or not, the confidence intervals must be considered.

For instance, while considerable variation was evident in the male suicide rate for Herefordshire for the period between 2001-2003 and 2015-2017, with the highest observed in 2015-2017, the confidence intervals for the local rate consistently encompassed the corresponding national figure (Figure 2). Consequently, it is can be stated that throughout this period no statistical significant difference was evident between the Herefordshire and national rates.

The local male suicide rate was more than five times higher than the female rate, with 50 male deaths between 2015-2017,compared with nine female deaths.

FIGURE 2 – Male suicide rate



For the period 2015 to 2017 the Herefordshire suicide rates for males and the population as a whole, while being higher than the corresponding rates for England, are not significantly different. For females, the local rate is lower than that reported nationally, but again the difference is not statistically significant.

Over the eight year period between 2010 and 2017 the numbers of suicides in Herefordshire ranged between 12 (in 2017) and 23 (in 2016). These local figures represent between 1.06 and 0.58 per cent of all deaths with an average of 0.87 per cent over the eight year period; across, slightly below national rates. When broken down by gender the proportions of deaths in Herefordshire represented by suicide for females are generally lower than those reported nationally throughout this eight year period, although the differences cannot be considered as being significant. In this period there have been no deaths of those aged 17 or under that have been recoded using either the intentional self-harm or injury/poisoning of undetermined intent ICD10 codes. However, deaths may have been recorded differently in other recording criteria such as coroner conclusions.

FIGURE 4 – Number of deaths by suicide by year, 2010 – 2017

Year	Number of deaths	Difference from 2012	% change from 2012
2010	20		
2011	14		
2012	18		
2013	18		0%
2014	17	1	-5.50%
2015	15	3	-16.50%
2016	23	5	28%
2017	12	6	-33.50%

The influence of small numbers on the variability of the rate also has implications for ranking areas according to rates. For instance, data from PHE Fingertips indicates in 2015/17 the Herefordshire male suicide rate was ranked as the 15th highest out of 152 Unitary Authorities and County Councils, while the ranks for 2014/16 and 2013/15, were 39th and 113th respectively. It should be noted that there were no statistical difference between the corresponding suicides or between the Herefordshire and national rates in these periods.

Future numbers of deaths by suicide recorded may be affected by the ruling in May 2019, that the civil standard of proof should be adopted by coroners in considering a suicide verdict. This means that suicide only needs to be "more probable than not" and therefore, suicide verdicts may become more common.

The evidence base for Herefordshire's Joint Strategic Needs Assessment (JSNA) is captured on the Understanding Herefordshire website. The Mental Health section contains information on the local analysis of suicide data. It is recognised that this could be further developed by coordinating information across organisations about suicidal behaviours, rather than suicide incidents.

Public Health England22 recognise the limitations of the information that can be gained about a local area through analysis of national data sources. They identify the following methods as options to collate local data and intelligence;

1. Undertaking a suicide audit to gather data from coroners' reports about individual suicides.
2. Examining demographic, social and service data held by partners across primary care, health services, social care and other partnersto help to understand the prevalence of risk factors and other related issues. This includes intelligence from any relevant NHS trust patient safety Serious Untoward Incident reviews and/or other patient safety incident reviews.
3. Working with partners to introduce real-time suicide surveillance.

22 Local suicide prevention planning: A practice resource by Public Health England https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585411/PHE_local_suicide_prevention_planning_practice_resource.pdf

Benefits of obtaining this local level data and intelligence include being able to identify high risks groups, local trends, demography and therefore opportunity to better understand and focus efforts in preventing suicides in Herefordshire.

Examples of developed Real Time Surveillance and Suicide Audits can be found in Cornwall and Cheshire and Merseyside.

How can we improve the use of data, research and effectively monitor progress?

- Develop a regular updated profile on suicides in the county.
- Monitor high risk groups, and emerging new high risk groups to inform activities to prevent suicides.
- Learn from areas with developed Real Time Surveillance and build a relationship with the coroner to establish local processes.
- Establish annual suicide audits, connecting to the bi-annual audit of substance misuse deaths where relevant.

Appendix A – Summary of what we can do

Each key area captures 'what can we do' to address that area. With guidance from the Mental Health Partnership Board key partners will use this section of the strategy to inform the development of an action plan. What can be done is summarised below;

Communities

- Develop new ways of talking about suicide to encourage the seeking and giving of help in communities, including social settings, public signage, open letters, coded language and anonymous help.
- Promote awareness of suicide among community groups, including mental health first aid and suicide specific training. Encourage local people with personal experience of suicide to share it appropriately in their communities. Actively promote focus on suicide amongst communities of interest.
- Promote information about good practice in mental wellbeing and suicide prevention, including through Talk Community hubs, linking to volunteers trained in MECC and mental health first aid. Encourage individuals and groups to develop innovative ideas for tackling suicide in their communities, including through the Talk Community seed fund.
- Continue to support informal community groups and social enterprises to grow and provide support to local people. This will include a specific focus on support for mental wellbeing and for young people and men.

Media

- Offer suicide prevention awareness training to local media.
- Ensure that WISH and other signposting routes clearly direct people to websites and social media that provide support and protection to people at risk of suicide.
- Invite local media to participate in this strategy and its key messages and adopt an approach to suicide prevention within the One Herefordshire partnership.
- Promotion of World Mental Health Day; Mental Health Awareness Week; and Suicide Prevention Day.
- Develop case studies on people's experience to share suicide prevention messages with the press, linked to local or national events.

Bereavement information and support

- Ensure that WISH has accurate information on sources of support and information, including local and national organisations.
- Offer support from the Samaritans to visit schools and colleges in the event of a child/ young person's suicide.
- Raise awareness of the work by bereavement organisations, community and faith based organisations that offer support to those bereaved or affected by suicide.
- Review options for immediate bereavement and signposting and support through criminal justice agencies, linked to potential for real time data and learning.
- Promote the establishment of a local peer led support group of people who have been bereaved through suicide.

Reducing means of access to suicide

- Access to the railway line across Hereford Hospital car park helipad area will be secured to reduce risk at that location.
- Promote an awareness of suicidal risk among property and housing developers, council services and other agencies to aid the designing out risk from new structures and buildings.
- Raise awareness with local people, organisations and community leaders of Zero Suicide Alliance training and seek resources to extend its provision.
- Establish a suicide audit and real time learning process to inform risk management and development of services and responses across the health, care and criminal justice systems.

Reducing the risk of suicide in high risk groups

- Support criminal justice agencies and 2gether NHS Trust to review how mental health needs are identified and supported for people going through custody and the courts.
- Through Talk Community hubs and wider Talk Community initiatives to provide training and resources to enable volunteers, professionals and employers to be confident in talking about and supporting people who are considering suicide.
- Promote a focus on managing isolation and loneliness of vulnerable people in rural and farming communities, through the Talk Community plan, hubs and integration of community health
- Herefordshire CCG, Wye Valley NHS Trust, 2gether Foundation and Taurus Healthcare to review clinical recording and responding to people presenting with high risk of suicide, focusing on primary care and accident and emergency.

Mental health services

- Promote the use of the five steps to wellbeing and Zero Suicide Alliance training.
- Work with schools, colleges, community, voluntary and faith organisations, including those working with young people, families and veterans, to promote opportunities to support people with mental wellbeing.
- Develop employer-based approaches to improve wellbeing in the workplace, targeting the agricultural and building trades.
- Ensure that people vulnerable to suicide are provided with a copy of the 'Letter of Hope' on discharge from hospital or on release from prison or custody.
- Recognise and review the work by 2gether NHS Foundation in seeking to achieve zero suicide in mental health hospital and review evidence and options around reducing suicide on discharge from hospital.

Self-harm

- Establish agreed ways of recording on the primary care system EMIS, self-harm in patients seen by GPs, including for children. Review recording of self-harm by schools
- Develop a joint local approach in Herefordshire to personality disorders to help improve support for people.
- Ensure that adults and young people who self-harm and are in contact with health or social care services have a personal safety or crisis care plan.
- Encourage individuals and groups to develop innovative ideas for tackling suicide in their communities, including through the Talk Community seed fund.
- Consider supporting the setup of local self-help and mutual support/interest group for people who self-harm, alongside social media channels. Tackling suicide in their communities, including through the Talk Community seed fund.
- Ensure comprehensive information and signposting to national and regional sources of support relating to self-harm.

Improving the use of data, research and effectively monitor progress

- Develop a regular updated profile on suicides in the county.
- Monitor high risk groups, and emerging new high risk groups to inform activities to prevent suicides.
- Learn from areas with developed Real Time Surveillance and build a relationship with the coroner to establish local processes.
- Establish annual suicide audits, connecting to the bi-annual audit of substance misuse deaths where relevant.

Appendix B - Research resource list

1. **Bristol Health Partner, More about the Improving Care in Self-Harm HIT** (webpage) http://www.bristolhealthpartners.org.uk/health-integration-teams/improving-care-in-self-harm-hit/more-about-stitch

2. **Bristol provides first long-term look at predictors of suicide attempts** (online article, March 2019) http://www.bristol.ac.uk/news/2019/march/first-look-at-predictors-of-suicide.html

3. **Exposure to, and searching for, information about suicide and self-harm on the Internet: Prevalence and predictors in a population based cohort of young adults** https://www.sciencedirect.com/science/article/pii/S0165032715003729?via%3Dihub

4. **Hospital Presenting Self-Harm and Risk of Fatal and Non-Fatal Repetition: Systematic Review and Meta-Analysis (Robert Carroll, Chris Metcalfe, David Gunnell)** https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0089944&type=printable

5. **House of Commons Health Committee, Suicide prevention, Sixth Report of Session 2016-17** https://publications.parliament.uk/pa/cm201617/cmselect/cmhealth/1087/1087.pdf

6. **Local suicide prevention planning: A practice resource by Public Health England** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585411/PHE_local_suicide_prevention_planning_practice_resource.pdf

7. **National Confidential Inquiry into Suicide and Safety in Mental Health Annual Report 2018** https://sites.manchester.ac.uk/ncish/reports/annual-report-2018-england-northern-ireland-scotland-and-wales/

8. **NHS Employers Calendar of national health and wellbeing campaigns table for 2019 to 2020** https://www.nhsemployers.org/retention-and-staff-experience/health-and-wellbeing/sustaining-the-momentum/calendar-of-national-campaigns-2018/calendar-of-national-health-and-wellbeing-campaigns-for-2019-to-2020-table

9. **Preventing suicide in community and custodial settings, NICE guideline** [NG105] (2018) https://www.nice.org.uk/guidance/NG105

10. **Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives (January 2019)** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772184/national-suicide-prevention-strategy-4th-progress-report.pdf

11. **Preventing suicide in England: A cross-government outcomes strategy to save lives (2012)** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf

12. **Preventing suicides in public places: A practice resource, by Public Health England** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/769006/Preventing_suicides_in_public_places.pdf

13. **Primary Care Mortality Database** https://digital.nhs.uk/services/primary-care-mortality-database

14. **Priorities for suicide prevention: balancing the risks and opportunities of internet use** https://www.bristol.ac.uk/policybristol/policy-briefings/suicide-prevention/

15. Probation Healthcare Commissioning Toolkit: A resource for commissioners and practitioners in health and criminal justice https://cpb-eu-w2.wpmucdn.com/blogs.lincoln.ac.uk/dist/9/8124/files/2019/03/Offender-Health-Commissioning-Toolkit-Full-Version-2h4lln7.pdf

16. Public Health England profiles https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

17. Responding to suicidal content online: Best-practice guidelines https://www.nspa.org.uk/wp-content/uploads/2016/02/NSPA-Guidelines-Responding-to-Suicidal-Content-Online-2016.pdf

18. Self-harm and suicide prevention frameworks by Health Education England and the National Collaborating Centre for Mental Health https://www.hee.nhs.uk/our-work/mental-health/self-harm-suicide-prevention-frameworks

19. Suicide by gases in England and Wales 2001–2011: Evidence of the emergence of new methods of suicide, by D. Gunnell, C. Coope, V. Fearn, C. Wells, S.-S. Chang, K. Hawton, N. Kapur https://www.sciencedirect.com/science/article/pii/S0165032714005448

20. Suicide by occupation, England: 2011 to 2015 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/suicidebyoccupation/england2011to2015

21. Suicides in the UK: 2017 registrations https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2017registrations

22. Suicide prevention: A guide for local authorities https://www.local.gov.uk/sites/default/files/documents/1.37_Suicide%20prevention%20WEB.pdf

23. Suicide Prevention National Transformation Programme https://www.rcpsych.ac.uk/improving-care/nccmh/national-suicide-prevention-programme

24. Suicide prevention: NIHR programme https://www.bristol.ac.uk/population-health-sciences/projects/suicide-prevention/research/

25. Suicide prevention: optimising medicines and reducing access to medicines as a means of suicide: Key therapeutic topic, NICE (2019) https://www.nice.org.uk/advice/ktt24/resources/suicide-prevention-optimising-medicines-and-reducing-access-to-medicines-as-a-means-of-suicide-pdf-58758013201093

26. Support after a suicide: A guide to providing local services A practice guide by Public Health England https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/590838/support_after_a_suicide.pdf

27. The assessment of clinical risk in mental health services: National Confidential Inquiry into Suicide and Safety in Mental Health http://documents.manchester.ac.uk/display.aspx?DocID=38466

28. The five year forward view for mental health https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

29. Transforming Children and Young People's Mental Health Provision: a Green Paper (December 2017) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf

30. Understanding Herefordshire – Mental Health https://understanding.herefordshire.gov.uk/health/mental-health/