B&NES, SWINDON AND WILTSHIRE PARTNERSHIP

Suicide and Self-harm Prevention Strategy

Swindon Locality 2019 – 2023 (DRAFT)

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Contents

1. Introduction 3
2. Governance arrangements 3
3. Background 4
3.1 Definitions and risk factors for suicide 4
3.2 Our vision 5
3.3 Six myths about suicide 6
4. Policy Context 7
4.1 National policy context 7
4.2 Regional policy context 7
4.3 Local policy context 7
4.4 Suicide by mental health patients 8
4.5 Suicide and Self-Harm Prevention Competencies 11
5 Suicide and Self-Harm Profile for the BSW Partnership area 12
5.1 Suicide rates per 100,000 for the latest reporting period 2015 -17 for persons (overall), Males and Females in B&NES, Swindon, Wiltshire, the South West and England. 12
5.2 Trend in suicide rates – persons 13
5.3 Trend in suicide rates - males 14
5.4 Trend in suicide rates - females 14
5.5 Self harm profiles 15
6. Suicide Profile for Swindon 18
6.1 Trends in suicide rates for Swindon 18
6.2 Demographic profile of suicides in Swindon 19
6.3 Service use profile for suicides in Swindon 23
6.4 Methods used in suicides in Swindon 24
7. Self-Harm Profile for Swindon 25
7.1 Local Hospital admission rates for self-harm 26
8. Areas for Action 28
8.1 Reducing the risk of suicide in high risk groups 28
8.2 Tailoring approaches to improve mental health in specific groups 31
8.3 Reducing access to means of suicide 35
8.4 Providing better information and support to those bereaved or affected by suicide 35
8.5 Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour 37
8.6 Supporting research, data collection and monitoring 37
8.7 Reducing rates of self-harm as a key indicator of suicide risk 37
9. Appendix 1: 39
10. References 39

DRAFT

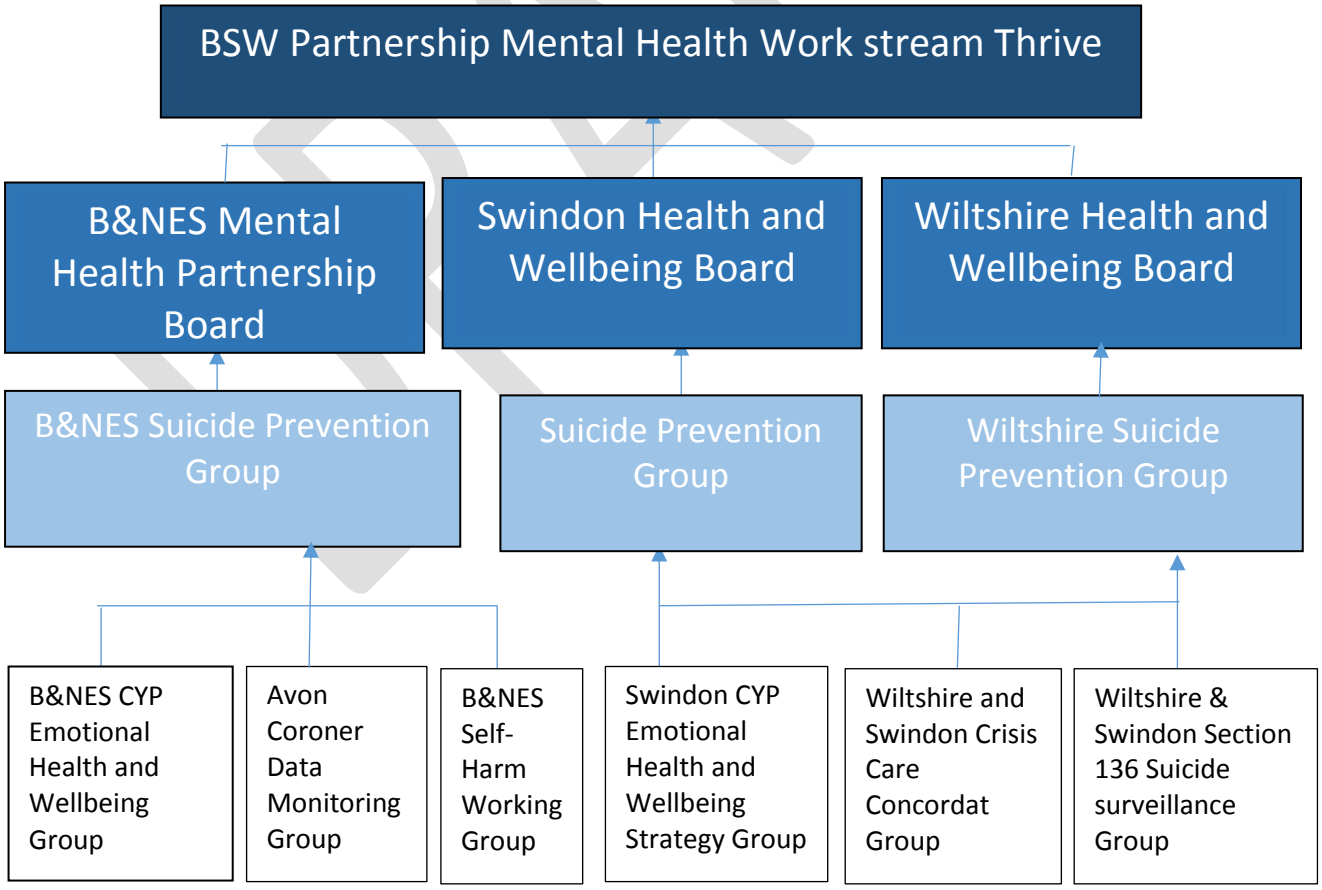
1. Introduction

This document outlines the commitment of B&NES, Swindon and Wiltshire (BSW) Partnership, formerly known as the Sustainability Transformation Partnership (STP) to work together to reduce suicide throughout the area. It acknowledges the benefits of working together to achieve this whilst maintaining a local focus garnering supporting from statutory, private, and third sector organisations, local communities and individuals. The first sections of this strategy reflect the commitments of the BSW Partnership with further local detail and commitment outlined from section 6.

2. Governance arrangements

Each local authority will maintain responsibility for their suicide prevention strategy and report to their own Health and Wellbeing or Partnership Boards. Joining strategies together at a B&NES, SWINDON AND WILTSHIRE (BSW) PARTNERSHIP level will ensure that we work together where synergies exist in a most efficient and effective way. Each local authority will localise the BSW Partnership Strategy and be responsible for their own action plans which can be brought together for reporting purposes.

Chart 1



*Swindon's suicide prevention group also includes a focus on a reduction of self-harm and implementation of the Better Mental Health Prevention Concordat.

3. Background

3.1 Definitions and risk factors for suicide

There are no standard definitions of suicide and self-harm but for use in this document the following definitions may provide clarity.

Suicidal act: Refers to all suicides and suicidal attempts

Suicide: In the UK, suicide is defined as deaths given an underlying cause of intentional self-harm or injury/ poisoning of undetermined intent

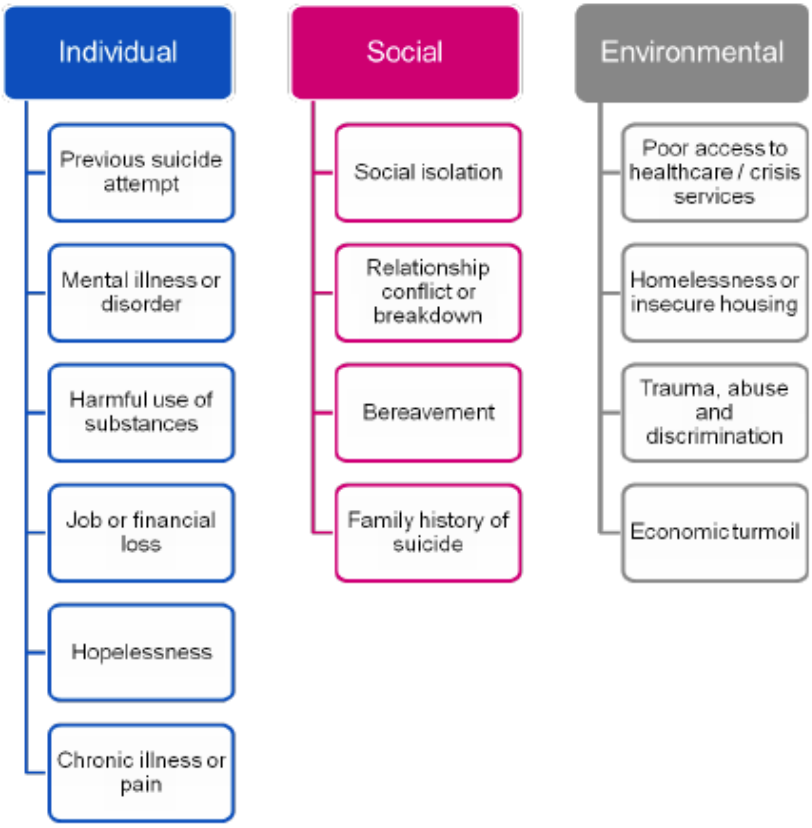
Attempted suicide: Act of self-poisoning or self-injury with suicidal intent, that is not fatal

Suicidal ideation: Recurring thoughts or preoccupation with suicide

Self-harm: Self-harm is defined as an intentional act of self-poisoning or self-injury, self-harm does not include attempted suicide. However, the PHE Fingertips data for hospital admissions for self-harm does not distinguish intent.

There is a great deal of complexity involved with an individual's decision to take their own life. However, these can be broken down into three domains highlighting key risk factors.

Chart 2. Key suicide risk factors, adapted from World Health Organisation, Preventing Suicide: A global imperative[i]



3.2 Our vision

The premise for this document is that at a population level suicide and self-harm is preventable. At a BSW PARTNERSHIP level and local level we are committed to reducing the rate of suicide throughout B&NES, Swindon and Wiltshire.

Every suicide is a tragic event and has devastating impacts on families, friends and communities.

All partners within the BSW Partnership suicide prevention network are committed to:

- *Reducing suicide, attempted suicide and self-harm.*
- *Ensuring that no one will think that suicide is their only option*
- *Tackling the stigma associated with suicide*
- *Supporting those who are affected by suicide.*

The national ambition to reduce the suicide rate by 10 per cent by 2020/21 has been set by the Independent Mental Health Taskforce in the Five Year Forward View for Mental Health[ii]. The BSW Partnership will strive to achieve this by 2020/21 and exceed this target by the end of the strategy in 2023.

Whilst the premise for this strategy is that suicide is preventable this in no way reflects on those who have lost loved ones, patients or clients to suicide. It acknowledges that individuals, be they parents, children, the wider extended family, friends or professionals, strive to keep those who feel suicidal safe on a daily basis. This strategy and accompanying action plan aims to reduce the risk, support those who experience suicidal ideation and those who support and care for them by applying the evidence to develop a strategic approach to reducing risk of suicide and self-harm throughout the BSW partnership area.

DRAFT

3.3 Six myths about suicide

There are a number of common misconceptions around suicide and suicidal ideation. It is important that the facts around suicide are widely understood to allow the appropriate support to be provided when someone is in need.

1. **MYTH:** People who talk about suicide do not intend to do it.

   FACT: People who talk about suicide may be reaching out for help or support. A significant number of people contemplating suicide are experiencing anxiety, depression and hopelessness and may feel that there is no other option.

2. **MYTH:** Most suicides happen suddenly without warning.

   FACT: The majority of suicides have been preceded by warning signs, whether verbal or behavioural. Of course there are some suicides that occur without warning. But it is important to understand what the warning signs are and how to look out for them.

3. **MYTH:** Someone who is suicidal is determined to die.

   FACT: On the contrary, suicidal people are often ambivalent about living or dying. Someone may act impulsively by drinking pesticides, for instance, and die a few days later, even though they would have liked to live on. Access to emotional support at the right time can prevent suicide.

4. **MYTH:** Once someone is suicidal, he or she will always remain suicidal.

   FACT: Heightened suicide risk is often short-term and situation-specific. While suicidal thoughts may return, they are not permanent and an individual with previously suicidal thoughts and attempts can go on to live a long life.

5. **MYTH:** Only people with mental disorders are suicidal.

   FACT: Suicidal behaviour indicates deep unhappiness but not necessarily mental disorder. Many people living with mental disorders are not affected by suicidal behaviour, and not all people who take their own lives have a mental disorder.

6. **MYTH:** Talking about suicide is a bad idea and can be interpreted as encouragement.

   FACT: Given the widespread stigma around suicide, most people who are contemplating suicide do not know who to speak to. Rather than encouraging suicidal behaviour, talking openly can give an individual other options or the time to rethink his/her decision, thereby preventing suicide.

Source: World Health Organization, Preventing suicide: A global imperative[i]

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4. Policy Context

4.1 National policy context

England's overarching mental health strategy 'No health without mental health' references suicide rates throughout as a key indicator of mental ill-health and states that suicide prevention can only be achieved by improving mental health across the whole population[iii].

In September 2012, HM Government published a strategy for the prevention of suicide in England, focusing on six key action areas[iv]. In January 2017, the scope was extended to include self-harm[v]:

1. Reducing the risk of suicide in high risk groups
2. Tailoring approaches to improve mental health in specific groups
3. Reducing access to means of suicide
4. Providing better information and support to those bereaved or affected by suicide
5. Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Supporting research, data collection and monitoring
7. Reducing rates of self-harm as a key indicator of suicide risk

In the Five Year Forward View for Mental Health the Independent Mental Health Taskforce set a national ambition to reduce the suicide rate in England by 10 per cent by 2020/21[ii]. This and various other national policy documents such as, The National Suicide Prevention Alliance Public Health England Guidance and Support Manual for Local Suicide Prevention plans (2016)[vi] , The NHS Long Term Plan (2019)[vii], and the All Part Parliamentary Group of Suicide and Self-harm Prevention Report, outline and reference the importance of suicide prevention with the requirement to develop local multiagency suicide prevention Group and develop a suicide prevention strategy and or action plan informed by a suicide audit.

The NHS Long Term Plan (2019)[vii] states that the NHS will continue to build on the reduction in suicide rates that have been seen in recent years and "reducing suicides will remain an NHS priority over the next decade."

4.2 Regional policy context

The BSW Partnership (formerly known as the Sustainability and Transformation Partnership (STP) has agreed to adopt the principles of Thrive to improve mental health and wellbeing across the footprint. The Thrive model aims to bring together statutory providers, voluntary services, businesses and communities to raise awareness of mental health, and to prevent mental health problems establishing and persisting. Suicide prevention is a key theme within the BSW partnership Thrive mental health work stream with a commitment to reduce suicide rates across the area by 10% by 2020/21 as laid out in the Five Year Forward View for Mental Health 2016[ii] .

4.3 Local policy context

Swindon Borough Council has a long established suicide audit or prevention group and Public Health has produced a suicide prevention audit and strategy since 2004.

At the beginning of 2018 the Swindon Health and Wellbeing Board, Swindon Borough Council Cabinet and Clinical Commissioning Group Governing Body signed up to the principles of the Prevention Concordat for Better Mental Health[viii]. The purpose of the national Prevention Concordat is to provide a focus for cross-sector action to deliver a tangible increase in the adoption of public mental health approaches across local authorities, the NHS, public, private and VCSE sector

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organisations, education settings and employers. This focus fits well with the Thrive approach. It outlines the three different levels of prevention including:

- Promoting good mental health and wellbeing
- Prevention of mental health problems, suicide and self-harm
- Improving the lives of people experiencing and recovering from mental health problems

In 2018 our suicide prevention group terms of reference were reviewed and amended to include a more holistic approach including responsibility to deliver commitments outlined in the Better Mental Health Prevention Concordat. A decision was taken to focus this work on those over the age of 18. Suicide Prevention for Children and Young People is now overseen by the Children and Young People Emotional and Mental Health Strategy Group.

In addition in 2015 Swindon adopted the Mental Health Crisis Care Concordat. This has resulted in the establishment of a multi-agency Swindon and Wiltshire Crisis Care Concordat Group with a focus of preventing mental health crisis, keeping people safe, improving responses to those in crisis and contributing to the parity of esteem for mental and physical health. Actions achieved by this group have contributed to suicide prevention within Swindon.

The CAMHS Transformation Plan identifies that our local priorities to provide support to our children and young people remain focused on ensuring there is robust provision to deliver early intervention and prevention, building individual resilience and reducing escalation of serious manifestations of poor mental health in self-harm and suicide – issues which continue to have a prevalence locally amongst our younger population.

4.4 Suicide by mental health patients

This multi-agency suicide prevention strategy primarily focuses on those who are not known to mental health services. There has been considerable work that has been undertaken by mental health service providers to reduce suicide and both adult and children and young people's mental health service providers in BSW partnership have their own strategies to reduce suicide. These are over seen by the Health Care Quality Improvement Partnership, however, it is important to summarise the key findings from these strategies to ensure our strategies align.

The Health Care Quality Improvement Partnership produces the National Confidential Inquiry into Suicide and Safety in Mental Health Annual Report**.** The 2018 report[ix] found that there were 1,612 patient suicides in the UK in 2016, this figure has fallen in recent years. There were 106 suicides by in-patients in the UK in 2016, around 7% of all patient suicides, continuing a long-term downward trend. However, the fall has been slower in recent years, reflecting the pattern. The report highlighted that the highest risk period for patient suicide was in the first 2 weeks after discharge.

During 2006-2016 there were 909 suicides per year on average by patients who had a history of alcohol or drug misuse, 56% of all patients who died. Only a minority were in contact with specialist substance misuse services.

The national report outlined 10 ways to improve safety for mental health services which are outlined pictorially in the diagram below.

Chart 3

Adult Mental Health Services

Avon and Wiltshire Partnership NHS Trust provide adult mental health services throughout the BSW Partnership area. They have developed their own Suicide Prevention Strategy (2017 – 2020) to reduce the rate of suicide by mental health patients under their care. The focus of suicide prevention is now on the crisis team as this team now intervenes where previously patients would have been admitted. There is also a focus on patients who have been discharged from care, particular within two weeks of discharge where the suicide rate has not reduced to the same extent as inpatients and patients are known to be at risk. AWP have now developed a zero suicide ambition plan.

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)[x] provide data for suicide rates in respect of all NHS trusts in England. The rates for 2011-13 and 2012-14 (the most up-to-date figures) for AWP show that, in 2011-13, AWP had a suicide rate of 11.4 per 10,000 people under mental health care, compared to the median of 7.65 for the rest of England.

The AWP strategy outlines actions that will be taken to:

- Reduce the risk of suicide in high risk groups
- Tailoring approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Learn from investigations and review into unexpected deaths
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviours
- Support research, data collection and monitoring.

AWP have produced an action plan to address these 7 priorities in order to achieve their aim of reducing suicide by 10% by 2020.

Children and Young People Mental Health Services

Oxford Health NHS Foundation Trust provide Children and Young People's mental health services across the BSW Partnership footprint. They have developed a Self-Harm and Suicide Prevention Strategy 2018 -2021 for all ages. This strategy acknowledges that suicide prevention is integral to patient care and a fundamental component of clinicians' daily activity. The strategy highlights large scale improvement work such as managing transitions that will impact on suicide prevention whilst identifying key areas for development based on accepted evidence and best practice.

Oxford Health Foundation Trust suicide prevention actions include:

- Safety planning – All patients at risk of self-harm or suicide will have a safety plan in place
- 48 hour follow ups after discharge from inpatients' services – All patients will receive face to face contact from the AMHT within 48 hours of discharge
- All clinical staff will receive suicide prevention training; suicide awareness training will be available for non-mental health and non-clinical staff
- Care interventions and support – Carers managing risk of self-harm or suicide are offered supportive and educational interventions
- Supporting families/carers bereaved by suicide – Families and carers bereaved by suicide are offered appropriate support and signposting
- Staff support – Staff affected by patient suicide are offered appropriate support and signposting.

In 2017 NCISH[xi] carried out a study into suicide of children and young people in the UK and identified ten common themes:

Family factors such as mental illness	Academic pressures especially related to exams
Abuse and neglect	Social isolation and withdrawal
Bereavement and experience of suicide	Physical conditions that may have a social impact
Bullying	Alcohol and illicit drugs
Suicide related to internet use	Mental ill-health, self-harm and suicide ideas

Based on these themes NCISH developed the key messages below:

- Suicide in young people is rarely caused by one thing; it usually follows a combination of previous vulnerability and recent events
- The stresses the study identified before suicide are common in young people; most come through them without serious harm

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- Important themes for suicide prevention are support for, or management of family factors (e.g. mental illness, physical illness, or substance misuse), childhood abuse, bullying, physical health, social isolation, mental ill-health and alcohol or drug misuse.

- Specific actions are needed on groups: 1) support for young people who are bereaved especially by suicide, 2) greater priority for mental health in colleges and universities 3) housing and mental health care for looked after children 4) mental health support for Lesbian, gay, bisexual and transgender (LGBT) young people.

- Further efforts are needed to remove information on suicide methods from the internet; and to encourage online safety, especially for under 20s.

- Suicide prevention in children and young people is a role shared by front-line agencies; they need to improve access, collaboration and risk management skills. A later, more flexible transition to adult service would be more consistent with our finding of antecedents across the age range.

- Services which respond to self-harm are key to suicide prevention in children and young people, and should work with services for alcohol and drug misuse, factors that are linked to subsequent suicide.

4.5 Suicide and Self-Harm Prevention Competencies

The House of Commons Health Committee has produced a report on suicide prevention[xii]. One of its recommendations is that Health Education England's (HEE) Mental Health workforce strategy should ensure that there are enough trained staff to implement the Mental Health Taskforce recommendations in The Five Year Forward View for Mental Health.

Based on these recommendations the National Collaborating Centre for Mental Health (NCCMH) to develop a self-harm and suicide prevention competence framework.

Three competency frameworks have been developed:

- Suicide and Self Harm Prevention Competencies – Adults and Older People
- Suicide and Self Harm Prevention Competencies – Children and Young People
- Suicide and Self Harm Prevention Competencies – Community and Public Health

The first two (above) will be most relevant to health and social care professionals, some of whom will have had some training in mental health. The Community and Public Health competencies are aimed more at front line staff working with the general population – all ages. This will include professionals working with the public across all spheres of civic life, including health and social care, education, the voluntary and community sector and more, for example the teachers, police, transport workers, community workers, employers, staff and many others.

In addition there is a fourth report: Suicide and Self-Harm Prevention Competencies – What does the competencies framework mean for my care?

This report is aimed at service users and carers and outlines how the competencies framework relates to the support, care and treatment that service users and carers might expect to receive.

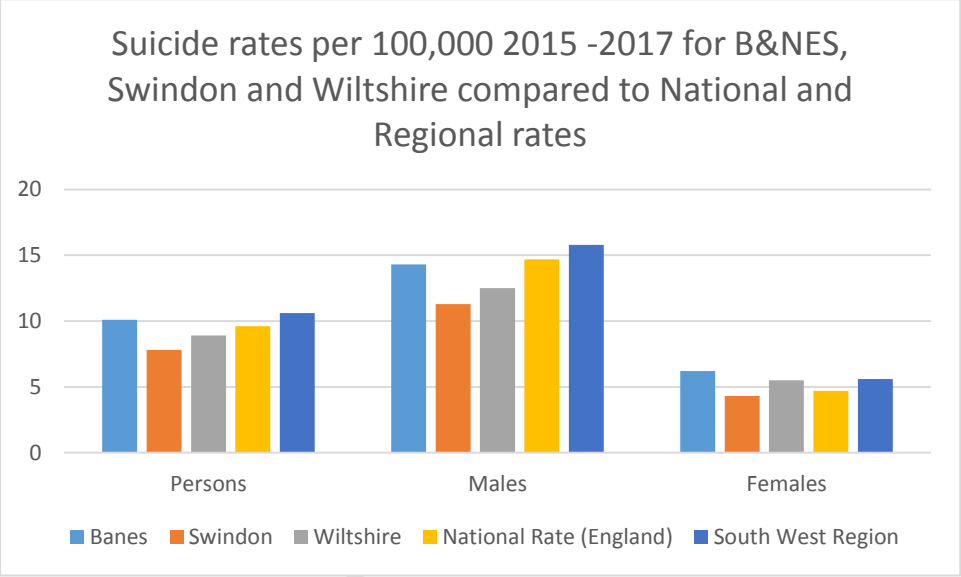
These frameworks are a useful resource for all individuals, organisations and agencies working with the general population.

5 Suicide and Self-Harm Profile for the BSW Partnership area

5.1 Suicide rates per 100,000 for the latest reporting period 2015 -17 for persons (overall), Males and Females in B&NES, Swindon, Wiltshire, the South West and England.

Local Authority	Persons	Males	Females
B&NES	10.1	14.3	6.2
Swindon	7.8	11.3	4.3
Wiltshire	8.9	12.5	5.5
National Rate (England)	9.6	14.7	4.7
South West Region	10.6	15.8	5.6

Chart 4

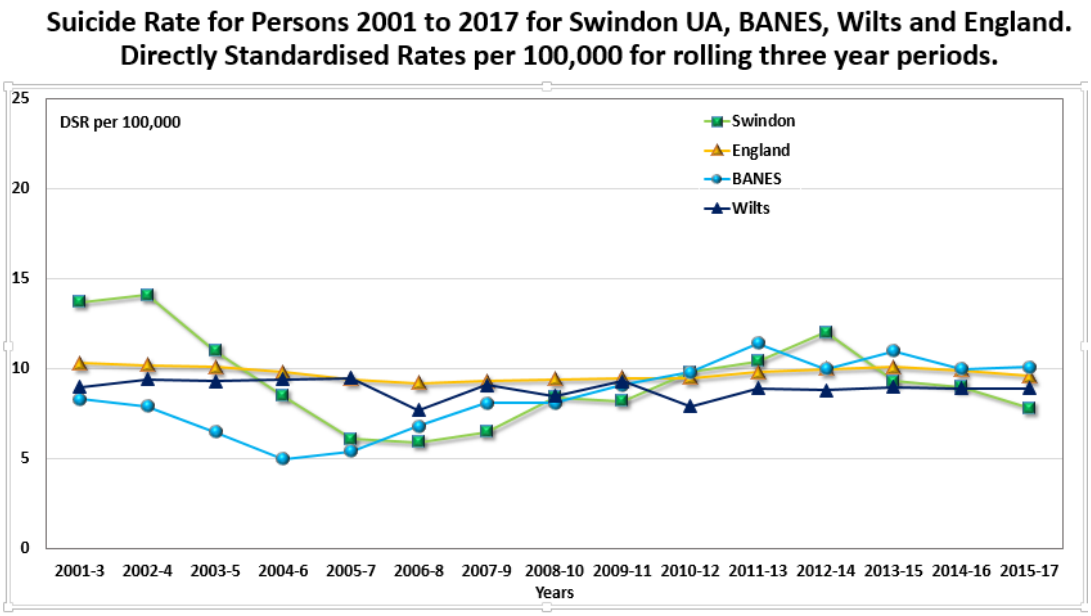


The chart above shows that for the latest reporting period 2015 -17 all three local authority areas had a lower suicide rate than the regional average for the South West. B&NES had a slightly higher overall rate than the national average although lower than the South West region. This was due to a higher rate of female suicides. In Wiltshire the overall rate was slightly lower than the national average but for females was slightly higher. In Swindon the rates were slightly below the national and regional averages overall and for males and females. None of the differences are statistically significant.

5.2 Trend in suicide rates – persons

The charts below show the suicide trend rates from 2001 - 2017 for each of the three Local Authority areas for the BSW Partnership. It can be seen that all three areas have a suicide rate generally in line with the national average. Swindon and B&NES rates have fluctuated over the period probably due to the relatively low numbers within both Authority areas. The rate in B&NES has slightly increased over the period from a very low rate back in 2004 -2006 to slightly above the national average in 2017. In Swindon the rate also rose between 2004 -2006 until 2012 -14 since when it has started to come down and is now slightly below the national average. The Wiltshire rate has been consistently just below the national rate for several years.

Chart 5



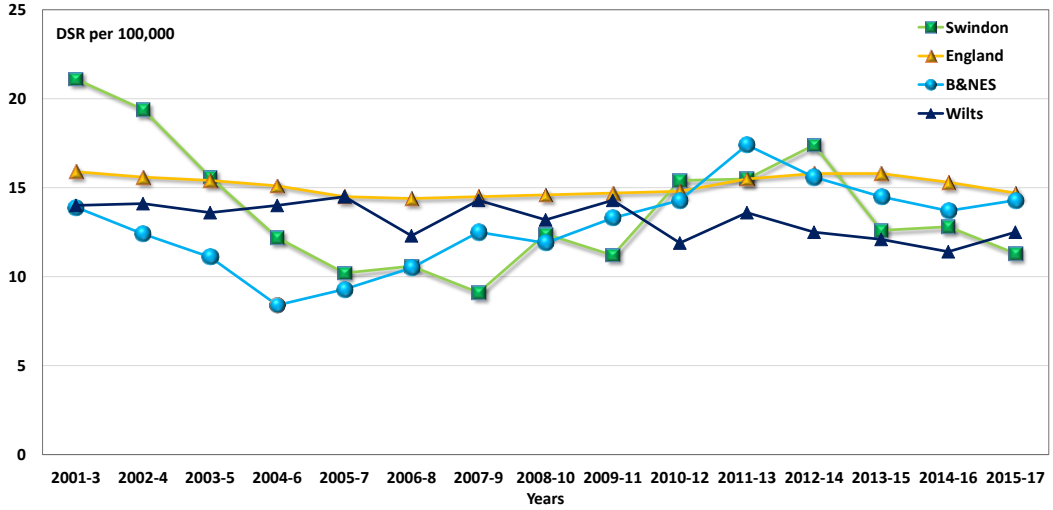
Source: PHOF/ONS

5.3 Trend in suicide rates - males

The suicide rates for males can be seen in the charts below. For all three areas the rates are slightly below the national average. The male suicide rates are very much higher than the female rates in all areas. This is in line with the national profile.

Chart 6

Male Suicide Rate 2001 to 2017 for Swindon UA, B&NES, Wilts and England. Directly Standardised Rates per 100,000 for rolling three year periods.



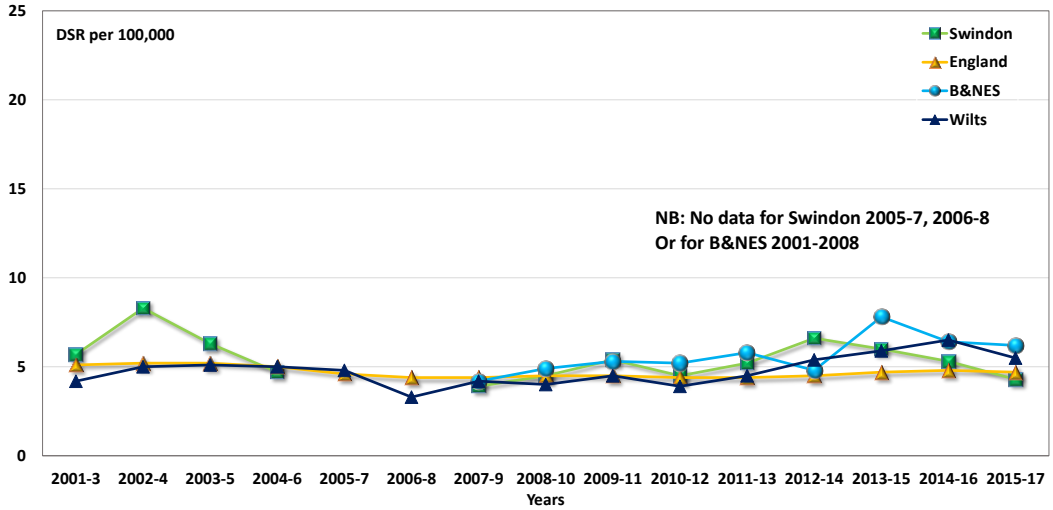
Source: PHOF/ONS

5.4 Trend in suicide rates - females

The charts below show the suicide rates for females for each of the Local Authority areas. The rates for Wiltshire and B&NES are slightly higher than the national average and for Swindon slightly below although again the figures are not statistically significantly different. All three areas saw a decrease in the last reporting period.

Chart 7

Female Suicide Rate 2001 to 2017 for Swindon UA, B&NES, Wilts and England. Directly Standardised Rates per 100,000 for rolling three year periods.



Source: PHOF/ONS

5.5 Self harm profiles

Self-harm has been described by the National Institute for Health and Care Excellence (NICE)[xiii] as "any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation. This commonly involves self-poisoning with medication or self-injury by cutting."

Self-harm often goes unreported and it is thought that hospital statistics underestimate overall rates of self-harm by about 60%. However, there are no comprehensive surveys of self-harm in the community at local level. Accident and emergency (A&E) data is of poor quality and lacks detail and therefore the most robust measure available is hospital admissions. They are used in the Public Health Outcomes Framework and other Public Health England tools to compare rates of self-harm between local authorities.

The charts below show the hospital admission rates for self-harm for each of the local authority areas against the national and regional rates per 100,000. It can be seen that the admission rates in Swindon are particularly high and although they had fallen slightly from 2014/15 in the last year they have increased again. The fall in admission rates for those between the ages of 10 – 24 years for Swindon fell at a greater rate but in the last year have increased. Admission rates for all ages for Wiltshire have slightly increased over the last couple of years and there has been a very slight increase in admissions for B&NES.

Chart 8

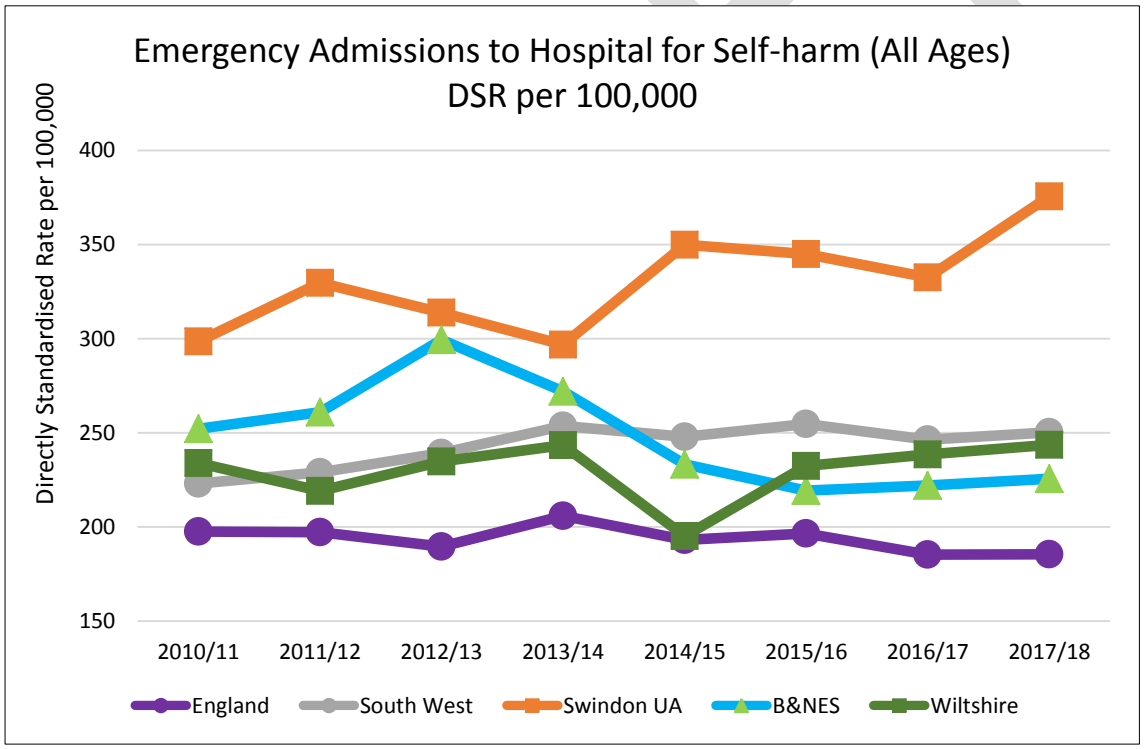
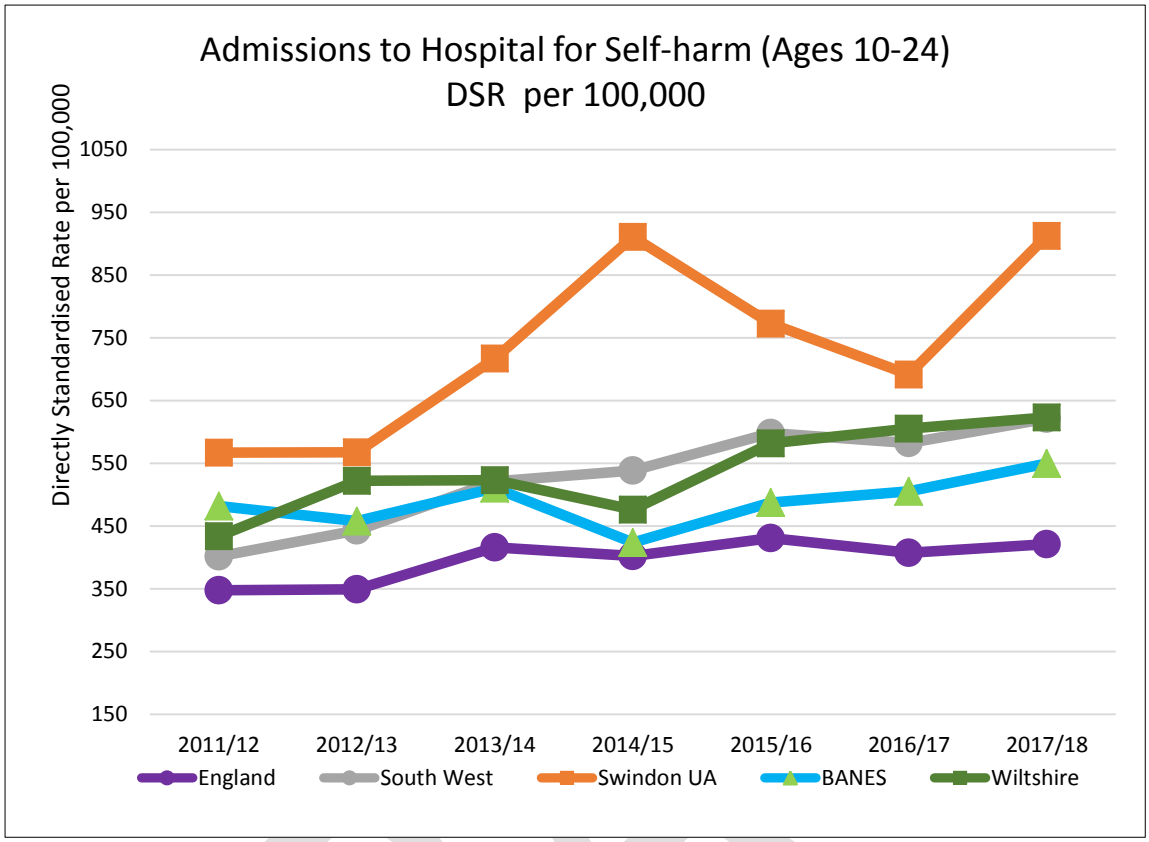


Chart 9



Research into self-harm and hospital admissions

As the rates of hospital admission for self-harm are higher than the national average across the South West Region the Directors of Public Health commissioned Public Health England South West Knowledge and Intelligence Service to carry out a piece of exploratory research into the causes. As Swindon's high rates are particularly high Swindon has been collaborating in this project.

The interim project report highlights a number of findings that are relevant to the BSW Partnership.

- Self-harm can mean many different things. Many people associate the term with cutting and in particular cutting without attempting suicide. Methods of self-harm can be divided into self-poisoning and self-injury. Studies of attendance at emergency departments show that approximately 80% of people have taken an overdose of prescribed or over the counter medication. However, general population studies have shown that for self-harm events that don't result in an admission, self-injury may be more common than self-poisoning.

- There are links between self-harm and other harms, e.g. for alcohol or substance misuse, unintentional injuries or assault, and many areas have high admission rates for more than one type of harm. There is scope for overlap, duplication and miss-recording between these and self-harm.

- Service provision that may be considered best practice may lead to higher admissions rates. For example at GWH, where previously patients who had self-harmed out of hours were invited to return to GWH for an appointment with the psychiatric liaison service are now seen on attendance. However, this has meant that they are admitted to the observation ward. Similarly close adherence to NICE guidance may also necessitate practices that result in more people, especially under 18s, being admitted awaiting psychiatric assessment.

- The England admission rates for self-harm are heavily influenced by the London region data. London has a large population (around 9 million compared to around 5.5m in the South West) and the lowest admission rates by some margin. When London is removed from the analysis of admission rates, the South West is found to be much more in-line with the remaining English regions. For females the South West has the highest admissions rates out of the regions at each age group but the gap to the England average without London is much reduced. For males, the South West is fairly typical of the English regions apart from London. Removing London from the analysis would also bring Swindon's rates closer to the (non-London) national average.

- Self-harm has increased in the South West in the last five years, especially amongst young people, young women and particularly due to overdoses.

- Self-harm is strongly linked to deprivation and studies which look at small area geographies show this more distinctly. It is also apparent that nationally the admissions gap between the most and least deprived has narrowed in recent years and that admissions may be rising fastest in some of the least deprived deciles.

The interim report detailed what is known about self-harm (in relation to admission rates) and explained what the key areas for further research are. These are being progressed by PHE and a report is expected in summer 2019. In the meantime the findings can be used locally as a 'checklist' of issues that LAs and CCGs can investigate depending on the local circumstances.

The priorities for further research include:

- Detailed analysis of A&E data including age and gender specific rates, repeat attendances and age standardised rates by LA and Trust. Followed by a comparison of A&E data with inpatient data.

- A qualitative study, led by the Care Forum, to explore patient journeys is underway in Swindon, Wiltshire, Bath and North East Somerset, Bristol, North Somerset, Somerset and South Gloucestershire. This is intended to find out more about what happens to people who come to A&E but aren't admitted and why do some people are admitted multiple times.

- Descriptive analysis of the crisis and liaison teams in each area including hours of operation and ages catered for and comparison with attendance and admittance rates.

- It is a strongly held view and one supported by some local analysis that a major problem in the South West is the number of young girls overdosing on analgesics. To explore this admission rates for young people (male and female) from intentional analgesic poisoning will be analysed.

- Conducting more detailed analysis into associated harms using age standardised rates and overlaying the rates for the individual harms over the top of the general harm indicator.

Additionally, looking at whether coding in the South West is more comprehensive (either in general or for particular types of harm).

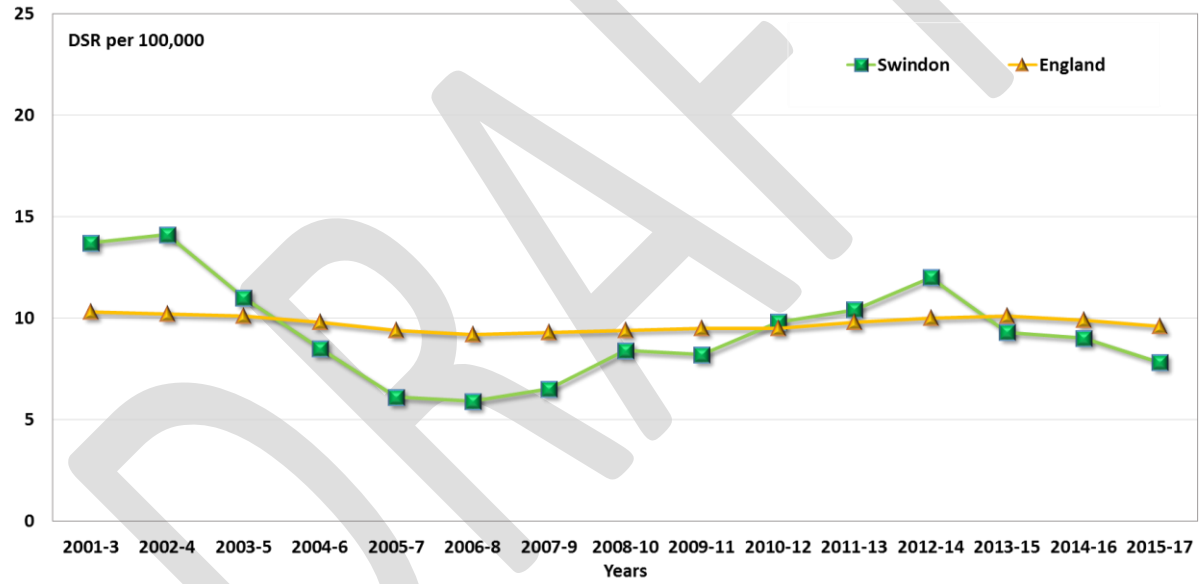
- Investigating coding practices in the South West to show whether coders in the South West are coding differently from other areas.

6. Suicide Profile for Swindon

6.1 Trends in suicide rates for Swindon

Since 2003 the suicide rates in Swindon have tended to be slightly below the national average although they rose above the national average during the period 2012 -14. Since then they have been decreasing slowly and for the latest period 2015 -17 the rate is 7.8 per 100,000. This is below the national rate of 9.6 per 100,000.

Chart 10 Suicide Rate for Persons 2001 to 2017 for Swindon UA and England. Directly Standardised Rates per 100,000 for rolling three year periods.



Source: PHOF/ONS

As can be seen in the figure below, the numbers of suicides in Swindon have fluctuated over time, probably due to the relatively low numbers rather than any particular causal factors in different years.

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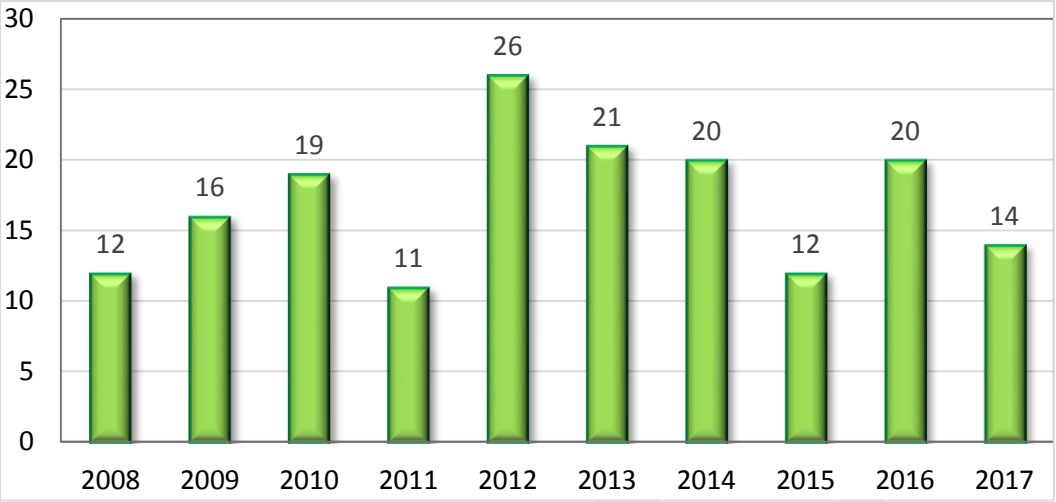
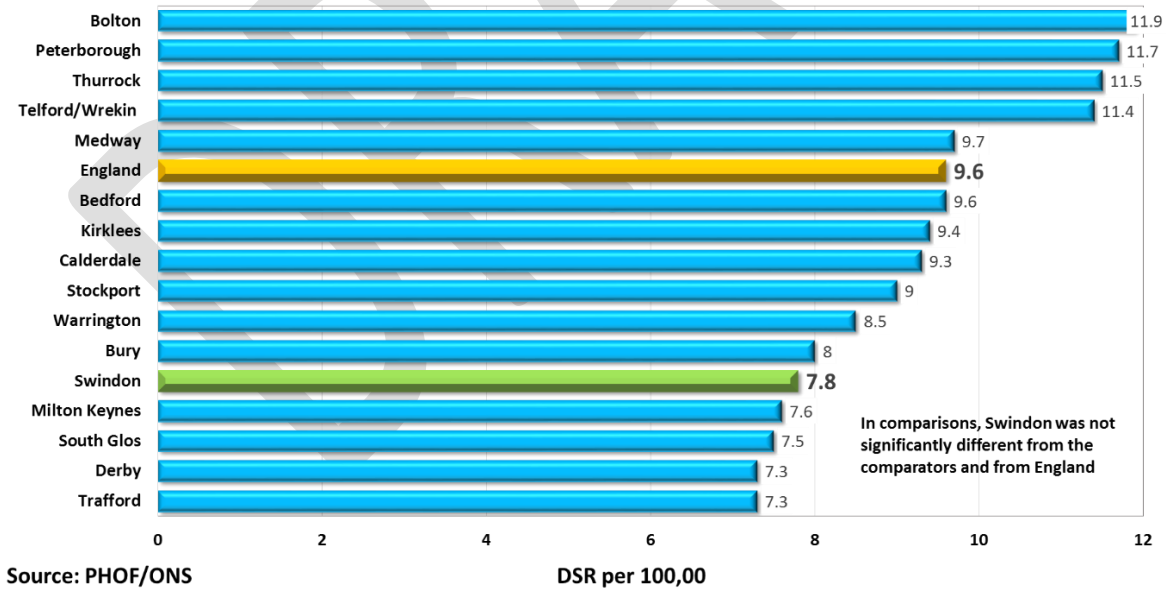
Chart 11. Number of Suicides in Persons in Swindon UA by Year 2008 to 2017.



Source: ONS

The chart below shows the Swindon suicide rate for all ages against Swindon comparator towns. This shows that the Swindon compares favourably to most of our comparators towns with the fifth lowest rate out of 16.

Chart 12. Suicide Rates for 2015-2017 for Swindon UA, Swindon's comparator towns and England. Directly Standardised Rates per 100,000.

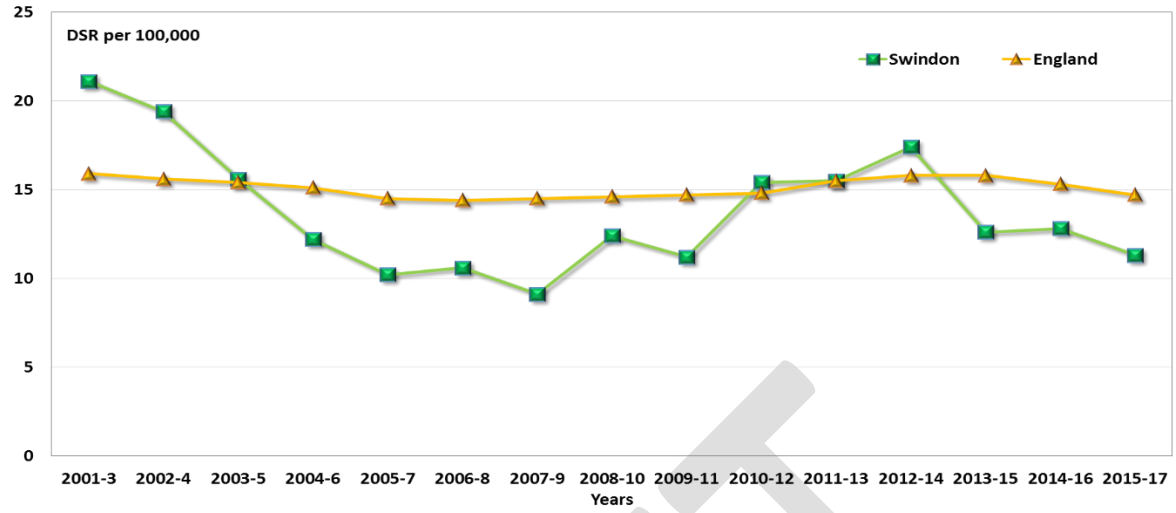


Source: PHOF/ONS

6.2 Demographic profile of suicides in Swindon

The suicide rate for males is higher than for females both nationally, regionally and locally. The graph below shows a decrease in male suicides in Swindon since 2012 -14. It is currently 11.4 deaths per 100,000 male population. This is below the national rate of 11.7, although the rates are not statistically significantly different.

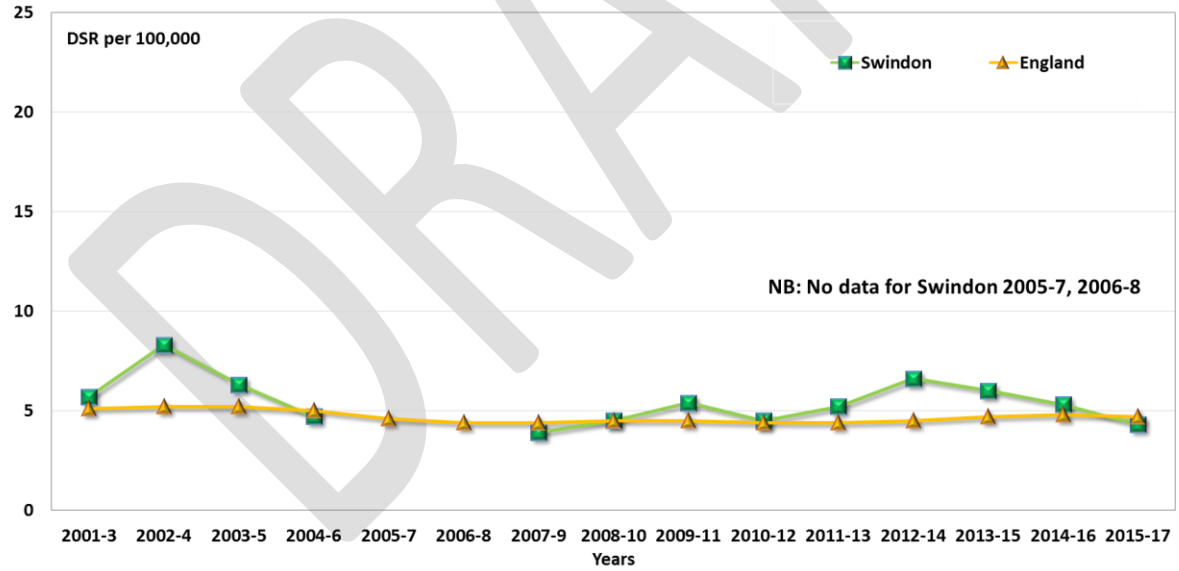
Chart 13. Male Suicide Rate 2001 to 2017 for Swindon UA and England. Directly Standardised Rates per 100,000 for rolling three year periods.



Source: PHOF/ONS

Since 2011 the suicide rate for females in Swindon has been above the national average. However, since 2012 -14 the rate has been decreasing and in 2015 -17 the rate was very slightly below the national average at 4.3 per 100,000. The national rate was 4.7 per 100,000.

Chart 14 Female Suicide Rate 2001 to 2017 for Swindon UA and England. Directly Standardised Rates per 100,000 for rolling three year periods.



Source: PHOF/ONS

The graph below shows a spike in numbers of suicides in Swindon in people in their forties, with men accounting for the majority of these suicides. Suicide is the biggest killer of men under the age of 50.

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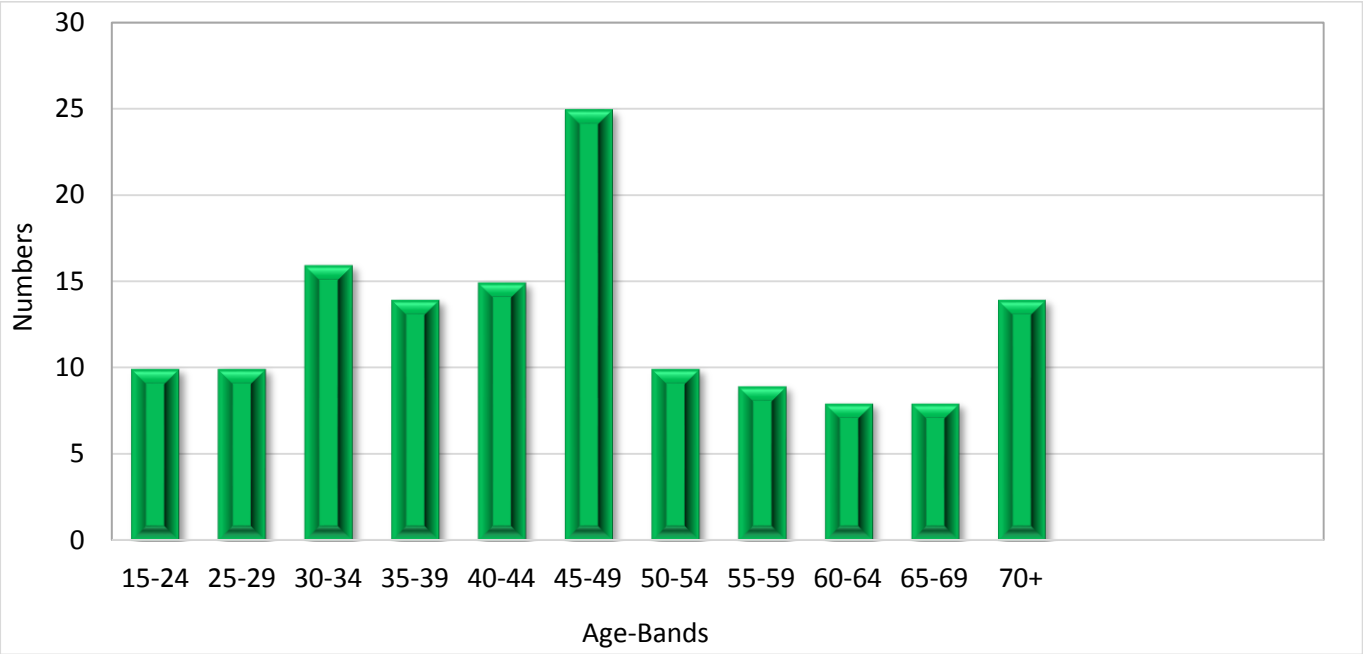
Chart 15 Suicide Deaths by Age-bands in Swindon in 2008-2017 (total = 139).



Source: Suicide Audit Database/Wiltshire Coroner

Deaths by those under 18 years of age

Deaths for those under the age of 18 are reviewed by the Child Death Overview Panel. Since 2011 there have been less than 5 confirmed deaths by suicide for those living in Swindon.

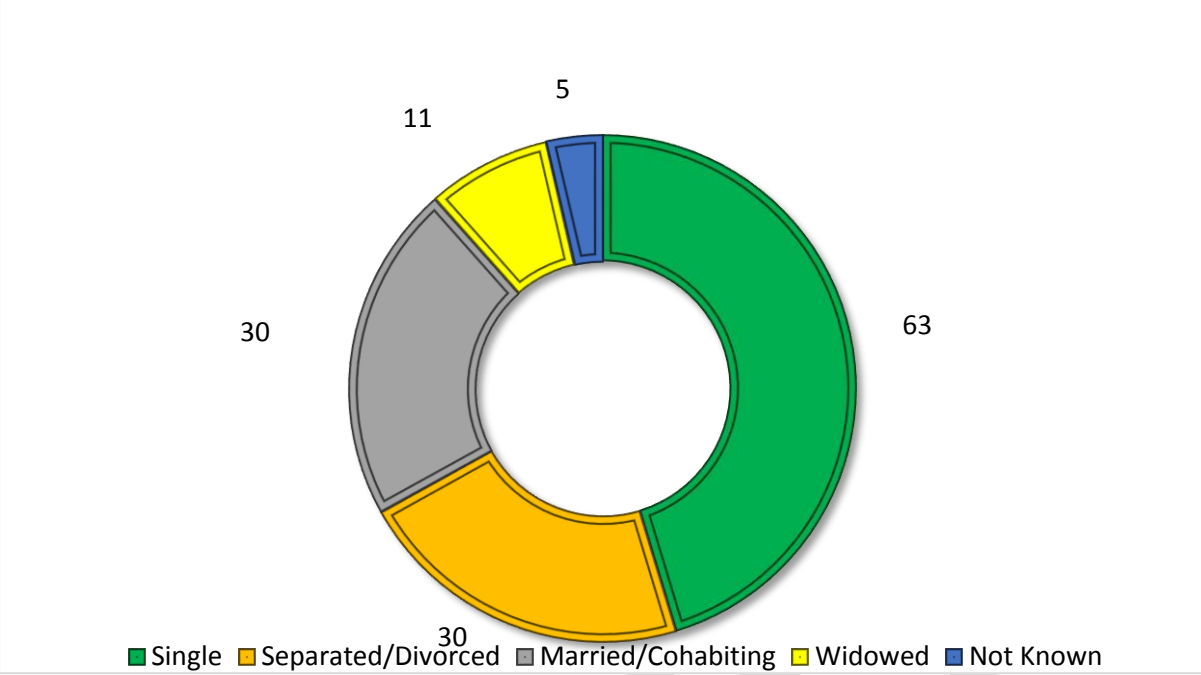
Local Suicide Data

The following data has been extracted from Swindon's local suicide audit database. The coroner informs Public Health of deaths by suicide following the inquest. Information is then provided by our local mental health services, substance misuse services, General Practices, and Great Western Hospital to gain a more detailed profile of those who have died by suicide. To avoid duplication, as deaths by those under 18 years of age are reviewed in more detail by the Child Death Overview Panel local suicide audit does not include those under 18.

Marital Status

The majority of suicide deaths (66.9%) from 2008-2017 were of people who were single or separated/divorced, as illustrated in the figure below.

Chart 16 Marital Status in Suicide Deaths in Swindon Population 2008-2017 (total = 139).

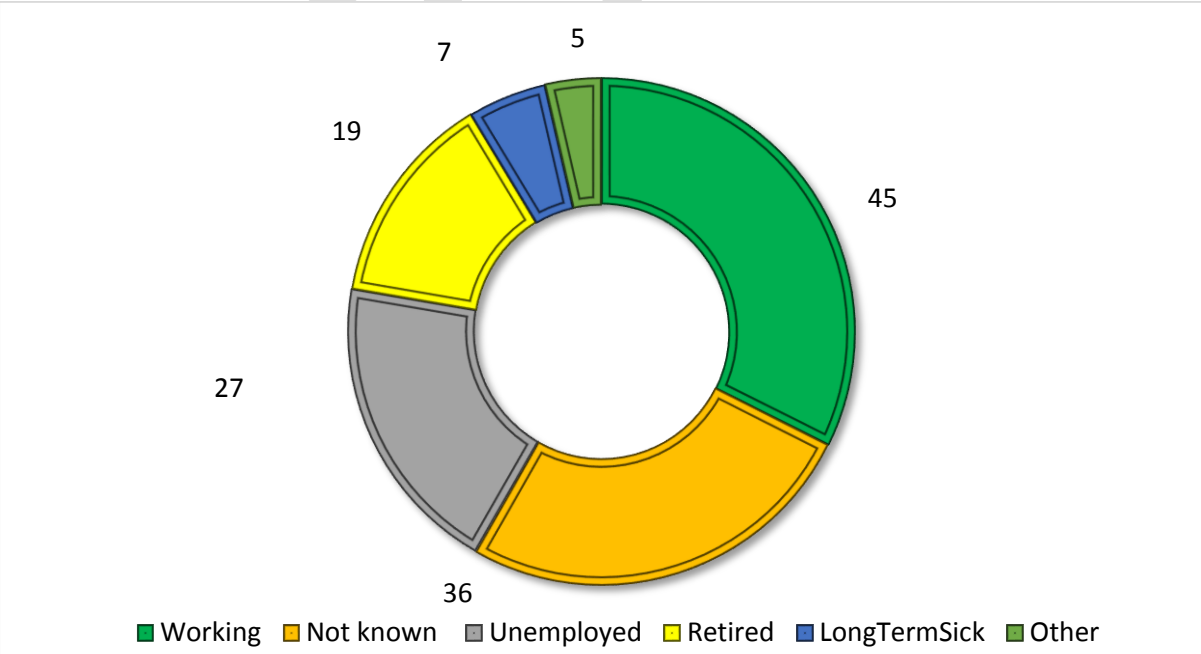


Source: Suicide Audit Database/Wiltshire Coroner

Occupational Status

There were more suicide deaths in employed (45 deaths) compared to unemployed people (27 deaths), as illustrated below. Other includes students, carers and housewives.

Chart 17 Occupational Status in Suicide Deaths in Swindon Population 2008-2017 (total = 139).



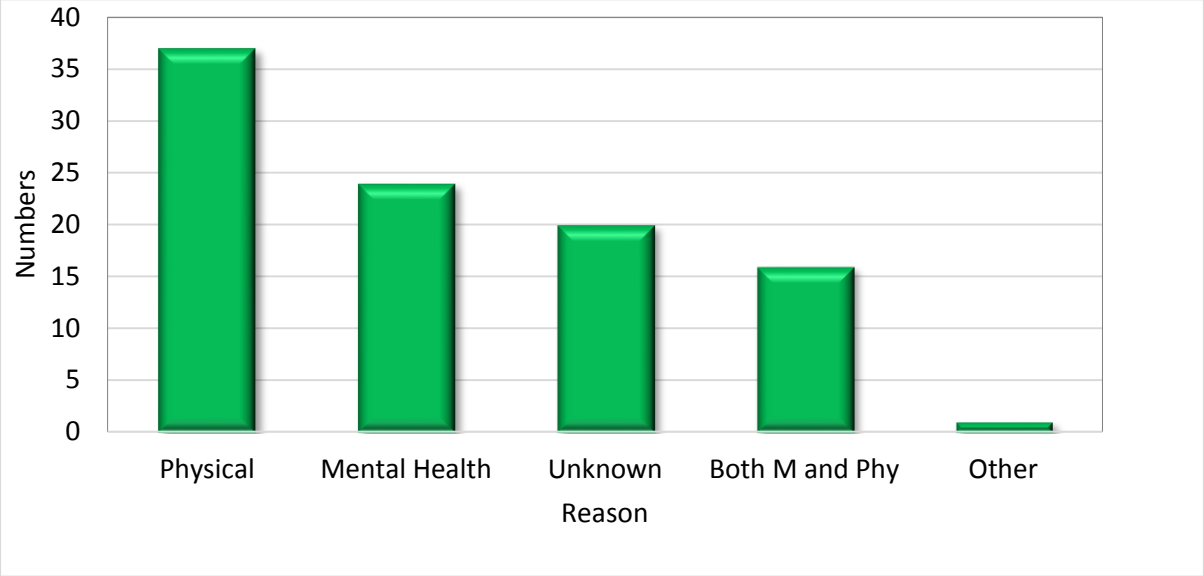
Source: Suicide Audit Database/Wiltshire Coroner

6.3 Service use profile for suicides in Swindon

Contact with GP services

The graph below shows that there were more contacts with GPs for physical health (37.8% of contacts) than mental health (24.5%) reasons by people who subsequently died by suicide in Swindon from 2008-2017. Out of 98 suicide deaths from 2008-2017 with primary care records available, a mental health assessment was on record for 55 people – there was no mental health assessment, or a blank one, on record for 43 people. Thirty of the 98 had a mental health diagnosis; 35 did not, and this was unknown for 33 people.

Chart 18 Reasons for contact with GP before Suicide Deaths in Swindon Population 2008-2017 (total = 98).

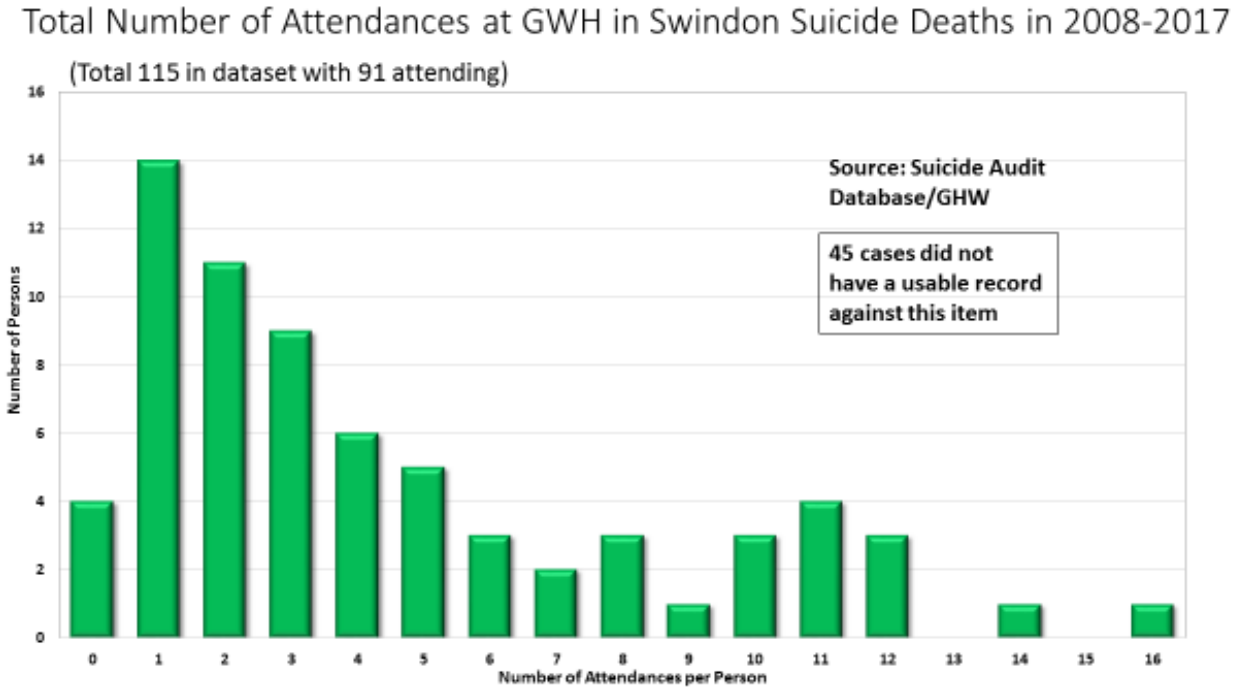


Source: Suicide Audit Database/Primary Care

Contact with Great Western Hospital

Regarding the secondary care service user profile for people who died by suicide between 2008-2017, there were 115 people in the database, of whom 91 attended GWH. Of these 91, 19 had had a psychosocial assessment recorded, 62 had not and this was not recorded for 10 people. As illustrated in the graph below, about half of the 91 people who attended GWH (45) attended 1 to 5 times, and **18 people attended 8 or more times**. However, 45 people did not have a usable record for this item. Reasons for attending were largely physical health-related, e.g. shoulder injury, sinus problem, wasp sting, swollen knee, cerebrovascular accident. With regard to self-harm, there were 11 attendances due to deliberate self-poisoning and overdose, 8 attendances due to lacerations (some recorded as deliberate), and two other attendances coded as Other Deliberate Self Harm. 53 attendances were in the year prior to the death.

Chart 19



Source: Suicide Audit Database/GWH

Contact with substance misuse services

Since 2011 data has been collected from the local substance misuse treatment provider. Of the 83 records in the database less than 5 were known to substance misuse services. The substances of misuse include heroin, crack, alcohol and cannabis. There was no recording for 10 individuals.

Contact with Probation

In 2019 we have started to collect data from probation. There is currently no data available.

6.4 Methods used in suicides in Swindon

The figure below illustrates that hanging/strangulation is the most common method of suicide in Swindon, accounting for 61.9% of deaths from 2008-2017. Self-poisoning is the next most common method, accounting for 20.1% of deaths. These findings and proportions mirror national trends in male suicides. However, in female suicides, at a national level, self-poisoning is almost as common a method (38.3% of deaths) as hanging (42.1%), according to ONS figures for 2017. There is variation within the local profile for males and females. For females, 40% died by hanging and 35% by self-poisoning compared to 64% and 15% respectively for males.

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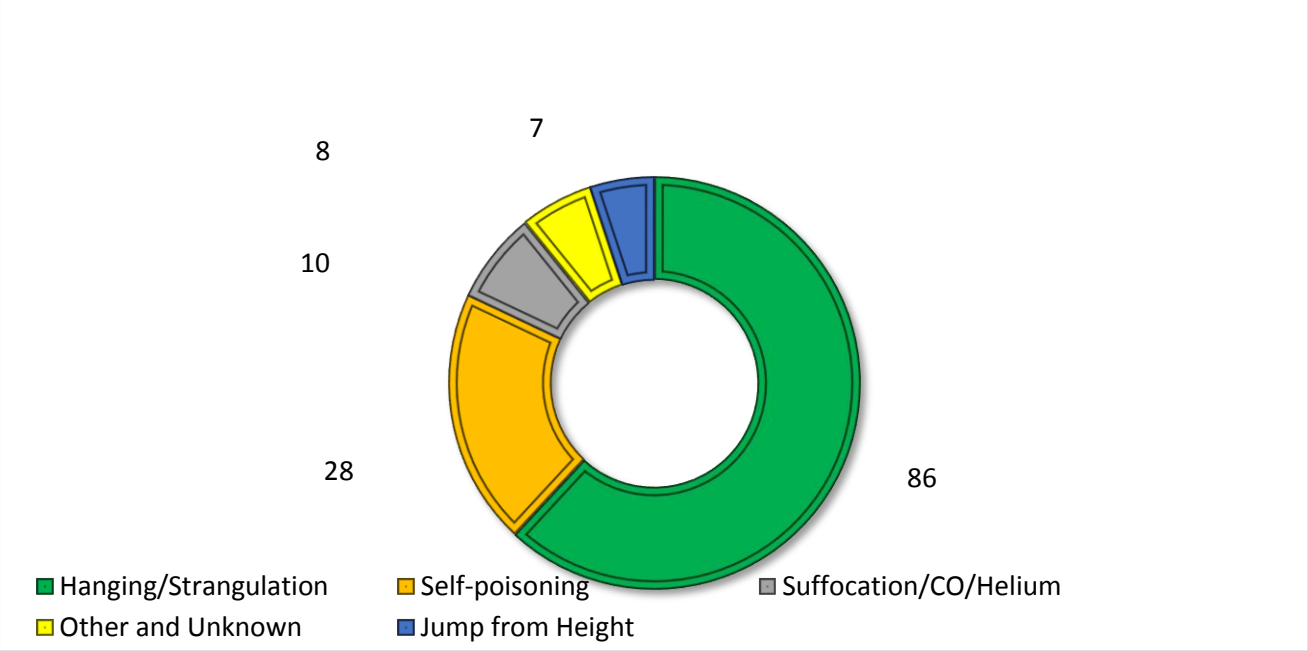
Chart 20 Methods in Suicide Deaths in Swindon Population 2008-2017 (total = 139).



Source: Suicide Audit Database/Wiltshire Coroner

7. Self-Harm Profile for Swindon

Self-harm is an expression of personal distress and there are varied reasons for a person to harm themselves irrespective of the purpose of the act. Self-harm is poorly understood in society and people who harm themselves are subject to stigma and hostility. There is a significant and persistent risk of future suicide following an episode of self-harm and the risk is higher with increasing age at initial self-harm.

In contrast to the trends in completed suicide, the incidence of self-harm has continued to rise in the UK over the past 20 years and, for young people at least, is said to be among the highest in Europe.

Self-harm is one of the top five causes of acute medical admission and those who self-harm have a 1 in 6 chance of repeat attendance at A&E within the year. Aside from the obvious danger of death, self-harm and suicide attempts can be seriously detrimental to an individual's long-term physical health, if they survive. Paracetamol poisoning is a major cause of acute liver failure. Self-cutting can result in permanent damage to tendons and nerves, not to mention scarring and other disfigurements. The NICE guidelines on self-harm note that people who have survived a medically serious suicide attempt are more likely to have poorer outcomes in terms of life expectancy.

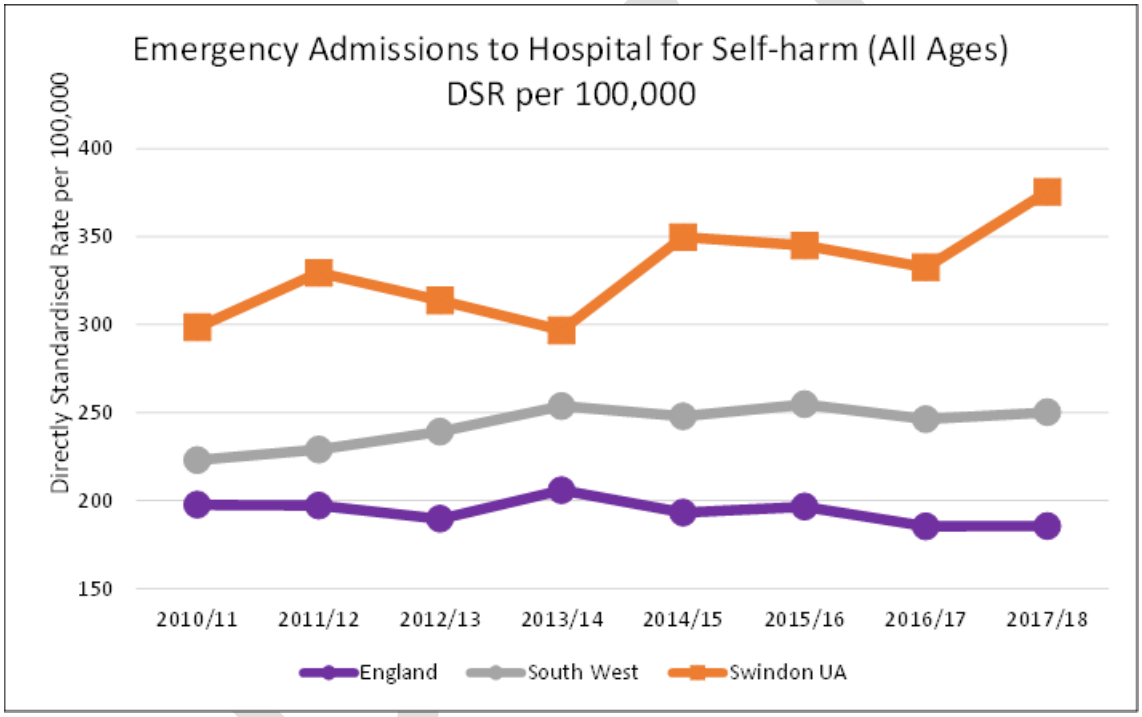
Those at greater risk of self-harm include women, young people, older people (who are more likely to do so in an attempt to end their life), people who have or are recovering from drug and alcohol problems, people in prison, people who are lesbian, gay, bisexual, transsexual or gender reassigned, socially deprived people living in urban areas and women of South-Asian ethnicity. Individual elements including personality traits, family experiences, life events, exposure to trauma, cultural beliefs, social isolation and income also heighten the risk of self-harm. Other factors such as education, housing and wider macro-socioeconomic trends such as unemployment rates may also contribute directly, or by influencing a person's susceptibility to mental health problems.

Self-harm often goes unreported and it is thought that hospital statistics underestimate overall rates of self-harm by about 60%. However, there are no comprehensive surveys of self-harm in the community at local level. Accident and emergency (A&E) data is of poor quality and lacks detail and therefore the most robust measure available is hospital admissions. They are used in the Public Health Outcomes Framework and other Public Health England tools to compare rates of self-harm between local authorities.

7.1 Local Hospital admission rates for self-harm

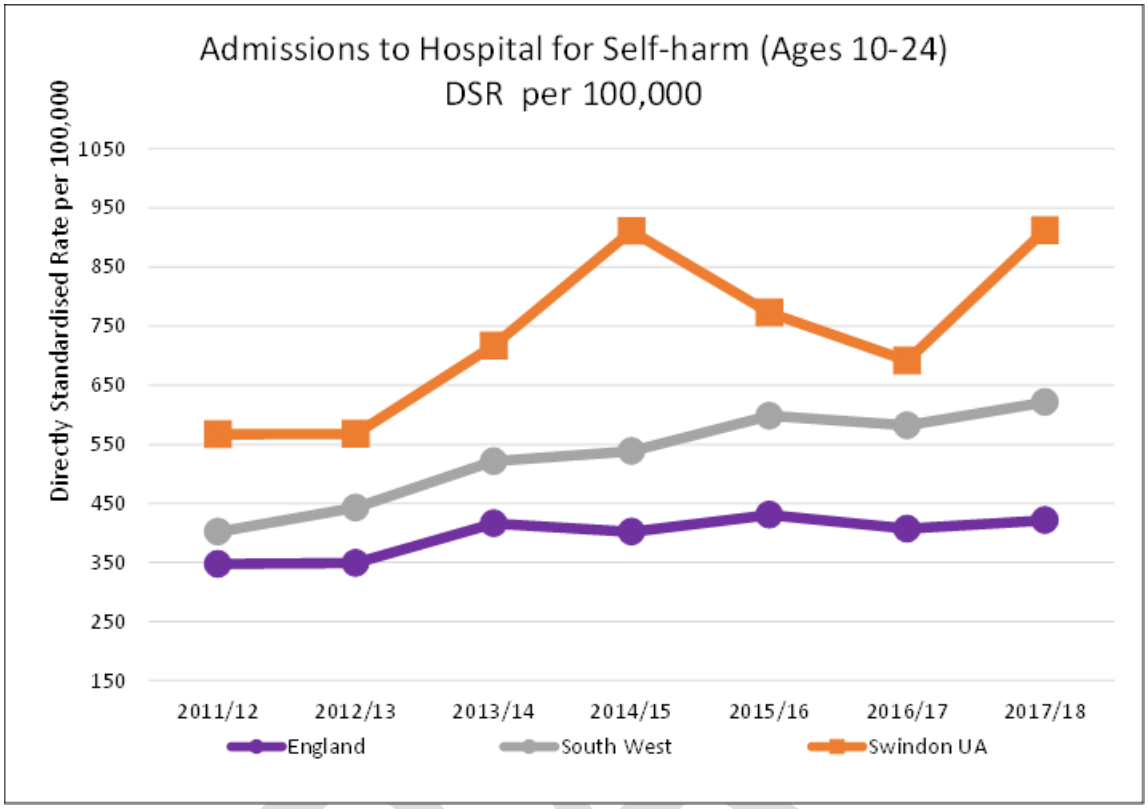
Swindon's hospital admission rates for self-harm are significantly higher than the England rates for both the all age measure and the young person's measure for 10 to 24 year olds (see below figures). The slight improvement between 2014/15 and 2016/17 has been reversed in the latest reporting period.

Chart 21 Admissions to hospital for self-harm (all ages) per 100,000



Source: Hospital Episode Statistics (HES) Copyright ©

Chart 22 Admissions to hospital for self-harm (10-24 years) per 100,000



Source: Hospital Episode Statistics (HES) Copyright ©

The distribution of excess admissions[1] was analysed in Swindon. 23% of all excess admissions were in males aged 25-44 years, 24% in females aged 10-24 years and 20% in females aged 25-44 years. Therefore, in addition to focussing on females in the 10-44 age range, and in particular the 15-19 year-olds, Swindon should also investigate males in the 25-44 age range and in particular, those aged 35-39 years, who accounted for 13% of the excess in 2016/17.

[1] The number of excess admissions is the observed number of admissions minus the expected number of admissions. The percentage of excess admissions is this excess number of admissions compared to the expected number of admissions.

8. Areas for Action

The priority areas for Swindon have been built around the recommendations in the national suicide prevention strategy. The following section will outline recommendations to address these priorities. Further detail can be found in the action plan.

8.1 Reducing the risk of suicide in high risk groups

People in care of mental health services

National data[ix] showed that from 2006-2016, nearly a third of all suicides were by mental health patients. Patients are at particular risk in the first two weeks post-discharge.

- Continue to implement the AWP Suicide Prevention Strategy (2017-2020) for adult mental health service patients, and the Oxford Health Self-Harm and Suicide Prevention Strategy (2018 -2021) for children and young people's mental health service patients.

- Following death of a patient by suicide, Swindon CCG, SBC Public Health and service providers should work more closely in partnership to review these deaths and share lessons learned.

- As recommended in the national suicide prevention strategy [v], promote the Information Sharing and Suicide Prevention Consensus Statement, published by the Department of Health in 2014, which encourages health professionals to share information about someone at risk of suicide with family members and friends.

Specific occupational groups, such as doctors, nurses, veterinary workers, agricultural workers and construction workers

Risk of suicide and self-harm is higher among those who are unemployed. However, evidence indicates that certain occupational groups including doctors, nurses, veterinary, agricultural and construction workers are also at a higher risk of suicide.

- Raise awareness of suicide risk among high risk occupational groups in Swindon, and signpost to local mental health support available.

- Continue to work with employers through the Mindful Employer Network to promote mental health in the workplace, and continue to promote and expand this network.

Young and middle aged men

Despite an encouraging reduction in suicide rates amongst men over the past four years both nationally and locally, suicide is the biggest killer of men under the age of 50. Men in Swindon are just under three times more likely to take their own life than women. The suicide rate is highest among men in mid-life (35-64 years), particularly among those in their forties, compared to other age groups. Research[xiv] has shown that men are less likely than women to seek help for mental problems and that stigma associated with such problems acts as a major barrier to seeking help.

- Raise awareness of and tackle the stigma around mental health problems among the public, particularly men, through implementing national and local campaigns in Swindon. Examples of national campaigns to raise awareness around mental health and tackle stigma include Time To Change (led by third sector organisations Mind and Rethink Mental Illness and

funded by the Department of Health, Comic Relief and the Big Lottery Fund), and campaigns targeting men specifically such as the Men's Sheds Associations and the Campaign Against Living Miserably (CALM).

- Ensure that these campaigns target settings that are typically frequented by men, such as sport settings (as recommended in the national suicide prevention policy) like football clubs and barber shops. The workplace will also be a key setting in which to raise awareness of and promote mental health, given the spike in suicides in Swindon among men in their forties, and that there are more suicides among working people in Swindon, rather than unemployed people.

People in contact with the criminal justice system, substance misuse services and homelessness services

Although there is no prison within Swindon Borough Council authority area we do have a police custody unit and support those leaving prison through the local probation service. Research[v] has shown that 9 out of 10 people in prison have a substance misuse or mental health problem and that those released from prison are vulnerable and at risk. Local findings from Threshold Homelessness Health Needs Survey found that nearly 40% of those who were homeless in Swindon had had custodial sentences and many were using drugs or alcohol or in recovery. Nationally, over half of all deaths of homeless people in 2017 were due to three factors: accidents (including drug poisoning) accounted for 40%, suicides accounted for 13% and diseases of the liver accounted for 9%[xv]

- Continue to raise awareness among staff within the police custody unit, the local probation service, substance misuse services and homelessness services of mental health problems and encourage them to be vigilant for signs of suicide risk among clients/offenders.

- Ensure the above services have mental health, suicide and substance misuse risk assessment procedures in place, and that staff refer individuals identified as being at risk to community-based or secondary mental health support, and/or to Turning Point, Swindon's substance misuse treatment service provider, as appropriate.

- Target and offer people in contact with the criminal justice system, substance misuse services and homelessness services mental health support through outreach workers within community mental health and wellbeing services.

- Ensure that all mental health service providers and substance misuse service providers are aware of dual diagnosis issues, and have pathways and referral routes to work in partnership with individuals with dual diagnosis problems.

Lesbian, Gay, Bisexual, Transsexual (LGBT) people

Evidence shows that LGBT people are more at risk of suicide ideation and suicide. One study in the UK found that 34.4% of trans adults had attempted suicide at least once and almost 14% of trans adults had attempted suicide more than twice.[xvi] This higher risk of suicide is related to experiences of discrimination, including stigma, transphobia and bullying. These negative experiences occur in many trans individuals' everyday lives, whether at home, work or school. This stigma and discrimination, and the fear of it happening, can make individuals in this situation feel unable to reach out for help when they need it. LGBT people are twice as high as heterosexual people to

attempt suicide and 1.5 times higher risk of depression and anxiety disorders and alcohol or other substance dependence[xvii.]

- Promotion and implementation of Public Health England and Royal College of Nursing guidance for Nurses on suicide prevention strategies with trans young people[xviii] and prevention suicide among lesbian, gay and bisexual young people[xix].
- Promotion of national and local resources for LGBT people
- Develop a workplace toolkit to help staff have informed conversations with LGBT people
- Develop a cross sector steering group to tackle inequalities and barriers to inclusion for the LGBT community.

Black and Minority Ethnic (BME) Groups

Nationally and locally there is little evidence on suicide risk in relation to Black and Minority Ethnic Groups. The coroner does not record this at registration of death so it is difficult to collect this data. Nationally they associate the prevalence of high levels of mental health for some BME groups as an indicator that they may be at higher risk of suicide although cultural issues may mitigate or exacerbate this. They point out that those who recently arrived in the country may need more support particularly for some groups such as asylum seekers or refugees. Locally we do not collect data on ethnicity (although we plan to try to obtain this for GP records in the future) but we do collect data on place of birth. Our records show that for 174 deaths currently recorded 27 had no record recorded and 22 were recorded with a place of birth outside England and 15 were outside the UK.

Children Looked After

Children looked after and young people leaving care are recognised as being at higher risk of self-harm and suicide than their peers. Swindon Borough Council has 340 children looked after (CLA) with approximately a third living outside Swindon Borough Council (August 2019). The Designated Nurse for children looked after is based in Swindon CCG and takes the strategic lead on improving the health outcomes for children looked after. There is a CLA Health Team, named nurse for children looked after and 2 specialist nurses. The emotional well-being of children looked after is screened using the Strength and Difficulties Questionnaire which is completed by foster carers, teachers and young people over 11 years of age and all those who have a high score, indicating emotional difficulties, are discussed at a monthly multi-disciplinary meeting. The CLA health team have close links with the local CAMHS service and there is a process in place for Swindon CCG to commission CAMHS services for children placed outside of Swindon who require a CAMHS service.

People experience socioeconomic disadvantage[xx]

People who are socioeconomically disadvantaged or who live in areas of socioeconomic deprivation have an increased risk of suicidal behaviour. Features of socioeconomic disadvantage include low income, unmanageable debt, poor housing conditions, a lack of educational qualifications, unemployment and living in a socioeconomically deprived area.

Suicide risk increases during periods of economic recession, particularly when recessions are associated with a steep rise in unemployment, and this risk remains high when crises end, especially for individuals whose economic circumstances do not improve. Multiple and large employer closures

resulting in unemployment can increase stress in a local community, break down social connections and increase feelings of hopelessness and depression, all of which are recognised risk factors for suicidal behaviour.

The risk of suicidal behaviour is increased among those experiencing job insecurity and downsizing or those engaged in non-traditional work situations, such as part-time, irregular and short-term contracts with various employers.

Suicide rates are two to three times higher in the most deprived neighbourhoods compared to the most affluent and admissions to hospital following self-harm are two times higher in the most deprived neighbourhoods compared to the most affluent.

People with financial problems, including debt, gambling and those in receipt of employment benefits:

- Job Centre Plus are delivering a robust approach to suicide prevention, from training staff to be Mental Health First Aiders and exploring external training such as Assist, to running their own staff learning on mental health awareness and safeguarding and resilience. They are also rolling out Continuous Professional Development sessions on suicide and self-harm for all staff and reviewing and enhancing their internal procedures for handling declarations of intent to attempt suicide and self-harm. Every Jobcentre also has Disability Employment Advisers (DEA) that support frontline staff in working with those with health conditions and disabilities and who often assist during crisis situations.

- Ensure Samaritans and other community mental health and wellbeing services are linked in with the Job Centre to support their clients.

- Guidance on harmful gambling from the Local Government Association and PHE[xxi] highlights that about half of people with gambling disorder (0.7% of the population aged 16 or over) have suicidal thoughts. Recommendations in this guidance for supporting those affected by harmful gambling should be explored.

- Ensure staff and volunteers in services accessed by socioeconomically disadvantaged individuals or groups are aware of the suicide risk and recognise, understand and respond appropriately to individuals who are in distress and may be suicidal

Those affected by the closure of Honda in Swindon

Recent announcements regarding the closure of Honda in 2021 may have a significant impact on the health and wellbeing of those directly and indirectly affected. A health and wellbeing working group has been established to mitigate some of the risks associated with such an economic change not just for Honda workers and their families but also employees and their families of businesses forming the supply chain to Honda.

8.2 Tailoring approaches to improve mental health in specific groups

The national suicide prevention strategy [iv] recommends implementing tailored approaches to improving mental health in a range of groups with specifics needs and characteristics that may lead to higher risk of suicide. These groups include:

- children and young people

- the lesbian, gay, bisexual and transgender (LGBT) community
- people from Black and Minority Ethnic (BME) groups
- people with long-term physical health conditions
- people with untreated depression
- Veterans
- users of drug and alcohol services
- perinatal mental health
- people in receipt of employment benefits.

The following recommendations are made to address mental health needs in vulnerable groups locally:

- Ensure community mental health and wellbeing service provision is inclusive and that vulnerable groups are specifically targeted with support by outreach workers.

- Work with primary care to upskill professionals on recognising and supporting those at risk of suicide.

- Ensure primary care professionals are aware of NICE guidance on depression [xxiii].

- Continue to work in partnership to prevent mental health crisis where possible and ensure effective response when crises do arise in line the Crisis Care Concordat throughout Swindon and the B&NES, SWINDON AND WILTSHIRE PARTNERSHIP. The Junction Café will provide additional out-of-hours crisis care support in Swindon from 2019 for those who are known to AWP and are referred by Police or AWP.

<u>Children and young people:</u>

- Ensure schools are aware of community mental health and wellbeing service provision, particularly for self-harm given the high rate of self-harm admissions among young people in Swindon.

- Review and promote self-harm resources available for children and young people, including the 'No harm done' resources, a series of films and toolkits that set out practical steps for young people, parents and health professionals to identify, understand and address self-harm that have been developed by the Department of Health and Social Care, the Royal College of Psychiatrists and third sector organisations.

- Roll out of the HarmLess tool developed by Oxford Health NHS Trust which provides guidance for those working with young people on having a conversation about self-harm, developing care plan and knowing when and where to refer/signpost. Ensure SENCo Champions, Designated teachers, Special Educational Needs and Disabilities Information and Advice Support Workers are specifically offered training

- Work with the Healthy Schools programme to have input into PSHE curriculum content around building mental resilience and to promote the use of MindEd web-based mental health educational resources for children and young people (as recommended in the national suicide prevention strategy).

- Implementation of the Trailblazer project which supports schools and colleges to improvement the mental health and wellbeing of pupils, students and staff.

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- Continue to work with schools and other educational settings to promote awareness of and tackle stigma associated with mental health problems through training programmes for teachers and other staff, such as Connect 5, Mental Health First Aid (MHFA) and Emotional Literacy Support Assistant (ELSA) training.
    - Training should be guided by Health Education England's Self-Harm and Suicide Prevention Competence Framework for Community & Public Health.

- Ensure the needs of those with Special Educational Needs are considered in the roll out of the actions above. Work with Special Educational Needs Coordinators and educational psychologists in schools to:
    - raise awareness of mental health and well-being of all pupils, particularly those identified with SEN
    - develop whole school approaches that centre around emotional literacy and resilience of all members of the school community, following findings that link these factors with high self- harm / suicide rates
    - provide structured supervision to all staff supporting 'at risk' students to ensure their resilience and emotional vulnerability is safeguarded
    - provide training to all staff to ensure knowledge of risk factors is high
    - ensure all information moves with CLA, due to the high self-harm / suicide rates in this group of CYP; ensure this group is prioritised and advocated for in any individual work being carried out within schools. Currently staff often do not know histories of these CYP but they are complex and the individuals are this at more risk of self-harm and suicide than other groups

- Tackle bullying or discrimination particularly associated with an individual's special educational needs.

- Improve the access for children looked after to specialist support for emotional wellbeing by having a specialist mental health post within the Children Looked after team. Ensure those children looked after with high Strength and Difficulties Questionnaire (SDQ) scores have the appropriate intervention to improve their emotional health and wellbeing. Ensure all foster carers have self-harm and suicide prevention training. All commissioned services for CLA should be trained in suicide and self-harm prevention including accommodation provided for care leavers.

<u>Older people</u>

In Swindon there have been 14 deaths by suicide since 2008. Several factors related to aging can increase the risk of suicide such as social isolation, loneliness, bereavement and ill-health. These issues are highlighted in the Ageing Well JSNA and will be addressed in the ageing well strategy, currently being developed, entitled "Making a Good Life – a lifetime of healthy ageing". Safeguarding issues with regard to this cohort of the population also need to be considered in relation to suicide ideation and risk.

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Users of drug and alcohol services:

- Work with Substance Misuse providers to ensure optimal awareness of mental health and suicide risk of clients, and ensure that staff refer individuals identified as being at risk to community-based or secondary mental health support as appropriate.

- As recommended above, ensure mental health service providers and substance misuse service providers are aware of and work in partnership on dual diagnosis issues.

- Implement and monitor actions taken to reduce the harm to children of alcohol-dependent parents Innovation project.

Those experiencing domestic abuse:

- Ensure training and support is offered for primary care and other frontline professional staff to improve identification and appropriate referral to support services of those experiencing domestic violence and abuse

- Work with domestic abuse support providers to ensure awareness of mental health and domestic abuse including coercive control and financial abuse and ensure clients are supported and have access to services

- Ensure mental health and domestic abuse service providers are aware of and work in partnership around domestic abuse issues

Perinatal mental health:

The B&NES, SWINDON AND WILTSHIRE PARTNERSHIP is developing a new, integrated approach to perinatal mental health services.

- Ensure peer-led perinatal mental health support is available in Swindon.

- Raise awareness among the public and health and social care professionals of the risk of perinatal mental health problems and how to recognise and identify such problems.

- Ensure those identified with perinatal mental health problems have access to relevant services.

Service Veterans

Evidence to date is that the overall rate of suicide is not higher for veterans than the general population; however, there is evidence that in male veterans aged less than 24, 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. Evidence also shows that many veterans who die by suicide often have pre-service vulnerabilities[xxii].

- Ensure veterans are highlighted as a risk group in GP training
- As part of implementing the military covenant ensure accessible mental health treatment for military veterans.

People with long-term physical health conditions:

- Continue to follow NICE guidance (Clinical Guideline 91)[xxiii] on depression in adults with a chronic physical health problem by offering group-based peer support to groups of patients with a shared chronic physical health problem through Lift Psychology.

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People with Learning disabilities

National evidence shows that rates of suicide and attempted suicide are lower than the general population for those with severe learning disability but there is some evidence to suggest that the rates are higher in people with limited intellectual function (including mild or borderline learning disabilities)

- NICE Guidance NG 54 (2016) Mental health problems in people with learning disabilities: prevention, assessment and management should be reviewed and implemented as appropriate.
- Ensure those working with people with LD are aware of positive ways to promote mental health and resilience.

People with Autism

Those with autism have been recognised as being at higher risk of suicide than the general population (NICE 2018)[xxiv]. Factors known to increase people's risk of suicide are more common in the autistic community, including social isolation, unemployment, trauma, abuse and other social and biological factors that increase the likelihood of mental health problems. In addition those with autism face other issues that make them more likely to consider ending their own lives. They may also find it more difficult to access services. Women with autism may be at particular risk.[xxv]

- An autism JSNA and strategy should be developed to ensure that mental health needs of this group are addressed
- Increase awareness of positive mental health for those with autism
- Ensure those with autism have access to services

8.3 Reducing access to means of suicide

Action to reduce access to means of suicide has been shown to reduce deaths by suicide.

- Work closely with Police, including the British Transport Police, and other partners to identify frequently used areas, monitor and reduce suicide risk at these places such as multi-storey carparks, bridges and the railway line.

- Work with colleagues in planning to embed suicide prevention principles in the rewrite of Swindon's Local Plan.

- Work with the CCG and Local Pharmaceutical Committee to continue to reduce the means to suicide through prescribed medication. This will include inappropriate use of repeat prescribing and hording of medication.

8.4 Providing better information and support to those bereaved or affected by suicide

Providing support for people bereaved by suicide is a key objective of the national suicide prevention strategy. When compared with people bereaved through other causes, those bereaved by suicide are at an increased risk of suicide, psychiatric admission and depression. The risk of friends and relatives of people who die by suicide making a suicide attempt themselves is 1 in 10. Close family members, particularly parents and spouses or partners, are thought to be the most vulnerable groups following a suicide, but there are also risks for extended family, friends and colleagues.

Based on PHE guidance on providing local services to support those bereaved by suicide[xxvi], and a consultation carried out with members of the Survivors of Bereavement by Suicide (SOBS) peer support group in Swindon, the following recommendations are made:

- Explore the benefits of setting up a system of real-time suicide surveillance in Swindon. Real-time suicide surveillance involves information sharing between agencies, such as Police, the Coroner and Public Health, on suspected suicides in order to ensure timely identification and referral of people bereaved by suicide to support, as there may be considerable delays between a suicide occurring and the coroner completing the inquest and issuing an official verdict of suicide.

- Consider developing a pathway to provide care and support locally to those bereaved by suicide. An example pathway developed by PHE[xxvi] is shown below, which highlights that, on first contact with the bereaved, they should be offered information, advice and guidance, including on local support available such as the SOBS support group and Cruse Bereavement Counselling. A more detailed version of this pathway can be found in the publication, "Support after a suicide: Developing and delivering local bereavement support services", by the National Suicide Prevention Alliance.

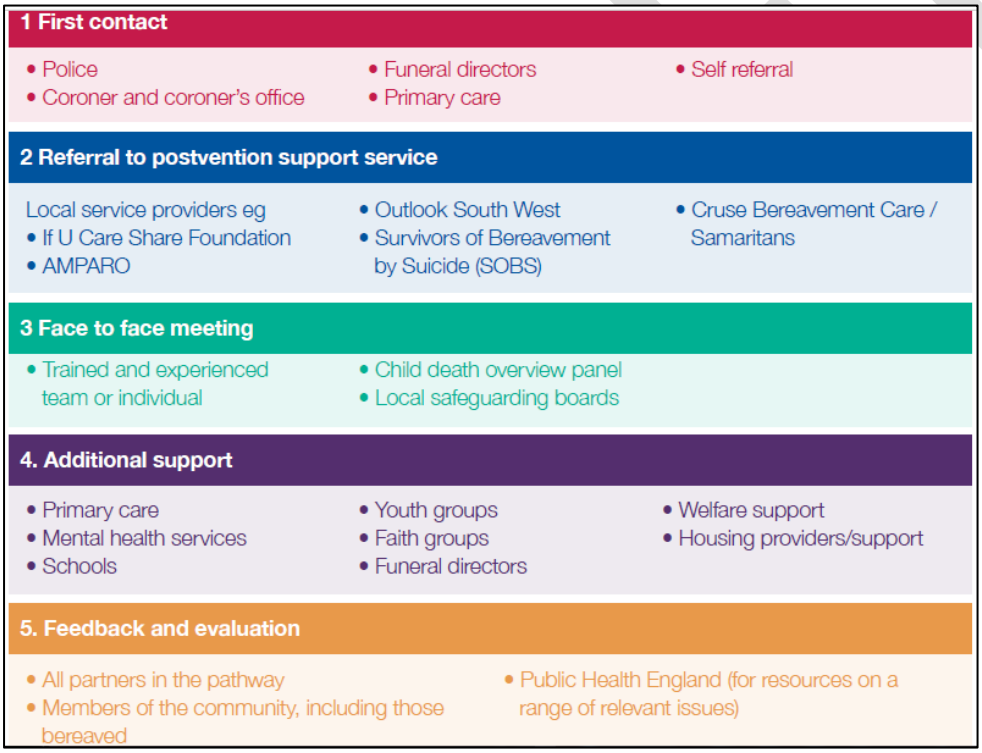

Chart 23 PHE example pathway of care and support for those bereaved by suicide[xxvi]

- Consider commissioning specialist suicide bereavement counselling. The consultation carried out with SOBS members in Swindon highlighted that many of them felt that counselling they had received wasn't fit for purpose.

- Develop and distribute post-vention (suicide bereavement support) guidance to schools. Ensure this guidance includes specific guidance for those with special educational needs.

- The implementation of national campaigns such as Time to Change to raise awareness of and tackle the stigma around mental health problems, as recommended above, will also contribute to tackling stigma around suicide and may make it easier for people to seek help following bereavement.

- Ensure peer support group continues to be available in Swindon.

8.5 Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour

Evidence suggests that inappropriate reporting of suicide may lead to 'copycat' behaviour among vulnerable groups, particularly young people.

- Continue to maintain strong links with local media on suicide prevention, and ensure local media are aware of the guidance published by the Samaritans[xxvii] on responsible media reporting of suicide.

- Work with local media to promote mental health awareness as part of national campaigns, such as Time to Change, Suicide Prevention Day and Mental Health Awareness Week.

8.6 Supporting research, data collection and monitoring

- Review the local suicide audit system to ensure all relevant data is being collected from all relevant agencies.

- As recommended above, explore the benefits of setting up a system of real-time suicide surveillance in Swindon in order to ensure timely identification and referral of people bereaved by suicide to support.

- As recommended above, work with partners including the Police and British Transport Police to monitor suicide risk at high frequency locations.

- Continue to support PHE-led self-harm research.

8.7 Reducing rates of self-harm as a key indicator of suicide risk

Previous self-harm, including attempted suicide, is the single strongest predictor of suicide. Self-harm admissions to hospital are a particular problem in Swindon - rates of hospital admissions for self-harm are consistently higher than those seen regionally or nationally, especially among young people aged 10-24 years.

- Continue the work of the multi-agency Task and Finish Group on reducing self-harm among children and young people. The work of this group contributes to sharing learning on and standardising approaches to self-harm assessment and interventions across agencies and the BSW Partnership. The group should look to:

    - Roll out the Harmless tool developed by Oxford Health throughout Swindon, including to foster workers, looked after children (LAC), schools, colleges, GPs, school nurses, and third sector youth providers.

- Review websites and apps available to share with schools and other professionals.
- Develop post-vention guidance for schools.
- Promote the Health Education England Self harm and Suicide Prevention Competency Framework to organisations in Swindon.

- Maintain or increase provision of community self-harm support, ensuring that:
  - Young people are specifically targeted;
  - Provision complies with NICE Clinical Guideline 133[xxviiixiii] on the long-term management of self-harm in people aged over 8 years old. This guideline emphasises the importance of:
    - Education of health and social care professionals about the stigma and discrimination usually associated with self-harm and the need to avoid judgemental attitudes, and on when and how the Mental Health Act (1983; amended 1995 and 2007) can be used to treat the physical consequences of self-harm.
    - Managing the endings of services, treatments or relationships and supporting transitions between services, through a process of planning with the service user.
    - Encouraging primary care professionals to refer people with a history and risk of self-harm to community mental health and wellbeing services or to CAMHS if they are under 18, and to monitor the physical health of these patients.
    - Ensuring community mental health and wellbeing services offer an integrated and comprehensive psychosocial assessment of needs, including skills, coping strategies, mental health problems and physical health problems, and risks to understand and engage people who self-harm and to initiate a therapeutic relationship. Needs assessments for children and young people should include a full assessment of the child's family, social situation, and child protection issues.
    - Ensuring community mental health and wellbeing services work with the person who self-harms and their family (if agreed with the person) to develop a care plan and a risk management plan, based on the psychosocial needs assessment.
    - The guideline also recommends that mental health services, including community services, consider offering 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm. The intervention should be tailored to individual need, and could include cognitive-behavioural, psychodynamic or problem-solving elements.
    - Provision complies with Health Education England's Self-Harm and Suicide Prevention Competence Framework for Community & Public Health.

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9. Appendix 1:

July 2019 Progress update on recomme

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