

Bristol Suicide Prevention Strategy 2013-2016

Produced by the Bristol Suicide Prevention and Audit Group

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This suicide prevention strategy for Bristol for 2013-2016 is an update of the strategy for 2010-2012. It has been produced by the Suicide Prevention and Audit Group.

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Executive summary

Introduction

During 2010 in Bristol, someone died from suicide approximately every 8 days. In the same year in England, as a whole, suicide claimed a life every 2 hours; this equates to over 4,200 deaths¹.

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

Suicide rates have been falling nationally – though this fall reversed in 2008, probably as a result of the economic crisis. Bristol has a relatively high rate compared to similar (core) cities. The highest incidence of suicides continues to be among adult males between the ages of 20 and 39, although these rates are reducing.

Action at a national level

The government's mental health strategy *No health without mental health*¹⁹ was published in 2011. It is important to acknowledge that suicide prevention starts with better mental health for all.

Including suicide as an indicator within the Public Health Outcomes Framework¹⁸ will help to track national progress against the overall objective of reducing suicide rates.

There are a number of other national initiatives and sources including *Avoidable Deaths*, a five year inquiry into deaths from suicide and homicide among people suffering mental illness; studies into self-harm; a revised care planning system for at-risk prisoners; and publication of *Help is at Hand* – a resource for people bereaved by suicide. Further information and resources such as *Practical Mental Health Commissioning* are available from www.nmhd.org.uk

Suicide in Bristol

Annual rates for suicide and undetermined injury fluctuate widely from year to year and whilst those fluctuations may appear pronounced, they can often be explained by the comparatively small numbers of suicides. Bristol's average mortality rate from suicide and undetermined death for the period of 2007-2009 was just above the national average (Bristol: 9.49; England & Wales: 7.90 deaths per 100,000 of the population). Recent data for 2010 indicates a similar heightened incidence in Bristol.

Suicide prevention in Bristol

The Suicide Prevention and Audit Group was set up in 2004 and meets quarterly. This group oversees and reports on the delivery of the initiatives identified in the action plan and is responsible for this revised strategy for 2013-2016. A coordinated audit system which gathers information on suicide and undetermined injury among the population of Bristol is produced and presented annually.

The most recent audit (update 2012)⁴ contains data from 1993 to 2010 and reports the following:

- Bristol mortality rates from suicide and undetermined injury are on average similar to the national rate, though slightly higher than that average since 2007
- Young men aged 20-39 years have the highest rates of suicide though there are signs of a gradual decrease
- The numbers of females who die by suicide has generally decreased over the last ten years, though recent figures show a slight rise
- Suicide and undetermined injury are most prevalent within postcodes identified as areas of high deprivation
- Death by hanging is the most common method of suicide, with self-poisoning being the second most common method
- The majority of deaths from suicide and undetermined injury occur within the home
- Deaths by jumping from Clifton Suspension Bridge have halved since the construction of barriers
- Deaths from suicide and undetermined injury within Her Majesty's Prison (HMP) Bristol have reduced to an average of one per year, based on available figures from 2006-2008
- The number of deaths from suicide and undetermined injury of people in contact with mental health services is slightly higher than the national average

Avon and Wiltshire Mental Health Partnership NHS Trust has its own suicide prevention strategy and an established system for clinical audits following unexpected deaths.

HMP Bristol has developed several initiatives. These include:

- A 'Listeners Scheme' under the guidance of the Bristol Samaritans
- An 'Insiders Scheme' which aims to improve quality of life for prisoners
- A bullying prevention strategy to ensure that each incident of bullying is investigated
- Both mental health awareness and relationship training
- Sign-up to a healthy prison strategy

Bristol also has a comprehensive mental health promotion strategy which aims to reduce discrimination and promote social inclusion and mental well-being.

Suicide prevention action plan for 2013-2016

A three year action plan has been produced to accompany this strategy and includes the ten main priority action areas below.

1.	Publish an annual suicide audit report for Bristol, including more detailed data collected about suspected suicide deaths on a case-by-case basis
2.	Monitor local media reporting of suicide and take action to improve reporting.
3.	<p>Reduce access to means by:</p> <p>Monitoring local hotspots in relation to deaths (e.g. bridges and car parks), gathering evidence about the effectiveness of safety measures and advising on further action.</p> <p>Continuing to work with Network Rail to monitor deaths associated with railways.</p> <p>Monitoring prescription of toxic medicines to reduce deaths by self-poisoning.</p>
4.	<p>Promote mental well-being by:</p> <p>Reviewing and developing the Bristol mental well-being promotion strategy and action plan to ensure strong links with this Suicide Prevention Strategy.</p> <p>Recognising that for many people, the roots of the reasons for suicidal behaviour lie in childhood, therefore ensuring that children and young people's needs are included in the review and development of the Bristol mental well-being promotion strategy.</p>
5.	<p>Develop specific actions for high risk groups which include:</p> <p>Asylum seekers, BME communities, LGBT people, offenders, those with a dual diagnosis, men, those in contact with mental health services, ex services veterans, those with long-term physical conditions, personality disorders, drug and alcohol dependence issues and the homeless.</p>
6.	Ensure that best practice relating to NICE guidelines is implemented locally.

7.	<p>Establish good service provision and practice for patients attending A&E/acute trusts following self-harm, including:</p> <p>Ensuring comprehensive psychosocial assessments for patients in acute hospitals following deliberate self-harm.</p> <p>Ensuring that there is timely follow-up care for patients 'at risk' on discharge.</p> <p>Auditing provision using a self-harm register. Supporting extension of the self-harm monitoring register to Frenchay and ensuring key outcomes / findings from this audit are disseminated to relevant staff groups.</p>
8.	<p>Work with the Coroner's Office, the Police and the Samaritans to provide families with information and access to support and promote the distribution of <i>Help is at Hand</i>.</p> <p>Conduct a scoping exercise on available support, including support for bereaved children and young people.</p>
9.	<p>Avon and Wiltshire Mental Health Partnership Trust and HMP Bristol to conduct audits on all deaths of people in the care of the Trust and of those in custody.</p>
10.	<p>Support the needs of First Responders such as the police, ambulance, rail and bridge staff.</p> <p>Offer ASSIST training and support to staff affected by incidents of suicide or attempts at suicide.</p>

Section 1: Introduction

Each year in England there are around 4,200 deaths from suicide¹. Suicide has a devastating impact on individuals, relatives and friends, agencies which provide care, front line service staff and on society as a whole. Suicide is often the end point of a complex history of risk factors and distressing events. The prevention of suicide therefore needs to address this complexity. This strategy is intended to outline the local approach to suicide prevention and it recognises the contributions that can be made across all sectors of society. The strategy draws on local experience and expertise and national research evidence and guidance.

In 2002², the government made suicide prevention a health priority and set a target to reduce the death rate from suicide and injury (and poisoning) of undetermined intent by the year 2010. The new national strategy launched in 2012¹ emphasises local action and supports this by bringing together knowledge about groups at higher risk of suicide, identifying evidence of effective interventions and highlighting available resources.

In 2004, the first suicide prevention strategy was produced in Bristol for the years 2004-2007³. This strategy was revised and updated to cover the periods 2008-2010 and then 2010-2012. This 2013-2016 strategy provides a further update on the continuous prevention work which has been carried out in Bristol since 2004; it reflects new national and local priorities and guidance.

The strategy includes a plan which contains ten areas for action to reduce the incidence of suicide. The Bristol Suicide Prevention and Audit Group oversees the implementation of this action plan. Progress against its objectives is presented annually to a wider meeting of the group and recorded in the Bristol Suicide Audit Report.⁴

What is suicide?

There is no universally accepted definition of suicide, as there are difficulties in determining the exact intent of a person who dies. However, a broad definition is that it is:

*'..a fatal act of self-harm with a conscious intent to end life.'*³

What is self-harm?

Self-harm is:

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

The intent of self-harm may be to stop conscious experience, interrupt conscious experiences, or be an appeal, or request, for help. It may be a way of coping, or surviving. It can take many forms, including poisoning and cutting.

Self-harm may be the result of deliberately choosing to take part in behaviours that are likely to injure, like fighting, or driving extremely recklessly, although less is known about these areas. Local evidence suggests that almost 1 in 5 16 year olds in Bristol have self-harmed.³⁷

Suicide prevention

Suicide prevention is not the sole responsibility of any one sector of society, or of health services alone. The greatest impact is likely to result from a combination of preventative strategies directed at:

- The factors which increase risk of suicidal behaviour in a population - e.g. availability of means, knowledge and attitudes concerning the prevalence, nature and treatability of mental disorders, and media portrayal of suicidal behaviour
- Recognised high risk groups - e.g. people with recurrent depressive disorders, previous suicide attempters, people who misuse alcohol, the unemployed, people with certain co-morbid mental and personality disorders⁷ and people recently discharged from psychiatric in-patient care

During the previous 10 year period, it has been suggested that it was not necessarily just the achievement of a suicide prevention target that was important:

*'..rather it [is] its role of a target, as a guiding beacon that can lead to the problem of suicidal behaviour being taken more seriously and galvanise more active planning of national policy to improve mental health and mental health care.'*⁶

Section 2: The national picture

This section describes national rates of suicide, current trends and the action that is being taken nationally to prevent suicide.

Suicide rates and trends

Suicide rates in England are low compared to those of many other European countries. In England, during the 3 year period from 2008-2010, the mortality rate from suicide was 12.2 deaths per 100,000 population for males and 3.7 deaths per 100,000 for females.³⁹ The past 4 years have seen a slight increase in suicide rates, however, the 2008-2010 rate nonetheless remains one of the lowest since the 1994-1996 average which is often used as a base line. There has been a sustained reduction in the rate of suicide among young men under the age of 35, which reverses the upward trend which began over 30 years ago.¹

Currently, around three-quarters of deaths from suicides are men; people aged 35-49 now have the highest suicide rate.¹ Rates of suicide in men aged over 75 are also relatively high, which is a recent trend; risk factors such as loneliness and physical illness may be contributing factors.¹

Mental health services

The number of people in contact with mental health services who died by suicide has reduced from 1,253 in 2000 to an estimated 1,187 in 2010, a reduction of 66 deaths (5%). The number of inpatients who died by suicide reduced from 196 in 2000 to 74 in 2010, a reduction of 122 deaths (62%). People with severe mental illness remain at high risk of suicide, both while in inpatient units and in the community. Inpatients and people recently discharged from hospital and those who refuse treatment are at highest risk.¹

Rates of self-harm

There are around 200,000 episodes of self-harm that present to hospital services each year. People who self-harm are at increased risk of suicide, although many who self-harm do not intend to take their own lives when they self-harm.⁴⁰ At least half of those people who take their own life have a history of self-harm and one in four have been treated in hospital for self-harm in the preceding year. Around one in every 100 people who self-harm, take their own life within a year. Risk is particularly increased in those repeating self-harm and in those who have used violent/dangerous methods to self-harm.⁴¹

In contrast to suicide, the rates of self-harm are highest in girls and women - the highest incidence being among 15-19 year olds. In men, the highest rates are in 20-29 year olds. Recent research in Bristol³⁷ indicates that 18.8% of local teenagers have self-harmed by the age of 16-17, a quarter of these episodes are carried out with suicidal intent. Rates of self-harm are much lower amongst those aged over fifty.⁸

Though the calls are not evidence of actual self-harm incidents, the number of children speaking to ChildLine counsellors about self-harming has grown steadily over recent years.⁹ In 2005, more than 5,200 children told ChildLine that they were self-harming and around half of them said they had been cutting themselves. This represents a three per cent increase on the previous year. Girls were 17 times more likely than boys to call about self-harm. The National CAMHS Support Service produced a self-harm in children and young people handbook and an e-learning package, to provide basic knowledge and awareness of self-harm in children and young people. It included advice about the ways in which staff in children's services could respond.

www.chimat.org.uk/resource/view.aspx?RID=105602

Offenders

People at all stages within the Criminal Justice System, including people on remand and recently discharged from custody, are at higher risk of suicide. The period of greatest risk is the first week of imprisonment.¹⁶

Reasons for the increased risk include the fact that a high proportion of offenders are young men, who are already a high suicide risk group. However, the increase in suicide risk for women prisoners is greater than for men. An estimated 90% of all prisoners have a diagnosable mental health problem (including personality disorder) and/or substance misuse problem.¹

In 2009-2011, there were 69 apparently self-inflicted deaths in English prisons per 100,000 prisoners. This follows a decrease year-on-year since 2004 when the rate was 132 deaths per 100,000.¹ The national strategy also mentions recently released prisoners as a risk group. The approach by Bristol's Public Health Directorate is to address 'offender health' rather than just prisoner health and is therefore in line with this addition.

The risk factors for suicide

A number of factors can increase an individual's vulnerability to suicide these include¹:

- Young and middle-aged men
- People in the care of mental health services, including inpatients and those recently discharged from psychiatric care
- People with a history of self-harm
- People in contact with the criminal justice system
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

Suicide is often precipitated by recent adverse events. These include relationship breakdowns, conflicts, legal problems, financial concerns, and interpersonal losses. There is also research into the links between suicide and terminal or chronic illness³⁸

The following points are also important in terms of suicide prevention.¹⁰

- Up to **half of all suicides have previously made failed attempts.**
- Only **a quarter of people (nationally) who die by suicide are under psychiatric care** in the year before their death (i.e. 75% are not)
- **5-10% of all suicides happen in the four weeks after discharge** from psychiatric hospital, making this a time of high risk
- **A number of occupational groups** - doctors, farmers, vets, dentists and pharmacists - are at increased risk of suicide, although deaths in these groups make up only 1-2% of all suicides. One important factor influencing the increased risk in these occupations is their **access to lethal means of suicide**
- A follow-up study of patients at a general hospital, reported a **0.7% risk of adults dying by suicide in the year following self-harm**, a 1.7% risk within five years and 2.4% at ten years. The risk was far higher in men than in women¹¹

More men die from suicide than women, but suicidal thoughts and self-harm are more common in women. Groups who have more frequent thoughts of suicide are:¹²

- Women
- Those aged 16 to 24
- Those not in a stable relationship
- Those with low levels of social support
- Those who are unemployed.

Self-harm occurs in all sections of the population but is more common among people who are disadvantaged in socio-economic terms and among those who are single or divorced, live alone, are single parents or have a severe lack of social support.¹³ According to NICE,⁵ risk factors for self-harm include a number of other 'associations' such as: life events; alcohol and drug use; mental disorder; child abuse, domestic violence and being within the criminal justice system. Within this are special groups such as young people. There are others for whom the evidence is not so well collected such as gay men lesbians and bi-sexuals.⁵

Table 1: Increased risk for groups at higher risk compared to the general population

High risk group	Estimated increased risk
Males compared to females	x 2-3
Current or ex-psychiatric patients	x 10
4 weeks following discharge from psychiatric hospital	x 100-200
People who have deliberately self-harmed in the past	x 10-30
Alcoholics	x 5-20
Drug misusers	x 10-20
Family history of suicide	x 3-4
Serious physical illness/disability	Not known/under review ³⁸
Prisoners	x 9-10
Offenders serving non-custodial sentences	x 8-13
Doctors	x 2
Farmers	x 2
Unemployed people	x 2-3
Divorced people	x 2-5
People on low incomes (social class IV/V)	x 4

Source: Adapted from information on Mental Health Specialist Library website at www.library.nhs.uk/mentalhealth

Section 3: Preventing suicide in England

Key national strategies and reports

- Preventing suicide in England: A cross-government outcomes strategy to save lives, HM Government 2012.¹
- Preventing suicide in England: Assessment of impact on equalities, HM Government 2012.¹⁴
- Preventing suicide in England: Prompts for leaders on suicide prevention, HM Government 2012.¹⁵
- Sources of information for families, friends and colleagues who may be concerned about someone at risk of suicide, HM Government 2012.¹⁶
- Preventing suicide in England: Statistical update on suicide, HM Government 2012.¹⁷
- Public health outcomes framework : Improving outcomes and supporting transparency, 2012.¹⁸
- No health without mental health: A cross government outcomes strategy for people of all ages, 2012.¹⁹
- Healthy Lives, healthy people: Update and way forward, 2011.²⁰
- Avoidable Deaths: Five-year report of the national confidential inquiry into suicide and homicide by people with mental illness.²¹
- Inquiry into suicide and homicide by people with mental illness: Annual report for England and Wales, University of Manchester 2012.²²

Six key action areas

The new (2012) strategy¹ outlines national action in six key areas.

Action area 1:	<i>Reduce the risk of suicide in key high-risk groups</i>
Action area 2:	<i>Tailor approaches to improve mental health in specific groups</i>
Action area 3:	<i>Reduce access to the means of suicide</i>

Action area 4:	<i>Provide better information and support to those bereaved or affected by suicide</i>
Action area 5:	<i>Support the media in delivering sensitive approaches to suicide and suicidal behaviour</i>
Action area 6:	<i>Support research, data collection and monitoring</i>

The strategy recognises that suicide prevention is not the exclusive responsibility of any one sector of society, or of health services alone.

Action to prevent suicide

There are a number of national projects and initiatives to reduce suicide. The national strategy update for 2006 listed the following key achievements:

- **Publication of *Reaching Out***, an evaluation of the three mental health promotion pilots aimed at young men²⁸
- **Expansion of the three centre study of self-harm** to a fourth centre in Derby. These centres help provide accurate data and trends and patterns of self-harm, identify any differences between centres, and detect any changes in patterns
- **Revised care planning system for at-risk prisoners (ACCT)** was developed, piloted and evaluated in 2004 with implementation taking place during 2005-2007
- **Publication of *Suicide Audit in Primary Care Trust Localities*** – a tool to support PCTs and other bodies carry out population-based audit of suicides and open verdicts²⁹
- **Publication of *Help is at Hand*** – a resource for people bereaved by suicide and other sudden, traumatic death³⁰
- **Publication of guidance on action to be taken at suicide hotspots**³¹
- **Commissioning of MediaWise to consult with the media** about the most useful ways of improving the portrayal of suicide and suicidal behaviour in the media
- **Working with mental health services in preventing suicide**, and in particular by providing early follow-up to high-risk patients who are discharged from hospital

The 2012 strategy recognises that the Government can achieve more in partnership with others than it can alone, and that services can achieve more through integrated working than they can through working in isolation from one another.

There are two other key strategy documents which, in combination with the national strategy, take a public health approach that uses both general and targeted measures to improve mental health and well-being and reduce suicides across the whole population. These are *Healthy Lives, Healthy People: Our strategy for public health in England* (2010) which gives an enhanced role to local government and local partnerships in delivering improved public health outcomes. From April 2013 responsibility for coordinating and implementing work on suicide prevention will become an integral part of local authorities' new responsibilities for leading on local public health and health improvement.

Health and well-being boards will also be able to support suicide prevention as they determine local needs and assets. Public Health England, the new national agency for public health, will also support local authorities, the NHS and their partners across England to achieve improved outcomes for the public's health and well-being, including work on suicide prevention.

The other linked strategy is *No health without mental health: A cross-government outcomes strategy for people of all ages* (2011). This approach should support reductions in suicide amongst the general population as well as those under the care of mental health services. The first agreed objective of *No health without mental health* is to ensure that more people will have good mental health.

Offenders

Research on the help-seeking behaviour of prisoners on release, commissioned from the Peninsula Medical School²⁷ will contribute to evidence on the factors which inhibit offenders from accessing treatment and support for mental health issues. A follow up study is underway with the Probation Service.

By the end of 2006, all prisons in the South West were implementing the ACCT Process (Assessment, Care in Custody and Teamwork).⁴³ All those people working with prisoners have had ACCT awareness training. ACCT assessors have specific training in assessing those at risk. The ACCT process joins up all the various agencies involved with the person at risk, including primary and secondary mental health care services.

Mental health awareness training has been delivered to people across South West prisons - the target was for 20% of all operational staff to attend. Mental health awareness training is also provided for prisoners who are 'Listeners'.

From 2004, the Prisons and Probation Ombudsman has conducted investigations into all deaths in custody and the Independent Police Complaints Commission (IPCC) was established to support this. In 2006 a *Forum for Preventing Deaths in Custody* was formally set up to ensure lessons were learned across all custody settings.³²

Future priorities for England

The national strategy is an evolving document which is reviewed regularly. The latest update identifies the following as priorities for the future.¹

- Taking forward the **recommendations of the media guidance** on ways to improve the way suicides and suicidal behaviour are portrayed.
- Ensuring that the knowledge and experience gained through the young men's mental health promotion pilots (such as CALM) support practitioners and other agencies in **developing effective approaches to engaging with young men**
- Ensuring effective promotion and **dissemination of the bereavement pack – *Help is at Hand*** – to ensure those who come into contact with bereaved people are able to offer appropriate support – particularly to the families
- Further improvements in the care of people in contact with mental health services, including **taking steps to incorporate the findings of the latest National Confidential Inquiry (NCI) report into clinical practice**. This includes action to reduce absconding from in-patient ward areas. Consideration of the findings of the review of open doors in acute in-patient wards areas when completed
- Further work with **people who self-harm**
- **Promoting the mental health of older people**. A commitment to working with the Older Persons Mental Health Programme to promote the mental well-being of older people with, or at risk of, mental health problems
- Taking forward actions from the **BME suicide research project** as part of the *Delivering Race Equality Programme*. Yet also recognising that people from black and minority ethnic communities are also more likely to have lower incomes or be unemployed
- Considering evidence of the risks of suicide and self-harm amongst **lesbian, gay and bisexual people**

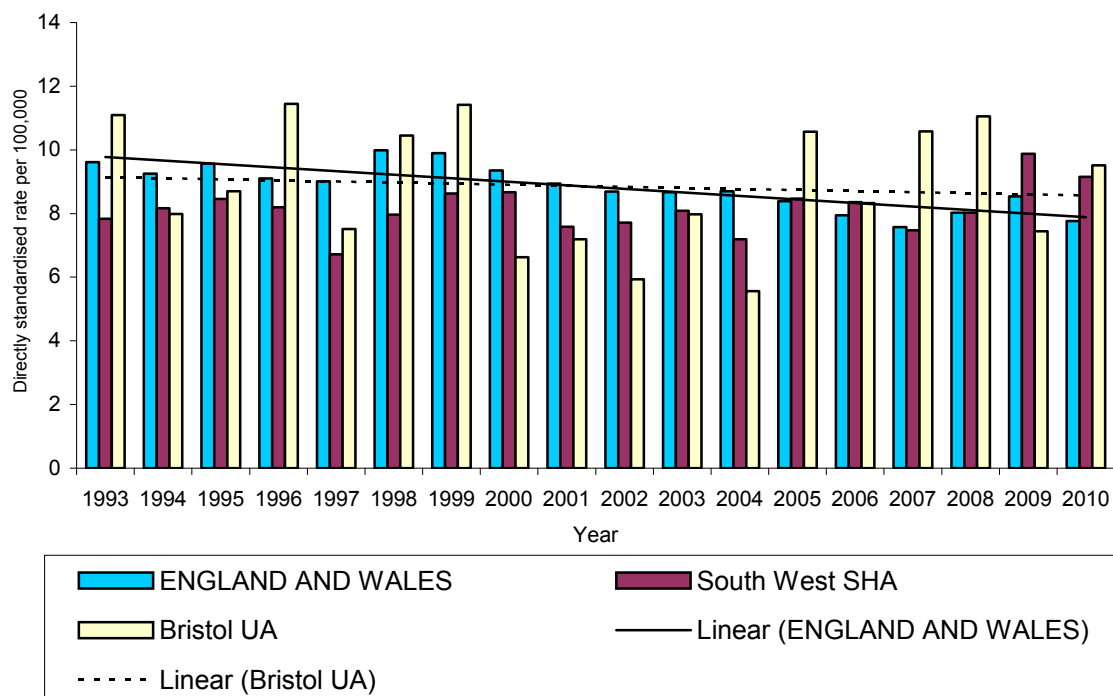
Section 4: Suicide in Bristol

This section summarises local rates and trends in the incidence of suicide, as well as particular risks in Bristol. Further information can be found in the latest Bristol suicide audit.⁴

Suicide rates and trends

Bristol's average mortality rate from suicide and undetermined death for the period of 2007-2009 was above the national average rate (Bristol: 9.49; England & Wales: 7.90 deaths per 100,000 population).

Figure1. Trends in mortality from suicide and undetermined death in the Bristol Unitary Authority Area in comparison to national and regional trends 1993-2010



Source: Compendium of Clinical and Health Indicators, 2012

Because annual rates for suicide can fluctuate widely from year to year, a three year rolling average is used to provide a more accurate representation of trends. Table 2. overleaf shows these averages from 1998 to 2010. While fluctuations from year to year may appear pronounced, they can often be explained by the comparatively small numbers.

Table 2. Directly standardised rate per 100,000 (95% confidence intervals) and numbers: mortality from suicide and undetermined death in the Bristol Unitary Authority Area.

Year	1998-2000	2001-2003	2004-2006	2007-2009	2010
Rate	8.14 (6.53-9.74)	7.04 (5.52-8.55)	8.14 (6.53-9.74)	9.49 (7.75-11.23)	9.51 (7.4-13.8)
Number	103	87	103	121	43

Source: Compendium of Clinical and Health Indicators, 2012

Risk in Bristol

The latest suicide audit identifies the following.⁴

Young men aged between 20 and 39 years have the highest rates of suicide in Bristol, which mirrors the national picture.

The numbers of females committing suicide has decreased over the last ten years, though recent figures show a slight rise. Male rates are also decreasing but at a more gradual rate.

Suicide and undetermined injury is most prevalent within the most deprived and socially fragmented areas of Bristol (BS4, BS5 and BS6).

Death by hanging is the most common method of suicide in Bristol, with self-poisoning being the second most common.

The majority of deaths from suicide and undetermined injury occur within the home.

Deaths by jumping from Clifton Suspension Bridge have halved since the construction of barriers. Further safety measures around the bridge parapets may prevent further deaths.

Within HMP Bristol the number of deaths from suicide and undetermined injury occur at an average of one death per year (from most recently available data).

The ten year average for deaths from suicide of people in contact with mental health services in Bristol for the period 2001-2010 was 38% which was higher than the national picture.

Section 5: Preventing suicide in Bristol

Key local documents

- Promoting positive mental health in Bristol: Strategic framework 2008 – 2011 (strategy and action plan)²³ being updated
- Avon and Wiltshire Mental Health Partnership NHS Trust Suicide Prevention Strategy 2010-2013²⁴
- Annual report of suicide and undetermined deaths in Bristol: 2012 Update
- Bristol Suicide Prevention Strategy 2013-2016 (this document)
- Joint Strategy for the Emotional Well-being and Mental Health of Children and Young People in Bristol, 2005-2008²⁵
- Bristol's mental health services : A vision for the future 2008²⁶
- Bristol Self-Harm Surveillance Register: Annual Report - 2011³⁴

Coordination, review and audit

Bristol Suicide Prevention and Audit Group

This group was set up in early 2004 and meets quarterly. It has a core membership of representatives from Avon and Wiltshire Mental Health Partnership Trust (AWP), Bristol Primary Care Trust, Mental Health Local Implementation Team, NHS Trusts, Bristol City Council, Network Rail and the Samaritans. Other public and voluntary sector agencies attend from time to time. The group liaises closely with Professor David Gunnell at Bristol University, who is an advisor for the national suicide prevention strategy and a member of Bristol's Suicide Prevention Group.

The group investigates supports and monitors local best practice around key priorities. It has developed this strategy and will monitor it along with its action plan. An audit report is produced annually⁴ and presented to wider stakeholders.

Suicide audit and review process

A coordinated audit and review system is in place in Bristol. The latest report, published in 2012, contains analysis of data from 1993 to 2010. Many suicides are recorded as undetermined (open) verdicts for a range of reasons and these were included in the audit.

For this reason, it is not possible to have completely accurate figures for actual suicides. The sources of data used to complete the annual audit are:

- Public Health Mortality Files (main source)
- Compendium of Clinical and Health Indicators
- Avon and Wiltshire Mental Health NHS Partnership Trust suicide audit
- Her Majesty's Prison (HMP) Bristol
- The Coroners Office
- University of Bristol
- ONS

To try to gain insights into trends and identify areas requiring a more immediate response, a case audit was developed in 2010.

Bristol case audit

Additional data is gathered from the Avon Coroner's Office, from GP records and from other (often NHS commissioned services) which provide health care to individuals prior to death. This has resulted in significantly improved knowledge about those who die by suicide, for example, over variables such as their ethnicity, housing situation, marital/co-habiting status and history of mental health difficulties.

The Suicide Case Audit Group reviews suspected suicide deaths which occur in Bristol, identifies key themes and makes recommendations for action. These are then imbedded in the action plan which is overseen by the Bristol Suicide Prevention Strategy Group.

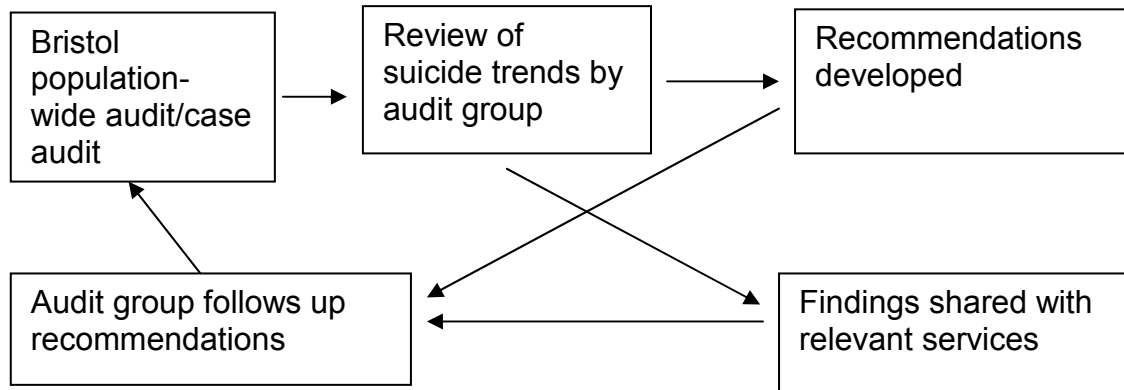
For example, a training need for GPs in suicide prevention skills and in risk assessment was identified. In response, a training sub-group was established which proactively searched for an appropriate training for GPs. The sub-group extended their search further for find options for training other health and community care professionals in suicide prevention, mental health and well-being promotion. As a result, programmes were commissioned, such as a two-day Mental Health First Aid course and a half-day Five Ways to Well-being seminar.

Loss and bereavement have repeatedly been indentified as risk factors for self-harm and suicide. One of the responses by the Group has been to build stronger working relationships with the Bristol Bereavement Forum. The PCT has also commissioned Bristol Cruse to deliver one-to-one counselling and group therapy to individuals suffering from loss due to suicide.

The case review of suspected suicide deaths has proved to be a valuable tool in exploring the personal circumstances of individuals who die from suicide and producing an informative base for actions aimed at increasing individual resilience and improving community mental health.

Figure 2:
process in Bristol

Suicide audit and review



Current suicide prevention activity

Mental health promotion

Bristol has a comprehensive mental health promotion strategy (see summary in Appendix B for an outline). This aims to reduce discrimination and promote social inclusion and mental well-being. Much of this work is undertaken by a range of voluntary, community and statutory organisations and individuals, supported by the Bristol Public Health Directorate.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

Research suggests that suicide risk is raised for virtually all mental disorders and also some medical disorders related to mental disorder, or substance abuse. Suicidal thoughts and actions, both past and present, increase risk further.

The number of deaths from suicide, or open inquest verdicts, of patients in contact with Bristol mental health services at the time of death, or in the previous 12 months, is shown below in table 3.

The average annual number of suicides of individuals in contact with mental health services over the 10-year period of 2001-2010 is approximately 13.5 deaths. This reflects the average rate projected for suicides in national reviews.

Table 3. Bristol Unitary Authority Area and AWPT deaths with suicide, open or narrative verdicts, 2001-2010

Year	PCT Deaths	AWPT Deaths	AWPT % of PCT deaths	3 year average %
2001	29	8	28%	-
2002	24	11	46%	-
2003	34	7	21%	32%
2004	24	13	54%	40%
2005	44	16	36%	37%
2006	35	18	51%	47%
2007	44	20	45%	44%
2008	45	15	33%	43%
2009	32	13	41%	39%
2010	43	14	33%	35%
<i>10-year Average</i>	35.4	13.5	38%	-

Source: Avon & Wiltshire Mental Health Partnership NHS Trust, 2012.

Suicide prevention within AWP is seen in the context of local community suicide prevention strategies and the Trust acknowledges that no single approach will address the issue alone. AWP works actively with local partner organisations.

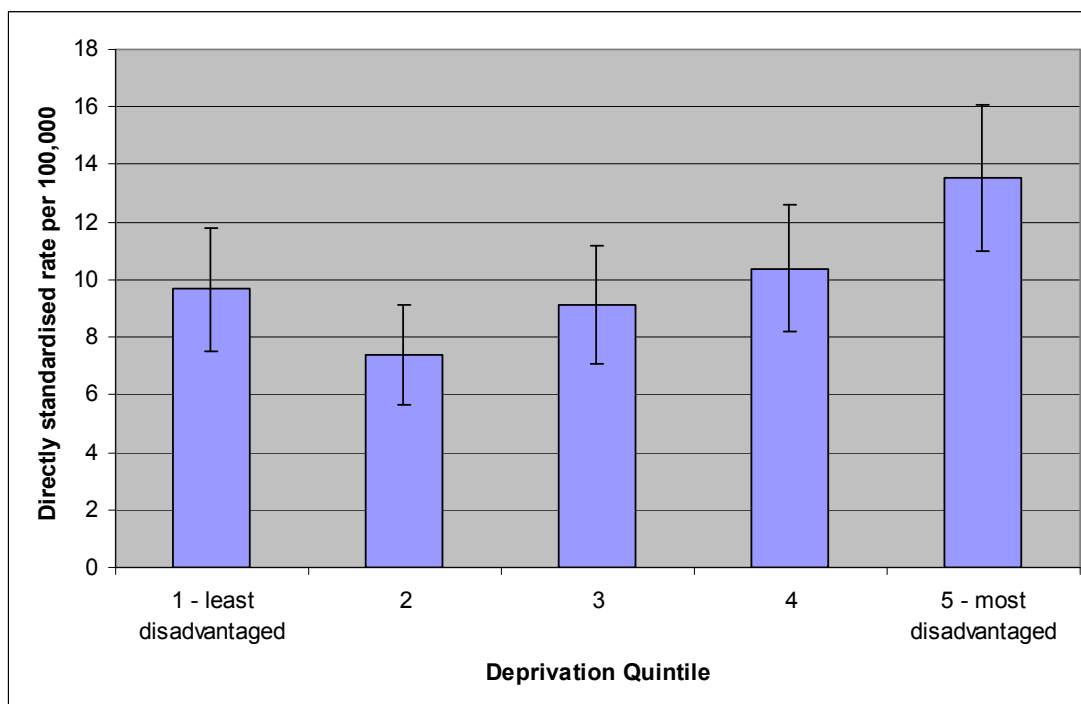
The Trust produces its own comprehensive suicide prevention strategy²⁴ which recognises that those at highest risk are people who have recently been discharged from hospital and those who have self-harmed. It aims therefore, to ensure that it:

- Maintains and develops existing relationships with public health, primary care commissioners, local authorities and other stakeholders and interested parties in respect of suicide
- Actively participates in public health led suicide prevention activities across its health communities
- Supports and engages with local and national suicide prevention research
- Continues to work to ensure that inpatient suicides are 'never-events'
- Eliminates all inpatient suicides using non-collapsible rails (NPSA, 2010)
- Undertakes an annual thematic analysis of all unexpected deaths and identifies lessons learned
- Disseminates lessons learned and good practice guidance in relation to suicide prevention across the organisation and the wider health community
- Develops, plans and implements a staff education/training programme regarding risk assessment and management that specifically addresses the clinical contribution to suicide prevention

Social disadvantage and suicide

The association between suicide rates with indices of deprivation has been well documented.⁴ Approximately 15% of the Bristol population live in wards that rank in the 10% most deprived in the country. This is in stark contrast to wards located within areas bordering Bristol (North Somerset 9%; Bath and North East Somerset 0%; South Gloucester 0%). Figure 3 below shows the relationship between mortality rates from suicide and undetermined death in Bristol and deprivation, with suicide rates clearly being highest in the most deprived quintiles. In fact, there is a stark contrast between quintile 5 (most deprived) and the more affluent quintile. Suicidal behaviour, particularly deliberate self-harm, has been shown to be much higher among manual occupational social groups and the unemployed and is most strongly associated with socio-economic deprivation.³³

Figure 3. Mortality from suicide and undetermined death in Bristol by deprivation quintile 2001-2010



Source: Public Health Mortality Files, 2012

Addressing complex needs

Bristol was selected, due to its significant concentration of people with multiple and complex needs, as one of 15 geographical areas eligible to apply for lottery funding under *Fulfilling Lives - Supporting People with Multiple and Complex Needs*. In response to this opportunity, a locally established partnership, led by Second Step, has put together a detailed proposal showing how it would deliver against its vision of bringing services together to ensure that they provide tailored support for people with multiple and complex needs. The focus would be on people who are experiencing at least two of the following: homelessness, re-offending, problematic substance misuse and mental ill health. Funding decisions will be made in the spring of 2013.

<http://ask.biglotteryfund.org.uk/help/england/fulfilling-lives/>.

Her Majesty's Prison (HMP) Bristol

HMP Bristol in Horfield houses around 600 male prisoners. It has a limited number of young offenders. The population includes both remand and convicted prisoners from all local courts, as well as being a Category B facility for the West of England.

The number of deaths from suicide within HMP Bristol between 2003 and 2005 was just under 2 deaths per year (Table 4). The most recently available figures, for the three year period (2006-2008), show a reduction in numbers of deaths down to an average of one per year.

Table 4. Deaths by Suicide in HMP Bristol

Years	2003 – 2005	2006 – 2008
No. of deaths	5	3

Source: HMP Bristol, 2010

Self-harm within the prison rose gradually between 2003 and 2005 with a slight dip in 2006. The average annual number of self-harm incidents in HMP Bristol in the 6-year period of 2003 and 2008 was 154 (see Table 5).

Table 5. Self-Harm Incidents in HMP Bristol

Years	2003	2004	2005	2006	2007	2008	6-year Ave
No. of self-harm incidents	95	156	190	140	167	174	154

Source: HMP Bristol, 2010.

There are several initiatives to prevent suicide in the prison including a **Listeners Scheme** performed by prisoners for prisoners who may be at risk from suicide or self-harm. Listeners are trained by the Samaritans.

Self-harm

Self-harm surveillance register

Approximately 2,250 people attend Bristol Royal Infirmary and Frenchay hospitals emergency departments for self-harm related incidents each year. 15-20% of all suicides have been seen in A&E in the previous 12 months. A self-harm surveillance register has been developed and is managed by a steering group drawn from the University of Bristol, UHB, AWP and NHS Bristol staff. In accordance with NICE Guidelines this aims to highlight the importance of general hospital services for self-harm patients, ensuring that there is:-

- Availability of a psychiatric liaison service so that all patients attending following self-harm can be offered a psychosocial assessment
- A maximum response time, since this can impact on the likelihood of assessment
- Collaboration in service delivery between PCTs and hospital and mental health trusts

The system also:

- Monitors rates and patterns of self-harm locally, including risk factors for repetition and suicide and medicines taken in overdose
- Provides data on current management of patients for clinicians and managers
- Evaluates services in relation to NICE guidelines for the management of self-harm
- Acts as a surveillance tool to allow early identification of changes in patterns of suicidal behaviour/suicide methods in Bristol
- Provides locally relevant data for clinician training
- Assesses impact of service changes

The annual report of this surveillance system for 2010-2011³⁴ catalogues a number of findings. The register reports that in 2011 there were 1485 attendances to Bristol Royal Infirmary's Accident and Emergency Department following self-harm. This equates to an average of 29 attendances a week (range 10-46). Of these attendances, 81% (1192/1479) attended outside of traditional working hours: Monday – Friday 9am-5pm. On average, the number of patients attending per day did not vary over the course of a week, with a median of 4 patients attending daily (range 0-12).

The 1485 attendances were made by 981 individuals, meaning roughly a third of attendances (34%, 502/1483) were repeat attendances. Of the 981 first presentations, 159 individuals went on to repeat their attendance, with a 'within-year' repetition rate of 16.2% (159/981).

The surveillance system has enabled the identification of potential areas for service improvement and will facilitate the evaluation of the impact service changes have on service users and healthcare costs.

Local self-harm studies

Although substantial numbers of adolescents self-harm, the majority of cases do not reach the attention of medical services and cannot therefore be included in the surveillance system. For this reason a local study was conducted at the community level to explore the prevalence of suicidal thoughts and plans and the inter-relationships between suicidal thoughts, suicide plans and self-harm among young people.³⁷

The report concluded that: self-harm and suicidal thoughts are common among 16/17 year olds. Although the majority of self-harm behaviour is not accompanied by a desire to die, all self-harm regardless of motivation is associated with increased risk of suicidal thoughts and plans, particularly when it is carried out repeatedly.³⁷

The role of the voluntary sector

The voluntary sector provides important support services in the local community. Many organisations do not have a focus on mental health or suicide and yet may still offer crucial support which helps to prevent suicide locally. They can offer help such as:

- Debt counselling
- Advice e.g. from organisations such as the Citizens Advice Bureau - NHS Bristol currently funds health related benefits advise to 4 agencies
- Practical support e.g. the Big Issue
- Substance misuse support
- Informal networks that can reduce social isolation e.g. elderly support networks, young men's groups.

Some of these organisations are described below. However, there are many others. Good sources for contact details and further information are the Voscur website³⁵ and the NHS Avon Mental Health Directory.³⁶

ARA (Addiction Recovery Agency) provides a full range of addiction treatment and support services

Avon Sexual Abuse Centre is for men, women and young people who have been sexually abused. It offers free confidential counselling.

Awaz Utaoh is a community organisation working with people from Black and minority ethnic communities and specifically with South Asian communities. It offers a range of initiatives, including practical help and counselling to victims of crime with language/cultural support.

Bristol Drugs Project offers free confidential help for people who misuse drugs, their relatives and friends. It has a wide range of projects and services locally which aim to reduce harm and actively promote change.

Bristol Crisis Service for Women (BCSW) offers support for women in emotional distress and particularly those who self-injure.

Bristol Patients Council is a user-led organisation for patients/service users of Bristol's mental health services.

Bristol Mind is a service for anyone in mental or emotional distress and their carers. It provides a helpline, information, advocacy and support.

Bristol Survivors Network is for users and ex-users of mental health services.

ChildLine is a free 24-hour helpline for children and young people in the UK.

Mothers for Mothers offers support, advice, information and empathy to mothers and their families suffering from postnatal illness.

Rethink works to help everyone affected by severe mental illness recover a better quality of life. A wide range of services include advocacy, carer support, community support, employment and training, helplines, housing, nursing and residential care and services dedicated to Black and minority ethnic communities.

Sane campaigns to combat the prejudice and intolerance surrounding mental illness and improve attitudes and services for individuals coping with mental health problems and their families. **Saneline** is a national mental health helpline.

SISH (Self-Injury Self-Help Group for Women) provides support for those who self-harm. This will include support groups for both men and women during 2013.

The Bristol Samaritans provides confidential, non-judgemental, emotional support. During the year 2011-2012 Bristol Samaritans received 56,800 phone calls; 1,600 emails; 2,200 text messages & 300 personal visits. They are core members of the Bristol Suicide Prevention Group and operate a range of initiatives in schools as well as supporting staff in 'hot spots' such as the rail network, car parks and Clifton Suspension Bridge.

The **Bristol South Mental Health Users Forum** provides advocacy, self-help and support for people who are mentally distressed or ill and who live in south Bristol.

Wellwomen Information provides information and support around emotional and physical health issues for women. It provides telephone helplines, an Asian women's counsellor, therapy groups and outreach work.

Bristol Action Plan 2013-2016

The following table describes broad objectives and actions. The Suicide Prevention and Audit Group will be working with detailed delivery plans for each objective and monitoring progress annually.

Aim	To reduce the death rate from suicide and injury (and poisoning) of undetermined intent in Bristol.
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	Objective	Action	Notes
1	Analyse Bristol data for trends and clusters of suicide Lead: Public Health Analyst	Publish annual suicide audit report for Bristol. Collect data of suspected suicide deaths (on a case by case basis) from Coroner's Office and additional information from General Practitioners including ethnicity, and place where suicide attempted – particularly when death occurred later in Hospital	All PCTs have a responsibility to carry out a suicide audit. There are a variety of systems in place across the country. An audit toolkit to support PCTs was launched in 2006. The most recent audit in Bristol (Update 2012) covered the period 1993-2010.
2	Promote responsible reporting of suicide in the local media Lead: Bristol PCT Communications Manager	Monitor local media reporting of suicide and take action to improve reporting.	The national strategy states that: <i>'The media have a significant influence on behaviour and attitudes. There is already compelling evidence that media reporting and portrayals of suicide can lead to copycat behaviour, especially among young people and those already at risk'²</i>

	Objective	Action	Notes
3	<p>Reduce access to means</p> <p>Leads: Public Health Analyst, Network Rail, Medicines Management</p>	<p>Monitor local hotspots in relation to deaths and gather evidence about the effectiveness of safety measures and advise on action.</p> <p>Continue to monitor deaths associated with railways.</p> <p>Monitor prescribing of medicines commonly associated with fatal overdose.</p>	<p>Reducing access to lethal methods of self-harm is a potential way of preventing some suicides. Suicidal behaviour is sometimes impulsive, so if a lethal method is not immediately available a suicidal act can be delayed or prevented altogether.</p> <p><i>Guidance on Action to be taken at Suicide Hotspots</i> provides advice to help identify hotspots and refers to evidence-based interventions that have proved effective.</p>
4	<p>Promote well-being</p> <p>Lead: Senior Health Promotion Specialist</p>	<p>Review and develop the Bristol Mental Health Promotion Strategy and Action Plan to ensure strong links with this Suicide Prevention Strategy 2013-2016.</p> <p>Include children and young people's needs in the review and development of the Bristol Mental Health Promotion Strategy.</p>	<p>Suicide rates reflect the mental health of the community as a whole. Bristol has a comprehensive mental health promotion strategy (see summary at Appendix B) aimed at reducing discrimination and promoting social inclusion and mental wellbeing.</p> <p>Recognising that for many people, the roots of the reasons for suicidal behaviour lie in childhood.</p>

	Objective	Action	Notes
5	<p>Identify local actions for high risk groups</p> <p>Lead: Associate Director of Public Health</p>	<p>Implement findings of the Equality Impact Assessment on the Strategy.</p> <p>Develop specific actions for high risk groups.</p> <p>Ensure that community development workers target high risk groups who may develop suicidal behaviour, as identified by the local audit.</p>	<p>There is a correlation between higher suicide rates and areas of disadvantage.</p> <p>High risk groups identified by the strategy include: people who have recently self-harmed; young men; prisoners; some occupational groups; recently discharged in-patients; asylum seekers, BME communities; LGBT people; those with a dual diagnosis; ex services personnel; those with long term conditions; personality disorders; drug and alcohol dependence issues and the homeless.</p>
6	<p>Identify gaps in NHS primary care</p> <p>Analyse and annually review Bristol data on the incidence, patterns and management of self-harm presenting at hospitals</p> <p>Lead: Mental Health Commissioner</p>	<p>Ensure that best practice relating to NICE guidelines on the treatment of people who self harm is implemented locally.</p> <p>Audit provision using a self-harm register</p> <p>Support the continuation of the Bristol Self-harm surveillance register and its extension to cover patients presenting to hospital services in the areas served by Frenchay and Southmead Hospitals</p>	<p>A history of self-harm is associated with an increased risk of suicide.</p>

	Objective	Action	Notes
7	<p>Identify gaps in NHS secondary care.</p> <p>Lead: Mental Health Commissioner</p>	<p>Establish good service provision and practice for patients attending A&E/acute trusts following self-harm.</p> <p>Ensure comprehensive psychosocial assessments for patients in acute hospitals following deliberate self-harm.</p> <p>Ensure that there is timely follow-up care for 'at risk' patients on discharge.</p>	<p>Bristol self-harm surveillance register</p> <p>Having a severe mental illness is a known risk factor for suicide. A significant number of suicides occur during a period of in-patient care, or shortly after discharge.</p> <p>In mental health services, risk of suicide is highest in the period immediately after hospital discharge. In 2006, the NCI published its third report <i>Avoidable Deaths</i>.</p>
8	<p>Develop support for those bereaved by suicide and those who have been witnesses to suicide.</p> <p>Leads: Senior Health Promotion Specialist, Samaritans.</p>	<p>Work with the Coroners Office, the police and the Samaritans to provide families with information and access to support.</p> <p>Conduct a scoping exercise on available support, which includes support for bereaved children and young people.</p> <p>Work towards filling gaps in the provision of support.</p>	<p><i>Help is at Hand</i> is a resource for people bereaved by suicide and other sudden, traumatic death.</p>

	Objective	Action	Notes
9	<p>Subject all deaths in custody and in the care of the Avon and Wiltshire Mental Health Partnership Trust to a full audit.</p> <p>Leads: Avon and Wiltshire Mental Health NHS Partnership, HMP Bristol.</p>	<p>Avon and Wiltshire Mental Health Partnership Trust and HMP Bristol to conduct audits into all deaths of people in the care of the Trust and people in custody, disseminating key messages / learning points from these audits to relevant staff members throughout the trust / prison and reporting annually to Health commissioners/Bristol City Council.</p>	<p>70 apparently self-inflicted deaths occurred in English prisons during 2005/2006 - a reduction of 17% in comparison to the previous year. Research highlights the importance of a whole-prison approach focusing on reducing distress amongst all prisoners, alongside individual interventions for the most vulnerable.</p> <p>From 2004, the Prisons and Probation Ombudsman, has been conducting all death in custody investigations. In 2006 a Forum for Preventing Deaths in Custody was set up.</p> <p>The latest available data shows that the numbers of in-patient suicides in England have fallen from 217 in 1997 to 154 in 2004 though this may be in part explained by the drop in inpatient numbers as a result of the move to increase community care.</p>
10	<p>Support the needs of First Responders.</p> <p>Well-being lead and Samaritans.</p>	<p>Investigate and meet needs of Rail Transport Police, Police Officers, Paramedics, Firefighters and others for information and training, particularly ASIST training.</p>	<p>Police, ambulance, rail and bridge staff, etc.</p> <p>Offering ASIST training and also emotional support to staff affected by incidents of suicide or attempts at suicide.</p>

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Appendix A: Preventing suicide in England:

A cross-government outcomes strategy to save lives 2012

The strategy is not a one-off document but an on-going, co-ordinated set of evolving activities. It seeks to be comprehensive, evidence-based, specific and subject to evaluation. For these reasons, when identifying high-risk groups as priorities for prevention, it selects only those for whom suicide rates can be monitored. The Strategy recognises however, that there are other groups for whom a tailored approach to their mental health is necessary if their risk of suicide is to be reduced. These approaches are illustrated among the 6 Goals below.

Goal 1: Reduce the risk of suicide in key high-risk groups

The following high-risk groups are priorities for prevention:

- young and middle-aged men
- people in the care of mental health services, including inpatients
- people with a history of self-harm
- people in contact with the criminal justice system
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers

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

Improving the mental health of the population as a whole is another way to reduce suicide. The measures set out in both *No health without mental health* and *Healthy Lives, Healthy People* will support a general reduction in suicides.

The strategy identifies the following groups for whom a tailored approach to their mental health is necessary if their suicide risk is to be reduced:

- Children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system
- Survivors of abuse or violence, including sexual abuse
- Veterans

- People living with long-term physical health conditions
- People with untreated depression
- People who are especially vulnerable due to social and economic circumstances
- People who misuse drugs or alcohol
- Lesbian, gay, bisexual and transgender people and Black, Asian and minority ethnic groups and asylum seekers

Goal 3: Reduce access to the means of suicide

One of the most effective ways to prevent suicide is to reduce access to high-lethality means of suicide. Suicide methods most amenable to intervention are:

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

Continued vigilance by mental health service providers will help to identify and remove potential ligature points. Safer cells complement care for at-risk prisoners.

Safe prescribing can help to restrict access to some toxic drugs.

Local agencies can prevent loss of life when they work together to discourage suicides at high-risk locations. Local authority planning departments and developers can include suicide in health and safety considerations when designing structures.

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

Effective and timely emotional and practical support for families bereaved by suicide is essential to help the grieving process and support recovery. It is important that GPs are vigilant to the potential vulnerability of family members when someone takes their own life.

Post-suicide community-level interventions can help to prevent copycat and suicide clusters. This approach may be adapted for use in schools, workplaces and health and care settings.

It is important that people concerned that someone may be at risk of suicide can get information and support as soon as possible.

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

The media have a significant influence on behaviour and attitudes. The government wants to support them by:

- promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media; and
- continuing to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention services

Local, regional and national newspapers and other media outlets can provide information about sources of support when reporting suicide. They can also follow the Press Complaints Commission Editors' Code of Practice and *Editors' Codebook* recommendations regarding reporting suicide.

The Government will continue to work with the internet industry through the UK Council for Child Internet Safety to create a safer online environment for children and young people. Recognising concern about misuse of the internet to promote suicide and suicide methods, they will be pressing to ensure that parents have the tools to ensure that children are not accessing harmful suicide-related content online.

Goal 6: Support research, data collection and monitoring

The Department of Health will continue to support high-quality research on suicide, suicide prevention and self-harm through the National Institute for Health Research and the Policy Research Programme.

Reliable, timely and accurate suicide statistics are essential to suicide prevention. The Department will consider how to get the most out of existing data sources and options to address the current information gaps around ethnicity and sexual orientation.

Reflecting the continuing focus on suicide prevention, the Public Health Outcomes Framework includes the suicide rate as an indicator.

Appendix B: Mental Health Promotion Strategy for Bristol

Promoting positive mental health in Bristol: Strategic framework 2008 – 2011²³

This strategy will be refreshed during 2013 in line with emerging priorities and structures.

Executive summary

Mental health promotion is such a broad concept that there is a danger of being overwhelmed by the task of describing it. This strategy is a starting point and attempts to introduce the scope of what can realistically be included as well as map out what is already going on and where future priorities lie.

Vision

The strategy is intended to promote and develop, over time, a co-ordinated multi-agency and inclusive approach to promoting positive mental health and emotional well-being in Bristol.

Aim

The aim of the strategy is to support, develop and co-ordinate mental health promotion initiatives based on evidence of effectiveness.

It recognises the positive initiatives already being implemented and aims to build on their good practice. It addresses the needs of the whole population including service users and carers and recognises the detrimental effects of stigma and social exclusion. The strategy promotes a flexible, realistic and inclusive approach.

What is mental health promotion?

Mental well-being is influenced by many factors including genetic inheritance, childhood experiences, life events, individual abilities to cope and levels of social support. It is also influenced by determinant type factors like adequate housing, employment, financial security and access to appropriate health care. Gender, age and culture can also have a significant impact on individual mental health and vulnerability to mental health problems. Racism, homophobia and other forms of discrimination are known to significantly affect mental health.

Mental health is not just a characteristic of individuals. Institutions and organisations, neighbourhoods and specific groups of people, like refugees, may have low levels of mental health as a result of poverty, deprivation, exclusion, isolation or low social status. There are many different definitions of mental well-being and these are influenced by our individual experiences and expectations, as well as by cultural and religious beliefs.

Mental health promotion works at different levels. Some are applicable to the whole population and aim to increase emotional resilience through interventions designed to promote self-esteem, life and coping skills. Others are directed towards individuals at specific risk, vulnerable groups or people with existing mental health concerns.

Strengthening the Bristol community

There is growing evidence that improving mental well-being has a positive impact on health and other social and economic outcomes. The past few years have seen government policies, programmes and projects give increasing emphasis to public mental health and well-being. This has in turn strengthened the focus of public health towards promoting and protecting mental health across whole populations.

This focus on improving mental well-being comes at time when the Government is implementing significant changes to the NHS and the welfare services. The new health services focus is expected to centre on the achievement of outcomes rather than process targets and these outcomes will be related to overall health, mental health and addressing 'upstream' social and environmental factors which can determine health status.

In Bristol, policy makers are already prioritising the inclusion of public mental health and well-being in strategic planning. There is a growing consensus that improving mental well-being isn't just a good idea but an evidence-based necessity.

In 2013, the Bristol Public Mental Health and Well-being Forum will be created. This forum should bring together leaders from all those sectors relevant to developing the updated all-ages public mental health promotion strategy and action plan. Its key objectives will be aligned to those identified in the Government strategy: *No health without mental health*¹⁹. These are:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

The implementation plan will follow 5 main domains:

- Promoting positive mental health and increasing resilience
- Tackling the wider determinants of health
- Health improvement
- Preventing ill health
- Preventing premature deaths and reducing health inequalities

Groups to target who are at higher risk of mental health problems include the following:

Children and young people	Adults
<ul style="list-style-type: none"> • Children with parents who have mental health or substance misuse problems • Those who suffer personal abuse or witness parental domestic violence • Looked after children • Child carers • Children and young people excluded from school • Teenaged parents • Young offenders • Lesbian, gay, bisexual, transgender young people • Black and minority ethnic communities • Families living in socio-economic disadvantage 	<ul style="list-style-type: none"> • People with mental health illness or a history of self-harm • Black and minority ethnic communities • Homeless people • Adults with a history of violence or abuse • Offenders and ex-offenders • Lesbian, gay, bisexual, transgender adults • Travellers, asylum seekers and refugees • People with learning disabilities • Isolated older people • Ex-military veterans • People with long-term physical conditions

The focus for future mental well-being initiatives in Bristol will be to raise awareness and understanding of the importance of well-being to a point where the population are able to talk openly and knowledgeably about using tools like the “five ways to well-being” in a way comparable to their recognition of the benefits of eating five fruit and vegetables a day to produce a healthy diet.

Appendix C: NICE Self-harm guidelines 2004⁵

A review is currently being undertaken to decide whether Clinical Guideline 16 should be updated.

Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care (Extract)

Clinical Guideline 16: key priorities for implementation

Respect, understanding and choice

People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm.

Staff training

Clinical and non-clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed.

Activated charcoal

Ambulance and emergency department services whose staff may be involved in the care of people who have self-harmed by poisoning should ensure that activated charcoal is immediately available to staff at all times.

Triage

- All people who have self-harmed should be offered a preliminary psychosocial assessment at triage (or at the initial assessment in primary or community settings) following an act of self-harm. Assessment should determine a person's mental capacity, their willingness to remain for further (psychosocial) assessment, their level of distress and the possible presence of mental illness
- Consideration should be given to introducing the Australian Mental Health Triage Scale, as it is a comprehensive assessment scale that provides an effective process for rating clinical urgency so that patients are seen in a timely manner
- If a person who has self-harmed has to wait for treatment he or she should be offered an environment that is safe, supportive and minimises any distress. For many patients, this may be a separate, quiet room with supervision and regular contact with a named member of staff to ensure safety

Treatment

- People who have self-harmed should be offered treatment for the physical consequences of self-harm, regardless of their willingness to accept psychosocial assessment or psychiatric treatment
- Adequate anaesthesia and/or analgesia should be offered to people who have self-injured throughout the process of suturing or other painful treatments
- Staff should provide full information about the treatment options, and make all efforts necessary to ensure that someone who has self-harmed can give, and has the opportunity to give, meaningful and informed consent before any and each procedure (for example, taking the person to hospital by ambulance) or treatment is initiated

Assessment of needs

All people who have self-harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment.

Assessment of risk

All people who have self-harmed should be assessed for risk: this assessment should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent.

Psychological, psychosocial and pharmacological interventions

Following psychosocial assessment for people who have self-harmed, the decision about referral for further treatment and help should be based upon a comprehensive psychiatric, psychological and social assessment, including an assessment of risk, and should not be determined solely on the basis of having self-harmed.

Copies of this quick reference guide can be obtained from the NICE website at www.nice.org.uk

Please feel free to use this space to feed back your comments on this strategy.

Please tear off and send to Ingrid Sommeling, NHS Bristol, South Plaza, Marlborough street, Bristol BS1 3NX. Or email comments to:

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