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Report of the Strategic Director of Health and Wellbeing to the meeting of the Health and Social Care Overview and Scrutiny Committee to be held on 6 April 2016.

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Subject: Bradford District Suicide Audit and Prevention Plan

Summary statement:

This report presents to Scrutiny an overview of findings from a recently conducted audit of deaths by suicide in the District 2013-15, and also presents the District's new multi-agency Suicide Prevention Plan in draft form, prior to its anticipated launch in April 2017.

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1. SUMMARY

This report presents to Scrutiny an overview of findings from a recently conducted audit of deaths by suicide in the District 2013-15, and also presents the District's new multi-agency Suicide Prevention plan in draft form, prior to its anticipated launch in April 2017.

Between 2013 and 2015, the coroner's files which were audited showed 76 conclusions of suicide in the District, while the Office for National Statistics (ONS) published figures (which include narrative conclusions) record 148 deaths in the same period. The audit considers key demographic information on those who took their own life, as well as service contact and medical/social history, and the manner and means of the deaths. This information, together with national strategies and evidence, informs the District's new prevention plan.

2. BACKGROUND

Suicide is a tragic event which, though rare, affects a large number of people each time it occurs, sending ripples through family and community life. As part of the District's new Mental Wellbeing Strategy 2016-2021, there is a commitment to support the development and implementation of a District-wide suicide prevention plan, sitting under the 'Our Wellbeing' aspiration of the strategy. This plan is now in its final stages of development, and is included as an appendix to this report. It is based on the premise that many suicides are preventable, and if early support or crisis intervention is offered we know we can see a different outcome in people's lives.

The suicide rate has been rising nationally since 2008, and Bradford has slightly higher rate of suicide than the England average. In Bradford, the ONS estimates that the 3 year rolling average rate of deaths by suicide is 11.4 per 100,000 people (2013-2015); this is above the national average of 10.1 per 100,000, and means Bradford has the 5th highest rate in Yorkshire and Humber. Using this way of counting suicides, the District sees around 40-50 suicides every year, or around one each week. In 2013, 3 out of 4 deaths from suicide in Bradford were by males, with the highest number of male suicides occurring between 20 and 44 years of age.

3. REPORT ISSUES

<u>National evidence and policy on suicide prevention</u>
Decades of international research on suicidal trends and prevention has identified that there are no cast iron methods of predicting or preventing a suicide. However a number of risk factors are common in many cases which can aid the targeting of resources and prevention work. These include:

- **Age and sex**, with males three times as likely to take their own life, and the peak age for suicide rising over the last 20 years from 20-29 to 35-45. Suicide is the second most common cause of death for 5-19 year olds, the leading cause of death for 20-34 year olds, and the second most common cause of death for 35-49 year olds.

- **having a mental health problem**, be it a mood disorder such as depression, anxiety or personality disorder, or an illness with psychotic episodes
- **having made a previous suicide attempt**
- **having a history of self-harm**
- **ethnicity**, with research showing lower rates of suicide amongst Islamic communities and higher rates amongst black males
- **the misuse of substances** (drugs and alcohol)
- **having a physical health problem**, particularly chronic pain
- **being in contact with the criminal justice system**
- **having ready access to the means of suicide**, for instance doctors (anaesthetic medication) and farmers (guns)
- **relationship breakdown**
- **financial strain** (research has shown a link between Work Capacity Assessments/benefit sanctions and suicide rates)
- **adverse life events**, for instance unemployment
- **previously bereavement by suicide,** for instance of a family member or close contact

Based on these risk factors, the Government's Suicide Prevention Strategy for England from 2012 set out 6 areas for action:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

This strategy was updated in January 2017, and sets out an ambition for a reduction in national rates of suicide of 10% by 2021, as well as making it mandatory for each local area to develop a suicide prevention plan by the wend of 2017. Other key policy and evidence resources include:

- NHS England Five Year Forward View for Mental Health (2016)
- Public Health England (2016): Local Suicide Prevention Planning: a Practice Resource
- Health Select Committee (2017): TBC

<u>Local Partnership Work around suicide prevention</u>

As part of the District's new Mental Wellbeing Strategy 2016-2021, there is a commitment to support the development and implementation of a District-wide suicide prevention plan, sitting under the 'Our Wellbeing' aspiration of the strategy. It is recognised that any efforts to tackle suicide rates cannot be seen in isolation from wider work to improve mental wellbeing in the District, ranging from services to support those with mental health problems to population level work to improve the mental wellbeing and emotional resilience of the residents of Bradford.

Partners in the district – including local GPs, representatives from Bradford District Care NHS Trust, Bradford Clinical Commissioning Groups, City of Bradford, West Yorkshire Police and West Yorkshire Fire and Rescue, as well as Bradford MIND, Bradford Samaritans, and Sharing Voices – meet regularly as part of the District's Suicide Prevention Group. During 2016, the group was reviewing the national and international evidence for effective suicide prevention, data and intelligence on suicides in Bradford, and has now produced a local plan of action in line with Public Health England guidance.

Additionally, Bradford District Care NHS Trust convenes its own internal suicide reduction and as part of its statutory duties it investigates the death by suicide of patients under its care in a Serious Incident investigation. The Child Death Overview Panel, responsible for reviewing all deaths of under 19s in the District, also reviews the small number of child suicide cases the District has seen.

Audit of deaths by suicide

In February 2017, access was granted for two public health staff members to audit Bradford-based suicide case files from the office of H M Coroner for the Western Area of West Yorkshire. The files which were audited showed that between 2013 and 2015 there were 76 conclusions of suicide in the District, while the ONS published figures (which include narrative conclusions) record 148 deaths in the same period.[1] Of the cases:

- 78% of those who took their own life were male, and 22% were female. The mean age at death was 45 for males and 50 for females (47 overall), with the highest number of deaths (30) in the 40-49 age bracket
- Fewer people who killed themselves were from a South Asian background than might be expected given the ethnicity structure of the population of the District, and more people who killed themselves were from a Central Eastern European background; this conclusion should however be interpreted with caution due to the low numbers involved
- 61% of all deaths were by hanging or strangulation and 17% were by self poisoning; other methods included falling from a height, jumping under a train, and cutting/ stabbing
- 78% of deaths occurred in the deceased's own home, with 22% in a more public place or workplace. A suicide note was left in 45% of cases
- 39% of people who died lived alone, and 65% were not in a long term relationship of any sort. 43% of cases had a long term physical health problem.
- More than half (57%) of those who took their own lives had at least one diagnosed mental illness, and of those who did not, 61% had anecdotal reference to suspected or historical mental health problems.
- 28% of cases had been in contact with secondary mental health services (for instance the community mental health team) in the 12 months prior to death; none were inpatients at the time of death. Nearly three quarters of those who killed themselves (71%) had seen their GP in the 6 months before death

[1] Data from the ONS counts deaths coded as 'undetermined intent' as well as suicide verdicts in an attempt to correct underestimation of the true number of suicides. In England and Wales, it has therefore been customary to assume that most injuries and poisonings of undetermined intent are cases where the harm was self-inflicted but there was insufficient evidence to prove that the deceased deliberately intended to kill themselves; this convention has been adopted across the UK (ONS 2012)

- At post mortem, drugs and/or high levels of alcohol were found in the system of the deceased in 50% of cases, suggesting that half of all cases were under the influence of drugs/alcohol at the moment they took their own life
- Adverse life events experienced by those who took their own life prior to death included: family difficulties or break up, debt or financial worries, bereavement, loneliness/isolation, unemployment, suffering from abuse (sexual, emotional, physical, or neglect), a sense of shame, being affected by the suicide of a close contact, having benefits recently stopped or being sanctioned, and problems at work

Using life expectancy estimates produced by the ONS, it is estimated that these deaths represent 2672 potential years of life lost, years which, if effective intervention had occurred, may have been saved.

Multi-agency Suicide Prevention Plan

The Bradford Suicide Prevention Plan has been endorsed by the district's Mental Wellbeing Partnership Board, and has the following vision statement:

> 'We ultimately aspire to prevent all suicides in the District; for us, no suicide is inevitable. As a short-term goal, we have and ambition for a 10% reduction by 2021; achieving this would mean that 5 lives will be saved each year after 2021.'

Given that the plan forms a part of the wider District mental wellbeing strategy, it takes the form of an action plan, grouped into the following categories:

1: Reducing the risk of suicide in key high-risk groups

…including actions to reduce inpatient and community mental health service user suicides through timely discharge planning, policies on absconding and self-discharge, and enhanced discharge follow-up, train blue light professionals in suicide prevention, tackle high suicide rates in men and drug/alcohol misusers

2: Using tailored approaches to improve the mental health of the population

…including actions to develop 'CARE Cards' guiding universal workers in steps to spotting suicidal individuals, increasing availability of Safetalk/ASIST suicide prevention training across the district

3: Reducing access to the means of suicide

…including actions to Ensure best practice in in-patient settings with regard to safe clinical areas, work with Network Rail and WY Police to identify 'hotspots'

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

…including actions to improve access to suicide-specific bereavement support, make copies of 'Help is at Hand' (PHE support guide) more widely available

5: Supporting the media in delivering sensitive approaches to suicide

…including actions to Provide briefing for local journalists on sensitive approaches using Leeds NUJ/Council written guidance, campaigning and awareness raising around WHO World Suicide prevention day (Sep 10th 2017), promoting evidence-based mobile apps: '5 ways to wellbeing' and 'Stay alive'

6: Supporting research, data collection and monitoring
…including conducting an audit of the coroner's files for suicide death inquests, and learning from serious incidents/after suicide for people in contact with secondary care

The full plan is attached as an appendix to this report.

4. FINANCIAL & RESOURCE APPRAISAL

There are no financial issues arising from this report; the action plan is based on partnership working and has no funding attached.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

There are no significant risks arising out of the implementation of the proposed recommendations; there is a requirement from national government to have a Suicide prevention plan for each local authority area by the end of 2017 (HM Government Suicide Prevention Strategy for England), and the main risk is to be in breach of this requirement.

6. LEGAL APPRAISAL

There are no legal issues arising from this report.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

There are no new or reviewed services, or removal of policies, practices, strategies, or functions, as a result of this report. Suicide rates are higher nationally in more deprived communities and certain ethnic groups (e.g. black African males).

7.2 SUSTAINABILITY IMPLICATIONS

There are no Sustainability issues arising from this report.

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

There are no greenhouse gas emissions impacts arising from this report.

7.4 COMMUNITY SAFETY IMPLICATIONS

There are no community safety implications arising from this report.

7.5 HUMAN RIGHTS ACT

There are no Human Rights Act implications arising from this report.

7.6 TRADE UNION

There are no trades union implications arising from this report

7.7 WARD IMPLICATIONS

Suicide rates differ by ward (see appendix)

7.8 AREA COMMITTEE ACTION PLAN IMPLICATIONS (for reports to Area Committees only)

Suicide rates differ by area committee (see appendix)

8. NOT FOR PUBLICATION DOCUMENTS

None

9. RECOMMENDATIONS

Recommended -

That Committee Members note and comment on the audit of deaths by suicide and the District Suicide Prevention Plan 2017-2021

11. APPENDICES

- Interim key findings: audit of deaths by suicide in Bradford District 2013-2015
- Bradford District Suicide Prevention Plan 2017-2021

12. BACKGROUND DOCUMENTS

- HM Government :'Suicide Prevention Strategy for England (2012; updated 2017)
- NHS England: 'Five Year Forward View for Mental Health' (2016)
- Public Health England: 'Local Suicide Prevention Planning: a Practice Resource' (2016)
- Health Select Committee: TBC (2017)