

# West Sussex **Suicide Prevention Strategy 2017-2020**



## **Acknowledgments**

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## 1 FOREWORD

When someone takes their own life, it is not only a personal tragedy but it also has a huge impact on family, carers, friends, colleagues and those providing support as well as members of the community. It is widely recognised that many suicides could be prevented.

The Suicide Prevention Strategy has been co-ordinated by the West Sussex Suicide Prevention Steering Group and its development has been overseen by the West Sussex Health and Wellbeing Board. The strategy aims to reduce the amount of people taking their own lives and address risk factors associated with suicide in West Sussex.

Suicide prevention has been on the work programme for the West Sussex Health and Wellbeing Board as suicide is the biggest killer of men aged 49 and under as well as the leading cause of death in people aged 10–34 years in the UK. Suicide rates in West Sussex have been increasing since 2008, in line with national trends.

This strategy will be developed into an Action Plan in 2018 so that practices can be implemented to start reducing West Sussex suicide rates while supporting those who experience complex mental health issues.

Amanda Jupp - Cabinet Member for Adults and Health

## 2 EXECUTIVE SUMMARY

### Introduction

Suicide is the leading cause of death in people aged 20–34 years in the UK. In West Sussex suicide-related costs, including lost output, police time and funerals, were estimated to be £367.4 million between 2013 and 2015. It is widely recognised that suicides are preventable.

### Aims

- To reduce the number of people taking their own lives in West Sussex
- To address the risk factors associated with suicide in West Sussex

### Policy context

The 2012 cross-Government National Suicide Prevention Strategy for England highlighted six priority 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
6. Support research, data collection and monitoring

## What we know about suicides in West Sussex

- West Sussex has generally had **similar suicide rates to the rest of England**, though suicide rates have been steadily **increasing** in West Sussex and England.
- More than three-quarters of all suicides in West Sussex were **men**.
- The highest frequency of suicides is in **early middle age**; suicides are less common in those under 45 years in West Sussex compared to England.
- The most common suicide methods in West Sussex are **hanging (46%), self-poisoning (24.4%) and railway deaths (11.3%)**. Self-poisoning and railway deaths may be more common than in England.
- Nearly two-thirds of those who die by suicide in West Sussex have a **mental illness**, which is similar to the rest of England.
- There is a history of **self harm** in a third of suicides locally. Emergency hospital admissions for self-harm are significantly higher than England and are increasing.
- Other important suicide risk factors locally include **deprivation, substance misuse, social isolation, having a long term condition, being a carer and bereavement**.
- In over a third of suicides, individuals have **seen their GP in the month before** they died. Around half of cases are **known to mental health services** and one third of those were seen within the week before death.

## Stakeholder engagement

An online stakeholder consultation of front line workers across sectors found:

- **Three quarters of respondents had ever spoken about suicidal thoughts** with customers, clients or patients, including respondents from all sectors including housing, libraries and education.
- Yet **41% of respondents did not feel confident** about talking to someone who was feeling suicidal. Library staff, emergency services and community health services were the least confident.
- The biggest **barriers** to supporting people at risk of suicide were **not having received relevant training**, not being confident and being worried that talking would make a suicide attempt more likely.
- Suggested actions to improve suicide prevention were: **Increased awareness of where to signpost and clearer referral pathways; training for frontline workers; more accessible mental health support; awareness raising to reduce stigma and publicise support available; and development of networks and leadership.**

## Priority areas for action in West Sussex 2017-2020

The following priority areas for action were identified on the basis of local patterns and risk factors for suicide, and the stakeholder consultation findings:

1. **Focus on reducing suicides in vulnerable middle aged and older people, particularly those experiencing financial difficulties and social isolation**
2. **Focus on preventing suicides in people in contact with mental health services, particularly those recently discharged or disengaged from care**
3. **Focus on preventing suicide in people who misuse alcohol or drugs, particularly those with a dual diagnosis**
4. **Focus on reducing self harm, particularly in young people**
5. **Focus on preventing suicide in people with long term conditions or requiring end of life care, and their carers**
6. **Improve support for people bereaved or affected by suicide**
7. **Increase confidence and skills of paid and volunteer workers to support people at risk of suicide, maximising the use of existing resources and support**
8. **Reduce access to the means of suicide, focusing on self-poisoning, railways and other public places**
9. **Monitor suicide patterns and trends in West Sussex**

## 3 INTRODUCTION

Suicide is the biggest killer of men aged 49 and under and the leading cause of death in people aged 20–34 years in the UK <sup>1</sup>. Suicide has a profound and enduring impact on families, friends, colleagues and the wider community. Between 6 and 60 people are thought to be affected by every suicide (Public Health England, 2016). There are also serious economic impacts; it is estimated that in England the average cost per completed suicide for those of working age is £1.67m (at 2009 prices). In West Sussex this equates to estimated suicide-related costs of £367.4 million between 2013 and 2015<sup>2</sup>. This includes lost output, police time and funerals, as well as intangible costs such as loss of life and distress of relatives. 60% of these costs relate to those bereaved (Knapp, McDaid, & Parsonage, 2011).

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<sup>1</sup> Source: Deaths registered in England and Wales (Series DR) 2015: ONS Statistical bulletin

<sup>2</sup> There were 220 suicides between 2013 and 2015 in West Sussex. These costs may be an underestimate as (i) they relate to 2009 prices (ii) South East England and West Sussex generally outperform most of England in terms of output.



Suicide rates in West Sussex have been increasing since 2008, in line with national trends. A recent audit of all suicides in West Sussex between 2013 and 2015 has provided unique insights into local patterns of suicide (see Section 6).

It is widely recognised that suicides are preventable. The multi-agency West Sussex Suicide Prevention Steering Group was set up to coordinate local implementation of the national strategy 'Preventing Suicides in England' (see Section 5). The Steering Group's achievements to date are presented in Section 8. An engagement exercise was recently carried out to determine the needs and views of front line workers in relation to suicide prevention (see Section 7). This suicide prevention strategy draws together findings from the suicide audit and engagement work to present a set of priority areas for action in West Sussex for 2017 to 2020 that are aligned with national strategic priorities (see Section 9).

## 4 AIMS

The overall aims of this strategy are:

- to reduce the number of people taking their own lives in West Sussex
- to address the risk factors associated with suicide in West Sussex

## 5 POLICY CONTEXT

### 5.1 National context

The **Five Year Forward View for Mental Health** set the ambition that by 2020/21 the suicide rate will be reduced by 10% nationally compared to 2016/17 levels (Mental Health Taskforce to the NHS in England, 2016). The 2012 **cross-Government National Suicide Prevention Strategy for England** (Department of Health, 2012) highlighted six priority areas for action to achieve this:

- 1. Reduce the risk of suicide in key high-risk groups** including men, people in the care of mental health services, people with a history of self harm, those in contact with the criminal justice system and specific occupational groups.
- 2. Tailor approaches to improve mental health in specific groups** including children and young people, people with long term physical health conditions, people in vulnerable social and economic circumstances, and people who misuse alcohol or drugs.
- 3. Reduce access to the means of suicide**, including at high-risk locations and on rail networks.
- 4. Provide better information and support to those bereaved or affected by suicide** as this group are at increased risk of mental health problems and may be at higher risk of suicide themselves.
- 5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour** as there are strong links between media reporting of suicide and imitative suicidal behaviour.
- 6. Support research, data collection and monitoring**

The **National Strategy Refresh**, published in January 2017, strengthened its focus on preventing suicide in men, addressing self-harm, and increasing support for people bereaved by suicide (Department of Health, 2017). **Public Health England (PHE)** have produced several valuable guidance documents for local authorities on the implementation of the national strategy at the local level (Public Health England, 2016).

The March 2017 report of the **House of Commons Health Committee on Suicide Prevention** (House of Commons Health Committee, 2017) emphasised the importance of reaching those at risk but not accessing traditional services; the need to improve training of clinicians in the identification of suicide risk; the need for follow up plans for patients presenting with self-harm; the need for high quality support for individuals bereaved by suicide and the

need for rapid communication between agencies so that public health teams can respond to possible suicide clusters.

The **Public Health Outcomes Framework** includes suicide rate as an indicator (4.10) of the numbers of people dying prematurely. There is also a suicide indicator in the Department of Health's **NHS Outcomes Framework 2016 to 2017**: 1.5 iii *Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services.*

## 5.2 Local context

Priority 2 (Wellbeing and Resilience) of the **West Sussex Joint Health and Wellbeing Strategy** is to develop *“a comprehensive system to support wellbeing and resilience for the whole of the West Sussex population, that is locally based and better integrated with treatment services”* (West Sussex County Council, 2015). Working to prevent suicides in West Sussex will help to achieve this outcome through ensuring individuals and families are resilient to economic and other pressures and filling gaps in current services.

The 2015 **Sussex Partnership NHS Foundation Trust Suicide Prevention Strategy** (Sussex Partnership NHS Foundation Trust, 2015) included a commitment to working with local public health teams on suicide prevention. Many of the actions align with this strategy, such as supporting people who are bereaved as a result of suicide.

One theme of the **West Sussex Mental Health Crisis Care Concordat Action Plan** (October 2015 update) (West Sussex Crisis Care Concordat, 2015) is to improve access to support before crisis point, and to support implementation of the West Sussex Suicide Prevention Strategy. One action was to support implementation of mental health training packages for all public facing agencies.

This strategy also aligns with the **West Sussex Children and Young People's Mental Health and Emotional Wellbeing Transformation Plan 2015-2020**, which includes a focus on early intervention and prevention and emphasises collaboration between providers.

## 6 WHAT WE KNOW ABOUT SUICIDES IN WEST SUSSEX

### 6.1 Data sources

A range of data sources have been used to create a picture of who dies by suicide in West Sussex, the methods used, the important local risk factors for suicide and what contact those who die by suicide have with health services. Key data sources include:

- Local level audit of coroner's inquests for suicides spanning 2013 and 2015 (see Appendix A)
- PHE Suicide Prevention Profile and Crisis Care Profile
- Office of national statistics
- Hospital episode statistics
- The annual report and 20 year review of the National Confidential Inquiry into Suicides and Homicides by People with Mental Illness

There are some differences in the suicide data between the West Sussex audit and the routine data sources used. Most notably, there were 220 suicides reported by the ONS between 2013-2015, and 213 suicides recorded in the local audit. These differences arise because of slight differences in the ONS and audit inclusion criteria. Directly age standardised rates have been presented where possible, in order to allow comparability between areas within West Sussex and against England.

### 6.2 Suicide rates

#### 6.2.1 Overall

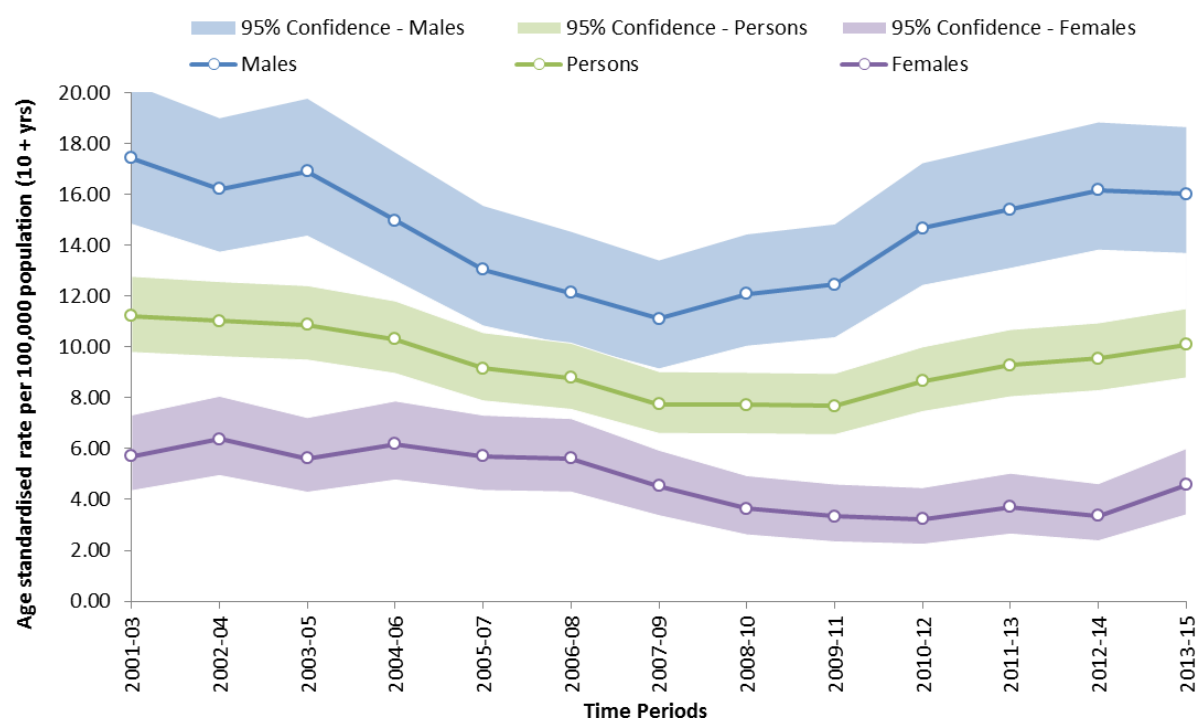
In 2013- 2015 there were 220 suicides in West Sussex, which equates to an age standardised rate of 10.1 suicides per 100,000 population per year<sup>3</sup>. Over the last 15 years West Sussex has generally had similar suicide rates to the rest of England, with the exception of 2007-2011 when local suicide rates were significantly lower than the national average. More recently, suicide rates have been steadily increasing in West Sussex and England<sup>4</sup>.

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<sup>3</sup> Source: ONS

<sup>4</sup> Source: Public Health Outcomes Framework

Figure 1 Directly age-sex standardised rate of suicide in West Sussex per 100,000 population; males, females and persons; 2001-03 to 2013-15



Source: ONS

## 6.2.2 Gender

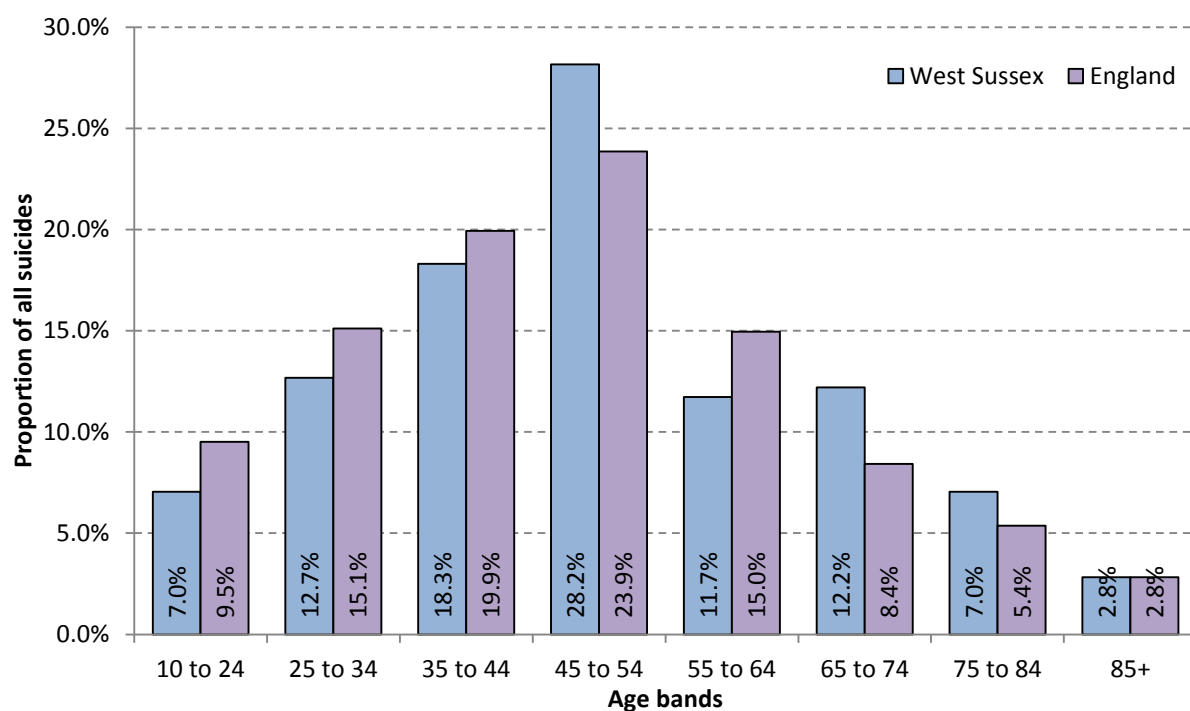
Reflecting patterns across England, suicide rates in West Sussex are higher in men (16.0/100,000 population in 2013-15) compared to women (4.6/100,000 population). Between 2013 to 2015, more than three-quarters of all suicides in West Sussex were men (168 of 220 suicides)<sup>5</sup>.

## 6.2.3 Age

In West Sussex, the audit found that the highest frequency of deaths was in early middle age, with nearly 30% of deaths occurring between the ages of 45 and 54. There were less than 5 deaths recorded among under-18 year olds (both male) and fifteen deaths in under-25s (7.0% of total). In general a lower proportion of suicides involve age groups less than 45 years in West Sussex compared to England (Figure 2).

<sup>5</sup> Source: ONS

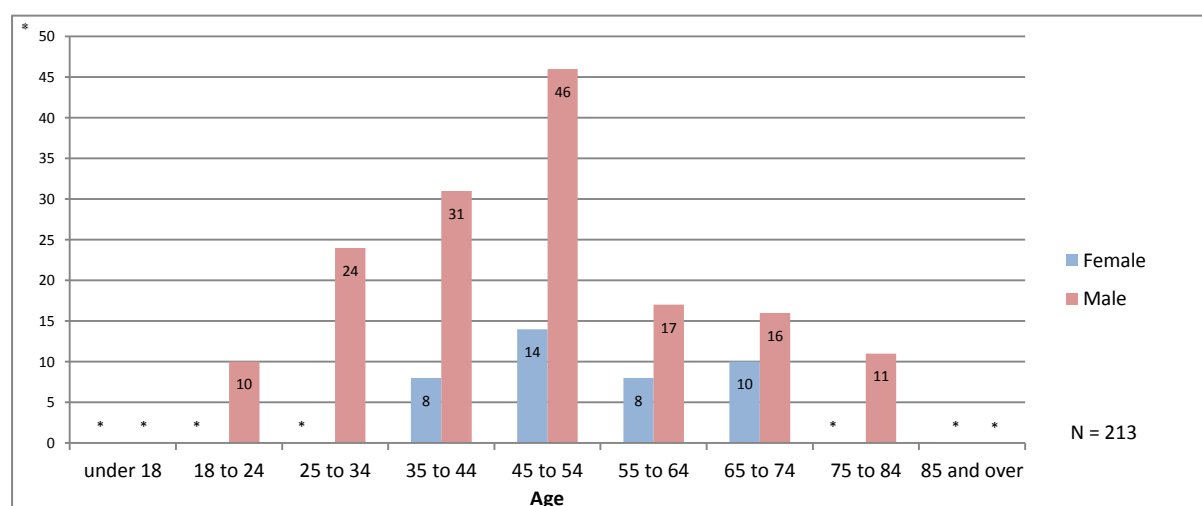
Figure 2 Suicides by Age Band, West Sussex and England (2013 to 2015)



Sources: ONS - Suicides in England, 2015 (year registered); West Sussex Suicide Audit (year of inquest). Note. This data is taken from two different sources and is therefore should be viewed with a degree of caution.

In West Sussex, men appear to be more likely to take their own lives at an earlier age; only 26.9% of female deaths were under the age of 45, compared with 41.6% of male deaths. One in three females was aged 65 or over, as were one in five males (see figure 3).

Figure 3 West Sussex suicide audit: number of deaths by age and gender



Source: West Sussex Suicide Audit (cases with inquest dates in 2013 to 2015)  
(Data suppressed (\*) for values fewer than five)

#### 6.2.4 CCG and district

There are slight variations in suicide rates between CCG areas and districts in West Sussex, but these differences are not statistically significant in 2013-2015.

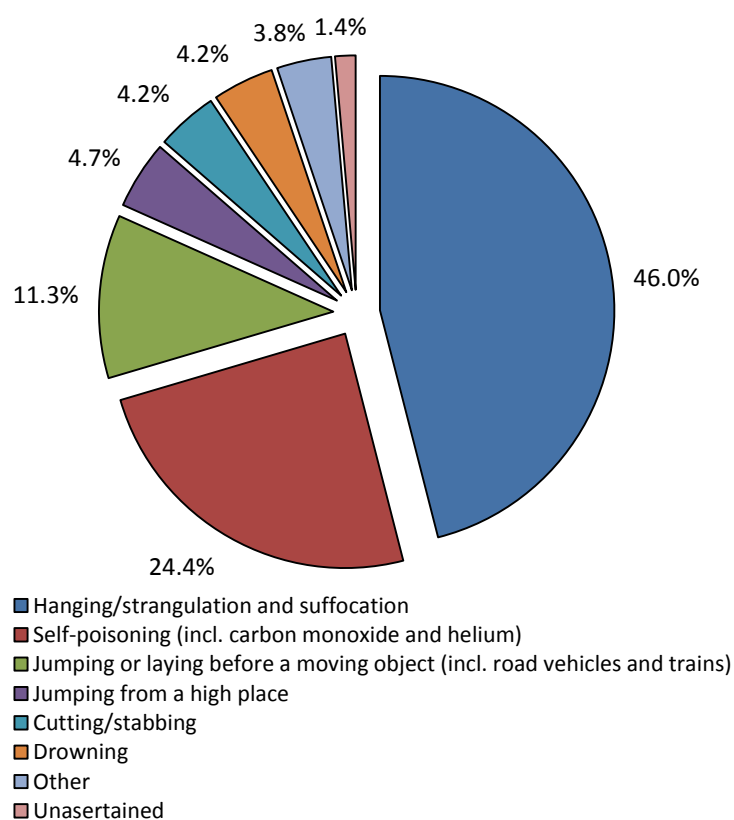
#### 6.2.5 Time of year

Globally, seasonal patterns of suicide have been identified, with higher suicide rates typically found in spring (Christodoulou, et al., 2012). The audit did not find firm evidence for seasonal variation in suicide rates, even when deaths from the previous audit (2011-2012) were included.

### 6.3 Suicide method

The suicide audit found that the most common cause of death for both males and females in West Sussex was by hanging, strangulation or suffocation (46%) (figure 4). Second to this was self-poisoning, which was more common in females (27% of suicides compared to 17% in men).

Figure 4 Proportion of suicides in West Sussex during 2013-15 by method



Source: West Sussex Suicide Audit (cases with inquest dates in 2013 to 2015)

The audit found differences in the age profiles of different methods, with self-poisoning occurring more than expected in the 65+ age cohort in West Sussex. A larger proportion of deaths from rail incidents occurred in under-35 year olds compared to older ages. Three rail related deaths related to women, whilst 19 related to men. Overall a third of suicides in West Sussex involved alcohol consumption, with a higher rate in men (36%) compared to women (15%). 17% of individuals were under the influence of illicit drugs at the time of death with similar rates in men and women.

It is difficult to directly compare suicide methods in West Sussex to the rest of England due to the differences in the data sources. Whilst the three most common methods of suicide are the same in England and West Sussex, the proportions for these groups may differ (tables 1 and 2). Nearly 60% of all suicides in England recorded between 2013-2015 were due to hanging, strangulation or suffocation<sup>6</sup>. This compares to 46% of cases in the West Sussex suicide audit who used these methods. Conversely, the proportion of suicides by jumping or laying in front of a train or car appeared to be higher in West Sussex (11.3%), according to the audit findings, than the rest of England (6.1%)<sup>7 8</sup>.

Table 1 Most common methods of suicides in England during 2013 to 2015 (year of registration)

2013 to 2015	England	
	Counts	Proportion
X70 Intentional self-harm by hanging, strangulation and suffocation	6,693	59.2%
X60-69 Intentional self-poisoning	2,182	19.3%
X81 Intentional self-harm by jumping or lying before a moving object	688	6.1%
Other (X71 to X80 and X82 to X84)	1,747	15.4%
Total	11,310	100.0%

Source: NOMIS Mortality Statistics – underlying cause, sex and age for England 2013 to 2015

Table 2 Most common methods of suicide in West Sussex during 2013 to 2015 (year of inquest)

2013 to 2015	West Sussex	
	Counts	Proportion
Hanging/strangulation and suffocation	98	46.0%
Self-poisoning (incl. carbon monoxide and helium)	52	24.4%
Jumping or laying before a moving object (inc. road vehicles and trains)*	24	11.3%

<sup>6</sup> Source: NOMIS Mortality Statistics – underlying cause, sex and age for England 2013 to 2015

<sup>7</sup> Source: NOMIS Mortality Statistics – underlying cause, sex and age for England 2013 to 2015

<sup>8</sup> It should be noted that these proportions are based on small counts, and small changes can make a large difference particularly at lower geographies.



Other	39	18.3%
Total	213	100.0%

\*22 cases involved trains and 2 involved road vehicles

Source: West Sussex Suicide Audit (cases with inquest dates in 2013 to 2015)

## 6.4 Location

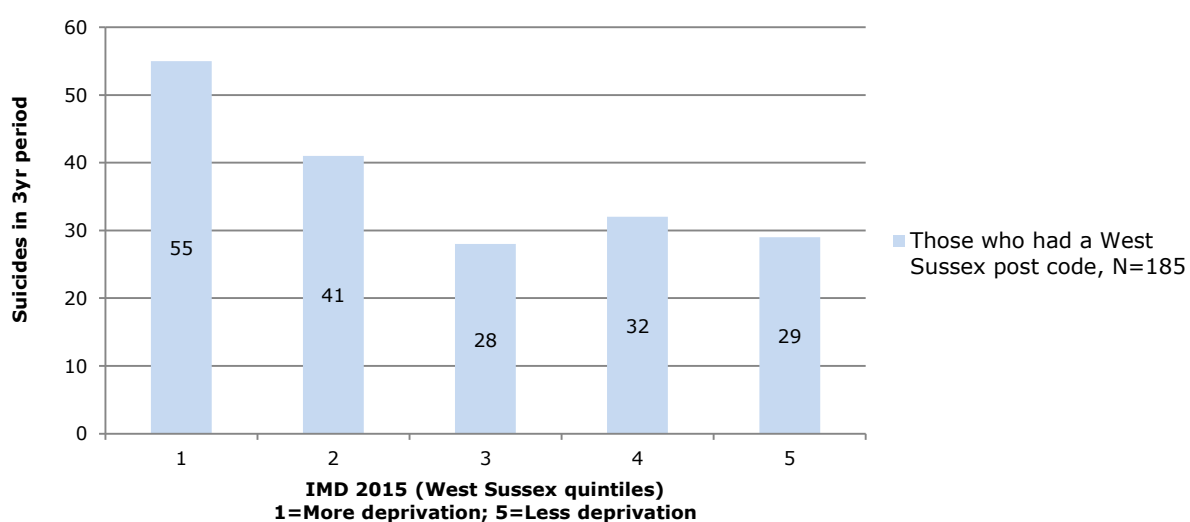
The suicide audit found that 56% of suicides took place at the individual's home; 8% were in wooded areas and a further 8% were at car parks, road bridges and other roadside locations such as laybys. With regard to rail deaths, three stations were the location of two suicides each were at/near stations where non-stopping trains passed through the station, whilst a further six stations saw one suicide each. One rail crossing, in a rural area near Chichester, was the location of three suicides, whilst a further seven crossings were the location of one suicide each.

## 6.5 Risk factors

### 6.5.1 Deprivation

A higher than expected proportion of the suicides in the audit were from residents living in the most deprived neighbourhoods in West Sussex (Figure 5), such as Bognor Regis and Worthing, and western areas of Littlehampton and Crawley. The link between suicidal behaviour and deprivation has also been shown at a national level (Samaritans, 2017).

Figure 5 Number of suicides in West Sussex by deprivation (IMD quintiles) 2013-15



Source: West Sussex Suicide Audit (cases with inquest dates in 2013 to 2015)

The audit found that in 15 cases (7%), financial difficulties, loss of benefits/eviction, or a perceived lack of opportunities were described as a primary driver for their suicide. Whilst

unemployment rates are lower in West Sussex (2.6%) compared to the rest of England (5.1%)<sup>9</sup>, there may be localised areas of higher unemployment within the county. The National Confidential Inquiry into Suicides and Homicides by People with Mental Illness found that economic factors are becoming more common as antecedents to suicides. The inquiry found that 13% of patients who died by suicide had experienced serious financial difficulties in the previous 3 months (University of Manchester, 2016).

### **6.5.2 Occupation**

Occupation was not analysed in the suicide audit due to low numbers with occupation recorded. National data shows that certain occupations are associated with higher risk of suicide. Low-skilled male labourers, for example construction workers, have a suicide risk 3 times higher than the male national average (ONS, 2017). Males working in skilled trades, for example, plasterers and decorators, also had more than double the risk of suicide. Other high risk groups include female culture, media and sport professions (69% higher) and female health professionals (24% higher), particularly female nurses. Previously high rates amongst farmers were not seen in the most recent ONS analysis (ONS, 2017).

### **6.5.3 Mental illness**

In the audit, 64% of individuals were recorded as having some level of mental health problem. This aligns with national data suggesting that 63% of those who die by suicide have a mental health diagnosis (University of Manchester, 2014). Where it could be discerned from the audit case files, 99 individuals were described as having a depressive illness (46%), 18% had anxiety disorders or phobias and 8% had schizophrenia. West Sussex has a significantly higher prevalence of depression (8.6%; 95% confidence interval (CI) 8.6, 8.7)<sup>10</sup> compared to England (8.3%; 95% CI 8.3, 8.3), but a lower prevalence of severe mental illness (0.83% compared to 0.90%)<sup>11</sup>.

### **6.5.4 Previous self-harm**

A full report on self-harm in West Sussex can be found in Appendix B. In the suicide audit 34% of all individuals had a known history of self-harm (including those with suicide attempts), rising to 50% in those under 25 years. The National Confidential Inquiry found that amongst suicides in people under mental health services, 68% had a history of self-harm (University of Manchester, 2016). The risk of suicide in the 12 months following an

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<sup>9</sup> Source: Annual Population Survey on NOMIS. Extracted from PHE Fingertips Suicide Prevention Profile

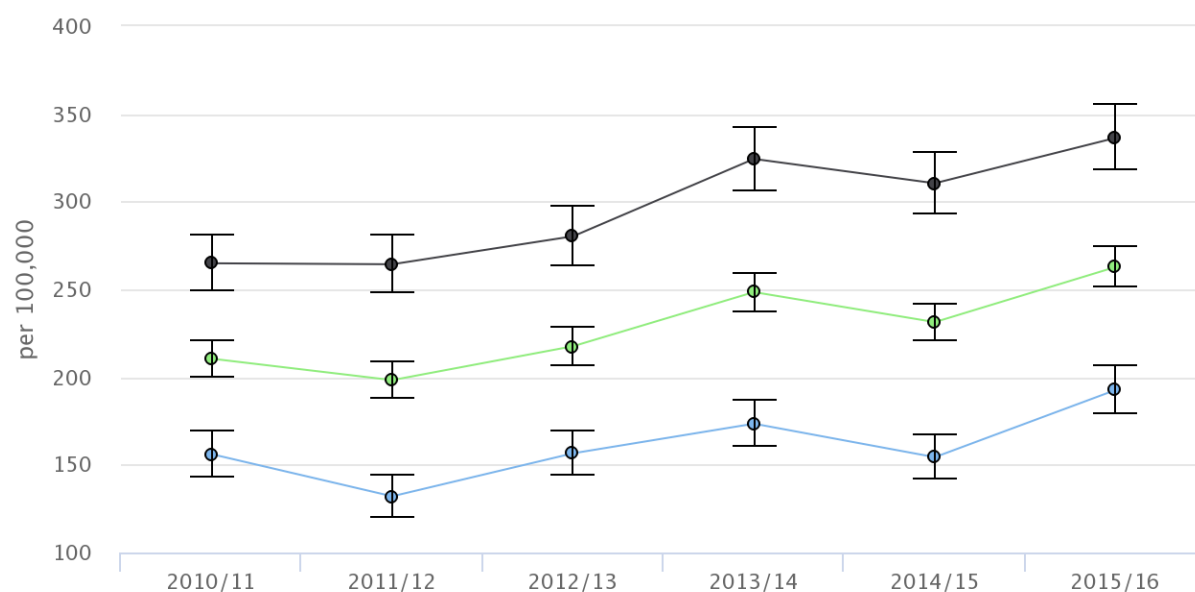
<sup>10</sup> Source: Quality Outcomes Framework data 2015-16 available from the Health and Social Care Information Centre; extracted from PHE Fingertips Suicide Prevention Profile

<sup>11</sup> Source: Quality Outcomes Framework data 2013-14 available from the Health and Social Care Information Centre; extracted from PHE Fingertips Suicide Prevention Profile

episode of self-harm is up to 66 times greater than the risk in the general population (Hawton, Zahl, & Weatherall, 2003).

In 2015/16, the directly age-sex standardised rate of emergency hospital admissions for self-harm was significantly higher in West Sussex (262.7/100,000) than England (196.5/100,000). The rate for emergency hospital admissions for self-harm in West Sussex has been steadily increasing (see figure 6). It has also exceeded the rate for England for all years since 2010/11 (except for 2011/12)<sup>12</sup>.

Figure 6 Emergency hospital admissions for intentional self-harm in West Sussex – partitioned by sex (2010/11 to 2015/16)



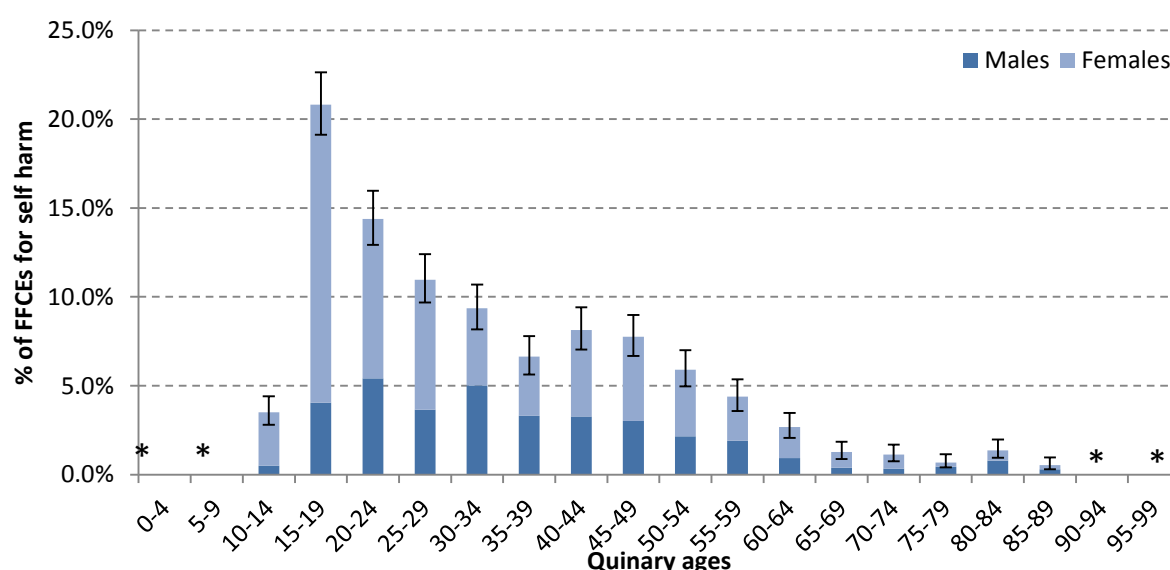
Source: PHE fingertips – inequalities tool – data partitioned by sex

In total, young people aged 10-24 account for 38.7% of all admissions for self-harm in West Sussex. Young people aged 15-19 accounted for more than a fifth of all admissions. The majority of admissions for self-harm were women (64.3% in 2015/16)<sup>13</sup> (see figure 7).

<sup>12</sup> Source: Hospital Episode Statistics 2015/16

<sup>13</sup> Source: Local analysis of Hospital Episode Statistics 2015/16

Figure 7 Proportion of first-finished consultant episodes (FCEs) to hospital in an emergency for self-harm in West Sussex by 5-year age groups (2015/16)



Note. \* indicates where data has been suppressed due to small counts (fewer than five)

In 2015/16, the majority of emergency admissions for self-harm in West Sussex were due to intentional self-poisoning (87.2%), whilst intentional self-harm by sharp object accounted for a further 9.5%. During 2014/15 to 2015/16, there were 3,861 emergency hospital admissions for self-harm in West Sussex. Of these, 46.2% (N = 1,783) were multiple admissions (i.e. the same patient admitted twice or more within the two years)<sup>14</sup>. Seventy-nine individuals were admitted to hospital 5 times or more during 2014/15 and 2015/16, accounting for 17.7% of all self-harm admissions in West Sussex. People resident in the most deprived decile have more than 3 ½ times the rate of admissions for self-harm than the most affluent group<sup>15</sup>.

### 6.5.5 Drug and alcohol use

32% of men and 13% of women identified in the suicide audit had a history of alcohol misuse. Roughly half of this group had consumed alcohol around the time of death. Similarly, roughly half of those with history of drug-misuse (26% of men and 17% of women) were believed to have taken drugs not prescribed to them near the time of death. The rate of opiate and crack cocaine use is significantly lower in West Sussex (4.2/1000 population) compared to the rest of England (8.4/1000)<sup>16</sup>. Alcohol related hospital admissions are also

<sup>14</sup> Source: Hospital Episode Statistics 2014/15 and 2015/16

<sup>15</sup> Source: Hospital Episode Statistics 2014/15 and 2015/16

<sup>16</sup> Source: National Treatment Agency for Substance Misuse and ONS; extracted from PHE Fingertips Suicide Prevention Profile

significantly lower in West Sussex (1050/100,000 population) compared to England (1258/100,000), although rates in Crawley CCG area are similar to England (1217/100,000)<sup>17</sup>.

#### **6.5.6 Interpersonal relationships and social networks**

27% of people identified in the suicide audit were separated or divorced, which is higher than rates of marital breakup in the general population in West Sussex (12.2%). Marital breakup is also more common in West Sussex compared to England (11.6%)<sup>18</sup>.

34% of suicides identified in the audit related to people living alone. This is much higher than the proportion of people living alone in the general population in West Sussex (13.5%). Living alone is also more common in West Sussex compared to England (12.8%). Furthermore West Sussex has the 10<sup>th</sup> highest rate in England (6.6%) of people over 65 years who live alone (compared to 5.2% in England)<sup>19</sup>.

There were a number of cases (4%) where an individual (typically a father) had limited contact with their child. This was often either due to a family court order or because the other parent had moved away. In some cases, the loss of access had a significant impact on the individuals' wellbeing and there were no cases for which there was a record of counselling being offered.

#### **6.5.7 Carers**

Eight individuals in the suicide audit were identified as being the primary carer for a relative or spouse. Caring duties were described as a main driver in their deterioration of their mental health and some had requested further support. This finding aligns with the West Sussex Carers Health and Social Needs Assessment, which found that carers tend to have much worse physical and mental health compared to non-carers (West Sussex County Council, 2013). Across the UK, the risk of suicide among carers has been found to be 70% higher than the national average (though this analysis includes both care workers and home carers) (ONS, 2017). The proportion of carers who have as much social contact as they would like, whilst low, is similar in West Sussex (36.1%) compared to the rest of England (38.5%)<sup>20</sup>.

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<sup>17</sup> Source: Calculated by Public Health England using Hospital Episode Statistics and ONS mid year population estimates; extracted from PHE Fingertips Suicide Prevention Profile

<sup>18</sup> Source: Census 2011; extracted from PHE Fingertips Suicide Prevention Profile

<sup>19</sup> Source: Census 2011; extracted from PHE Fingertips Suicide Prevention Profile

<sup>20</sup> Source: Personal Social Services Survey of Adult Carers in England 2012-13, available on NHS Digital; extracted from PHE Fingertips Suicide Prevention Profile

### **6.5.8 Physical health and disability**

The audit found that 94 cases (44%) had ongoing physical health problems or disabilities. Joint pain and/or mobility issues were present in over 10% of all cases. In several cases these conditions directly contributed to the suicide, due to pain or loss of independence. In addition, several cases had a terminal illness and had chosen to end their life before their health deteriorated further. The proportion of people whose day to day activities are limited by their health or disabilities is significantly lower in West Sussex (17.2%) compared to England (17.6%)<sup>21</sup>.

### **6.5.9 Criminal justice**

Up to 5% of the deaths audited concerned individuals being investigated for crimes, and the majority of these were male. Many of these were sex-crimes or relating to child pornography or grooming. Other crimes, such as financial fraud or embezzlement were also identified, mainly amongst businessmen with families or spouses.

### **6.5.10 Victim of violence or abuse**

In the suicide audit 21% of women (n=11) and 7% of men (n=12) were known to have been the victim of violence in the past. Rates of domestic abuse incidents are significantly lower in West Sussex (17.1/1000 population) compared to the rest of England (20.4/1000)<sup>22</sup>.

### **6.5.11 Bereaved by suicide or other bereavement**

The audit found that 16 individuals (7.5%) had been bereaved by suicide (12 of which were family members). In addition 17 individuals (8%) had experienced a bereavement not related to suicide at some point in the past; in most cases it was not known whether this contributed to the suicide.

## **6.6 Contact with services**

### **6.6.1 General practice**

A previous study found that 63% of people who died by suicide had consulted their GP in the last year, and that suicide risk increased with increasing number of GP consultations, especially in the 2 to 3 months prior to suicide. In those who attended more than 24 times, risk was increased 12-fold. However, suicide risk was also found to be 67% greater amongst those who not visited the GP at all compared to those who had (University of Manchester, 2014).

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<sup>21</sup> Source: Census 2011; extracted from PHE Fingertips Suicide Prevention Profile

<sup>22</sup> Source: Office for National Statistics; extracted from PHE Fingertips Suicide Prevention Profile

For 122 cases in the audit, the date of the last contact with their GP could be discerned. Sixty one individuals had visited their GP in the last year for a mental health problem, amounting to 29% of all cases and 50% of those with complete records. Of those whose records were present, 81 deaths occurred within a month (31 days) of seeing their GP last. This means that at least 38% of all individuals had seen their GP in the month before they died; this figure may be an underestimate given that nearly half of suicide cases had no record of last GP contact. Of these, 36 visited their GP for mental health reasons, 38 visited for physical health reasons, five for both physical and mental health reasons, and two where the reason for the visit was unknown (table 3).

Table 3 Reasons for visiting GP in month prior to suicide

	Counts
<b>Total number of cases</b>	<b>213</b>
Number of cases known to have visited GP in month (31 days) prior to death:	81
<i>Number for mental health reasons:</i>	36
<i>Number for physical health reasons:</i>	38
<i>Number for physical and mental health reasons:</i>	5
<i>Number where the reason for the visit was not recorded:</i>	2
Number of cases with no contact with GP in month prior to death*:	132

\*this includes cases that had visited a GP but not in the month before death, and those cases where no contact was recorded i.e. patients not registered, or where the information about GP visits was incomplete

Source: West Sussex Suicide Audit (cases with inquest dates in 2013 to 2015)

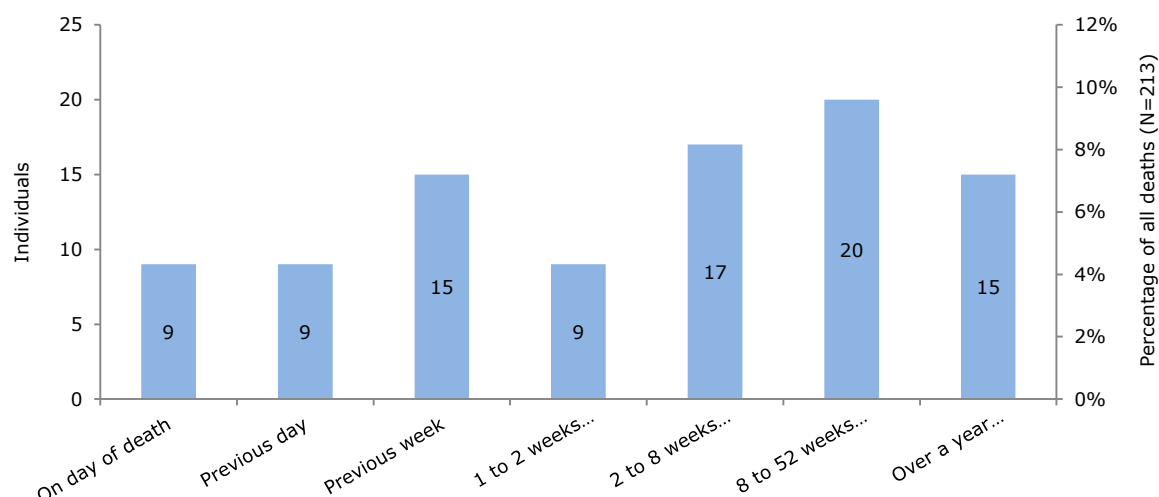
## 6.6.2 Mental health services

Around half of cases in the audit (107 of 213) were known to have had any contact with mental health services. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness found that between 2004-14, 28% of suicides in the UK general population were by people who had had contact with mental health services in the last 12 months. Overall, rates of suicides amongst those under mental health care are falling (University of Manchester, 2016).

The audit found that individuals had accessed a range of services including community mental health teams, crisis support and inpatient care. Contact with alcohol misuse services and substance misuse services was recorded for nine individuals (4%) and 12 individuals (6%) respectively. The date of last contact with mental health services was recorded for 94 individuals. Eighteen individuals (8.5% of all suicides and 16.8% of those with mental health service contact) were seen either on the day or the day before their death (see figure 8). In total 33 individuals were seen in the week before they died; this amounts to 15.5% of all cases and 30.8% of cases with any contact with mental health services. The National

Confidential Inquiry found that, amongst those with any contact with mental health services, 49% of suicides occurred within seven days of last contact (University of Manchester, 2016).

Figure 8 Timing of last contact with mental health services before suicide



Source: West Sussex Suicide Audit (cases with inquest dates in 2013 to 2015)

Routine data shows a very low proportion of people in contact with mental health services have a crisis plan in place in all three CCGs in West Sussex: 0.6% in Crawley, 0.2% in Coastal West Sussex and 0.1% in Horsham and Mid Sussex, compared to 13.3% in England in quarter 2 2015/2016<sup>23</sup>. However PHE notes some concerns regarding the quality of this data.

Forty-eight cases in the audit had some record of inpatient care, of which 35 cases had dates of last admission/discharge provided. Twelve of the 35 cases died whilst receiving inpatient care or within a month of discharge. The National Confidential Inquiry found that the highest risk of suicide is found in the two weeks after discharge from inpatient care. Suicides whilst receiving inpatient care are decreasing, whilst suicides under crisis resolution home treatment teams are increasing (University of Manchester, 2016).

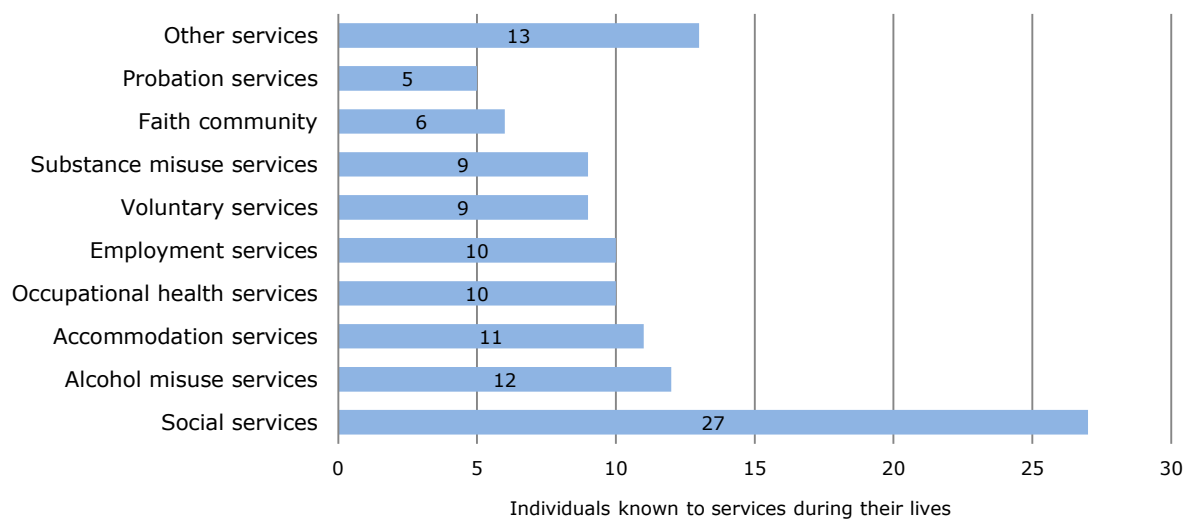
### 6.6.3 Other community services

The audit found that 27 individuals (12.6%) were known to have been involved with social services during their lifetime, either receiving support themselves or as a principal family member. Several individuals had also been involved with accommodation services (5%) and employment services (5%), amongst others (see figure 9).

<sup>23</sup> Source: Data from the Health and Social Care Information Centre, extracted from the PHE Fingertips Crisis Care Profile



Figure 9 Number of individuals known to other services



Source: West Sussex Suicide Audit (cases with inquest dates in 2013 to 2015)

#### 6.6.4 Accident and emergency and hospital admissions

In the audit, 60 individuals (28%) were known to have attended accident and emergency or hospital in the year before their deaths. Of these, 26 individuals attended hospital because of a failed suicide attempt or suicidal thoughts. Although records are incomplete, sufficient data exists to show that nine individuals were discharged from hospital within the month before their death, after having being admitted for a suicide attempt.

The proportion of calls to 111 from over 65 year olds that relate to mental health is significantly higher in Coastal West Sussex CCG area (35.1% (95% CI 32.9, 37.2)) and Horsham and Mid Sussex CCG area (30.4% (95% CI 26.6, 34.5)) compared to the rest of England (23.5 % (95% CI 23.2, 23.7)). Across West Sussex the proportion 111 calls relating to mental health from 18 to 64 year olds is similar or lower than the rest of England<sup>24</sup>.

<sup>24</sup> Source: Health and Social Care Information Centre data extracted from the PHE Fingertips Crisis Care Profile

## 7 STAKEHOLDER ENGAGEMENT

### 7.1 Aim and methods

Local frontline workers were invited to take part in an online survey conducted via the “Have Your Say” portal. The survey was available for completion between 6<sup>th</sup> March and 28<sup>th</sup> April 2017. The specific objectives of the consultation were:

- to determine frontline workers’ confidence in approaching/ signposting people contemplating suicide and people bereaved by suicide
- to estimate availability and uptake of suicide prevention training, and barriers to accessing training
- to understand barriers to frontline workers supporting people at risk of suicide
- to gather views on what resources, processes and services would help to reduce suicide in West Sussex

The consultation intended to gather the opinions of staff from a wide range of organisations and sectors, such as the voluntary sector, local community organisations, emergency services, housing and social care, primary care, and health and wellbeing services (e.g. wellbeing hubs, leisure services) among others. The full stakeholder consultation report is found in Appendix C.

### 7.2 Experiences of supporting people who are suicidal

There were 202 participants in the six-week online consultation. Respondents were from a range of sectors including housing, education, libraries, primary care, substance misuse services, mental health services, children, family and community services, and third sector counselling and support services (see table 4).

Table 4 Number of respondents to the consultation by sector and broad area of work

Sector	Number of respondents
<b>Private</b>	<b>22</b>
Housing	17
Other	3
Mental health services	2
<b>Statutory</b>	<b>150</b>
Library	31
Education	26
Housing	20
Children, YP, social and community services	19
Community health and wellbeing	16
Other	10
Emergency services	8
GP	7
Substance misuse	7
Mental health services	6
<b>Third sector</b>	<b>30</b>
Third sector counselling/ support	21
Housing	8
Other	1
<b>Grand Total</b>	<b>202</b>

Source: West Sussex Suicide Prevention online consultation

The majority of respondents (n=158) have daily contact with members of the public, whilst 26 have weekly contact. Three quarters of respondents had ever spoken with customers, clients or patients about suicidal thoughts, including some respondents from all sectors (see table 5). For example, 38.7% of respondents from library services and 84.4% of respondents who work in housing reported that they had spoken with someone who is suicidal. Half of those who had ever spoken about suicide said this happened 'rarely' (n=74), whilst for 46 participants it was a daily or weekly occurrence.

Table 5 The number and proportion of respondents who reported that they had spoken with customers/clients/patients about suicidal thoughts they are experiencing by job role

	Total respondents	Spoken to individuals about suicidal thoughts	% spoken to individuals about suicidal thoughts
Mental health services	8	8	100.0%
Substance misuse	7	7	100.0%
GP	7	7	100.0%
Third sector counselling/ support	21	20	95.2%
Housing	45	38	84.4%
Children, YP, social and community services	19	16	84.2%
Community health and wellbeing	16	13	81.3%
Education	26	20	76.9%
Emergency services	8	6	75.0%
Other	14	8	57.1%
Library	31	12	38.7%
	202	155	76.7%

83 respondents (41%) felt somewhat unconfident or not at all unconfident about approaching or talking to someone who was feeling suicidal. Similar numbers were not confident about approaching someone bereaved by suicide (42.6%). Levels of confidence vary by job role (see table 6). GPs and mental health staff were most likely to say that they felt confident approaching or speaking to someone who is suicidal, whereas staff from the library services were the least likely to feel confident in fulfilling this role.

Table 6 : Levels of confidence approaching or speaking to someone who is suicidal by job role

	Total respondents	Confident		Unconfident	
		Count	%	Count	%
Mental health services	8	8	100.0%	0	0.0%
GP	7	7	100.0%	0	0.0%
Third sector counselling/ support	21	17	81.0%	4	19.0%
Children, YP, social and community services	19	14	73.7%	5	26.3%
Substance misuse	7	5	71.4%	2	28.6%
Education	26	18	69.2%	8	30.8%
Housing	45	29	64.4%	16	35.6%
Community health and wellbeing	16	8	50.0%	8	50.0%
Emergency services	8	4	50.0%	4	50.0%
Other	14	4	28.6%	10	71.4%

Library	31	5	16.1%	26	83.9%
Total	202	119	58.9%	83	41.1%

Only 12 respondents (5.9%) had no knowledge of where to refer someone who was feeling suicidal, whereas 46 respondents (22.8%) would not know where to refer someone bereaved by suicide. Respondents were generally aware of a wide range of services to which they signpost someone who is suicidal, with the Samaritans and GPs most commonly cited. By far the most commonly reported barrier to supporting people at risk of suicide was not having received relevant training (56.9% respondents)(see table 7). Other frequently reported barriers were not being confident about talking to a person who appears suicidal and being worried that talking about it would make a suicide attempt more likely.

Table 7 Number and proportion of respondents who identified the following barriers to supporting people at risk of suicide

Barriers	Count	%
I have not received relevant training	115	56.9%
I'm not confident on how to approach or talk to a person who is distressed or appears suicidal	57	28.2%
I would be worried that asking a person about suicidal thoughts would make them more likely to attempt suicide	53	26.2%
I don't know how to recognize if a person is likely to be suicidal	51	25.2%
I do not know where to signpost people at risk of suicide	45	22.3%
I don't have the time to give support to individuals	40	19.8%
It's not part of my role to support people at risk of suicide	31	15.3%
I don't have the time to liaise with other services	23	11.4%
I would find it distressing to talk to someone who is suicidal	22	10.9%
Approaching or supporting people at risk of suicide is discouraged by my organisation	1	0.5%

### 7.3 Actions to better support people at risk of suicide

#### 1. Awareness of where to signpost

Information on where to signpost people with suicidal thoughts was almost universally felt to be useful (97.5%)(see table 8). Respondents raised the desire for a database or centrally held list of support groups/organisations that details who they are, what they do and how they can be contacted. This could be in the form of a website, a helpline, or leaflets; *“a “one stop” access point of services and times available”* (Emergency Services). 82.2% specifically endorsed having leaflets or posters available. In addition, respondents felt having a named contact with whom they could speak to would be helpful. The role of this contact would be to provide advice and further support; *“designated lead for this area with responsibility for cross service communications and support”* ( Education). This could be fulfilled by a Suicide Prevention Champion, or similar role.

There was a general feeling that workers want to know what the resources of other services are like. This will help to manage the expectations of clients, ease burden (where possible), and refer appropriately; *“better understanding of resource pressures, impacting different*

*organisations and how we can work with our current resources to gain the most effective outcome for client and organisations concerned” (Housing).*

Table 8 Proportion of respondents who thought the following actions would be helpful to support people at risk of suicide

<b>Potential action to better support people at risk of suicide</b>	<b>% helpful</b>	<b>% not helpful</b>	<b>% don't know</b>
Information on where to signpost people with suicidal thoughts	97.5%	0.5%	2.0%
Clear communication/referral routes between your organisation and support organisations	93.1%	1.0%	5.9%
General training for staff on mental health or emotional wellbeing	92.1%	2.0%	5.9%
Specific training for staff in your organisation on how to approach or talk to a person who has suicidal thoughts	92.1%	0.5%	7.4%
Information on which groups are at risk of suicide in your local area	83.7%	5.0%	11.4%
Guidance on confidentiality and sharing information on suicide risk with families and friends	82.7%	6.9%	10.4%
Physical resources e.g. leaflets or posters on sources of support	82.2%	5.4%	12.4%
Clear local leadership on suicide prevention	74.8%	6.9%	18.3%
A local web/social media presence relating to suicide prevention	72.8%	9.4%	17.8%
Being part of a wider network of organisations working towards suicide prevention in West Sussex	66.8%	10.9%	22.3%
Information on local suicide hotspots (i.e. locations at which there is a concentration of suicides or suicide attempts)	61.4%	18.8%	19.8%
Having a suicide prevention champion within your organisation	47.5%	19.3%	33.2%
You or your organisation making a pledge to help reduce suicides locally	46.5%	18.3%	35.1%

## **2. Clear referral pathways**

Having clear communication and referral routes between organisations was endorsed as helpful by the vast majority of respondents (93.1%); *“clear referral routes between your organisation and support organisations – this one is absolutely key”* (education). It was felt that training, particularly across organisations, could be a good way to create links between organisations and suicide prevention support services. This was felt to help raise awareness of the support services available and to clarify referral pathways; *“training/talks direct to staff on the support services and what they do/offer”*(housing).

## **3. Training for frontline workers**

Just over a quarter of respondents had been offered training in suicide prevention, the majority of whom took up the training (n=52). All but one participant found the training helpful or very helpful in learning skills in how to talk to a person who was suicidal. In contrast, nearly a quarter of those who had training found it unhelpful for learning where to sign post a suicidal individual.

The majority of respondents (92.1%) agreed that receiving training on mental health and how to speak with someone experiencing suicidal thoughts would help them to better

support people at risk of suicide. Some respondents specified that training school staff, social workers, youth workers and carers, would be important. It was suggested that training should cover the signs of suicidal thoughts, what to say, how to listen, and what services they can signpost to. Guidance on confidentiality and sharing information with families and friends was also felt to be useful by the majority of respondents (82.7%).

*“Training could be rolled out to service providers so that support workers can also be aware of and have increased knowledge of what to do/how to respond to a customer who is expressing suicidal thoughts.”*(Children, young people, social and community services)

#### **4. More accessible support**

A powerful message across all types of respondents was the need for easily accessible support for people at risk of suicide. Several key features of accessible support were identified from the responses:

- **Timely:** including extended opening hours, and being available immediately or with a short waiting time
- **Local or community based**
- **Non-judgemental and safe**
- **Ongoing:** for example with support available after the initial suicide risk is dealt with, or ongoing progress checks at home
- **Free**
- **Joined up:** the importance of easily linking to other services was highlighted.

Many respondents recommended **non-face to face services** including helplines, online support or live chat rooms, text or email support, or using apps and social media. The importance of using professionals to monitor online activity was occasionally raised. Having different means of accessing support was highlighted as important to address differing needs of individuals. *“Having a texting service to a helpline number rather than just a phone line initially I think would help. Depressed people often find it difficult to talk but can write what they feel.”*(mental health services)

Suggested improvements to **primary care** included having young person or mental health focused GPs, or having psychiatric nurses based in GP practices. One respondent proposed that GPs should identify carers and offer tangible support other than simply signposting to Carers UK.

Some respondents suggested ways in which **mental health services** could be improved, including better direct access to crisis care and more proactive follow up for non-attenders *“Better follow up of people who are referred to specialist mental health services. There*



*seem to be insufficient staff to follow up this high risk group. Also, patients who have been referred should not be discharged because they do not attend appointments. Their failure to attend is often a result of their underlying mental illness.”(GP)*

Several respondents indicated that there were numerous opportunities for suicide prevention in **non- health service settings**. *“Suicide prevention should be everybody’s responsibility, not just the health services. Teachers, support workers, friends and family - everyone should have the basic awareness.”(GP)* Staff from the fire and rescue service, education, Find it Out, housing and library services suggested ways in which they could contribute. Suggestions included enquiring how vulnerable individuals were coping (e.g. as part of a home fire/gas safety check), listening to problems, and signposting to support services.

Several respondents suggested a **community-based “drop in”** service would be helpful, particularly if it was informal. *“promoting access to “chat points” within the community so that they know there is always someone to talk to.” (Other).* Some suggested organised support groups, which could be focused around specific activities such as gardening.

## **5. Awareness raising to reduce stigma and publicise support available**

A large number of respondents suggested that publicity around what services and support are available would be important. There was also strong support across all types of respondent for awareness-raising to decrease shame and stigma associated with mental health problems. Many spoke specifically of the need for openness around suicide or suicidal thoughts, including messages such as suicidal thoughts are common, and that those seeking help will be taken seriously. Two respondents proposed using people with lived experience of suicidal thoughts to raise awareness. *“Suicide should not be a taboo subject. People’s attitudes need changing through education.”( Children, YP, social and community services)*

Respondents had many ideas for where publicity and awareness raising could be carried out. A popular suggestion was posters and leaflets in locations such as GP surgeries, libraries, toilets, bus stops, railway stations, schools, supermarkets, car parks, beauty spots, social security offices, district and county council buildings. Several respondents suggested school talks or assemblies. Some respondents emphasised the need for online information. Having a local web/social media presence relating to suicide prevention was endorsed as useful by around three quarters of respondents (72.8%).

## **6. Development of networks and leadership**

Clear local leadership on suicide prevention was felt to be helpful by 74.8% respondents. Some respondents specified that this could come from their own management or the Health

and Wellbeing board. It was felt this could raise the profile of suicide prevention and improve links between different organisations. This could be achieved through development of a local strategy that spans across all organisations; *“Leadership from the Health and Wellbeing Boar, a clear strategy and commitment and a manageable action plan that involves all organisations, not just the ‘usual’ suspects”*. ( Mental Health Services). Making a pledge to help reduce suicides locally was felt to be useful by less than half of participants (46.5%).

Around two thirds (66.8%) of respondents felt that it would be helpful to be part of a wider network of organisations working towards suicide prevention in West Sussex. Regular attendance at meetings was seen as an effective way to improve communication between organisations, and to help understand what local groups and services are able to provide ; *“I suggest regular meetings – once a quarter perhaps – where we can update each other on trends and helpful information which would prove useful in reducing suicide”*. (Children, YP, social and community services)

Some respondents commented that a conference or suicide prevention day would be a helpful way to build links with suicide prevention support services. This could provide networking opportunities and help raise awareness of services and training they may provide through stands or talks; *“network opportunities like an open day in a locality area where relevant organisations could display their service”*. (Children, YP, social and community services)

Overall, only 47.5% respondents felt that having a suicide prevention champion within their organisation would be helpful. However, the fact that 33.2% said they did not know suggests that the role of a suicide champion was unclear to many participants. Amongst those who were supportive of this proposal, most felt that a champion could act as a direct point of contact between organisations in order to feedback on any changes to services, provide examples of good practice, be knowledgeable on local trends/data, and direct others towards appropriate training and resources; *“it would be good if we had a suicide (prevention) champion who could attend relevant discussions and perhaps team meetings of other organisations and cascade relevant information/training to practitioners”*. (Children, YP, social and community services)

## 8 WHAT WE HAVE ALREADY ACHIEVED ON SUICIDE PREVENTION IN WEST SUSSEX

Table 9 outlines key areas of achievement in the 2015 West Sussex Suicide Prevention Action Plan.

Table 9 Areas of achievement

National strategy priority	West Sussex Action	Impact/ outputs
Reduce the risk of suicide in key high-risk groups	SPFT suicide prevention strategy and action plan created	<ul style="list-style-type: none"> <li>December 2016 Care Quality Commission report noted increased board level scrutiny of deaths, improved learning from incidents and reduction in suicides amongst those receiving care from SPFT<sup>25</sup> (Care Quality Commission, 2016)</li> <li>Recent increases in the % of patients on Care Programme Approach discharged from hospital and followed up within seven days<sup>26</sup></li> </ul>
	Implementation of West Sussex Training Needs Analysis on mental health and suicide prevention awareness (Coastal West Sussex Mind, 2014)	<ul style="list-style-type: none"> <li>Between April- July 2015 Coastal West Sussex Mind and Grassroots Training ran a pilot training initiative for public and community sector staff. In total 850 people attended 54 training events across West Sussex (Coastal West Sussex Mind, 2015).</li> <li>During a further training roll out from May 2016 – Jan 2017, 354 participants attended 24 training events across West Sussex. Courses included Mental Health First Aid and SafeTalk (Coastal West Sussex Mind, 2017).</li> </ul>
	Development of a new website aimed at	The West Sussex wellbeing website has been rolled

<sup>25</sup> CQC report noted “in the years 1 June 2014 to 31 May 2016 there were 516 unexpected deaths of which 193 were classed as suicide. Of these, 94 suicides occurred in the period 1 June 2015 and 31 May 2016, compared with 99 in the same reporting period for the previous year. This shows that there had been a reduction in the number of suicides over the period.”

<sup>26</sup> Source: Mental Health Five Year Forward Dashboard <https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/>

	% patients followed up within 7 days discharge	
CCG	Q1 2016/2017	Q2 2016/2017
Crawley	78.2%	87.5%
Horsham and Mid Sussex	84.7%	100%
Coastal West Sussex	79.5%	92%

	improving the wellbeing of the West Sussex population	out <a href="http://www.westsussexwellbeing.org.uk/">http://www.westsussexwellbeing.org.uk/</a>
Tailor approaches to improve mental health in specific groups	Review the recent escalation of suspected suicides amongst children and young people and formulate a multi-agency response	<ul style="list-style-type: none"> <li>• Within the suicide prevention steering group, a children and young people subgroup has been created.</li> <li>• A one year pilot is planned for two transition workers between children and adult services, to be based at Horsham YMCA.</li> <li>• In June 2016 an extraordinary multi-agency meeting was held to discuss a potential suicide cluster involving young people.</li> </ul>
	CCGs and their partners to consider the emotional wellbeing needs of patients and their carers with long term conditions	<ul style="list-style-type: none"> <li>• West Sussex Wellbeing Hub staff are trained in Mental Health First Aid and pathways are agreed between the hubs, GPs, Time to Talk and other local mental health providers.</li> <li>• The West Sussex Improving Access to Psychological Therapies (IAPT) service, Time to Talk, is one of the first sites in England to expand its support to people living with long-term health conditions.</li> </ul>
Provide better information and support to those bereaved or affected by suicide	Develop a tiered support model for the wider social network of a CYP who has taken their own life	<ul style="list-style-type: none"> <li>• The potential impact of suicides on peer groups was discussed at the multi-agency suicide cluster meeting June 2016.</li> </ul>
Support research, data collection and monitoring	Produce a Suicide Audit every two years or as agreed by the Public Health and Social Research Unit.	<ul style="list-style-type: none"> <li>• Suicide audit completed in February 2017 and used to inform the new suicide prevention strategy.</li> </ul>

## 9 PRIORITY AREAS FOR ACTION IN WEST SUSSEX 2017-2020

Nine priority areas for action were selected on the basis of the audit and consultation findings.

Table 10 Priority areas for action

Priority area	Rationale for prioritising this area	
	Local data & audit findings	Consultation findings
<b>1. Focus on reducing suicides in vulnerable middle aged and older people, particularly those experiencing financial difficulties and social isolation</b>	Middle and older age groups most at risk locally. High rates of social isolation, marital break up locally, which were commonly cited as contributory factors in audit. More suicides more deprived areas.	Some participants highlighted the need for better support for isolated people
<b>2. Focus on preventing suicides in people in contact with mental health services, particularly those recently discharged or disengaged from care</b>	64% in audit had mental health problem; half had contact with mental health services. 8.5% last contact on day or day before death. Audit identified issues with disengagement from care.	Some concerns about inadequate follow up after discharge
<b>3. Focus on preventing suicide in people who misuse alcohol or drugs, particularly those with a dual diagnosis</b>	Amongst male suicides in audit, a third had history of alcohol misuse and a quarter history of drug misuse.	Highlighted need for joined up work between substance misuse and mental health services
<b>4. Focus on reducing self harm, particularly in young people</b>	Much higher rates in West Sussex than England, and increasing. 34% suicides in audit had history of self harm (50% of <24 year olds).	Several respondents discussed need to increase self esteem in young people

<b>5. Focus on preventing suicide in people with long term conditions or requiring end of life care, and their carers</b>	44% in audit had ongoing physical health problem/ disability. Nearly a fifth seen at GP with physical health problems in month before suicide.	Some comments on need to focus on people with long term conditions and carers
<b>6. Improve support for people bereaved or affected by suicide</b>	7.5% suicides in audit had been bereaved by suicide themselves (further 8% other bereavement)	Identified lack of knowledge about where to signpost those bereaved by suicide.
<b>7. Increase confidence and skills of paid and volunteer workers to support people at risk of suicide, maximising the use of existing resources and support</b>	In the coroners case files audited some GPs had identified a need for additional training in suicide risk assessment.	Lack of training and confidence cited as biggest barriers to suicide prevention. Only a quarter already received training. Universal agreement that information on where to signpost would help suicide prevention. Some who had training didn't get useful information on where to signpost
<b>8. Reduce access to the means of suicide, focusing on self-poisoning, railways and other public places</b>	Apparent greater % of suicides locally due to rail deaths compared to England (11% vs 6%). 24.4% suicides in audit related to self-poisoning, and more common in older age groups, particularly using prescription medications. Compares to 19.3% suicides in England due to self – poisoning.	-
<b>9. Monitor suicide patterns and trends in West Sussex</b>	Suicide audit provided useful information to shape strategy.	

## 10 APPENDICES

Appendix A: Full audit report

Appendix B: Full self harm report

Appendix C: Full consultation report

Appendix D: Evidence review

## 11 WORKS CITED

Care Quality Commission. (2016). *Sussex Partnerships NHS Foundation Trust Quality Report*.

Centre for Mental Health. (2015). *Aiming for 'zero suicides': An evaluation of a whole system approach to suicide prevention in the East of England*.

Christodoulou, C., Douzenis, A., Papadopoulos, F., Papadopoulou, A., Bouras, G., Gournellis, R., et al. (2012). Suicide and seasonality. *Acta Psychiatr Scand*, 125(2), 127-46.

Coastal West Sussex Mind. (2014). *West Sussex Emotional Wellbeing and Mental Health Training Needs Analysis*.

Coastal West Sussex Mind. (2015). *Evaluation Report: Provision of Mental Health Awareness and Suicide Prevention Training*.

Coastal West Sussex Mind. (2017). *West Sussex CCGs Funded Adult Mental Health Training Programme: Final Evaluation Report*.

Department of Health. (2012). *Preventing suicide in England: a cross-government outcomes strategy to save lives*.

Department of Health. (2017). *Preventing suicides in England: Third progress report on the cross-government outcomes strategy to save lives*. Department of Health.

Hawton, K., Zahl, D., & Weatherall, R. (2003). Suicide following deliberate self-harm: long term follow up of patients who presented to a general hospital. *British Journal of Psychiatry*, 182(6), 537-542.

House of Commons Health Committee. (2017). *Suicide Prevention: Sixth Report of Session 2016-2017*.

- Knapp, M., McDaid, D., & Parsonage, M. (2011). *Mental health promotion and prevention: the economic case*. London School of Economics, Personal Social Services Research Unit. Department of Health.
- Local Government Association. (2017). *Suicide Prevention: A Guide for Local Authorities*.
- Mental Health Taskforce to the NHS in England. (2016). *Five year forward view for mental health*. NHS.
- ONS. (2017). *Suicide by occupation, England: 2011 to 2015*.
- Public Health and Social Research Unit, WSCC. (2017). *West Sussex Suicides Audit 2013-2015*.
- Public Health England. (2016). *Local suicide prevention planning: a practice resource*. Public Health England.
- Riblet, N., Shiner, B., Young-Xu, Y., & Watts, B. (2017). Strategies to prevent death by suicide: a meta-analysis of randomised controlled trials. *The British Journal of Psychiatry*, 1–7. doi: 10.1192/bjp.bp.116.187799.
- Samaritans. (2017). *Dying from inequality: Socioeconomic disadvantage and suicidal behaviour*.
- Sussex Partnership NHS Foundation Trust. (2015). *Suicide Prevention Strategy*.
- University of Manchester. (2014). *Suicide in primary care in England: 2002-2011. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*.
- University of Manchester. (2016). *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Making Mental Health Care Safer: Annual Report and 20-year Review*.
- West Sussex County Council. (2013). *West Sussex Carers Health and Social Needs Assessment*.
- West Sussex County Council. (2015). *West Sussex Joint Health and Wellbeing Strategy 2015-2018*.
- West Sussex Crisis Care Concordat. (2015). *West Sussex Action Plan for Adults*.
- Zalsman, G., Hawton, K., Wasserman, D., Heeringen, K. v., Arensman, E., Sarchiapone, M., et al. (2016). Suicide prevention strategies revisited: 10 year systematic review. *Lancet Psychiatry*, 3, 646-59.





