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Blackburn with Darwen

Suicide Prevention Strategy

2016-2019

Creating Suicide Safer Communities to Save Lives

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Foreword

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Executive Summary

In England, approximately one person dies every two hours as a result of suicide[1] and is considered a significant public health problem. Suicide is preventable but when it does occur, not only is it a tragic loss of life but it leaves a lasting impact on families and the wider community. Circumstances that lead a person to die by suicide are complex. Research suggests that suicide is often associated with the loss of something significant for the individual, such as a bereavement or separation, relationship breakdown, redundancy/unemployment, debt, poor health/incapacity, homelessness, reputation, self-worth and sense of purpose. Nonetheless, there is much that can be done to reduce deaths by suicide, including the early identification of 'at risk' groups and triggers, and various evidence based interventions.

Groups identified as high risk from death by suicide and self-harm by the national strategy include: Children in Care; care leavers; 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 (LGBT) people; and Black, Asian and minority ethnic groups and asylum seekers.

The purpose of the Blackburn with Darwen Suicide Prevention Strategy is to provide a framework for action across the life-course to prevent avoidable loss of life through suicide. It intends to provide an approach to suicide prevention that recognises the contributions that can be made across all sectors of our society. It draws on local experience and research evidence, aiming to prevent suicide and promote mental health and wellbeing.

The suicide and undetermined death rate (age standardised) for Blackburn with Darwen is currently reported as 10.0 per 100,000 for the period 2012 – 2014. This is similar to the regional average of 10.3 per 100,000 and higher than the England average of 8.9 per 100,000 for the same period. The suicide rate for BwD male mortality for the period 2012-2014 is 17.0 per 100,000, similar again with the North West average of 16.3 per 100,000 and higher than the England average of 14.1 per 100,000[2].

Although self-harm and attempted suicides are separate issues, there are links and therefore this was therefore identified for inclusion in the strategy as a local priority for action. Hospital admission rates for self-harm among 10-24 year olds in Blackburn with Darwen are amongst one of highest across England, at 561.9 per 100,000, which is higher than both the regional (440.4 per 100,000) and national (352.3 per 100,000) rates for 2010/11-12/13. Similarly, the age and sex standardised Emergency Hospital Admissions for intentional self-harm for all ages in BwD is 316.7 per 100,000 (2014-15), again significantly higher that the regional (257.7) and England (191.4) averages.

Blackburn with Darwen's suicide audit for 2012 and 2013 showed that male suicides were much higher than female suicides; approximately 90% were male. Additionally, the audit revealed that 50% and 77% of deaths by suicide were recorded as being White Male aged 45+ years, in 2012 and 2013 respectively. Furthermore, an emerging theme for Blackburn with Darwen was the occupation of the deceased, as 21% were linked to the building trade, including plumbers and plasterers.

It is important that local data and insight is used to help inform interventions that will help reduce suicide in individuals that are considered high risk. Blackburn with Darwen's Suicide Prevention Strategy includes priority areas for action within a Strategic Action Plan. The priority areas are based on guidance from the national strategy *Preventing Suicide in England,* and have been developed and agreed after extensive consultation with stakeholders.

The two key objectives for the Suicide Prevention Strategy include:

- Reduction in the suicide rates in Blackburn with Darwen
- Better support for those bereaved or affected by suicide

The following priority areas for action have been identified by stakeholders:

1. Joint working (and commissioning where relevant) to develop clear, consistent and streamlined pathways across services
2. Reduce the risk of suicide in high risk groups
3. Focus on raising awareness and promoting mental wellbeing in the whole population and where relevant, tailor to different community groups and those identified as high risk
4. Support people bereaved by suicide and people affected by attempted suicide
5. Support research, data collection and monitoring

These priorities will be addressed through the Suicide Prevention Action Plan (2016-19) included as part of the strategy, which will be monitored by the Blackburn with Darwen's Suicide Prevention Group.

There are key national policy and local strategic drivers and networks upon which to build on and co-ordinate action with the focus on suicide prevention. This strategy and action plan takes a life course approach in line with the refreshed BwD Health and Wellbeing Strategy (2015-18) 'plan on a page', which the Health and Wellbeing Board is accountable. In particular, the cross cutting Suicide Prevention Strategy will contribute to the achievement of outcomes identified in a range of local strategies, including Early Help Strategy for Children, Young & Families; Transforming Lives; Mental Health Crisis Care Concordat; Integrated Delivery of Health and Social Care and locality working.

The causes of suicide are complex and the combined efforts of society are required to make a difference to save lives. Suicide prevention is not the sole responsibility of any one sector, such as the health services. It is important that stakeholders and partners work together to help prevent the tragedy of suicide, and by co-ordinated local action and commitment we will achieve the goal of reducing deaths by suicide in Blackburn with Darwen.

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1.0 Purpose

The Blackburn with Darwen Suicide Prevention Strategy will provide a framework for action across the life-course to prevent avoidable loss of life through suicide. It intends to provide an approach to suicide prevention that recognises the contributions that can be made across all sectors of our society. It draws on local experience and research evidence, aiming to prevent suicide and promote mental health and wellbeing.

2.0 Introduction

Every suicide is a tragic event which has a devastating impact on the friends and family of the person who has died, and can be felt across the whole community. While the events and circumstances leading to each suicide will be different, there are a number of areas where action can be taken to help prevent loss of life. It is important that we all work together to reduce the rate of suicide in the borough.

Suicide rates can fluctuate year on year and can be influenced by changes in social and economic circumstances. Periods of high unemployment or severe economic problems have had an adverse effect on the mental health of the population and have been associated with higher rates of suicide. This may be one of the factors that influenced the rise of suicide rates in 2008 prior to which, suicide rates had been falling.

Unfortunately, the increase in suicide rates seen in 2008 are still not showing any signs of decline as recently released figures from the Office of National Statistics (ONS)[3] for the UK revealed a 4 percent rise in deaths by suicide in 2013. ONS further highlighted that in 2013 the highest rate was in men aged 45 to 59 at 25.1 deaths per 100,000; the highest for that age group since 1981. This is similar to Blackburn with Darwen (BwD) figures which not only has a high suicide rate compared to the national and regional average but also has a high incidence of suicides among males over 45 years.

Local suicide data and information underpin the Blackburn with Darwen strategy but equally, national evidence, recommendations and guidance have also been used in its development.

Local and national experience tells us that suicide prevention is not the sole responsibility of one agency. Most progress can be made when the public sector; voluntary, community and faith sector, and the private sector working together to deliver a joined up approach to suicide prevention, supporting individuals, families and communities. Such work involves the commissioning of services based on the best available evidence and intelligence to improve the mental well-being and resilience of the whole population. Additionally, the need for targeted work with those groups in society who are at increased risk of suicide, support for those affected by suicide and also scrutinising the circumstances around a death by suicide so that lessons can be learned.

The Blackburn with Darwen Suicide Prevention Steering Group has driven this strategy forward and has a diverse membership including representatives from the NHS, Local Authority and several local voluntary sector organisations. The group was set up to co-ordinate the delivery of priorities around

suicide prevention in the borough. The BwD Suicide Prevention Group meets regularly and has co-ordinated the development of this strategy and action plan, and will lead on the implementation and monitoring of progress. The Suicide Prevention Group will provide updates to the Blackburn with Darwen Health and Wellbeing Board and other relevant groups.

3.0 Definitions

3.1 Suicide

The World Health Organisation's (WHO) definition of suicide is *'the act of deliberately killing oneself'*[4]. However, the definition in England and Wales is broader and defined *as 'deaths given an underlying cause of intentional self-harm or injury/poisoning of undetermined intent'*[5]. In England and Wales the assumption has been 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[6]. This assumption however cannot be applied to children due to the possibility that these deaths were caused by other situations for example, neglect or abuse. For this reason, data on suicides in England only include persons aged 15 years and over for deaths from injury of undetermined intent and therefore may under-report deaths as a result of suicide in children.

In addition, another factor that may contribute to under reporting of suicides is if any doubt exists that the individual had clear motives to end their own life. In these circumstances an open verdict may be entered. Most open verdicts among adults are cases where suicide occurred but was not proven[7].

3.2 Self-harm

Self-harm is defined as *'when a person intentionally damages or injures their body'*. Self-harm is usually a way of coping with, or expressing, overwhelming emotional distress[8] and can take many forms. This includes poisoning and cutting, as well as intentionally not taking prescribed medication for a health condition such as epilepsy or diabetes, pulling hair and biting. Self-harm can also include taking drugs or drinking too much alcohol to harm oneself. This is different to drinking or taking drugs for pleasure[9].

Self-harm and attempted suicides are separate issues. An act of self-harm is not necessarily an attempt or even indicator of suicide[10]. For some people self-harm is a way of coping and can reduce their suicidal feelings. It is estimated that 3-4% of those admitted for self-harm will die by suicide within 10 years[11] with people who self-harm repeatedly being at a high and persistent risk of suicide[12 13].

4.0 National Policy Drivers

4.1 Preventing Suicide in England National Strategy

The *Preventing Suicide in England*[14] national strategy, published 2012, and a '*One Year On'* progress report, released January 2014, identified two overall objectives and six areas of action to reduce suicides in England.

The overall objectives are:

1. A reduction in the suicide rate in the general population in England
2. Better support for those bereaved or affected by suicide.

The six key areas for action to support delivery of these objectives are:

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

High Risk Groups

Groups identified as high risk from death by suicide and self-harm by the national strategy include: Children in Care; care leavers; 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 (LGBT) people; and Black, Asian and minority ethnic groups and asylum seekers.

The national *Preventing Suicide in England* Strategy has been used as the main policy driver to help direct the Blackburn with Darwen Suicide Prevention Group formulate this local strategy and action plan.

4.2 Men, Suicide and Society - Report by the Samaritans

The *Men, Suicide and Society* report[15] highlights the gender disparity in death by suicide. Men are three times more likely to die by suicide then women. Also there is a strong socio-economic inequality in death by suicide. Those in the poorest socio-economic circumstances have around 10 times higher risk of suicide than those in the most affluent communities. The report raises three concerns:

1. Suicide research needs to investigate what interventions work for whom under what circumstances.
2. Attention must be given to the needs of boys, teenagers and young men to prevent vulnerability in later years.
3. Progressive social and economic policies are required to tackle the root causes of suicide in men (and women) of low socio-economic position.

The report makes nine recommendations (Appendix 1) to national government, statutory services, local authorities, and the third sector to recognise the heightened risk of suicide in disadvantaged

men in mid-life and take action to reduce suicide in this group. The Blackburn with Darwen Suicide Prevention Strategy takes account of these recommendations and actions to address them are included in the suicide prevention action plan.

4.3 No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages

No Health Without Mental Health[16] (2011) sets out six shared objectives to improve the mental health and well-being of the nation, and to improve outcomes for people with mental health problems through high quality services.

Six Objectives:

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

The strategy was produced in collaboration with many of the Department's partner organisations. It will enable more decisions about people's mental health to be taken locally, and stresses the interconnections between mental health, housing, employment, and the criminal justice system.

4.4 Mental Health Crisis Care Concordat

The *Mental Health Crisis Care Concordat*[17] (2014) is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

The Concordat focuses on four main areas:

1. Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
2. Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
3. Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.
4. Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.

Although the Crisis Care Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention. The Concordat builds on and does not replace existing guidance. Current service provision should continue while the Action Plan is being developed.

Blackburn with Darwen has signed up to a local declaration and worked in collaboration with partners to develop and implement the Lancashire Mental Health Crisis Care Concordat[18]action plan.

4.5 Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing.

The report of the Children and Young People's Mental Health Taskforce *Future in Mind*[19], jointly chaired by the Department of Health and NHS England, establishes a clear and powerful consensus about how to make it easier for children and young people to access high quality mental health care when they need it. *Future in Mind* describes an integrated whole system approach to driving further improvements in children and young people's mental health outcomes with the NHS, public health, voluntary and community, local authority children's services, education and youth justice sectors working together.

In 2015-16, a phased approach commenced a five year forward plan which releases national funding to Clinical Commissioning Groups (CCGs), based on the development and implementation a collaborative Local Transformation Plan.

Transformation priorities:

1. Build capacity and capability across the system
2. Developing evidence based community Eating Disorder Services for children and young people
3. Roll-out of the Children and Young People's Improving Access to Psychological Therapies programme (CYP IAPT)
4. Improving perinatal mental health services
5. Bring education and local children and young people's mental health services together around the needs of the individual child through a joint mental health training programme

A Pennine Lancashire Transformation Group has been established to co-ordinate and implement the Emotional Health and Wellbeing Transformation Plan across the health economy. The Blackburn with Darwen Transformation Plan has been approved by the Blackburn with Darwen Health and Wellbeing Board, and forms part of the Lancashire Emotional Health and Wellbeing Systems Board, and self-harm has been identified as key area for action. Improving children and young people emotional health and wellbeing has been identified as a clear priority of the 'Start Well' life stage.

4.6 *Other relevant policy developments*

Public Health England published the *Public Health Outcomes Framework 2013-2016*[20] in November 2013 which includes indicators on both suicide and self-harm. These outcomes come under the Public mental health outcomes in England which are specifically related to both the public health strategy, Health Lives Healthy People[21], and the mental health strategy, No Health Without Mental Health[22]. The inclusion of suicide as an indicator within the Public Health Outcomes Framework will help to track national and local progress against the overall objective to reduce the suicide rate.

Furthermore, the National Institute for Health and Care Excellence (NICE) issued guidance on self-harm in June 2013[23] which covers the initial management of self-harm and long-term support for children and young people (aged 8 years and older) and adults (aged 18 years and older).

In April 2014, the Coalition government published an update to its mental health strategy[24]. This seeks *'Parity of Esteem'* i.e. *'Valuing mental health equally with physical health'*[25] for people with

mental health conditions. It also recommends that public services should reflect the importance of mental health in policy planning by putting it on a par with physical health.

In 2014, the World Health Organisation (WHO) produced a global report on suicide prevention[26]. This report highlights that suicide occurs all over the world and can take place at almost any age. Globally, suicide rates are highest in people aged 70 years and over, although this does vary depending on the country. The report is a call for action to address suicide and it emphasises the importance of reducing access to means of suicide and ensuring that there is responsible reporting of suicide in the media and early identification and management of mental and substance use disorders in communities and by health workers in particular. WHO Member States have committed themselves to work towards the global target of reducing the suicide rate in countries by 10% by 2020.

In August 2014 the Chief Medical Officer's Annual Report on Public Mental Health Priorities found that *'It is increasingly apparent that suicide prevention in geographical areas must have sound backing from local authorities, including public health. Such agencies can provide the stimulus for important local initiatives and their evaluation'*.[27]

Most recently, in September 2014, Public Health England has published '*Guidance for developing a local suicide prevention action plan*'[28]. The document gives local authorities further advice about how to develop a suicide preventing action plan, monitor data and trends as well as improving mental health in the area.

The development of this suicide prevention strategy has been shaped by the themes and principles within all these policies and guidelines.

5.0 Local Drivers

5.1 Blackburn with Darwen Health and Wellbeing Strategy

Blackburn with Darwen's Health and Wellbeing Strategy (2012-2015)[29] provides the agreed overarching vision, principles and priorities to improve the health and wellbeing of the local population across the life course. The *Integrated Strategic Needs Assessment*[30] (ISNA), which incorporates the views of a wide range of partners and local residents, informs the priorities for co-ordinated partnership action.

Cross cutting themes of the Health and Wellbeing Strategy include:

- Identification, prevention & early intervention
- Positive mental health & wellbeing
- Poverty & financial inclusion (fairness)

In relation to this and the local authority's commitment to the mental wellbeing agenda, a Mental Wellbeing Action Plan has been developed which will link in with this Strategy.

Start Well (0-25) priorities:

1. Embed routine enquiries about childhood adversity into everyday practice
2. Ensure an effective multi-agency Early Help offer provides the right help at the right time

3. Support families through a consistent approach to parenting skills and support
4. Improve children and young people's emotional health and wellbeing

Live Well (people of working age) priorities:

1. Develop and support opportunities for employers to improve workplace health and wellbeing
2. Develop BwD as a healthy place - where people have access to healthy homes, healthy neighbourhoods and health promoting services

3. Encourage people to take control of their own health and wellbeing

Age Well (50+) priorities:

1. Develop BwD as a dementia friendly community
2. Increase support to reduce social isolation and loneliness

3. Tackle the wider determinants of health of older people including finance, employment, housing and fuel poverty
4. Develop the local integrated service offer to promote independence

Health and Wellbeing Board - Mental Wellbeing Action Plan objectives:

1. Commissioning for Mental Wellbeing
2. Developing Services to Help People Feel Good and Function Well
3. Increasing Awareness of Mental Wellbeing
4. Developing a community which helps people to feel good and function well

A detailed Mental Wellbeing Action Plan underpins the above objectives which aim to provide an overarching evidence based framework to capture a wide range of partnership initiatives and programmes which contribute to Mental Health and Wellbeing in borough.

5.2 Early Help Strategy: For Children, Young People and Families in Blackburn with Darwen

The Early Help Strategy[31] sets out the key principles and approach that all partners will take in coordinating early intervention and prevention activities for children, young people and their families who are facing problems.

Key principles:

1. Focusing on the identification and access to early help opportunities with families
2. Commitment from all professional staff, volunteers and family members to working together
3. Positive interventions and sharing responsibility for the achievement of better outcomes for children, young people and their families
4. Working to overcome barriers to achieving better outcomes for all
5. Promote shared learning across organisations to ensure that what we do is based on good evidence

The *Early help Strategy* incorporates the legal framework and principles of *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children (March 2015), which is defined as:*

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best outcomes.

5.3 Transforming Lives

Transforming Lives draws on national evidence in relation to Early Help, and work by the Audit Commission, the Early Action Task Force, and the Marmot Review 2010. These national policy sources all document the benefits achieved through agencies working together at the earliest opportunity; working with people facing multiple problems to secure better outcomes and reducing the costs of service delivery. The programme aims to reduce demand, lower cost and deliver better outcomes, whilst recognising the importance of involving families and individuals as key partners in delivery.

Principles:

1. Identifying and taking opportunities as early as possible with people who require our support
2. Committing to working together with all organisations, to ensure the delivery of the Transforming Lives approach and the achievement of improved outcomes for people
3. Recognising that working with people, is everyone’s business, and it is everyone’s job to support individuals in the manner outlined within the Transforming Lives approach
4. Recognising that the individual(s) is/are central to defining and addressing the problems that they face and they are key partners in this approach
5. Working with the individual(s) and other services to overcome barriers to achieving better outcomes
6. Recognising that taking action early is an investment that reduces demand on high cost services

Transforming Lives cohort:

A targeted approach to supporting people identified with experiencing complex needs was felt to have the biggest impact on addressing inter-generational harm and reducing future demand on crisis and statuary services. The Transforming Lives cohort includes people with:

- Mental health and wellbeing problems
- Substance misuse, including alcohol
- Repeat victim or perpetrator of violence or aggression (accept those deemed at high risk)
- Frequent user of emergency services/and or unscheduled care (e.g. A+E) for genuine or non-genuine reasons
- Frequent and malicious caller to emergency services (e.g. police, fire or ambulance)
- Repeat offender for crime or anti-social behaviour (accept those deemed at high risk)

5.4 Integrated Delivery of Health and Social Care

Integrated care is the means by which care can be co-ordinated around the needs of the individuals in the community to enable this goal to be realised. Successful delivery of the integrated agenda will reduce inappropriate demand, improve quality and productivity and increase utilisation of community assets. It was agreed that the initial focus for the borough's approach to integration will be those deemed most at risk of hospital admission, including those with long term conditions, mental health problems, substance misusers and the frail and elderly populations. Integrated care plans for these groups of people have focussed on the development of four integrated locality teams, which include self-care and wellbeing services:

- Blackburn North
- Blackburn East
- Blackburn West
- Darwen

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6.0 Local Suicide Trends

6.1 Overall Suicide Rates

The rate of suicide and undetermined death (age standardised) for BwD is reported by the Public Health Outcomes Framework (PHOF) as 10.0 per 100,000 population for the period 2012 – 2014. This figure is similar to the North West rate of 10.3 per 100,000 and higher than the England rate 8.9 per 100,000.

Figure 1 below shows the suicide rate over a 13 year period (2001 – 2014) by 3 year rolling rates. It clearly illustrates the rate of suicide per 100,000 population was significantly higher for BwD in 2010-2012. The rate for 2012-2014 is not significantly different than the England average.

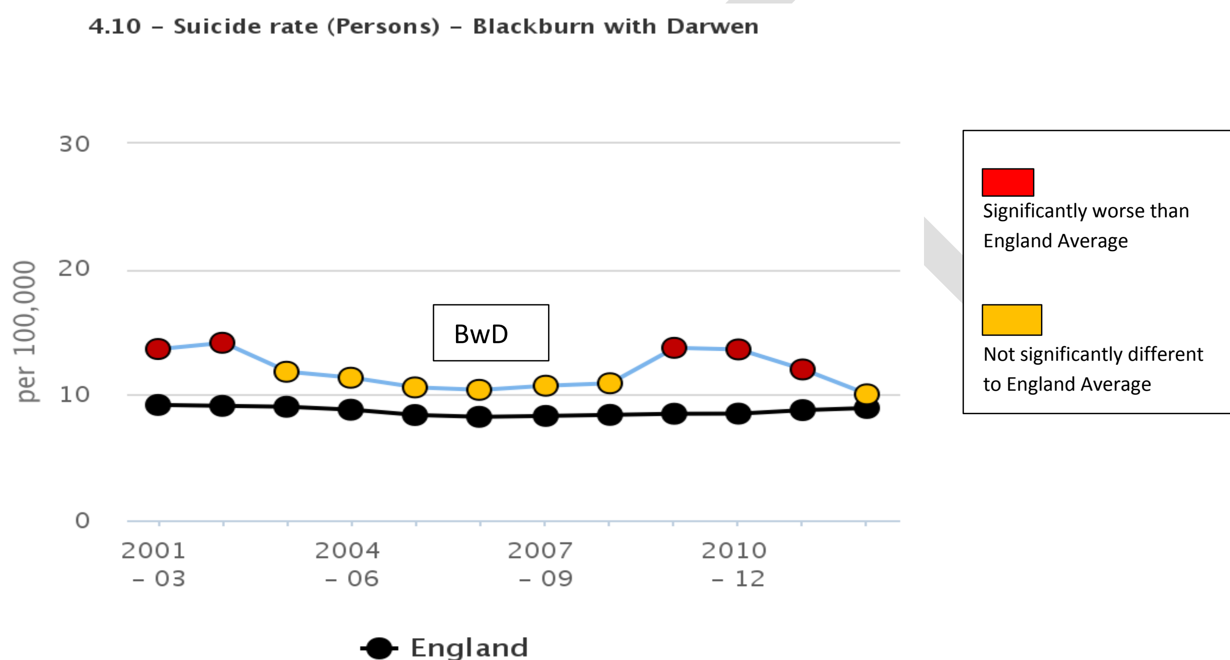

Figure 1 – Three year rolling directly standardised suicide rate (Persons) per 100,000 for Blackburn with Darwen from 2001 – 2014. Source: Public Health England

6.2 Suicide Rate by Gender

The rate of mortality from suicide and deaths undetermined in BwD is higher among men than women. The rate for females is too small for a value as reported by the PHOF. The suicide rate for Blackburn with Darwen males for the period 2012-2014 is 17.0 per 100,000. Again it is similar to the North West average of 16.3 per 100,000 and significantly higher than the England rate of 14.1 per 100,000.

The trend for suicide rate for males for Blackburn with Darwen over a 13 year period (2001-2014) is illustrated in figure 2 and clearly shows that the rate was significantly higher in 2011-2013. In 2012-2014 it is not significantly different than the England average[32].

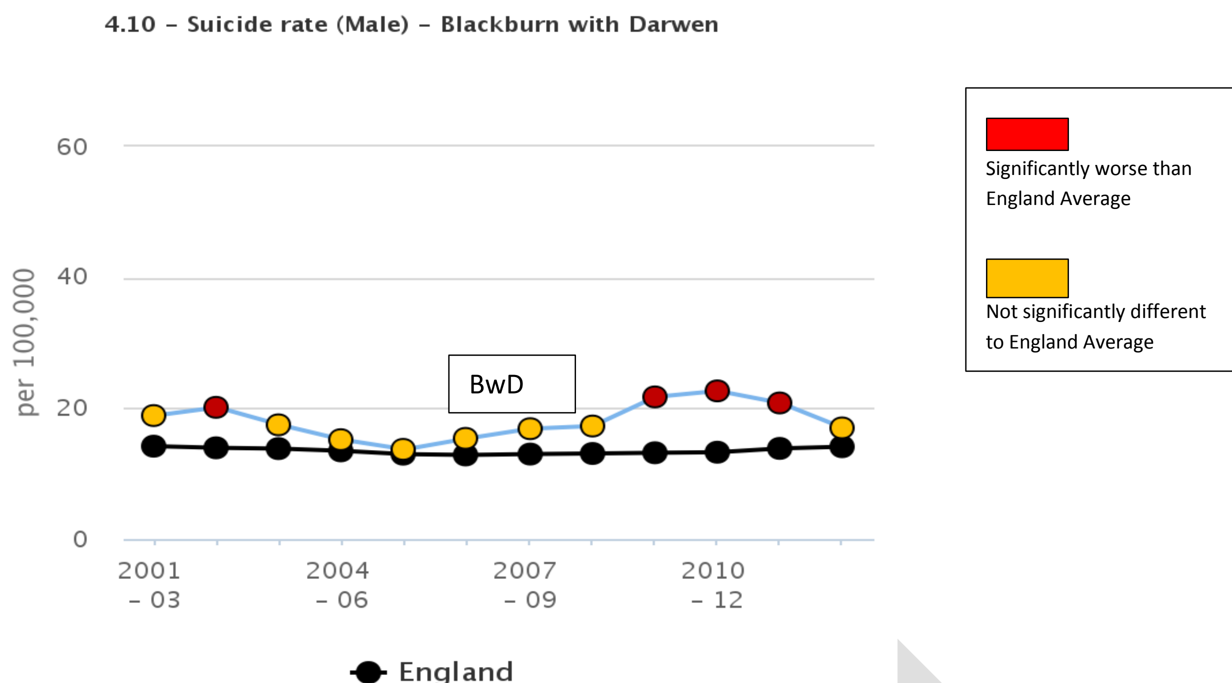

Figure 2 - Three year rolling directly standardised suicide Rate (Males) per 100,000 for Blackburn with Darwen from 2001 – 2014. Source: Public Health England

6.3 Blackburn with Darwen Suicide Audit

Blackburn with Darwen suicide rates are determined via the Office of National Statistics (ONS) and local auditing of information provided from a number of sources. These include the Coroner's Office, primary care records, hospital admissions, mental health services (if applicable).

The Public Health Department plays a crucial role in collating and analysing suicide data which helps with identifying local trends and produce recommendations for action. This requires a whole system approach involving a wide range of local partners and agencies. Recognising trends in suicide occurrence and identifying preventative factors from the available data and individual records can contribute to reducing the number of deaths by suicide. This in-turn can help positively impact on the borough's public health goal of increasing overall life expectancy.

A suicide audit was recently conducted for BwD. After being informed by the Coroner of a death by suicide in the borough, there was a subsequent review of the deceased person's medical records to assess factors that may have contributed to their death. The audit carried out retrospectively revealed 16 deaths by suicide in 2012 and 13 deaths in 2013.

A number of recommendations were made after the audit was conducted which are detailed in Appendix 2.

Blackburn with Darwen Suicide Audit Findings

- In the two year period of the audit, there were a total of 29 deaths by suicide and death undetermined (16 in 2012, and 13 in 2013)

- Male suicide rates were much higher than female suicides: 90% (n=26) and 10% (n=3) respectively.

- In 2012, 50% (n=8) and in 2013, just under 77% (n=10) of deaths by suicide were recorded as being White males aged 45+ years

- The methods for suicide in BwD were as follows:
    - 38 % (n=11) by hanging
    - 34% (n= 10) by self-poisoning (using prescribed medicines)
    - 10% (n=3) jumping from a height
    - 7% (n=2) jumping or lying in front of a moving object
    - 4% (n=1) cutting and stabbing
    - 7% (n=2) of deaths had no records for cause of death

- All female deaths by suicide (n=3) were by self-poisoning, consistent with local and national trends.

- Location of death were as follows:
    - 38% (n=11) individual's own home
    - 21% (n=6) other residential address
    - 10% (n=3) in the woods
    - 7% (n=2) in a car park
    - 7% (n=2) hostel setting
    - 3% (n=1) on the railway
    - 14% (n=4) of deaths had no details recorded of location

- The audit revealed 21% of individuals (n=6) who died by suicide were employed/linked with the building trade consistent with local trends which indicate a higher prevalence of suicides in residents in semi-routine/routine occupations.

- The audit helped identify a number of factors which may have contributed to an individual's decision to die by suicide. Depression was a factor in 41% of deaths (n=12). This was followed by 14% (=4) who had experienced a relationship breakdown. Substance misuse was also noted as a contributory factor for 7% (n=2) of individuals.

6.4 Self-harm

Hospital admission rates for self-harm among 10-24 year olds in Blackburn with Darwen is 561.9 per 100,000, which is higher than both the regional (440.4 per 100,000) and national (352.3 per 100,000) rates; one of highest across England (2010/11-12/13)[33]. However, research estimates that as many as 1 in 10 young people will self-harm.

Self-harm can occur at any age but younger people are more likely to self-harm than older individuals. Of those who present at hospitals, two-thirds of patients who self-harm are under the age of 35 years. Overall, women are more likely to self-harm than men[34 35]. Older adults presenting to hospital with self-harm are a high-risk group for subsequent suicide, particularly older men[36].

Emergency Hospital Admissions for intentional self-harm for all ages in BwD is also higher than the England average[37]. The age and sex standardised Emergency Hospital Admissions for Intentional Self-Harm for Blackburn with Darwen is 316.7 per 100,000 (2014-15), which again is significantly higher that the regional (257.7) and England (191.4) averages.

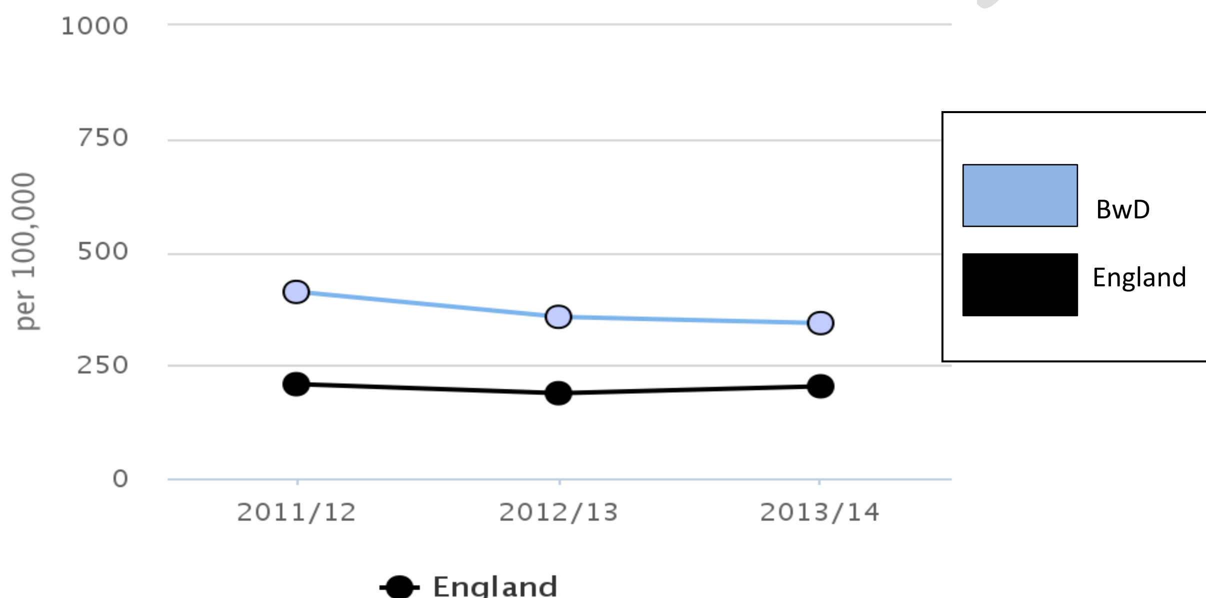

Figure 3 - Directly age standardised (per 100,000) Emergency Hospital Admissions for Self-Harm for Blackburn with Darwen from 2011-2014. Source: Public Health England

BwD's suicide audit for 2012-2013 revealed that 10% of individuals who died by suicide were self-harming 12 months prior to their death and 10% were known to have self-harmed within 12 months of their death. The audit did also reveal that 35% of the individuals had no record of self-harm. However, it is well documented that people who self-harm do not seek help from health or other services and so are not recorded.

Suicide risk is particularly increased in those people who self-harm repeatedly and also in those who have used violent and/or dangerous methods of self-harm[38].

7.0 Blackburn with Darwen Suicide Prevention Strategic Action Plan (2016-19)

7.1 Blackburn with Darwen Suicide Prevention Action Plan

Key objectives:

- Reduction in the suicide rate in Blackburn with Darwen; and
- Better support for those bereaved or affected by suicide

The Blackburn with Darwen Suicide Prevention Action Plan has the following:

Priority Areas for action

1. Joint working (and commissioning where relevant) to develop clear, consistent and streamlined pathways across services
2. Reduce the risk of suicide in high risk groups
3. Focus on raising awareness and promoting mental wellbeing in the whole population and where relevant, tailor to different community groups and those identified as high risk by local data
4. Support people bereaved by suicide and people affected by attempted suicide
5. Support research, data collection and monitoring

Blackburn with Darwen's priority areas for action have been developed after extensive consultation with stakeholders and partners, through a series of multiagency workshops throughout 2015, which were co-ordinated by the Suicide Prevention Strategy Group.

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7.2 Outcome Frameworks

The following are Outcome Frameworks that are relevant to the Blackburn with Darwen Suicide Prevention Action Plan.

The Public Health Outcomes Framework[39] for England 2013–2016 identifies four key indicators relevant to the proposed Blackburn with Darwen Suicide Prevention Action Plan:

- Domain 1: social connectedness
- Domain 2: hospital admissions as a result of self-harm
- Domain 4: excess under 75 mortality in adults with serious mental illness *and* suicide

The NHS Outcomes Framework 2015/16[40] identifies three key areas relevant to this plan:

- Domain 1 – Preventing people from dying prematurely: Reducing premature death in people with mental illness
    - 1.5 i Excess under 75 mortality rate in adults with serious mental illness (shared with Public Health Outcomes Framework (PHOF) 4.9)
    - ii Excess under 75 mortality rate in adults with common mental illness
    - iii Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services (shared with PHOF 4.10)

- Domain 2 – Enhancing quality of life for people with long-term conditions: Enhancing quality of life for people with mental illness (PHOF 1.6)

- Domain 3 – Helping people to recover from episodes of ill health: Improving outcomes from planned treatments. Includes:
    - ii *Psychological therapies*
    - iii *Recovery in quality of life for patients with mental illness*

The Adult Social Care Outcomes Framework 2015–16[41] shares the Public Health Outcomes Framework indicator of social connectedness:

- Domain 1: Enhancing quality of life for people with care and support needs.
    - Avoiding loneliness and isolation is one of the outcome measures for this domain

Both the Adult Social Care and NHS Outcomes Frameworks contain safeguarding domains that are relevant to work the suicide prevention agenda.

- Adult Social Care domain 4: Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm
- NHS Domain 5: Treating and caring for people in a safe environment and protect them from avoidable harm

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7.3 Suicide Prevention Action Plan

Priority 1: Joint working (and commissioning where relevant) to develop clear, consistent and streamlined pathways across services					
	Actions	Outputs	Timescale	Lead Responsible	Progress Update
All Age Groups	• Map and identify relevant mental wellbeing and suicide prevention pathways through the life-course • Identify any gaps • Work with commissioners and service providers to address gaps • Share the pathway with relevant agencies • Develop a self-harm/attempted suicide pathway • Join up alcohol and drugs strategies and services with suicide prevention	• Robust pathways in place • More effective early identification of at risk individuals of suicide • Self-harm/attempted suicide pathway developed and implemented • Suicide Prevention Strategic Plan linked in with other key strategies such as the Mental Health Concordat		Start Well Suicide Prevention Group Live Well Suicide Prevention Group Age Well Suicide Prevention Group	

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Priority 2: Reduce the risk of suicide in high risk groups					
	Actions	Outputs	Timescale	Lead Responsible	Progress Update
All Age Groups					
Low socio-economic group and deprivation	• Support actions and interventions to reduce socio-economic inequalities	• Early identification, and challenge, of national policies that could increase socio-economic inequalities • Development of local Health and Wellbeing Strategy with a key focus on reducing inequality		Start Well Suicide Prevention Group Live Well Suicide Prevention Group Age Well Suicide Prevention group	
Men	• Encourage critical reflection on gender role socialisation • Map and engage with services that deliver interventions to men • Provide support and suicide prevention training and help implement early identification systems to recognize those at risk • Provide interventions such as online support to men around mental wellbeing	• Local data audited and BwD high risk groups identified • High risk groups engaged and included in service needs and re-design if required • Training for staff in primary and secondary healthcare, social services, education, and the voluntary sector.			

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	Actions	Outputs	Timescale	Lead Responsible	Progress Update
All Age Groups LGBT (Lesbian, Gay, Bi-sexual and Trans)	• Provide support and suicide prevention training and help implement early identification systems to recognize those at risk	• Training for staff in primary and secondary healthcare, social services, education, and the voluntary sector.			
History of Self-harm	• Self-harm training provided to frontline staff who may come in contact with people self-harming including GP's teachers, A&E staff, District Nurses • Audit the implementation of NICE 'Self Harm: Longer Term Management' Guidance by relevant service providers and clinical settings • Help and support for parents/carers with young people self-harming • Self-harm support groups – map across the borough and identify any gaps • Design and implement a Self-Harm register in A & E • Pathways in place to sign-post and support those individuals that are found to self-harm	• Best practice self-harm training identified and a working group established to implement across BwD • A comprehensive audit completed to ascertain implementation of the NICE self-harm guidance • Mapping of self-harm support services in BwD completed and gaps or service needs identified • A self-harm register and related pathways developed in partnership with relevant HP's and service users. • All pathways reviewed and recommendations highlighted			

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	Actions	Outputs	Timescale	Lead Responsible	Progress Update
All Age Groups Mental health services including inpatients	• Pathways reviewed and seamless pathways developed • 24hour access to Mental Health Practitioners • Training to GP's and front line staff who can implement early identification systems and processes to help identify and respond to high risk individuals • Look at demographic data from in-patients alongside BwD suicide audit data to identify at risk groups • Adverse Childhood Experiences (ACE's) Programme - determine its best use in practice • Plan and Implement MECC (Make Every Contact Count)	• Training delivered • The demographics of inpatients ascertained • Review the outcome of the ACE's research and how best to implement • MECC implemented across various staff groups			

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	Actions	Outputs	Timescale	Lead Responsible	Progress Update
Live Well Middle Aged men	• Suicide prevention interventions to be informed by an understanding of men's beliefs, concerns and contexts • Enable interagency working to address the multiple difficulties experienced by men in mid-life, through clear allocation of responsibility and accountability for suicide prevention at local level • Promote social connectedness in men in mid-life			Live Well Suicide Prevention Group	
Occupational Groups	• Audit local suicide data and identify any trends in occupational groups • Provide support to employers via the Healthy Settings Agenda	• Audit complete and trends identified • Local private and public sector employers engaged and given information and support			

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	Actions	Outputs	Timescale	Lead Responsible	Progress Update
Age Well Occupational Groups	• Map services aimed at >65 years • Audit local suicide data and identify any trends in occupational groups • Provide support to employers to support employees when retiring	• Mapping completed and gaps and service needs identified • Audit complete and trends identified • Local private and public sector employers engaged and given information and support		Age Well Suicide Prevention Group	

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Priority 3: Focus on raising awareness and promoting mental wellbeing in the whole population and where relevant, tailor to different community groups and those identified as high risk by local data					
	Actions	Outputs	Timescale	Lead Responsible	Progress Update
All Age Groups	• Embed 5 ways to Wellbeing into existing local services • Identify at risk groups via a suicide audit and develop working groups to take actions forward • Brief intervention - implement and deliver MECC (Make Every Contact Count) training for frontline staff to identify mental health issues and sign-post • Deliver ASIST training to front-line staff • Set up three separate suicide prevention task and finish groups to implement interventions at each life-stage	• Brief questionnaire developed and conducted with relevant services to audit the use of the 5 Ways to Wellbeing • Suicide audit conducted and trends identified • Staff groups to benefit from training identified and training delivered • Groups set-up which reports back to the main Suicide Prevention Strategy Group		Start Well Suicide Prevention Group Live Well Suicide Prevention Group Age Well Suicide Prevention Group	

	Actions	Outputs	Timescale	Lead Responsible	Progress Update
Start Well • CYP • Children in Care • Care leavers • Youth Justice System • Young Carers • Abuse victims • Sexual abuse survivors • Vulnerable due to social economic/circumstances • Drugs and alcohol misuse • LGBT	• Ensure training needs identified for services working with each at risk group • Develop universal suicide early identification tool and ensure all relevant services including Job Centre Plus have pathways in place to help those in need of support • Ensure services are available to CYP and their families and carers outside normal working hours	• Training needs identified and subsequently a programme developed and delivered to relevant services • Universal tool developed and implemented (after piloting) • Mapping exercise to identify services that are available to children and young people complete. Gaps and needs highlighted • Mapping exercise to identify services and support available to families and carers complete. Gaps and needs highlighted		Start Well Suicide Prevention Group	
Live Well and Age Well • Criminal Justice system • Survivors of abuse • Veterans • People Living with Long-Term Conditions • Abuse victims • Sexual abuse survivors • Vulnerable due to social economic/circumstances • Drugs and alcohol misuse	• Identify individuals/groups/organisations that can help engage with those identified at risk e.g. LGBT, BME • Ensure training needs identified for services working with each at risk groups • Develop universal suicide early identification tool and	• Key individuals/groups/organisations identified and included in implementing the suicide prevention action plan • Training needs identified and subsequently developed and delivered to relevant services • Universal tool developed and implemented (after piloting)		Live Well Suicide Prevention Group Age Well Suicide Prevention Group	

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	Actions	Outputs	Timescale	Lead Responsible	Progress Update
• Untreated Depression • LGBT • BME	• ensure services have pathways in place to support those identified as high risk	• Pathways in place			
Priority 4: Support people bereaved by suicide and people affected by attempted suicide					
	Actions	Outputs	Timescale	Lead Responsible	Progress Update
All Age Groups	• Map all known suicide bereavement services; including those available on the web • Raise awareness of services • 'Help Is At Hand' and – given out post-verdict at coroner's inquest and funeral directors.	• Services mapped gaps and needs identified • Raise awareness of existing bereavement support to services such as the Coroner's Office, funeral directors, GP's and other settings where those bereaved by suicide will come in contact with • Copies of 'Help Is It Hand' provided to the Coroner's Office		Start Well Suicide Prevention Group Live Well Suicide Prevention Group Age Well Suicide Prevention Group	

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Priority 5: Support research, data collection and monitoring					
	Actions	Outputs	Timescale	Lead Responsible	Progress Update
All Age Groups	• Audit 2012-2013 data provided by coroner to public health • Report trends including at risk groups • Map research currently being done in BWD around suicide and suicide prevention • New research and engagement topics identified • Link with ELHT and other relevant agencies to gather and record data related attempted suicides • Use the BwD Communications Team as a link with wider media outlets in BwD to deliver and promote suicide prevention messages and report any suicides appropriately and stipulated by nation strategy	• Audit completed and report compiled • Mapping exercise completed and research findings used if applicable and feasible • Research groups formed when necessary to conduct research • Working group established to take this forward and develop attempted suicide data collation • BwD communications team updated regularly about developments in suicide prevention messages		Start Well Suicide Prevention Group Live Well Suicide Prevention Group Age Well Suicide Prevention Group	

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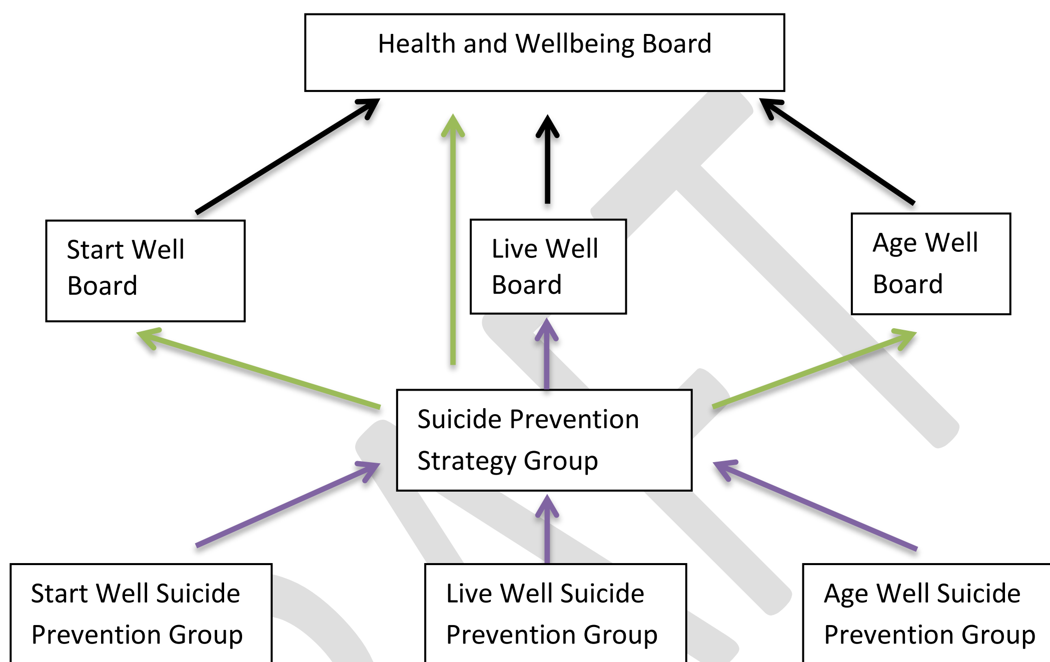
8.0 Accountability

This strategy will be implemented by three groups each corresponding to a life course i.e. Start Well, Live Well and Age Well, with the Suicide Prevention Strategy Group having leadership responsibility to monitor and deliver the overall Suicide Prevention Plan. Accountability for Suicide Prevention is with the Health and Wellbeing Board.

8.1 Governance Structures



8.2 Reporting arrangements

Each life stage Suicide Prevention Group will co-ordinate and implement the appropriate section of the Suicide Prevention Action Plan, and quarterly reports will be collated and reviewed by the Suicide Prevention Strategy Group. Annual reports will be produced by the Suicide Prevention Strategy Group, who will monitor and ensure delivery of cross cutting themes. Reports will be presented the Health and Wellbeing Board, and its sub groups, on an annual basis or more frequently as required.

Suicide Prevention Delivery Groups	**Key linkages**
Start Well Suicide Prevention Group	Healthy Child Programme Strategy Group Pennine Lancashire Transformation Plan Group Local Safeguarding Children's Board (LSCB)
Live Well Suicide Prevention Group	Transforming Lives Group Making Every Adult Matter (MEAM) Group Lancashire Mental Health Crisis Care Concordat Group Local Safeguarding Children's Board (LSAB)
Age Well Suicide Prevention Group	Loneliness and social isolation Group Wider determinants Group Local Safeguarding Children's Board (LSAB)

9.0 Acknowledgements

The causes and effects of suicide are multi-faceted, requiring inputs from different stakeholders to help prevent and manage suicide. It is therefore recognised that the successful implementation of this strategy requires a partnership approach with active involvement of different agencies. It cannot be an exclusive responsibility of any one organisation or service.

The Blackburn with Darwen Suicide Prevention Strategy has been developed through a consultative process led by Public Health involving statutory and voluntary agencies from across the borough. The Suicide Prevention Steering group has been integral in helping to shape the final strategy and the aim and objectives within it. The partners involved in drafting this strategy include:

- Blackburn with Darwen Borough Council
- Families Health and Wellbeing Consortium
- Blackburn with Darwen Clinical Commissioning Group
- Lancashire Constabulary
- Samaritans
- Blackburn with Darwen Carers
- Lancashire Mind
- Re-Align Futures
- Blackburn College
- Lancashire Care Foundation Trust
- Lancashire LGBT
- East Lancashire Hospitals NHS Trust
- Blackburn with Darwen District without Abuse (BDDWA)
- Community Wellbeing Service
- CRI
- Child Action North West (CANW)
- Creative Support
- Blackburn with Darwen Age UK
- Lifeline

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Appendix 1

Men, Suicide and Society - Why disadvantage men in mid-life die by suicide

Recommendations from the report:
Samaritans calls on national government, statutory services (such as health, welfare, employment and social services), local authorities and the third sector to take action to reduce suicide in disadvantaged men in mid-life.

1. Ensure that suicide prevention strategies include explicit aims to reduce socio-economic inequalities and gender inequalities in suicide.
2. Inform suicide prevention measures with an understanding of men's beliefs, concerns and contexts – in particular their views of what it is to 'be a man'.
3. Enable inter-agency working to address the multiple difficulties experienced by men in mid-life, through clear allocation of responsibility and accountability for suicide prevention at local level.
4. Support GPs to identify and respond to distress in men, recognising that GPs are the most likely formal source of help to be consulted by this age-group
5. Provide therapies which address the specific psychological factors associated with suicide – particularly, for men, social and emotional skills, managing stress and the expectations of others.
6. Develop innovative approaches to working with men that build on the ways men do 'get through' in everyday life.
7. Join up alcohol and drugs strategies and services with suicide prevention, recognising the links between substance misuse, masculinity, deprivation and suicide.
8. Recognise the profound role of social disconnection in the suicide risk of men in mid-life, and support men to build social relationships.
9. Assist men excluded from the labour market to (re)enter employment.

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Appendix 2

Recommendations from Blackburn with Darwen's 2012-13 Suicide Audit (completed in Autumn 2015).

The following are recommendations for preventing death by suicide and injury undetermined in Blackburn with Darwen developed from the information and insight revealed by the local audit.

1. **Target interventions at White middle aged men.** Interventions and prevention programmes should be implemented across the life-course but particular focus on the high risk group i.e. over 45 years old White men and men over 50 years old that are single and/or divorced. It is important that this is linked to the 'Age Well' agenda and bought to the attention of the Blackburn with Darwen Age Well Group as loneliness and isolation could potentially be a contributing factor in suicides.

2. **Understand risk for men linked to building trades**. With the audit results also showing men working in the building trade are at high risk of death by suicide it is important that more insight and engagement work with this group is conducted to understand their thoughts and issues around mental health and support networks they access or would like to access.

3. **Making Every Contact Count.** Engaging with health professional's that come in contact with the high risk groups as highlighted by the audit should be offered training such as Applied Suicide Intervention Training (ASIST) and Mental Health First Aid (MHFA) e.g. GP's, Primary Care Staff.

4. **Review prescribing policy to reduce access to means.** Deaths by 'poisoning by solid or liquid substances' were all as a result of medicines prescribed to the deceased. In-light of this, CCG and Mental Health Services may need to review their prescribing policy and establish whether the current policy is effective in taking into account prescribing medication to individuals who are potentially at risk of death by suicide. Additionally, Mental Health Services may also need to examine their practice in identifying individuals at risk of suicide and establishing whether this is effective. This may also require reviewing how care plans for individual's are developed and implemented and whether they take into account the risk the individual may pose when prescription drugs are readily accessible to them.

5. **Data quality issues: improve Equality and Diversity monitoring**. Anecdotal evidence does suggest that sexual orientation may play a part in mental health and wellbeing issues for many individuals. And for many, issues surrounding their sexual orientation could play a significant role in an individual's decision to die by suicide. We cannot draw any conclusions that this is the case for Blackburn with Darwen. However, we cannot overlook the fact that in some instances data was incomplete when conducting the local audit. For Equality and Diversity purposes, it is important that all professionals ensure data quality, particularly relating to protected characteristic groups is documented.

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6. **Data quality issues: develop a self-harm register**. Individuals that self-harm are at increased risk of death by suicide. However, the audit revealed that data in relation to self-harm was incomplete for numerous records. With self-harm being a significant risk factor, East Lancashire Hospitals Trust and Mental Health Services may want to consider implementing a self-harm register where repeat attendances/admissions are recorded and identified. And as a result, suitable interventions are offered to the individual and relevant staff groups are provided with appropriate training on self-harm.

7. **Workforce development for Job Centre Plus**. With the audit revealing a number of the deceased were either unemployed or long-term sick at the time of their death; it is crucial that active engagement is sought with the Job Centre Plus and other employment support agencies. Training such as ASIST and MHFA should be promoted and offered to staff to help identify individuals at risk of suicide and provide appropriate interventions.

8. **Parity of esteem: Holistic approach to supporting people with depression.** According to a leading mental health charity MIND, I in 4 people will suffer from a mental health problem each year; most commonly depression. Depression was recorded in 28% of individuals that died by suicide in BwD in 2012 and 2013. Preventing depression by promoting mental health and wellbeing is very important. But where a depressive illness is being experienced by an individual, interventions need to be provided that prevent the escalation of circumstances leading to a death by suicide. It is important that agencies across the borough that provide a service incorporating mental health and wellbeing share information with Primary and Secondary Care organisations. But also with organisations and agencies that may not necessarily promote health (including mental health) and wellbeing as their core service, it should be encouraged that they could promote interventions and programmes opportunistically using the Make Every Contact Count (MECC) model.

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