Brighton & Hove Suicide Prevention Strategy:

And Action Plan January 2019 - December 2021

Draft 18th December 2018

Contents

Index of Acronyms used in this document

Acronym	Full Name	What does this mean?
APMS	Adult Psychiatric Morbidity Survey	Provides data on the prevalence of both treated and untreated psychiatric disorder in the English adult population (aged 16 and over).
CIPFA Partners	Chartered Institute of Public Finance and Accountancy	These are other local authority areas that have a similar population profile compared with Brighton and Hove and against whom performance can be compared. The partners are different depending on the issue being measured.
CMHD	Common Mental Health Diagnoses	Depression (including subthreshold disorders) Anxiety disorders (panic disorder, phobias, social anxiety disorder, Obsessive Compulsive Disorder and Post Traumatic Stress Disorder
ESA	Employment and Support Allowance	ESA has replaced incapacity benefit, and involves a medical test, the work capability assessment .
IMD	Indexes of Multiple Deprivation	A nationally recognised measure of deprivation.
ONS	Office of National Statistics	UK's largest independent producer of official statistics and its recognised national statistical institute.
QOF	Quality Outcome Framework	These are measures decided by the Department of Health, called indicators, upon which GP practices are given points based on how they are doing against these measures.
SPFT	Sussex Partnership NHS Foundation Trust	The NHS mental health trust for Brighton & Hove.
STP	Sustainability and Transformation Partnership	These are partnerships of NHS and local councils who come together to run services in a more coordinated way, to agree system-wide priorities, and to plan collectively how to improve residents' day-to-day health. Sussex and East Surrey STP covers the Brighton & Hove area.

Executive Summary

World Mental Health Day 2018 (10th October 2018) saw the announcement of the appointment of the first minister for Suicide Prevention. One of the core responsibilities of the new appointment will be to ensure that every local area has an effective suicide prevention plan in place[1].

Public Health Teams, within the Local Authorities have lead responsibility for delivering the Suicide Prevention Strategy[2] with local strategies delivered by the local steering group.

Delivery of the strategy is dependent on a partnership approach across the Council, NHS, community and voluntary sector and communities. The local steering group and stakeholders meetings have established a robust partnership to support this. Going forward there are further opportunities to strengthen delivery of this important strategy. These include:

- the forthcoming Brighton & Hove Joint Health & Wellbeing Strategy which will aim to make health and wellbeing everyone's business across the City
- inclusion of Suicide Prevention as a priority work-stream in the Sussex and East Surrey Sustainability & Transformation Partnership (STP)
- Prioritisation of suicide prevention in the NHS Long Term Plan and the closer working between providers and commissioners as part of delivering this plan

Analysis of evidence of risk and actual incidence of cases has identified the following communities as being at higher risk of suicide locally:

- Males aged 30-54 years
- Individuals with existing mental health problems
- Those in contact with Mental Health support
- People who present with incidents of self-harm
- Those living in areas of deprivation
- The LGBTQ+ Community
- People with drug and alcohol problems

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[1] PM pledges action on suicide to mark World Mental Health Day, Published 9th October 2018, accessed online 16th October 2018

[2] Preventing suicide in England A cross-government outcomes strategy to save lives, 2012:

'Local responsibility for coordinating and implementing work on suicide prevention will become, from April 2013, an integral part of local authorities' new responsibilities for leading on local public health and health improvement.',

- Members of the BME community
- People with physical health problems
- People who have been bereaved
- Young adults including students

Brighton and Hove has a long history of multi-agency suicide prevention, and suicide prevention plans are seen as central to driving local delivery of the National Strategy. The objective of the local strategy is to tailor effective prevention interventions to local need.

Currently, the steering group for the strategy meets three times a year. In addition, a wider stakeholders' meeting is held annually in March.

The 2019-21 Suicide Prevention Strategy has been refreshed using the latest information about the incidence of suicide and at risk communities. The Strategy has also been informed by stakeholder voice via the annual stakeholder event.

Building on the national evidence of good practice, a strong evidence base of local need combined with partnership working across the Clinical Commissioning Group (CCG) primary care, mental health services and the third sector, this strategy will support effective interventions with the aim of delivering the 10% reduction.

The scope of this strategy is both adults and young people, including school age and university students.

National Guidance

Suicide Prevention is underpinned by a range of national guidelines, detailed below. The 2012 policy: Preventing Suicide in England, A cross-government outcomes Strategy to Save Lives, continues to be the definitive guidance in respect of overall objectives but this was given practical substance in 2016 when two documents Local Suicide Prevention Planning and Support after Suicide, A Guide to Providing Local Services were published. These three documents have been used to structure the content of the local strategy presented here.

Resource	**Publication**
Preventing suicide in community and custodial settings	*NICE guideline, September 2018*
Preventing Suicide In England: The Third Progress Report of the Cross-government Outcomes Strategy to Save Lives	*HM Government, January 2017*
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, Annual Report 2017	*Health Care Quality Improvement Partnership, October 2017*
Suicide Prevention, A Guide for Local Authorities	*Local Government Association, February 2017*
Local Suicide Prevention Planning, A Practice Resource	*Public Health England, October 2016*
Support after Suicide: A guide to Providing Local Services, A Practice Resource	*Public Health England, October 2016*
The Five Year Forward view For Mental Health	*A report from the independent Mental Health Taskforce to the NHS in England February 2016*
Mental Health and Prevention, Taking Local Action for Better Mental Health	*Mental Health Foundation, 2016*
Preventing Suicide in England, A cross-government outcomes Strategy to Save Lives	*HM Government, September 2012*

Evidence Base

The national evidence, detailed above provides effective approaches to support suicide prevention. The latest NICE guidance[3] identifies a range of interventions:

- suicide prevention partnerships, strategies and action plans
- gathering and analysing suicide-related information
- awareness raising by suicide prevention partnerships
- how suicide prevention partnerships can reduce access to methods of suicide
- training by suicide prevention partnerships
- how suicide prevention partnerships can support people bereaved or affected by a suspected suicide
- reducing the potential harmful effects of media reporting of a suspected suicide

These recommendations bear strong comparison with the principles identified in the 2012 cross-government strategy *Preventing Suicide in England*[4] identifies priorities for action under six headings:

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

The Third Progress Report of the Cross Government Outcomes Strategy to Save Lives (January 2017) expanded the scope to include addressing self-harm as a new key area:

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

This strategy uses the structure laid out in the 2012 guidance to shape delivery and also addresses the additional priorities for action identified by Public Health England in their 2016 planning guidance:

- Reducing risk in men, especially in middle age
- Mental health of children and young people

[3] Preventing suicide in community and custodial settings, NICE, September 2018

[4] https://www.gov.uk/government/publications/suicide-prevention-strategy-launched

- Treatment of depression in primary care including safer prescribing
- Safer acute mental health care
- Tackling high frequency locations
- Reducing isolation

The strategy combines information about people at risk of suicide as evidenced from the national guidance and compares this with findings of need from local data sources, in order to identify groups in particular need. Some communities that are identified as at risk from national guidance may not present within the local data, however these groups have been included as a priority group within the strategy because of evidence based on the their mental health need. An example of this is the Black and Minority Ethnic community were evidence of completion of suicide is low, but mental health need is high, thereby evidencing potential risk.

The Local Commissioning Context

Commissioning of services plays an important role in supporting suicide prevention. Locally a range of mental health provision is available in the city including NHS community based support, inpatient provision and psychosocial support, as well as that delivered through primary care. All these services are within the scope of the strategy as many of those vulnerable to suicide may be in contact with these services. But in particular in respect of directly commissioned services supporting suicide prevention and wellbeing, the city council and CCG both commission services relevant to this agenda, including:

- Grassroots who provide training to help promote mental health awareness, suicide alertness, and positive wellbeing. The service has also developed a downloadable digital suicide prevention resource in the form the Staying Alive App
- Rethink Mental Health: Survivors of Suicide which supports those bereaved or affected by suicide

One of the challenges going forward will be to ensure that we effect positive change by embedding suicide prevention within the fabric of services.

The wider range of services relevant to suicide prevention includes:

- Mental Health Services, primary care, adult social care
- Children and young people's mental health including CAMHS and other services including online counselling and YMCA support. The Public Health Schools Programme has prioritised support for staff, parents and pupils related to emotional wellbeing.
- Drug & alcohol services, tackling homelessness, action to address loneliness in older people, money advice, support for neighbourhood and community groups and workplace mental health initiatives are among the wide range of services relevant to suicide prevention.

- The Older People's Programme and Age-Friendly City approach.

Suicide Prevention and Mental Health Prevention and Wellbeing Services are in the process of being recommissioned as part of a wider proposal to deliver a "Community Roots" service in the city. The recommendations and evidence of need presented in this Strategy have informed the service specification.

Achievements so far

During 2017-18, 169[5] individuals were trained in suicide prevention from over 100 different organisations. This training was commissioned by public health and delivered by Grassroots Suicide Prevention. Additionally, this service also trained 64 individuals in Understanding and Working with Self-Injury. Grassroots Stay Alive App continues to be one of the leading digital suicide prevention resources.

Over 4,000 mental health Crisis cards developed jointly between Sussex Police and Brighton and Hove Council's Public Health Team have been distributed to audiences ranging from the Universities, hostels, Seafront Team and mental health services and supported accommodation including hostels.

World Suicide Prevention Day takes place each year on the 10th September and this year saw information stalls at the entrance to Jubilee Library and at Brighton Station, members of the local community were engaged in conversations about suicide prevention work in the city. An evening event included a talk about the 'Real Talk' suicide prevention training, followed by a screening of a short film about Grassroots' volunteer Change Makers. SOS Rethink Mental Health also used the day to launch their short documentary film which examines the personal experiences of men who have attempted to take their lives.

A week long photography exhibition took place at Brighton Station using the long wall along the wooden walkway at the back entrance. Following the theme of 'Working Together' this included portraits of local people who care about suicide in the community, and are taking action to prevent it.

The Audit of the Coroner's records of Suicide cases continues with findings for the 2015-17 period available early in 2019..

Public Health continues to hold the successful annual Stakeholder Event, attended by representatives from East Sussex Fire and Rescue Service, Grassroots, Brighton and Sussex Medical School, Brighton Housing Trust, Brighton and Hove Wellbeing Service, Mankind, University of Brighton, YMCA, Allsorts Youth Project, Sussex Police, Grassroots and SOS Rethink Mental Health.

[5] Provided by Grassroots either ASIST (96) or SafeTalk (73)

Progress so far

In January 2017 the Government announced its ambition to achieve a 10% reduction in suicides by 2020/21.

Table 1 below forecasts how delivery of the national commitment would look locally. To reach the target of a 10% reduction, Brighton & Hove would need to see an average fall of 2.5% in the latest aggregated mortality rate published in the four years between 2016-17 and 2020-21.

The first data period 2014-16 saw positive attainment of the trajectory (to 14.82 per 100,000 people) with an actual rate for this period of 14.4 per 100,000. However, in 2015-17 the actual mortality rate rose to 16.0 per 100,000 people, in excess of the required trajectory.

ONS report on deaths based on the year when the death was registered, not when the deceased died. It is probable that the gap between the year of death and year of reporting has adversely affected the number of cases during the 2015-17 period[6], and it is still possible that the overall reduction will be achieved locally. The actions delivered as part of this strategy will contribute to attaining this.

Table 1: Progress Against Target: 10% Reduction in Suicide Rate by 2020

		Trajectory to reach 10% target		Actual	
Published in Year	**Most recent published data.**	**Cumulative % reduction**	**Rate per 100,000**	**Actual Rate per 100,000**	**Status**
2016-17	2013-15, aggregated for 3 years	Baseline	15.2		
2017-18	2014-16, aggregated for 3 years	2.5% reduction	14.82	14.4	Achieved
2018-19	2015-17, aggregated for 3 years	5% reduction	14.44	16.0	Not Achieved
2019-20	2016-18, aggregated for 3 years	7.5% reduction	14.06	*Pending*	
2020-21	2017-19, aggregated for 3 years	10% reduction	13.68	*Pending*	

Source: PHE Suicide Profile

[6] The possibility of a positive fall in deaths is based on the Coroner's records which for 2016 show 40 deaths and for 2017 31 cases. These deaths are cases that occured in Brighton and Hove, ONS report on suicides of Brighton and Hove residents. There is therefore a difference in the criteria used. But the positive change between those two years is likely to impact on the ONS data set too.

Local Information about Suicides

Local Information about suicides is available from:

- Office of National Statistics (ONS) who publish annual data showing a three year rolling number of deaths as well as a rate which can be compared with other areas in the Region, our Benchmark Partners and England;

Latest data available 2015-17

- ONS on request will also provide the number of deaths per calendar year of Brighton and Hove residents;

Latest data available 2017

- NHS Digital provide local public health teams with a mortality file of deaths of residents which can be used to generate information about demographic and geographical characteristics of the suicide cases;

Latest data available 2017

- Audit of the Coroner's records of suicide provides in-depth information about suicides that have taken place in the city. Suicides of Brighton and Hove residents that has taken place elsewhere are not available. This is a valuable source of information about local cases and the forthcoming findings from the audit of 2015-2017 cases will help shape local delivery.

Latest data available 2015. Provisional information available for 2016 and 2017

What do we know about suicide in Brighton and Hove: Overview

Locally, rates of deaths by suicide and injury undetermined[7] are consistently higher than that for England. The most recent local rate (2015-17) sees the city having the second highest rate of suicide when compared with other England's Districts authorities[8] and the 7th highest rate of suicides in County and Unitary Authority areas[9]. The city has the highest suicide rate in the region when compared with our benchmark partners, and local authorities (2014-16).[10]

The city saw a generally positive change in deaths by suicide up to the 2010-12 period after which the rate of mortality started to increase.

Table 2: Three year rolling suicide and undetermined injury deaths number and rolling mortality rate per 100,000 population for Brighton and Hove and England, 2002-2004 to 2015-2017

Year	Brighton & Hove				England
	Number of suicides	Suicide rate per 100,000	Lower Confidence Interval	Upper Confidence Interval	Suicide rate per 100,000
2002-2004	120	18.0	14.7	21.3	10.2
2003-2005	116	17.3	14	20.5	10.1
2004-2006	115	17.6	14.3	21	9.9
2005-2007	110	16.7	13.5	20	9.4
2006-2008	114	17.6	14.3	21	9.2
2007-2009	103	15.4	12.3	18.5	9.3
2008-2010	98	14.8	11.9	18.1	9.4
2009-2011	99	14.0	11.3	17.2	9.5
2010-2012	91	12.6	10.1	15.7	9.5
2011-2013	105	14.4	11.5	17.2	9.8
2012-2014	99	13.4	10.8	16.5	10
2013-2015	108	15.3	12.3	18.3	10.1
2014-2016	103	14.4	11.5	17.3	9.9
2015-2017	113	16.0	13.0	19.1	9.6

Source: ONS

[7] 'Injury undetermined' refers to deaths given an open verdict by Coroners.

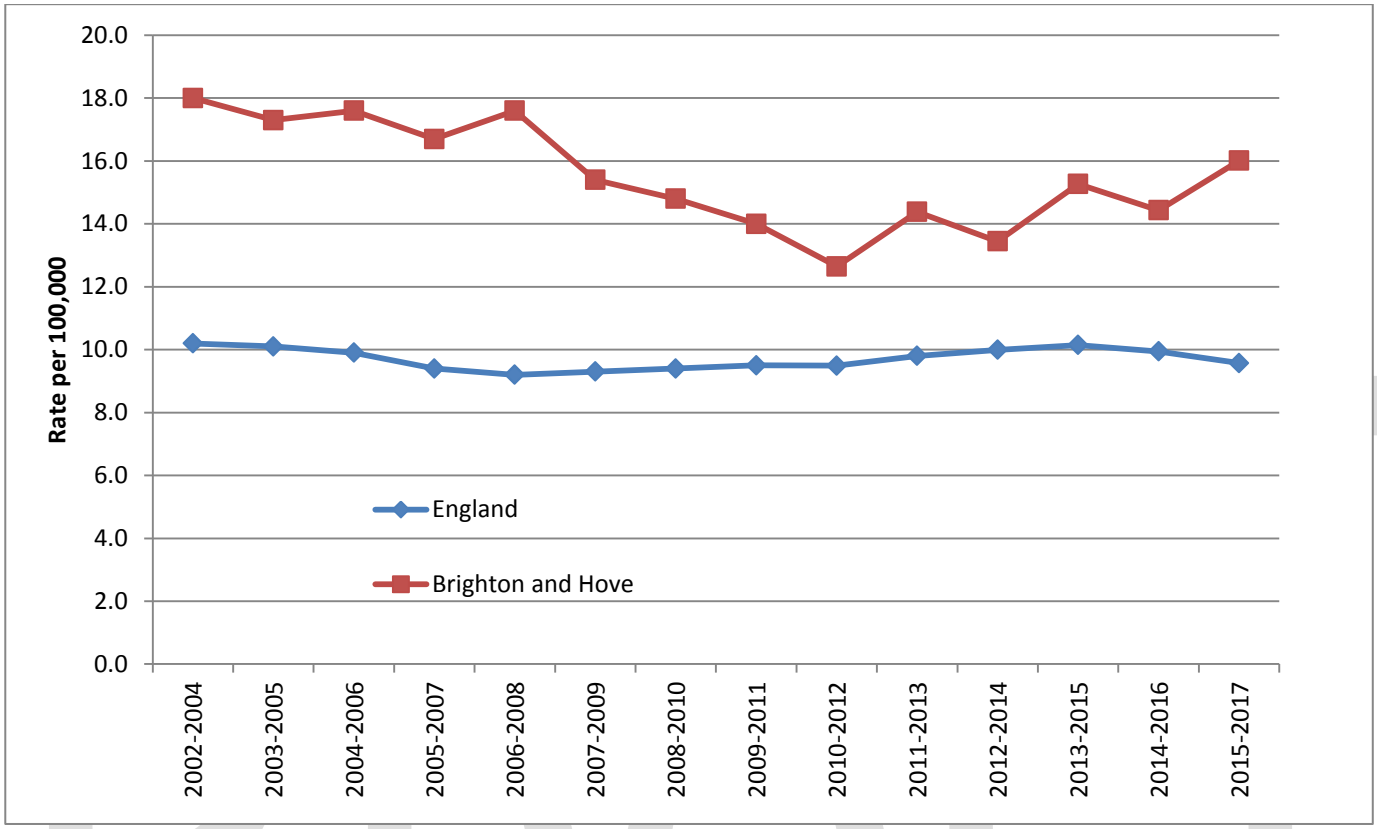
[8] The seven district authorities with the highest suicide rates per 100,000 were St Helens (17.9), Weymouth and Portland (17.8), Pembrokeshire (17.6), Powys (16.9), Eastbourne (16.9), Merthyr (16.2), Brighton and Hove (16.1)

[9] Highest rate St Helen's (17.9 per 100,000)

[10] Portsmouth, Southampton, Bournemouth, Bristol, Southend-on-Sea, Plymouth, Sheffield, Medway, York, Coventry, Newcastle-upon-Tyne, North Tyneside, Swindon, Leeds and Nottingham.

The total number of deaths each year attributable to suicide in the city fluctuates between years. This needs to be borne in mind when considering information about single years. However, from 2010-12 there has been increase in the number of suicide cases reported by ONS for Brighton and Hove residents.

Chart 1: Suicide Rate for Brighton and Hove Residents and England, 2002-2017 – Year Based on Date when Death Registered



Source: ONS Mortality File

Table 3: Number of suicides registered in each calendar year, Brighton & Hove Residents, 2006-2017

Calendar year when death registered	Suicide and undetermined injury deaths in Brighton and Hove
2006	40
2007	35
2008	36
2009	34
2010	32
2011	28
2012	30
2013	43
2014	32
2015	37
2016	40
2017	42

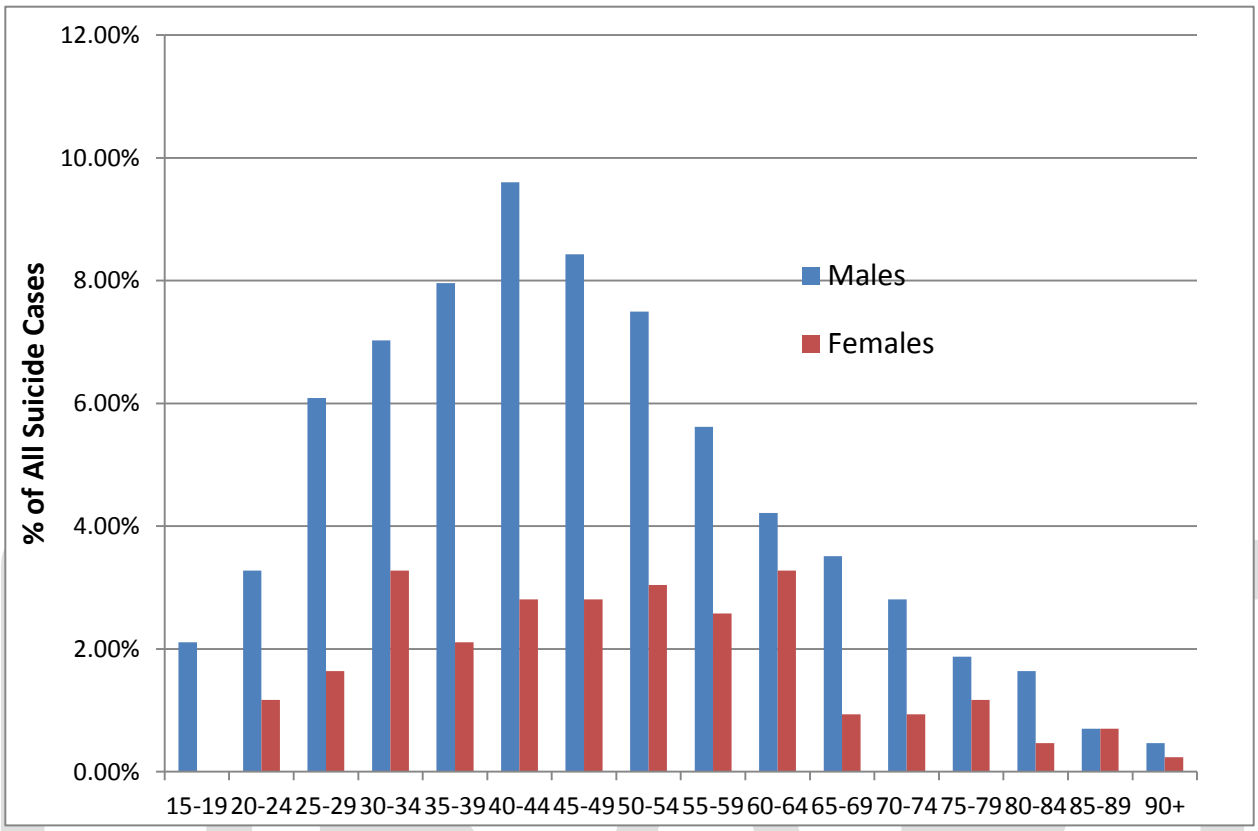
Source: ONS Mortality file 2017

Age and Gender

The ONS mortality data for suicide shows that there were a total of 429 deaths between 2006-17. Of these 311 (72.8%) were male. This bears comparison with England where in 2016 three-quarters of those who died were male[11]. Males aged 30-54 years are over represented amongst those who take their life. This finding is in line with the national data set which identifies males aged 20-44 years and females aged 50-54 years as having higher rates of suicide.

[11] ONS Suicides in the UK, 2016 Registrations, November 2017

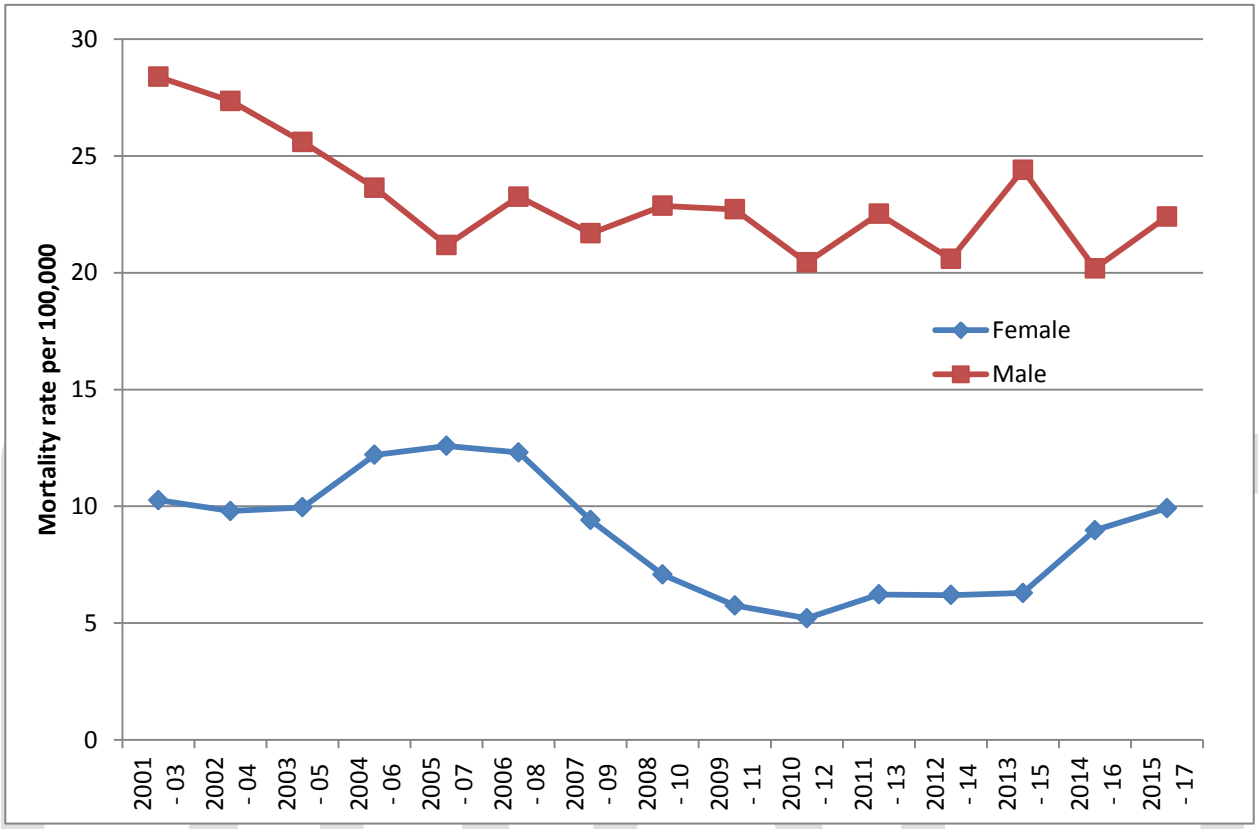
Chart 2: Number of suicide and undetermined injury deaths by age and gender, Brighton and Hove Residents, 2006-2016



Source: NHS digital Civil registration data

Across England, the most recent rise in rates of death by suicide and injury undetermined has been driven by a rise in deaths of women. Local deaths for deaths amongst women appear to show an increase from 2013-15 (see Chart 3). Men account for 73% of the total in Brighton & Hove, comparable to 75% nationally. The average age of men who die by suicide was 47.3 years in 2013-15; for women it was 46.8 years.

Chart 3: Mortality rate per 100,000 people by suicide and injury undetermined, Brighton & Hove Residents, 2001-03 – 2015-17



Source: PHE Suicide Profile

Summary

- The city has the 2nd highest suicide rate in England (2015-17)
- The local trend is not following the trajectory required to achieve the 10% reduction by 2020/21.

Who is at greater risk of suicide?

The next section of strategy will look at communities at greater risk of suicide based on national guidance. We have already identified that males aged 20-44 years are disproportionately affected. But other communities have been recognised, as at greater risk including those identified in the Guidance from 2012. These include:

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

The Strategy also recognises that other communities may need targeted support if their suicide risk is to be reduced:

- children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system;
- survivors of abuse or violence, including sexual abuse;
- veterans;
- people living with long-term physical health conditions;
- people with untreated depression;
- people who are especially vulnerable due to social and economic circumstances;
- people who misuse drugs or alcohol;
- lesbian, gay, bisexual and transgender people; and
- Black, Asian and Minority Ethnic groups

The next section will look at the communities that have been identified as at higher risk.

People in the care of mental health services

Information about an individual's contact mental health services is recorded in the inquest records held by the Brighton and Hove Coroner. Screening of the suicide cases for 2016-17 is ongoing with as at 16th January 2019, 62 of the 71 cases for the 2016-17 calendar years having been fully reviewed. Of these cases 39 had been in contact with their GP about their mental health, 62.9%.

Findings from the local audit of the coroners deaths completed in 2015 found that of the 43 cases reviewed 79% (n=34) of those who died had been in contact with a health professional about their mental health. Of these most (n=15, 34.8%) had been in contact with their GP and 11 (25.6%) had been supported by Sussex Partnership NHS Foundation Trust's (SPFT). The remaining 8 cases had received

support from private therapists, substance misuse services a health visitor, university well-being service, Priory Hospital and specialist mental health supported accommodation.

The coroners records for the calendar years 2016 and 2017 are currently being reviewed. Provisional findings indicate 40 deaths in 2016 and 31 in 2017. When the deaths in 2017 (n=31) were directly compared, on a case-by-case basis with SPFT records of Serious Incident reviews, 14 (45.2%) cases had been reviewed by the Trust indicating that the deceased had been in contact with their services.

Our local mental health provider remains an outlier with the suicide rate at 11.9 per 100,000 people receiving mental health care compared to the median rate of 7.13 per 100,000 for other Mental Health Trusts[12].

Given that many of those who take their life had accessed some help for their mental health this finding provides an opportunity to support health professionals with suicide prevention training.

- This finding evidences the need to ensure that front line clinical professionals both those operating within specialist mental health services and the wider sphere of primary and community care, including those within the private sector, are trained to provide effective suicide prevention.

Mental health problems

Brighton & Hove has higher rates of mental health problems than the average for England, including higher proportions of people on a GP register for depression and for severe mental illness[13]. A significantly higher proportion of Brighton & Hove residents than nationally report high levels of anxiety[14].

Data from the Quality Outcome Framework (QOF) reported by Public Health England Fingertips includes incidence/prevalence[15] data for our community locally and in comparison with our comparator CCGs for Common Mental Health Disorders as well as Serious Mental Illness. Brighton and Hove has the highest percentage of patients with long term mental health problems and also the highest percentage of patients with depression and anxiety when compared with our Nearest Neighbours.

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[12] SPFT, Report to Board of Directors, 27 September 2017 Format of Paper Suicide Prevention Strategy, Author Emma Wadey, Nurse Program Director, Presenter Rick Fraser, Chief Medical based on data from National Confidential Inquiry into Suicides and Homicides (NCISH), who collect data from Mental Health Trusts

[13] https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

[14] http://www.phoutcomes.info/ Indicator 2.23 (iv), Health Improvement

[15] *Prevalence* the percentage of a population that is affected with a particular disease at a given time.

Incidence sometimes loosely expressed simply as the number of new cases during some time period

The relationship between poor mental health and suicide is complex: many individuals with poor mental health may not be at risk of suicide, and similarly individuals who take their life may not have a mental health history. However, one the reasons for the city's high rate of suicide could be related to pre-existing poor mental health within the city as a whole. Untreated depression is also recognised as a risk factor in suicide. Findings from the local audit of suicide cases in 2015 found that 77% of those who died had an existing mental health diagnosis, which may evidence this explanation.

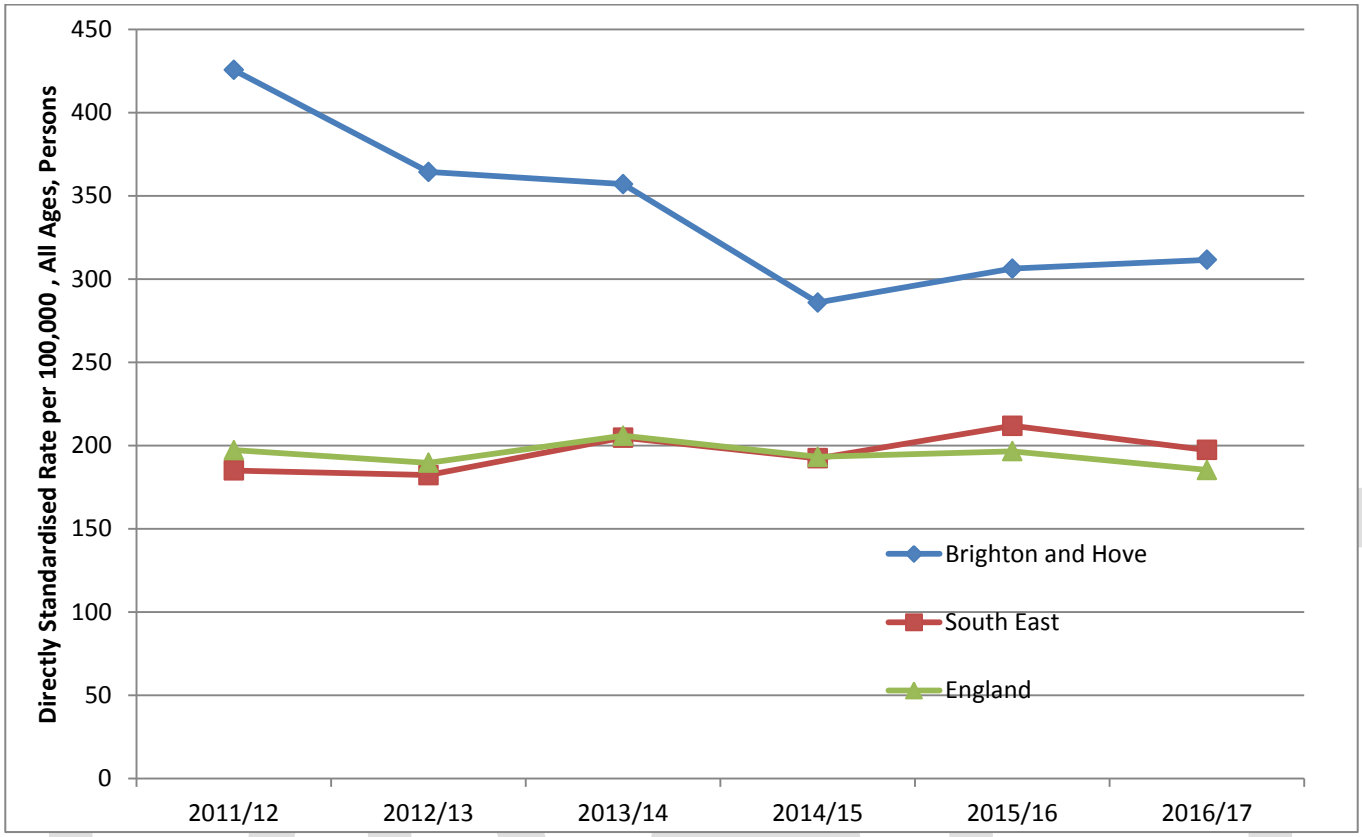
- This finding supports the provision of preventative mental health promotion which may have a positive impact on more significant mental ill-health including suicide.

People with a history of Self-harm

The national strategy for suicide prevention published in 2012 included an emphasis on addressing self-harm, and the third annual report on this strategy published in January 2017 establishes the principle that self-harm should be addressed in its own right in addition to being a risk factor for suicide. The strongest identified predictor of suicide is previous episodes of self-harm: nationally, 50% of people who die by suicide have a history of self-harm, and local Coroner's records reflect this. As shown below, local rates for hospital admission for self-harm are above that for England and the South East.

The presentation of these admissions bears some comparison with that of the suicide rate for the city. Suicides were falling until the 2010-12 period, and self-harm was also falling until 2014/15 when admissions started to rise. There may however be different factors affecting these changes.

Chart 4: Rate of Emergency Admissions for Deliberate Self-Harm, Directly Age Standardised Rate per 1,000, Brighton and Hove, South East and England, 2011/12 to 2016/17



Source: PHE Fingertips

Emergency hospital admission data for Self-Harm during 2016-17 for Brighton and Hove residents was 311.5 per 100,000 (n=1,023 admissions). This is higher than the rate for England of 185.3. The city has the 5th highest rate when compared with our benchmark partners[16].

The table below shows the number of admissions for self-harm during the 2017-18 calendar year. An admission is when a patient is admitted to a ward in a hospital. Across this period 48.5% of the admissions were for women. This is much higher than the proportion of women who take their life. The age profile of admissions is also different to that of the suicide cases. Thirty-seven percent of admissions were aged 24 years or younger, and 70% of admissions were for patients aged under 40 years. This is a much younger profile when compared with the suicide cases.

[16] Portsmouth, Southampton, Bristol, South-end-on Sea, Plymouth, Sheffield, Medway, York, Coventry, Newcastle-Upon-Tyne, North Tyneside, Swindon, Leeds, Nottingham.

Table 5: Number of admissions to hospital for self-harm by age, Brighton and Hove residents, 2017-18

Age	(n)	%
10-24 years	355	*36.9%*
25-39	323	*33.6%*
40-54	193	*20.1%*
55-69	67	*7.0%*
70+	24	*2.5%*
	962	

Source: Hospital Episode Statistics, NHS digital

Repeat attendances are also a characteristic of these admissions with 144 of those admitted during this time having more than one attendance during this period.

A comprehensive Needs Assessment of Self-harm amongst children amd young people February 2018 focused on this condition amongst Brighton and Hove residents aged 10-24 years. Around 20% of 14-16 year olds in Brighton & Hove report that they have self-harmed. The recommendations from the 2018 needs assessment were:

1. Develop an action plan and an infrastructure/resource to implement this plan
2. Refresh the citywide definition for self-harm, supported by a common risk assessment and set of supporting resources
3. Explore options for improving communication and information sharing between services
4. Prioritise engagement with children and young people in the development of services
5. Develop a consistent training offer for professionals and families
6. Engage with local organisations/teams working on reducing online harm
7. Improve collection and use of data on self-harm
8. Review the interventions and approaches used by services for young people who self-harm in Brighton & Hove and make recommendations

Several of these recommendations are directly transferable to the Suicide Prevention Action Plan (below) and as an overarching principle the Strategy should support the delivery of these recommendations.

Self-harm was discussed as part of the consultation completed at the annual Stakeholder event in March 2018. Attendees suggested three possible ways to address this issue, comments are reported verbatim below:

- Expand the Self-Harm Clinic at the RSCH. Consider broadening the age profile of those able to access this service to include a younger population of 14 year olds.

- Raise awareness of this issue: schedule events, for example at fresher's fairs/ other events where there are young people through the year. More 1 hour talks like the suicide prevention stalls

- Aid the police so that they know about the pathway/ support available for people who have self-harmed.

- As noted in the analysis above individuals who self-harm are younger and more likely to be female when compared with those who take their life. However, this strategy recognises that in a similar way to issues in relation to general mental health, the city's high rates of self-harm is probably a contributory factor to our high rates of suicide. As such the local strategy and action plan includes a commitment to reducing rates of self-harm, reflecting national policy.

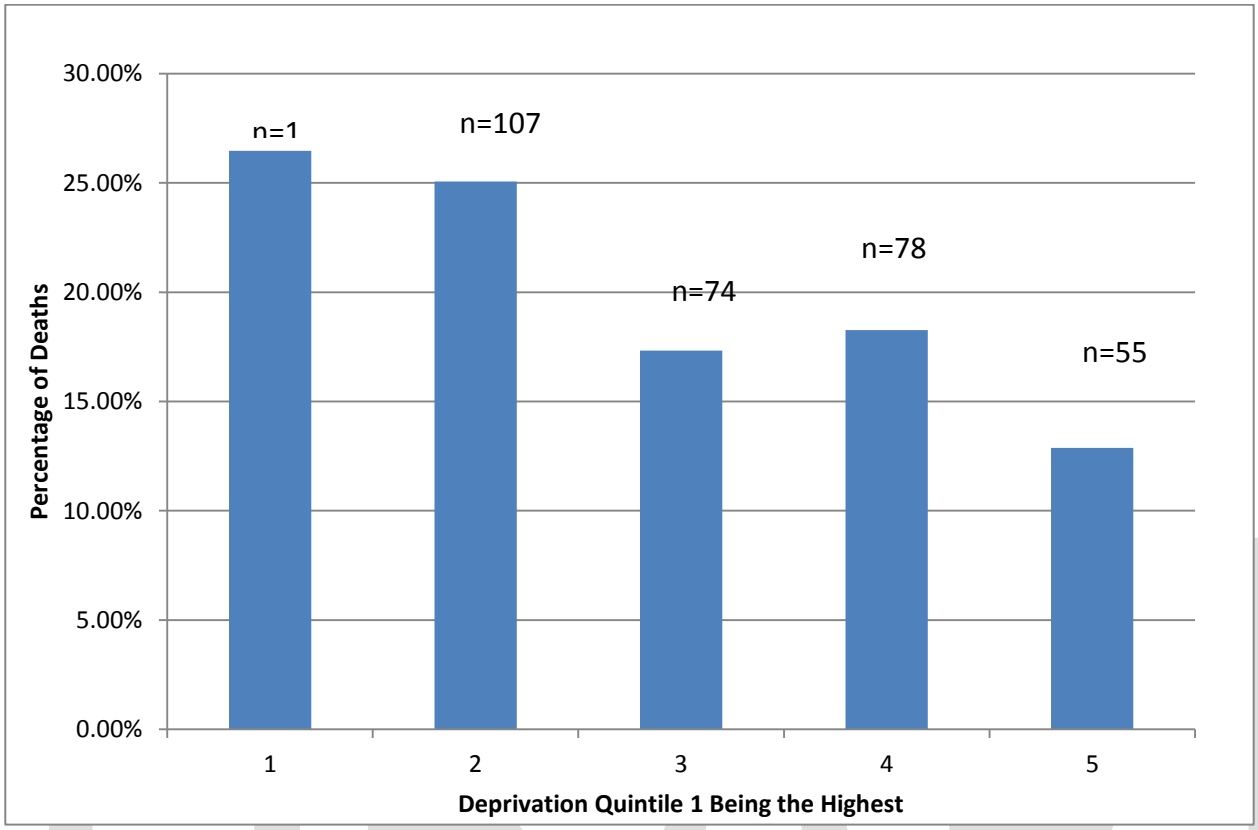
People who are especially vulnerable due to social and economic circumstances;

Brighton & Hove has an Index of Multiple Deprivation (IMD) score of 23.4%, which is higher than England (21.8%) [2015]. When compared with the IMD for 2010 the city has become less deprived relative to other authorities. However, the city is one of the most deprived areas in the South East and has a population with significant health needs and inequalities[17] . The highest concentration of deprivation is in the Whitehawk, Moulsecoomb, and Hollingbury areas of the city but is also found around St. James's Street and Eastern Road.

When the deaths across the 2006-2016 period are reviewed by deprivation quintile, 53% of those who died lived in the most or second most deprived areas of the city.

[17]http://www.bhconnected.org.uk/sites/bhconnected/files/Brighton%20%26%20Hove%20JSNA%202017%20executive%20summary%20VFINAL%2015%2008%2017.pdf

Chart 5: Proportion of Deaths Suicide and Injury Undetermined By Deprivation Quartile, Brighton & Hove, 2006-2016



Source: NHS digital Civil registration data

*two cases were not attributed to a quintile

Some of the risk factors for suicide listed by Public Health England on the suicide prevention profile are strongly linked to deprivation. Brighton & Hove has higher rates of care leavers and also of people who are homeless or insecurely housed. The city has near to average rates of unemployment and lower rates of long term unemployment than the average for England; however, it has significantly higher rates of Employment and Support Allowance (ESA) claimants for mental & behavioural disorders per 1,000 working age population[18]. According to the audit of Coroner's records for those who died by suicide in 2015, 40% were unemployed and a further 28% were economically inactive including retired people, students and home carers.

Deprivation in Brighton and Hove is also experienced by those who are homeless, including those who are hostel residents as well as those rough sleeping. The City has historically had one of the second highest numbers of rough sleepers in the England. A review of deaths of homeless individuals (including hostel residents) in 2015 found that of the 18 who died during that year fewer than 5, of the deceased had taken their own life.

[18] https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna

Being in financial difficulties is also recognised as a risk factor in respect of suicide. The 2015 audit found that 7 of the deceased had financial difficulties that may have contributed to their death. In some of these cases there were debts related to gambling.

Many of those living in less affluent parts of the city are often doing so as a consequence of other factors that have already impacted on their health and wellbeing. Focusing on the local geography alone may not be effective in targeting those in need. Working in collaboration with agencies that support these communities may also prove effective e.g. the local Department of Work and Pensions, food banks and other community groups.

- Recognising the geographical differences that exist in the city will be important in shaping the strategy going forward. Ensuring that primary care in these areas are prioritised when receiving suicide prevention training for example, and that agencies who directly support these communities have accessed suicide prevention resources.

People who misuse drugs or alcohol

The relationship between poor mental health and substance misuse is well established. Research shows that mental health problems are experienced by the majority of drug (70%) and alcohol (86%) users in community substance misuse treatment[19]. Provisional findings from the suicide cases across the 2016 and 2017 calendar years found that 11.4% (8 of the 71 deaths across the two years) were known to local substance misuse services. The 2015 suicide audit identified that 14 of the 43 (32.6%) deceased had a substance misuse problem. Not all of these cases had been in contact with Substance Misuse Services.

- Recognising the potential risk of suicide amongst those accessing substance misuse services, and aiding staff and clients to intervene to reduce this, is included in the Strategy.

Lesbian, gay, bisexual and transgender people (LGBTQ+ Community)

An estimated 11-16% of the population are lesbian, gay or bisexual and 2,760 people are estimated to be trans adults. The Count me in Too Survey of the LGBTQ+ community completed in 2008 found 79% of respondents reported some form of mental difficulty[14].

Stonewall's Gay and Bisexual Men's Health Survey 2012[20] found that one in seven (13%) of gay and bisexual men were currently experiencing moderate to severe levels of mixed depression and anxiety

[19] Better care for people with co-occurring mental health and alcohol/drug use conditions A guide for commissioners and service providers, Public Health England, 2017

[20] Mental health Stonewall health briefing, 2012

compared to 7% of men in general. A further 9% of gay and bisexual men experienced moderate to severe levels of depression with mild or no anxiety compared to 2% of men in general. Overall, 22% of gay and bisexual men experienced moderate to severe levels of depression. Bisexual men were more likely to experience moderate to severe levels of depression (26%).

Nationally information about sexuality and suicide is not available. The most recent local information from the 2015 audit found that of the 43 deaths that year, nine (20.9%) of those who died were from this community.

A crude comparison with the estimated population (11-16%) shows that this community were over-represented amongst those who took their life in 2015.

- Given the underlying higher incidence of poor mental health and the over representation within the suicide cases from this community this finding evidences the need to ensure positive preventative support to this community within the strategy.

Black, Asian and Minority Ethnic Groups (BAME)

The most accurate information that we have about the ethnicity of the population continues to come from the 2011 Census. In 2011, 20.3% (n=42,871) of adults aged 16-74 years came from ethnic groups other than White British. Identifying ethnicity post-mortem can be difficult. Ethnicity is only recorded formally as part of the findings of autopsy and this may not reflect the deceased's self-expressed ethnicity. As a consequence information about ethnicity was not recorded in 10 of the 43 deaths recorded as part of the 2015 audit of suicides. White British Ethnicity was recorded in 84.8% of the cases were ethnicity was recorded

However, information from the Adult Psychiatric Morbidity Survey (APMS) which provides information about the prevalence of a range of common mental health conditions[21] found the ethnic group with the highest proportion of a Common Mental Disorder was the Black: African, Caribbean, Black British group: 13.7% males and 31.9% females. In the 2011 Census the adult population for this community was 3,561 individuals of whom based on the prevalence data presented here 855 (24%) will have a Common Mental Health Disorder.

- Though the incidence of suicide appears to be low in this community the occurrence of common mental health conditions is high and as such access to suicide prevention strategies should be prioritised.

[21] generalised anxiety disorder, depressive episode, phobia, obsessive compulsive disorder and panic disorder as well as an amalgam of any Common Mental Health Disorders

People living with long-term physical health conditions

People with long term physical health conditions are recognised as being at greater risk of suicide in the 2012 strategy. Conditions including epilepsy, cancer, coronary heart disease and chronic obstructive airways disease are associated with higher suicide risk. The contribution of chronic pain is also recognised as increasing the risk of suicide.

Data from the audit of suicide deaths in 2015 found that 46% of those who died had a physical illness or disability.

- Recognition of the association between poor physical health, including being in pain, and mental health is the first step in addressing this relationship. The use of routine assessment for depression as part of personalised care planning within services supporting physical health needs is seen as an effective intervention.

Bereavement

Providing better information and support to those bereaved or affected by suicide is one of the six priorities of the 2012 National Strategy. People bereaved by suicide are particularly vulnerable, and for every person who dies by suicide at least 10 people are directly affected.[22] [23] Locally, the 2015 audit found that 8 of the 43 who took their life had been affected by bereavement.

This topic was raised at the Stakeholder Event in March 2018. Suggestions for improvement included:

- the need to provide more clarity about the support services that are available, for example, are they one-to-one or group based, are they generic bereavement or for those affected by suicide?
- The need to support First Responders: police/ambulance staff etc. so that they are confident to sign-post to support.
- Recognise the impact on First Responders too.
- Potential to develop a resource for children and young people who are bereaved. This might include a named worker: 'Suicide Bereavement Liaison Officer'.

- Support to those bereaved will continue to form a thematic strand within the Suicide Prevention Strategy.

[22] generalised anxiety disorder, depressive episode, phobia, obsessive compulsive disorder and panic disorder as well as an amalgam of any Common Mental Health Disorders

[23] Local suicide prevention planning: a practice resource, 2016

Children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system

Suicide amongst children is very rare. In Brighton and Hove across the 2006-2016 period no one under the age of 15 took their own life. But 8 young people aged 15-19 years did take their own life across this period. Provisional data from the coroner's office for the 2016 and 2017 calendar years shows that there were 6 deaths amongst young people aged 17-25 years.

A survey conducted by NHS Digital and published in November 2018 identified that one in eight (12.8%) of children and young people aged between five and 19 years, surveyed in England in 2017, had a mental disorder[24] [25]. Where information is directly comparable (the five-15 years age group) this shows a slight increase in the overall prevalence of mental disorder rising from 9.7% in 1999 and 10.1% in 2004 to 11.2% in 2017.

In relation to self-harm and suicide the survey found that a quarter (25.5%) of 11 to 16-year-olds with a mental disorder had self-harmed or attempted suicide at some point, compared to 3.0% of those who were not diagnosed as having a mental disorder. In 17 to 19-year-olds with a mental disorder, nearly half (46.8%) had self-harmed or made a suicide attempt. The survey also asked about recent incidents of self-harm or suicide attempts. The survey found that 11-16 year olds with a disorder were more likely to have self-harmed or attempted suicide (13%) compared with those who did not have a disorder (0.3%).

Findings from the study also focused on the mental health of young women aged 17-19 years. The survey found rates of emotional mental disorder and self-harm were higher in this group than others. These finding corroborate similar findings identified in the Adult Psychiatric Morbidity Survey (APMS) which found younger women aged 16-24 years are most likely 15.1%[26] to experience mental health disorders that would benefit from interventions and treatment.

Being in care when young is recognised as a factor affecting adult mental health[27.] The city has historically had a higher proportion of Looked After Children with England, which impact on the mental health and wellbeing of our adult population. However, data from the Performance Analysts at Brighton and Hove Council Children's Services team found the Children In Care rate per 10,000 is 76.8 at September 2018,

[24]Mental disorders were grouped into four broad categories - emotional, behavioural, hyperactivity and other less common disorders.

[25] "Mental Health of Children and Young People in England, 2017", NHS Digital, 2018

[26] Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014

[27] The mental health of looked after children under 5 years Mental Health of Looked After Children in the UK: Summary Joe Sempik, Centre for Child and Family Research, Loughborough University, LE11 3TU, NICE, Accessed online 01/05/2018

down from 82.3 per 10,000 at September 2017. This is below the March 2017 contextual neighbour average (82), and above the national average (62) and statistical neighbour average (63).

Adults who have been in care as children are also recognised as at risk of suicide due to this childhood experience.

- Recognise the emerging mental health needs and suicide risk of children and young adults within the suicide prevention strategy.
- Work with children and young people's with mental health diagnoses, who are more likely to self-harm and are at risk of suicide, via services , such as CAMHS and schools to support young people, their parents and carers, and schools to ensure access to suicide prevention resources (leaflets, digital support and Apps) as well as training.
- Support interventions to address self- harm – see section 7.2 of the action plan

University Students

A recent increase in national focus in student mental health and in suicide prevention generally, has led to the creation of a joint initiative between Brighton and Sussex Universities to deliver the Safer Universities model. The media have recently drawn public attention to the issue of student mental health, publishing case studies and testimonies from those affected by the burgeoning pressures on students including, escalating debt, fragmented friendship and family ties, fear of failure and social pressures including substance misuse.

- Work with Suicide Safer University Group to support young adults and in particular students who may be at risk of suicide.

People in contact with the criminal justice system

Locally, Mendos provides psycho-social support to those in contact with the criminal justice service. The service provides information and advocacy for people with mental health problems who are involved in the criminal justice system. Locally very few of those who died in 2015 had a forensic history.

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

The 2012 National Suicide Prevention Strategy identified the groups listed above as being at greater risk of suicide. Employment status and occupation are recorded as part of the audit of coroner's records in 2015 there were two deaths recorded were the profession of the individuals included the professions identified above. Provisional findings from the 2016-17 audit indicate a similar number of these professionals across the two years.

Survivors of abuse or violence, including sexual abuse

The audit of suicide case in 2015 found that fewer than 5 of the deceased had experienced childhood abuse. Early childhood trauma can have a profound effect on an adults mental health.

Veterans

This community are recognised as an at risk population, particularly in respect of those who may have a mental health diagnoses related to the experience of trauma resulting from their career.

Locally, it was estimated that in 2013 there were over 11,000 ex-service personnel living in the city of whom 70% are aged 65 years or over.

Summary

Based on our intelligence the suicide prevention strategy should address the particular needs of:

- Males aged 30-54 years
- Individuals with existing mental health problems
- Those in contact with Mental Health support
- People who present with incidents of self-harm
- Those living in areas of deprivation
- The LGBTQ+ Community
- People with drug and alcohol problems
- Members of the BME community especially
- People with physical health problems
- People who have been bereaved
- Young adults including students

What other factors might be affecting suicide rates? - Other factors that may impact on suicide

The local audit of suicide cases uses the risk criteria developed by Leeds City Council. Impulsivity is included in the assessment criteria and in 2015, seven of those who took their life appeared to do so impulsively. Impulsivity is a character trait and has the potential to be recognised and thereby modified.

Loneliness and relationship breakdown are recognised risks for suicide. Brighton & Hove has higher proportions of residents living alone than the average for England, both for all ages and for older people. The coroner's records for 2015 also showed that nearly half of those who died by suicide had recent experience of bereavement or relationship breakdown.

Higher risk locations

The Office of National Statistics produce annual data about Brighton and Hove residents who complete suicide. This data source provides information about the location of the individuals death. This information is only available for Brighton and Hove residents, the data set does not include information about non-residents who complete suicide in the city. The effect of this is that cases in some locations such as hotels and railway stations are likely to be under-estimated.

The completion of the Suicide Audit of Local Cases (2015-17) will provide a better insight into frequent locations as this data looks at all deaths in the city including those of non-residents.

Between 2006 and 2017, 52.8% of deaths by suicide of local residents reported by ONS took place at home and, 144 (33.6%) suicides by local residents took place in a public place. The remainder of deaths occurred in an acute hospital to which the individual had been transferred.

When considering deaths in public places, the seafront is a high risk/frequency location for the city both in respect of drownings and falls. Between 2008-2017, 32 (22.2%) of the deaths in public places occurred along the seafront and cliffs. Fifteen of these deaths were drownings and thirteen related to falls. Other deaths at this location related to causes including hanging.

An analysis of both the coroner's cases and ONS data for both accidental and suicide related falls in proximity to the Undercliff area (from Brighton Marina to Rottingdean) identified 14 deaths between 2006-16 at this location.

There were also 16 (11.1%) deaths of Brighton and Hove residents across this period at Beachy Head, near Eastbourne.

Railway stations were also cited as locations in relation to 17 (11.8%) deaths. Stations ranged across wide geographical area. Deaths at local stations by non-residents are not included in this dataset.

Hotels were recorded as a location of death in 6 (4.2%), deaths for Brighton and Hove residents, but this may underestimate the frequency of this location.

There is evidence that suicide in public places can be prevented by a range of tailored interventions including barriers, CCTV, training for staff working near the site and Samaritans signs[28].

A map of locations that have been identified as high risk is available on request.

- The locations identified will be used to prioritise actions in respect of reducing access to the means of suicide objective within the Suicide Prevention Strategy.

Stakeholder Engagement 2018

Feedback from the Stakeholder Event March 2018

Addressing the needs of at risk groups was one of the themes of the Stakeholder Event held in March 2018. Findings from that consultation event have been incorporated into the individual sections above as appropriate. Additionally, in response to directed questions, participants responded:

- Greater integration of suicide prevention within the statutory sector (x 4 separate comments). This would include more joined up working with Sussex Partnership Foundation Trust (SPFT) and Public Health, as the work streams do not look very joined up.
- Support the Trust's Towards Zero Suicide approach.
- Develop a better partnership between the Wellbeing Service and the Recovery College.
- Don't just focus on suicide look at mental health as a whole. For example: earlier intervention around pre-triggers and underlying trauma in at risk-groups. As well as more holistic mental health work e.g. 5 ways and peer support.
- Some of the professional groups identified (e.g. doctors and nurses) may worry about their confidentiality being broken and therefore not access support.

The stakeholder event was also asked about tailored approaches to improve mental health in specific groups and responses received were:

- Work with particular risk communities via services/organisations they might already be accessing;
- Use simple language to explain what each service is and does, and who can access: direct access by clients or via a professional;
- Need to include LGBTQ+ Communities;
- Need to include the needs of migrants;
- Messages need to be tailored to different community's needs;
- Train and empower peers with the appropriate skills, for example listening skills and wellbeing skills so that they can support each other.

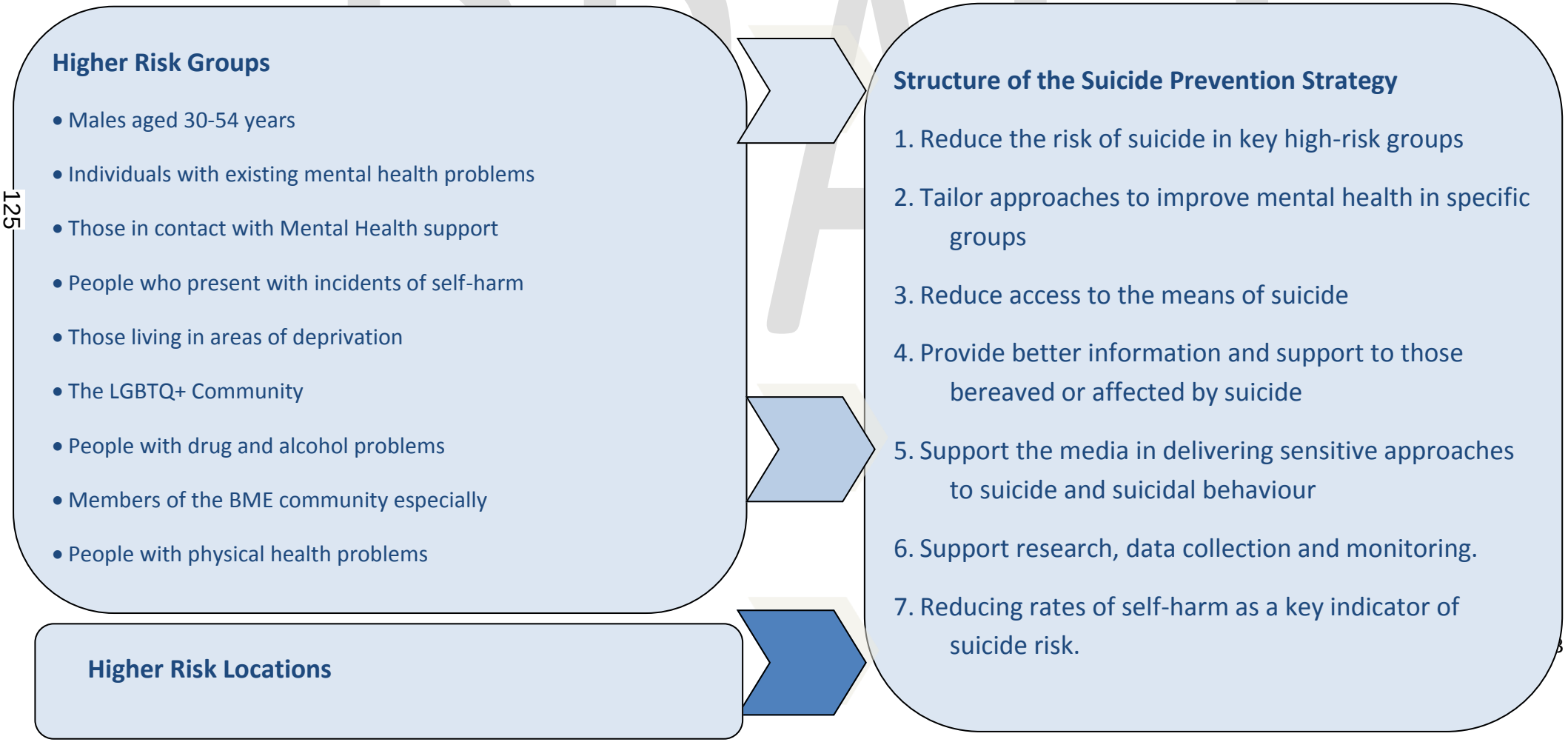
[28] Preventing suicides in public places, 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/481224/Preventing_suicides_in_public_places.pdf

Big Health And Care Conversation November 2018

Mental health was one of the themes discussed with those attending this service user engagement event in November. In relation to suicide there were several comments made about the need to improve emergency access to mental health support, the value of a local 'place of safety' and the inappropriateness of A&E for those in mental health distress.

Developing the 2019-21 Strategy

Using the intelligence that we have collated above the next step in developing the suicide prevention strategy is to align these findings with the 7 key priorities identified in the 2012 strategy.



Draft Strategy Action Plan for 1 January 2019 - December 2021

1. Reduce the risk of suicide in key high-risk groups – identified as at risk through strategic guidance and local intelligence				
(n)	Objective	Action	Ongoing Actions	Lead Responsibility
1.2	***Training for professionals who work with those at risk***			
1.2.1	Assess the extent (reach/coverage/gaps) of suicide prevention training provided locally. This would include both in-house profession specific training as well as access and uptake of Public Health/CCG locally commissioned provision.	Agree priority groups. Review, agree and prioritise key professional groups including: GPs, and primary care staff (see below), Sussex Partnership NHS Foundation Trust (see below), Substance Misuse Services (Pavilions), Sussex Police, Fire Service, Coastguard, Sussex Community NHS Foundation Trust (SCFT), Brighton and Sussex University Hospital NHS Trust (BSUH), Brighton and Hove City Council Adult Social Care, Children's Social Care, South East Coast Ambulance Service (SECAMB), Department of Work and Pensions (DWP) [Job Centre] and others.	Liaise with each organisation to assess current provision of Suicide Prevention Training, agree a target proportion of staff per organisation who will have received Suicide Prevention Training, across an agreed time period and monitor.	**Action: Public Health, Steering Group**
1.2.2	Ensure training meets the standards outlined in the National Collaborating Centre for Mental Health, Self-Harm and Suicide Prevention Competence	Raise awareness of the Frameworks and as appropriate assess training against these.	Monitor use of the Framework against locally delivered training.	**Action: Public Health, Steering Group**

	Framework[29]			
1.2.3	Work with third sector organisations that support the at risk populations: for example but not exclusively: men; individuals with physical health problems; LGBTQ+ Community; those vulnerable due to social and economic circumstances, people with drug and alcohol problems, the BAME community and others	Continued delivery of suicide prevention training courses, including for example ASIST, SafeTALK, Real Talk, Understanding and working with Self-Injury, Mental Health First Aid and Mental Health Awareness Courses targeted to organisations that support at risk populations. Raise the profile of online training resources such as Health Education England's: We need to talk about suicide e-learning Module http://www.nwyhelearning.nhs.uk/elearning/HEE/SuicidePrevention/	Report on the uptake of these courses, recording the organisation and client group supported. Feedback findings and learning from service delivery on an ongoing basis to ensure that at risk groups have access to suicide prevention resources that meet their needs.	**Lead: Public Health, Grassroots**
1.2.4	Support the provision of suicide prevention training for General Practitioners and those working in primary care practices.	Mental Health training including for Suicide prevention is included in Serious Mental Illness Locally Enhanced Service (SMILES) training requirements for GPs.	Monitor uptake of suicide prevention training by GPs. Work with the regional Health Education England (HEE) Trainer to identify	**CCG** **Action: Health Education**

[29] Self-Harm and Suicide Prevention Framework, National Collaborating Centre for Mental Health, October 2018 [Separate frameworks available for Adults and Older People, Children and Young People and Community and Public Health].

			Primary Care Practices who would like to pilot the new HEE training modules.	**England Regional Co-ordinator**
1.2.5	Ensure therapists who provide private psycho-therapy support are aware of the Suicide Prevention Training and encourage uptake.	Liaise with course leaders for counselling PGDip at Brighton University so that suicide prevention is included in the curriculum of the course. Approach private therapy centres e.g. The Rock Clinic as a way of engaging with these practitioners. Similarly, Brighton Wellbeing Service. Consider incentivising uptake for example through a voluntary sign-up scheme.	Ongoing	**Lead: Public Health**
1.3	***Support individuals at risk***			
1.3.1	Sussex Partnership NHS Foundation Trust (SPFT) will work towards mandatory suicide prevention training for all staff.	The Trust will provide Suicide Prevention training for staff (ASIST AND SAFETALK). The Trust will work towards mandatory e–learning training for all staff by April 2019 using Health Education England's (HEE) "We need to talk about Suicide' training programme. The Trust will support the suicide prevention competency framework launched by HEE in October 2018. The Trust's expanded training offer reflects the updated Clinical Risk Policy, with now includes: learning from serious incidents, reflective practice and 'risk circles'. The Suicide Prevention Steering Group will work in	Ongoing	**Lead: Sussex Partnership Foundation NHS Trust**

		partnership with the Trust's Towards Zero Suicide Steering Group. Which will provide opportunities to share learning.		
1.3.2	SPFT will improve Care Planning to better identify those at Risk of Suicide	The Trust's Care Plans have been updated to include Suicide Prevention. The Trust will continue to seek to improve the quality of care plans across the organisation by using coproduction and engagement with key partners e.g. GP's. The Trust is working towards implementation of the 'Triangle of Care'. This is a programme of work that promotes effective carer involvement in risk and care planning, and formal family liaison and support for people affected by suicide. The Sustainable Transformation Partnership (STP) programme team have embedded the National Confidential Inquiry recommendations into their programme plan (see appendix 1)	Ongoing	**Lead: Sussex Partnership Foundation NHS Trust**
1.3.3	SPFT will improve Risk Assessment to better identify those at Risk of Suicide	The Trust's Care Plans have been updated to include Suicide Prevention. The Trust will continue to seek to improve the quality of care plans across the organisation by using coproduction and engagement with key partners e.g. GP's. The Trust is working towards implementation of the 'Triangle of Care'. This is a programme of work that promotes effective carer involvement in risk and care planning, and formal family liaison and support for people affected by suicide.	Ongoing	**Lead: Sussex Partnership Foundation NHS Trust**

		The Sustainable Transformation Partnership (STP) programme team have embedded the National Confidential Inquiry recommendations into their programme plan (see appendix 1).		
1.3.4	SPFT will improve Risk Assessment to better identify those at Risk of Suicide	The Trust's Clinical Risk Policy and Training Strategy has been updated to include a set of minimum standards and incorporates: • multidisciplinary based risk formulation in complex cases, • new electronic clinical records, • learning and evidence from national evidence (e.g. NCISH, Suicide Prevention Strategy) • local sources (e.g. SI Reviews). A new more user friendly risk assessment tool has been developed. People with Emotionally Unstable Personality Disorders (EUPD) are now included in the diagnoses at risk. Regular audits of those at risk, experiencing crisis and delivery of relapse prevention as well as care planning will take place. Ligatures with no anchor points, rather than low lying anchor points have been introduced. A Trust Wide Risk Panel reviews cases of high and ongoing risk.	Ongoing	**Lead: Sussex Partnership Foundation NHS Trust**

2. Tailor approaches to improve mental health in specific groups – identified through strategic guidance as at risk				
(n)	Objective	Action	Ongoing Actions	Lead Responsibility
2.1	Challenge stigma associated with mental health and suicide, and signpost to support.	• World Suicide Prevention Day 2019 and 2020 to be supported, including initiatives such as the #IAMWHOLE campaign. • Distribute the Mental Health Crisis Cards, developed with Sussex Police. • Workplace suicide prevention guidance to be circulated. • Expand use of Grassroots Stay Alive app, which includes a Safety plan function for individuals identified as at risk. • Promote preventative mental health resources including: Five Ways to Wellbeing, Every Mind Matters and other preventative and self-management resources, including digital applications.	Commission support of World Suicide Prevention Day and World Mental Health Day. Monitor use of the Mental Health Crisis Cards. Workplace guidance on suicide prevention has been circulated. Business in the community Samaritans suicide prevention toolkit & Business in the community Samaritans postvention toolkit Continue to promote use of the Stay Alive app by promoted it's use through training, posters and flyers, with funding for further upgrades identified.	**Leads: Grassroots, Public Health, CCG**

2.2	Ensure provision for those at higher risk of suicide: Males aged 30-54 years Individuals with existing mental health problems Those in contact with Mental Health support People who present with incidents of self-harm Those living in areas of deprivation The LGBTQ+ Community People with drug and alcohol problems Members of the BME community especially People with physical health problems People who have been bereaved Young adults including students	The Invitation to Tender and Service Specification, of contracts post October 2019, will recognise the needs of these high risk groups within the recommission.	Monitor recommissioning plans to ensure groups at higher risk of suicide are included. Ongoing	**Leads: Public Health, CCG**

2.3	Consider how best to reach people who may be at higher risk with a particular focus in 2019-20 on: • **Men**	Develop ways of working in partnership with organisations where males are visible e.g. public houses, sports organisations: football, rugby, cricket, music venues, motor sports, barbers and others. Identify groups that support Male Mental Health: e.g. Campaign Against Living Miserably (CALM). Ongoing commissioned services that are particularly relevant to men for example MENDOS, a mental health support service for people in contact with the Criminal Justice System, who are mostly men. Promote locally national campaigns that support men's mental health.	Ongoing	**Lead: Grassroots, Public Health, Campaign Against Living Miserably.**

2.4	• Reduce suicide amongst the **LGBTQ+** community	Ongoing commissioning of services that are engage with members of this community. A new pilot outreach campaign has been commissioned; Grassroots is the lead partner with support from the Samaritans, Brighton and Hove LGBT Switchboard, and MindOut. Pilot ends Nov 2018 findings will be fed back to this group to inform future work. Develop ways of engaging with this community to aid awareness and prevention of suicide. For example: use bars and venues as a vehicle for supporting Suicide Prevention. Consider links with Pride. Consider use of social networking apps to promote MindOut's out of hours service for example via Grindr using a designated Facebook page. MindOut will continue to deliver weekly Suicide Prevention support such as the 'Out of the Blue' peer support group, case work support, online support services as well as training and support to the LGBTQ community as a whole.	Report on project by Christmas 2018. Consider support needs in the context of recommission. Ongoing	**Leads: Helen Jones (MindOut), Gary Smith (Pavilions), Liz Tucker (Public Health), Linda Harrington (CCG).**

2.5	Reduce suicide amongst people who misuse **drugs or alcohol** and have mental health problems. This population are often referred to as having co-existing substance misuse an mental health problems – Dual Diagnosis. .	Work in collaboration with the existing Dual Diagnosis steering group, made up of the mental health and substance misuse service. Share findings of case reviews completed as part of the Drug Related Death review process with this meeting, including cases of suicide. Training for drug & alcohol staff in suicide awareness is provided. Work with primary care to raise awareness of the suicide risk of those with substance misuse problems who may not be being supported by either the mental health or substance misuse services.	Public Health attend the Dual Diagnosis meetings, feedback findings to the Suicide Prevention Group. Raise awareness in primary care of the link between substance misuse and suicide.	**Leads: Public Health, CCG, Public Health**

2.6	Support the mental health needs of the **Black, Asian and Minority Ethnic Communities** and reduce their risk of suicide. Strong evidence of depression especially amongst Black Females[30].	Review findings from the audit of suicide cases in 2015-17 to provide local evidence of prevalence amongst these communities. The Trust for Developing Communities are currently commissioned to work with identified BME communities – monitor engagement. Rethink are supporting the Women's Multi-cultural group at Hangleton (twice a year).	Make links with organisations that work with other BME communities. Develop strategies to provide preventative mental health support and suicide prevention to these communities.	**Lead: Public Health**

[30] Common Mental Health Conditions, Rapid Needs Assessment, 2018, Public Health BHCC.

2.7	Support the mental health needs of **Children and young people**	Implement the Healthy Child Programme, working with families and identifying vulnerability including Adverse Childhood Experiences. Implement the Whole School Approach to Emotional Mental Health and Wellbeing (EMHWB) aimed to improve children and young people's psychological well-being.	Relevant issues from ongoing reports to come to the steering group. Continue to focus on work with universities, Looked after Children and the young LGBTQ+ Community. Review the access targets to ensure that 32% of Children and Young People are accessing mental health services (2018/19) and 35% by 2020. These targets may change on the basis of new prevalence data.	**Lead: Public Health**
2.8	**Students:** reduce the risk amongst the student community.	Work jointly with the Safer Universities Strategy delivered by Sussex and Brighton Universities. The CCG will continue to improve pathways between primary and secondary mental health and wellbeing services provided by the universities. Grassroots to deliver 'Suicide Talk' sessions to the Universities.	Brighton and Sussex University 'Suicide Safer University" working group is operational: regular scheduled meetings. Update and feedback from the Universities Strategy to be a standing item at the Suicide Prevention Meeting.	**Lead: East Sussex Commissioner for Mental Health.** **Brighton and Sussex Universities**

2.9	Reduce the risk of suicide for those experiencing **social deprivation.**	Continue to commission service that support those experiencing social deprivation. Target and prioritise preventative mental health support and suicide prevention resources including training posters signposting mental health services, to areas of deprivation via existing health and social support infrastructures: geographically based services such as primary care, community centres etc. Work with organisations that support those who are deprived for example food banks, Department of Work and Pensions, to enable those using these services to access preventative mental health support and suicide prevention resources. Mind are currently commissioned to deliver mental health outreach to these communities. Neighbourhood Action Plans incorporate details of mental health support arrangements including those for–Hangleton Knoll, East Brighton, Moulsecoomb & Bevendean and Portslade.	Identify and agree priority areas. Utilise existing health promotion resources to support self-management and sign-posting to support services.	**Lead: Public Health, Mind In Brighton and Hove**

2.10	Reduce **Social Isolation** as a risk factor affecting suicide.	Support the work of the Public Health Programme Manager in reducing loneliness. In conjunction with the Public Health Programme Manager use the guidance detailed in recent publications: • 'A connected society A strategy for tackling loneliness – laying the foundations for change', HM Government 2018 • 'An overview of reviews: the effectiveness of interventions to address loneliness at all stages of the life-course' HM Government, 2018 to deliver an evidence based approach to addressing this issue. We will work in partnership with the CCG's Social Prescribing service to ensure best practice in the provision of mental health and suicide prevention.	Befriending and other community support services including transport and signposting are already commissioned. Ongoing	**Leads: Public Health, CCG**

2.11	Reduce the risk of suicide amongst those experiencing **Financial disadvantage/unemployment**	Work with the DWP to support their activity in identifying mental ill health and suicide risk amongst those accessing their services. Enable DWP staff to access suicide prevention training. Work with the city's licensing team to provide mental health resources, including Metal Health Crisis Cards, Samaritan's cards to gambling premises. Work with the Money Advice Service to provide mental health resources, including Metal Health Crisis Cards, Samaritan's cards in their advice centres. The CCG commissions money advice at Millview hospital and money advice is provided in the community, and money advice is also included within the scope of the recommissioning of services during 2019. Work with Pay Day Loan shops to provide mental health resources including Metal Health Crisis Cards, Samaritan's cards. Work with local organisations that support individuals experiencing gambling harm such as Breakthrough to raise awareness of the risk of suicide and provide appropriate interventions as needed: e.g. training for staff, sign posting to points of help for anyone identified as being at risk.	Ongoing	**Leads: Department of Work and Pensions, Public Health**

2.12	Reduce the risk of suicide amongst recent or vulnerable **migrants**	Findings from the in-depth needs assessment into the Migrant Community in relation to suicide and mental health to be considered and actioned by the Suicide Prevention Steering Group as needed.	Incorporate recommendations from the needs assessment as relevant.	**Leads: BHCC Communities Team**
2.13	Specific **occupational groups**, such as doctors, nurses, veterinary workers, farmers and agricultural workers.	Support the CCG in their promotion of the Practitioner Health Programme for General Practitioners. Investigate the support available to nursing staff particularly those working in primary care. For example the Royal College of Nursing have a 'Healthy You' page on their website: Royal College of Nursing Healthy You	Ongoing	**Leads: CCG**

3. Reduce access to the means of suicide				
(n)	Objective	Action	Ongoing Actions	Lead Responsibility
3.1	Reduce the risk of incidents at high frequency/high risk locations.	The seafront and cliff areas are a high risk/frequency location. Take action to reduce risk in line with the evidence base as per location for example: consider further signage and improved fencing. The existing infra-structure has also been assessed, and areas for repair identified. Samaritans signage is already in place along the seafront. Continue to ensure signage is in good condition. Provide training where this may support staff working at higher risk areas, including Night Time Economy (NTE) staff, Door Staff and Beach Patrol. Training for the lifeguard and seafront team is ongoing.	Continue to map 'hot spots' from ONS Mortality data, Coroner's records and surveillance intelligence (deaths and attempts [where information is available]). Ongoing: provision of training and review of high risk locations. Seafront and NTE teams to receive suicide prevention training.	**Lead: Public Health**

4. Provide better information and support to those bereaved or affected by suicide				
(n)	Objective	Action	Ongoing Actions	Lead Responsibility
4.1	Ensure family and friends affected by suicide have easy access to information that can help.	Update the Council webpages and CCG website to ensure those seeking support are able to access contact details for organisations from whom they can access help. Also include links to useful documents such as the PHE 'Help Is At Hand Booklet'. Continue to distribute the 'grief support' cards as well as the Help is at Hand with each invitation to inquest from the Coroner's office and by Sussex Police attending incidents. Include information about groups that can provide emotional bereavement support as part of the letter inviting attendance at the Inquest. A similar approach should be used when professionals are invited to inquest.	Consider consultation with these groups to ensure their experiences are incorporated into future service delivery	**Lead: Public Health**
4.2	Directly support those bereaved or affected by suicide and recognise the wider impact of a death on local communities.	Provide direct support in the form of local specialist services including: Rethink's Survivors of Suicide groups and one-to-one support Facing the Future groups led by Cruse and Samaritans A Brighton & Hove SOBS group meets monthly Cruse is commissioned to provide general bereavement support.	Under the newly commissioned services applying the Support After Suicide Partnership (SASP) principles, promoting use their Help is at Hand booklet.	**Lead: SOS Rethink Mental Health, Cruse and Samaritans**

4.3	Recognise and support the psychological impact on professionals who have witnessed, or had contact with individuals who have completed suicide. This should include response to those bereaved and response to a death of a young person.	Identify key groups e.g. Sussex Police, Ambulance, Coastguard, Search and Rescue, Beach Patrol, primary care and other front line workers. In collaboration with these agencies look at existing de-brief/support systems. Look at research literature to inform and improve future practice. Disseminate links to existing online support including Mind's Blue Light Mental Health Support. Mind Blue Light Resources Consider use of specific training, including effective de-brief training and support for this stakeholder group. PABBS (Postvention Assisting those Bereaved by Suicide) also provide training for first responders.	Evidence of training needs assessment and provision.	**Lead: Public Health**

5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour				
(n)	Objective	Action	Ongoing Actions	Lead Responsibility
5.1	*Because of the national reach of most media, responsibility for interventions around this work stream will lie with national regulators.* Work to achieve reporting of local cases that meets national guidelines.	Review local media both mainstream printed and online e.g. The Argus, coverage of suicide and consider reporting against the Independent Press Standards Organisation (IPSO) recommendations regarding reporting suicide and the Samaritans guidance. Also promote use of the Samaritans, guidance for the media on the reporting of and portrayal of suicide. www.samaritans.org/media_centre/media_guidelines.aspx Monitor online media and contact moderators as needed. Consider: reporting of high volume deaths and 'contagion effect' e.g. Beach Head Summer 2018	Proposals going forward: comprise contacting the owners of local media , to have clarity about the suicide guidance they are using; run a short workshop for student and employed journalists in respect of good reporting practice.	**Lead: Public Health, BHCC Communications Team, Rethink SOS, East Sussex Commissioner for Mental Health.**

6. Support research, data collection and monitoring				
(n)	Objective	Action	Ongoing Actions	Lead Responsibility
6.1	Ensure that actions to support a reduction in suicide are informed by robust evidence.	Review suicide and self-harm data from: • Public Health England Suicide Prevention Profile Fingertips • Office for National Statistics • Analysis of suicide data from the Public Health Mortality file. • Coroner's records – three year audit • Public Health England Suicide Prevention Profile – Emergency Admissions for self-harm • A&E attendances for self-harm. From A&E flat file.	Include a summary of current incidence as a standing item at the annual planning meeting in March. Continue to update all relevant local data, for review by the steering group, working groups on an ad hoc basis as data is updated.	**Lead: Public Health, Intelligence.**
6.2	Consider development of a real time surveillance system to identify cases of possible suicide or attempted suicide.	Sussex Police and other emergency services including British Transport Police Sussex Police, already keep a record of suspected cases from Sussex Police and Coroner's Records	Standing Item at future meetings	**Lead: Sussex Police**

6.3	Learn from the case reviews completed between GPs and Sussex Partnership clinical staff. Learn from Significant Incident Reports from Sussex Partnership or BSUH for any suspected suicide of a person in receipt of services. To identify issues that can be addressed at this meeting.	Discuss with CCG and Sussex Partnership staff how best to embed these meetings into the governance process. Share the findings from these reviews: primary care and NHS Trust, with the Suicide Prevention meetings. Improve links between the clinicians' meetings and significant incident reporting systems.	Standing Item for future meetings.	**Lead: CCG** **Sussex Partnership Foundation NHS Trust**
6.6	Value the importance of Continued Professional Development (CPD) and Continued Learning.	Support CPD and continued learning by working with the Public Health Librarian to routinely identify new national guidance and key research articles for circulation to the wider Suicide Strategy Prevention Group and steering group/ working groups, as relevant.	Ongoing	**Lead: Public Health Librarian**

7. Reduce rate of self-harm as a key indicator of suicide risk				
(n)	Objective	Action	Ongoing Actions	Lead Responsibility
7.1	Continue to monitor incidents of self –harm as detailed above in respect of hospital admissions and A&E attendances.	Ongoing	Standing Item for future meetings.	**Lead: Sussex Partnership Foundation NHS Trust, Public Health**
7.2	Ensure those presenting to A&E with self-harm are effectively supported.	A&E departments at the Royal Sussex County Hospital and the Royal Alexandra Children's Hospital: • Work with acute services to ensure staff have been trained in suicide prevention. • Monitor continued provision of psychosocial assessments at A&E following self-harm and follow-up for those at risk. Support (where evaluation shows evidence of effectiveness) the continued provision of Psychodynamic Interpersonal Therapy (PIT) clinics at RSCH.	Implementation, Monitor and evaluation. Report to steering group	**Lead:** **CCG**

7.3	Continue to support the implementation of the recommendations from the Needs Assessment of Self-harm Young People (10-24 years) and specifically.	• Improve collection and use of data on self-harm 2.1 above • Develop a consistent training offer for professionals and families 7.2 above.	Ongoing monitoring	**Lead: Public Health**
7.4	Deliver effective self-harm training.	Map coverage and evaluate effectiveness of self –harm training provided: • through the Public Health Schools programme • by Grassroots Suicide Prevention – understanding self-injury course Promote use of the Self-Harm Preventative Apps including CalmHarm Blue Ice	Reports to steering group as findings are made available.	**Lead: Public Health, Grassroots**

Appendix 1. National confidential inquiry into suicide and safety in mental health annual report: 2018- Key clinical messages

1. Our "10 ways to improve safety" continue to reflect the evidence we have collected over several years on the features of clinical services that are associated with lower patient suicide.

2. A renewed emphasis on reducing suicide by in-patients is needed, in particular by (1) improving the physical safety of wards, with the removal of potential ligature points (2) care plans at the time of agreed leave (3) development of nursing observation as a skilled intervention.

3. The evidence in this year's report also emphasises key measures that services should take to reduce patient suicide risk:
    - Follow up within 2-3 days after hospital discharge
    - Safe prescribing of opiates and psychotropic drugs
    - Reducing alcohol and drug misuse.

4. Female patients who die by suicide have a unique risk profile and require a particular focus on:
    - Treatment of depression, following NICE guidance
    - Developing services that meet quality standards for self-harm care
    - Improving services for people with a diagnosis of personality disorder, in line with our recent report.

5. Recent self-harm is increasingly common as an antecedent of suicide in mental health patients but may not be given sufficient weight at assessment. Protocols for managing self-harm patients who are under mental health care should highlight the short term risk.

6. Suicide in people under 20 is rising. A broad range of stressors appear to play a part, reflecting the lives of young people in general. Therefore, a wide range of professionals have a role in prevention including those working in self-harm, mental health, social care, primary care, youth justice and the voluntary sector.

7. Preventing suicide in students requires specific measures, including:
    - prevention, through promotion of mental health on campus
    - awareness of risk, including the fact that conventional risk factors, e.g. alcohol or drug misuse, may be absent
    - availability of support especially at times of risk, e.g. exam months
    - strengthened links to NHS services, including mental health care

8. Clinical measures most likely to prevent patient homicides are:
    - reducing alcohol and drug misuse
    - maintaining treatment and contact