

MILTON KEYNES MULTI-AGENCY SUICIDE PREVENTION PLAN

Derys Pragnell, Public Health, Milton Keynes Council

2017

Contents	Page Number
Contents	2
Executive Summary	3
Introduction	5
1.0 Policy Context	6
1.1 National Policy Context	6
1.2 Local Policy Context	6
2.0 Epidemiology	7
2.1 Peer Comparator Local Authorities	7
2.1.1 Men	8
2.1.2 Women	9
2.1.3 Children and Young People	9
2.1.4 Socioeconomic Circumstances	9
3.0 Aims and Objectives of the Milton Keynes Suicide Prevention Plan	11
3.1 Objective 1: Reduce the Risk of Suicide in Key High Risk Groups	11
3.1.1 Men	11
3.1.2 People in the care of mental health services	12
3.1.3 People with a history of self-harm	14
3.1.4 People in contact with the criminal justice system	17
3.1.5 Specific occupational groups	18
3.2 Objective 2: Tailor approaches to improve mental health in specific	19
3.3 Objective 3: Reduce Access to the means of suicide	20
3.3.1 Most common methods of suicide	20
3.3.2 High Risk Locations	21
3.4 Objective 4: Provide better information and support for those bereaved or affected by suicide	21
3.5 Objective 5: Engage with and support the media in delivering sensitive approaches to suicide and suicidal behaviour	22
3.6 Objective 6: Support research, data collection and monitoring	22
Appendix 1	24
References	25-28

Executive Summary

Suicide is a devastating public health issue affecting individuals, families and communities. Prevention is complex and cannot be delivered by one organisation.

Recorded suicide rates in Milton Keynes are similar to national levels and those of peer comparator local authorities. 54 residents of Milton Keynes died by suicide between the years 2013/15. 19 people were killed in road accidents in Milton Keynes in the same period.

Suicide and injury/poisoning of undetermined intent was the leading cause of death for males in three age groups (5-19, 20-34, and 35-49 years) — in England and Wales in 2014. Each of these deaths could potentially have been prevented.

Each completed suicide is known to directly adversely affect at least 10 other individuals from family members, work colleagues, witnesses and health care staff and the majority of people who take their life by suicide will have had previous attempts also impacting on the wider community.

The overarching aim at a local level, is to achieve a reduction in the rate of suicide amongst the Milton Keynes population by implementing evidence based preventative interventions.

To produce this plan an audit of coroner's records was undertaken alongside an epidemiological review, review of national policy and best practice. Key stakeholders were involved through existing groups associated with mental health service commissioning and prevention including the Mental Health and Learning Disability Partnership Board, and Mental Health Partnership Board.

In January 2017 the Local Crisis Care Concordat hosted a workshop to review findings of the audit, map existing initiatives and consider gaps and opportunities with a view to developing this local Suicide Prevention Plan.

This plan adopts the objectives highlighted in the 2012 National Suicide Prevention Strategy (NSPS) and is in line with 2016 guidance for local suicide prevention planning (PHE,2016).

The national key areas for action are to:

- Reduce the risk of suicide in key high risk groups;
- Tailor approaches to improve mental health in specific groups;
- Reduce access to the means of suicide;
- Provide better information and support to those bereaved or affected by suicide;
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour;
- Support research, data collection and monitoring.
- Reduce rates of self-harm as a key indicator of suicide risk

Recommendations

Recommendations are made under each objective, with a simplified version in the form of an action plan presented in the appendix.

The following actions should be prioritised:

- Ensure suicide prevention is incorporated within Milton Keynes adult and children's mental health service strategic planning and commissioning in line with national recommendations.
- Ensure front line staff have the knowledge and experience to identify and either refer to or offer appropriate support for people who may be at risk of suicide
- Develop health promotion initiatives aimed at improving mental health literacy, particularly amongst mid age and older men.
- Ensure the implementation of NICE standards and pathways relating to depression management in primary care (CG90) and managing patients who self-harm (CG16 and CG33)
- Work with the coroner and police towards a 'real time' data system to ensure up to date information about cases as they occur and reduce the need for full audit.

INTRODUCTION

Suicide is a devastating public health issue affecting individuals, families and communities. It also has a significant economic impact; the economic cost of each death by suicide of a working age individual in England is £1.67m. This covers direct costs of care, indirect costs relating to loss of productivity and earning and intangible costs associated with pain, grief and suffering.

Many factors combine to result in suicide which means prevention is complex and challenging and cannot be delivered by one organisation. Local Government, statutory services, the third sector, local communities and families each have a role to play in suicide prevention.

The following objectives are highlighted in the 2012 National Suicide Prevention Strategy (NSPS):

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

This Suicide Prevention Action Plan is the result of a review of national research and evidence base, epidemiological analysis and local suicide audits, combined with the outputs from multi-agency discussions. It is built around the identified areas for action in the National Suicide Prevention Strategy 'Preventing Suicide in England'.

1.0 POLICY CONTEXT

1.1 National Policy Context

In 2012, the coalition Government published 'Preventing Suicide in England: A cross-government outcomes strategy to save lives'. The strategy reaffirmed the importance of suicide prevention to the health and wellbeing of the nation, outlining the most recent evidence and making recommendations to build on the success of the previous strategy from 2002.

Its overall aim was to:-

Reduce the suicide rate of the general population in England and better support those bereaved or affected by suicide.

The following key areas for action were identified:-

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

The National Strategy was followed in 2014 by '*Preventing suicide in England: One year on*', further strengthening the evidence base. This was followed in 2016 by Guidance from Public Health England on developing a local suicide prevention plan. The Third progress report of the national strategy was released in 2017 strengthening the focus on men, self-harm and support for bereaved families. It expanded the strategy to include a priority action on reducing rates of self-harm as a key indicator of suicide risk.

Reflecting the continuing focus on suicide prevention, the current Public Health Outcomes Framework includes the suicide rate as an indicator. Other indicators with direct relevance to suicide prevention are self-harm and excess under 75 mortality in adults with serious mental illness.

The Five year forward view for mental health (2016) recommended all areas had a suicide prevention plan in place by 2017, with plans in place to contribute to a 10% reduction in suicide nationally. Each plan should demonstrate how areas will implement evidence based preventative interventions that target high risk locations, support high risk groups (including young people who self-harm) within their population.

1.2 Local Policy Context

A new mental health commissioning strategy for Milton Keynes is being shaped at the time this plan is being published. The strategy sets out priorities in relation to the commissioning of mental health services, including health and wellbeing of clients; it also highlights the need to support prevention of mental health problems and promotion of better mental wellbeing for all.

2.0 EPIDEMIOLOGY

Figures published by the Office of National Statistics (2016) reveal there were 6,122 deaths from suicide or injury of undetermined intent amongst people aged 10 and over registered in the UK in 2014, 4882 of these deaths were registered in England, more than three quarters were amongst males.

The overall rate of suicide in England was 10.1 per 100,000. For males it was 16 per 100,000 and females 4.9 per 100,000. Nationally year on year although the rate of suicide fluctuates, trends can be seen, particularly that male rates of completed suicide are typically three times that of females with highest rates amongst mid age groups (45-59 age range).

The trend for suicide and undetermined injury for Milton Keynes fluctuates but since 2005 has been statistically similar to the national and regional rate.

A 3-year rolling average provides a smoother and more accurate representation of trends and avoids drawing undue attention to year-on-year fluctuations. This is particularly important for Milton Keynes as it is a relatively small population and annual deaths from suicide fluctuate year on year. The directly standardised suicide death rate for Milton Keynes currently reported on the Public Health Outcomes Framework (PHOF) is 8.6 per 100,000 for the 3-year aggregated period of 2013-15. This is statistically similar to the rate for England which is 10.1/100,000.

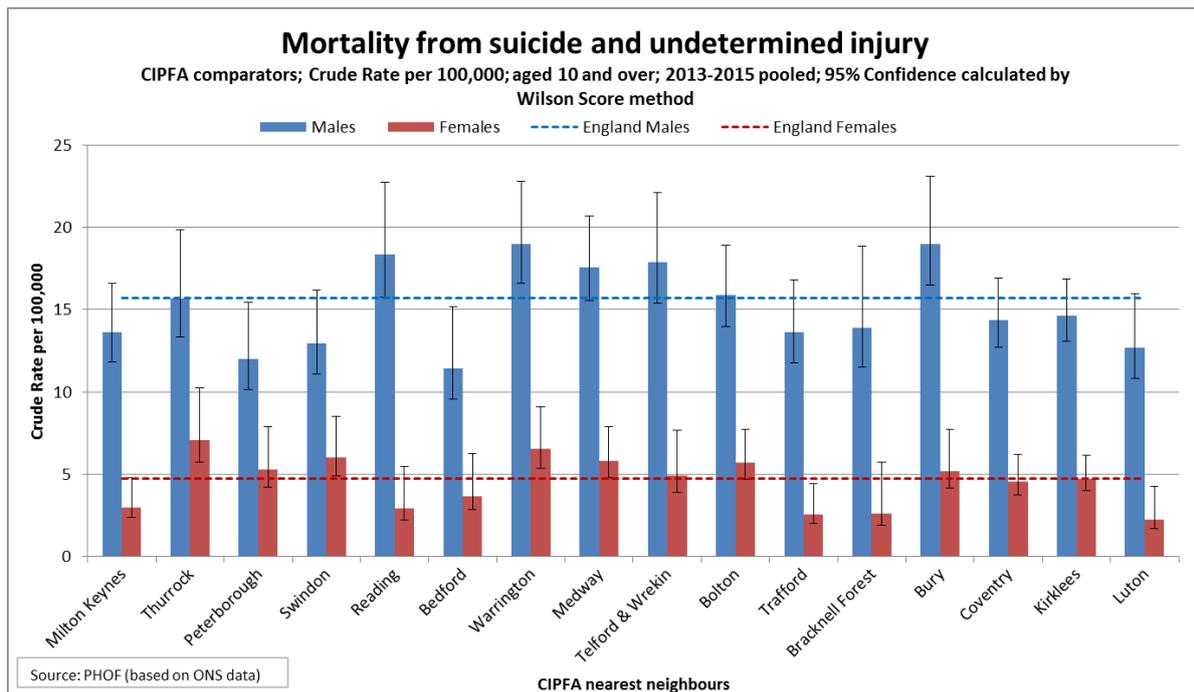
2.1 Peer Comparator Local Authorities

Figure 1 show staking a 3 year rolling average, the Crude rate per 100,000 of Mortality from suicide and undetermined injury for people aged 10+ years for 2012-15 in Milton Keynes is not statistically significantly different to that of peer comparator local authorities.

For males, Milton Keynes (14.6) and peer comparator authorities have a similar rate to England (15.8) and peer comparator Local Authorities.

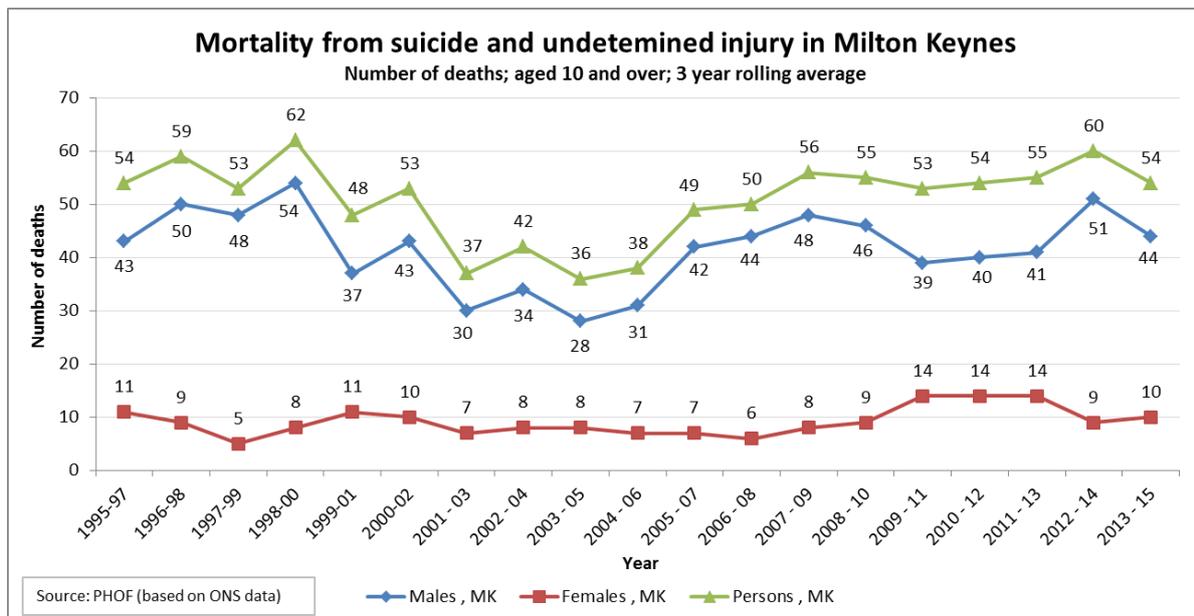
For females, Milton Keynes rates (2.99) appear lower than England and similar neighbours but numbers are so low across Milton Keynes and the majority of similar neighbours that it is difficult to get a true statistical comparison and confidence intervals will be very wide. For this reason these numbers are not reported on the current Public Health Outcomes Framework.

Figure 1: Mortality from suicide and undetermined injury for CIPFA comparators 2013-2015.



Fortunately as figure 2 shows, numbers of deaths for suicide and undetermined injury in Milton Keynes are low. Numbers fluctuate year on year **and** taking a 3 year rolling average there were 54 deaths between 2013 and 2015, averaging 18 each year.

Figure 2: Mortality from suicide and undetermined injury in Milton Keynes



Nationally the highest rates of suicide were in the 45-59 year old age range for both males and females. In depth analysis from the local audit found the highest rates in Milton Keynes were in 40-49, followed by the 50-59 year old age group.

2.1.2 Women

In Milton Keynes, the DASR for Suicide and Injury of Undetermined Intent amongst women, for the years 2013-2015 was not calculated nationally as the number of cases was too small to give an accurate picture (though local analysis gives a figure of 2.99 per 100,000). The England average was 4.7 per 100,000.

2.1.3 Children and Young People

In England, between 2013-2015, 18 children aged 10-14 took their own life, the rate was around 0.2 per 100,000. The suicide rate in England for children and young people between the ages of 10-29 has remained relatively stable since 2005; however the rate in 15-19 year olds has risen for the last three years (ONS 2015).

A recent study by NCISH6 (from 2017 publication) found academic pressures, bereavement, bullying, alcohol or drug misuse and childhood abuse in many cases. More than half of those who died had a history of self-harm and 27 per cent had expressed suicidal thoughts in the week prior to death

The Milton Keynes Child Death Overview Panel (CDOP) is responsible for ensuring a review is undertaken of each death of a child that normally resides in Milton Keynes to determine whether modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths. A suspected suicide would result in a Rapid Enquiry, following the Rapid Response Process and inform a later CDOP.

In Milton Keynes there have been no cases of suicide reviewed over the past 5 years but in 2010/11 there were 3 cases of 'apparent suicide' reviewed amongst the under 18 age range in Milton Keynes. (MKC 2016 – reference CDOP report)

Although numbers of cases of completed suicide amongst CYP in Milton Keynes are low. There is a link between suicide and prior self-harm and so opportunities to prevent self-harm and boost children and young people's mental wellbeing should be reviewed.

2.1.4 Socioeconomic Circumstances

Throughout history, periods of high unemployment or severe economic problems have been associated with an adverse effect on the mental health of the population and speculated to be linked to higher rates of suicide. Studies have concluded that there is a significant short term increase in suicide rate amongst people of working age at times of economic downturn and increased unemployment, with men being particularly affected.

Nationally, people living in the most deprived areas have a greater incidence of suicide than those living in more affluent areas. People living in the most deprived areas of the UK are at 10 times greater risk of suicide than those in the most affluent group living in the most affluent areas. (Branas et al 2015).

The Samaritans (2015) report on Men and Suicide highlights that midlife men living in areas of deprivation should be a focus in suicide prevention plans.

Milton Keynes has a small number of suicides annually and examining 5 aggregated years of suicides by Lower Super Output Area (LSOA) and Index of Multiple Deprivation, did not show this relationship between deprivation and suicide. This does not mean that it doesn't exist as the overall as numbers are too small to show any possible statistical significance.

Information gleaned from the local suicide audit (2016) did highlight financial concerns to feature prominently in a number of suicides and there does need to be an awareness of potential financial pressures impacting on individuals across the spectrum.

3.0 AIMS AND OBJECTIVES OF THE MILTON KEYNES SUICIDE PREVENTION PLAN

The Suicide Prevention Plan for Milton Keynes adopts the objectives highlighted in the National Suicide Prevention Strategy (NSPS). The overarching aim of these objectives at a local level is to achieve a reduction in the rate of suicide amongst the Milton Keynes population.

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

Below is an overview of the key activities under each objective. It is recognised there is some repetition where a particular action relates to more than one objective. A simplified version in the form of an action plan is presented in the appendix.

3.1 Objective 1: Reduce the Risk of Suicide in Key High Risk Groups

Nationally the following groups have been identified as at greatest risk of suicide: -

- Men (mid age);
- People in the care of mental health services;
- People with a history of self-harm;
- People in contact with the criminal justice system;
- Specific occupational groups.

3.1.1 Men

Nationally and locally, mid age and older men have been identified as having the highest rates of suicide. Nationally there is a clear link between suicide in men and lower socioeconomic circumstances, this is not reflected locally when looking at deprivation quintile (though very small numbers mean these findings should be treated with caution) but financial concerns do feature prominently in information gleaned from local suicide audit.

Other factors associated with suicide in men include depression, particularly undiagnosed and untreated depression, poor emotional literacy (resulting in reaching crisis point before accessing services), alcohol or drug misuse, unemployment, family and relationship problems, social isolation and low self-esteem. Increasing rates amongst older men are thought to reflect depression, social isolation, bereavement and limiting physical illness (DH,2012).

Reducing Risk in men needs to include a focus on economic factors such as debt, social isolation, drugs and alcohol, and raising awareness about local services and developing treatment and support settings that men are prepared to use.

Actions Required

- Develop health promotion initiatives aimed at improving men's emotional literacy - promoting early identification of depression, awareness of available related support/advice services and early identification and access to primary care and Improving Access to Psychological Therapies (IAPT) Services.
- Ensure frontline staffs working with men in the most vulnerable groups are competent to engage men in conversations about wellbeing and mental health and to signpost effectively for support.

3.1.2 People in the care of mental health services

People who had been in contact with mental health services in the 12 months prior to their death make up 28% of all suicides in the UK (Appleby 2016).

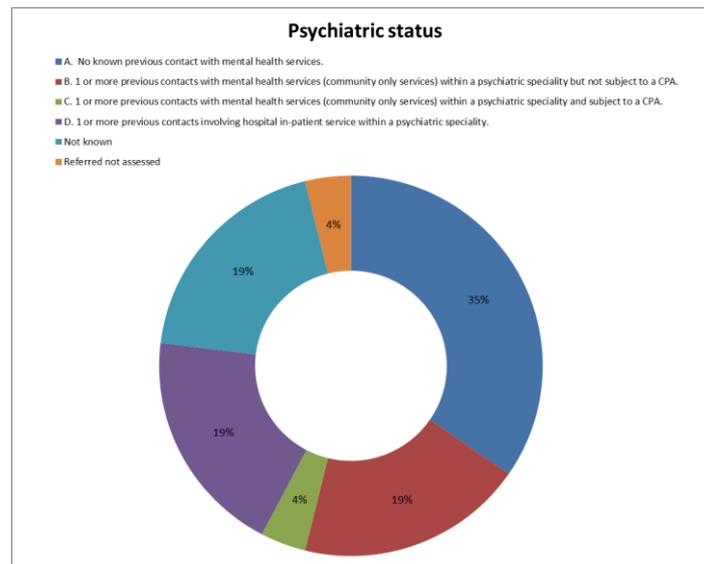
The number of suicides by mental health inpatients in England has risen in recent years, mainly as a result of increases in the number of people accessing services. However, the suicide rate amongst mental health patients has fallen overall. Where suicides occur the most common methods are hanging (43%), self-poisoning (25%), and jumping/multiple injuries (15%). Opiates were the most common type of drug in self-poisoning.

The number of mental health inpatients in the local audit was fewer than 5 and so cannot be reported due to data suppression requirements. Each death was subject to a full investigation and the recommendations and actions drawn up have been put in place.

Overall, the annual number of suicides under Crisis Resolution and Home Treatment (CRHT) Teams has increased. One third of these patients died by suicide within one week following discharge. It is notable that 43% of these patients lived alone, The National Enquiry into Suicide and Homicide by People with Mental Illness (2016) concludes crisis teams are unlikely to be a safe setting for patients at high risk or who live alone and recommend the use CRHT should be kept under regular review and services should ensure that patients are followed up within 2-3 days of hospital discharge and that care plans are in place.

In the local audit, 42% of the deceased were known to psychiatric services and of these, 55% had had some contact with the service in the 14 days preceding their suicide (figure 8). A few outpatient deaths had been subject to an internal investigation the and recommendations made for future management of vulnerable individuals

Figure 4 – Psychiatric status of individuals in the Milton Keynes 2015 Suicide Audit.



Actions Required

- Review local practice against key elements of safer care highlighted within the National Confidential Enquiry into Suicide and Homicide by People with Mental Illness (2016) appendix 1
- Continue to ensure robust monitoring of KPIs within commissioned inpatient mental health services to ensure effective discharge planning ensures a high proportion of follow up of within 7 days of discharge from psychiatric in-patient care.

3.1.3 Contact with Primary Care

Many people with mental health problems are not in contact with specialist mental health services. Depression is one of the most important risk factors for suicide and undiagnosed/untreated depression can heighten suicide risk. Most depression (and some other mental illness) is treated in primary care. Forty-five of the 52 cases in the local audit (87%) were registered with a GP – 18 of whom (40%) had been seen during the 30 days preceding their death. In only 11 of these 18 cases (61%) was a mental health issue recorded as being discussed, the remaining 7 individuals (39%) were recorded as attending for physical health problems only.

The stigma associated with mental health problems can act as a barrier to people seeking and accessing the help that they need, increasing isolation and suicide risk. It is not known why those individuals who attended their GP practice in the days prior to their suicide did not discuss their mental health but improving emotional literacy as well and encouraging appropriate help-seeking behaviour could contribute to more troubled/depressed individuals seeking the help they need earlier. It is hardly surprising that some individuals had not spoken to their GP about their mental state when the audit contained cases which recorded that individuals had taken their own lives without giving any prior indication of their mental state to friends or family. Primary care staff could be better primed to consider mental distress for individuals presenting with physical health problems.

GPs have a key role in the care of people who are feeling suicidal and as well as information about the deceased, amongst the coroner's notes were examples of GPs working hard to get suicidal patients the necessary care. Frustration was expressed in copies of GP letters about referrals to secondary mental health service which bounced back because of incomplete details or instances where suicidal patients were not accepted by the service. In those cases where information was incomplete it may be worth investigating if it is possible to obtain the missing data via a phone call to the practice rather than a lengthy delay where the referral is returned by post.

The time taken between referral and assessment was an issue and there were a small number of cases where patients had killed themselves following a referral to ASTI but whilst waiting for their initial assessment. Access to mental health services is a topic which may need to be investigated with the relevant professionals.

Actions Required

- Ensure the implementation of NICE guidelines to improve the identification, treatment and management of depression in primary care (CG90) and awareness of suicidality
- Robust pathways must be in place between primary care, emergency departments, secondary care, inpatient care and community care on inpatient hospital discharge and these must be known to G.P.s
- Ensure serious incident reviews are undertaken for all suicide cases and appropriate learning shared

3.1.4 People with a history of self-harm

Though the majority of people who self-harm don't go on to take their life by suicide, the majority of people who take their life by suicide have previously self-harmed and self-harm is considered nationally to be one of the strongest identified predictors of suicide. People who frequently present to hospital following self-harm are a particularly vulnerable group (2016).

The Third progress report on the National Strategy (2017) highlighted self-harm as the single biggest indicator of suicide risk. Nationally, around half of people who have died by suicide have a history of self-harm, 1 in 4 have been treated in hospital for self-harm in the preceding year.

The Psychiatric Morbidity Study (2014) for Mental Illness and Wellbeing in England shows that the number of people reporting to have self-harmed has increased since 2007. A fifth of young women (under 24) surveyed had reported ever having self-harmed and there were significant increases in reported self-harm in men and women aged between 25-34. However, only around 28 per cent of men and 43 per cent of women surveyed received medical or psychiatric treatment after self-harming.

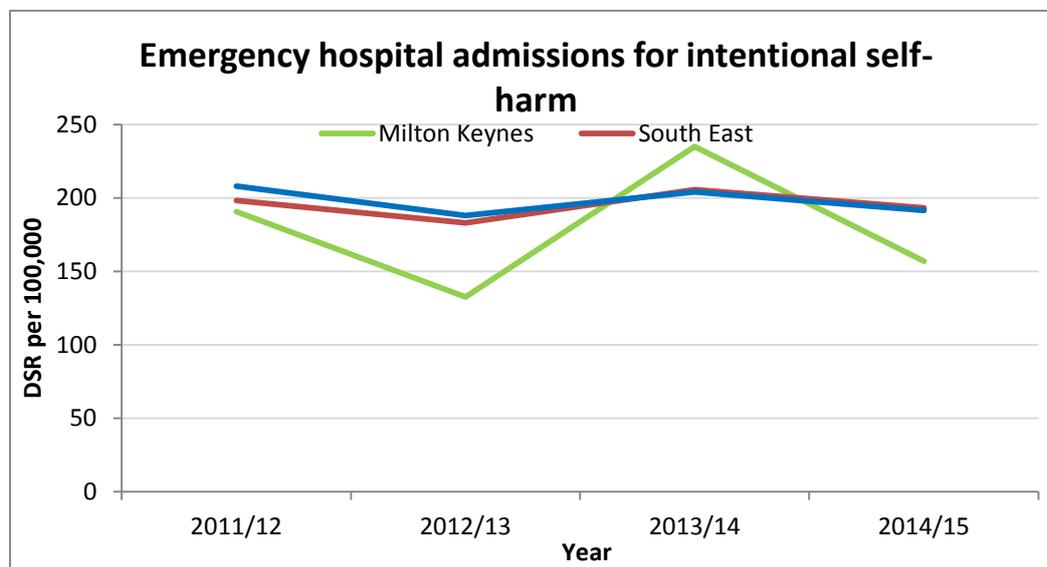
The following factors in self-harm appear to indicate increased risk of future suicide: being an older teenage boy; violent method of self-harm; multiple previous episodes of self-harm; apathy,

hopelessness, and insomnia; substance misuse; and previous admission to a psychiatric hospital (Hawton, K., 2005). 30 per cent of adolescents who self-harm report previous episodes, many of which have not come to medical attention. At least 10 per cent repeat self-harm during the following year, with repeats being especially likely in the first two or three months (Hawton, K., 2005). The latest data also shows a higher prevalence of hospital admissions of girls under 17 for self-harm.

In the most recent Milton Keynes Suicide Audit 15% of individuals had a recorded history of self-harm and 33% had a recorded history of previous suicide attempts. One of the particular issues is that many people who self-harm do not seek help from health or other services and consequently their self-harming is not recorded.

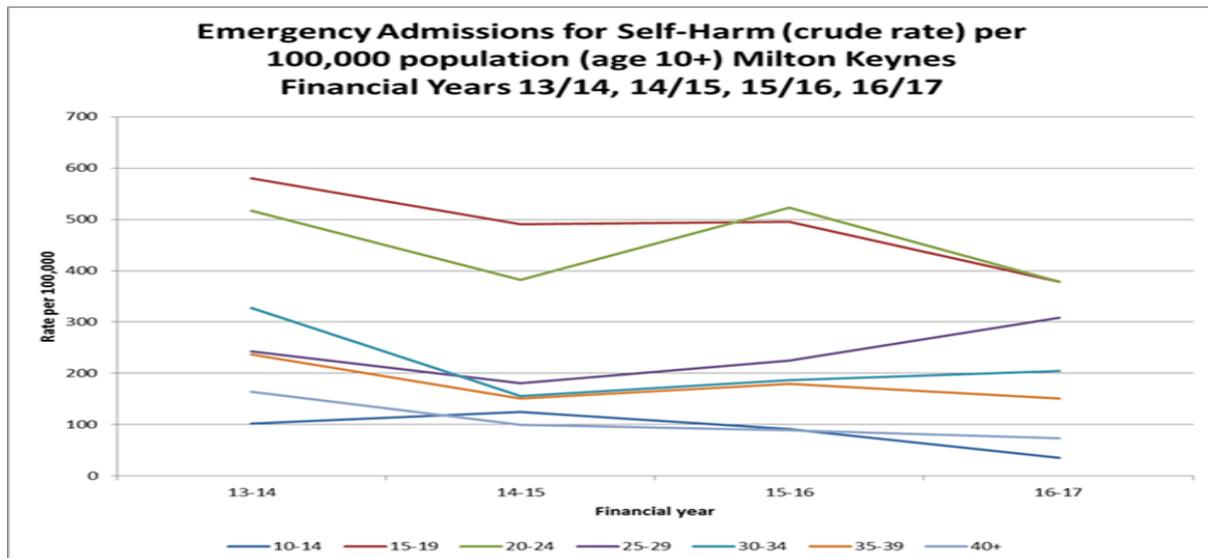
Historically, the rate of emergency hospital admissions for self-harm in Milton Keynes has been variable, but statistically significantly high in 2009/10 and 2013/14 reducing again in 2014/15. The current rate is similar to the national average.

Figure 5 – Emergency hospital admissions for self-harm



Source: PHE, Suicide Prevention Profile <http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/4/gid/1938132834/pat/6/par/E12000008/ati/102/are/E06000042/iid/21001/age/1/sex/4>

Figure 6: Emergency Admissions for self-harm (crude rate) per 100,000 population (Milton Keynes)



Not everyone who self-harms needs to visit a hospital, so admissions are likely to be the ‘tip of the iceberg’ with regard to self-harm prevalence in an area. Some individuals who self-harm may attend accident and emergency, but not be admitted. Emergency departments have an important role in treating and managing people who have self-harmed or have made a suicide attempt. ‘Preventing suicide in England’ reports that there are still problems in some places with the quality of care, assessment and follow-up of people who seek help from emergency departments after self-harming. Attitudes towards and knowledge of self-harm among general hospital staff can be poor and a high proportion of people who self-harm are not given a psychological assessment.

The National Institute for Health and Care Excellence (NICE) developed a guideline for the treatment of self-harm in July 2004 (reviewed in 2014). This guidance set out effective pathways for self-harm and in particular highlighted the importance of undertaking psychosocial assessments for people who have presented at emergency departments for self-harm. The evidence suggests this can be effective in achieving better outcomes for people who self-harm as well as being a low cost intervention that all hospitals could implement. Yet, only around 60 per cent of people receive such an assessment.

There is currently a lack of consistent high quality self-harm services across the country. It is important that everyone who attends A&E for self-harm receives an assessment that meets NICE guidelines. There are a series of guides and other visuals for parents and children and young people that have been developed nationally. These could be adapted for local work in terms of awareness raising and prevention.

Actions Required

- Ensure local implementation of the NICE standards and pathways (CG16 and CG33 for managing patients who self-harm)
- Ensure robust pathways are in place for people who have self-harmed or attempted suicide, with particular consideration of follow-up for people who seek help from emergency departments after self-harming.
- Ensure appropriate suicide awareness training is in place, prioritising emergency departments and other frontline emergency providers including unplanned care.

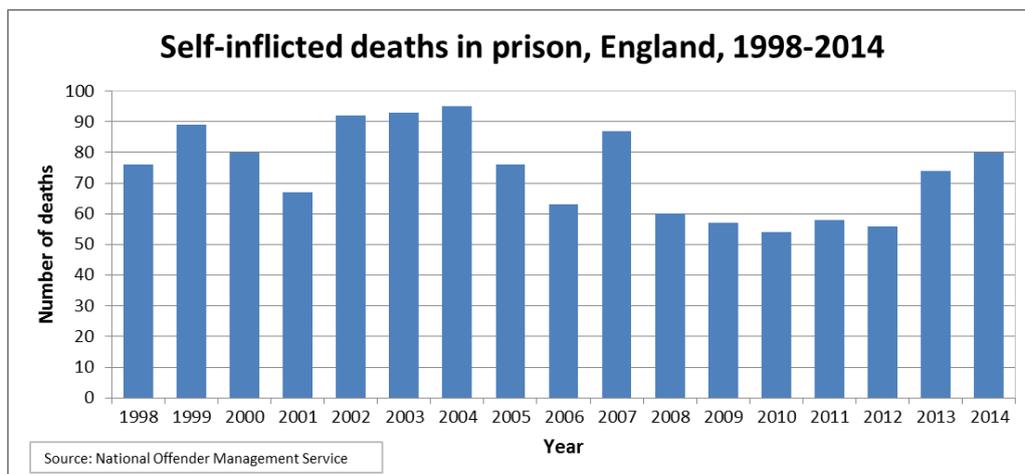
3.1.5 People in contact with the Criminal Justice System

People at all stages within the criminal justice system, including people on remand and recently discharged from custody, are at high risk of suicide. The period of greatest risk is the first week of imprisonment. Each death is investigated first by the Prison Ombudsman and then by the coroner and recommendations are made so that actions which may prevent another death in similar circumstances can be implemented.

The Milton Keynes Suicide Audit did not collect information directly from any agency within the Criminal Justice System. However, the audit pro-forma does ask if the deceased had had contact with the Criminal Justice System in the past 12 months. Over 90% of cases had no recorded history in the Coroner's notes and fewer than 5 individuals had a history of any contact. Woodhill prison (which houses category A males) and Oakhill Secure Training Facility are within Milton Keynes' boundary. As the number is less than 5 we cannot report the number of deaths that occurred amongst individuals who were in the prison at the time of their death but it is notable that some did occur.

Across England, prisoner deaths were fairly consistent between the years 2008-2012 at approximately 54-60 deaths each year. This is shown by Figure 7.

Figure 7 – Self-inflicted deaths in prison, England, 1998-2014.



Numbers rose in 2013 to 74 deaths and again in 2014 to 80 deaths. Most of these deaths were by men, suicides in women prisoners remain very low. The prison service has a suicide prevention and self-harm national strategy in the form of Prison Service Instruction (PSI) 64/2011. This PSI is very detailed and covers everything associated with the risk of suicide, self-harm, bereavement management and post incident investigation. It also outlines training, roles and responsibilities. The strategy is used in every prison in England and Wales.

Actions Required

- Seek assurance from NHS England that prison staff have appropriate training packages and a robust action plan in place

3.1.6 Specific occupational groups

Traditionally certain occupational groups have been identified as having higher risks of suicide. Males working in the lowest-skilled occupations have a 44% higher risk of suicide than the male national average; the risk among males in skilled trades is 35% higher (ONS,2017). The risk of suicide among low-skilled male labourers, particularly those working in construction roles, is 3 times higher than the male national average. For males working in skilled trades, the highest risk is among building finishing trades; particularly, plasterers and painters and decorators have more than double the risk of suicide than the male national average (ONS,2017).

The risk of suicide is elevated for those in culture, media and sport occupations for males (20% higher than the male average) and females (69% higher); risk is highest among those working in artistic, literary and media occupations. For females, the risk of suicide among health professionals is 24% higher than the female national average; this is largely explained by high suicide risk among female nurses (ONS,2017).

Suicide by occupational group does vary across different geographies though and it is important for local strategies to be alert to this. Regardless of job type there is an association between suicide and occupation where there is low job control, low social support and high job demands.

Loss of a job, unemployment and debt are also stressors and previously, periods of high unemployment or severe economic problems have had an adverse effect on the mental health of the population and been associated with higher rates of suicide (DH,2012).

The Milton Keynes local audit looked at employment status and found that, where this was known, 55% of individuals had been employed, although whether this was full or part time was not always obvious and occupation varied from low skilled jobs through to Director level. No particular occupation was over- represented nor were there any cases from high risk occupational groups. 15% of individuals were unemployed and 19% retired.

Actions Required

- Ensure work to improve wellbeing in workplaces across Milton Keynes prioritises 'mental wellbeing', especially workplaces with a higher proportion male/lower paid workforce particularly low skilled male labourers working in construction roles. Include unemployed populations as a focus for prevention work.

3.2 Objective 2: Tailor approaches to improve mental health in specific groups

Some people are more vulnerable to suicide, sometimes because of their life circumstances but also because they may find themselves facing multiple problems. Coping with one or more of these may be possible but a series of them may result in individuals being unable to cope and contemplating or attempting suicide.

The NSPS identified the need to improve mental health of the population as whole but specifically tailored measures for *'groups with particular vulnerabilities'*. They specifically identify:

- 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 and domestic violence;
- 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;
- Black, Asian and minority ethnic groups and asylum seekers.

There is good evidence that the more disadvantaged a person is and the more distressed a person is, the more difficult it is for them to access services.

As well as identifying groups at greatest risk of suicide (in order to tailor information, advice and support) to prevent suicide, it is important to raise the profile of services that can offer support at times of emotional distress (mental health services, helplines, self-help groups, peer support groups, psychological support) and to ensure people who are at their most vulnerable are made aware of and feel comfortable to access them. Often this can be achieved by ensuring a co-ordinated approach to promoting and signposting services to people when they might be at their most vulnerable.

In addition it is important that wider public mental health work builds a platform upon which to promote positive mental health and prevent mental illness amongst these most vulnerable groups as well as the wider population and consideration is given to developing community based solutions including awareness raising campaigns and mental health awareness training for people in contact with higher risk populations as recommended in Guidance. Wider public mental health work should be developed focusing on the needs of those most vulnerable to suicide as well as the general population.

Actions Required

- Evidence based training packages such as Applied Suicide Intervention Skills Training (ASSIST), Mental Health First Aid and Skills Based Training on Risk Management (STORM) should be reviewed, promoted and recommended. GP training and training for staff who work closely with the most vulnerable groups should be prioritised.
- Provider services and frontline health and social care staff working with the identified *'groups with particular vulnerabilities'* should ensure staff have received appropriate training to enable them to be confident and competent in recognising signs of mental distress and to signpost/act appropriately.
- Childrens Commissioners should review the *'effective based interventions'* relating to Children and Young People from the National Suicide Prevention Strategy and take action accordingly.

- The publication ‘Promoting children and young people’s emotional health and wellbeing, a whole school approach’ and public health approach to promoting young people’s resilience should be reviewed with a view to implementation across educational settings throughout MK.
- Youth Mental Health Awareness Programmes like Youth Aware of Mental Health (YAM) – evidenced to reduce suicidal ideation and suicide attempts amongst young people) should be implemented locally

3.3 Objective 3: Reduce Access to the means of suicide

One of the most effective ways to prevent suicide is to reduce access to high-lethality means of suicide. This is because people sometimes attempt suicide on impulse and restricting access to means can reduce this. Although ‘method substitution’ is bound to occur, there is evidence that initiatives aimed at reducing the availability of means will have considerable impact on impulsive suicidal acts or those that occur as a result of an acute or temporary crisis.

3.3.1 Most common methods of suicide

One way to prevent suicide is to reduce access to high-lethality means of suicide as people sometimes attempt suicide on impulse. The suicidal impulse may subside if the impulse is not available. Nationally, hanging /strangulation followed by self-poisoning are now the most common methods of suicide. Locally a slightly different picture exists – hanging /strangulation was the most frequent cause of death (50%), followed by jumping/lying before a train then self-poisoning. The difference is most likely due to the proximity of the local rail network.

Actions Required

- Implement NICE quality standards on safe prescribing .
- Work regionally and with the local coroner to ensure awareness of emerging suicide methods
- Work with the Rail Industry to support their Suicide Prevention initiatives at a local level.

3.3.2 High Risk Locations

The identification of frequently used places, also known as ‘hotspots’, and the management of same is an effective way of restricting access to the means of suicide. The majority of suicides occurring in Milton Keynes were at home, or on the rail network. A variety of other places featured but no one hotspot was identified.

Actions Required

- Work towards implementing guidance on Preventing suicide in public places (2015).
- Work with the coroner to ease audit by completion of basic proforma at the time a case is heard.
- Take part in the 'real time data' notification system

3.4 Objective4: Provide better information and support for those bereaved or affected by suicide

Suicide is a devastating event for families and can also have a profound effect on the wider community.' *Individuals bereaved by suicide have an increased risk of suicide and suicidal ideation, depression, psychiatric admissions as well as poor social functioning'*(PHE 2016). Consequently, it is important that timely information and practical support for families bereaved or affected by suicide is in place.

There should also be resources available to support those who are concerned about a family, friend, or colleague.

Actions Required

- As part of any training delivery related to suicide prevention, ensure clinicians working in primary care and mental health services are aware of the potential vulnerability of family members when someone takes their own life and available support.
- Ensure a co-ordinated approach to ensuring existing available resources offering support at times of crisis i.e. (*'Help is at Hand and Health Talk Online*) are made available and signposted to at appropriate locations or services.
- Work with regional partners via the Thames Valley Suicide Prevention Intervention Network (SPIN) to implement a system where family members of individuals who have ended their life by suicide are notified swiftly of available local support and Services.
- Ensure local schools have a system in place to support pupils and staff in the event of suicide (e.g. *Samaritans Step by Step post-suicide intervention service or services offered by Child Bereavement UK*).

3.5 Engage with and support the media in delivering sensitive approaches to suicide and suicidal behaviour

The National Suicide Prevention Strategy cites evidence that media reports and portrayals of suicide can lead to copycat behaviours and promotes the need for responsible reporting and portrayal of suicide and suicide behaviour in the media.

In 2006, the Press Complaints Commission first added a clause to the editors Code of Practice recommending the media avoid excessively detailed reporting of suicide methods. This was strengthened in 2009 with the inclusion of details of local support organisations promoted. The

Samaritans have since produced guidance for the media on the reporting of, and portrayal of, suicide. In 2016, the National Statistics definition of suicide has been modified to include deaths from intentional self-harm in 10- to 14-year-old children in addition to deaths from intentional self-harm and events of undetermined intent in people aged 15 and over.

Actions Required

- Ensure local media are aware of Samaritans Guidance on reporting and portrayal of suicide.
- Consider developing a protocol for a local consistent response to requests from the media following a suicide

3.6 Objective 6: Support Research, Data Collection and Monitoring

The NSPS highlights the need to build on existing research evidence relating to suicide, expand and improve data collection and monitor progress against the objectives of the NSPS. Much work in this area requires national intervention; however, there are some local actions Milton Keynes can take.

There are multiple sources of data on suicide of varying quality which become available over varied timescales after the event. These include ONS data, NHS Information Centre data and some statutory service data. Analysis of additional information from completed inquests can give further insight.

In line with Public Health England recommendations this plan has been developed in partnership with key stakeholders, including stakeholders where data may be available to further inform planning (such as national rail data). Work is also underway to link with other Suicide Prevention leads (Oxfordshire, Berkshire and Buckinghamshire) via the Thames Valley Suicide Prevention and Intervention Network (SPIN) and East Midlands Leads via PHE organised events.

Actions Required

- Establish a multi-agency Suicide Prevention Action planning Group for Milton Keynes with cross sector membership whose purpose is to monitor and drive forward the implementation of the Suicide Prevention Plan.
- Continue to undertake a review of statistics relating to suicide and self-harm on an annual basis.
- Consider establishing a system whereby the requirements for audit are routinely collected by the local coroner's office.
- In leau of routine collection (above) undertake detailed audits of suicides in Milton Keynes on at least a 3 yearly basis (to gain further insight).
- Significant Incident Audits should be undertaken for all suicide cases in Milton Keynes and key messages shared.

- Work with partners to establish a 'real time' data system and put in place a process of regular consideration of data.
- Continue to work with transport partners (i.e. National Rail) to identify hotspots.

Appendix 1

Box 1: Key elements of safer care in mental health services

Key elements of safer care in mental health services:

1. Safer wards
 - Removal of ligature points
 - Reduced absconding
 - Skilled in-patient observation
2. Care planning and early follow-up on discharge from hospital to community
3. No 'out of area' admissions for acutely ill patients
4. 24 hour crisis resolution/home treatment teams
5. Community outreach teams to support patients who may lose contact with conventional services
6. Specialised services for alcohol and drug misuse and "dual diagnosis"

7. Multidisciplinary review of patient suicides, with input from family
8. Implementing NICE guidance on depression and self-harm
9. Personalised risk management, without routine checklists
10. Low turnover of non-medical staff

Key elements of safer care in the wider health system:

1. Psychosocial assessment of self-harm patients
2. Safer prescribing of opiates and antidepressants
3. Diagnosis and treatment of mental health problems especially depression in primary care
4. Additional measures for men with mental ill-health, including services online and in non-clinical settings

References

Appleby, L et al (2016) The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Making Mental Health Care Safer: Annual Report and 20-year Review. October 2016. University of Manchester. Available online at: <http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/2016-report.pdf>

Branas, C et al. (2015) The impact of economic austerity and prosperity events on suicide in Greece: a 30 year interrupted time series analysis. *BMH Open* 2015; 5e0056619

Centre for Suicide Research. 2012. Assessment of suicide risk in people with depression Accessed at: <http://cebmh.warne.ox.ac.uk/csr/clinicalguide/assess.html>

Department of Health (DH) 2015. 'Statistical update on suicide'. London: Department of Health, Available online at: <https://www.gov.uk/government/publications/suicide-prevention-second-annual-report>

Department of Health (DH) 2012a. Preventing Suicide in England; a cross-government outcomes strategy to save lives. London: Department of Health (2012). Available online at: <http://www.dh.gov.uk/health/2012/09/suicide-prevention>

Department of Health (DH). 2014. Preventing suicide in England: One year on. First annual report on the cross-government outcomes strategy to save lives. London: Department of Health (2014) Available online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/278119/Annual_Report_FINAL_revised.pdf

Department of Health (DH) 2015. Preventing suicide in England: Two years on, Second annual report on the cross-government outcomes strategy to save lives. London: Department of Health (2015). Available online at: <https://www.gov.uk/government/publications/suicide-prevention-second-annual-report>

Department of Health (DH) 2017. Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives: London: Department of Health (2017). Available online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/582117/Suicide_report_2016_A.pdf

Department of Health. 2015. Statistical Update on Suicide (Feb 2015) Available online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/405411/Statistical_update_on_suicide_acc.pdf

Hawton, K (2005) Suicide and deliberate self-harm in young people. *BMJ* 2005; 330:891. Available on line at: <http://www.bmj.com/content/330/7496/891>

HM Government. 2012. Preventing Suicide In England – A cross-government outcomes strategy to save lives.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216928/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

Knapp, Martin, McDaid, David and Parsonage, Michael. 2011. *Mental health promotion and mental illness prevention: the economic case*. 15972. Department of Health, London, UK

Public Health England. 2014. Guidance for developing a local suicide prevention action plan. Available online at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/359993/Guidance_for_developing_a_local_suicide_prevention_action_plan_2.pdf

Public Health England. 2015. Suicide prevention: suicides in public places.

Available online at: <https://www.gov.uk/government/publications/suicide-prevention-suicides-in-public-places>

Mann et al, 2005. Suicide Prevention Strategies, a Systemic Review. *Jnl of the American Medical Association*. 294 (16). Pp 2064-74

Milton Keynes Council. 2016. Milton Keynes Child Death Overview Panel (CDOP) Annual Report 2015/16.

Ministry of Justice. Management of prisoners at risk of harm to self, to others and from others (Safer Custody). Ministry of Justice; 2013

Available online at: <https://www.justice.gov.uk/downloads/offenders/.../psi-64-2011-safer-custody.doc>

NCISH. National Confidential Inquiry into and Homicide by People with Mental Illness. 2016 <http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/2016-report.pdf>

NHS Digital. (2014) Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 Available online at:

<http://content.digital.nhs.uk/catalogue/PUB21748>

NHS England Mental Health Taskforce. The Five Year Forward View for Mental Health NHS in England; 2016

NHS National Patient Safety Agency and Mental Health Network (2011) Preventing Suicide :A toolkit for community mental health

Available online at:

<http://www.nhsconfed.org/~media/Confederation/Files/public%20access/Toolkit%20for%20community%20mental%20health.pdf>

NICE (National Institute of Clinical Excellence). Depression in adults: recognition and management: CG90. NICE 2016.

Available online at: <https://www.nice.org.uk/guidance/cg90>

NICE (National Institute of Clinical Excellence). Self-harm in over 8s: short-term management and prevention of recurrence:CG16 .NICE;2004

Available online at: <https://www.nice.org.uk/guidance/cg16>

NICE(National Institute of Clinical Excellence) .Self-harm in over 8s: long-term management: CG33.NICE;2011

Available online at: <https://www.nice.org.uk/guidance/cg133>

ONS. 2008. Health Statistics Quarterly 38. Social Inequalities in male mortality for selected causes of death.

ONS. 2015.

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2015registrations>

ONS. 2016. Statistical Bulletin. Suicides in the UK. 2014 Registrations.

<http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2014registrations>

[ONS.2017. Suicide by occupation, England: 2011 to 2015. Analysis of deaths from suicide in different occupational groups for people aged 20 to 64 years, based on deaths registered in England between 2011 and 2015.](#)

Available online at :

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/suicidebyoccupation/england2011to2015>

Public Health England. 2015. Promoting children and young people's emotional health and wellbeing, a whole school approach. Available online at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414908/Final_EHWP_draft_20_03_15.pdf

Public Health England. 2016. Local Suicide Prevention Planning. A practice resource.

Available online at::

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/564420/phe_local_suicide_prevention_planning_a_practice_resource.pdf

Public Health England and the National Suicide Prevention Alliance.2016. Help is at Hand

Available online at:

<https://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf>

RCGP/RCPsych Primary Care and Mental Health Forum. Suicide Mitigation in Primary Care.

Available online at:

http://www.connectingwithpeople.org/sites/default/files/SuicideMitigationInPrimaryCareFactsheet_0612.pdf

Samaritans. 2016. Help when we need it most: How to prepare for and respond to a suspected suicide in schools and colleges.

Available on line at :

http://www.samaritans.org/sites/default/files/kcfinder/files/HWWNIM_Feb17_Final_web%283%29.pdf

Samaritans. 2013. Media Guidelines on Reporting Suicide. Available on line at:

<http://www.samaritans.org/sites/default/files/kcfinder/branches/branch-96/files/Samaritans%20Media%20Guidelines%20UK%202013%20ARTWORK%20v2%20web.pdf>

Samaritans. 2015. 'Men Suicide and Society.' Available on line at:

<http://www.samaritans.org/sites/default/files/kcfinder/files/press/Men%20Suicide%20and%20Society%20Research%20Report%20151112.pdf>

WHO (World Health Organisation). 2011. Impact of economic crisis on mental health. WHO Regional Office for Europe.

Zalsman, G. Hawton, K, Wasserman, D, Van Heeringen, K, Arensman, E, Sarchiapone, M et al. 2016. Suicide Prevention Strategies Revisited: 10 year systematic review: Lancet Psychiatry. Available on line at:

[http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(16\)30030-X/abstract](http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)30030-X/abstract)

