SUICIDE PREVENTION STRATEGY
FOR REDBRIDGE 2013/15
CONTENTS

1. Executive Summary
2. Introduction
3. National and Local Context
4. The Challenge of Suicide Prevention
5. Aims and Overall Objectives
6. Next Steps
7. Governance
A Suicide Prevention Strategy for Redbridge 2013-2015

1. Executive Summary

Suicide prevention policy in England is experiencing great change. A new national strategy ‘Preventing Suicide in England – A cross-government outcomes strategy to save lives’ was published in September 2012 alongside the re-organisation of health and public health structures under the Health and Social Care Act 2012 implemented in April 2013.

Suicide is a major issue for society and a serious but preventable public health problem that can have lasting harmful impacts, economically, psychologically and spiritually on individuals, families and communities. While its causes are complex and no strategy can be expected to completely remove the tragedy of suicide, there is much that can be done to ensure that we reduce the likelihood of suicide and to ensure support is available for those at their most vulnerable.

Statistics produced by the Office for National Statistics indicate that the suicide rate in England has been in steady decline for most of the last decade until 2008 when there was a small increase in the number of suicide deaths. The mortality rate from suicide was 12.2 deaths per 100,000 population for males and 3.7 deaths per 100,000 population for females, between 2008-2010 in England. In Redbridge deaths from suicide or undetermined injury, between 2008-2010 (combined), were 55 with a directly age standardised mortality rate of 6.8 per 100,000 compared to an England average of 7.9 per 100,000 and London average of 7.1 per 100,000.

Although suicide rates have been at an historical low recently, the experience is that suicide rates can be volatile as new risks emerge. A recent study published by the University of Liverpool suggests that the economic crisis and recession are having an adverse impact on suicide rates. Researchers calculated that more than 1000 suicides between 2008 and 2010 could be attributed to unemployment. Prevention of suicide calls for working across sectors at a local and national level. There is a need to tackle all the factors which may increase the risk of suicide in the communities where they occur if our efforts are to be effective. Suicide prevention is most effective when it is combined as part of wider work addressing the social and other determinants of poor health, wellbeing or illness. The aim is to reduce lives lost to suicide and people bereaved or affected by a suicide receive the right support.

This strategy outlines the ways in which Redbridge Public Health and local partners aim to work towards a reduction in suicides amongst the population of Redbridge in line with the National Suicide Prevention Strategy for England and the National Mental Health Strategy –No health without mental health.

The overall objectives of the ‘Preventing Suicide in England’ strategy are:

- a reduction in the suicide rate in the general population in England
- better support for those bereaved or affected by suicide
The Six Key Areas for Action to support delivery of these objectives are:

- 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

2. **Introduction**

Suicide and attempted suicide are human tragedies with many contributing factors. These often occur in circumstances of hopelessness and despair. There is no single cause and no simple solution.

In 2002 the Department of Health produced the National Suicide Prevention Strategy for England and building on its success the Government in 2012 has published a new national all-age suicide prevention strategy for England. To complement national efforts, Redbridge has developed a borough-wide suicide prevention strategy to co-ordinate work across the sectors/agencies in achieving the overall objectives of the National Suicide Prevention Strategy of reducing the suicide rate in the general population and improving support for those bereaved or affected by suicide.

The Redbridge Suicide Prevention Strategy is not a one off document but an ongoing, co-ordinated set of activities that will develop over several years, evolving as new priorities and new evidence emerge.

3. **The National and Local Context**

The All Party Parliamentary Report set out the context of suicide prevention in England, local suicide prevention plans now and the challenges and opportunities for those plans in the future.

The Report concludes that the future of local suicide prevention plans, through this period of transition, depend upon several inter-connected factors:

- Leadership and local champions
- Identification of suicide prevention as a priority
- Availability of resources
- Long term survival of suicide prevention groups

Local suicide prevention plans are not a statutory requirement of the new National Suicide Prevention Strategy and this is a major barrier to their survival. The future of local suicide prevention plans is fragile, often relying upon the commitment of dedicated individuals.
The National Suicide Prevention Strategy identifies six key areas for action to support delivery of the above objectives:

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.

Each action area has a series of more precise objectives. There are inevitably links between several of the objectives, and therefore a number of actions are cross-referenced. In addition many activities currently underway form part of existing complementary strategies i.e. Redbridge Mental Health Promotion Strategy. Where this is the case reference to those strategies are made.

**Other strategies supporting suicide prevention strategy**

Healthy Lives, Healthy People; the strategy for public health in England \(^1\) gives a new, enhanced role to local government and local partnerships in delivering improved public health outcomes. Local responsibility for coordinating and implementing work on suicide prevention became, from April 2013, an integral part of local authorities’ new responsibilities for leading on local public health and health improvement.

Health and wellbeing boards will support effective local partnerships and will be able to support suicide prevention as they determine local needs and assets. Public Health England, the new national agency for public health, will also support local authorities, the NHS and their partners across England to achieve improved outcomes for the public's health and wellbeing, including work on suicide prevention.

No health without mental health: A cross-government outcomes strategy for people of all ages\(^2\) is key in supporting reductions in suicide amongst the general population as well as those under the care of mental health services. The first agreed objective of No health without mental health aims to ensure that more people will have good mental health. To achieve this, we need to:

- improve the mental wellbeing of individuals, families and the population in general; ensure that fewer people of all ages and backgrounds develop mental health problems; and
- continue to work to reduce the national suicide rate.

---

\(^1\) Healthy lives, healthy people: our strategy for public health in England. Department of Health (DOH) 2010

\(^2\) No health without mental health: a cross-government mental health outcomes strategy for people of all ages. Department of Health (DOH) 2011
The Outcomes Framework outlines suicide prevention as one of the outcome measurements.

In England, approximately one person dies every two hours as a result of suicide.\(^3\)

Suicide rates in England have been at an historical low recently and are low in comparison to those of most other European countries. In England in 2008-10, the mortality rate from suicide was 12.2 deaths per 100,000 population for males and 3.7 deaths for females.\(^4\) The latest 15-year trend in the mortality rate from suicide and injury of undetermined intent using three-year pooled rates is shown in the Figure 1:

![Figure 1: Mortality trend from suicide and injury undetermined (ICD10 X60-X84, Y10-Y34 excl Y33.9) in England, all ages, 1993-95 to 2008-10](image)

Source: Health and Social Care Information Centre Indicator Portal

Although there has been a slight increase in suicide rates in the past couple of years the 2008-10 rate remains one of the lowest in recent years. In London there are over 575 deaths attributed to suicide and undetermined injury each year. This equates to a rate of around 7.1 per 100,000 people which is slightly lower than the England rate of 7.9. Overall there has been a reduction of 8.6% in suicide rates in London compared to 2001-03 pooled data (8.3 deaths per 100,000 population). The suicide rates for England, London and Redbridge 2008-10 pooled data are described in the tables below:

---

\(^3\) Preventing suicide in England, A cross-government strategy to save lives. Department of Health DOH 2012

Table 1 Mortality (Directly Standardised Rates per 100,000 from suicide (ICD 10 X60-X84), 2008-10 pooled

<table>
<thead>
<tr>
<th>All ages</th>
<th>Number</th>
<th>DSR</th>
<th>Ranking in 33 London Boroughs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Where ranking of 1 is the worst)</td>
</tr>
<tr>
<td><strong>Males</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Redbridge</td>
<td>30</td>
<td>7.59</td>
<td>14</td>
</tr>
<tr>
<td>London</td>
<td>845</td>
<td>7.08</td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>7425</td>
<td>9.27</td>
<td></td>
</tr>
<tr>
<td><strong>Females</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Redbridge</td>
<td>9</td>
<td>2.21</td>
<td>19</td>
</tr>
<tr>
<td>London</td>
<td>281</td>
<td>2.29</td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>2155</td>
<td>2.55</td>
<td></td>
</tr>
<tr>
<td><strong>Persons</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Redbridge</td>
<td>39</td>
<td>4.88</td>
<td>15</td>
</tr>
<tr>
<td>London</td>
<td>1126</td>
<td>4.65</td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>9580</td>
<td>5.66</td>
<td></td>
</tr>
</tbody>
</table>

Source: Health and Social Care Information Centre Indicator Portal

Redbridge suicide rate for males (7.59 per 100,000) is higher than the London average (7.08 per 100,000) but lower than the England average (9.27 per 100,000). While the female suicide rate of 2.21 per 100,000 is slightly lower than London (2.29 per 100,000) and England (2.55 per 100,000).

Table 2 Mortality (Directly Standardised Rates per 100,000 from suicide (ICD 10 X60-X84) and injury undetermined (Y10-Y34 excl Y33.9), 2008-2010 pooled

<table>
<thead>
<tr>
<th>All ages</th>
<th>Number</th>
<th>DSR</th>
<th>Ranking in 33 London Boroughs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Where ranking of 1 is the worst)</td>
</tr>
<tr>
<td><strong>Males</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Redbridge</td>
<td>43</td>
<td>10.76</td>
<td>18</td>
</tr>
<tr>
<td>London</td>
<td>1302</td>
<td>10.82</td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>9765</td>
<td>12.22</td>
<td></td>
</tr>
<tr>
<td><strong>Females</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Redbridge</td>
<td>12</td>
<td>2.93</td>
<td>23</td>
</tr>
<tr>
<td>London</td>
<td>425</td>
<td>3.48</td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>3124</td>
<td>3.72</td>
<td></td>
</tr>
<tr>
<td><strong>Persons</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Redbridge</td>
<td>55</td>
<td>6.79</td>
<td>18</td>
</tr>
<tr>
<td>London</td>
<td>1727</td>
<td>7.10</td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>12889</td>
<td>7.92</td>
<td></td>
</tr>
</tbody>
</table>

Source: Health and Social Care Information Centre Indicator Portal

Redbridge mortality rate from suicide and undetermined injury in males (10.76 per 100,000) is slightly lower than London (10.82 per 100,000) and 12.22 per 100,000 for England. Redbridge is ranked 18th worst compared to 33 London
boroughs. The rate for females is 2.93 per 100,000 which is less than London (3.48 per 100,000) and England (3.72 per 100,000) a ranking of 23rd worst compared to 33 London boroughs.

Table 3 Mortality (Directly Standardised Rates per 100,000 from suicide (ICD 10 X60-X84) and injury undetermined (Y10-Y34 excl Y33.9) in Outer North East London, 2008-2010 pooled

<table>
<thead>
<tr>
<th>All ages</th>
<th>Number</th>
<th>DSR</th>
<th>Ranking in 33 London Boroughs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Where ranking of 1 is the worst)</td>
</tr>
<tr>
<td>Males</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barking and Dagenham</td>
<td>32</td>
<td>13.8</td>
<td>6</td>
</tr>
<tr>
<td>Havering</td>
<td>39</td>
<td>11.05</td>
<td>17</td>
</tr>
<tr>
<td>Redbridge</td>
<td>43</td>
<td>10.76</td>
<td>18</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>41</td>
<td>13.03</td>
<td>7</td>
</tr>
<tr>
<td>Females</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barking and Dagenham</td>
<td>3</td>
<td>1.09</td>
<td>32</td>
</tr>
<tr>
<td>Havering</td>
<td>11</td>
<td>2.77</td>
<td>24</td>
</tr>
<tr>
<td>Redbridge</td>
<td>12</td>
<td>2.93</td>
<td>23</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>7</td>
<td>2.08</td>
<td>29</td>
</tr>
<tr>
<td>Persons</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barking and Dagenham</td>
<td>35</td>
<td>7.14</td>
<td>15</td>
</tr>
<tr>
<td>Havering</td>
<td>50</td>
<td>6.69</td>
<td>19</td>
</tr>
<tr>
<td>Redbridge</td>
<td>55</td>
<td>6.79</td>
<td>18</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>48</td>
<td>7.43</td>
<td>13</td>
</tr>
</tbody>
</table>

Source: Health and Social Care Information Centre Indicator Portal

Redbridge has one of the lower rates of death from suicide and undetermined injury for all ages (2008-10) in the Outer North East London sector and is ranked 18th worst in 33 London boroughs.
Table 4 Mortality (Directly Standardised Rates per 100,000 from suicide (ICD 10 X60-X84) and injury undetermined (Y10-Y34 excl Y33.9) in Redbridge compared to statistical neighbours, 2008-2010 pooled

<table>
<thead>
<tr>
<th>All ages</th>
<th>Number</th>
<th>DSR</th>
<th>Ranking in 33 London Boroughs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(Where ranking of 1 is the worst)</td>
<td></td>
</tr>
<tr>
<td><strong>Males</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Redbridge</td>
<td>43</td>
<td>10.76</td>
<td>18</td>
</tr>
<tr>
<td>Hounslow</td>
<td>52</td>
<td>15.11</td>
<td>5</td>
</tr>
<tr>
<td>Merton</td>
<td>33</td>
<td>9.75</td>
<td>20</td>
</tr>
<tr>
<td>Barnet</td>
<td>48</td>
<td>8.9</td>
<td>27</td>
</tr>
<tr>
<td>Harrow</td>
<td>28</td>
<td>7.98</td>
<td>29</td>
</tr>
<tr>
<td>Ealing</td>
<td>63</td>
<td>12.62</td>
<td>9</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>47</td>
<td>11.78</td>
<td>12</td>
</tr>
<tr>
<td>Croydon</td>
<td>31</td>
<td>5.98</td>
<td>32</td>
</tr>
<tr>
<td>Sutton</td>
<td>35</td>
<td>11.14</td>
<td>16</td>
</tr>
<tr>
<td>Enfield</td>
<td>42</td>
<td>9.44</td>
<td>24</td>
</tr>
<tr>
<td><strong>Females</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Redbridge</td>
<td>12</td>
<td>2.93</td>
<td>23</td>
</tr>
<tr>
<td>Hounslow</td>
<td>17</td>
<td>5.28</td>
<td>4</td>
</tr>
<tr>
<td>Merton</td>
<td>7</td>
<td>1.72</td>
<td>31</td>
</tr>
<tr>
<td>Barnet</td>
<td>15</td>
<td>2.56</td>
<td>27</td>
</tr>
<tr>
<td>Harrow</td>
<td>10</td>
<td>2.72</td>
<td>25</td>
</tr>
<tr>
<td>Ealing</td>
<td>16</td>
<td>3.53</td>
<td>16</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>18</td>
<td>4.48</td>
<td>8</td>
</tr>
<tr>
<td>Croydon</td>
<td>13</td>
<td>2.2</td>
<td>28</td>
</tr>
<tr>
<td>Sutton</td>
<td>8</td>
<td>2.67</td>
<td>26</td>
</tr>
<tr>
<td>Enfield</td>
<td>14</td>
<td>3.21</td>
<td>22</td>
</tr>
<tr>
<td><strong>Persons</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Redbridge</td>
<td>55</td>
<td>6.79</td>
<td>18</td>
</tr>
<tr>
<td>Hounslow</td>
<td>69</td>
<td>10.25</td>
<td>3</td>
</tr>
<tr>
<td>Merton</td>
<td>40</td>
<td>5.72</td>
<td>27</td>
</tr>
<tr>
<td>Barnet</td>
<td>63</td>
<td>5.68</td>
<td>28</td>
</tr>
<tr>
<td>Harrow</td>
<td>38</td>
<td>5.37</td>
<td>29</td>
</tr>
<tr>
<td>Ealing</td>
<td>79</td>
<td>8.11</td>
<td>8</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>65</td>
<td>8.06</td>
<td>10</td>
</tr>
<tr>
<td>Croydon</td>
<td>44</td>
<td>4.06</td>
<td>33</td>
</tr>
<tr>
<td>Sutton</td>
<td>43</td>
<td>6.65</td>
<td>21</td>
</tr>
<tr>
<td>Enfield</td>
<td>56</td>
<td>6.22</td>
<td>23</td>
</tr>
</tbody>
</table>

Source: Health and Social Care Information Centre Indicator Portal
Statistical Comparators
Redbridge mortality rate from suicide and undetermined injury is in the middle of the range amongst our statistical comparators for males, females and all persons.

Figure 2 Mortality trend from suicide in Redbridge 1993 to 2010 Gender, All ages

Mortality trend from suicide (ICD 10 X60-X84) in Redbridge by gender, all ages, 1993 - 2010

Source: Health and Social Care Information Centre Indicator Portal
Figure 3 Mortality trend suicide and injury undetermined in Redbridge 1993 to 2010 All ages

Nationally the highest rates of suicide are in males 15-44 years in Redbridge suicide mortality in this age group account for ? of all suicide deaths in the borough.
Self harm
Self-harm could be defined as an intentional act of self-poisoning or self-injury irrespective of the apparent purpose of the act\(^5\). There is a broad spectrum of self-harming behaviour ranging from deliberate recklessness to highly lethal attempts at suicide. Most common forms of self-harm involve: cutting, burning, scalding, hitting or scratching, breaking bones, taking high dosage of medication and swallowing toxic substances.

The majority of people who self-harm are aged between 11 and 25 years. In England, it is estimated that there are 220,000 hospital attendances annually due to deliberate self harm (DSH) and only a minority of adolescents and adults who self harm present to hospital.

DSH frequently leads to non-fatal repetition with worldwide studies giving an estimated median risk of repetition of 16% within one year and 23% over four years.

UK studies have estimated that in the year after an act of deliberate self harm the risk of suicide is 30–50 times higher than in the general population.

Self-harm is important for Redbridge as there are high emergency admission rates to A&E which will contain an element of self harm. Redbridge mental health strategy sets an objective to reduce the number people to going to the acute services/settings when they are in crisis and people with self-harm may end up in A&E. There is need to set up a project analysing acute data on self-harm to understand the socio- demographic & clinical profile of the cohort of patients using A&E when in crisis to inform commissioning of appropriate interventions.

Clinical guidelines for the management of self-harm, highlight the need for primary and secondary care services to provide a thorough assessment of mental health and social needs, precipitating factors and the risk of further self-harm or suicide among self-harming patients with whom they come into contact. In conducting a proper psychiatric history with a diagnostic assessment to differentiate between people who have harmed themselves as a way of dealing with psychological and other emotional disturbances, and those whose self damaging behaviour is attributable to a psychiatric disorder and a resultant disturbed mental state. Making such a differentiation is important not only in assessing risk but also in deciding future management plans.

There is a need to ensure such best practices are embedded across the care pathway and that the existing pathways are examined to understand required service improvements in line with proposed NICE guidelines.

Because it is not possible to ascertain the exact location of suicides from databases it is not possible to identify suicide ‘hotspots’ across the borough without undertaking a local suicide audit. This would allow us to identify local population groups at particular risk and devise prevention strategies at local

---

\(^5\) The National Institute for Clinical Excellence (NICE) 2004
level, information would be needed from PH mortality files and local coroners to identify local ‘hotspots’, types and combinations of drugs used in drug-related suicides, and other risks associated with the local area. We also need to collate information for planning population based suicide prevention in the borough, including a critical review of evidence for effectiveness of suicide prevention interventions.

In order to achieve this, a working group would need to:

- Engage local stakeholders, in order to obtain insight in the local context, views and expertise on prevention of suicide, to describe existing initiatives, to prevent duplication of work and to build commitment for collaborative working on suicide prevention.
- Describe determinants and characteristics of suicide in Redbridge, in order to inform planning by identification of determinants which can be modified or whose effect can be improved.
- Review the effectiveness of interventions to prevent suicide, in order to inform the planning of local interventions.

Many statutory and voluntary sector services in Redbridge could potentially contribute to suicide prevention. Effective partnerships across all sectors are fundamental in addressing risk and protective factors. Some of the key local stakeholders include:

- Health and wellbeing board
- Public Health
- Suicide prevention steering group
- Whipps Cross University Hospital (WXUH)
- Barking, Havering and Redbridge University Hospital Trust (BHRUT)
- London Borough of Redbridge (LBR)
- North East London Foundation Trust (NELFT)
- Mental health service users
- Clinical Commissioning Group (CCG)
- Social care
- Housing
- Education
- Police
- Transport
- Voluntary sector
- Coroners

The implementation plan sets out actions in line with the national and local priorities.

4. The challenge of suicide prevention

The factors associated with suicide are many and varied – they include:

- Gender – males are three times as likely to take their own life as females;
- Age – people aged 35-49 now have the highest suicide rate;
• Mental illness;
• The treatment and care they receive after making a suicide attempt;
• Physically disabling or painful illnesses including chronic pain; and
• Alcohol and drug misuse.

Stressful life events can also play a part. These include:

• The loss of a job;
• Debt;
• Living alone, becoming socially excluded or isolated;
• Bereavement;
• Family breakdown and conflict including divorce and family mental health problems; and
• Imprisonment.

For many people, it is the combination of factors which is important rather than one single factor. Stigma, prejudice, harassment and bullying can all contribute to increasing an individual’s vulnerability to suicide.

Redbridge has many of the main risk factors of poor mental health. At a community level these have been identified as: high unemployment, ethnically diverse population, high levels of crime, and poor housing conditions. Additionally, Redbridge has many of the main risk factors at an individual level: poor physical health especially chronic disease, caring for a family member with a chronic disease, financial strain and high rates of alcohol and drug misuse.

5. The aims

Redbridge Suicide Prevention strategy aims to reduce the suicide rate in the borough. This strategy has been developed in line with the National Suicide Prevention Strategy for England and builds on existing work.

**Overall objectives:**

1. To reduce the suicide rate in Redbridge population
2. To provide better support for those bereaved or affected by suicide
3. To support high risk groups and engage them to address risk factors
4. To work through the suicide prevention steering group to develop and agree evidence based initiatives reflecting the needs of the local population
5. To link with mental health promotion strategy to ensure joint delivery
6. To update knowledge of health workers on local picture and national strategy for suicide prevention
7. To engage with media personnel to agree on sensitive approaches to reporting suicide and suicidal behaviour
Objective 1: To reduce suicide rates in Redbridge population

Redbridge mortality from suicide and undetermined injury in all ages (2008-2010) of 6.79 per 100,000 is lower than London average of 7.10 per 100,000. This ranks Redbridge as 18th worst borough compared to the 33 London boroughs.

To achieve this objective a multi-pronged approach is required that addresses suicide at 3 levels, i.e.

a) Whole population approach to suicide prevention
b) Suicide prevention for specific groups who are more vulnerable
c) Suicide prevention by reducing access to means of suicide

a) Whole population approach to suicide prevention
This builds on the national mental health strategies measures set out in both No health without mental health and Healthy Lives, Healthy People which support a general reduction in suicides. This includes:

• Building individual and community resilience to increase social cohesion, community control over local resources and build on community assets
• Promoting mental health and wellbeing for the whole population to reduce stigma and discrimination associated with mental disorders
• Create healthier living, learning and working environments
• Improve public awareness and understanding of emotional problems, including warning signs of suicide.

b) Suicide prevention for specific groups
In support of this whole population approach we should include tailored measures for groups with particular vulnerabilities or problems with access to services. They are groups of people who may have higher rates of mental health problems including self-harm. These are not isolated groups, and many individuals may fall into more than one of these groups.

The strategy identifies the following groups for whom a tailored approach to their mental health is necessary 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
• Black, Asian and minority ethnic groups and asylum seekers.
Although the majority of the suicides are among young people, it is important we identify and provide targeted interventions to other groups.

c) Suicide prevention by reducing access to the means of suicide

Suicide is sometimes an impulsive behaviour\(^6\). Reducing access to lethal methods of self-harm is known to be an effective way of preventing suicide\(^7,8,9\). A certain number of the people will attempt suicide using an alternative method, known as ‘method substitution’. To effectively prevent suicide there is a case for reducing access to high-lethality means of suicide.

Suicide methods most amenable to intervention are:

- Hanging and strangulation in psychiatric inpatient and criminal justice settings
- Self-poisoning
- Those at high-risk locations
- Those on the rail and underground networks.

Objective 2: To better support for those bereaved or affected by suicide

Suicide can have a profound effect on families, the local community, staff that respond to suicide scenes and witnesses of suicide. It is important to:

- provide effective and timely support for families bereaved and other people affected by suicide e.g. friends and colleagues
- have in place effective local responses to the aftermath of a suicide
- provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide.

Objective 3: To reduce risk in high risk groups and engage them to address risk factors

The National Strategy identified a number of population groups who are priorities for prevention based on evidence available which shows they are statistically at an increased risk of suicide and ability to monitor the impact of preventative measures taken using routine data collected.

The groups at high risk of suicide are:

- Young and middle-aged men
- 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.
Locally we need to identify which groups are at risk and develop preventative measures.

**Objective 4: To work through the suicide prevention steering group to develop and agree evidence based initiatives reflecting the needs of the local population**

There is much to be done to improve mental health and reduce suicides in Redbridge. The local suicide prevention steering group with key partners should be established to decide where to focus efforts and which actions to prioritise. Suicide is a complex social issue, requiring commitment, collaboration and partnership across sectors, to enable shared ownership of plans, shared knowledge and intelligence and shared responsibility for outcomes.

**Objective 5: To engage with media personnel to agree on sensitive approaches to reporting suicide and suicidal behaviour**

The media have a significant influence on behaviour and attitudes. There is evidence to suggest that the reporting of suicide in the media can increase the rate of suicide, particularly amongst young people who may already be at risk. It is apparent that the media have a role to play in suicide prevention, by limiting certain aspects of reporting, providing details of local support organisations and help lines and by portraying suicide in ways, which may discourage imitation.

We want to support them by:

• promoting responsible reporting and portrayal of suicide and suicidal behaviour in the media
• continuing to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention services.

**Objective 6: To update knowledge of health workers on local picture and national strategy for suicide prevention**

To ensure that all people with mental health problems and those at risk of suicide, especially people who self-harm, are identified, diagnosed early and are referred to appropriate services there is need to train community

---

'gatekeepers', frontline workers and specialist staff to identify, assess, refer and manage people at risk of suicide.

To achieve this, we should provide appropriate training on suicide and self-harm for staff working in:
- schools and colleges,
- emergency departments and other emergency services,
- primary & secondary care
- other care environments e.g. nursing homes
- the criminal and youth justice systems

**Objective 7: To link with mental health promotion strategy to ensure joint delivery**

In line with Redbridge mental health strategy, there is need to co-ordinate borough-wide suicide prevention work across the sectors.

**Next Steps**
- Set up a local suicide prevention group within a Health and Well-being Board reporting structure
- Work with neighbouring local authorities where appropriate to develop a suicide prevention strategy
- Update the Suicide Prevention strategy to include current guidance, informed by local suicide profile

**Governance**
The Suicide Prevention Steering Group will be accountable to the Crime and Safety Partnership which is chaired by the Borough Police Commander. Annual reports will be presented to the board.