

West Yorkshire and Harrogate
Health and Care Partnership



Suicide prevention Five year strategy

2017-2022

November 2017

Suicide prevention strategy

Foreword

In England, nearly 100 people a week died by suicide in 2015. Suicide is the biggest killer of people under the age of 35 and the biggest killer of men under the age of 50. It tears families apart and leaves a lasting impact. And it is entirely preventable.

As of 2015, Yorkshire and Humber has the highest suicide rate in the country. Each year, we know that thousands of people with suicidal thoughts get the help and support they need from local mental health services. We also know that the majority of people who die by suicide do not have any contact with mental health services in their last year of life.

Organisations from across the region are joining forces to stop this needless loss of life. This includes mental health and ambulance services, police and fire services, local authorities, prison services, and charities.

We are aligning our efforts to offer the right support, at the right time, to those in need. We will do this at a regional level, as well as locally within each of our six areas – Bradford, Airedale, Wharfedale and Craven; Calderdale; Harrogate and Rural District; Kirklees; Leeds; and Wakefield.

Working together, we are adopting a zero suicide philosophy where each and every death by suicide is seen as preventable. Suicide will no longer be viewed as inevitable, or a terminal prognosis. We know that where this same approach has been taken internationally, there have been dramatic results.

This strategy is an ambitious and practical one, with clear aims and 12 objectives to help us achieve them. By 2020/21, we want to see a 10% reduction in suicides across West Yorkshire and Harrogate. And by 2022, we are aiming for a 75% reduction in targeted services and suicide hotspots.

This will equate to dozens of lives saved. Thank you to everyone working to make this happen.

Rob Webster

Lead chief executive, West Yorkshire and Harrogate Health and Care Partnership

Chief executive, South West Yorkshire Partnership NHS Foundation Trust

Introduction

Death by suicide accounts for more deaths worldwide than war and natural disasters combined with 800,000 deaths globally each year. Suicide is a serious public health problem. However, suicides are preventable with timely, evidence-based and often low-cost interventions. For national responses to be effective, a comprehensive multiagency suicide prevention strategy is needed (World Health Organisation, 2017).

In 2015, 4820 people are recorded as having died by suicide in England. Suicide is the biggest cause of premature death in men under 50 and the biggest killer of young people – male and female – aged under 35 in the UK. The rates of suicide have steadily risen in England since 2007 after many years of a reduction in the rate. In 2015, the Yorkshire and Humber region had the highest suicide rate in England.

As suicides can be prevented, there is a real need for society to understand and begin to tackle the complex nature of what leads individuals to take their own lives. If people could be identified and helped during times of despair then many lives would be saved.

The national strategy *Preventing suicide in England: A cross-government outcomes strategy to save lives* (2012) identified six key areas for action:

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

Much good work has already been done but there is more to do. The national strategy update, *Preventing Suicides in England* (Department of Health, 2017) is very clear that a multi-agency suicide prevention plan is required for each local authority with support from partners, including health, social care, police, fire, ambulance, independent, voluntary and criminal justice services.

The Sustainability and Transformation Plan (STP) for the West Yorkshire Health and Care Partnership (WYHCP) ¹ aims to provide locally relevant solutions to address the triple aims of improving health and wellbeing, care and quality and finance and efficiency across the West Yorkshire area. In support of this, the WYHCP has identified suicide prevention as a key strategic objective for the mental health programme to build on the progress already made in response to the national strategy key areas for action.

The overall aim of this five-year suicide prevention strategy is to develop working relationships between partner agencies to provide an evidence-based but practical framework across the WYHCP region to help reduce the frequency of suicide and minimise the associated human and financial costs, and the impact on others. The main targets for this strategy are to reduce suicide by 10% across the WYHCP population and by 75% in targeted areas using a 'zero-suicide' philosophy.

¹ See <http://www.southwestyorkshire.nhs.uk/west-yorkshire-harrogate-sustainability-transformation-plan/>

Our vision

All suicides are preventable, and partners will adopt a collaborative evidence-based approach resulting in fewer people dying by suicide

West Yorkshire Health and Care Partnership Mental Health Programme

The WY Health and Care Partnership Mental Health Programme is a dedicated work stream of the wider WYHCP. The programme aims to develop a shared vision and a standard approach across agencies that will ensure that we deliver a consistent set of agreed patient led outcomes that reflect best practice and meets the needs of the people in WYHCP.

The WYHCP Mental Health Programme (formerly known as the Urgent and Emergency Care Vanguard Mental Health Programme) has been working on suicide prevention for the WYHCP region since November 2015. Over the past year, focussed work with WYHCP partners has led to the development of this strategy.

In WYHCP there are six local authorities in Bradford, Airedale, Wharfedale and Craven; Calderdale; Harrogate and Rural District; Kirklees; Leeds; and Wakefield (Figure 1), covering a population of 2.7 million people. Each local authority has a public health department and each of these departments has developed local suicide prevention plans. The strategy will provide a framework and an opportunity for the regions' partners to work collaboratively to prevent death of people by suicide, whether they have had contact with mental health service or not, while aligning and building on existing local plans aimed at preventing suicide.



Figure 1
West Yorkshire
Health and Care
Partnership

Within WYHCP, there is a WY Police Authority, a WY Fire and Rescue Services and Yorkshire Ambulance Service plus Her Majesty's Prison Service (HMP) and local Clinical Commissioning Groups (see Figure 2). These agencies, together with the voluntary sector (e.g. Samaritans, State of Mind, Papyrus, and Winston's Wish) are crucial to the success of suicide prevention within WYHCP.

Our health and care economy //

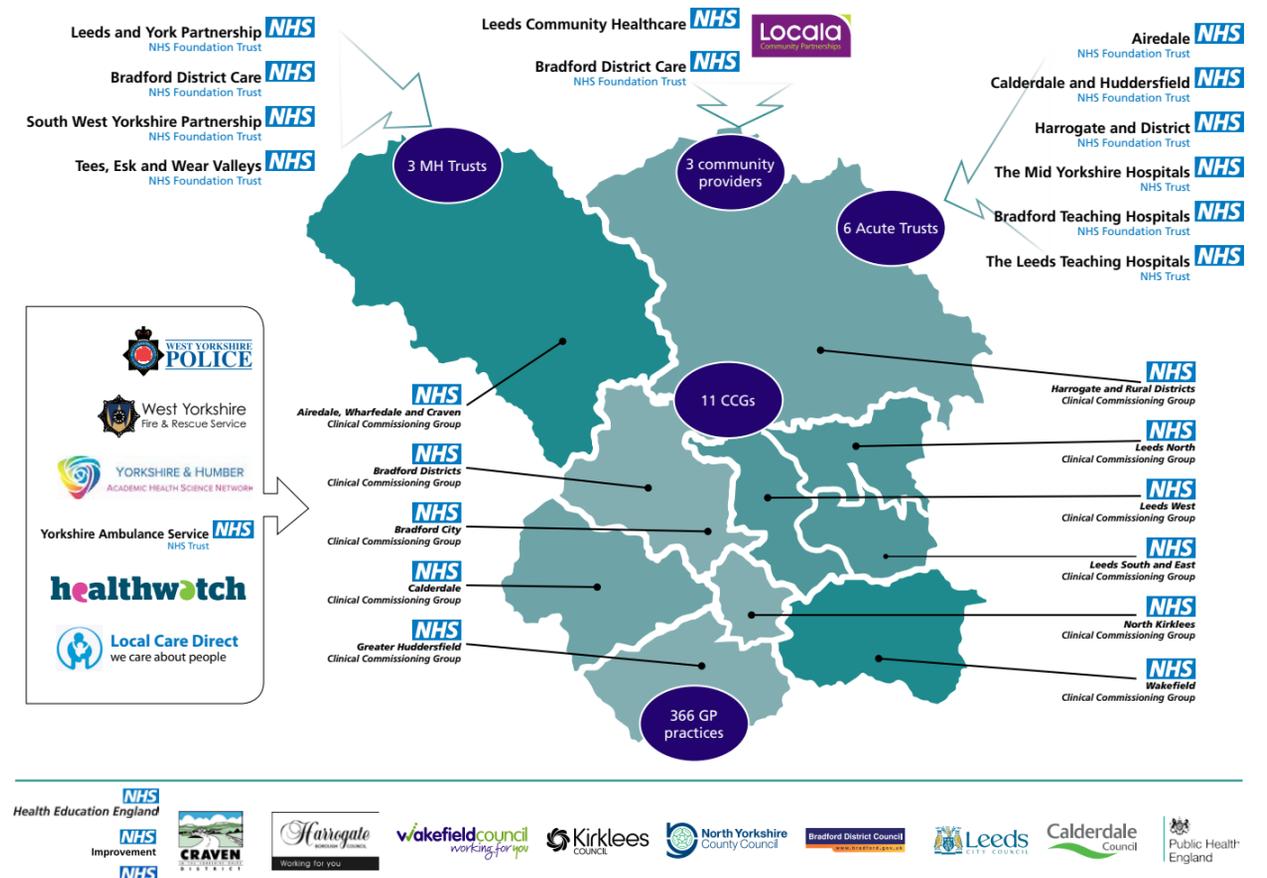


Figure 2
West Yorkshire WYHCP partner agencies

Delivering the strategy

By all partners working together under the framework of the WY Sustainability and Transformation Plan (2016), locally relevant solutions can be identified and developed to address the triple aims of improving health and wellbeing, care and quality and finance and efficiency across WYHCP.

The delivery of the strategy will be led and co-ordinated by the **WY Federation of NHS Trusts (FONT)**, which is a collaboration between the three WY NHS trusts who provide

mental health services – Bradford and District Care Foundation Trust (BDCFT), Leeds and York Partnership Foundation Trust (LYPFT) and South West Yorkshire Partnership Foundation Trust (SWYPFT), with a shared agreement to work collaboratively on all matters relating to suicide prevention across the WYHCP area.

Specifically, the FONT will lead the implementation of this strategy by working across traditional geographical and organisational boundaries, pooling resources and sharing good practice and lessons learned. A dedicated strategy lead will be supported by a suicide prevention project manager, who will receive analytical and administrative support. Monthly exception reports will be provided to the WYHCP mental health programme group, who will also receive an annual report and reports on request.

In addition, the WYHCP *Suicide Prevention Advisory Network (SPAN)* will continue to meet to ensure collaboration across all agencies in delivering the strategy and aligning actions led by NHS providers with existing population-based approaches across agencies in WY. This is important as nearly two-thirds (65%) of all those who died by suicide in WY in 2014, did not have contact with mental health services in the previous 12 months.

Resources will be drawn from pooling existing resources and making collaborative bids for funding. Joint working will be reinforced by a memorandum of understanding between the three NHS Trusts and clear terms of reference for the FONT and SPAN.

Business cases will be submitted to the WYHCP mental health programme as required and collaborative bids will be made by partners to other funding bodies as opportunities arise. It is anticipated that business cases will be strengthened due to multi-agency involvement.

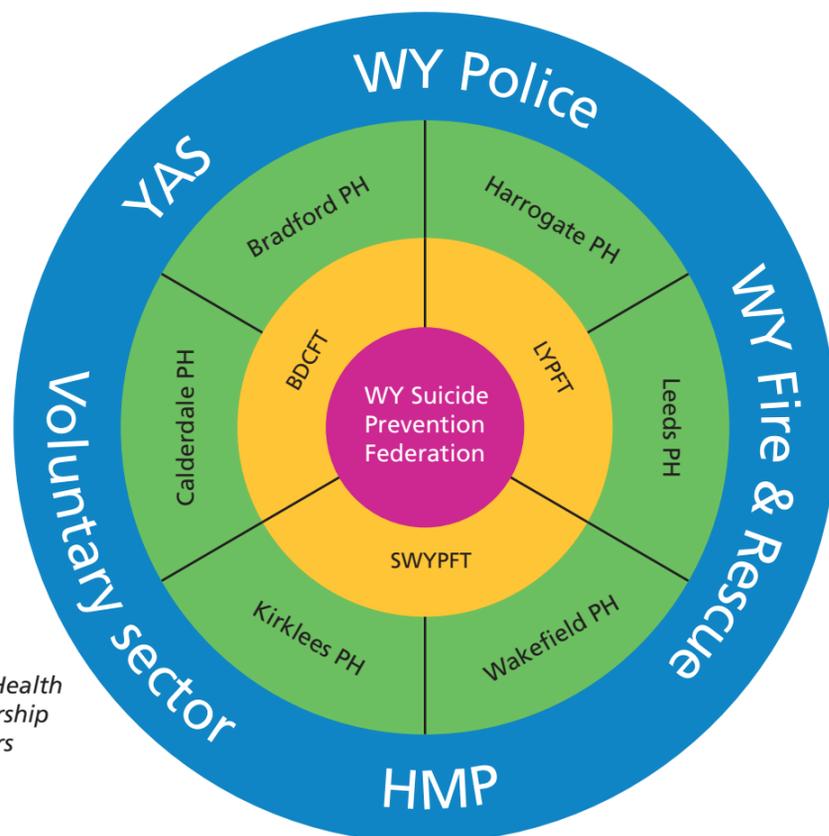


Figure 3 West Yorkshire Health and Care Partnership link with partners

Case for change

A multiagency approach is increasingly important because after many different initiatives and a consistent downward trend between 1991 and 2007, the rate of suicide in England then began to increase (Figure 4 below). A reduction of 10% in the frequency of suicides is a key target of the national *Five Year Forward View For Mental Health* by 2020/21 (NHS England, February 2016).

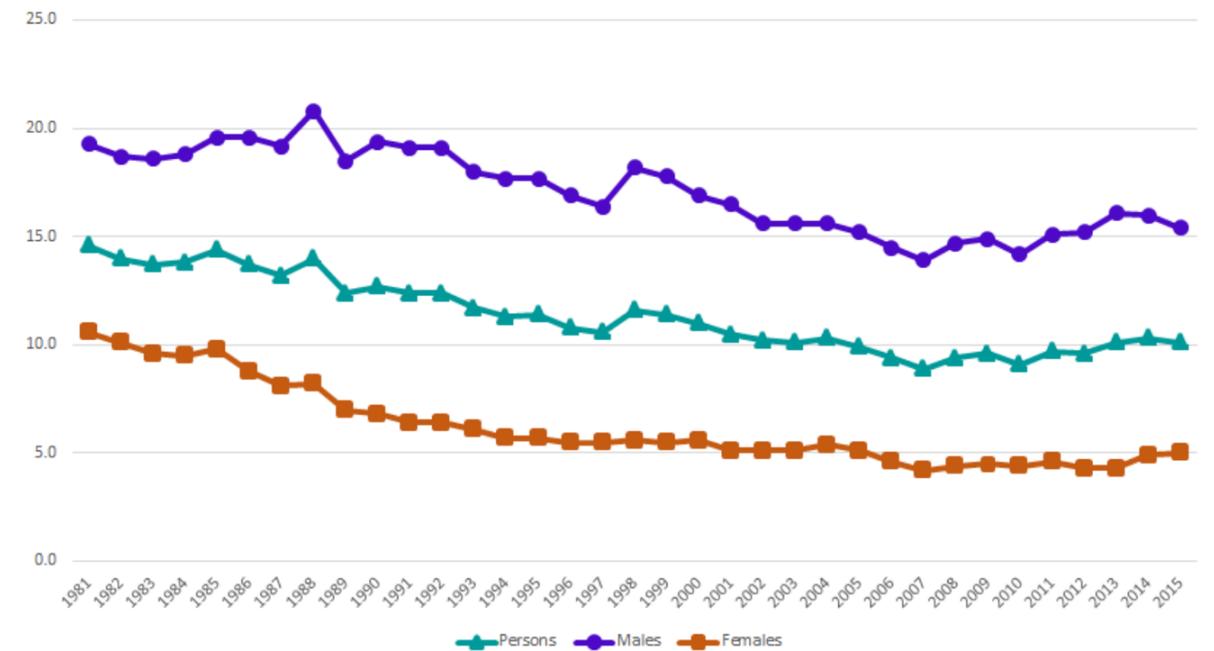


Figure 4 England suicide rates over time

The figures from 2015 showed that out of all the regions in England, Yorkshire and Humber had the highest suicide rate (Figure 5).

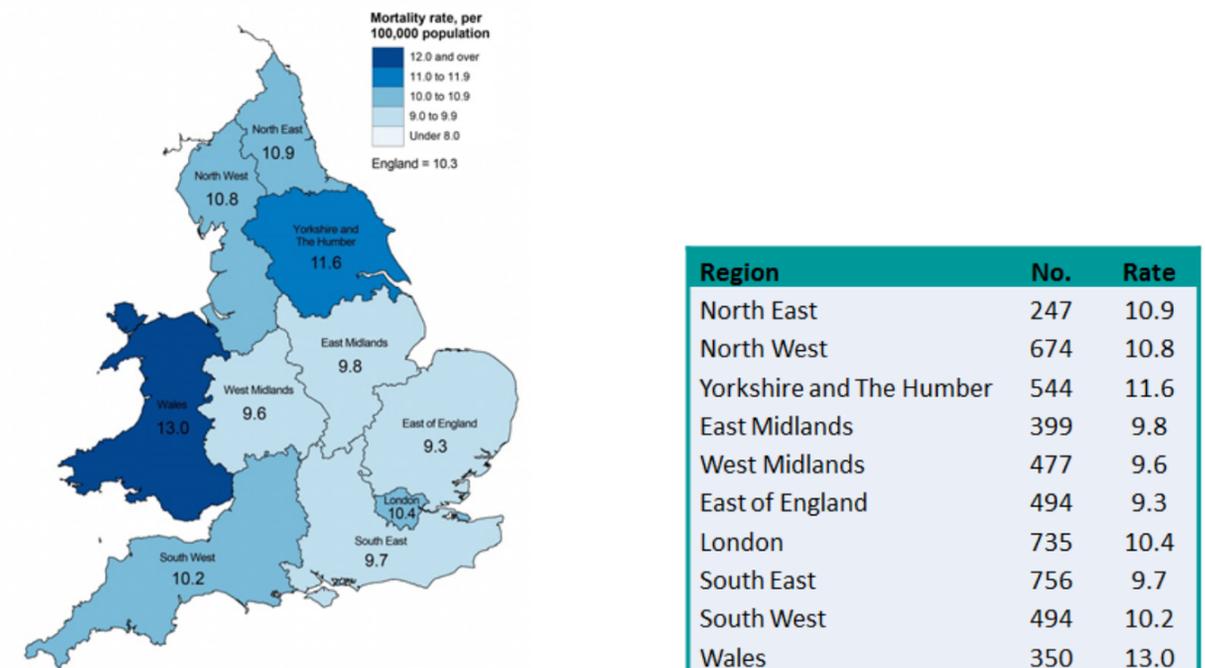


Figure 5 Age standardised suicide rate by regions of England, 2015

The number of suicides in WYHCP steadily increased over time from 188 in 2010 to 241 in 2015 (Table 1). There are a number of characteristics of the WYHCP population, which at least partially explain the higher risk of suicide in the region in 2015 (Office of National Statistics, 2016; 2017). West Yorkshire has almost four times as many people in the most deprived areas compared to the national average, with Bradford having 42% of its population living in the most deprived 20% of the country compared with 25% in Calderdale. There is a positive correlation between deprivation in WYHCP and suicide risk.

	2010	2011	2012	2013	2014	2015
ENGLAND	4,202	4,518	4,513	4,727	4,882	4,820
YORKSHIRE & THE HUMBER	380	464	482	502	451	544
Bradford	45	44	52	58	46	44
Calderdale	21	23	12	28	24	19
Craven	5	4	5	4	5	1
Harrogate	14	14	14	14	12	13
Kirklees	31	34	36	26	37	45
Leeds	51	67	86	62	55	91
Wakefield	21	23	30	26	27	28
Total West Yorkshire HCP	188	209	235	218	206	241

Table 1 Frequency of suicide in England, Yorkshire and Humber and WYHCP, 2010-2015

People in WYHCP generally report lower happiness and more dissatisfaction with life compared to the national average and this is also associated with increased suicide risk. The prevalence of opiate and crack cocaine use in WYHCP is higher per 1000 population than the national average and long-term unemployment in WYHCP is associated with an increased risk of suicide.

In summary, suicide is a significant and long-standing public health issue across WYHCP, and there remains a clear case for change and joint working across agencies to support the development and delivery of this strategy.

Monitoring and evaluating suicide prevention

The Five Year Forward View for Mental Health set the target to reduce the number of people taking their own lives by 10% by 2020/21 (NHS England, July 2016). Age standardised rates per 100,000 population and three-year rolling averages are the key metric to be used to measure achievement of this target. These are generally used for monitoring purposes in preference to single-year rates, in order to produce a smoother and more accurate trend over time (Figure 6).

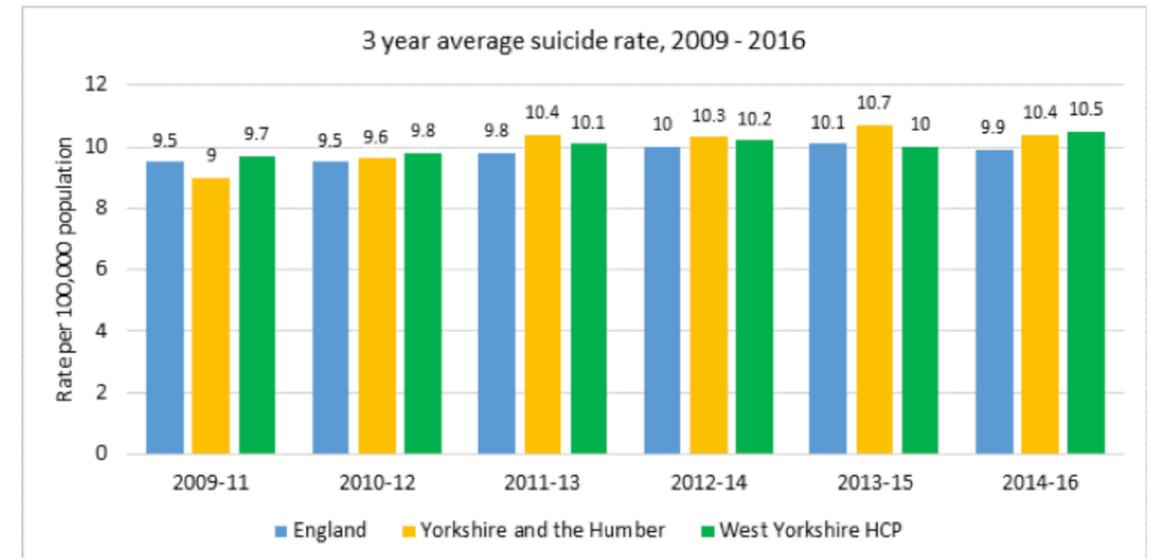


Figure 6 Age standardised rolling three year rates per 100k population

The data in Figure 6 show that WYHCP region rates of suicide are increasing and higher than both the England and Yorkshire and Humber average rates. Within WYHCP the rates for suicide range from 9.2 per 100k population in Bradford to 11.5 in Craven. Suicide is an ongoing issue in WYHCP and it appears to be getting worse from a rate of 9.7 per 100k population for the period 2009-11 to 10.5 in 2014-16, an increase of over 8%.

NHS mental health trusts in West Yorkshire

The link between suicide and mental disorders (in particular, depression, personality disorder and alcohol use disorders) is well established. In addition, experiencing conflict, disaster, violence, abuse, or loss and a sense of isolation are strongly associated with suicidal behaviour. Suicide rates are also high amongst vulnerable groups who experience discrimination, such as refugees and migrants; indigenous peoples; lesbian, gay, bisexual, transgender, intersex persons; and prisoners (World Health Organisation; WHO, 2017).

In 2014, 66 people (35% of all suicides) who had contact with mental health services in WYHCP in the previous 12 months died by suicide. There is a significant correlation between depression and serious mental illness and suicide risk in WYHCP. In addition, although emergency admissions for self-harm are high in WYHCP, this appears to be protective against future completed suicide, as people who access services following self-harm are less likely to die by suicide (Office of National Statistics, 2016).

NHS trusts that provide services for people with mental health and related problems are key to identifying and preventing suicidal behaviour. Suicidal thoughts and plans are very common as reasons for accessing mental health services and it is not surprising that the rates of suicide per 100,000 mental health service users tends to be much higher than the rate for the general population (Table 2).

Mental health services prevent many suicides, but it is difficult to accurately measure how many deaths are actually prevented because we never know who would and who wouldn't have eventually died by suicide had we not intervened. For example, it is of note that in SWYPT in 2016-17, out of 35,617 initial risk assessments, it was identified that 7973 service users had suicidal ideation, plans for suicide or both. In the same time period 28 service users died by suicide (0.35%). Providing access to mental health services for people who require specialist care is a priority for the NHS.

The figures in Table 2 suggest a significant increase in numbers of people who access mental health services but a downward trend in terms of suicide rates between 2011 and 2015. This trend is welcomed. However, suicide rates increased in Bradford and Leeds from 2014-2015.

Year	Bradford & District Community Trust			Leeds & York Partnership Trust			South West Yorkshire Partnership Trust		
	No of service users	No of suicides	Rate per 100k	No of service users	No of suicides	Rate per 100k	No of service users	No of suicides	Rate per 100k
2011	13629	20	146.7	24052	27	112.3	38564	31	80.4
2012	14851	14	94.3	32984	27	78.8	42268	34	80.4
2013	16886	17	100.7	37302	24	64.3	42211	24	56.9
2014	20425	14	68.5	42394	19	44.8	42843	31	70
2015*	20608	22	106.8	43314	26	60	43966	24	54.6

Table 2 Suicide rates per 100,000 mental health service users in West Yorkshire (2011-2015)

The figures are provided by The National Confidential Inquiry into Suicides and Homicides and represent suicide rates of individuals who have been in contact with mental health services in the 12 months prior to suicide. This would exclude individuals who were referred and never seen.

* Suicide figure projected in 2015 as data returns are only 72% complete so likely to change

What do partners across WYHCP currently provide?

As part of the development of this strategy, a survey of 16 partners within WYHCP (see Figure 2) was completed in late 2016. The main themes found were:

- There is a lot of suicide prevention work already ongoing across WYHCP agencies.
- Very few organisations had a suicide prevention strategy.
- Variability across health care providers in terms of:
 - » use of approaches to assess risk;
 - » training provided to staff;
 - » clinical pathway for suicide;
 - » methods of care planning, and
 - » interventions offered.

- Incompatible IT systems across partners.
- Lack of data sharing amongst partners.
- A willingness and commitment to collaborate across WYHCP.

Despite the above inconsistencies and variations in practice, there was also clear evidence from the survey of a strong knowledge and skills base in suicide prevention in WYHCP, and many innovations in this area.

Evidence to support suicide prevention

In addition to the survey of partners, a review of relevant and recent literature and systematic reviews on suicide prevention was undertaken. An earlier systematic review by Mann and colleagues (2005) found education in depression recognition and treatment helped prevent suicide. The review also found evidence that public educational campaigns based around recognising depression and decreasing stigma of mental health and suicide helped reduce suicide. Other factors that helped reduce suicidal behaviours were restricting access to means of suicide and direct cognitive therapy, which was found to halve suicide re-attempt rates when offered as an intervention.

A systematic review undertaken by Krysinska and colleagues (2008) found that on in-patient areas, suicide and self-harming behaviors were reduced with anti-depressant medication, while those with schizophrenia or schizoaffective disorders could be helped by treating depressive symptoms. Four studies of non-pharmaceutical interventions showed telephone counselling, cognitive behavioral therapy, systemic behaviour family therapy and non-directive support were successful in reducing suicidal ideation.

Using a different approach, Pirkis and colleagues (2015) conducted an international review focused on the locations of suicide, methods used and preventative measures implemented. Analysis of data from 18 studies of various hotspots, including locations in England, the USA and Hong Kong, found that the number of people taking their own life dropped from 5.8 each year on average (863 suicides over 150 study years) before interventions were introduced to 2.4 afterwards (211 suicides over 88 study years). Interventions to encourage help-seeking (e.g. placement of signs or crisis telephones) reduced the number of deaths by half when used in combination with restricting access to means.

Those in contact with the criminal justice systems are known to have a higher suicide rate than the general population, and in 2016 those in prison were up to 10 times more likely to die by suicide. Pratt and colleagues (2009) focussed on recently released prisoners. They found they had a marked increase in suicide rates compared to the general population. Males were eight times higher risk and females 36 times higher risk within the first year of release from prison compared to the general population.

A recent review by Turecki and Brent (2014), looked at wider issues relating to suicidal behaviour and its prevalence and prevention. Population risk factors have been shown to increase suicide rates and these include rapid changes to social structure, economic turmoil and social isolation. There are environmental factors that impact upon suicide including negative media coverage, access to means of suicide and poor access to mental health care.

The National Confidential Inquiry into Suicides and Homicides by People with Mental Illness (NCISH) 2016, found an alarming increase in suicides in individuals in mental health crisis teams particularly following a recent discharge from an in-patient mental health area. They ascribe this increase to a lack of service resources and say it could be improved by earlier access to the right support and follow up on discharge.

A more recent local public health audit found a number of factors associated with an increased risk of suicide. These include living alone, interpersonal stressors, financial difficulties, substance misuse, mental health problems and physical health issues.

Individuals bereaved by suicide are much more likely to suffer from severe depression or post-traumatic stress disorder (PTSD) or even adopt suicidal behaviours as highlighted by Young and colleagues (2012). It has also been shown by Pitman and colleagues (2015) that those bereaved by suicide have a significantly increased risk of suicidal behaviours and suicide attempts. The government document *Help is at Hand* (2010) is very clear that practical measures need to be in place to support those bereaved by suicide.

Dr Ed Coffey of the Henry Ford Healthcare system in Detroit formulated a 'zero suicides' philosophy in treating those in their perfect depression management program (Coffey and Coffey, 2016). Of the many thousands of people treated, no suicides were recorded over a two-year period. This system has stimulated lots of interest across the world and two UK NHS trusts have adopted the philosophy and techniques. Detailed risk assessment, care plans, evidence-based care and good engagement are imperative for success.

In summary, the research findings suggest a number of interventions that have shown promise in preventing suicide. These can be broadly categorised as restricting access to means, providing evidence-based bio-psychosocial interventions for self-harming behaviour; improving access to the help required and managing despair and depression effectively. This provides a useful framework for suicide prevention initiatives; illustrated as a READ approach (Figure 7) that should be relevant for all settings and circumstances.

Our Philosophy

For any strategy to be a success, it requires an underlying positive culture strengthened by a shared philosophy. The 'zero suicide' philosophy underpins this strategy and is based on two important assumptions;

1. **Risk is proportionate to the level of intervention** and support received by the person at risk, so if the risk is identified and the care, treatment and engagement provided is high quality, timely and appropriate, and matched to the individual's needs, then the risk of suicide is lower.
2. **Suicide is not a terminal prognosis or inevitable** for any individual and can be prevented. It is not a foregone conclusion for anybody and there is always hope that things will improve.

Rates of suicide are usually reported as a frequency or rates per 100,000 population, and although suicide will not be eradicated completely across the whole population, zero suicide for individuals is **always** possible. The aspiration for each person therefore is to avoid suicidal behaviour and this can be achieved if the right care and support are provided at the right time, and agencies can promote this further by setting ambitious targets for suicide reduction.

Priorities for West Yorkshire

From the survey of partner agencies, regular meetings between partners and the review of the research evidence, a number of priorities for suicide prevention were identified by partner agencies.

Sharing training and learning resources was identified as something that would allow staff to benefit from a shared resource that is delivered in a consistent and reliable way across the WYHCP .

Each partner needs to be able to access key data quickly and efficiently in order for the whole WYHCP to benefit from expertise and resources. There is usually a delay in acquiring information about suicides so a 'real time' system will allow useful data to be instantly available. The data can be shared across agencies and will improve planning and provision of interventions. A mortality review framework is under development for use across the WYHCP NHS trusts.

It has been identified from the regional public health suicide audits and from the research literature that there are known high risks predisposing individuals to suicidal behaviours. A high risk decision support tool for non-mental health services has been drafted and will be refined and piloted. This will highlight high-risk individuals and sign post them to specific interventions.

Services to support those bereaved by suicide have not yet received the recognition and resources they warrant and the WYHCP will seek to invest into these services and improve interventions for those bereaved by suicide.

West Yorkshire Suicide Prevention Strategy READ structure



Figure 7
READ structure for suicide prevention

New NICE guidance on Preventing suicide in community and custodial settings is currently in development [GID-PHG95] Expected publication date: 18 September 2018, <https://www.nice.org.uk/guidance/indevelopment/gid-phg95>. This strategy and those who are working to implement it will need to align future plans with this guidance once published

Different partners within the WYHCP have their own priorities and objectives. The **Public Health Departments** in WYHCP already have extensive plans in place to reduce suicide, largely based on the six key areas of the national strategy; *Preventing suicide in England: A cross-government outcomes strategy to save lives (2012)* and recent national guidance on developing local plans (Public Health England, 2016). In Leeds they have a range of suicide prevention activities and resources delivering a range of local services and interventions based on their recent audit of suicides, <http://www.leeds.gov.uk/phrc/Pages/Suicide-Prevention.aspx>. Likewise, in Wakefield <http://www.wakefield.gov.uk/mentalhealth> a number of actions are already in place. In Kirklees, there is a multi-disciplinary action suicide prevention planning group developing many initiatives including 'talking saves lives,' to raise awareness of how we all have a part to play in looking out for people around us; scoping the pathway for a young person who self-harms and developing a crisis card for front line workers who come into contact with the public <http://www.kirklees.gov.uk/healthwellbeing>. There is a comprehensive 3-year suicide prevention plan in Calderdale based on findings from their recent audit of suicides and the national strategy <https://www.calderdale.gov.uk/v2/council/council-departments/directorates-and-service-areas/public-health> and similar work is underway in Bradford, where award winning first response crisis services have been established and a mental health strategy is in place <https://www.bradford.gov.uk/adult-social-care/care-and-support-from-us>

Public health services are aiming for access to real time information when there is a suspected suicide. They also believe that representation at local meetings from operational managers who are aware of whole system issues would help to reflect locally what is happening or what is being worked on to overcome issues around suicide prevention. A strong link with the WYHCP strategy and its output into their local action plans would also compliment work and prevent duplication. Active engagement with the general population to raise awareness is very important and helps to identify high risk individuals and be able to sign post them to appropriate services for specific interventions. Finally, public health would like closer collaborative with frontline services to raise awareness and share expertise.

West Yorkshire Fire and Rescue Service launched its new Safer Communities Strategy in April 2017. The focus on home visits will target vulnerability and then deliver a wider assessment in comparison to the traditional focus on fire safety. The key elements will feature smoking cessation, social isolation, cold homes in the winter, crime prevention, falls and frailty. Within the assessments, crews are trained to recognise signs of safeguarding concerns and have processes in place to register concerns through to the local authorities. In addition, they are piloting the potential for staff to have some simple conversations around mental health and then, if required, be able to signpost any concerns that have been identified in the individuals through agreed referral pathways.

Independent research by the charity Mind shows that members of the emergency services are even more at risk of experiencing a mental health problem than the general population, but are less likely to seek support. **Yorkshire Ambulance Service** is prioritising the mental wellbeing of its staff as part of its ongoing commitment to employee wellbeing. In addition, YAS has mental health nurses within the Emergency Operations Centre who act as a specialist resource for frontline staff when dealing with patients in mental health crisis. The WYHCP also presents an opportunity to develop and utilise shared pathways for those at risk of suicide as well as specific suicide bereavement services. It is hoped that YAS data will inform

public health intelligence on this subject through its work with PHE's Knowledge and Intelligence service around self-harm.

Mental health and protecting the vulnerable are recognised as priorities within the **West Yorkshire Police** and Crime Plan. West Yorkshire Police have a key role to play in providing a first response to those in crisis suffering with mental ill health and also have a responsibility to identify and support those who come to our attention on a regular basis. WYP's approach to problem solving and early help recognises that identifying and responding earlier to problems needs to be the focus rather than waiting for a crisis situation. West Yorkshire Police understand that collaboration with partners, especially those working in health, social care and other specialist support agencies is key to improving how we help people who are vulnerable and in need. At both force and district level there is a good level of partnership working through the Police and Crime Commissioners Mental Health Forum, where partners work together with WYP to continuously improve services. West Yorkshire Police also have access to mental health professionals in the district control rooms and are currently working towards sharing real time surveillance data with public health to help them respond more quickly and effectively to emerging trends. West Yorkshire Police are committed to working in partnership through the West Yorkshire Suicide Prevention Advisory Network (SPAN) in order to reduce and prevent suicidal behaviours in the county.

Her Majesty's Prison Service has some very specific issues with suicidal behaviours in those who are incarcerated. The Ministry of Justice report that there were 37,784 incidents of self-harm and 116 suicides across the prison estate in 2016. The rate of suicide for prisons can be up to 10 times that of the general population with outdated prisons, severe overcrowding and dwindling budgets compounding the issue, and post-release the risk of suicide is also very high. At times, prison staff can feel professionally isolated and would benefit from close liaison and joint working with health partners. Expertise could also be shared across the WYHCP with all partners benefitting from the each other's speciality area.

Strategic objectives

In time, as the WYHCP arrangements mature and the suicide strategy action plan is implemented, it is anticipated that the work of all the partner agencies will merge in this area and a number of objectives based on the above priorities have already been identified. These are based on the national strategy, scoping of existing services offered by partner agencies, work in progress and a review of the evidence-base for effective suicide prevention.

The 12 objectives of this strategy for 2017-19 are:

To clarify where we are, where we want to be, how we will get there and how we will know when we get there, we will,

1. Launch WY suicide prevention strategy and disseminate widely

To enable timely and effective delivery of the strategy, we will,

2. Agree a memorandum of understanding across WYHCP Federation of NHS Trusts (FONT)
3. Relaunch multiagency Suicide Prevention Advisory Network (SPAN) across WYHCP agencies

4. Explore opportunities to engage experts by experience and carers in delivering the strategy
5. Conduct a learning needs analysis across partner agencies and share training and learning resources
6. Explore the links and barriers to being able to share data between the NHS providers, CCGs, local authorities, public health and other partners

To embed the zero suicide philosophy and the READ approach, we will,

7. Develop a “real time” system for identifying apparent suicides across WYHCP
8. Refine our mortality review system for apparent suicides in line with national guidance
9. Construct a ‘high risk’ decision support tool for primary care and non-mental health services
10. Commission an evidence-based suicide prevention app
11. Scope and improve suicide bereavement services across WYHCP
12. Work towards an evidence-based shared pathway for children, young people and adults at risk of self-harm and suicide based around critical time interventions

Outcome measures

By following the zero suicide philosophy, establishing a single suicide prevention pathway and closer collaboration with partners via the FONT and SPAN, it is envisaged current interventions will become safer and more effective.

These improvements in the structures and processes along with real time monitoring and shared data will make teams and services more effective at responding to the needs of high risk individuals and communities, and therefore reduce the number of suicides and associated human and financial costs.

By 2020/21, the Five Year Forward View for Mental Health set the ambition that the number of people taking their own lives will be reduced by 10% nationally. In addition, the WYHCP has an ambitious target of a 75% reduction in the number of suicides in specifically targeted areas (e.g. mental health services, custody suites, suicide hotspots) by the end of 2022.

Progress in achieving these targets will be monitored and evaluated by using the following performance indicators across WYHCP and by local authority area:

- Frequency of suicides per year across WYHCP
- Suicide age-standardised death rate per 100,000 population per year
- Suicide age-standardised death rate per 100,000 population, 3-year rolling average
- Suicide rate per 100,000 users of mental health services per year
- Suicide rate per 100,000 users of mental health services per year, 3-year rolling average

The FONT will develop the action plan, oversee delivery of the objectives of the strategy and monitor the trajectory against the performance indicators and achievement of targets. The structural and process outcomes will be monitored by the FONT and SPAN. An annual review and refresh of the action plan will evaluate progress, determine priorities and identify action for the following year.

References

- Coffey, M.J. and Coffey C.E. (2016). How we dramatically reduced suicides, *New England Journal of Medicine Catalyst*. <http://catalyst.nejm.org/dramatically-reduced-suicide/>
- Comer, K. (2016). Audit of suicides in Calderdale 2012-2014. Calderdale Metropolitan Borough Council.
- Department of Health (2012). Preventing suicide in England: A cross-government outcomes strategy to save lives.
- Department of Health (2017). Preventing Suicides in England. Third progress report of the cross-government outcomes strategy to save lives.
- Everitt, M., Eaton, V., Ward, C. and Sehmbi, V. (2016). Audit of suicides and undetermined deaths in Leeds 2011-2013. Leeds City Council.
- Fraise J. (2015). An analysis of suicides and other undetermined deaths in the Kirklees district: Audit period January 2011 – December 2013. Kirklees Metropolitan Borough Council.
- Fraise J. (2015). An analysis of suicides and other undetermined deaths in the Wakefield district: Audit period January 2011 – December 2013. Wakefield Metropolitan District Council.
- Krysinska, K., Leitner, M., Barr, W. and Hobby L. (2008). Effectiveness of interventions to prevent suicide and suicidal behaviour: a systematic review. *Scottish Government Social Research*.
- Leigh-Hunt, N., Eaton, V., Ward, C., Hollingworth, L., Womack J. (2012). Audit of suicides & undetermined deaths in Leeds 2008-2010. Airedale, Bradford & Leeds NHS and Leeds City Council.
- Mann J., Apter, A., Bertolote, J., Beautrais, A, Currier, D., et al. (2005). Suicide prevention strategies: a systematic review. *Journal of the American Medical Association*. 294(16):2064-74.
- NHS England (2010). Help is at Hand.
- NHS England (2016). Five Year Forward View for Mental Health. February
- NHS England (2016). Implementing the Five Year Forward View for Mental Health. July
- Office of National Statistics (2016). Suicides in England and Wales by local authority, 2002-2015.
- Office of National Statistics (2017). Suicides in Great Britain: 2016 registrations.
- Pitman, A.L., Osborn D., Rantell, K. and King M.B. (2015). Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults, *BMJ Open*. doi: 10.1136/bmjopen-2015-009948.
- Pirkis, J., Too, L.S. and Cheung, Y.T.D. (2015). Interventions to reduce suicides at suicide hotspots: a systematic review and meta-analysis, *The Lancet*. 2(11):994–1001.
- Pratt, D, Appleby, L., Piper, M., Webb, R. and Shaw, J. (2009). Suicide in recently released prisoners: a case-control study, *Psychological Medicine*. Doi: 10.1017/S0033291709991048.
- Public Health England (2016). Local suicide prevention planning: A practice resource
- Robinson J, Spittal MJ, Turecki, G, & Brent DA. (2016). Suicide and suicidal behaviour. *The Lancet*. 387: 1227–39
- University of Manchester. (2016). Making Mental Health Care Safer: Annual report and 20-year review. National

Confidential Enquiry into Suicides and Homicide by People with Mental Illness.

World Health Organisation (2017). Preventing Suicides: A Community Engagement Toolkit. Pilot Version 1.0.

Young, I.T., Iglewicz, A., Glorioso, D., Lanouette, N., Seay, K., Ilapakurti, M. and Zisook, S. (2012). Suicide bereavement and complicated grief. *Dialogues Clinical Neurosciences*. Jun; 14(2): 177–186.

Authors

Dr Michael Doyle, South West Yorkshire Partnership NHS Foundation Trust and University of Manchester
Richard Watterston, South West Yorkshire Partnership NHS Foundation Trust

Acknowledgments

All the agencies across West Yorkshire and the WYHCP Mental Health Programme Suicide Prevention Task And Finish Group

Mike Garnham, South West Yorkshire Partnership NHS Foundation Trust

Dr Mike Ventress, South West Yorkshire Partnership NHS Foundation Trust

Dr Isabelle Hunt, National Confidential Inquiry into Suicides & Homicides, University of Manchester

Jessica Raphael, National Confidential Inquiry into Suicides & Homicides, University of Manchester

