HEALTH AND CARE OVERVIEW AND SCRUTINY COMMITTEE
MEETING
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SUICIDE AND SELF-HARM IN GLOUCESTERSHIRE

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1. Background to Suicide and Self Harm

1.1 Definition
Suicide can be defined as intentionally ending one’s life. Such a death is one in which the coroner has decided that there is clear evidence that the injury was self-inflicted and the deceased intended to take their own life. Open verdicts or undetermined injury are those where there may be doubt about the deceased’s intentions. For the purposes of officially measuring overall suicide rates in England however, suicides and open verdicts are combined as there is evidence to suggest that most open verdicts are in fact suicides

Self-harm is when somebody intentionally damages or injures their body. It is a way of coping with or expressing overwhelming emotional distress. Sometimes when people self-harm they intend to die but often the intention is more to punish themselves, express their distress or relieve unbearable tension. Self-harm can also be a cry for help. The term therefore covers a wide range of behaviours and it involves different degrees of risk to life and suicidal intent. Self-harm is however not generally used to refer to harm arising from overeating, body piercing, body tattooing, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself.

1.2 Addressing the Issue of Suicide
Suicide prevention remains both a national and local Public Health priority, with Gloucestershire’s Health and Wellbeing Strategy prioritising Mental Health, based on this. Though it is said to be a relatively rare event as it represented just 0.92% of deaths in all ages in England between 2008 and 2010 (1.13% in Gloucestershire), suicide is however recognised as the third largest contributor to premature deaths (after heart disease and cancer). It also contributes to potential years of life lost, as well as causing significant distress to bereaved families and others affected by it.

The causes of suicide are varied and complex. There is no single factor that can prevent suicide as the likelihood of a person taking their own life depends on several factors:
- Gender – males are three times as likely to take their own life as females
- Age – people aged 40–49 now have the highest suicide rate nationally
- Mental illness
- Physically disabling or painful illnesses including chronic pain
- Alcohol and drug misuse.

Stressful life events also play a part:
- The loss of a job
- Imprisonment
- Debt
- Living alone, becoming socially excluded or isolated

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1 [http://www.gloucestershire.gov.uk/CHandler ashx?id=53311&p=0](http://www.gloucestershire.gov.uk/CHandler ashx?id=53311&p=0)
2 Source: NHS Information Centre, Gloucestershire PHIU
3 Deaths that occur at too young an age
4 An estimate of the average years a person would have lived if he or she had not died prematurely
• **Bereavement**
• **Family breakdown** and conflict including divorce and family mental health problems.

Even though having a mental illness increases the risk of suicide, of people in the UK who die by suicide, only about 25% would have been in contact with mental health services in the 12 months before the suicide. Though no one single organisation is able to positively influence the various factors that determine the likelihood of an individual taking their live, there are however many things we can do to enable this in our communities, within families and outside hospital and care settings, to help those who think the only option is to end their own life. Every suicide is a tragedy for the individual and their family and this highlights the importance of ensuring people of all ages can access the help they need, when they need it.

Following the publication of the National Suicide Prevention Strategy in 2002\(^5\), suicide rates in England fell to their lowest in 2007. Since then however, there have been rises in most English regions as well as most Local Authorities in the South West including Gloucestershire. Concerns have been expressed at the possible link with the recession, as there is evidence to show that past periods of high unemployment or severe economic problems around the world (e.g. in Australia, Russia, Southeast Asia) have had an adverse effect on the mental health of the population and have been associated with higher rates of suicide.

The evidence shows that the economic downturns of the 1990s tended to have the greatest effects on men of working age. A recent study in England\(^6\) found a significant rise in suicide during the 2008-10 recession, while a study across 54 countries (including the UK) published September 2013\(^7\) which looked at differential effects of the economic crisis, found important differences in men and women. This study which took place in 27 European and 18 American countries found that the increases in suicide rates were mainly in men. Rises in national suicide rates in 2009 seemed to have been associated with the magnitude of increases in unemployment, particularly for men and in countries with low unemployment levels before the crisis. The authors surmised that the rise in the number of suicides was only a small part of the emotional distress caused by the economic downturn, as they assessed that non-fatal suicide attempts could be 40 times more common than completed suicides, with about 10 people experiencing suicidal thoughts for every suicide attempt.

In an effort to build on the successes of the 2002 strategy in the face of a rising suicide rate, Government published a new suicide strategy for England in 2012\(^8\), which is outcome-focused and has the twin objectives of:

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

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It gives greater prominence to measures to support families, as well as preventive steps for different population and age groups.

A revised Gloucestershire Suicide Prevention Strategy was approved by the Gloucestershire Health and Well-being Partnership on May 4th 2011, following extensive consultation with stakeholders including Gloucestershire Local Involvement Network (LINk), who provided helpful feedback, especially with regards to the development of the supporting action plan. LINk published their review of services for suicide and self-harm prevention in two separate reports and many of their recommendations are included in our local action plan.

There is now in place a Gloucestershire Suicide Prevention Partnership Forum (GSPPF) which brings together key stakeholders in the county to develop and deliver a countywide suicide prevention strategy and action plan. The Forum has reviewed the action plan in line with the new National Strategy, as well as the South West Suicide and Self Harm report\(^9\), and is overseeing the further development of our local rolling action plan. Their activities will feed into the countywide Mental Health Strategy, the Joint Health and Wellbeing Strategy and the implementation plans supporting both. The terms of reference and membership of the forum are provided in Appendix 1.

2. Epidemiology of suicide and self harm

2.1 Suicide (All Ages)
Determining the precise number of suicides in any one year is difficult. This is not only because a death cannot be considered to be suicide until after the Coroner has ruled that the individual intended to take his or her own life, but also because the outcomes of inquests are often not available in the year of death. This therefore has implications for the provision of timely data on suicide. Gloucestershire has however been conducting regular population-based suicide audits to understand the local patterns of suicide and self-harm, as well as to inform preventive action. Such an audit is currently underway and some of the results of the analysis have informed this report.

Annual suicide rates in Gloucestershire have fluctuated greatly over the past two decades or so, but local rises and falls have tended to generally follow regional and national trends. At various points, our rates have been below and above the England average (Figure 1). Due to the tendency for rates based on relatively small figures (such as Gloucestershire’s average of about sixty annually) to fluctuate widely from year to year, it is preferable to explore three-year moving averages in order to have a better understanding of local trends.

Figure 1 shows the recent (from 2007/9) increase in suicide rates, which is also apparent in the regional and national picture. This increase is mainly driven by rates in males which are generally three to four times higher than rates in females (in line with the national picture).

The most recently available pooled data (2010 to 2012) shows that the suicide rate (persons) over this period in Gloucestershire though not significantly different\(^\text{10}\) from that of the South West, is however significantly higher than the national rate. Rates across the districts are also not significantly different when they are compared with one another, whilst the rates in Gloucester and Cheltenham were significantly higher than the national rate (Figure 2). These high district rates are also mainly driven by suicides in males.

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\(^{10}\) Refers to statistical significance. A result is called "statistically significant" if it is unlikely to have occurred by chance.
2.1.1 Pattern of Suicides in Gloucestershire in All Ages

In order to get a good picture of possible patterns of suicides in the county to inform preventive activities, data over a period of four years (2009-2012) were combined and analysed. Figure 3 shows high numbers of deaths in the working age groups with the highest in the 40 – 44 year age band, in line with the national picture. Of the 241 deaths recorded over this period, there were nine deaths in young people aged 15 to 19 years (i.e. 3.7%), whilst there were 41 deaths (17%) in people aged over 65 years.

The overwhelming majority of deaths (79.6%) were in males, being four times more than deaths in females. A third left a suicide note.
Of the 224 cases with marital information available, almost 40% of the deaths were in people who were single, with 26% married and 20% divorced or separated.

In terms of employment status, this was unknown in 17.5% of deaths. Amongst the others however, 21% were unemployed, 26% were working full time, while 16% were retired. Also, almost 10% were long term sick. This distribution may however be different if everyone’s employment status were available for analysis.

Figure 4 shows that about half of methods of deaths are by strangulation. Other common methods include self-poisoning, jumping from a height and jumping before a train. New methods of suicide are being seen e.g. asphyxiation using Helium and Argon Gas, which need to be monitored.

![Figure 4: Suicide Methods in Gloucestershire, 2009-2012](image)

Source: GCC Strategic Needs and Analysis Team

NB: Argon Gas – 0.4%; Helium Gas – 0.4%; Not known – 0.4%

The national document which provides guidance on what action to take at suicide hotspots defines such a place as ‘.... a specific, usually public, site which is frequently used as a location for suicide and which provides either means or opportunity for suicide (e.g. a particular bridge from which individuals frequently jump to their deaths)’. More than one suicide at a particular site in any period for which there are records, should give cause for concern.

Suicides that occurred between 2008 and 2010 (193 deaths) were analysed for any potential hotspots. This analysis showed that about 64% of deaths occurred at home. A further analysis of suicides in 2011 and 2012 (140 deaths) showed majority of deaths (60%)

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11 Commonly used for inflating balloons. It is also used in welding and other commercial and scientific processes
12 A gas mostly used in the welding and other high temperature industrial processes
continue to occur at home. The analysis showed that areas which could be considered as hotspots in Gloucestershire include rivers/canals, multi-storey car parks, railway tracks/stations

In terms of mental health history, two thirds (66.3%) did not have any known previous contact with mental health services; while about 16% had one or more previous contact involving hospital mental health inpatient services and a similar proportion (16.3%) had one or more contacts with community mental health services – the great majority of those in contact with community mental health services (87.2%) not being subject to the Care Programme Approach (CPA)\(^{14}\), suggesting such people were not assessed to be in need extensive support prior to their death.

Of the 31% of people who had a lifetime history of self-harm, 20% was only within the 12 months prior to death, while 7% was only prior to the 12 months before death.

About 74% had no previous suicide attempt while about 12% had attempted suicide once, 2.8% twice and 6.7% thrice before. About 50% had suicidal thoughts six months before their death.

The Coroner often makes comments on what in their opinion were contributory factors to the suicide. Though such comments were made in only around a quarter (26.6%) of cases, Table 1 is however instructive in terms of what these issues were. 72% of these were not mental health related, but social, financial, physical health and lifestyle issues.

\(^{14}\) A particular way of assessing, planning and reviewing a person’s mental health care needs. This is used for people receiving secondary mental health services where further support is needed with engagement, coordination and risk-management. This can include people who:

- are diagnosed as having a severe mental disorder
- are at risk of suicide, self harm, or harm to others
- tend to neglect themselves and don't take treatment regularly
- are vulnerable. This could be for various reasons, such as physical or emotional abuse, financial difficulties because of their mental illness or cognitive impairment
- have misused drugs or alcohol
- have learning disabilities
- rely significantly on the support of a carer, or have their own caring responsibilities
- have recently been detained under the Mental Health Act
- have parenting responsibilities
- have a history of violence or self-harm
### Table 1: Contributory factors to Suicide according to Coroner

<table>
<thead>
<tr>
<th>Issue</th>
<th>No of cases in which this was a factor</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health problems including depression, anxiety and bi polar disorder</td>
<td>18</td>
<td>28</td>
</tr>
<tr>
<td>Debt or financial problems, including repossession of house</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Physical health problems including terminal illness</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>In trouble with police or facing court appearance</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Employment or housing issues</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Marital or relationship difficulties</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Alcohol either at time of death or as an ongoing problem</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Grief/death of loved one</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Mistakenly believing oneself to be terminally ill</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Self harm</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>64</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Source: GCC Strategic Needs and Analysis Team

GCC’s Strategic Needs and Analysis Team have used the ACORN Tool\(^{15}\) to analyse the post-code data available for people who died by suicide over this period to segment them and try and build a picture of the lifestyle, behaviour and attitudes of ‘consumers’ in these postcode areas. We will be exploring how we might use this to target messages and interventions.

### 2.2 Suicides in Young People

The numbers of suicides in children and young people aged up to 19 years in Gloucestershire from 1994 to 2007 have generally been a maximum of two or three annually except once when we had 6 deaths.

More recent data obtained from the Child Death Review Process which looks at individual deaths in children and young people up to the age of 18 years also show that suspected suicides have been about two annually at the most since 2008 until we had four deaths in 2012.

Following these four deaths, the subsequent meeting of the Gloucestershire Children’s Safeguarding Executive on November 22, 2012 recommended that further work around prevention should be coordinated within the existing set up of the county’s suicide prevention strategy and action plan. The GSPPF subsequently constituted a Children and Young People Task and Finish (CYP T&F) Group, whose terms of reference are attached in Appendix 2. The group has been meeting regularly and providing reports to both the Children’s Safeguarding Board and the GSPPF.

We had three deaths in 2013 (i.e. up to November 7th, 2013). Initial information from the Child Death Review Process on the most recent seven deaths (2012 and 2013) show that six of them (about 87%) have been in males with ages at death ranging from 12+ to 17 years.

\(^{15}\) [http://acorn.caci.co.uk/what-is-acorn](http://acorn.caci.co.uk/what-is-acorn)
years. Though three of the seven were known to mental health services, the Child Death Review Process did not however think that mental illness was a factor in these specific deaths. **Family discord/relationship problems and bullying** were thought to be contributory factors in four out of the seven (57%) deaths.

Because these numbers are very small with potential of misleading inferences, we can learn a little bit more from the Child Death Overview Panels of Local Safeguarding Children Boards in the NHS South West Region who have analysed the data available to them on suicide in young people in the region from January 2008 to January 2013. 72% of these deaths occurred in the home with 84% by hanging/strangulation.

Based on 25 case histories (which is also a small sample), their findings around apparently significant factors include the following:

- Families (parents/siblings) affected by mental health/emotional health problems (including substance misuse)
- Families experiencing unemployment/financial distress and/or debt
- Relationship difficulties between parents and parenting problems
- Domestic abuse
- Previous or current child protection concerns
- Birth father not playing a role
- History of being bullied
- Evidence for low self-worth
- Relationship difficulties
- Previous threat of self-harm or suicidal ideation
- Previous self-harm
- Being known to police/courts/social care
- Internet searches for suicide methods
- Some discussion within their peer group about suicide
- Triggering event – family row, worsening of relationship difficulties

Following the four deaths in 2012, the CYP T&F Group started monitoring the ‘near misses’[^16]. There have been 15 incidents since November 2012– seven **males** and eight **females**. 13 of the 15 incidents (about 87%) have involved **hanging/strangulation** with different items, while the remaining two incidents involved jumping from a high place. About a third of the young people were aged under 15 years.

Only in six cases (40%) were the young people either in contact with/have used the 2Gether NHS Foundation Trust Children and Young Peoples Service or known to have mental health problems. Other notable factors in these cases included child protection concerns, family discord, suicide in sibling and previous overdose/self-harm admission.

### 2.3 Self-harm (All Ages)

Self-harm is a common and often hidden problem. Accessible data on this are admission figures which though representing just a tip of the ice-berg (as many people who self harm do not attend hospital), nonetheless provides useful information.

[^16]: Attempted suicides
It is estimated that 3-4% of those admitted for self-harm will die by suicide within 10 years\textsuperscript{17} with people who self-harm repeatedly being at a high and persistent risk of suicide\textsuperscript{18,19}. The rate of self-harm is higher among women and girls than among men and boys, although completed suicide is more prevalent among men and boys. Though people from all ages and social class can harm themselves, there is a higher incidence of self-harm among prisoners, asylum seekers, veterans from the armed forces, people bereaved by suicide, some cultural minority groups and people from sexual minorities.

The incidence of self-harm has risen in the UK over the past 20 years with the number of admissions (and patients admitted) for self-harm having increased in all English regions. The South West Public Health Observatory detailed the comparative trends in rates from 2001/2 to 2008/9\textsuperscript{20}. The highest rates were in the North East with the South West generally in the middle of the pack.

Official national statistics published in October 2013 showed that a significant number of acute hospital cases among young people have resulted from self-harm with admissions for this being particularly high among teenage girls\textsuperscript{21}.

### 2.3.1 Pattern of Self-harm in Gloucestershire (All Ages)

Data released by Public Health England in September 2013 showed that hospital stays for self-harm in Gloucestershire in 2011/12 were significantly worse than the England average. Within the districts, significant rates were in Gloucester, Cheltenham, and Stroud, while the rates in the Cotswold and Forest of Dean were better than national average\textsuperscript{22}. Locally available admission figures show that Gloucestershire has seen a sustained increased in self-harm admissions for both genders since 2005 (Figure 5).

**Figure 5: Self-harm admissions in Gloucestershire by Gender, 2005 - 2010**

Source: Gloucestershire Public Health Intelligence Unit


\textsuperscript{20} South West Public Health Observatory (2011). Suicide and Self Harm in the South West. September 2011

\textsuperscript{21} \url{http://www.hscic.gov.uk/article/3579/Hospital-statistics-on-teenagers-girls-predominate-in-self-harm-cases-boys-in-assaults}

Analysis of admissions to acute hospitals of Gloucestershire residents for self-harm from April 2009 to March 2013 provides us with further local information.

There were a total of 3,354 patients with 5,623 admissions over this period. The majority of admissions were in females (60%) with the ethnicity as predominantly White British. In terms of the diagnosis, about 85% of admissions were for poisoning, but this may grossly underestimate the occurrences of other methods such as cutting, as these do not usually result in admissions except when they are very severe. Paracetamol-related poisoning was responsible for more than a third (34%) of all admissions for poisoning (Figure 6). Following this at a distant second are anti-depressants. Other common medications used include sedatives and anti-inflammatory drugs.

**Figure 6: Primary Diagnoses of Self-harm Admissions in Gloucestershire, 2009-2013**

In terms of **frequency of admissions**, three-quarters of patients were admitted just once over the period, about 14% admitted twice and 5% thrice (Figure 7).
Figure 7: Frequency of Admission for Self-harm in Gloucestershire, 2009 to 2013

Figure 8 shows the distribution by age of patients. There is a peak for teenagers/young adults with a peak at 17 years. There are secondary peaks in patients in their forties and late twenties.

Figure 8: Self-harm Patients in Gloucestershire by Age, 2009 to 2013

Source: GCC Strategic Needs and Analysis Team

There seem to be an association with deprivation, with almost half of all patients (49%) resident in the three most deprived deciles of the county (Figure 9).
2.4 Self-harm in Children and Young People

There were a total of 555 children and young people aged under 19 years (16.5% of all admissions) admitted to acute hospital over the four year period. The number of patients admitted start to rise from age 13 peaking at 17 years with a slight decrease at 18 years (Figure 10).

About eight out of ten (79.5%) were female. The major diagnosis was aminophenol derivative poisoning (Paracetamol-related) which was in more than half (53.2%) of admissions, followed by Non-steroidal anti-inflammatory drugs, anti-depressants and sedatives. This has been the pattern of poisoning highlighted by data available to us since 1999. Cutting was in 4.2% of admissions while asphyxiation was the diagnosis in 0.7% of admissions.
Inpatients stay in hospital for self-harm from September 2013 has been highlighted as increasing and particularly impacting on services. Comparison of data from September to November 2013 with the same period in 2012 shows a two to three fold increase over these months.

It is pertinent to note that the Online Pupil Surveys over the years have shown that the proportion of young people in Gloucestershire who report self-harming has increased since 2008 (Table 2)

Table 2: Comparative Results of Self-harm Question in the Online Pupil Survey, 2008-2012

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>57/20</td>
<td>70.9</td>
<td>61/20</td>
<td>72.0</td>
<td>62/05</td>
<td>71.4</td>
</tr>
<tr>
<td>Occasionally</td>
<td>14/63</td>
<td>18.1</td>
<td>15/40</td>
<td>18.1</td>
<td>17/22</td>
<td>19.8</td>
</tr>
<tr>
<td>Once a week</td>
<td>3/26</td>
<td>4.0</td>
<td>2/95</td>
<td>3.5</td>
<td>2/43</td>
<td>2.8</td>
</tr>
<tr>
<td>Several times a week</td>
<td>2/8</td>
<td>3.6</td>
<td>2/71</td>
<td>3.2</td>
<td>2/87</td>
<td>3.0</td>
</tr>
<tr>
<td>Daily</td>
<td>2/74</td>
<td>3.4</td>
<td>2/82</td>
<td>3.3</td>
<td>2/63</td>
<td>3.0</td>
</tr>
<tr>
<td>Total answered</td>
<td>80/80</td>
<td>100.0</td>
<td>85/18</td>
<td>100.0</td>
<td>86/90</td>
<td>100.0</td>
</tr>
<tr>
<td>Not answered</td>
<td>10/32</td>
<td>11.3</td>
<td>9/96</td>
<td>10.1</td>
<td>1/55</td>
<td>4.0</td>
</tr>
<tr>
<td>Total</td>
<td>91/12</td>
<td>9474</td>
<td>90/55</td>
<td>9055</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: GCC Strategic Needs and Analysis Team

3. Preventing Suicide – what the evidence says and available interventions/services

It is difficult to predict which individuals will die by suicide because suicide is a statistically rare event, unlike other causes of death. This unpredictability is a challenge because, while there is a broad international consensus that many suicide deaths are preventable at a population level, there are no clear ways in which it is possible to predict and prevent suicidal behaviour at an individual level. 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. Powerful suicide prevention measures include developing individual resilience from birth through the life course, and building population resilience and social connectedness within communities. This is because risk and protective factors for suicide operate at not only the individual level, but also at the social and contextual levels as detailed in Table 3.
Table 3: Risk and Protective Factors for Suicide

<table>
<thead>
<tr>
<th>Risk factors for suicide</th>
<th>Protective factors for suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td></td>
</tr>
<tr>
<td>gender (male)</td>
<td>gender (female)</td>
</tr>
<tr>
<td>mental illness or disorder</td>
<td>mental health and wellbeing</td>
</tr>
<tr>
<td>chronic pain or illness</td>
<td>good physical health</td>
</tr>
<tr>
<td>immobility</td>
<td>physical ability to move about freely</td>
</tr>
<tr>
<td>alcohol and other drug problems</td>
<td>no alcohol or other drug problems</td>
</tr>
<tr>
<td>low self-esteem</td>
<td>positive sense of self</td>
</tr>
<tr>
<td>little sense of control over life circumstances</td>
<td>sense of control over life's circumstances</td>
</tr>
<tr>
<td>lack of meaning and purpose in life</td>
<td>sense of meaning and purpose in life</td>
</tr>
<tr>
<td>poor coping skills</td>
<td>good coping skills</td>
</tr>
<tr>
<td>hopelessness</td>
<td>positive outlook and attitude to life</td>
</tr>
<tr>
<td>guilt and shame</td>
<td>absence of guilt and shame</td>
</tr>
<tr>
<td><strong>Social</strong></td>
<td></td>
</tr>
<tr>
<td>abuse and violence</td>
<td>physical and emotional security</td>
</tr>
<tr>
<td>family disputes, conflict and dysfunction</td>
<td>family harmony</td>
</tr>
<tr>
<td>separation and loss</td>
<td>supportive and caring parents/family</td>
</tr>
<tr>
<td>peer rejection</td>
<td>supportive social relationships</td>
</tr>
<tr>
<td>social isolation</td>
<td>sense of social connection</td>
</tr>
<tr>
<td>imprisonment</td>
<td>sense of self-determination</td>
</tr>
<tr>
<td>poor communication skills</td>
<td>good communication skills</td>
</tr>
<tr>
<td>family history of suicide or mental illness</td>
<td>no family history of suicide or mental illness</td>
</tr>
<tr>
<td><strong>Contextual</strong></td>
<td></td>
</tr>
<tr>
<td>neighbourhood violence and crime</td>
<td>safe and secure living environment</td>
</tr>
<tr>
<td>poverty</td>
<td>financial security</td>
</tr>
<tr>
<td>unemployment, economic insecurity</td>
<td>employment</td>
</tr>
<tr>
<td>homelessness</td>
<td>safe and affordable housing</td>
</tr>
<tr>
<td>school failure</td>
<td>positive educational experience</td>
</tr>
<tr>
<td>social or cultural discrimination</td>
<td>fair and tolerant community</td>
</tr>
<tr>
<td>exposure to environmental stressors</td>
<td>little exposure to environmental stressors</td>
</tr>
<tr>
<td>lack of support services</td>
<td>access to support services</td>
</tr>
</tbody>
</table>


It is instructive to note that the Online Pupil Survey is showing that key protective factors like the ability to make and keep friends, happiness, feeling satisfied with their lives, feeling confident about the future, are going in the wrong direction among Gloucestershire's school children since 2008.

Evidence suggests that the risk factors that contribute to suicides or deaths from assault in children are complex and often accumulate over childhood, making it imperative for preventive interventions to be multi-pronged and starting early in the life course.

Preventive activities undertaken so far by the CYP T&F Group include:

- Distribution of **resources** to all schools and colleges to raise awareness among young people about **sources of support** available to them
- Updating and distribution of the **Little Red Book**\(^{23}\) to professionals in contact with children and young people
- Promotion of the **Samaritans' Step-by-Step service**\(^{24}\) to schools and colleges and establishment of links with schools affected by suicide.

\(^{23}\) [http://www.ghll.org.uk/documents/Little_Red_BookFINAL_2.pdf](http://www.ghll.org.uk/documents/Little_Red_BookFINAL_2.pdf)
• Promotion of the Samaritans’ suicide prevention guide to schools and colleges
• Informing/reminding colleges of services available to them from the Children and Young People’s Service

• Inclusion of additional questions on self-harm into the Online Pupil Survey to further inform our understanding of its extent and pattern

• Work is underway to develop a referral pathway for all professionals (including voluntary agencies) which would enable them to identify vulnerable children and young people, and provide/refer them to the appropriate support. All safeguarding leads will be involved in this piece of work under the leadership of the GCC Safeguarding Lead.

• Gloucestershire Healthy Living and Learning (GHLL) is working with secondary school Lead Teachers, the police schools unit and Samaritans to produce a Key Stage 4 resource for teachers that helps them address the difficult subject of suicide in the young. A draft is currently being consulted upon with relevant stakeholders.

• GHLL is currently developing a ‘safe, healthy relationship curriculum’ for Key Stages 1-5

• Work is underway to develop an app which focuses on suicide prevention and provision of information on sources of help for young people

Other relevant interventions commissioned by Public Health include the following:

• All schools that have been identified as being outliers in the Online Pupil Survey on mental wellbeing indicators, as well as those affected by the recent suicides or near misses are being offered interventions by GHLL around bullying and self-harm and encouraging social connectedness through ‘something kind’ workshops, as well as curriculum development. These schools are also being prioritised for the delivery of the MenTalk programme delivered by Cheltenham Town Football Club. MenTalk uses the medium of football to help develop emotional literacy in boys.

• Expansion of the delivery of Youth Mental Health First Aid (MHFA) training for professionals in contact with children and young people. This enables the early identification of mental health problems and subsequent sign-posting to sources of help.

• Applied Suicide Intervention Skills Training (ASIST) has been commissioned to be implemented for relevant professionals/groups

Public Health is in the process of commissioning a volunteer buddying provision for young people who have a diagnosis of a psychotic illness with the aim of promoting good mental health.

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24 This service provides support following a suicide and helps with prevention of further incidents
25 Formerly known as Children and Adolescent Mental Health Service (CAMHS)
26 http://www.ghll.org.uk/
27 www.ghll.org.uk/partnership-projects/the-songwriting-charity/
28 http://s382090889.initial-website.co.uk/health/know-yer-balls-project/
29 MHFA is a national training programme designed to reduce stigma and discrimination around mental health, improve awareness and understanding of common mental health problems, and improve confidence in dealing with one’s own mental health and supporting others in distress, whether they are employees, colleagues, family and friends, or members of the public
30 http://asist.org.uk/en/
wellbeing, reducing social disability and loneliness, as well as preventing relapse. Public Health will also be undertaking a **campaign for young people** in May which will focus particularly on emotional resilience and awareness of support that is available to young people.

The new suicide prevention strategy for England details the suicide methods that are most amenable to intervention as:

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

2gether NHS Foundation Trust which provides our adult in-patient mental health service has consistently implemented measures aimed at preventing inpatient suicides and has not recorded any inpatient suicide since April 2009, except for one in May 2012. The Trust has made substantial investments in ensuring that all the inpatient units are completely free of non-collapsible ligature points. All windows have also been replaced with ligature-free restricted opening which prevents both jumping and absconding through windows.

With significantly fewer opportunities within wards, absconding is becoming more important for people who are determined to die by suicide. 2gether NHS Foundation Trust is also leading the work across the south of England on the ‘Improving Safety in Mental Health’ programme which is developing and testing a safety bundle for the prevention of absconding from wards.

Preventing self-poisoning would involve close monitoring and limiting access to means of poisoning by carers, families and friends, as well as by health professionals. The CCG in collaboration with the Hospitals and Mental Health Trusts are reviewing the clinical pathways for the management of self-harm for children and adults. This review would align with the referral pathway being developed by GCC’s safeguarding lead.

High-risk locations are considered to be those places with a potential for suicide by:

- Jumping from a height (bridges, viaducts, high-rise hotels, multi-story car parks, tall buildings, cliffs etc.)
- Placing oneself in front of a moving vehicle (for trains, about 50-60% occur on open track, 30% at stations and 10% at level crossings)
- Other methods, particularly car exhaust poisoning

The GSPPF set up a **Task and Finish (T&F) Group on ‘Hotspots’** which has been exploring data and information available, in order to determine local high-risk locations and recommend interventions for these places. Members of this group include Gloucestershire Constabulary, Network Rail, Samaritans, NCP Car Parks, GCC and 2gether NHS Foundation Trust.

**Effective local interventions for high-risk locations** include:
- Preventive measures – barriers/nets on bridges from which suicidal jumps have been made; provision of emergency telephone numbers e.g. Samaritans
- Working with Local Authority planning departments and developers to include suicide risk in health and safety considerations when designing multi-storey car parks, bridges and high-rise buildings that may offer suicide opportunities
- Environmental assessments in care and hospital settings to include assessing the risk of vulnerable patients accessing open windows/balconies. (Fall from windows by the Health and Safety Executive\(^{31}\))
- Working with local and regional media outlets to encourage responsible media reporting on suicide methods and locations

The Hotspot T&F Group has been working closely with the two Samaritan branches in Gloucestershire who have set aside **funding for signage** to cover identified hotspots in the county.

- Work is underway with Cheltenham Railway Station to put Samaritan signage in relevant locations, while work with Gloucester Station is planned for early 2014
- NCP Car Parks in the county (including Bruton Way in Gloucester and Brewery Car Park in Cheltenham) have agreed to signage being placed in the three sites owned/managed by them and are currently reviewing the available signs and posters.
- Work is still ongoing with car parks owned by other parties which includes Merrywalks Car Park in Stroud and multi-storey car parks owned by Gloucester City Council.
- Work will begin in 2014 in collaboration with the Gloucestershire Highways Bridge Engineer regarding exploring signage options on relevant motorway and road bridges.

The group will be working with Cheltenham Borough Council Planning Department on proposed new car park development to influence the inclusion of appropriate suicide prevention measures in the planning process.

Member organisations of the GSPPF led by Survivors of Bereavement by Suicide (SOBS) worked with the Hospitals Trust to ensure that their recent new build car park at Gloucestershire Royal Hospital had barriers that met the recommended height.

### 3.1 Precipitating Events

Not everyone possessing or experiencing risk factors for suicide will go on to take their lives. Those who do so may have not only been exhibiting ‘warning signs’ but may have also experienced a precipitating event which gets them to the ‘tipping point’. Table 4 gives examples of typical triggers or precipitation events to suicide, the interplay of which can be complex and not always necessarily occurring sequentially.

\(^{31}\) http://www.hse.gov.uk/pubns/hsis5.pdf
Table 4: Examples of typical triggers or precipitating events to suicide

<table>
<thead>
<tr>
<th>Risk factors</th>
<th>Warning Signs</th>
<th>Tipping Point</th>
<th>Imminent Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mental health problems</td>
<td>• Hopelessness</td>
<td>• Relationship ending</td>
<td>• Expressed intent to die</td>
</tr>
<tr>
<td>• Gender – male</td>
<td>• Feeling trapped – like there’s no way out</td>
<td>• Loss of status or respect</td>
<td>• Has plan in mind</td>
</tr>
<tr>
<td>• Family discord, violence or abuse</td>
<td>• Increasing alcohol or drug use</td>
<td>• Debilitating physical illness or accident</td>
<td>• Has access to lethal means</td>
</tr>
<tr>
<td>• Family history of suicide</td>
<td>• Withdrawing from friends, family or society</td>
<td>• Death or suicide of relative or friend</td>
<td>• Impulsive, aggressive or anti-social behaviour</td>
</tr>
<tr>
<td>• Alcohol or other substance misuse</td>
<td>• No reason for living, no sense of purpose in life</td>
<td>• Suicide of someone famous or member of peer group</td>
<td></td>
</tr>
<tr>
<td>• Social/geographical isolation</td>
<td>• Uncharacteristic or impaired judgement or behaviour</td>
<td>• Argument at home</td>
<td></td>
</tr>
<tr>
<td>• Financial stress</td>
<td></td>
<td>• Being abused or bullied</td>
<td></td>
</tr>
<tr>
<td>• Bereavement</td>
<td></td>
<td>• Media report on suicide or suicide methods</td>
<td></td>
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<tr>
<td>• Prior suicide attempt</td>
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</tbody>
</table>


The various MHFA Training Programmes (including a LITE version) and the ASIST Programme help with recognition of these and subsequent signposting.

The mental health charity SANE conducted a study which aimed to understand **suicidal feeling from the first person perspective**, as well as improve understanding of the process of suicide to enable improved prevention\(^32\). Their findings underscore the complex nature of suicidal feelings and the suicidal process as detailed in some of the insights provided in Appendix 3.

Evidence would therefore suggest that a **suicide prevention model** would require activities and services across the community that address the needs of:

- The broader population e.g. improving wellbeing
- Specific groups identified as being at risk
- Individuals who may be at high risk of suicide

Such a model should be informed by knowledge of:

- Risk and protective behaviours
- Resilience and vulnerability
- The impact of the interaction of personal factors and life events, including mental health
- Warning signs and tipping points

Our local action plan which is based on such a model and owned by partners in the Forum, has interventions for the broader population, groups who may be at higher risk, as well as individuals.

4. Additional Interventions and Services Available for Suicide and Self-harm Prevention in Gloucestershire

Though there are no services that are specifically for suicide prevention, a number of services available in Gloucestershire do contribute to the suicide prevention model detailed above. Suicide and self-harm prevention is an integral part of our Mental Health and Wellbeing Strategy especially in relation to objectives one and five contained within it. This strategy which is an all age one encompassing the whole spectrum from mental wellbeing to mental illness and recovery, was endorsed by the Gloucestershire Health and Wellbeing Board in May 2013. The board also endorsed the governance structure which includes oversight of the implementation of the strategy by a Mental Health and Wellbeing Partnership Group33 reporting to the Joint Commissioning Partnership Board.

4.1 Improving Individual and Population Mental Wellbeing

Resilience of individuals, families and communities are important determinants of mental wellbeing. Reducing the social and other determinants of mental ill health also improves wellbeing. Available services that help achieve these include (but are not limited to):

- Gloucestershire Early Childhood Team which aims to work in partnership with others to empower practitioners to enable each child to be happy and fulfilled. They offer professional support and advice to ensure high standards in early years integrated care and education (in maintained and non-maintained settings) and improved outcomes for all children.

- There are 39 Children’s Centres in the county which offer a variety of services as specified in their contracts. Centres have staff to provide direct support or access and signposting to other service specialists. These include health services; parenting support; family workers; early education; basic skills training; special educational needs services and in addition a wide range of information, advice and guidance on employment; welfare; benefits and budgeting.

- GCC provides a vehicle for universal health improvement in schools and colleges via Gloucestershire Healthy Living and Learning. All schools and settings have the support of a professional to help them identify and focus on those children who need it most. Every school/college working towards the award is expected to demonstrate commitment to improving the mental health of its pupils. The Gloucestershire online pupil survey informs the process and the reporting tool measures the impact of interventions.

- Public Health Nursing Service (school nursing and health visiting) which includes a mental health element that identifies parental and child mental health needs and provides structured support and/or referral. It also offers parenting support for behavioural and attachment problems, as well as identifies vulnerable and harder to reach children and families requiring targeted and specialist services.

- GP Practices which are an important source of information and referral to services that promote individual wellbeing.

- Personal, Social, Health and Economic Education (PSHE) curriculum in schools which provides learning opportunities and experiences that help equip young people

with the knowledge, understanding, attitudes and practical skills to live healthily, safely, productively and responsibly, as well as grow and develop as individuals and as members of families and of social and economic communities.

- Services promoting healthy lifestyles e.g. ‘Stop Smoking’, alcohol, drugs and weight management services. Active Gloucestershire (a sports partnership in the county) works to get residents involved in sport and physical activity irrespective of age, ability or interest.

- Services that promote participation and inclusion e.g. Time Banks, various volunteering organisations across the county, North Cotswold Befriending Service for older, disabled or isolated people, and Art Lift (a primary care based art programme for people with mental health conditions as well as those who may be at risk of developing them). The Barnwood Trust are currently leading the implementation of eight learning sites using an asset-based community development approach to develop inclusive and cohesive communities which are also dementia friendly across the county with funding from Public Health and the Clinical Commissioning Group.

- Services that address the wider determinants of mental ill health include adult learning opportunities, benefit advice services (including those delivered through GP surgeries), as well as a variety of Jobcentre Plus work initiatives. Others include services for victims of domestic abuse and sexual violence, as well as local initiatives addressing crime (including hate crime) and anti-social behaviour in communities. Affordable warmth programmes are available across the county and are aimed at preventing fuel poverty especially in older people.

- Awareness raising activities include media briefings and articles on Mental Health Day. Five simple actions which can improve well-being in everyday (Five Ways to Wellbeing) continue to be promoted within health and education sectors (Appendix 4).

Public Health is in the process of commissioning interventions that promote the mental wellbeing of people out of work, focusing on people with long term health conditions who have been through the Government’s Work Programme without securing a job.

### 4.2 Recognising, Managing and Treating Mental Health Conditions

Public Health commissions Mental Health First Aid training and the ‘Lite’ version which are available to stakeholder groups and individuals and carers.

**Mental health services for children and young people** which are commissioned jointly by GCC and the CCG from 2gether NHS Foundation Trust are available in the county. These services have an emphasis on developing the capacity in non-specialist staff and professionals to provide interventions at lower levels of need as well as targeting particular vulnerable groups such as Looked After Children. The focus is always to intervene as early as possible in the lifetime of problems with more young people. Other areas of focus include:

- Improving liaison arrangements with other parts of the system e.g. hospitals

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34 The Work Programme was launched in June 2011 as part of the government’s long-term economic plan to give tailored help to people who have already been out of work for some time, or are in danger of becoming long-term unemployed.
• Reducing demand for inpatient mental health care by developing community-based care that can support young people in their local community or at home
• The offer of a practitioners’ advice line and Primary Mental Health Workers working in the community, including schools

Specific services commissioned include:

• A generic service for children and young people with mild to moderate mental health difficulties
• A Paediatric Liaison/Hospital Education Service
• A Vulnerable Children’s Service
• A Learning Disability Service
• Parenting Groups to support families of children and young people with an identified conduct disorder and behavioural problems
• Professional Telephone Advice Line
• Specialist provision for children and young people with moderate to severe mental health needs including those with a learning disability
• Specialist mental health inpatient services out of county (now commissioned by NHS England)

The 2gether Trust also works with various Voluntary and Community Sector organisations to complement the services that can be offered, and is currently a pilot area for the children and young people Improving Access to Psychological Therapies (CYP IAPT) programme which aims to make early intervention with low level needs easier.

Demand for these mental health services has however begun to challenge supply in the last 12 months with referrals increasing thereby putting pressure on capacity available. Part of the increased demand is in the numbers of young people (previously known and unknown to services) presenting with more complex problems and or self-harm including at Accident and Emergency departments. This increase in demand is reflected regionally and nationally as well, with the attendant situation of mental health inpatient beds (commissioned by NHS England) not always available when needed. Work is ongoing locally to try and make local arrangements work as well as possible, including exploring alternatives that could be developed to meet this demand.

There has also been an increase in the numbers of young people presenting with eating disorders.

It is important to re-iterate that many young people who die by suicide or who self-harm are not known to mental health services and/or not considered to be ‘mentally ill’, or in need of mental health inpatient admission.

**Mental health services for adults and older people** are jointly commissioned by GCC and the CCG through 2gether NHS Foundation Trust. Services available include:

• Primary Mental Health service based in GP Practices
• Psychological Therapies service
• Community based mental health teams including:
o Assertive Community Treatment service for adults with severe and enduring mental illness who have complex needs and are difficult to engage in generic services
o GRiP (Gloucestershire Recovery in Psychosis for young people with first episodes)
o Recovery Teams
o Eating Disorder Service (all ages)
o Community teams for older people

- Acute and Recovery Mental Health inpatient services
- Criminal Justice Liaison Service
- Hospital Mental Health Liaison Service
- Better2Work which supports people with ongoing mental health problems who want to find routes into employment, voluntary work, education or training
- Supported Accommodation Service
- Managing Memory 2gether
- Crisis Resolution and Home Treatment Team (CRHTT)

Suicide prevention is a relevant issue for all these services/teams with each one required to risk-assess as part of their assessment process. This requirement is detailed in the Trust wide policy on assessing and managing risk.

GPs who feel their patients present a suicide risk are able to refer to the CRHTT or to Recovery Teams. Patients being managed by the other mental health services/teams may be referred to CRHTT if their risk increases to a level requiring CRHTT input.

**Priorities for 2014** which are currently being worked on include:

- The development of an implementation plan to support the Mental Health and Wellbeing for Gloucestershire which was endorsed by the Health and Wellbeing Board in May.
- Phase two of the implementation programme of the Primary Care based Mental Health Intermediate Care Teams to achieve comprehensive coverage for all 85 GP practices across the county. These teams will be responsible for the care of patients with specific mental health problems (i.e. common mental health problems and ongoing recurrent psychosis)
- Implementation of integrated care across primary and hospital care for both mental health and physical health problems
- Achievement of the 15% access target for psychological therapies for people with common mental health problems (anxiety and depression, whilst maintaining the appropriate recovery rates and waiting times for treatment
- Expansion of the provision of psychological therapies to include improved access for people with severe mental illness, Personality Disorder and Bi-polar disorder
- Exploration of the possibility of rolling out the Recovery ‘pop-up’ Colleges following a review of the evaluation of a pilot programme
- Completion of an independent review of crisis and emergency responses including urgent mental health assessments, as well as their interface with the Police and the Ambulance Trust
• Review of the Adult Eating Disorder pathway as well as the Child and Adolescent Home Treatment Eating Disorder Service.

• Review of adult social care pathway/care management to include:
  o Pathways to assessment
  o Support planning and brokerage
  o Review of funded packages
  o Finance/administrative support for community care budget
  o Implementation of personalisation and access to personal budgets.

• Review of Individual Place and Support\(^{35}\) (IPS) vocational services

• Complete review with the view of identifying gaps in the delivery of the acute and community hospital psychiatric liaison service\(^{36}\) across Children and Young People and Adult services

### 4.3 People Bereaved by Suicide

Families and friends bereaved by a suicide are at increased risk of mental health and emotional problems and at potentially higher risk of suicide themselves. Organisations/services available to support family and friends include:

- **Survivors of Bereavement by Suicide** (SOBS)
- **Winston’s Wish**
- **Samaritans’ Step by Step programme** which supports communities (including schools) after a suicide

### 4.4 Self-harm

The **Rethink Self-harm Helpline**\(^{37}\) commissioned by Public Health which has been formally found to be effective on evaluation, is planned to have its opening hours expanded from four to seven days a week in the 2014/15 financial year.

### 5. Conclusion

This report provides HCOSC members with our understanding of the patterns of suicide and self-harm in the county, as well as their underlying determining and risk factors. It details the various interventions taking place to prevent suicide and self-harm, as well as services available to Gloucestershire residents that impact on these. Additional interventions continue to be explored and relevant services reviewed in response to the local evolving knowledge and developments in relation to demand for services.

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\(^{35}\) An evidence-based approach to supported employment for people with a severe mental illness.

\(^{36}\) Liaison psychiatry commonly refers to services aimed at addressing the mental health needs of people being treated in acute hospitals for physical disorders. This includes people presenting in A&E following an overdose or self harm, people with a combination of a mental and physical health problem whose mental health needs have to be met while in the acute hospital, people with medically-unexplained symptoms and people with dementia.

\(^{37}\) [http://youtu.be/xk5Q4-C5cVw](http://youtu.be/xk5Q4-C5cVw)
HCOSC members are invited to note:

- Our understanding of the pattern of suicide and self-harm in county and the apparent increase in demand for services generally
- The existence of a Suicide Prevention Partnership Forum (and sub-groups) which has responsibility for the implementation of the Suicide Prevention Strategy and rolling action plan for the county.
- The ongoing refresh of the action plan informed by local information and data on suicides and self-harm
- The existence of a Mental Health and Wellbeing Partnership Group which has responsibility for the implementation of an all age Mental Health and Wellbeing Strategy endorsed by the Health and Wellbeing Board.
- The reporting line of the Gloucestershire Suicide Prevention Partnership Forum to the Mental Health and Wellbeing Partnership Group and the governance structure supporting this.
- The role of the Safeguarding Children’s Board in addressing the current issues with suicides and attempts in children and young people
- That various preventive interventions being taken forward by the sub-groups of the GSPPF as well
- The services and interventions commissioned by the County Council, Public Health and the CCG which impact on suicide and self-harm.
- The services/interventions provided by voluntary and community groups that support preventive work
- The ongoing work taking place between the commissioners, service providers and other interested parties in response to the apparent trends and demands on services.
- The priorities within mental health services commissioning for 2014/15
Appendix 1: Terms of Reference of the Gloucestershire Suicide Prevention Partnership Forum (GSPPF)

GLOUCESTERSHIRE SUICIDE PREVENTION PARTNERSHIP FORUM (GSPPF)

Purpose of the Forum

The Gloucestershire Suicide Prevention Partnership Forum works to improve the lives of people and carers in Gloucestershire, by focusing action on suicide and self-harm prevention.

The Forum brings together key stakeholders in the county to develop and deliver a countywide suicide prevention strategy and action plan and contribute to reducing the stigma around suicide and self-harm.

Tasks of the Forum

The key tasks of the Forum will be to:

1. Develop the countywide Suicide Prevention Strategy 2011-15 and rolling Action Plan (for two years from April 2012, to be reviewed annually), which add value to existing arrangements and support the delivery of suicide prevention initiatives at a local level.
2. Support delivery of the content of the Gloucestershire Suicide Prevention Strategy 2011-15 and annual rolling Action Plans, ensuring that their objectives are aligned with relevant national and local strategies and policies.
3. Ensure that ‘high risk’ localities/groups are identified and receive special focus in planned activities/interventions.
4. Influence the NHS (Clinical Commissioning Group) and Local Authority commissioning, planning processes and services for people in relation to suicide prevention.
5. Make recommendations on the development of suicide prevention services and advise on the prioritisation of such developments to the Gloucestershire Mental Health Partnership Group, as well as to the Joint Commissioning Partnership.
6. Provide a quarterly update to the Gloucestershire Mental Health Partnership Group and an annual update to the Joint Commissioning Partnership on progress against the strategy and action plan.
7. Draw on the experience and expertise of existing relevant South West regional groups and other national and regional policy streams, to inform and influence the suicide prevention agenda in Gloucestershire.
8. Support the collection and collation of information and data sharing in Gloucestershire to inform the suicide audit process, which contributes to the review of the strategy and action plan as necessary.
9. Ensure robust communication between the GSPPF and individual organisations/networks.
10. Establish ‘Task and Finish’ groups as necessary to produce/review appropriate actions/interventions.
11. Co-opt representatives from other organisations/agencies/networks, on invitation as relevant to tasks.
12. Maintain a focus on self harm as well as suicide prevention.
13. Address issues of stigma relating to mental health for individuals and families.

Accountability

The Partnership will report to the Gloucestershire Mental Health and Wellbeing Strategy Group (which reports to the Joint Commissioning Programme Board). It will also seek to establish connections with other stakeholder groups impacting on suicide prevention.

Meeting Arrangements

The group will meet quarterly.

Membership of GSPPF

Membership of the Forum will include organisations/networks likely to have the greatest impact on reducing the suicide rate within Gloucestershire. Named members will send a representative from their organisation if they are unable to attend, ensuring they are fully briefed.

Members required to attend regularly. If the main representative is unavailable, please ensure that a colleague can attend wherever possible.

- Gloucestershire County Council
- Clinical Commissioning Group
  - Joint Commissioner – Mental Health
  - GP lead – Mental Health
- 2gether NHS Foundation Trust
- Gloucestershire Hospitals NHS Foundation Trust
- Gloucestershire Constabulary
- Gloucestershire Probation Trust
- Gloucestershire Healthwatch
- Job Centre Plus
- Gloucestershire Coroners Service
- Housing (District Councils)
- Schools
- Voluntary and Community Sector
- Samaritans Gloucester and Cheltenham
- Survivors of Bereavement by Suicide (SOBS)
- Rethink Mental Illness Gloucestershire
- GayGlos
- Carers Gloucestershire
- Churches Together
- Turning Point

Last updated July 2013, to be reviewed annually.
Appendix 2: Terms of Reference of the Task and Finish Group on Prevention of Suicide in Children and Young People

GLOUCESTERSHIRE SUICIDE PREVENTION PARTNERSHIP FORUM (GSPPF)

Task and finish group on prevention of suicide in Children and Young People.

Purpose of the task and finish group.

This group has convened at the request of the Gloucestershire Safeguarding Board, in the light of recent serious incidents resulting in child deaths.

The purpose of the group is to consider what short and long term measures could be taken to ensure that the Suicide Prevention Action Plan adequately reflects actions needed to prevent further child death by suicide in the framework of suicide prevention work.

Tasks of the group

1. To meet for a time limited period to share skills and knowledge regarding the current situation, and report to the GSPPF. Time period – until long term actions are identified and shared with the GSPPF, for inclusion in the action plan.
2. To identify short and long term actions to improve the prevention of suicide in children and young people in Gloucestershire. Short term actions will be taken on and carried out by agreement by members of the Task and Finish group.
3. Long term actions will be included in the Suicide Prevention Action Plan, with the agreement of the GSPPF.
4. Influence the NHS (Clinical Commissioning Group) and Local Authority commissioning, planning processes and service for children and young people in relation to suicide prevention, via the GSPPF.
5. Make recommendations on the development of suicide prevention services and advise on the prioritisation of such developments to the Mental Health Local Implementation Team (or successor organisation), the Shadow Health and Wellbeing Board and the Children and Young People’s Partnership, via the GSPPF.

Accountability
For the time that it is in existence the partnership will report to the GSPPF and the Gloucestershire Safeguarding Board. Short term actions will be conveyed to the safeguarding board, and long term actions will be conveyed to the CDOP.

Membership of the Task and Finish Group. Members may attend as required.

- NHS Gloucestershire – Chair. (Sola Aruna, Frances Clark-Stone, Nevila Kallfa, Imelda Bennett)
- GCC Gloucestershire Healthy Living and Learning (Jan Courtney)
- GCC (Jane Bee, Paula Steed, )
- Federation of FE Colleges (Sylvie Kilkenny, Fiona Quan)
- 2gether NHS Foundation Trust (Maria Price-Griffiths, Ruth Turnbull)
- Samaritans (Chris Ing, Beverley Bleasdale)
- Gloucestershire Constabulary (Marcus Griffiths)
Appendix 3: SANE: The feeling of being suicidal and the process of suicide

Experiences of self:

You see people reacting to you, and life carrying on as normal. People laugh at jokes, make banal chit chat round the water cooler, and somehow you’re part of that, but you’re not. Because actually you’re locked in this glass coffin, but have just enough air to not suffocate. You’re an actor. People are responding to their expectations of you, and not the real you. Because the real you is actually already dead, but your body is still breathing. Somehow you happen to be out of bed, at work, looking like you’re a real functioning human being, and yet nobody actually gets that none of it is real. You’re on autopilot, and going through the motions.

Experiences of world and others:

I felt that a glass box separated me from the person who was still out there functioning. When there was no pressure on me to perform my public role I could do nothing. My husband tried to chivvy me along. I stood on a tennis court tears streaming down my cheeks unable to raise the racket.

The suicidal body:

It’s like there’s something twisting your lungs, just the idea of spending the night by yourself makes you feel like you’re about to die already. And that’s why you’re suicidal in the first place; you feel on the edge of death constantly, like any moment your heart will give out just from how sad you are. It doesn’t feel like you’re killing off yourself and all your potential; it feels like you’re just speeding along something already happening.

The experiences of suicidal exhaustion:

Throughout all my depression I’ve always been able to be okay for other people. But I couldn’t do it any more, I just couldn’t. And they kept saying to me, what is it, what is it? I’m going “I’m just so tired”. That’s all I kept saying, “I’m so tired”. For ages. And they were going “but why?” And I couldn’t explain what that meant, I just knew that I was so tired. And I wanted peace, I wanted some peace. And suicide was the only way.

You feel exhausted, like ... I don’t know, like mentally exhausted. It’s just a really draining thing to be depressed, it’s so tiring. You get so tired I can’t even explain how tired you get.

I’ve tried so very very hard, months and months have bone by can’t think straight any more my brain feels overloaded, exhausted so exhausted my body has got so weak.
Things people do without thinking, you find as hard as climbing Everest. That is what it is like to feel suicidal.

God, everything makes demands! “Stuff” is demanding. It needs stuff doing with it. Even the carrier bags from the shopping are demanding, because they need something doing with them – recycling, bin, whatever.

The process of suicide:

“I had this stressful job, I decided I couldn't carry on so I went to the doctors. He put me on the sick. Then you start feeling worthless when you're on the sick. Not doing anything, you're a letdown. All that type of business.”

A man who attempted suicide in his late forties

“[The morning she died] we'd had a text message that very close friends (…) had had a baby. (…) And that normally would have been something that would have got Rachel very, very excited, very very happy (…) but it didn't do anything with, for her. (…) She'd started to reply and didn't finish the reply. (…) The last thing she did was to order the flowers (…) for the mother. And then [she] walked out and killed herself.”

A man whose wife died by suicide in her fifties

“I do feel, even when I'm well that that's my role: to look after everybody. I think that's a mother isn't it, to look after everybody but myself, and it's very difficult because I feel as if, if I admit to anybody that I'm not coping, then it's almost as if I'm failing.”

A woman in her fifties with several recent suicide attempts

“He was unfit, and getting older, but he'd made no plans to retire. He could have retired at 55, taken a brilliant pension, had half the week off and still carried on working part time. It was ridiculous, it didn't make any sense, but I think he liked being a bit of a martyr, sometimes, you know, making himself ill, very tired.”

A man whose father died by suicide in his late fifties

“When I get into a panic the main thoughts that dominate are ‘Who am I?’ ‘What is this thing called life?’ ‘How can I have the confidence to act?’ ‘The world is so big, how can my understanding of it have any authority?’, and so on. And from those doubts spring all the fearful imaginings that I might fall apart completely and be overwhelmed by a sea of doubts. (…) When I am anxious all sorts of possibilities sprawl out before me; one of the challenges is containing the sense of infinite indecisiveness. (…) Anxiety is like a veil before my eyes, which is anything from almost entirely opaque to almost entirely transparent.”
A woman who died by suicide in her early twenties

“She would not have wanted to be apart from the world. Even though, increasingly, she felt her brain was taking her apart from the world.”

Her mother

“I was very good at coping with things on my own and sorting things out for myself and never asking for help or support from anybody. Because I’m, you know, “It’s Laura, she can sort it.” I’m independent. But you’re not, that’s the thing.”

A woman who attempted suicide in her forties

“We tried to encourage him to take partners for his GP practice so he could occasionally have a holiday, but he wouldn't trust anyone. The extra admin stuff he did, it was because one of the receptionists had done it once, got it wrong once, and he'd decided: ‘Right, I'm going to do it myself from now on'. That was the kind of attitude he had to most things, he didn’t really trust anyone to do anything.”

A man whose father died by suicide in his fifties

I do try very, very hard the week before to keep all those balls in the air. And I race around. I describe myself sometimes as running around like a headless chicken… I must seem to everybody as if I'm coping so well, because I've got twenty things going on at once, and it's wonderful, isn't it, and I'm managing, and then bang, that's it.

A woman in her fifties with several suicide attempts
Appendix 4: Five Ways to Wellbeing

Five ways to wellbeing

A review of the most up-to-date evidence suggests that building the following five actions into our day-to-day lives is important for well-being:

**Connect...**

With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.

**Be active...**

Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.

**Take notice...**

Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.

**Keep learning...**

Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more confident as well as being fun.

**Give...**

Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you.