Walsall Council

Walsall Multi-Agency Suicide Prevention Strategy 2018-2023

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NHS
Walsall
Clinical Commissioning Group

NHS
Dudley and Walsall
Mental Health Partnership
NHS Trust

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Definitions

Black and minority ethnic groups (BME): refers to members of non-white communities in the UK

Child and adolescent mental health services (CAMHS): A term for all services that work with children and young people who have difficulties with their emotional or behavioural wellbeing

Dual Diagnosis: is the condition of suffering from a mental illness and a comorbid substance abuse problem

DWMHPT: Dudley & Walsall Mental Health Partnership Trust

IAPT: Improving Access to Psychological Therapies

In-patient suicide: Death by suicide of a person who was registered as being an inpatient within a ward/unit/hospital at the time of their death, irrespective of the exact location of their death

LGBT/LGB&T: lesbian, gay, bisexual and transgender. These are terms used to describe sexual and gender identity.

Mental health literacy: knowledge and understanding of mental health

NEET: Young People Not in Education, Employment or Training

Patient suicide: Death by suicide of a person who had been in contact with mental health services in the 12 months prior to their death, but excluding IAPT and other primary care based mental health services

Self-harm: Causing intentional harm to ones' body - usually a way of coping with or expressing overwhelming emotional distress

Suicide: The act of deliberately taking one's own life

Suicide rate: Refers to the number of suicides that have been adjusted to take into account epidemiological variations in populations (groups of people) such as age, gender, number of people receiving a service, etc. and are expressed as number per 100,000 population.

WHT: Walsall Healthcare NHS Trust

WPH: Walsall based counselling service

Foreword

Suicide is a major issue for society and is a major cause of life years lost. More lives are lost to suicide in England than to road traffic accidents each year. It is important for us to recognise that suicide is not inevitable - many deaths through suicide are preventable as suicide is often the end-point of a complex pattern of risk factors and distressing events.

The effects of these suicides are often felt in the wider community and in particular, by those who have had their lives shattered by the loss of a loved one. Each and every suicide is a tragedy, and one that has a devastating effect on friends and families. Many organisations across Walsall are working hard to support people who are struggling to cope and experiencing feelings which may lead to suicide.

Suicide prevention is a complex public health challenge that requires close working between the different NHS and partner organisations. This strategy will build on priorities set out in the National Suicide Prevention Strategy and existing and emerging evidence around suicide such as from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

According to research evidence, the risk of suicide in the whole population increases in times of financial difficulty, so it is vital that activity to support suicide prevention is maintained as a priority over the next few years. The risk factors that contribute to suicide are wide-ranging and complex, so the task of preventing suicide requires action from all parts of society and across organisations from the public, private and voluntary sectors. It is a task we all have a duty to address this task.

Multi-agency stakeholders are at the centre of the action to reduce suicide. As a partnership, we will build relationships and together develop new initiatives across organisational and professional boundaries with a view to recognising and showcasing good practice. This strategy will not only draw attention to the challenges and barriers experienced but also seek to influence stakeholders to make a difference by taking action.

Introduction

Walsall Multi-Agency Suicide Prevention Strategy takes a broad approach to improving the mental health and wellbeing of people living in the borough. It seeks to raise awareness of suicide, encourage help-seeking behaviour amongst high risk groups and to tackle the social, health and economic factors that increase suicide risk.

Why do we need a strategy?

Suicide is often the culmination of a complex array of risk factors, mental ill-health, and distressing life events; however, it is not inevitable. By working together, we can lower the rate of suicide in the borough.

Each life lost to suicide impacts negatively on many others that they are connected to, such as family, friends, work colleagues and carers.

Current suicide prevention work requires further development and mechanisms need to be formulised into a strategy to ensure people in distress have increased options for support and are given information in a clear and consistent way. We want a society where people in distress receive appropriate and timely early intervention, prevention and crisis support services.

Our vision

We individually and collectively aspire to prevent all deaths by suicide in Walsall; offering hope, support and recovery to those experiencing mental distress

The vision will have been achieved when

- We see a continuing decrease in the number of suicides in Walsall
- Every person in Walsall understands how to protect their own mental health
- Every individual sees suicide prevention as their business and are skilled to respond appropriately
- Information and data are time relevant and sufficiently detailed to inform prevention
- Those affected by suicide have access to timely and appropriate local information and support
- The means of suicide are dramatically reduced
- Those supporting the bereaved are equipped to provide preventative suicide support
- The local media delivers messages sensitively

Background

National Policy drivers

The government published the Five Year Forward View for Mental Health (2016). It outlines a number of recommendations that are relevant to suicide prevention, including the development of a local plan.

Walsall remains within the lowest national suicide quintile. However, in line with the national target our ambition is to decrease suicide rate by 10% by to 2021. Other national drivers include:

- National Confidential Inquiry into Suicide and Homicide Report: Suicide by children and young people (2017)
- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2017)
- Independent Commission on Acute Adult Psychiatric Care (2016)
- Safer services: A toolkit for specialist mental health services and primary care 10 key elements to improve safety (2018)
- Public Health England: Local Suicide Prevention planning (2016)
- Public Health England: Support after a suicide: A guide to providing local services: National Suicide Prevention Alliance (2017)

Local drivers

The key local documents and groups influencing the direction of travel are as follows:

- Walsall Adult Mental Health Needs Assessment (2016)
- Walsall Children and Young People Emotional Wellbeing and Mental Health Needs Assessment (2015)
- Walsall Children and Young People's Mental Health and Wellbeing Transformation Strategy Action Plan 2017- 2021
- Mortality Surveillance Groups
- Findings from Serious Incidents (SIs) reviews arising from deaths by suicide, reported by DWMHT
- Recommendations from Coronial rulings
- Mortality Reduction Groups
- Mental health crisis concordat
- Data from self-harm in CAMHS

How have we written the strategy?

In writing this strategy, we have taken into consideration national aims, guidelines, and evidence, including those set out in the National Suicide Prevention Strategy. A suicide prevention consultation event was held in January 2018 where strategic partners came together to inform the development of this suicide prevention strategy. This strategy also draws on information gathered from the Walsall Adult Mental Health Needs Assessment including public and stakeholder consultation (See Appendix 1). The partnership will continually learn from local experience, utilising individual and service-user lived experience, and local data, alongside regional input and national policy, to deliver and support the best possible actions to reduce suicide and also care for those affected by suicide.

The Walsall Multi-Agency Suicide Prevention Strategic Partnership

The Walsall Multi-agency Suicide Prevention Strategic Partnership is a fluid group which is jointly led by Public Health Walsall Council and Walsall Clinical Commissioning Group (CCG), which jointly report to the Health and Wellbeing Board. Members of the partnership are from a range of diverse statutory, non-profit and private bodies including:

- Accord Housing Group
- British Transport Police
- Dudley & Walsall Mental Health Partnership Trust
- Network Rail
- NHS Walsall CCG
- Rethink
- Samaritans
- University of Wolverhampton
- Walsall Bereavement Support Services
- Walsall Council Public Health
- Walsall Council Social Care
- Walsall Healthcare NHS Trust
- West Midlands Clinical Network
- West Midlands Fire Service
- West Midlands Police
- People with lived experience and their families
- Probation Service
- West Midlands Ambulance service
- Older people's services
- Organisations representing at-risk groups Inc. BME, LGBTQ, young people, employers
- Voluntary sector including One Walsall
- Coroner's office
- Employment support services
- Carer organisations
- Housing associations
- Faith leaders
- Schools and colleges
- Housing providers i.e. WHG and Accord

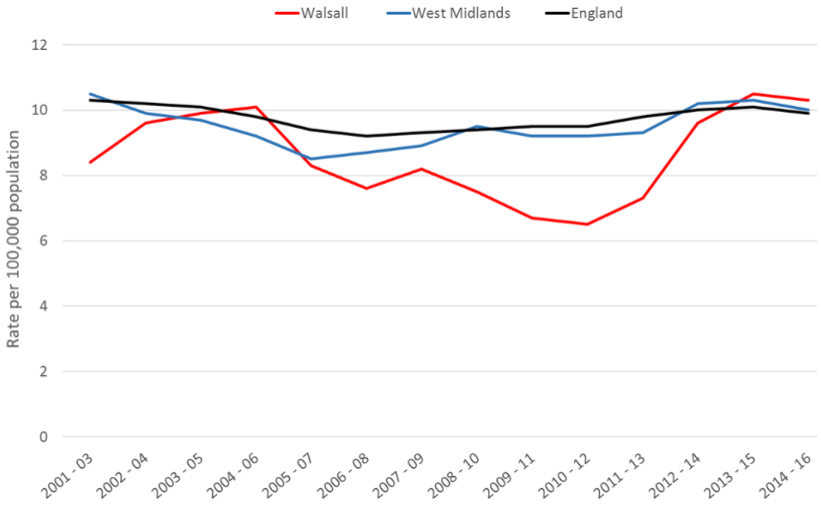
National and local suicide data

We have assessed data from the Office of National Statistics and also from a review of serious incidents undertaken by Walsall CCG Quality and Safety Team. The review occurred between May 2015 and December 2017 within the Walsall Health Care Acute Trust and the Dudley and Walsall Mental Health Trust.

Suicide trends

FIGURE 1. SUICIDE RATE IN WALSALL, COMPARED TO THE WEST MIDLANDS REGIONAL AVERAGE AND THE OVERALL RATE FOR ENGLAND.

Walsall generally has had a lower suicide rate than the West Midlands and National average since 2001.



However, in recent years and there has been a continually increasing rate in Walsall, which as of 2016, was higher than both the regional and national average rates. In the UK, there were 223 (3.6%) fewer suicides registered in 2016 than in 2015. The age-standardised rate has also seen a reduction nationally, with 10.4 persons per 100,000 dying from suicide in 2016, compared with 10.9 per 100,000 in 2015.

Suicide trend by sex

In the UK, age standardised suicide rates generally decreased between 1982 and 2007. Following the economic recession in 2008, suicide rates in subsequent years increased to reach a peak of 11.1 deaths per 100,000 in 2013.

Of the 5,965 suicides registered in the UK in 2016, a total of 4,508 were male and 1,457 were female. The current age-standardised suicide rate for the UK is 16.0 per 100,000 for males and 5.0 per 100,000 for females.

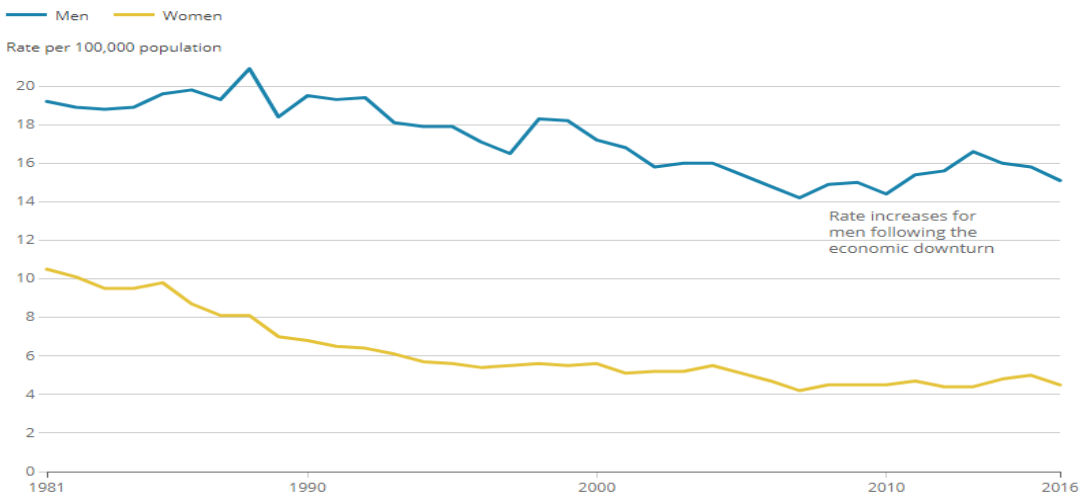


FIGURE 2. THE TREND IN SUICIDE RATES IN MEN AND WOMEN, IN ENGLAND AND WALES BETWEEN 1982 AND 2016.

From 2007 onwards, there was an increase in the age-specific rate for men aged 45 to 59 years, from 18.3 per 100,000 in 2007 to 25.1 per 100,000 in 2013. Men are currently at least three times as vulnerable to death from suicide as women.

Gender and Age of those dying by suicide

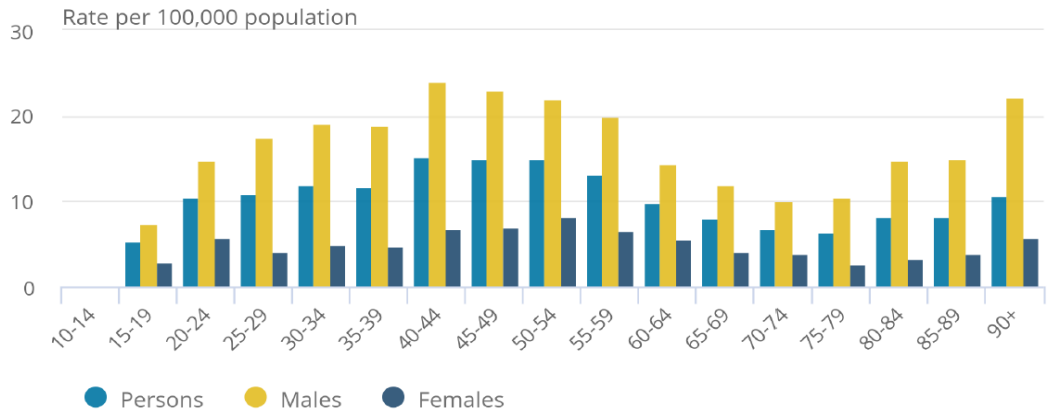


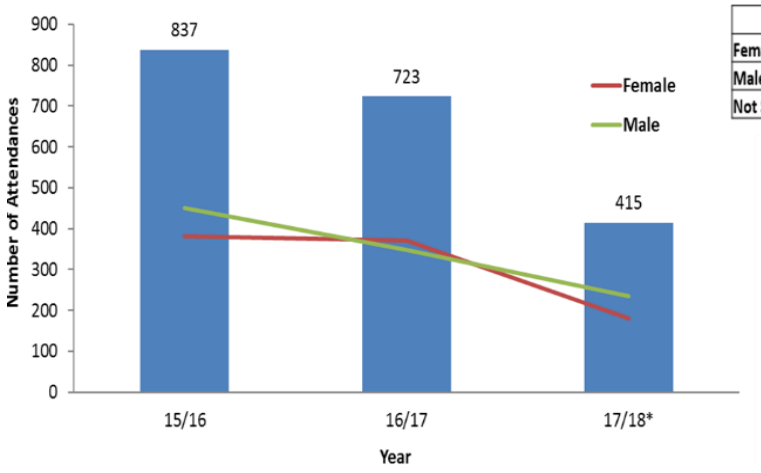
FIGURE 3. THE AGE SPECIFIC RATES OF PEOPLE DYING BY SUICIDE IN THE UK IN 2016.

In 2016 in the UK, age-specific suicide rates increased with age for those between the 15 – 19 year age groups and 40 to 44 year-olds. The rate declined significantly between the 55-

59 age groups and 70 to 74 year-old age group and increased for those in the over 74 year age groups. Persons aged 40 to 44 years had the highest age-specific suicide rate at 15.3 per 100,000. The 40 to 44 age group had the highest rate among males at 24.1 per 100,000, whilst females aged 50 to 54 years had the highest rate amongst females at 8.3 per 100,000.

Overall, the national age-specific male suicide rate is approximately three times higher than the female rate. The greatest suicide rate increases were seen in age groups 80 years and over in both males and females. Males in this age group are more than four and a half times more likely to die by suicide than females and are most likely to complete suicide. Many factors contribute to this such as the deterioration of mental and physical health, bereavement, social loneliness and poverty (Mushtaq, et al, 2014).

A & E attendances for self-harm



	Year			
	15/16	16/17	17/18*	Total
Sex	837	723	415	1975
Female	382	372	180	934
Male	451	349	234	1034
Not Specified	4	2	1	7

Attendances in December

2015: 96
2016: 69
2017: 19 (up to 27th)

FIGURE 4. ATTENDANCES OF WALSALL CCG PATIENTS CODED AS "SELF-HARM" AT WALSALL A&E FROM 1ST APRIL 2015 TO 27TH DECEMBER 2017. *DATA FOR 2017/18 INCLUDES ATTENDANCES UP TO 27TH DECEMBER 2017.

In the review of local serious incidents, 1975 attendances to A & E occurred for self-harm between 2015 and 2017. There has been a drastic decline in the numbers of attendances over the duration of this period, which may be associated with the implementation of the 'Walsall "frequent flyers" Multidisciplinary Meetings' that are attended by the Beacon/mental health teams/housing to make individualised plans for frequent attenders of A&E.

A& E attendances coded as self-harm are fairly equally split between males (52%) and females (47%) (In 1% of cases, sex was not specified) and have halved during this period. Insufficient data exists to show that the proportion of individuals discharged from hospital within the month before their death, after a previous suicide attempt. Improvement of data quality and collection protocols is required.

Age distribution of A & E attendances for self-harm

The Walsall suicide review of A& E attendances for serious self-harm incidents concur with the national trends.

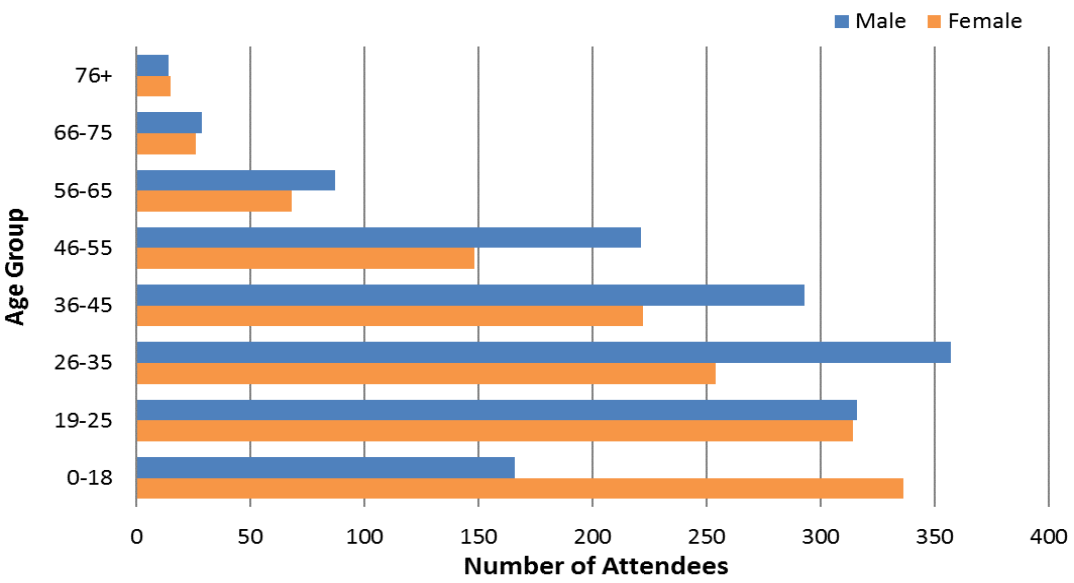


FIGURE 5. THE AGE AND SEX DISTRIBUTION OF PATIENTS INVOLVED IN SERIOUS REPORTED INCIDENTS RELATED TO SUICIDE AND SERIOUS SELF-HARM.

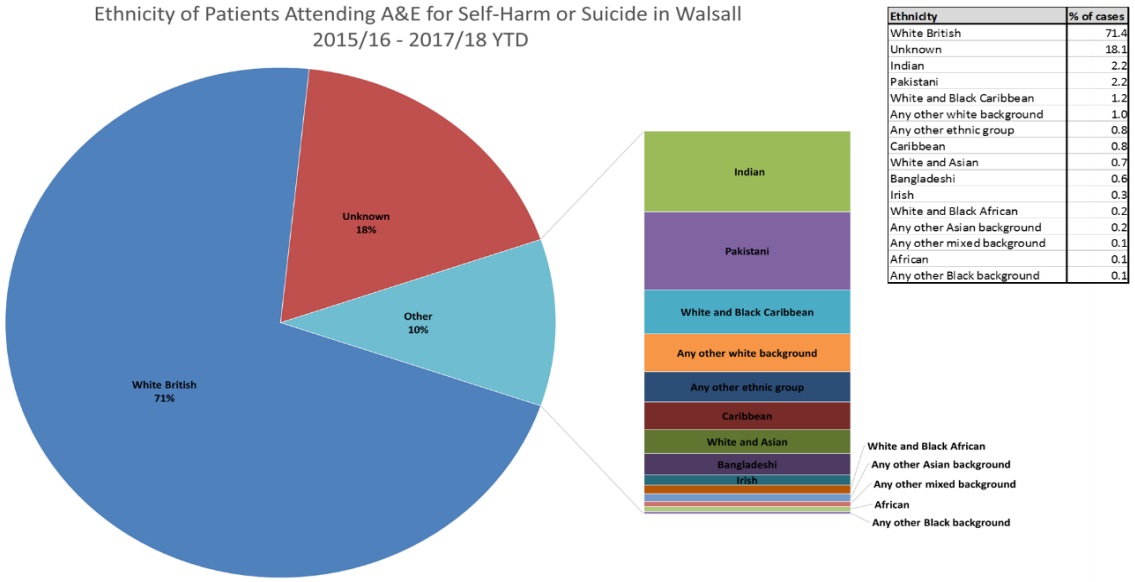
The number of attendances in the month of December in each age category has drastically declined between 2015 and 2017. The largest number of overall A & E attendances for serious self-harm were by males within the 19 to 65 age group categories. By contrast, attendances for serious self-harm were highest in the 0-18 and 76+ year age groups for females and in these categories were higher than attendance by males.

Suicide in Mental Health Patients

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness found that between 2004 -14, 28% of all suicides in the UK were by people who had had contact with mental health services in the last 12 months. Overall, rates of suicides amongst those under mental health care are falling (University of Manchester, 2016). National data suggests that 63% of those who die by suicide have a mental health diagnosis (University of Manchester, 2014).

A & E attendances suicide and self-harm by ethnicity

Understanding the diversity of need is an important factor in being able to support people from different backgrounds. The Serious incident review conducted in 2018 by the CCG captures an overview of attendance of A & E for serious incidents by ethnicity.



Ethnicity	% of cases
White British	71.4
Unknown	18.1
Indian	2.2
Pakistani	2.2
White and Black Caribbean	1.2
Any other white background	1.0
Any other ethnic group	0.8
Caribbean	0.8
White and Asian	0.7
Bangladeshi	0.6
Irish	0.3
White and Black African	0.2
Any other Asian background	0.2
Any other mixed background	0.1
African	0.1
Any other Black background	0.1

FIGURE 6. THE ETHNICITY OF ATTENDANCES FOR SELF-HARM AND SUICIDE

The largest proportion of Serious Incidents related to suicide and serious self-harm occurred in those classified as White British 1975 (71%) were classified as White British. The largest proportion of non-white groups were classified as Indian (64, 2.2%) and 289 were classified as unknown.

Data on ethnicity is generally not consistently captured across services within the health and social care sector, and is often viewed as a sensitive subject, often resulting in practitioners not asking or recording ethnic demographics (Siddique, 2014). More work is required nationally and locally to effectively capture ethnicity data in incidents of Self-harm and Suicide to enable the effective and appropriate targeting of support to at-risk groups.

Young people and suicide

Suicide is the leading cause of death among young people aged 20-34 years in the UK. In 2015, 1,659 young people took their own lives. Every year many thousands more attempt or contemplate suicide, harm themselves or suffer alone, afraid to speak openly about how they are feeling (Papyrus, 2018).

Perinatal mothers

Up to one in five women are affected by mental illness during pregnancy or within the first year after birth (Royal College of General Practitioners, 2018). More local data is required to understand the incidence of self-harm and maternal deaths by suicide in Walsall.

Risk of suicide in LGBTQ people

People who are LGBTQ are at an increased risk of death by suicide. Although being LGBTQ in itself is not a risk factor for suicide, there are higher risk indicators for suicide and self-harm amongst people identifying as LGBTQ. Among LGBT youth in the UK, one in two reported self-harming at some point in their life and 44% reported having thought about suicide (PHE, 2015). More local data is required to understand the incidence of self-harm and deaths by suicide amongst people identifying as LGBTQ in Walsall, to ensure that suicide prevention interventions are targeted appropriately.

Deprivation

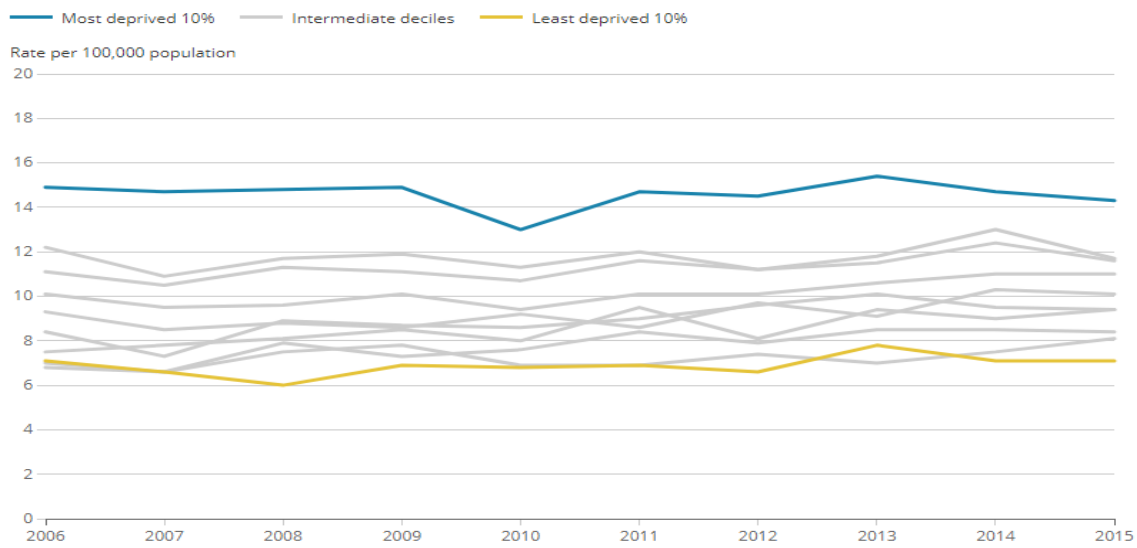


FIGURE 6. THE SUICIDE RATE PER DEPRIVATION DECILE IN ENGLAND 2006 – 2015.

People among the most deprived 10% of society are more than twice more likely to die from suicide than the least deprived 10% of society.

The Association of Unemployment with Suicide

A study conducted across various regions of England between 2000 and 2010, showed that levels of unemployment correlate strongly with suicides. Each year during this period saw a 1.4% increase in the number of male suicides in correlation with increasing unemployment. The association of unemployment and suicide among women was not significant.

The Association of Occupation with Suicide

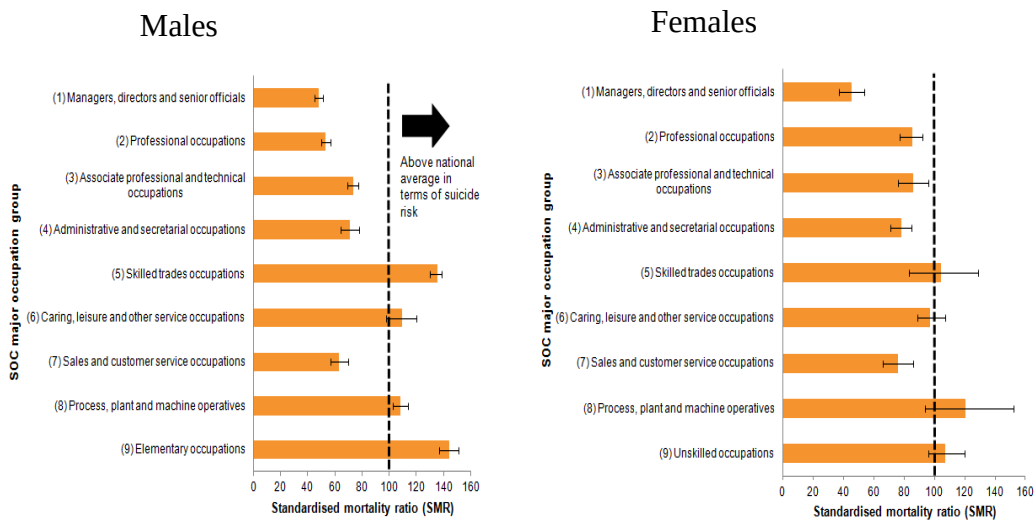


Figure 7. Incidence of suicide in each of the major occupational groups, as classified by the Standard Occupational Classification (Version 2010), in males and females, during 2011 – 2015 in England.

Amongst the 9 major occupation groups (Figure 7), elementary occupations (that is, low-skilled workers) had the highest risk of suicide, which was 44% higher than the national average. Suicides in this group accounted for 17% (1,784 out of 10,688) of all male suicides with an occupation recorded. Elementary occupations can be subdivided into “elementary trades and related occupations”, and “elementary administration and service occupations”. Risk of suicide varies widely between these 2 groups; for elementary trades the risk was almost 3 times above the national average but for elementary administration and service occupations the risk was no different to the national average (ONS, 2017).

Males working in skilled trades, for example, plasterers and decorators, also had more than double the risk of suicide. Other high risk groups include female culture, media and sport professions (69% higher) and female health professionals (24% higher), particularly female nurses. (ONS, 2017).

Occupation was not analysed in the suicide review due to low numbers with occupation recorded. National data shows that certain occupations are associated with higher risk of suicide. Individuals working in roles as managers, directors and senior officials had the lowest risk of suicide, in fact in corporate managers and directors, risk factors for suicide were more than 70% lower for both sexes.

Job-related features such as low pay, low job security and having access to, or knowledge of, a method of suicide increases risk *i.e*. doctors, dentists, nurses, vets and agricultural workers such as farmers were at increased risk of suicide.

Relationships

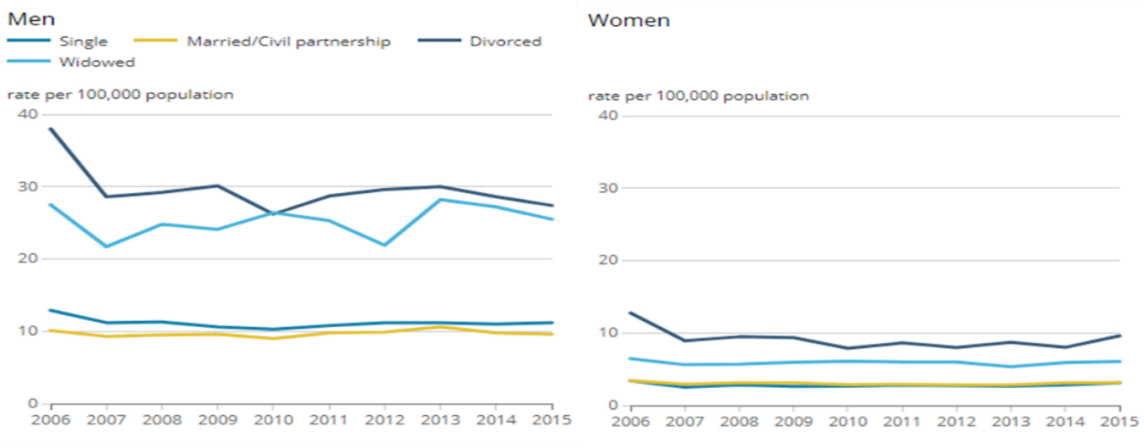


FIGURE 8. RATES OF SUICIDE IN MEN AND WOMEN BY MARITAL STATUS, IN ENGLAND AND WALES BETWEEN 2006 AND 2015.

Relationship breakdown can also contribute to suicide risk. The greatest risk exists among divorced men, followed by widowed men who in 2015 were over two and a half times more likely to end their lives than men who were married or in a civil partnership.

Method of suicide

In 2016 in the UK, the most common method of suicide for both males and females was hanging, suffocation and strangulation. Although this has been the case for many years, the proportion of deaths from hanging has steadily been increasing.

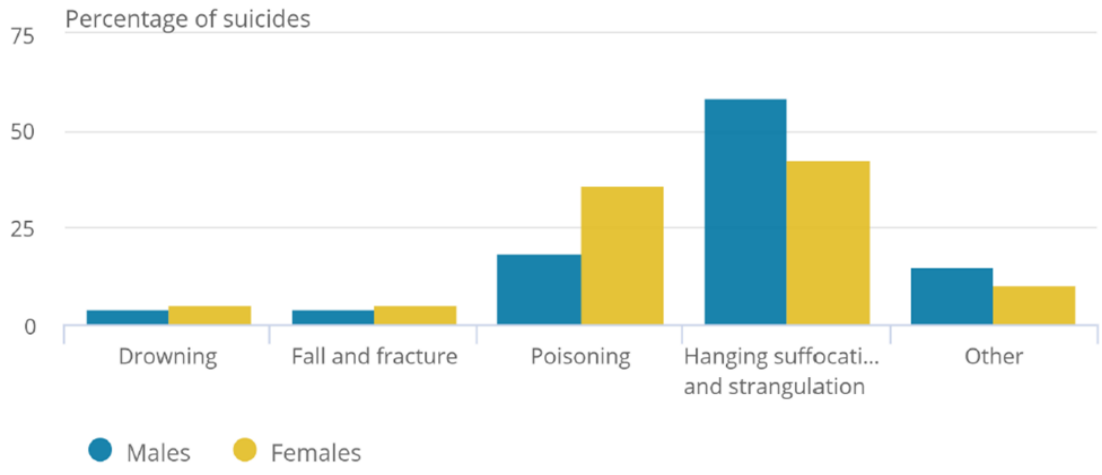
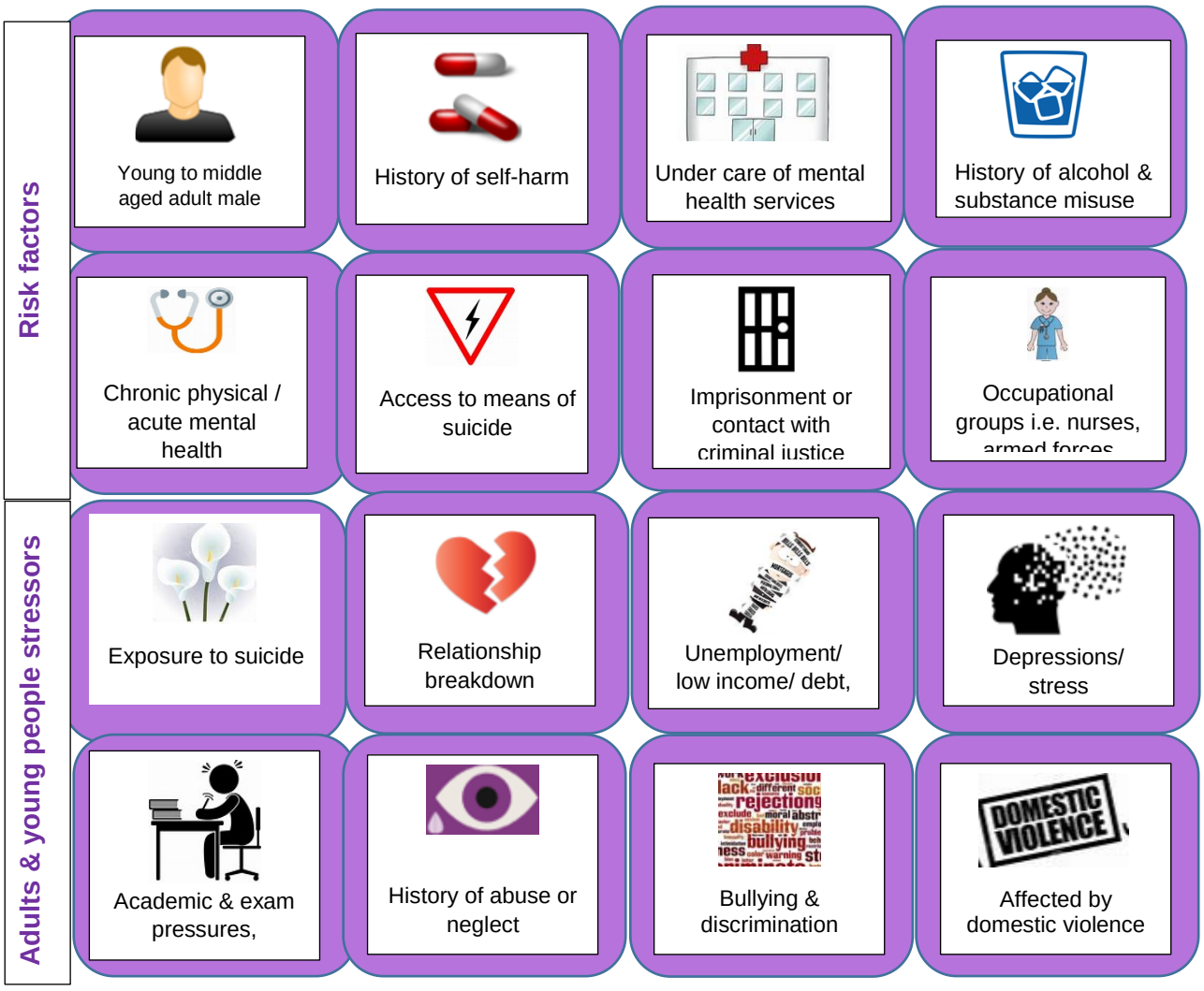


FIGURE 9. PROPORTION OF SUICIDES BY METHOD, FROM DEATHS REGISTERED IN 2016 IN THE UK.

Of all suicides occurring during this period, 58.7% of males and 42.8% for females were either hanged, suffocated or strangulated followed by poisoning, which was the second most common method of suicide for both males (18.3%) and females (36.2%). The proportion of deaths from drowning, falls and other methods has generally remained consistent for both males and females.

Understanding Suicide Risk

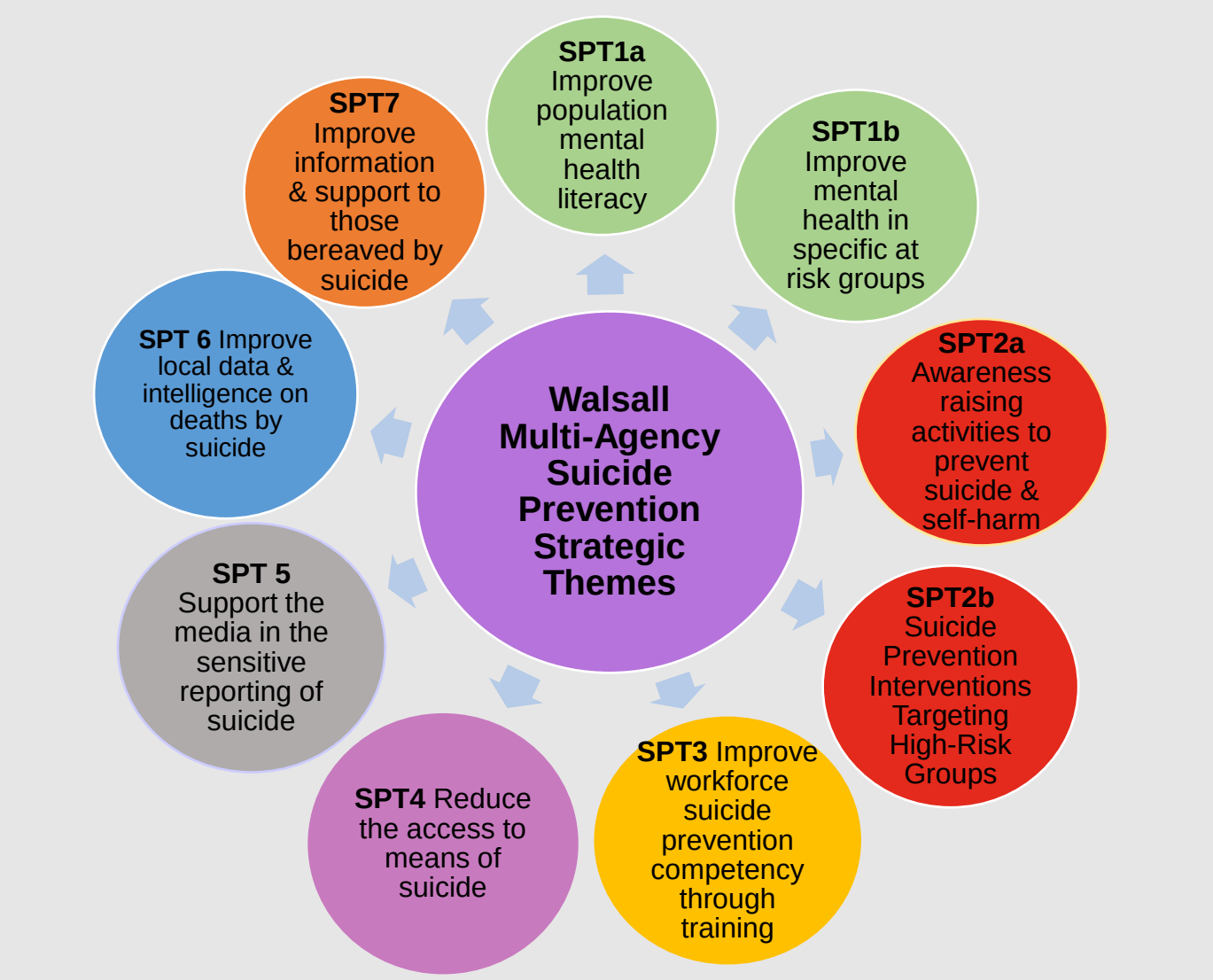
These national and local data demonstrate that suicide risks are often a multi-faceted complex set of reasons including economic adversity, increased family breakdown leaving more men living alone; the decline of many traditionally male-dominated industries; and social expectations about masculinity, lifestyles and being less inclined to seek help. The following provides an overview of the most significant predictive indicators that someone may have an additional risk of suicide.



Although there are significant predictive suicide risk indicators, this does not inevitably mean that they are personally at increased risk or that suicide is inevitable. This strategy therefore seek to prevent suicide across the populations and in particular in high risk groups.

Walsall Strategic Suicide Prevention Model

Following the consultation event with key stakeholders, the following themes were identified as key points for suicide prevention. The strategy is set out in the following strategic themes.



SPT1 Improve mental health literacy & well-being

In line with the national mental health and suicide prevention agenda, we in Walsall believe that everyone, irrespective of where they live, should have the opportunity to achieve good mental health and wellbeing. This strategy supports actions to enhance individual well-being, reduce mental ill-health and build community resilience.

SPT1a Improve the mental health literacy of Walsall

Our current local position

- Walsall is developing a local approach to improve mental health literacy and tackle mental health stigma and discrimination
- Recently increased investment in IAPT service
- Mental health first aid training is offered to people across Walsall communities
- Walsall Mental Health Enablement service undertake road shows raising mental health awareness
- Emotional wellbeing tool kit developed to sign post to support for children
- My Wellbeing tool for children in schools

Our current local challenges

- Stigma remains a huge barrier to recognising and addressing mental ill-health for the public and for those dealing with mental health conditions and symptoms
- Families not knowing where to go for support for their children and their adult loved ones
- Difficulty reaching people not in mental health services
- Insufficient accurate data is available at local level
- No local evaluation has been undertaken to understand the mental health impact of the economic down turn.

Where we want to be

- Achieve Walsall-wide wellbeing resilience and mental health literacy
- Create an environment where mental health stigma is openly challenged.
- Provide appropriate locally accessible early intervention and prevention services
- Respond to the voice and needs of the young people and their families
- Direct preventative and early intervention in all schools and towards looked after children, care leavers and NEET's in particular
- All women and their families understand the signs of perinatal depression are able to easily access support if in need

We will achieve this by

- Developing a steering group to coordinate community-based interventions to improve local population mental health literacy and reduce stigma Inc. in education
- Sourcing and promote the availability of accessible self-help mental health materials enabling adults (population wide)to recognise their own distress and understand how to improve their own wellbeing
- Building mental health awareness raising into public health, social care & health care contracts
- Improving emotional and wellbeing support and advice in workplaces in general and in particularly in predominantly male workforces
- Creating a mental health information and engagement hub - linked to MCW and facilitated by volunteers and peer mentors
- Recruiting and coordinating mental health and suicide prevention champions from within local communities

SPT1b Improve mental health in specific at risk groups continued

Our current local position

- Mental health staff embedded in the Integrated Health & Social Care Locality Teams
- Perinatal mental health support services are under development
- Health visitors, midwives and other partners trained to identify perinatal mental health need and to provide support for pregnant women and new mothers.
- Mental health recovery service for people experiencing mental ill health is available
- Mental health crisis car
- Making Connections Walsall service available to reduce elders isolation and loneliness

Our current local challenges

- A range of services are not available to appropriately meet the needs of high risk groups i.e. men, BME, LGBTQ, young people > or <17 years, carers
- No budget available to specifically target and meet the diverse needs of high risk groups i.e. men, African Caribbean, LGBTQ, young people > or <17 years, carers
- Those most at risk are least likely to seek help (unemployed, men and BME groups).
- Impact of social media on local on self-harm and suicidal behaviour
- Gaps in provision for people with unstable borderline Personality Disorder, dual diagnosis and autism
-

Where we want to be

- All people in Walsall have access to information and support when in crisis
- Intervention services are responsive to all those in mental health need
- Walsall improves population mental health in particular of groups at high risk of mental ill-health
- All services are aware of the Care Programme Approach (CPA) and offer carer support to those in need

We will achieve this by

- Encouraging the development of a range of appropriate services to meet the diverse needs of our Walsall population, including men, BME, LGBTQ, young people > or <17 years, carers, care-leavers and those who are unemployed
- Exploring the development of a crisis café people in crisis can access when in need
- Promoting and facilitating financial counselling and access to employment and benefits advisors for those in financial distress
- Developing a mental health prevention and crisis concordat group
- Developing awareness raising interventions that are appropriately and effectively targeted towards those identified as high-risk groups
- Co-produce interventions with all communities, in particular those most affected

SPT2 Activities Raising Awareness & Preventing Suicide & Self-harm

Having a number of protective factors in combination can significantly reduce a person's risk for mental ill-health, self-harm and suicide. These factors include: being in the presence of reasons for living; hopefulness and optimism; being in control of behaviour, high self-efficacy; physical activity, family connectedness; supportive schools and work environments; religious belief / traditions.

The partnership felt that statutory, private, community and voluntary sector organisations all have an important role to play in reducing suicide & self-harm. Activities seeking to prevent suicide and self-harm must also take into account the social and economic factors affecting the individual such as: family breakdown, income, employment, debt and housing etc.

SPT2a Awareness Raising Activities to Prevent Suicide & Self-harm

Our current local position	Our current local challenges
• DWMHPT Mental Health Suicide Prevention Group has prioritised ensuring robust policies and procedures are in place for suicide risk mitigation 2016-18 • Suicide prevention training is provided within the DWMHPT • Samaritans and British rail prevention campaign at hotspots across Walsall	• No budget available for, community engagement in suicide prevention activities • No specifically locally funded suicide prevention training available

Where we want to be

- Stigma preventing people accessing support is eradicated
- As a partnership we will undertake multi-stakeholder self-harm and suicide prevention engagement activities across communities
- All professionals across services are competent and confident having a conversation about suicide and providing appropriate support
- Walsall communities understand suicide risk and how to appropriately intervene
- Self-help, crisis advice and support is easily accessible

We will achieve this by

- Raising awareness of risk of self-harm and suicide within education with children and staff - Taking into account underlying causes involving technology such as cyberbullying
- Coordinating suicide prevention campaigns tackling stigma and raising awareness of suicide population wide including in education establishments
- Remodel adult crisis services and extending access of CAMHS to include prevention ensuring greater transition support
- Working towards ensuring all young people in education and NEET understand, are able to appropriately express their emotions, and access support including confidential support offered by Child Line

SPT2b Suicide Prevention Interventions Targeting High-Risk Groups

Suicide prevention involves taking an appropriate and timely approach to those in need. Suicide occurs in all population groups, and self-harm is a risk indicator affecting all groups. High risk groups are diverse and include; men, people who misuse substances, people under the care of mental health services, socially excluded groups, social and economic stressors to name a few. Reducing suicide risk in these high-risk groups therefore requires appropriate targeting.

Our current local position

- DWMPHT has a 3 yearly suicide prevention strategy and an annual suicide prevention plan.
- Reviews of suicides are undertaken by Walsall CCG to better understand the suicides occurring in Walsall.
- The DWMPHT Suicide Prevention Group has prioritised ensuring robust policies and procedures are in place for suicide risk mitigation 2016
- DWMPHT and the Beacon are actively working on agreeing an operational dual diagnosis protocol

Our current local challenges

- No budget available for, community engagement in suicide prevention activities
- No specifically locally funded suicide prevention training available for those working with high risk groups
- Barriers to engagement such as the diversity of language and culture
- Men more difficult to engage in prevention services

Where we want to be

- In keeping with the recommendation of the national suicide prevention strategy we aim to drive forward the multiagency borough-wide suicide prevention strategies and plans,
- Each agency within the wider partnership identifies its own suicide prevention objectives and priorities and commits to taking forward joint action to prevent suicide
- More consistent recording of diversity ethnic information is undertaken to better inform and enhance our suicide prevention approach
- Local organisations implement NICE guidelines on self-harm

We will achieve this by

- Working with money homes and jobs and food banks to provide mental health awareness raising and signposting to practical support to people in financial distress including facilitating access to financial counselling as appropriate
- Improving care pathways to enable appropriate and timely access to mental health services and between primary care, acute secondary care including A&E, secondary mental health care and discharge planning
- Developing a self-harm and suicide information sharing protocol between key partners
- Providing follow-up support for people presenting to A & E for self-harm or suicide attempts
- Exploring local strategies and contracts for substance misuse and criminal services to have suicide prevention risk protocol and a pathway to mitigate and reduce suicide and raise self esteem

SPT3 Improve workforce suicide prevention competence

Raising suicide awareness beyond the health and social care workforce professional boundaries is key to preventing suicide amongst identified vulnerable groups.

Our current local position

- Walsall Public Health Department currently has a workplace health service in place.
- A number of partners offer mental health first aid training to Walsall stakeholders including Walsall council and DWMHPT which touches on suicide
- DWMHPT Mental Health Suicide Prevention Group has prioritised training and supporting the workforce for 2016-18

Our current local challenges

- Lack of information on where to signpost people with suicidal thought
- No clear shared suicide prevention pathway is in place for those who are suicidal
- Limited capacity of organisations to respond to and engage proactively with individuals in distress and those perceived to be at high risk
- Confidence of practitioners in asking questions about issues contributing to suicide prevention such as domestic violence etc.
- Concerns of blame in professionals

Where we want to be

- To have a coordinated whole-system suicide prevention workforce across strategic partners including service users; the voluntary sector; statutory and private organisations
- Suicide prevention to be integrated into workforce policy and standard professional practice
- Suicide prevention is addressed through dual diagnosis and multi-agency working
- Front line staff have the confidence and capability to engage with distress and appropriately support those in need
- All workplaces actively promote, protect and improve workforce wellbeing and are equipped to effectively address underlying mental health sickness absence

We will achieve this by

- Making available appropriate multiagency training on suicide prevention and self-harm for all frontline staff (e.g. primary care, A&E, education, mental health, police officers and criminal justice, job centres, housing associations, pubs and clubs, mental health practitioners
- Enabling managers to identify and support staff who may be affected by mental illness, stress and anxiety
- Raising awareness of self-harm amongst people working in educational establishments
- Developing suicide prevention guidance proforma for frontline staff

SPT4 Reduce Access to the Means of Suicide

Reducing the access to the means of suicide is one of the most evidenced areas of suicide prevention and can include physical interventions (e.g. barriers on bridges), as well as opportunities for positive interventions.

Our current local position

- Advertisement placed for help from The Samaritans are placed at hot spot locations
- Prescribers follow appropriate guidelines on prescription medicines e.g. paracetamol through medicines management and trust policies
- DWMHPT work to identify and mitigate potential ligature risks in inpatient settings

Our current local challenges

- Walsall has a number of hotspots for suicide including the Black Country Junction 10 bridge. Access to medication, availability of medicines online e.g. helium and stockpiling in patients' homes, potential ligature risks in inpatient settings are also of local concern.

Where we want to be

- We want it to be harder for people experiencing emotional distress to have access to the means to take their own life
- When an individual approaches a high risk location they receive a message of hope and are signposted to easily accessible support

We will achieve this by

- Working with planning departments to build suicide prevention consideration into building planning processes
- Reviewing the safety of locations where suicides have taken place and consider appropriate mitigation, access to the Samaritans' national telephone number and messages of hope
- Support Network Rail, British Transport police and the Samaritans with general suicide prevention work

SPT5 Supporting the media in the sensitive reporting of suicide

According to the Samaritans. "Research shows that inappropriate reporting of suicide may lead to 'imitative' behaviour. For example, if vulnerable groups such as people with mental health problems and young people are provided with details about the method of suicide used, it can lead to more deaths using the same method."

Our current local position	Our current local challenges
• The suicide prevention strategic partnership has communication leads across organisations which are being harnessed to support the media in raising awareness and sensitively reporting incidents of suicide • We have access to the Samaritans' Media Guidelines for Reporting Suicide	The partnership raised concerns about • The role of the media in publicising high profile cases and celebrity suicides • The media's representation of suicide and mental illness potentially resulting in stigmatisation and "copycat" deaths. • The use of social media in cascading information about suicidal incidents

Where we want to be

- To adopt the Samaritans' Media Guidelines for Reporting Suicide which aimed at those reporting suicide in any media, guiding towards factual description rather than dramatic portrayal
- To have a policy in place which guides the local media to take a sensitive approach to suicide and mental illness reporting to reduce stigmatisation and copycat deaths
- Appropriately use the media to promote messages of mental health resilience

We will achieve this by

- Liaising with media professionals to support the press to use appropriate language
- Creating yearly campaigns and agree a local action plan to breakdown stigma Inc. supporting and "challenging stigma: Media campaign to support World Suicide Prevention Day

SPT6 Improving local data & intelligence on deaths by suicide

Accurate and timely suicide statistics are vital to the measure the success of any strategy. Analysis of circumstances surrounding suicide can identify risk factors, highlight trends and patterns and inform interventions to prevent further suicides.

Our current local position

- The suicide review conducted in January 2018 provided an overview of the current situation in Walsall.
- Local timely suicide prevention DWMHPT Suicide Prevention Group is working towards maximising learning from Serious Incidents and Investigations for 2016-18
- CCG currently undertake Suicide and Serious Incident reviews
- Public health intelligence available to integrate data

Our current local challenges

- Limited national and local suicide and self- harm data available
- Limited data available on some risk groups i.e. homeless service users, BME, LGBTQ and transient populations and a concerted effort is required to achieve improvement
- Sharing of data between partners i.e. GPs, hospitals, community services etc.

Where we want to be

- To have a shared process for monitoring suicides against the objectives of the national strategy
- To coherently and consistently undertake surveillance and reporting of self-harm and suicide ross the boroughs partners
- To learn lessons following every attempted or completed suicides in Walsall
- An area delivering best practice in suicide prevention where the incidents of suicide is vastly reduced

We will achieve this by

- Working in partnership to develop information sharing protocols to best utilise real time surveillance of suicides and near misses
- Working towards developing a local system which identifies and flags up those at risk
- Working with the Black Country Coroner Service to analyse data on completed suicide
- Developing and improving the process of identifying high risk individuals
- Continuing to monitor local suicide rates and attempts, admissions and incidents of self-harm
- Maintaining up-to-date directory on organisations relevant to suicide prevention ensuring that partners have information
- Disseminating lessons learned following attempted or completed suicides in Walsall

SPT7 Improve information & support to those bereaved by suicide

It is well recognised that people affected by suicide also have an increased risk of suicide and that the closer the relationship with the deceased the greater the risk. Addressing the impact of suicide and ensuring appropriate information and messages are given to the bereaved, is key to reducing the negative impact on others (Pitman et al, 2016).. Bereavement support required varies according to the individual and their relationship with the deceased.

Our current local position	Our current local challenges
• WPH provides general counselling support services, including for those affected by suicide. • Walsall Bereavement Support Services provide bereavement support only to children.	• Time lapse between incident and support to those bereaved • Lack of funding has resulted in the decommissioning of adult bereavement services. • People do not know about available local services. • Domestic arrangements post-suicide e.g. funerals and pensions are of concern. • Pathways for bereavement services are non-existent between services. • No clarity over what information should be given to relatives.

Where we want to be

- Have a pathway for bereavement service developed to support those bereaved by suicide
- Improve information and support to those bereaved by suicide ensuring those bereaved by suicide are given timely support
- commissioners, providers and users in Walsall to collaborate to ensure appropriate suicide bereavement support is available

How we will get there

- Developing a multiagency information sharing protocol which identifies those bereaved by suicide
- Undertaking suicide debrief for working directly on an suicide incident or with the bereaved family
- Developing pathways for bereavement services
- Updating and maintaining Council, CCG, NHS and other stakeholder webpages to ensure effective signposting for those bereaved by suicide
- Resourcing suicide support services
- Identifying and providing appropriate support to individuals bereaved by suicide Inc. Give 'Help is at Hand' leaflets to carers and families, signposting to bereavement services and Update and maintain local webpages

Making It Happen – Leadership, Partnership & Resources

Suicide prevention is most effective when it comprises part of wider work addressing the social and other determinants of poor health, wellbeing or illness. We believe that our strategy, does this by seeking to tackle and address the 'risk factors' and encourage and support the 'protective factors'.

Leadership

Robust leadership will be vital to delivery of this suicide prevention and mental health promotion strategy. It is envisaged that the mental health partnership board will provide strategic leadership. The local NHS and local Authority are to act as 'exemplars' to enable the widening of this strategy across partners.

Partnership Working

It is clear that improving mental well-being and preventing suicides in Walsall is a challenging task. It is only possible if all partners across the borough accept responsibility for joint action and delivery. It is vital that the opportunities provided by these potentials are fully exploited.

Whilst partnership working at a strategic level is vital, greater partnership working at a community level is also crucial. Non statutory partners and local community organisations have a key role to play. A major aim of this strategy is to maximise the potential of the 'third sector' in delivering improved mental health and well-being for Walsall residents.

Resources

This strategy is written at a time of significant financial constraints. Commissioners operating at a locality level are encouraged to commission from a range of providers, including private and "third sector" organisations.

Whilst much may be achieved through working "smarter" and with a greater partnership focus it is clear that resources will be required to achieve Walsall wide improvement in mental well-being and suicide prevention locally. Key resources required in the short-term include:

- Appointment of a mental health / suicide prevention programme officer.
- Dedicated capacity of an information officer to develop and maintain a suicide surveillance system for Walsall.

Further financial planning will be required to identify commissioning priorities and deliver this strategy over the next 5 years. At present, the Walsall Suicide Prevention Partnership do not have a comprehensive training strategy for suicide prevention and mental health promotion. The development /commissioning of a comprehensive training programme is needed to underpin the delivery of this strategy.

Risks

Aligning this strategy with the broader mental health agenda, mental health commissioning vision, financial plans is a real challenge. The success of this strategy is reliant on the prioritisation of financial investment.

How we will monitor, evaluate and review strategy impact

It is anticipated that implementation, quarterly review and evaluation of this strategy will be led by a specialist in mental health promotion, and an across agency steering group, accountable to the mental health partnership board. We will evaluate the impact of the strategy by monitoring the following areas:

- Inviting and valuing the views and feedback of people who have been affected by suicide bereavement,
- Monitoring the views and experiences of service users and their carers,
- Monitoring the views of professional staff,
- Inviting and valuing feedback from community groups and individuals,
- Local suicide rates; attempts and admissions and incidents of self-harm,
- Incidence of help-seeking behaviours, such as use of telephone help lines,
- The numbers recorded as experiencing suicidal ideation,
- The use of standard questionnaires to monitor depression and anxiety, and the improvements in waiting times, access and completion rates for treatment of depression.

This will be achieved through the:

- Strategic leadership of the Mental Health Partnership Board.
- Appointment of a co-ordinator for suicide prevention and mental health promotion.
- Establishment of a clear evaluation and monitoring system.
- Establishment of a comprehensive training programme to underpin actions in strategy.
- Refinement of resource implications and include in commissioning plans.

Strategy Alignment

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. To ensure that the Walsall Suicide Prevention Strategy is not a 'stand-alone' initiative, but one that informs and is informed by other strategic initiatives through inclusion of relevant partners/stakeholders, we are working to align and / or incorporate the Walsall Suicide Prevention Strategy with other strategies and programmes including:

- Mental Health and Wellbeing strategies,
- Crisis Care Concordat,
- Sustainability and Transformation plans,
- Walsall (CAMHS) Transformation Plan
- Walsall Partnership - Toxic Trio Strategy
- Homelessness service Review2008
- DWMHPT Self-Harm Policy for Walsall CAMH Service
- DWMHPT Investigating Deaths (Mortality Review) Policy 07/09/2017
- Network Rail and Highways England covering road, rail, bus, tram / metro and waterway services and infrastructure
- Black Country Reducing Reoffending Strategy 2018 – 2020
- The Walsall plan
- Green spaces strategy
- Volunteer strategy
- Workforce strategy
- Social care mental health strategy

Where to go for help in Walsall

There are a range of mental-wellbeing and suicide-prevention resources, services and support available either nationally or locally.

Someone to talk to in time of need

- C.A.L.M.: National helpline for men to talk about any issues they are feeling, which exists to prevent male suicide in the UK - 0800 58 58 58 – an online web chat service is also available at www.thecalmzone.net
- Papyrus is a dedicated service for young people up to the age of 35 who are worried about how they are feeling or anyone concerned about a young person. 0800 068 41 41 - www.papyrus-uk.org text 07786 209697 or email pat@papyrus-uk.org
- Rethink national advice service - 0845 456 0455
- Samaritans 116 123 (free to call) Samaritans offer emotional support 24 hours a day
- SANEline provide mental health information and support between 4.30pm – 10.30pm daily 0300 304 7000 http://www.sane.og.uk/

Emergency intervention

If you are concerned about an immediate risk of harm to yourself or someone else call:

- 999 or go to your nearest A & E department.
- Dudley Walsall and mental health trust- Crisis service

Advice and guidance

- NHS Choices: 24-hour national helpline providing health advice and information - 111.
- Walsall Citizen's Advice Bureau - 0300 330 1159
- Walsall Council Welfare Rights and Debt - 01922 652250
- Walsall Council Early Help – 0300 555 2866 (Option 1)
- Walsall M.A.S.H - 0300 555 2866

Bereavement

- Survivors of bereavement by suicide 0844 561 6855
- The road ahead a guide to dealing with the impact of suicide from if u care share foundation https://www.ifucareshare.co.uk/support/support-after-suicide/resources
- Help-is-at-hand after the suicide: booklet providing practical support and guidance for those bereaved by suicide. It also contains a more extensive listing of other relevant resources. www.supportaftersuicide.org.uk

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Appendix - Walsall Multi-Agency Suicide Prevention Governance Arrangements