LONDON BOROUGH OF LAMBETH SUICIDE PREVENTION STRATEGY

2018-2021

EXECUTIVE SUMMARY

INTRODUCTION

Mental Health and Wellbeing has been an area of focus in Lambeth for many years. Through our local partnerships we have developed innovative and person centred approaches to supporting people affected by mental illness. Rates of suicide in Lambeth are generally lower than England. However, there are more people affected by mental illness. It is therefore important that we retain this focus on broader mental health issues within the requirement to have a suicide prevention plan. One suicide is one too many. In view of this our suicide prevention strategy and action plan focuses as much on the wider context of poor mental health as a potential risk factor as it does on suicide itself.

WHY SUICIDE IS A CONCERN

- Suicide is the leading cause of death among young people aged 20-34 years in the UK (ONS 2015), accounting for 24% of deaths in this age group in men and 12% in women. It is also the leading cause of death among men aged 35-49 (followed closely by heart disease).
- Lambeth has a higher prevalence of some of the key risk factors for suicide than the benchmark for England (including severe mental illness and substance misuse)
- Many of the risk factors and social determinants which make people vulnerable to suicide are more prevalent in times of economic instability: loss of employment, debt, relationship breakdown, substance misuse and loneliness are known contributory factors for suicide.
- We therefore need to ensure that all those who are in known "at risk" groups receive the support they need to build up protective factors and to ensure that they have access to help in times of crisis. Suicide prevention needs to be part of a wider effort to promote mental wellbeing and to improve individual and community resilience.

WHAT WE KNOW

- The number of deaths from suicide in Lambeth each year is 24 (average over period 2014-2016, source: Primary Care Mortality Data)
- The suicide rate in men in Lambeth is almost 3 times higher than in women.
- The suicide rate in Lambeth for all persons (10.2 per 100,000 population) is similar to that for London (PHOF, data for 2014-2016)
- Individuals with a history of self-harm are at increased risk of death by suicide. Our admission rate for intentional self-harm is similar to the London benchmark (the Lambeth rate was 100 per 100,000 population in 2015/2016). Self-harm is more common than suicide and it is important that we provide early interventions for people with a history of self-harm.

WHAT WE WILL DO

- The purpose of this strategy is to provide a multi-agency framework for action across the life-course to prevent avoidable loss of life through suicide. It draws on local experience and research evidence, aiming to prevent suicide and promote mental health and wellbeing.
- Our key priorities will be: 1. People who are vulnerable due to economic circumstances, 2. Children and young people, 3. People who misuse substances, 4. People in the care of mental health services, 5. BME groups, migrants and asylum seekers 6. Improving access to timely suicide and self-harm data

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ACKNOWLEDGEMENTS

With thanks to all those who have helped us with the strategy through signposting and contribution at consultation events. Particular thanks to Denis O'Rourke, James Crompton, Ian Diley, Ruth Hutt, Sarah Corlett, Hiten Dodhia and Judith Eling and the members of the Lambeth Living Well Collaborative.

FOREWORD

While Lambeth has a relatively low suicide rate, each year in Lambeth, around 24 people take their own lives. The consequences of each one of these deaths from suicide is far reaching, affecting on average an additional 10 people.

Suicide has many causes and the majority, if not all of these deaths are preventable. Mental health is a key factor but the majority of those who die by suicide were not in contact with mental health services. The causes are a complex interaction of individual risk factors (such as ill health, substance misuse, mental illness, history of trauma); social risk factors (such as debt, isolation, relationship breakdown or racism) and wider environmental factors (economic recession, housing crises). As such, there is no one solution to preventing suicide.

A thriving and prosperous local economy, safe communities, a focus on health and wellbeing and a strong start in life can reduce some of the risks of suicide.

We will make use of our networks across London and SE London as well as our local partnership to maximise the impact of our local suicide prevention plans, working at scale where appropriate, but recognising that many of the actions will be local and set within a Lambeth context.

No single organisation can do this alone. We will work through existing agencies and partnerships to build upon and strengthen the actions that we know have an impact. The strategy will build on the approaches developed with the Lambeth Living Well Collaborative and Black Thrive working closely with communities to develop effective approaches which can make a real difference and reduce the number of people who take their own lives.

Councillor Jim Dickson

London Borough of Lambeth

February 2018

INTRODUCTION

The impact of an individual dying by suicide or making an attempt to do so are far reaching. The death will profoundly impact on people in the individual's workplace, family and community. It is estimated that for every person who dies at least 10 people are directly affected. The death will impact on their ability to work effectively, to continue with caring responsibilities and to have satisfying relationships. The impact of a death by suicide thus extends into future generations. The economic cost of suicide is also substantial (estimated to be £1.67 million for the death by suicide of someone of working age).

Suicide risk reflects wider inequalities as there are marked differences in suicide rates according to people's social and economic circumstances, with those in poorer communities more likely to be affected. People in the lowest socio-economic groups living in the most deprived geographical areas are 10 times more at risk of suicide than those in the highest socioeconomic group living in the most affluent areas. Approaches aiming to protect those who are vulnerable in this way (for example people in debt or who are homeless) are vital to reducing risk.

There are specific factors that increase the risk of suicide. The strongest identified predictor of suicide is previous episodes of self-harm. Mental ill-health and substance misuse also contribute to many suicides.

Suicide is preventable and it is our collective responsibility to do all that we can to reduce deaths through suicide. This must be through a multi-agency approach bringing together the Council, primary care and secondary care services, voluntary and third sector organisations as well as communities and individuals. A strategy that is to succeed in reducing suicide deaths needs to combine a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide.

AIMS

Nationally, a target has been set for the suicide rate in England to be reduced by 10 percent by 2020/2021, with the starting point taken as the publication of the Five Year Forward View for Health in 2016. The national plan says that all local areas should have multi-agency plans contributing to a 10% reduction nationally. At a local level, it would be difficult to demonstrate a 10% reduction in a meaningful way, as suicide numbers tend to fluctuate year-on-year and a 10% reduction of the suicide rate in Lambeth would translate into very small numbers of individual deaths, which could be difficult to distinguish from this underlying variation.

Some local authorities have adopted a Zero Suicide approach. A zero suicide approach acknowledges that while it may not be possible to prevent every suicide, we should aspire to do so. Zero Suicide is not a short-term performance measure, rather it is concerned with not accepting any suicide as inevitable, and is an approach that aims to transform attitudes to suicide prevention.

The strategy for Lambeth aims to contribute to the 10% target set nationally, with the intention that this will foster our bigger ambition and aspiration, which is to prevent every suicide.

UNDERSTANDING SUICIDE IN LAMBETH

Every year, around 24 people living in Lambeth will die from suicide. There are also a significant number of suicide deaths that occur within the borough of people who are resident in other local authority areas. An essential part of effective suicide prevention is understanding who is dying from suicide, where they died, what methods they used and what risk factors might have contributed to the suicide.

We have some of this information from the data that was available to the Public Health Intelligence Team as well as data that was available through open sources; we would have a better understanding of local issues related to suicide if we had information from a detailed suicide audit using coroner's data and this may be possible in the future.

The text below summarises key points from data analysed to date. The full analysis can be found in the as a fact sheet on our Lambeth JSNA website to this strategy document.

KEY STATISTICS FOR LAMBETH

NUMBER OF SUICIDE DEATHS EACH YEAR

Over the 3-year period 2014-2016, on average 24 Lambeth residents died each year from suicide.

One quarter of these were female.

SUICIDE RATES

- Suicide rates vary significantly between the regions and countries of the UK. Northern Ireland has the highest rate, followed by Scotland, then Wales, with London having the lowest.
- Within London, there are no significant differences between the suicide rate in Lambeth and the rates in its statistical neighbours. The suicide rate in Lambeth 2014—2016 was 10.2 per 100,000 population.

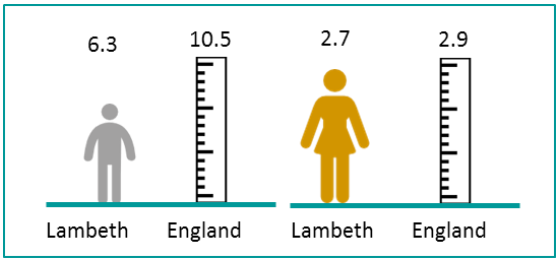
TRENDS

There has been a general decrease in suicide rates in Lambeth, London and England in the period 2001-2016.

AGE

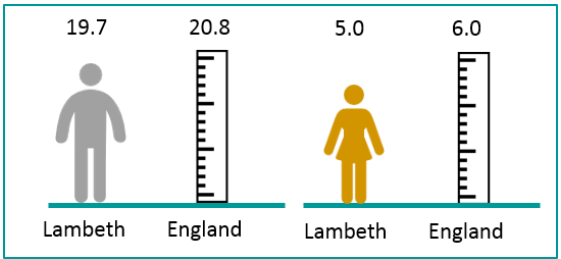
Most suicides in Lambeth occur in people aged between 20-50 years.

In males, the most frequent age band is 30-39 year olds whereas in females it is 20-29 year olds.



Age 10-34 years

Suicide crude rates per 100,000, Lambeth residents, 5 year average (2011-15), male and female (source: PHOF) compared to benchmark (crude rate for England)



Age 35-64 years

Suicide crude rates per 100,000, Lambeth residents, 5 year average (2011-15), male and female (source: PHOF) compared to benchmark (crude rate for England)

- The suicide rate for men in the age range 10-34 years is lower than the benchmark (England).
- For women the rate is similar to the benchmark (though numbers have been combined for all female suicide deaths in London as they are too small to analyse by borough).
- In the older age group (35-64), the rate in men is similar to the benchmark (England), whereas in women it is lower than the benchmark (again, the rate given for women is that for the whole of London).

LOCATION OF SUICIDE

Key points

- 47% of suicide deaths in Lambeth residents or occurring in Lambeth were certified in hospital. However most of these deaths had not occurred in hospital and were therefore excluded from the analysis of location.
- 59% of suicide deaths occurred in residential premises (excluding deaths where location was unknown)
- Of known non-residential locations, the commonest were train stations and rail tracks, followed by the River Thames and parks, churchyards and cliffs.

COUNTRY OF ORIGIN

Key points

- Ethnicity is not recorded in ONS data and was not available in the PCMD dataset analysed. The best available proxy was “country of origin” of the deceased.
- At the time of the UK census 2011, 38% of the population of Lambeth was non-UK born.
- Local data suggests that there are differences in suicide rate linked to country of origin, with a particularly high rate in people born in North America and the Caribbean, however due to the small number of suicide deaths it is not possible to demonstrate a statistical difference.

METHOD OF SUICIDE

Key points

- Hanging, strangulation and suffocation are the commonest suicide method overall and the commonest in males, whereas in females death by poisoning is marginally more common than hanging.
- Poisoning has become less common over the time period analysed (2001-2017), while there has been a slight increase in the proportion of suicides occurring as the result of hanging/strangulation/suffocation. There has been little change over time in the proportion of deaths occurring by jumping or falling.

OCCUPATION

Key points

- The largest number of suicide deaths occurred in people who were unemployed or students or retired.
- In people recorded as having an occupation, the largest number were working in skilled trades, followed by professional occupations.
- Local data suggests that people working in certain occupational groups are at significantly increased risk of suicide. The group with the highest rate is those working in skilled trades occupations (predominantly, in Lambeth, those in skilled metal, electrical and electronic trades, textiles, printing and other skilled trades, and skilled construction and building trades). The second highest rate is in those working as process, plant and machine operatives (predominantly transport and mobile machine drivers and operatives).

SELF HARM

Key points

- The number of emergency admissions for self-harm is much larger than suicide counts each year; and those admitted for self-harm represent only a proportion of those who self-harm as many people do not present to hospital after a self-harm episode
- The peak age group overall and in males is 20-29 year olds; in females the peak spreads across the 10-19 and 20-29 year age bands.
- Just over half of admissions for self-harm are in people of white ethnicity, about 17% are in black ethnicities (about a third each African, Caribbean and other Black background).
- 6% of those admitted due to self-harm are discharged to a mental health inpatient unit, and a further 1% to a high security psychiatric unit.
- The majority of self-harm admissions occur as a consequence of exposure to drugs (prescribed and non-prescribed)
- The second most frequent reason (9%) is intentional self-harm by a sharp object.
- The most common type of drugs used in self-harm are non-opioid analgesics, antipyretics and antirheumatics: 37% of all admissions (this groups includes paracetamol and ibuprofen).

Deprivation

- Analysis of suicide rates by IMD (Index of Multiple Deprivation) decile band shows that there is a far larger burden of suicide deaths in the 5 most deprived deciles compared to the 5 least deprived.
- The life expectancy gained if the most deprived quintile in Lambeth had the same mortality from suicide as the least deprived quintile would be 0.14 years in males, and 0.02 years in females (PHE 2015).

Risk factor prevalence

Key points

Lambeth has a higher than average prevalence (as compared to England as well as to London) for the following risk factors for suicide:

1. Substance misuse (both alcohol and opiates and/or crack cocaine use)
2. Severe mental illness
3. Contact with the criminal justice system (in children/young people aged 10-18)
4. Loneliness (as measured by % of households occupied by a single person)
5. Children in care/care-leavers

Currently unknown

The following characteristics of individuals who died from suicide and other additional details are not available from current data but would be very valuable in understanding suicide patterns and local issues in Lambeth:

- Ethnicity and protected characteristics
- Chronic ill health/disability/terminal illness
- Substance misuse
- Engagement with mental health services and other services
- Local context (e.g. large-scale local redundancies by a single employer)
- High-frequency locations (as almost half of deaths certified in hospital, location information is missing for almost half of all suicide deaths)
- Immigration status and refugee status

AREAS FOR ACTION

We have adopted the 6 initial key priority areas and the 7th, recently added key area, from the national suicide strategy (DH 2012) to develop a set of priorities for Lambeth. The 7 key areas are:

1. Reducing the risk of suicide in key high risk groups
2. Tailoring approaches to improve mental health in specific groups
3. Reducing access to means of suicide
4. Providing better information and support to those bereaved
5. Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Supporting research, data collection and monitoring
7. Reducing rates of self-harm as a key indicator of suicide risk

Joint Actions with South East London Mental Public Health Group

The SE London Mental PH Group has been meeting bi-monthly to discuss ways of working together on public mental health improvement; one of the key areas discussed was suicide prevention. Joint working is proposed as being the preferred approach in the following action areas:

- Working collaboratively with coroners and other agencies to improve data collection and intelligence in relation to suicide
- Provision of training programmes on suicide prevention (e.g. STORM training)
- Reducing access to means of suicide (e.g. working with Network Rail, TfL, British Transport Police)
- Responsible reporting of suicides by media and local press
- Providing better information and support to those bereaved or affected by suicide
- Improving access to crisis support and counselling for people in at risk occupations (e.g. outreach via Trade Associations)

Working across South East London and London creates economies of scale for some elements of suicide prevention which cross borough boundaries.

Local Priority Actions

Priority action areas were identified on the basis of local need (data analysis and consultation), discussion with STP partners and the literature on suicide and self-harm trends and risk factors. A mapping exercise was undertaken highlighting the evidence of what works in suicide prevention, what the Lambeth situation is and local developments planned. The full analysis can be found in appendix I.

SUMMARY OF PRIORITY AREAS FOR ACTION

Priority areas that we have identified in Lambeth are:

1. People who are vulnerable due to economic circumstances,

2. Children and young people,

3. People who misuse substances,

4. People in the care of mental health services,

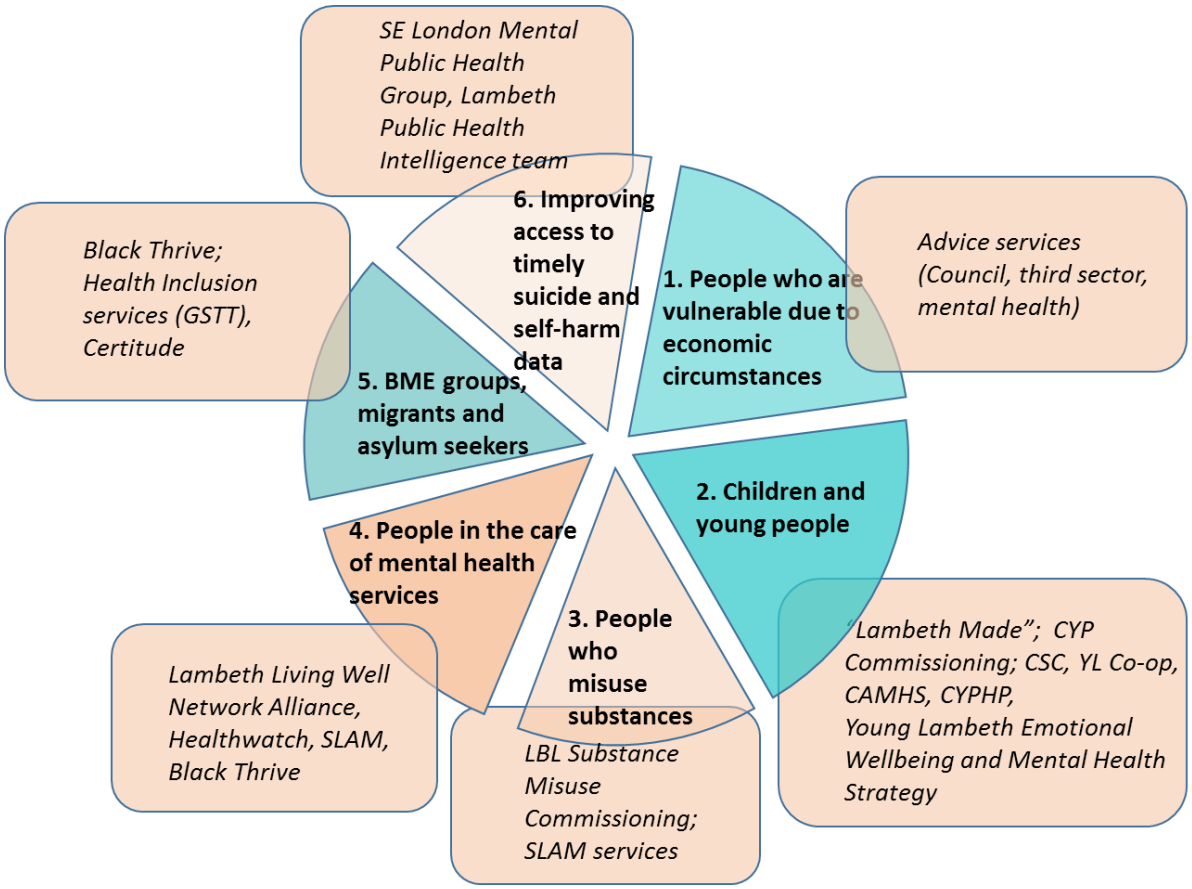
5. BME groups, migrants and asylum seekers

6. Improving access to timely suicide and self-harm data

Priority Actions are based on evidence of what works and knowledge of local programmes following engagement with a range of local stakeholders.

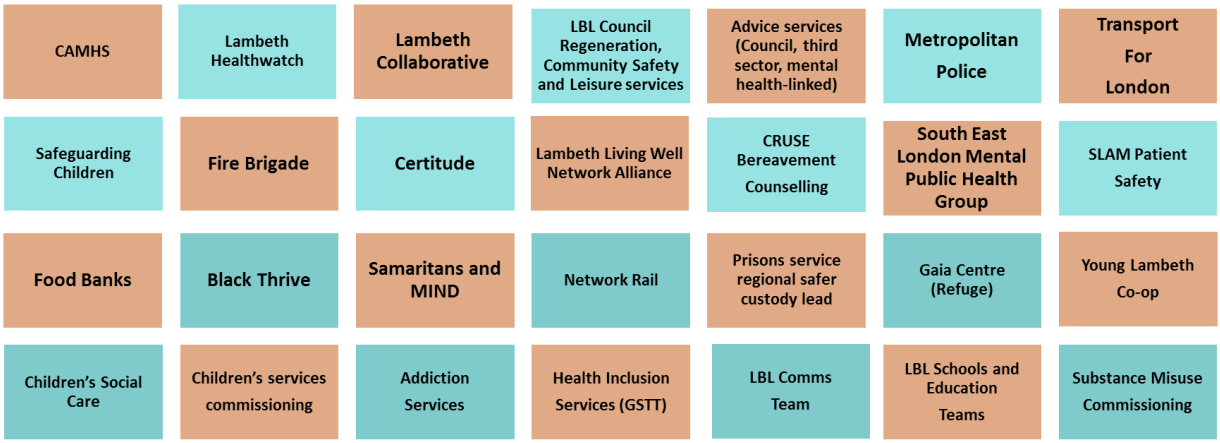
PRIORITY AREAS AND OVERLAP WITH EXISTING WORK PROGRAMMES

The diagram below illustrates the services, strategies and programmes that are already operating across that borough which relate to the six priorities we have identified for our suicide prevention strategy.



OUR SUICIDE PREVENTION PARTNERSHIP APPROACH

The combined knowledge, experience and resources of organisations across all sectors are necessary in order to achieve the ambitions of this suicide prevention strategy. We have started to engage with the following partners, with the aim of building a network for suicide prevention across Lambeth:



GOVERNANCE

The Suicide Prevention Strategy has been developed by the Lambeth Public Health Team (London Borough of Lambeth) with support from the Lambeth Living Well Collaborative and other partners. It is meant to be a "live" document with an annual action. It will report into Staying Healthy Board, with overall Governance resting with Lambeth Health and Wellbeing Board. The Strategy will run from 2018-2021, with a 6-monthly review of the action plan.

MONITORING AND EVALUATION

An annual action plan will be produced for each year of the strategy. The priorities for the first year are outlined in Appendix II.

The fundamental outcome which this strategy aspires to contribute to is a reduction by 2020/2021 of at least 10% in the number of people dying by suicide, compared to 2016/2017 levels.

The relatively small number of suicides at local level make it difficult to measure a significant change in rates. However, there are alternative methods of monitoring success in reducing suicide attempts and self-harm, and a set of indicators will be developed in conjunction with a more detailed elaboration of the action plan.

APPENDIX I – PRIORITY ACTION AREAS

Priority action areas were identified on the basis of local need (data analysis and consultation), discussion with STP partners and the literature on suicide and self-harm trends and risk factors. Priority action areas have been highlighted in shaded rows in the action plan.

Area for action	What works	Lambeth position	Local developments planned
Men	Delivering information and support through trusted sources e.g. through peers, and undertaking outreach work in the community	Ratio of deaths in Lambeth is in line with national expectations. There are no Men's Sheds listed in Lambeth in open directories.	
People in the care of mental health services	Ensuring access to specialist community teams, providing 24 hour crisis care and developing local policies on dual diagnosis patients	Lambeth has an "evening sanctuary" for out-of-hours crisis support at the Mosaic Clubhouse Certitude provides "Solidarity in a Crisis" out of hours emotional support over the phone and in person (peer support). The service is available Mon-Fri 6pm to 12 midnight and Sat and Sun 12 midday to 12 midnight	Planned transformation of adult mental health services Data is being obtained from SLAM on the numbers of Lambeth patients who have died from suicide
People in contact with the criminal justice system	Providing suicide awareness training for those who work in prisons, probation services and the courts and focus interventions on transition times	Lambeth has a prison in its geographical area (Brixton) though the majority of prisoners are not residents. There have been suicide deaths at the prison historically. NHS England commission offender health contract. The Regional Safer Custody Lead runs a developmental programme for all London prisons (due to be implemented in HMP Brixton during 2018). Risk assessment training is also provided to mental health nurses working in police stations (including Brixton). The National Probation Service provide a 2-day suicide prevention training to all staff. The NPS has a Suicide Prevention Action.	Engagement with PHE Justice Health Team and London Safer Custody Lead

			Engagement with LBL YOS and with probation service
Specific occupational groups	Encouraging employers to promote mental health in the workplace and reduce stigma to increase help seeking behaviour. Working with local occupational health services to strengthen support available to employees	Local data shows that specific occupational groups are at higher risk of suicide, particularly those working in skilled building trades, and in elementary administration and service roles ONS data shows nationally there is higher risk in certain other groups also, including in school teachers	Mental health and wellbeing have been considered in the recommissioning of the Occupational Health Service and Employee Assistance services for Council and School staff Lambeth Council Leadership Essentials (phase 1) being offered to all people managers and has wellbeing as one of the cross cutting themes. It specifically refers to supporting staff and developing staff as well as being supportive and addressing wellbeing issues within management
People who misuse drugs and alcohol	Integration of assessment, care and support for people with co-morbid substance misuse and mental health problems (dual diagnosis)	Local data shows that Lambeth has rates of substance misuse that are higher than the benchmark A number of commissioned services operate in the borough: Lambeth Consortium (community support), Drug and Alcohol Service (tier 2 and 3), Lambeth Harbour (recovery) as well as third sector services: Aurora Project (peer mentoring)	
Community-based approaches	Education of primary care doctors targeting depression recognition and treatment	Suicide prevention training (STORM training) is provided free to frontline staff (3 sessions provided 2016-2017)	Mental health promotion provision is due to be reviewed (SLAM/CCG)

	Community based awareness campaigns to reduce stigma and discrimination and increase help seeking behaviour Providing suicide prevention training to specific groups of people who have the greatest opportunity to identify people at risk of suicide e.g. GPs, faith leaders, teachers Providing financial and debt counselling support to vulnerable individuals	The current mental health promotion offer includes a number of training sessions for community organisations MHFA (Mental Health First Aid) training sessions are offered to frontline staff-6 courses offered in 2016/2017 to volunteers/voluntary sector staff Brixton Reel Film Festival Wellbeing Communities Network Event Small grants fund for mental wellbeing Mental Wellbeing blog	No current mental health and wellbeing strategy
Children and Young People	Developing schools-based awareness programmes targeted at specific times in the curriculum e.g. exams and transitions		The Young Lambeth Emotional Wellbeing and Mental Health Strategy and Plan 2015-2020 Lambeth Made: Children and Young People's Plan for Lambeth 2017-2022 "Chat Health"-messaging service for young people in Lambeth and Southwark, giving access to a school nurse for advice, including on emotional health Well Centre in Streatham is a youth health centre; a counsellor is part of the team

			APHR 2016/2017 focus on CYP
People who are vulnerable due to economic circumstances	Collaborating with voluntary sector and housing association and homelessness services to provide and promote financial and debt counselling support to vulnerable individuals Providing suicide awareness training to frontline service providers across education, housing, employment	Longstanding higher than average levels of deprivation in Lambeth as well as recent austerity measures mean that this is an important priority for the borough	Local advice services include: Advising Communities Brixton Advice Centre Lambeth Law Centre Citizens Advice Lambeth There is a Food Bank in Norwood
Pregnant women and those who have given birth in the last year	The perinatal period is potentially a time of increased risk for having a mental health condition and for suicide		
LGBT people	Evidence shows that LGBT young people are at greater risk of suicide as well as self-harm than their heterosexual peers Actions that would improve mental health in this group include: -anti-bullying policies in schools that specifically reference LGBT -schools should collect data on bullying and harassment disaggregated by type		
BME groups, migrants and asylum seekers	Evidence shows that migrants are at increased risk of suicide There is evidence that people of African and Caribbean descent have an increased suicide risk as inpatients. There is also evidence for an increased suicide risk in those born in Scotland and Ireland.		Engagement with Black Thrive around stigma, discrimination and access to mental health services

	Asylum seekers and refugees have a significantly increased suicide risk. People with no recourse to public funds may face difficulties accessing mental health services provided by hospital trusts as a result of NHS charging rules.	The Health Inclusion Clinic will register with a GP all asylum seekers and refugees who face difficulties accessing health care services. There are psychological services provided for people who experienced torture or trauma which are not subject to NHS charging regulations (Freedom from Torture, Helen Bamber Foundation)	Community groups signpost to health services but there are access issues related to overseas visitors' charging regulations
Restricting Access to means	There is evidence that restricting access to suicide means (e.g. control of analgesics) and structural interventions have been very effective at reducing suicide deaths	There is insufficient intelligence to allow targeting measures that reduce access to means of suicide	
Supporting those bereaved by suicide	Ensure all first responders have supplies of signposting information, e.g. Help is at Hand z-card Disseminate information via the Coroner's office, local funeral directors and voluntary sector organisations Ensure individual approaches for anyone identified as being at risk of contagion, including rapid referral for community mental health support	CRUSE bereavement counselling in Lambeth provide a service for people affected by suicide. They provide an initial information service for those recently bereaved followed by a number of options including groups.	
	Ensuring local media are aware of the Samaritans' guidance on responsible media reporting Working with the local media to encourage them to provide information about sources of support and contact details of helplines when reporting mental health and suicide stories	No incidents of irresponsible reporting by Lambeth print media have been identified	

	Real-time suicide surveillance promotes timely support for people affected; permits identification of potential suicide clusters and contagion and assists with responses to increasing suicides within institutions (e.g. schools)	There are significant limitations to the data currently accessible in order to understand suicide in the borough.	Analysis to date is based on Primary Care Mortality Dataset data, which is taken from death certificate findings Shared measurement on mental health outcomes with Black Thrive
Reducing self harm	Self-harm is the most important risk factor for subsequent death by suicide. People who frequently present to hospital following self-harm are a particularly vulnerable group.	Lambeth's rate of self-harm admissions are not significantly different from those for London and England.	NICE standards and pathways CG16 and CG133 Lambeth Made CYP Plan The Young Lambeth Emotional Wellbeing and Mental Health Strategy and Plan 2015-2010

Lambeth Suicide Prevention Strategy Action Plans

Actions agreed by the South East London Public Health Mental Health Group (2018/19)

Priority Area	**Action**
1. Reducing the risk of suicide in key high risk groups	**People who use drugs and alcohol** 1.1 Ensure there is no 'wrong door' for dual diagnosis (mental health and substance misuse) patients through the implementation of new public health guidance around dual diagnosis
2. Providing better information and support to those bereaved or affected by suicide	2.1 Review SLAM's offer with regard to bereavement support
3.Supporting research, data collection and monitoring	3.1 In the absence of timely suicide data from the coroner to inform a formal suicide audit, work with SLAM to improve access to more meaningful data to improve near time reporting of suicide, attempted suicide and self-harm
4.Reducing rates of self-harm as a key indicator of suicide risk	4.1 Ensure NICE guidance for supporting those who self-harm is reflected across the SLAM service 4.2 Review crisis provision for individuals in distress – particularly the out-of-hours pathway.

Lambeth 2018/19 Suicide Prevention Plan summary

Objective	Actions	Owner	Deadline
1. Reduce the risk of suicide in high risk groups	**People in the care of mental health services** **1.1** Input into the redesign of the community offer for mental health services, to ensure that early access and crisis support meets needs of high-risk groups including Sanctuary opening hours; review role of Solidarity in Crisis and support for community development approaches to build resilience.	***CCG mental health commissioning lead/Public Health****/Certitude*	*March 2019*
	People in contact with the criminal justice system **1.2** Review current actions in the Youth Offending Service (YOS) to prevent suicides in young offenders	***Public Health****/Youth Offending Service (YOS)*	*March 2019*
	Specific occupational groups **1.3** Integrate health and wellbeing into the Council's own employment policies (eg: staff development and Leadership programmes). This includes work on level 2 of the Healthy Workplace Charter. Target groups for access and support through occupational health and employee assistance are staff/contractors in construction and education.	*Human Resources, Health and Safety team/****Public Health***	*September 2018*
2. Tailoring approaches to improve mental health in specific groups	**Community based approaches** **2.1** Review provision of suicide prevention (STORM) training and Mental Health First aid training to front-line staff and consider expansion to other groups	***CCG/Public Health***	*September 2018*
	Children and Young People **2.2** Review access to acute assessment for Children and Young People (CYP) via the Children and Young People's Mental Health Service	*Young People's commissioning/* ***Public health***	*September 2018*
	2.3 Review CYP needs and current offer around promotion of resilience and suicide prevention in schools (including anti-bullying, emotional problems, self-harm, bereavement) with a particular focus on Looked After Children, young people leaving care, young people with no recourse to public funds.	*Young people's commissioning/* ***Public health***	*December 2018*

Objective	Actions	Owner	Deadline
	This will review will include the virtual offer (eg: Chat Health/council website); online support and usage of the Well Centre and will also deliver a strategic approach to young people's mental health and wellbeing across the borough (eg: Black Thrive/Youth violence and CYPHP)		
	2.4 Ensure staff dealing with young vulnerable people receive appropriate training (eg: Leaving Care Team)	*Young people's commissioning*	*March 2019*
	People who are vulnerable due to economic circumstances		
	2.5 Review training needs of staff in advice services/food banks/Job Centre Plus and whether Job Centre Plus flag up vulnerable clients using a Safeguarding Alert.	***Public Health**/Advice Services/Food Bank*	*March 2019*
	LGBT people		
	2.6 Review whether best practice is currently implemented in Lambeth schools (eg: anti-bullying policy referencing LGBT, data disaggregated by protected characteristic). Explore possibility of peer mental health champions through Young Lambeth Co-op.	***Public Health**/Schools and Education team/YL Co-op/Community Safety partners*	*March 2019*
	BME groups, migrants and asylum seekers		
	2.7 Identify concrete actions and indicators that address inequality in outcomes for BME people (particularly people of African Caribbean decent, asylum seekers and refugees) around suicide and self-harm	*Black Thrive/**Public Health***	*September 2018*
3. Providing better information and support to those bereaved or affected by suicide	**3.1** Map current provision of local bereavement support services and review whether signposting information is widely available to people across all age groups (eg: Help is at Hand z card, advertising of bereavement services).	***Public Health***	*March 2019*

Objective	Actions	Owner	Deadline
4. Supporting research, data collection and monitoring	**4.1** Conduct an audit of meaningful data to improve near time reporting of suicide, attempted suicide and self-harm highlighting prevalence among stated strategic target groups and other local vulnerable groups eg: • People with contact with mental health services • Providers of substance misuse services • Pregnant women & postnatal • Migrants and asylum seekers • Homeless people • Women who experience violence • Women in the criminal justice system • Men in the criminal justice system (including Brixton prison) This will also include the collection of surveillance data on substances used in poisonings and where they were purchased.	***Public Health*** *with relevant service providers eg: SLAM, substance misuse, homeless commissioners, regional safer custody lead (prisons), YOS*	*March 2019*
	4.2 Explore setting up a real-time suicide surveillance system with the police	***Public Health***	*March 2019*
	4.3 Review how Black Thrive and Lambeth Alliance's Shared Measurement relates to suicide risk factors/outcomes	***Public Health****, Black Thrive, Lambeth Alliance*	*March 2019*
5. Reducing rates of self-harm as a key indicator of suicide risk	**5.1** Review how self-harm episodes are currently followed up in primary and secondary care.	***Public Health/CCG****, CYP commissioning team/LBL Education team*	*March 2019*
	5.2 Work with schools/education team to review/develop preventative interventions in school; include a review of self-harm protocol for schools.	***CCG Children's commissioning***	*September 2019*

APPENDIX III: DATA FACTSHEET

Every year, around 24 people living in Lambeth will die from suicide. There are also a significant number of suicide deaths that occur within the borough of people who are resident in other local authority areas.

To help understand who is dying from suicide, how this changes over time, we can analyse data that is available to us from the Primary Care Mortality Data (PCMD) dataset, as well as data published by Public Health England on their "Suicide Prevention Profile" webpages. The suicide profiles published there for each local authority area are publicly accessible and allow comparison both of suicide rates as well as of suicide risk factors. There may be further information available in the future from a full suicide audit, however there are currently data access issues for this data. This would allow us to understand in more detail the circumstances leading up to suicide deaths and provide additional demographic and risk factor information such as ethnicity.

The data summarised here is taken from the PCMD dataset covering a period from 2001-2017. As suicide numbers are very small for individual years the conclusions that can be drawn from analysing such a long time period are more meaningful. Another difficulty with interpreting suicide numbers is that fluctuate year-on-year and it can be misleading looking at numbers for individual years. Further information on understanding suicide statistics is available on the Samaritans' website (www.samaritans.org) and on the ONS website (www.ons.gov.uk).

DEFINITIONS

1. The WHO definition of suicide is "the act of deliberately killing oneself".
2. The Lambeth suicide data analysis uses the definition of suicide adopted by the Office of National Statistics (ONS), which reflects the coding used by WHO (ICD-10). This includes deaths from the ICD-10 groups "intentional self-harm" (for persons aged 10 years and over) as well as "injury/poisoning of undetermined intent" (for persons 15 years and over). Deaths from an event of undetermined intent in 10 to 14 year-olds are not included because the assumption cannot be made that in this age group the deaths were self-inflicted, and the possibility of unverifiable accidents, neglect or abuse cannot be excluded.
3. This definition will vary from a Coroner's verdict of suicide. Coroners record a verdict of suicide only when there is evidence beyond reasonable doubt that the injury was self-inflicted, and the deceased intended to take their own life. Including "events of undetermined intent" mitigates against the undercounting of suicide that is known to occur when relying on coroners' verdicts, as coroners record an open verdict when there is doubt about the deceased's intentions. Research has shown that most open verdicts are likely to be suicides.
4. Suicides are recorded by ONS only once an inquest has been completed. As inquests may not be conducted in the year of death there can be considerable delay until a death is recorded. Data used for analysis counts suicides in the year in which they were recorded rather than the year of death. This is consistent with ONS practice.
5. Self-harm is defined as an intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent (NICE 2011). Self-harm admission data analysed was provided by Secondary Uses Service (SUS) and reports on admissions to hospital for self-harm in patients for whom Lambeth CCG is responsible.

KEY STATISTICS FOR LAMBETH

NUMBER OF SUICIDE DEATHS EACH YEAR

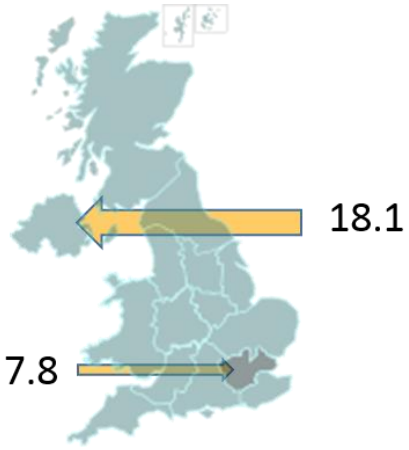
Over the 3-year period 2014-2016, on average 24 Lambeth residents died each year from suicide.

One quarter of these were female.

SUICIDE RATES

Highest age-standardised suicide rate: Northern Ireland 18.1 per 100,000 (2016)

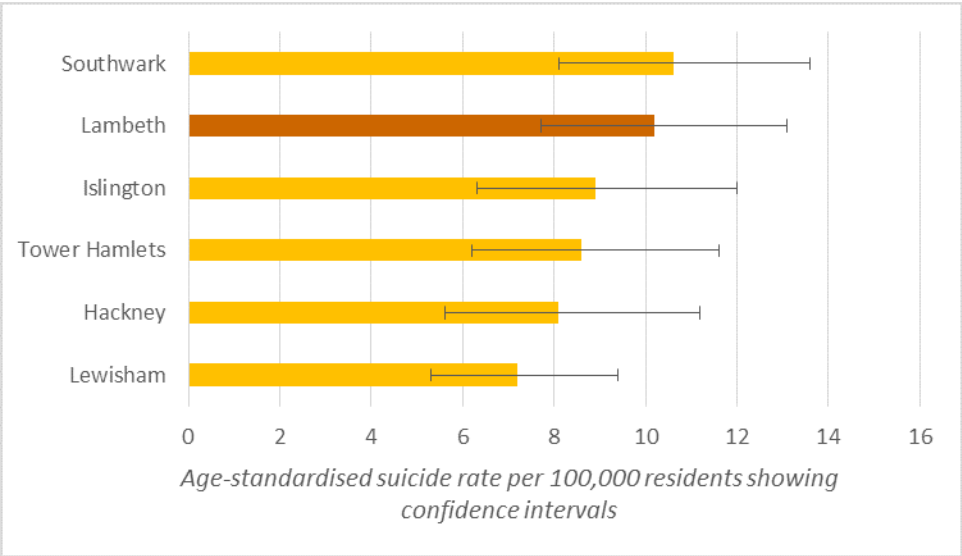
Lowest age-standardised suicide rate: London 7.8 per 100,000 (2016)



Highest and lowest age-standardised suicide rates in regions of the UK, 2016 (ONS), rate per 100,000 residents

Suicide rates vary significantly between the regions and countries of the UK. Northern Ireland has the highest rate, followed by Scotland, then Wales, with London having the lowest.

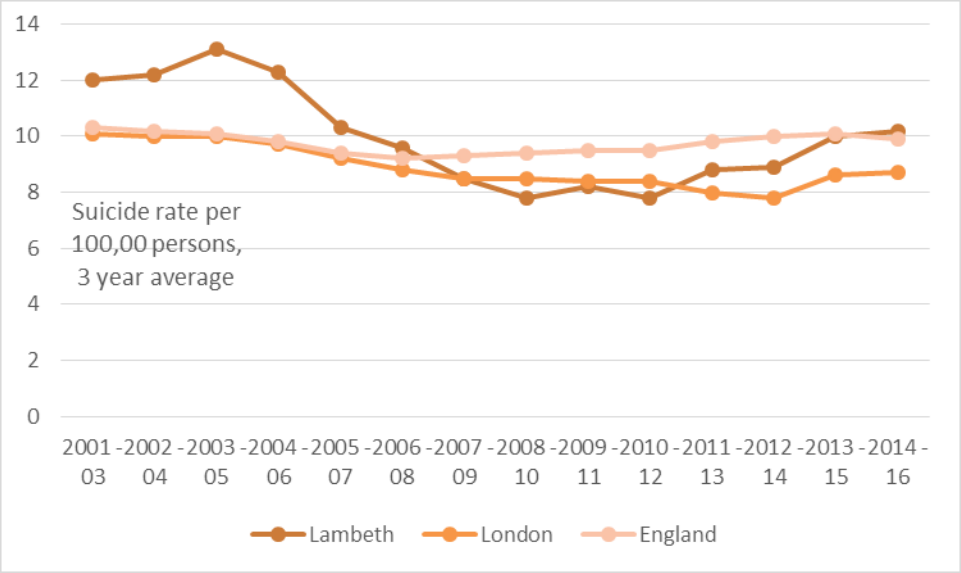
Within London, the boroughs' suicide rates have wide confidence intervals due to smaller numbers and there are no significant differences between the suicide rate in Lambeth and the rates in its statistical neighbours.



Age-standardised suicide rates per 100,000 per year, 2014-2016, for Lambeth and statistical neighbours (source: PHOF)

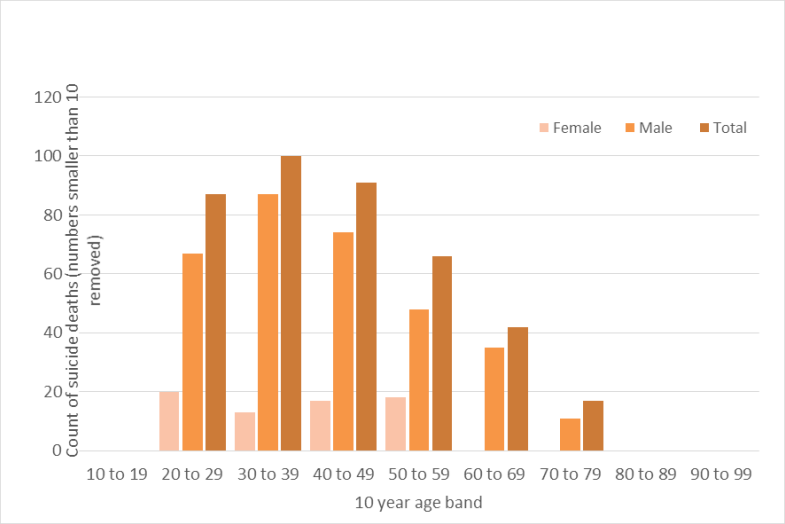
TRENDS

There has been a general decrease in suicide rates in Lambeth, London and England in the period 2001-2016.



Suicide rate in all persons showing 3-year averages, for Lambeth, London and England (source: PHE PHOF)

AGE

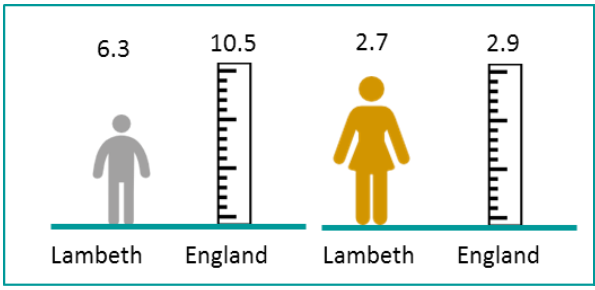


Count of suicide deaths in 10 year age bands for all persons, males and females, Lambeth residents, 2001-2017

Most suicides in Lambeth occur in people aged between 20-50 years.

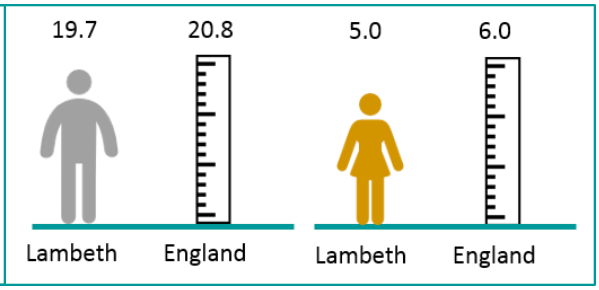
In males, the most frequent age band is 30-39 year olds whereas in females it is 20-29 year olds.

At the extremes of age (under 20 and over 79) suicide numbers are so small that they could not be shown (suicide numbers smaller than 10 cannot be reported).



Age 10-34 years

Suicide crude rates per 100,000, Lambeth residents, 5 year average (2011-15), male and female (source: PHOF) compared to benchmark (crude rate for England)



Age 35-64 years

Suicide crude rates per 100,000, Lambeth residents, 5 year average (2011-15), male and female (source: PHOF) compared to benchmark (crude rate for England)

The suicide rate for men in the age range 10-34 years is lower than the benchmark (England).

For women the rate is similar to the benchmark (though numbers have been combined for all female suicide deaths in London as they are too small to analyse by borough).

In the older age group (35-64), the rate in men is similar to the benchmark (England), whereas in women it is lower than the benchmark (again, the rate given for women is that for the whole of London).

COUNTRY OF ORIGIN

Ethnicity is not recorded in ONS data and was not available in the PCMD dataset analysed. The best available proxy was "country of origin" of the deceased.

At the time of the UK census 2011, 38% of the population of Lambeth was non-UK born.

Crude suicide rate in UK-born residents per year per 100,000 population (based on 2011 Census and PCMD from 2001-2017)

Crude suicide rate in non-UK-born residents per year per 100,000 population (based on 2011 Census and PCMD from 2001-2017)

Note on the data: overlapping confidence intervals

Deaths in UK-born residents 7.9 per 100,000 (CI 6.9 to 8.9)

Deaths in non-UK born residents 9.8 per 100,000 (CI 8.38 to 10.46)

Crude suicide rate in Lambeth residents by region of birth per 100,000 population (source: Census 2011 and PCMD 2001-2017).

Note: Apparent differences between regions of birth may not be significant due to small numbers

Key points

Local data suggests that there are differences in suicide rate linked to country of origin, with a particularly high rate in people born in North America and the Caribbean, however due to the small number of suicide deaths it is not possible to demonstrate a statistical difference.

LOCATION OF SUICIDE

47% of suicide deaths in Lambeth residents or occurring in Lambeth were certified in hospital. However most of these deaths had not occurred in hospital and were therefore excluded from the analysis of location. The data available recorded the location in which the deceased had been certified dead by a medical practitioner rather than the actual place of death, and in some instances the location stated did not reflect where the individual had died, particularly in relation to deaths by drowning in the Thames as bodies are generally retrieved some distance downstream.

59% of suicide deaths occurring in Lambeth or in Lambeth residents occurred in residential premises. These were also excluded from the analysis summarised in the figure as they are unlikely to be amenable to an intervention to the location.

Of the locations analysed for suicide deaths in Lambeth residents and suicide deaths occurring in Lambeth, the commonest locations were train stations and rail tracks, followed by the River Thames

Key points

59% of suicide deaths occurred in residential premises (excluding deaths were location was unknown)

Of known non-residential locations, the commonest were train stations and rail tracks, followed by the River Thames and parks, churchyards and cliffs.

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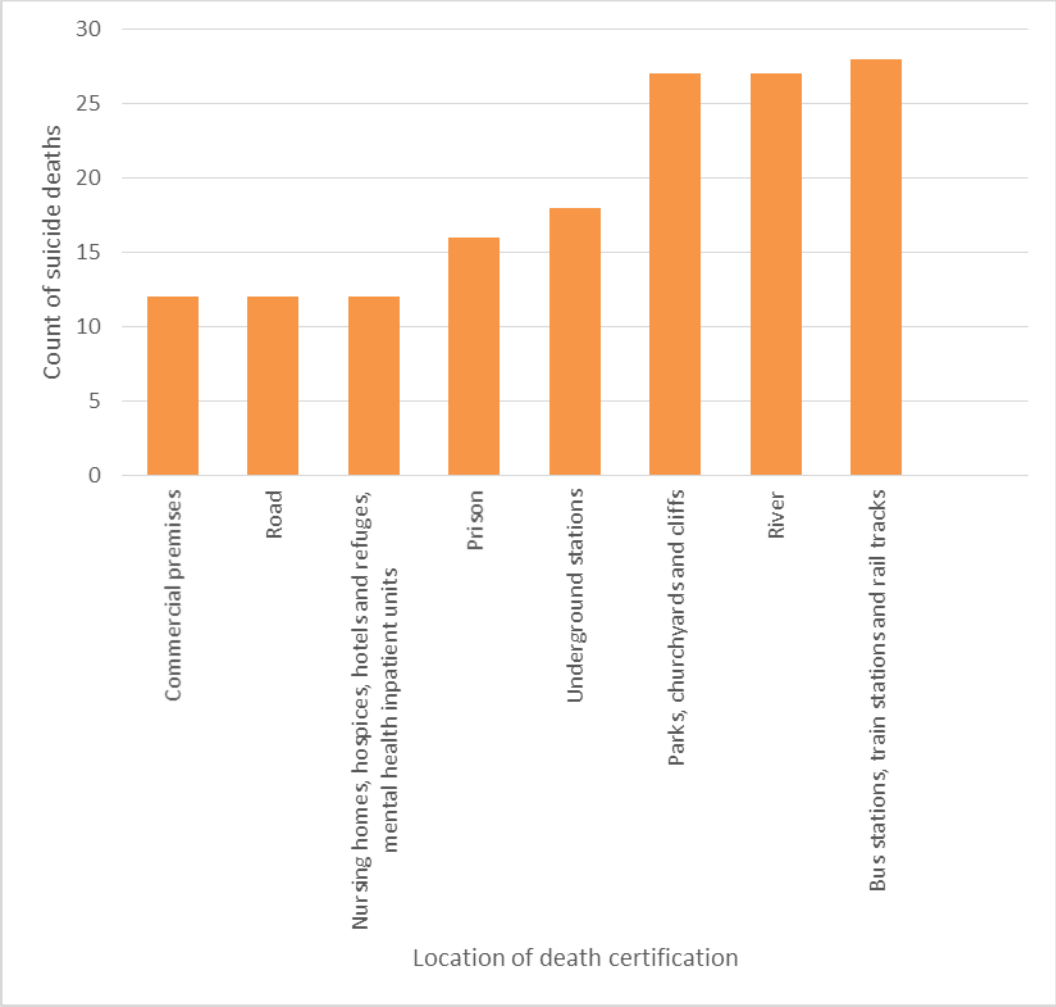


Suicide counts by location of death certification, Lambeth residents and suicide deaths occurring in Lambeth, 2001-2017

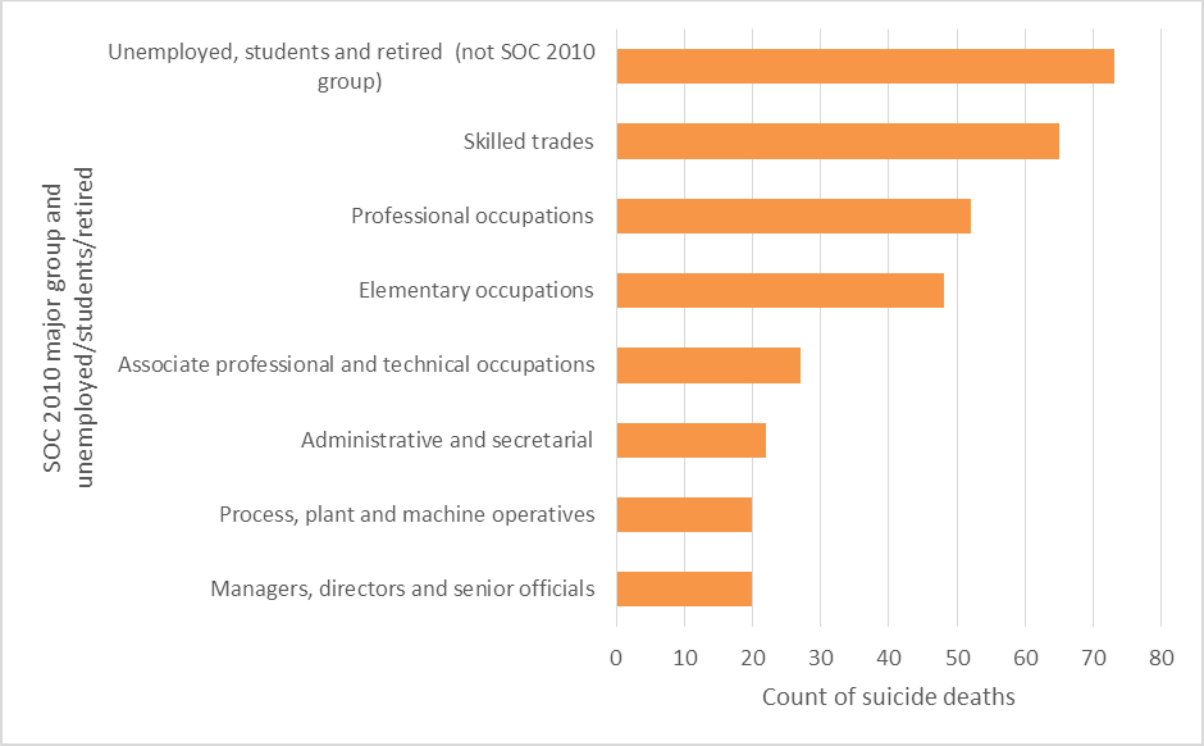
Occupation

Occupations were recorded in Primary Care Mortality data and were converted to SOC 2010 codes (the current standard occupational classification for the UK).

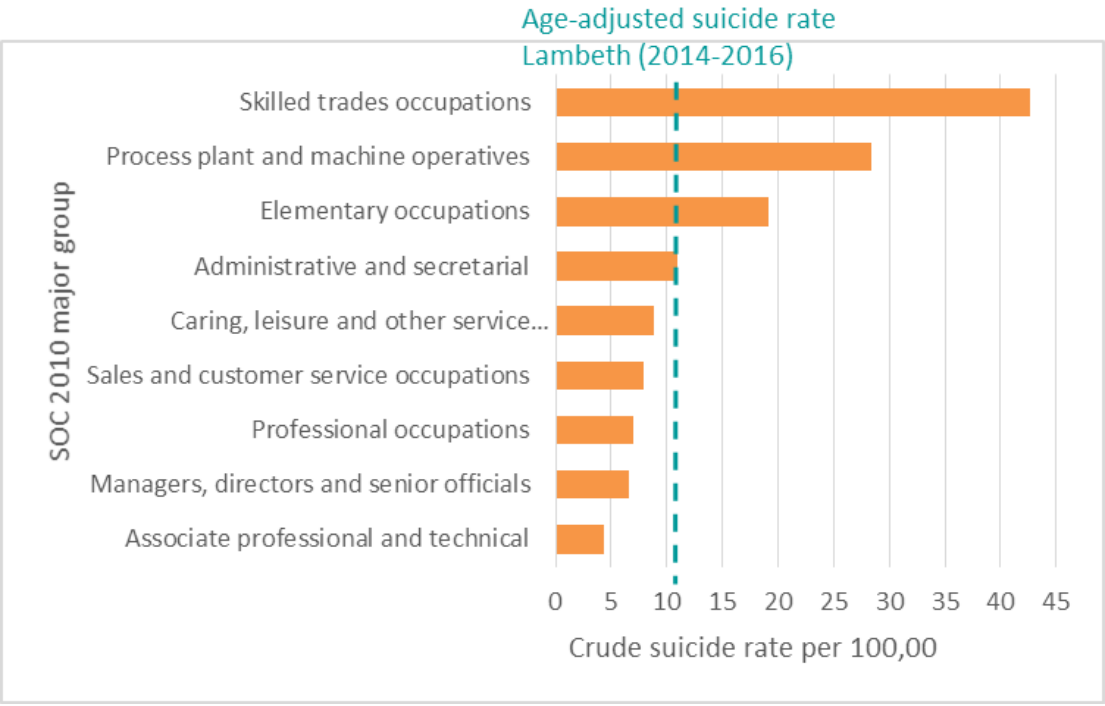
Key points

The largest number of suicide deaths occurred in people who were unemployed or students or retired.

In people recorded as having an occupation, the largest number were working in skilled trades, followed by professional occupations.



Suicide deaths in Lambeth residents, 2001-2017, by SOC 2010 major occupational group and for unemployed/students and retired, excluding those with no record of occupation.

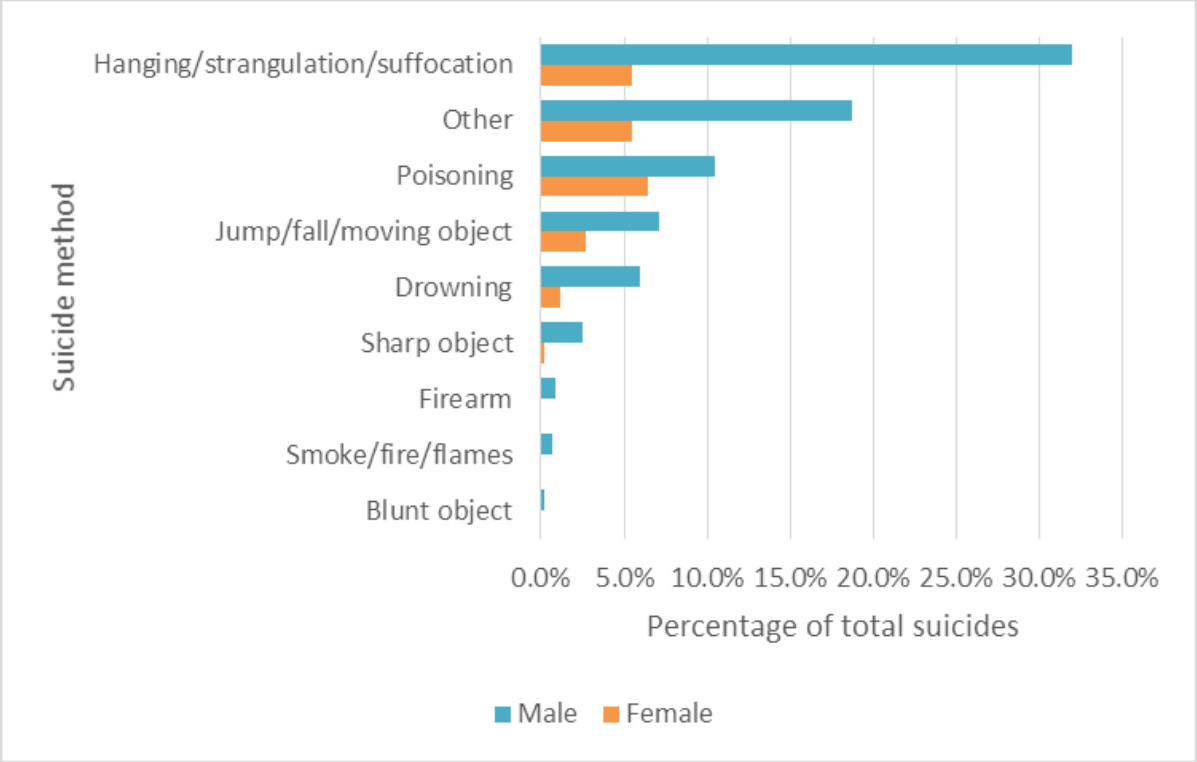


Crude suicide rates for SOC 2010 major occupational groups, per 100,000 population, in Lambeth residents (2001-2017; using 2010 as approximate midpoint for size of occupational groups in Lambeth, source: NOMIS). Dashed line shows age-adjusted suicide rate for Lambeth (2014-2016) as benchmark.

Key points

Local data suggests that people working in certain occupational groups are at significantly increased risk of suicide. The group with the highest rate is those working in skilled trades occupations (predominantly, in Lambeth, those in skilled metal, electrical and electronic trades, textiles, printing and other skilled trades, and skilled construction and building trades). The second highest rate is in those working as process, plant and machine operatives (predominantly transport and mobile machine drivers and operatives).

SUICIDE METHOD

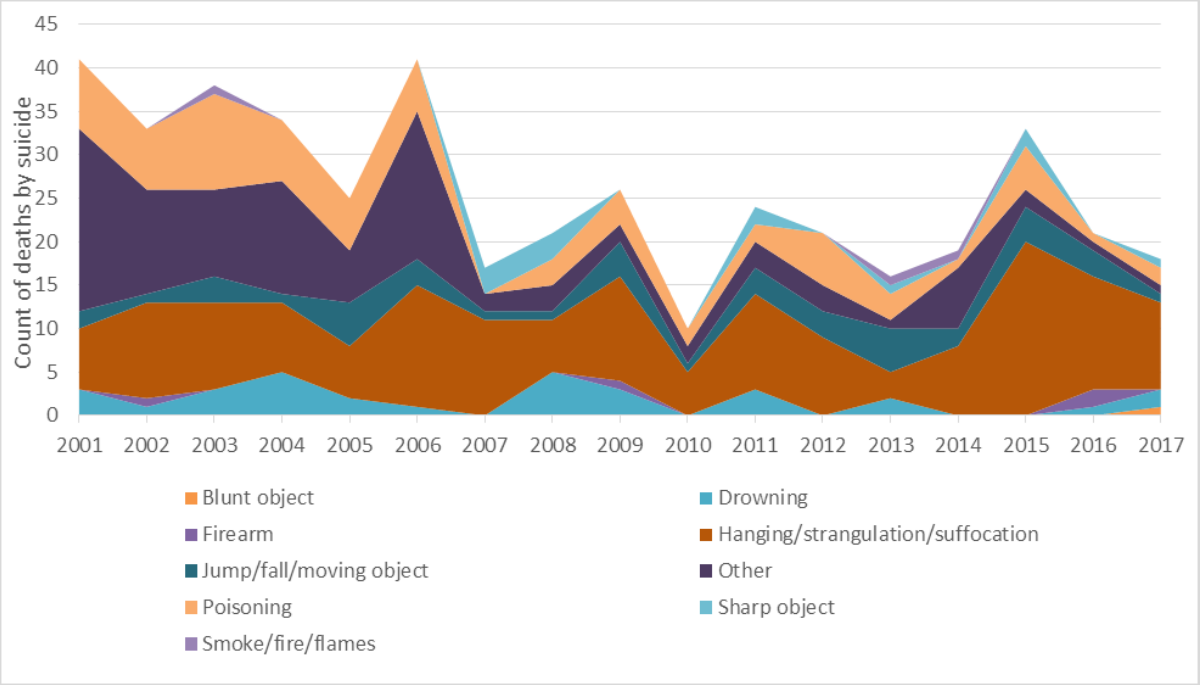


Proportion of total suicide deaths occurring by different methods, showing male and female deaths, Lambeth residents, 2001-2017

Key points

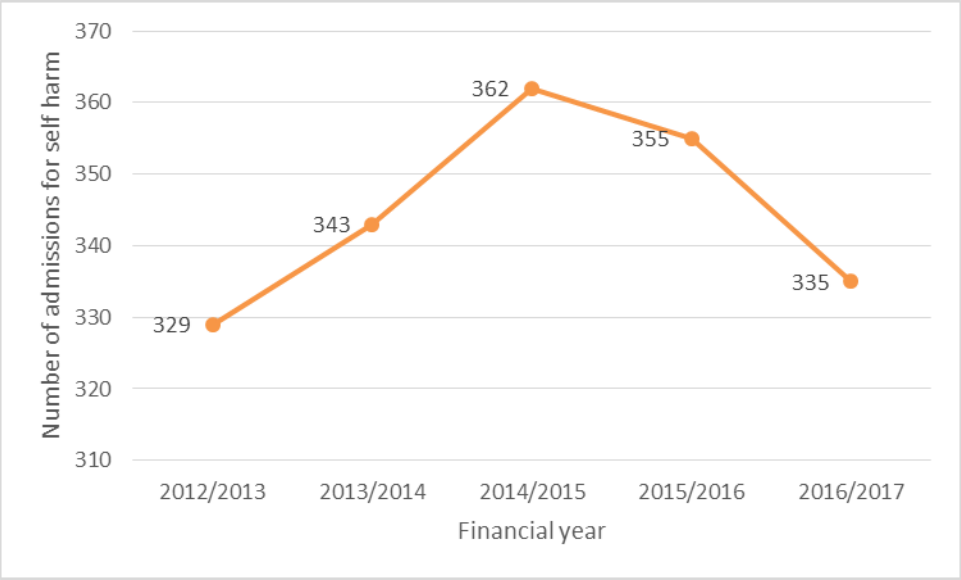
Hanging, strangulation and suffocation are the commonest suicide method overall and the commonest in males, whereas in females death by poisoning is marginally more common than hanging.

Poisoning has become less common over the time period analysed (2001-2017), while there has been a slight increase in the proportion of suicides occurring as the result of hanging/strangulation/suffocation. There has been little change over time in the proportion of deaths occurring by jumping or falling.

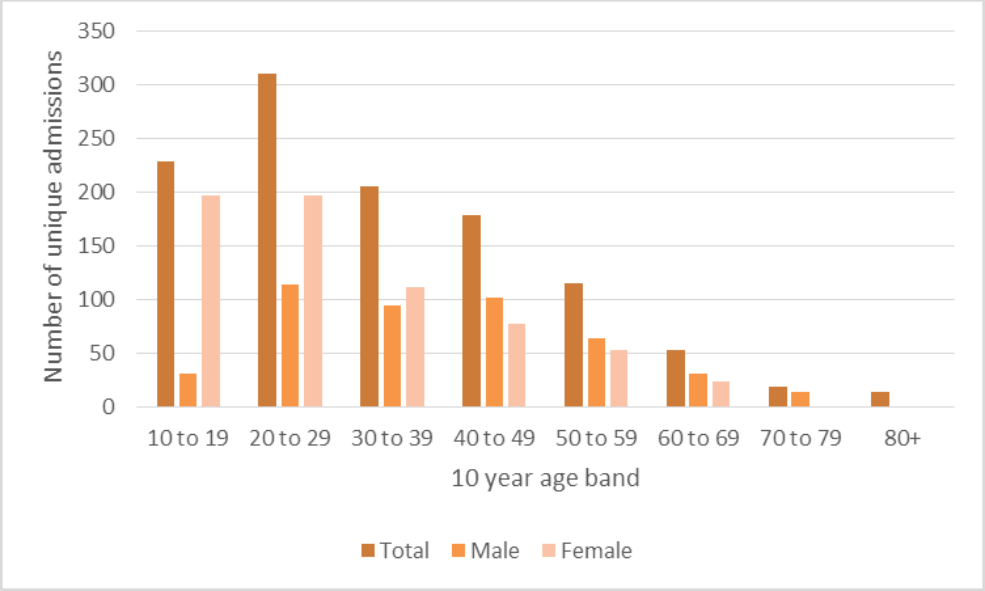


Trends in suicide methods shown as size of coloured area corresponding to proportion of deaths occurring by that method. Lambeth residents, 2001-2017.

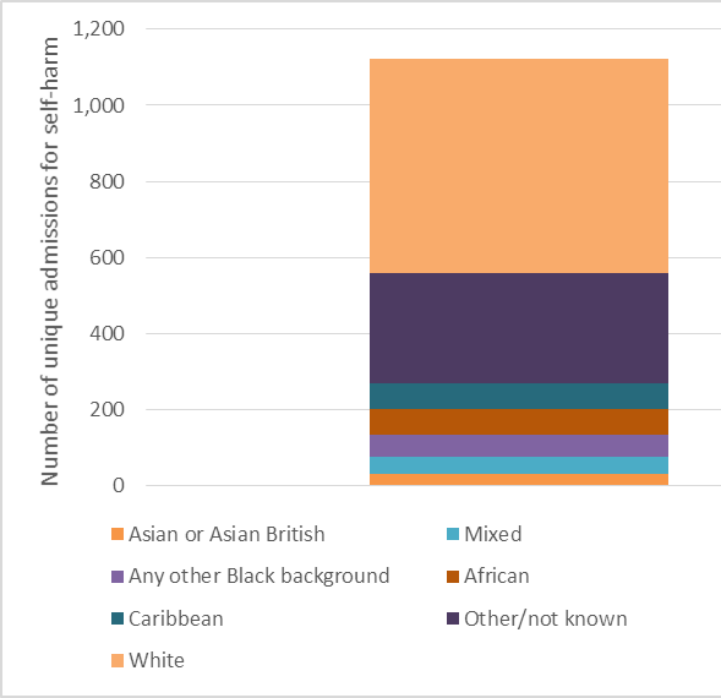
SELF-HARM



Number of emergency admissions due to self-harm, for Lambeth CCG responsible patients, for period 2012/2013-2016-2017 (source: Lambeth CCG, 2017)



Unique admissions for self-harm, by 10 year age bands, for males, females and all persons, Lambeth CCG, 01/04/2012-31/10/2017



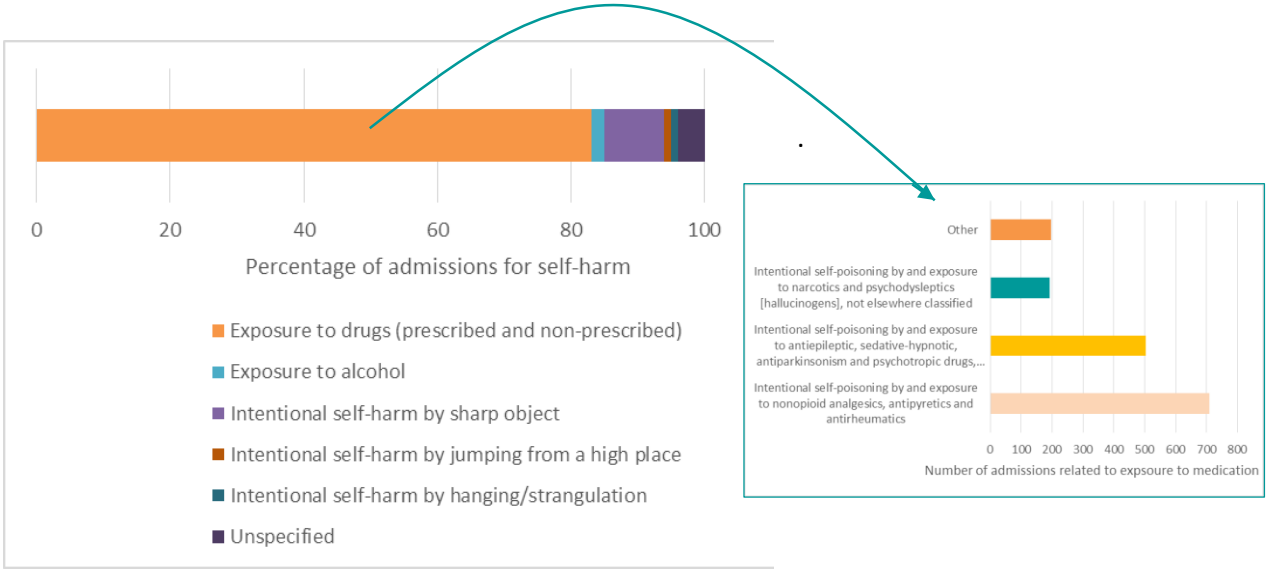
Unique admissions for self-harm, by ethnicity, Lambeth CCG responsible patients, 01/04/2012-31/10/2017

Discharge destination	% of discharges after self-harm admission
High security psychiatric accommodation	1%
Penal establishment or police station	1%
Patient died	1%
General hospital ward	4%
Mental health inpatient unit	6%
Permanent or temporary place of residence	87%

Discharge destinations from self-harm emergency admissions, Lambeth CCG, 01/04/2012-31/10/2017

Key points

- The number of emergency admissions for self-harm is much larger than suicide counts each year; and those admitted for self-harm represent only a proportion of those who self-harm as many people do not present to hospital after a self-harm episode
- The peak age group overall and in males is 20-29 year olds; in females the peak spreads across the 10-19 and 20-29 year age bands.
- Just over half of admissions for self-harm are in people of white ethnicity, about 17% are in black ethnicities (about a third each African, Caribbean and other Black background).
- 6% of those admitted due to self-harm are discharged to a mental health inpatient unit, and a further 1% to a high security psychiatric unit.



Reason for emergency admission after self-harm, Lambeth CCG, 01/04/2012-31/10/2017

Key points

- The majority of self-harm admissions occur as a consequence of exposure to drugs (prescribed and non-prescribed)
- The second most frequent reason (9%) is intentional self-harm by a sharp object.
- The most common type of drugs used in self-harm are non-opioid analgesics, antipyretics and antirheumatics: 37% of all admissions (this groups includes paracetamol and ibuprofen).

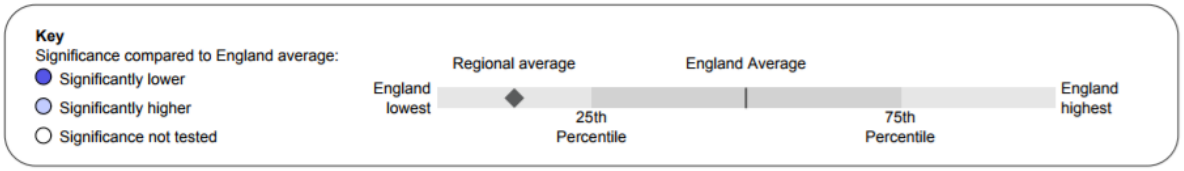
Deprivation

Analysis of suicide rates by IMD (Index of Multiple Deprivation) decile band shows that there is a far larger burden of suicide deaths in the 5 most deprived deciles compared to the 5 least deprived.

The life expectancy gained if the most deprived quintile in Lambeth had the same mortality from suicide as the least deprived quintile would be 0.14 years in males, and 0.02 years in females (PHE 2015).

RISK FACTOR PREVALENCE

Lambeth has a higher prevalence than the benchmark value (the average for England) and the regional average in the following, which are all known to be risk factors for suicide (Source: PHE Fingertipsreports):



1. Substance misuse

	Period	Local count	Local value	Region value	England value	England lowest	Range	England highest
Estimated prevalence of opiates and/or crack cocaine use: rate per 1,000 population aged 15 - 64	2011/12	3,074	13.4	9.6	8.4	1.9		20.8
Alcohol-related hospital admission (Broad): directly age standardised rate per 100,000 population (Persons)	2014/15	3,199	1572	1252	1258	833		2100

2. Children in the care system

	Period	Local count	Local value	Region value	England value	England lowest	Range	England highest
Looked after children: rate per 10,000	2014/15	485	78.0	52.0 ~	60.0	20.3		157.9
Children leaving care: rate per 10,000	2014/15	325	52.3	31.1 ~	26.8	10.9		64.2

3. Contact with the criminal justice system

	Period	Local count	Local value	Region value	England value	England lowest	Range	England highest
Children in the youth justice system: rate per 1,000 aged 10 - 18	2014/15	286	10.8	7.0	6.5	2.3		14.1

4. Severe mental illness

	Period	Local count	Local value	Region value	England value	England lowest	Range	England highest
Severe mental illness recorded prevalence (QOF): % of practice register (all ages)	2015/16	4,836	1.28	1.09 ~	0.90	0.52		1.52

5. Loneliness

	Period	Local count	Local value	Region value	England value	England lowest	Range	England highest
People living alone: % of all households occupied by a single person	2011	44,691	14.9	12.8	12.8	8.0		23.4

Key points

Lambeth has a higher than average prevalence (as compared to England as well as to London) for the following risk factors for suicide:

6. Substance misuse (both alcohol and opiates and/or crack cocaine use)
7. Severe mental illness
8. Contact with the criminal justice system (in children/young people aged 10-18)
9. Loneliness (as measured by % of households occupied by a single person)
10. Children in care/care-leavers

CURRENTLY UNKNOWN

The following characteristics of individuals who died from suicide and other additional details are not available from current data but would be very valuable in understanding suicide patterns and local issues in Lambeth:

- Ethnicity and protected characteristics
- Chronic ill health/disability/terminal illness
- Substance misuse
- Engagement with mental health services and other services
- Local context (e.g. large-scale local redundancies by a single employer)
- High-frequency locations (as almost half of deaths certified in hospital, location information is missing for almost half of all suicide deaths)
- Immigration status and refugee stat