Northamptonshire Suicide Prevention Strategy 2017 - 2020

Produced by Northamptonshire Suicide Prevention Partnership as part of Northamptonshire Prevention Concordat
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Foreword

Suicide is still a huge taboo in our society. People are genuinely scared to talk about it, and don’t feel able to intervene when they believe a loved one is at risk but every life lost represents someone’s partner, child, friend or colleague, and their death will profoundly affect people in their family, their friends, their workplace, and the people they know through clubs and groups and in their local neighbourhood. Suicides can be prevented; together we need to create a culture in Northamptonshire where everyone can talk about their mental health problems without fear, embarrassment or judgement and an environment where everyone can access the help they need, when they need it.

We all have a role to play.

By talking openly about suicide we can remove the fear that stops people asking for help. We may feel uncomfortable, or frightened of saying the wrong thing, but if we tackle this stigma then we will help save lives. When it comes to our physical health we believe the NHS should do everything possible to keep us alive and well – the same must be said for mental health and we must make sure that our local services can provide early help and respond when a person is in crisis. Preventing suicide is achievable, and it’s everyone’s business. The Suicide Prevention Partnership has been formed to help us understand the causes of suicide in our county, to share information and intelligence, and most importantly, to work together to make sure that no one feels so unsupported that they take their own life. Members of the Partnership have produced this strategy which sets out our shared ambition to reduce suicide in our county and help people to manage the pain and suffering that suicide brings.

Lucy Wightman
Northamptonshire County Council
Director of Public Health

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Northamptonshire Healthcare NHS Foundation Trust
Chief Operating Officer
1. Introduction

The effects of suicide can be devastating. In Northamptonshire approximately 60 individuals take their own life each year and many more people – family, friends, colleagues, neighbours, employers, professionals, and the wider society feel the impact.

We believe that too many people die from suicide in our county and that preventing suicide can, and must, be a priority for us all. We also believe that in many cases, while the reasons that lead to someone to taking their own life may be extremely complex, deaths may have been prevented if the signs of distress that the person was displaying were recognised and appropriate support provided. A partnership based approach gives us our best chance of making a real difference in reducing deaths by suicide in Northamptonshire.

To support this approach, a multi-agency suicide prevention forum has been established in Northamptonshire which will take responsibility for driving forward implementation of this strategy as part of the partnership work driven by the Prevention Concordat and the Mental Health Transformation Strategy. The Northamptonshire Suicide Prevention Partnership Forum brings together key stakeholders in the county with the aim of improving the lives of people and carers in the towns and rural areas of the county, by focussing action on suicide and self-harm prevention. While all of the work undertaken to improve the wellbeing and resilience of individuals and communities supports the aim of suicide prevention, by producing a separate suicide prevention strategy, the intention is to undertake a more specific and detailed review of suicide in Northamptonshire, and to use this to plan and deliver a multi-agency response. A partnership based approach which includes groups and communities, all public sector partners, workplaces, third sector and faith groups, patients and carers, gives us our best chance of improving data collection and analysis and using local, knowledge, experience and intelligence to plan a multi-agency response ultimately in making a real difference in reducing deaths by suicide locally.

The Suicide Prevention Strategy for Northamptonshire therefore, sets out
the main findings from currently available data including the Office for National Statistics, Public Health England Suicide Prevention Profiles and local data in the form of the Primary Care Mortality Database and the latest published data from coroners reports (2016). It also sets out a clear Partnership Framework for action to inform individual organisational delivery plans that includes an ambition to improve our data collection and analysis.

In producing this document we have followed the suicide reporting codes of practice produced by the Samaritans Suicide reporting - codes of practice | Samaritans and have not included details of methodologies. All the data included in this strategy is available to the public.

This strategy is the first step on a shared journey. We do not expect our actions plans to be static, but to develop as we develop our understanding of suicide and its impacts, forge wider and new partnerships and improve our knowledge and experience of “what works”.
2. National Context

Nationally suicide has been recognised as a growing issue for many years. In 2012 the UK Government published "Preventing suicide in England: A cross-government outcomes strategy to save lives". This was followed in September 2014 by Public Health England’s “Guidance for developing a local suicide prevention action plan” targeted specifically at public health staff in local authorities. In Northamptonshire a Crisis Care Concordat was developed, with the aim of improving the systems of care and support so that people in crisis because of a mental health condition are kept safe. The Prevention Concordat builds on this by aiming to reduce and prevent mental ill health.

In January 2015 the All-Party Parliamentary Group (APPG) on Suicide and Self-Harm Prevention reviewed progress in developing local suicide prevention plans and found implementation to be patchy across the country. At the time of data gathering for the APPG report, Northamptonshire was one of the local authority areas that had not competed our county partnership plan, although a number of organisations and individuals were developing their own plans and were working together to reduce stigma and improve care.

In October 2016 Public Health England (PHE), supported by the National Suicide Prevention Alliance, published updated Guidance (Local suicide prevention planning: A practice resource) structured around the three main elements that the All-Party Parliamentary Group on Suicide and Self-harm Prevention recommended should be in place in every local authority area. These three elements are:

1. Establishing a multi-agency suicide prevention group involving all key statutory agencies and voluntary organisations.
2. Completing a suicide audit.
3. Developing a suicide prevention strategy and/or action plan that is based on the national strategy and the local data.

This guidance has informed the development of the Suicide Prevention Partnership and this strategy.
The National Picture

The most recent figures for suicides in the United Kingdom were published by the Office for National Statistics in 2016. The figures are published by sex, age, area of usual residence of the deceased, and suicide method.

For the first time in 2016, the definition of suicide has been extended to include deaths from intentional self-harm in 10-14 year old children in addition to people aged 15 and over. Suicide rates in England have increased since 2007¹ making suicide the biggest killer of men under 50 as well as a leading cause of death in young people and new mothers. On average, 13 people kill themselves every day in England.

The need to develop local suicide prevention strategies and action plans that engage a wide network of stakeholders in reducing suicide is set out in the government’s national strategy for England, *Preventing suicide in England: a cross-government outcomes strategy to save lives* and is a key recommendation in the Mental Health Taskforce’s report to NHS England, *The five year forward view for mental health*. The framework for action set out in this strategy responds to these recommendations.

National suicide figures from the ONS:

In 2016, there were 4,575 registered deaths due to suicide in England among people aged 10 and over.

Three quarters of suicides were male (3,464 male and 1,111 female suicides in England in 2016).

Numbers of suicides in England have been falling following a peak in 2014 and decreased by 5% between 2015 and 2016.

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¹ HMG Jan 2017 Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives
Analysis of deaths registered in England between 2011 and 2015 found that suicide rates amongst male low-skilled labourers and skilled tradesmen were significantly higher than the male national average. Females in culture, media and sports occupations and female health professionals had higher suicide rates than the female national average. Amongst both sexes, managers, directors and senior officials had the lowest risk of suicide.

The peri-natal period is also a high risk period for suicide among women. The 2017 MBRRACE-UK report states that “maternal suicide is the third largest cause of direct maternal deaths occurring during or within 42 days of the end of pregnancy. However, it remains the leading cause of direct deaths occurring during pregnancy or up to a year after the end of pregnancy, with 1 in 7 women who die in the period between 6 weeks and one year after pregnancy dying by suicide.”
3. Suicide in Northamptonshire

The data to inform this strategy for Northamptonshire was taken from a range of sources including Mortality rates from suicides, and suicide and injury undetermined produced for local authorities by the Office for National Statistics, Public Health England Suicide Prevention Profiles and local data from the Primary Care Mortality Database and where possible the rates of suicide, demographics of the individuals concerned and the location and type of suicide can be compared with England as a whole, the East Midlands Region and in localities across the county.

The prevalence of suicide in Northamptonshire broadly mirrors the prevalence in England as a whole and in the East Midlands Region, although there is some variation in the prevalence of suicide across the county.

Demographics of the 100 Northamptonshire deaths by suicide

Key findings from Northamptonshire Suicide Annual Report 2017 show that 55 deaths were recorded as a conclusion of death by suicide in 2016-17 (Primary Care Mortality Databases (PCMD), 2017). Suicide rates are higher in Corby and Kettering in 2014-16. Men are more at risk than women but rates in women are increasing. Hanging and Strangulation are the most common causes of death. The rates of hospital admissions as a result of self-harm in young people were significantly higher in Northamptonshire than the national average.
Key Findings

1. The age standardised suicide rate in Northamptonshire continues to increase from 2007-09 to date.
2. The number of suicides decreased however from 2015 to 2016, according to ONS data.
3. The age standardised suicide rate, presented as a three year average, shows that the Northamptonshire rate is not significantly different to the England average from 2001-03 to date.
4. When data is drilled down to smaller areas, Daventry District has a suicide rate that is statistically significantly lower than Corby, the East Midlands and England. Corby has the highest rate but this is not statistically significantly different from the other areas, bar Daventry.
5. The rate of mortality where the underlying cause was suicide has grown faster for females than males, reaching a recent peak in 2015.
6. Deaths from intentional self-harm are most prevalent (49% of all deaths from suicide) in those aged between 41 and 60 years old, more specifically those aged 50-59 years. When looking at prevalence by 5 year age bands, Northamptonshire appears to have a higher number of older people dying from intentional self-harm than might be expected by the national average.
7. Hanging, strangulation and suffocation remains the most common means of death from intentional self-harm; poisoning also registers as a common method in the local data, but due to small number suppression is not as evident in the published data from ONS.
8. Deaths from hanging, strangulation and suffocation are most common in those aged 70-74, 50-54 and 55-59 years.
9. The proportion of all suicides caused by hanging, strangulation or suffocation has dropped slightly for males locally, and more sharply for females.
10. New causes of mortality from suicide are being employed.
11. Many deaths occur at home and in urban areas.
12. The number of inquests opened that recorded a verdict of suicide has increased steadily since 2006.
Prevalence of Suicide in Northamptonshire

Comparing rates across the East Midlands, Northamptonshire does not appear to be an outlier. Figure 1, taken from PHE Fingertips Database, shows that on each of the suicide rate indicators below, Northamptonshire does not lie significantly outside the comparison figures for England as a whole.

Figure 1: Spine chart of suicide related indicators for Northamptonshire, PHE 2017

Northamptonshire performance against the same range of indicators related to suicide is also considered similar to other local authorities in East Midlands and East Midlands as a whole.
Figure 2: Comparative performance in suicide related indicators in local authorities in East Midlands, PHE 2017

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Compared with benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide: age-standardised rate per 100,000 population (3 year average) (Persons)</td>
<td>2014 - 16</td>
<td>9.9</td>
</tr>
<tr>
<td>Suicide: age-standardised rate per 100,000 population (3 year average) (Male)</td>
<td>2014 - 16</td>
<td>15.3</td>
</tr>
<tr>
<td>Suicide: age-standardised rate per 100,000 population (3 year average) (Female)</td>
<td>2014 - 16</td>
<td>4.8</td>
</tr>
<tr>
<td>Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Persons)</td>
<td>2012 - 14</td>
<td>31.9</td>
</tr>
<tr>
<td>Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Male)</td>
<td>2012 - 14</td>
<td>50.2</td>
</tr>
<tr>
<td>Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Female)</td>
<td>2012 - 14</td>
<td>13.7</td>
</tr>
<tr>
<td>Suicide crude rate 10-34 years: per 100,000 (5 year average) (Male)</td>
<td>2011 - 15</td>
<td>7.4</td>
</tr>
<tr>
<td>Suicide crude rate 10-34 years: per 100,000 (5 year average) (Female)</td>
<td>2011 - 15</td>
<td>2.7</td>
</tr>
<tr>
<td>Suicide crude rate 35-64 years: per 100,000 (5 year average) (Male)</td>
<td>2011 - 15</td>
<td>20.8</td>
</tr>
<tr>
<td>Suicide crude rate 35-64 years: per 100,000 (5 year average) (Female)</td>
<td>2011 - 15</td>
<td>6.0</td>
</tr>
<tr>
<td>Suicide crude rate 65+ years: per 100,000 (5 year average) (Male)</td>
<td>2011 - 15</td>
<td>12.6</td>
</tr>
<tr>
<td>Suicide crude rate 65+ years: per 100,000 (5 year average) (Female)</td>
<td>2011 - 15</td>
<td>4.4</td>
</tr>
</tbody>
</table>
The available data indicates an increase in the numbers of suicides in the county when comparing county wide figures for 2009 and 2016, with numbers of suicides increasing in 3 of the boroughs and districts, decreasing in three localities (Daventry, East Northamptonshire and South Northamptonshire) and remaining the same in Kettering.

**Figure 3: Number of deaths from suicide and injury undetermined registered 2009-16 by local authority aged 10 and over, ONS 2017**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Corby</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>11</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Daventry</td>
<td>7</td>
<td>6</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>5</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>East Northamptonshire</td>
<td>7</td>
<td>5</td>
<td>9</td>
<td>3</td>
<td>7</td>
<td>8</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Kettering</td>
<td>11</td>
<td>3</td>
<td>10</td>
<td>3</td>
<td>9</td>
<td>5</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>Northampton</td>
<td>14</td>
<td>20</td>
<td>21</td>
<td>21</td>
<td>18</td>
<td>23</td>
<td>23</td>
<td>17</td>
</tr>
<tr>
<td>South Northamptonshire</td>
<td>8</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>8</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Wellingborough</td>
<td>5</td>
<td>1</td>
<td>7</td>
<td>4</td>
<td>8</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Northamptonshire</td>
<td>58</td>
<td>41</td>
<td>64</td>
<td>46</td>
<td>58</td>
<td>66</td>
<td>73</td>
<td>63</td>
</tr>
</tbody>
</table>

There is however variation in the number of deaths from suicide in each locality and the county as a whole year on year, with Corby having the highest rates for mortality from suicide for those aged 10 and above, (although this is not statistically significantly different to any other borough or district except Daventry). Rates have been increasing since 2012 in Corby, East Northamptonshire and Kettering. Daventry District currently has a suicide rate that is statistically significantly lower than Corby, the East Midlands and England.
Gender

In 2016-17 local data in the PCMD revealed that 85% of numbers of deaths from suicide were in males; in the 2015-16 the figure was 77%. Nationally about three quarters of deaths from suicide were in males in 2016, but there has been more variation over time with females, reaching a peak in 2015. The data set taken from coroners reports indicates that 86% of suicides recorded in Northamptonshire in 2016 were male, and 14% female. Suicide in both males and females is increasing, but the rate of increase appears to be faster among females.

Percentage of suicide by gender, 2011-2017

source: PCMD 2017
Age

Nationally the 40-44 year old age group had the highest rate of mortality from suicide. Six years of Primary Care Mortality Database (PCMD) data (April 2011 to March 2017) indicate that in Northamptonshire the prevalence of deaths from intentional self-harm appear to be higher among a slightly older cohort. 49% of all deaths from suicide in the county are in those aged between 41 and 60 years old, using the age categories traditionally selected in this analysis. This is corroborated by the age standardised death rate from intentional self-harm when split by age, however 70-74 year olds show a high rate of mortality from suicide in 2014 and 2015 which is not picked up elsewhere. It should be noted that mortality from suicide in those aged 65 years and over was not reported in the Office for National Statistics data for Northamptonshire in 2013 which may be due to the suppression of counts of less than five.
Self-harm results in approximately 110,000 inpatient admissions to hospital each year in England, 99% are emergency admissions. Self-harm is an expression of personal distress and poorly understood in society, subject to stigma and hostility. It is defined as an intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent.
However, following an episode of self-harm, there is a significant and persistent risk of suicide which varies markedly between genders and age ups. Self-harm is one of the top five causes of acute medical admission and those who self-harm have a 1 in 6 chance of repeat attendance at A&E within the year.

Self-harm and suicide attempts can be seriously detrimental to an individual’s long-term physical health, if they survive. The NICE guidelines on self-harm note that people who have survived a medically serious suicide attempt are more likely to have poorer outcomes in terms of life expectancy.

Those at greater risk include:

- **Women** - rates are two to three times higher in women than men,
- **Young people** - Self-harming in young people is not uncommon (10-13% of 15-16-year-olds have self-harmed in their lifetime),
- **Older people** who harm themselves are more likely to do so in an attempt to end their life,
- People who have or are recovering from drug and alcohol problems,
- Self-harm in prisons is associated with subsequent suicide, prevention and treatment of self-harm is an essential component of suicide prevention in prisons,
- People who are lesbian, gay, bisexual or gender reassigned,
- Those living in social deprivation in urban areas,
- Women of South-Asian ethnicity,
- Individual elements including personality traits, family experiences, life events, exposure to trauma, cultural beliefs, social isolation and income.
- Other factors such as education, housing and wider macro-socioeconomic trends may also contribute directly, or by influencing a person’s susceptibility to mental health problems.

Northamptonshire’s 2015/16 rate for emergency hospital admissions due to intentional self-harm is statistically significantly higher than the national average and the highest in the East Midlands. The rate has increased since the previous data period in 2014/15, but not significantly so.

Figure 7: Hospital admissions for self-harm

<table>
<thead>
<tr>
<th>Area</th>
<th>Count</th>
<th>Value</th>
<th>95% Lower CI</th>
<th>95% Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>109,749</td>
<td>196.5</td>
<td>195.4</td>
<td>197.7</td>
</tr>
<tr>
<td>East Midlands region</td>
<td>9,559</td>
<td>203.0</td>
<td>198.9</td>
<td>207.1</td>
</tr>
<tr>
<td>Derby</td>
<td>678</td>
<td>260.1</td>
<td>240.7</td>
<td>260.7</td>
</tr>
<tr>
<td>Northamptonshire</td>
<td>1,835</td>
<td>250.0</td>
<td>243.4</td>
<td>267.0</td>
</tr>
<tr>
<td>Nottingham</td>
<td>666</td>
<td>252.8</td>
<td>235.3</td>
<td>271.2</td>
</tr>
<tr>
<td>Derbyshire</td>
<td>1,628</td>
<td>242.6</td>
<td>231.6</td>
<td>254.1</td>
</tr>
<tr>
<td>Northamptonshire</td>
<td>1,617</td>
<td>205.3</td>
<td>195.4</td>
<td>215.6</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>1,280</td>
<td>181.7</td>
<td>171.8</td>
<td>192.0</td>
</tr>
<tr>
<td>Leicestershire</td>
<td>546</td>
<td>150.7</td>
<td>127.8</td>
<td>164.4</td>
</tr>
<tr>
<td>Rutland</td>
<td>862</td>
<td>129.9</td>
<td>121.4</td>
<td>138.3</td>
</tr>
</tbody>
</table>

Local data is currently unavailable on the male/female experiences of intentional self-harm. Nationally the female rate is significantly higher than the male. This contrasts with the mortality from suicide rate in which males are far more prevalent than females. Nationally, almost 11% of emergency hospital admissions in young people aged 15 to 19 years in 2014/15 was as the result of intentional self-harm (Source: PHE, 2017). In Northamptonshire there are high rates of admission related to self-harm in young people, particularly in the 15-19 age group and hospital admissions for self-harm have been increasing over time in the 10 to 19 age groups. Admissions for self-harm are highest in the 15-19 age group, followed by those aged 20-24. Self-harm among younger people in Northamptonshire is higher than the national average. It is important to note the increases in admissions may be due to an increasing burden but also may reflect improved data collection or differences in coding or local pathways of care.

In the three year period 2013/14 to 2015/16 there were 85,753 visits to Accident and Emergency (A&E) department by young people aged 15-
24 registered to Nene and Corby CCGs. Self harm is by far the largest external cause of emergency admission, accounting for 45% of admissions. There was a slightly higher number of females attending A&E each year compared to males and female attendance was 5% higher in 2015/6 than 2013/4 and 2014/5. Male attendance did not change over the period. At age 15 only 48% of those attending A&E are female but at age 20 55% attendees are female. 74% of females are coded as White British compared to 71% of males.

Figure 8: Emergency admissions for intentional self-harm by gender in England 2015-16

Figure 9: Age standardised mortality rate from intentional self-harm in Northamptonshire 2013-15 by sex, NOMIS 2017
Underlying cause: actuals, rates and trends

A wide variety of methods are employed to inflict self-harm and these are grouped into different categories in the Office for National Statistics data extracts. However due to the fact that this is published with no restrictions on access, small numbers have been suppressed to protect against identification. This therefore does restrict the analysis possible. The most common means of death from intentional self-harm is by hanging, strangling or suffocation. Intentional self-poisoning is also relatively common. In 2015 the published data recorded that suicides from smoke, fire and flames became more prevalent. When the male/female split is explored hanging, strangling and suffocation remains a common means for both sexes. This means of death is most common in those aged 70-74, followed by those aged 50-54 and 55-59 respectively which largely reflects the pattern for suicides by all methods.

Over time PCMD data indicates that in Northamptonshire the use of hanging, strangling or suffocation as a means of suicide has dropped for both males and females. In 2011-12 the male proportion of all deaths in Northamptonshire from these means was 56%, this has since dropped to 49% in 2016-17. Use of these methods by females has dropped more sharply, from 67% in 2011-12 to 25% in 2016-17, however the small numbers involved may skew the results.

Place of death

The local deaths registrations data collected in the PCMD shows that 2015-16 saw the most deaths from suicide occurring at home in the period of April 2011 to March 2017. Most suicides occur in urban areas, which fits with the profile of the population, overall.

The proportion of deaths reported in Northamptonshire that result in an
inquest is lower than across the region and England as a whole, with only 10% of reported deaths resulting in an inquest in 2016 compared to 12% in East Midlands and 16% in England. This has been a consistent pattern since 2006. The number of inquests opened that recorded a verdict of suicide has increased steadily since 2006 and sits behind accident and misadventure and natural causes in terms of volume. A number of deaths occurred while individuals were detailed in state institutions such as prison, police custody or by the Mental Health Act or Deprivation of Liberty Orders.

Figure 10: The percentage of deaths in state detention in Northamptonshire, East Midlands and England 2016, Ministry of Justice 2017
Summary

Each death by suicide has a huge impact on our society. The prevalence of death by suicide has increased in Northamptonshire over the last few years and even though the overall prevalence of suicide in our county is not significantly higher than the rate of deaths by suicide in other areas of the country, some areas of our county seem to have much higher rates of suicide than others and we need to understand why this is. Men are currently significantly more at risk of suicide, however rates are increasing faster in women than in men. Northamptonshire also appears to have more older people dying from intentional self-harm than might be expected by the national average and we need to explore this further to better understand why this might be. We also need to understand the higher than expected numbers of young people admitted to hospital for self-harm and how we manage that risk.

Every death by suicide is one too many. This strategy sets out what we know about suicide in our county, how we aim to develop our understanding further and how we plan to work together to reduce deaths by suicide in the future.
4. Priorities for Northamptonshire

The National Suicide Prevention Alliance (NSPA) Strategic Framework 2016-19 outlines two principle objectives: to reduce the suicide rate in the general population and provide better support for those bereaved or affected by suicide and identifies 7 priority areas:

1. Reducing stigma
2. Encouraging help-seeking
3. Providing the appropriate support
4. Reducing access to mean
5. Reducing the impact of suicide
6. Improving data and evidence
7. Working Together

The Public Health England Practice Resource: Local suicide prevention planning, published in 2016 sets out six areas for action. PHE recommend that local areas should aim to tackle all six areas set out below in the long term, but also recommends priorities for short term action using a co-ordinated whole system approach.

The Northamptonshire Partnership Forum have therefore developed a set of short and longer term priorities, informed by the national strategy, PHE guidance, local need and resource availability. This list of priorities will form the basis of our partnership approach to reduce suicide in our county over the next five years, but it important to note that while delivery against each priority area is important, the delivery of all priorities is essential if we are to achieve our aim of reducing suicide in Northamptonshire.
Northamptonshire Suicide Prevention Partnership priorities

Priority 1: Work in partnership

We have established the Northamptonshire Suicide Prevention Strategy Partnership which is made up of a wide range of partners. We shall seek to widen the partnership and find ways of involving service users and carers. This group cannot achieve its ambitions in isolation and the work of other wider partnerships can and should impact positively on our aim to reduce suicide in the county. The Partnership will report to the Mental Health Strategic Transformation Plan Board as part of the Prevention Concordat arrangements, and to the Health and Wellbeing Board through the Director of Public Health. Each organisation represented on the partnership will be responsible for reporting on plans and progress, risks and issues via its own governance arrangements.

We plan to:

- Work with partners via the Prevention Concordat
- Develop the partnership to include wider representation
- Develop ways of engaging with, and learning from, people who have had suicidal thoughts or who have been impacted by suicide
- Review organisational policies and procedures to support our workforce
- Learn from and share learning with other areas

Priority 2: Improving our understanding of the causes and effects of suicide

We know that a more comprehensive set of data and information would help us to identify high risk groups and plan our services more effectively and to monitor our progress towards reducing suicides in our county.

We plan to:

- Establish an agreed data set to measure progress and inform our plans
- Establish data transfer from coronial services with the aim of producing an annual coronial data audit
- Use research and local knowledge and experience to develop our understanding of suicide and its impact
- Improve our understanding of the “triggers” for suicide
Priority 3: Reducing the risk of suicide in key high risk groups

The population group with the highest suicide rate in England and Northamptonshire is middle aged men. There may a number of factors influencing this, including higher rates of risk factors such as alcohol misuse, economic pressures unemployment or redundancy and debt and sometimes this may be thought to be the outcome of a reluctance to ask for help among this group.

The use of specific methods of self-harm among this group may also be a factor. The Confidential Inquiry findings 2015 suggest good physical health care for mental health patients may help to reduce suicide risk.

Women with any past history of psychotic disorder, even where not diagnosed as postpartum psychosis or bipolar disorder, should be regarded as at elevated risk in future postpartum periods.

We plan to:

- Work together to reduce the risk of suicide in identified high-risk groups by improving access to support, reduced access to the means of suicide and early identification of emotional distress and risk of, or actual self-harm

- Reduce stigma around emotional distress and suicidal thinking by encouraging people to seek help, and ensuring that services are responsive and offer appropriate support. We will use evidence such as that produced in the Men’s Health Forum document “How to make mental health services work for men”

- Offer suicide awareness training to frontline staff

- Make the link between physical health problems or chronic pain and suicide risk by training front line staff and via Making Every Contact Count

- Raise awareness of the groups who are known to be at increased risk of suicide including men, mental health service users and people with a history of self-harm, and those who are vulnerable and for whom a particular focus may be needed in suicide prevention. These groups may include people in contact with the criminal justice system, some occupational groups – doctors, vets, farmers and agricultural workers, veterans, women in the post-natal period and LGBT (lesbian, gay, bisexual and transgender) people

- Submit a bid to NHS England for a specialist perinatal mental health service
Priority 4: Improve positive emotional health and wellbeing and resilience among high risk groups, including young people.

We know that there are above average rates of self-harm among young people in Northamptonshire and that people who self-harm are at increased risk of suicide in the following year.

We plan to:

• Review our Child and Adolescent Mental Health provision and develop a more integrated approach across children’s services

• Review our investment in young people’s counselling services

• Review how vulnerable groups of young people, including young people known to the criminal justice system are supported to access to universal health care provision and targeted support when they need it

• Review the self-harm pathway to ensure that young people are given the right care, at the right time

• Develop and implement a depression pathway to ensure people with depression are treated using an evidence based approach, are supported in the community and are referred for specialist help when they need it

Priority 5: Reducing the impact of suicide

Approximately 60 individuals in Northamptonshire take their own life each year and many more people – family, friends, colleagues, neighbours, employers, professionals, and the wider society feel the impact. Northamptonshire has a range of counselling services, mainly provided by Voluntary organisations but has no dedicated bereavement counselling services for those bereaved by suicide.

We plan to:

• Seek opportunities to develop bereavement counselling for those bereaved by suicide

• Through our workplace health initiative, encourage workplaces to adopt “Reducing suicide, a toolkit for employers” which supports senior leadership, line managers, HR and occupational health and safety professionals identify a member of staff who may have suicidal feelings and gives practical advice on how to deal with a crisis situation

• Develop a communication plan that will include the promotion of local agencies that can provide support both to those who are experiencing low mood or suicidal feelings and to those bereaved by suicide
5. Next Steps

Northamptonshire is currently producing a Prevention Concordat that all key stakeholders will be invited to sign up to. The Northamptonshire Prevention Concordat for Better Mental Health is underpinned by an understanding that taking a prevention-focused approach to improving the public’s mental health is shown to make a valuable contribution to achieving a fairer and more equitable society. The Northamptonshire Concordat promotes evidence based planning and commissioning to increase the impact on reducing health inequalities.

This Northamptonshire Suicide Prevention Strategy will form one of the partnership initiatives that support the Concordat and will be submitted to the Northamptonshire Health and Wellbeing Board and the Boards of partner organisations for approval.

We will circulate the strategy among our partners and across a wider audience, including voluntary sector and service users, seeking their involvement in, and advice on developing the plans to deliver this strategy. Working in partnership a detailed action plan will be developed, supported by individual organisational plans. The Action Plan will be monitored annually and an update report will be produced for the Health and Wellbeing Board in November 2018.