MANCHESTER JOINT STRATEGIC NEEDS ASSESSMENT
ADULTS AND OLDER PEOPLE

CHAPTER: Mental Health and Emotional Health & Wellbeing

TOPIC: Suicide Prevention

WHY IS THIS TOPIC IMPORTANT?

Every suicide is both an individual tragedy and a loss to society. **On average, 13 people kill themselves every day in England.** Suicide rates in England have increased nationally since 2007, making suicide the biggest killer of men under 50 as well as a leading cause of death in young people and new mothers (ONS 2015). Suicides are not inevitable and while numbers are relatively small, the impact of suicide on families, friends and communities is significant. Many others providing care and support will also feel the impact. Longer term the effects can extend to psychological trauma, reduced wellbeing and quality of life and even premature mortality amongst those affected. The economic impacts of suicide are profound. The average cost of a completed suicide of a working age individual in England is £1.67m. For every year that an individual suicide is prevented, costs of £66,797 are averted (LSE 2011). Individuals with mental health issues are particularly at risk. Between 2003 and 2013, 18,220 people with mental health problems took their own life in the UK (University of Manchester 2015).

Whilst we know that people in the care of Mental Health Services are at higher risk of suicide than the general population, three quarters of suicides occur in people who have not been in touch with Mental Health Services within the previous 12 months (ONS 2014). It is therefore crucial that a broad, community-based approach is taken to suicide prevention.

The Government Report, *Preventing Suicide in England: Third Progress Report of the cross government outcomes strategy to save lives* highlights the importance of local action supported by national coordination in suicide prevention. The national Suicide Prevention Strategy is being refreshed and publication is expected early 2017.

Public Health England (PHE) recommends that local authority areas develop local multi agency suicide prevention action plans to coordinate suicide prevention activity, overseen by partnership groups. PHE published specific guidance for public health staff in local authorities to support this work.

The Greater Manchester Mental Health Strategy highlights suicide prevention as one of its key prevention priorities during the first two years. The focus is on working with the Greater Manchester Suicide Prevention Executive to reduce suicide risk by reflecting the main elements of the national strategy i.e. men's mental health, mental health services, self-harm, young people, suicide hotspots, working with the media, early follow-up on hospital discharge, adopting NICE guidance on depression and self harm. Supporting the development of real time data and information and workforce development to support suicide prevention.

Within Manchester, suicide prevention work is underpinned by the public mental health programme and is a core outcome of the mental wellbeing priority within the Joint Health and Wellbeing Strategy. Manchester Mental Health and Social Care Trust has a

comprehensive Suicide Prevention Strategy focused on preventing suicides of those within its services and convenes a regular suicide prevention group.

THE MANCHESTER PICTURE

1. **Suicide in Manchester and risk factors**
2. **Factors affecting suicide risk**
3. **Public health England suicide data for Manchester**

1 SUICIDE IN MANCHESTER AND RISK FACTORS

Numbers of suicides in Manchester are as follows –

Year	Number of suicides (all ages) and injuries of undetermined intent (15+ only)		
	Persons	Male	Female
2008	54	44	10
2009	59	45	14
2010	66	55	11
2011	65	48	17
2012	53	38	15
2013	38	30	8
2014	48	36	12
2015	45	38	7

Please note: Official statistics are based on the number of deaths registered in an area over a given time period.

When examining suicide trends over time it is important to look over a relatively long period. Increases and decreases for a year at a time should not be considered in isolation. There may be fluctuations year on year but these should not be viewed as ‘true’ changes to the trend that are attributable to any specific psycho-social predictors (e.g. unemployment). The numbers above represent date of registration for suicides. The time for a coroner to reach a verdict may take many months and therefore the recorded death may appear the year after occurrence. (For example in 2014 the median delay for registration of suicides in Manchester was 267 days. This compares to a median delay of 150 days for England).

When looking at suicide data published by Public Health England, Manchester has similar rates of both years of life lost due to suicides and suicide rates for both males and females compared to the UK average. It has higher rates of suicides for people aged 35 - 64 (particularly males) and females aged 10 - 34 years.

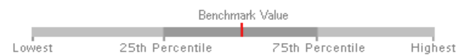
Compared with benchmark Lower Similar Higher Not Compared

* a note is attached to the value, hover over to see more details

Recent trends: (in development) – Could not be calculated · Increasing / Getting worse · Increasing / Getting better · Decreasing / Getting worse · Decreasing / Getting better · No significant change · Increasing · Decreasing

Data quality: Significant concerns · Some concerns · Robust

Export table as image

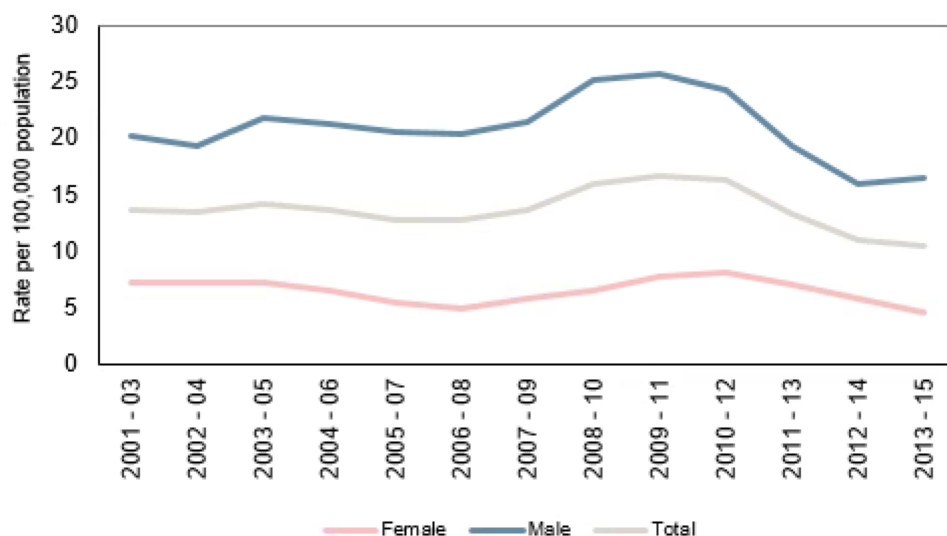


Indicator	Period	Manchester			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Lowest	Range	Highest
Suicide: age-standardised rate per 100,000 population (3 year average) (Persons)	2013 - 15	–	130	10.5	11.3	10.1	5.6		17.4
Suicide: age-standardised rate per 100,000 population (3 year average) (Male)	2013 - 15	–	103	16.4	17.6	15.8	8.5		27.5
Suicide: age-standardised rate per 100,000 population (3 year average) (Female)	2013 - 15	–	27	4.6	5.3	4.7	-	*Insufficient number of values for a spine chart*	-
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Persons)	2012 - 14	–	133	35.4	38.3	31.9	10.7		62.6
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Male)	2012 - 14	–	101	53.8	60.7	50.2	16.4		101.6
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Female)	2012 - 14	–	32	16.1	16.2	13.7	0.0		26.2
Suicide crude rate 10-34 years: per 100,000 (5 year average) (Male)	2011 - 15	–	58	9.6	12.4	10.5	4.5		25.3
Suicide crude rate 10-34 years: per 100,000 (5 year average) (Female)	2011 - 15	–	200	3.6*	3.6	2.9	2.5		4.0
Suicide crude rate 35-64 years: per 100,000 (5 year average) (Male)	2011 - 15	–	120	29.1	24.0	20.8	8.9		39.7
Suicide crude rate 35-64 years: per 100,000 (5 year average) (Female)	2011 - 15	–	462	6.6*	6.6	6.0	5.0		7.1
Suicide crude rate 65+ years: per 100,000 (5 year average) (Male)	2011 - 15	–	12	11.3	12.3	12.6	2.9		26.2
Suicide crude rate 65+ years: per 100,000 (5 year average) (Female)	2011 - 15	–	147	4.3*	4.3	4.4	3.7		5.6

Suicide rates for Manchester, North West and England
Public Health England
https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/0

The age-standardised mortality rate for **men and women** from suicide and injury undetermined in Manchester was 10.5 per 100,000 in 2013-2015, which is not significantly different from rates of 11.3 for the North West and 10.1 for England. The use of age standardised rates allows differences in the age profile of local authorities/regions are taken into account to enable more accurate comparisons to be made. This is important in areas such as Manchester that has an age profile quite different to other cities and areas. The rate shows that Manchester has slightly more mortalities from suicide and injury undetermined than England, but less than the North West, and these differences are not due to Manchester having a younger age profile than other areas and England as a whole.

Deaths from suicide and injury undetermined



Source: Public Health England © Crown Copyright 2016

The age-standardised mortality rate from suicide and injury undetermined in Manchester was 16.4 per 100,000 **males** in 2013-2015, compared to a rate of 4.6 per 100,000 **females** in the same time period. This again shows clear differences in suicide by gender. Tracking the rate over time shows an increase in deaths from suicide and injury undetermined in Manchester from 2008 to 2012 – this coincides with the 2008 economic recession. The rates have been falling in recent years, especially for males, with the total rate for 2013-2015 being the lowest rate for a number of years.

2 FACTORS AFFECTING SUICIDE RISK

The causes and consequences of suicide are complex and there are many myths and misunderstandings associated with the subject. Frequently, several factors act cumulatively to increase a person's vulnerability to suicidal behaviour. Research evidence shows the following groups to be at risk of suicide.

Males – Males are three times as likely to die by suicide as females, particularly adult men under 50. (ONS 2015)

Age groups – The 45 – 59 age group has the highest rates of suicides in the UK for both males and females. (ONS 2015)

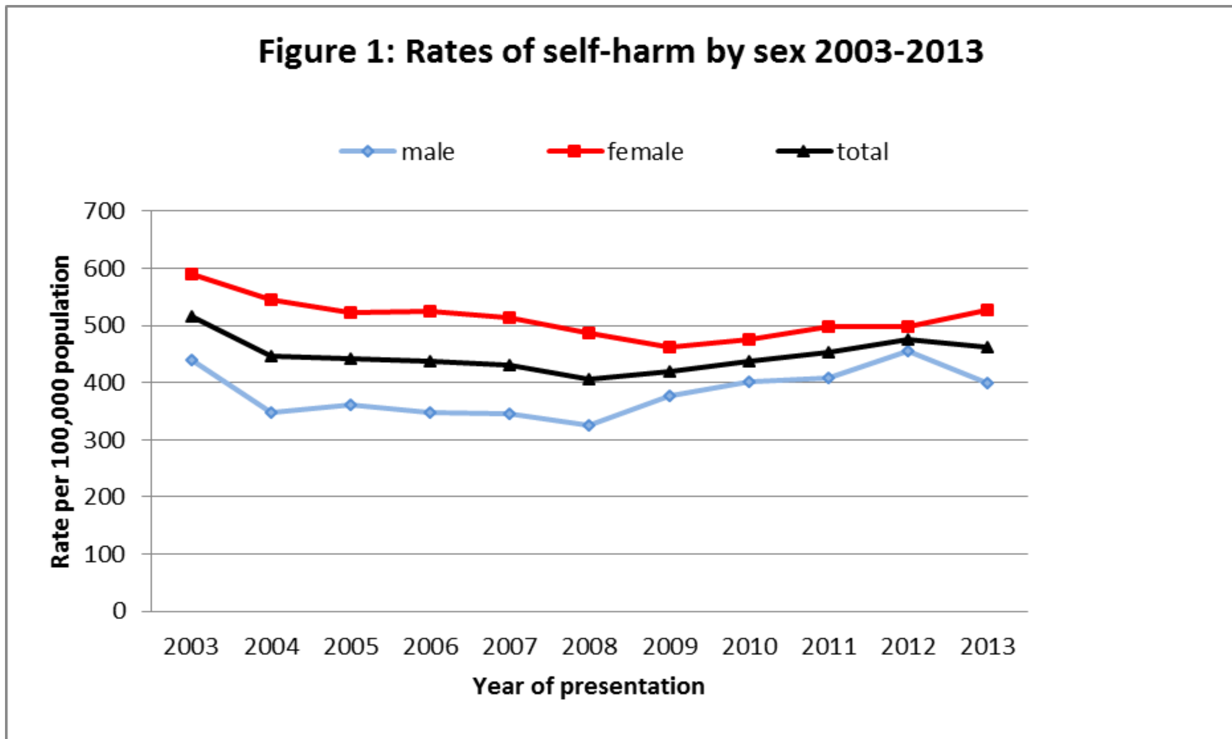
Mental Health – a number of studies have shown that up to 90% of people who die by suicide had one or more mental illness however only around 25% of people who take their lives in the UK (and in Manchester) have been in contact with mental health services prior to their death (ONS 2014). In the case of depression, studies have shown that, on average, the risk of suicide is about 15 times higher than the average for the general population. The Mental Health Foundation (2015) estimates that 70 per cent of recorded suicides are by people experiencing depression, often undiagnosed.

Self Harm – Self-harm, including attempted suicide, is the single biggest indicator of suicide risk. The UK has high rates of self-harm resulting in over 200,000 hospital attendances per year in England. Approximately 50 per cent of people who have died by

suicide have a history of self-harm (Foster et Al 1997)[1], and in many cases there has been an episode of self-harm shortly before someone takes their own life. Self harm rates in Manchester appear to have been rising in recent years based on hospital data collected as part of Manchester Self Harm project.

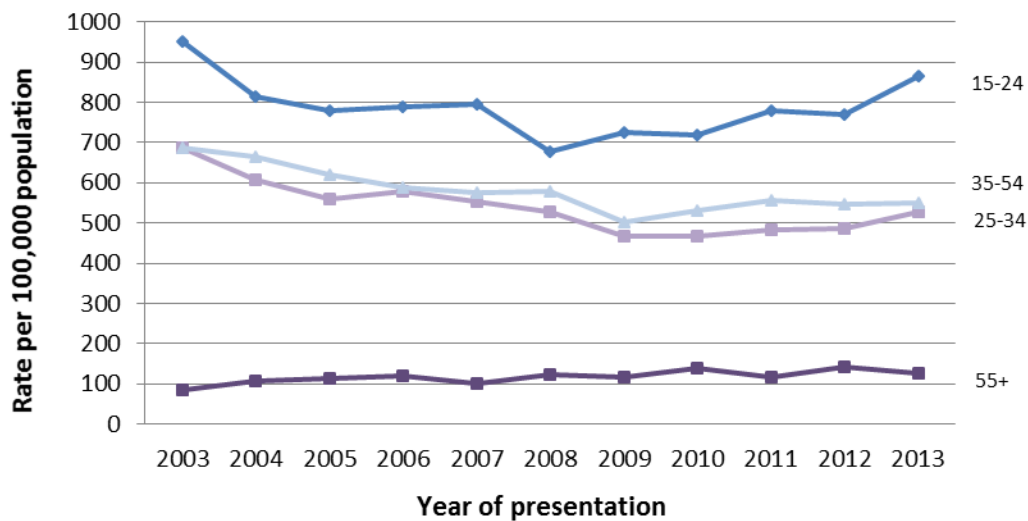
Self-harm in Manchester 2003-2013

- Rates of self-harm in Manchester have increased since 2008/9 but fell in men in 2013
- The increase in men was largest in the 35-54 year age group
- The increase for wowmen was largest in the 15-24 year age group



Source: Manchester Self Harm Project

[1] Foster T, Gillespie K, McClelland R. Mental disorders and suicide in Northern Ireland. Br J Psychiatry 1997;170:447–52



Source: Manchester Self Harm Project

Children and young people (including those who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system) – although numbers of children and young people who die by suicide are low it remains the second most common cause of death in young people. According to The Office of National Statistics, in 2014 there were 476 deaths of 15 to 24 year olds from self-harm or undetermined intent in England and Wales representing a rate of 6.6 deaths per 100,000 population aged 15 to 24 years. Further one study that looked at suicides in the UK between 1997 and 2003 observed that three times as many young men as young women (15 – 19) die by suicide – mirroring the adult ratio; and 14% of young people were in contact with mental health services prior to their death, compared to 26% in adults. (2013 National Confidential Inquiry into Suicide and Homicide)

Recently published research (University of Manchester 2016) examined reports from a range of investigations and inquiries on 130 people under the age of 20 who died by suicide between January 2014 and April 2015. It was found that 28% of young people who died had been bereaved and in 13% of cases there had been a suicide of a family member or a friend. 36% had a physical health condition such as acne or asthma, and 29% were facing exams or exam results when they died.

There are also strong links between childhood physical, sexual and emotional abuse and suicidal thoughts and behaviours and bullying during childhood is also a risk factor for suicide attempts in adults.

The number of students who took their own lives in England and Wales rose by 50% between 2007 and 2011, from 75 to 112, despite the number of students as a whole rising by only 14% (ONS 2012). The number of student suicides at local level is not available however and this is an area of concern for Manchester.

Survivors of domestic abuse or violence, including sexual abuse – there are strong links between intimate partner violence and suicidal thoughts and behaviours. Domestic violence and abuse also has considerable impact on the short and long-term mental

health of victims and survivors of abuse and their children. Victims are four times more likely to suffer depression, and suffer more post traumatic stress disorder (PTSD), anxiety, insomnia, self-harm, increased substance use and have thoughts about suicide. 40% of high-risk victims report having mental health issues, 16% report they have considered or attempted suicide, and 13% report self-harming as a result of abuse (Bristol Safe Lives 2015). Manchester has higher rates of domestic violence and abuse compared to other core cities. Rates are also on the increase with the number of domestic abuse incidents reported in the city increasing by 35% between April 2014 and March 2015. (Manchester City Council 2016).

People with physically disabling or painful illnesses including chronic pain and long term conditions – The National Confidential Inquiry into suicide and homicide by people with a mental illness (2015) found that around a quarter of patients who die by suicide have a major physical illness and this rises to 44% in patients 65 and over. Manchester has high rates of people with a long term condition or disability and it is estimated that by 2030 there will be 26% more people aged 65 and over with a limiting long term illness living in Manchester (PANSI 2014). All ethnic groups have experienced a steady increase in people living with a long term illness in recent years. 2011 census data shows that the number of people of South Asian (Indian, Pakistani and Bangladeshi) rose in comparison with other Black Minority & Ethnic (BME) groups between 2001 and 2011. This links between physical illness and suicide highlights the importance of integrating mental and physical health for people of all ages across primary, secondary and specialist NHS services, including for people with long-term physical health conditions and ensuring timely physical health assessments and follow-up treatment for people living with mental health problems.

Alcohol and Drug Use – Alcohol and drug use amplifies suicidal thoughts, plans and deaths. A recent UK based study (Ness et Al 2015)[2] found that the use of alcohol significantly increased suicide risk particularly in women.. There were an estimated 4,709 opiate (heroin) and/or crack cocaine users aged 15-64 in Manchester in 2011/12, a rate of 12.97 per 1,000 population (1.3%). This is higher than the estimated rate for England, which is 8.4 per 1,000 population.38 Local prevalence estimates for alcohol misuse are not available however applying national estimates of adults dependant on alcohol would equate to 22,670 in Manchester. Manchester has a higher incidence of co-existing Mental Health and substance misuse issues compared to the North West and England. In 2014/15 there were 331 individuals who entered treatment at a specialist alcohol misuse service who were in receipt of treatment from mental health services for a reason other than substance misuse at the time of assessment. This equates to 32.5% of those entering treatment, compared to 18% in the North West and 20% in England. This suggests a level of complexity in the lives of some Manchester residents that may lead to thoughts of harming themselves. A recent report by the prison and probation ombudsman (2015) in to 19 deaths in UK prisons between April 2012 and September 2014 highlighted a possible link between New Psychoactive Substances and self harm and suicide.

Lesbian, gay, bisexual and transgender (LGBT) – there is growing evidence of the increased risk of self harm and suicidal thoughts and behaviours amongst LGBT people. A study conducted in the UK highlighted the impact of homophobia as a key factor. Research Conducted by the London School of Hygiene & Tropical found that gay and

[2] Ness, J., Hawton, K., Bergen, H., Cooper, J., Steeg, S., Kapur, N., . . Waters, K. (2015). Alcohol use and misuse, self-harm and subsequent mortality: an epidemiological and longitudinal study from the multicentre study of self-harm in England. Emergency Medicine Journal, 32(10), 793-799. doi: 10.1136/emermed-2013-202753

It is estimated that between 5-7% of the UK population identifies as LGBT. Research by bisexual men under the age of 26 were six times more likely to attempt suicide or self- The Lesbian and gay foundation (2013) suggests that Manchester has an LGB population harm compared to men in that group aged over 45. (McDermott et al 2008)[3] of 24,950 – 34,930.

Black, Asian and minority ethnic groups and asylum seekers – Studies have found self-harm and suicide to be higher amongst Asian women than other groups (Ineichen B et al 2008)[4]. Contributory factors include lack of self-determination, excessive control, weight of expectations of the role of women and concerns about marriage Prevalence data on death by suicide however is limited as ethnicity is not recorded on death certificates.

Specific occupational groups – doctors, nurses, veterinary and agricultural workers are at heightened risk of suicide with doctors and farmers at highest risk (Scottish Government Social Research 2008). A number of factors contribute to this, not least easier access to the means of suicide.

Veterans – Some research (Woodhead et al 2011) suggests that veterans are at increased risk of suicide and that this risk is greater for those who leave early (as opposed to longer serving personnel), younger individuals, those experiencing post-traumatic stress disorder (PTSD) and those with a history of childhood trauma.

Criminal Justice System – The World Health Organisation and International Association for Suicide Prevention recognise that prisoners are a high risk group for suicide, as are those on remand and those recently discharged from custody. The risk is greatest in the first week of imprisonment. Figures published by the Ministry of Justice in 2015 show that Self-inflicted deaths decreased to 82 in the 12 months ending June 2015 compared to 91 in the same period of 2014. Very recent figures however show an increase to a record number of 119 self-inflicted deaths in 2016 – which is 29 more than the previous year and the highest number since records began in 1978 (Ministry of Justice 2017).

New mothers - The 2016 Mother and Babies: Reducing Risk Through Audits and Confidential Enquiries across the UK (MBRRACE-UK) study reported that Between 2009 and 2014, 111 women died by suicide in the UK during or up to a year after the end of pregnancy (20 of whom died during or within 42 days of the end of pregnancy) making this the leading cause of direct maternal deaths occurring up to one year after the end of pregnancy.

Social and economic circumstances – people who are unemployed are two to three times more likely to die by suicide than those who are in work. (Platt, 2003)[5], with unemployed men more at risk than unemployed women (Platt & Hawton, 2000)[6]. Unemployment can result in poorer mental health, such as anxiety and depression, lower self-esteem and feelings of hopelessness, all of which increase the likelihood that someone will think that life is not worth living. Debt and austerity measure may well increase risk. Recent research in the British Medical Journal found that Work Capability Assessment for people on disability benefits was independently associated with and increase in suicides, self-reported mental health problems and antidepressant prescribing

[3] McDermott, E., Roen, K., & Scourfield, J. (2008). Avoiding shame: young LGBT people, homophobia and self-destructive behaviours. Culture Health & Sexuality, 10(8), 815-829. doi: 10.1080/13691050802380974

[4] Ineichen B. (2008)Suicide and attempted suicide among South Asians in England: who is at risk? Mental Health Fam Med. 2008 Sep; 5(3): 135–138

[5] Platt, S. (2003) Suicide and work. In Suicide in Specific Populations, pp. 25–28. Medicine Publishing Company.

[6] Platt, S. & Hawton, K. (2000) Suicidal behaviour and the labour market. In The International Handbook of Suicide and Attempted Suicide (eds K. Hawton & K. van Heeringen), pp. 309–384. John Wiley & Sons.

(Barr et al 2015)[7]. The high levels of deprivation and health-related worklessness that persist in Manchester make this risk factor a particular concern. The number of health-related benefit claimants has remained high even during times of economic growth. In many cases there will be multiple health conditions accompanied by a range of complex social circumstances for example low skills, family and relationship issues, social isolation, debt and housing problems.

Bereavement by suicide – people bereaved by the sudden death of a friend or family member are 65% more likely to attempt suicide if the deceased died by suicide than if they died by natural causes. As well as the increased risk of suicide attempt, those bereaved by suicide were also 80% more likely to drop out of education or work. In total, 8% of the people bereaved by suicide had dropped out of an educational course or a job since the death (BMJ open 2016).

3 PUBLIC HEALTH ENGLAND SUICIDE DATA FOR MANCHESTER

Age standardised mortality rate
The Public Health Outcomes Framework (PHOF) includes a number of outcome indicators in respect of suicide. Manchester has higher than average rates of

- Estimated prevalence of opiates and / or crack cocaine use (15-64)
- Long term health problems or disability % of people whose day to day activity are limited by their health or disability
- Children in the Youth Justice system (aged 10-18)
- Looked after children and children leaving care (under 18)

Full table available at http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data

WHAT DO WE NEED TO DO TO ACHIEVE THIS? / The Manchester challenge

Manchester's Local Suicide Action Plan has the following aims and objectives:

- Reducing the misery of mental distress
- Reducing the prevalence of suicidal ideation across the lifespan
- Preventing attempted suicides and deaths by suicide
- Identifying people at risk of suicidal thoughts and behaviours who 'fall beneath the radar' e.g. people working under high performance pressure
- Strengthening initiatives to increase emotional / psychological resilience
- Ensuring better support for those bereaved or affected by suicide
- Strengthening partnerships to work together to reduce suicide
- Raising awareness that suicide prevention is everybody's responsibility
- Developing creative and far reaching public engagement initiatives
- Identifying and responding to the training needs of workforces working with people who may experience suicidal thoughts and behaviours
- Reducing the stigma and blame surrounding suicide and disclosing suicidal thoughts for individuals and workers

[7] Barr et Al (2015) 'First, do no harm': are disability assessments associated with adverse trends in mental health? A longitudinal ecological study . J Epidemiol Community Health doi:10.1136/jech-2015-206209

- Engaging with the media to ensure suicides are reported sensitively
- Working with commissioners to advocate for suicide prevention as a priority
- Using evidence based practice and measures evaluate our approaches and interventions

WHAT ARE WE CURRENTLY DOING?

There is much interest and commitment from a range of agencies and organisations across sectors in the city in contributing to the prevention of suicides that can be harnessed.
Below are some examples of work being delivered by different organisations either specifically related to suicide prevention or more broadly focused on improving public mental health and wellbeing. This list is not exhaustive and specifically does not provide a detailed list of the many community projects supporting this agenda. It is intended to demonstrate the range of activities and partners engaged in this work.

Connect 5 training: Provided by buzz Health and Wellbeing Service, commissioned by Public Health. Connect 5 equips staff with the skills to have mental wellbeing conversations with people that they work with as well recognising and responding to suicidal thoughts and knowing where people can get help. The service has recently secured additional funding from the Office of the Police and Crime Commissioner to work across staff groups within the Criminal Justice System in Greater Manchester

Boost resilience training: buzz is providing 'Boost' six week emotional resilience courses to the public in each locality

Self Help Materials: buzz maintains the Mental Health in Manchester website which provides a guide to better mental health and getting help, including emergency contacts and help lines.

Manchester City Council and Manchester CCGs invest in a range of local mental health support via community voluntary organisations.

Greater Manchester Mental Health Foundation Trust has a comprehensive strategy to reduce suicide risk and deaths within its services and convenes a bi monthly Suicide Prevention Group to oversee the strategy and ensure learning is shared.

Child and Adolescent Mental Health Services (CAMHS) provided by Central Manchester Foundation Trust (CMFT): Specialist Community Mental Health Services for Children and Young People and Child and Adolescent Mental Health Wards have been rated as outstanding in the latest CQC report (June 2016)

Places of Welcome is a network of small community organisations, including faith communities, who offer an unconditional welcome to local people for at least a few hours a week. The network is based on trust, respect and generosity. They have developed a set of guiding principles, the 5P's - Place, People, Presence, Provision and Participation. Each Place of Welcome needs a coordinator who can manage it on a week by week basis; acting as the point of contact, supporting volunteers, connecting with the wider Places Of Welcome network, and manage signposting information. Manchester Diocese is currently setting up a scheme in Wythenshawe (along with others in greater Manchester) and hopes to support many more over the coming months.

The Sanctuary Is provided by Self Help and provides mental health crisis support to adults who are experiencing anxiety, panic attacks, depression, suicidal thoughts or are in crisis. It offers space to talk and assistance with coping.

Centre for Suicide Prevention (University of Manchester): Is a leading UK centre for research into suicidal behaviour and have two major research programmes – The National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness and Manchester Self-Harm Studies (MASH)

Network Rail work in Partnership with Samaritans to reduce the incidence of suicides at its stations and lines. Their programme includes hotspot identification, social deprivation mapping, media management, Samaritans training courses made available to railway personnel and campaign materials.

Samaritans volunteers provide a 24 hour telephone, text and email service for people who need emotional support including those who have suicidal thoughts or plans. Samaritans also provides an outreach service to Manchester Prison and works in partnership with Network Rail to provide training to its staff and signage for stations.

The Manchester Suicide prevention Plan
The local plan was endorsed by the Health and Wellbeing Board on 31st August 2016 and Manchester's Suicide Prevention Partnership, currently chaired by Councillor Joanna Midgley, is now formally established. A number of actions in addition to those listed above include the following.

Suicide audit
Public Health England recommend that local areas carry out regular audits of suicides in their area using Coroners records, to identify local contexts and issues that may be relevant when designing suicide prevention actions. Our suicide audit (look at the detail of all suicides registered in 2015) has just taken place (Feb 2017). The data is currently being analysed and This will give us more detailed information about local context to guide our approach.

Train the trainer sessions are being delivered to skill up a pool of people from different organisations to deliver suicide prevention awareness sessions to particular workforces as well as open sessions.
.
CAMHS with support is organising an event to develop a rapid **response for schools** and the wider school community following the suicide or suspected suicide of a young person.

Development of **broader campaigns/ communications** activity to reach key groups let them know what help is available in Manchester. The key message is that there is help – Samaritans, Sanctuary (phone line and overnight emotional support for people in crisis).

Looking at **clinical services** – particularly around self harm and pathways into community support for people leaving formal mental health services.

A key priority for this year is ensuring **people affected by suicide receive appropriate support** – support is patchy across GM and there is potentially a lot of unmet need.

WHAT DO WE NEED TO DO TO ACHIEVE THIS?			
Opportunities for action Manchester Suicide Prevention Partnership has the following priorities for action -			
Pillar		**Action Area**	**Partners including:**
1	Leadership and steering group	The Suicide Prevention Partnership will oversee the delivery of the plan.	Suicide Prevention Ambassadors Key leads for targeted actions in the plan
2	Evidence, data and intelligence	We will produce, promote and maintain a joint strategic needs assessment for suicide prevention in Manchester We will carry out local suicide audit in line with PHE recommendations We will work to identify local hot spots and opportunities to reduce access to means and promote support	Led by Public Health Team, MCC Public Health with resource support from partners Network Rail, GMP, Highways Agency, GM suicide prevention executive
3	Suicide Prevention Awareness	We will establish a network of suicide prevention ambassadors to advocate for suicide prevention within their work areas and disseminate key messages – this will include providing regular support We will carry out presentations to key groups and workforces We will develop key messages and communications about suicide prevention We will run ‘open’ suicide prevention awareness sessions for workforces and the public We will work with Greater Manchester colleagues to develop engaging public campaigns to reduce the stigma of suicide and let people know where support is available	Using Suicide Prevention Ambassadors Network / Members of Partnership
4	Mental Health and Wellness Promotion	We will deliver resilience training and workshops with the public including young people. We will disseminate mental health self help / self care resources and self help services	Buzz Health and Wellbeing Service Manchester Mind Self Help

Pillar		Action Area	Partners including:
5	Training	We will work to ensure that key staff groups who come into contact with people at risk of suicide are equipped to provide appropriate compassionate support. This should be part of core workforce training programmes. E.g. Domestic abuse workers, social workers, Student Services, Primary Care etc.	Manchester City Council, buzz Health and Wellbeing Service, Manchester Mind, 42nd Street Organisations working with people at risk e.g. Homelessness, Domestic Abuse, Drugs and Alcohol GPs / Primary Care Mental Health Services
6	Suicide Intervention & Ongoing Clinical/Support Services	We will set up a task group to explore issues about Self Harm and how this can be addressed We will establish pathways into appropriate community support for people receiving mental health services and prioritising people being discharged from services We will strengthen and develop initiatives that provide support for people in distress and ensure they are promoted, including managing distressing thoughts	CCGs, Mental Health Trust, Mental Health Providers Forum, Healthy Schools Programme, CAMHS, 42nd Street Self Help, Samaritans, Suicide Prevention Ambassadors
7	Suicide Bereavement	We will strengthen, develop and promote support available for people bereaved or affected by suicide – this could include families and friends, workplaces and schools and colleges	Survivors of Bereavement by Suicide (SOBS), CAMHS, GMP, Public Health etc
8	Evaluation measures	We will develop an evaluation framework to assess the impact of the local plan	Suicide Prevention Partnership (including University of Manchester)
9	Capacity building / sustainability	We will Integrate suicide prevention into existing approaches to community asset building and self care and embed suicide prevention into relevant strategies and plans	Our Manchester Leads, buzz health and wellbeing service, Public Health, CCGs etc

NICE guidelines

Preventing suicide in community and custodial settings – in development. Expected publication date September 2018
https://www.nice.org.uk/guidance/GID-PHG95/documents/final-scope

Mental health of adults in contact with the criminal justice system – in development. Expected publication date March 2017
https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0726

Health of people in the criminal justice system – pathway
https://pathways.nice.org.uk/pathways/health-of-people-in-the-criminal-justice-system

The above actions are based on a strong evidence base. A brief summary is presented here.

Media guidelines

There is evidence that media reports and coverage of suicide are linked to an increase in suicide rates and that reporting of suicides particularly affects vulnerable groups. Guidelines produced by The Samaritans (2008) call for caution and sensitivity in order to avoid copycat behaviour and include suggestions for reporting, including the correct phraseology, avoiding explicit details of suicide, avoiding labelling places as suicide hotspots, and encouraging public understanding of the complexity of suicide.

Postvention
Andriessen (2009) defines postvention as "activities developed by, with, or for suicide survivors, in order to facilitate recovery after suicide, and to prevent adverse outcomes including suicidal behaviour". Postvention policies are recommended to be in place to reduce the likelihood of additional suicides or further suicidal behaviour.

Limiting access to means of suicide
A number of factors may influence an individual's decision regarding method in a suicide act, but there is substantial evidence to support that easy access influences the choice of method (Sarchiaphone 2011)
There is international evidence that restrictions of access to common means of suicide has led to lower overall suicide rates, particularly regarding suicide by firearms in USA, detoxification of domestic and motor vehicle gas in England and other countries, toxic pesticides in rural areas, barriers at jumping sites and hanging, by introducing "safe rooms" in prisons and hospitals Furthermore, a decline in the prescription of barbiturates and tricyclic antidepressants, as well as limitations on the pack size for paracetamol and salicylate has reduced suicides by overdose.

Interventions for railway networks
Although internationally suicide by collision with a train accounts for 1-12% of all suicides, with up to 94% of all attempts resulting in death, there is limited evidence for effective suicide prevention practices. (Krysinka et al 2008) Only one review was identified in the literature search.
There is some evidence to support the effectiveness of suicide pits (i.e. deep channels between the rails) and sliding doors on platforms to restrict access to the track. There are also studies that show responsible media reporting of suicide and community media campaigns do help to reduce the numbers of rail suicide. There is also indirect evidence (from the car industry) that points to the effectiveness of airbags and skirts at the front of trains to reduce the severity of injuries.

Gatekeeper training
Gatekeeper training teaches specific groups of people to identify people at high-risk of suicide and refer those people for treatment, and can be aimed at family and community members as well as health and social care professionals. This training has been identified as a key intervention for suicide prevention Australian Government Department of Health and Ageing, (2007)

Medication
Safinofsky (2007) asserts that suicide prevention should begin with adequate case finding, and physicians should aggressively pursue recognition and treatment of depression and suicidality but not put their entire faith in medication. Similarly, Cardish (2007) reported that the first line of treatment for suicidality in personality disorder should be psychological treatments, but that medication may sometimes be complementary and make the treatment more feasible, particularly in times of crisis.

There is fairly good evidence that lithium reduces completed suicide and attempt rates in people with bipolar disorder and recurrent unipolar depression. Antidepressants and psychological treatments may reduce suicidal ideation in depressed patients. However, antidepressant trials do not target suicidality as an outcome, and inferences made are post hoc. Safinoksky (2007), Aguilar and Aguilla et al (2007) assessed the effect of antipsychotic medication on suicidality in patients with schizophrenia, and found that it was not possible to draw any significant conclusions.

Psychotherapy
There is some evidence that therapies such as dialectical behaviour therapy, cognitive behaviour therapy and problem-solving may reduce suicide attempts, suicidal behaviour or self-harm (Stanley et al 2009). However, Crawford et al (2007) found no evidence that enhanced psychosocial treatments following self-harm have a marked effect on the likelihood of subsequent suicide. There is a lack of research on the impact of psychosocial interventions on suicidal behaviour in people with bipolar disorder (Fountulakis et al 2009) Based on the Tarrier et al study (2008) a cognitive therapeutic approach to addressing suicidal thoughts and behaviours has been developed which is transdiagnostic, i.e. it applies regardless of psychiatric diagnostic classifications. The Tarrier et al (2008), meta-analytic review was conducted by researchers at the University of Manchester, UK. Three findings should be highlighted. First, therapy was effective if suicide was targeted and not psychiatric symptoms. Second, individual therapy was more effective than group sessions. Third, therapy was effective in adults but less so with adolescent clients. Since then two studies have shown that this approach is feasible, acceptable, and effective in people who experience psychosis and live in the community Tarrier et al (2014) and in people incarcerated in the UK (Pratt et al 2015). It should be noted that both of these studies took place in Manchester.

REFERENCES AND LINKS

Aguilar, E. J., & Siris, S. G. (2007). Do antipsychotic drugs influence suicidal behavior in schizophrenia? *Psychopharmacology Bulletin, 40*(3), 128-142.
Prisons and Probation ombudsman 2015. Learning lessons bulletin: Fatal incident investigations issue 9. |
http://www.ppo.gov.uk/wp-content/uploads/2015/07/LLB_FII-Issue-9_NPS_Final.pdf

Andriessen, K. (2009). Can postvention be prevention? *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 30*(1), 43-47.
https://www.researchgate.net/publication/24177623_Can_Postvention_Be_Prevention

Barr et Al (2015) 'First, do no harm': are disability assessments associated with adverse trends in mental health? A longitudinal ecological study . J Epidemiol Community Health doi:10.1136/jech-2015-206209
http://jech.bmj.com/content/70/4/339

Cardish, R. J. (2007). Psychopharmacologic management of suicidality in personality disorders. *Canadian Journal of Psychiatry - Revue Canadienne de Psychiatrie, 52*(6 Suppl 1), 115S-127S A Literature Review: Scottish Government Social Research 2008
http://www.gov.scot/resource/doc/251539/0073687.pdf

Crawford, J., Thomas, O., Khan, N., & Kulinskaya, E. (2007). Psychosocial interventions following self harm. Systematic review of their efficacy in preventing suicide. *British Journal of Psychiatry, 190*(1), 11-17.
http://bjp.rcpsych.org/content/190/1/11.1.figures-only

Ford Hickson, Calum Davey, David Reid, Peter Weatherburn, Adam Bourn(2016). Mental health inequalities among gay and bisexual men in England, Scotland and Wales: a large community-based cross-sectional survey. Journal of Public Health. Doi:10.1093/pubmed/fdw021
http://sigmaresearch.org.uk/articles/item/articles2016k

Foster T, Gillespie K, McClelland R. Mental disorders and suicide in Northern Ireland. Br J Psychiatry 1997;170:447–52
http://www.ncbi.nlm.nih.gov/pubmed?linkname=pubmed_pubmed&from_uid=26600412

Fountoulakis, K. N., Gonda, X., Siamouli, M., & Rihmer, Z. (2009). Psychotherapeutic intervention and suicide risk reduction in bipolar disorder: a review of the evidence. Journal of Affective Disorders, 113(1-2), 21-29
https://hungary.pure.elsevier.com/hu/publications/psychotherapeutic-intervention-and-suicide-risk-reduction-in-bipo

Greater Manchester Mental Health Strategy 2016
https://www.greatermanchester-ca.gov.uk/downloads/file/161/greater_manchester_mental_health_strategy

HM Government (2017). Preventing Suicide in England: third progress report of the cross government outcomes strategy to saves lives.
http://cdn.basw.co.uk/upload/basw_35347-8.pdf

Ineichen B. (2008)Suicide and attempted suicide among South Asians in England: who is at risk? Ment Health Fam Med. 2008 Sep; 5(3): 135–138.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2777567/#

Institute of Public Care, Oxford Brookes University: Projecting Adult Needs and Service Information System (PANSI),
http://www.pansi.org.uk/

Krysinska, K., & De Leo, D. (2008). Suicide on railway networks: epidemiology, risk factors and prevention. *Australian and New Zealand Journal of Psychiatry, 42*(9), 763-771
Risk and Protective Factors for Suicide and Suicidal Behaviour:
https://www.ncbi.nlm.nih.gov/pubmed/18696280

Lesbian and gay foundation (2013)
https://lgbt.foundation/policy-research

London School of Economics (2011)
Manchester Self Harm Project
http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/MaSH/

McDermott, E., Roen, K., & Scourfield, J. (2008). Avoiding shame: young LGBT people, homophobia and self-destructive behaviours. Culture Health & Sexuality, 10(8), 815-829. doi: 10.1080/13691050802380974
https://www.ncbi.nlm.nih.gov/pubmed/18975229

Manchester City Council (2016) Delivering Differently: Manchester's Domestic Violence and Abuse Strategy 2016-20
http://www.google.co.uk/url?url=http://www.manchester.gov.uk/download/meetings/id/21197/7domestic_violence_and_abuse_strategy&rct=j&frm=1&q=&esrc=s&sa=U&ved=0ahUKEwjVr-re8d_RAhVMJsAKHYizBU8QFggUMAA&usg=AFQjCNH1OU35BfvCuGHaGZcanVkxXktUKQ

Mental Health Foundation (2015): Fundamental Facts about Mental Health
https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-15.pdf

MBRRACE (2016) Saving Lives, Improving Mothers' Care
Surveillance of maternal deaths in the UK 2012–14
https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202016%20-%20website.pdf

Ministry of Justice Statistics bulletin (2017)
Deaths in prison custody to June 206Assaults and Self-harm to March 2016
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/585863/safety-in-custody-Deaths-dec-16.xls

Ness, J., Hawton, K., Bergen, H., Cooper, J., Steeg, S., Kapur, N., . . Waters, K. (2015). Alcohol use and misuse, self-harm and subsequent mortality: an epidemiological and longitudinal study from the multicentre study of self-harm in England. Emergency Medicine Journal, 32(10), 793-799. doi: 10.1136/emermed-2013-202753
https://www.psych.ox.ac.uk/publications/567803

ONS (2012) Deaths by suicide for students aged 18 and above, 2007-2011
http://www.google.co.uk/url?url=http://www.ons.gov.uk/ons/about-ons/what-we-do/publication-scheme/published-ad-hoc-data/health-and-social-care/november-2012/deaths-by-suicide-for-students-aged-18-and-above--2007-2011.xls&rct=j&frm=1&q=&esrc=s&sa=U&ved=0ahUKEwikwpiohf7RAhWBC8AKHZGdBQAQFggUMAA&usg=AFQjCNHTzXiMo7E2chXs7xdxvXlu-XACCg

ONS 2014 Statistical Update on Suicide
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/278120/Suicide_update_Jan_2014_FINAL_revised.pdf

ONS 2015 Suicides in the UK 2015 registrations
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2015registrations

Personal Social Services Research Unit, London School of Economics and Political Science Mental health promotion and mental illness prevention: The economic case.
https://www.lse.ac.uk/LSEHealthAndSocialCare/pdf/MHPP%20The%20Economic%20Case.pdf

Pitman A, Osborn D, Rantell K & King M (2016) BMJ Open 2016;6:e009948 doi:10.1136/bmjopen-2015-009948 Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults
http://bmjopen.bmj.com/content/6/1/e009948

Pratt, D., Gooding, P., Eccles, S., Awenat, Y., & Tarrier, N. (2015). Cognitive Behavioural Suicide Prevention for Male Prisoners: Case examples. Cognitive and Behavioural Practice
https://kclpure.kcl.ac.uk/portal/en/publications/cognitive-behavioral-suicide-prevention-for-male-prisoners(0eecb78d-1715-4852-b881-abda1d4ce751)/export.html

Public Health England (2016) Local Suicide Prevention Planning: A practice resource
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/564420/phe_local_suicide_prevention_planning_a_practice_resource.pdf

SafeLives (2015), Insights Idva National dataset 2013-14. Bristol: SafeLives
http://www.safelives.org.uk/file/insights-idva-national-dataset-2013-2014pdf

Sakinofsky, I. (2007a). Treating suicidality in depressive illness. Part I: current controversies. *Canadian Journal of Psychiatry - Revue Canadienne de Psychiatrie, 52*(6 Suppl 1), 71S-84S.
https://www.researchgate.net/publication/297575812_Treating_suicidality_in_depressive_illness_part_1_Current_controversies

Samaritans (2008) 'Ten things to remember when reporting suicide'
http://www.samaritans.org/sites/default/files/kcfinder/files/press/10%20things%20to%20remember%20when%20reporting%20suicide.pdf

Sarchiapone, M., Mandelli, L., Iosue, M., Andrisano, C., & Roy, A. (2011). Controlling access to suicide means. International Journal of Environmental Research and Public Health, 8(12), 4550-4562.
http://www.mdpi.com/1660-4601/8/12/4550

Stanley B et al (2009) Cognitive Behaviour Therapy for Suicide Prevention (CBT-SP): Treatment Model, Feasibility and Acceptability
J Am Acad Child Aolesc Psychiatry 2009 Oct. 48 (10): 1005-1013
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2888910/

Tarrier, N., Taylor, K., & Gooding, P. (2008). Cognitive-behavioural interventions to reduce suicide behaviour: A systematic review and meta-analysis. Behaviour Modification, 32(1), 77-108.
http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0026124/

Tarrier, N., Kelly, J., Maqsood, S., Snelson, N., Maxwell, J., Law, H., . . . Gooding, P. A. (2014). The cognitive behavioural prevention of suicide in psychosis: A clinical trial. Schizophrenia Research, 156(2-3), 204-210. doi: 10.1016/j.schres.2014.04.029
https://www.ncbi.nlm.nih.gov/pubmed/24853059

University of Manchester (2013) National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report (2013),
http://research.bmh.manchester.ac.uk/cmhs/centreforsuicideprevention/nci/reports/NCIAnnualReport2013V2.pdf

University of Manchester (2015) National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Annual Report 2015: England, Northern Ireland, Scotland and Wales July 2015. Manchester:
http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci

University of Manchester (2016). Suicide by children and young people in England. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester:. http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci

Woodhead, C., Rona, R. J., Iversen, A., MacManus, D., Hotopf, M., Dean, K, Fear, N. T. (2011). Mental health and health service use among post-national service veterans: results from the 2007 Adult Psychiatric Morbidity Survey of England. Psychological Medicine, 41(2), 363-372. doi: 10.1017/s0033291710000759 https://kclpure.kcl.ac.uk/portal/en/publications/mental-health-and-health-service-use-among-postnational-service-veterans(6111acf9-dc35-48bd-8072-affd6743882a)/export.html

Date first version completed: February 2017
Date of latest version:

It is hoped that you have found this topic paper useful. If you have any comments, suggestions or have found the contents particularly helpful in your work, it would be great to hear from you.

Responses can be sent to jsna@manchester.gov.uk