South Gloucestershire Suicide Prevention Strategy, 2019-2021

DRAFT

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Introduction

Every suicide death is a tragedy and impacts on friends, family, support services, health care professionals and society as a whole. However, suicides are not inevitable and there are many ways in which services, communities, individuals and society can prevent suicides.

In this strategy, we aim to share national and local information on deaths by suicide and related policy and guidance, and to outline the approach to suicide prevention in South Gloucestershire. Although the suicide rate in South Gloucestershire is lower than the average for England or the South West, we recognise the enormous impact that each suicide has and will work together to provide support to promote mental health and wellbeing and prevent suicide.

The strategy has been informed by local expertise and experience as well as national research evidence and guidance. The overall aims of the strategy, reflecting the principles in *No Health Without Mental Health* (2011)[1] are to:

1. Promote good mental health and prevent suicides among people living and working in South Gloucestershire.
2. Ensure people who may be at risk of suicide in South Gloucestershire can access support where and when they need it.
3. Ensure that people living and working in South Gloucestershire know how to help and support those at risk of or affected by suicide.

A detailed action plan to address these aims will be developed alongside this strategy, to be overseen by the South Gloucestershire Mental Health Partnership and updated at least every year. Suicide prevention in South Gloucestershire requires collaboration between several agencies across the area. We will work through the Mental Health Partnership to ensure that the strategy and accompanying action plan is developed and delivered with consideration of existing partnerships, partner agency strategies and action plans.

National Suicide Prevention Strategy

In 2012 the Coalition Government published *Preventing Suicide in England: A cross-government outcomes strategy to save lives*.[2] This cross-government strategy had the two main objectives of reducing the suicide rate in the general population in England and better supporting those bereaved or affected by suicide. It specified six key area for action:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

Further updates to the strategy in subsequent progress reports have added further clarified local authorities' role in suicide prevention, including an expectation that every local authority put in place a multi-agency suicide prevention plan.[3] In 2017 the scope of the strategy was expanded to include self-harm prevention in its own right[4] and the Government stated a national ambition to achieve a 10% reduction in suicides by 2020/21 (as part of the *Five Year Forward View on Mental Health*[5]).

Definition of suicide and data reporting

In the UK, suicide deaths are determined by coroners. To record a verdict of suicide, the coroner must be certain, beyond reasonable doubt, that the person took their own life and intended to do so. If a coroner does not feel that the standard of proof has been met, he or she can declare a conclusion of accidental death, declare an open conclusion or choose to solely use a narrative conclusion.[6]

The Office for National Statistics (ONS) uses coroners' to code deaths by suicide according to International Classification of Disease 10 (ICD-10) codes.[7] The ONS definition of suicide includes deaths given an underlying cause of intentional self-harm or an injury/poisoning of undetermined intent. ONS reports deaths from intentional self-harm for persons aged 10 years and over, and deaths where intent was undetermined for those aged 15 years and over. Deaths from an event of undetermined intent in 10- to 14-year-olds are not included.[8]

ONS suicide figures are presented for deaths registered in a calendar year. Given the potential delay between a death and the return of a coroner's verdict of suicide, in published suicide figures many deaths appear in the statistics of a year that is later than the year in which the death occurred.[8]

Given the nature of data reporting for suicide, the definition of suicide used in the statistics provided in this report may vary from the ONS definition according to the source of the data and some are reported as year of death rather than year of registration.

Deaths from suicide – the national picture

This section provides an overview of suicide rates in England. More information is available from the ONS report *Suicides in the UK*[8], *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*[9] and *Safety in Custody Statistics England and Wales*[10], published by the Ministry of Justice.

Overview[8]

- In 2017, a total of 4,451 suicides were registered in England. This is equivalent to an age-standardised[1] suicide rate of 9.2 per 100,000 population.
- Female suicide rates in England are consistently lower than male suicide rates. In 2017, three-quarters (75%) of suicides were among men.
- The most common method of suicide was hanging, strangulation and suffocation (men: 60%; women: 42%), followed by poisoning (men: 18%; women 38%).
- Rates of suicide increased with age up to a peak in 45-49 year olds (22.4 per 100,000 in men; 6.2 per 100,000 in women).
- There has been an overall decrease in suicide rates over the past 20 years. More recently, there was an increase in suicide rates among men from 2007 to around 2014, with decreases seen in the last few years. Among women, suicide rates have remained fairly stable since 2007.

Suicides among mental health patients[9]

- Around a quarter (27%) of suicides in England between 2005 and 2015 were identified as patient suicides (i.e. the individual had been in contact with mental health services in the 12 months prior to death).
- Around 1 in 10 of patient suicides were among in-patients (~2% of all suicides).
- The rate of both patient and in-patient suicides has decreased since 2005, although the rate of decrease in in-patients has slowed in recent years.
- Around two-thirds of patient suicides were in people with a history of self-harm.

[1] Age-standardised suicide rates per 100,000 population are standardised to the 2013 European Standard Population. Age-standardised rates are used to allow comparison between populations which may contain different proportions of people of different ages.

Suicides in custody[10]

- The number of self-inflicted deaths in custody in England and Wales have fluctuated in recent years. The number of self-inflicted deaths between 2008 and 2017 ranged from 58 to 122 deaths per year.

Suicides in South Gloucestershire

This section provides a summary of information available about suicide rates in South Gloucestershire. Further detail is provided in Appendix 1.

Overview

The most recent suicide audit for South Gloucestershire found that in the three years between 2015 and 2017:

- There was a total of 54 deaths from suicide in South Gloucestershire. This equates to an average of 18 deaths from suicide per year.
- The age-standardised suicide rate for South Gloucestershire (7.9 per 100,000) was slightly lower than that seen in England (9.9 per 100,000) or the South West (10.8 per 100,000).[2]
- Consistent with national trends, the rate of suicide among men was over three and a half times that among women.[2]
- The highest number of deaths from suicide in South Gloucestershire were among 45 to 64 year-olds, and 25 to 44 year olds.
- The most frequently used method of suicide was hanging, strangling or suffocation (44%).
- Based on a three-year rolling average, the suicide rate in South Gloucestershire was higher in 2012-14 compared to 2006-08, but has decreased in recent years.
- Suicide rates in South Gloucestershire were higher in areas of greater deprivation compared to those of lower deprivation. However these differences were not statistically significant and there was not a clear relationship between deprivation of residence and suicide rates.

Other data sources show that:

- Between 2012 and 2017, 2% of child deaths across the West of England were due to suicide or deliberate self-inflicted harm.[11] In South Gloucestershire, there have been 3 deaths in children/young people until age 18 by or deliberate self-inflicted harm in the last five years.
- Among the deaths by suicide reviewed by the Avon Coroner's Court during 2016, the most common location of suicide was the person's home.[3]

[2] Data for South Gloucestershire are available before those for England or the South West Region. Data for England and South West therefore represent the three years between 2014 and 2016.

[3] Data provided by Avon and Wiltshire Mental Health Partnership NHS Trust.

Suicide among mental health patients

Among the deaths by suicide reviewed by the Avon Coroner's Court during 2016, 25% of people overall had been in contact with acute mental health services in the previous year, which is very similar to the national figure. A further 31% of people had been in contact with some sort of counselling service in the community, meaning that in total 56% of people were engaged in help in relation to their mental health.[3]

Suicide in prisons in South Gloucestershire

- There were no self-inflicted deaths at HMP Leyhill (a category D men's prison) between 2004 and 2018. In this time period the number of self-harm incidents ranged from six (in 2015) to fourteen (in 2018 to date). The instances of self-harm were usually described as being minor.
- There have been 3 self-inflicted deaths since 2016 in HMP/YOI Eastwood Park (a closed remand prison for women holding 430 young offenders and adults). There were 4879 self-harm incidents over the last 3 years (2015 to 2018). The most prevalent methods of self-harm were cutting and ligature.

South Gloucestershire's approach to suicide prevention

This section sets out the Mental Health Partnership's intentions for suicide prevention. These intentions reflect our overall aims and are consistent with the national strategy.

A detailed action plan will be developed to go alongside this strategy, which will set out the specific actions the MH Partnership intends to take to prevent suicide in South Gloucestershire. The action plan will be developed with reference to national strategies and guidance, including the *NICE Guideline on Preventing suicide in community and custodial settings*[12], the *Public Health England practice resource on Local suicide prevention planning*[13], the National Collaborating Centre for Mental Health *Self-harm and Suicide Prevention Competence Framework*[14] and partner agency strategies or action plans (see box).

We will work in partnership to promote positive mental health and prevent suicide

Suicide prevention has been the responsibility of the South Gloucestershire Mental Health Partnership (MH Partnership) since 2017. This is based on the evidence that good mental health and wellbeing services on a community level are vital to suicide prevention, and to ensure that suicide is not considered in isolation. The MH Partnership is accountable to the South Gloucestershire Health and Wellbeing Board.

The MH Partnership will:

- Develop a detailed action plan
- Review progress against the detailed action plan every year
- Review findings from the annual local suicide audit
- Support partnership organisations to develop their own strategies and plans

Partner Agency Suicide Prevention Strategies

AWP's Suicide Prevention Strategy runs from 2018 to 2020 and addresses the six key areas set out in the National Suicide Prevention Strategy along with a further key area of 'Learning from investigations and reviews into unexpected deaths'.

The **Bristol, North Somerset and South Gloucestershire Crisis Concordat group** was established following publication of a national concordat in 2014, which sets out how organisations work together to: prevent mental health crises for those with mental health problems; improve access to care and support; ensure high quality urgent care for those in crisis and ensure recovery services are in place to prevent further crisis. The BNSSG group reports into the main Avon, Somerset and Wiltshire Crisis Concordat group.

The **"Safer Custody" Prison Service Instruction** (PSI) 64/2011 came into force from the 1st April 2012 and is effective until the 31st January 2016. This instruction states that any prisoner identified as at risk of suicide or self-harm must be managed using specific procedures (including assessment, review, case management).

UWE Bristol, together with Bristol University have developed a Suicide Prevention and Response Plan to ensure that they are proactively working towards suicide reduction and support amongst the student population across Bristol.

The **Highways England Suicide Prevention Strategy** outlines how the safety of roads will be improved by reducing the number of people who attempt to take their lives on our network and reduce the devastating impact suicide has when tragedies occur.

Promoting positive mental health

No Health Without Mental Health[1] advocates that suicide prevention starts with better mental health for all, and that local prevention strategies should be informed by people who been affected by suicide.

The vision for Mental Health in South Gloucestershire, as set out in the Adult Mental Health and Emotional Wellbeing Strategy is that 'we will support an environment which empowers people and communities to promote and sustain their own mental health and to enable those who experience mental health problems to obtain the right help and support at the right time and in the right place for them'.[15]

A list of support services which can help people manage their mental health and wellbeing including services and advice, mental health services, local community support, support for parents, carers, people with long term conditions and helplines can be found in South Gloucestershire's Mental Health Resource List.

We will provide support to people bereaved or affected by suicide

The national strategy highlighted the importance of ensuring that there is timely information and support provided to those bereaved or affected by a suicide, as well as the means to deliver a rapid community-based response if there is an emerging cluster. Resources should also be made available to support those who are concerned about a family member, friend of colleague.

Information on national and local bereavement support can be found on the *South Gloucestershire Council website*.[4]

For further information contact mentalhealth@southglos.gov.uk.

We will capture the voice of those affected by suicide

The South Gloucestershire Wellbeing Network is made up of people with experience of mental ill health either directly themselves or as a carer. It provides an opportunity to share experiences and make recommendations about local services. There are two seats on the MH Partnership for the Network to ensure there is a strong user voice in local decision making.

In addition to working locally to capture the voice of people affected by suicide, our strategy and accompanying action plan will reflect guidance and information from projects that have been informed by those affected by suicide such as the suicide prevention report from the *Health and Social Care Alliance Scotland*.[16]

We will use local and national intelligence to prioritise suicide prevention actions for those at risk of suicide

Some groups of people are known to be at higher risk of suicide compared with the general population. We will continue to produce and review the local suicide audit and use available local and national data to inform the detailed action plan. The detailed plan will incorporate actions relating to reducing suicide risk in groups

[4] http://edocs.southglos.gov.uk/bereavementguide

identified as being at higher risk of suicide or who warrant especial consideration due to vulnerabilities or issues relating to access to services (see box).

Data sources include indicators relevant to suicide prevention provided by Public Health England on the Suicide Prevention Profile (e.g. suicide rate, self-harm and excess mortality in adults aged under 75 with serious mental illness), along with data provided from the Avon Coroner's Office and Bristol Self-Harm Surveillance Register.

The National Strategy also highlights the importance of reducing the access to the means of suicide. We will use local data to further inform our action plan relating to specific means of and locations of suicide, to ensure that partners work together effectively to reduce means of suicide and/or target particular locations when needed.

Groups specified within the National Suicide Prevention Strategy

The 2012 *National Suicide Prevention Strategy* identified several groups as being at high risk of suicide and therefore key groups for action. These were:

- Men
- People in the care of mental health services including inpatients
- People with a history of self-harm
- People in contact with the criminal justice system
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers

Outside of the key risk groups, the national strategy and South Gloucestershire's Adult Mental Health Needs Assessment identified additional groups of people with particular vulnerabilities or issues relating to access to services. These were:

- 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.
- Survivors of abuse or violence, including sexual abuse
- Veterans
- People living with long-term physical health conditions
- People with untreated depression
- People who are especially vulnerable due to social and economic circumstances
- People who misuse drugs or alcohol
- Lesbian, Gay, Bisexual and Transgender people
- Black, Asian and minority ethnic groups and asylum seekers
- Disabled people
- Smokers
- People in the Gypsy, Roma and Traveller communities

Suicide and self-harm

Self-harm, whether involving intentional self-poisoning or self-injury, is one of the most important risk factor for subsequent death by suicide, even though most people who self-harm do not intend to take their own life. People who frequently present to hospital following self-harm are a particularly vulnerable group. While most people who self-harm do not die by suicide, the strong link between self-harm and suicide make this a matter of concern.[13]

The third progress report on the national suicide prevention strategy highlighted the link between self-harm and suicide risk and stated that the scope of the national strategy should be extended to include self-harm prevention in its own right.[4]

We will use local and national intelligence to further our understanding of the relationship between self-harm and suicide in South Gloucestershire in order to target our suicide prevention actions accordingly. We will also ensure that the MH Partnership considers self-harm a priority, working with partner agencies to better understand risks and local issues, raise awareness and coordinate support. The *Improving Care in Self-Harm Health Integration Team*[5] will play an important part in self-harm prevention and awareness.

We will support the media in delivering sensitive approaches to suicide and suicidal behaviour

Suicidal behaviour can be prompted by the way suicide is reported in the media. The risk of such behaviour can increase when a media story describes the suicide method, uses a graphic or dramatic headline or image, and repeatedly or extensively sensationalises a death.

Samaritans publishes *Media Guidelines for Reporting Suicide*[17] and provides a comprehensive media advice service for journalists and programme makers, to support safe and informative coverage of suicide and self-harm.

We will monitor and evaluate our progress against this strategy and accompanying action plan

Progress in delivering the agreed actions and working towards the aims of the strategy will be assessed through regular reporting to the Mental Health Partnership. Details of our approach to monitoring and evaluation of the strategy will be developed as part of the detailed action plan.

[5] http://www.bristolhealthpartners.org.uk/health-integration-teams/improving-care-in-self-harm-hit/

Public Consultation

Section to be completed after full Public Consultation Nov 2018 – Jan 2019

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Appendix 1: Suicides in South Gloucestershire

This section summarises information from the most recent South Gloucestershire suicide audit. Additional data are provided from an analysis of Avon Coroner's Court data where stated. Deaths by suicide among children are described in the last section and are based on data from the West of England Child Death Overview Panel.

Methodology

- Suicide statistics in South Gloucestershire include suicides and deaths of undetermined intent and were identified using International Classification of Disease 10 (ICD-10) codes X60 through X64 (Intentional self-harm) and Y10 through Y34 (Injury/poisoning of undetermined intent), excluding Y33.9. Deaths among 10-14 year-olds coded as injury/poisoning of undetermined intent are not included.
- Data for South Gloucestershire and comparative tables were accessed via the Office of National Statistics (ONS) mortality dataset from the Public Health England South West Knowledge and Intelligence Team.
- Age-standardised rates were calculated using the 2013 European Standard population structure. Population data were extracted from the ONS website.

Suicide in South Gloucestershire, the South West and England

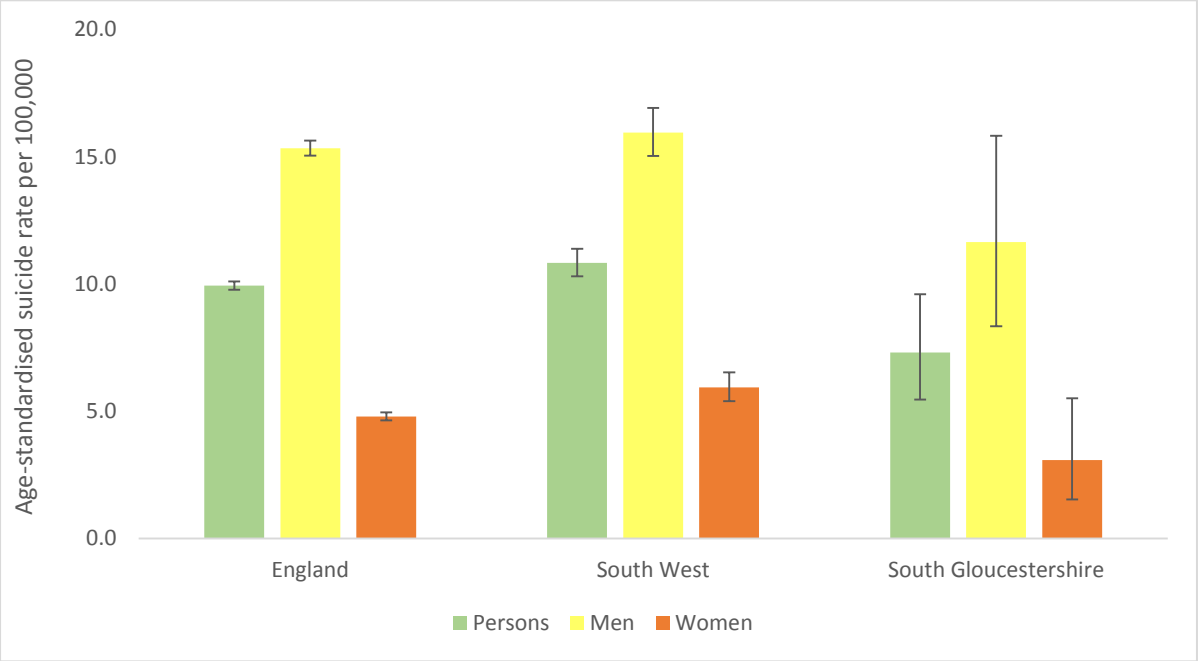
In the three years between 2014 and 2017, there was a total of 54 deaths from suicide in South Gloucestershire among those aged 15 years or older (Table 1). This equates to an average of 18 deaths from suicide per year and a rate of 7.9 per 100,000 population. The highest number of deaths from suicide were among 45 to 64 year-olds, and 25 to 44 year olds, although rates were highest in those aged 65 to 74 (Table 1).

Table 1. Numbers of deaths by suicide, South Gloucestershire (2015-2017)

Age group	Persons	Rate per 100,000
15-24	7	6.9
25-44	16	7.6
45-64	17	7.8
65-74	9	10.9
75+	5	7.2
Overall	**54**	**7.9**

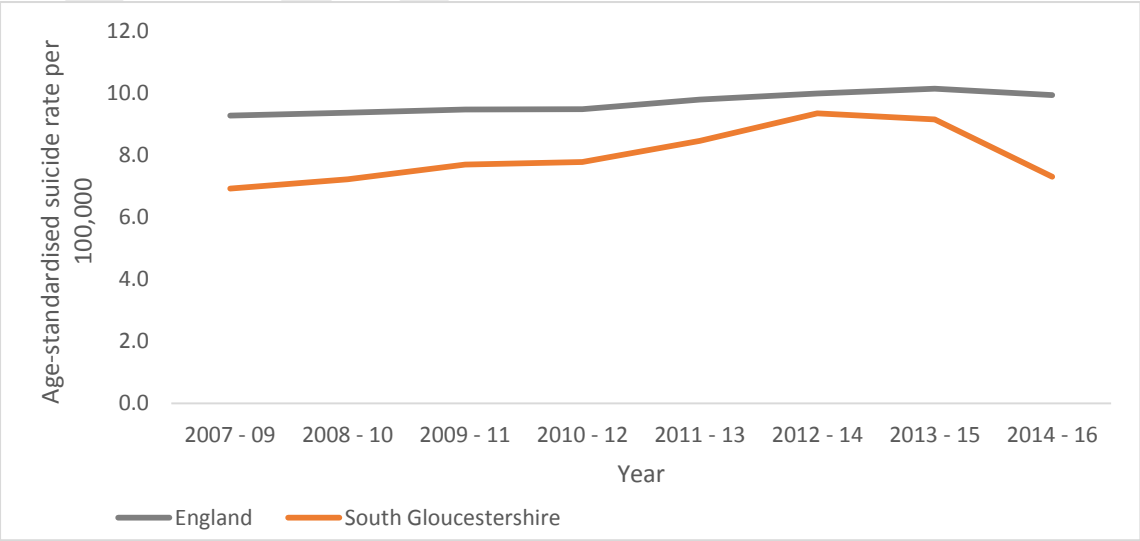
Suicide rates in 2014-2016 were slightly lower in South Gloucestershire than those seen in England and the South West, although this difference was not statistically significant (Figure 1).

Figure 1: Age-standardised suicide rates by sex, England, South West and South Gloucestershire (2014-2016)



Based on a three-year rolling average, the suicide rate in South Gloucestershire was higher in 2012-14 compared to that in 2007-09, but has decreased in more recent years (Figure 2).

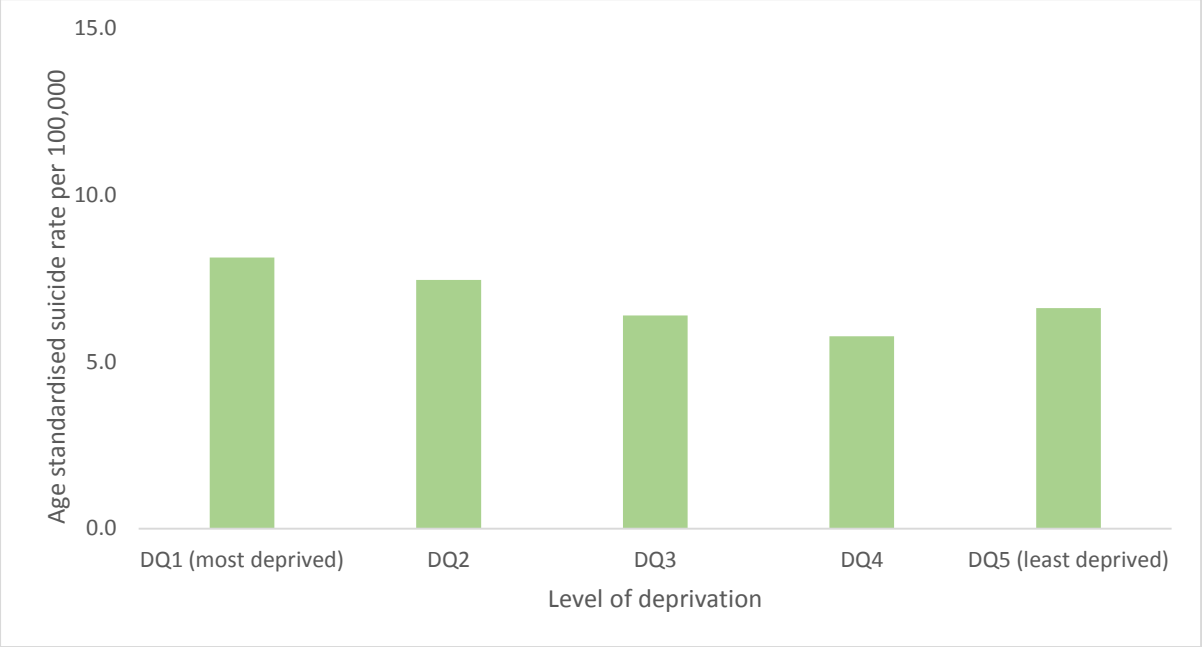
Figure 2: Age-standardised suicide rate for South Gloucestershire and England (3-year rolling average, 2007-2016)



Deprivation and suicide

Suicide rates in South Gloucestershire were higher in areas of greater deprivation compared to those of lower deprivation (Figure 3). However these differences were not statistically significant and there was not a clear relationship between deprivation of residence and suicide rates.

Figure 3: Age-standardised suicide rate by local deprivation quintile (DQ), 2008-16



Suicide methods

The most frequently used method of suicide was hanging, strangling or suffocation (44%)(Table 2). Among the deaths by suicide reviewed by the Avon Coroner's Court during 2016, the most common location of suicide was the person's home.

Table 2: Method of suicide, South Gloucestershire (2015-2017)

Method	Proportion of suicides
Hanging, strangulation and suffocation	44%
Poisoning	31%
Other	24%

Suicides in persons in contact with mental health services

Among the deaths by suicide reviewed by the Avon Coroner's Court during 2016, 25% of people overall had been in contact with acute mental health services in the previous year, which is very similar to the national figure. A further 31% of people had been in contact with some sort of counselling service in the community, meaning that in total 56% of people were engaged in help in relation to their mental health.[6]

Suicide and self-harm in prisons

There are three adult prisons in South Gloucestershire, HMP Leyhill, HMP/YOI Eastwood Park and HMP Ashfield.

HMP Leyhill is an open category D prison holding a maximum of 515 prisoners who are serving a wide range of sentences (many of them indeterminate sentences) for a broad range of offences. Unlike other Category D establishments in England and Wales HMP Leyhill does not restrict which prisoners can be accommodated by offence type or sentence length. There is no limit on the number of prisoners serving life/indeterminate sentences who can be accommodated at any one time. Prisoners are located in a hostel style environment within the prison grounds. Leyhill has a resettlement role, so many prisoners are allowed out of the prison on licence daily. This includes day release for supervised work, community employment placements or resettlement leave. There were no self-inflicted deaths at HMP Leyhill between 2004 and 2018. In this time period the number of self-harm incidents has ranged from six (in 2015) to fourteen (in 2018 to date). The instances of self-harm were usually described as being minor.

HMP/YOI Eastwood Park is a closed remand prison for women, holding 430 young offenders (those aged 18 to 21) and adults. It holds prisoners of all ages and categories pending their court appearances in addition to women serving sentences up to 12 months. The prison holds remand and convicted prisoners, from those serving a few days to those serving much longer sentences. Many services are provided, including a mother & baby unit, specialist 24-hour health care, a dedicated resettlement unit, drug recovery service, specialist substance misuse unit, and a personality disorder unit (NEXUS). There have been 3 self-inflicted deaths since 2016 in HMP Eastwood Park. There were 4879 self-harm incidents over the last 3 years (2015 to 2018). The most prevalent methods of self-harm were cutting and ligature.

[6] Data provided by Avon and Wiltshire Mental Health Partnership NHS Trust.

Suicide in Children

The West of England Child Death Overview Panel (CDOP) reports data on deaths of children (those aged <18 years). Among the 557 child deaths in the West of England in the five years between 2012 and 2017, only 2% of were due to suicide or deliberate self-inflicted harm.[11] In South Gloucestershire, there have been 3 deaths from suicide among under 18 year-olds in the last five years.

Appendix 2: Additional information – Mental Health Partnership activities

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

AWP's Suicide Prevention Strategy runs from 2018 to 2020 and addresses the six key areas set out in the National Suicide Prevention Strategy along with a further key area of 'Learning from investigations and reviews into unexpected deaths' (Box **1**).

Box 1**: Action areas in the AWP Suicide Prevention Strategy 2018-2020[*]**

- ACTION AREA 1: Reduce the risk of suicide in high risk groups
  - Inpatient care
  - Intensive services
  - Improve risk assessment and management processes
  - Family and carer involvement in risk assessment and management processes
  - Dual diagnosis
  - Unexpected death review process

- ACTION AREA 2: Tailoring approaches to improve mental health in specific groups
  - Partnership working
  - Children and young people
  - Perinatal mental health
  - BAME, LGBTQ, and unemployed individuals

- ACTION AREA 3: Reducing access to means
  - Environmental safety monitoring of inpatient areas
  - Supply of medication
  - Proportionate information sharing to reduce the risk of suicide
  - Monitor 'suicide hot-spots'

- ACTION AREA 4: Learning from investigations and reviews into unexpected deaths
  - Incident management
  - Information sharing and learning

- ACTION AREA 5: Support for people bereaved or affected by suicide

- ACTION AREA 6: Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour

- ACTION AREA 7: Supporting research, data collection and monitoring

Bristol, North Somerset and South Gloucestershire Crisis Concordat

The National MH concordat was published by the Department of Health in February 2014. The document outlines how organisations (including police, criminal justice, ambulance, health, local authorities and MIND) who have signed up to the national concordat will work together;

- To prevent mental health crisis for those with mental health problems
- To improve the access to care and support for those who are in a mental health crisis
- To ensure the quality of urgent care treatment for those in crisis is of the highest
- To ensure that recovery services are in place and are aimed at preventing future crisis.

The overarching principle for this concordat is that mental health provision is given the same parity of esteem as physical health service.

The national concordat required a local response from each CCG area. Following the merger of Bristol, North Somerset and South Gloucestershire CCGs, and an intensive programme of work to develop a place of safety for people in extreme mental distress who are detained for their own safety and the safety of others under section 136 of the mental health act, enabling the person to receive the right treatment and care as quickly as possible in a dedicated suite rather than a police cell, a new Governance structure for the Concordat has been created and agreed. Under this structure, there will be an overarching Crisis Concordat group across the Avon, Somerset and Wiltshire areas and underneath this will sit separate BNSSG and BSW (Bath, Swindon and Wiltshire) Crisis Concordat groups, which will report into the main ASW group.

Highways England

The Highways England vision is to work with partners to reduce the number of suicide incidents in the South West and contribute to the vision that no one attempts to take their life on the strategic network. This will be achieved through a number of key principles:

- Prevention: To reduce the number of people who reach a point in their lives where they wish to take their own life
- Crisis Intervention: To intervene with those who do reach a crisis point to reduce the number of people who attempt suicide.
- Postvention**:** To reduce the know impact of suicide or attempted suicide. This includes reducing the impact amongst the public, and addressing the trauma

that our staff, supply chain and any witnesses to a distressing event may experience.

The Highways England Suicide Prevention Strategy outlines how we will improve the safety of our roads by reducing the number of people who attempt to take their lives on our network and reduce the devastating impact suicide has when tragedies occur.

Highways England will work with our partners in order to reduce the number of incidents on the strategic network. The Highways England suicide prevention strategy can be found at*: https://www.gov.uk/government/publications/suicide-prevention-strategy*

University of the West of England

UWE Bristol recognizes that good mental health and emotional wellbeing are fundamentally important to everyone in our community, both staff and students, ensuring that they can engage, perform and flourish to the best of their ability. Building confidence in UWE students and enhancing their ability to manage the challenges presented by university life are essential components of the University experience and are key to maintaining good mental health. Equally, UWE Bristol emphasizes the importance of a supportive community where people know, “it is OK not to be OK” and that if you reach out for help you will be supported to be safe and to achieve the goals you have set yourself.

UWE Bristol, together with Bristol University have developed a Suicide Prevention and Response Plan to ensure that we are proactively working towards suicide reduction and support amongst the student population across Bristol. Built on Universities UK Step Change Framework, existing guidance and an audit of our existing provision, the strategy will enhance UWE Bristol’s activity in respect of suicide prevention, intervention and post-vention, and will ensure we target provision toward certain vulnerable groups or individuals who may need additional support, for example, care leavers, students who have been bereaved, or those with a mental health difficulty.

As a component of the Mental Wealth First Strategy, the Suicide Prevention and Response Plan is a whole university plan and is led by Pro-Vice Chancellor, Student Experience.

Preventing suicide in Prison

The “Safer Custody” Prison Service Instruction (PSI) 64/2011 came into force from the 1st April 2012 and is effective until the 31st January 2016. This instruction states that any prisoner identified as at risk of suicide or self-harm must be managed using the Assessment, Care in Custody and Team-work (ACCT) procedures. A number of elements are included in the ACCT framework such as identifying those at risk,

opening an ACCT, Assessment, Review, completing the Care Map, management of the ACCT plan and closing the ACCT. Prisoners with open ACCTs tend to be moved to blocks with higher staffing levels; also plans are in place to provide prisoners who are released from prison with an open ACCT document with discharge packs showing where they can seek help should they need it on release. The prisons also run a Listener Scheme. This is a peer support service which aims to reduce suicide and self-harm in prisons by training prisoners to provide emotional support to other prisoners by becoming 'Listeners'. Samaritans volunteers select, train and support prisoners to become Listeners. Listeners provide confidential emotional support to their fellow inmates who are struggling to cope.

Role of the police

There has been a focus on the need to improve police response to those in crisis – specifically what sort of service a person receives when they make contact by phone. A huge amount of work has been done, with the cooperation of those with lived experience and with the 27 different organisations which provide mental health services across the Avon and Wiltshire area, to identify 'blockers' in the system and work out how the police can increase their responses for people in crisis. The police also maintain a tracker of the activity they currently undertake. The tracker contains details of a range of programmes and projects they are working on and includes Suicide Prevention.

At present, the police lack firm data on some of the specifics around people attempting or completing suicide. However, because preserving life is an important part of the police purpose as an agency, they have begun to identify areas where they are receiving higher numbers of calls in relation to 'concerns for welfare'. Where these areas are identified they are commencing a process of problem-solving their way around the situation, looking at the issue from a 'harm reduction' perspective.

Suicide risk in current or former military service personnel

The suicide risk for current or former military service personnel is extremely high. Historically, a military suicide is usually a violent act. At present there is not a record of whether a person who has taken his/her life has served in the military. The question isn't asked. Determining whether someone is affected by PTSD is important to understand an individual's suicide risk. There have recently been cases highlighted in the press and on social media of veterans or serving members of HM Forces taking their lives. PTSD is the assumed cause of suicide among veterans, although this is not always the case. Social media tend to 'jump' on veteran suicides and hound the families for more information. As with other groups identified at higher risk of suicide the causes are varied and sometimes extreme.