BIRMINGHAM SUICIDE PREVENTION STRATEGY

2019-2024

FINAL DRAFT V12

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EXECUTIVE SUMMARY

Death through suicide reflects the ultimate loss of hope and leaves a significant and lasting impact on families, communities, employers and society.

Prevention suicide requires partnership working across the breadth of society and building on the 2012 national strategy this strategy has been developed through a co-production partnership between the Council and a wide range of organisations as a shared approach to reducing deaths through suicide.

Although in Birmingham the rate of suicide is low compared to other cities, and the national rates, there is a shared ambition to maintain the lowest rate of suicide of any of the core cities in England and continue to reduce deaths through suicide in the City over the next decade through a Zero Suicide approach.

The Birmingham Suicide Prevention Strategy is a co-produced strategy that sits alongside national strategy and is based on a combination of local and national evidence and data. In Birmingham in addition to the nationally recognized high risk groups we also have higher rates of suicide among individuals working in skilled trade occupations like construction and among citizens born in Poland and Eastern European countries.

The Strategy sets out a series of key priority areas for action across the partnership under six core areas:

Reducing the risk of suicide in high-risk groups

Improving mental health in specific groups

Reducing access to means of suicide

Provide better information and support to those bereaved or affected by suicide

Support the media in delivering sensitive approaches to suicide and suicidal behaviour

Support research, data collection and monitoring

The Birmingham Suicide Prevention Working Party that will be the driving partnership group that will enable and oversee delivery of the action plan that underpins these priorities and will report into the Health and Wellbeing Board through the Director of Public Health.

We are confident through the shared action of partners, communities and citizens Birmingham will achieve its ambition to reduce the rate of suicide in the city to zero.

BIRMINGHAM

WORKING TOWARDS A SUICIDE FREE CITY

Birmingham City Council

Public Health, July 2019

Numbers have been rounded

THE NATIONAL PICTURE

In 2017 there were **5,821** suicides registered in the UK, an age standardised rate of **10.1** deaths per 100,000

Male Suicide Rate **15.5** deaths per 100,000

Female Suicide Rate **4.9** deaths per 100,000

AGE SPECIFIC RATES

24.8 Age 45 - 49

The highest age specific suicides rates within these age groups

6.8 Age 50 - 54

ACCESS TO SERVICES

two thirds of people who die through suicide have been in contact with Services

one third of people have had no contact - **young men** are the most likely to be among this third.

THE LOCAL PICTURE

In 2015/17 there were **205** suicides registered in Birmingham, which equates to **70** deaths per year

Male Suicide Rate **11.3** deaths per 100,000

Female Suicide Rate **4.1** deaths per 100,000

53% of suicides in Birmingham over the last 10 years have taken place in the **home**

76% of suicides in Birmingham are men

residents born in **Poland** and **Eastern Europe** have a higher rate of suicide.

30.5 deaths per 10,000 occur in the **Skilled Trades Occupations**

42,000 people in Birmingham work in this sector

3,700 mental health in-patient admissions during 2017/18

AT RISK & VULNERABLE

Men have a... **3x** greater risk of suicide than women

Self-harm is the single biggest indicator of suicide risk

4.7 households per 1,000 households are in temporary accommodation

in Birmingham **1,977** individuals presented to A&E with self-harm in 2017/18

Nationally... **45%** of suicides involved patients with a history of alcohol misuse and **33%** had a history of drug misuse.

There is growing evidence of increased rates of mental health problems, self-harm, and suicidal thoughts among **LGBT** people.

Data sourced from: Birmingham Suicide Prevention Strategy 2019 - 2024; Graphics: Canva; The Noun Project

INTRODUCTION

Every suicide is one too many.

The death of someone by suicide has devastating effects on families, friends, workplaces and communities. For each person that dies this way at least 10 people are affected and only 1 in 3 who take their life are known to Mental Health Services[1].

Suicide is one of the leading causes of years of life lost (YLL)[2]; in Birmingham as well as across England and in terms of absolute numbers suicide is 4th highest cause of YLL (2014-2016), behind infant mortality, coronary heart disease and lung cancer.

There is an associated economic cost and the average cost per suicide for those of working age is £1.7 million in England[3], which includes intangible costs (loss of life to the individual, the pain and suffering of relatives), as well as lost output (both waged and unwaged), police time and funerals[4]. But above all, suicide is preventable and by working together we can reduce this tragic loss of life and provide better support for those left behind.

In 2012, the UK Government published a national strategy 'Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives' which set out overall objectives of:

- A reduction in suicide rate in the general population in England
- Better support for those bereaved or affected by suicide

The Birmingham Suicide Prevention Strategy builds on this to set out priorities for action and a shared ambition for the city to reduce deaths through suicide, as part of our wider ambition to become a mentally healthy city.

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[1] Local Suicide Prevention Planning

[2] Preventing Suicide in England: a cross-government outcomes strategy to save lives 2012: https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england

[3] No health without mental health: A cross-Government mental health outcomes strategy for people of all ages https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215808/dh_123993.pdf.

[4] Knapp, Martin and McDaid, David and Parsonage, Michael (2011) Mental health promotion and mental illness prevention: the economic case. 15972. Department of Health, London, UK.

The Strategy is a collaboration between organisations, communities and citizens to take collective and individual action over the next five years to significantly reduce the rate of suicide in the city, address inequalities in suicide by focusing on those in highest risk groups, and improve care and support for those affected by suicide.

CONTEXT OF SUICIDE AND SUICIDE PREVENTON

The context of suicide and suicide prevention is set out in terms of policy at local and national levels as well as the picture from the data and research nationally and the evidence from cities.

Policy Context

The Five Year Forward View for Mental Health set the ambition that by 2020/21 the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels. This included development and delivery of local multi-agency suicide prevention plans.

In 2012 the Department of Health released its national suicide prevention strategy Preventing Suicide in England. The National Strategy identified six key areas for action to support delivery of objectives. These six areas provide the themes for our local approach and are being used as the basis for the Birmingham suicide prevention action plan which accompanies this strategy.

The NHS Long Term Plan [5] contains suicide prevention & reduction ambitions including the following;

- Suicide reduction will remain a NHS priority
- Full coverage across the country of the existing suicide reduction programme
- Design and roll out of a Mental Health Safety Improvement Programme with a focus on suicide prevention and reduction for mental health inpatients
- Use of decision support tools to increase our ability to deliver personalised care and predict future behaviour, such as risk of self-harm or suicide.
- Bereavement support for families and staff bereaved by suicide , who are likely to have experienced extreme trauma and are at heightened risk of crisis themselves, which will be rolled out to all areas of the country.
- A new approach to the longer term management of self-harm

[5] https://www.longtermplan.nhs.uk/online-version/

There have been a number of other national publications to support this strategy; such as:

- Preventing suicide in England: Third progress report (2017)[6]
- Public Health England's Local suicide prevention planning practical resource (2016)[7]
- National Confidential Inquiry into Suicide and Homicide Report: Suicide by children and young people (2017) [8]
- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2017) [9]
- Public Health England: Support after a suicide: A guide to providing local services: National Suicide Prevention Alliance (2017)[10]

These publications, alongside stakeholder engagement and the local data have informed the development of this strategy. This local strategy will in time align with the wider action plan to support a Mentally Healthy City and the Health Inequalities Framework for Birmingham which will be developed over 2019/20.

The Picture of Suicide

The picture of suicide in England is limited because the data is drawn from death certification.

For many years the coroner has had to be certain beyond reasonable doubt that the death was through suicide before confirming this on the death certificate, this has probably led to an under-estimate of the scale of suicide. However in 2017/18 the guidance for coroners changed to allow 'death through suicide' to be based on reasonable judgement and this is likely to see an increase in the number of deaths attributed to suicide.

It is important to also recognise that although there may be a link between self-harm and suicide, the data on self-harm reflects a larger group of people, some of who have no intention of dying.

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[6] Department of Health (England). Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives. 2017.
[7] Public Health England Local suicide prevention planning: A Practice resource: https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan
[8] Suicide by children and young people in England. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2017.
[9]The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report: England, Northern Ireland, Scotland and Wales.
October 2017. University of Manchester
[10] Public Health England: Support after a suicide: A guide to providing local services: National Suicide Prevention Alliance https://www.gov.uk/government/publications/support-after-a-suicide-a-guide-to-providing-local-services

The National Picture

Suicides have seen an overall decreasing trend since time series began. However male suicides remain significantly higher than females. Suicide rates are higher among specific groups of occupation as well as specific population groups such as lesbian, gay, bisexual and trans people, ethnic minority people and refugee and asylum seekers.

The highest rates regionally are seen in the North of England. With the West Midlands close to the England average. The lowest rates are in London.

In 2017[11] there were 5,821 suicides registered in the UK, an age-standardised rate of 10.1 deaths per 100,000 population. The UK male suicide rate of 15.5 deaths per 100,000 was the lowest since time-series began in 1981; for females, the UK rate was 4.9 deaths per 100,000, this remains consistent with the rates seen in the last 10 years. Males accounted for three-quarters of suicides registered in 2017 (4,382 deaths), which has been the case since the mid-1990s. Suicide is currently the most significant cause of death among Males below the age of 50 and young people aged 5 to19[12].

The highest age-specific suicide rate was 24.8 deaths per 100,000 among males aged 45 to 49 years; for females, the age group with the highest rate was 50 to 54 years, at 6.8 deaths per 100,000.

A third of people who die through suicide have been in contact with mental health services before their death, a further third have been in contact with primary care services but the remaining third have had no contact with services. Young men are the most likely to be among the third with no contact with services before their death. In 2017 hanging or strangulation was the most common method for suicide followed by poisoning.

Data is lacking on how many suicide attempts are among those previously bereaved by suicide, but research suggests around 1 in 10 bereaved people have made an attempt[13].

Non-fatal self-harm is one the strongest risk factors for subsequent suicide. The data on self-harm is based on clinical data from presentation to healthcare services, so is likely to be an underestimate of the actual number of people affected. Evidence suggests that the UK has one of the highest rates of self-harm in Europe[14] and for all

[11]https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2017registrations

[12] ONS: Deaths Registered in England and Wales (series DR): 2017

[13] Pitman AL, Osborn DP, Rantell K, King MB. Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults. BMJ open. 2016 Jan 1;6(1):e009948.

[14] Horrocks, J., House, A. & Owens, D. (2002). Attendances in the accident and emergency department following self-harm; a descriptive study. University of Leeds, Academic Unit of Psychiatry and Behavioural Sciences.

age groups the annual prevalence is approximately 0.5%[15] of the population experience self-harm.

Self-harm is most common among young people with the highest rates of hospital admissions due to self-harm in the 15-19 age group. (648.6 admissions per 100,000 in 2017/18[16]).

Research also shows us that girls are twice as likely to self-harm than boys[17] and admission rates for girls almost doubled in two decades, from 7,327 in 1997 to 13,463 in 2017.

The Local Picture

The latest figures in Birmingham indicate the suicide rate to be significantly lower than the England average[18].(fig 1)

The number of death registrations for suicide and injuries of undetermined intent in 2015-17 was 205[19] which equates to around 70 per year. Rates for Birmingham are similar to some of nearest statistical neighbours[20], but lower than most.

Fig 1: Age standardised rate of suicide (all persons) per 100,000 population 2015-17 (3yr average) Source: PHE Fingertips

[15] NICE (2003). "Self-harm in over 8s: long term management." Clinical Guideline 133. Available at: https://www.nice.org.uk/guidance/cg133/resources/selfharm-in-over-8s-longterm-management-35109508689349

[16]https://fingertips.phe.org.uk/search/self%20harm#page/3/gid/1/pat/6/par/E12000005/ati/102/are/E08000025/iid/92796/age/6/sex/4

[17] Morgan C, Webb RT, Carr MJ, Kontopantelis E, Green J, Chew-Graham CA, Kapur N, Ashcroft DM. Incidence, clinical management, and mortality risk following self harm among children and adolescents: cohort study in primary care. bmj. 2017 Oct 18;359:j4351.

[18] https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/0/gid/1938132828/pat/6/par/E12000005/ati/102/are/E08000025

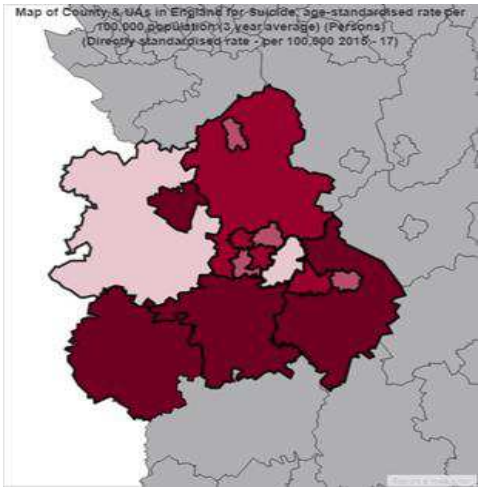
[19] Public Health Outcomes Framework indicator 4.10.

[20] CIPFA nearest neighbours - https://www.cipfa.org/policy-and-guidance/publications/n/nearest-neighbour-model-england

There has been some fluctuation in the 3 year rate for Birmingham as in 2014 due to a backlog of coroners cases being processed within a single year, however this has now rebalanced and the current trend is in line with the previous 3yr rate.

Compared to the rest of the West Midlands, Core cities group and the CIPFA comparator group, the 3 year rate of suicide in the city is one of the lowest, (fig 2). However it is important to note that because of the size of the city the overall count of suicides across the three years is second highest and in one year, on average, there are more deaths through suicide in Birmingham than across the whole three year period in Solihull.

Fig 2: Comparison map and table of Age standardised rate of suicide (all persons) per 100,000 population 2015-2017 (3yr average) across the West Midlands region



	Count	Rate
Birmingham	205	7.6
Shropshire	67	8.0
Coventry	76	8.8
Walsall	65	9.1
Dudley	77	9.4
Solihull	52	9.5
Staffordshire	225	9.7
Wolverhampton	66	9.9
Sandwell	86	10.4
Worcestershire	165	10.8
Warwickshire	169	11.3
Herefordshire	59	11.7

Source: Fingertips, Public Health England

Compared to the Core Cities group Birmingham currently has the lowest rate of suicide and across the CIPFA comparison group (a group of demographically matched areas) the 3yr rate of suicide in the city is one of the lowest, (fig 3).

Fig 3: Comparison tables of Age standardised rate of suicide (all persons) per 100,000 population 2015-2017 (3yr average) across the Core Cities and the CIPFA nearest neighbours group for Birmingham

	Rate
Core City Average	**11.8**
Leeds	11.8
Bristol	10.6
Liverpool	9.9
Manchester	9.3
Nottingham	9.2
Sheffield	7.7
Birmingham	**7.6**

	Rate		Rate
CIPFA Average	**10.8**		
Salford	12.3	Nottingham	9.2
Bolton	11.9	Walsall	9.1
Leeds	11.8	Bradford	9.0
Bristol	10.6	Leicester	8.9
Sandwell	10.4	Coventry	8.8
Liverpool	9.9	Sheffield	7.7
Wolverhampton	9.9	**Birmingham**	**7.6**
Kirklees	9.4	Derby	7.3

Public Health England's suicide prevention profile[18] highlights that Birmingham has high levels of some of the recognised risk factors for suicide but despite this has lower overall rates of suicide than other areas in the West Midlands and Core Cities.

Fig 4: Some of the Suicide Prevention Risk Factors - Birmingham

When we explore the detail of the deaths through suicide in Birmingham it highlights some important differences:

- 76% of suicides in Birmingham are men and they most commonly occur in ages 30-49, for women the largest age group is 40-49. (fig 5)

- Birmingham residents born in Poland and Eastern Europe have a higher rate of suicide compared to people born in the UK; however this may not account for recent migration trends and is likely to be a reflection of the larger numbers of working age males in the denominator population. (fig 6)

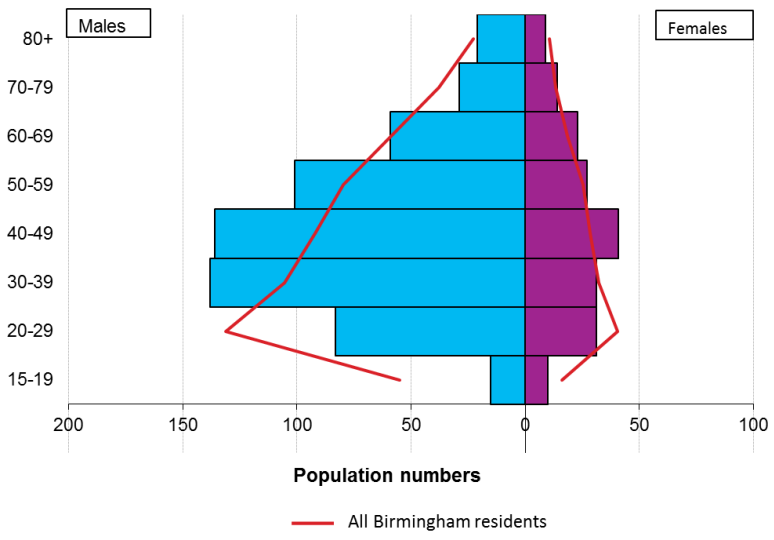
- 53% of suicides in the last 10 years have taken place at home. Other common locations were other residential properties (6%), public green spaces (4%), canals or rivers (4%), railways (4%). Hospitals were recorded as place of death in 16% of suicides, with no further information on where the suicide took place

  Methods of suicide were similar to national rates, with hanging or suffocation accounting for 63% of male and 44% of female suicides since 2007; poisoning was more common for females than males (31% vs 15%)

- Similar to national patterns, occupations with higher numbers of suicides in Birmingham were skilled trades, process plant and machine operatives and elementary occupations. (fig 7)

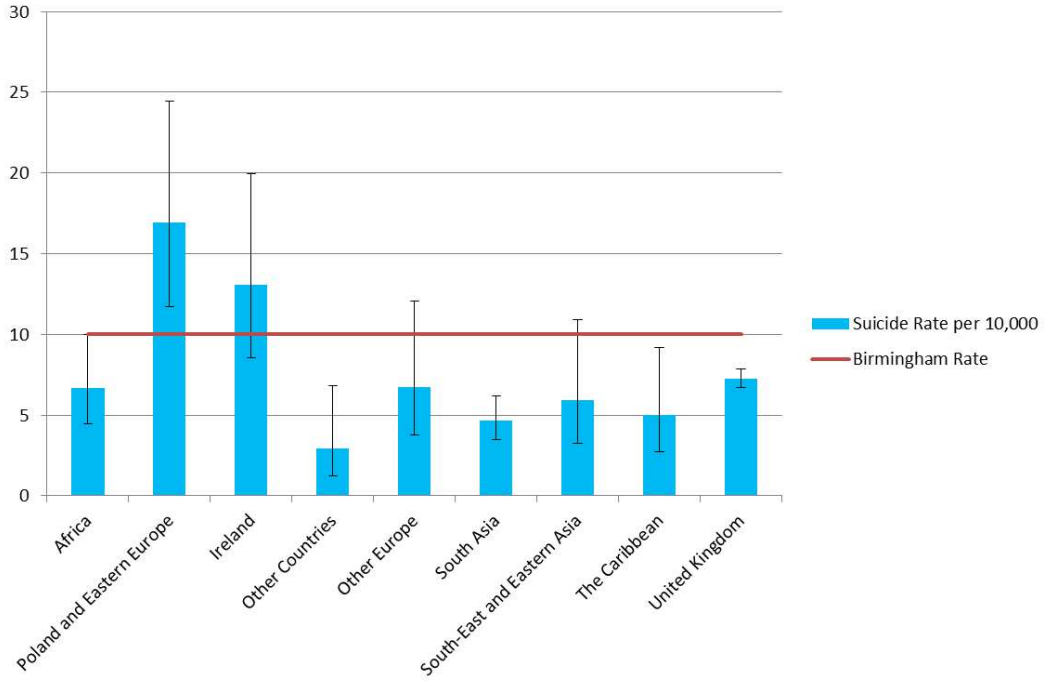
- Nationally, students had a lower rate of suicides than the general population. This appears to also be true for Birmingham according to local analysis

Figure 5: Population pyramid showing age and sex distribution of deaths due to suicide and undermined injury, Birmingham residents, 2007-2017



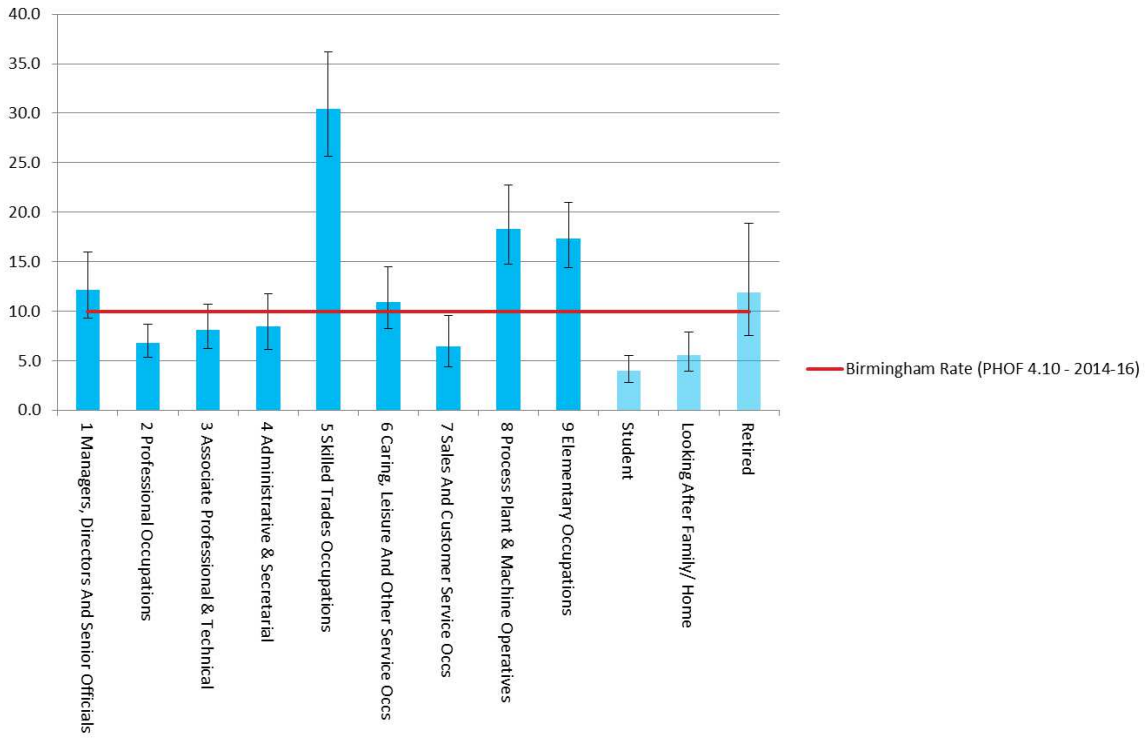
Source: Primary Care Mortality Data, NHS Digital

Figure 6: Crude suicide rate by country of birth, Birmingham residents, 2007-2017



Denominator Source: ONS Detailed Country of Birth Analysis from the 2011 Census

Figure 7: Crude suicide rate by occupation group (males and females), Birmingham residents, 2007-2017



Denominator Source: NOMIS annual population Survey Employment by occupation Apr 17 to Mar 18, and Economic inactivity table
https://www.nomisweb.co.uk/reports/lmp/la/1946157186/report.aspx#tabjobs

OUR SUICIDE PREVENTION AMBITION

Our ambition for this strategy is to **maintain the lowest rate of suicide of any of the core cities[21] in England and continue to reduce deaths through suicide in the City over the next decade through a Zero Suicide approach**

We will achieve this ambition through collaboration and working together at every level of the city and in every community, family and workplace, focusing our efforts in six key areas (building on the National Suicide Prevention Strategy):

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**

We can achieve a step change in suicide prevention and mental wellbeing but only if we all step up to act. It is important that we take action across all six areas simultaneously in order to effect change.

[21] Major cities are defined as being the 'Core City Group' reflecting the largest cities in England. This allows us to benchmark progress against comparable populations and urban context.

OUR PRIORITIES

Priority One: Reduce the risk of suicide in key high-risk groups

The inclusion of specific high risk groups within this strategy is underpinned by findings of the National Confidential Inquiry[22], National Strategy and local intelligence.

- **Men**

  Men have a 3 times greater risk of suicide than women, in Birmingham this risk is highest among working age men between 30-49yrs.

  In Birmingham there are an estimated 414,319 men[23], the current 3yr average rate of suicide in men in the city is 11.3/100,000, meaning over the last three years and estimated 47 men have died through suicide.

  Men are a large and diverse group of the population. However focusing on raising awareness of mental health issues and suicide amongst men and reducing the stigma on men talking about their mental health can be effective interventions.

- **People with a history of self-harm**

  Self-harm, including attempted suicide, is the single biggest indicator of suicide risk.

  In Birmingham in 2017/18 1,977 individuals presented to A&E with self-harm.

  There is already NICE guidance on the treatment of self-harm which includes psychosocial assessment and mental health liaison support in the emergency department. Psychiatric Liaison service is specialist multidisciplinary mental health service, working within all acute hospitals in Birmingham for people that present at A&E.

  Alongside this important provision it is important that clinical commissioners ensure that good local data is driving service improvement to minimise the risk for this group when they present in the emergency department or in primary care.

[22] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report: England, Northern Ireland, Scotland and Wales.
[23] ONS Mid-Year population Estimates 2017 – Males aged 18+

- **People with alcohol and drug-related problems**

  Nationally 45% of suicides involved patients with a history of alcohol misuse, 33% had a history of drug misuse.

  13.6%[24] of adults in Birmingham are binge drinkers of alcohol, and while this is lower than the national average it still represents approximately 115,469 adults in the city. A further 1.66% are dependent drinkers, approximately 14,094 adults.

  There are around 6,666 individuals in treatment for drug use[25].

  There is existing NICE guidance on dual diagnosis, i.e. substance misuse and mental health issues, and it is important that our drug and alcohol support services and mental health services are working closely together to support individuals and reduce the risk of suicide through the care pathway.

- **People in the Care of Mental Health Services (including in-patients)**

  Around 60-70 inpatients die by suicide per year nationally. Of all patients who died through suicide in the first week after discharge in 2017, the highest number occurred on the second (19%) and third (21%) day.

  There were 3,700 mental health in-patient admissions during 2017/18in Birmingham[26], although some of these represent readmission of the same individuals, each admission is an opportunity to intervene and prevent suicide after discharge.

  The national campaign for all mental health trusts to achieve Zero suicides provides an excellent framework for action and Birmingham Mental Health Trust will need to work with partners across primary and secondary care to achieve this and reduce the risk for in-patients and patients supported by community services.

In addition local data indicates two specific high-risk groups identified by place of birth and occupation:

- **Birmingham residents born in Poland and Eastern Europe**

  According to the last census there were approximately 16,562 Birmingham residents born in Poland and Eastern Europe and this figure is likely to be higher today. This group has the highest suicide rate by country of Birth and is two thirds higher than the City's population as a whole

[24] PHE Local Alcohol Profiles for England
[25] PHE Public Health Profiles : Adults in treatment at specialist drug misuse services
[26] Hospital Episode Statistics (ICD10 codes F00-F99)

By the nature of being a thriving city there is some churn in the population with people moving into the city and leaving the city but there is a growing population who have moved into Birmingham from Poland and Eastern Europe. We need to work with these communities and the groups that are most engaged with them as well as with service providers to ensure mental health and wellbeing services are culturally appropriate.

- **People in skilled trades occupations (e.g. construction industry)**

  In Birmingham the rate of suicide among men and women in skilled trade occupations, like construction, is three times the average for the city.

  It is estimated that 42,000 people in Birmingham work in a skilled trade[27].

  Birmingham is a city with a significant amount of construction and building development, providing jobs for local people as well as attracting transient trades people from outside the city. We have to work with employers, developers and trade professional bodies to raise awareness of suicide and reduce the risks associated with the workplace.

Although these are in many ways broad categories of individuals, by addressing them in a focused way there is likely to be a positive impact on the general mental wellbeing of the city and reduce the risk of suicide.

Priority Two: Tailor approaches to improve mental health in specific groups

As well as targeting high-risk groups, another way to reduce suicide is to improve the mental health of the population. For this whole population approach to reach all those who might need it, the national strategy recommends tailored measures to improve the mental health of groups with particular vulnerabilities or problems with access to services.

The groups highlighted in the national strategy are:

- **Children and young people, specifically looked after children, care leavers and children and young people in the youth justice system**

  Children and young people have an important place in the strategy. Too many children are developing poor mental well-being and the risk of suicide is greater when children have mental health issues. Looked after children and care leavers are between four and five times more likely to self-harm in adulthood.

[27] NOMIS Annual Population Survey by SOC2010 2017/18

In Birmingham when we focus on the highest risk groups of children and young people, this is the scale of the population in 2017:

1,838 Looked after children[28]
726 Care Leavers [29]
870 Children and young people in the youth justice system

Focusing our efforts on preventing suicide among these children and young people who are at highest risk will have a broader positive impact on the wider population of children and young people.

- **Survivors of abuse or violence, including sexual abuse**

There is a strong link between individuals experiencing violence and abuse and suicide, which is why it is important that there are coherent and evidence based services of support for people enduring violence and abuse.

We know from the research into adverse childhood events (ACE) that the impact of abuse, neglect and violence can play out across a lifetime. While there is no routinely collected data on the distribution of those with defined ACES in Childhood, commissioned surveys[30] [31] suggest that almost half (47%) of Adults (aged 18-69) had at least one of these experiences in childhood. In Birmingham this could potentially equate to almost 350,000 adults.

Over 40,000[32] individuals experience domestic abuse in the City and it is important that all of our specialist support services are actively thinking about the mental health and wellbeing of clients.

There are also 31,692 people affected by violent crime in the city in 2017/18[33] and as well as considering the physical impact of this violence it is essential

[28] DfE Children Looked After in England Local Authority Tables 2017
[29] DfE Children Looked After in England Local Authority Tables 2017 - Number of children who ceased to be looked after during the year
[30] ACEs in Blackburn with Darwin Council –with Liverpool John Moores University 2014 https://www.blackburn.gov.uk/Pages/aces.aspx
[31] Hughes K et al. Relationships between adverse childhood experiences and adult mental well-being: results from an English national household survey. BMC public health. 2016
[32] Birmingham Domestic Abuse Prevention Strategy 2018 – 2023 https://www.birmingham.gov.uk/downloads/file/10086/domestic_abuse_prevention_strategy_2018_-_2023
[33] Police.UK – Reported Violence and Sexual Offences 2017/18 (to September) Extrapolated from published rate using ONS mid-year population data

that commissioners and service providers address the short and long term psychological impact.

- **Veterans**

  In Birmingham there are an estimated 93,000 veterans[34].

  The Council and many partner organisations are signatories to the Armed Forces Community Covenant which sets out a commitment to address the needs of veterans and provides an important opportunity to specifically think about the needs of this group of individuals.

- **People living with long-term conditions and disability**

  There is a strong evidence of an association between long-term health conditions and poor mental health.

  In Birmingham approximately 198,000 people are living with a long-term health condition or disability[35]. Nationally two thirds of people with a long term physical health condition also have a co-morbid mental health problem, mostly anxiety and depression. Therefore we would estimate at least 130,680 people are living with mental health problems and long term health conditions. It is important that we consider the mental health and wellbeing of individuals with long term conditions, especially chronic pain, and clinical and social care professionals are actively talking about mental health issues, especially where physical health is deteriorating.

- **People with untreated depression**

  People who have untreated depression are at increased risk of suicide and self-harm and around half of all completed suicides are related to depressive and other mood disorders (ICD-10 F3)[36]. Only around 1 in 3 people with depression receive treatment, and there are inequalities in treatment seeking behaviour and receipt of treatment.[37] With around 55,000[38] adults on the primary care depression registers of Birmingham GPs, there may potentially an additional 110,000 people who are not in receipt of treatment and at higher risk of suicide than those receiving help.

[34] 2011 Census (ONS) estimates 11% – applied to Birmingham Population
[35] https://www.nomisweb.co.uk/census/2011 (table KS301EW)
[36] Bachmann S. Epidemiology of suicide and the psychiatric perspective. International journal of environmental research and public health. 2018 Jul;15(7):1425.
[37] Adult Psychiatric Morbidity Survey 2014: NHS Digital
[38] Quality and Outcomes Framework 2017-18 Recorded Disease Prevalence Table 2: Depression

We need to increase awareness of the signs and symptoms of depression and ensure that people are aware of the support available and how to access it themselves or to signpost others.

- **People who are especially vulnerable due to social and economic circumstances**

  There are strong links between mental ill-health and social factors like unemployment, debt, social isolation, family breakdown and bereavement. Adults aged between 16 and 59 who live alone for example are significantly more likely to have common mental disorders (CMD) than those who live with others. There are also marked differences in CMD prevalence among labour market cohorts. Using age-standardised figures, the CMD rate in employed people is 15.2% (aged 18-64) compared to 28.8% in the unemployed and 33% among people who are economically inactive[34]. Birmingham's claimant rate is the highest of all of the core cities at 7.3%, and economic data shows around 37,000 are unemployed and seeking work with an additional 217,000 people economically inactive[39] . Between these two cohorts there may be around 82,000 in a vulnerable position suffering with CMD.

  We need to work to improve the advice and support available to people who are more vulnerable due to their circumstances. This means delivering mental health support together with practical advice in front line services (such as debt, benefits and housing), with mental health awareness embedded within service delivery.

- **Lesbian, gay, bisexual and transgender people**

  Between 2-5%[40] of the population nationally identify as lesbian, gay, bisexual and/or trans, however data from the GP patient survey in 2017[41] would suggest in Birmingham the figure is between 2.5- 3.9% .

  Nationally and internationally there is evidence of increased rates of mental health problems, self-harm and suicidal thoughts among LGBT people, especially LGBT young people[42].

In Birmingham, it is estimated, that between 17,563 and 43,908[43]identify as LGBT based on the national estimates.

[39] Economically Inactive – includes full time students, looking after family and those unable to work for health reasons
[40] Annual Population Survey (2017 data), Office for National Statistics
[41] NHS GP Patient Survey (2017). IPSOS Mori. https://gp-patient.co.uk/surveysandreports2017
[42] NIESR Report: Inequality among lesbian, gay bisexual and transgender groups in the UK 2016
[43] Calculated on Birmingham Population 16 and over

Addressing these issues requires action across the whole system and is as much about ensuring that mental health services are accessible and culturally competent to support LGBT people as tackling the discrimination and harassment that add to the burden of mental ill health.

- **Black, Asian and minority ethnic groups**

People from Black, Asian and minority ethnic groups often face cultural stigma around mental health problems and there are inequalities in access to health services. Research suggests that Black Adults for example have the lowest treatment rate of any ethnic group[44] but have higher rates of serious mental illness such as psychosis[45]. There is also evidence that some immigrant groups may be at higher risk of suicide. In a review Non-European immigrant women (including Black African and South Asian) were at the highest risk for suicide attempts. Risk factors among migrants and ethnic minorities were found to be: language barriers, worrying about family back home, and separation from family[46].

42% of the population of Birmingham come from a non-white British ethnic background[47]; in some parts of the city non-white ethnic groups are becoming the majority population, however there remain issues with culturally competent services and issues of stigma and discrimination around mental health within some ethnic minority communities.

We need to work with communities to reduce stigma around mental health and suicide as well as bridge the gap between service providers and communities to ensure individuals in need are able to access support.

- **Refugees and asylum seekers.**

People who are refugees and asylum seekers may require additional support as a result of trauma that they may have experienced in their country of origin or during their journey to the UK

There are approximately 1,800 asylum seekers in Birmingham, though this figure fluctuates during the year being accommodated by the government and awaiting a decision on their asylum claim. This is in addition to people who have already been granted refugee status (or some other leave to remain)

[44] Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital
[45] Kirkbride, J et al. Psychoses, ethnicity and socio-economic status. The British Journal of Psychiatry, 2006 193(1), 18–24
[46] Forte A et al. Suicide risk among immigrants and ethnic minorities: a literature overview. International journal of environmental research and public health. 2018
[47] ONS Census 2011: KS201

and have settled within the City… Support for refugee communities is inconsistent but delivered through a range of voluntary, community and public sector agencies and services.

The Home Office and its contracted providers (Serco and Migrant Help from September 2019) are responsible for the welfare of asylum seekers they are accommodating and supporting. Once people leave that accommodation those duties come to an end and it is the responsibility of mainstream public sector services to identify, engage with and support refugee communities who may be experiencing crisis or at risk of crisis. Mental health is a consistent concern – including awareness and self-help, cultural sensitivities, visibility in and engagement with the health system, as well as specific and relevant services for refugee communities and it is vital that we maintain this focus.

- **People in Contact with the Criminal Justice System**

People who come into contact with the criminal justice system are high risk of for suicidal behaviour and self-harm[48] and experience many of the risk factors associated with these behaviours such as mental illness, adverse life events, drug and alcohol misuse and relationship breakdown as well as the effects of incarceration, and adjustment to life after release. We need to ensure an efficient and consistent approach across all partner organisations involved in the Criminal Justice System, to recognise and support poor mental health and other risks.

Priority Three: Reduce access to the means of suicide

Restricting access to the means of suicide is an important component of this strategy. It is a well evidenced and effective area of suicide prevention particularly in cases of impulsive suicide, where if the means are not easily available at the time of crisis the suicidal impulse may pass[49] [50].

The most common methods of suicide in both Birmingham and England are hanging, suffocation and poisoning.

Addressing access requires action at many different levels, including:

[48] Borschmann R, Young JT, Moran PA, et al. Self-harm in the criminal justice system: A public health opportunity. The Lancet Public Health. 2018 Jan 1;3(1):e10-1.
[49] Florentine JB and Crane C (2010) Suicide prevention by limiting access to methods: a review of theory and practice. Social Science & Medicine 70(10): 1626–1632
[50] HM Government: Preventing Suicide in England; A cross-government outcomes strategy to save lives

- Considering risk of suicide in the planning, design and refurbishment of housing and public spaces and facilities (e.g. car parks) for both new and change of use facilities for vulnerable people near to high risk locations.
- Mapping potential high risk sites through reviewing self-harm data and reports from health and police services and take action to reduce risk e.g. barriers, signage.
- Increase awareness of suicide risk, and steps to intervene, in staff working in high risk areas e.g. park wardens, traffic wardens.
- Reduce the risk of medication stockpiling through safer prescribing practice, especially for patients in high risk groups.
- Support retailers and vendors to consider suicide risk in the sale of potentially fatal gases and liquids.

Reducing access in many ways is one of the simplest steps that we can take but because of the variety of ways in which individuals die through suicide it is an area which requires continual review and collaboration between partners as things progress.

Priority Four: Provide better information and support to those bereaved or affected by suicide

For those bereaved by suicide the impact is severe.

Families and friends who are bereaved are at highest risk of mental health problems but it can have also have a profound effect on the local community or on the workplace/school or college where the individual was.

For every life lost at least 10 people are affected, with research suggesting that this could be as high as 135[51] people in need of support. Based on the number of suicides in Birmingham we would estimate that between 700 and 9,500 people affected by suicide are in need of support annually.

There is no national specialist service for those bereaved by suicide in the NHS but there are many charities which provide support and advice to bereaved individuals.

It is important that all organisations in the city think about how they can support individuals who are bereaved, including when that bereavement is through suicide, this includes:

[51] Cerel, Julie, et al. "How many people are exposed to suicide? Not six." Suicide and Life-Threatening Behaviour (2018).

- Employers utilising the evidence based toolkits in suicide post-vention from Public Health England and Business in the Community
- Promoting the 'Help at Hand' resource to relatives when a death occurs alongside the 'Waiting Room Resource Key' to support signposting to help.
- Working between public sector and third sector partners to ensure an appropriate bereavement support service that recognises the specific aspects of death through suicide with consideration of capacity, real time referral and data sharing requirements.
- Considering public awareness campaigns to raise awareness of the support available for individuals affected by a death through suicide.

Priority Five: Support the Media in delivering sensitive approaches to suicide and suicidal behaviour

How the media portrays suicide and what is reported can have a significant influence on behaviours and attitudes.

The way in which the UK media has reported suicide has changed fundamentally over the years – in part due to charities, like Samaritans working in the area of suicide prevention.

Ultimately, we can only reduce the numbers of suicides each year if we continue to talk about the issue and the media has an important role in educating the public on suicide prevention and are able to utilise mass readership and viewing to publicise sources of help and support available. However inappropriate reporting may put vulnerable individuals at risk, effect the bereaved and may lead to imitative behaviour.

Research consistently demonstrates that risk significantly increases if details of suicide methods are reported, or if the coverage is extensive or sensationalised.

The media need to continue to cover this important topic but this need to be done without putting vulnerable people at risk.

We need to work with local and regional media, especially considering media focused on high-risk communities, to increase awareness of national guidelines on responsible reporting of deaths through suicide and promoting a positive and culturally sensitive discussion in the media about mental health issues.

Priority Six: Support research, data collection and monitoring

Accurate and timely data on suicides statistics is vital for understanding patterns and behaviours, reducing risk and informing action to prevent future suicides. Such intelligence will also provide some of the measures of success for this strategy.

Currently there is a limited source of information and intelligence regarding local suicides to inform prevention activity in the city. However there are future opportunities to develop a system of real time surveillance with partners.

We have to work together across the partnership supporting this strategy to develop more a coherent and robust picture of suicide and self-harm and the related risk factors in the city to support service planning and monitor the impact of this strategy on outcomes and risk reduction.

MOVING INTO ACTION

Governance & Accountability

Tackling suicide requires major action from a wide range of organisations working in partnership.

We recognise that our NHS commissioning and provider partners have geographies which extend beyond the geographical boundary of the city, most often with Solihull.

Ultimately there is shared responsibility between the NHS and the Council for delivery of this strategy. This shared responsibility comes together through the statutory Health and Wellbeing Boards and the Mentally Healthy City sub-board that is being established in 2019/20. The Mentally Healthy City sub-board will link with the NHS STP Mental Health Delivery Board which reports up through the NHS governance framework and both will draw on the external stakeholder Mental Health Partnership Group.

The Suicide Prevention Working Group will oversee the delivery of the action plan and monitor progress against the plan. This group will report to the Mental Health Programme Delivery Board and the Health and Wellbeing Board through the Mentally Healthy City Sub-Board. Annex 2 sets out the current terms of reference.

The Suicide Prevention Working Group will oversee delivery of an annual action plan that will be signed off by the Director of Public Health on behalf of the Health and Wellbeing Board and the Clinical Commissioning Group.

Measuring Success

Fortunately suicide is still a relatively infrequent occurrence, however we will track progress for this strategy through metrics linked to our ambition.

Our ambition is to maintain the lowest suicide rate of the core cities in England and achieve a zero deaths through suicide ambition over the next decade; these will be monitored through the national indicators on 3yr rolling rates and counts published by PHE.

Alongside these indicators we are also developing through the action plan for 2019/20 a suite of metrics to track progress against the priority areas for action.

Principles for Action

Across the implementation of this strategy we have agreed a set of core principles which are shared across the partnership, these are:

1. We are open to share and learn as we implement action to move forward the strategy in the city.
2. We recognise the inequalities in mental health and self-harm that sit behind the picture of suicide and will work collectively to address these.
3. We understand that the implementation of this strategy will require action by all partner organisations, by communities and by citizens working together.
4. We are committed to keeping citizens at the centre of what we do.

Action Plan Development

The Suicide Prevention Working Group will be responsible for co-developing an annual action plan which will be approved by the Director of Public Health for Birmingham City Council, in consultation with the chairs of Health and Wellbeing Board and STP/CCG Boards.

Keeping Citizens at the centre

We are committed to keep Citizens at the centre of what we do as we move forward this work and therefore the final section of this strategy is dedicated to the voices of citizens affected by suicide and self-harm.

'When I look back over the period of time leading up to my suicide attempt, I realise I actually hit all the 'high risk' markers. A holistic approach is needed rather than a 'tick box' one. If a person is saying no to thinking of acting on suicidal thoughts, yet all the indicators point to significant risk factors, such as recent abuse or assault, significant depression, a major life circumstance, a history of self-harm including drug misuse, every effort should be made to ensure safety of that individual. My own personal experience is that I would have benefitted from Increased input from a community mental health team, a link between mental health and drug misuse teams, my doctor not supplying large quantities of medication on prescription at once and retailers being giving training to be made aware of potentially fatal means being sold.'

'My life took a desperate turn when I lost my job and got into debt. I couldn't face life failing my family. I had enough medication from my Doctor to end it. They would be better without me. If I hadn't been found as soon as I was, my children would have been growing up without their Daddy and this haunts me every day. I was scared to tell anyone how I felt because I thought my children would be taken into care. Looking back, I wasn't a danger to anyone, only myself. Maybe I wouldn't have got that far if it wasn't such a stupidly scary thing to talk about or if people could talk to me without being scared themselves. People are too scared to even say the word.'

ANNEXES

1. Membership of the Suicide Prevention Working Group
2. Suicide Prevention Working Group TOR
3. 2019/20 Draft Action Plan

ANNEX 1 – Suicide Prevention Working Group Membership[52]

Name	Organisation
Justin Varney	Director of Public Health - BCC
Duncan Vernon	Public Health - BCC
Amanda Lambert	Public Health - BCC
Dennis Wilkes	Public Health - BCC
Jenny Riley	Public Health - BCC
Mo Philips	Public Health - BCC
Elaine Woodward	NHS England
Helen Wadley	Birmingham MIND
Paul Sanderson	PHE
Kerry Webb	BSMHFT
Joanne Carney	BSOL CCG
Gemma Coldicott	BSOL CCG
Jennifer Weigham	BSOL CCG
Dario Silverstro	BSOL CCG
Clare Walker	Solihull MBC
Elaine Kirwan	BWC NHS FT
Lisa McGowan	BWC NHS FT
Sean Russell	WMCA
Karen Edwards	NHS England
Dave Brown	PAPYRUS
Lesley Hales	CRUSE Birmingham

[52] As at May 2019

ANNEX 2 – Suicide Prevention Working Group Terms of Reference

Terms of reference Birmingham Suicide Prevention Working Group

1. Aim

The Birmingham Suicide Prevention Working Group aims:

• to reduce the rate of suicide and self-harm within Birmingham

• to provide a forum for successful multi-agency partnership working at strategic and operational level

• to work across STP area Birmingham and Solihull

2. Objectives

To facilitate and promote joined up partnership arrangements where appropriate in ensuring effective working to reduce suicide rates across STP area

3. Responsibilities

• to develop and agree a multi-agency suicide prevention strategy and action plan for Birmingham (and work across/with Solihull's strategy and plan)

• to monitor the implementation of the suicide prevention strategy

• to review and update the strategy as appropriate

• to inform and influence commissioning of specific projects and initiatives to meet the aims of the suicide prevention strategy over and above routine MH commissioning by CCGs

• to commission and analyse an annual statistical and intelligence update

• to publicise ongoing work and recent developments

• to facilitate partnership working between organisations represented on the Working Group

• to influence the work of all agencies and individuals who could help prevent suicide and self-harm, including those with lived experience.

4. Membership

To ensure that as many people and organisations are aware of, and involved in, suicide prevention this group has two types of members:

• those that regularly attend the meetings of the working group

• those who don't regularly attend the meetings, but are on the circulation list and may attend the meetings on an ad-hoc basis.

[regular attenders must include one representative from each of the Task and Finish groups; member from each political party; DPH, PHE/NHSE, Solihull, CCG, MH Trust, VCSE]

[Others who are to be included in the circulation list who may attend on an ad hoc basis include emergency services; police; fire; CJS; railways]

5. Accountability

This group will report to the local Health and Wellbeing Board, the appropriate STP board, and Health Committees within the Council.

6. Administrative support

Public Health will provide the Chair and the admin support for the Group initially until further review.

7. TOR approval and review date

Terms of reference will be reviewed every two years. The next review date will be Feb 2021.

8. Frequency of Meetings

Meetings of the working group will be held quarterly (unless otherwise agreed by the working group). Where possible, meetings will be held in different venues across Birmingham.

ANNEX 3 – Draft Action Plan

The Action Plan will be fully worked up with Partners at the Suicide Prevention Working Party meetings.

Costs associated with partners will be paid by those organisations.

It is felt that only sundry expenses and Officer time will be associated with Birmingham City Council and those will be met from the Public Health Grant.

Action Plan

		Initial Actions	Detail	Lead	Partners	Timescale
Priority 1: Reduce the risk of suicide in key high-risk groups						
1	**Men**	Raise awareness among men of the support available Reduce stigma among men including finding different language to use and not presuming that men don't want to talk. Consider community leaders/ faith leaders as ambassadors. Develop health promotion initiatives which are targeted at men and delivered in locations frequented by men (job centres, youth centres, sports venues, barbers, tattoo artists, music venues, pubs and clubs. Safe space for men to talk.	Learn from other areas e.g. wave 1 SP sites and trailblazer sites. For example- sports focussed programme; men only programmes; campaigns Detail to be agreed			
2	**Self-Harm**	Implement NICE guidance on the treatment of self-harm , including assessments at Emergency Department, including psychosocial assessments and mental health liaison services Improve local monitoring of people who present with self-harm Ensure services in place for those who self-harm Serial presentations of self-harm should be red-flagged as a high suicide risk. Raise awareness with schools/ Children's Trust regarding self-harm and serial self-harmers.	Work with local CCG commissioners/psychiatric liaison to ensure evidence is collected towards the Public Health Outcome Framework measurement of people presenting with self-harm. Make the local Emergency Care Data Set as robust as possible and raise awareness of the NHS			

		Initial Actions	Detail	Lead	Partners	Timescale
			CQUIN for people who frequently attend Emergency Department having self-harmed Detail to be agreed			
3	**Substance Misuse**	Ensure that Mental Health and Substance Misuse services are implementing the NICE Dual Diagnosis guidance Ensure greater focus on alcohol and drug misuse is as a key component of risk management in mental health care Dual diagnosis pathways to be reviewed and embedded to enable the most effective partnership working (Substance Misuse/ Mental Health). More joined up care required as D&A Programmes often exclude people from mental care.	Contact: adele.flannegan@aquarius.org.uk			
4	**Mental health patients**	<u>MH Inpatients</u> NHSE to support/challenge all MHT zero suicide ambition inpatient plans to include: - Assessment and risk management based on best practice. - SI process/learning - Safety plans <u>Primary care/IAPT service</u> Suicide prevention training for all GP's.	Online programmes to be	NHS England		

		Initial Actions	Detail	Lead	Partners	Timescale
		Ensure IAPT providers do not include self-harm/suicide risk as an exclusion criteria	sent (Dr Cave). For all GP's provide training and materials – in identifying patients at risk of death by suicide.			
5.	**Birmingham Residents Born in Poland and Eastern Europe**	Work with Polish and Eastern European communities and the groups that are most engaged with them as well as with service providers to ensure mental health and wellbeing services are culturally appropriate/ sensitive. Learn from other areas with existing focused services in place DWP – work psychology specific sessions with interpreters. Work with Polish and Eastern Europe ex-pats to know where communities are. Highlight suicide and mental wellbeing through community events. Develop champions (P&EE). Undertake training for P&EE for translators. Campaign to reduce stigma in Polish/ EE communities.	Link with CEO of the Polish Ex Pats Association and Director of Health Policy in Warsaw Michelle & Stephen Handsworth JCP – find out if this has been done or if this is volunteering. TWR/ PH/ Barney Thorne	DPH/ Birmingham Public Health DWP		
6.	**People in Skilled Trade Occupations**	Work with employers, developers and trade professional bodies to raise awareness of suicide and reduce the risks associated with the workplace. Thrive at Work – link to PHE toolkit for employers. Promote the Zero Suicide Alliance training with SME's and Construction Companies.	Mates in Mind Mental Health First Aiders. Greater Birmingham Chamber of Commerce/	DPH/ Birmingham Public Health		

		Initial Actions	Detail	Lead	Partners	Timescale
		Need a safe space for men to talk. Skilled trades – hidden population of self-employed plumbers, electricians, roofers, builders, etc. Aquarius Life – delivering introduction to Mental Health to skilled trade apprentice programmes.	Birmingham City Council Procurement Team. Specialist regulatory body i.e. Corgi etc. Contact: adele.flannegan@aquarius.org.uk			

		Action	Detail	Lead	Partners	Timescale
	Priority 2 Tailor approaches to improve mental health in specific groups					

7	**Those in prison or facing a custodial sentence**	Engage the Criminal Justice System in a way that will ensure those most vulnerable are identified and supported across organisational boundaries.	Develop new approaches to support those in crisis in the CJS (pre and post prison)			
8	**Children and Young People**	Work with schools and youth services to raise awareness and reduce the risks and promote anti bullying and to tackle self-harm. Schools to work with parents to have conversations regarding mental health resilience. All families with a child under 5 have a named Health Visitor; ensure all Health Visitors have suicide awareness training as standard. Build emotional resilience in primary school age children. Work with Looked After Children Care Leavers Team to raise awareness of personal resilience and mental wellbeing. Birmingham Children's Trust already work in partnership with Education, Forward Thinking Birmingham, BCT/ Health regarding safety plans for suicide and self-harm. Early support and prevention – support risk factors for children with Autism/ SEN. Ensure Children's Homes are a safe environment. Schools to have staff trained in Mental Health Awareness	BCC School Support/ lead practitioner for MH. Training to be included in Specialist Community Public Health Nursing - Health Visiting (SCPHN - HV).			

		and MH First Aid.	Link, learn, and share. Custody Cells – good practice.	Police BCC/ schools/ colleges / unis		
9	**Survivors of abuse or violence, including sexual abuse**	Survivors of Modern Day Slavery. Mental Health Awareness training for BHAROSA support staff.	Link with David Grey Adult Social Care/ Police.	Public Health		

10	**Veterans**	Dishonourably discharged – minimal or no support for them. JSNA Deep Dive – this will reveal actions.	Details to be agreed.	Elizabeth Griffiths – BCCPH.		
11	**People with Long Term Health Conditions**	Utilise Commonwealth Games to promote volunteer opportunities. SEN/ Autism and their families – nature of disability puts this group at risk of social isolation etc.	Undertake Autism Research – high risk group.			
12	**People with untreated depression**	Increase awareness of the signs and symptoms of depression and ensure that people are aware of the support available and how to access it themselves or to signpost others.				
13	**People who are especially vulnerable due to social and economic**	Financial and debt advice, homelessness services for vulnerable people…develop a local debt pathway. Suicide awareness training to frontline service providers across education, housing, employment and others	Ensure that the staffing in these services are trained in either MHFA, Assist or the new Suicide First Aid so that people can identify and speak to people about suicide and			

	circumstances		signpost people appropriately.			
14.	**Lesbian, gay, bisexual and transgender people**	Ensure that mental health services are accessible and culturally competent to support LGBT people. Tackling the discrimination and harassment that add to the burden of mental ill health. (How)				
15.	**Black, Asian and minority ethnic groups**	Work with communities to reduce stigma around mental health and suicide. Bridge the gap between service providers and communities to ensure individuals in need are able to access support. Consider safe hubs in faith communities.				
16.	**Refugees and asylum seekers.**					
17	**Develop/spread best practice in supporting families and communitie**	Learn from the services actively supporting bereaved families and communities. Collate best practice examples from 3rd Sector				

	s.					
18	**Raising Awareness**	Community based awareness campaign to reduce stigma and discrimination against Mental Health Disorders and Suicide. Encourage commissioners to ensure all programmes are accessible and appropriate for disabled people. Suicide prevention training for housing providers and benefit teams. Accommodation Providers to single men/ refugees need to be aware that middle-aged single men are part of the high-risk group. Mental health first aid training for food bank and union staff. Peer Support Programmes consider growing a Brum Survivors Network of Peer Support Champions from suicide survivors. Undergraduate and postgraduate training at universities. Promote local support groups/ networks for those bereaved by suicide. Coordinate with PHE on campaigns. GBCC – promote Zero Suicide Alliance and Mental Health First Aiders with SME's.	Engage with faith groups, respected leaders/ elders, and community groups. Commissioning Managers Raise awareness of housing officers and lettings staff.	Homeless Partnership Board.		

			BCU			

		Action	Detail	Lead	Partners	Timescale
	Priority 3 - Reduce access to the means of suicide					
19	Planning and Building Design	High Risk Environments – amends the developer's toolkit to reflect suicide prevention measures when reviewing planning applications. Mapping potential high risk sites through reviewing self-harm data and reports from health and police services and take action to reduce risk e.g. barriers, signage. Children's Homes should be included in safe environment with reduced risks. All new buildings have HIA and put prevention points into new HIA's i.e. Custody Suites.	Work with the Local Authority Property and Housing team to include suicide risk in building design considerations for major refurbishments and upgrading of social housing stock and corporate assets Work with planning and developers to include suicide risk in new building design considerations, especially in relation to multi-storey car parks, bridges and high rise buildings that may offer suicide opportunities.	Kyle Stott.		
20	Suicide Prevention Training	Increase awareness of suicide risk, and steps to intervene, in staff working in high risk areas e.g. park wardens, traffic wardens. Develop Suicide Prevention Training Strategy. Training and awareness of how to	Map suicide training provided across the city. To include online resources Identify good practice in suicide prevention training Develop and resource a local training plan Police have a checklist for			

		manage home environments. (children's homes, residential homes, PD/LD). Make suicide prevention training a part of the contract with providers who work with vulnerable adults such as CGL. Work with DWP as advisers often get 'journal' messages mentioning suicidal thoughts. Map training offer in West Midlands	custody cells – good practice. Follow up with PHE			
21.	Identification and reduction of Hotspot risk.	PH to coordinate a multi-agency response once areas have been identified. These agencies might include Transport Police, Network Rail and private landlords in addition to the usual agencies. Specific action plans for specific hotspots should be identified in a timely manner, taking care not to draw attention to them in the process.' Raise awareness with Housing Officers/ Social Workers.	Mapping the location of confirmed and possible suicides and self-harm locations to identify "hot spot" locations. Informing partner agencies and those that have responsibility for buildings/land used for suicide to raise awareness and target training. Establish a process for alerting train station staff if someone with high suicide risk goes missing from acute care. - Take action to reduce risk (i.e. install signage, barriers) in line with evidence base			
22	Identification and removal of potential risk points within public	Ensure robust risk assessment procedures for all areas where				

.	services buildings.	suicide could occur Hospital, prisons, care centres to review ligature points and potential high risk areas				
23	Safer Prescribing	Reduce the risk of medication stockpiling through safer prescribing practice, especially for patients in high risk groups. Promote NICE guidelines on the appropriate use of drug treatments for depression. Promote safe prescribing of painkillers and antidepressants, including through the following: - Provide information to the CCG, GPs and hospital prescribers on deaths caused by prescription drugs, with recommendations. - Undertake a needs assessment for people addicted to prescribed medication.	Establish a time limited working group to oversee needs assessment and make recommendations			

24	Control of Gases and Liquids	• Support retailers and vendors to consider suicide risk in the sale of potentially fatal gases and liquids.	Develop and co-ordinate an engagement strategy with retailers .			

	Issue	Action	Detail	Lead	Partners	Timescale
	Priority 4: Provide better information and support to those bereaved or affected by suicide					
25	Support Resources	• Ensure that the 'Help is at Hand' booklet is promoted and suggested to relatives by Police/funeral directors/first responders etc. • Ensure that the Waiting Room Resource Key is available for all professionals (this will enable prevention as well as it helps to signpost people to the right service). • Research best practice i.e. Start a Conversation campaign (Barney Thorne – Leics Police). • Research Norfolk Police/ Public Health. • A bereaved person needs to have the consistency of just speaking to one person to prevent repeated re-telling of events.	Any service with linkage to bereaved relatives who should have a copy – make the handbook local by adding in specific local telephone numbers.	Police (FDS)		
26	Investment in Services	• Investment in services		PHE		

		supporting those bereaved by suicide – in particular young people. (CRUSE has some really good data that can help with quantifying this). Ensure services are consistent with PHE guidelines. • What are the Commissioning Gaps – the early help that's working.	Austin Rodriguez and Dario?	NHS Trust CRUSE (CCG currently fund CRUSE)		
27	Raising Awareness of Available Support	• Public awareness campaigns to raise awareness of the support available for individuals affected by a death through possible suicide. • Create an App to give advice, animated short clips, signposts help, sometimes it's better to see than read information.		Police/ LA Natasha McLeish (BHC)		
27	Postvention Support	• Support easier accessible suicide bereavement services e.g. improve communication between mental health/crisis services and families- create Postvention service				

		development in Birmingham (i.e. postvention suicide group support sessions, individual family support counselling etc.) • Reduce the impact of suicide - Standardise proactive approach to offering services/support to those bereaved by suicide. (Minimal waiting list required as support in needed THEN). • Support Employers utilising the evidence based toolkits in suicide postvention from Public Health England and Business in the Community • Prevention awareness HS2 by bridges.				

	Issue	Action	Detail	Lead	Partners	Timescale
	Priority 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour					
~~28~~	~~Promotion of expert guidelines~~	~~Work with local and regional media, especially considering media focused on high-risk communities to increase awareness of well-developed expert guides such as by The Samaritans (https://www.samaritans.org/media-centre/media-guidelines-reporting-suicide)~~ Utilise Social Media in a positive way to promote/ manage mental wellbeing, suicide, and death. Manipulation of media i.e. teenage myth-busting (Momo challenge).	~~Incorporate into wider CCG and BCC communications plans~~			

	Priority 6 Support research, data collection and monitoring					
29	Increase Intelligence	Utilise real time surveillance to start to identify trends and hot-spots. Real time surveillance regarding individuals presenting at A&E with self-harm, especially serial presentations. Develop a systematic approach to local intelligence gathering and partnership dissemination (including ethnicity). Explore alternative sources of data and intelligence which identifies populations of interest and informs an agile local partnership response to suicide prevention needs in the city. Identify suicides of non-Birmingham residents that take place within Birmingham. Need to understand BAME cultures to help services engage parents on behalf of children	Sudden death form. Work with the Coroner, WM Police, WM Ambulance Service, Network Rail and BTP to define enhanced, timely and systematic intelligence monitoring. Intelligence to be shared with the Birmingham SP Partnership; enabling an informed response to suicide clusters and drives a proactive response to post-suicide bereavement support. Develop a clear intelligence group to support the aims of the Board Produce a report for the steering group based on currently available data Steering group to identify intelligence needs for future	WM Police Papyrus	*Solihull, B&S Coroner, WMP, WMCA*	

		(Papyrus have done this). An audit of companies undertaking mental health first aider training to see the spread and types of businesses interested. Triangulation of data to include research and local knowledge. Commission a piece of work to get better data around the reasons people decide to take their own life.	development of strategy Approach PHE/ONS for suicide data based on place of death within Birmingham Develop a methodology to identify similar events Use Wave 1 sites as benchmark especially autism work.			