

**NO**MORE  
Zero Suicide

Preventing suicide in  
Cheshire & Merseyside

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# A Zero Suicide Strategy for Cheshire and Merseyside

2015-2020

43210%

## 1. What is our vision?

Cheshire and Merseyside is a region where suicides are eliminated, where people do not consider suicide as a solution to the difficulties they face. A region that supports people at a time of personal crisis and builds individual and community resilience for improved lives.

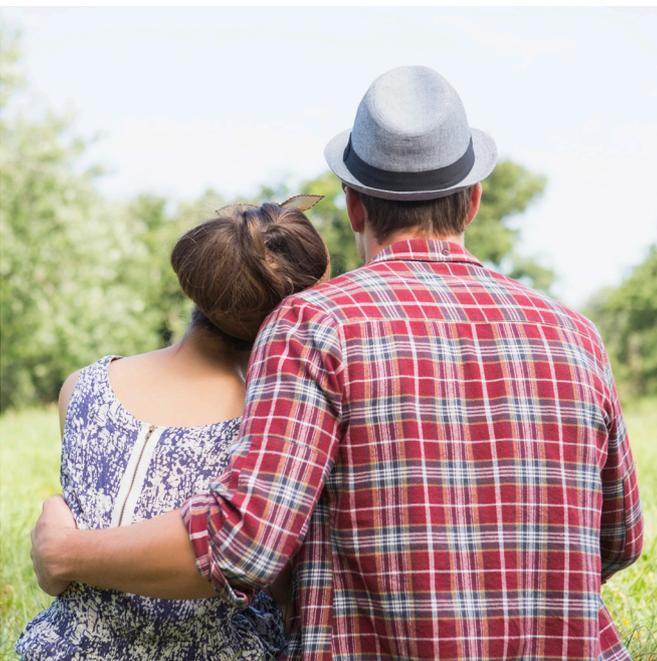
## 2. What is the aim of this document?

This strategic document sets out to be bold, ambitious and innovative, to raise awareness about suicide and to create a momentum for change that eliminates suicides for the Cheshire and Merseyside Region.

## 3. What do we plan to do?

Suicides are not inevitable. There are many effective ways in which services, communities, individuals and society as a whole can help to prevent suicides. The aims of this strategy are underpinned by key objectives:

- A. Cheshire and Merseyside becomes a Suicide Safer Community
- B. The Health Care System transforms care to eliminate suicide for patients
- C. Support is accessible for those who are exposed to suicide
- D. A strong, integrated Suicide Reduction Network provides oversight and governance



## 4. Why are we doing this?

Key drivers:

1. Locally, men account for eight out of every ten suicides, therefore our actions must particularly engage with and positively influence men.
2. Increase in pressures and negative circumstances on local populations including deprivation, vulnerability, debt, unemployment – therefore our actions must consider and influence the wider determinants and socioeconomic factors in people's lives, we must think and act holistically
3. Local audit data suggests over a 1/3 of people who complete suicide in our region had been in contact with their GP in the month before their death and 1/2 had been in contact with mental health services, therefore our actions must change and positively influence the culture, attitude and practice within Secondary and Primary healthcare towards suicide prevention.
4. We also know many suicides occur out-of-the-blue i.e. the individual did not have a diagnosed mental health problem and many close to them had no idea they were considering suicide - therefore our actions must change and positively influence the culture, attitude and practice within our communities, the voluntary sector and local authorities.

Suicide is a major social and public health issue. It is a cause of early death and increased mortality rates, and is seen as an indicator of underlying rates of mental ill-health. The impact on family and friends can be devastating and it carries a huge financial burden for the local economy and contributes to worsening inequalities. The highest numbers of suicides are recorded in men aged 35-54 years and among women 40-59 years. Family and friends are up to 3 times more at risk of taking their own lives and they experience severe effects on their health, quality of life, ability to function well at work and in their personal lives.

This strategy is an all-age suicide prevention strategy, recognising that suicide and suicidal risk varies across the life course and that prevention and age-appropriate interventions are particularly important for young people. It is specifically about the prevention of suicide rather than the related problem of non-fatal self-harm. Although people with a history of self-harm are identified as a high risk group, this strategy has not tried to cover the causes and care of all self-harm. Similarly, assisted suicide is a separate issue, outside the scope of the strategy.

## 5. National Picture

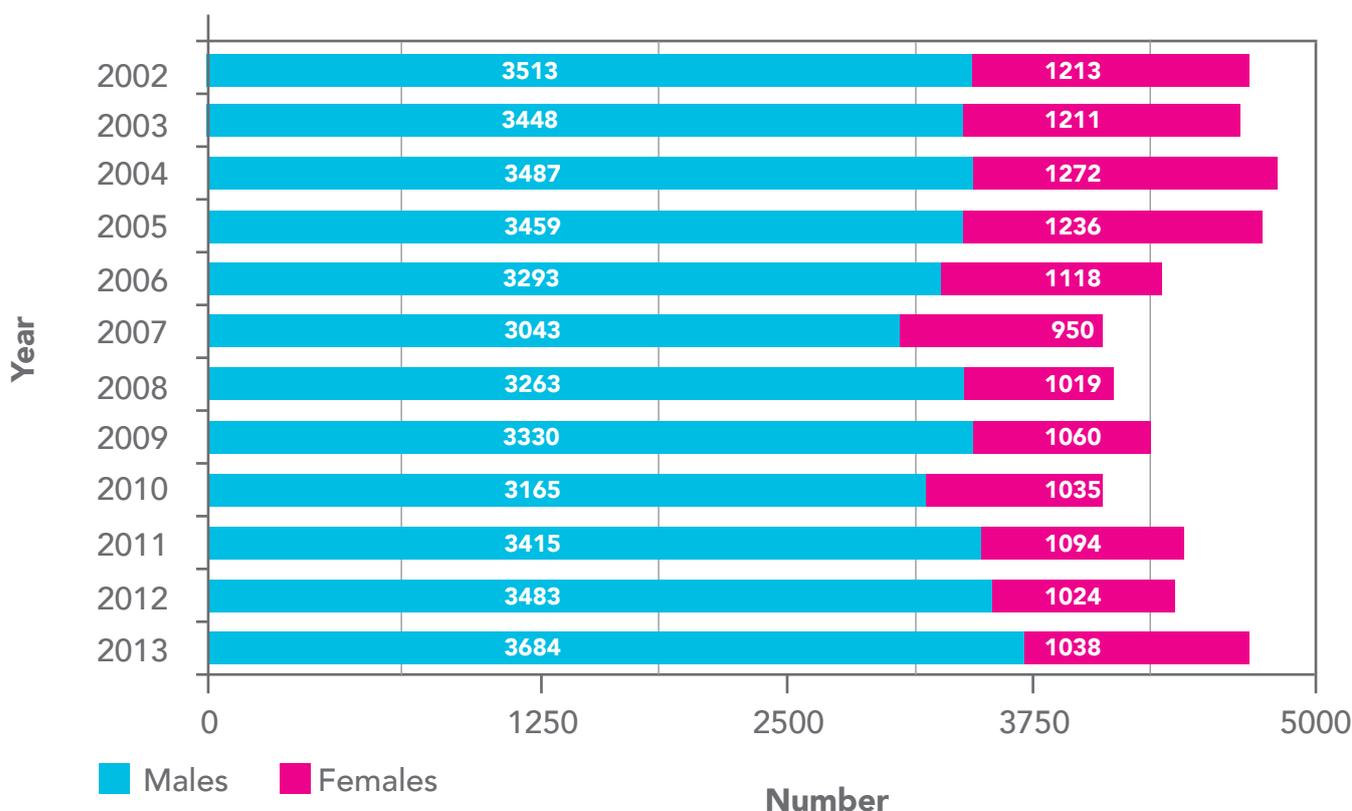
There were 4,727 deaths due to suicide and undetermined injury in England in 2013 with a three-year rate of 8.8 per 100,000 for 2011-13. Suicide in males is more than three times more likely than females (13.8 for males in 2011-13, compared to 4.0 for females).

There has been a rise in overall patient suicide, matching rise in general population, prison suicides are at the rate of 0.7 per 1,000 and a considerable rise in apparent suicides within two days of release from police custody. Furthermore, in 2014 there were 84 self-inflicted deaths in prisons in England and Wales compared to 75 in 2013.

According to national and international research, the total cost to society of suicide has been estimated as being £1,700,000 per case. This consists of: both direct costs (the services used by the individual leading up to and immediately following the suicide) and indirect costs (time lost from work and human costs due to lost years of disability free life and costs to the family).

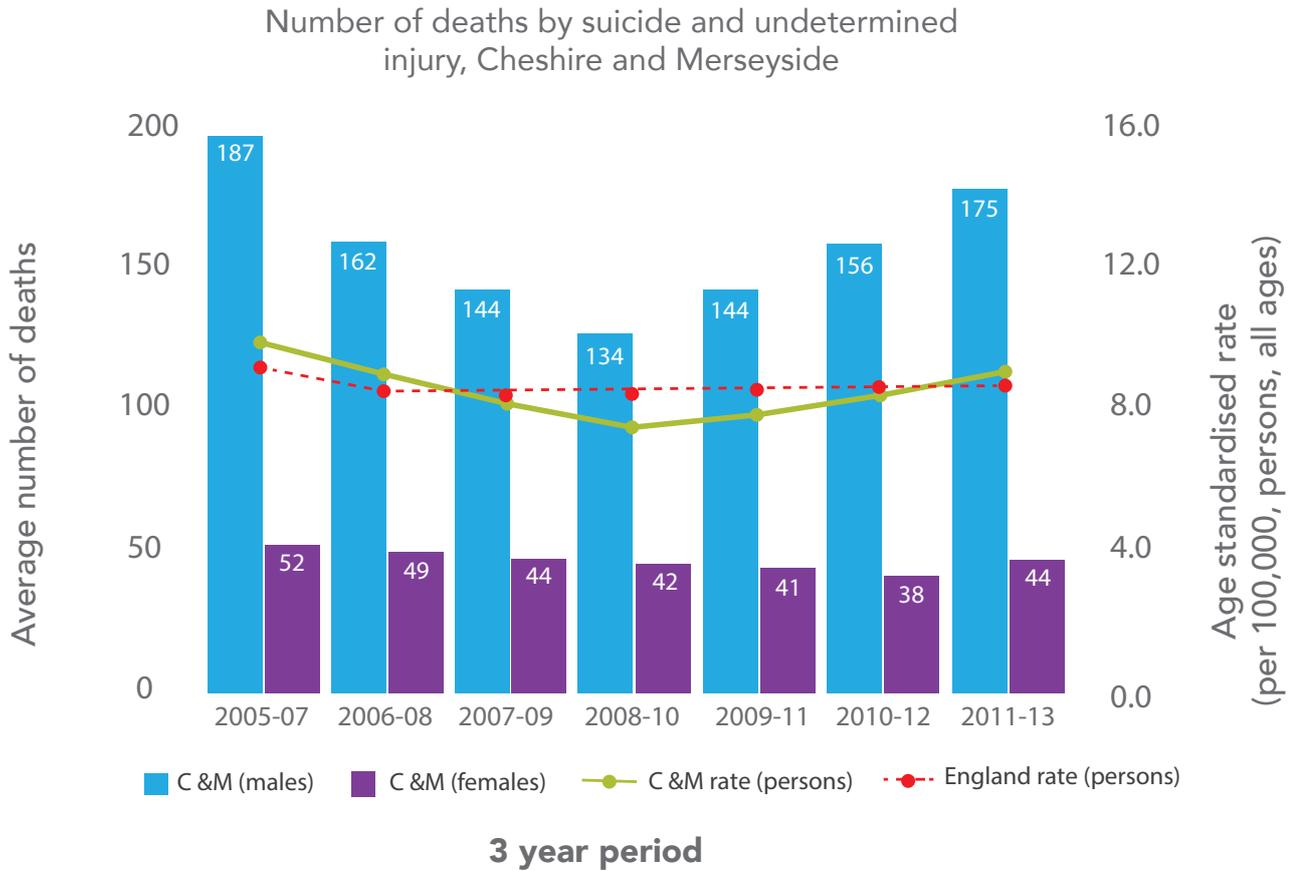
Previously, periods of high unemployment or severe economic problems and reduced social capital have had an adverse effect on the mental health of the population and have been associated with higher rates of suicide. The lowest number of deaths by suicide and undetermined injury in England was in 2007, (3,993). Following the 2008/09 recession, numbers have increased, with the 4,727 deaths in 2013 similar to levels in 2002, (4,726).

Total deaths by suicide and injury undetermined by year, England



Source data: ONS

In Cheshire and Merseyside, the recent lowest three-year number of deaths for men was in 2008-10, with an average of 134 deaths per year. This increased to an average of 175 per year from 2011-13.



Source data: Public Health Outcomes Framework, PHE 2014

## 6. Local Picture (Cheshire and Merseyside)

Between 2011 and 2013, there were 657 suicides and deaths of undetermined injury across Cheshire and Merseyside, an average of 219 per year and a cost to the economy of £372.3 million per year. The most recent suicide rate available for the sub-region (2011-13) is 9.2 per 100,000, which is statistically similar to the England rate of 8.8 per 100,000. By local authority, the rates in the sub-region vary between Cheshire East's rate of 7.9 per 100,000 up to St Helens suicide rate of 11.9 per 100,000.

However, while this gives numbers and rates of suicides across Cheshire and Merseyside, there is a need for further qualitative information to provide a more detailed understanding. The suicide audits currently undertaken across Cheshire and Merseyside provide more detailed information and for the first time have been combined into a joint report in 2014 to look for themes and trends. The report is more inclusive, since it reduces the chance of suicides in neighbouring local authorities being missed.

The estimated number of people experiencing suicidal thoughts or attempting suicide across Cheshire and Merseyside has been calculated at 85,288 and 13,884 respectively.

## 7. How do we plan to do it?

The national strategy 'Preventing suicide in England- a cross-government outcomes strategy to save lives', was published in 2012. The Cheshire Merseyside Suicide Reduction Action Plan (the SRAP) adopts the 6 national actions giving every stakeholder from the sub-region a clear framework to work from. We also want to ensure each of the 4 key objectives outlined on the next page are achieved by each of us working together. The action plan is outlined in Table 1.

<p><b>Objective A</b></p>	<p>All nine local areas in Cheshire and Merseyside achieve suicide safer community accreditation by 2018</p> <p>Canadian Suicide Safer Community Model:</p> <ol style="list-style-type: none"> <li>1. Establish a Suicide Safer Community committee</li> <li>2. Establish the population size of your community</li> <li>3. Identify organisations representing your committee</li> <li>4. Create and agree an action plan or strategy with identified priorities</li> <li>5. Support and commission accessible suicide intervention services</li> <li>6. Support and commission accessible suicide bereavement support</li> <li>7. Support and commission promotion of mental health and wellness activities</li> <li>8. Support and commission proactive suicide prevention activities</li> <li>9. Establish a pool of formally trained gatekeepers</li> <li>10. Participate in World Suicide Prevention Day</li> </ol>
<p><b>Objective B</b></p>	<p>The health care system transforms care to eliminate suicide for patients</p> <ol style="list-style-type: none"> <li>1. Effective suicide risk assessment, safety plans and treatment, across all Primary Care, Community Care and Secondary Care services whether patients present for physical and/or mental health care by October 2016</li> <li>2. All 3 secondary care Mental Health trusts within the region to adopt the Henry Ford 'Perfect Depression Care' model of zero suicides by 2018</li> </ol> <p>Perfect Depression Care Model A quality improvement model in mental health care that in Detroit has reduced suicides by 75%</p> <ul style="list-style-type: none"> <li>• Safe Care</li> <li>• Effective Care</li> <li>• Patient Centred Care</li> <li>• Timely Care</li> <li>• Efficient Care</li> <li>• Equitable Care</li> </ul> <ol style="list-style-type: none"> <li>3. Cheshire and Merseyside are signed up to the Mental Health Care Crisis Concordat with action plans that put patients and carers at the centre of decisions by April 2015</li> </ol>
<p><b>Objective C</b></p>	<p>Support is accessible for those who are exposed to suicide</p> <ol style="list-style-type: none"> <li>1. A Suicide Liaison Service is in place to provide support to those who are exposed to suicide, alleviating the distress of those bereaved or affected by suicide and providing an effective community response to suicide clusters by April 2015</li> </ol>
<p><b>Objective D</b></p>	<p>A strong, integrated Suicide Reduction Network provides oversight and governance</p> <ol style="list-style-type: none"> <li>1. A Suicide Reduction Network is built, supported and evolving that is person-centred at all times and engages stakeholders across health, public, private and voluntary sectors</li> <li>2. A Suicide Reduction Action Plan is agreed that reflects the six key areas for action in the National Suicide Prevention Strategy</li> </ol>

## 8. Who is going to do it?

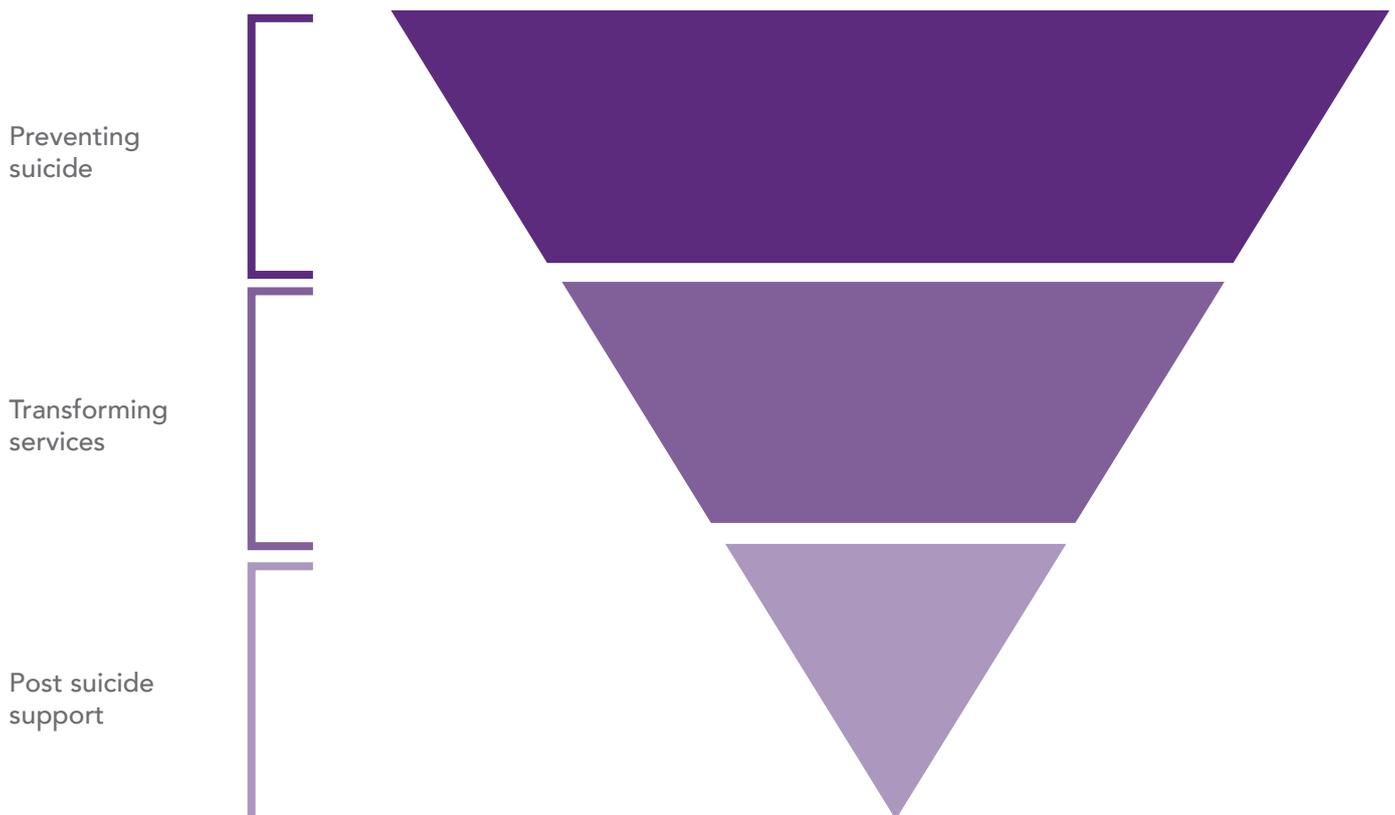
In 'Preventing Suicide: A global imperative' the World Health Organization call for a systematic response to suicide and making prevention a multisectoral priority involving not only health care but education, employment, social welfare, the judiciary and others.

The factors leading to someone taking their own life are often complex, however they are all amenable to change. The prevention of suicide has to address this complexity. No one organisation is able to directly influence all factors, it is vital that services, communities, individuals and society as a whole work together to help prevent suicides. Therefore, we have identified four arenas where actions need to occur:

Wider Community	e.g. community and voluntary sector organisations, sports clubs, educational establishments, faith groups, retail organisations, housing trusts, prisons and probation services, workplaces, employment support
Health & Wellbeing Boards	e.g. Local Authorities, Public Health, CCGs
Primary Care	e.g. GP Practices, Community Health Trusts, IAPT providers
Secondary Care	e.g. Mental Health Trusts, A&E Departments, CAMHs Teams, Hospitals, Ambulance Trusts

We also have identified three stages of action. The diagram and its orientation represent the priority and scale of the three stages within this strategy.

Three stages of action have been identified to deliver the four strategic objectives as a) Preventing suicide, b) Transforming services and c) Post suicide support. Figure 1 represents the priority and scale of the three stages utilised in the strategy.



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a) **Preventing Suicide** – Prevention is the largest stage incorporating actions and activities that build individual and community resilience, targeted at groups or populations that reduce the likelihood of an individual reaching the point of feeling suicidal or considering suicide as a solution to the difficulties they face.

The preventative stage links firmly with the promotion of mental wellbeing and the recognition that communities have their own strengths and assets to support people. The Cheshire and Merseyside Suicide Reduction Network (CMSRN) has grown out of the actions of local community organisations and champions, e.g.: State of Mind, Opening Up Cricket, CALM, SOBS, Papyrus, Samaritans . To achieve a Suicide Safe community requires such preventative actions to be scaled up.

The Cheshire and Merseyside Directors of Public Health recognise that childhood and adolescence are the formative years for good mental health and that 75% of mental health problems in adult life (excluding dementia) start by the age of 18. Consequently children and young people’s emotional wellbeing and mental health will be a priority for the Champs Public Health Collaborative 2015-2017. Preventing suicide in children and young people needs to address mental health problems and access to treatment, combined with improving peer attitudes and the material and physical circumstances of young people’s lives.

b) **Transforming services** - Direct efforts to stop an individual from attempting to take their own life intentionally. This activity includes implementing the Mental Health Care Crisis Concordat, Perfect Depression Care, Primary Care interventions and training of healthcare professionals.

Inspiration for the aim to be bold, ambitious and innovative arose out of a workshop with Dr Coffey in September 2014. Invited by the Cheshire and Merseyside Strategic Clinical Network for Mental Health and Mersey Care NHS Trust. Dr. Coffey’s innovative work on “Perfect Depression Care” has been widely cited as a model for eliminating suicide and transforming health care. The Perfect Depression Care model developed at the Henry Ford Medical Centre, Detroit, where suicides have been reduced to zero, from 80 per 100,000 to 22 per 100,000 in the first four years and then the subsequent years the rate per 100,000 has been zero. Dr Coffey’s work has inspired the primary and secondary care trusts to work innovatively and the CMSRN wants to maintain this momentum and the links to national aspirations for zero suicide.

c) **Post suicide support** - The provision of a suicide liaison service that provides crisis intervention, support and assistance for those affected by a suicide. Alleviating the distress of those bereaved or affected by suicide, reducing the risk of imitative suicidal behaviour and suicide clusters and promoting the healthy recovery of the affected community

## 9. Vulnerable groups and those most at risk

Some populations are at higher risk than others:

- middle-aged men
- people known to mental health services
- people with a history of self-harm
- people who have made previous suicide attempts
- people with frequent GP attendance, increasing attendance, and also non-attendance
- young people, especially those who are looked after
- people in contact with the criminal justice system
- veterans
- lesbian, gay, bisexual and transgender people
- Black British, Eastern Europeans and ethnic minority groups
- people living alone
- those who are unemployed or on long term sickness
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

Negative life events, experiences and poor health conditions are unequally distributed across the population and can all play a part in increasing the risk of suicide. These include: people with untreated depression, physical health problems, survivors of violence and abuse, those experiencing relationship problems, financial problems and misuse of alcohol and drugs .

Suicide is perhaps the cause of death most directly affected by psychological factors: personality and individual differences (e.g. hopelessness/optimism), cognitive factors (e.g. belongingness and burdensomeness), social factors (e.g. isolation) and negative life events (e.g. childhood adversities and trauma in adulthood).

Recent research highlights that about two fifths of the recent increase in suicides among men during the 2008-10 recession can be attributed to rising unemployment.



**Table 1: Action Plan – 1st April 2015 to 31st March 2017**

The following action plan outlines the key aims/objectives for focus 2015/2017 underpinning the 'No More' strategy

	Objective	Actions	Who For	By Whom	Timescales
A	The Cheshire Merseyside Region and all nine local authorities achieve Suicide Safer Community accreditation	<ol style="list-style-type: none"> <li>1. Establish a Suicide-Safer Community committee</li> <li>2. Establish the population size of your community</li> <li>3. Identify organisations representing your committee</li> <li>4. Create and agree an action plan or strategy with identified priorities</li> <li>5. Support and commission accessible suicide intervention services</li> <li>6. Support and commission accessible suicide bereavement support</li> <li>7. Support and commission promotion of mental health and wellness activities</li> <li>8. Support and commission proactive suicide prevention activities</li> <li>9. Establish a pool of formally trained gatekeepers</li> <li>10. Participate in World Suicide Prevention Day</li> </ol>	Vulnerable Groups and the wider community at risk of poor mental health & wellbeing	<p><b>Leads</b></p> <p>Local Authority Directors of Public Health for all nine local areas</p> <p>Local Health and Wellbeing Boards (HWBBs)</p> <p><b>Support</b></p> <p>Champs Public Health Collaborative</p> <p>Local Authority Mental Health Champions</p>	31 <sup>st</sup> March 2017

Objective		Actions	Who For	By Whom	Timescales
B	CM Health Care System transforms care to eliminate suicide for patients	<ol style="list-style-type: none"> <li>1. Effective suicide risk assessment, safety plans, treatment and workforce training across all Primary Care, Community Care and Secondary Care services</li> <li>2. All 3 secondary care Mental Health Trusts within the region to adopt the Henry Ford 'Perfect Depression Care' model</li> <li>3. Cheshire and Merseyside are signed up to the Mental Health Care Crisis Concordat with action plans that put patients and carers at the centre of decisions</li> <li>4. Reduce access to the means of suicide</li> </ol>	High Risk Groups	<p><b>Leads</b></p> <p>Cheshire &amp; Mersey Clinical Commissioning Groups (CCGs)</p> <p>NHS Mental Health Trusts: Mersey Care, Five Boroughs Partnership, Cheshire</p> <p>Wirral Partnership</p> <p>IAPT Providers</p> <p>CAMHS Providers</p> <p><b>Support</b></p> <p>CMSRN Operational Group</p>	<p>31<sup>st</sup> March 2016</p> <p>31<sup>st</sup> March 2017</p> <p>30<sup>th</sup> April 2015</p> <p>31<sup>st</sup> Oct 2016 to have implemented PHE National Guidance on hotspots</p>
C	Support is accessible for those who are exposed to suicide	<ol style="list-style-type: none"> <li>1. A Suicide Liaison Service is in place to provide support to those who are exposed to suicide, alleviating the distress of those bereaved or affected by suicide and providing an effective community response to suicide clusters</li> </ol>	Those bereaved or affected by suicide	<p><b>Leads</b></p> <p>Local Authority Directors of Public Health for all 9 local areas</p> <p><b>Support</b></p> <p>Champs Public Health Collaborative</p>	30 <sup>th</sup> April 2015

	Objective	Actions	Who For	By Whom	Timescales
D	A strong, integrated Suicide Reduction Network provides oversight and governance	<ol style="list-style-type: none"> <li>1. A Suicide Reduction Network is built, supported and evolving that is person-centred at all times and engages stakeholders across health, public, private and voluntary sectors.</li> <li>2. A Cheshire Merseyside Suicide Reduction Action Plan is agreed that reflects the National Suicide Prevention Strategy</li> <li>3. A joint standardised suicide audit process for Cheshire Merseyside is developed</li> <li>4. Support the media in delivering sensitive approaches to suicide and suicidal behaviour</li> </ol>	Stakeholders, partnerships, providers and key agencies engaged with the Cheshire Mersey SRN	<p><b>Leads</b></p> <p>Local Authority Directors of Public Health for all 9 local areas SRN Partnership Board</p> <p><b>Support</b></p> <p>Champs Public Health Collaborative SRN Operational Group</p>	<p>30<sup>th</sup> April 2015</p> <p>30<sup>th</sup> September 2015</p> <p>31<sup>st</sup> March 2016</p>

## 10. How will we know we have achieved it?

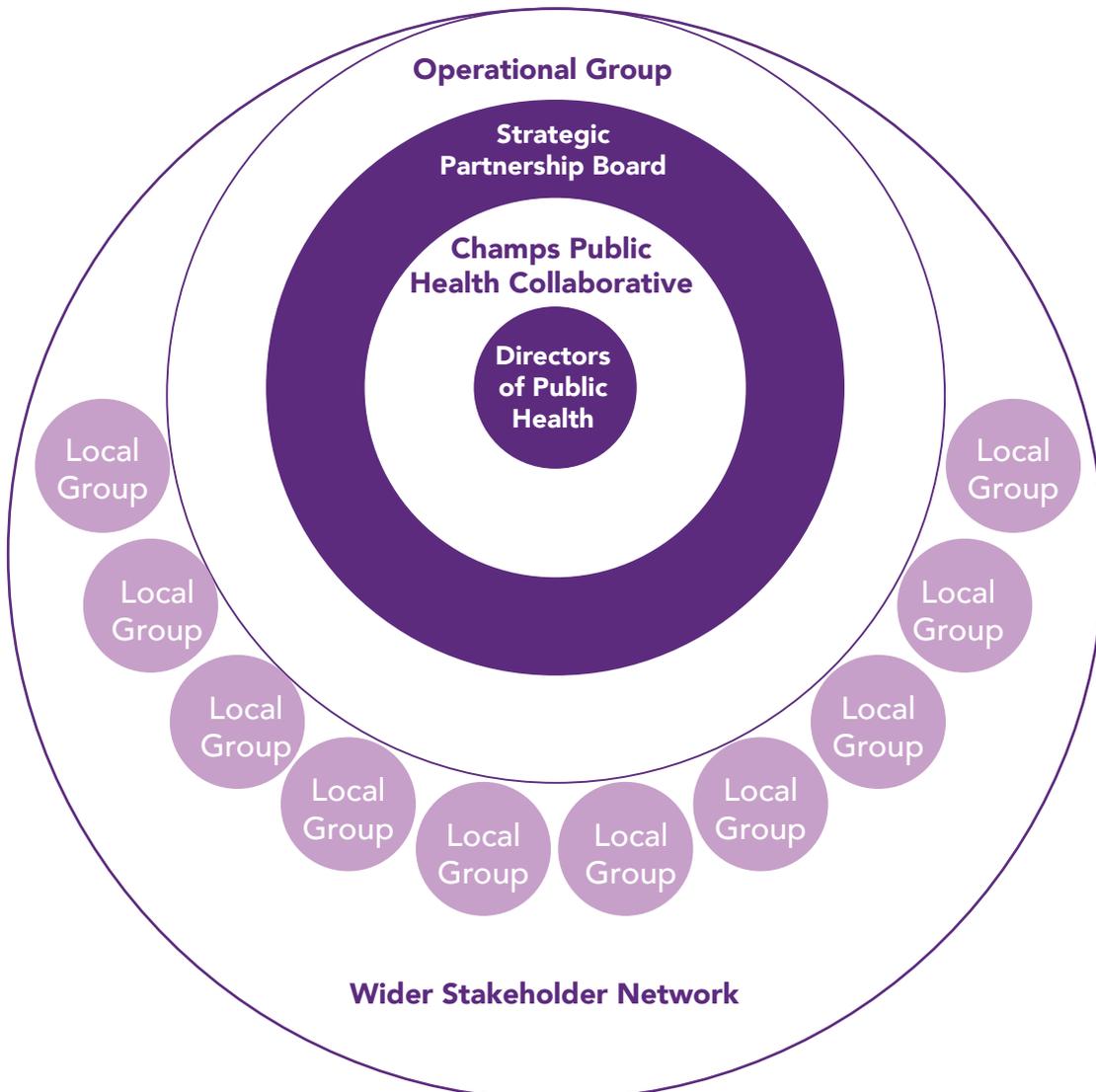
We will have achieved our overarching aim when we have reached zero suicides across Cheshire & Merseyside. In respect of the Suicide Reduction Action Plan, this should be regarded as a practical tool in achieving the overarching aims and will be periodically updated to reflect changing needs and demands. Nevertheless there are key milestones that we need to hit and these will be managed via the quarterly meetings of the Cheshire and Merseyside Suicide Reduction Network Operational Group and progress will be reported to the Strategic Partnership Board and the Cheshire and Merseyside Directors of Public Health. Local areas will be responsible for their own action plans and delivery. In 2015 a robust evaluation framework will be established to ensure progress and effectiveness.

## 11. Accountability and Governance

From April 2013 the co-ordination of suicide reduction became a local authority responsibility, with guidance provided by Health & Wellbeing Boards, as set out in the government's 2012 national strategy for suicide reduction "Preventing suicide in England - A cross-government outcomes strategy to save lives".

The Cheshire Merseyside Suicide Reduction Network (CMSRN) was formed in 2008 to seek greater co-ordination of responses to and understanding of patterns of suicide. The CMSRN consists of four components: a Partnership Board, an Operational Group, Local Suicide Prevention Groups, and a Stakeholder Network. The four components take an integrated approach to a strategic direction and the systematic implementation of action plans and robust provision of effective prevention, treatment and crisis services.

**Figure 2: Structure of the Cheshire Merseyside Suicide Reduction Network**



### References

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- <sup>2</sup> Lukas C. and Seiden H 2007 Silent Grief: Living in the wake of suicide. Jessica G Publishers, London UK,.
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- <sup>4</sup> DH 2015 Statistical update [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/405411/Statistical\\_update\\_on\\_suicide\\_acc.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/405411/Statistical_update_on_suicide_acc.pdf)
- <sup>5</sup> Knapp M. et al 2011 Mental Health Promotion and Prevention: The Economic Case. Department of Health
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- <sup>7</sup> Number of suicides registered in each calendar year, 2002-2013, by sex in England and Wales [www.ons.gov.uk/ons/about-ons/business-transparency/freedom-of-information/what-can-i-request/published-ad-hoc-data/health/december-2014/number-of-suicides-registered-between-2002-and-2013--by-sex-and-english-region.xls](http://www.ons.gov.uk/ons/about-ons/business-transparency/freedom-of-information/what-can-i-request/published-ad-hoc-data/health/december-2014/number-of-suicides-registered-between-2002-and-2013--by-sex-and-english-region.xls)
- <sup>8</sup> PHE Fingertips [www.fingertips.phe.org.uk](http://www.fingertips.phe.org.uk)
- <sup>9</sup> Cheshire and Merseyside Suicide Audit Joint Report 2014, November 2014, Cheshire and Merseyside Suicide Reduction Network, champs collaborative
- <sup>10</sup> Adult Psychiatric Morbidity in England 2007, [www.hscic.gov.uk/pubs/psychiatricmorbidity07](http://www.hscic.gov.uk/pubs/psychiatricmorbidity07)
- <sup>11</sup> WHO 2014 Preventing suicide A global imperative
- <sup>12</sup> DH 2015 Future in Mind <https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people>
- <sup>13</sup> Foster, Rayner, Allen 2012 Self Harm and Suicide Amongst Children and Young People, Literature Review. Univ Salford
- <sup>14</sup> DH 2012 Preventing suicide in England - A cross-government outcomes strategy to save lives [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/430720/Preventing-Suicide-.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf)