A Zero Suicide Redbridge

Redbridge Suicide Prevention Strategy
2018 – 2021
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Foreword

In Redbridge, 698 lives were lost to suicide between 2001 and 2016. A life lost is a significant loss to families, friends, the Redbridge community, and society as a whole.

Whilst suicide rates in England are reducing, we are seeing an increase in the number of people who take their own life in Redbridge. This increase calls for pragmatic solutions to identify and address the complexity of suicide risk factors in the Borough.

Over the next three years, we have set ourselves the ambition of significantly reducing the number of suicides in Redbridge. With our strategic and delivery partners, we will work to enable our residents to experience good mental health, support those who experience mental illness and support our workforce to be able to identify and respond to needs as early as possible.

We have taken a life course approach to ensure that we capture risk factors and those at greatest needs at key stages of life. Within the three key life course stages, Early Years, Children and Young People and Adults, we have identified the following focus:

1. Maximise early contact to improve mental health and resilience;
2. Improve mental health and resilience via quality education;
3. Provision of good quality services and Improve crisis response.

We would like to thank the Redbridge Suicide Prevention Strategy Group for developing the strategy and the on-going commitment to reducing the number of lives lost to suicides.

Cllr Mark Santos
Cabinet Member for Health, Social Care, Mental Health and the Ageing

Gladys Xavier RN FFPH
Director of Public Health and Commissioning
Introduction

In the UK, someone dies by suicide every 90 minutes. Thirteen people die by suicide every day in England. There is a significant loss to families, friends, communities and society as a whole when someone takes their own life.

Suicide is a serious but preventable public health problem with lasting harmful impact on individuals, families and communities. All deaths from intentional self-harm for persons aged 10 and over, and deaths where the intent was undetermined for those aged 15 and over is defined as suicide. In 2012, the Government published a national suicide prevention strategy for England, Preventing Suicide in England. A Cross Government Outcomes Strategy to save Lives. The national strategy presented two key ambitions:

1. a reduction in the suicide rate in the general population in England; and
2. better support for those bereaved or affected by suicide.

National strategic context

The ambition in the national suicide prevention strategy for a downward trend in suicides is to be realised by achieving 10 per cent reduction in suicides by 2020. To achieve this ambition, six key areas were identified for action as follows:

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; and
6. Support research, data collection and monitoring.

With the lead responsibility for suicide prevention following the transfer of public health from the NHS into local government, Redbridge Council established a multi-agency and multidisciplinary Suicide Prevention Strategy Group and published its first suicide prevention strategy in 2013.

Public Health England published guidance in 2014 to support Local Authorities in developing local suicide prevention action plans. The document provided guidance on working with key stakeholders, monitoring data, trends and hot spots, how to engage with local media, and how to work with transport to map hot spots. The guidance also provided advice on working on local priorities to improve mental health.

The 2016 NHS Five Year Forward View (FYFV) for Mental Health identified key ambitions with the aim of achieving parity of esteem between mental and physical health for children, young people, adults and older people.
Local strategic context

The 2013-2015 suicide prevention strategy identified the following objectives for Redbridge:

1. reduce the suicide rate in Redbridge population;
2. provide better support for those bereaved or affected by suicide;
3. support high risk groups and engage them to address risk factors;
4. work through the suicide prevention steering group to develop and agree evidence based initiatives reflecting the needs of the local population;
5. link with mental health promotion strategy to ensure joint delivery;
6. update knowledge of health workers on local picture and national strategy for suicide prevention;
7. engage with media personnel to agree on sensitive approaches to reporting suicide and suicidal behaviour.

The Health and Wellbeing Strategy for Redbridge 2017-21 identifies mental wellbeing as a priority in Redbridge. Within this priority, Redbridge seeks to support local residents to maintain good mental health and emotional wellbeing, and maximise their resilience to and recovery from adverse situations and events.

This strategy builds on existing work that seeks to prevent suicides in Redbridge. This strategy seeks to:

1. refresh the data on suicides in Redbridge. Regional, national and other comparators will be used as benchmarking to increase our understanding of the scale of the issue in Redbridge;

2. streamline the ambitions set out in the last Redbridge Suicide Prevention Strategy; and

3. strengthen partnerships to improve delivery of ambitions through a multi-agency suicide prevention action plan.
Suicide Prevention approach in Redbridge

A life course approach is being taken with suicide prevention in Redbridge to systematically identify risk factors and maximise health-enhancing opportunities. This will ensure that our residents are supported along various stages of their life to achieve good health and wellbeing and life experience during later life.

A life course approach recognises that wider cultural, economic, biological and psychosocial factors shape health and disease risk. Adopting this approach in health and social care provides an opportunity for effective planning and implementation of services.

An ageing population and population growth poses significant challenges to the way in which we plan and deliver services. It also presents a significant challenge to the cost of health and social care as increasing population means increasing pressures on health and social care services and budgets at a time where budgets are increasingly diminishing.

The World Health Organisation\(^1\) presents that a life-course approach provides an efficient and equitable response in addressing challenges in planning health and social care support. This life-course approach to suicide prevention will enable us to identify developmental stages, critical life periods and risk factors that allow us to:

1. support the mental wellbeing of our residents in order to promote resilience and prevent escalation of challenges and concerns;

2. work more effectively with those at the greatest risk of suicides to reduce risk factors;

3. work with key health and social care services and community organisations to support groups that experience the greatest suicide risk factors; and

4. develop and deliver effective support to those bereaved or affected by suicide.

A multi-agency Suicide Prevention Strategy Group was established in 2013 to provide leadership in assessing the needs of our residents and the development and implementation of an effective strategy and action plan to reduce the rate of suicides in the Borough.

The Suicide Prevention Strategy Group reflects the life-course and multi-agency and multi-disciplinary approach being taken to reduce the rate of suicide in Redbridge.

Membership of the Strategy Group includes partners across the following agencies:

- London Borough of Redbridge
  - Public Health
  - Social Care
  - Children’s Services
  - Housing
  - Education
- Redbridge Local Safeguarding Children Board (LSCB)
- Redbridge Safeguarding Adults Board (RSAB)
- Barking, Havering and Redbridge University Hospital Trust (BHRUT)
- NELFT
- Child and Adolescent Mental Health Service (CAMHS)
- Clinical Commissioning Group (CCG)
- British Transport Police (BTP)
- Metropolitan Police
- One Place East
- Coroner
- Network Rail

The work of the Suicide Prevention Strategy Group and wider partners are acknowledged in the production of this revised strategy and action plan.

**Redbridge collaborating with neighbours**

In addition to local plans, Redbridge is collaborating with neighbouring boroughs to maximise delivery for mental health outcomes across a bigger geographic area. The collaboration seeks to harness expertise and shared resources.

A joint Barking and Dagenham, Havering and Redbridge Suicide Prevention Strategy with a set of agreed actions is to be delivered across the three boroughs in partnership.
Suicide risk factors

There are many reasons why people take their own life. Risk factors of suicides are complex and can stem from psychological, economic, cultural, and social factors. We know that people in marginalised groups are at greatest risk of poor mental health and mental illness. These include people from black, Asian and minority ethnic groups (BAME), people who have had contact with the criminal justice system, lesbian, gay, bisexual and transgender people and people with disabilities.

We also know that following years of a downward trend, the rates of suicide is increasing in England and is the leading cause of death for men aged 15-49. Among those who died by suicide, a quarter had been in contact with a health professional, usually their GP, a week before their death. In the same way, over a quarter (28 per cent) of those who took their own life had been in contact with mental health services within 12 months before their death.

Key risk factors to suicidal behaviour are discussed below.

Gender

Around three out of four suicides in 2016 were males (ONS, 2017). Suicide rate for males is 15.7 per 100,000 and 4.8 per 100,000 for females. This represents a 3.1 per cent decrease for males from 2015 and 9.4 per cent in females. In 1981, almost two out of three (62.4 per cent) deaths by suicide were by males. The following years saw a decline in suicides and a steeper decrease among females. The percentage of males taking their own life has remained significantly higher than females and has remained around 75 per cent of suicides since the 1990s.

A recent report by the Samaritans suggests that men are more vulnerable to changes in economic climate than women. This vulnerability includes an increased risk of suicides among men compared to women. The report noted that suicides in England and Wales increased significantly during the recession in 2008-09. The increase was marked by males aged 35-44 years. An increase in suicide was also noted among men aged between 45-64 years of age. The report hypothesised that economic uncertainty may have been a factor in the increase in suicides among middle-aged men. A reduction in income was suggested as a significant factor as there was no significant change in suicide rate by socioeconomic status. The rational offered for this being that those who experience socioeconomic disadvantage may be less vulnerable to economic “shocks” as they “have fewer assets to lose” though changes in the social welfare system may heighten existing vulnerabilities.
Socioeconomic risk factors

Having stable employment and housing contributes to the experience of good mental health. Stable employment and housing are also important in enabling people to recover well from mental health issues.

Suicide affects those that are most vulnerable. The risk of suicides increases with socioeconomic disadvantage. According to the Government Response to the Health Select Committee’s Inquiry into Suicide Prevention, those living in the most disadvantaged communities and from the poorest backgrounds are more likely to attempt suicide or have suicidal ideation. The document highlighted that men living in areas of deprivation are 10 times more likely to take their own life than men living in more affluent areas.

Research commissioned by the Samaritans explored evidence and existing literature on socioeconomic disadvantage and the risk of suicides. The study explored the correlation between suicidal behaviour and socioeconomic deprivation. The study found that periods of economic instability and increases in unemployment increased the risk of suicides. For those whose economic circumstances do not improve following economic recessions remains at increased risk of suicidal behaviour. The report also identified that those living in deprived communities who experience job insecurity, unmanageable debt, and a loss of home, were at greatest risk of suicides.

Age

Suicide rates increase with age. The proportion of middle-aged men, 45-64 year olds, who took their own life increased significantly between 2007 and 2014. The suicide rate in 2016 was highest among 40-44 year olds (15.1 per 100,000). Among females, 50-54 year olds had the highest rate of suicide (8.1 per 100,000). The highest rate of suicide in males was among 40-44 year olds (23.7 per 100,000).

Suicide among young people

The suicide rate in children and young people in the UK is relatively low. A national study by the University of Manchester on suicide by children and young people in England reported an average of 428 deaths by suicide by people under the age of 25 years in a 10 year period between 2003 and 2013. The study examined suicides by people under the age of 20 years who died between January 2014 and April 2015. A significant proportion of young people who took their life were male representing 70 per cent of deaths by suicide in the study period. The study found that whilst suicides were lower in the under 20 age group, self-harm is more common in young people with the highest rates in females between the age of 15 to 19.

The study found that out of the deaths by suicides that occurred during the study period, over 1 in 4 of the young people had been bereaved. Of those who had been bereaved, 1 in 10 of those bereavements was via suicide of a friend or a family
member. Just under a third of the young people who had taken their own life were facing exams or expecting exam results at the time of their death; academic pressures was a risk factor in 29 per cent of suicides in this age group.

Adding to our understanding of suicides by young people, the study found that suicidal ideation was not expressed by many of the deaths suggesting that the lack of suicidal ideation does not indicate low risk of suicide.

**Stressful life events**

The risk of suicide is increased for people who experience life events that are stressful or perceived as stressful. There is an increased risk of suicidal behaviour among those with low social support, those who are socially excluded or isolated and experience feelings of shame and humiliation as a result of change of personal circumstances. These circumstances may include the loss of a job, debt and financial strain, family breakdown and conflict including divorce. Bereavement, mental health problems, high levels of crime, imprisonment and poor housing conditions are among factors that increases suicide thinking and behaviour.

**Mental state and wellbeing**

Individuals with pre-existing mental health problems may also be more likely to become unemployed, and are therefore also at greater risk of suicidal behaviour.

The Adult Psychiatric Morbidity Survey (APMS)\textsuperscript{ix} also known as The National Study of Health and Wellbeing is conducted every 7 years in England and seeks to inform and improve local and national planning for health and support services. The survey collects information on wellbeing, disability, physical health, pain, lifestyle behaviours, work and stress, life events and many others. In 2014, the APMS interviewed around 7,500 adults aged 16 and over seeking to identify the everyday stresses, strains and joys affect the health of people living in England.

Data from the most recent APMS reports the following findings:

- 5.4% of adults in England reported they have experienced suicidal thoughts in the past year and 0.7% said they had attempted suicide in the past year;
• 6.4% of adults in England reported they have ever self-harmed. This is highest in young women aged 16-24 (26%);

• around one in six adults (17 per cent) met the criteria for a common mental disorder (CMD) such as depression and anxiety. CMDs are often associated with physical and social problems and cause marked emotional distress and interfere with daily function;

• those who live alone had higher proportions of suicidal thoughts and attempts compared to people living with others;

• people who were unemployed were more likely to have suicidal thoughts and attempts compared to those in employment;

• two-thirds of Employment and Support Allowance (ESA) recipients had suicidal thoughts (66%) and nearly half (43%) had ever attempted to take their own life;

• women were more likely than men to have reported CMD symptoms;

• one in five women (19 per cent) had reported CMD symptoms;

• one in eight men (12 per cent) reported CMD symptoms;

• women were more likely than men to report severe symptoms of CMD (10 per cent of women surveyed reported severe symptoms compared to 6 per cent of men).

**Suicide risk factors in Redbridge**

In Redbridge, many related risk factors to suicide are relatively low:

• The percentage of people with depression recorded on GP register is significantly lower in Redbridge (4.9%) compared to England (9.1%);

• The percentage of people with severe mental illness in Redbridge (0.85%) is significantly lower compared with England (0.9%);

• Self-reported wellbeing in Redbridge is similar compared with England ie the percentage of people with a high anxiety score (22.2%, 2016/17) and the percentage of people with low happiness score (7.9%) is similar to the England and London average, 8.5% and 7.7%, respectively.

Risk factors among children and young people in 2015/16 are also significantly lower in Redbridge compared with England eg:

• Looked after children: 28.6 per 10,000 under 18 population compared with 60.3 per 10,000 population in England;

• Children leaving care: 18.6 per 10,000 under 18 population compared with 27.2 per 10,000 population in England
• Children in the youth justice system: 4.6 per 1,000 aged 10 – 18 compared with 5.6 per 1,000 population in England.

Whilst Redbridge enjoys relatively good mental health and wellbeing outcomes, some risk factors require attention. The rate of statutory homelessness among households in temporary accommodation in Redbridge in 2016/17 (21.1 per 1000 households) and eligible people not in priority need (1.8 per 1000 households) was significantly above the England average (3.3 per 1,000 households) and (0.8 per 1,000 households) respectively.

The table below shows a range of mental health indicators in Redbridge and how Redbridge compares with London and England.

Mental health and wellbeing indicators in Redbridge (2016/17)

<table>
<thead>
<tr>
<th>Mental Health and Wellbeing Indicators</th>
<th>Redbridge</th>
<th>England</th>
<th>London</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression recorded prevalence (QOF): % of practice register aged 18+</td>
<td>4.9</td>
<td>9.1</td>
<td>6.6</td>
</tr>
<tr>
<td>Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+</td>
<td>9.6</td>
<td>13.7</td>
<td>12.4</td>
</tr>
<tr>
<td>Depression and anxiety among social care users: % of social care users</td>
<td>47.1</td>
<td>54.2</td>
<td>54.5</td>
</tr>
<tr>
<td>Long-term mental health problems (GP Patient Survey): % of respondents aged 18+</td>
<td>2.9</td>
<td>5.7</td>
<td>4.3</td>
</tr>
<tr>
<td>New cases of psychosis: estimated incidence rate per 100,000 population aged 16-64 (2011)</td>
<td>33.2</td>
<td>24.2</td>
<td>40.6</td>
</tr>
<tr>
<td>Severe mental illness recorded prevalence (QOF): % of practice register all ages</td>
<td>0.85</td>
<td>0.92</td>
<td>1.10</td>
</tr>
<tr>
<td>ESA claimants for mental and behavioural disorders: rate per 1,000 working age population (2016)</td>
<td>15.3</td>
<td>27.5</td>
<td>23.0</td>
</tr>
</tbody>
</table>

Source: Public Health England
A study by The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) examined suicides among young people. The study also examined suicides (and homicide) by people who had been in contact with secondary and specialist mental health services in the previous 12 months (known as patient suicides). The 20 year review of the NCISH reported the following:

- Between 2004-2014, 28% of all suicides in the UK were by people under mental health care;

- There are around 3 times as many suicides by Crisis resolution/home treatment (CRHT) patients as in-patients.

The Inquiry identified changes in suicides among people who had been in contact with mental health services. Among patient suicides:

- Over half of the patients who died by suicide had a history of substance use;

- Economic adversity (unemployment, homelessness and financial difficulties) were of concern with 13% experiencing financial difficulties in the previous 3 months;

- Isolation – 5% of patient suicides were among people living alone in the UK for less than 5 years.

Findings of the study are helpful in understanding the antecedents of suicide among children and young people. Critical to our understanding is the high rate of children and young people who took their own life or self-harmed but were not in contact with mental health services. Effective delivery of services for people with mental health conditions is crucial to preventing mental distress and suicides. Based on the findings of the study and review of data such as the APMS, the coordination and delivery of early intervention is paramount in addressing risk factors in children and young people. Addressing the multiplicity of risk factors is critical in preventing some mental illnesses and preventing suicides among adults who may experience adverse stressful life events.

An effective multi-agency and multi-disciplinary partnership is therefore required to assess risk factors in order to develop and implement an effective suicide prevention strategy and action plan.
Suicide data

In 2016, 5,668 deaths by suicide were registered in the UK. A statistically significant fall in the rate of suicide was noted from 10.1 per 100,000 people in 2015 to 9.5 per 100,000 in 2016. The Office for National Statistics (ONS) reported 202 fewer deaths by suicide in England in 2016 than in 2015. This represents a 3.4 per cent decrease in suicides from 2015. This is the third consecutive year that the rate of suicide has fallen in the UK.

Suicides among males have continued to decrease in recent years and so has suicides by females. The highest rate of suicide by males was recorded in 1988 and the lowest in 2007 – 20.8 per 100,000 population and 13.9 per 100,000 population respectively. Suicides among females has continued to improve from the 1980s with a rate of 4.5 per 100,000 population in 2016.

Redbridge Suicide Profile

Between 2001 to 2016, there were 698 suicides in Redbridge. Data shows that the numbers of suicides in Redbridge had begun to decline over the years. However, in recent years, the number of people who die by suicide has started to increase.

Suicide trajectory: 2001 - 2016

Table 1 shows trends in suicides since 2001 and includes the most recently published data (November 2017). The table shows periods where suicides in Redbridge have been significantly lower than the England average – indicated by a blue dot. Recent data shows that the rate of suicides in Redbridge is similar to that of England and London region – indicated by a yellow dot.

The lowest rates of suicides was seen between 2005-07 with 37 suicides and 2006-2008 with 39 suicides. The highest number of suicides during this period occurred more recently between 2014-2016 with a count of 60 deaths.
Table 1: Trends in suicide in Redbridge

<table>
<thead>
<tr>
<th>Period</th>
<th>Count</th>
<th>Value</th>
<th>Lower CI</th>
<th>Upper CI</th>
<th>London</th>
<th>England</th>
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<tbody>
<tr>
<td>2001 - 03</td>
<td>49</td>
<td>7.7</td>
<td>5.6</td>
<td>10.2</td>
<td>10.1</td>
<td>10.3</td>
</tr>
<tr>
<td>2002 - 04</td>
<td>55</td>
<td>8.8</td>
<td>6.5</td>
<td>11.5</td>
<td>10.0</td>
<td>10.2</td>
</tr>
<tr>
<td>2003 - 05</td>
<td>55</td>
<td>8.4</td>
<td>6.2</td>
<td>11.0</td>
<td>10.0</td>
<td>10.1</td>
</tr>
<tr>
<td>2004 - 06</td>
<td>44</td>
<td>6.8</td>
<td>4.9</td>
<td>9.2</td>
<td>9.7</td>
<td>9.8</td>
</tr>
<tr>
<td>2005 - 07</td>
<td>37</td>
<td>5.4</td>
<td>3.8</td>
<td>7.5</td>
<td>9.2</td>
<td>9.4</td>
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<td>2006 - 08</td>
<td>39</td>
<td>5.8</td>
<td>4.1</td>
<td>8.0</td>
<td>8.8</td>
<td>9.2</td>
</tr>
<tr>
<td>2007 - 09</td>
<td>45</td>
<td>6.6</td>
<td>4.8</td>
<td>8.9</td>
<td>8.5</td>
<td>9.3</td>
</tr>
<tr>
<td>2008 - 10</td>
<td>55</td>
<td>7.9</td>
<td>5.9</td>
<td>10.4</td>
<td>8.5</td>
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<td>2009 - 11</td>
<td>57</td>
<td>8.2</td>
<td>6.1</td>
<td>10.7</td>
<td>8.4</td>
<td>9.5</td>
</tr>
<tr>
<td>2010 - 12</td>
<td>53</td>
<td>7.4</td>
<td>5.5</td>
<td>9.7</td>
<td>8.4</td>
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<td>2011 - 13</td>
<td>47</td>
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<td>2012 - 14</td>
<td>44</td>
<td>6.6</td>
<td>4.7</td>
<td>9.0</td>
<td>7.8</td>
<td>10.0</td>
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<tr>
<td>2013 - 15</td>
<td>58</td>
<td>8.9</td>
<td>6.7</td>
<td>11.6</td>
<td>8.6</td>
<td>10.1</td>
</tr>
<tr>
<td>2014 - 16</td>
<td>60</td>
<td>9.1</td>
<td>6.8</td>
<td>11.8</td>
<td>8.7</td>
<td>9.9</td>
</tr>
</tbody>
</table>

Source: Public Health England (based on ONS source data)

Graph 1 illustrates changes in the rate of suicides between 2001 and 2016. The line graph shows a steep decline in suicides from 2002-04 to 2005-07 and then a gradual increase from 2006-08 to 2008. The rate of suicides is showing an upward trend in recent years from 2013-15. The rate of suicide in Redbridge has seen sharper fluctuations compared to London and England where there has been steadier changes.
Graph 1: Trends in suicide in Redbridge

![Graph 1](image1)

Source: Public Health England (based on ONS source data)

Gender differences in suicide in Redbridge

Based on ONS data, the last few years has seen an increase in the rate of suicide in men in Redbridge. The number of suicides among males in Redbridge is significantly higher than among females as can be seen in Graph 2. Effective interventions targeted at men are critical to tackle this significant inequality in mortality.

Graph 2: Trend – Male and Female suicide in Redbridge

![Graph 2](image2)

Source: Public Health England (based on ONS source data)
Table 2 and Table 3 shows the number of suicides among males and females in Redbridge between 2001 and 2016.

Table 2: Suicide rate males

<table>
<thead>
<tr>
<th>Period</th>
<th>Count</th>
<th>Value</th>
<th>Lower CI</th>
<th>Upper CI</th>
<th>London</th>
<th>England</th>
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<tbody>
<tr>
<td>2001 - 03</td>
<td>38</td>
<td>11.7</td>
<td>8.1</td>
<td>16.2</td>
<td>14.9</td>
<td>15.9</td>
</tr>
<tr>
<td>2002 - 04</td>
<td>42</td>
<td>13.3</td>
<td>9.4</td>
<td>18.1</td>
<td>14.8</td>
<td>15.6</td>
</tr>
<tr>
<td>2003 - 05</td>
<td>43</td>
<td>12.9</td>
<td>9.2</td>
<td>17.5</td>
<td>14.8</td>
<td>15.4</td>
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<tr>
<td>2004 - 06</td>
<td>38</td>
<td>12.0</td>
<td>8.3</td>
<td>16.6</td>
<td>14.7</td>
<td>15.1</td>
</tr>
<tr>
<td>2005 - 07</td>
<td>33</td>
<td>10.1</td>
<td>6.8</td>
<td>14.3</td>
<td>14.0</td>
<td>14.5</td>
</tr>
<tr>
<td>2006 - 08</td>
<td>34</td>
<td>10.5</td>
<td>7.1</td>
<td>14.9</td>
<td>13.5</td>
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<tr>
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Source: Public Health England (based on ONS source data)
Graph 3: Trend – Male suicide rate in Redbridge

Source: Public Health England (based on ONS source data)
### Table 3: Suicide rate females

<table>
<thead>
<tr>
<th>Period</th>
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<td>-</td>
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<td>2008 - 10</td>
<td>12</td>
<td>3.5</td>
<td>1.8</td>
<td>6.3</td>
<td>4.1</td>
<td>4.5</td>
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<td>2.3</td>
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<tr>
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<td>2.4</td>
<td>6.9</td>
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<td>1.9</td>
<td>6.3</td>
<td>4.1</td>
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</tr>
<tr>
<td>2012 - 14</td>
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<td>2.9</td>
<td>1.4</td>
<td>5.4</td>
<td>3.7</td>
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<td>-</td>
<td>-</td>
<td>4.1</td>
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<td>2014 - 16</td>
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<td>2.7</td>
<td>1.3</td>
<td>5.1</td>
<td>4.2</td>
<td>4.8</td>
</tr>
</tbody>
</table>

*Source: Public Health England (based on ONS source data)*
Graph 4: Trend – Female suicide rate in Redbridge

 Whilst the rate of suicides among females follow a similar national trend of being significantly lower than males. Rates of suicide among females have remained similar compared to the national average. There have not been noted periods where this rate has been lower than the England average. This perhaps suggests that some work is required to prompt a decrease in suicides among females in Redbridge.
Age differences in suicide in Redbridge

Table 4 shows the number of deaths due to intentional self-harm and events of undetermined intent, by age group. The number of suicides among middle-aged adults in Redbridge, aged between 45-64 years, is higher compared to other age categories. Between 2006 until 2010-12, the trend was reverse where higher numbers of suicides were among 25-44 year olds.

Table 4: Number of deaths by age group

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
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<tr>
<td>15-24yrs</td>
<td>7</td>
<td>10</td>
<td>9</td>
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<td>25-44yrs</td>
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<td>25</td>
<td>21</td>
<td>19</td>
<td>17</td>
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<td>15</td>
</tr>
<tr>
<td>45-64yrs</td>
<td>11</td>
<td>11</td>
<td>13</td>
<td>13</td>
<td>15</td>
<td>19</td>
<td>21</td>
<td>23</td>
<td>22</td>
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<td>8</td>
<td>12</td>
<td>13</td>
<td>15</td>
<td>14</td>
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</tbody>
</table>

Source: Primary Care Mortality Data Extracts

Public Health England (PHE) Mental Health and Wellbeing indicators for Children and Young People shows an estimated 150.7 per 100,000 of 10-24 year olds in Redbridge has been admitted to hospital admission as a result of self-harm. Attention should therefore be given to developing strategies and implementing services and programmes that address the mental health needs of children and young people in Redbridge.

Number of suicides by occupation type

Table 5 shows that the number of suicides in Redbridge is higher among those in higher managerial, administrative and professional occupations. This trend is further illustrated by Graph 5.

The national trend reported by the ONS in March 2017 identified that individuals in higher paid occupation groups had the lowest risk of suicides. This national trend is not replicated in Redbridge where the trend is reversed. The number of deaths by suicide by those in higher managerial occupational groups, higher paid occupation, is higher compared to those in semi-routine and routine occupations.
### Table 5: Number of suicides by occupation type

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher managerial, administrative and professional</td>
<td>30</td>
<td>40</td>
<td>37</td>
<td>33</td>
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<td>37</td>
<td>40</td>
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<td>35</td>
<td></td>
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<tr>
<td>Intermediate occupations</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small employers and own account workers</td>
<td>8</td>
<td>10</td>
<td>15</td>
<td>19</td>
<td>21</td>
<td>19</td>
<td>17</td>
<td>18</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Semi-routine and routine occupations</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>51</td>
<td>52</td>
<td>52</td>
<td>49</td>
<td>56</td>
<td>57</td>
<td>55</td>
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<td></td>
</tr>
</tbody>
</table>

Source: Primary Care Mortality Data Extracts

### Graph 5: Trend – Number of suicides by occupation type

![Graph showing the trend in number of suicides by occupation type](source)

Source: Primary Care Mortality Data Extracts
Suicide rate across Outer North East London (ONEL)

The rate of suicide in Redbridge has increased in recent years. Redbridge had lower rates of suicide in previous years compared to other boroughs in ONEL. However, Redbridge currently has a higher rate of suicide compared to its neighbours. The higher rate in Redbridge is not statistically significant.

Table 6 shows the rate of suicides in Redbridge compared with Barking and Dagenham and Havering and also with London and England.

Table 6: Rate of suicides across ONEL (2014-16), rate per 100,000

<table>
<thead>
<tr>
<th>Area</th>
<th>Rate</th>
<th>LCI</th>
<th>UCI</th>
</tr>
</thead>
<tbody>
<tr>
<td>B&amp;D</td>
<td>6.9</td>
<td>4.7</td>
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</tr>
<tr>
<td>Havering</td>
<td>8.1</td>
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<td>10.7</td>
</tr>
<tr>
<td>Redbridge</td>
<td>9.1</td>
<td>6.8</td>
<td>11.8</td>
</tr>
<tr>
<td>London</td>
<td>8.7</td>
<td>8.2</td>
<td>9.1</td>
</tr>
<tr>
<td>England</td>
<td>9.9</td>
<td>9.8</td>
<td>10.1</td>
</tr>
</tbody>
</table>

Source: Public Health England (based on ONS source data)

Graph 6: Rate of suicides across ONEL (2014-16)

Source: Public Health England (based on ONS source data)
Redbridge suicide rate compared with statistical neighbours

The NHS RightCare mental health conditions pack identifies 10 local authorities that have similar characteristics to Redbridge. Comparing the rate of suicide in Redbridge against statistical neighbours provides a point of reference to assess whether rates in Redbridge is above or below what is expected.

Data on the rate of suicide in Redbridge and its statistical neighbours are presented in Table 7.

Table 7: Rate of suicides by statistical neighbours (2014-16), rate per 100,000

<table>
<thead>
<tr>
<th>Area</th>
<th>Rate</th>
<th>LCI</th>
<th>UCI</th>
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</thead>
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<td>Redbridge</td>
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<td>11.8</td>
</tr>
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<td>Hounslow</td>
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<td>12</td>
</tr>
<tr>
<td>Merton</td>
<td>9.0</td>
<td>6.5</td>
<td>12.2</td>
</tr>
<tr>
<td>Barnet</td>
<td>9.7</td>
<td>7.8</td>
<td>12.0</td>
</tr>
<tr>
<td>Harrow</td>
<td>8.2</td>
<td>6.1</td>
<td>10.7</td>
</tr>
<tr>
<td>Ealing</td>
<td>9.8</td>
<td>7.7</td>
<td>12.2</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>10.8</td>
<td>8.5</td>
<td>13.5</td>
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<tr>
<td>Croydon</td>
<td>8.0</td>
<td>6.4</td>
<td>10.0</td>
</tr>
<tr>
<td>Sutton</td>
<td>6.7</td>
<td>4.6</td>
<td>9.4</td>
</tr>
<tr>
<td>Enfield</td>
<td>6.1</td>
<td>4.5</td>
<td>8.1</td>
</tr>
<tr>
<td>Slough</td>
<td>9.6</td>
<td>6.7</td>
<td>13.4</td>
</tr>
<tr>
<td>London</td>
<td>8.7</td>
<td>8.2</td>
<td>9.1</td>
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<tr>
<td>England</td>
<td>9.9</td>
<td>9.8</td>
<td>10.1</td>
</tr>
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</table>

Source: Public Health England (based on ONS source data)

Graph 7 illustrates the rates of suicide shown in Table 7. The rate of suicide in Redbridge is similar to those of its statistical neighbours with the exception of Sutton and Enfield with seemingly lower rate. This difference is however not statistically significant.
Summary - inequalities in suicide

Trends for Redbridge show an increase in suicides in the last few years. The inequality observed in suicide surveillance supports the need for a targeted approach to preventing and reducing the rate of suicides in Redbridge.

Whilst the increase in suicides in Redbridge is similar compared to the national and regional average, every life lost is a significant loss to families, friends, the wider Redbridge community and to society. The number of males who take their own life is significantly higher compared to females - this follows the national and regional trend and is therefore not unique to Redbridge. Similarly, the national trend of higher suicide among 45-64 year olds is also observed in Redbridge.

An effective action plan that identifies and addresses risk factors, supports those at increased risk of suicides and delivers much needed support to those bereaved or affected by suicide is essential to realising the ambitions of the Redbridge Suicide Prevention Strategy of a downward trend in suicides. This ambition is in line with the mental wellbeing ambition of the Redbridge Health and Wellbeing Strategy where “local people are supported to maintain good mental health and emotional wellbeing, and maximise their resilience to and recovery from adverse situations and events”.

Graph 7: Rate of suicides by statistical neighbours (2014-16), rate per 100,000

Source: Public Health England (based on ONS source data)
Current suicide prevention landscape in Redbridge

In the autumn of 2016, a partnership between three Outer North East London (ONEL) Boroughs, Barking and Dagenham, Havering and Redbridge Public Health, was established to explore areas in suicide prevention where collaboration would enhance local plans given that the three boroughs share the same acute mental health provider.

A suicide prevention self-assessment checklist was created in partnership to enable each borough to assess its delivery of objectives of the national suicide prevention strategy published in 2012.

Suicide prevention self-assessment

The suicide prevention self-assessment checklist contains prompts and enquiries about service delivery in line with the six areas for action aimed at supporting the delivery of the ambitions of the national suicide prevention strategy:

1. Reducing the risk of suicide in key high-risk groups;
2. Tailoring approaches to improve mental health in specific groups;
3. Reducing access to the means of suicide;
4. Providing better information and support to those bereaved or affected by suicide;
5. Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour;

The suicide prevention checklist can be found in Appendix 1.

The process of the self-assessment facilitated closer working relationship with partners and stakeholders and enabled identification of areas of good practice and uncovered assets and opportunities in Redbridge to maximise support to residents in improving mental wellbeing and in preventing people from getting to a stage where they may take their own lives. The self-assessment checklist was completed by the CCG and Redbridge Council’s Children and Families Service including the Youth Offending & Targeted Prevention Service (YOTPS) and the commissioned Care Leaving Service through Barnardo’s.
Summary of findings

Taking a life course approach, findings from the self-assessment is presented for adults and children and young people separately. This approach is taken for easier identification of progress and gaps in the two key stages of life.

1. Reducing the risk of suicides in high risk groups

The ambition of the national strategy to reduce the rate of suicide in the general population was to be delivered by a focus on groups where numbers of suicides are higher and also where such groups have been known to statistically have an increased risk of suicides compared to the general population.

The self-assessment checklist examined targeted strategies and effective services in place in Redbridge to support adults, and children and young people.

Adults

1. Awareness raising and training sessions have been offered to faith and community leaders to recognise mental health problems in people who may be seeking their support and advice;

2. There is a greater emphasis on considering physical health issues for people with mental health problems, and potential co-morbid mental health problems for people with physical health problems;

3. A 24-hour crisis response service is available, and a programme of work is in place to integrate crisis pathways, mainstreaming 24/7 telephone access and Police Street triage;

4. With low bed base, there is a dependence on robust community services such as Home Treatment Team (HTT). Recent pressures have led to out of area placements (first time in approximately five years). Recent CQC report has identified some issues and these are being addressed through provider action plan;

5. All assessments that have been undertaken by Psychiatric Liaison in Emergency Departments in King George’s Hospital and Queen’s Hospital, have a letter sent to GP within 24 hours;

6. CCGs have a dedicated clinical lead for mental health covering all three BHR CCG areas enabling a more focussed approach to engaging and supporting GPs in dealing with MH issues. This would include improving communication with specialist services and addressing primary/secondary interface issues.
Children and young people

1. Additional investment has been made to improve crisis response for 2017/18;

2. Children and Young People are supported on an individual need basis if they display mental health issues and are referred to CAMHS as necessary;

3. Practitioners within the Children and Families Service are trained to support emotional wellbeing of children and young people but do not have particular specialisms in relation to mental health conditions or suicide;

4. Children and Families Service Practitioners are knowledgeable in relation to referral route to CAMHS but have not been provided with early help pathway as wellbeing hub has not yet been launched;

5. Training is available via the LSCB Training Programme on working with families with parental mental health concerns;

6. Children and Families Service practitioners work holistically when assessing and care planning - the assessment framework includes emotional wellbeing;

7. A CAMHS worker (part time) based in Looked After Children (LAC) Service provides direct support;

8. LAC can receive support direct from the CAMHS worker based in the Service;

9. Referrals can be made by Children and Families Service to CAMHs but there is not usually a 24 hour response. The Emergency Duty Team (EDT) will refer to Accident and Emergency in a crisis if necessary;

10. Children and young people with a Child Protection (CP) Plan or a Child in Need (CiN) Plan are referred to CAMHS if required;

11. Suicide is considered in risk assessments, however, early intervention services for those at increased risk are not in place.
2. Tailor approaches to improve mental health in specific groups

Work with adults

Specific groups considered:
- Adults with long-term conditions;
- low socio-economic status;
- BME communities;
- Veterans;
- Substance misuse.

1. IAPT, talking therapies for people with mild to moderate mental health problems, is focussing on people with long term physical health conditions with co-morbid mental health problems;

2. Access targets for this group are increasing during 2017/18;

3. People who are especially vulnerable due to social and economic circumstances - public awareness raising campaign has been undertaken during 2016/17;

4. CCGs monitor take up of mental health services from people from minority communities. A dedicated service has been commissioned from RedbridgeCVS to raise awareness of mental health issues within minority communities;

5. Providers are contractually obliged under the armed forces covenant to ensure that veterans are not disadvantaged in accessing services;

6. Substance misuse: included in support provided by R3 for adults. R3 are present in King George’s Hospital Emergency Department 3 days per week.

Work with children and young people

Specific groups considered:
- Schools;
- Looked after children;
- Care leavers;
- Substance misuse.
- Asylum seekers

1. There are CYP mental health transformation plans in place which will improve services to a greater number of young people, and addressing the issues identified through the development of Wellbeing Hubs;

2. Work is undertaken in some schools through PHSE lessons and activities relating to resilience, bullying etc. but this is not consistent;

3. Mental health is assessed during Care Planning and reviewing;
a. A CAMHS worker is based in the Service part time to provide direct support;
b. Mental health is included in Health Check when a child or young person becomes looked after, and again at six months and then annually;
c. Mental health is assessed within the Strengths and Difficulties Questionnaire (SDQ);

4. Care Leaving Service delivered in Redbridge by Barnardo's:
   a. A CAMHS nurse is part of the team (part time);
   b. Nurse is supported by a volunteer counsellor and Team Manager who is a qualified mental health professional;
   c. Service includes advocacy for young people to get into adult services working with PAs and young people;

5. Need assessed on an individual basis as part of the Children and Families Assessment or the Common Assessment Framework (CAF). Specialist referrals made as appropriate for therapeutic services to CAMHS, Safer London etc.;

6. Practitioners in social care know referral pathways;

7. Information to specialist support around suicide is available on FiND/MARCo;

8. Information is provided at multi-agency training courses within the LSCB Training Programme;

9. Substance misuse - Included in support provided by FUSION for children and young people (part of NELFT);

10. Some awareness of increased risk with asylum seekers. Large numbers of young asylum seekers mean resources are stretched.

3. Reduce access to the means of suicide

There are various work currently being undertaken in the rail industry to prevent loss of life involving vulnerable persons. Network Rail is developing a suicide prevention action plan to monitor data, trends and hot spots. The intelligence is used to drive location specific action plans. Network Rail works closely with industry partners to improve mitigations at identified hot spots by reducing access to means.

Additionally, in partnership with the Samaritans, training is delivered for staff likely to be working in Hotspot/At Risk areas. Designated staff, Land Sheriffs, are trained to support vulnerable individuals across the rail network and deliver preventative interventions.
4. **Provide better information and support to those bereaved or affected by suicide**

Children and young people
1. Information and support where required is provided to parents/carers through the Child Death Overview Panel (CDOP)/LSCB;

2. Signposting to services including Survivors of Bereavement by Suicide (SOBs), Papyrus (Prevention of Young Suicide), Young Minds and Samaritans on Families Information Direct (FiND)/Multi-Agency Resource Centre on-line (MARCo);

3. Information is displayed on posters in GP surgeries, schools etc.

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

Membership of the Suicide Prevention Strategy Group includes a communication and media representative from the Local Authority who will advise and share information with media outlets where necessary.

6. **Local intelligence**

1. Public health intelligence function provides updates on suicide audit based on annual release of mortality data;

2. Bi-monthly meeting with the Coroner facilitates timely sharing of suspected suicides and enables identification of trends in order to respond to emerging needs and trends;

3. Information and statistics are used to produce CDOP Report and are used in the Annual Public Health Report.
## Action Plan

The table below shows the over-arching action plan to be delivered over the lifespan of the Suicide Prevention Strategy.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Key actions</th>
<th>Lead Partner</th>
</tr>
</thead>
</table>
| Reducing the risk of suicides in high risk groups | 1. Training of frontline agencies and staff to improve identification of risk factors and those at greatest risk. Training to be prioritised for key agencies working with the following priority groups:  
   a. Residents who misuse drugs or alcohol;  
   b. Residents in the care of mental health services, including inpatients;  
   c. Residents in contact with the criminal justice system;  
   d. Lesbian, gay, bisexual and transgender residents;  
   e. Residents with a history of self-harm.  
   2. Provision of high-quality mental health services;  
   3. Improve crisis pathway and response | Public Health Education  
NELFT  
Redbridge CCG |
| Tailor approaches to improve mental health in specific groups | 1. Expand the scope of the Suicide Prevention Strategy Group to provide strategic oversight for public mental health;  
2. Improve mental health education as part of Personal, Social, Health and Economic (PSHE) education and other School-based approaches;  
3. Training for Primary Care to improve identification of risk factors and those at greatest risk;  
4. Service audits – ascertain demographics of current access of mental health services across the borough; | Public Health Education/Children Services  
CAMHS  
Redbridge CCG  
NELFT |
5. Maximise local, regional and national mental health programmes;

6. Improve and increase access to talking therapies for people at greatest risk. Improvements to take account of access by the following key resident groups:
   a. Residents from BME communities;
   b. People living with long-term physical health conditions;
   c. Young Carers.

| Reduce access to the means of suicide | 1. Environmental assessments to reduce or remove access to means in inpatient settings; | NELFT  
Redbridge CCG  
Network Rail  
British Transport Police  
Public Health  
Planning and Regeneration |
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<tbody>
<tr>
<td></td>
<td>2. Primary Care – medicines management;</td>
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<td>3. Hotspots - On-going work to review hotspots including reducing the number of people using the rail network to take their own life.</td>
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| Provide better information and support to those bereaved or affected by suicide | 1. Delivery of effective and timely support for those bereaved or affected by suicide; | Samaritans  
Redbridge CCG  
NELFT  
Coroner |
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<td>2. Mental Health Asset Mapping;</td>
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<td>3. Produce mental health and crisis directory.</td>
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</table>
| Support the media in delivering sensitive approaches to suicide and suicidal behaviour | Media training and engagement to promote responsible reporting of suicides | Communications
Local Media Outlets
Samaritans |
|---------------------------------------------|-----------------------------------------------------------------|------------------------|
| Local intelligence                          | 1. Maximise local service data for identifying risk factors and groups at greatest risk;  
2. Maximise data sharing meetings with Coroner to understand emerging trends to support preventative work and service planning;  
3. On-going surveillance of suicides to support service planning and delivery. | Coroner
Public Health |
**Priorities across the life course**

Taking a life course approach to planning and implementation of actions, the table below provides an overview of key priorities to be taken over the next three years arranged according to three key life course stages:

1. Early Years;
2. Children and Young People;
3. Adults

Within each life course stage, priority groups are identified.

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Early Years</th>
<th>Children and Young People</th>
<th>Adults</th>
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<tr>
<td>2018/19</td>
<td>1. Develop perinatal mental health workplan to identify pregnant women at greatest risk; 2. Implement work plan of the Perinatal Mental Health Practitioner.</td>
<td>1. Promote wellbeing: a. Mental health curriculum in primary and secondary schools; b. Mental health education in out-of-school settings including children and young people who are not in education, employment or training. 2. Improve access to early intervention and crisis response</td>
<td>1. Provision of high-quality mental health services: 1. Clarify, and where currently unavailable, establish crisis pathway. Particular attention to be paid to the following groups of residents: a. People with pre-existing conditions including frequent callers and attenders at A&amp;E; b. People with substance misuse issues</td>
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<tr>
<td>Year 2</td>
<td>Training – frontline and parents</td>
<td>Provision of high quality mental health service including on-going implementation of the CAMHS Transformation Plan.</td>
<td>Training: Up skill the workforce to facilitate early identification and early intervention. Priority workforce to be trained: frontline and primary care</td>
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<td>2019/20</td>
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<td>Year 3</td>
<td>Review of perinatal mental health support</td>
<td>Promote wellbeing – implement training for secondary schools and other settings including Pupil Referral Units and Youth Offending.</td>
<td>Training: supporting the workforce to improve their own mental health and resilience</td>
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<td>2020/21</td>
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**Monitoring Progress**

The Redbridge Suicide Prevention Strategy is accountable to the Health and Wellbeing Board. The strategy and action plan will be reviewed annually by the Redbridge Suicide Prevention Strategy Group.

Various dashboards and indicators will enable us to monitor and evaluate the impact of the strategy and action plan in improving mental health outcomes and reducing the number of suicides in Redbridge. These include Public Health Outcomes Framework, the NHS Outcomes Framework, and other relevant health and social care indicators.
References


ii Mental Health Taskforce Strategy. The Five Year Forward View For Mental Health. A report from the independent Mental Health Taskforce to the NHS in England February 2016.

iii Statistical bulletin: Suicides in Great Britain: 2016 registrations.


vii Office for National Statistic. 7 September 2017. Suicides in Great Britain: 2016 registrations. Registered deaths in GB from suicide analysed by sex, age, area of usual residence of the deceased and suicide method.


