The London Borough of Hammersmith and Fulham

Suicide Prevention Needs Assessment 2021-2024

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Abbreviations

APMS	Adult Psychiatric Morbidity Survey
BTP	British Transport Police
CALM	Campaign Against Living Miserably
CAMHS	Child and Adolescent Mental Health Services
CYP	Children and Young People
HBSC	Health Behaviour in School-Aged Children
IMD	Index of Multiple Deprivation
LBHF	London Borough of Hammersmith and Fulham
NCMD	National Child Mortality Database
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
PHE	Public Health England
RMI	Rethink Mental Illness
WHO	World Health Organisation

Executive Summary

Executive summary: Suicide Prevention Needs Assessment

Suicide is a complicated topic, and any prevention plan has to reflect that complexity. The Samaritans' media guide helpfully advises that 'most of the time there is no single event or factor that leads someone to take their own life'.[1] With that in mind, approaching a suicide prevention strategy is most helpfully done by carefully examining local data, and listening to key agencies and people to gain a better understanding of the needs of the borough. This document describes relevant national policies, shows us local data, and reflects on what works internationally, and nationally and in London. This needs assessment will then provide the foundation for recommendations and a suicide prevention action plan.

Epidemiological description

Between 2001 and 2020, there were 339 deaths by suicide and injury of undetermined intent in residents of Hammersmith and Fulham. This means that there has been an average of 17 deaths by suicide every year in LBHF.

The most recent LBHF rate of suicide was 10.4 per 100,000 population (for 2018-20). This is higher than the London suicide rate of 8 per 100,000 population but similar to the England rate of 10.4 per 100,000 population

The image below from the Public Health Outcomes Framework shows that Hammersmith and Fulham has the fifth highest suicide rate in London (2018-20 PHOF)

Area	Recent Trend	Count	Value
England	-	15,249	10.4
London region	-	1,820	8.0
Camden	-	76	12.7
Hounslow	-	76	11.1
Sutton	-	57	11.0
Ealing	-	91	10.6
Hammersmith and Fulham	-	56	10.4

Data from the coroner's office on suicide

We were able to look at 58 coroner's inquests between 2015 to 2020, which were concluded as death by suicide, and involving LBHF residents. This enables us to build a more detailed picture of risk factors in the borough. Similar to national patterns, almost three quarters (72%) of the 58 suicides were in men. For men, the rate was highest in those aged 50 to 59 years, and for women, the rate was highest in those in

[1] Media_Guidelines_FINAL.pdf last accessed 12.11.21

the slightly older age group of 60 to 69 year-olds. Of the 46 residents who did have information on their occupation, the highest number of residents (8/46; 17%) who died by suicide were from professional occupations – with the caveat that the numbers are very small to draw meaningful conclusions.

It is slightly more helpful to look at the relationship in Hammersmith and Fulham between **deprivation** and suicide risk, with the highest proportion 44% (21/48) of suicides occurring in the second and third most deprived deciles.

It is important to note that of the 58 completed suicide we were able to review in detail, two thirds (66%, 38/58) were known to either drug and alcohol or mental health services, delineating a clear risk in this client group, but also a potential for positive interventions by services.

Risk factors for suicide

There are certain known **factors** which may **increase** an individual's **risk of suicide.** In LBHF:

- **7%** of the adult population in Hammersmith and Fulham has a **diagnosis of depression.** This is **lower** than the **London** and **England** depression diagnoses levels.
- **1,386** residents were in treatment at **drug or alcohol** misuse services. The rate of adults in treatment is **higher** in LBHF than the London and England averages.
- **74%** of carers reported that they experienced **social isolation**. This is a **higher** proportion than in London and England.
- Over the past two years, LBHF has had the **fourth highest crime rate** in London.
- **6%** of adults are **unemployed** this is higher than London and England.

Evidence review – what works for suicide prevention

A **literature review** of the best international and national evidence for suicide prevention found the following key positive preventative interventions:

- Restriction of lethal means
- School based awareness programs.
- Training for health practitioners in the community.
- Data sharing from sources such as coroners used to identify anyone who may be affected by a suicide or need bereavement support.

A deeper dive into prevention methods targeting men showed a **multi-dimensional** approach to be the most successful. Effective interventions included:

- Awareness campaigns which have utilised posters, leaflets and websites providing information on symptoms of depression and resources available.

- The use of ‘gatekeepers’ who are key members of the community which have face-face contact with individuals and are trained to recognise and refer those at risk of suicide to support services.
- Support services which are discrete and not overtly associated with mental health.
- Interventions that promote social interaction, peer-support and co-leadership in facilitating services.

Qualitative views from professional and voluntary groups

We conducted a few semi-structured interviews with key professionals, as well as voluntary organisations who work in the field of suicide prevention. A few key themes emerged from these interviews: which included concerns that there were gaps for people with co-existing substance misuse and mental health diagnosis (dual diagnosis), gaps in local counselling services, and that we need more training for agencies on suicide awareness. Lack of communication between agencies was also highlighted as a concern.

The Leader of the Council hosted a professionals and stakeholder brain storming session in October 2021, which yielded a number of helpful suggestions including closer work in substance misuse and mental health services, and training for members of the public, as well as support for frontline service staff who have experienced the suicide of a client.

1. Introduction

1.1 Purpose of this document

The document combines data from the coroner's office, NHS, and police services (Metropolitan Police and British Transport Police), to create a detailed and meaningful picture of people at greatest risk of suicide. We describe the national policy as it stands, as well as examples of best practice from other parts of the UK and internationally, on what works to reduce suicides and self-harm.

We also describe local services for suicide prevention and bereavement support, and then make recommendations for action for all partners.

1.2 Definitions

This Suicide Prevention Strategy is based on the Office for National Statistics definition of suicide; this includes all deaths from intentional self-harm for persons aged 10 years and over and deaths caused by injury or poisoning where the intent was underdetermined for those aged 15 years and over.[2]

The suicide statistics in this strategy are based on the calendar year on which the death has been registered, as opposed to the number of deaths that occurred in that calendar year. There is commonly a delay between the date on which a death by suicide occurred and the date it is registered due to the case being referred to the Coroner for an investigation. The time taken to carry out such an investigation can result in a delay in the death being registered.

[2] Suicide rates in the UK QMI | Office for National Statistics

2. Policy Context

2.1 National Policy Context

2.1.1 National Strategy

In England, in 2012 the Government published an integrated national strategy: ***Preventing Suicide in England: a cross-government outcomes strategy to save lives.***[3] The strategy brings together knowledge about high-risk groups, evidence-based interventions and highlights the resources that are available. Crucially, it explicitly acknowledges the importance of multi-agency working.

The strategy mandates local authorities the responsibility to lead local suicide prevention work in collaboration with local partners such as CCG, voluntary sector, and police. The strategy identifies two key objectives and six actionable areas which suicide prevention plans should reflect and work towards, in 2017 the scope was extended to include self-harm,[4] these are outlined in **Box 1**:

Box 1: Key Objectives and actions from the national suicide prevention strategy: Preventing Suicide in England: a cross-government outcomes strategy to save lives [3]

Key Objectives:

- Reduce the suicide rate in the general population of England
- Offer better support for those bereaved or those affected by suicide

Key areas for action:

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

2.1.2 Five Year Forward View for Mental Health

In 2016, the Mental Health Taskforce, an independent body, published a "***Five Year Forward View for Mental Health"*** for the NHS in England.[5] This was updated in 2017

[3] Department for Health. (2012). Preventing suicide in England: A cross-government outcomes strategy to save lives
[4] Department of Health. (2017). Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives.
[5] NHS Mental Health Taskforce. (2016). The five year forward view for mental health.

with the **"*Five Year Forward View for Mental Health: One Year On".*** [6] These reports set an objective to reduce suicide rate by 10% in England by 2020/21 compared to 2016/17 levels. The reports also made recommendations for local authorities to have multi-agency suicide plans in place by 2017, to set out targeted action in high risk locations and support high risk groups.

2.1.3 Evidence-based guidelines

In 2016, Public Health England (PHE) in partnership with the National Suicide Prevention Alliance published a guidance manual: ***"Local Suicide planning: A practice resource"***.[7] This manual was specifically developed to support local suicide prevention planning. The guidance makes three key recommendations for successful local implementation of the national strategy, these include the following:

- Establish a local multi-agency suicide prevention group
- Complete a local suicide audit
- Develop a local suicide prevention strategy and action plan which is based on the national strategy and local data.

Other relevant policy developments include the ***Public Health Outcomes Framework*** published by Public Health England in 2013,[8] this includes indicators on both self-harm and suicide.

The National Institute for Health and Care Excellence (NICE) have issued guidelines on self-harm [9,10] and preventing suicide in community and custodial settings [11]. These are evidence based clinical guidelines for professionals involved in the management of self-harm and those working in services where suicide is more likely respectively. In 2019 NICE published a Suicide Prevention Quality Standard.[12] It provides quality statements covering five key areas. This includes:

1. Multi-agency suicide prevention partnerships
2. Reducing access to methods of suicide
3. Collaboration with local media
4. Involvement of family, carers or friends of at-risk patients
5. Bereavement support

2.2 Regional Policy Context

In 2017, the Mayor of London launched **Thrive LDN**; an initiative to improve mental health and wellbeing. The key objectives of the project include reduction in the number of suicides and a commitment to 'zero suicide'. Thrive London is supported by the Mayor of London and led by the London Health Board in collaboration with the Greater London Authority, Healthy London Partnership, NHS England, and London Councils.

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[6] NHS England. (2017). Five Year Forward View for Mental Health: One Year on.
[7] PHE. (2016). Local Suicide Prevention Planning. A practice Resource.
[8] PHE. (2013). Public Health Outcomes Framework
[9] NICE. (2004). Self-harm in over 8s: short-term management and prevention of recurrence (CG16).
[10] NICE. (2011). Self-harm in over 8s: long-term management (CG133).
[11] NICE. (2018). Preventing suicide in community and custodial settings (NG105).
[12] NICE. (2019). Suicide prevention NICE quality standard (QS189).

In 2017, Thrive London launched six ambitions which included making London a 'Zero Suicide City'.[13]

In 2018, the Mayor of London published ***"The London Health Inequalities Strategy"***.[14] The strategy prioritises improving the mental health of Londoner's, with an objective of achieving the shared ambition that London will be a zero-suicide city. The strategy sets a goal of reducing suicides by 10% by 2021 in line with the Five Year Forward View national target through collaboration with the Metropolitan Police, TfL and the London Fire Brigade.

In 2018, the London Councils also published a guidance document for London Local Authorities: ***"A suicide prevention plan: A London where everyone can thrive".***[15] The guidance sets out a model Suicide Prevention framework designed to assist borough level Suicide Prevention plans by sharing best practice examples of existing plans and initiatives from London boroughs. The guideline supports boroughs with the following objectives 15 [15]:

- Reducing the risk in men
- Engaging ethnic minority communities
- Bereavement support
- Preventing and responding to self-harm
- Mental health of children and young people
- Acute Mental Health Care
- Supporting Primary care
- Tackling High Frequency Locations
- Reducing isolation and loneliness
- Media engagement

2.3 Local Policy context

2.3.1 Tri-Borough Suicide Prevention Strategy 2013-2018

In 2013 the City of Westminster, Royal Borough of Kensington and Chelsea and the London Borough of LBHF produced a tri-borough suicide prevention strategy from 2013-2018.[16] The strategy aimed to promote inter-agency working and identified five main priority areas to be actioned by stakeholders. These are outlined in **Box 2**:

Box 2: Tri-Borough suicide prevention strategy 2013-2018 key priority areas for action [16]

[13] The Mayor of London. (2017). Thrive LDN.
[14] Greater London Authority. (2018). The London Health Inequalities Strategy.
[15] London Councils. (2018). A Suicide Prevention Plan: A London where everyone can thrive.
[16] Tri-Borough Suicide Prevention Strategy. City of Westminster, London Borough of Hammersmith and Fulham, Royal Borough of Kensington and Chelsea. 2013-2018.

Key priority areas:

1. Timely communication and information sharing between agencies on identification of at-risk individuals and care pathways.

2. Public education and awareness on suicide and/or mental health promotion – through community outreach, anti-stigma campaigns, etc.

3. Promotion of existing suicide prevention resources, interventions, or support services (e.g., Maytree respite or telephone helplines like Samaritans/CALM).

4. Training for frontline workers (GPs, A&E, and concerned others) through programmes like mental health first aid training or applied suicide intervention skills training.

5. Targeted interventions for at risk groups (bereaved families, people from BME background, people with mental health issues, people known to mental health services, etc).

Highlights of progress against the 2013-2018 strategy include[16]:

- NWL Collaborative Clinical Commissioning group's training programme
    - The central London CCG commissioned a suicide awareness training and suicide intervention training on behalf of the three boroughs for clinicians and front-line staff
- Campaign Against Living Miserably (CALM)
    - The Local Authority Public Health department commissioned CALM: a service targeting men at risk of suicide. It provides a telephone helpline and raises awareness of depression.
- Coroner's Audit
    - A suicide audit of coroner's data was completed by Public Health in 2014 to improve understanding of the population characteristics of the cohort for targeted preventative work.
- Children and young people
    - The Three Borough Local Safeguarding Children's Board completed a task and finish group on preventing suicide with children and young people.
- British Transport Police (BTP)
    - The BTP published a new strategy "From Crisis to Care, A Strategy for Supporting People in Mental Health Crisis and Prevention Suicide on the Railway 2016-2019". The strategy recognises the role of police in responding to people in crisis and in referring vulnerable people to support services.

2.3.2 Towards Zero Suicide: A Suicide Prevention Action Plan 2018-2021

In 2018, a suicide prevention action plan was produced which aimed to build on the progress made from the Tri-Borough Suicide Prevention Strategy 2013-2018[17]. The production of the action plan was overseen by the multi-agency Suicide Prevention Working Group which includes representation form mental health trusts, the local authority public health department, voluntary sector and CCG. The action plan identified four borough level priority areas for 2018-2021. These are outlined in **Box 3**:

Box 3: **Towards Zero Suicide: A Suicide Prevention Action Plan 2018-2021 key priority areas for action [17]**

Key priority areas:

1. Reducing the risk of suicide in high-risk groups
    - Men aged 15-59 years
    - People who have attempted suicide
    - Substance misusers

2. Tailoring approaches to improve mental health in specific groups
    - Target schools and early years
    - Ensure up to date information is easily accessible
    - Better understand the mental wellbeing needs of the local population
    - Provision of specialist mental health promotion services for target groups

3. Provide better information and support to those bereaved or affected by suicide
    - Provide effective and timely support for families bereaved or affected by suicide

4. Promotion of a multiagency approach
    - Improve sharing of information
    - Ensure the voice of the bereaved is heard

[17] Towards Zero Suicide. A Suicide Prevention Action Plan (draft version 1) for Hammersmith and Fulham. 2018-2021

2.3.3 Local drivers

- **Health and wellbeing strategy**
    - The 2016-2021 Joint Health and Wellbeing Strategy (for the three boroughs) identified 'good mental health for all' as one of its priorities and commits to reducing high suicide rate amongst men.

- **Past suicide Prevention working groups**
    - In 2011, a tri-borough multi-stakeholder suicide prevention working group was established.
    - The membership was made of a range of stakeholders including local mental health trusts, London underground, acute trusts, local authority, public health, police (British transport and metropolitan), clinical commissioning groups, academic institutions, community providers and families bereaved by suicide.
    - The group aimed to promote effective inter-agency working in communicating, managing and preventing suicides in the tri-borough area.

- **North West London Sustainability and Transformation Partnership (NWL STP)**
    - The NWL STP 2019/20 – 2023/24 plan supports the Long-Term Plan Mental Health Implementation Framework.
    - Key mental health priorities included in the plan are:
        - Enhancing the mental health crisis model, so anyone experiencing a crisis can call NHS 111 and have access to 24/7 mental health support
        - Expand specialist perinatal mental health services
        - Specialist community teams to support children and young people with autism and their families
        - Integrated models of primary and community mental health care
        - Support for individuals who self-harm
        - Focus on suicide prevention and reduction for mental health inpatients
        - Put in place suicide bereavement support

- **West London NHS trust (WLHT)**
    - In 2021 WLHT developed the 2021-2024 Suicide Prevention Strategy.
    - The aims set out in the strategy commit to achieving zero suicides amongst those who come into contact with services provided by the trust, and to work with local partners to support suicide prevention across North West London.
    - The strategy focuses on the seven key areas of action set out in the national strategy (2.1.1 Box 1).

- **North-West London Suicide Prevention Plan – Rethink Mental Illness**

- Rethink Mental Illness (RMI) is working with the North-West London Integrated Care System to develop a multi-agency suicide prevention plan. It aims to bring together resources to join up health, social care, voluntary sector and grassroots organisations to work collaboratively and reach under-served groups.
- RMI is working to roll-out suicide awareness training for professionals and implement innovative projects and pilots for the local population.
- The training will target those who are most likely to encounter people who are at risk of suicide. And aims to increase overall awareness and literacy around suicide.
- A North West London suicide prevention network and steering group will be established.
- Suicide prevention initiatives will be co-produced by working with local people who have lived experience of suicidal ideation, self-harm, or bereavement by suicide.

3. Epidemiology

3.1 High Risk Groups

Key message:

There are certain known risk factors which increase an individual's risk of suicide. LBHF has higher levels of some of these factors that may predispose to completed suicides:

- **Drug or alcohol misuse**: 1,386 residents were in treatment at drug or alcohol misuse services. This is higher than London and England figures.
- **Social isolation**: 74% of carers reported that they experienced social isolation. This is higher than London and England figures.
- **Crime**: LBHF has had the 4th highest crime rate in London
- **Unemployment**: 6% of adults are unemployed in LBHF which is higher than London and England.

There are certain known risk factors which can put an individual at an increased risk of suicide. These risk factors include, but are not limited to;

- Mental illness
- Self-harm
- Substance misuse
- Social isolation
- Criminal problems
- Financial and employment problems

3.1.1 Mental illness

In LBHF Clinical Commissioning Group (CCG), **17,575 adult patients** are diagnosed with **depression** and **3,434** are diagnosed with a **Severe Mental Illness**, which represents 6.6% and 1.1% of the total CCG patient list respectively.[18]

The **prevalence of depression is lower in LBHF** compared with the total prevalence in London and in England, with the prevalence of depression in these regions being 8.2% and 11.6% respectively. The **prevalence of other Severe Mental Illness in LBHF** is equal to the total prevalence in London, but **higher than the prevalence in England**, with the prevalence of severe mental illness being 1.1% and 0.9% in these regions respectively.

Mental illness can commonly go under-reported due to social stigma and a lack of understanding surrounding mental illness. The Adult Psychiatric Morbidity Survey (APMS) has created estimates on the prevalence of both treated and untreated psychiatric disorder in the English Adult population. These estimates have been applied to the LBHF adult population and are presented in Table 1. These estimates suggest that 33,326 adults have a common mental health disorder. Regarding suicide, these estimates suggest that **20.5% of the adult population**, which is equivalent to 37,954 residents, have had **suicidal thoughts** and that **6.1% of the adult population**, which is equivalent to 11,294 residents, have **attempted suicide** during their lifetime.[19]

[18] Quality Outcomes Framework 2019-20 | NHS Digital
[19] Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014. | NHS Digital

Table 1: Estimated prevalence and number of residents in LBHF with a mental illness.

Mental Illness	Estimated Prevalence	Estimated Number of LBHF Residents
Common Mental Health Disorder	18.0%	33,326
Anxiety	5.9%	10,923
Depressive Episode	3.3%	6,110
Phobias	2.5%	4,629
OCD	2.0%	3,703
Panic Disorder	0.8%	1,481
Personality Disorder	17.0%	31,474
PTSD	4.0%	7,406
Bipolar Disorder	3.3%	6,110
Self-harm	6.4%	11,849
Suicidal thoughts	20.5%	37,954
Suicide attempts	6.1%	11,294

Note: The estimated prevalence of mental illness has been created by the adult psychiatric morbidity survey.

3.1.2 Self-Harm

Self-harm is one of the strongest predictors of suicide.[20] In LBHF, in 2019-20, there were 135 emergency hospital admissions for intentional self-harm.[21] This equates to a rate of 73.9 emergency hospital admissions for intentional self-harm per 100,000 population. This is the 12th lowest emergency hospital admissions for intentional self-harm in London. In 2019/20, the LBHF emergency hospital admissions for intentional self-harm was lower than the both the London and England rate which were 81.6 and 192.6 admissions per 100,000 population respectively.[22]

Among patients who were admitted for intentional self-harm since October 2016, the majority (82%; 185/226) were admitted due to intentional self-harm by poisoning. 41 patients were admitted due to self-harm harm by hanging, drowning, jumping or other implement.

Furthermore, 60% (135/226) of patients admitted for intentional self-harm were female.

The majority of admissions for self-harm (92%; 209/226) were among adults, with paediatric admissions making up 8% (17/226) admissions for self-harm since 2016.

Where ethnicity is stated, over half (54%; 104/194) of all admissions since October 2016 have been among white British residents. This is followed by residents from Other white ethnic backgrounds who make up 20% (38/226) of admissions for self-

[20] Hawton, K, Zahl, D, Weatherall, R. Suicide following deliberate self-harm: long-term follow-up of patients who presented to a general hospital. BJ Psych. 2003;182(6): 537-542.
[21] Public Health England, Public Health Profiles. [Online]. Available from: https://fingertips.phe.org.uk/
[22] Public Health England, Public Health Profiles. [Online]. Available from: https://fingertips.phe.org.uk/

harm. Residents from other ethnic backgrounds each make up less than 5% of admissions.[23]

The majority of residents who are admitted for self-harm come from more deprived areas of LBHF. Almost half – 46% (104/227) - of admissions for self-harm since October 2016 were among residents living in the three most deprived deciles of LBHF.

3.1.3 COVID-19 Pandemic and Mental Health

The COVID-19 pandemic caused both a significant loss of life and disruption, which had considerable consequences on mental health. However, between February 2020 and March 2020 the number of individuals referred to talking therapies in LBHF CCG decreased from 895 to 145 individuals referred.[24] Referrals rapidly increased between May and October 2020 to levels similar to before the COVID-19 pandemic; in October 2020 865 individuals were referred to talking therapies. While online therapy sessions did allow talking therapies to continue during the COVID-19 pandemic, the decrease in referrals indicates that access to mental health services was impacted.

3.1.4 Substance misuse

In 2019/20, 916 residents were in treatment at specialist drug misuse services in LBHF, which equates to a rate of 6.2 residents per 1,000 population.[25] This is **higher** than both the London and England rate of adults at specialist drug misuse services, with the rate of adults in specialist drug misuse services being 4.2 and 4.4 per 1,000 population respectively.[21]

In LBHF, 470 residents were in treatment at specialist alcohol misuse services in 2019/20. This equates to a rate of 3.2 adults in alcohol misuse treatment services per 1,000 population. This rate is higher than both the London and England rate of adults in specialist alcohol misuse services, with the rate of adults in specialist alcohol misuse services being 1.5 and 1.7 per 1,000 respectively. LBHF also has the highest rate of adults in treatment at specialist alcohol misuse services out of all London boroughs.[26] It should be noted that a higher number of persons in substance misuse treatment is positive, and ensures the borough is meeting the needs of this very vulnerable group.

The predicted number of residents who are dependent on drugs is higher than the number who were in treatment at specialist drug misuse services; 5,014 people are predicted to be dependent on drugs. Moreover, 5,326 are predicted to be at a higher risk of alcohol-related health problems.[27]

3.1.5 Social Isolation

[23] Imperial College Healthcare NHS Trust, List of Patient Spell discharges for Hammersmith & Fulham with diagnosis of self-harm between 2016-2021 (2021)
[24] NHS Digital. Psychological Therapies, Reports on the use of IAPT services. [Online]. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-report-on-the-use-of-iapt-services.
[25] National Drug Treatment Monitoring System. Adults in Treatment. [Online]. Available from: https://www.ndtms.net/ViewIt/Adult.
[26] National Drug Treatment Monitoring System. Adults in Treatment. [Online]. Available from: https://www.ndtms.net/ViewIt/Adult.
[27] Institute of public care. Projecting Adult Needs and Service Information. [Online]. Available from: https://www.pansi.org.uk/index

LBHF council continues to prioritise the inclusion and advancement of all residents, by combatting social isolation and loneliness.[28] While anyone can experience social isolation and loneliness, social isolation is more commonly associated with later life. Several life events are also recognised as potential triggers for social isolation across the entire life course,[29] including;

- **Pregnancy:** Inadequate social networks and maternal depression during pregnancy can increase the risk of social isolation.
- **Childhood and Young People:** Adverse childhood experiences, being bullied, being a young carer and not being in employment, education or training can increase the risk of social isolation.
- **Working age:** Being unemployed, relationship breakdown, poor social networks, being a carer and being physically or mentally unwell can increase the risk of social isolation.
- **Retirement and later life:** bereavement, loss of mobility, poor quality living conditions, being a carer and being physical or mentally unwell can increase the risk of social isolation.

While there is no comprehensive dataset on social isolation in LBHF, we do have information regarding social isolation among adult carers. In LBHF, 25.8% of adult carers reported having as much social contact as they would like, thereby indicating that 74.2% of adult carers experience social isolation.[30] The proportion of adult carers in LBHF who have as much social contact as they would like is lower than both the London region and England, with 33.2% and 32.5% respectively of adult carers receiving as much social contact as they would like. This indicates that social isolation is an issue in LBHF.

3.1.6 Crime and Interaction with the Metropolitan Police

Between July 2019 and June 2021, 40,800 crimes were recorded in LBHF which equates to a crime rate of 222 crimes per 1,000 population. For this time period crime rate for LBHF was 23% higher than the crime rate for London as a whole which had a crime rate of 181 crimes reported per 1,000 population between July 2019 and June 2021. Furthermore, LBHF had the 4th highest crime rate in London between 2019 and 2021.[31]

Police officers can often be a key point of contact for people who are at risk of self-harm or suicide. Since 2018, there have been an average of 61 interactions annually between LBHF residents at risk of self-harm or suicide and the Metropolitan Police.[32] Interactions include being sectioned and taken to a pace of safety, as well as engaging with individuals who have suicidal ideation.

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[28] Hammersmith And Fulham Council. The Change We'll Bring Together: Manifesto. [Online]. Available from: http://democracy.lbhf.gov.uk/documents/s99536/Appendix%201%20-%20Manifesto%202018-2022%20-%20The%20change%20well%20bring%20together.pdf

[29] Public Health England, UCL Institute Of Health Equity. Reducing Social Isolation Across the Life course. Local Action on Health Inequalities. 2015.

[30] Public Health England, Public Health Profiles. [Online]. Available from: https://fingertips.phe.org.uk/

[31] Metropolitan Police. Crime Data Dashboard. [Online]. Available from: https://www.met.police.uk/sd/stats-and-data/met/crime-data-dashboard/

[32] Metropolitan Police (2021) Interactions

3.1.7 Unemployment

As of 2021, it is estimated that 6,700 adults were unemployed in LBHF[33]. This accounts for 6.3% of the economically active adult population. This is higher than the unemployment rate across London and Great Britain which are 6.1% and 4.9% of economically active adults respectively.[28]

It is estimated that there are a further 20,000 economically inactive residents in LBHF, which includes students, those looking after a family or home, and those who are unable to work due to illness of disability. This accounts for 16.0% of the adult population of LBHF and is lower than the proportion of economically inactive adults across both London and Great Britain, which is 20.5% and 21.3% of adults respectively.[28]

3.1.8 COVID-19 and Unemployment

Since the COVID-19 pandemic, the number of LBHF residents claiming benefits for unemployment has increased. Between March and May 2020 there was a 117% increase in residents claiming benefits for unemployment; the number of adults claiming unemployment benefits rose from 4,645 in March 2020 to 10,065 in May 2020. Throughout 2020, claimant count in LBHF was highest in December 2020 at 10,815.[34]

[33] Nomis. Labour Market Profile - Hammersmith and Fulham. [Online]. Available from: https://www.nomisweb.co.uk/reports/lmp/la/1946157249/report.aspx#tabeinact
[34] Office for National Statistics. Claimant Count by Sex And Age. [Online]. Available from: https://www.nomisweb.co.uk/datasets/ucjsa

3.2 Suicide data

Key message:

- The group with the highest number of completed suicides in LBHF are men aged 50-59 years
- There are no ethnicity data on suicides, however the place of birth for the cohort of 58 deaths showed that the majority were born in the UK
- For the 58 deaths available from the coroner's office, many had a missing occupation listed, the highest number of suicides occurred amongst residents in professional occupations, including financial services, consultancy, healthcare and research, followed by those in skilled trade occupations, including those in the construction industry
- The place of suicide was most commonly the resident's home
- We also note that the highest number of suicides occurred in the second and third most deprived deciles, and this may relate to unemployment as a risk factor for suicide
- In LBHF, the majority (two thirds) of completed suicides were in persons known to either substance misuse or psychiatric services. This means that there are some intervention points that will be helpful in suicide prevention for persons in contact with these services

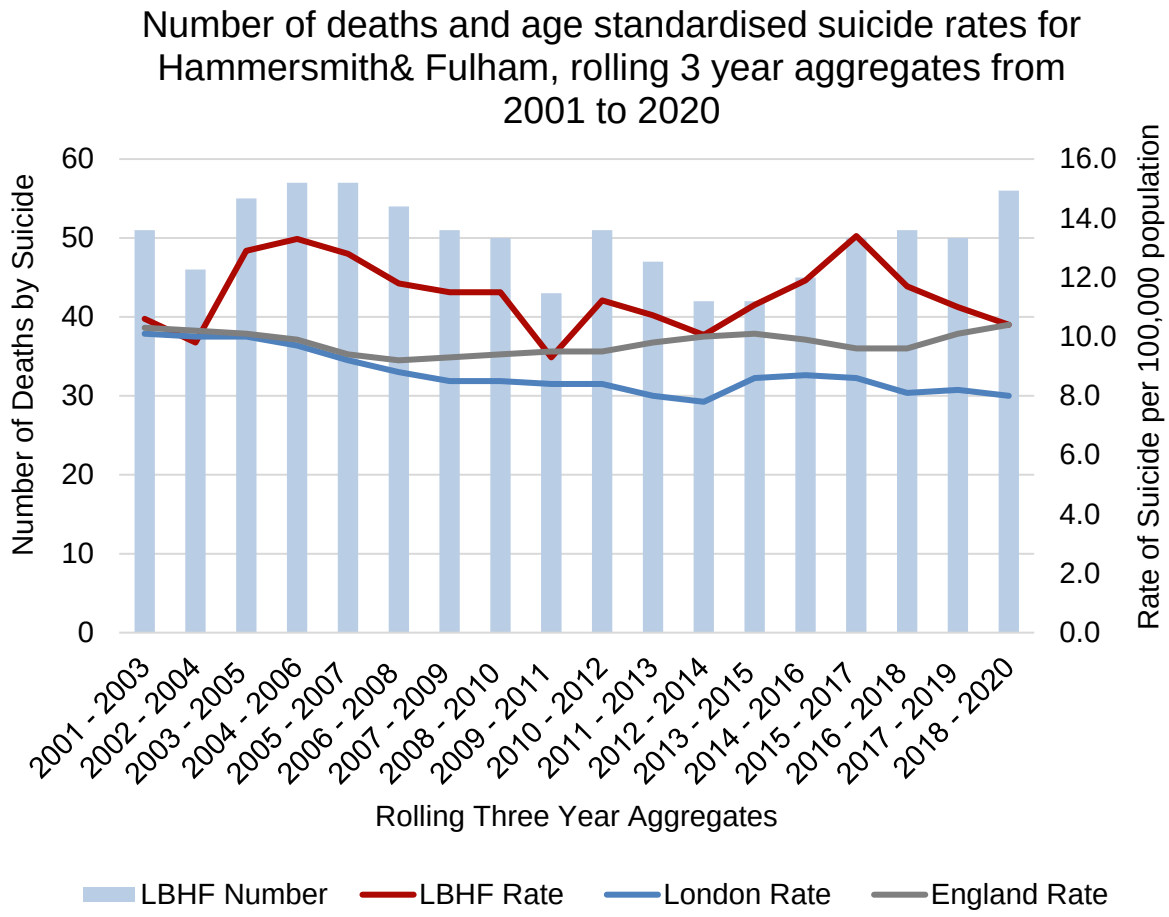
3.2.1 Suicide Rate

Between 2001 and 2020, 339 deaths by suicide and injury of undetermined intent were registered to have occurred among LBHF residents.[35] This averages 17 deaths by suicide per year in LBHF.

Three-year rolling aggregates are used to provide the rate of suicide to ensure reliable rates can be produced. The rate of suicide between 2018 and 2020 is 10.4 per 100,000 population. This is **higher than the London rate** of 8.0 deaths by suicide per 100,000 population and the same as the England rate of 10.4 deaths by suicide per 100,000 population between 2018 and 2020. Since 2001, LBHF has overall had a higher suicide rate than both London and England, with a slight drop in 2009-2011 and 2012-2014. Three-year rolling aggregates of the number and rate of suicide in LBHF since 2001 can be seen in Figure 1.

[35] Office for National Statistics. Suicides in England and Wales by local authority. [Online]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority

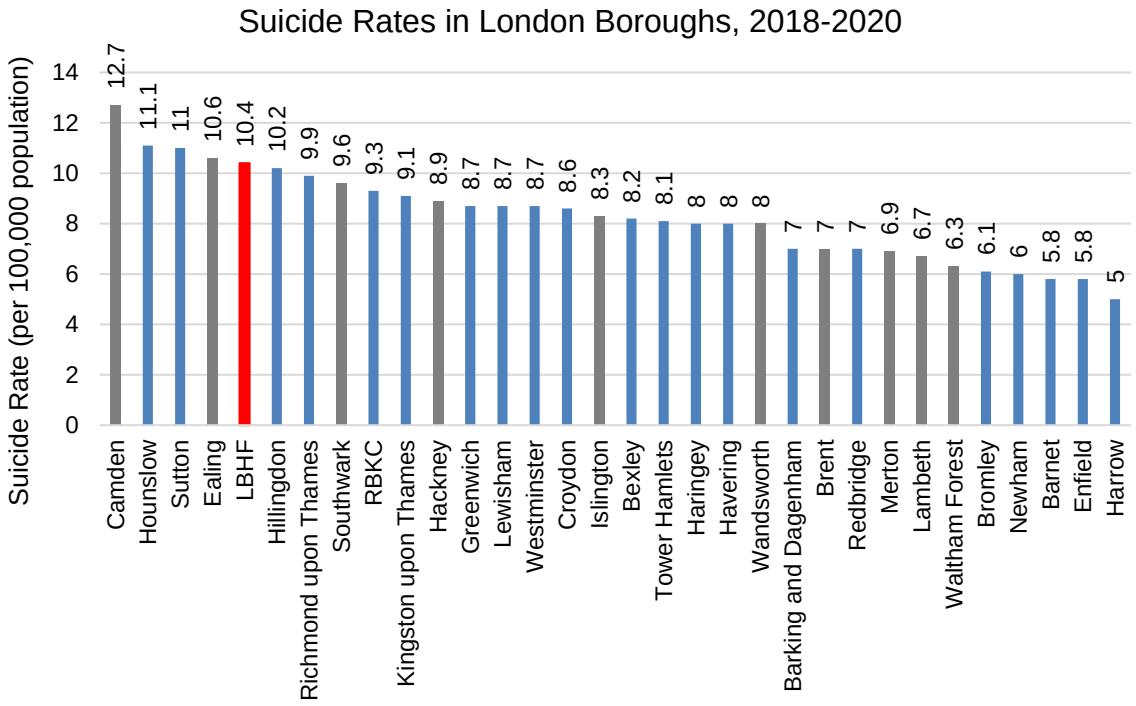
Figure 1: Number of deaths and age-standardised suicide rates for LBHF local authority residents, rolling three-year aggregates, deaths registered 2001 to 2020. The age-standardised suicide rates are also shown for London and England. Age-standardised suicide rates are per 100,000 population.



The **rate of suicide in LBHF** was the **fifth highest in London**, (10.4 deaths by suicide per 100,000 population), between 2018 and 2020 (Figure 2).[36] The rate of suicide in LBHF is also higher than the average across London boroughs which are demographically similar; the average suicide rate across the ten London boroughs most demographically similar to LBHF was 8.5 deaths per 100,000 population between 2018 and 2020.

[36] Office for National Statistics. Suicides in England and Wales by local authority. [Online]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority

Figure 2: The Suicide Rate by London Borough between 2018 and 2020. Suicide Rate is calculated as the number of deaths by suicide per 100,000 population. The number of suicides are collected as a three-year rolling aggregate from 2018 to 2020. LBHF is highlighted in red, and the ten most demographically similar boroughs to LBHF are highlighted in grey.



3.2.2 Age and Gender

Between 2015 and 2020, 58 coroner's inquests involving LBHF residents have been concluded as death by suicide. **From these 58 suicides, 42 (72%) of the residents were male and 16 (28%) of the residents were female**.[37] This is similar to national figures where males account for 76% of deaths by suicide and females account for 24%.[38]

Irrespective of gender, the **modal age group of those who died by suicide was 20-29**, with 15 (26%) deaths by suicide occurring among residents aged 20-29. However, the highest rate of suicide across the total population was among **residents aged 50-59**, with a rate of 59.8 deaths by suicide per 100,000 population (Table 2).[31] This is contrary to what is observed on a national level, with the highest suicide rates occurring among people aged 40-49.[32]

[37] West London Coroner's Court. Deaths by Suicide. 2021
[38] Office for National Statistics. Suicide in England and Wales: 2020 Registrations. [Online]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2020registrations

Among males in LBHF, the highest suicide rate was 114.5 deaths by suicide per 100,000 population among residents aged 50-59. Among females the highest suicide rate was 54.0 deaths by suicide per 100,000 population among residents aged 60-69.[31]

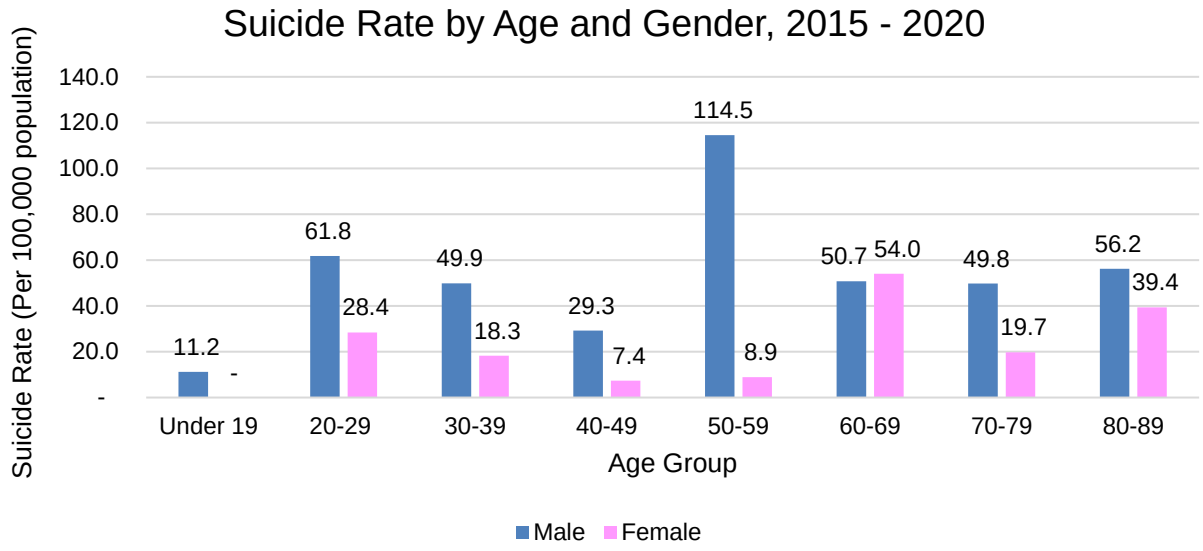
For males in LBHF, the youngest death by suicide was aged 16 and the oldest was 82. Among females in LBHF, the youngest death by suicide was aged 21 and the oldest was 87.[31]

Table 1: The Number of Deaths by Suicide and Six-Year Aggregated Suicide Rate by Age and Gender. These figures represent the number of coroner's inquests which have concluded to be a death by suicide between 2015 and 2020. Rate of Suicide is the number of deaths by suicide between 2015 and 2020 per 100,000 population.

Age Group	Total Suicide Number	Total Suicide Rate (Per 100,000)	Male Suicide Number	Male Suicide Rate (Per 100,000)	Female Suicide Number	Female Suicide Rates (Per 100,000)
10-19	*	5.6	*	11.2	*	-
20-29	15	44.4	10	61.8	5	28.4
30-39	12	34.8	9	49.9	*	18.3
40-49	5	18.4	*	29.3	*	7.4
50-59	13	59.8	12	114.5	*	8.9
60-69	7	52.6	*	50.7	*	54.0
70-79	*	33.0	*	49.8	*	19.7
80-89	*	46.3	*	56.2	*	39.4
Total	58	31.5	42	46.5	16	17.1

* Groups of less than 5 have been suppressed.

Figure 3: The aggregated Suicide rate among LBHF residents by age and Gender. The suicide rate represents the number of coroner's inquests which have concluded to be a death by suicide between 2015 and 2020, per 100,000 population.



3.2.3 Place of Birth

There is limited data collected regarding the ethnicity of residents who have died by suicide; however, information is available concerning their place of birth.

The majority of residents (52%; 30/58) who died by suicide were born in the United Kingdom. This is followed by residents born in Eastern Europe or Africa, with 8/58 (14%) deaths by suicide occurring among residents born in Eastern Europe, and 6/58 (10%) deaths by suicide occurring among residents born in Africa. Residents born in North America, Western Europe, South America, Oceania and Asia accounted for a smaller proportion of deaths by suicide (Figure 4).[39]

The rate of suicide was highest among residents born in Eastern Europe; between 2015 and 2020 the rate of suicide among residents born in Eastern Europe was 88.9 deaths by suicide per 100,000 population (Table 3). This was followed by residents born in North America, with the rate of suicide being 83.3 deaths per 100,000 population. The lowest rate of suicide was among Asian residents; the rate of suicide was 6.3 deaths per 100,000 population. The rate of suicide among residents born in the UK was 28.3 deaths per 100,000 population.[40,41] Across England and Wales

[39] West London Coroner's Court. Deaths by Suicide. 2021
[40] West London Coroner's Court. Deaths by Suicide. 2021
[41] Office For National Statistics. Population by Country of Birth. [Online]. Available from: https://data.london.gov.uk/dataset/country-of-birth

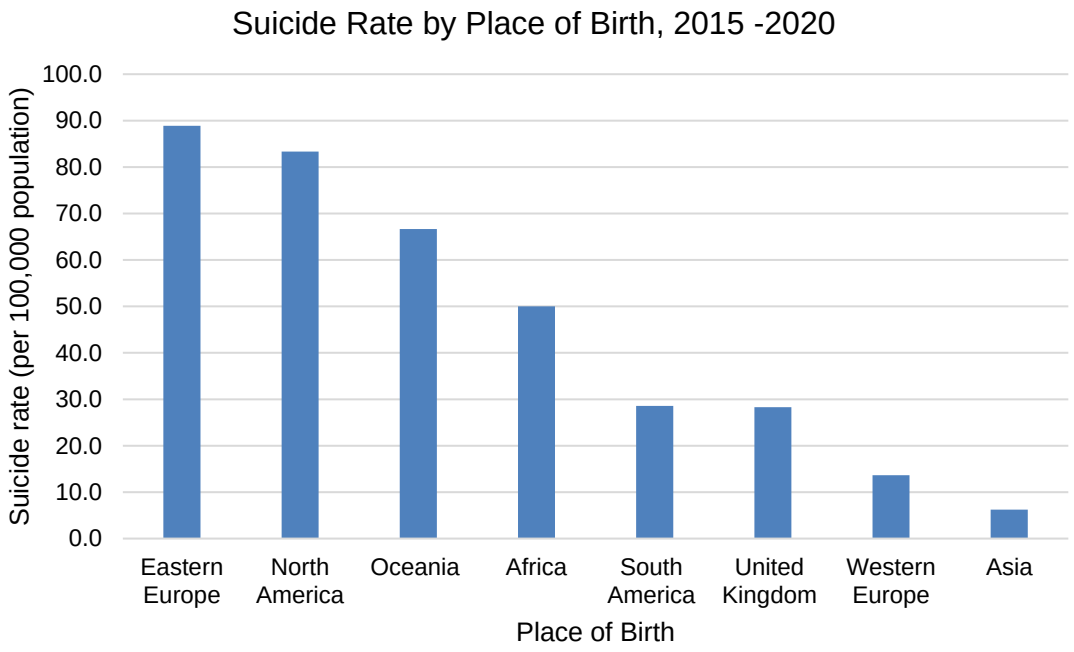
suicide rates are higher among people born in Eastern Europe and the Caribbean and lower among people born in Asia.[42]

Table 2: The Number of Deaths by Suicide and Suicide Rate by Place of Birth. These figures represent the number of coroner's inquests which have concluded to be a death by suicide between 2015 and 2020. Rate of suicide is the number of deaths by suicide between 2015 and 2020 per 100,000 population.

Country	Number of Suicides	Suicide Rate (Per 100,000)
Eastern Europe	8	88.9
North America	5	83.3
Oceania	*	66.7
Africa	6	50.0
South America	*	28.6
United Kingdom	30	28.3
Western Europe	*	13.6
Asia	*	6.3
Total	**58**	**31.5**

* Groups of less than 5 have been suppressed.

Figure 4: Suicide rate by Place of Birth among LBHF residents between 2015 and 2020, per 100,000 population.



[42] Shah A, Lindesay J, Dennis M. Suicides by country of birth groupings in England and Wales: age-associated trends and standardised mortality ratios. Social Psychiatry and Psychiatric Epidemiology. 2010;46(3):197-206.

3.2.4 Occupation

Past research has shown that certain occupations are at a particularly high risk of suicide. Nationally, groups which are at a higher risk of suicide included males in construction and building trades, males and females in artistic, literary and media occupations and female nurses.[43] Furthermore, there is a significantly higher risk of suicide among people who are unemployed.[44]

In LBHF, 12 of the 58 residents (21%) who died by suicide between 2015 and 2020 had no information regarding their professional occupation. From the 46 residents who did have information regarding their occupation, the largest proportion of residents (8/46; 17%) who died by suicide were from Professional Occupations including occupations in financial services, consultancy, healthcare and research. The second highest proportion of deaths by suicide occurred among residents in Skilled trade occupations (6/46; 13%), including those in the construction industry, Elementary Occupations (5/46; 11%), including those in cleaning and security occupations, Students (5/46; 11%) and those who were unemployed (5/46; 11%) (Figure 5).[45]

The rate of suicide was highest among residents working in Elementary Occupations; between 2015 and 2020 the rate of suicide among residents working in Elementary Occupations was 138.9 deaths per 100,000 population (Table 4). This was followed by residents working in Skilled Trade Occupations, with the suicide rate being 100.0 deaths per 100,000 population. The lowest rate of suicide rate was among residents in Process, Plant and Machine Operative Occupations, with no suicides occurring among residents in these occupations between 2015 and 2020. Followed by this, the second lowest rate of suicide was among residents working in Professional Occupations, with the rate of suicide being 18.0 deaths per 100,000 population.[39]

Across England between 2011 and 2015, the largest proportion of all suicides occurred among individuals working in Skilled Trade Occupations (24%), followed by those working in Elementary Occupations (16%).[46] The high proportion of deaths by suicide among those working in Skilled Trade Occupations or Elementary Occupations are similar to figures seen in LBHF.[47]

Across England, the lowest proportions of deaths by suicide occurred among individuals working in Sales and Customer Service Occupations (4%) and those working in Caring, Leisure and Other service occupations (6%).[40] These figures also

[43] Office for National Statistics. Suicide by occupation, England: 2011 to 2015. [Online]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/suicidebyoccupation/england2011to2015

[44] Samaritans. Dying from Inequality. [Online]. Available from: https://media.samaritans.org/documents/Socioeconomic_disadvantage_and_suicidal_behaviour_-_Full.pdf

[45] West London Coroner's Court. Deaths by Suicide. 2021

[46] Office for National Statistics. Suicide by occupation, England: 2011 to 2015. [Online]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/suicidebyoccupation/england2011to2015

[47] Nomis. Labour Market Profile - Hammersmith and Fulham. [Online]. Available from: https://www.nomisweb.co.uk/reports/lmp/la/1946157249/report.aspx#tabeinact

similar to local suicide figures in LBHF.[41] However, since the number of suicides is small, caution should be used interpreting these numbers.

Table 3: The Number of deaths by suicide and suicide rate in LBHF by occupation. These figures represent the number of coroner's inquests which have concluded to be a death by suicide between 2015 and 2020 (n=58). Rate of suicide is the number of deaths by suicide between 2015 and 2020 per 100,000 population. Occupations are grouped according to the Standard Occupational Classifications 2020.

Occupation Groups	Number of Suicides	Suicide Rate (Per 100,000)
Elementary occupations	5	138.9
Skilled trade occupations	6	100.0
Prisoner	*	83.3
Unemployed	5	72.5
Student	5	63.3
Sales and customer service occupations	*	50.0
Professional Occupations	8	25.8
Caring leisure and other service occupations	*	22.7
Retired	*	20.8
Associate professional and technical occupations	*	20.5
Administrative and secretarial occupations	*	20.4
Managers, directors and senior officials	*	18.0
Process, plant and machine operatives	*	-

* Groups of less than 5 have been suppressed.

3.2.5 Place of Death, Location of the Usual Address and Deprivation

The majority of residents who died by suicide in LBHF between 2015 and 2020 died at home; 71% (41/58) of residents died at their home. The other 29% (17/58) of residents died in a variety of other locations including prison, hospital, the River Thames and Tube Stations. However, with all the deaths that occurred at hospital the suicidal incident occurred in the resident's home.[48]

The highest number of suicides occurred in the second and third most deprived IMD deciles (deciles 2 and 3); 44% (21/48) of deaths by suicides occurred among residents living in deprivation deciles 2 and 3 (Figure 8). The highest rate of suicide occurred in the deprivation decile 3; the suicide rate between 2015 and 2020 was 50.20 deaths per 100,000 population in deprivation decile 3 (Table 5).[45]

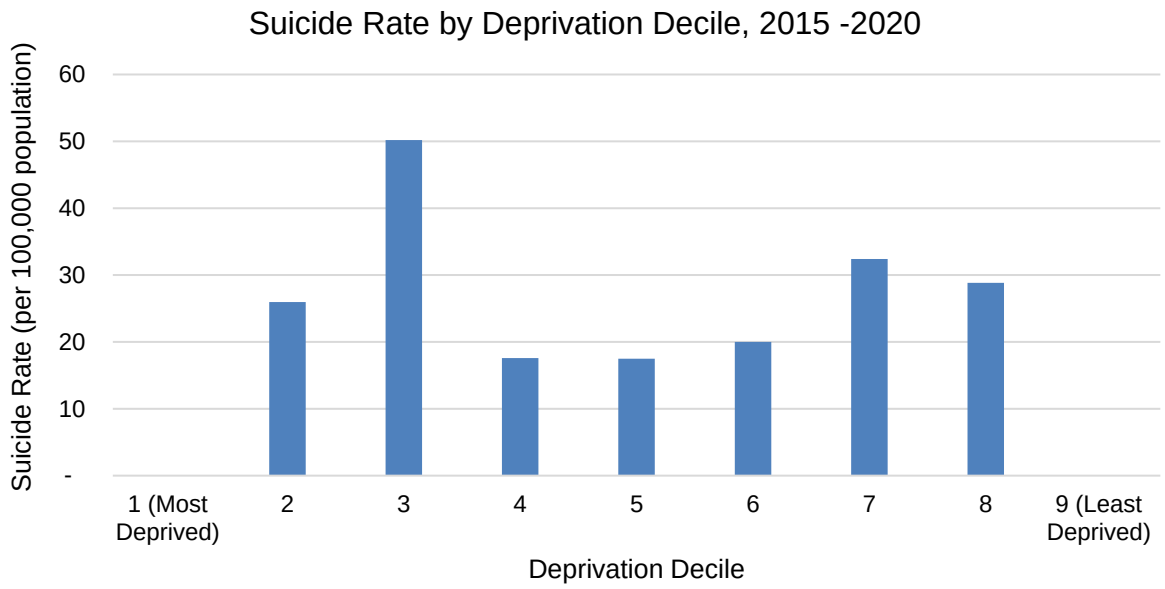
National research has shown that areas of higher socioeconomic deprivation tend to have higher rates of suicide.[49]

[48] West London Coroner's Court. Deaths by Suicide. 2021
[49] Samaritans. Dying from Inequality. [Online]. Available from: https://media.samaritans.org/documents/Socioeconomic_disadvantage_and_suicidal_behaviour_-_Full.pdf

Table 4: The Number of deaths by suicide and suicide rate in LBHF by Deprivation Decile. These figures represent the number of coroner's inquests which have concluded to be a death by suicide between 2015 and 2020. Rate of suicide is the number of deaths by suicide between 2015 and 2020 per 100,000 population.

Deprivation Decile	Number of Suicides	Suicide Rate (per 100,000)
1 (Most Deprived)	0	-
2	8	26.0
3	13	50.2
4	5	17.6
5	5	17.5
6	5	20.0
7	7	32.4
8	5	28.8
9 (Least Deprived)	0	-

Figure 5: Suicide Rate by Deprivation Decile of the Normal place of residence among Residents of LBHF between 2015 and 2020. Deprivation Decile is classified according to the Index of Multiple Deprivation where 1 is the most deprived 10% of LSOAs in the UK.



3.2.6 Known to Services

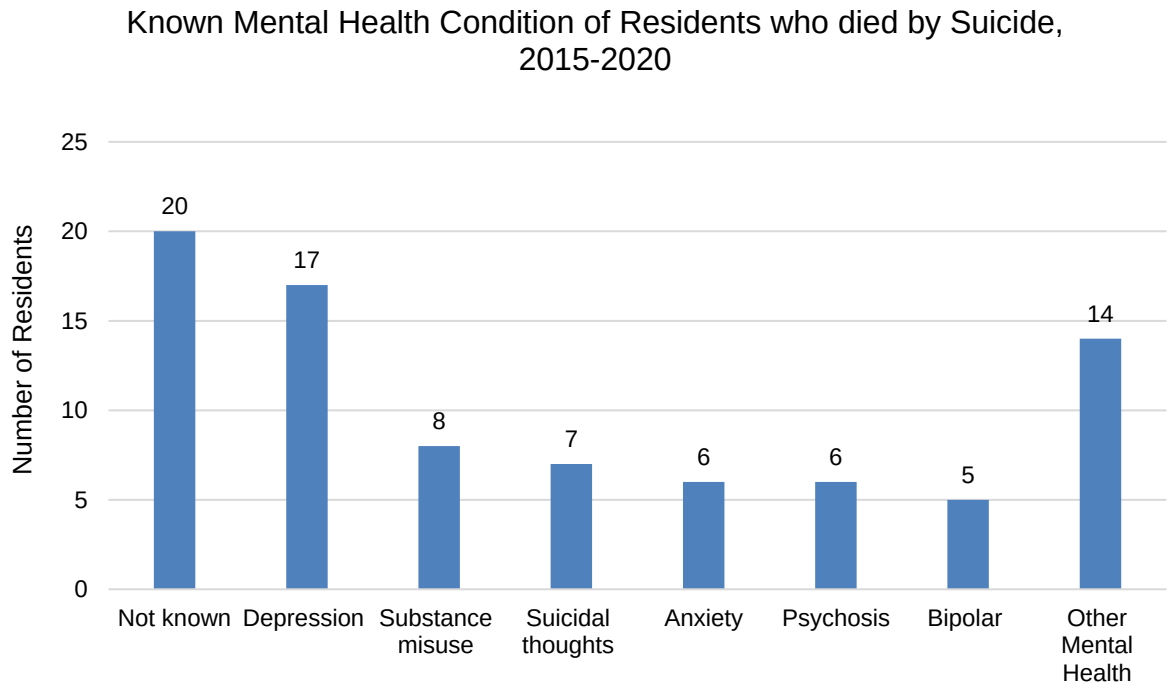
The Cross-Government Suicide Prevention Workplan includes a zero-suicide ambition for mental health inpatients, looking to expand to all mental health service users.[50] In

[50] Department of Health And Social Care. Suicide prevention: cross-government plan. [Online]. Available from: https://www.gov.uk/government/publications/suicide-prevention-cross-government-plan

LBHF, the majority (66%, 38/58) of residents who died by suicide between 2015 and 2020 had been known to Mental Health or Drugs and Alcohol Services.

Of those who were known to services, 17 (45%) had depression, 8 (21%) had substance misuse problems and 7 (18%) had suicidal thoughts (Figure 9). The other 20 residents (34%) were not known to mental health services. Furthermore, a small number of residents who died by suicide were known to the criminal justice system.[51]

Figure 6: Mental health Condition of residents who died by suicide in LBHF between 2015-2020, if known to Mental health or Drugs and Alcohol Services.



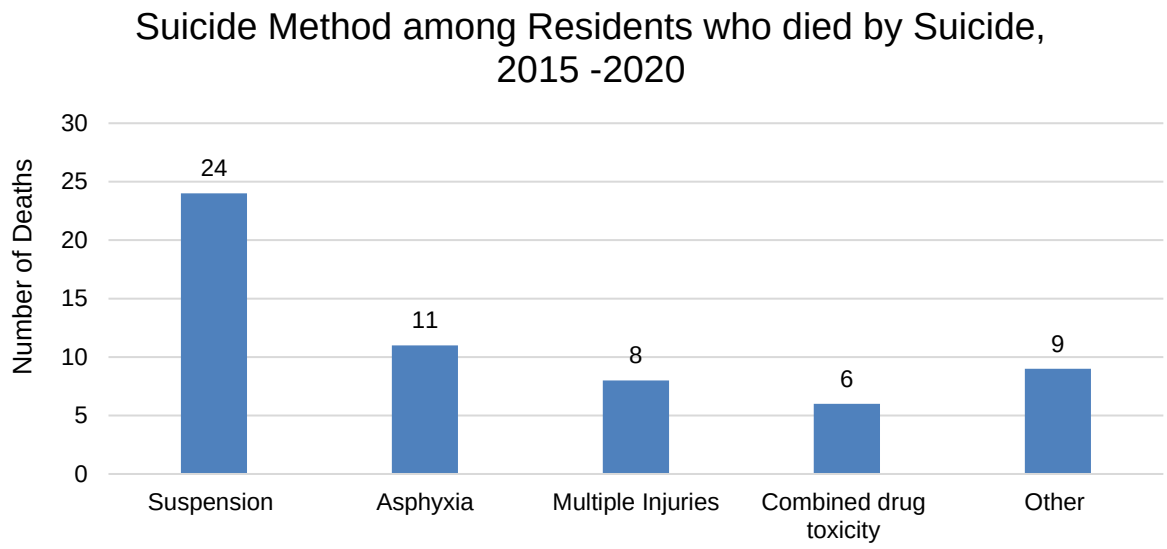
3.2.7 Method

In 2020, in England and Wales the most common method of suicide was by hanging or suspension, accounting for 61.7% of suicides among males and 46.7% among females.[52]

In LBHF, between 2015-2020, the most common method of suicide among both males and females was suspension which accounted for 41% (24/58) of all suicides in that time frame. Following this, the second most common method of suicide was asphyxia (19%; 11/58) often using a plastic bag, and the third most common method of suicide was Multiple Injuries (14%; 8/58) often as a result of jumping from a height.[48]

[51] West London Coroner's Court. Deaths by Suicide. 2021
[52] Office for National Statistics. Suicide in England and Wales: 2020 Registrations. [Online]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2020registrations

Figure 7: The Number of Deaths by Suicide by method of death among Residents of LBHF between 2015 and 2020.



4. What works to prevent suicides?

Key message:

- It is important to understand the persons locally affected by suicide, and then tailor interventions accordingly.
- High risk groups in LBHF include men aged 50-59 years, those in elementary occupations, those in either mental health or substance misuse services, and those persons living in more deprived areas of the borough. This knowledge can then inform recommended interventions.
- The restriction of lethal means is an effective method of suicide prevention as well as reducing the opportunity for suicide in locations where suicide is common.
- School awareness programmes, and training of professionals working with people at risk of suicide are recommended methods of prevention.
- Statutory services who may come into contact with individuals at risk of suicide have an opportunity to engage further and make referrals to support services before crisis point is reached.
- Effective suicide prevention methods targeting men are predominantly multidimensional.
- Interventions targeting men can include awareness campaigns, the use of 'gatekeepers', support services which are discrete and not overtly associated with mental health, interventions that promote social interaction, peer-support, and co-leadership in facilitating services.

4.1 Literature Review

4.1.1 Methodology

A review of established literature was carried out using the databases Cochrane library, NHS evidence, Google Scholar and PubMed. Keywords and MeSH terms used to search the literature can be found in appendix 1.

Research studies and reviews published between 2000 and 2021 and written in English were included. The titles and abstracts of each of the studies found were assessed to determine whether the study was relevant to the strategy. A review of grey literature was also conducted, this included guidelines, reports and papers from NICE, Samaritans, Greater London Authority, Department of Health and Social Care, PHE, Local Government Association, and WHO.

4.1.2 Review of effective suicide prevention methods

Findings from several international studies and systematic reviews have identified the following measures to be effective in suicide prevention: [53,54,55,56,57,58,59]

- **Restriction of lethal means**, particularly in relation to painkillers and erection of physical barriers in sites where suicide is common.
- **School based awareness programs** and **training of health practitioners** in the community to recognise and treat depression and suicidality.
- **Brief Intervention and Contact (BIC) model** produced by WHO, which includes patient education and follow up. This has been shown to reduce the odds of suicide amongst people who have previously attempted suicide.

NICE Guideline

The NICE guideline: *Preventing suicide in community and custodial settings* [60] highlights the need to reduce the opportunity for suicide in locations where suicide is more likely. The guideline makes the following recommendations:

- Providing information about where help can be found when a person feels unable to cope.
- Using CCTV or other surveillance methods to allow staff to monitor when help is needed.
- Increasing the number and visibility of staff or times when staff are available.
- Provide safer cells in custodial settings.
- Make suicide prevention training available for those working with groups who are at high risk of suicide and those who are supporting people bereaved by suicide.
- Data from sources such as coroners should be used to identify anyone who may be affected by a suicide or may benefit from bereavement support.

Suicide prevention in men

In LBHF the highest rates of suicide are amongst men aged 50-59 years, and amongst those who live in more deprived areas of the borough. The Samaritans report on male suicide prevention in middle-aged, less well-off men highlights the need for intervention from services at earlier stages before a person reaches crisis point.[71] Waiting until crisis point often meant that the support was less likely to succeed. Men with lived experience who took part in this research reported that support from statutory

[53] Zalsman G, et al. Suicide prevention strategies revisited: 10-year systematic review. The Lancet Psychiatry. 2016; 3: 646–59.
[54] Riblet N, et al. Strategies to prevent death by suicide: a meta-analysis of randomised controlled trials. The British Journal of Psychiatry. 2017; 1–7.
[55] WHO Regional Office for Europe's Health Evidence Network. For which strategies of suicide prevention is there evidence of effectiveness? 2004.
[56] Stone DM, Crosby AE. Suicide Prevention. Am J Lifestyle Med. 2014; 8: 404.
[57] Feltz-Cornelis CM van der, Sarchiapone M, Postuvan V, et al. Best Practice Elements of Multilevel Suicide Prevention Strategies: A Review of Systematic Reviews. Crisis 2011; 32: 319.
[58] Mann JJ, Apter A, Bertolote J, *et al.* Suicide Prevention Strategies: A Systematic Review. JAMA. 2005; 294: 2064–74
[59] du Roscoät E, Beck F. Efficient interventions on suicide prevention: A literature review. Rev Epidemiol Sante Publique 2013; 61: 363–74.
[60] NICE. (2018). Preventing suicide in community and custodial settings. NICE guideline [NG105]

services focused exclusively on a single issue.[71] This focus often led to failure in the exploration of the other problems the men were experiencing.[71]

Statutory services dealing with housing, substance misuse or employment have an opportunity to engage further with individuals who may be at risk of suicide and refer them to support services.[71]

Several suicide prevention strategies targeting men which were reported to be successful have predominantly been multidimensional, utilising several different methods in conjunction.[61] The following methods have shown to be effective:

- **Awareness campaigns**
  Interventions have included posters, leaflets and websites providing information on the symptoms of depression as well as resources that are available to men. Cinema advertisements, public lectures, annual action days and community workshops have also been utilised.[62,63,64,65,66]

- **Gatekeepers**
  These are individuals who have face-to-face contact with members of the community and are trained in the recognition and referral of those at risk of suicide. Gatekeepers can include community leaders, doctors, nurses, pharmacists, police officers, priests, schoolteachers and youth workers.

  Studies investigating the use of "gatekeepers" reported a decrease in male suicide rates, however since these studies did not solely focus on gatekeeper involvement it is difficult to directly attribute the reduction in male suicide to this alone.[62,64,67,68] Thus, highlighting the importance of multi-faceted suicide prevention programmes.

- **Discrete support settings**
  Studies have reported that men desire more discrete services which are not overtly associated with mental health, reflecting an awareness of the stigma associated with the use of mental health services. The use of interventions that promote social interaction, such as sports-based activities or social media have been highly valued by men, in addition to community-based informal support centres.[69,70]

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[61] Struszczyk, et al. Men and suicide prevention: a scoping review, Journal of Mental Health. 2019. 28:1,80-88.
[62] Hubner-Liebermann, et al. Reducing suicides through an alliance against depression? Gen Hosp Psychiatry. 2010. 32:514–8.
[63] Matsubayashi T, Ueda M, Sawada Y. The effect of public awareness campaigns on suicides: Evidence from Nagoya, Japan. J Affect Disorder. 2014.152:526–529.
[64] Ono Y, Sakai A, Otsuka K, et al. Effectiveness of a multimodal community intervention program to prevent suicide and suicide attempts: A quasi-experimental study. PLoS One. 2013. 8:e74902.
[65] Szekely A, Thege BK, Mergl R, et al. (2013). How to decrease suicide rates in both genders? An effectiveness study of a community-based intervention (EAAD). PLoS One. 2018. 8:e75081.
[66] Wang J, Ha¨usermann M, Berrut S, Weiss MG. The impact of a depression awareness campaign on mental health literacy and mental morbidity among gay men. J Affect Disorder. 2013. 150:306–12.
[67] Knox KL, Litts DA, Talcott GW, et al. Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: Cohort study. BMJ. 2003. 327:1376–8.
[68] Shelef L, Tatsa-Laur L, Derazne E, et al. An effective suicide prevention program in the Israeli Defense Forces: A cohort study. Eur Psychiatry. 2016. 31:37–43.
[69] Jordan J, McKenna H, Keeney S, et al. (2012). Providing meaningful care: Learning from the experiences of suicidal young men. Qual Health Res. 2012. 22:1207–19
[70] Shand FL, Proudfoot J, Player MJ, et al. What might interrupt men's suicide? Results from an online survey of men. BMJ Open. 2015. 5:e008172

Similar findings have been reported by the Samaritans.[71] Men who took part in the research reported that they felt apprehensive about attending services which claimed to offer 'help and support' since this implied that there was something 'wrong' with them which needed to be 'fixed'. The men also spoke of the stigma that they felt when seeking support and therefore found it harder to engage with help-seeking services.[71]

- **Peer-support and co-leadership**
  Several men also reported that they appreciated when an initiative did not make them feel like a beneficiary but rather enabled them to contribute through running or facilitating the service, which made them feel valued and respected. The reframing of the initiative to become less to do with 'being fixed' is likely to appeal to men at a more earlier preventative stage. Men also highlighted the benefits of engaging in initiatives involving peer-support and focussing on shared goals, such as in team sports.[71]

4.2 Case studies from the UK

Outlined in this section are case studies of suicide prevention interventions from the UK. These examples have taken a tailored approach to target specific high-risk groups within that area. The examples highlight collaborative working with local partners, the use of real time data to coordinate action and the importance of research and data collection to understand and better identify potential at risk groups.

Torbay: Getting barbers to help young men

In Torbay suicide is the main cause of death in young men under 35 years. The public health team at Torbay council in collaboration with the suicide prevention charity Papyrus launched the Lions Barbers Collective. The movement aims to encourage barbers to raise the topic of emotional wellbeing with their clients. Barbers can sign up to bespoke 'Barber Talk' training which trains them to listen, advise and recognise depression and other mental health issues. Barbers can then signpost their clients to a range of agencies that can help. Torbay council plans to take the Lions Collective concept to other settings such as the local boxing clubs and pubs.[72]

Kent and Medway: targeting middle-aged men with a marketing campaign

Research carried out by Kent and Medway's suicide prevention steering group found that only a fifth of victims had been in touch with secondary mental health services in the 12 months before they died. In depth focus group research identified that most men did not identify themselves as suffering from mental illness, but they did highlight events such as relationship breakdown, job worries and financial pressures as key concerns and tended not to share these with their loved ones. The steering group designed a social marketing campaign called 'Release the Pressure' to make men aware of a 24/7 charity helpline.[72]

[71] Samaritans. Out of sight, out of mind: Why less-well off, middle-aged men don't get the support they need. 2020
[72] Local Government Association. Suicide Prevention: A Guide for Local Authorities. 2017

The campaign deliberately avoided using the words mental health and instead highlighted the experiences of real men to help men identify with the issues. The campaign was promoted on social media, billboards, petrol pumps, pubs, and local newspapers. BBC South East also covered the campaign. This led to a 56% increase in male callers received by the helpline (an increase of 200 calls a month).[72]

Cheshire and Merseyside: Working with Coroners

Cheshire and Merseyside have nine local authorities which are part of the Champs Public Health Collaborative Network. The coroner's service has partnered with the network to create a real-time suicide surveillance programme. This involves coroners providing information about suicides via a secure email to public health intelligence leads for Cheshire and Merseyside. The leads then alert the public health suicide prevention officers in the relevant local authority area who can then coordinate a quick response.[72]

Lincolnshire: Helping high-risk farmers

The Lincolnshire Rural Support Network runs health checks at local livestock markets in partnership with the NHS. As well as checking physical health the health checks also include conversations about emotional wellbeing. Farmers can then be referred to their GP, or more often they will be linked up with a case worker from the network if they require support. The network consists of a team of volunteers including solicitors and land agents, who offer their services for free. This initiative has shown to be a success after 44% of clients reported improvements in their ability to manage their own mental wellbeing and 59% showed an improvement in how hopeful they felt about their future.[72]

5. Self-Harm and suicide in Children and Young People (CYP)

Key message:

- Since 2017, there have been 22 admissions for intentional self-harm in Hammersmith & Fulham among young people aged 18 or below.
- 47% (10/22) were of white ethnic backgrounds and 52% (11/22) were of ethnic minority backgrounds. This is similar to the estimated ethnicity proportions of 10- to 18-year-olds living in Hammersmith & Fulham; 47% are from white ethnic backgrounds and 53% were from an ethnic minority background.
- 59% (13/22) of self-harm admissions occurred in residents living in the 40% most deprived LSOAs in the borough.
- The rate of suicide among CYP aged 10 to 19 years in LBHF is 5.6 per 100,000 as a six-year rolling aggregate between 2015 and 2020. This is lower than the England figure of 15.7 per 100,000.
- Nationally the rate of suicide in CYP increases significantly with age, with higher rates amongst those in their late teens and early 20s and amongst males.
- Data from the National Child Mortality Database (NCMD) shows that there is no correlation between social deprivation and suicide in CYP, this contrasts with the situation in adults.
- Of the 86 deaths recorded in the NCMD where ethnicity was recorded, 79% (68/86) were from a white ethnic background.

5.1 Review of effective suicide and self-harm prevention methods for CYP

Self-harm prevention in CYP

In England, a quarter of 11-16-year olds and nearly half of 17-19-year olds with a mental disorder reported that they have self-harmed or attempted suicide at some point in their lives.[73] Studies show a link between mental health disorders and self-harm and suicide, hence advocate for multiple therapeutic/psychosocial interventions to help reduce self-harm in children. The following methods have shown to be effective in reducing self-harm:

- **Therapeutic/Psychosocial Interventions:**
  Studies concur that therapeutic interventions have proven effective in reducing self-harm in children and adolescents; most efficacious interventions provided the greatest number of sessions.[74] Dialectical behavioural therapy and

[73] Royal College of Paediatrics and Child Health. Mental Health. Suicide. Available from: Suicide – RCPCH – State of Child Health. 2020

[74] Brent, D. A., McMakin, D. L., Kennard, B. D., Goldstein, T. R., Mayes, T. L., & Douaihy, A. B. Protecting adolescents from self-harm: a critical review of intervention studies. Journal of the American Academy of Child & Adolescent Psychiatry. 2013. 52(12), 1260-1271.

mentalisation therapy demonstrate the most effectiveness, while cognitive behavioural therapy shows some potential. [75,76,77,78]

a. **Dialectical Behaviour Therapy**
   Dialectical behavioural therapy (DBT) is a form of therapy that skills-training, exposure and response prevention, contingency management, problem-solving training, and cognitive modification strategies with mindfulness, validation, and acceptance practices.[79] Evidence suggests DBT is an effective intervention for reducing self-harm among children with existing mental health problems and children with repetitive self-harming behaviour.[80,81]

b. **Mentalisation Therapy:**
   Mentalisation based therapy is a long-term psychotherapy which helps make sense of one's own actions and feelings and those of others. Studies demonstrate that mentalisation therapy is associated with a reduction in self-harm for children and adolescents.[82]

- **School-based Intervention**
  School-based interventions such as gatekeeper training for teachers, show some efficacy in reducing the frequency of self-harm.[83,84] Schools can play a vital role in identifying mental health needs at an early stage and refer young people to specialist support, thus have the potential to reduce self-harm [85,86].

Suicide prevention in CYP

Suicide is one of the leading causes of death in children and adolescents and has been increasing every year.[87] Studies on suicide prevention for children show no clear single method but highlight a variation of approaches. They emphasise the need for multifaceted approaches to suicide prevention strategies targeting

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[75] O'Connor, R. C. and Robb, K. A. Identifying suicide risk factors in children is essential for developing effective prevention interventions. Lancet Psychiatry. 2020. 7(4):292-293.
[76] Hawton, K., Witt, K. G., Salisbury, T. L. T., Arensman, E., Gunnell, D., Townsend, E., & Hazell, P. Interventions for self-harm in children and adolescents. Cochrane database of systematic reviews. 2015. 12.
[77] Moran, P., & Asarnow, J. R. JOURNAL OF THE AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY. 2015. 54(2), 97-107
[78] Morken, I. S., Dahlgren, A., Lunde, I., & Toven, S. The effects of interventions preventing self-harm and suicide in children and adolescents: an overview of systematic reviews. 2020.8.
[79] Washburn, J. J., Richardt, S. L., Styer, D. M., Gebhardt, M., Juzwin, K. R., Yourek, A., & Aldridge, D. Psychotherapeutic approaches to non-suicidal self-injury in adolescents. Child and adolescent psychiatry and mental health. 2012. 6(1), 1-8.
[80] Mehlum, L., Tørmoen, A. J., Ramberg, M., Haga, E., Diep, L. M., Laberg, S., & Grøholt, B. Dialectical behavior therapy for adolescents with repeated suicidal and self-harming behavior: a randomized trial. Journal of the American Academy of child & adolescent psychiatry. 2014. 53(10),1082-1091.
[81] Witt, K. G., Hetrick, S. E., Rajaram, G., Hazell, P., Salisbury, T. L. T., Townsend, E., & Hawton, K. Interventions for self-harm in children and adolescents. *Cochrane database of systematic reviews*. 2021. 3.
[82] Witt, K. G., Hetrick, S. E., Rajaram, G., Hazell, P., Salisbury, T. L. T., Townsend, E., & Hawton, K. Interventions for self-harm in children and adolescents. *Cochrane database of systematic reviews*. 2021. 3.
[83] Naz, A., Naureen, A., Kiran, T., Husain, O., Minhas, A., Razzaque, B., & Chaudhry, N. Exploring lived experiences of adolescents presenting with self-harm and their views about suicide prevention strategies: a qualitative approach. International journal of environmental research and public health. 2021. 18(9), 4694.
[84] Ross, V., Kolves, K., & De Leo, D. Teachers' perspectives on preventing suicide in children and adolescents in schools: A qualitative study. Archives of suicide research. 2017. 21(3), 519-530.
[85] Department of Health & Social Care & Department for Education. Government response to the consultation on transforming children and young people's mental health provision: A green paper and next steps. 2018.
[86] Siu, A. M. Self-Harm and suicide among children and adolescents in Hong Kong: a review of prevalence, risk factors, and prevention strategies. Journal of Adolescent Health. 2019. 64(6), S59-S64.
[87] O'Connor, R. C. and Robb, K. A. Identifying suicide risk factors in children is essential for developing effective prevention interventions. Lancet Psychiatry. 2020. 7(4), pp. 292-293. (doi: 10.1016/S2215-0366(20)30094- 8:

children.[88] The following methods have shown to be effective in reducing suicidal attempts, behaviour and ideation:

- **Gatekeeper Education/Training**
  Gatekeeper prevention strategies show especially promising results when implemented in an institutional setting, such as schools, as this environment is arguably better suited to the structure that is needed to implement a successful gatekeeper program.[89,90]

  Findings show that school-based gatekeeper training is effective in improving identification and knowledge of people at risk of suicidal behaviour, preventing suicidal ideation and attempts short terms, and possibly suicide attempts in the long term.[91,92,93,94,95]

- **Psychotherapy**
  Multiple studies have demonstrated efficacy for psychotherapeutic methods, namely Cognitive Behavioural Therapy (CBT), focused on preventing suicide attempts and reducing suicidal ideation.[96,97] They found that CBT significantly reduces the severity of suicidal ideation and curbs suicidal behaviour.[98,99,100] Evidence suggests that combining psychotherapy, such as CBT with pharmacological treatment might lead to a reduction in suicidal ideation and behaviour than treatment with antidepressants alone,[101] highlighting the need for a multifaceted and combined approach to suicide prevention strategies.

- **Pharmacological Treatment**

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[88] Calear, A. L., Christensen, H., Freeman, A., Fenton, K., Grant, J. B., Van Spijker, B., & Donker, T. A systematic review of psychosocial suicide prevention interventions for youth. European child & adolescent psychiatry. 2016. 25(5), 467-482.
[89] Isaac, M., Elias, B., Katz, L. Y., Belik, S. L., Deane, F. P., Enns, M. W., & Swampy Cree Suicide Prevention Team (12 members) 8. Gatekeeper training as a preventative intervention for suicide: a systematic review. The Canadian Journal of Psychiatry. 2009. 54(4), 260-268.
[90] Isaac, M., Elias, B., Katz, L. Y., Belik, S. L., Deane, F. P., Enns, M. W., & Swampy Cree Suicide Prevention Team. Gatekeeper training as a preventative intervention for suicide: a systematic review. The Canadian Journal of Psychiatry. 2009. 54(4), 260-268
[91] Morken, I. S., Dahlgren, A., Lunde, I., & Toven, S. The effects of interventions preventing self-harm and suicide in children and adolescents: an overview of systematic reviews. 2020. Research, 8
[92] Mo, P. K., Ko, T. T., & Xin, M. Q. School-based gatekeeper training programmes in enhancing gatekeepers' cognitions and behaviours for adolescent suicide prevention: A systematic review. Child and adolescent psychiatry and mental health. 2018. 12(1), 1-24.
[93] Van Der Feltz-cornelis, C. M., Sarchiapone, M., Postuvan, V., Volker, D., Roskar, S., Grum, A. T., & Hegerl, U. Best practice elements of multilevel suicide prevention strategies. Crisis. 2011
[94] Beautrais, A., Fergusson, D., Coggan, C., Collings, C., Doughty, C., Ellis, P., & Surgenor, L. Effective strategies for suicide prevention in New Zealand: a review of the evidence. NZ Med J. 2007. 120(1251).
[95] King, C. A., Arango, A., & Foster, C. E. Emerging trends in adolescent suicide prevention research. Current opinion in psychology. 2018. 22
[96] Brown, G. K., & Jager-Hyman, S. Evidence-based psychotherapies for suicide prevention: future directions. American Journal of Preventive Medicine. 2014. 47(3), S186-S194.
[97] Beautrais, A., Fergusson, D., Coggan, C., Collings, C., Doughty, C., Ellis, P., & Surgenor, L. Effective strategies for suicide prevention in New Zealand: a review of the evidence. NZ Med J. 2007. 120(1251).
[98] Cox, G., & Hetrick, S. Psychosocial interventions for self-harm, suicidal ideation and suicide attempt in children and young people: What? How? Who? and Where?. Evidence-based mental health. 2017. 20(2), 35-40
[99] Stanley, B., Brown, G., Brent, D. A., Wells, K., Poling, K., Curry, J., & Hughes, J. Cognitive-behavioral therapy for suicide prevention (CBT-SP): treatment model, feasibility, and acceptability. Journal of the American Academy of Child & Adolescent Psychiatry. 2009. 48(10), 1005-1013.
[100] Van Der Feltz-cornelis, C. M., Sarchiapone, M., Postuvan, V., Volker, D., Roskar, S., Grum, A. T., & Hegerl, U. Best practice elements of multilevel suicide prevention strategies. Crisis. 2011
[101] Zalsman, G., Hawton, K., Wasserman, D, van Heeringen, K., Arensman, E., Sarchiapone, M & Zohar, J. Suicide prevention strategies revisited: 10-year systematic. 2016.

- There is an indication that pharmacological treatment may help decrease suicidal risk in children with mental disorders.[102] Selective serotonin reuptake inhibitors (SSSRIs), Serotonin and norepinephrine reuptake inhibitors (SNRIs), dual action antidepressants, high-potency anxiolytics, atypical antipsychotics show a potential for effective treatment in the short and long term.[103] Pharmacological methods are highly encouraged to be used in conjunction with psychotherapy to be even more effective in reducing suicide.[104,105]

- **Medical Practitioner Education/Training**
  Studies reveal that providing medical practitioners in primary care with training to help them identify and treat depression, the main risk factor for suicide, has shown to result in lower suicide rates.[106]

- **Means Restriction**
  Evidence suggests that reducing access to means of suicide reduces the rate of suicide by that method.[107,108]

5.2 Epidemiology

5.2.1 Self Harm in Hammersmith & Fulham

Between 2017 to 2021, there were 22 admissions to the Emergency Departments for intentional self-harm in Hammersmith & Fulham in children and young people (those aged under 18) as recorded by Imperial College Healthcare NHS Trust. The majority, 77% (17/22), of self-harm admissions occurred due to intentional self-poisoning. The remaining self-harm admissions occurred due to self-harm using another method.[109]

A similar number of children and young people who were admitted for self-harm came from white and ethnic minority backgrounds; of those who had their ethnicity recorded, **47% (10/22) were of white ethnic backgrounds and 52% (11/22) were of ethnic minority backgrounds.** This is similar to the estimated ethnicity proportions of 10- to 18-year-olds living in Hammersmith & Fulham; 47% are from white ethnic backgrounds and 53% were of ethnic minority backgrounds.[110]

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[102] Beautrais, A., Fergusson, D., Coggan, C., Collings, C., Doughty, C., Ellis, P., & Surgenor, L. Effective strategies for suicide prevention in New Zealand: a review of the evidence. NZ Med J. 2007. 120 (1251).
[103] Van Der Feltz-cornelis, C. M., Sarchiapone, M., Postuvan, V., Volker, D., Roskar, S., Grum, A. T, & Hegerl, U. Best practice elements of multilevel suicide prevention strategies. Crisis. 2011.
[104] Mann, J. J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A, & Hendin, H. Suicide prevention strategies: a systematic review. Jama. 2005. 294(16), 2064-2074.
[105] Zalsman, G., Hawton, K., Wasserman, D., van Heeringen, K., Arensman, E., Sarchiapone, M, & Zohar, J. Suicide prevention strategies revisited: 10-year systematic. 2016.
[106] Beautrais, A., Fergusson, D., Coggan, C., Collings, C., Doughty, C., Ellis, P., & Surgenor, L. Effective strategies for suicide prevention in New Zealand: a review of the evidence. NZ Med J. 2007. 120(1251).
[107]Mann, J. J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A., & Hendin, H. Suicide prevention strategies: a systematic review. Jama. 2005. 294(16), 2064-2074.
[108] Florentine, J. B., & Crane, C. Suicide prevention by limiting access to methods: a review of theory and practice. Social science & medicine. 2010. 70(10), 1626-1632.
[109] Imperial College Healthcare NHS Trust, List of Patient Spell discharges for Hammersmith & Fulham with diagnosis of self-harm between. 2021. 2016-2021.
[110] Greater London Authority. (2016). Housing-led Ethnic Group population projections.

Among children and young people admitted for self-harm, **59% (13/22) of admissions occurred among residents living in the 40% most deprived LSOAs in the borough**.[111] The highest proportion of children and young people admitted for self-harm lived in Wormholt and White City ward (the proportion has been suppressed due to small numbers).

5.2.2 Self Harm Nationally

Across England in 2014, the Health Behaviour in School-Aged Children (HBSC) survey was completed by 5,335 children aged 11-15 years. The survey examines the associations between self-harm, demographics, and social context in school aged children in England.[112]

Key findings from the report show that 22% of 15-year olds reported that they had ever self-harmed. **The rate among girls was almost three times higher than that among boys; 32% of girls reported that they had self-harmed compared to 11% of boys. Self-harming behaviours are most likely to occur between the ages of 12 and 15 years**.[113] If we extrapolate these figures to the Hammersmith & Fulham population, we would estimate that approximately 1,200 girls and over 400 boys between the ages of 12 and 15 have self-harmed.[114]

Furthermore, the HBSC found that **self-harming behaviour was more prevalent among children from low socio-economic backgrounds** than among children from higher socio-economic backgrounds. Self-harming behaviour was found to be **more prevalent among young people living in one parent households**; 35% of 15-year-olds who reported living with one parent reported to having self-harmed, compared to 17% of 15 year olds living in a two-parent household. However, it is important to note that one parent households are more likely to be below the poverty line.

The HBSC survey found that parents may play an important role in protecting young people from self-harming. Children who reported finding it more difficult to talk to their parents had a higher prevalence of self-harm, compared to children that reported easy communication with their parents.

The school environment is also associated with children's health and wellbeing. Children who reported ever self-harming were less likely to trust their teachers, feel safe or feel like they belonged in their school. Moreover, children who reported ever self-harming were more likely to have been bullied in the last two months.

Community can also have a large impact on children's health and wellbeing, especially as young people transition from childhood to adolescence, and have more unsupervised time in their communities. Young people who had negative opinions

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[111] Imperial College Healthcare NHS Trust, List of Patient Spell discharges for Hammersmith & Fulham with diagnosis of self-harm between. 2021. 2016-2021.
[112] Public Health England. Intentional self-harm in adolescence: An analysis of data from the Health Behaviour in School-aged Children (HBSC) survey for England, 2014. 2017.
[113] Hawton K, Saunders KEA, and O'Connor RC. Self-harm and suicide in adolescents. The Lancet. 2012. 379(9834): 2373-2382.
[114] London Population Projections Explorer [Internet]. 2021 [cited 3 December 2021]. Available from: https://apps.london.gov.uk/population-projections/

about the safety and supportiveness of their community, including relationships with their neighbours and access for young people to go in their community, were more likely to have ever self-harmed compared to young people who had a positive perception of their neighbourhood.

5.2.3 Suicides in Hammersmith & Fulham and Nationally

In Hammersmith & Fulham, the rate of suicide among residents aged between 10 to 19 years old is **5.6 per 100,000 persons** as a six-year rolling aggregate between 2015 and 2020.[115] This amounts to fewer than five deaths across the six years. In the UK, suicide is one of the leading causes of death in children and young people. The rate of suicide in children aged between 10 to 19 years old in **England** is **15.7 per 100,000 persons** as a six-year rolling total aggregate between 2015 and 2020. Hammersmith & Fulham therefore has a lower suicide rate among CYP than the national rate.

National data from the ONS shows that in England in 2020 while the suicide rate was the same in males and females aged 10 to 14 years old, the rate was almost 2.5 times greater among males aged 15 to 19 years old (6.6 deaths by suicide per 100,000 population) compared to females aged 15 to 19 years old (2.7 deaths by suicide per 100,000 population).[116] **Similarly in Hammersmith & Fulham, the rate of suicide among males aged 15 to 19 years old was higher than among females**; as a six year rolling total rate the rate of suicide was 12.6 per 100,000 population, whereas no deaths occurred by suicide among females between 2015 and 2020 in Hammersmith & Fulham. [117]

5.2.4 Characteristics of CYP who die from suicide

The number of suicides in CYP in Hammersmith & Fulham aged below 19 years between 2015-2020 is below five deaths. It is therefore not possible to draw meaningful conclusions from such small numbers. To understand the common characteristics of CYP who die from suicide national data from the National Child Mortality Database (NCMD) thematic report (2021) has been used.[118] The report draws on child mortality data from April 2019 to March 2020 collated from the regional Child Death Overview Panels in England.

The NCMD report states that in England 108 deaths in CYP below 18 years that were likely to be due to suicide were recorded between April 2019 to March 2020. **78% (84/108) of these deaths were amongst CYP aged between 15 and 17 years**. **The number of likely suicides increased significantly with age, since the suicide rate of CYP aged 17 years (8.3 deaths per 100,000 population) was almost three times higher than that of CYP aged 16 years (2.8 per 100,000).** This is in agreement to the 2017 report published by the University of Manchester on

[115] West London Coroner's Court. Deaths by Suicide. 2021
[116] Office for National Statistics. Suicides in England and Wales. [Online]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesintheunitedkingdomreferencetables
[117] West London Coroner's Court. Deaths by Suicide. 2021
[118] National Child Mortality Database. (2017) Suicide in Children and Young People. National Child Mortality Database Programme Thematic Report.

"Suicide by Children and Young People" [119] which found that of the 922 suicides that occurred between 2014-2015 in England and Wales amongst CYP aged under 25 years, the highest rates of suicide were amongst those in their late teens and early 20s and amongst males.

The NCMP report states that 61% (66/108) of likely suicides were amongst males, with 29% (31/108) amongst 17-year-old males. Even after adjusting for the gender distribution in the population the death rate amongst males (2.2 deaths per 100,000 population) remained higher than that of females (1.5 per 100,000 population). However, for deaths where the child was 13 years and under 50% (5/10) were male and 50% (5/10) were female.

The data showed no correlation between social deprivation and suicide based on the IMD 2019 score of the child's area of residence. This contrasts with the situation in adults where rates of suicide are higher amongst those living in areas of deprivation. Of the 86 deaths where ethnicity of the CYP was recorded**, 79% (68/86) were from a white ethnic background and 21% (18/86) were from a 'black, Asian, mixed or other ethnic background'. This is similar to the general population projection figures in England for 2020**, where 75% of 9-17 year olds are estimated to be from white ethnic background and 25% are from black, Asian, mixed or other ethnic backgrounds.

Of the 104 deaths where the location of death was recorded 61% (63/104) of the deaths occurred at home, followed by 29% (30/104) which happened in a public place. The most common method of suicide was hanging or strangulation, accounting for 69% (73/104) of all deaths. The second most common method was jumping or lying in front of a fast-moving object such as train, accounting for 12% (13/104) of all likely suicides.

[119] The University of Manchester. (2017). Suicide by Children and Young People.

5.3 Risk factors for suicide amongst CYP

The *"Suicide by Children and Young People"* report published by the University of Manchester [119] identifies 10 common themes in suicide by children and young people. These are outlined in the table below:

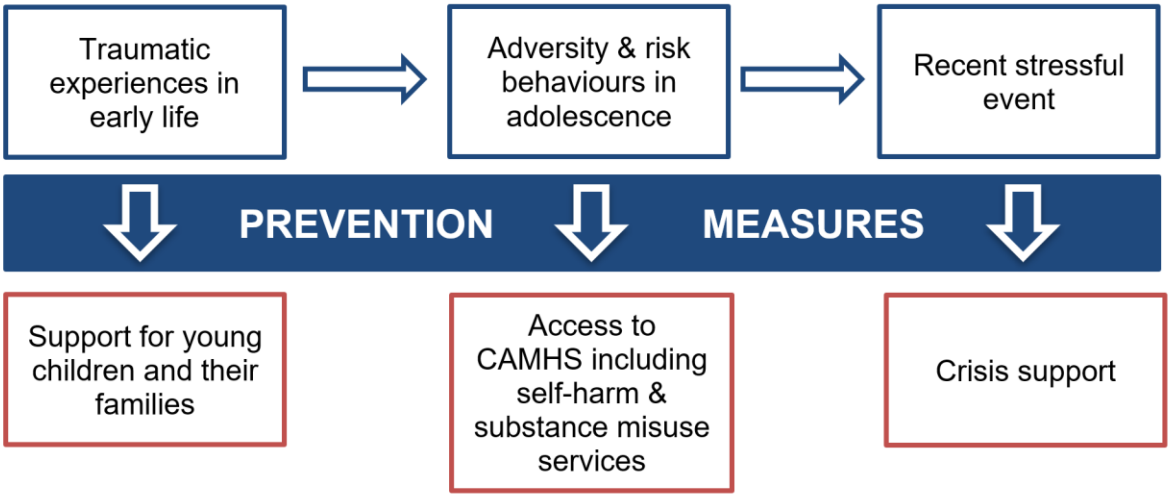
Box 4: Ten common themes in suicide by CYP

Key themes:

1. Family factors such as mental illness
2. Abuse and neglect
3. Bereavement and experience of suicide
4. Bullying
5. Suicide-related internet use
6. Academic pressures, especially related to exams
7. Social isolation or withdrawal
8. Physical health conditions that may have social impact
9. Alcohol and illicit drugs
10. Mental ill health, self-harm, and suicidal ideas

The report highlights that suicide in CYP is rarely caused by one single issue. It is usually a combination of factors, such as traumatic experiences earlier in life, a recent stressful event, a build-up of adversity and high-risk behaviours. Each factor is open to prevention, illustrated in figure 8.

Figure 8. Suicide in CYP caused by a combination of factors.



Source: The University of Manchester. Suicide by Children and Young People. 2017

6. What services exist in LBHF?

Key message:

- There are a range of organisations working with suicide prevention in the borough, for different groups including children, men, and other specific demographics.
- However, there is no single door for such third sector support, similar to the offer from adult crisis mental health services and children's services.

Suicide prevention and bereavement services available to residents in the borough can be divided into three broad categories. These are: Crisis Support Services, Non-urgent Support Services, Bereavement Support. Description of these services can be found in **Appendix 2**. These services target different groups including children, young people, men, and other specific demographics. Majority of the services available are helplines and information services provided by the voluntary sector and NHS. **Table 5** includes helpline numbers for anyone requiring urgent support.

Table 5. Urgent support lines

Organisation	Contact
North West London Mental Health Trust	24/7 support line: 0800 0234 650
West London Trust - Mental Health Single Point of Access	24/7 support line: 0800 328 4444
Shout	24/7 crisis text: Text "Shout" to 85258
Childline	24/7 support line: 0800 1111
The Mix	11am – 11pm support line: 0808 808 4994
Samaritans	24/7 crisis line: 116 123 Email: jo@samaritans.org
Papyrus	9am – 12am support line: 0800 068 4141 Text: 07860 039967
SPEAK CAMHS	24/7 support line offered by CAMHS practitioners: 0800 328 4444 Choose Option 2, Operating Hours: Mon-Fri 8am-11pm Weekend and Bank Holidays: 12pm-8pm

6.1 Ripple

Ripple is an online interceptive suicide prevention tool, designed to help and support individuals conducting searches relating to self-harm or suicide. The tool detects when a user is searching for online content relating to suicide or self-harm and immediately displays a message of hope and a selection of mental health resources on the user's

device in a range of different communication options including call, text and webchat from free charity services which are available 24/7.

The founder of Ripple, Alice Hendy, presented the tool to the adult social care team in September 2021, an online event attended by almost 145 persons.

Ripple nationally will be rolled-out in four phases:

- Phase 1. A Browser Extension
- Phase 2. Wi-Fi Network Integration
- Phase 3. Internet Service Providers offerings
- Phase 4: Forceful manufacture download

Ripple is currently in the development of Phase 2 and aims to complete phase 4 by end of 2024.

6.2 Support in prisons

Wormwood Scrubs is a category B men's prison located in LBHF. The prison includes a multi-faith prison chaplaincy which provides support for the emotional and spiritual well-being of prisoners and some aspects of prisoner rehabilitation. Prisoners who are known to be self-harming are provided with mandatory pastoral visits on a weekly basis. Chaplains are available to provide care and support to prisoners who are involved in or have been affected by serious illness or death.

This need assessment acknowledges the higher risk that prisoners have with regard to suicide, but as prison healthcare sits within NHS England, we will not comment further on this area. LBHF is in an open dialogue with NHS England about future suicide prevention work.

6.3 Papyrus work with schools in Hammersmith & Fulham

Papyrus is a national charity that aims to reduce the number of CYP who die from suicide, by tackling the stigma around suicide and equipping young people and their communities the skills to recognise and respond to suicidal behaviour.

The charity has developed a safer schools and college guide[120] for teachers and school staff, this has been shared with schools in LBHF. The guide aims to equip teachers with the skills required to support school children with suicidal ideation. It uses a 'community-model' approach, which supports the belief that suicide is everyone's business and that the community must be equipped to support and prevent young people dying from suicide. In 2019/2020 30 staff members from LBHF schools were trained in basic suicide awareness and prevention training delivered by Papyrus.

6.4 Anna Freud Centre: Link Programme

[120] Papyrus. (2018). Building Suicide-Safer Schools and colleges' guide. A guide for teachers and staff.

Hammersmith & Fulham is participating in the 2021/2022 Link Programme led by the Anna Freud Centre and funded by the Department of Education. The programme is a national initiative to support children's mental health, it aims to bring together local leaders in education and mental health to identify the support required by CYP locally.

7. What do local people think about suicide prevention in LBHF?

Key messages:

- Increased social isolation was a key issue that was raised by stakeholders.
- Communication between services dealing with vulnerable people who are at high risk of suicide needs to improve, along with better training for professionals on how to detect warning signs for suicide.
- Greater support is needed for people with dual diagnosis.

As part of the development of the LBHF suicide prevention strategy a **stakeholder consultation** was undertaken in the form of semi-structured interviews. The objective of the interviews was to understand the factors which were currently working in suicide prevention, what didn't work and what needed to be changed. The interviews intended to gather opinions of individuals from a wide range of organisations, including the Metropolitan Police, health professionals and homeless hostels. A total of 7 semi-structured interviews were conducted. A thematic analysis identified 6 themes outlined in the box below:

Box 5: Key themes identified from stakeholder consultations.

Key themes:

1. Increased social isolation
2. Lack of communication between services
3. Poor support for dual diagnosis
4. Reduction in drug and alcohol services due to COVID
5. Lack of awareness of suicide and warning
6. Non-existing or limited counselling services for people who are suicidal and or self-harm.

4 out of 7 stakeholders indicated that increased **social isolation** was an issue in suicide prevention. 3 out of 7 of stakeholders thought that a lack of communication between services, poor support for dual diagnosis, reduction in drug and alcohol services due to COVID and a lack of awareness of suicide and warning signs were all contributory factors in suicide and could be improved for better prevention. 2 out of 7 of stakeholders thought that there were non-existent or limited counselling services for people who are suicidal and or self-harm. A full breakdown of the responses can be found in **Appendix 3.**

An event was hosted by the **Leader of the council** on 12 October 2021, which brought together a number of professionals and stakeholders working in the field of suicide prevention. Full notes are available on request, and the key highlights were:

- Support and training for homeless shelter staff and VCS groups.
- We need to look at best practice and how we can work better together.
- We need to work with H&F's Integrated Care Partnership.
- With all multi-agency meetings for homelessness, violence against women and girls and multi-agency risk assessments-keep suicide in mind
- Think about **Papyrus programme the ASSIST** suicide prevention model.
- Think about people who drop out of support services and then complete suicide
- Work with the construction industry unions as this seems to be a risk in H&F.
- Work on family bereavement support after a suicide.
- Think of debt alleviation as a risk factor.
  Review access to mental health services.
- Clarity needed on crisis young people's mental health services, and thresholds for self-harm for young people who do not meet the threshold.
- Enable step down services after mental health crisis as an intervention. Key points in someone's life-where we need to be sharper and have better wraparound support/service: day discharged from mental health treatment and first few days/weeks; losing job; grief; trauma.

Appendices

Appendix 1: Key words and MeSH terms used to search literature

Search terms
prevention OR intervention OR strategy OR programmes
AND
suicide
AND
male OR men
AND
Middle-aged* OR 40-59 years
AND
Deprived*
children OR adolescent
AND
school
AND
self-harm or self-injury

Appendix 2: Support services in LBHF

Type of service	Organisation	Description
Crisis Support Services	CALM (Campaign Against Living Miserably)	LBHF in partnership with the London boroughs commissions the charity Campaign Against Living Miserably (CALM) to provide a free and confidential helpline and webchat which is open from 5pm to midnight every day. CALM also offers a bereavement support service through the Support After Suicide Partnership (SASP).
Crisis Support Services	Childline	Helpline which provides help for anyone under 19 in the UK with any issue they're going through including crisis help.
Crisis Support Services	Crisis Tools	Provides resources to help professional support young people in crisis.
Crisis Support Services	Ealing, Hammersmith& Fulham and Hounslow Mind	Provides advice and support to empower anyone experiencing a mental health problem, and campaigns to improve

		services, raise awareness and promote understanding.
Crisis Support Services	Hammersmith & Fulham Safe Space	The Safe Space is a local hub run by MIND which provides support for people nearing crisis point. It is available to LBHF residents or those registered with a GP in the borough aged 18 years and older. The hub professionals listen and work with the client to better cope with their issues. This can include developing coping mechanisms, signposting to a range of activities provided free of charge, and provision of resources. They also offer face to face, telephone and video-conference support.
Crisis Support Services	Mental Health Single Point of Access (NHS)	Provides a single-entry point for referrals to secondary mental health services and support in a mental health crisis in the boroughs of Hounslow, LBHF, and Ealing.
Crisis Support Services	NHS urgent mental health helpline	Provides 24-hour advice and support for people of all ages. People can speak to a mental health professional who can then carry out an assessment to help decide the best course of care.
Crisis Support Services	No Panic	Mental health charity which helps and supports those living with panic attacks, phobias, obsessive compulsive disorders and other related anxiety disorders. No Panic also provides support for the carers of people who suffer from anxiety disorders.
Crisis Support Services	North West London 24/7 crisis line	North West London Mental Health trust has a put in place a 24/7 crisis line for people of all ages. The lines are free to call and can provide advice to those in crisis. These crisis lines are supported by trained

		mental health advisors 365 days a year.
Crisis Support Services	Papyrus	Suicide prevention charity which provides confidential support and advice to young people below 35 years struggling with thoughts of suicide, and anyone concerned about a young person.
Crisis Support Services	Samaritans	Charity which provides crisis help for anyone who is struggling, including those who are suicidal.
Crisis Support Services	SANE	Mental health charity which provides emotional support, guidance and information to anyone affected by mental illness, including families, friends and carers.
Crisis Support Services	Shout UK	Mental health charity which provides free, confidential, 24/7 text messaging support service for anyone who is struggling to cope.
Crisis Support Services	The Mix	Provides free confidential support for young people aged under 25 years.
Crisis Support Services	Young Minds	Mental health charity for children, young people and their parents. They provide a helpline and a text messaging service for support.
Non-Urgent Support Services	Anxiety UK	Charity which provides help and advice to people affected by anxiety, stress and anxiety-based depression.
Non-Urgent Support Services	Bipolar UK	Mental health charity which supports people affected by bipolar disorder by providing practical information, advice and support by phone and email, as well as through their website.
Non-Urgent Support Services	Combat Stress	Mental health charity for veterans. It provides a range of community, outpatient and residential mental health services to veterans with complex mental health problems.

Non-Urgent Support Services	Good thinking	Digital wellbeing service which provides a range of resources to help improve the mental wellbeing of young people.
Non-Urgent Support Services	Kooth App	Kooth is an app which provides free, safe and anonymous online support and counselling for young people.
Non-Urgent Support Services	Men's Health Forum	Health charity for men and boys in the UK, particularly those in the most disadvantaged areas and communities. The charity provides information, services and treatments needed to live healthier, longer and more fulfilling lives. It provides information on mental health conditions like depression, anxiety, self-harm etc. and how and where to get help for specific conditions.
Non-Urgent Support Services	Rethink Mental Illness	Is a charity and provider of services for people living with mental illness. They provide online advice and information including a service directory.
Non-Urgent Support Services	The Listening Place	Charity which provides free, face-to-face on-going support with trained volunteers for those who are struggling with suicidal ideation. Sessions can be accessed through appointments and are based on active listening and befriending.
Non-Urgent Support Services	West London Action for Children	Is a charity which provides free, confidential, and professional counselling and therapy, parenting groups and groups for children in schools in LBHF.
Non-Urgent Support Services	Ripple	Ripple is an online interceptive suicide prevention tool, designed to help and support individuals conducting searches relating to self-harm or suicide. The tool detects when a user is searching for online content relating to

		suicide or self-harm and immediately displays a message of hope and a selection of mental health resources on the user's device.
Non-Urgent Support Services	Amadeus recovery house	A community-based short stay house run by West London Trust, that offers an alternative to a hospital stay for people experiencing a mental health crisis. The recovery house provides a safe and restful space for people who need help to get through an episode of acute mental illness and begin their recovery.
Non-Urgent Support Services	Best for You (BFU)	A digital platform for mental health support that includes different resources for young people and carers.
Bereavement support services	Cruse Bereavement Care	Charity which promotes the well-being of bereaved people and supports those bereaved by death to understand their grief and cope with loss. The services are free for bereaved people and include a helpline, private email, one to one support, group support, signposting and bereavement awareness training to external organisations. The local branch for NWL residents is situated in Kensington and Chelsea.
Bereavement support services	Brent, Wandsworth, and Westminster Mind	NWL commission Brent, Wandsworth and Westminster Mind to provide postvention service for NWL. The service is a single point of contact providing practical support for individuals, families and others bereaved and affected by suicide. It can also refer on to other appropriate services. Referrals are initially received from the Police via The Thrive Hub database.

Bereavement support services		
Bereavement support services	British Association of Counselling and Psychotherapy	Provides details of all counsellors and therapists locally and further afield that provide bereavement services.
Bereavement support services	The Good Grief Trust	Charity which provides resources for people experiencing bereavement.
Bereavement support services	AtaLoss.org	Signposting website which provides details of bereavement services.
Bereavement support services	West London Centre for Counselling	Charity providing a free, confidential counselling service for people 18 years and older who live in LBHF or who are registered with a GP in the borough.
Bereavement support services	Help Counselling	Help Counselling provides affordable short- and long-term counselling to residents in West London.
Bereavement support services	Surviving the Loss of your World (SLOW)	Bereavement charity which provides space and support for bereaved families to connect with each other.

Appendix 3: Number and proportion of responses by theme and stakeholder

	Emergency consultants	Homeless Hostels	Prison services	Army/MH educator	Community Psychiatrist	Metropolitan Police	Family member of suicide victim/charity worker	Total	% Of Respondents
Increased social isolation	1		1		1		1	4	57%
Lack of communication between services		1	1			1		3	43%
Poor support for dual diagnosis	1	1			1			3	43%
Reduction in drug and alcohol services due to COVID	1	1			1			3	43%
Lack of awareness of suicide and warning signs				1		1	1	3	43%
No/limited counselling service for suicidal/self-harm people		1			1			2	29%