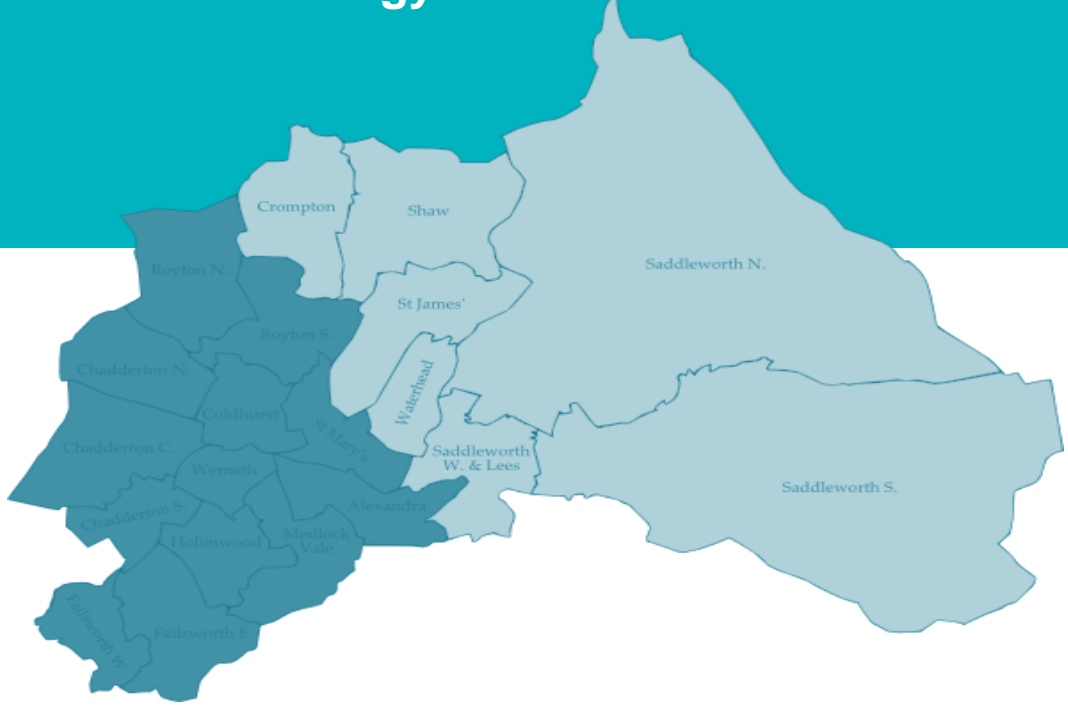


Oldham Council Suicide Prevention Strategy and Action Plan 2017-2020



| Author | Contributors |
|----------------------------------|---------------------------------|
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Foreword

The number of deaths to suicide in Oldham is significant, with seventeen deaths occurring in 2016. This is seventeen too many. The majority of suicides occur in men, with increased risk seen in those within the lowest socioeconomic groups and living in the most deprived geographical areas. Other at risk groups include those who self-harm, children and young people and those with untreated depression. Individuals who have been bereaved by suicide, those who are isolated, and those with a history of drug and alcohol misuse are also at increased risk.

This strategy builds on Oldham Council's work to date and sets out a bold and ambitious five year plan for reducing and ultimately eliminating suicides in Oldham. To do this will require a co-ordinated effort with our partners to ensure that suicide prevention becomes everyone's business.

Many of our partners and third party mental health providers have been involved in the development and creation of Oldham's Suicide Prevention Strategy and Action Plan.

We have taken guidance from the National Suicide Prevention Strategy 2012, the Five Year Forward View for Mental Health, the recently published PHE resource for local Suicide Prevention Planning 2016 and the Greater Manchester Suicide Prevention Strategy 2017-2021. In doing so we have developed a plan for action which fits with both the national and GM guidance.

Alan Higgins

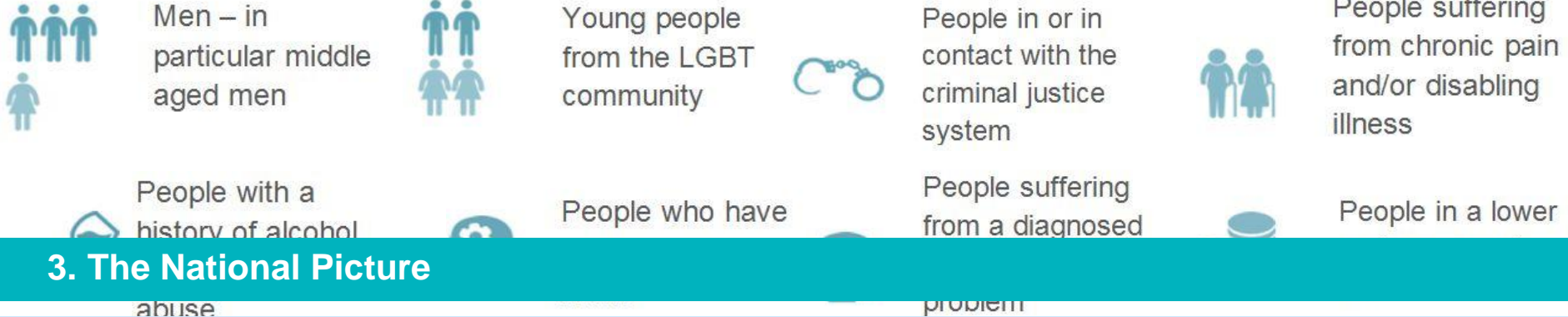
1. Introduction

Every suicide is an individual tragedy and a loss to society, with suicide being one of the top twenty leading causes of death worldwide. More than one million deaths per year are attributed to suicide globally (ONS 2016), with more than 6,000 people across the United Kingdom and Republic of Ireland alone becoming victims of suicide each year. Approximately 75% of all deaths by suicide are committed by men.

It is estimated that 60 people are significantly and negatively impacted for each suicide, including family and friends, work colleagues, health professionals, and police. Those that are bereaved and affected by suicide are in turn at a heightened risk of experiencing suicidal thoughts and ideation themselves.

In addition to the significant emotional cost, the financial cost of a death by suicide is considerable. It is estimated that the cost of a completed suicide is £1.67 million, or alternatively put, costs of £66,797 may be averted for every year of life as a result of each individual suicide.

2. Who is at risk?



3. The National Picture

3.1 In 2012, the government published a new national strategy: *Preventing Suicide in England*. This encompasses six 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

3.2 Additionally, the responsibility of local authorities to develop their own suicide prevention strategies was identified in this document. The National Strategy recommended that local authorities should aim to tackle all six areas of the national strategy in the long term, with recommended priorities for short term action below;

- 1) Reducing risk in men, especially in middle age, with a focus on: economic factors such as debt, social isolation, drugs and alcohol, developing treatment and support setting that men are prepared to use.
- 2) Preventing and responding to self-harm, with a range of services for adults and young people in crisis, and psychological assessment for self-harm patients

4. The Greater Manchester Picture

4.1 The total population of Greater Manchester is approximately 2.8million people and in 2015 there were 201 deaths by suicide in Greater Manchester. The greatest numbers were seen in Wigan, with the lowest in Trafford.

Figure 1: Numbers of suicides by Borough (2015)

| | Total | Male | Female |
|------------|-------|------|--------|
| Bolton | 20 | 17 | <5 |
| Bury | 14 | 12 | <5 |
| Manchester | 36 | 30 | <5 |
| Oldham | 12 | 10 | <5 |
| Rochdale | 15 | 14 | <5 |
| Salford | 23 | 18 | 5 |
| Stockport | 14 | 8 | 6 |
| Tameside | 18 | 17 | <5 |
| Trafford | 9 | 9 | 0 |
| Wigan | 40 | 32 | 8 |

4.4 The recent Greater Manchester Suicide Audit completed in 2016 identified a number of key trends



Social Isolation; lack of relationships and friendship groups



Physical health issues – injuries, chronic illnesses, severe illnesses



Contact with Police



Job loss and financial issues



Occupation; especially the construction industry



Bereavement; in particular for those bereaved by suicide



Relationship breakdown; in particular for men

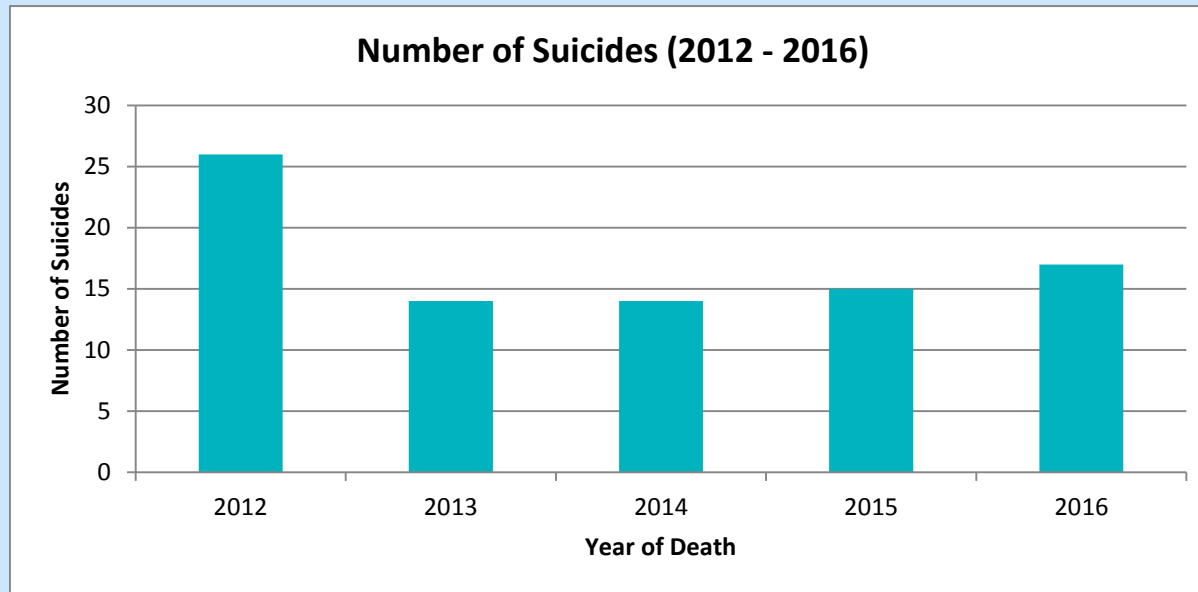


Internet; to access information on methods

5. Oldham Suicide Audit

5.1 Suicide by number

Figure 1: Number of Residential Suicides 2012-2016

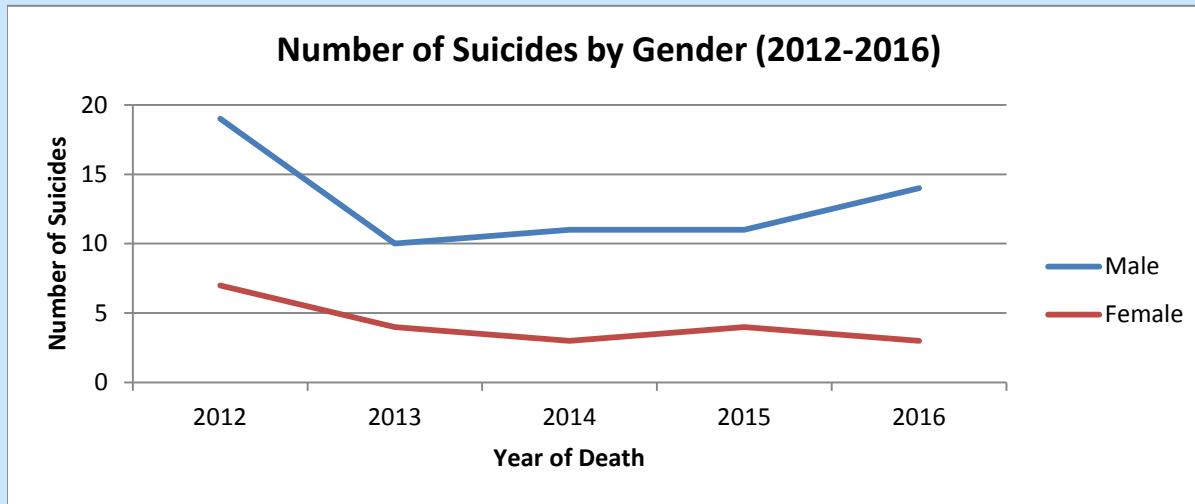


Source: PCMD 2012-2016

5.1.1 The table above shows us that there has been an overall decrease in suicide in Oldham from 2012 to 2016. The previous audit identified 161 verdicts of suicide between 2004 and 2011. There were 86 verdicts of suicide between 2012 - 2016. The above chart illustrates that suicides have decreased since 2012, however a slight increase is beginning to emerge from 2015 and suicide remains an area of concern for Oldham.

5.2 Suicide by gender

Figure 2: Number of Residential Suicides by Gender 2012-2016

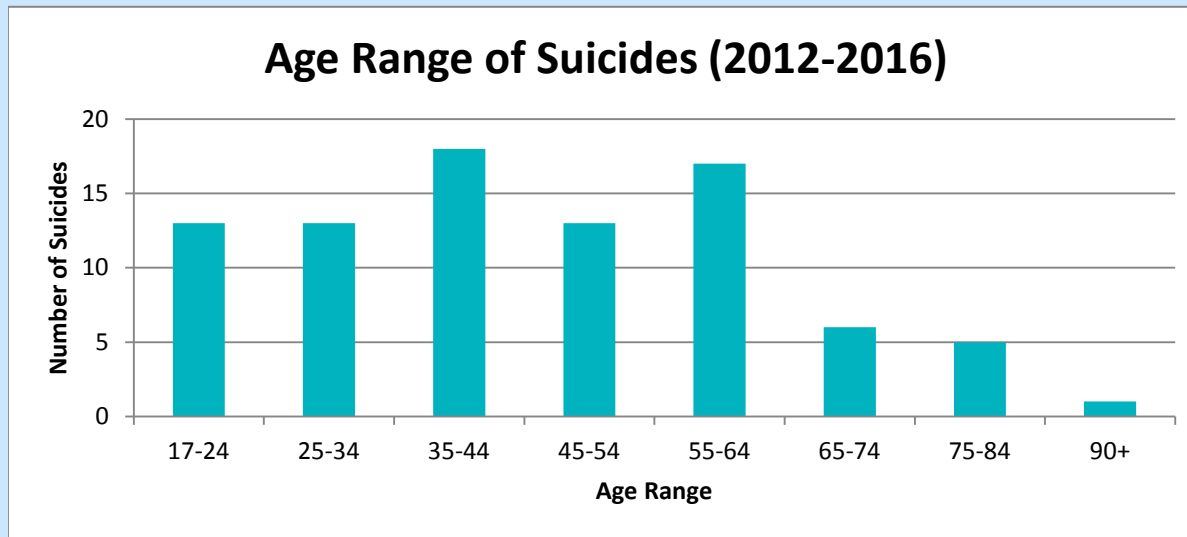


Source: PCMD 2012-2016

5.2.1 Rates of suicide are higher in males (76%) than females (24%) in Oldham, and this is representative of both the national picture and Greater Manchester. While both male and female suicides dropped in 2013, male suicide has begun to rise as of 2015, whereas female suicide has remained constant in its lower precedence.

5.3 Suicide by Age

Figure 3: Age range of Residential Suicides 2012-2016



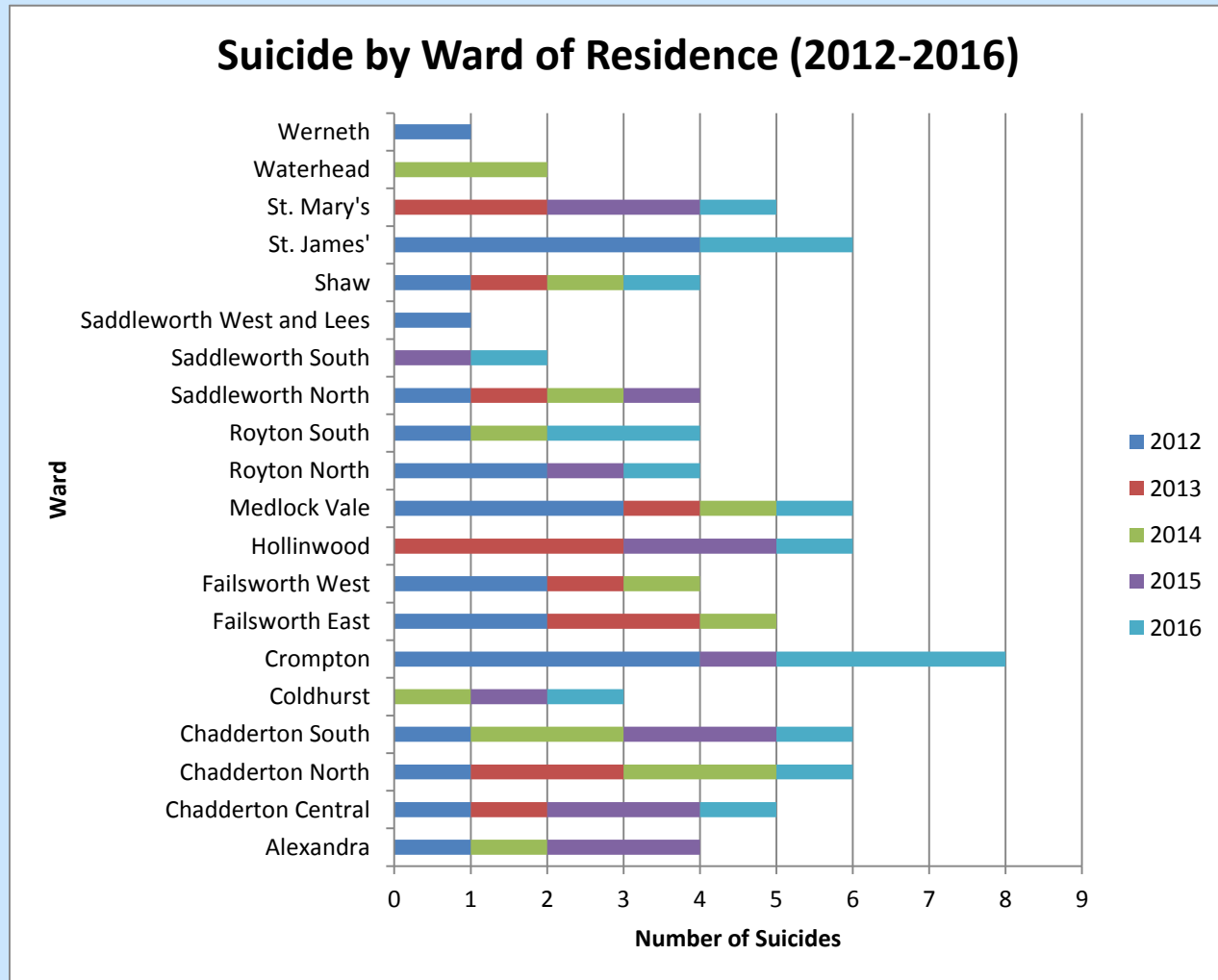
Source: PCMD 2012-2016

5.3.1 Suicides affect all age groups but for Oldham the highest proportion of residential suicides are in the age group 35 to 44 years, similar to the national average. There are also a high number of suicides in the age group 55 to 64 years compared to the national average, where nationally rates decline after the age of 50. For Oldham, the decline in suicides is after the age of 64 years.

5.3.2 Another area for concern is the relatively high rate of suicide amongst young people in Oldham (17-34 years), with a rate of 21.1 suicides per 100,000 people. Rates of suicide among younger people are higher in Oldham both compared to the national average and amongst our neighbours in Greater Manchester – Oldham has the second highest rate of suicide in the 10-34 years age group in Greater Manchester.

5.4 Suicide by Oldham District Area

Figure 4: Suicide by Ward of Residence 2012-2016



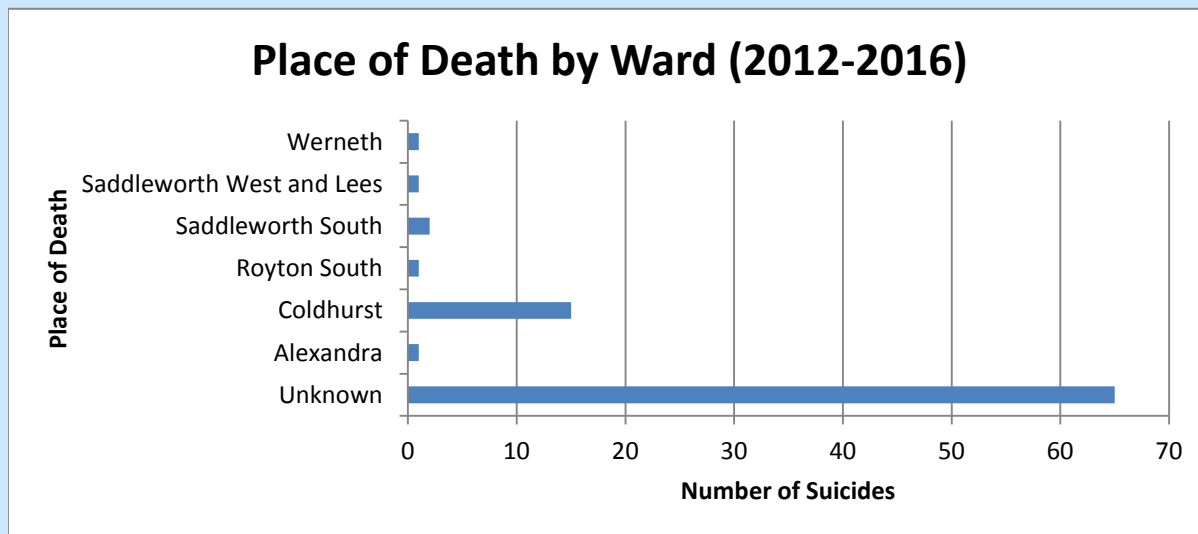
Source: PCMD 2012-2016

5.4.1 Suicide is generally higher in more deprived areas and on average the wards of Crompton, Chadderton North and South, and Hollywood, Medlock Vale, St James's and St Mary's have higher than average suicide rates and historically have been higher than the more affluent areas of Oldham.

5.4.2 Locally suicide rates vary significantly across the borough. However a trend has begun to emerge with more affluent areas of Oldham's suicide rates beginning to increase from 2012.

5.5 Suicide by Place of Death

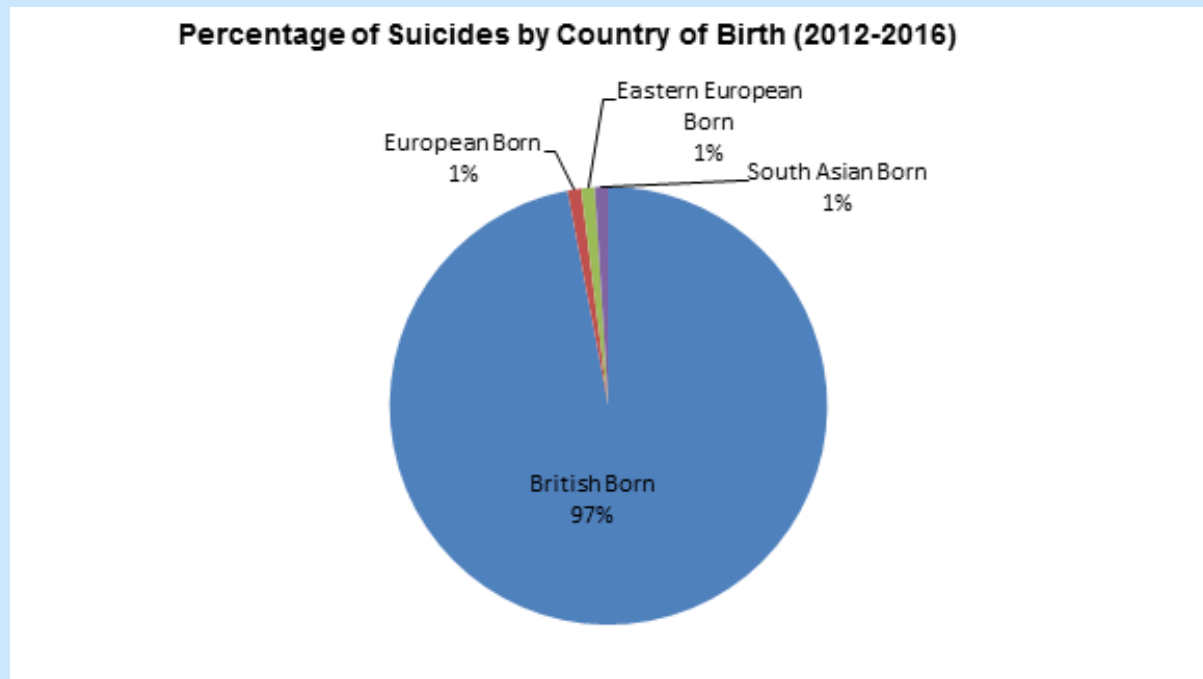
Figure 5: Suicide by place of Death 2012-2016



5.5.1 The ward in which the most suicides took place is Coldhurst, although data for the location of the majority of suicides was not available to the audit.

5.6 Ethnicity

Figure 5: Suicides by Country of Birth of Deceased 2012-2016

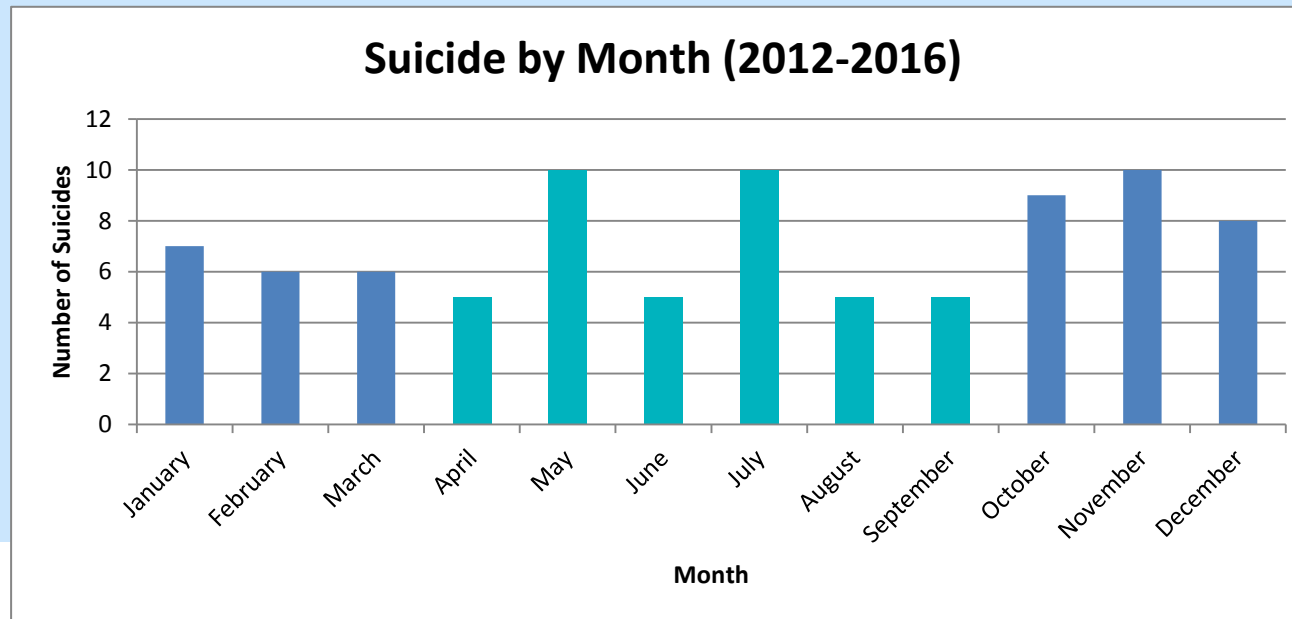


Source: PCMD

5.6.1 The recording of ethnicity in the deaths databases refers to country of birth rather than ethnicity of the deceased. Therefore, deaths occurring in the British born section could be from any ethnic group born in the UK. The chart does clearly illustrate that the majority of suicide occur in people born in the UK.

5.7 Suicide by Month

Figure 6: Suicides by Month 2012-2016

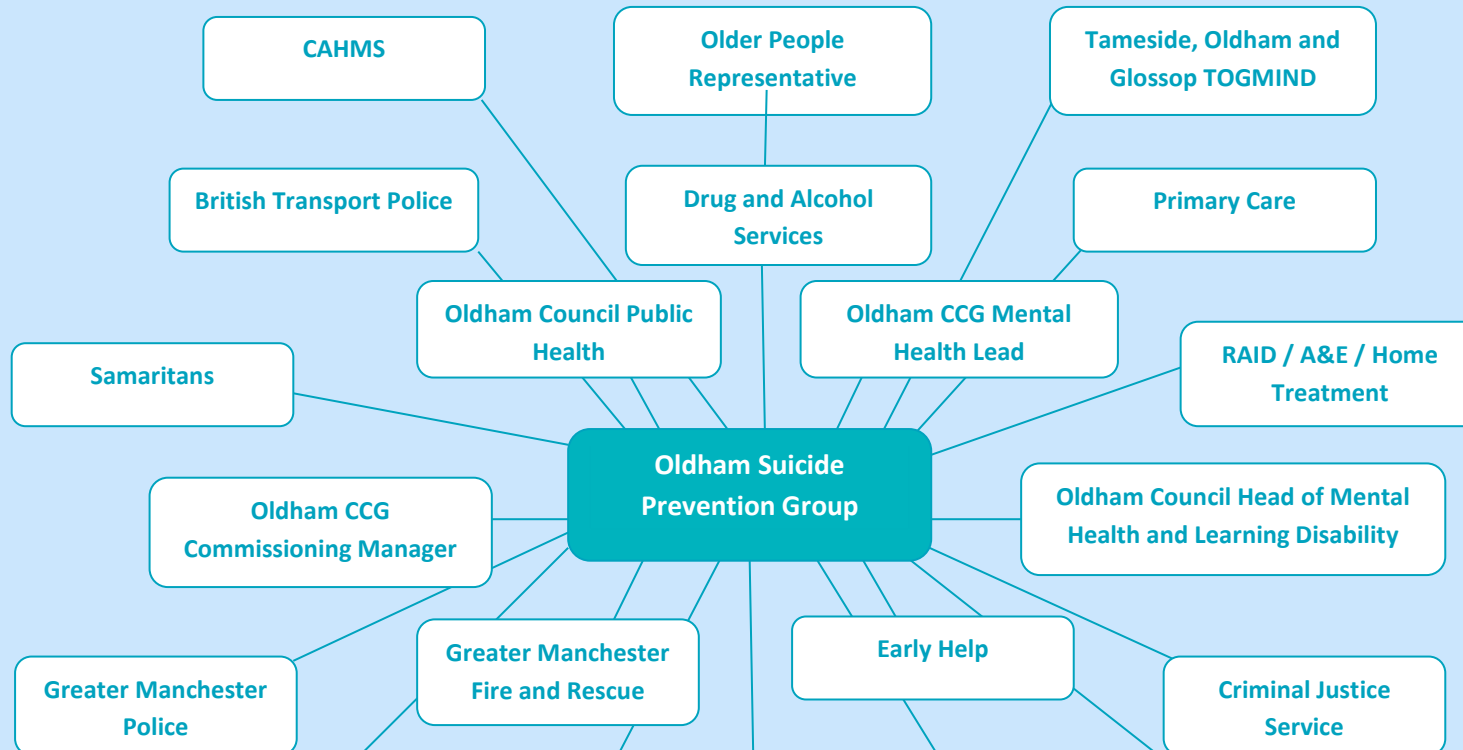


Source: PCMD

5.7.1 The chart above (figure 6) illustrates the number of suicides by month. The chart shows that the number of suicides peak in May, July and November. A slightly higher number of suicides occur in the winter months, with 53% occurring during the winter months October to March compared to 47% during the summer months April to September. However, suicides rates fluctuate widely throughout the year.

6. Oldham Multi-Agency Suicide Prevention Group

Oldham Council relaunched a multi-agency suicide prevention group in October 2016. The group's aim is to identify and agree improvements for the prevention of suicide in all services and age groups; including children, older people and people of working age. Additionally, this Strategy and Action Plan has been developed in partnership with the group.



7. Oldham Priorities for Action

We have grouped our actions into six areas for action. These have been developed taking into consideration the priority areas for action recommended in the National Suicide Prevention Strategy and the Greater Manchester Suicide Prevention Strategy. The full Action Plan can be found in Appendix A.

1) Male Suicide

There is a clear disparity between the sexes in terms of suicide in Oldham. Male deaths account for three quarters of the total number of local suicides over recent years: between 2012 and 2016 there were 65 male deaths (75.5%) and 21 female deaths (24.5%) in Oldham. This is representative of both the national picture and Greater Manchester. The chart below illustrates the disparity between the sexes for Oldham.

- Develop and implement initiatives to support the delivery of the Whole School and College Approach to Mental Health and Emotional Wellbeing in Schools and Colleges
- Identify and support children/young people/vulnerable families where children are at risk of emotional and behavioural problems
- Provide accessible and engaging interventions for children and young people who offend, in their area and in custodial or secure settings in order to improve their mental health.
- Help seeking information such as leaflets referring to services provided in Section 136 Suite in the Royal Oldham Hospital

3) Tackling High Frequency Locations

Suicides in Oldham take place largely in the home of the deceased. Outside of the home, a key area of concern is Greenfield Railway Station, where three suicides and one suicide attempt has been carried out since 2013. In the past, there has been suicides both in Acute care settings and from buildings of height in the borough.

4) Media Engagement

Research shows that inappropriate reporting of suicide may lead to imitative or 'imitational' behavior. Reporting on suicide and the inquests that follow can be difficult for media outlets. As a Council, our Communications department along with GMP, Samaritans and local media outlets must report the story sensitively while still ensuring that the public are kept informed.

Oldham will;

- Ensure that any reporting on suicide;
 - Provides information about sources of support and helplines when reporting suicide
 - Avoids insensitive and inappropriate graphic illustrations with media reports of suicide
 - Avoids use of photographs taken from social networking sites without relative consent
 - Avoids the re-publication of photographs of people who have died by suicide
 - Reports appropriately where there is evidence of a cluster
- Share the 'Samaritans' Media Guidelines for Reporting Suicide with Council Communications Team, GMP and NHS media teams and ensure that they are aware of the sensitive nature of suicides.
- Challenge, where possible, the publication of harmful or inappropriate material with reference to the updated laws on promoting suicide

5) Bereavement Support

Death causes great pain and sadness whatever the cause of death, with those bereaved through suicide facing additional pressures and pain.

To achieve this aim, the following actions are being taken;

- Provide resources for primary care staff to raise awareness of the vulnerability and support needs of family members when someone takes their own life.
- Provide bereaved families with an explanation of policies on investigation of patient suicides, opportunity to be involved and information on any actions taken as a result. Refer families to Oldham Bereavement Support Services.
- Develop an offer for specific suicide bereavement support services in Oldham. This could involve partnering with out of borough services such as SOBS, or 'fast-tracked' bereavement support services through CCG commissioned services
- Promote Public Health England Help Is At Hand document to key partners and make available in Oldham libraries.
- Provide accessible, concise information on the processes and standards in a Coroner's enquiry to family members.

6) Treatment of Depression in Primary Care

Primary Care plays an important role in treating depression, as the first point of contact for many. 80% of people who had taken their own life in 2015 had visited their GP in the six months prior to their death, presenting opportunities to identify suicide risk. For this reason, the treatment of depression in Primary Care has been identified as a priority area for action for Oldham.

Actions being taken are:

- Potential pilot of suicide risk assessment to commence in Primary Care, potentially through EMIS.
- Safe prescribing of painkillers and anti-depressants, plus skilling up primary care practitioners in identification and initial management of risk.

Key Guidance Documents and Toolkits

- *Greater Manchester Suicide Prevention Strategy*
- *Cheshire and Merseyside Suicide Prevention Strategy*
- *Preventing Suicide in England: A cross government outcomes strategy to save lives*
- *HM Government (2014) Preventing suicide in England: One year on First annual report on the cross-government outcomes strategy to save lives*
- *Suicide prevention: developing a local action plan (Public Health England)*
- *Samaritans, Suicide Statistics Report 2014*
- *Samaritan's Best Practice Suicide reporting tips*
- *MIND guidance on supporting someone who feels suicidal*
- *CALM (Campaign Against Living Miserably)*

Acknowledgements

Oldham Council Public Health
Oldham Council Business Intelligence Service
Oldham Clinical Commissioning Group
Pennine Acute Trust
Pennine Care Foundation Trust
Greater Manchester Police
Greater Manchester Fire and Rescue
Oldham Probation Service

Acknowledgements (cont.)

Positive Steps

Tameside, Oldham and Glossop MIND

Rochdale, Oldham and District Samaritans

British Transport Police

MH:2K

First Choice Homes

Contour Homes

Alcohol Dependency Solutions

Survivors Manchester

Regender



APPENDIX A

| | | | |
|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|---------------------|------------|
| Name | Oldham Council Suicide Prevention Strategy: Suicide Prevention Action Plan | | |
| Duration: | 2017 – 2020 | | |
| Relevant strategies: | Mental Health Strategy Schools Mental Health Framework Locality Plan Oldham JSNA GM Crisis Care Concordat | | |
| Board responsible for monitoring plan: | Health and Wellbeing Partnership Board | | |
| Plan Author: | Jennifer McErlain: Project Manager, Public Health | | |
| Implementation date: | TBC | Review date: | TBC |

| Priority Area 1: | | | Male Suicide | | |
|----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------|
| Objective (if applicable): | | | Reducing the heightened risk of suicide in men, particularly young and middle-aged men. | | |
| Ref: | Action: | Start: | End: | Measure/outcome: | Lead officer/partner: |
| 1.0 | <p>Oldham Council Social Care, Acute Care, Primary Care and Mental Health services to proactively promote and signpost to organisations that are aimed specifically at improving the mental health of men;</p> <ul style="list-style-type: none"> • Campaign Against Living Miserably (CALM) • Men in Sheds • Andy's Man Club at OCL • Survivors Manchester • Safe and Well Service delivered by the Fire Service | September 2017 | December 2019 | Number of vulnerable people signposted to secondary mental health providers and support groups | All |
| 1.1 | Pre Suicide Prevention Day (10 th September 2017) Campaign to promote organisations that are aimed specifically at improving the mental health of men (as above). | September 2017 | September 2017 | Comms material to be circulated through social media | Council Communications Team |

| Priority Area 2: | | | Mental Health of Children and Young People (and in pregnancy) | | |
|----------------------------|---------|--------|---------------------------------------------------------------------------|------------------|-----------------------|
| Objective (if applicable): | | | Improve the mental health of children, young people and expectant mothers | | |
| Ref: | Action: | Start: | End: | Measure/outcome: | Lead officer/partner: |

| | | | | | |
|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| 2.0 | Develop and implement initiatives to support the delivery of the Whole School and College Approach to Mental Health and Emotional Wellbeing in Schools and Colleges | July 2017 | July 2018 | Commission training for graduated response Commission training for Whole School and College Approach Map services providing support to schools and colleges | Public Health |
| 2.1 | Identify and support children/young people/vulnerable families where children are at risk of emotional and behavioural problems | October 2017 | December 2019 | Implementation of protocols to meet the needs of children living in disadvantaged households | Oldham Children's Social Care |

| | | | | | |
|-----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------|---------------------------------------------------------|----------------------------------------|
| 2.2 | Provide accessible and engaging interventions for children and young people who offend, in their area and in custodial or secure settings in order to improve their mental health. | October 2017 | December 2019 | Number of youth offenders accessing interventions | Youth Justice Service (Positive Steps) |
| 2.3 | Help seeking information such as leaflets referring to services provided in Section 136 Suite in the Royal Oldham Hospital | September 2017 | December 2017 | Help seeking information provided in Section 136 suites | Pennine Acute |

| Priority Area 3: | | | Tackling High Frequency Locations | | |
|----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|------------------------------------------------------------------|-----------------------------------------------------------------------------------------|------------------------------|
| Objective (if applicable): | | | Reduce the opportunities people have to commit suicide in Oldham | | |
| Ref: | Action: | Start: | End: | Measure/outcome: | Lead officer/partner: |
| 3.0 | Include suicide risk in health and safety considerations by Local Authority Planning departments and Environmental Health Officers and developers when designing high structures that may offer suicide opportunities | January 2018 | December 2019 | Suicide considerations in standard risk assessment/health and safety tick box template. | Oldham Planning Department |
| 3.1 | Maintain the number of Samaritans signs on Greenfield Railway Station Bridge and station area | October 2017 | December 2017 | Continued presence of signs on Greenfield Railway Bridge | The Samaritans Public Health |
| 3.2 | Greenfield Railway Station staff to receive basic suicide | January 2018 | July 2018 | Number of frontline staff trained by Greater | GMP |

| | | | | | |
|-----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-----------------------------------------------------|
| | prevention and recognition training | | | Manchester Police | |
| 3.3 | Engage with British Transport Police, Northern Rail and Network rail to identify opportunities to further prevent suicide at their locations. | September 2017 | December 2019 | Relationship to be built between Oldham Council Public Health and Transport authorities | Public Health Oldham Suicide Prevention Group |
| 3.4 | Review Suicide Prevention Standards for Acute Care being developed based upon NICE guidance associated with mental health inpatient settings (e.g. 12 points to a safer service) and see which approaches can be adopted | September 2017 | December 2019 | Recommendations made based on Suicide Prevention Standards for Acute Care guidance | CCG Pennine Care Pennine Acute GP Clusters |
| 3.5 | Risk assessment tool fully utilised within A&E admissions and wards | September 2017 | December 2019 | Number of patients referred through the risk assessment tool in A&E | Pennine Acute |
| Priority Area 4: | | | Media Engagement | | |
| Objective (if applicable): | | | The media to report on suicide and suicide behaviour sensitively, taking into account guidance and support from other stakeholders. | | |
| Ref: | Action: | Start: | End: | Measure/outcome: | Lead officer/partner: |
| 4.0 | Ensure that any reporting on suicide; • Provides information about sources of support and helplines when | August 2017 | September 2017 | All suicides reported on in a sensitive and appropriate way | Oldham Council Communications Team |

| | | | | | |
|-----|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|----------------|-------------------------------------------------------------------|--------------------------------------------------|
| | <p>reporting suicide</p> <ul style="list-style-type: none"> • Avoids insensitive and inappropriate graphic illustrations with media reports of suicide • Avoids use of photographs taken from social networking sites without relative consent • Avoids the re-publication of photographs of people who have died by suicide • Reports appropriately where there is evidence of a cluster | | | | |
| 4.1 | <p>Share the 'Samaritans' Media Guidelines for Reporting Suicide with Council Communications Team, GMP and NHS media teams and ensure that they are aware of the</p> | August 2017 | September 2017 | Number of organisations aware of the Samaritans media guidelines. | Public Health Oldham Council Communications Team |

| | | | | | |
|--|-------------------------------|--|--|--|--|
| | sensitive nature of suicides. | | | | |
|--|-------------------------------|--|--|--|--|

| | | | | | |
|-----|-----------------------------------------------------------------------------------------------------------------------------------------|-------------|---------------|------------------------------------------------------------|-----|
| 4.2 | Challenge, where possible, the publication of harmful or inappropriate material with reference to the updated laws on promoting suicide | August 2017 | December 2019 | Evidence of challenge of harmful or inappropriate material | GMP |
|-----|-----------------------------------------------------------------------------------------------------------------------------------------|-------------|---------------|------------------------------------------------------------|-----|

| Priority Area 5: | | | Bereavement Support | | |
|-----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|---------------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------|
| Objective (if applicable): | | | Provide better information and support to those bereaved or affected by suicide | | |
| Ref: | Action: | Start: | End: | Measure/outcome: | Lead officer/partner: |
| 5.0 | Provide resources for primary care staff to raise awareness of the vulnerability and support needs of family members when someone takes their own life. | January 2018 | December 2019 | Number of primary care staff who have received training on resources | CCG Pennine Care TOG MIND |

| | | | | | |
|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
| 5.1 | Provide bereaved families with an explanation of policies on investigation of patient suicides, opportunity to be involved and information on any actions taken as a result. Refer families to Oldham Bereavement Support Services. | January 2018 | December 2019 | Proportion of families who are referred to Oldham Bereavement Support Services. | GMP |
| 5.2 | Develop an offer for specific suicide bereavement support services in Oldham. This could involve partnering with out of borough services such as SOBS, or 'fast-tracked' bereavement support services through CCG commissioned services | January 2018 TBC | TBC | GM Mental Health Transformation Bid includes funding for developing bereavement services in each GM locality. Funding not confirmed until early 2018 | CCG Public Health |
| 5.3 | Promote Public Health England <i>Help Is At Hand</i> document to key partners and make available in Oldham libraries. | January 2018 | December 2019 | <i>Help Is At Hand</i> document readily available in libraries. | Public Health |

| | | | | | |
|-----|------------------------------------------------------------------------------------------------------------------|--------------|---------------|------------------------------------------|--------------------------------------------------|
| 5.4 | Provide accessible, concise information on the processes and standards in a Coroner's enquiry to family members. | January 2018 | December 2019 | Number of families receiving information | The Coroners Service (based in Rochdale Council) |
|-----|------------------------------------------------------------------------------------------------------------------|--------------|---------------|------------------------------------------|--------------------------------------------------|

| Priority Area 6: | | | Treatment of Depression in Primary Care | | |
|----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| Objective (if applicable): | | | Early awareness of the risk of suicide in people with depression | | |
| Ref: | Action: | Start: | End: | Measure/outcome: | Lead officer/partner: |
| 6.0 | Potential pilot of suicide risk assessment to commence in Primary Care, potentially through EMIS. | September 2018 | September 2018 | <ul style="list-style-type: none"> Identify needs codes Identify GP practices Develop template Establish working group | CCG Public Health Pennine Care Public Health England |
| 6.1 | Safe prescribing of painkillers and anti-depressants, plus skilling up primary care practitioners in identification and initial management of risk. | January 2018 | December 2019 | Primary Care practitioners trained in identification and initial management of risk | Pennine Care Pennine MSK Partnership |