Preventing Suicide in Bristol Annual Report 2022

Leonie Roberts, Consultant in Public Health

Magdalena Szapiel, Senior Public health Specialist

Contents

Acknowledgements

To members of the Suicide Prevention Group, the Avon Suicide Prevention Audit Group and all those who work with to make Bristol a safer and more compassionate city.

1.0 Introduction

Suicide is a preventable tragedy with a devastating impact. In England one person will die every 2 hours by suicide and many more will attempt suicide. Suicide can have a lasting effect on individuals, their friends, families, colleagues, and communities.

Every single life lost to suicide is one too many.

Around 40 lives are lost to suicide in Bristol each year.

The current 3-year average suicide rate in Bristol is 12.3 per 100,000, similar to the England average of 10.4 per 100,000 population. The suicide rate for females is 5.5 per 100,000 population and for males 19.1 per 100,000 population, more than three times the female rate.

The trend has been remained fairly static with each 3-year rate since 2005-07 reporting as being between 10.6 and 12.8 per 100,000 which equates to between 120 and 147 preventable deaths per 3-year period.

The reasons leading to an individual taking their own life can be complex. There are many social, economic, psychological, and cultural factors that can all interact to lead a person to suicidal behaviour.

There are also many protective factors that can help to reduce suicidal behaviour. These include being in full-time employment, have a strong and support friends and family and the ability to access effective mental health.

The Preventing Suicide in England – a cross governmental strategy to save lives was launched in 2012 under the 2010 to 2015 Conservative and Liberal Democrat coalition government. It set clear and evidence-based priority action areas at a national and local level. The Mental health and wellbeing plan is currently out for consultation.

The Bristol ambition is to become a Zero suicide city.

2.0 Analysis of trends in suicide in Bristol

The analysis draws on data from a variety of different sources including Primary care Mortality Database, Office for National Statistics, Ministry of Justice and National Offender Management Service and Public Health Outcomes Framework.

Suicide deaths are defined as deaths from suicide and undetermined intent, classified by underlying cause of death, using international Classification of Diseases (ICD-10) codes X60-X84 (age 10+), Y10-Y34 (ages 15 and over).

Due to small numbers in any one year, analysis is conducted over a number of years to ensure statistical significance.

Rates are calculated using a three-year rolling average.

2.1 Suicides in Bristol from 2006 to 2020

The number of suicides in Bristol fluctuate from year to year but, on average 43 people die by suicide each year.

Bristol has seen an increase in the number of deaths registered as suicide in 2018-2020 which is consistent with the pattern for England. This may be down to a change in the coroner's law. Before 2018, in order for a Coroner to return a verdict of suicide in an inquest, the fact that the deceased deliberately took his/her own life must be established beyond reasonable doubt (criminal standard of proof). This was changed to the civil standard of proof i.e. the balance of probabilities following *Maughan, R (On the Application Of) v Senior Coroner for Oxfordshire* [2018] EWHC 1955 (Admin) case.

Table 1 Number of deaths from suicide and injury of undetermined intent in Bristol registered between 2006 and 2020. Source: Primary Care Mortality Database via NHS digital

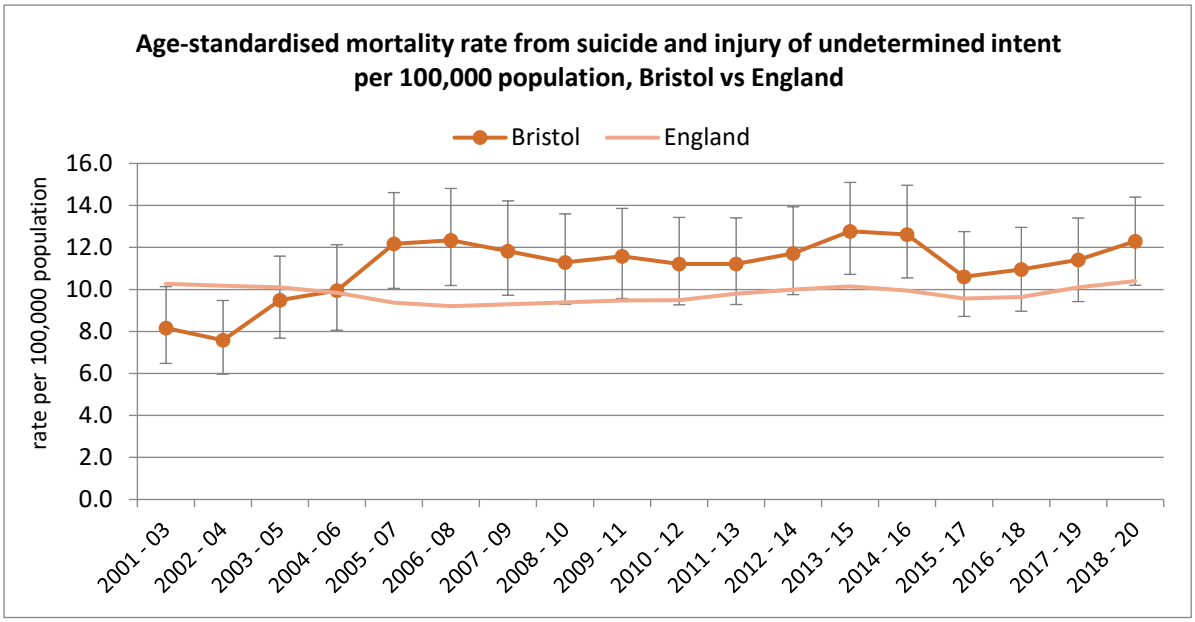
Year of registration	Male	Female	Total
2006	34	7	41
2007	36	8	44
2008	32	13	45
2009	24	8	32
2010	35	8	43
2011	41	10	51
2012	24	8	32
2013	32	14	46
2014	43	16	59
2015	27	15	42
2016	27	12	39
2017	29	9	38
2018	34	14	48
2019	43	9	52

2020	31	11	42

Figure 1 below shows the age standardised mortality rate from suicide and injury of undetermined intent from 2001 to 2020. Although the rate has risen this raise is not statistically significant (note the overlapping confidence intervals) and between 2017-2019 and 2018-2020, the last two reporting periods, although rates are higher than England these are not statistically different to the England average.

Put simply, this means that the rate of death by suicide in Bristol has remained relatively stable since 2005.

Figure 1: Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, Bristol vs England. *Source: Public Health England, Public Health Outcomes framework*



2.2 Gender and age

Historically, both in England and locally the rate of male suicides have been consistently higher, although the ratio of male to female suicide rates has changed over time. The female rates peaked in the 1960 (Thomas and Gunnell, 2010).

During the period 2018-2020 76% of suicides and undetermined death in Bristol were males. (Public Health Outcomes Framework, OHID)

The differences between male and female suicides may be due to the method of suicide as men are more likely than women to choose high lethality methods, such as hanging.

Figure 2 illustrates the age standardised mortality rate for suicide and injury of undetermined intent among females from 2001 to 2020. The number of female suicides rose between 2011

and 2015. Between 2015 and 2020 Bristol is not statistically different from the England average.

Figure 2 FEMALES: Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, Bristol vs England. Source: Public Health England, Public Health Outcomes framework

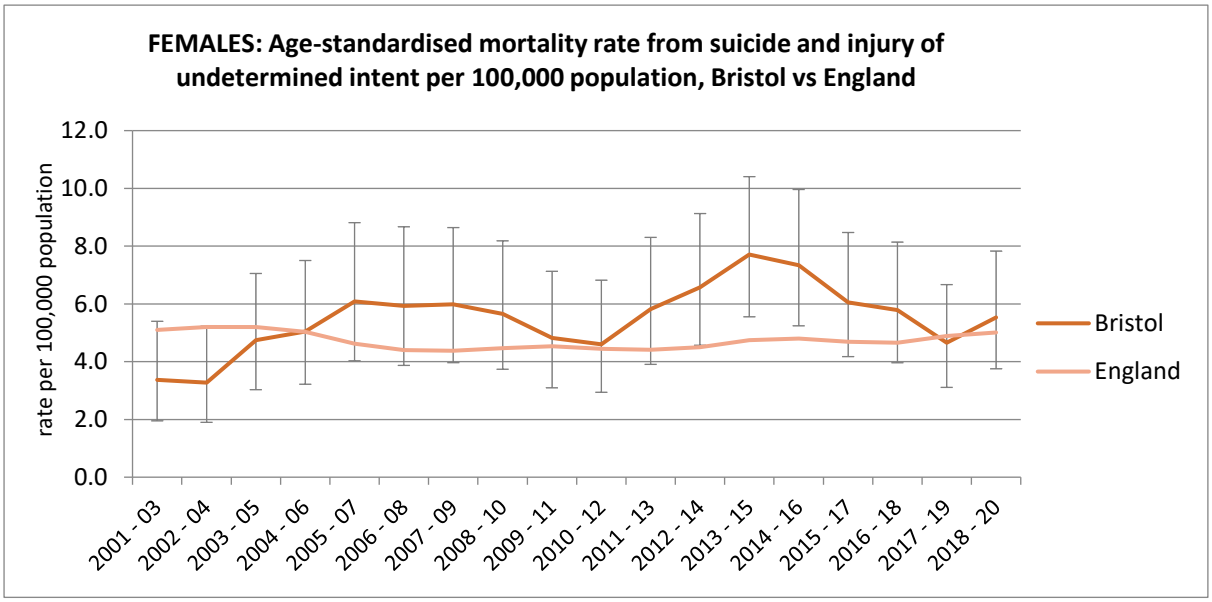


Figure 3 shows the age-standardised mortality rate from suicide and injury of undetermined intent between 2001 and 2020. The rate of suicide among men has not significantly changed over time. Between 2010 and 2020 the rate of suicide among men is not statistically significant from the England average

Figure 3 MALES: Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, Bristol vs England. Source: Public Health England, Public Health Outcomes framework

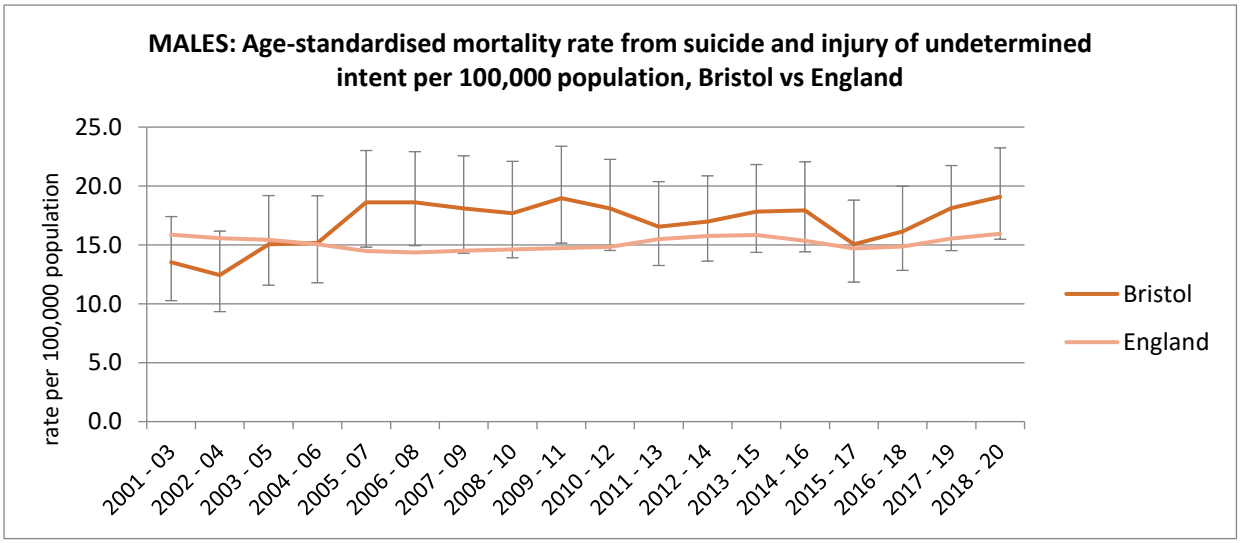


Table 2 and the figures 4 and 5 provide a breakdown of suicide death by age group for males and females. This shows that the rate of suicide is greater among middle-aged men within Bristol, and this is statistically higher than the England average. It also shows that the rate among young and middle-aged women is higher in Bristol, but this is not significantly different from the England average, meaning that this difference could be due to chance variation.

Table 2 Deaths from suicide and injury of undetermined intent by age group (5-year averages; 2016-2020) – crude rate per 100,000. Source: Primary Care Mortality Database 2021 via NHS Digital & ONS population estimates for Bristol values and ONS Suicides in England and Wales, 1981 to 2020

	Bristol		England	
Age band	*Male*	*Female*	*Male*	*Female*
10 - 34	9.0	3.8	11.2	3.7
35 - 64	25.9	8.0	19.7	6.1
65+	14.7	4.9	12.4	4.0

Figure 4 MALES: Deaths from suicide and injury of undetermined intent by age group (5-year averages, 2016-2020) – crude rate per 100,000. Source: Primary Care Mortality Database 2021 via NHS Digital & ONS population estimates for Bristol values and ONS Suicides in England and Wales, 1981 to 2020

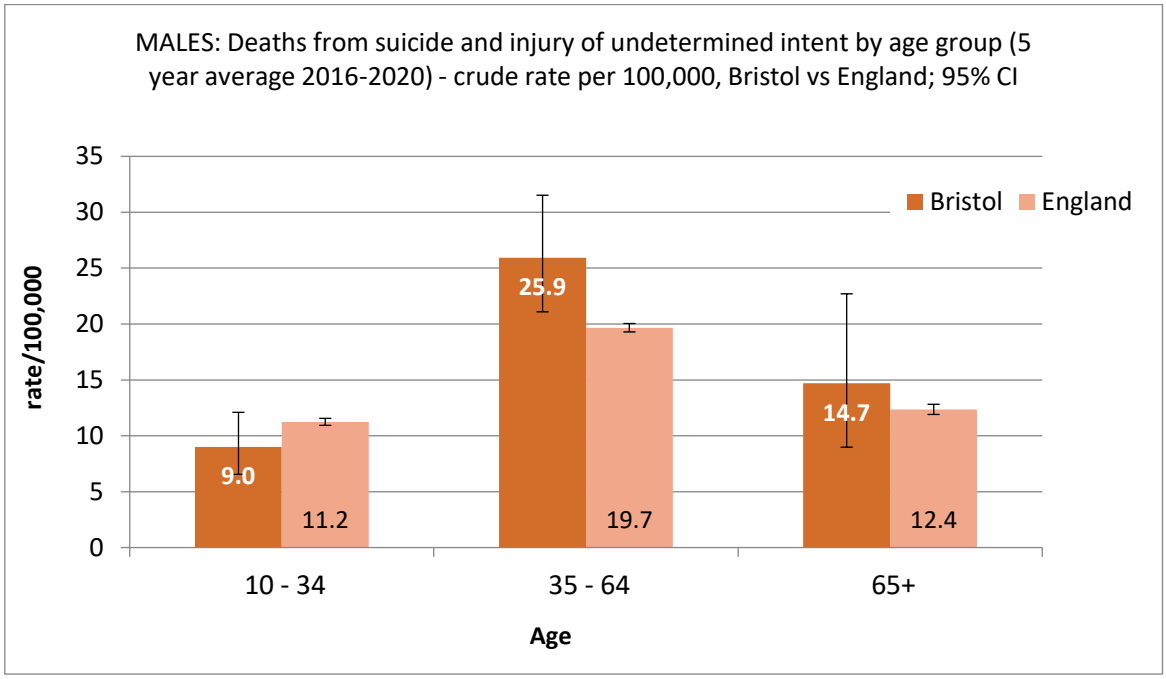
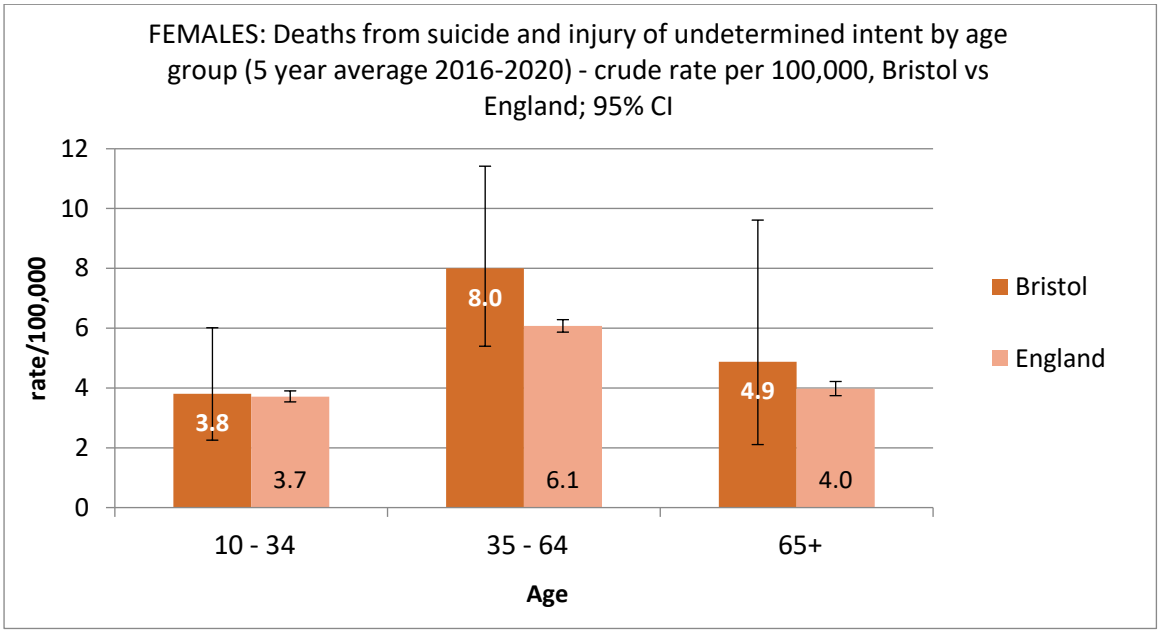


Figure 5 FEMALES: Deaths from suicide and injury of undetermined intent by age group (5-year averages; 2016-2020) – crude rate per 100,000. Source: Primary Care Mortality Database 2021 via NHS Digital & ONS population estimates for Bristol values and ONS Suicides in England and Wales, 1981 to 2020



2.3 Socio-economic factors

There is a strong association between area level deprivation and suicide and suicidal behaviour within the literature. (Mcdaid and Science, 2017) .

Nationally, people among the most 10% of society are more than twice as likely to die by suicide than the least deprived.

Figure 6 and table 3 provides the breakdown of suicide death by deprivation* in Bristol. Although there is an apparent trend linked to deprivation within Bristol, this is not statistically significant, meaning that this difference could be due to chance variation, and is less marked for women.

Figure 6 Mortality from suicide and injury of undetermined intent in Bristol by deprivation quintile and gender; 2011-2020, age standardised rate per 100,000 population. Source: Primary Care Mortality Database 2021 via NHS Digital, ONS population estimates, English Indices of Deprivation 2019 - Department for Communities and Local Government

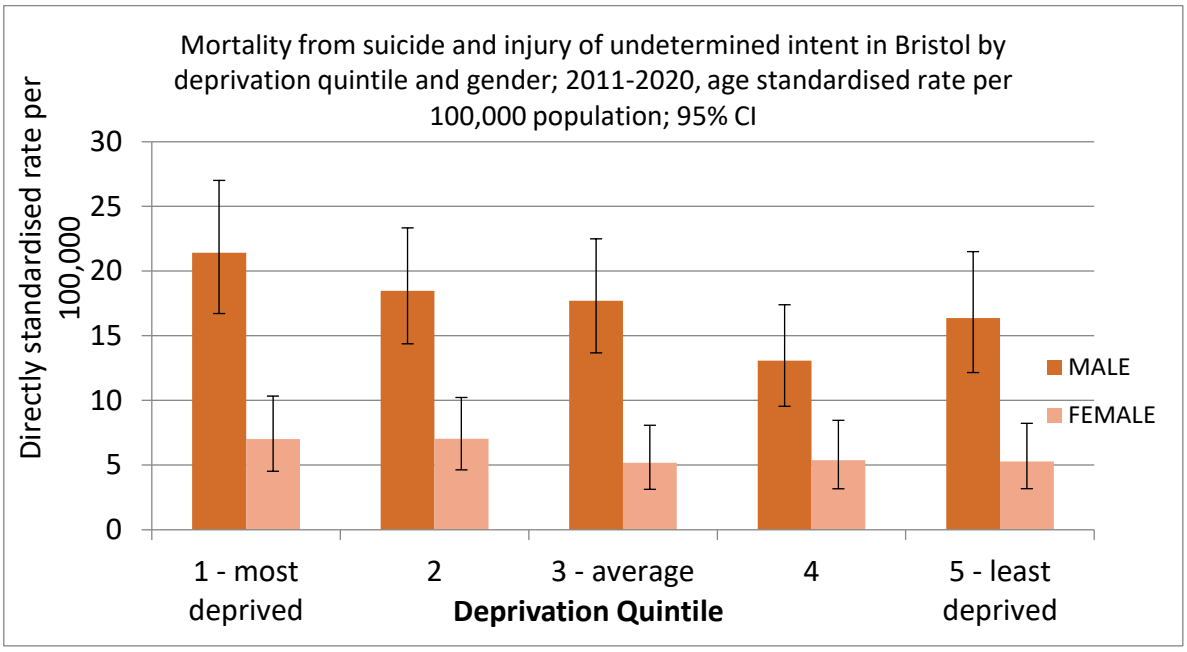


Table 3: Mortality from suicide and injury of undetermined intent in Bristol by deprivation quintile 2011-2020, age standardised rate per 100,000 population. Deprivation quintiles based on IMD 2019 deprivation scores.

Deprivation quintile	*Number of deaths*	*ASR*	*LL*	*UL*
1 - most disadvantaged	104	14.1	11.5	17.2
2	104	12.8	10.4	15.6
3	92	11.5	9.2	14.2
4	74	9.4	7.2	12.0
5 - least disadvantaged	75	10.6	8.3	13.4
Bristol	449	11.8	10.7	13.0

2.4 Method of death

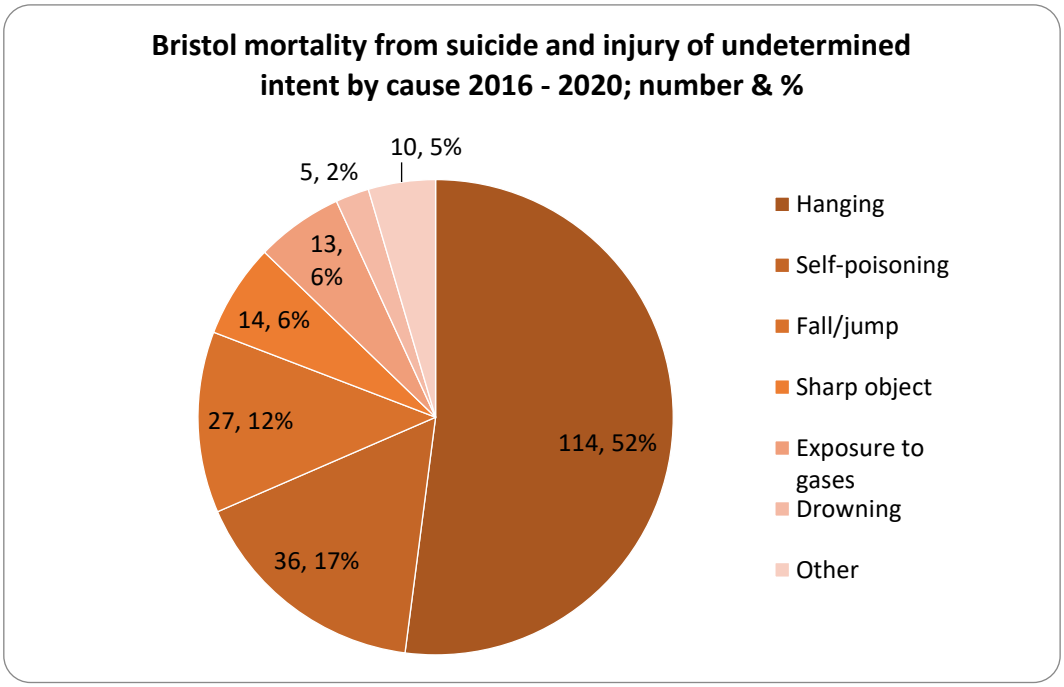
Hanging was the most common cause of mortality from suicide and undetermined death between 2016 and 2020 for both men and women, this is similar to the rest of England. This was followed by self-poisoning. There is a relatively high proportion of deaths from falling or jumping compared to the England average (over a half of deaths due to a fall/jump have been located in the vicinity of Avon Gorge and Clifton Suspension Bridge)

There are different patterns for men and women and Table 4 and figure 7 provides a summary of all of the methods used by gender.

Table 4 Method of suicide by gender and cause 2016-2020. Source: Primary Care Mortality Database 2021 via NHS Digital

Cause of death	Male (number)	%	Female (number)	%
Hanging	86	52.4%	28	50.9%
Self-poisoning	20	12.2%	16	29.1%
Fall/jump	22	13.4%	5	9.1%
Sharp object	12	7.3%	2	3.6%
Exposure to gases	11	6.7%	2	3.6%
Drowning	4	2.4%	1	1.8%
Other	9	5.5%	1	1.8%
Total	164		55	

Figure 7: Mortality from suicide and injury of undetermined intent by cause, Bristol 2016-2020. Source: Primary Care Mortality Database 2021 via NHS Digital



2.5 Place of death

In common with the rest of England 58% of all suicides and undetermined death took place at home between 2016 and 2020.

18.7 % took place in a public place such as a park or railway. 8.7% of deaths took place in the Avon Gorge/Portway area.

2.6 Safety in custody statistics

The number of apparent self-inflicted deaths within Bristol Prison increased from 3 to 8 in 2014-2016 and this continued to 2018 but has since gone down to 3. The rate of self-harm incidents has increased significantly between 2015 and 2021

Table 5. Deaths in Bristol Prison between 2010 and 2021. Source: Ministry of Justice and National Offender Management Service, Safety in Custody Statistics: Safety in Custody summary tables to December 2021

Bristol Prison	2010-12	2011-13	2012-14	2013-15	2014-16	2015-17	2016-18	2017-19	2018-20	2019-21
Apparent self-inflicted deaths:	4	3	1	3	8	9	8	2	3	3
Apparent natural cause deaths:	3	2	2	3	4	4	3	4	3	1
Total deaths:	7	5	3	6	12	14	13	7	7	5

Table 6. Self-harm incidents in Bristol Prison between 2004 and 2021. Source: Ministry of Justice and National Offender Management Service, Safety in Custody Statistics: Safety in Custody summary tables to December 2021

Year	Self-harm incidents
2004	156
2005	190
2006	102
2007	164
2008	149
2009	79
2010	131
2011	111
2012	87
2013	84
2014	80
2015	246
2016	256
2017	427
2018	426
2019	957

2020	878
2021	514

3.0 Local Suicide Audit

To provide a closer analysis of local issues, patterns and possible areas for intervention Avon and Wiltshire Mental Health Partnership NHS Trust gather data from Avon coroner's Court in Bristol to identify high risk groups, locations of concerns, patterns and trends and evidence for targeted interventions.

This analysis is shared with the Avon Suicide Audit group consisting of suicide prevention leads from Bristol, North Somerset, South Gloucestershire, and Bath and Northeast Somerset.

There were 312 deaths from suicide and undetermined intent during the last three-year period 2016-18 which were reviewed by the Coroner's Court in Avon. There has not been an audit completed since this point due to difficulties in accessing the data. The real time surveillance programme of work will fill this gap going forward.

3.1 Ethnicity

Ethnicity was only recorded on three quarter of the sample taken so it is not possible to draw accurate conclusions. Ethnicity is not one of the mandatory items that coroners are required to complete.

Ethnicity has been recorded in 243 cases of which 60% were White British, 11% White Other and 7% Black, Asian, or other minority ethnic group (2016-2018)

3.2 History of self-harm

Table 7 below shows that overall 40 percent of people who died by suicide had a history of some form of self-harm. For females this was 47 percent. However, this information was inconsistently recorded within the coronial records and was largely extracted from reviewing the narrative surrounding the person's death.

Table 7 Proportion of cases with a recorded history of self-harm, all deaths 2016-2018

History of self-harm	Male	Female	Total
Yes	38%	47%	40%
No	7%	6%	7%
Not recorded	55%	47%	53%

3.3 Access to health and support services

25% of people had been in contact with secondary care mental health services within 12 months of their deaths, which is consistent with national data. A further 38% of people had been in contact with some sort of counselling or other primary care-based psychological care service in the community.

Table 8 Access to mental health and support services, all deaths 2016-2018

Service	%
GP only	38%
Mental health services	25%
Drug & alcohol services	2%
Other	1%
Not recorded	33%
Total	*100%*

4.4 Key psychological diagnosis or recorded health problems at the time of death.

Over 70% of people had been identified as experiencing some form of diagnosable mental and/or physical health problem prior to their death.

Physical health problems including chronic pain was recorded for 17% of the diagnoses. The most common association is with low mood and anxiety.

Table 9 Key diagnosis before death between 2016 and 2018 (This is greater than 100% due to multiple problems)

Diagnosis noted	% in total
Low mood	38%
Anxiety	18%
Physical health problems (incl. COPD & cancer)	14%
Other mental health disorders	11%
Alcohol abuse	9%
Personality disorder	7%
Drug abuse	6%
Bi-polar affective disorder	4%
Chronic pain	3%
Schizophrenia	3%
PTSD	2%
Depression	2%
Attention deficit hyperactivity disorder (*ADHD*)	2%
Not recorded	29%

4.0 Self-harm

In 2020/21 in Bristol there were 1,717 emergency admissions to hospital due to intentional self-harm (the rate of 332.4 per 100,000 population, significantly higher than England average of 184 per 100,000). That is a 6% increase compering to the previous year. 68% of those admissions were among females. The rates of intentional self-harm were almost 2 times higher among women than men. In 2020/21, there were 1,173 female admissions in Bristol, a rate of 443.5 per 100,000 Number of male admissions was significantly lower at 538 – a rate of 221.8 per 100,000 in 2020/21 (Joint Strategic Needs Assessment Data Profiles, Self-Harm Chapter JSNA Health and Wellbeing profile 2021-22 Self-harm (bristol.gov.uk)). However, as the majority of self-harm does not warrant hospital admission the numbers above are only the tip of the iceberg.

It has been estimated that about 50% of people who died of suicide have previously self-harmed (Preventing suicide in England: Fifth progress report of the cross government outcomes strategy to save lives; Preventing suicide in England: Fifth progress report of the cross-

gove rnment outcomes strategy to save lives (publishing.service.gov.uk)) The risk of suicide is heightened within the first year after self-harm.

The Bristol self-harm register recorded detailed information on those presenting to emergency department in Bristol Royal Infirmary up until 2018.

Demographics

- There were 1,750 episodes of self-harm presenting to the Bristol Royal Infirmary (BRI) in 2018. This was made up by 1286 individuals, therefore roughly 1 in 3 of the episodes were repeat attendances.
- Male self-harm attendances in 2018 were higher than those in 2017
- Female patients make up a greater proportion of self-harm patients at BRI 59.8 v 40.2. Females were on average younger
- 12.7% of attendances are among students (aged 15 and over) Restricting that to those 18 and over – 80% of presentations were among university students. 220 presentations per year,

Cited causes

- 7% cited debt, money, finance or gambling as precipitating factors for self-harm
- 7.7% were indicated to be in patients who had experienced domestic violence. This excludes those who have experienced historic child abuse.

Method of self-harm

- Self-poisoning was the most frequently used method of self-harm (66.4%) About 8.8% of people used both self-injury and self-poisoning

Mental health

- 4 out of 5 patients had a history of self-harm
- 69.4% had received previous psychiatric treatment

Self-harm resulting in a death by suicide

- Data for suicide is only available until 2017. Overall, 77 people who attended BRI following self-harm died by suicide.

5.0 Bristol Suicide Prevention Action Plan 2017 – 2022

The Bristol ambition is to become a Zero Suicide City.

The Preventing Suicide in England – a cross governmental strategy (2012) was launched in 2012 and set clear and evidence-based priority action areas at a national and local level.

1. Provide better information and support to those bereaved or affected by suicide
2. Reduce the risk in key high-risk groups
    a. Young and middle-aged men,
    b. people with a history of self-harm
    c. people in the care of mental health services
    d. people in contact with the criminal justice system
    e. specific occupational groups
3. Tailor approaches to improve mental health in specific groups including children and young people and users of drugs and alcohol.
4. Reduce access to means
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring
7. Reduce rates of self-harm as a key indicator of suicide. This was added in the Preventing Suicide in England: Third progress report. (Department of Health, 2017)

The NHS Mental Health Implementation Plan published in 2019, sets out an ambition to reduce the number of suicides in England by 10 per cent by 2021. It also states that by 2023/24, all systems will have suicide bereavement support services providing timely and appropriate support to families and staff in place.

The Bristol Suicide Prevention Action Plan is based on the national strategy, 'Preventing Suicide in England: a cross-government outcomes strategy to save lives and takes account of the NHS Mental Health Plan ambitions.

The action plan is delivered by a range of partners, including NHS, local authority, academic, voluntary sector, and criminal justice services. During the period of the current plan there have been many changes including the launch of the NHS Mental Health Transformation programme, the establishment of Integrated Care Systems and since 2020 the Covid pandemic. This report marks the final year of the current plan and the launch of a new Suicide Prevention Strategy supported by an annual plan

Action	Lead Partners	RAG
Action Area one: Provide Better Information and support to those bereaved by suicide		
Coroners and emergency services to provide resources for those bereaved by suicide. E.g., a copy of 'Help is at Hand'. **Progress against action:** Help at Hand is made available to all those bereaved by suicide.	Samaritans / Cruse / Coroner service	Action complete
Coroner and services involved in suicides (e.g., Police, Pathologists) to provide accessible, concise information and support on the processes and standards in a Coroner Inquiry to family members. **Progress against action:** Avon & Somerset Police ask the families bereaved by suicide if they would like to be contacted by the Avon-wide Beside service. If they consent, then their contact details are shared with the Avon Real Time Surveillance System coordinator. The Police are also able to provide the 'Help is at Hand' leaflet.	Coroner service	Ongoing
Assess levels of bereavement support and 1-1 counselling available for those affected by suicide, and whether needs are being met. **Progress against action:** A suicide bereavement service has been established with NHS funding, this service is being evaluated and will produce a report, however, this action is still ongoing.	Clinical Commissioning Group	Ongoing
Review the implementation of the *PHE guidance on Support after a Suicide: a guide to providing local services* in Bristol and to identify gaps. **Progress against action:** This action is complete – this was reviewed by the RTSS group and the Avon wide Bereavement service is now in place	Public Health	Action Complete
Tailor approaches to improve mental health and reduce risk in specific groups including children and young people		
University Students: Develop strengthened approach between University of Bristol, UWE, Public Health, NHS, and national partners to improve student mental health in Bristol and reduce suicides **Progress against action :** Joint work has been undertaken by both universities to implement mental	University, Bristol City Council, NHS	Action completed This remains

health and suicide awareness programmes across the campus and learning programmes. This work was supported by an Office for Students funded programme which was student led. With very high numbers of students in the city, this work continues to be a high priority. There was a report produced after end of UUK project. universities have a copy.		a priority area - work ongoing
Children and young people: Review, develop and launch the mental health badge within the Healthy School's scheme. Continue roll out of mental health training to the wider children and young people's workforce. **Progress against action:** The school's mental health badge has been relaunched. Bristol was successful in obtaining funding for young people's mental health The Healthy Schools Programme was relaunched in Bristol in January 2020, but engagement with schools has been very difficult due to the COVID pandemic and the impact that this had on schools. The number of schools who have achieved Healthy Schools awards is therefore very low. The basic mental health and wellbeing criteria are contained in the Healthy Schools Essential award. Schools who achieve this can then go on to work towards the Specialist Mental Health and wellbeing award. The mental health criteria for these two awards have been designed reflect a whole school approach to mental health. To date 3 schools have achieved the Essential Award and 1 of these schools has also achieved the Specialist Mental Health and Wellbeing award. In 2020 BNSSG CCG obtained funding for 3 mental health support teams in schools. Two of these teams were placed in education settings in South Bristol and East Central Bristol. Schools in areas of highest deprivation were targeted, where risk factors for poor mental health are higher. Bristol was allocated a third team in January 2022, which was placed in settings in North Bristol, again focusing on areas of highest deprivation. Bristol is due to get another 1.5 teams by 2024, which will provide this service for 50% of the school age population.	Public Health	Action completed This remains a priority area - work ongoing

In 2021/22 BCC commissioned Off the Record (OTR) and 1625IP to deliver mental health training to the wider children and young people workforce. This was targeted at professionals working with vulnerable young people and those working in post 16 settings. During this period • 179 professionals were trained in resilience building • 18 professionals were trained in supervision skills. • Two courses were interrupted by staff sickness, and it has been difficult to rearrange these during 2021/22, so this training will therefore be completed in Autumn 2022.		
Reduce the risk in key high-risk groups including men, people in contact with mental health services, debt and financial vulnerability, people in contact with criminal justice system		
Men including debt/financial issues: Develop and implement a targeted approach for the promotion of men's mental health. This will include suicide prevention training, and the development of health improvement programmes targeting men **Deliver the Hope project across BNSSG** which targets individuals in acute distress created by debt, unemployment, financial difficulties and welfare difficulties **Progress against action:** The Hope Project provides emotional and practical support for men aged 30-64. The project has been recognised nationally and an independent evaluation has been published in BMC Psychiatry and Journal of Mental Health.	Suicide prevention transformation fund and Public Health	**Identified action completed** **This remains a priority area - work ongoing**
People in contact with Mental Health Services and/or drug and alcohol services: Avon and Wiltshire Partnership Trust (AWP) to provide an update on the action identified in their suicide prevention strategy **Progress against action:** The AWP suicide prevention strategy objectives are aligned to the National Suicide Prevention Strategy for England (NSPS), and aims to reduce the suicide rate in the group of people who come into direct and indirect contact with our services. We also aims to provide better	AWP	**This remains a priority area - work ongoing**

support for those bereaved or affected by suicide. The focus of our efforts will centre on the seven main NSPS objectives: 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 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 the rates of self-harm as a key indicator of suicide risk		
Criminal justice/prison: Improve timely information about suicide affecting those in prison and the criminal justice system **Progress against action:** **The caveat is that self-harm and suicide prevention is led by more than one of the teams, the prison and the health provider have reporting, and escalation routes are through their respective organisations, HMPPS and for health reportable to NHSEI H&J Commissioning. Collaborative working and review is in place.** **Reporting is through more than one route and although there will be quarterly reporting, the reporting and action plan and prevention methods will be more frequent** • HMP Bristol have Suicide Prevention plans in place and leads for this work " • "Quarterly reporting of suicide and self-harm in HMP Bristol and identified preventative actions." **Collectively we had been looking to engage with this network, thinking not only about the risk whilst in prison but also the connection and ongoing need on release.**	HMP/NHS England	**This remains a priority area - work ongoing**
Women: Provide suicide prevention and awareness training to staff working with victims and survivors of	Next Link /	**This remains**

abuse. Promote appropriate forms of support and knowledge of referral to specialist agencies for victims of abuse. **Progress against action:** - Training programme has been developed with Keeping Bristol Safe Partnership. This includes a Tier 1 training that will cover basic awareness of domestic abuse and other key areas relating to the Domestic Abuse Act 2021. This will launch in Autumn 2022. Tier 2 workshops with focus on key areas with shorter sessions will follow in 2023. - Work has been delivered with the Domestic Abuse and Survivor Forum to ensure the voice of lived experience is included in our training and they have also been consulted on approach and content - Currently a mapping of training activity is being carried out to see what else is being delivered in the city to ensure a more strategic approach is being taken and duplication avoided. - Housing staff have been delivered a number of basic awareness sessions via webinar, and given information on the Domestic Abuse Act 2021 and the implications for Housing - A housing IDVA has been employed who is based in housing and is offering advice and delivering training .	University of Bristol Samaritans	a priority area - work ongoing
Reduce access to means		
High risk areas: Avon Gorge Working Group to report to Avon Suicide Prevention Group on key concerns, improvements, actions and risks. **Progress against action:** The notes of the last meeting are not out as yet. The last available set of notes were from March. There isn't anything in there that can be shared. This work is also still ongoing	Avon Gorge working Group	Ongoing
Reduce the rates of self-harm		
The STITCH HIT reports to the group on key findings, priorities and progress. This includes communicating with and following up on people who present at emergency departments after self-	STITCH steering Group	Ongoing

harming and signpost to appropriate services. **Progress against action:** A review is currently being undertaken to set up a data collection system for self-harm presentations at emergency departments and minor injury units.		
Support local media in reporting suicide and suicidal behaviour		
Ensure the Samaritans Guidance for media reporting of suicide is implemented by local media outlets **Progress against action:** There has been substantial support for the local media in the reporting of suicide and suicidal behaviour. Media coverage will continue to be monitored and support given where appropriate.	Samaritans	Ongoing
Provide training to Bristol people to enable them to prevent and respond to suicide		
Commission and deliver suicide prevention training across the city **Progress against action:** Thrive Bristol's training programme includes courses on suicide prevention. Each year approximately 350 people attend, from voluntary , faith and community organisations, advice services, and housing. At least 90% of respondents report an improvement in their knowledge, skills, and confidence. ZSA suicide prevention module has been promoted widely and UoB has rolled it out to staff and students (a new student module was launched in Jan 2022). Suicide prevention is now included in mandatory training to taxi drivers, delivered by BCC. There is also a new ZSA module for taxi drivers later this year.	Public Health	Ongoing

6.0 Summary and Recommendations

The NHS 2019 national ambition to reduce the number deaths by 10% has not been achieved either nationally or locally. However, Bristol Suicide rates have remained relatively stable and are comparable to the rest of England. In summary, action has prevented any increase in deaths but has not achieved the ambitions to reduce deaths.

The current evidence supports continued focus on preventative action with men, students, young people, people in contact with mental health services, offenders and on self-harm prevention. Evidence also suggests a focus on treating depression and anxiety and an understanding of the impact of this and support, for GPs who require not only the skill and time to recognise potential risk, but also the resources and systems through which to provide a compassionate response.

Looking forward, the impact of successive lock downs and the Covid pandemic combined with pressures on the cost of living and a global instability means that it is highly likely there will be an increase in emotional and mental health problems. Indeed, this is already being reported by schools and GPs. Furthermore, the establishment of Integrated Care System and the implementation of the Healthier Together Community Mental Health framework brings new opportunities for closer working with the NHS and wider partnership working.

To support delivery over the next three years a new Suicide Prevention Strategy and Plan for Bristol is being developed to take account of the new set of partnership arrangements and ensure an ongoing focus on priority areas for suicide prevention in Bristol, including delivery of the mental health concordat. The new Strategy and plan will be published on the Bristol City Councils web site.

Terminology

Suicide the National Statistics definition includes all deaths from intentional self-harm for persons ages 10 and over, and deaths where the intent was undetermined for those aged 15 and over.

Suicide attempt is used to mean any non-fatal suicidal behaviour and refers to intentional self-inflicted poisoning, injury or self-harm which may or may not have a fatal intent or outcome. (World Health Organization, 2014)

This definition is complicated as it includes non-fatal self-harm without suicidal intent.

Suicidal behaviour refs to a range of behaviours that include thinking about suicide (or ideation), planning for suicide, attempting suicide and suicide itself. (World Health Organization, 2014)

Suicidal ideation active Thoughts about taking action to end one's life including identifying a method, having a plan, or having intent to act (McHugh *et al*, 2019)

Suicidal ideation passive Thoughts about death or wanting to be dead without any plan or intent (McHugh *et al*, 2019)

Self-harm The Royal College of Psychiatrists defines self-harm to an intentional act of self-poisoning or self-injury carried out by a person, irrespective of the type of motivation or degree of suicidal intent. (Royal College of Psychiatrist, 2010)

Non-suicidal self-injury self-injurious behaviour with no intent to die

References

Department of Health (2017) 'Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives', *Public Health England*, (January). doi: 10.1089/jcr.2015.0033.

Geulayov, G. *et al.* (2018) 'Incidence of suicide, hospital-presenting non-fatal self-harm, and community-occurring non-fatal self-harm in adolescents in England (the iceberg model of self-harm): a retrospective study', *The Lancet Psychiatry*. Elsevier Ltd, 5(2), pp. 167–174. doi: 10.1016/S2215-0366(17)30478-9.

Hawton, K., Saunders, K. E. A. and O'Connor, R. C. (2012) 'Self-harm and suicide in adolescents', *The Lancet*. Elsevier Ltd, 379(9834), pp. 2373–2382. doi: 10.1016/S0140-6736(12)60322-5.

Mcdaid, D. and Science, P. (2017) 'SOCIOECONOMIC DISADVANTAGE AND Full report', (March).

O'Connor, R. C. *et al.* (2018) 'Suicide attempts and non-suicidal self-harm: national prevalence study of young adults', *BJPsych Open*, 4(3), pp. 142–148. doi: 10.1192/bjo.2018.14.

Royal College of Psychiatrist (2010) 'Suicide and Risk : Helping People Who Self-Harm', *Policy*, p. 137.

Thomas, K. and Gunnell, D. (2010) 'Suicide in England and Wales 1861-2007: A time-trends analysis', *International Journal of Epidemiology*, 39(6), pp. 1464–1475. doi: 10.1093/ije/dyq094.

World Health Organization (2014) 'Preventing suicide Preventing suicide', *Preventing suicide: A global imperative*, p. 92.