Richmond Suicide and Self-Harm Prevention Strategy

2022 - 2025

Public Health

LONDON BOROUGH OF RICHMOND UPON THAMES

Final Version [1.0]

Final Version [1.0] December 2022

Executive Summary

Vision

Our vision is that Richmond will be a home to communities that are happy, thriving, and resilient.

We believe that with the right support at the right time, people can recover from crisis, psychological distress, and mental disorder.

We believe suicides are preventable and aim to ensure individuals:

- value their own life and the lives of others
- never feel that suicide is the only option
- are supported in times of need, by safe, integrated, and compassionate services

1. Aim and Objectives

The overall aim of this strategy is to *reduce the rate of suicide, suicidal behaviour and self-harm* through the following objectives:

1. Improve understanding of local need – conduct of a suicide audit, pathway mapping and a needs assessment

2. Challenge the stigma and discrimination associated with mental disorder by:

- Increasing awareness of mental health and mental disorder
- Adopt more sensitive media reporting in relation to mental disorder, self-harm and suicide

3. Improve access to information and postvention support - for those concerned or affected by suicide

4. Prevent self-harm and suicide amongst young people – support the development of Mental Health Support Teams in schools, effective and accessible self-harm and suicide prevention pathways

5. Improve access to services for groups at higher risk of suicide - increase the numbers of people from high-risk groups accessing appropriate services and improve integrated working between mental health and substance misuse services

6. Improve crisis care pathways – improvements in crisis care pathways, including, improved crisis planning and safer discharge

Where are we now?

1.1 Richmond Profile of Risk Factors

The tables below show how Richmond compares with London on several measures and risk factors associated with suicide (OHID, 2022). [1]

Indicator	Period	Richmond			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Depression: Recorded prevalence (aged 18+)	2020/21	↑	17,560	9.3%	8.7%*	12.3%	6.2%		19.8%
Mental Health: QOF prevalence (all ages)	2020/21	→	2,048	0.86%	1.11%*	0.95%	0.58%		1.55%
Estimated prevalence of opiate and/or crack cocaine use	2016/17	–	623	4.9	9.3	8.9	25.5		2.1
Long-term health problem or disability: % of population	2011	–	21,447	11.5%	14.2%	17.6%	25.6%		11.2%
Self-reported wellbeing - people with a low satisfaction score	2020/21	–	-	-	5.7%	6.1%	-	*Insufficient number of values for a spine chart*	-
Self-reported wellbeing - people with a low worthwhile score	2020/21	–	-	*	3.6%	4.4%	-	*Insufficient number of values for a spine chart*	-
Self-reported wellbeing - people with a low happiness score	2020/21	–	-	*	8.3%	9.2%	-	*Insufficient number of values for a spine chart*	-
Self-reported wellbeing - people with a high anxiety score	2020/21	–	-	23.2%	23.8%	24.2%	32.4%		15.9%
Prisoner population: count ⚠	Sep 2018	–	-	-	7677*	78533*	-	*Insufficient number of values for a spine chart*	-
Children entering the youth justice system (10-17 yrs)	2017/18	–	-	-	-	-	-	-	-
Children leaving care: rate per 10,000 children aged under 18	2017/18	→	64	14.2	27.3	25.2	9.3		160.6
Marital breakup: % of adults	2011	–	15,271	10.2%	10.6%	11.6%	16.3%		7.7%

[1] Suicide Prevention Profile - OHID (phe.org.uk)

Richmond Profile of Risk Factors cont.

Social Isolation: percentage of adult social care users who have as much social contact as they would like (18+ yrs)	2019/20	–	815	48.9%	42.9%	45.9%	34.3%		56.6%
Social Isolation: percentage of adult carers who have as much social contact as they would like (18+ yrs)	2018/19	–	25	21.0%	33.2%	32.5%	11.7%		45.7%
Older people living alone: % of households occupied by a single person aged 65 or over	2011	–	9,434	11.8%	9.6%	12.4%	6.0%		16.7%
People living alone: % of all usual residents in households occupied by a single person	2011	–	26,008	14.1%	12.8%	12.8%	8.0%		23.4%
Unemployment (model-based)	2020	–	4,700	4.1%	6.0%	4.7%	8.2%		3.0%
Statutory homelessness - Eligible homeless people not in priority need	2017/18	–	-	*	1.0	0.8	8.1		0.1
Statutory homelessness - households in temporary accommodation	2017/18	→	282	3.3	14.9	3.4	40.1		0.0
Domestic abuse-related incidents and crimes	2020/21	–	-	35.2*	35.1	30.3	14.0		59.7
Long term claimants of Jobseeker's Allowance	2021	↓	150	1.2	2.3	2.1	8.4		0.2
Children in care	2021	→	131	29	47	67	210		24
Estimated prevalence of common mental disorders: % of population aged 16 & over	2017	–	20,430	13.2%*	19.3%*	16.9%*	24.4%		11.6%
Estimated prevalence of common mental disorders: % of population aged 65 & over	2017	–	2,514	8.3%*	11.3%*	10.2%*	14.6%		7.3%

1.2 What is the Scale of the Problem?

1.2.1 Every suicide is tragic, and the impact can be devastating for all those affected. Suicides can be prevented, mainly by having a caring and compassionate society that supports vulnerable individuals and people at times of personal crisis.

1.2.2 There are a wide range of local stakeholders that have a role to play in preventing suicide. Many people who take their own lives have not been in touch with mental health services. There are many things we can do in our communities and outside hospital and care settings to help those who think suicide is their only option.

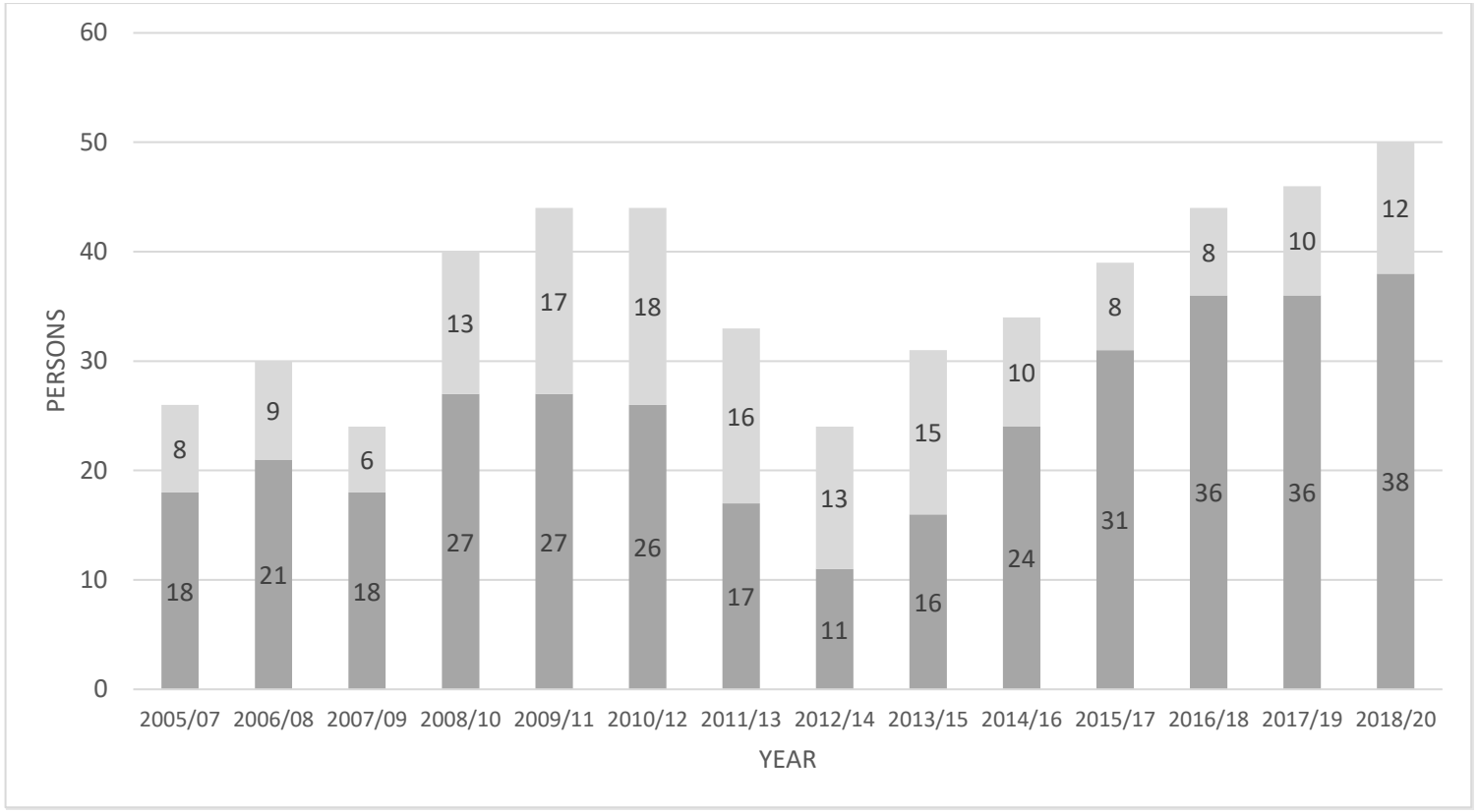
1.2.3 Although the number of people who take their own lives in England has followed a downward trend over the last 20 years, more recent data indicates that the national suicide rate (plus death from injury of undetermined intent) has increased since 2006 from 9.2 per 100,000 to 10.4 per 100,000 in 2020. The suicide rate in Richmond, 9.9 per 100,000, remains below the England average but is higher than the London average, although not this is not statistically significant. The rate equates to approximately 10–15 suicides per year.[2] Figure 2 below shows that Richmond's suicide rate has been increasing each year since 2014. This contrasts with the trend for London which has shown a modest decrease over the same period.

1.2.4 Figure 1 below shows the consistent difference in the number of deaths (3 year rolling average) between men and women in Richmond. As the graphic shows, for every female death there are approximately three males dying through suicide or from an injury of undetermined intent.[3]

[2] Suicide Prevention Profile - OHID (phe.org.uk)

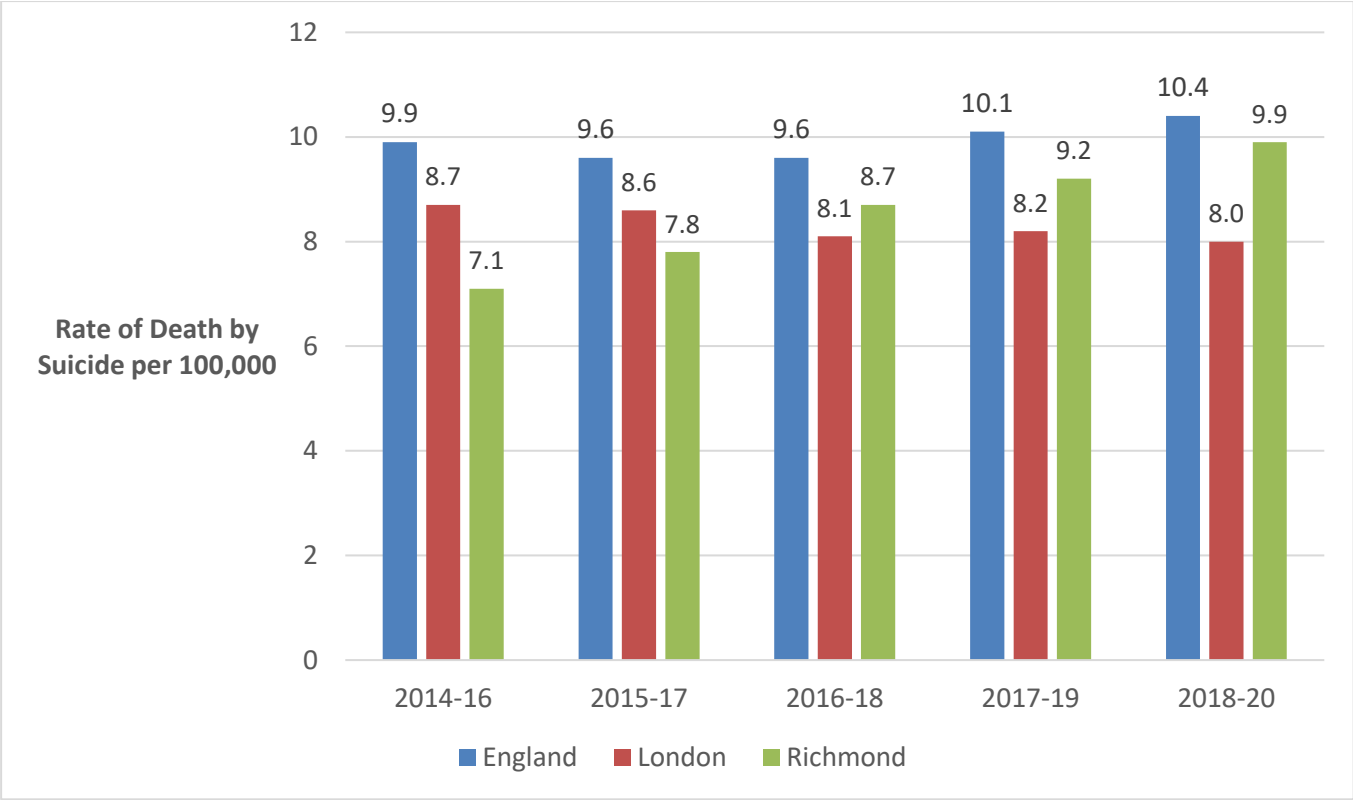
[3] Open verdicts are generally coded by the ONS as deaths from injury or poisoning of undetermined intent. When national statistics are presented, suicides and deaths of undetermined intent are combined. This reflects research studies which show that most open verdicts are most likely suicides, although they do not meet the high legal standard of evidence required for a Coroner to record a suicide verdict.

1.2.5 **Figure 1. Number of Suicides and Deaths Due to Injury of Undetermined Intent in Richmond by Gender (3 year average).**



Source: OHID. 2022. Suicide Prevention Profile. http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data

1.2.6 **Figure 2. Age-standardised suicide death rates per 100,000 across 3-year aggregates, England, London and Richmond**



Source: OHID. 2022. Suicide Prevention Profile. http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data

1.3 Suicide in England since the COVID-19 pandemic - early figures from real-time surveillance

1.3.1 There is no evidence of the large national increase in suicide post-lockdown that many feared.

1.3.2 There appears to have been no rise in suicide post-lockdown, at least in the areas[4] providing real-time suicide surveillance. The higher figures in 2020 should be seen in the context of a rising national rate and maturing real-time surveillance systems

1.3.3 There are several important caveats. These early figures could change over time or with the inclusion of more areas. Higher rates in some local areas or population sub-groups cannot be ruled out, especially as the effect of COVID-19 itself has varied between communities.

1.3.4 It is too soon to examine the full long-term impact of the economic adversity resulting from COVID-19 on mental health and suicide.[5]

[4] Real-Time Suicide Surveillance areas across 10 Sustainability and Transformation Plan Areas in England, NE, NW, central and SW, covering a population of 9 million.

[5] display.aspx (manchester.ac.uk)

1.4 Risk Groups and Risk Factors.[6]

The following tables show groups at increased risk of suicide as well as factors and mental health conditions that increase an individual's risk

Risk Groups	Risk Factors	Additional Risk Factors	Mental Health Conditions[7]
Young and middle-aged men	Life History; adverse childhood experiences; history of sexual or physical abuse; history of parental neglect	Being gay, lesbian or transgender, arising from the prejudice these groups often face	Severe depression: People with severe depression are much more likely to attempt suicide than the general population
People in the care of mental health services	Mental health; developing a serious mental health condition	Being in debt	Bipolar disorder: about one in three people with bipolar disorder will attempt suicide at least once. People with bipolar disorder are 20 times more likely to attempt suicide than the general population
		Long-term physical health condition	
History of self-harm and suicide	Drugs or alcohol dependencies	Being homeless	Psychosis: it is estimated that 1 in 20 people with psychosis will take their own life
People in the criminal justice system	Employment; poor job security, low levels of job satisfaction or being unemployed	Being a war veteran High Risk occupations, doctor, nurse, pharmacist, farmer and armed forces	Borderline personality disorder: it is estimated that just over half of people with borderline personality disorder will make at least one suicide attempt
Specific occupational groups including construction workers, doctors, veterinary workers, farmers, and agricultural workers	Stressful life event; Bereavement, divorce and separation and terminal health condition	Being in prison or recently released from prison	Anorexia nervosa: it is estimated that around one in five people with anorexia will make at least one suicide attempt
	Genetics and family history Living alone		

[6] Department of Psychiatry (ox.ac.uk)

[7] NHS Choices, http://www.nhs.uk/Conditions/Suicide/Pages/Causes.aspx

2 Where do we want to be?

2.1 Vision

Our vision is that Richmond will be a home to communities that are described as happy, thriving, and resilient. We believe that with the right support at the right time, people can recover from crisis, psychological distress and mental disorder.

We believe suicides are preventable and aim to ensure individuals.

- value their own life and the lives of others
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2.2 Aim and Objectives

The overall aim of this strategy is to reduce the rate of suicide, suicidal behaviour and self-harm through the following objectives:

1. **Improve understanding of local need** – conduct of a suicide audit, pathway mapping and a needs assessment
2. **Challenge the stigma and discrimination associated with mental disorder by:**
   - Increasing awareness of mental health and mental disorder
   - Adopt more sensitive media reporting in relation to mental disorder, self-harm and suicide
3. **Improve access to information and postvention support -** for those concerned or affected by suicide
4. **Prevent self-harm and suicide amongst young people –** support the development of Mental Health Support Teams in schools, effective and accessible self-harm and suicide prevention pathways
5. **Improve access to services for groups at higher risk of suicide -** increase the numbers of people from high-risk groups accessing appropriate services and improve integrated working between mental health and substance misuse services
6. **Improve crisis care pathways –** improvements in crisis care pathways, including, improved crisis planning and safer discharge

2.3 Outcomes

- Reduction in suicides – aim to reduce suicides to below the London average
- Reduce admissions for self-harm
- Establish and maintain effective care pathways to help people in crisis
- Provide high quality care for people in crisis
- Increased use of co-produced and personalised safety planning in support services

2.4 Enablers

- A multi-agency partnership approach to deliver a defined action plan (Crisis Care Concordat)
- Focus on local intelligence gathering
- Seamless and integrated care pathways
- Clinical commissioning support for strategic actions
- Feedback and consultation with stakeholders

2.6 Approach

The Crisis Care Concordat (CCC) was formed in 2018 and provides a multi-agency forum to lead on the reduction of suicides in Richmond. This strategy is a refreshed version of the previous strategy which was delivered during 2019 – 2022. The development and implementation of the new strategy and action plan will be the responsibility of the CCC. Key partners in the delivery of this strategy are, Richmond Council, South West London (SWL) Integrated Care System, Primary Care Networks, East London Foundation Health Trust, South West London and St. George's Mental Health NHS Trust, service users, families/carers, communities, people with lived experience and the voluntary sector.

2.7 Guiding Principles

All activities undertaken as part of this strategy should be guided by the following principles[8]:

Principle	Description
Equity and Equality	Provision of services should be proportional to need and targeted to the areas that need them the most to avoid increasing health inequalities.
Accessibility	Services should be accessible to all, with factors including, geography, opening hours and access for people with disabilities considered.
Early Intervention and Prevention	People will receive information, opportunities, and support to help them take care of their own health and wellbeing, prevent deterioration, and lead independent lives.
Integration	Service provision and care pathways should be integrated, with all relevant providers working together. This will maximise the benefits of delivery.
Effectiveness	Services should be evidence-based and provide value for money.
Quality	Services and activities commissioned will be of high quality, with quality and patient/ resident playing a key role in the assessment of what makes a 'good' service. The delivery of quality services will be a high-profile factor in the commissioning process.
Sustainability	Services should be developed and delivered with consideration of social, economic, and environmental sustainability.
Safeguarding	People's health and social care services will be safeguarded, throughout their experience.
Dignity and Respect	All people who use or encounter services will be treated with dignity and respect, recognising that people are often going through difficult times.

[8] Wandsworth Borough Council, Public Health Division, Strategy Toolkit, 2015

3 Innovative Approaches to Prevention

3.1 Children and Young People Self-harm and Suicide Prevention Pathway

3.1.1 Recent national surveys have identified increased prevalence of mental health disorders in children and young people. A young person with a diagnosed mental disorder is also more likely to have self-harmed or attempted suicide at some point. In 2020, one in six (16.0%) children aged 5 to 16 years were identified as having a probable mental disorder, increasing from one in nine (10.8%) in 2017. The increase was evident in both boys and girls.[9]

3.1.2 The data highlights that for young people between 11 and 16 years with a mental disorder, 25.5% had self-harmed or attempted suicide at some point compared to 3.0% for those without a disorder. For those between 17 to 19 years with a disorder the rate is even higher with almost half (46.8%) reporting that they had made a suicide attempt or self-harmed at some point. Young women with a mental disorder between the ages of 17 and 19 have been identified as a particularly high-risk group with just over half (52.7%) reporting that they had self-harmed or made a suicide attempt.[10]

3.1.3 In 2022, the Crisis Care Concordat and the Children's Emotional Health and Well-being Board agreed that an accessible self-harm and suicide prevention pathway be developed to respond to the increased prevalence of mental health disorders in children and young people. The pathway incorporates Kingston Council as well as Richmond as children's services are shared through Achieving for Children.

The pathway and toolkit supports the following groups:

- Children and young people
- Parent and carers
- Staff working in schools and colleges
- Youth services
- Children's services
- General Practitioners
- Community and voluntary sector services

[9] Mental Health of Children and Young People in England, 2020: Wave 1 follow up to the 2017 survey - NHS Digital
[10] https://files.digital.nhs.uk/A6/EA7D58/MHCYP%202017%20Summary.pdf

3.1.4 Self-harm and suicide ideation span a broad spectrum of risk. Low risk scenarios can be adequately supported by schools with appropriate psychological interventions. Higher risk situations require more robust safety planning. Providing a range of interventions graded on the degree of risk provides the opportunity for clear referral pathways.

3.1.5 The iTHRIVE[11] model of risk support provides an evidence-based framework to map and implement local responses to self-harm and suicide ideation. The model uses an integrated, person centred, and needs led approach to support the mental well-being of children and young people. It identifies need across five categories: Thriving, Getting Advice and Signposting, Getting Help, Getting More Help and Getting Risk Support.

3.1.6 The pathway consists of:

- Advice and signposting for children and young people
- Best practice guidance for parents/ carers and frontline services to respond to disclosure of self-harm and suicidality
- A simple route to services based on the presenting level of need
- Specific advice for manging self-harm and suicide ideation in schools, colleges, and youth settings
- Access to evidence-based resources, information, advice, and guidance

3.1.7 A multi-disciplinary task and finish group was established to support the pathway development. Active engagement with children, young people, parents, carers, and universal services ensured the appropriateness of the pathway.

3.1.8 The pathway also provides the opportunity to include good practice advice and guidance. This additional material will support more informed responses to self-harm and suicide ideation across universal services. The task and finish groups were supported by specialist mental health services to advise on additional evidence-based content.

[11] THRIVE-Framework-for-system-change-2019.pdf (implementingthrive.org)

3.2 Suicide Prevention Community Action Plan

3.2.1 During 2018, a task group, led by public health, was set up to formulate a Community Action Plan to mitigate against the risk of suicide clusters and contagion. A small multi-agency group created the plan based upon a practice resource developed by Public Health England.

3.2.2 The term “suicide cluster” describes a situation in which more suicides than expected occur in terms of time, place, or both. A suicide cluster usually includes three or more deaths. With suicidal behaviour increasingly spreading via the internet and social media, a greater number of suicides than expected may well occur in a specific time-period and be spread out geographically (so called mass clusters).

3.2.3 Suicide clusters understandably cause great concern and may lead to hasty responses. It is important that plans for such occurrences are prepared in advance, to ensure a measured and effective response. The Richmond Suicide Prevention Community Action Plan provides a systematic process to identify potential clusters and provide a series of swift interventions to mitigate the threat.

3.2.4 The Community Action Plan has two specific facets: active surveillance through a Suicide Surveillance Group and mitigation through a multi-agency Suicide Response Group. The plan has been developed with partners including Public Health, the Clinical Commissioning Group, Metropolitan Police, Local Safeguarding Children Board and Adult Social Care. The Suicide Surveillance Group will meet regularly throughout the year to monitor the levels of suicide and identify potential suicide clusters and contagion.

3.2.5 The Community Action Plan has been refreshed in 2022 to incorporate changes to incorporate new governance structures. SWL Integrated Care System has established a SWL Suicide Surveillance Group to provide a multi-agency approach to surveillance across the region.

3.3 Thrive Pan London Suicide Prevention Hub

3.3.1 Thrive LDN is working with the Metropolitan Police to provide a Suicide Prevention Data Information Sharing Hub. The hub provides real time information to Local Authorities on suspected suicides. This information enables appropriate support for families and friends of the deceased. People experiencing bereavement from suicide are more at risk of dying by suicide.[12] Following consent from the family, information of the Next of Kin is passed on to relevant services so that they can access bereavement support and other support services. The hub is in the process of expanding the scope to include incidents of life-threatening self-harm where the individual does not die.

3.3.2 The information contained on the Thrive Hub will also be helpful to ensure that the Suicide Prevention Group has real time information relating to suspected suicides. The hub will provide several important pieces of information including means of death, location, demographics, and support services the deceased was in contact with.

3.4 South West London Suicide Bereavement Service

3.4.1 The Suicide Bereavement Service is an NHS England pilot programme funded for an initial 12- month period from November 2019. Funding has been agreed to continue this service. The project aims to establish a service to support individuals and families affected by suicide. There are plans to expand the offer to include counselling support from 2022. The pathway will utilise the Thrive LND data sharing hub (described in section 2.11) to enable a Suicide Bereavement Liaison Worker to contact the family and encourage onward referrals into appropriate services.

[12] Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults | BMJ Open

4 How will we get there?

4.1 Strategic Objectives and Action Plan 2022/23

Objective	Action	Measures / Outcomes	Owner	Timescale
1. Understand local need	1.1 Maintain information sharing protocol with THRIVE LDN and the Metropolitan Police to access real-time suicide and self-harm surveillance	• Information sharing agreed and protocol reviewed on an annual basis	Richmond Council	April 2023
	1.2 Borough representation at the South West London Suicide Surveillance Group	• Regular monitoring of Real Time Suicide Surveillance (RTSS) platform to identify trends and patterns to inform strategy development • Regular monitoring of suicide data to mitigate risk of cluster and contagion • RTSS audit to inform strategy development	Richmond Council	Bi-monthly
2. Challenge stigma and discrimination	2.1 Proactively distribute suicide reporting guidelines to local media groups to support safe and non-stigmatising reporting of suicides	• Media organisations identified, and Samaritans guidance distributed with accompanying letter from the Director of Public Health	Richmond Council	January 23
	2.2 Mental Health First Aid (MHFA) and suicide prevention training delivered to frontline and community and voluntary sector staff to enable appropriate responses to individuals experiencing self-harm and suicidality	• MHFA and suicide prevention training for community and voluntary sector commissioned • Establish baseline of the number of individuals trained and increased investment in MHFA and suicide prevention courses	Richmond Council	September 22
3. Improve access to information and training	3.1 Support secondary schools (including independent schools), colleges, and universities to access suicide prevention and self-harm prevention training.	• Number of schools, colleges and universities accessing Papyrus suicide prevention training for schools	Richmond Council	December 22
	3.2 Primary care self-harm and suicide prevention fact sheets developed and distributed to primary care settings	• Fact sheets distributed to GP practices and primary care settings • Evaluate impact of factsheets to establish improved responses to self-harm and suicide	Integrated Care Board	December 22

	3.3 'Help is at Hand' booklets and Z cards distributed to primary care settings	• All GP and health centres provided with 'Help is at Hand' materials	Integrated Care Board	December 22
	3.4 Survey Primary Care Networks to establish suicide prevention needs in primary care settings.	• *Survey developed and circulated to Primary Care Networks* • *Findings disseminated and recommendations inform future suicide prevention action plan*	Integrated Care Board	TBC
	3.5 Work closely with stakeholders to provide preventative approaches at frequently used locations including railways, bridges, and the river Thames	• Identify and engage with key stakeholders including Network Rail, South West Trains, Port of London Authority, RNLI, Transport for London and the Samaritans. • Representatives to be included in suicide prevention planning through the Crisis Care Concordat meetings • Provide up to date intelligence to stakeholders through the Real Time Suicide Surveillance data • Agree plans to escalate preventative approaches at frequently used locations.	Richmond Council	January 23
4. Prevent self-harm and suicide in young people	4.1 Support the implementation of Mental Health Support Teams (MHST) and the 'Whole School Approach' (WSA) to children and young people's mental health and well-being	• Regularly attend strategic partnership groups and MHST cluster meetings to promote WSA • Develop WSA seminar to support schools to adopt approach • Support the evaluation of the MHST in South West London (report published August 2022)	Integrated Care Board Richmond Council	September 22
	4.2 Ensure support for young people who self-harm and/or are suicidal through locally developed self-harm pathway and toolkit	• Establish task and finish group to develop self-harm and suicide prevention pathway and toolkit • Co-produce toolkit and pathway with stakeholders • Implement and evaluate toolkit and pathway	Richmond Council	December 22
	4.3 *[Place holder St. Mary's University]*	• *[Place holder St. Mary's University]*	TBC	TBC
5. Improve Access to local services	5.1 Improve integrated support for individuals experiencing co-occurring mental health and substance misuse support	• Support development of a multi-agency co-occurring conditions strategic action plan • Ensure robust suicide prevention practice is by both mental health and substance misuse	Integrated Care Board Richmond Council	December 22

		services and is implemented as part of a co-occurring conditions action plan		
	5.2 Develop suicide prevention campaigns to improve access to support and care services	• Facilitate communication campaigns to improve access to support and care services for children, young people, and adults • Plan and deliver suicide prevention campaigns for high-risk groups	Crisis Care Concordat	March 23
	5.3 Refresh Suicide Community Action Plan (CAP) to mitigate against cluster and contagion.	• Refreshed CAP approved by CCC and adults and children's safeguarding boards • Review CAP on an annual basis	Richmond Council	September 22
	5.4 Increase access to MHFA Training and suicide prevention training for school staff, first responders and universal services to ensure appropriate support can be accessed for children and young people experiencing psychological distress.	• Baseline of numbers receiving training established, and annual review of number of courses delivered	Richmond Council	September 22
	5.5 Promote awareness of SWL Suicide Bereavement Service across frontline services	• Increased referrals and numbers of individuals supported by Suicide Bereavement Service	Integrated Care Board	March 23
6. Improve crisis responses and pathways	6.1 Develop and disseminate effective crisis care pathways for children, young people, and adults	• Pathways complete • Crisis pathways information disseminated across universal and targeted services • Communication strategy to raise awareness of crisis pathways and support services developed	Integrated Care Board	March 23
	6.2 Ensure safer hospital discharge with follow up within 72 hours after leaving hospital.	• 95% of service users leaving hospital will have a face-to-face review and risk assessment within 72 hours upon discharge.	Mental Health Trust	Quarterly update
	6.3 Effective liaison in urgent care centres and A&E to identify self-harm and suicidal behaviour and refer to appropriate support.	• 95% of attendances to urgent care, receiving an assessment from the Core 24 team within 1 hour.	Mental Health Trust	Quarterly Update
	6.4 Ensure effective suicide prevention and safety responses in drug and alcohol services	• Suicide awareness and safety planning for drug and alcohol services commissioned	Richmond Council	March 23

	6.5 Establish effective crisis responses for people experiencing financial hardship	• Establish task and finish group to identify pathways of support • Improve awareness of financial support and crisis pathways	Crisis Care Concordat	December 22

5 How Will We Measure Success? - Monitoring the Strategy

5.1 Governance

5.2.1 The Suicide Prevention Strategy has been agreed by [ ]

5.2.2 The multi-agency Crisis care Concordat will be responsible for overseeing the progress and delivery of the action plan and will report back to the Health and Well-being Board.

5.3 Strategic Performance Indicators

Indicator	2021/22 (Baseline)	2022/23	2023/24	2024/25
Suicide Rate	9.9 Per 100,000	[ ] Per 100,000	[ ] Per 100,000	[ ] Per 100,000
Self-harm Hospital admissions (10-24)	367.8 per 100,000	[ ] Per 100,000	[ ] Per 100,000	[ ] Per 100,000
Number of Richmond residents in secondary care dying by suicide	[tbc]	[ ]	[ ]	[ ]
Adult males accessing psychological therapies	[tbc]	[ ]	[ ]	[ ]
Increase referrals to postvention interventions through the SWL Suicide Bereavement Service	34	[ ]	[ ]	[ ]

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