Wolverhampton Joint Strategic Needs Assessment

All Age Suicide Prevention

Topic Specific Report

May 2023

CONTENTS

ACKNOWLEDGEMENTS

The Public Health team of the City of Wolverhampton Council expresses its gratitude to all those who have contributed to this needs assessment, which has provided a comprehensive understanding of the actions that professionals, organisations, and communities can take to prevent suicides in Wolverhampton. Appreciation is extended to all the individuals who are part of the Suicide Prevention Stakeholder Forum, Mental Health Stakeholder Forum, and One Wolverhampton Adults Mental Health Strategic Working Group for their valuable guidance and input throughout this process.

SCOPE

The purpose of this rapid needs assessment is to provide an evidence-based, data-informed overview of suicide in Wolverhampton. The aims of the needs assessment are to understand the incidence of suicide in people of all ages living in Wolverhampton and to consider who is at greatest risk of suicide and why – considering the risk factors that can influence an individual to consider suicide, and what protective factors can help to reduce the risk. This needs assessment is intended to provide a comprehensive overview to the stakeholders across the city to enable partners to shape a refreshed local suicide prevention strategy and action plan.

FOREWORD

This renewed needs assessment for our city is both timely, and needed now we find ourselves reflecting on and trying to make sense of the past three years, where, we all faced a common threat. With this said, suicide, has always had the potential to indiscriminately effect us all. A commitment to understand the underpinning drivers of completed suicide and the ripple effect it leaves behind, are the basis of a compassionate strategy which drives action.

You will see some of this needs assessment focus on a review of the statistics, they are essential to informing where resource and focus is needed. Mindful also that an absence of evidence, does not always mean there is an absence of need and we should aim to omit no one. We must hold on to those guiding principles to inform and devise a multi faceted strategy. I want to honour the loss within what can feel like a faceless presentation of numbers and demographic categories. Each number represents a life lost, someone's someone, and a ripple effect of what can feel like a complicated grief.

Finally, please do take care when reading this needs assessment, whether you are a service lead, strategist, a user of services or a researcher, you are first and foremost a human being comprising of needs and indeed strengths. Whilst we want this document to inform and inspire hope, it remains that its main focus is on a subject that can be shrouded in myth, misunderstanding, fear and pain. Please take some time to review the list of local and national services included in this document, resources you may need for yourself, someone you care about, or someone you are yet to meet.

Clare Dickens MBE
Chair of Wolverhampton's Suicide Prevention Stakeholders Forum.

EXECUTIVE SUMMARY

Background

Suicide prevention is a systemwide priority. Each instance of suicide is a tragic event that profoundly affects families, friends, and communities. The risk of suicide is closely linked to broader inequalities, with significant variations in suicide rates based on people's social and economic conditions, with higher rates observed in economically disadvantaged communities. However, it's important to recognise that suicide is not inevitable and can be prevented through appropriate support and strategies. Suicidal incidents typically involve multiple contributing factors, emphasising the need for a comprehensive, systemwide approach to prevention. Engaging multiple partners and addressing various risk factors are crucial components of effective suicide prevention efforts. In more recent times, key policy drivers such as the national suicide prevention strategy and NHS Long Term Plan have acted as enablers for local action to preventing suicides.

Local Context

Wolverhampton is home to 263,700[1] residents, the population is proudly diverse with over 40% from ethnic minority communities. The city has many positives with nearly 80% of the population stating their health is good, or very good, and score of happiness, as measured through the Annual Population Survey, being above the England average[2].

However, Wolverhampton faces numerous challenges, including significant levels of deprivation, currently ranked as the 24th most deprived local authority. When compared against national benchmarks, using several indicators, people in Wolverhampton have a lower life expectancy, earn a lower wage, are less likely to be in paid employment and therefore more reliant on benefits. Furthermore, against national averages, residents of Wolverhampton are more likely to be a victim of crime, obtain lower qualification levels and experience higher levels of housing related issues such as fuel poverty. This context is especially relevant considering that individuals residing in more deprived communities are at a heightened risk of being exposed to factors that contribute to suicide.

Despite these challenges, suicide rates in Wolverhampton have declined over the past two decades and is currently at its lowest point. The current rate is significantly below the national average and the lowest among all areas in the West Midlands region. Nevertheless, it is important to acknowledge that over 50 suicides occurred within the city during the most recent three-year reporting period which serves as a reminder to system partners that additional efforts are necessary to address the issue effectively.

Suicide prevention work in Wolverhampton is aligned with the priorities set out in the City of Wolverhampton Council's 'Our City: Our Plan' and the 'Public Health Vision 2030', as well as priorities set out through the Integrated Care System. Furthermore, many partners who take a key role in this agenda, progress suicide prevention efforts within their respective organisation to ensure policies are adopted in various settings including education, voluntary community sector and statutory services. The Wolverhampton Suicide Prevention Stakeholder Forum is an established network of partner organisations who lead this agenda locally supported through the Public Health team at City of Wolverhampton Council, the forum feed into the Health and Wellbeing Board and One Wolverhampton, which forms part of the Integrated Care System.

Evidence Review

Research has found that there are some sections of the population who are disproportionately exposed to a range of factors that could increase the likelihood of suicide:

- Men – being male does not inherently mean increased suicide risk, however, the prevalence of suicide has been significantly higher in men when compared with women, suggesting risk factors are managed differently by men and therefore requiring tailored approaches
- People with a diagnosed mental health condition or those with poor mental health that are not known to local services
- People with long term physical conditions
- People who are unemployed and people from some occupational groups

Whilst suicides in children and young people are lower than the adult population there is an increased risk of exposure to factors that contribute to suicide in some groups, such as looked after children, care leavers and those in the youth justice system, this is generally synonymous to risk of worse mental wellbeing in children and young people as recognised in various strategies published to direct improvements in mental health of this group.

There is also an increased risk of suicide in people where the following risk factors are prevalent:

- Problem gambling
- Excessive alcohol consumption
- History of self-harm
- Chronic loneliness and isolation

Local services and professionals

Tackling suicide requires a systemwide multi-agency approach, there is a professional and personal duty of care in all professionals to support someone in distress. To enable the workforce to recognise those at risk of suicide, it is important to facilitate training in recognising the signs and symptoms someone in distress may display and for them to be able to respond. There are a number of services within the city that people in distress can be encouraged to access. However not all local professionals are aware of these services and how they can be accessed. It is therefore important to ensure that all local professionals and local services are better connected.

To understand the needs of the local population there is a need to improve the quality of data recorded where individuals are accessing support. This includes better recording of demographic data and reasons for presentation to services. It is however recognised that presentation to services may not be explicitly related to suicide ideation making it difficult to provide systematic recording of data.

Recommendations

1. To roll out suicide prevention awareness training across the city targeting professionals working with groups at higher risk.

2. To facilitate screening for wellbeing for those with long term physical conditions to identify the prevalence of any risk factors and to undertake a safety plan type intervention where indicated.

3. To develop suicide prevention interventions for groups at increased risk such as men, migrant communities, people exposed to domestic abuse.

4. To recognise the link between domestic abuse and suicide; specifically, the increased risk of suicide in both victims and perpetrators of domestic abuse. To address this through a specific training programme.

5. To create and deliver suicide prevention messages for people in financial difficulties or those at risk and for these to be consistently applied across organisations these individuals will be in contact with.

6. Work with services such a Network Rail, Highways, and mental health settings to reduce access to means to suicide.

7. To embed routine enquiries about financial hardship into mental health services and to ensure that services have appropriate resources for signposting and referring for specialist support.

8. To monitor incidence of suspected suicides through the regional real time surveillance system and ensure timely multi-agency action is taken as appropriate, including work with media, reducing risk of further associated suicides and ensuring bereavement support is offered.

9. To highlight the protective factors that can offer protection against suicide ideation as part of awareness campaigns, including World Suicide Prevention Day, Mental Health Awareness Week, World Mental Health Day, and Childrens' Mental Health Week.

10. To work with local services on improving awareness of support services across the city.

11. To work with local services to embed best practice, such as NICE guidance on self-harm, so that interventions related to suicide prevention are evidence led and effective.

12. Ensure that the service offer for suicide prevention, intervention and postvention is equitable and takes into consideration special requirements such as digital exclusion, sensory impairment, and language barriers.

13. To work with commissioners and services to improve the quality of information recorded by services, such as systemically recording suicide ideation being the reason for presentation to services. This will facilitate a clearer understanding of local need.

14. To obtain a better understanding on which groups are accessing support services related to suicide prevention and consider how to reduce any identified health inequalities.

SECTION 1: BACKGROUND AND CONTEXT

Introduction

Suicide prevention is a systemwide priority. Every case of suicide represents an individual tragedy and a loss to society. It has a devastating effect on families as well as survivors. Suicide risk reflects wider inequalities as there are marked differences in suicide rates according to people's social and economic circumstances with those in poorer communities more likely to be affected. Suicide behaviours are complex; there is commonly no single explanation of why people take their own life and multiple factors usually contribute to each death. Every suicide is a tragedy which causes considerable damage and suffering for families and communities, yet there is a belief, endorsed by the World Health Organisation that every suicide is preventable.

A public health approach to suicide prevention consists of working across the system, including local communities, aiming to protect those who are most vulnerable, for example, people and families in debt, those living in poverty, homeless, unemployed and those experiencing loneliness and isolation. Many of these risk factors of suicide have been exacerbated by the events of the last three years, namely the Covid 19 pandemic and the more current cost of living crisis, which is having an impact on those considered to be most vulnerable.

Reducing risk factors requires engagement from systemwide partnerships including health, social care, education, statutory services, voluntary services, and the communities that use these services. Locally in Wolverhampton the Suicide Prevention Stakeholder Forum (SPSF) engages these partners to work towards understanding and managing these risks.

Suicide prevention also includes work to promote positive mental health and prevent the development of mental illness, in vulnerable groups. It is important suicide prevention work builds upon and complements wider mental health strategies.

1.1 National policy drivers

NHS Long Term Plan (LTP) (2019)[3]

The plan reaffirmed commitment of the NHS to prioritise the reduction of suicides from 2019 to 2029. The proposed deliverables encompass various initiatives, including achieving full coverage of the existing suicide reduction program across the country, an enhanced mental health crisis model ensuring that individuals in crisis can access 24/7 mental health support by calling NHS 111 and an expansion of specialist perinatal mental health services, providing comprehensive care to women from preconception through two years after childbirth.

Furthermore, there was commitment to increase investment in specialist community teams dedicated to supporting children and young people with autism, adults with severe mental illnesses, and individuals who self-harm. A new Mental Health Safety Improvement Programme was launched to improve the safety of mental health inpatients with a focus on suicide prevention and a comprehensive suicide bereavement support offer was to be made available for families and staff working in mental health crisis services throughout the country.

National Suicide Prevention Strategy 2012[4]

In 2012, the publication of 'Preventing suicide in England: A cross-government outcomes strategy to save lives' emphasised the importance of a public health approach to preventing suicide. The strategy endorsed the development of multi-agency strategies and action plans to address this issue effectively. The strategy outlined seven key areas for action, which included reducing the risk of suicide in high-risk groups, implementing targeted mental health interventions, limiting access to suicide methods, providing comprehensive support to those affected by suicide, promoting responsible media coverage of suicide, supporting research and data collection, and addressing self-harm rates as a crucial indicator of suicide risk. These priorities were subsequently incorporated into the Wolverhampton Suicide Prevention Strategy and Action Plan for the period 2016-20, ensuring local alignment with the national strategy.

Local Suicide Prevention Planning: a practical resource (Public Health England)[5]

This practical resource acts as a comprehensive guide for local areas, providing a roadmap to address key priorities in suicide prevention. It emphasises the importance of reducing risk in middle-aged men, focusing on economic factors such as debt, social isolation, and substance misuse. The resource highlights the need for developing treatment and support services that specifically cater to the preferences of men. Additionally, it addresses the imperative to prevent and respond to self-harm and emphasises the significance of addressing mental health issues in children and young people.

The guide also places importance on the treatment of depression in primary care, promoting the safe prescribing of painkillers and antidepressants. It recognises the critical role of acute mental health care by emphasising the need for suicide-safe wards and appropriate hospital discharge processes that consider patient needs. In the community, the resource recommends initiatives to reduce isolation through community-based support and infrastructure. The resource acknowledges the significance of bereavement support, particularly for those who have experienced the loss of a loved one to suicide.

Five Year Forward View for Mental Health[6]

The Five Year Forward View for Mental Health was a strategic plan that was published by the NHS in 2016. It outlined a comprehensive vision and framework for improving mental health services and support over a five-year period. The key goals of the plan incorporated prevention and early help, access to high quality services, integration of mental and physical health and workforce development. The plan represented a commitment to transforming mental health care in England by promoting a more integrated and person-centered approach to mental health support. The legacy of this plan continues through the NHS LTP and ongoing central government investment in mental health support.

National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)[7]

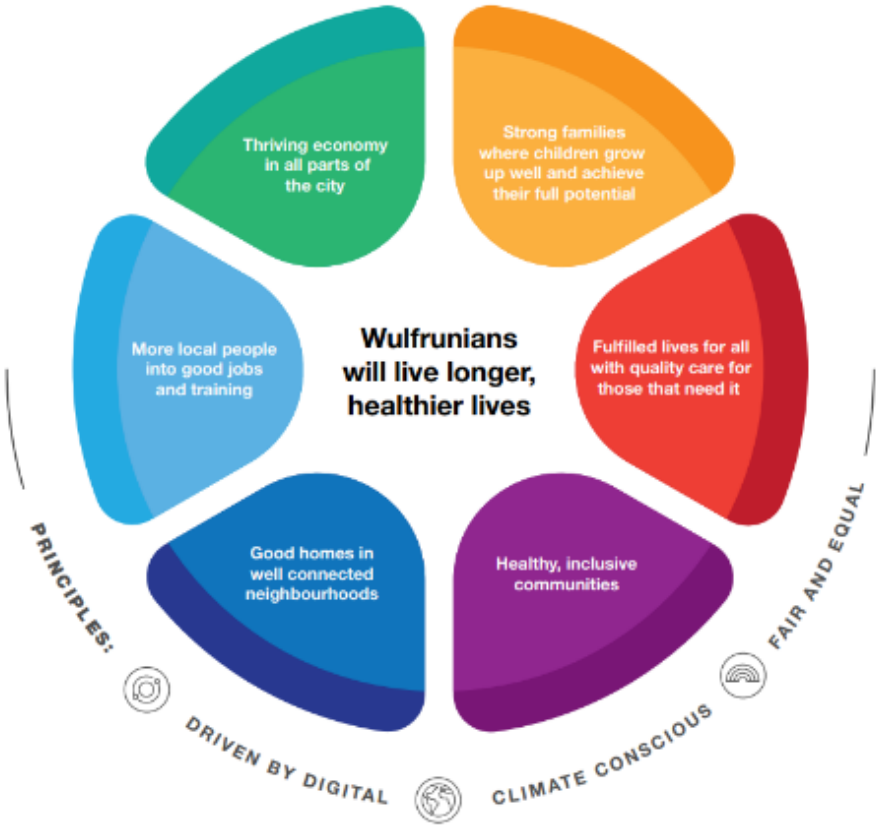
NCISH is a unique research project led by the University of Manchester's Centre for Mental Health and Safety, in collaboration with other academic institutions and organisations that

informs policy, practice, and training in mental health care. The project aims to investigate and improve patient safety and the quality of mental health care for people who have died by suicide or have self-harmed. The NCISH collects and analyses data from various sources, including national databases, clinical records, and coroners' records, to gain insights into the circumstances and factors surrounding suicides and self-harm incidents.

1.2 City of Wolverhampton context

Our City: Our Plan[8]

In 2019, the council launched Our City: Our Plan, which outlines priorities for the period between 2019 and 2024. These priorities span the life course ensuring children get the best start possible, families are supported, economy is thriving, and communities live a healthy and fulfilling life. These priorities are aligned with the determinants of health and wellbeing, which can act as protective factors in preventing incidents of self-harm or suicide.



City of Wolverhampton Public Health Vision 2030[9]

The Public Health Vision proposes that by 2030 residents of the city will live longer, healthier, and more active lives, every child will have the best start in life, the gap in healthy life expectancy will reduce, both within the city and between the England average, and ensure everyone is protected from harm, serious incidents, and avoidable health threats. Preventing suicide in people of all ages is aligned with each of these priorities.

Wolverhampton Suicide Prevention Stakeholder Forum (SPSF)
SPSF Charitable Trust oversees the formulation and delivery of the local suicide prevention strategy and action plan. The forum established in 2016 in response to the national suicide prevention strategy, a local needs assessment was completed at this time which informed the development of the Wolverhampton Suicide Prevention Strategy and Action Plan 2016-2020[10].

Through its constitution as a charitable trust the forum is able to fundraise and allocate this funding to initiatives to prevent suicide in Wolverhampton. The forum is made up of numerous partners from the statutory and voluntary sectors including the City of Wolverhampton Council, NHS providers including acute and specialist mental health, voluntary sector, emergency services, education, and transport.

The Wolverhampton Suicide Prevention Strategy and Action Plan aims to provide a multi-agency approach to suicide prevention across Wolverhampton. Through raising awareness of suicide, compelling organisations and the community to take positive action, upskilling workforces through information and knowledge enabling them to better understand and respond to poor mental wellbeing and suicide ideation. The plan also incorporates influence on services and policies so that suicide prevention is robustly considered and embedded in routine business, to provide a coordinated suicide support offer which can be accessed by services and communities and support NHS partners in reaching suicide reduction objectives set out in various policies.

Integrated Care System
On 1 July 2022, an Integrated Care System (ICS) was established across the Black Country. Under the ICS structure, place-based partnerships will lead the detailed design and delivery of integrated services across their localities and neighbourhoods. One of the workstreams under the Black Country ICS is an All Age Suicide Prevention Workstream which will hold strategic oversight of local suicide prevention forums across each of the 4 localities in the Black Country: Dudley, Sandwell, Walsall and Wolverhampton. The established local forums are expected to continue to lead on development and delivery on their local placed based strategies. At Place level, One Wolverhampton provides the ICS structure locally, with various strategic working groups established to progress key priorities, suicide prevention sits within the adults mental health strategic working group.

1.3 Aims of the needs assessment
The aims of this needs assessment were to understand the prevalence of suicide in people living in Wolverhampton and consider which possible risk factors are likely to have contributed to these through the study of data.

Furthermore, the needs assessment reviewed the current evidence base with regards to the risk factors and protective factors that contribute towards suicide or can be effective in preventing suicide which can inform interventions to protect vulnerable individuals.

Additionally, mapping of services was undertaken to understand which services are currently accessed within Wolverhampton that can support persons at risk of suicide and understand who is currently accessing these.

Finally, the needs assessment sought to engage with professionals working in Wolverhampton to understand their awareness of the local suicide prevention strategy, their knowledge and skills in supporting people at risk of suicide, and their awareness of local support services.

1.4 Methodology

The methodology applied in achieving the aims of this needs assessment consisted of both qualitative and quantitative information. Data available from national and local sources across various organisations were utilised to understand the epidemiology of suicide in Wolverhampton.

Research techniques were applied to synthesise evidence available from credible sources regarding risk factors, and the prevalence of these in particular groups of people, protective factors that help mitigate suicidality and through review of best practice interventions. Lived experience was considered through current research available and applied accordingly. Additionally, desktop exercises were completed to form a picture of current support services available in Wolverhampton and to understand who is accessing the provision and why.

Qualitative approaches were applied to engage with professionals working in Wolverhampton, who may support individuals at risk of suicide, or may have expressed suicide ideation, to understand their professional knowledge base, whether they have received training in suicide prevention awareness and their knowledge of local services that can help people in distress.

The process was led through a task and finish group which was made up of representatives of the Wolverhampton Suicide Prevention Stakeholder Forum.

SECTION 2: SUICIDE STATISTICS

2.1 Definition

In the UK, the conclusion of a suicide verdict is determined by a coroner. When a death is reported, the coroner conducts an investigation to establish the circumstances surrounding the death. This investigation involves gathering evidence, conducting post-mortem examinations, and considering any available information such as medical records and witness statements. The coroner's role is to establish the cause of death and provide an official verdict based on the evidence.

The Office for National Statistics (ONS) definition of suicide includes deaths given an underlying cause of intentional self-harm or an injury/poisoning of undetermined intent. In England and Wales, it has been customary to assume that most injuries and poisonings of undetermined intent are cases where the harm was self-inflicted but there was insufficient evidence to prove that the deceased deliberately intended to kill themselves. However, this cannot be applied to children due to the possibility that these deaths were caused by unverifiable accidents, neglect or abuse. Therefore, only deaths of undetermined intent in those aged 15 years and over are included. For age band 10-14 years old, suicide can be concluded only if the act of suicide is proved as being intentional.

2.2 Data sources

This section makes use of various data to understand the epidemiology of suicide. In particular, open access data offered through the Fingertips tool[11] was utilised to understand key headlines around suicide incidence and prevalence across national, regional and local geography. Black Country Coroner data was accessed through local arrangements, which provides more in-depth information on circumstances surrounding a suicide, a total of 41 cases, spanning approximately three years are incorporated from this data set. Data pertaining to support services in Wolverhampton was accessed through direct requests to the respective organisations. Additionally, to understand ethnicity in more depth, an exercise was completed matching suicides with ethnicity through hospital presentation data, this data provided information on 97 suicides that occurred between 2016-2020. Finally, data offered through the NCISH has been applied where available and appropriate. All data transfer and handling adhered to data protection protocols.

Limitations

Due to the publication schedule of the ONS, official verified data on suicides for the year 2022 is not yet available. This poses a challenge in comprehending the epidemiology of suicide in the context of significant events during 2022, such as the lifting of Covid-19 restrictions and the initiation of the recovery period, as well as the onset of the cost of living crisis. These socio-economic factors may have potentially influenced suicide rates. Furthermore, the existing ONS data offers limited information on demographics, which restricts the ability to obtain a comprehensive understanding of the circumstances preceding suicides.

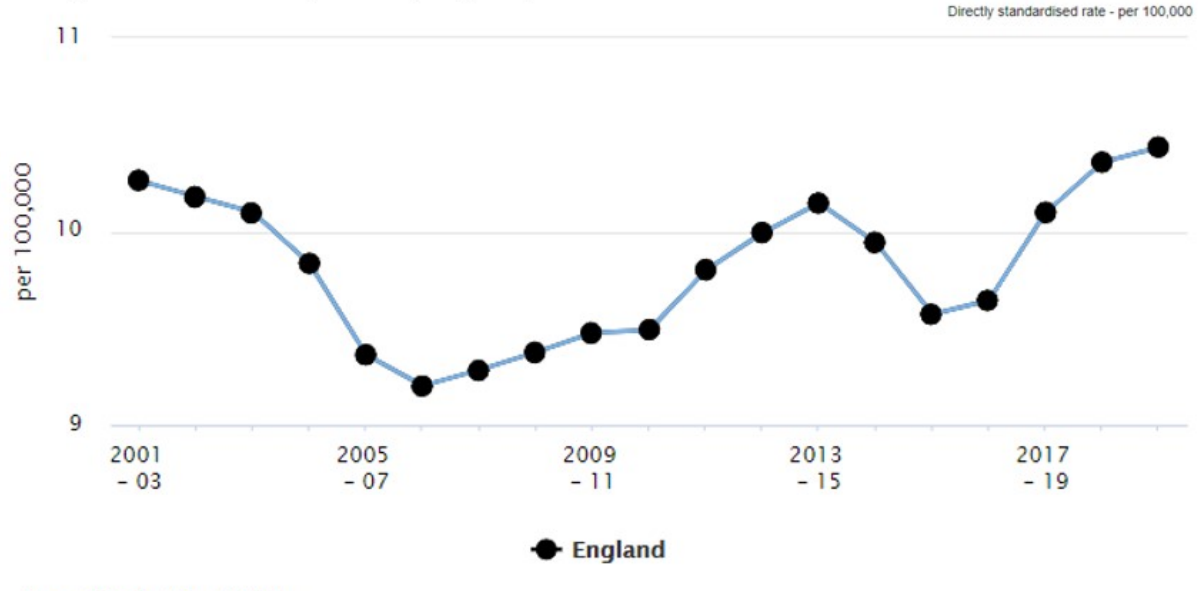
The data provided by the Black Country Coroner does include information for the year 2022; however, it is important to note that this data is provisional and subject to potential changes until formally published by ONS. Nevertheless, the likelihood of significant

discrepancies between the Black Country Coroner data and the subsequent ONS publication is expected to be minimal. It is important to acknowledge that when analysing coroner data, numerous variables often have low frequencies, making them unreportable and limiting the ability to confidently interpret trends and patterns based on this data alone. Additionally, coroner data is subject to error and varying interpretation during data input, due to the subjective nature of many fields and free text options within the reporting template.

2.3 National

Suicide rates across England have remained similar since 2001 with peaks and troughs during that period. In 2021, 5,583 suicides were registered in England and Wales, 6.9% higher than in 2020 (5,224 deaths), equivalent to an age-standardised mortality rate (ASMR) of 10.7/100,000 (95% CI = 10.3 – 10.6). Whilst this was statistically significant compared to the 2020 ASMR (10.0/100,000), it was consistent with the pre-coronavirus (COVID-19) pandemic rates in 2019 and 2018. The latest rate has returned to pre-coronavirus pandemic levels following a decrease in 2020 that was likely to be caused by two factors; a decrease in male suicides at the start of the coronavirus pandemic, and delays in death registrations because of the pandemic.

Figure 1: Suicide rate (Persons) England, 2001-2021

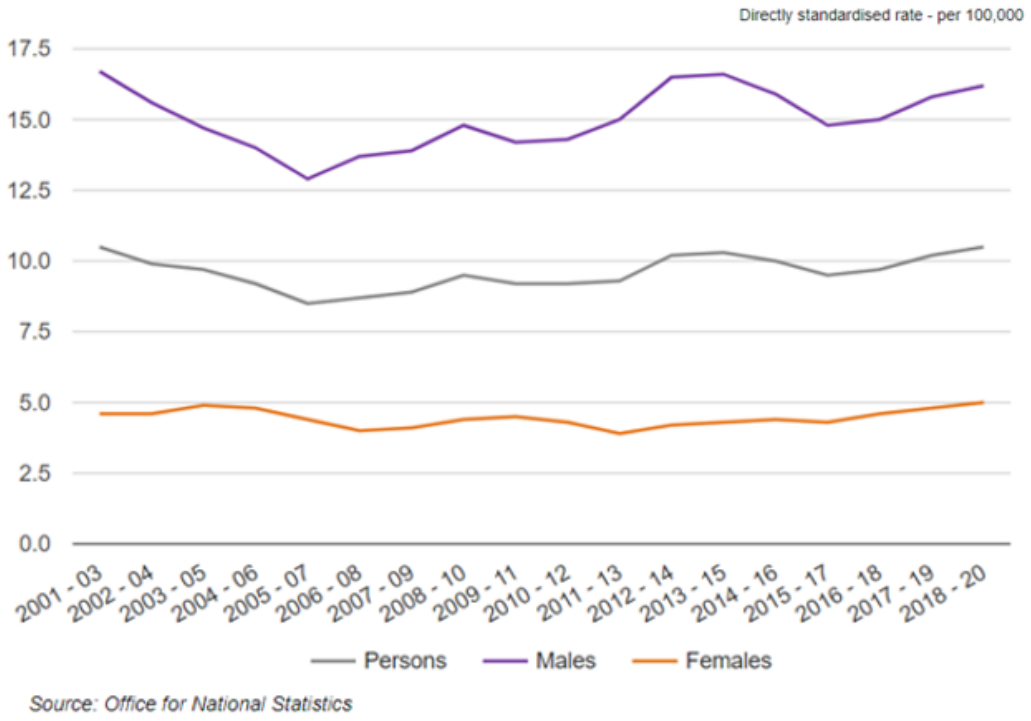


Source: Office for National Statistics

2.4 Regional

Suicide rates in the region decreased from 2001 but have been gradually increasing since 2005. There was a reduction between 2015 and 2017 followed by a period of increase up to 2020. Figure 2 also shows that men in the West Midlands region are three times more likely than women to die by suicide. The most recent data for West Midlands shows the suicide rate for the period of 2019-2021 was 10.7 (95% CI = 10.2 – 11.2).

Figure 2: Suicide rate (Persons and gender) West Midlands, 2001-2021



Source: Office for National Statistics

2.5 Wolverhampton

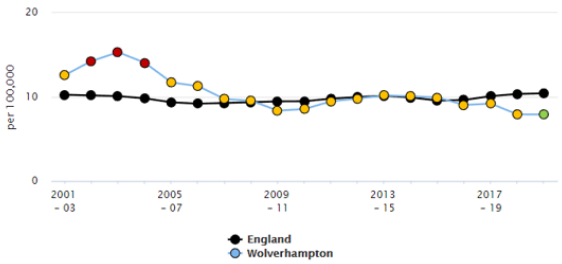
This section provides a more comprehensive examination of suicides that occurred in Wolverhampton, utilising multiple sources of data with analysis across various demographics. According to the latest three-year rolling average (2019-2021) reported by ONS, the incidence of suicides in Wolverhampton remain unchanged compared to the previous period, with 53 recorded cases representing a rate of 7.9/100,000 (95% CI = 5.9-10.4), this rate is lower than both West Midlands (10.7, 95% CI = 10.2 – 11.2) and England (10.4, 95% CI = 10.3 – 10.6). The highest rate recorded for the city was between 2003 – 2005, where it reached 15.3. Wolverhampton currently has the lowest rate of suicide reported across the region.

For 2022, Black Country Coroner reported 13 suicides registered, however this is provisional data.

Figure 3: Suicide rate (persons) Wolverhampton 2001-2021

Directly standardised rate - per 100,000

Show confidence intervals Show 99.8% CI values ▶ More options



Recent trend: Could not be calculated

Period		Wolverhampton Count	Value	95% Lower CI	95% Upper CI	West Midlands	England
2001 - 03		81	12.6	10.0	15.7	10.5	10.3
2002 - 04		92	14.3	11.5	17.5	9.9	10.2
2003 - 05		97	15.3	12.4	18.7	9.7	10.1
2004 - 06		90	14.1	11.3	17.3	9.2	9.8
2005 - 07		75	11.7	9.2	14.7	8.5	9.4
2006 - 08		72	11.3	8.8	14.2	8.7	9.2
2007 - 09		62	9.8	7.5	12.5	8.9	9.3
2008 - 10		60	9.5	7.3	12.3	9.5	9.4
2009 - 11		53	8.4	6.3	11.0	9.2	9.5
2010 - 12		56	8.6	6.5	11.1	9.2	9.5
2011 - 13		63	9.5	7.3	12.2	9.3	9.8
2012 - 14		64	9.8	7.5	12.5	10.2	10.0
2013 - 15		66	10.2	7.9	13.0	10.3	10.1
2014 - 16		66	10.1	7.8	12.9	10.0	9.9
2015 - 17		66	9.9	7.7	12.7	9.5	9.6
2016 - 18		60	9.0	6.9	11.7	9.7	9.6
2017 - 19		61	9.2	7.0	11.8	10.2	10.1
2018 - 20		53	7.9	5.9	10.4	10.5	10.4
2019 - 21		53	7.9	5.9	10.4	10.7	10.4

Source: Office for National Statistics

Figure 4: Suicide rate (persons) 2019-2021

Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	15,447	10.4	10.3	10.6
West Midlands region	–	1,645	10.7	10.2	11.2
Stoke-on-Trent	–	106	16.4	13.2	19.5
Herefordshire	–	64	12.6	9.6	16.1
Worcestershire	–	186	12.0	10.3	13.8
Staffordshire	–	277	11.9	10.5	13.3
Shropshire	–	99	11.6	9.3	14.1
Telford and Wrekin	–	53	11.4	8.6	15.0
Warwickshire	–	172	11.2	9.5	12.9
Sandwell	–	93	11.2	9.0	13.7
Dudley	–	86	10.3	8.2	12.7
Solihull	–	59	10.3	7.8	13.3
Coventry	–	89	9.3	7.3	11.5
Walsall	–	65	9.0	7.0	11.5
Birmingham	–	243	8.7	7.6	9.8
Wolverhampton	–	53	7.9	5.9	10.4

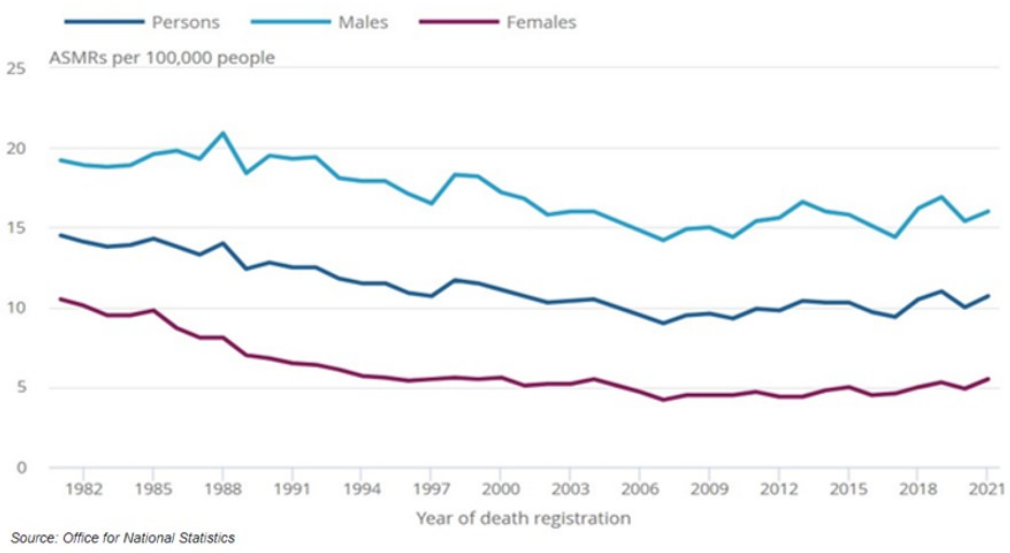
Source: Office for National Statistics

Gender

Historically, men make up approximately 75% of suicides nationally. In 2021, the suicide rate for males in England and Wales was 16.0/100,000; consistent with rates between 2018 and 2020. For females, in 2021, the rate was 5.5/100,000, this is consistent with rates between 2018 and 2020.

ONS reporting by gender shows that across the time series of data, since 2001, for Wolverhampton the gender split is slightly higher with males accounting for 80% of suicides, with the remaining 20% of suicides being female.

Figure 5: Suicide rate by sex, England and Wales, 1982-2021



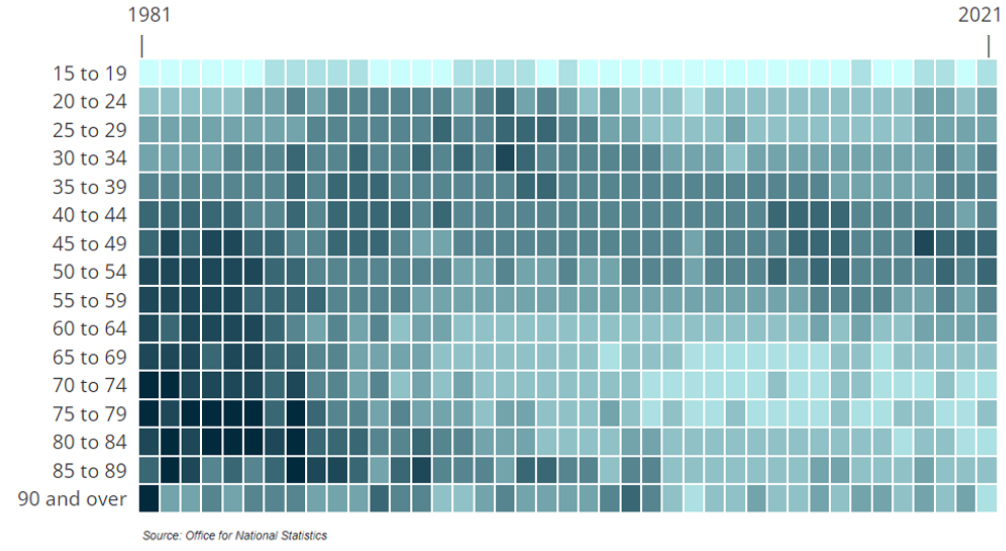
Source: Office for National Statistics

Age

ONS reports that the highest suicide rate in 2021 was seen among people aged 45-54. Among women, those aged 45 to 49 years had the highest age-specific suicide rate at 7.8/ 100,000 (146 registered deaths), among men, those aged 50 to 54 years had the highest age-specific suicide rate at 22.7/100,000 (456 deaths). Furthermore, data reports that females aged 24 years or under have seen the largest increase in the suicide rate since the time series began in 1981. Despite having a low number of deaths overall, rates among the under 25s have generally increased in recent years, particularly in females between 10-24.

Over the last three decades there has been a change in the pattern of suicide rates, shifting from higher rates among older people to now being more prevalent among the middle-aged population. ONS does not offer suicide by age at local authority level. However, Black Country Coroner data provides some insight and reports similar age trends to the national picture.

Figure 6: Age-specific suicide rates by five-year age groups, England and Wales, registered between 1981 and 2021



Source: Office for National Statistics

Ethnicity

Mortality breakdown by ethnicities is not routinely reported through central sources such as ONS. However, a local exercise matching suicides with recent hospital presentation was completed to provide a snapshot for Wolverhampton. The exercise matched 97 suicides over the period of 2016-2020, during the same period ONS recorded 98 suicides.

Suicide by ethnicity in Wolverhampton was by in large aligned to the ethnic population makeup of the city. When observing ethnicity by gender, Asian men had a noticeable higher percentage (20.4%) compared to Asian women (11.1%), and White women had a higher percentage (72.2%) compared to White men (59.3%). It should be noted ethnicity is self-reported and therefore at risk of erroneous recording. Coroner data was not used for ethnicity due to low recording.

Table 1: Suicide by ethnicity, in Wolverhampton, for 2016-2020

Ethnicity	% Suicide deaths	% of population
Asian	18.1%	21.2%
Black	9.7%	9.3%
Mixed	5.6%	5.3%
Other	4.2%	3.6%
White	62.5%	60.6%

Source: Midlands and Lancashire CSU

Deprivation

ONS reports that based on the past decade, overall, both men and women residing in the most deprived areas generally experience higher suicide rates compared to those in the least deprived areas. However, this disparity between the most and least deprived areas is primarily observed among individuals of working age. Living in a deprived area increases the risk of suicide for nearly all working age groups, but it particularly affects those in their late 30s to late 40s. Within this age group, suicide rates in the most deprived areas tend to be more than double compared to the least deprived areas.

Black Country Coroner data for Wolverhampton reports that nearly 80% of suicides were within populations that resided in the more deprived areas of the city, with nearly 50% coming from the two most deprived deciles.

Other factors

There are many other variables derivable from the data available, which can add context to suicides. However, some of these variables require further research to understand the relative risk they add to suicide risk. Wolverhampton data has shown that those working in skilled trade occupations had the highest number of deaths compared to other occupational groupings, this is mirrored in national reports. Hanging was the most common method of suicide, and most suicides took place in the home. Previous suicide attempts were noted in 51%, and 58% had a record of previous incidents of self-harm. In respect of mental health history, 44% were known to mental health services, NCISH reports that 27% of all suicides are in those known to mental health services in the 12 months prior to their death.

SECTION 3: EVIDENCE REVIEW

Introduction

This section of the needs assessment considers the evidence base for suicide prevention in the UK. A death by suicide usually follows a period of distress that can be caused by a significant life event, a period of adversity and long term poor mental wellbeing. A death by suicide does not occur when someone wants to die, but because they feel they can no longer live the life that they are currently living. As well as the loss of life there is the resulting impact of suicide on bereaved families, communities and the professionals that have worked with them.

Typically, no single initiative or organisation prevents suicide. A collective effort that recognises and assesses risk factors, encourages conversation on a topic that for many is considered taboo and which engages multiple agencies to identify and support the most vulnerable is required. The World Health Organisation[12] approach to suicide prevention recommends the following key effective evidence-based interventions which require a collective effort to implement: limit access to the means of suicide, interact with the media for responsible reporting of suicide, foster socio-emotional life skills in adolescents, early identification, assessment, management, and follow up anyone who is affected by suicidal behaviours.

Scope

The purpose of this evidence review was to examine several key aspects related to suicide, based on the available literature at the time of completing the needs assessment. The specific areas explored were:

1. Identification of risk factors influencing suicide ideation.
2. Examination of the groups most affected by these risk factors.
3. Evaluation of interventions that can be implemented to mitigate the likelihood of suicide.
4. Assessment of the impact of suicide on individuals bereaved or exposed to suicide.

By focusing on these elements, the evidence review aimed to provide a comprehensive understanding of the factors contributing to suicide and potential strategies for prevention. It should be noted that the review was conducted based on the literature accessible during the completion of the needs assessment.

Methodology

Various research platforms were utilised to access a wide breadth of literature. Key search terms were used to draw out the most relevant information from academic research studies, grey literature, and journals. The collected findings were analysed using a qualitative narrative synthesis approach, which involved interpreting the results and constructing an integrated and comprehensive understanding that addressed the research objectives. This method facilitated the synthesis of information from various sources to provide an informative overview of the subject matter.

3.1 Groups at higher risk of suicide

There are a number of prevalent risk factors that can contribute to a suicide and each tragedy of a death by suicide is likely to have been influenced by a combination of these. These risk factors include but are not limited to poor mental health, chronic physical illness, addiction, chronic loneliness or isolation, deprivation or the trauma of an adverse life event such as bereavement or the end of a relationship. It is also important to recognise that coroners are required to record only the "when, where and how" of any suicide verdict, whilst the underlying reason(s) why someone took their life is rarely recorded. Understanding and addressing the 'why' represents a significant part of the efforts to prevent suicide.

Additionally, data on incidents of suicide show a higher prevalence in particular groups that have been the subject of enquiry and where targeted preventative intervention has been recommended. It is however acknowledged that a person may still be at high risk of suicide even though they might not be assessed as a member of a high-risk group as suicidal thoughts (and risk) can vary across a relatively short time period.

Some groups in society are at greater risk of suicide ideation due to the greater prevalence of collective risk factors and an absence of, or barriers to, protective factors to reduce these risks. This evidence review considers the multiple risk factors that can contribute to suicide and interventions that can be implemented to mitigate these risk factors and enhance protective factors.

Men

Both nationally and globally suicide is more prevalent in males, but there are still a significant number of women who decided to end their lives. Although men are more likely to die by suicide, women are more likely to attempt suicide, a phenomenon for which Canetto and Sakinofsky (1998)[13] coined the term *gender paradox*. One of the reasons to explain the disparity and the increased incidence of completed suicides in men is likely to be the increased lethality of the method used by men. The World Health Organisation recognises that for every suicide completed there are many more attempts of suicide and the most significant risk factor for suicide is a previous attempt.[14]

According to Richardson *et al.* (2021)[15] the five risk factors with the strongest evidence predicting suicidal behaviour in men were:

1. alcohol and/or drug use/dependence
2. being unmarried, single, divorced, or widowed
3. having a diagnosis of depression
4. low levels of education
5. previous suicide attempts

This list itself indicates a number of groups of men where preventative interventions should be aimed. Richardson *et al* (2021) systematic review of suicidal behaviour in men confirmed the risk factors in men are multiple and that these can change in relevance throughout an individual's life indicating the need for a periodic review of assessed need in in men identified as being at risk. Potential explanations for the gender differences in suicidal behaviour include disparities in early life experiences, differences in emotions and

emotional expression, social/cultural norms, coping, situational factors, differences in method selection, and biological factors.

Across eight studies there was evidence that being unmarried, divorced, widowed, separated, or single was associated with a significantly increased risk of suicide death and attempts relative to those who were married. There is also links between experiences in childhood and later suicide in men including a link between low household income as a child and later suicide mortality in men. Two studies [16] [17] uncovered a relationship between social and material deprivation and suicidal death. This suggests that risk assessments need to be comprehensive and multifactorial to identify some of the more covert or hidden risk factors such as adverse experiences in childhood which individuals may not openly disclose as adults.

Men with mental illness are at an increased likelihood to engage in behaviours that are harmful to both them and others compared with men without a mental illness. These behaviours include substance abuse, excessive alcohol intake, recreational drugs, anger, violence, or other risky behaviours (Wendt and Shafer, 2016)[18]. Men's reluctance to seek help often relates to a number of different reasons including gender ideology, poor health literacy and disregard for symptoms.

Given the significant gender disparity a number of preventative interventions target men specifically have been implemented nationally. Key learnings from NHS England and Improvement funded (NHSEI) suicide prevention projects delivered between February 2020 and June 2021 for middle-aged men (40-60 years old) living in Cheshire and Merseyside[19] included a series of recommendations on the design of suicide prevention interventions aimed at men. These recommendations can be applied in the design and evaluation of local interventions.

The study recommended that programmes should tackle social determinants of health and men's health inequalities in male-friendly spaces, deliver interventions in a safe setting where men usually reside, use language familiar to men, use facilitators who are non-judgemental and supportive, respectful, empathetic, genuine, passionate and adaptable.

Furthermore, the study recommended delivering male-only sessions in male communities which is accessible during non-working hours, using an activity and include goal setting, use a group-based environment and ensure services are aware of the social environment and personal experience of the local men participating in the intervention.

People with Long Term Physical health conditions

The existence of long term physical health problems is a risk factor in both men and women, in particular when this co-exists with depressive symptoms. Often the depressive symptoms are due to the actual or perceived impact of the physical condition such as loss of agility or mobility, and chronic pain that impacts negatively on the quality of the individual's life.

There are examples of conditions where there is a high odds ratio of depression associated with a physical illness: respiratory diseases such as chronic obstructive pulmonary disorder (COPD) and asthma (OR=1·5–2·06), cardiovascular diseases such as coronary heart disease

and stroke (OR=1·53–1·54), degenerative diseases such as osteoporosis and multiple sclerosis (OR=2·33–2·54)

Increasing awareness of suicide risk and suicide prevention in medical professionals in acute care settings and multi-disciplinary teams who work with these groups of patients is an opportunity to recognise those at risk. Staff can be trained in assessing wellbeing, recognising risk and facilitating safety planning where risk factors are recognised.

Prevalence of poor mental health

There is correlation between poor mental health and the incidence of suicide. Bachman (2018)[20] suggests that between 60% and 98% of deaths by suicide are in people with a psychiatric disorder. Therefore, efforts to promote positive mental health and prevent the development of mental illness, in particular with vulnerable groups is within the scope of suicide prevention work. Additionally, it is estimated that less than half of those living with a diagnosable mental illness seek help (Sickel, Seacat and Nabors, 2019)[21] indicating a significant level of hidden need in the community.

In 2019 Public Health England (PHE) had identified ten population sub-groups at increased risk of declining mental wellbeing due to facing various inequalities. These population groups are:

1. black and minority ethnic groups (BAME) [ethnic minorities]
2. people living with physical disabilities
3. people living with learning disabilities
4. people with alcohol and/or drug dependence
5. prison population, offenders and victims of crime
6. LGBT (lesbian, gay, bisexual and transgender) people
7. carers
8. people with sensory impairment
9. homeless people
10. refugees, asylum seekers and stateless persons

Local partnerships will need to ensure that universal suicide prevention interventions such as awareness training, campaigns and preventative therapeutic services are adapted as targeted interventions aimed at these groups.

The cognitive or communication needs and/or preferences of these groups should be considered and where practical those that work with them including professionals, family members and carers should be involved in the co-creation, delivery and evaluation of these. This applies to preventative interventions as well as those to be accessed by people with suicide ideation in moments of crisis. Commissioners and service providers should ensure services like crisis cafes and telephone helplines can be accessed by people with a range of language and literacy needs.

Whilst suicide is prevalent in people with a clinically diagnosed mental disorder there are a significant number of people who die by suicide who have never seen a mental health professional or been diagnosed with a mental illness. According to Tang *et al* (2022)[22] identifying the characteristics of people who die by suicide without receiving services, often with a fatal first attempt, is crucial to reducing suicide rates through guiding improvements to service pathways and "just in time" interventions. Developing real time surveillance systems that recognise and respond to attempted suicide will present an opportunity for prompt intervention and de-escalation.

It is recognised that people may not use formal services for variety of reasons, including service inaccessibility, stigma, poor mental health literacy, preference for informal support, or negative past healthcare experiences. This can be equally applicable to universal services as well as those targeted at people during moments of crisis. Identifying the characteristics associated with non-use of services within this population is critical to address these barriers, develop alternative pathways into services, re-design current services, and inform the development of interventions or more appropriate "care" models that these individuals can be connected with. Whilst progress is being made with newer services which can be accessed without referral including the crisis café model the utilisation and efficacy of these for those experiencing suicide ideation will need to be evaluated over time.

Given the above a number of priorities for action can be identified including scrutiny of data on who is accessing support for their emotional mental health and wellbeing, and which groups are underrepresented across the groups that are accessing support. This also highlights the need for suicide prevention awareness across the many touchpoints within the community that such individuals are more likely to be in contact with. This includes universal settings and services including workplaces, primary care, educational settings, and social/leisure settings.

Higher Risk Occupational Groups

Preventing suicide in England: Third progress report on the cross-government outcomes strategy to save lives[23] states that the risk of suicide and self-harm is higher in people who are unemployed, which indicates that targeted preventative interventions for those not in employment. However, evidence shows there are certain occupational groups who are at higher risk due to many factors such as work related stress, workplace culture or access to means of dying by suicide. These groups include:

- doctors
- nurses
- veterinary workers
- farmers and agricultural workers
- skilled and manual workforce

However, it is understood suicide risk by occupational groups may vary locally, and it is vital that local partners are alert to this and adapt their suicide prevention interventions accordingly.

People who self-harm

Self-harm is defined as 'any act of self-poisoning or self-injury carried out by an individual irrespective of motivation'. Each year, there are an estimated 200,000 hospital attendances

for self-harm, mostly for self-poisoning and evidence suggests that around 50% of people who die by suicide have previously self-harmed. This risk of suicide is particularly heightened in the first year after self-harm, especially the first month. It is important to note that the majority of self-harm occurs in the community and does not lead to hospital attendance, skewing the figures. Rates of self-harm in the community have risen since 2000, especially in young people.

Prevalence statistics are unreliable because it is a problem that is sometimes hidden, the NICE guidance on Self Harm (2022) quotes a recent national study[24] which reported that 7.3% of girls aged 11 to 16, and 3.6% of boys aged 11 to 16, had self-harmed or attempted suicide at some point. The figures for 17- to 19-year-olds were 21.5% for girls and 9.7% for boys. For some people, self-harm is a one-off episode but repetition is also common, with 20% of people repeating self-harm within a year.

The relationship between suicide and self-harm is complex. It is known that many people who die by suicide have a history of self-harm, and self-harm is a significant concern in its own right. However, not everyone that self-harms will have suicidal thoughts.

NICE guidance[25] for preventing and managing self-harm makes a series of recommendations:

Interventions for someone who has self-harmed should include:

- a psychosocial assessment undertaken at the earliest opportunity to understand why the person has self-harmed, and to ensure the person receives the care needed
- structured, person-centred, cognitive behavioural therapy (CBT)-informed psychological intervention (for example, CBT or problem-solving therapy) that is specifically tailored for adults who self-harm. This intervention should start as soon as practical after the incident of self-harm.
- consider developing a safety plan in partnership with people who have self-harmed which acknowledges triggers and warning signs of increased distress, further self-harm or a suicidal crisis and identifies coping strategies. The safety plan should be held by the individual, and be shared with the family, carers and relevant professionals and practitioners as decided by the person.
- continuity of care for people who have self-harmed should be a priority; the number of different staff they see should be minimised.
- support and information may need to be adapted for particular groups for example, people with neurodevelopmental conditions or a learning disability, people from underserved groups, and those who do not speak English as a first language.

Domestic abuse

Studies have shown that both victims and perpetrators of domestic abuse are likely to be disproportionately exposed to a range of factors that can increase the risk of suicide. With regards to the prevalence of domestic abuse in the UK, The Crime Survey for England and Wales (CSEW)[26] estimated that nationally, 5.0% of adults (6.9% women and 3.0% men) aged 16 years and over experienced domestic abuse in the year ending March 2022; this equates to an estimated 2.4 million adults (1.7 million women and 699,000 men).

Five main cohorts have been identified as at risk of death by suicide (of what? Suicide? death by suicide?) due to being affected by domestic abuse. These are:

1. Victims who die by suicide during the abuse
2. Victims who die by suicide months or years after abuse has ended
3. Victims who are also thought to be perpetrators (at some point)
4. Perpetrators, including convicted, accused and under investigation for domestic abuse
5. Children and young people living in households impacted by domestic abuse

National Suicide Prevention Alliance (NSPA 2001)[27] reported evidence on the prevalence of suicidal ideation and attempts amongst domestically abused people in the UK, working with refugees client base (2021) and reported that of their sample group of 3519, 24% reported they had felt suicidal at some point.

An analysis of the 2014 English Adult Psychiatric Morbidity Survey (NHS 2016)[28] found that 35% of women who had attempted suicide in the past year had experienced intimate partner violence in the same period.

The National Child Mortality Database looked at 108 deaths that were assessed as highly or moderately likely to be due to suicide, between 2019 – 2020. It found a third (31%) of children and young people who died by suicide were living in a household impacted by domestic abuse.

A study by Kent and Meadway[29] found that from all perpetrators of domestic abuse more males died by suicide, which correlates with higher numbers of male domestic abuse perpetrators and the higher prevalence of suicide in men from the wider population. The study also reported that in respect of victims, increasing males are dying by suicide, despite 67% of victims being female and 33% being male.

This increased incidence of suicide in those who are victims, perpetrators or those who are exposed to domestic abuse indicates that integrated referral pathways, and system level support can increase detection, documentation, and referrals to support services. Health, social care and third sector professionals working with domestic abuse victims or perpetrators will benefit from training in suicide prevention awareness to apply professional curiosity and to identify and respond empathetically to victims who feel suicidal and connect them to appropriate information, services, and social support.

Loneliness

Loneliness is defined as *the subjective perception of a lack of contact with other people*[30] This is a feeling in people who are physically isolated or feeling a lack of connection with those that are around them. Loneliness affects most people at some time, but chronic loneliness has been linked to poor physical health, mental health and poor personal wellbeing. There is now more data on loneliness for the UK population, including from during the pandemic using consistent measures for adults. A narrative review of the literature on suicidal thoughts and behaviours and social isolation[31] concluded that 'both objective social isolation and the subjective feeling of loneliness should be incorporated in the risk assessment of suicide. Interventional studies targeting social isolation for suicide prevention are needed.'

Reported loneliness is higher for those who are:

- 16-24 years old
- female
- single or widowed
- living with a limiting mental health condition
- renters
- feeling lower neighbourhood belonging
- lower local social trust

Loneliness is associated with premature mortality[32], physical and mental ill-health, worse cognitive function and increased use of health services. While living alone has been consistently linked with self-harm and suicide, it is currently not clear whether subjective loneliness *per se* is the primary reason why people living alone may be at increased risk of suicidal behaviour. As an example, living alone after the end of a turbulent relationship could be more of a protective factor than living with somebody abusive or where there is incompatibility. Interventions to heightening awareness of the negative impacts of loneliness should be pursued, and to challenge the view that loneliness is normal or acceptable.

Conversations about loneliness should be encouraged; and loneliness has been made a ministerial responsibility by the UK Government.[33] Families and communities should be encouraged to reach out to those at risk of loneliness to enhance their sense of community, belonging and social connection; targeting and co-creating interventions with those groups identified as being at greatest risk of loneliness. Feeling connected to others, partners, relatives and friends as well as one's community is recognised as a protective factor to protect against suicide risk therefore campaigns that reinforce the importance of connection with others should be an integral part of community suicide prevention intervention.

Alcohol misuse

Alcohol misuse has consistently been implicated in the precipitation of suicidal behaviour. Alcohol abuse may lead to suicidality through disinhibition, impulsiveness and impaired judgment, but it may also be used as a means to ease the distress associated with the act of suicide. An evidence review of the relationship between alcohol use and suicide [34] recommends that people with alcohol dependence or depression should be screened for other psychiatric symptoms and for suicidality, and programmes for suicide prevention must take into account drinking habits and should reinforce healthy behaviour patterns.

Looking specifically at the association between alcohol and suicide risk, a study of 14,949 adults[35] who measured their alcohol consumption using the Alcohol Use Disorders Identification Test (AUDIT)[36] and self-reported past year suicide attempt, suicidal thoughts and non-suicidal self-harm, showed that:

- Daily or almost daily binge drinking, dependence symptom score and harmful effects of alcohol use score were all associated with increased odds of suicide attempts, suicidal thoughts and non-suicidal self-harm.

- For drinking quantity and frequency, the highest consumption group had increased odds of suicide attempts and suicidal thoughts, but no associations with non-suicidal self-harm were observed.
- Similarly, concern from others about drinking was associated with suicide attempts and suicidal thoughts, but not with non-suicidal self-harm.
- Conversely, daily or almost daily binge drinking was associated with all three outcomes; weekly binge drinking was associated with increased odds of suicidal thoughts, but not with suicide attempts or non-suicidal self-harm; and monthly binge drinking was not associated with any outcomes

The study further recommends that regular monitoring of alcohol use by clinicians and inquiring about suicidal behaviour in anyone who reports harmful drinking or concerning changes in their drinking, could be an effective measure for identifying people at high risk of suicide, requiring selective suicide prevention.

Gambling

Suicidality amongst those who gamble at problematic levels is notably higher than in the general population. In a UK population study, 19.2% of problem gamblers had thought about suicide in the past year, in comparison to 4.1% among those with no signs of problem gambling. In the same study, 4.7% of problem gamblers had made a suicide attempt in the past year, in comparison to 0.6% of those with no problem gambling[37]. Those with problem-gambling behaviours (both in treatment and community settings) are more likely to attempt suicide or have suicidal thoughts[38].

A systematic review of qualitative evidence on gambling-related suicides and suicidality by Marionneau and Nikkinen (2022)[39] concluded that the two main processes that connect gambling to suicide or suicidality are indebtedness and shame. Besides completed suicides, indebtedness is also often reported as a reason for contemplating suicide, heavy debts can make the individual feel like suicide is the only solution.

In only one study[40], gambling was rather seen as a coping mechanism to deal with other trauma in life that was also identified as the main reason for suicidality. It is estimated that at present currently only around 9,000 people a year receive treatment for gambling disorder[41] in the UK, but this disguises the scale of the problem with around 340,000 people classified as “problem gamblers”. A recent UK study[42] found that around 30% of gamblers entering treatment in 2015 had attempted suicide, a figure which had increased over the previous 3 years.

Gambling with Lives [43]estimates deaths related to gambling fall between 250 and 650 every year in the UK, a minimum of one every working day, representing between 4% to 11% of total suicides. This indicates that gambling behaviours need to be acknowledged as a risk factor to suicide.

Where people are accessing support for financial wellbeing, screening for gambling behaviours that could identify actual or probable problem gambling should be undertaken. Services that support people with gambling need to be engaged with as part of local suicide prevention forums to ensure that the principles of safety planning can be applied where gambling and or other behaviours indicate an increased level of need.

3.2 Children and Young People

Samaritans[44] reported that in England, for the period of 2019-2021, <1% of suicides (n=38) were within the 10-14 age bracket. For the age bracket 15-19, this rose to >3% (n=521). The National Child Mortality Database reported for period of April 2019 – March 2020 the suicide rate for children was 1.8/100,000, the rate for general population averages 9.8/100,000 from available data. The suicide rate among children and young people is below that in the general population, however, this group are vulnerable to suicidal feelings.

The risk is greater in children or young people who:

- have mental health problems or
- behavioural disorders,
- misuse substances,
- have experienced family breakdown,
- have experienced abuse or neglect or
- come from families where there is a prevalence of mental health problems or
- have been affected by suicide in the family.

The risk may also increase when young people identify with people who have taken their own life, such as a high-profile celebrity or another young person.

Looked after children, care leavers and children and young people in the youth justice system are also at greater risk. Children and young people in the youth justice system experience many of the same risk factors as adults in the criminal justice system. Looked after children and care leavers are between four and five times more likely to self-harm in adulthood. They are also at five-fold increased risk of all childhood mental, emotional and behavioural problems and at six to seven-fold increased risk of conduct disorders. [45]

Preventing suicide in children and young people is closely linked to safeguarding and the work of the local safeguarding children boards. It is important that local safeguarding specialists are an integral part of the local suicide prevention forum and that suicide prevention work is woven into local safeguarding arrangements.

3.3 The impact of Covid-19 and emerging financial crisis

The impact of the global Covid-19 pandemic on the incidence of suicide is still emerging, whilst it was recognised that a number of the known risk factors for suicide were likely to be exacerbated in times of uncertainty, upheaval and a rapid and significant change in how people lived and worked. During the pandemic, the Samaritans (2021)[46] highlighted those with pre-existing mental health conditions, young people, middle-aged men, healthcare workers and people in prison as being the most vulnerable groups.

Tackling known risk factors that are likely to be exacerbated by the pandemic is crucial as a means to reducing risk of suicide. These risk factors include depression, post-traumatic stress disorder, hopelessness, feelings of entrapment and burdensomeness, substance

misuse, loneliness, domestic violence, child neglect or abuse, unemployment, and financial insecurity.

One of the most significant concerns, is the effect of economic damage from the pandemic. One study[47] reported that after the 2008 economic crisis, rates of suicide increased in two thirds of the 54 countries studied, particularly among men and in countries with higher job losses.

The UK population is currently experiencing a period of significant increases in the cost of living with increased inflation, rising interest rates and increased energy costs which is resulting in pressure on households and affecting quality of life. This is impacting all households across the UK universally and is likely to be compounded for those in lower socio-economic groups. There are a number of supportive interventions that have been mobilised across communities such as food banks, community shops and warm spaces to alleviate some of the pressure. The utilisation of these offers and the profile of households or individuals who have taken these up is not yet known. However these places are recognised as a community touchpoint where some individuals at risk of suicide may present so opportunities to develop interventions with the workforce in these settings should be explored.

Preventative measures to support men in particular need to be developed proactively should there be another economic crisis that results in significant job losses. Employers, the financial sector, welfare rights services, housing associations, social landlords should receive training in suicide prevention awareness.

Responsible communication, examples of how individuals can be helped, promoting the importance of mental health support, signposting sources of help, reporting stories of hope and recovery, and avoiding alarmist and speculative headlines that may heighten risk of suicide should be part of this response.

3.4 The impact of suicide

Those bereaved by suicide are a high-risk group for adverse health outcomes and suicidal behaviour. A national cross-sectional study[48] using an online survey of 7158 participants who had been bereaved or affected by suicide was undertaken which concluded:

Of 5470 respondents, 1641 (30%) reported they had engaged in high-risk behaviours following the suicide. The most common high-risk behaviours related to:

- alcohol and drug misuse (494, 47%),
- recklessness with finances (259, 25%),
- sexual promiscuity (193, 18%),
- lack of road safety (187, 18%), and
- aggressive behaviour (118, 11%).

Of 5056 respondents,

- 1911 (38%) reported suicidal ideation and
- 382 (8%) of 4818 respondents made a suicide attempt following the person's death

The majority (77%) of respondents reported the suicide had a major impact on their lives, particularly those who had lost a family member (95%).

Only 20 (<1%) reported no impact from the death by suicide. Adverse social life events following the death by suicide were reported by over a third (39%) of respondents. The most common were family problems, relationship breakdown, and financial difficulties.

Women were more likely to have reported adverse events compared to men, especially family problems, unemployment/job loss, and financial problems. Gambling was more commonly reported by men than women.

The varying levels of impact suicide has on individuals who knew the deceased has been termed the "Continuum of Survivorship" by Cerel *et al.* (2014)[49]. This model suggests people can be either:

- "**exposed**" to suicide, that is, anyone who knows someone who has died by suicide, for example, first responders and acquaintances;
- **"affected"** by suicide through experiencing distress but not regarding themselves as bereaved. This includes friends, classmates, work colleagues and neighbours and finally
- "**suicide bereaved,"** who experience significant short- or long-term impact of the death. This includes family and close friends.

Those exposed to suicide, therefore, are not limited to close family members or friends, and estimations of suicide "survivors" range from 6 to 135 for every death by suicide (Berman, 2011;[50] Cerel *et al*., 2018; Shneidman, 1973) This indicates a different response is necessary for these three groups of individuals following an incident of suicide.

The economic impacts of suicide are profound, although comparatively few studies have sought to quantify these costs. In 2009[51] the cost per completed suicide for those of working age only in England was calculated at £1.67m, this includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as lost output (both waged and unwaged), police time and funerals. In addition to this is the emotional impact on families, friends, work colleagues, associates and organisations associated with the individual.

In particular, there is a recognition of timely support for those first responders who are not considered to be acquaintances of the deceased but have been in attendance at the scene of the incident. This support should include training on how to support and communicate with the bereaved as well as actions to address the personal impact that traumatic events can have on these individuals.

For those within the community who are not closely related to the deceased but may be affected when an acquaintance dies by suicide will be difficult to identify or reach with an offer of support. Encouraging people to talk to their friends or families or contacting a universal support service for help during times of distress should be encouraged as part of universal interventions.

NICE quality standard [QS189][52] recommends for those who are suicide bereaved that support after a suspected suicide can reduce the risk of suicide, especially when tailored to the person's needs. It is important to identify people who may need support as soon as possible so that they can be given practical information and access support if, and when, they need to. The offer of support to those bereaved by suicide can include:

- One to one practical and emotional support
- Bereavement counselling
- Bereavement peer support

These interventions should allow people to discuss their loss and grief, explore ways in which they might be able to cope and find ways of dealing with their loss.

3.5 Protective factors

Whilst there is a significant evidence base on risk factors for suicide, less is documented about protective factors; thus indicating that the absence of risk factors, or mitigations to minimise the impact of these risks should be considered as protective factors. The Centre for Disease Control and Prevention[53] advocates that a range of factors at the individual, familial/friends, community, and societal levels can protect people from suicide:

Circumstances that protect against suicide risk

Individual Protective Factors

These personal factors protect against suicide risk:

- Effective coping and problem-solving skills
- Reasons for living (for example, family, friends, pets, etc.)
- Strong sense of cultural identity

Relationship Protective Factors

These healthy relationship experiences protect against suicide risk:

- Support from partners, friends, and family
- Feeling connected to others

Community Protective Factors

These supportive community experiences protect against suicide risk:

- Feeling connected to school, community, and other social institutions
- Availability of consistent and high quality physical and behavioral healthcare

Societal Protective Factors:

These cultural and environmental factors within the larger society protect against suicide risk:

- Reduced access to lethal means of suicide among people at risk
- Cultural, religious, or moral objections to suicide

Efforts should be taken to highlight and promote protective factors at a community level in proactive communication using these in an asset based approach. In more personalised interventions such as safety planning, people at risk of suicide should be encouraged to

consider and recognise the presence of protective factors and propose actions to strengthen these.

3.6 Individual Safety Planning Type Interventions (SPTI)

Risk assessment to predict future suicide or repetition of self-harm is not recommended nor is global risk stratification that identifies individuals as low, medium or high risk of suicide. Scales can provide false reassurance and should not replace patients receiving a comprehensive psychosocial assessment of their individual situation, risks and needs, as well as their assets and strengths (Steeg, 2018)[54]. Instead personalised safety planning approaches that aim to prevent rather than predict are indicated. The components of a safety plan are:

- Reasons for living and/or ideas for getting through tough times
- Ways to make the situation safer
- Things to lift or calm mood
- Distractions
- Sources of support, to include people of trust to that individual

The goal of safety planning is to reduce the imminent risk of suicidal behaviour by constructing a predetermined set of coping strategies and sources of support in a plan[55 56]. The intention for the plan is for an individual to use these strategies to avert their thoughts about suicide and manage their suicidal urges during times of distress or crisis. Safety planning has become an established part of standard clinical care for people at risk of suicide, however, a meta analysis by Nuij *et al.* (2021)[57] found that SPTIs for suicide prevention were associated with reductions in suicidal behaviour, but no effect was identified on suicidal ideation.
This suggests that other interventions are needed to reduce suicidal ideation, the contemplations, wishes, and preoccupations with death and suicide.

The meta-analysis indicated that the relative risk of suicidal behaviour for participants who received a safety plan was reduced (RR=0.57, 95% CI 0.408–0.795, p value=0.001, number needed to treat =16). This means that those who received a safety plan were 43% less likely to have suicidal behaviours and that completing safety plans with 16 patients would prevent one episode of suicidal behaviour. However, each presentation with suicide ideation is complex and different so such findings should be treated with caution and may not be generalisable.

In developing a safety plan adults should be asked whether they would like their family, carers or friends to be involved in their care and are made aware of the limits of confidentiality. NICE[58] states families, carers and friends can help to support a person who has suicidal thoughts or plans. They can also provide valuable input to an assessment of the person's needs to help keep them safe. However if the person has mental capacity, it is important for them to discuss who they would or would not like to be involved if there is a concern over suicide risk.

3.7 The role of support services

The response to suicide prevention encompasses a broad range of services throughout the system. Due to the diverse array of services involved, it is not feasible to provide a concise outline of each organisation's role. However, gaining an understanding of the contributions of universal, primary, and secondary care services can offer insights into how these services can support suicide prevention efforts.

Universal services provided through voluntary and community sector

Voluntary sector providers are integral to local suicide prevention alliances working alongside the statutory sector. Their multifactorial role involves:

- direct support to individuals in distress and/or those around them through advice and signposting through face to face or virtual means including telephone help
- empowering communities including workforce through training in recognising and supporting those at risk of suicide
- working with those affected by suicide by delivering bereavement support including personalised interventions i.e. counselling or psychosocial interventions where indicated.

Primary care services

Primary care services play an essential part in suicide prevention and have a role at individual level. The report, 'Suicide in Primary Care in England: 2002-2011' published in March 2014[59] found that there was an increased risk with increasing GP consultations, particularly in the two to three months prior to suicide. The highest risk was among patients who consulted with their GP more than 24 times in the year prior to suicide. Mental illness was frequently unrecognised in those who died by suicide; however, it is possible many suicides were not preceded with diagnosable mental health conditions. Primary care workforce may therefore benefit from suicide specific training as they have opportunities to implement interventions such as safety planning.

In 'Suicide Prevention and COVID-19: the role of primary care during the pandemic and beyond'[60], Mughal *et al.* recommend that response to identified heightened suicide risk in primary care should include the following components:

- supported self-management, including a discussion about staying safe during difficult times and signposting to self-care resources (for example, online and voluntary sector support).
- follow-up with active surveillance for deterioration; and
- referral to specialist mental health services.

Additionally the Royal College for Psychiatrists[61] recommends primary care services should be able to assess the presence of risk factors such as mental and neurocognitive disorders, social exclusion, loneliness and bereavement, functional disability and physical conditions, and alcohol and substance misuse in older patients.

In order to deliver this effectively there is a need to offer primary care workforce appropriate training and support in the context of a busy and demanding service. There is also a need for the primary care team to be well connected to mental health services including liaison psychiatric and community services. Tailored services for primary care teams to signpost patients who have suicidal thoughts or have harmed themselves are

needed to facilitate effective care for people in distress. Moreover a more positive and understanding approach helps build a therapeutic alliance between suicidal patients and their therapists, which can be a protective factor against suicide (Collins, 2003)[62]. This applies equally to practitioners in primary care as it does to professionals in other services.

Secondary care services

Acute services' responsibilities specifically for suicide prevention requires services to ensure patient safety through:

- safety in inpatient settings through removal of potential ligature points, measures in place to prevent patients from leaving the ward without staff agreement; monitoring of ward entry and exit points, and by improving the in-patient experience through recreation, privacy and comfort.
- care planning and early follow up on discharge, and support after discharge through 24 hour crisis resolution/home treatment services

Additionally acute settings should remain vigilant when people present at emergency departments and look beyond the clinical issues to understand the causes of the injury, which may identify mental health issues or suicide ideation.

SECTION 4: SERVICES PROVIDING SUPPORT

Whilst there are a number of specialist services that deliver specific prevention and postvention support for those at risk of suicide and those bereaved by suicide it is recognised that a wider range of professionals and members of the local community across the range of universal services have a role in suicide prevention. This is aligned with the overall ethos that 'suicide prevention is everyone's business' and as many professionals and members of the community should be aware of how to recognise someone in distress and encourage them to seek help.

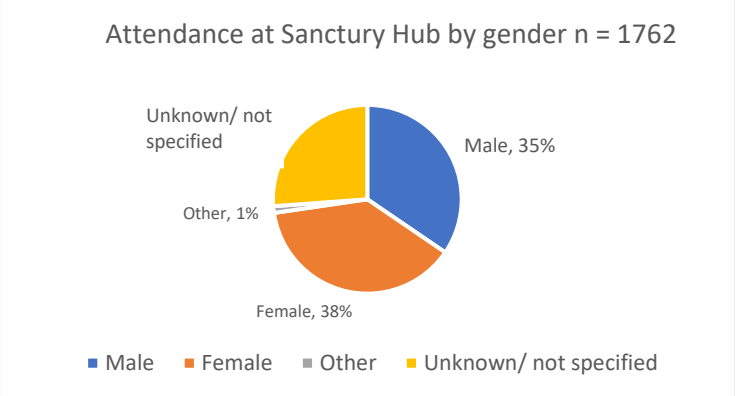
There are a number of established services in Wolverhampton that are specifically intended to support individuals in distress, including those who may be experiencing or expressing suicide ideation.

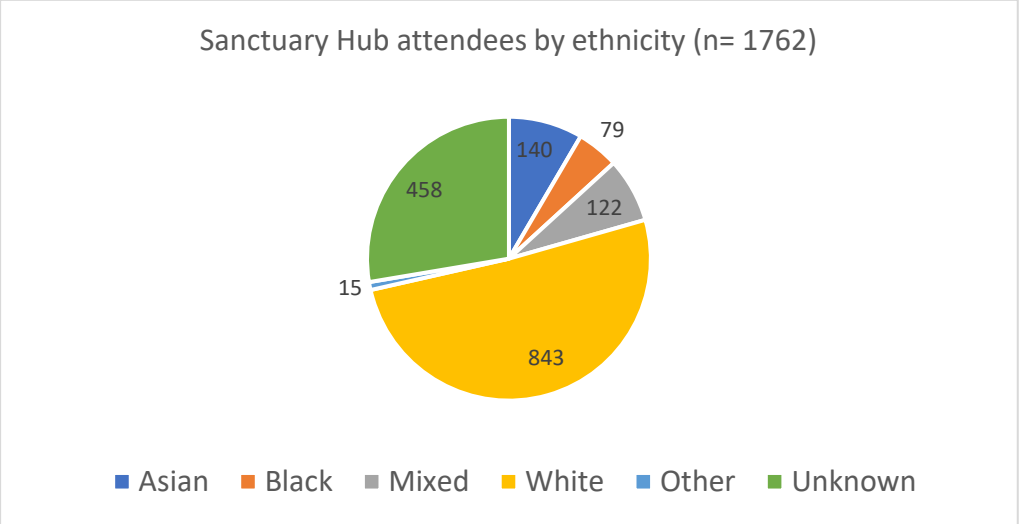
These services and their offer is summarised below:

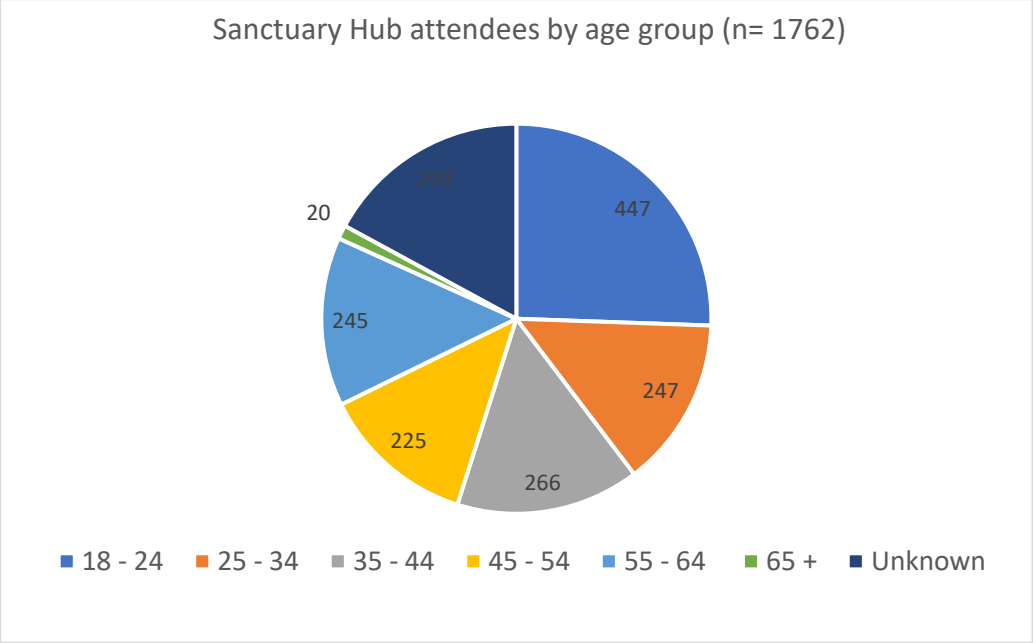
Rethink 24/7 Helpline
This helpline was mobilised in May 2020 during the first national lockdown and was implemented across the Black Country area: Wolverhampton, Walsall, Dudley and Sandwell. The helpline was intended as a first point of contact for residents in the city, including those known to mental health services. The service was actively promoted as a means to ensure anyone with concerns about their mental health and wellbeing including anyone experiencing a crisis could call and seek advice. Depending on the presenting need the caller could either be given a brief intervention over the phone or be referred on to an appropriate service. The service can also be contacted by text.

Sanctuary Hub Wolverhampton
The hub is a safe place for people aged 18 or over to seek advice for any concerns about their emotional mental health and wellbeing in person. The service is open Monday to Friday between the hours of 6pm and 11 pm and on a Saturday or Sunday between 12pm and 11pm. As alternatives to attending in person individuals can contact the service by phone, text, email or WhatsApp.

Currently service data is available for January – December 2022 only. During this period the service was accessed by 1762 individuals. Where gender has been recorded there has been a higher proportion of females compared with males accessing the service. It is however noted that gender was not specified or recorded in 461 cases or 26% of total attendances.







Where ethnicity is known or recorded the largest number of attendees are recorded as White, followed by Asian. However it is acknowledged that in 458 attendances (28% of attendances) ethnicity was not recorded.

This shows that where age is known the largest number of attendances are from those aged 18-24 (447 attendances) out of a total of 1463 attendances (31% of all attendances where age is recorded).

The lowest attendances are from those aged 65 or above.

Samaritans

The Samaritans offer emotional telephone support for people who are experiencing feelings of emotional distress or despair, including those who may be considering suicide. Individuals

in times of distress can contact the service by phone, text or email. The service is co-ordinated at a regional level.

PAPYRUS

PAPYRUS Prevention of Young Suicide is the UK charity dedicated to the prevention of suicide and the promotion of positive mental health and emotional wellbeing in young people. The service offers a helpline that is available 24 hours a day, 7 days a week aimed at children and young people under the age of 35 who are experiencing thoughts of suicide or for anyone concerned that a young person could be thinking about suicide. The service is actively promoted across Wolverhampton.

Improving Access to Psychological Therapies (IAPT)/ NHS Talking Therapies for Anxiety and Depression

IAPT services are intended to help people overcome their depression and anxiety, and better manage their mental health through a talking therapies approach.

The numbers of patients accessing IAPT in Wolverhampton is as follows:

Year	**2019/20**	**2020/21**	**2021/22**
Total	7126	5565	7013
New patients	4191	3253	2312
Previously known	2935	4469	2544

Across all three years those aged 25-49 are the group most frequently accessing the service (63%) of all activity.

The reasons for individuals accessing the IAPT service are not complete, as an example in 2021/22 the reason for presentation was not recorded in 3634 (52%) out of a total of 7013 patients. Where the reason for presentation is recorded the most common reasons for presentation were as follows:

	2019/20	**2020/21**	**2021/22**
Depressive episode	2432	2253	1665
Generalised anxiety disorder	493	241	866
Recurrent depressive disorder	165	116	250
Post-traumatic stress disorder	70	62	176

It is noted that there were no recorded presentations specifically for anyone experiencing suicide ideation, however this could be down to data recording anomalies.

Kaleidoscope Plus Group (KPG)

KPG is a charity organisation that supports recovery for people experiencing ill-health, whilst also promoting independence; to support inclusion and facilitate community integration and participation for people with health problems.

As well as delivering training in suicide prevention awareness, KPG facilitate:

- **Midlands Suicide Bereavement Support Group**
  This monthly group is for people who have been bereaved by suicide.
    - The service supports those aged over 18 bereaved by suicide, living anywhere in the Midlands region.
    - The monthly group brings together those people who have shared experiences of suicide bereavement and to support each other in an informal setting.
    - The service leads ensure resources, books and wellbeing supplies are available to the attendees and those affected by suicide.
    - The service provides a safe space where individuals feel understood and are supported with each individual experience treated with equal importance.

      This service was operational from September 2020; 4 service users from Wolverhampton accessed this service. Of these, 2 attended face to face and 2 chose to attend an online session.

- **Midlands Self Harm Support Group**
  The service offers support to parents/carers of young people who self-harm, living anywhere in the Midlands region. The monthly group brings together those people who have shared experiences of looking after a young person who self-harms, and to support each other in an informal setting.

- **Rethink Support After Suicide Service**
  This service supports those who are bereaved by suicide through one-to-one and group provision.
    - 1:1 Support: This offer includes 1:1 support from a suicide bereavement worker for six personalised weekly support sessions followed by fortnightly sessions with the option to extend support if needed. After 1:1 sessions end, the service will facilitate monthly check-in for up to 6 months and support on key anniversary dates.

    - Bereavement Counselling: Rethink provides a suicide bereavement counselling for between 6-8 weekly sessions with the option to extend to an additional 8 fortnightly sessions if needed.

The Rethink Support After Suicide Bereavement Support service was mobilised in June 2022, through NHS Long Term Plan Wave 4 funding which is due to end in March 2024. This service supports next of kin and other close family members of any age who are bereaved by suicide in the Black Country.

Between June 2022 and February 2023 a total of 66 referrals have been made to the service from across the Black Country with 63 of the referred individuals accessing support immediately. Of these referrals 18 were for bereaved individuals living in Wolverhampton.

SECTION 5: PROFESSIONALS VIEW

Many professionals across a range of organisations and services are touched by suicide in their working life. This includes professionals working directly with those experiencing distress or suicide ideation as well as those who are bereaved by suicide.
Workforces in universal services should be supported to acquire knowledge and skills in suicide prevention as well as an awareness of the services people can access in times of distress or when affected by a suicide of someone close to them.

In order to understand the skills and knowledge of professionals working in Wolverhampton a survey was developed and disseminated across local services through the partner members of the Wolverhampton Suicide Prevention Stakeholders Forum.
There were 75 responses to this survey. The largest number of respondents were from the NHS (28/75 respondents) followed by the voluntary sector (19/ 75 respondents).

Knowledge
Of the 75 respondents:

- 31 (41%) were aware of the Wolverhampton suicide prevention strategy.
- 35 (47%) were aware of their organisation's intent and policy regarding suicide prevention.

This indicates that further efforts will be required as the next local suicide prevention strategy and action plan are launched to ensure that all local stakeholders are involved in co-creating the strategy and disseminating any resulting action plans across their service area. Further work is also required to strengthen staff understanding of their organisation's intent, policy and their implications for staff. This can be reinforced collectively through both the Suicide Prevention Stakeholder Forum and by individual employers to their workforce.

Understanding of the term suicide prevention
The respondents were asked whether they considered a number of terms to be part of suicide prevention:

What do you understand the term suicide prevention to be?	Number responding	%
Identification of those at increased risk of suicide	70	93.33%
Enabling the community to support those at risk of suicide	71	95%
Learning from incidents of suicide	64	85 %
Ensuring those at risk have a plan to keep them safe	69	92%
Other (please specify): be aware of how to contact safeguarding team if someone is deemed at risk More research into identifying how people once they have made a decision to end their life, can appear to have improved in their mental state, as their loved ones and professionals (if they have even confided in anyone) Listening to people and their concerns/views To have services that people can contact 24/7 to talk about any concerns and worries Educating the whole community about suicide and putting things in place to reduce the likelihood that suicide is seen as the answer to an often anguished situation.	6	8%

preventing suicide and lowering rates of suicide, keeping more people safe and supported enabling right time/right place assessment of need		
Not Answered	0	0.00%

This indicates a good understanding of the scope of suicide prevention work among those who completed the survey.

Training in Suicide Prevention

From the respondents, 63 would like to attend training in suicide prevention, 12 respondents did not wish to, and 44 respondents indicated they had previously attended suicide prevention training. Of these 44,

- 20 had attended training in the last 12 months,
- 8 in the last 12-24 months and
- 16 had completed training more than 24 months ago.

Respondents were asked what topics they would like to receive training on. The responses were as follows:

Option	Total	Percent
Attitudes, myths and stigma around suicide	56	75%
Signs that may indicate someone is having thoughts of suicide	65	87%
Having a safe, sensitive conversation with someone thinking of suicide	69	92%
To support a safety plan with someone thinking of suicide	67	89%
Local services that can help someone thinking of suicide	70	93%
Not Answered	0	0%

Interestingly the option with the largest number of responses was local services that can help someone thinking of suicide. This indicates a need to ensure that local professionals are aware of local services that people in distress can be directed towards.

Knowledge of local services

Respondents were asked whether they were aware of a number of non-statutory services in Wolverhampton who can help support someone who is feeling suicidal.

Responses from the 75 respondents were as follows:

Respondents were asked whether they were aware of a number of non-statutory services in Wolverhampton who can help support someone who is feeling suicidal.

Service	Yes, respondents are aware of the service		No, respondents are not aware of the service	
Samaritans	75	100%	0	0
Rethink 24/ 7 Helpline	37	49%	38	51%
Sanctuary Hub	39	51%	36	48%
Kaleidoscope Plus Group	38	51%	37	49%
Papyrus	37	49%	38	51%
Rethink Bereavement Support	31	41%	44	51%

These responses indicate that whilst all responding professionals are aware of Samaritans, the other local services are not as well-known with only half respondents being aware of their offer. This indicates that work is required to improve professionals' understanding of these services and how to refer people who require support to them. Given that 93% of survey respondents felt that knowledge of the local service offer was an important component of any suicide prevention training programmes, this must be a key element of any further training and/or awareness campaigns.

Skills

Professionals were asked to indicate how much they agreed or disagreed with a number of statements that indicate their level of skill to support someone at risk of suicide:

'I am confident in my ability to respond when I suspect an individual many be at risk of suicide'.

50 respondents (66%) either agreed or strongly agreed with this statement.

'I am knowledgeable about warning signs for suicide'

46 respondents (61%) either agreed or strongly agreed with this statement

'I would be comfortable asking individuals direct questions about suicidal thoughts and behaviours'

56 respondents (75%) either agreed or strongly agreed with this statement

These responses indicate there is a need for further training and/ or supervision on suicide prevention awareness.

Other statements

Professionals were asked to indicate how much they agreed or disagreed with the following statements:

'I feel my employer would be responsive to issues I bring up related to the safety of individuals at risk of suicide'

61 (81%) respondents either agreed or strongly agreed with this statement

'I feel I can access support within my organisation or partner organisation to help me when working with someone at risk of suicide'

62 (83%) respondents either agreed or strongly agreed with this statement

'I feel confident in signposting someone at risk of suicide to services that can help them'

49 (65%) respondents either agreed or strongly agreed with this statement. This was the question where the lowest proportion of professionals felt confident in signposting someone at risk of suicide to services that can help them. This response indicates that one in three professionals are not confident in advising someone in distress to a service that can help them.

SECTION 7: SUMMARY

Based on data presented, the suicide rates in Wolverhampton have reached their lowest point to date from data available and have generally decreased since 2001, albeit with some fluctuations. While Wolverhampton has the lowest suicide rate amongst the West Midlands region, the city recorded more than 50 suicides during the most recent three-year reporting period.

At national, regional and local levels suicide is more prevalent in men, making up three quarters of total suicides, this rate is slightly increased for Wolverhampton. There are a number of risk factors that can elevate the likelihood of an individual reaching a state of distress, among many other risk factors, the distress from financial hardship, chronic loneliness, problem gambling, exposure to domestic abuse, substance/alcohol misuse, long term conditions (physical and mental) or bereaved by suicide can all exacerbate suicide ideation. The role of preventative interventions therefore becomes one of recognising and addressing the impact of any of these on an individual at the earliest point.

Whilst there is currently no clear evidence base to indicate that the incidence of suicide increased during the Covid-19 pandemic, there is evidence to indicate that the sudden and significant changes to how people lived during this time has had an impact on mental health and wellbeing. This highlights the need to promote wellbeing at a universal level in addition to delivering targeted prevention campaigns in the groups identified as being at higher risk.

Local data can indicate where preventative interventions should be targeted, however, the incompleteness of some data prevents local partners from being able to identify the specific groups where the interventions would have greatest impact. Specifically the gaps in data include recording of ethnicity in coroner data and recording of reasons for presentation in people accessing mental health services.

Local professionals value the training in suicide prevention awareness suggesting that an ongoing offer of training in recognising the signs of symptoms of distress will be beneficial. A series of training programmes was made available to professionals living and working in Wolverhampton during 2022 as part of the OHID Better Mental Health Fund programme of work. Although the intention was to offer this training to 280 local professionals, the level of interest in the training meant that additional sessions were arranged resulting in a total of 357 individuals completing the training.

Professionals informed that they were confident in their ability to respond when they suspected an individual may be at risk of suicide, but one in three is not confident. Many were knowledgeable about warning signs for suicide but more work is needed to raise the current level.

Professionals were not fully aware of the local services that people in distress can access implying a need to ensure services are better integrated so that all professionals can readily signpost or refer people in distress to a service that can help. The local service offer needs to be covered in detail in any future training.

Wolverhampton has mobilised well as a system to address suicide prevention, offering universal, primary and secondary care approaches, whether that be suicide specific or broader mental health services. Governance is aligned to the right places such as the Health and Wellbeing Board and Integrated Care System, with a local delivery group well established and supported across partners. There is a need however, to continue momentum within this field by offering a comprehensive and ongoing training offer for professionals, improving data capturing attributable to suicide ideation, continuing awareness campaigns and promoting empathy amongst all towards supporting someone contemplating suicide.

SECTION 8: STAKEHOLDER ENGAGEMENT

Engaging a range of stakeholders was important to ensuring the needs assessment process was robust and appropriately consulted upon. Groups consulted included:

- Wolverhampton Suicide Prevention Stakeholders Forum
- Mental Health Stakeholders Forum
- One Wolverhampton Adults Mental Health workstream
- Black Country Mental Health Trust
- ICS Suicide Prevention Group
- Children and Young People Emotional Mental Health and Wellbeing Board

During consultations partners were asked to provide their feedback on emerging themes and recommendations. Feedback included the need to focus on better data capturing, particularly ethnicity of suicide, to consider how children and young people have a defined workstream as part of the resultant strategy and action plan following this JSNA, to consider emerging evidence in the link between domestic abuse and suicide,and similarly recognising the link between gambling and suicide.

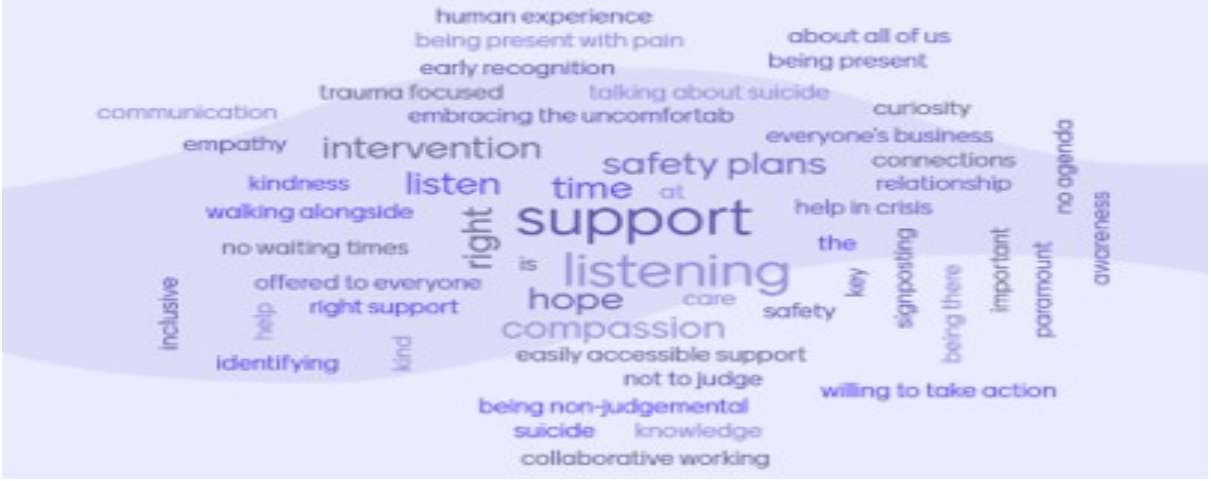
During consultations within meetings, creative methods were deployed to obtain feedback, including use of interactive tool Mentimeter. Two questions were asked of partners as part of this process:

1. What does suicide prevention mean to you as a professional?

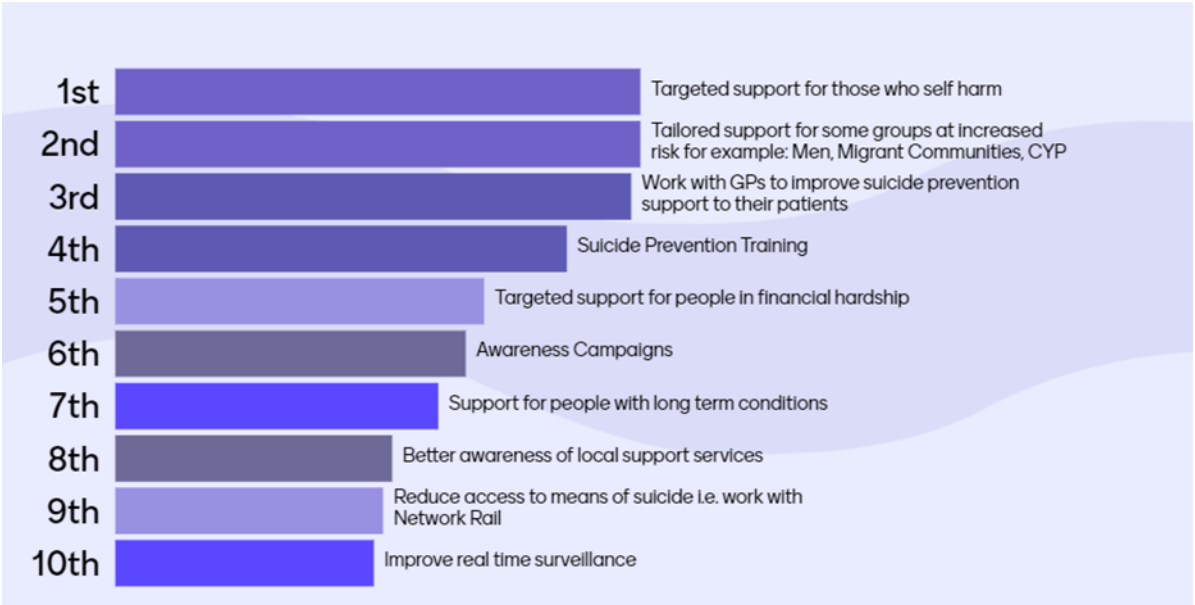
2. Please rank the following proposed actions in order of priority:
    - Improve real time surveillance
    - Tailored support for groups at increased risk e.g. men, migrant communities
    - Suicide prevention awareness training
    - Awareness campaigns
    - Support for people with long term conditions
    - Targeted support for people in financial hardship
    - Reduce access to means of suicide
    - Work with GPs to improve suicide prevention support to their patients
    - Better Awareness of support services
    - Targeted support for those who self-harm.

The findings from this exercise are summarised below. Additionally, as reported earlier in the document, a survey was carried out with professionals working across the city.

What does suicide prevention mean to you as a professional?



How would you rank these in order of priority?



SECTION 9: RECOMMENDATIONS

1. To roll out suicide prevention awareness training across the city targeting:

    a. professionals working with the groups at higher risk and
    b. those working in any community touchpoints where people who do not readily engage with the traditional offer of services may attend.

    As far as possible training courses should be co-created with the sectors and professionals who are the intended beneficiaries. Arrangements for ongoing supervision or support for professionals working in organisations where this is not readily available should be considered. Training should reinforce the local offer of support available to people in Wolverhampton to help improve delegates' knowledge of the local offer.

2. To facilitate screening for wellbeing for those with long term physical conditions to identify the prevalence of any risk factors and to undertake a safety plan type intervention where indicated.

3. To develop suicide prevention interventions for groups at increased risk such as men, migrant communities, people exposed to domestic abuse, those affected by gambling related harm and those experiencing chronic loneliness. The development of these interventions should be led by agencies and services that work with these groups.

4. To recognise the link between domestic abuse and suicide, specifically, the increased risk of suicide in both victims and perpetrators of domestic abuse. To address this:

    a. offer health professionals, and those who work in the domestic abuse sector, suicide prevention training to identify and respond empathetically to victims who feel suicidal and connect them to appropriate information, services, and social support and to encourage 'professional curiosity' at high risk points in a vulnerable person's life to open dialogue for support
    b. embed safety planning for all that use domestic abuse or mental health services, whether or not they show suicidal ideation
    c. greater postvention support following a suicide to ensure family and friends are supported in a timely and appropriate way, being referred to support services where possible.

5. To create and deliver suicide prevention messages for people in financial difficulties and for these to be consistently applied across organisations these individuals will be in contact with. This should be a particular focus given the current cost of living pressures and economic uncertainty.

6. Work with services such a Network Rail, Highways and mental health settings to reduce access to means to suicide in the city.

7. To embed routine enquiries about financial hardship into mental health services and to ensure that services have appropriate resources for signposting and referring for specialist support and advice. This includes matters relating to cost of living pressures, employment, debt, and benefits.

8. To monitor incidence of suspected suicides through the regional real time surveillance system and ensure timely multi-agency action is taken as appropriate, including work with media, reducing risk of further associated suicides and ensuring bereavement support is offered to those affected.

9. To highlight the protective factors that can offer protection against suicide ideation as part of awareness campaigns including World Suicide Prevention Day, Mental Health Awareness Week, World Mental Health Day and Childrens' Mental Health Week.

10. To work with providers on improving awareness of support services amongst the workforce and wider community.

11. To work with services to embed best practice, such as NICE guidance on self-harm, so that interventions related to suicide prevention are evidence led and effective.

12. Ensure that the service offer for suicide prevention, intervention and postvention is equitable and takes into consideration special requirements such as digital exclusion, sensory impairment and language barriers.

13. To work with commissioners and services to improve the quality of information recorded by services, such as systemically recording suicide ideation being the reason for presentation to services. This will facilitate a clearer understanding of local need.

14. To obtain a better understanding on which groups are accessing support services related to suicide prevention and consider how to reduce any identified health inequalities.

Appendix 1: Population overview of Wolverhampton

Population

Wolverhampton population has increased by 5.7%, from around 249,500 in 2011 to 263,700 in 2021, this is lower than the overall increase for England (6.6%) and West Midlands (6.2%). Wolverhampton ranks 64th for total population size out of 309 local authority areas in England, which is a fall of two places in a decade and means Wolverhampton is the third most densely populated of the West Midlands' 30 local authority areas.

Age and Gender

The Census 2021 reports there has been an increase of 6.6% in people aged 65 years and over, an increase of 3.7% in people aged 15 to 64 years, and an increase of 12.5% in children aged under 15 years. This means currently 19.7% of Wolverhampton's population is 14 and under, 11.8% are 15-24, 13.6% are 25-34, 13.5% are 35-44, 13.3% are 45-54, 11.6% are 55-64, 8.6% are 65-74 and 7.8% are over 75.

The gender split between males and females is almost equal at 49.1% and 50.9% respectively. Gender identity reports 92% identify with the sex registered at birth, 0.4% identify with a sex different to that registered at birth, 0.15% identify as Transwoman, 0.19% as Transman, 0.03% as non-binary and 7.25% do not report their identity.

Ethnicity

According to 2021 Census data 45% of Wolverhampton's residents are from ethnic minorities. 21% of the city's residents are Asian. There is a wide variation in the proportion of residents from ethnic minorities across the different electoral wards. The wards with the highest proportion of residents from ethnic minorities are Blakenhall, (77%) St Peters (72%) and Ettingshall (58%). The wards with the lowest proportions of ethnic groups are Wednesfield North (9%), Bushbury North (15%) and Tettenhall Wightwick (20%).

Deprivation

In 2019, Wolverhampton was ranked as the 24th most deprived local authority nationally. The Index of Multiple Deprivation (IMD) combines information from the seven domains to produce an overall relative measure of deprivation. The domains are combined using the following weights:

- Income Deprivation (22.5%)
- Employment Deprivation (22.5%)
- Education, Skills and Training Deprivation (13.5%)
- Health Deprivation and Disability (13.5%)
- Crime (9.3%)
- Barriers to Housing and Services (9.3%)
- Living Environment Deprivation (9.3%)

Income

Gross Household Disposable Income per head in Wolverhampton in 2020 was £15,911 compared to an England average of £21,962.

The average weekly wage in Wolverhampton is £560 compared to an England average of £613.

Employment
Wolverhampton currently has an employment rate of 70.8%- this is the proportion of working age adults who are in employment. Nationally the rate is 75.1%. When considering ethnicity, the employment rate for White people is 67.6% compared to 76.6% nationally. For ethnic minorities in Wolverhampton the employment rate is 77.9% compared to a national rate of 67.7%.

22.6% of the working age population in Wolverhampton claim Universal Credit, compared with an England average of 14.1%

The unemployment claimant rate is 7.4% compared with an England average of 3.8%. This equates to 12,060 residents claiming JSA or those claiming UC who are out of work.

Education, Skills and Training
9.5% of the population of Wolverhampton have no formal qualifications, which is above the national average. Attainment at Key Stage 4 (GCSE) has improved between 2019 and 2021 after which there has been a decline, this mirrors the national trend for England, and overall local attainment is below the national average. The number of 16-17 year olds Not In Education or Training (NEET) has reduced since 2018 and is lower than the England average

Health and Disability
Life expectancy for both men and women in Wolverhampton are below the national average. There are several inequalities between men and women and those living in the most affluent and deprived areas of the city. Premature mortality from all causes in people aged under 75 in 2018/20 was 444.8/100,000 residents compared to a national average of 336.5/100,000. In men specifically the rate was 557 per 100,000; for women the rate was 336.8 per 100,000, both considerably above the national average of 411 and 264.8.

The rate of alcohol related admissions in Wolverhampton is above the England average at 663.7/100,000. For males the rate was 1140.7 and for females 636 compared to 850.7 for males and 494.4 for females nationally. The most common conditions related to alcohol are high blood pressure, irregular heartbeat and alcohol related mental health disorders.

Crime
The total recorded crime rate for Wolverhampton in 2021/22 was 132.2/1000 population, higher than the national rate of 88.7/1000 population. This is also the highest rate within the Black Country with Dudley at 95.3 Sandwell at 119.6 and Walsall at 116.3 per 1000 population.

Barriers to Housing and Services
The overall city distribution of housing is as follows:

- 57% privately owned
- 28% social rented
- 13% privately rented
- 2% living rent free

- 6% of homes are considered to be overcrowded, in that they have fewer bedrooms than required for the occupants.

57% of Wolverhampton's homes are privately owned. There is a wide range of variation between wards; 83% of homes in Penn are privately owned (the highest level in the city) compared with St Peters which has the lowest level of private ownership at 31%. Overall private home ownership is below the national average of 63%.

GLOSSARY

This glossary defines some of the terms used within this Needs Assessment

MENTAL ILLNESS Mental illness may be 'characterised by a combination of abnormal thoughts, perceptions, emotions, behaviour and relationships with others' (WHO, 2018b), which affect mood, and the ability to function effectively and appropriately. The term is often used interchangeably with 'mental health issues/problems/difficulties', or mental 'ill health', 'distress' or 'condition'. However, these terms are broad and can mean something that everyone experiences as part of everyday life, for instance stress, worry or grief. Mental illness can also mean an acute, diagnosed condition, mental health crisis or suicidal depression. Examples of mental illness include: eating disorders, depression, anxiety, bipolar affective disorder, psychoses, intellectual disabilities and developmental disorders including autistic spectrum disorder

SUICIDAL BEHAVIOUR: Suicidal behaviour covers a range of behaviours related to suicide and self-harm in vulnerable individuals, including suicidal thoughts, deliberate recklessness and risk taking, self-harming not aimed at causing death, and suicide attempts. Around 20% of young people have self-harmed (non-suicidal) by the age of 20, and far fewer (around 2–3%) make suicide attempts.

SUICIDE: Suicide is the deliberate act of taking one's own life.

SUICIDAL INTENT There is evidence (explicit and/or implicit) that at the time of injury the individual intended to kill self or wished to die and that the individual understood the probable consequences of his or her actions.

SELF HARM Intentional self-poisoning or injury irrespective of the apparent purpose of the act.

SUICIDE ATTEMPT A suicide attempt is a deliberate action undertaken with at least some wish to die as a result of the act. The degree of suicidal 'intent' varies and may not be related to the lethality of the attempt.

SUICIDE IDEATION: Thoughts of engaging in suicide-related behaviour.

NHS LONG TERM PLAN: A plan proposed by NHSE which outlined its intentions for services in the next 10 years. It includes a significant commitment to suicide bereavement support, including; post-crisis support for families and staff who are bereaved by suicide, Suicide bereavement support for [bereaved] families, and staff working in mental health crisis services in every area of the country.

PREVENTION, INTERVENTION AND POSTVENTION:

PREVENTION is preventing conditions of illness from arising.

INTERVENITION is the action of providing support or services to produce a different outcome or change a situation. In the case of mental illness and suicide, it is to work with a

person experiencing suicidal thoughts to help them identify reasons why they might want to keep safe, to agree a plan for doing so and to engage further support as required.

POSTVENTION is a response to a suicide by providing support and assistance for those affected
https://www.universitiesuk.ac.uk/sites/default/files/field/downloads/2021-07/guidance-for-sector-practitioners-on-preventing-student-suicides.PDF

SAFETY PLAN: A written, prioritised list of coping strategies and/or sources of support that the person who has self-harmed can use to help alleviate a crisis. Components can include recognising warning signs, listing coping strategies, involving friends and family members, contacting mental health services, and limiting access to self-harm methods.

NHS TRUSTS – Organisations who may act as Health Care Providers and provide hospital services, community services and/or other aspects of patient care generally serving either a geographical area or a specialised function (such as an ambulance service). In any particular location there may be several trusts involved in the different aspects of healthcare for residents.

REAL TIME SURVEILANCE: When data of who is likely to have died by suicide is made available to analysts immediately after the event occurs so the appropriate organisations can be notified and respond appropriately in a timely manner.

ICS (Integrated Care Systems) are a collaboration of NHS organisations and local councils. In an ICS, they take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.

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