DRAFT Lancashire Self-Harm and Suicide Prevention Strategy 2024 - 2029

Foreword from CC Michael Green, Chair of Health and Wellbeing Board

Every death by suicide is one death too many and Lancashire County Council are committed to reducing the number of people who die by suicide in Lancashire. We can all play a part in reducing the stigma around suicide to encourage openness and greater awareness. We want everyone in Lancashire to feel able and to seek the help and support they need.

Every suicide is a tragedy. The factors that lead to suicide are complex, often multifaceted and wide reaching. Suicide has a ripple effect on our communities, evidence suggests for each incident around 135 people are exposed (knew the person).

The impacts of an individual attempting to take their own life and others are wide reaching. It is our collective responsibility to do what we can to provide the support that people need to reduce self-harm and suicide attempts.

Together we can raise awareness and address the risk factors, supporting people to stay mentally well and offering the right help at the right time to meet individual needs.

It is essential we have a coordinated multi-agency approach bringing together local authorities, integrated care board and wider health partners, emergency and acute services, voluntary and third sector organisations as well as communities, workplaces, peers and individuals. We all have a role to play to raise awareness, reduce the cause and contributory factors, create opportunities for people to have hope and increase the support for people who need it.

The Lancashire Self-harm and Suicide Prevention Strategy is a call to action.

- We all have a role to play in suicide and self-harm prevention; its everyone's business
- One suicide is one too many
- Nearly everyone has times when they feel very down and can't see a way out, sometimes these feelings are so strong and overwhelming it can lead to suicidal thoughts and attempts to end their life
- If you are feeling suicidal and/ or struggling to cope, help is available in Lancashire
- It is important to talk about self-harm and suicide – it helps to tackle the stigma. We need to increase the visibility of prevention training e.g. Orange Button scheme and raise awareness by encouraging people to talk more about suicide prevention and support.

Introduction

Lancashire Self-harm and Suicide Prevention Strategy 2024-29 is aligned to the national Suicide Prevention Strategy and national cross sector actions published in September 2023. It recognises the important role of national government, as well as continued action across our systems including the NHS, local government, the voluntary, community and social enterprise (VCFSE) sectors, employers and individuals. The national strategy sets out actions which include:

- Reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner.
- Improve support for people who have self-harmed.
- Improve support for people bereaved by suicide.

It identifies the requirements for improvement in data and evidencing partner engagement including people with lived experience and identifies a range of priority groups at higher risk of suicide and self-harm. It provides an overview of effective crisis support, effective bereavement support to those affected by suicide and a strong emphasis on making suicide everyone's business. It also sets out over 100 actions led by government departments, the NHS, the voluntary sector and other national partners Suicide prevention strategy: action plan - GOV.UK (www.gov.uk).

The Lancashire Self-harm and Suicide Prevention Strategy mirrors the national action areas focussing on priorities based on local data and intelligence. Lancashire's Strategy reflects key achievements to date on tackling this public health challenge and sets out our five year forward plan with an annually produced action plan.

In producing the Lancashire Strategy, we have used a range of data including local real time surveillance (RTS) reporting of suspected suicides. RTS data collection was established with key partners (Lancashire and South Cumbria Integrated Care Board and the Police) in 2018 following additional national investment due to the rates of suicide in Lancashire, with one area being the fourth highest in the Country. As a result, we receive weekly updates which allows us to obtain detailed intelligence to identify trends which are shared with relevant partners.. This work aims to ensure timely action to address any trends and monitor suicide rates at a Lancashire and place-based level. The information also provides further insights to address evidence gaps, understand the often multi-faceted issues which may cause someone to consider suicide as an option and inform future changes to prevent further deaths.

Aim

To reduce suicides and self-harm in Lancashire.

Objectives.

- Strengthening partnerships to work together to reduce suicide and self-harm.
- Produce an annual multi-agency action plan and review progress made.
- Raising awareness that suicide and self-harm prevention is everybody's responsibility.
- Preventing attempted suicides and deaths by suicide and better managing self-harm.
- Raising awareness to reduce the stigma associated with suicide and self-harm.
- Identifying and responding to the training needs of the workforce, educational settings and our communities working and supporting people who may have experience or act upon suicidal thoughts and/ or who are self-harming.
- Strengthening initiatives to increase emotional/ psychological resilience.
- Ensuring continued support for those bereaved or affected by suicide.
- Using evidence-based practice and measures to evaluate our approaches to suicide prevention and self-harm.

Context

There is no single reason why a person takes their own life, and, in some cases, it may be difficult to determine the reason. Suicide is complex and can be impacted by a range of psychological, social, economic and cultural risk factors.

The national strategy highlights that a person may be exposed to a range of risk factors although this does not necessarily mean they will have suicidal thoughts or end their life. However, data suggests some characteristics are particularly significant risk factors which include the following:

- Gender – males are three times as likely to take their own life as females.
- Age – females aged 45-49 and males aged 50 to 54 have the highest suicide rate.
- People with a previous suicide attempt or have self-harmed are at an increased risk factor.
- Mental illness – although not all people who take their own lives have been in contact or had recent engagement (within six months) with mental health services.
- Chronic pain - physically disabling or painful illnesses including chronic pain.
- Substance use - alcohol and drug misuse.
- Problematic gambling
- Criminal Justice - people who have left prison or have been / or are in contact with the criminal justice service.
- Stressful life events can play a part. These include job loss. financial difficulties, becoming socially excluded or isolated, bereavement, family or relationship breakdown, and conflict including divorce and family mental health problems, and imprisonment.
- Trauma and people who are impacted by domestic abuse, adverse childhood experiences, abuse and sexual violence.

- Occupation - certain occupations such as agricultural, construction industries, care workers and health care staff (doctors, dentists, nurses and vets).
- Neurodivergent - people with neurodiversity conditions such as autism and ADHD.
- Homelessness - suicide is the second most common cause of death among people who are homeless.
- Carers (male and female carers have a risk of suicide that was almost twice the national average).
- Care leavers.
- Veterans (serving in the military for longer periods of time and serving on operational tours were associated with reduced suicide risk; while younger veterans and those who left after a short career were more at risk).
- Those identifying as LGBTQ+.
- New mothers (maternal suicide is the leading cause of direct (pregnancy-related) death in the year after pregnancy)).
- The risk factors fluctuate with age, for example, for young people, risk factors include adverse childhood experiences, stressors such as academic pressures, bullying and relationship difficulties, and recent or historic events such as bereavement or trauma. For older people, psychiatric illness, deterioration of physical health and functioning are risk factors.

Wider factors include media coverage and research has found strong links between certain types of media coverage and increasing suicide rates. The risk of media reporting influencing imitational suicidal behaviour increases if details of suicide methods are reported, if the story is placed prominently and if the coverage is sensationalised and/or extensive. To support local media colleagues, they are invited to annual training and the Samaritans' media guidelines are circulated in Lancashire. Work also continues with Police colleagues to ensure guidelines are followed in relation to high risk locations and social media reporting.

The guidance can be found here http://www.samaritans.org/media-centre/media-guidelines-reporting-suicide. The media could be used positively to raise awareness and address the stigma, supporting preventative messages.

Figure 1 Illustrates some of the multiple issues which can impact on someone taking their own life

Suicide data and intelligence

In 2023, the England suicide rate increased from the previous year (2022), the North West has seen the biggest increase in rates from 2022 to 2023.

In 2023 there were 6,069 registrations of people who took their own lives in England and Wales, which is over 17 registrations per day. This is equivalent to a rate of 11.4 deaths per 100,000 people and an increase compared with 2022 (10.7 deaths per 100,000). [i] The rates vary across the country with the highest rates in the North West, with a rate in 2023 of 14.7 per 100,000 and in the North East the rate is 14.5 per 100,000. The lowest rate in the country is in London at 7.3 per 100,000 and more learning is needed on why rates are lower in London. When comparing 2022 and 2023 registrations, the number of suicides increased 17.9% in the North West, 15.1% in the North East and 14.9% in the East of England.

There is still important work to be undertaken, and the system needs everyone to participate in suicide prevention programmes to address this as a societal need.

Figure 2 highlights that male suicides are much higher than female suicides both nationally and locally

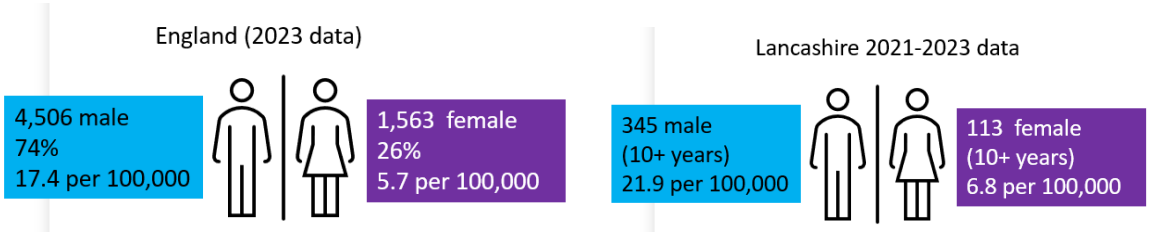
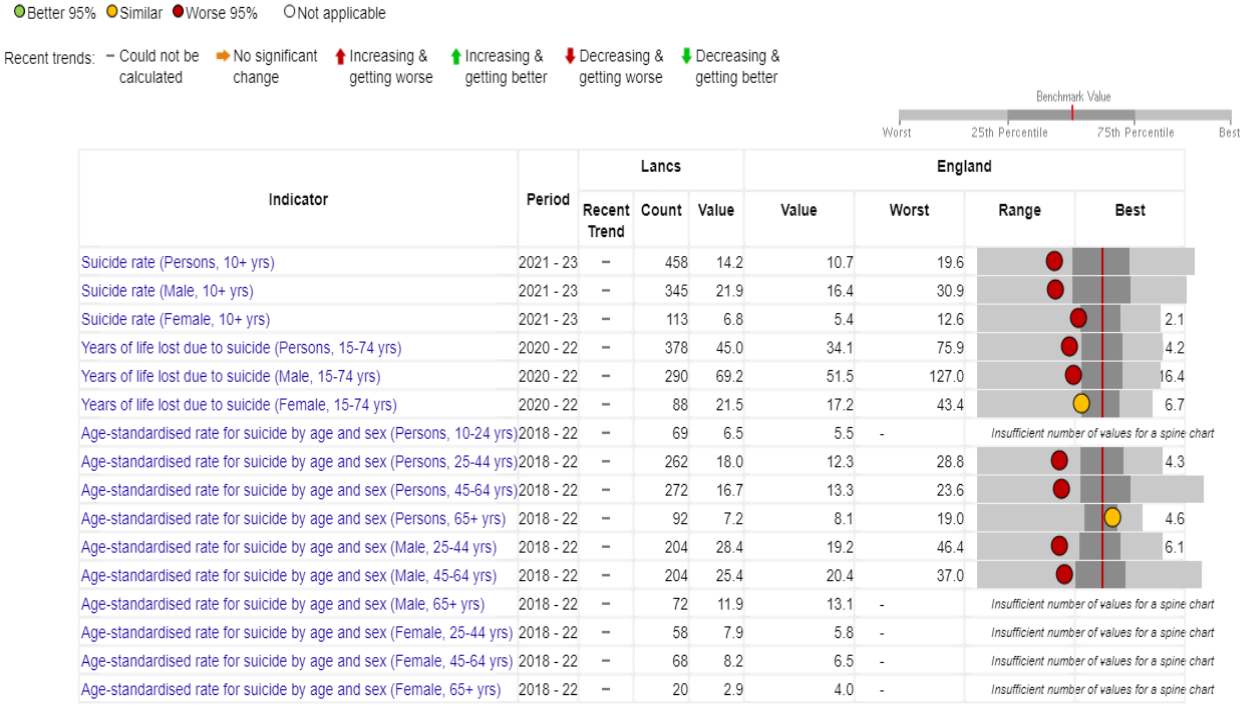


Figure 3: The all persons, male and female suicide rate in Lancashire remains worse than in England.

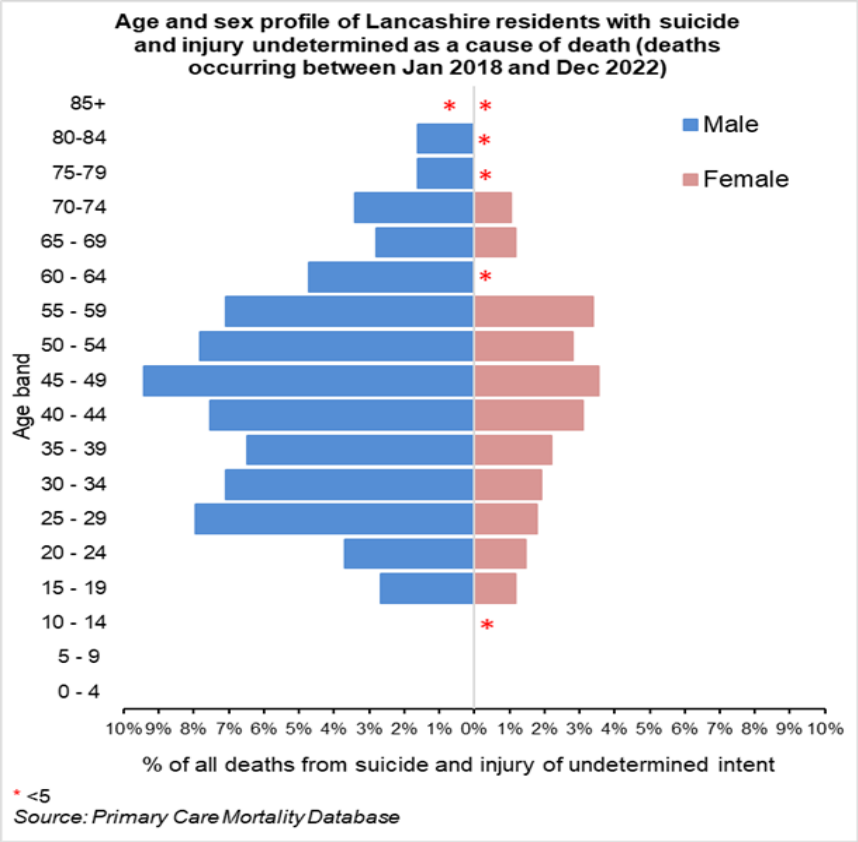


Indicator	Period	Lancs			England			
		Recent Trend	Count	Value	Value	Worst	Range	Best
Suicide rate (Persons, 10+ yrs)	2021 - 23	–	458	14.2	10.7	19.6		
Suicide rate (Male, 10+ yrs)	2021 - 23	–	345	21.9	16.4	30.9		
Suicide rate (Female, 10+ yrs)	2021 - 23	–	113	6.8	5.4	12.6		2.1
Years of life lost due to suicide (Persons, 15-74 yrs)	2020 - 22	–	378	45.0	34.1	75.9		4.2
Years of life lost due to suicide (Male, 15-74 yrs)	2020 - 22	–	290	69.2	51.5	127.0		16.4
Years of life lost due to suicide (Female, 15-74 yrs)	2020 - 22	–	88	21.5	17.2	43.4		6.7
Age-standardised rate for suicide by age and sex (Persons, 10-24 yrs)	2018 - 22	–	69	6.5	5.5	-	*Insufficient number of values for a spine chart*	
Age-standardised rate for suicide by age and sex (Persons, 25-44 yrs)	2018 - 22	–	262	18.0	12.3	28.8		4.3
Age-standardised rate for suicide by age and sex (Persons, 45-64 yrs)	2018 - 22	–	272	16.7	13.3	23.6		
Age-standardised rate for suicide by age and sex (Persons, 65+ yrs)	2018 - 22	–	92	7.2	8.1	19.0		4.6
Age-standardised rate for suicide by age and sex (Male, 25-44 yrs)	2018 - 22	–	204	28.4	19.2	46.4		6.1
Age-standardised rate for suicide by age and sex (Male, 45-64 yrs)	2018 - 22	–	204	25.4	20.4	37.0		
Age-standardised rate for suicide by age and sex (Male, 65+ yrs)	2018 - 22	–	72	11.9	13.1	-	*Insufficient number of values for a spine chart*	
Age-standardised rate for suicide by age and sex (Female, 25-44 yrs)	2018 - 22	–	58	7.9	5.8	-	*Insufficient number of values for a spine chart*	
Age-standardised rate for suicide by age and sex (Female, 45-64 yrs)	2018 - 22	–	68	8.2	6.5	-	*Insufficient number of values for a spine chart*	
Age-standardised rate for suicide by age and sex (Female, 65+ yrs)	2018 - 22	–	20	2.9	4.0	-	*Insufficient number of values for a spine chart*	

Based on data from the primary care mortality extracts, over the five years between 2018-2022 there have been suicide deaths in every age band from 10-14 to 85+ years. For this five-year time period, in Lancashire 75% of suicides are by men and 25% by women, which is in line with national trends. According to the 2023 figures in England 74% of suicides were male and 26% were female.

Figure 4 shows the gender and age distribution in Lancashire and figure 5 provides further analysis of this data (2018-22).

Figure 4: Age and sex profile of Lancashire residents with suicide and injury underdetermined as a cause of death (2018 -2022 data)



Rates vary across age groups, gender and deprivation which is illustrated in figure two and three.

Figure 5: Proportion of the suicide deaths by gender, age band and deprivation quintile (IMD 2019) of residents in Lancashire, 2018-2022

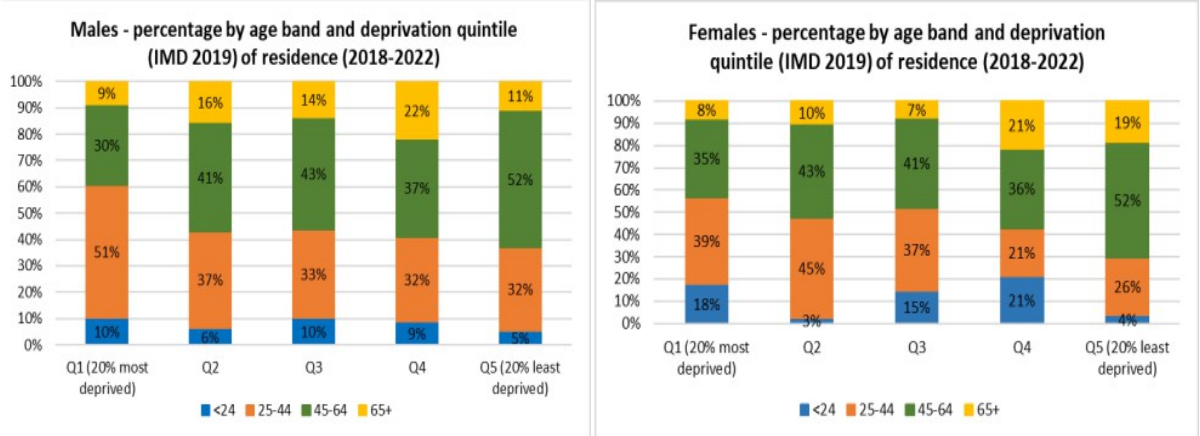
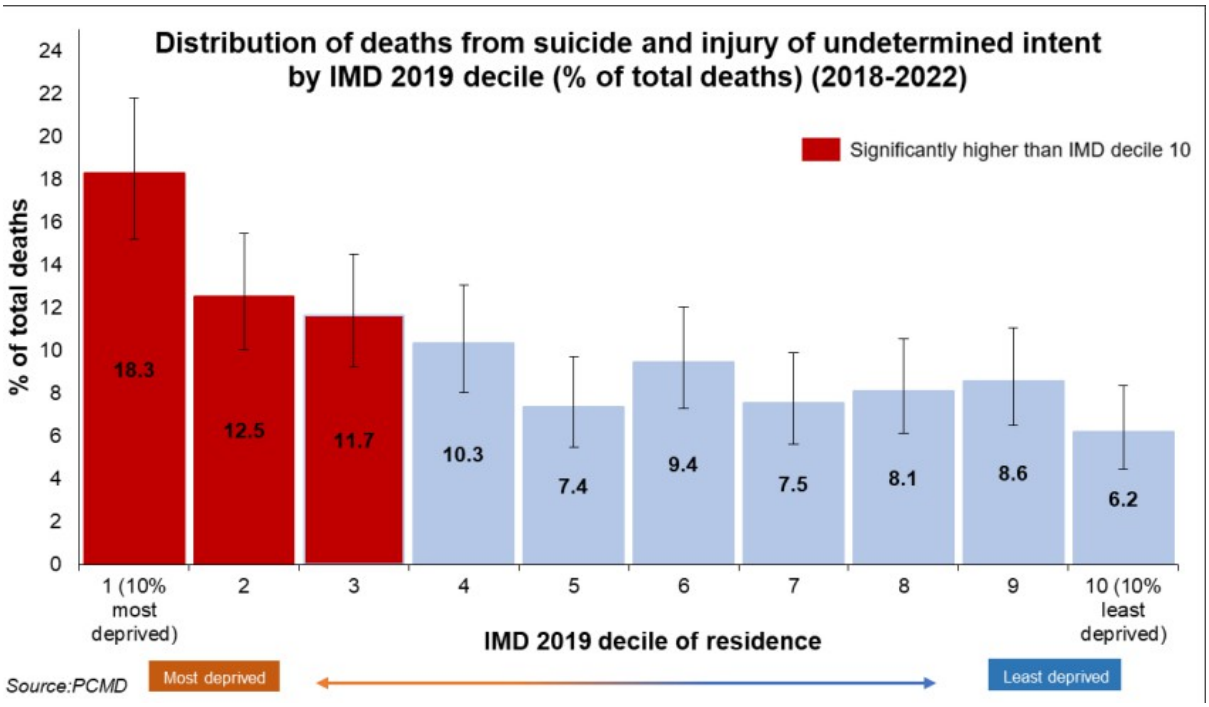


Figure 6: The distribution of deaths from suicide and injury of undetermined intent by IMD 2019 quintile of residents in Lancashire, 2018-2022

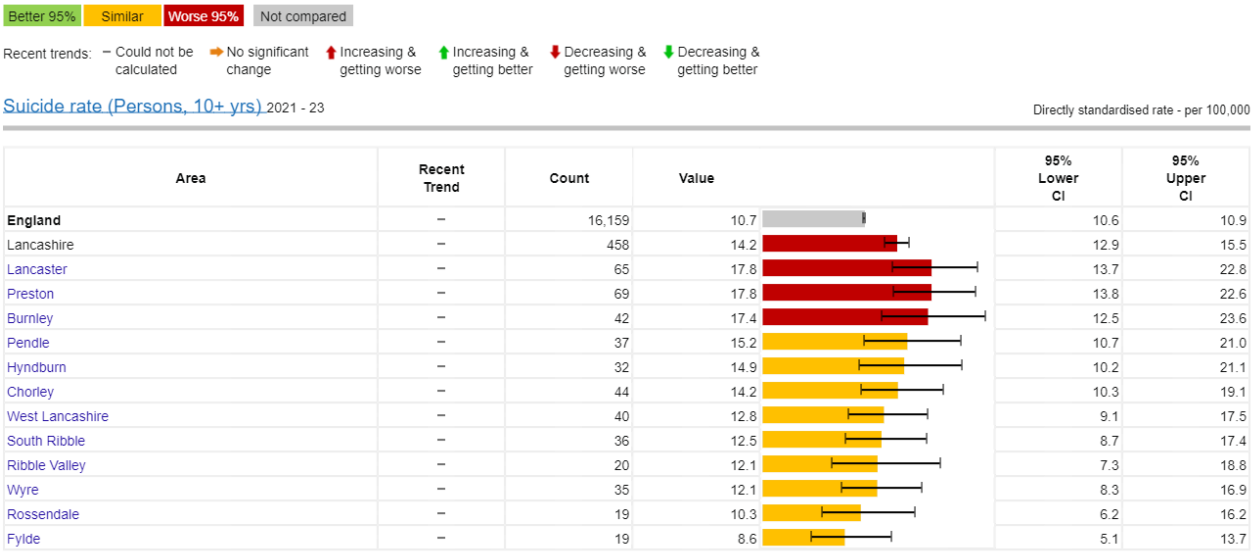


The highest rates of suspected suicide in Lancashire Districts in 2022/23 that are above the national average of 10.7 per 100,000 were in Burnley, Chorley, Hyndburn and Preston (source Lancashire and South Cumbria Integrated Care Board). Suicide statistics are often reported

and compared as "rates per 100,000" rather than counts or raw numbers. This is because raw numbers do not take the baseline population into account and counts can be small.

All suspected suicides will be determined by the coroner as they are the only officials who can determine whether an individual's death was suicide or not. There is a lag in the official data, and it can take some time from the date of death, to the coroner inquest.

Figure 7: Across Lancashire, in Lancaster, Preston and Burnley the 2021-23 suicide rate is above the England rate.



Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	16,159	10.7	10.6	10.9
Lancashire	–	458	14.2	12.9	15.5
Lancaster	–	65	17.8	13.7	22.8
Preston	–	69	17.8	13.8	22.6
Burnley	–	42	17.4	12.5	23.6
Pendle	–	37	15.2	10.7	21.0
Hyndburn	–	32	14.9	10.2	21.1
Chorley	–	44	14.2	10.3	19.1
West Lancashire	–	40	12.8	9.1	17.5
South Ribble	–	36	12.5	8.7	17.4
Ribble Valley	–	20	12.1	7.3	18.8
Wyre	–	35	12.1	8.3	16.9
Rossendale	–	19	10.3	6.2	16.2
Fylde	–	19	8.6	5.1	13.7

Source: DHSC, Fingertips

Self-harm

Self-harm occurs when individuals intentionally hurt themselves to cope with difficult emotions. It can include behaviours such as:

- Cutting
- Over-dosing
- Hitting (self)
- Burning or scalding
- Picking or scratching skin
- Pulling hair
- Ingesting toxic substances
- Eating disorders

People self-harm for a variety of different reasons. Often this is due to care eliciting behaviour and a need for support but sometimes there is no known cause and a coping mechanism for expression of inner frustrations. Self-harming behaviours may have the following functions:

- To communicate distress to others
- To relieve unbearable feelings
- To provide soothing and comfort by releasing tension and gaining care from others
- To feel alive if feeling l numb due to life experiences
- To punish themselves as they feel shame and self-blame
- Because they feel like they deserve it due to previous trauma and learnt behaviour
- To control things in their life when everything feels out of control

Members of the public attending hospital for self-harm are at higher risk of suicide, especially immediately after hospital attendance[1].

In 2022/23 there were 73,239 emergency admissions for intentional self-harm in England which is equivalent to a rate of 126.3 per 100,000 in all ages and a rate of 123.7 in Lancashire (1,555 admissions). Lancashire's 2022/23 rate of emergency admissions for intentional self-harm is similar to the England rate with the recent trend exhibiting a decrease, in line with the national picture.(ii) This rate varies with age with a national rate of 251.2 (per 100,000) in the age group 10 to 14, 468.2 in 15 to 19-year-olds and 244.4 in 20 to 24-year- olds. In Lancashire, the rate of hospital admissions for self-harm is significantly above the national average in 10–14-year-olds (511.1 per 100,000) and below the national average in 15 to 19 and 20 to 24-year-olds. When compared with Lancashire's nearest statistical neighbours (NHS England), Lancashire's rate of hospital admissions for intentional self-harm in 10–14-year-olds is significantly higher than 13 out of 15 of its nearest statistical neighbours; it's similar to two nearest statistical neighbours. The rate of hospital admissions for self-harm in 10–14-year-olds is higher than the England rate in also six of Lancashire-12's 15 nearest statistical neighbours. NHS England Adult Social Care Statistics Team identifies nearest neighbours that are a comparison with the 15 other councils with the most similar statistical

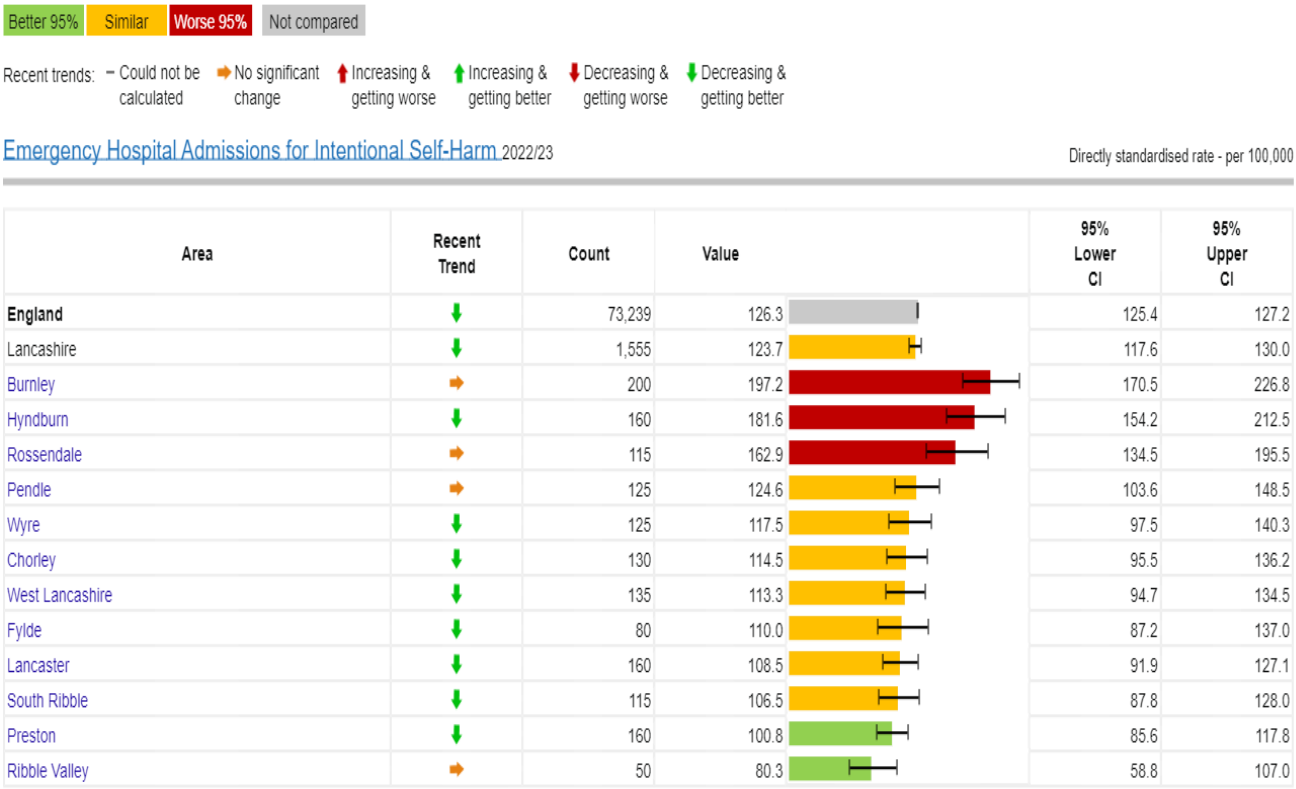
characteristics in terms of social and economic features. Over the past two decades thehas been an upward trend in self-harm incidence in adolescents. It's believed that around 10% of young people self-harm, but it could be as high as 20%[vii].

Not everyone who dies by suicide will have previously self-harmed, and not everyone who self-harms will go on to end their lives. The annual report for 2023 by the National Confidential Inquiry into Suicide and Safety in Mental Health indicates that 64% of people who took their life had a history of self-harm. This has decreased by 9% between 2010 and 2020. Other research outlines the increased risk factors[1]. Rates of self-harm vary in different settings, for example in 2022 the rate in female prisoners in England and Wales was 342 per 1,000. The figure is lower for suicides in prisons and the average annual figure in England and Wales for the last ten years is 80 per year[vi].

Rate of emergency hospital admissions for intentional self-harm per 100,000 population (all persons, all ages) (2022/23) (Source: DHSC, Fingertips):

- Lancashire-12 area (123.7) is similar to England (126.3).
- In line with the national picture, Lancashire-12 area's female rate (173.3) is higher than the male rate (75.7); male rate is better than the England rate (85.8) and female rate is similar to the England female rate (168.0). Recent trend shows that both male and female rates are decreasing, in line with the national picture.
- At a district level, Burnley (197.2), Hyndburn (181.6) and Rossendale (162.9) have significantly higher rates than England. Recent trend shows that Burnley and Rossendale rate has remained unchanged whereas the Hyndburn rate is decreasing.
- Burnley's rate of emergency hospital admissions for intentional self-harm remains in the top 20% in England districts and upper tier authorities (2022/23). Burnley and Hyndburn's 2022/23 rates are worse than the North West average.
- Preston (100.8) and Ribble Valley (80.3) have significantly lower rates than England and the other seven districts have similar rates to England
- The recent trend shows the rate to be decreasing in eight Lancashire-12 districts and in Burnley, Rossendale, Pendle and Ribble Valley the rate remains unchanged.

Figure 8: Self-harm data for 2022/23 from fingertips: Emergency hospital admissions for intentional self-harm, all ages



Emergency Hospital Admissions for Intentional Self-Harm 2022/23

Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	73,239	126.3	125.4	127.2
Lancashire	↓	1,555	123.7	117.6	130.0
Burnley	→	200	197.2	170.5	226.8
Hyndburn	↓	160	181.6	154.2	212.5
Rossendale	→	115	162.9	134.5	195.5
Pendle	→	125	124.6	103.6	148.5
Wyre	↓	125	117.5	97.5	140.3
Chorley	↓	130	114.5	95.5	136.2
West Lancashire	↓	135	113.3	94.7	134.5
Fylde	↓	80	110.0	87.2	137.0
Lancaster	↓	160	108.5	91.9	127.1
South Ribble	↓	115	106.5	87.8	128.0
Preston	↓	160	100.8	85.6	117.8
Ribble Valley	→	50	80.3	58.8	107.0

Source: DHSC, Fingertips

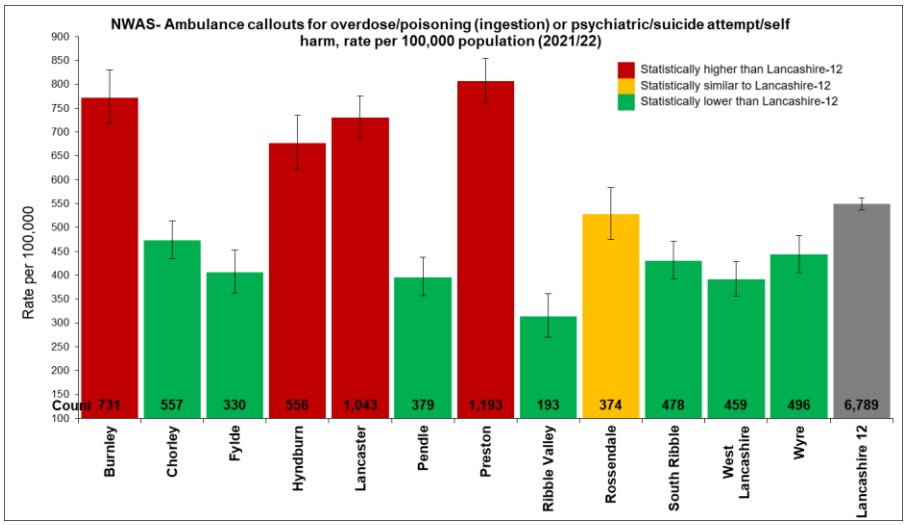
Rate of hospital admissions for intentional self-harm per 100,000 population (all persons, children and young people) (2022/23) (Source: DHSC, Fingertips):

- Lancashire-12 area's rate (511.1) in children aged 10-14 years is significantly higher than the England rate (251.2) with the recent trend showing no significant change for Lancashire and an increasing trend for England.
- Lancashire-12 area's rate (396.2) in children and young persons aged 15-19 years is significantly lower than the England rate (468.2) with the recent trend showing a decreasing trend, in line with the national picture.
- Lancashire-12 area's rate (167.7) in young persons aged 20-24 years is significantly lower than the England rate (244.4) with the recent trend showing a decreasing trend, in line with the national picture.
- For 10-14 and 15-19 year olds, in line with the national picture, the rate is higher in females than males. For 20-24 year olds, Lancashire-12 area's rate is similar in females and males; England rate is higher in females.

In 2021/22, across the Lancashire 12 districts, the Northwest Ambulance Service (NWAS) was called out 6,789 times for intentional self-harm including suicide, and overdoses. Between 2018/19 and 2020/21, there was no statistically significant change in the rate of callouts in any of the districts. However, over the four financial years to 2021/22, in Burnley, Hyndburn, Lancaster and Preston the rate of callouts for overdose/poisoning or psychiatric/suicide attempt/self-harm remains significantly higher than the overall Lancashire- 12 rate.

Figure nine below shows the 2021/22 rate of ambulance callouts for overdose/poisoning or psychiatric/suicide attempt/self-harm across the 12 districts compared with the overall Lancashire-12 rate.

Figure 9: NWAS ambulance calls out for or overdose/poisoning or psychiatric/suicide attempt/self-harm



Source: NWAS

Note: More recent data might show the impact of the pandemic, i.e. how much underreporting we might now be seeing because of the pandemic and its legacy.

Suicide audits

In 2023, there were two deep dive suicide audits. The first was a ten-year thematic review of children and young people below the age of 18 years in Pan Lancashire (including cases in Blackpool and Blackburn with Darwen), This review was classified by a Child Death

Overview Panel (CDOP) and completed as a multi-agency audit. The second audit involved a deep-dive review of all suicide cases in Lancashire (of all ages) for suicides that occurred in 2022. The key recommendations have been captured within the action plan.

Overview of the thematic review of deaths in children and young people across Pan-Lancashire

In Lancashire any suspected suicide cases associated with an under 18-year-old (or up to 25 years old for young people with special educational needs and disabilities) will initiate a joint agency response (JAR) led by the Sudden Unexplained Death in Childhood (SUDC) team. The JAR examines the circumstances of the case and reviews any additional support considered necessary for the family, friends and school or wider community following an agreed multi agency protocol. Subsequently, a multi-agency child death review meeting takes place, and all the information gathered from partners will be reported to the coroner for review. The findings are then presented at CDOP, where the partnership assesses broader learning and recommendations.

The thematic review included all deaths in children and young people under the age of 18 years that occurred between April 2013 and June 2022 classified by a CDOP as Category 2 on the statutory analysis form. (Category 2 relates to deaths due to suicide or deliberate self-inflicted harm. This includes deaths as the result of hanging, shooting, self- poisoning with drugs, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm).

The analysis considered demographic data related to age, sex, ethnic group, suspected cause of death, and factors that have previously been associated with suicides in children and young people.

Key findings

1. There were 38 Category 2 deaths (deaths due to suicide or deliberate self-inflicted harm), of which 55.2% (n=21) were confirmed suicides, in children and young people (CYP) resident pan-Lancashire (Blackburn with Darwen, Blackpool & Lancashire). There was an average of fewer than five deaths per year.
2. Deaths were more common in older groups, with those aged 15 to 17 years representing 78.9% (n=30) of the total number. There were eight deaths (21.1%) in those aged 14 or below, of which seven were due to misadventure or which had an open or narrative verdict.
3. Just over half of the deaths (n=20, 52.6%) occurred in boys/young men compared to 47.4% (n=18) in girls/young women. Young women aged 16-17 years represented almost three-quarters of the total number of deaths among females (n=13, 72.2%), whereas those aged 16-17 years among males accounted for 50% (n=10).
4. The most common method was hanging, accounting for 29 (76.3%) deaths. The remaining deaths involved falling from a height, jumping in front of moving objects, or overdose. Most deaths occurred at home (n=23, 60.5%) or in a public place (n=13, 24.2%)
5. Blackburn with Darwen, Blackpool, Chorley, Lancaster, and Preston accounted for around two-thirds (n=22, 57.9%) of all deaths. Deaths were reported from all areas

except Ribble Valley, South Ribble, and Pendle. There was no obvious pattern indicating one area having more deaths compared to another.

6. Most children and young people (n=30, 78.9%) had multiple factors recorded by CDOP in terms of their background, social environment, and household circumstances.
7. More than half of all children and young people experienced issues related to household functioning (including parental separation, family member with a mental health condition or substance use, and presence of domestic abuse); had one or more mental health conditions or suicidal ideation; experienced a loss of key relationships; had problems with service provision (gaps in service, transitioning to adult mental health services, information and communication issues); had previously attempted suicide or engaged in non-suicidal self-harm.
8. Around a third of all children and young people have experienced problems at school including exam and study related worries, low attendance; bullying; and experienced conflict with key relationships or some form of abuse or neglect.
9. One in five of the children and young people used drugs or alcohol (most commonly cannabis); suffered a bereavement or other significant personal loss; had a diagnosed or suspected neurodevelopmental conditions (ASD); or has used social media and the internet to find information on/research methods of suicide.
10. Fewer than five children and young people had a diagnosed medical condition or sexual orientation, or identity documented.

Deep dive audit – all ages in Lancashire

A deep dive audit was conducted on 72 recorded suicides cases in 2022 over an eight-week period at the coroner's office in Lancashire. The audit met the criteria (residents of Lancashire) and included all age groups.

<u>Key findings from the audit</u>

- As with national data, relationship breakdown is seen as a key contributory factor in males. The greatest risk is among divorced men at a national level, in Lancashire we identified a high rate across males regardless of marital status.
- Risk factors such as debt, loneliness, adverse childhood experiences, alcohol and drugs, traumas are more commonly noted. The impact of Covid and increased loneliness was noted as a contributory factor. Other risk factors such as problematic gambling are less commonly noted.
- 45% had previously attempted to take their life, 23% had a documented history of self-harm.
- 33% had visited the GP in the last 3 months (most visits are linked to mental health) and over 42% were taking medication linked to mental health.
- 19% of occupations appeared as a risk factor in delivery drivers, security officers and skilled tradesperson roles.
- 20% of cases, a physical health condition was noted.

- 12.5% of cases were recorded to have been involved in the criminal justice system (CJS) (range from breach of the peace to a third of the cases involved in the CJS were linked to sexual crimes related to children).
- 61% of suicides happened at home and hanging was the most common method (68%).
- 29% of cases had recorded alcohol misuse.
- 18% of people were connected with services in the voluntary sector or other services such as social services and drug and alcohol services.
- 19% had recorded debt.
- 18% had recorded substance use.
- 15% had recorded childhood trauma (including adverse childhood experiences).
- 15% had recorded being isolated or lonely
- 7% had been impacted by suicide bereavement.

Other audit findings included that in some cases:

Individuals were referred to mental health services but were deemed too complex and referred back to their GP as the service was unable to support as they surpassed the threshold. In most of these cases this was not recorded on GP notes and no follow-up took place.

Several agencies were involved but did not communicate with each other to establish an outcome or ensure the individual had accessed services.

Individuals had been invited to engage with services but when no contact was received, they were discharged, or referrals were closed.

Individuals were sometimes not asked about their alcohol/drug use and when they were there was an inconsistency in referrals and missed opportunities to follow-up or offer an intervention.

People have been proactive and made an attempt to contact the crisis team and other services to seek help for themselves or for family members/ friends.

In the information provided there were no clearly defined risk factors.

Impact of suicide

Each suicide is one too many and the impact is far reaching and impacts a significant number of people, not only on immediate family, friends but also on work colleagues, and wider members of their community. For every one suicide the evidence suggests that 135 people are impacted,[iv] and based on this figure, in 2022/23 over 14,175 people in Lancashire could have been affected by suicide.

Bereavement by Suicide

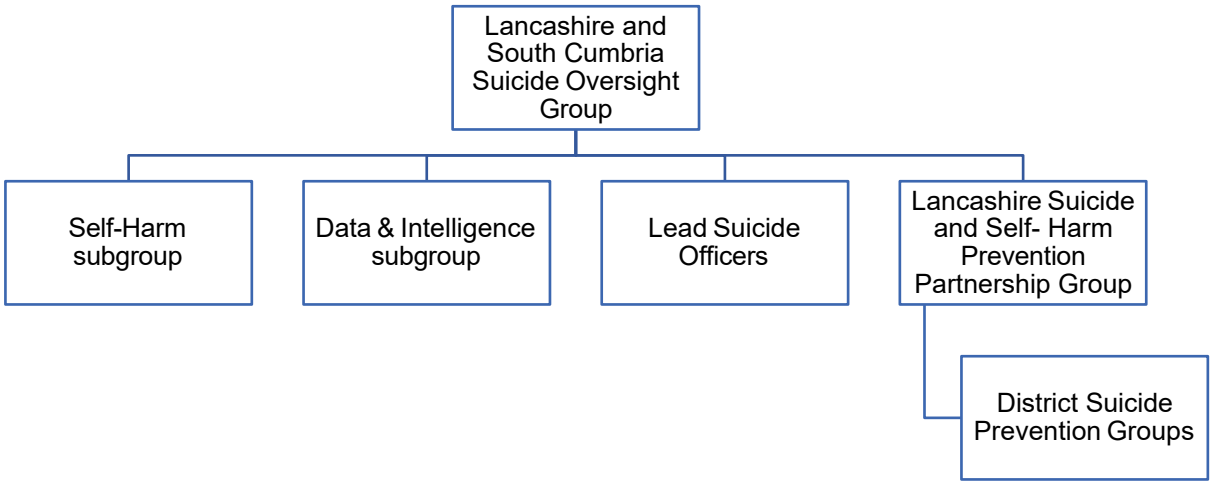
Those bereaved by suicide have an increased risk of suicide and are more likely to experience poor mental health. Bereavement support is available to anyone impacted by suicide and there are a range of organisations which can help.

Governance

Actions and progress will be reported to Lancashire and South Cumbria Suicide Prevention Oversight Group and various other partnership boards as appropriate e.g. for children and young people this will include the Children and Young People's Transformation Delivery Board and Child Safeguarding Partnership. Partners will hold each other to account to ensure actions are delivered. The Lancashire Health and Wellbeing Board will have oversight for the Strategy and action plan and updates will be covered under the Happier Minds programme and Best Start in Life programme (two of the three Lancashire Health and Wellbeing Board priorities). The strategy and action plan will publish this information online on Lancashire County Council's webpage Suicide and self-harm - Lancashire County Council so that our priorities and the progress against them are transparent to everyone. Copies of updated action plans will also be available online.

Below is a high-level overview of the key strategic partnership groups focused on suicide prevention and or self-harm. There are a range of task and finish groups which have been established and a wide range of partnerships addressing the various risk factors previously outlined.

Figure 10. Governance and Oversight



The governance structure enables suicide prevention and self-harm work by:

- **Influencing** parts of the wider system to help prevention and intervention.
- **Doing:** Implement or commission specific research, projects, and interventions where it makes sense to do so at a larger scale and scope.
- **Awareness**: Increase awareness of suicide prevention across the health, care, and VCFSE system.
- **Sharing and supporting** good practice and data across the health, care, education, district councils and VCFSE system and wider system.

This Strategy has been co-designed with stakeholders through an online survey, and extensive

consultation meetings in line with the principle that suicide is everyone's business.

Performance monitoring

To measure the outcome of the Strategy and our action plan we will monitor the following:

- Suicide rates across Lancashire
- The rates of intentional self-harm across Lancashire
- The rates of attempted suicides across Lancashire
- The number of people accessing support for suicide bereavement
- The number of people trained in suicide prevention, such as number of orange button holders

Achievements in 2023/24

1. Partnership and leadership - formation of Lancashire and South Cumbria Oversight Group (chaired and SRO is the Lancashire's Director of Public Health) which brings together key stakeholders from Lancashire and South Cumbria to give strategic oversight. Establishment of the Lancashire Suicide and Self-harm Partnership which is the operational group tasked with delivering the Suicide Prevention and self-harm action plan (with 150 partners involved). The RTS subgroup analyses data and intelligence to inform interventions. There have also been locally formed district partnerships.
2. In partnership with the LSCICB and other key partners a logic model has been developed as a framework for suicide and self-harm prevention which includes five key pillars: leadership, prevention, intervention, postvention and intelligence.
3. Self-harm practice guides have been developed for educational settings, adults and professionals. The guides outline pathways and provide essential information about self-harm education to address stigma. Self-harm kits have been piloted in schools. We are awaiting evaluation of the impact of this work.
4. Lancashire has undertaken a Local Government Association (LGA) peer sector review on self-harm support for secondary schools and the key findings have helped to shape the action plan for this strategy.
5. A thematic review of deaths over the last ten years has been completed and the findings are captured in the suicide and self-harm prevention action plan.
6. Partnership protocols have been established for working with the SUDC team and CDOP.
7. A Community Contagion Prevention Response Policy and process has been developed and implemented, along with a protocol to support professionals and direct responses following a suspected child suicide. The overarching purpose of this multi-agency response is to minimise community distress and the risk of contagion. This practice is now used as good practice and shared with neighbouring authorities.
8. Local action plans have been developed with districts and specific interventions put in place in certain locations where multiple incidents have occurred.
9. Suicide prevention training is delivered by a range of partners. Some of which are commissioned by the LSCICB and some by Lancashire County Council, Additionally, there are long-term plans to explore joint commissioning. Nationally, mental health support lead training has been offered to schools and efforts have been made to promote this for those who have not signed up to the offer of support.
10. In Lancashire and South Cumbria, the Orange button community scheme has been initiated. The orange button is worn by people who have received specialised suicide prevention training. While they cannot provide counselling, they offer an intervention and signposting to relevant services. As of January 2024, there were 1,438 orange

button holders in Lancashire.

11. In 2022, more than 3,000 professionals in Lancashire participated in self-harm training. The goal was to enhance their knowledge of professional and provide support in handling self-ham incidents
12. Annual training held by Samaritans for local media outlets regarding covering suicide sensitively to support the system to recognise everyone's contribution to addressing this critical topic of suicide.
13. Several CYP and adult campaigns highlighting support services related to the risk factors identified in suicide prevention, such as debt, gambling, isolation, mental health.
14. Engagement of communities to ensure co production campaigns and projects.
15. World suicide prevention day events to ensure this topic is relatable to local services and support networks for its population.
16. LSCICB have commissioned a range of services for children and young people to achieve the THRIVE approach, this programme includes bereavement support.

Action Plan - 2024 – 2029

The key themes of the Lancashire Suicide Prevention and Self-harm Action Plan mirror the national Suicide Prevention Strategy priority areas as follows:

1. Improving data and evidence
2. Providing tailored and targeted support to priority groups
3. Addressing risk factors
4. Online safety, media, and technology
5. Providing effective and appropriate crisis support
6. Tackling means and methods of suicide
7. Providing timely and effective bereavement support
8. Making suicide prevention everyone's business

It also sets out the priority groups for Lancashire which are:

- Children and young people
- People living with a long-term physical health condition
- University students
- People in contact with the criminal justice service
- People who have previous attempted to take their life
- People with a history of self-harm
- Middle aged men
- People bereaved by suicide
- People impacted and perpetrator of domestic abuse
- Survivors of abuse or violence, including sexual abuse and
- Veterans
- Specific occupational groups for example delivery drivers and skilled tradesperson roles
- People with financial difficulty and economic adversity
- LGBTQIA+ people
- Asylum seekers and refugees
- Pregnant women and new mothers

The Action Plan 24/25 can be found in **Appendix 1**

References

[i] ONS: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2023

[ii] DHSC, Fingertips. https://fingertips.phe.org.uk/search/self%20harm#page/1/gid/1/pat/15/ati/502/are/E10000017/iid/92796/age/5/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

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[iv] https://www.suicideinfo.ca/how-many-people-are-affected-by-one-suicide/