Suicide Prevention in York

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Current picture and impact of covid.

The most recent data that can be compared to national figures covers the years 2018-2020. This data shows that the rates of suicide in York were not significantly different to the national average at this time; however the suicide rates for York men is slightly above the national average. This includes deaths that were inquest informed suicide, and also deaths of undetermined intent.

Nationally, there is no visible trend of additional suicides linked to the dates of covid lockdowns or the years 2020-2021 compared with previous years. However, we do acknowledge that the mental health harms of covid measures are may take longer to be develop and become fully apparent.

Through 2021, there were 16 inquest confirmed suicide deaths in York.

York suicide safer community strategy 2018-2023

The five year York Suicide Safer Community Strategy was launched in 2018, and has two years remaining. The aim of the strategy is to reduce suicide risk and increase support for people affected by suicide, with the vision of Suicide Safer Community designation as set out in the HWBB strategy.

The strategy includes a series of action areas:

1. Reducing the risk of suicide in high risk groups
2. Tailored approaches to improve mental health in specific groups
3. Reducing access to the means of suicide
4. Providing better information and support to those bereaved or affected by suicide
5. Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Supporting research, data collection and monitoring
7. Reducing rates of self-harm
8. Training and awareness raising
9. Preparedness and post incident management

Going into 2021 significant progress has been made on several areas of the strategy; most notably work with the river safety team on reducing access to

the means of suicide (action area 3), and work with local media and in developing event response protocols within organisations (action area 5). There have also been a pattern of annual conferences which were successful at building a conversation about York's ambition to be a suicide safer community.

York delivery group, leadership, and regional working

To deliver the strategy the suicide prevention delivery group has met regularly throughout 2021. The membership of this group has also been recently refreshed, to strengthen the multi-disciplinary approach.

The previous suicide prevention lead Andy Chapman left CYC in the summer of 2021. The group is now chaired by Fiona Phillips, consultant in public health, and coordinated by Jen Irving, public health specialist practitioner.

Regionally there is an ICS suicide prevention alliance, as well as several subgroups and peer support structures for public health professionals working on the topic. The York delivery group is well linked into these meting structures and this provides opportunity for discussing the application of national guidance, and exploring regional best practice and opportunities for collaboration.

Improved information flow

<u>Real time surveillance</u>

Real time reporting and monitoring is a cornerstone of delivering this strategy: as well as being central to identifying and responding to clusters, it provides a local understanding of high risk groups or locations which is needed to prioritise other work.

Since summer 2021 suspected suicide data is now provided weekly directly from the coroner's office to public health. This includes information about the person who has died, the location of the death, and an initial assessment of the means and cause of death. This information is not perfect, it is a snapshot of information and is often incomplete, but it is vital in early identification of local clusters or high risk locations.

The real time surveillance days from July 2021-December 2021 shows there were 13 suspected suicides in York (some of these will not be found to be a

suicide at inquest). These people had an average age of 55 (the youngest was 36, the eldest 89). From the information available in the days after the death, there was no apparent connection between the people, and no common location.

Post inquest summary

The public health team now also receive a post inquest report from the coroner's office. This provides a much more complete view of the person in the weeks and months before their death. In particular we receive information about their mental and physical health conditions, and recent care or service use, previous suicide attempts, and family circumstances. This level of information is only available once the inquest has been completed, often several months after the death. This is a new line of information for the delivery group and will provide good insight into local priorities for the remainder of this strategy period.

MIRT offer and SOBS role in leading annual service of remembrance

Introductions to MIRT

MIRT have provided emotional and practical support to families who have been bereaved by a suspected suicide for many years. Over the last six months there have been strengthening links between the coroner's office and the major incident response team (MIRT).

The coroner's office now makes a personal phone call to every family to offer an introduction to MIRT. Through 2021 MIRT offered suicide bereavement support to 20 York families. Snapshot data from the coroner's office indicates that 57% of eligible families accepted an introduction to MIRT first time, with another 15% were unsure but accepted the offer of another call in three months. The service is continuing to listen to feedback to improve this figure.

Unfortunately 11 families were not able to access the service because they live outside of the area; these families were directed to national services. MIRT and the coroner's office are working to improve relationships with other postvention teams to ensure a good offer to all families. . Additionally, in 2022 the coroner's office has committed to further enhancing the links to MIRT by extending the offer of an introduction to more close contacts of the deceased,

not just the primary next of kin. We hope this will increase the numbers of people successfully introduced to MIRT.

SOBS service of reflection

The 2021 Service of Reflection Conference was run and delivered by the peer support group Survivors of Bereavement by Suicide and was well attended both in person and through video call. York SOBS has grown considerably over the last few years, and it was excellent to see this years' service of reflection delivered as a community led event.

Clarifying approach to training in 2022

Towards the end of 2021, the delivery group put a renewed focus on developing a strategic approach on suicide prevention training for York. We are developing a view on the priority workforce groups and their training needs. In particular we are considering where we can influence the training specified within contracts for commissioned services and also our role in influencing compliance competency standards where they exist for professional workforces.

The next strategy

Towards the end of 2022 we will also develop a project plan to develop the next suicide prevention strategy that we will develop through consultation and engagement in 2023.