Preventing Suicide in Kingston:

A multi-agency strategy 2024-29

Executive Summary

THE ROYAL BOROUGH OF KINGSTON UPON THAMES

FAIRER KINGSTON

SAFER KINGSTON

Contents

1. Foreword

Suicide prevention is everyone's business and there are many ways in which individuals, communities, services, and society as a whole can help to prevent suicides. I call on everyone to consider this strategy, the groups identified and the risk factors set out, to truly consider and bring forward action to ensure that the preventable is prevented, and that families and communities do not suffer the devastating impact that suicide brings.

Kingston's first Suicide Prevention Strategy was launched in 2016, and it is timely to update the strategy now, when we are facing significant challenges as a society following the Covid-19 pandemic and the on-going cost-of-living crisis. Suicide disproportionately affects some of the most disadvantaged and vulnerable people in our society, therefore, given the challenges we are facing, we must redouble our collective efforts to prevent suicide.

Each suicide is a tragedy; the loss to family and friends which is so very personal to them, and I acknowledge that behind the figures and descriptions in this strategy is a person lost to suicide and lost to their family and community. Through this strategy we will work with people of all ages across Kingston to prevent suicide.

I would like to dedicate this strategy to my wonderful predecessor and colleague, Dr Jonathan Hildebrand (1961-2016), who sadly died by suicide, and to whom I pay tribute:

"A man of substance, truly humble, remarkable. Principled and inspirational."

I commend this strategy to you, my last as Director of Public Health for Kingston, as I step down after 18 years of public service in the borough. I would like to take this opportunity to thank everyone who has helped develop this strategy, particularly those with lived experience of suicide.

Iona Lidington
Director of Public Health
Royal Borough of Kingston upon Thames

This new Suicide Prevention Strategy for Kingston has been developed in consultation with a broad range of organisations and most importantly people with lived experience of suicide. We know every suicide is a tragedy that affects families and communities and has long lasting effects on people that are left behind. Therefore, it was important to me to involve people who have first-hand experience.

The strategy describes the many different issues and suicide risks that can have an impact on individuals. But it also clearly sets out how we plan to take forward enhanced efforts to prevent suicide in Kingston. Suicides are not inevitable and by working together we can make a difference to people's lives, creating hope through collective action so that all of our residents feel supported when they are in crisis.

The strategy supports our commitment in our Council Plan 2023-2027 to work with partners to ensure the borough is fairer and safer and that residents start well, live well and age well. I commend this report and look forward to supporting this critical work as we go forward.

Cllr Sabah Hamed
Portfolio Holder for Adult Social Care
and Public Health

2. Introduction

Why we need a new strategy

Kingston's Suicide Prevention strategy was published in 2016 and progress has been made in implementing many of the priorities and actions therein. There was a commitment for all local authorities to have Multi-agency Suicide Prevention Plans in the Cross-Government Suicide Prevention Workplan 2019. However, the Covid-19 pandemic meant that some areas of the strategy were not completed.

There have been many changes since our first strategy, including the impact that the Covid-19 pandemic and lockdown have had on the mental health of all residents, particularly children. More recently, the cost of living crisis has presented new challenges.

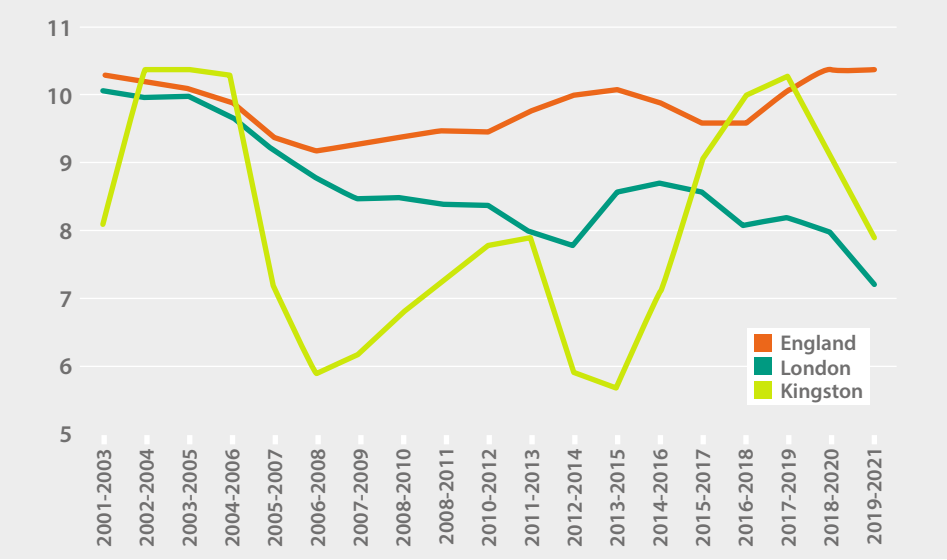
The strategy is also part of wider work to promote mental health and prevent mental illness which was reviewed as part of Kingston's Better Mental Health Joint Strategic Needs Assessment in 2022. It supports the commitment in the Council Plan to work with partners to ensure the borough is fairer and safer and that residents - **Start Well, Live Well and Age Well** - along with a number of other local strategies that support suicide prevention are referred to in relevant sections of the report.

The strategy was developed with local partners using insights from local data and stakeholder engagement. It is also informed by the new National Strategy (2023-2028)[1] that was launched on 11th September 2023.

Suicide Data for Kingston Upon Thames

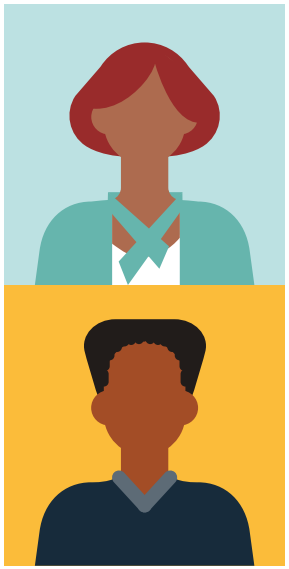
There are around ten suicides a year by Kingston residents. Suicide rates fluctuate considerably because of the relatively small numbers and therefore multi-year data is used to assist with tracking trends. The latest data shows 36 deaths by suicide in the borough across 2019-2021, at a rate of 7.9 / 100,000 residents, slightly higher than London (7.2 / 100,000) and lower than England (10.4/ 100,000).

Age-standardised suicide rate / 100,000 population, rolling three year aggregates



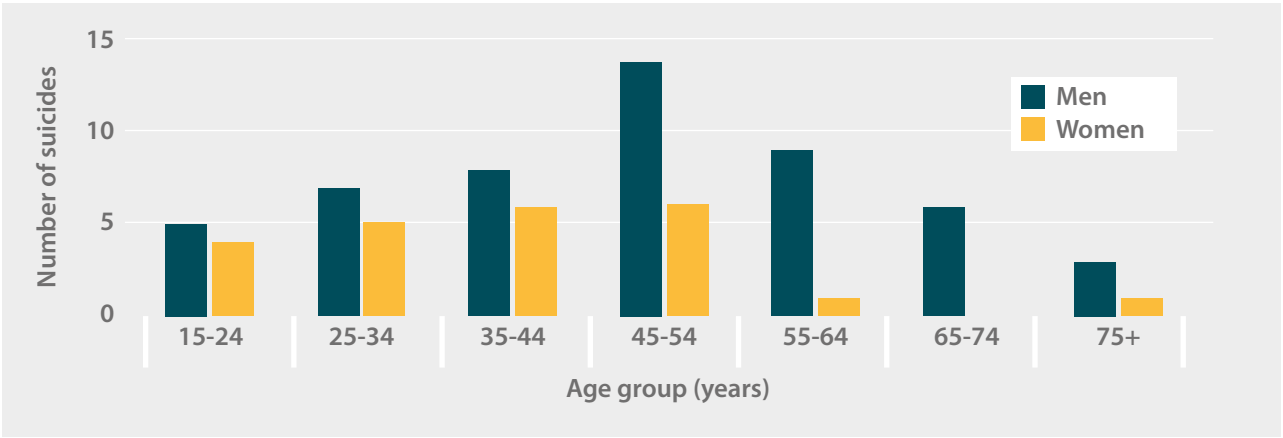
Source: ONS Suicides in England and Wales by local authority September 2022

An audit was undertaken of suicides in Kingston both by residents and by those who took their own lives in Kingston between January 2018 and December 2021. It used data from the Primary Care Mortality Data (PCMD) and suspected suicides on the Thrive London Suicide Surveillance Database from October 2021 to September 2023.



Age and Sex

Number of deaths by suicide, by age group and sex, 2018-21



Source: the NHS Primary Care Mortality Database

The majority of suicides in Kingston are men (more than double that of women) and this is in line with national figures. The age profile of male and female suicides also differs. In women, 90% of suicides were in people aged under 55. For men, 65% were aged under 55.

Ethnicity/Place of Birth

Ethnicity is not recorded in the Primary Care Mortality Data (PCMD) so we do not have data on the ethnicity of those who took their own lives in Kingston but national data indicates that estimated rates of suicide were highest in White and Mixed ethnic groups.

Comparison with the previous audit

When considering the 75 deaths by suicide (both residents and non residents) identified from the scoping exercise, a summary comparison to the previous audits can be seen below:

Measure	2010-14*	2015-17	2018-21
Number of deaths by suicide per year (residents & non residents)	12.3	16.7	**18.8**
Proportion of deaths by suicide involving Kingston residents	82%	**85%**	71%
Proportion of male suicides	66%	**72%**	69%
Median age at time of death	**50**	45	46

* Adjusted to use the same methodology as in the 2015-17 and 2018-21 audits

The 2018-21 audit against 2015-17 and 2010-14 showed that the number of deaths recorded a year has increased, and the proportion of suicides involving Kingston residents has decreased. This highlights the importance of steps to reduce suicides at destinations in Kingston which is covered in Priority 6.

Suicide attempts

It is impossible to obtain accurate data on attempted suicides or determine whether an act of deliberate self-harm was an attempt at suicide or not. Some attempts will be reported to the police, or ambulance service, but others will result in A&E attendance or in-patient admission.

The police do not collect data on suicide attempts and there is no specific London Ambulance Service data on suicides or attempts. South West London & St George's Mental Health Trust (SWL&StG MHT) recorded ten attempts by patients who were Kingston residents from April 2018 to March 2022.

For many people self-harm is a coping mechanism and not a suicide attempt, but we know that self-harm is associated with a significant risk of subsequent suicide. (NCISH 2022 report - 67% of suicide patients who died had a history of self harm).

Self harm

Emergency admissions for self-harm in Kingston in residents over 14 years appear to have increased significantly since 2018-19. Of these:

- 70% were women - (65% nationally).
- The largest number were aged 19-28.
- 93% had an ethnicity recorded, with 76% of people recorded as white.
- Areas with a higher rate of A&E attendance seemed to correlate with areas of higher deprivation in Kingston (Chessington South, Norbiton and Surbiton South).

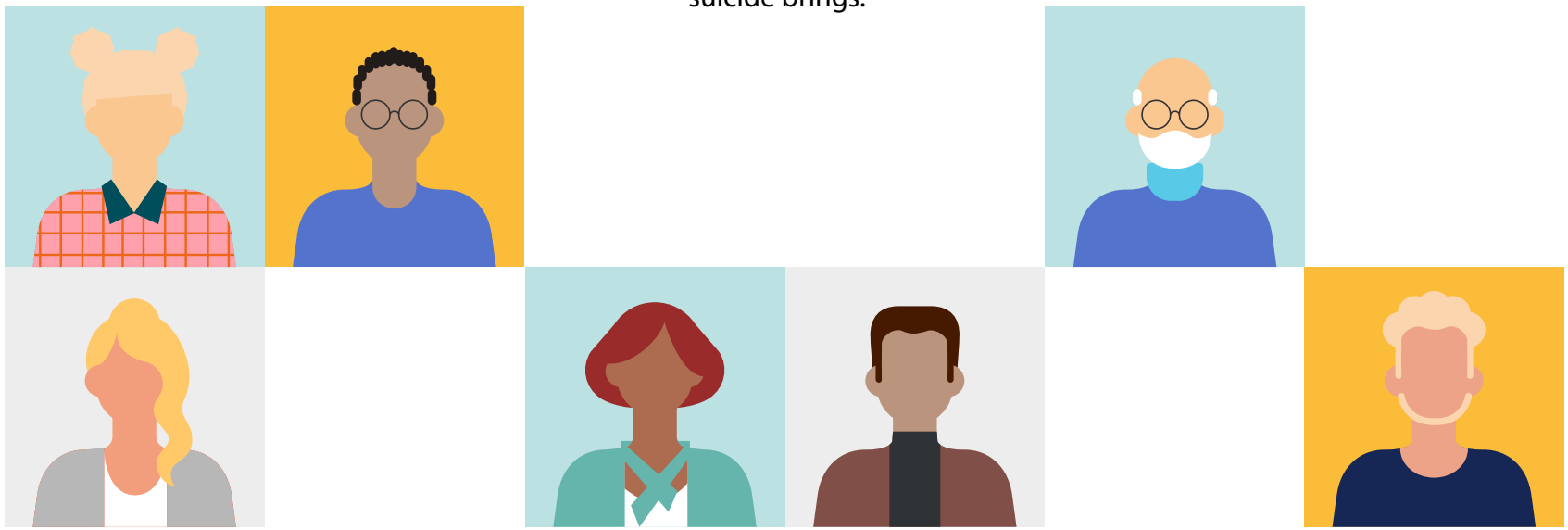
Additional Risk Factors

Suicides did not increase during the Covid-19 pandemic but a number of the risk factors for suicide did, in particular financial difficulties, alcohol misuse and self-harm in children and young people. Young people, ethnic minorities and people who live alone were some of the most affected by the Covid-19 pandemic. They have also been a concern in suicide prevention.

Ambition and vision for the next five years

This multi-agency strategy sets out our ambitions for suicide prevention over the next five years and will deliver an annual action plan based on these ambitions. This will include actions by the Council, Health and Social Care, Schools, Colleges, Universities, Workplaces, the Community and Voluntary sectors and Emergency Services.

However, this strategy and action plan are not the limits of suicide prevention – suicide prevention is everyone's business. We call on **everyone** to consider this strategy, the groups identified and the risk factors set out to ensure that the preventable is prevented, and that families and communities do not suffer the devastating impact that suicide brings.

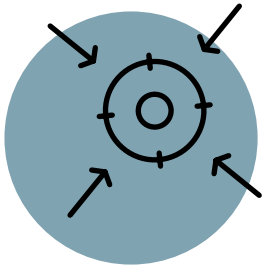


3. Kingston's Eight Priority Areas (not in order of importance)

Aligned with our stakeholder engagement findings, suicide audit and reflecting the national strategy, we have identified eight priorities for Kingston's strategy.

1

Improving data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.



2

Tailored, targeted support to priority groups, including higher risk groups to provide bespoke interventions that are effective and accessible for everyone.

3

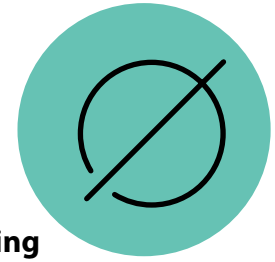
Addressing common risk factors at a population level to provide early intervention and tailored support.

4

Promoting Online Safety to reduce harm, improve support and signposting, and provide helpful messages about suicide and self-harm.

5

Providing effective crisis support across sectors for those who reach crisis point.



6

Reducing access to means and methods of suicide.

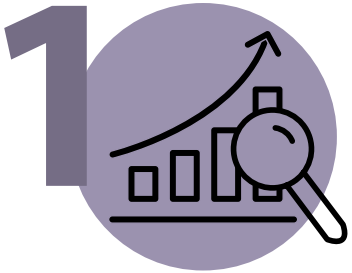
7

Providing effective bereavement support to those affected by suicide.

8

Suicide prevention is everyone's business so that we can maximise our collective impact and support to prevent suicides.

4. The strategy



PRIORITY 1: Improving data and evidence

to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.

Strategy

To develop more high quality data driven evidence and intelligence, and better understanding of **suicide rates in particular groups**, has been noted nationally.

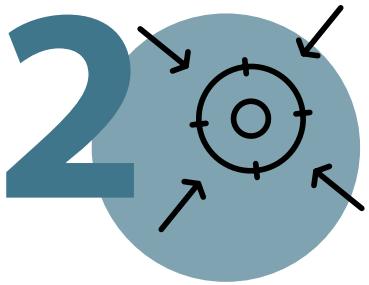
These include:

- Occupational groups identified as at higher risk of suicide.
- Autistic people.
- People affected by domestic abuse.
- People experiencing harmful gambling.
- Ethnic minority groups including people who are Gypsy, Roma or Travellers.
- Refugees and asylum seekers.
- People who are Lesbian Gay and Bisexual.
- People who are Transgender.

The views and experiences of people affected by suicide is also essential for understanding trends, and the potential impacts and suitability of actions and solutions.

Our aims:

1. Improve the collection and co-ordination of data on suicides, attempted suicides and self harm and the monitoring of trends and patterns.
2. Improve the intelligence gathering from local partners to better understand the circumstance around suspected suicides and suicide attempts to ensure all lessons are learnt.
3. Further develop the involvement of people with lived experience in the implementation and review of the strategy.



PRIORITY 2: Tailored, targeted support to priority groups

including higher risk groups to provide bespoke interventions that are effective and accessible for everyone.

Strategy

The national strategy has identified groups considered for tailored/ targeted action. Some have higher suicide rates than the general population e.g. people in contact with mental health services, others, although low, have increased rates in recent years, such as children and young people.

High-risk groups identified are:

1. Children and young people.
2. Middle-aged men.
3. People who have self-harmed.
4. People in contact with mental health services.
5. People in contact with the justice system.
6. Autistic people.
7. Pregnant women and new mothers.

Kingston Context

Kingston's data and stakeholder engagement supports prioritising all of these groups.
In addition:

- The local data supports broadening the priority of pregnant women and new mothers to include women at times of identified risk.
- Stakeholders wanted to broaden 'People in contact with mental health services' to 'People with mental health problems'.
- The latest national data also supports adding people with Attention deficit hyperactivity disorder (ADHD).

High Risk Groups

1. Children and young people up to 25

The suicide rate in under-20s is relatively low compared with older age groups, but rates across all age groups under 25 have been increasing over the last decade in females under 25 across England.

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) 2017 report on the factors related to suicide by children and young people aged 10-19 age found **ten common themes:**

- Family factors such as mental illness.
- Abuse and neglect.
- Bereavement and experience of suicide.
- Bullying.
- Suicide-related internet use (Promoting Online Safety is also covered in Priority 4).
- Academic pressures, especially related to exams.
- Social isolation or withdrawal (tackling loneliness in young people is covered in Priority 3).
- Physical health conditions that may have social impact.
- Alcohol and illicit drugs.
- Mental ill health, self-harm and suicidal ideas.

In its 2024 report NCISH reported that deaths by suicide of students (18 and 21) were most common in October and April (start of the academic year and exams), recommending support be enhanced at these key times of risk and provide a clear pathway to mental health services.

In Kingston

2017 national estimates that 11.2% of 5 to 17 year olds nationally have mental health disorders extrapolates to 3,257 children with mental health difficulties in Kingston.

Our aims:

1. Improve access to mental health support and services that benefit young people's wellbeing, in particular for those experiencing risk factors for suicide.
2. To improve suicide prevention activity within schools, colleges and universities.
3. Improve information and advice available to parents/carers, primary care and community services about signs to be concerned about and support for children and young people, including those who disengage with mental health services. This should include access to local crisis helplines and national resources.

2. Middle-aged men

National research shows that socio-economic disadvantage is strongly associated with suicide in this demographic. Family or relationship problems, social isolation and loneliness are also common factors.

Two thirds of men had been in contact with frontline agencies or services in the three months before their death, in particular primary care services (43%). The national strategy has highlighted the importance of ensuring that there is appropriate support and signposting for suicide prevention from the services men commonly interact with, especially, but not limited to primary care.

69% of suicides in Kingston were by men. The greatest number were aged 45 - 54 , followed by 55-64 (compared with the national priority group of 40-54).

Local stakeholders were keen to improve awareness of support for men by those in frontline services and highlighted the need to improve support for younger men to prevent problems in the future.

Kingston has a number of initiatives in place including a Kingston College project for young men, the Kingston Carers Network men's group and training for local barbers to create spaces where men can open up and be signposted to support.

Our aims:

1. Further develop initiatives to support men based on best practice including opportunities for men to support other men going through similar experiences.
2. Provide support and signposting for suicide prevention in places and services where men and boys go and ensure opportunities to identify mental health issues are in place and support is provided, as soon as possible.

3. People who have self-harmed

We know that self-harm is associated with a significant risk of subsequent suicide. The risk is particularly increased in those who repeatedly self-harm or use violent/ dangerous methods of self-harm. NCISH has developed the 'Toolkit for Self Harm' from the NICE Quality Standard for Self-Harm. They recommend that local providers review their services against this toolkit annually.

The Samaritans 2020 report on self-harm **'Pushed from pillar to post'** recommends group activities which foster connection, peer support, self-care apps and online guides. It also recommends engaging people with lived experience in the development of services to improve effectiveness.

Emergency admissions for self-harm in Kingston in residents over 14 years appear to have increased significantly since 2018-19.

- 70% were women - similar to 65% seen nationally.
- The largest number of admissions in the 19-28 age group.
- Areas with a higher rate of A&E attendance seemed to correlate with areas of higher deprivation (Norbiton, Chessington South and Surbiton South).
- The vast majority of those admitted had only one admission over the four years, but 20% had more than one admission.
- 76% of all those who had three or more self harm inpatient episodes were women.
- 93% had an ethnicity recorded, with 76% of people recorded as white.
- In Black and mixed ethnicities, over 80% of inpatients were female.
- Peak admissions were springtime - possibly related to exam stress.

Our aims:

1. To provide self harm services in line with best practice.
2. Build awareness and understanding among schools, families and others on how to support children and young people who self harm.

4. People with mental health problems

When individuals are in contact with mental health services, it is crucial that they are offered safe, compassionate and patient-centred care each and every time. NCISH developed the 'Safer Services Toolkit' based on the 10 key elements for safer care for patients which have been shown to reduce suicide rates. This includes best practice for safer care in mental health services, primary care and hospitals.

National data on patient suicides in England between 2010 and 2020 found that patients diagnosed with certain conditions have higher rates of suicide such as, affective disorders, including depression and bipolar, (42%), personality disorders, (11% and increasing), schizophrenia and other delusional disorders, (16%), eating disorders, (a quarter to a third of people diagnosed with anorexia nervosa and bulimia nervosa have attempted suicide).

In Kingston we have broadened the national priority to include those with mental health problems as well as those in contact with services given issues raised about access to mental health services by some groups and concern raised about waiting times. 14.4% of Kingston residents aged 16 or over were estimated to have a common mental health disorder, such as anxiety or depression in 2017, this is over 20,000 people, and the latest 2021 Health Index for England shows that Kingston's anxiety levels are higher than the national average.

Our aims:

1. Ensure there is safer care in mental health services, primary care and hospitals in line with best practice.
2. Improve access to mental health support, in particular by those with conditions that have higher or increasing rates of suicide and those who have lower levels of uptake of services.
3. Provide mental health support in places, and according to the different needs, of patients based on their ethnicity, age, sexuality etc.

5. People in contact with the justice system

People in contact with the justice system have higher rates of suicide and self-harm behaviour than the general population. Stakeholders in Kingston raised the lack of joined up pathways to support people of all ages in the criminal justice system and the importance of improving connection with the Criminal Justice system.

Our aims:

1. Increase access to mental health support by people in contact with the criminal justice system.

6. Autistic people and people with Attention Deficit Hyperactivity Disorder (ADHD)

Evidence suggests that autistic people, including autistic children and young people, may be at a higher risk. Undiagnosed or late-diagnosed autism may be a preventable risk factor for suicide and, therefore, earlier identification and timely access to autism assessment services is vital.

A needs-led rather than diagnosis-led approach has been adopted in some areas, which means that families without diagnosis are also supported. This support potentially reduces the risk of suicide as interventions can be put in place as soon as needs are apparent and can reduce isolation experienced.

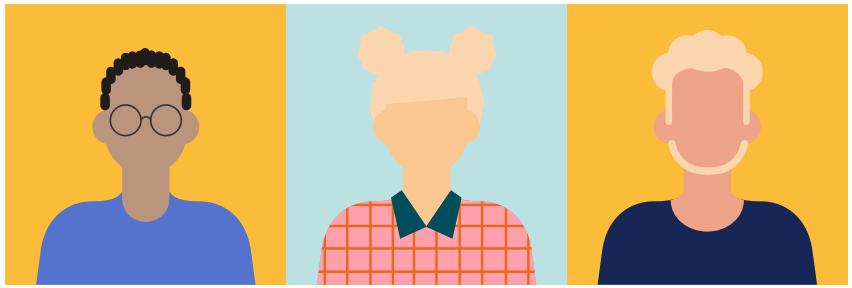
National data from NCISH found that in 2011-2021, 2% of all patient suicides were autistic people and 1% of all patient suicides were people with ADHD.

The need to improve support for autistic people of all ages, in particular the need to improve access to mental health support, was a very strong theme from Kingston's stakeholders. Healthwatch Kingston's Neurodiversity and health and care services report published in March 2022 made a number of recommendations:

- Make health and carer services including mental health properly accessible to neurodiverse residents.
- Commission a specialist pathway for neurodiverse people with functional mental health needs.

Our aims:

1. Improve access to mental health support for all people with, or waiting for, a diagnosis of autism or ADHD depending on their needs.
2. Improve training and support for clinicians , carers and families of people with autism or ADHD on suicide prevention.



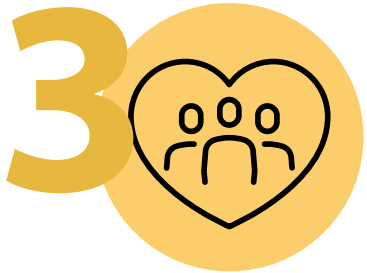
7. Pregnant women, new mothers and women in at risk groups

- The September 2022 Office of National Statistics reported that comparison between 2015 and 2021 showed a statistically significant increase in the suicide rate for females aged 10 to 24 and 25 to 44 years[2].
- Nationally suicide is the leading cause of direct deaths six weeks to a year after the end of pregnancy[3].
- Complex problems remain extremely common in women who die by suicide and there are several overlapping risk factors that services need to consider including current and past mental ill health, domestic abuse, substance misuse, baby loss, teenage parenthood and experience of the care system[4].

In Kingston, 90% of suicides in women were aged under 55. Local stakeholders have raised concerns regarding support for women during the menopause and mothers supporting children with particular needs including autism. The need to address the unique mental health challenges faced by women, including young women, was raised in the consultation.

Our aims:

1. Increase awareness of and access to mental health support for new mothers.
2. Increase awareness and access to perinatal mental health support, particularly by young women at higher risk of suicide.
3. Increase awareness of and access to mental health support for women during times of identified risk.



PRIORITY 3: Addressing common risk factors

at a population level to provide early intervention and tailored support.

Strategy

Addressing risk factors linked to suicide is a central part of effective suicide prevention and an opportunity for effective early intervention, as well as appropriate, tailored support for those experiencing suicidal thoughts or feelings. The cumulative impact of different risk factors is also important as is the importance of early intervention and signposting.

Links have been evidenced between suicide and social determinants of health such as housing, poverty, employment and education. Specific factors (many linked to wider determinants) have been identified as priority areas to address within the national strategy:

Common risk factors identified are:

1. Physical illness.
2. Financial difficulty and economic adversity.
3. Harmful gambling.
4. Substance misuse.
5. Domestic abuse.
6. Social isolation and loneliness.

Kingston Context

In addition to these areas Kingston stakeholders and data also identified the following risk factors and we have amended our priorities in light of these:

- Domestic abuse was raised by local stakeholders, but data and feedback has also raised recent and historical sexual abuse as an area where more support is needed.
- Family breakdown is another area identified by local stakeholders and supported by local data.
- Trauma was raised by local stakeholders both in relation to abuse and to veterans.

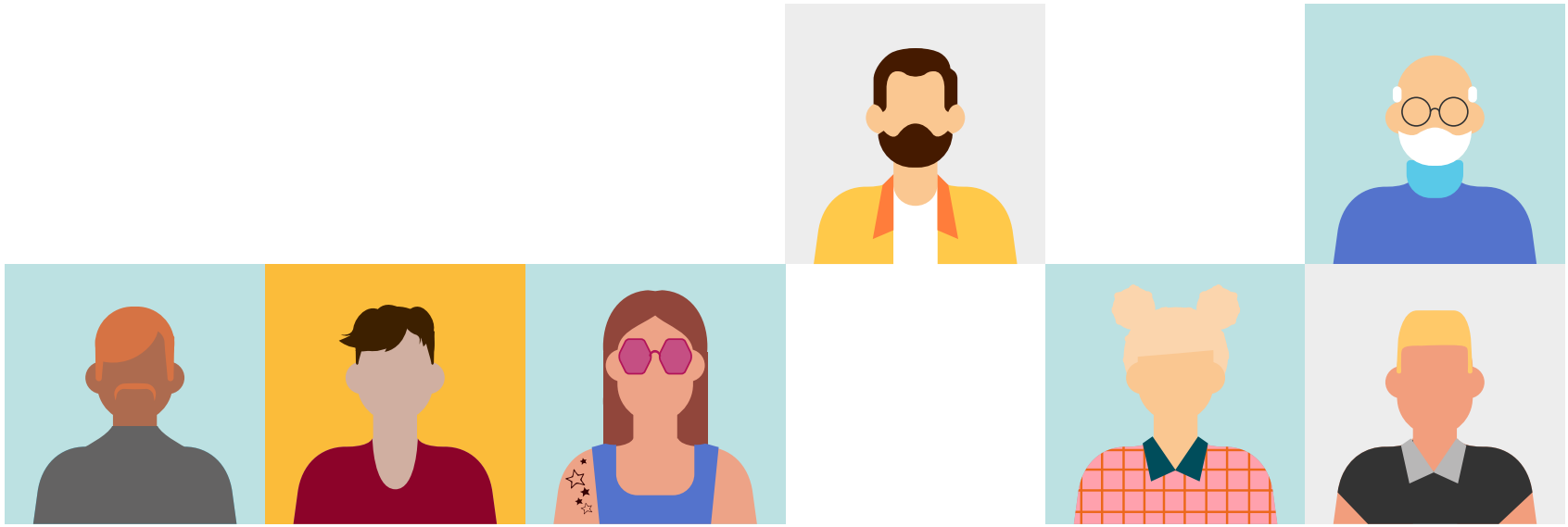
1. Physical illness

Diagnosis of a severe physical health condition may be linked to higher suicide rates. Evidence from NCISH suggests that over half of men aged 40 to 54 who died by suicide had a physical health condition.

In Kingston data is limited but physical health conditions were mentioned in a number of the suicides on the Thrive hub. Kingston's JSNA 2023 notes a number of areas with high proportions of people claiming benefits for support with a limiting long-term physical or mental health condition or disability.

Our aims:

1. Ensure mental health needs are integrated into programmes supporting people with severe physical health conditions.
2. Improve awareness of and access to NHS Talking Therapies (previously known as Kingston iCope) by people with severe physical health conditions, particular in areas of higher need.
3. Ensure those caring for people with severe physical health condition are trained in suicide prevention.



2. Financial difficulty and economic adversity

Financial difficulty and adversity can result in suicidal thoughts or action. National data from NCISH 2023 found that between 2010-2020 there was an increase in patients who had experienced recent economic adversity. It recommends that frontline staff should be aware of the risks of new problems concerning the loss of jobs, benefits and housing, among other issues, and should have the information to signpost patients to sources of financial support and advice.

A 2021 Samaritans report on **'The impact of economic disruption on young adults'** noted that the pandemic economic disruption in young adults, including job loss, meant that they were more likely to report suicidal thoughts afterwards, compared to those who have not experienced any economic disruption.

The cost of living crisis network run by Kingston Information and Advice Alliance (KIAA) raised concerns about an increase in people who use their services feeling unable to cope, with some feeling suicidal. Stakeholders noted the value of working together to support people. For example: The Cambridge Road Estate has a one stop shop approach where mental health support is provided alongside a number of other services including a food bank, financial support and healthcare.

Our aims:

1. Ensure those providing support to people with financial problems, of all ages, are offered suicide prevention training.
2. Improve signposting for finance and debt support by primary care and mental health services.
3. Further develop and coordinate mental health support for people who are homeless or in temporary accommodation, and ensure those working with homeless people are able to manage the risk and impact of suicide for people experiencing homelessness.
4. Improve access to welfare benefits and financial advice for all those with mental health conditions.

3. Harmful gambling

There is increasing national evidence of the relationship between harmful gambling and suicide, including in younger people. This is not an area that was identified specifically in local data. however it will be important to continue to monitor given the identification of it nationally.

Our aim:

1. Develop a whole Council approach to tackling gambling-related harm.

4. Substance misuse

A high proportion of people in contact with mental health services in England who died by suicide between 2010 and 2020, presented with both alcohol misuse (45%) and drug misuse (35%). In a study of middle-aged men that died by suicide in 2017, 49% had experienced alcohol misuse, drug misuse or both, particularly those unemployed, bereaved or had a history of self-harm or violence. A recent study showed that mental health trusts that implemented a policy on co-occurring drug and alcohol use observed a 25% fall in patient suicides.

Data from the Kingston substance misuse team on deaths in treatment between February 2018 and December 2021 found that three of the deaths were classified as 'suspected suicide' (10% of the total). The rate of deaths of people who died whilst in treatment for alcohol use in Kingston has been higher than the national rate dating back to 2016/17 (except 2019/20).

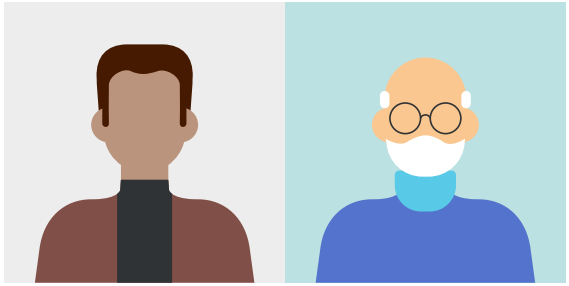
Our aims:

1. Embed suicide prevention in drug and alcohol policy and services.
2. Improve mental health treatment for people with mental health conditions who also misuse alcohol and drugs.

5. Domestic abuse and sexual abuse

The national strategy notes the increase in evidence on a link between domestic abuse and suicide. The 2022 NCISH report notes that the majority of patients with a history of domestic violence were female and that self-harm, previous alcohol or drug misuse and personality disorder diagnosis were more common in this group, potentially reflecting previous trauma or abuse. The Women's Mental Health Taskforce report (2018) suggests that women's experiences of physical and sexual violence are likely to be factors in recent increases in suicide in women.

In Kingston, previous sexual abuse was noted in some of the Kingston cases on the London Thrive hub. Domestic abuse increased in Kingston during the pandemic and a recent sexual harassment survey by Youth Council shows evidence of increase in sexual assault in Kingston.



Our aims:

1. Increase access to mental health support by survivors of domestic abuse and sexual abuse.
2. Increase the consideration of domestic violence by clinicians when assessing suicide risk.

6. Trauma

Research consistently finds a strong link between traumatic experiences and suicidal thoughts and behaviours. The 2023 national report from NCISH noted the importance of offering psychological therapies to address previous trauma.

Trauma can sometimes lead to PTSD (post traumatic stress disorder) and national research into the mental health of UK Armed Forces personnel found that there has been a moderate increase in PTSD in recent years. The Charity Help for Heroes has made a number of recommendations to improve support for veterans.

Many asylum seekers and refugees will experience traumatic events. Children seeking asylum experience a range of mental health difficulties, including post-traumatic stress disorder (PTSD).

The Royal Borough of Kingston has signed the Armed Forces Covenant and is committed to supporting veterans in Kingston. The 2021 Census showed that Kingston has over 2,600 veterans (2% of our adult population), the sixth-equal highest level in London.

Kingston Refugees Asylum Seekers Migrants Strategy 2016-2019 notes that Refugees and asylum seekers report levels of anxiety, depression, phobias and post-traumatic stress disorder (PTSD), higher than in the rest of the population or other migrant groups.

Our aims:

1. Continue to work on embedding trauma informed principles across all services and improve coordination of this work.
2. Increase access to evidence based psychological treatments for those who have experienced trauma.
3. Implement best practice to reduce suicide risk in veterans.

7. Social isolation, loneliness and relationship breakdown

Social isolation (having few people to interact with regularly) and loneliness (not having the quality or quantity of social relationships we want, regardless of social contacts) have been closely linked to suicidal ideation and behaviour. National evidence shows that:

- Social isolation was experienced by 15% of under-20 year olds and 11% of 20 to 24 year olds who died by suicide.
- Of men aged 40 to 54 who died by suicide, 11% reported recent social isolation.

The most prevalent search on **Connected Kingston**, our local social prescribing platform, was for 'friends'. Kingston's Better Mental Health JSNA 2022 includes recommendations to:

- Tackle social isolation amongst older carers.
- Increase the ways of identifying people who are lonely and supporting them to access local services.
- Work with older people, particularly those who are not accessing existing services, to develop ways for them to build social connections.

Kingston is part of the South London Listens programme and one of the priorities in this is tackling loneliness through, among other things, developing Be Well hubs. In Kingston a number of local organisations have already signed up to be 'Be Well hubs', including churches, the Islamic Resource Centre and Kingston Carers Network.

Our aims:

1. Further develop and promote opportunities for people to connect with each other, particularly young people, men, carers and those experiencing other risk factors for suicide.
2. Identify opportunities to increase access to relationship support.

PRIORITY 4: Promoting Online Safety

to reduce harm, improve support and signposting, and provide helpful messages about suicide and self-harm.

There has been emerging evidence of the link between the online environment and suicide across different age groups. Online platforms, however, also provide an invaluable way to raise awareness and improve access to support to resist suicidal ideation and self-harm. The Samaritans have provided useful advice on Controlling the suicide and self-harm content you see online.

In recent years, good progress has been made in Kingston to tackle the stigma surrounding mental health, in particular through the work of the Champions for Change programme now provided by Mind in Kingston. Local stakeholders felt, however, that there was still considerable stigma surrounding suicide and that local work by Champions for Change should also involve suicide prevention approaches.

Local stakeholders raised concerns about the lack of co-ordination of sites providing information about mental health support for both children and adults. The need for more support for parents to manage access to media and keep their children safe was also raised.

Our aims:

1. Ensure it is easy for people of all ages who need help to resist suicidal ideation and self-harm to access support on all local websites, including specialist support for specific groups, such as veterans.
2. Further develop support for residents, in particular children and young people and their parents, for healthy and safe usage of online platforms.
3. Continue to tackle stigma around suicide and promote help seeking for those who need it, in partnership with community groups, so that campaigns meet the needs of and all ages and demographics, so that no one suffers in silence.

PRIORITY 5: Providing effective crisis support

across sectors for those who reach crisis point.

It is essential that timely and effective crisis support is available to those who need it. Research by NCISH suggests that, of all deaths by suicide by people in contact with mental health services in England between 2010 and 2020, 13% were under the care of Crisis Resolution and Home Treatment teams and noted that patients and carers emphasised the need for clarity about what to do and who to contact in a crisis.

The Right Care, Right Person (RCRP) model is soon to be introduced across London. It changes the way the emergency services respond to calls involving concerns about mental health. It is aimed at making sure the right agency deals with health related calls.

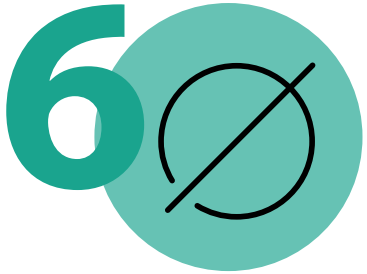
In Kingston stakeholders raised concerns about awareness and access to crisis support and a lack of a joined up crisis pathway in Kingston, particularly for children and young people. They also raised the need for more support to help those who have previously made attempts from attempting again.

Our aims:

1. Anyone, whatever age, experiencing suicidal crisis, and their families and carers, are easily able to access timely and effective support and information when and where they need it.
2. Pathways between services and sectors are improved so that there is a more joined-up approach to crisis prevention and response, including through timely follow-up and aftercare.
3. Information about crisis support is provided in a wide range of places, particularly where high risk groups or those experiencing risk factors are likely to see it.

Trigger warning

This section contains potentially distressing content around methods and means of suicide.
Please take care if you do choose to read.

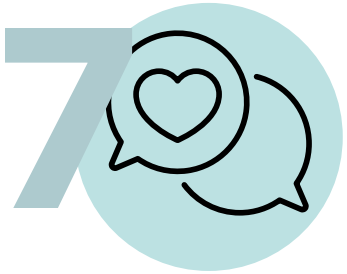


PRIORITY 6: Reducing access to means and methods of suicide.

The most effective suicide prevention measure remains restricting access to the means of suicide. This involves action to prevent suicides in public spaces and reducing accessibility to other means such as prescribed medicine.

Our aims:

1. Increase awareness of support in potential high risk locations in particular the riverside.
2. Ensure there is an agreed process in place to identify and respond to a possible suicide cluster, i.e. where there may be more suicides than expected in a particular area, or a suspected link between suicides.
3. Work with GPs, hospitals and pharmacists to promote safe prescribing.



PRIORITY 7: Providing effective bereavement support to those affected by suicide.

Evidence suggests family, friends, carers and acquaintances who are bereaved by suicide may have a risk of dying by suicide that is up to three times higher than the general population, particularly among men and young people.

Deaths by suicide in public places can also be traumatising for first responders and other witnesses, and further increases the impact of the death. Compassionate, effective and timely support for people bereaved by suicide is essential.

In Kingston the **'Help is at hand'** resource is promoted. Produced by the Support After Suicide Partnership is an important guide for people affected by suicide and provides emotional and practical support. The South West London Suicide Bereavement Service was set up in 2019 and provides support individuals, families and others affected by death by suicide, as well as signposting to bereavement support organisations, peer support groups and/or mental health services for counselling.

In 2022 Healthwatch Kingston and Kingston Voluntary Action made a number of recommendations to improve access to bereavement support in Kingston, including by ethnic minority groups, and children and young people. There has been some promotion of suicide prevention and postvention support for schools but limited work with employers in this area.

Our aims:

1. All individuals bereaved by suicide, including friends and family as well as first responders, are offered timely, compassionate and tailored support.
2. Improve awareness of local, regional and national bereavement support, including suicide bereavement, across all ages.
3. Workplace and education settings are provided with support so that they are able to prepare for and recover from a suspected or attempted suicide and provide appropriate support to those who are bereaved by suicide.
4. Ensure bereavement support, including suicide bereavement support, meets the needs of all groups, including children and young people, people with learning disabilities and people from different ethnic minority groups.

PRIORITY 8: Suicide prevention is everyone's business

so that we can maximise our collective impact and support to prevent suicides.

Suicide prevention should be everyone's business. Every person, organisation and service up and down the country potentially has a role to play. The most common risk factors are described in priority 3 but other less predictable reasons why people might take their own lives include: noise, racism, abuse. For this reason it is essential that as many organisations as possible, including employers, sign up to support this strategy so that they are trained to identify and support people and to consider suicide prevention in their services and work environments.

In Kingston there has been a long rolling programme of suicide prevention training. Over 300 frontline staff have attended Suicide Awareness Training since 2015. This includes people working with both adults and children such as school nurses, housing staff and people working in voluntary sector organisations. A review is needed of which groups have attended and where there are gaps. Over 60 staff, including GPs and staff in substance misuse services attended Suicide Response Training to help them in risk assessment and safety planning since 2019.

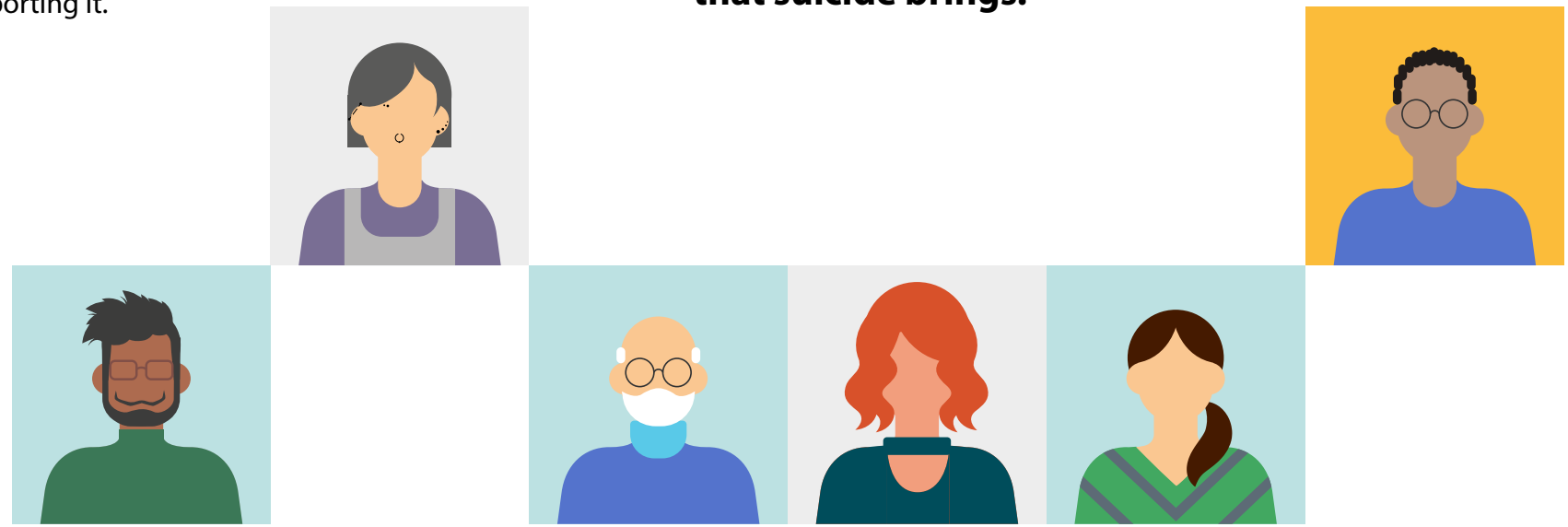
A leaflet for frontline staff was created for anyone working with someone in mental distress. It has been used by Kingston Council staff as well as Kingston Police, Kingston University, voluntary sector organisations and Kingston First for local businesses.

Our aims:

1. Every individual across Kingston has access to training and support, appropriate to their needs, that gives them the confidence and skills to save lives.
2. Ensure that when people experiencing suicidal thoughts or feelings reach out, they receive timely, appropriate support, no matter what service the individual initially accesses, to help prevent suicide.
3. Employers (especially those in high-risk occupations) have appropriate mental health and wellbeing support in place for their staff.
4. An increasing number of local organisations adopt this strategy and commit to supporting it.

Final remarks

We call on everyone to consider this strategy, the at-risk groups identified and the risk factors, as well as the roles that each person and their organisations can play in working together in an even more cohesive and informed way, to deliver improved outcomes and ensure that the preventable is prevented, and that families and communities do not suffer the devastating impact that suicide brings.



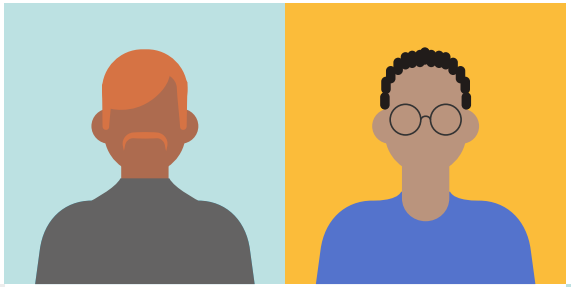
Endnotes

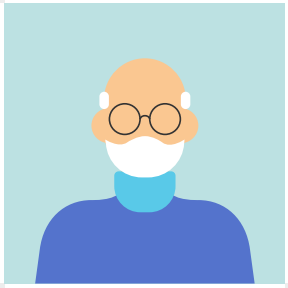
1 https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028/suicide-prevention-in-england-5-year-cross-sector-strategy#priority-areas-for-action
Suicide prevention strategy for England: 2023 to 2028, Dept. of Health and Social Care September 2023.

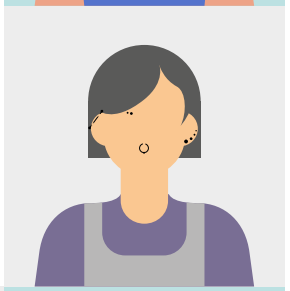
2 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2021registrations Suicides in England and Wales: 2021 Office for National statistics.

3 https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2022/MBRRACE-UK_Maternal_CORE_Report_2022_v10.pdf Knight M et al,. (2022). Saving Lives, Improving Mothers' Care Core Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20. Oxford: National Perinatal Epidemiology Unit.

4 https://www.npeu.ox.ac.uk/mbrrace-uk/reports MBRRACE-UK Saving Lives Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21.







For more information please visit:

https://www.kingston.gov.uk/kingston-suicide-prevention