

KENT AND MEDWAY MULTI-AGENCY SUICIDE PREVENTION STRATEGY 2015-2020

Final draft (v.15) for approval

This draft strategy has been updated following the public and stakeholder consultation in early 2015.

Acknowledgments

Thanks to all the members of the Kent and Medway Suicide Prevention Steering Group for their support in developing this strategy. Membership of the group includes individuals from the following organisations:

British Transport Police
Canterbury Christ Church University
Carers Representatives
Kent Coroners
Kent and Medway Partnership Trust (KMPT)
Kent County Council
Kent Police
Medway Council
Network Rail
NHS England
Rethink Mental Illness
The Samaritans
West Kent Clinical Commissioning Group (West Kent CCG)

Thank you too, to the many individuals and organisations who took part in the consultation events and completed the online consultation survey.

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1. *Introduction*

- 1.1 Every suicide is a tragic event which has a devastating impact on the friends and family of the victim, and can be felt across the whole community. While the events and circumstances leading to each suicide will be different, there are a number of areas where action can be taken to help prevent loss of life.
- 1.2 This strategy is a continuation of work undertaken as a result of the 2010-2015 Kent and Medway Suicide Prevention Strategy. While there has been progress in many areas, sadly suicide still accounts for approximately 1% of all deaths in Kent and Medway every year. Kent and Medway also has a higher rate of suicide than the national average (9.2 per 100,000 compared to 8.8 per 100,000 2011-2013 pooled data).
- 1.3 This strategy combines evidence from suicides in Kent with national research and policy direction. It is clear from both local and national experience that suicide prevention is not the sole responsibility of one agency; most progress can be made when the public sector, charities and companies work together to deliver a range of measures.
- 1.4 This is why this strategy has been developed by the Kent and Medway Suicide Prevention Steering Group which consists of a range of partners doing what they can (both individually and together) to reduce the number of suicides in Kent and Medway. A wider consultation process (featuring two consultation events and an online survey) took place between January and March 2015 to ensure that the widest number of individuals and organisations had their chance to input. (A review of the responses to the consultation is included as Appendix ii).
- 1.5 To ensure that this strategy does not discriminate unfairly against any particular group within Kent and Medway, an equality impact assessment (EqIA) was also undertaken during the drafting process. (The EqIA is included as Appendix iv).
- 1.6 The Suicide Prevention Steering Group will co-ordinate the delivery of the action plan and monitor progress against the strategic priorities at regular meetings and by providing updates to the Adult Social Care and Health Committee of Kent County Council (KCC) and the Medway Health and Wellbeing Board.

2. *National policy context*

- 2.1 Since the publication of Kent and Medway's 2010-2015 Suicide Prevention Strategy in 2010, the Coalition Government has published the *Preventing Suicide in England*¹ national strategy in 2012 and a 'One Year On' progress report in January 2014². The priorities contained within the 2012 national strategy match the strategic priorities within the *Kent and Medway Suicide Prevention Strategy 2010-15* very well, however the 'One Year On' national progress report identified six issues which will need further examination in a Kent and Medway context. These are;

- Self-harm
- Supporting people's mental health in a financial crisis
- Helping people affected or bereaved by suicide

¹ [Preventing suicide in England; A cross-government outcomes strategy to save lives](#)

² [Preventing suicide in England: One year on](#)

- Improve wellbeing and access to services for middle aged men
 - Improve wellbeing and access to services for children and young people
 - Improve data and information from coroners
- 2.2 In September 2012 the Department of Health published “*Prompts for local leaders on suicide prevention*”³ which is a checklist of questions designed to aid the development and implementation of local suicide prevention policies.
- 2.3 Other relevant policy developments have included Public Health England publishing the *Public Health Outcomes Framework 2013-2016*⁴ in November 2013 (which includes indicators on both suicide and self-harm), and the National Institute for Health and Care Excellence (NICE) issuing new guidance on self-harm in June 2013⁵.
- 2.4 In April 2014, the Coalition Government published an update to its mental health strategy⁶. It seeks ‘Parity of Esteem’ for people with mental health disorders and recommends that public services should reflect the importance of mental health in their policy planning by putting it on a par with physical health.
- 2.5 In 2014, The World Health Organisation produced a global report on suicide prevention (WHO 2014). It highlights that suicide occurs all over the world and can take place at almost any age. Globally, suicide rates are highest in people aged 70 years and over, although this does vary depending on the country. The report is a call for action to address suicide and it emphasises the importance of reducing access to means of suicide and ensuring that there is responsible reporting of suicide in the media and early identification and management of mental and substance use disorders in communities and by health workers in particular. WHO Member States have committed themselves to work towards the global target of reducing the suicide rate in countries by 10% by 2020.
- 2.6 In August 2014 the Chief Medical Officer’s Annual Report on Public Mental Health Priorities found that “It is increasingly apparent that suicide prevention in geographical areas must have sound backing from local authorities, including public health. Such agencies can provide the stimulus for important local initiatives and their evaluation”.⁷
- 2.7 More recently, (September 2014) Public Health England has published “*Guidance for developing a local suicide prevention action plan*”. The document gives local authorities further advice about how to develop a suicide prevention action plan, monitor data and trends as well as improving mental health in the area.
- 2.8 In February 2015 the Coalition Government published “Preventing suicide in England: Two years on”. This document highlighted three areas of England which have adopted a “Zero Suicide” ambition and asked other areas to consider the concept. As a result, the consultation process for this strategy did consider it, and more work will be done in the first year of the strategy to understand how the best elements of the approach can help Kent and Medway.
- 2.9 The development of this strategy has been shaped by the themes and principles contained within all of the documents referenced above.

³ [Department of Health Prompts for local leaders on suicide prevention](#)

⁴ [Public Health Outcomes Framework 2013-2016](#)

⁵ [NICE Guidance Quality Standard 34 self-harm](#)

⁶ [Making mental health services more effective and accessible](#)

⁷ [Chief Medical Officers Annual Report p 243](#)

3. *Kent policy context*

- 3.1 Since the development of the 2010-2015 Kent and Medway Suicide Prevention Strategy the context of mental health commissioning has changed greatly. CCGs have replaced PCTs and have assumed system leadership of mental health services, KCC and Medway Council remain the leads for social care and the respective Public Health departments lead on prevention and wellbeing. Health and Wellbeing Boards have been established and commissioning arrangements in relation to the criminal justice system, and drug and alcohol treatment services have also changed considerably.
- 3.2 The current strategy for mental health commissioning in Kent is the “Live It Well” strategy. This is due for a refresh in 2015. When considering the Suicide Prevention Strategy, it is important to note that it forms a part of a wider mental health strategy.
- 3.3 During the development of this Strategy, the Kent and Medway Crisis Care Concordat has been signed by over 30 agencies and organisations all committing to give better support to those individuals who experience a mental health crisis. The Suicide Prevention Steering Group will maintain close links with the Concordat to share learning and ensure the impact of any actions are maximised.

4. *Current statistics*

- 4.1 There has been an increase in the annual number of people taking their own life in Kent and Medway. This section sets out a number of statistics relating to those suicides and the information has been used to shape the strategic priorities contained in Section 5 of this strategy.

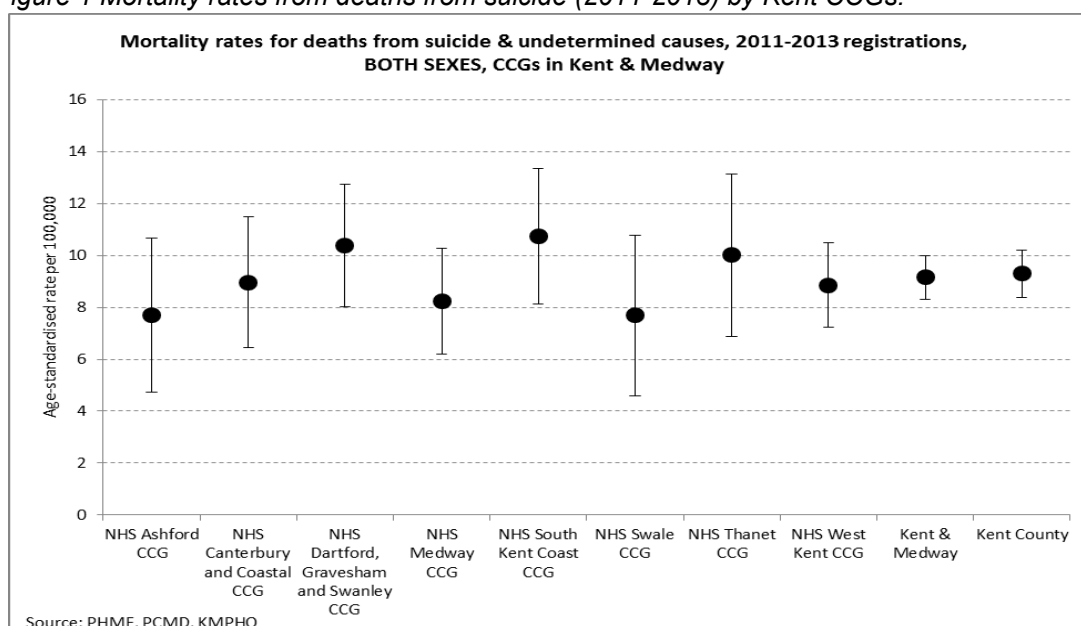
Table 1: Annual number of deaths from suicide and undetermined causes, CCGs in Kent & Medway, both sexes, 2002-2013 registrations

Area	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
NHS Ashford CCG	13	9	3	11	7	9	4	6	7	7	5	14
NHS Canterbury and Coastal CCG	12	16	16	16	16	17	10	20	13	14	15	21
NHS Dartford, Gravesham and Swanley CCG	22	28	27	16	18	22	8	21	15	23	23	28
NHS Medway CCG	23	12	20	21	23	22	14	19	14	13	20	31
NHS South Kent Coast CCG	17	26	20	27	13	20	12	19	18	25	22	18
NHS Swale CCG	4	7	16	8	12	5	8	11	9	3	8	13
NHS Thanet CCG	9	15	15	8	12	17	11	13	8	17	14	9
NHS West Kent CCG	39	35	31	39	36	36	35	42	30	30	38	48
Kent & Medway	139	148	148	146	137	148	102	151	114	132	145	182

Source: PHMF, PCMD, KMPHO

- 4.2 The data in Table 1 shows the number of deaths from suicide and undetermined causes for the different Clinical Commissioning Groups (CCGs) across Kent and Medway. There was a considerable increase in the overall number of suicides in 2013 compared to any of the previous years. The rates of suicide across Kent CCG’s (Fig 1 on next page) show that Thanet, South Kent Coast and Dartford, Gravesham and Swanley CCG’s have higher rates than the Kent average.

Figure 1 Mortality rates from deaths from suicide (2011-2013) by Kent CCGs.



- 4.3 The Kent and Medway rate of 9.2 suicides per 100,000 population (2011-2013 pooled data) is higher than the national rate of 8.8 per 100,000 (2011-13 pooled data).
- 4.4 However these rates mask the gender differences in suicide. Males are more likely to commit suicide than females (Figs 2 & 3). The rate for males in Kent and Medway (2011-13) is 14.5 deaths per 100,000 people. Nationally the rate is 13.8 per 100,000 for men. For females in Kent and Medway, it is 4.2 deaths per 100,000 compared to 4.0 nationally. This highlights the need for prevention services to be targeted towards men, who traditionally are low users of services such as talking therapies.
- 4.5 For males the rates are higher in Canterbury and Coastal, Dartford, Gravesham and Swanley, South Kent Coast and Thanet CCGs. Rates for females are highest in West Kent and Ashford CCGs.

Figure 2. Mortality rates from suicide and undetermined causes, Kent & Medway, by year of registration and gender, 2002-2013

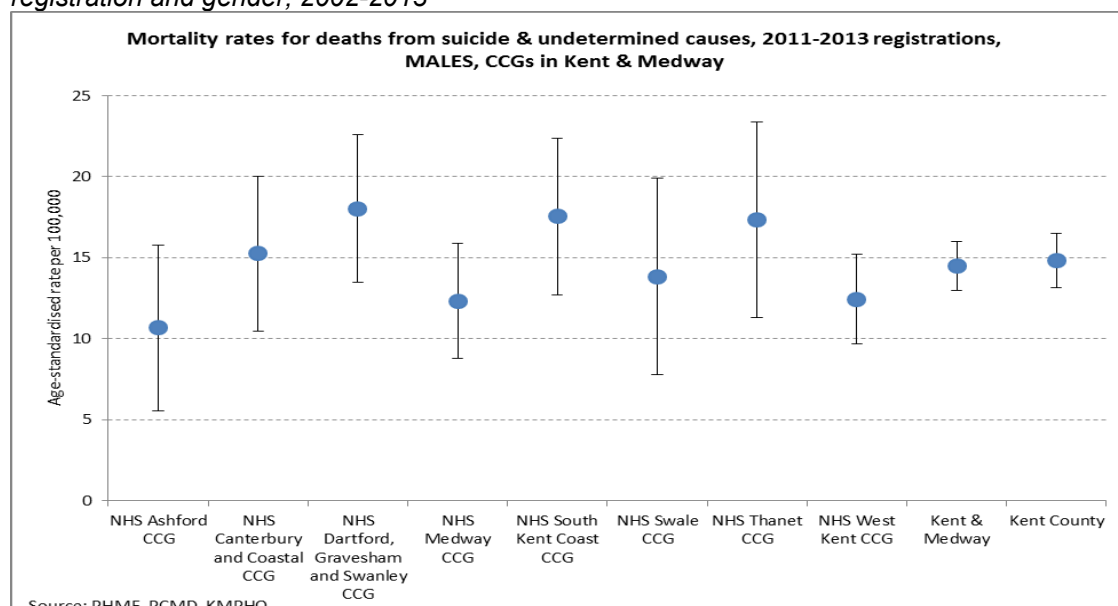
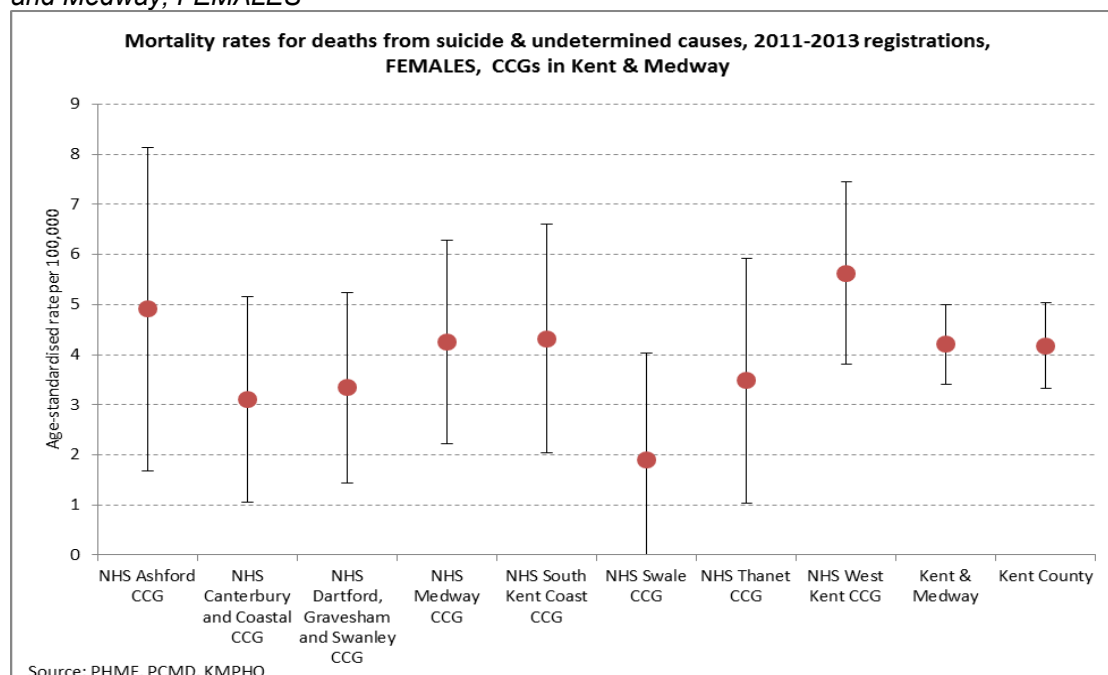


Figure 3: Mortality rates for suicide and undetermined causes, 2011 – 2013 (pooled), CCGs in Kent and Medway, FEMALES



4.6 Gender and age

Figures 4 and 5 show the number of deaths from suicide and undetermined causes for Kent & Medway, by age band and gender between 2002-2013 and the number of deaths from suicide and undetermined causes, Kent & Medway, by age band and gender. The data show that the suicide numbers are considerably higher in men for all age categories. The highest numbers are in men aged between 40 and 54 years old.

Figure 4 Numbers of suicide by year of registration and gender

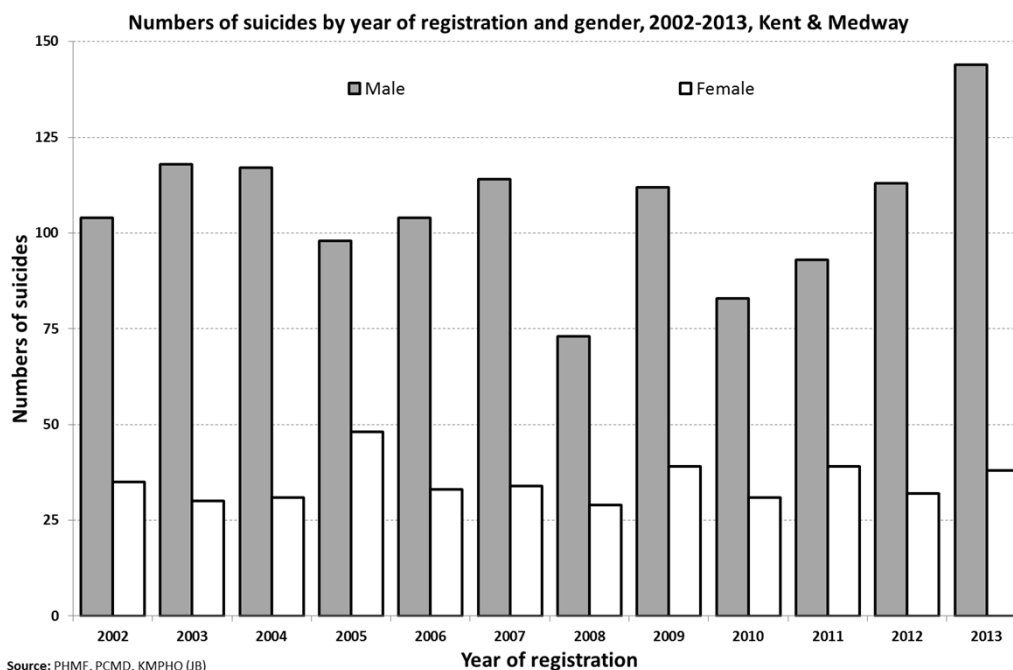
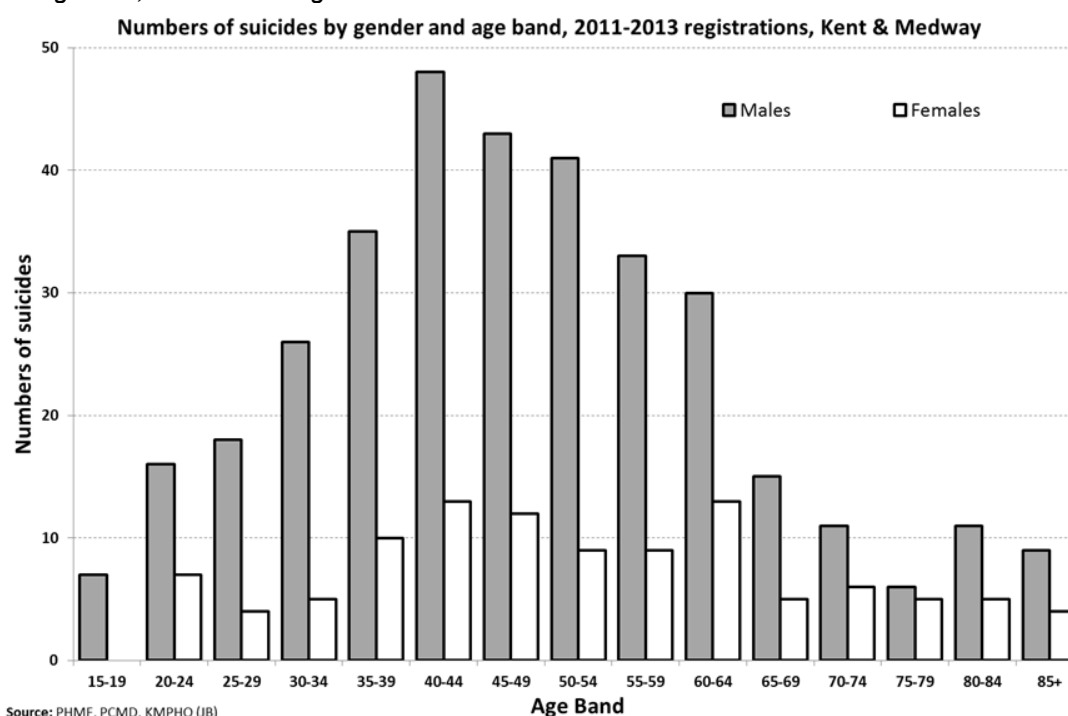


Figure 5: Numbers of deaths from suicide and undetermined causes, Kent & Medway, by age band and gender, 2011-2013 registration.



4.7 Country of birth

Coroners do not currently record ethnicity on death certificates, however they do record country of birth. While this is not a good indication of ethnicity, in order to see if there were any notable trends, the Kent and Medway Public Health Observatory has examined the country of birth of 1730 individuals in Kent who took their life between 2002 and 2013. The vast majority were born in England, and the next two most frequent countries of birth were Scotland and Wales. However eleven people born in Poland, nine born in India, and eight born in Germany have killed themselves in Kent between 2002 and 2013.

4.8 As part of the implementation of this strategy, the Steering Group will monitor suicide statistics relating to country of birth and work with other agencies (both locally and nationally) to try and improve the ability to assess the risk of suicide within ethnic groups.

4.9 Occupation

The coalition Government's 2012 Preventing Suicide in England strategy identified that "some occupational groups are at particularly high suicide risk. Nurses, doctors, farmers and other agricultural workers are at higher risk probably because they have ready access to the means of suicide and know how to use them."⁸

4.10 However it goes on to say that "Risk by occupational group may vary regionally and even locally. It is vital that the statutory sector and local agencies are alert to this and adapt their suicide prevention interventions and strategies accordingly."⁹

⁸ P.19

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216928/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

⁹ Same reference as 7

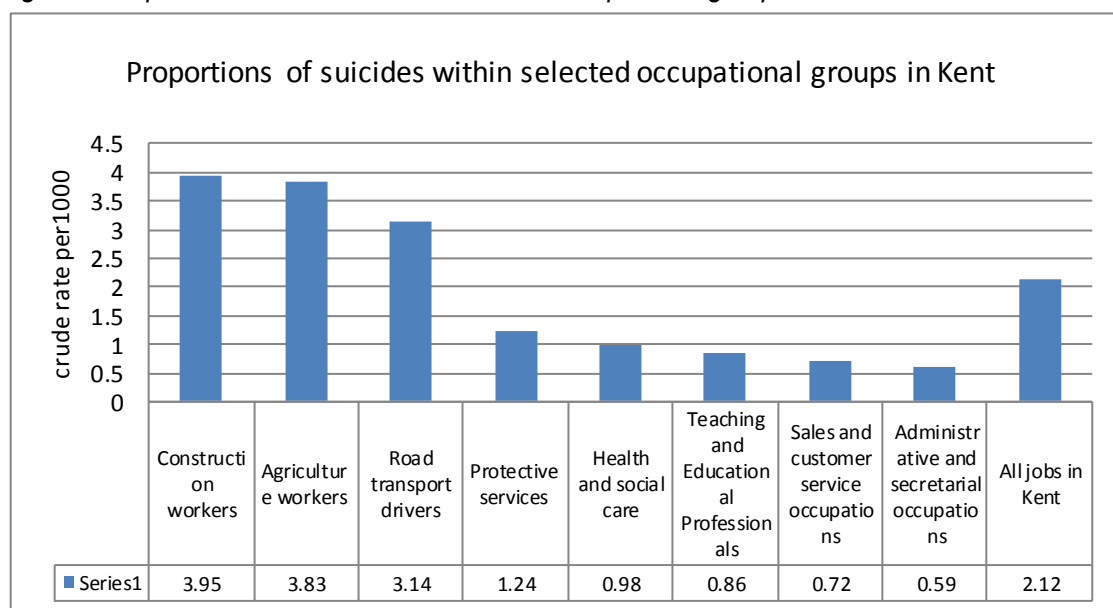
- 4.11 It is for this reason that during the preparation of this Strategy, the Kent Public Health Observatory examined the occupation (as written by the Coroner on the death certificate) of 1730 individuals in Kent who took their life between 2002 and 2013.
- 4.12 The following table groups the occupations into categories, and shows that the highest numbers of suicides are within the “Professional and managerial” and the “Construction, transport and building trades” categories.

Table 2 Occupations of suicide victims in Kent between 2002-2013 KMPHO

Occupation type	Numbers of suicides in Kent between 2002 and 2013
Professional and managerial	497
Construction, transport and building trades	462
Sales, services and administration	290
Health and personal services	105
Leisure, media and sport	74
Agriculture	50
Protection services	42
IT, Science and Engineering	41
Unknown	169
Total	1730

- 4.13 It is important to note that these are *numbers* rather than *rates* and do not take into account the scale of the differences within these occupations in Kent. The chart below matches the numbers of suicides with the number of people within each occupation in Kent (as taken from the 2011 Census) to calculate a crude rate. Although this data should be met with some caution, it does give an indication of which occupations are more vulnerable.

Figure 6 Proportion of suicides within selected occupational groups in Kent 2002-13



Source: Kent Public Health 2014 and the 2011 Census

4.14 Figure 6 shows that construction workers had the highest crude rates of suicide of any occupation group between 2002-13, closely followed by agricultural workers. Road transport drivers also had a rate well above the average for all jobs in Kent and Medway. Agricultural workers were one of the high risk occupations identified nationally, however construction workers and road transport drivers were not. Health workers in Kent and Medway have a comparatively low rate despite being one of the nationally highlighted high risk occupations.

4.15 Method of suicide

Figure 7 shows the total numbers of deaths from suicide and undetermined causes broken down by method. It compares the 2004-2008 period with 2009-2013. The data show that between 2009-2013, there were more suicides via hanging and jumping in comparison to 2004-2008, although there were fewer people taking their own life via gas and smoke.

Figure 7 Total numbers of deaths from suicide and undetermined causes, comparing 2004-8 with 2009-13, males and females, main suicide method, Kent and Medway

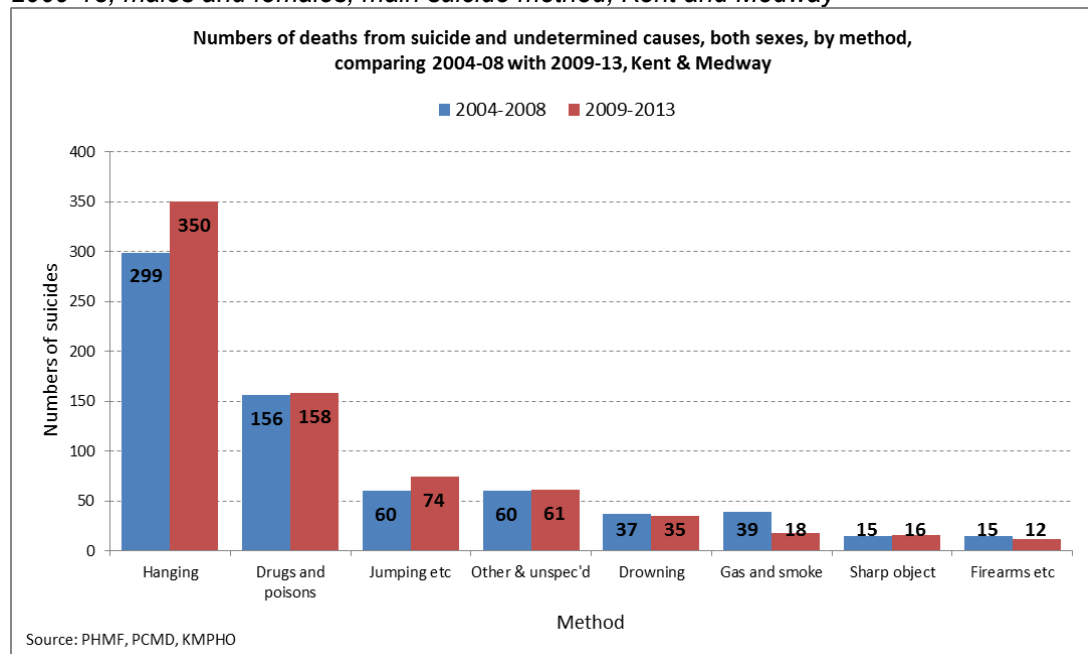
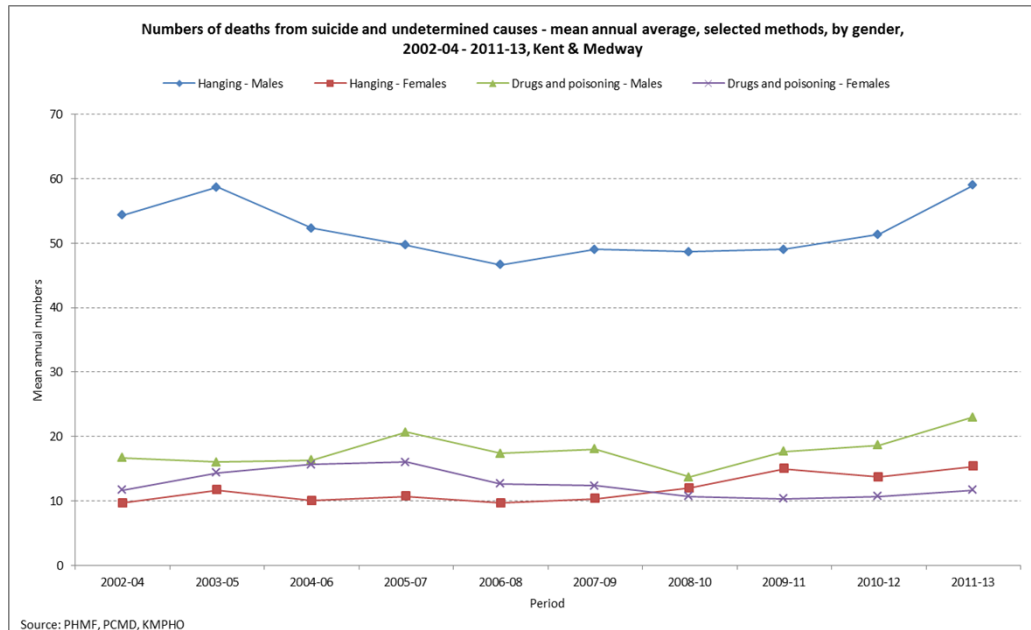


Figure 8 (following page) shows the annual average numbers of deaths from suicide and undetermined causes from selected causes for males and females between 2002 and 2013.

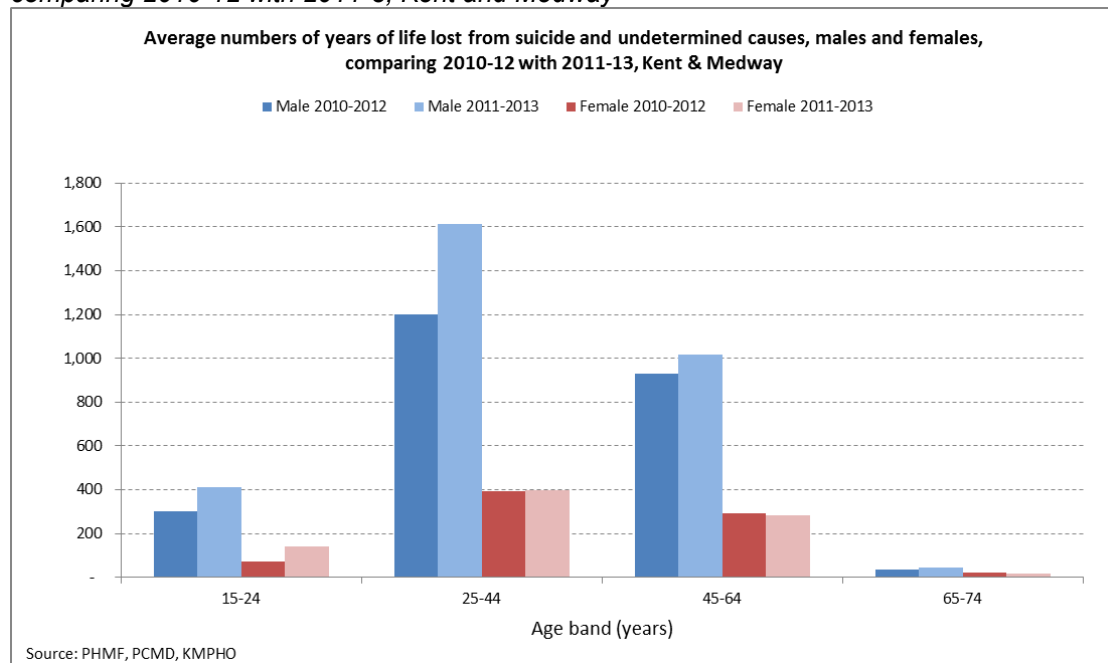
Figure 8: Annual average numbers of deaths from suicide and undetermined causes, 2002-4 – 2011-13, males and females, main suicide method, Kent and Medway



4.16 Years of life lost

Figure 9 shows the annual average years of life lost from suicide and undetermined causes, males and females comparing 2010-12 with 2011-13. As one would expect, the average years of life lost is considerably greater in younger men aged between 25 and 44 years of age. However, the number of life years lost in men in this age group increased by 33% in 2011-2013.

Figure 9: Annual average years of life lost from suicide and undetermined causes, males and females comparing 2010-12 with 2011-13, Kent and Medway



4.17 Self-harm

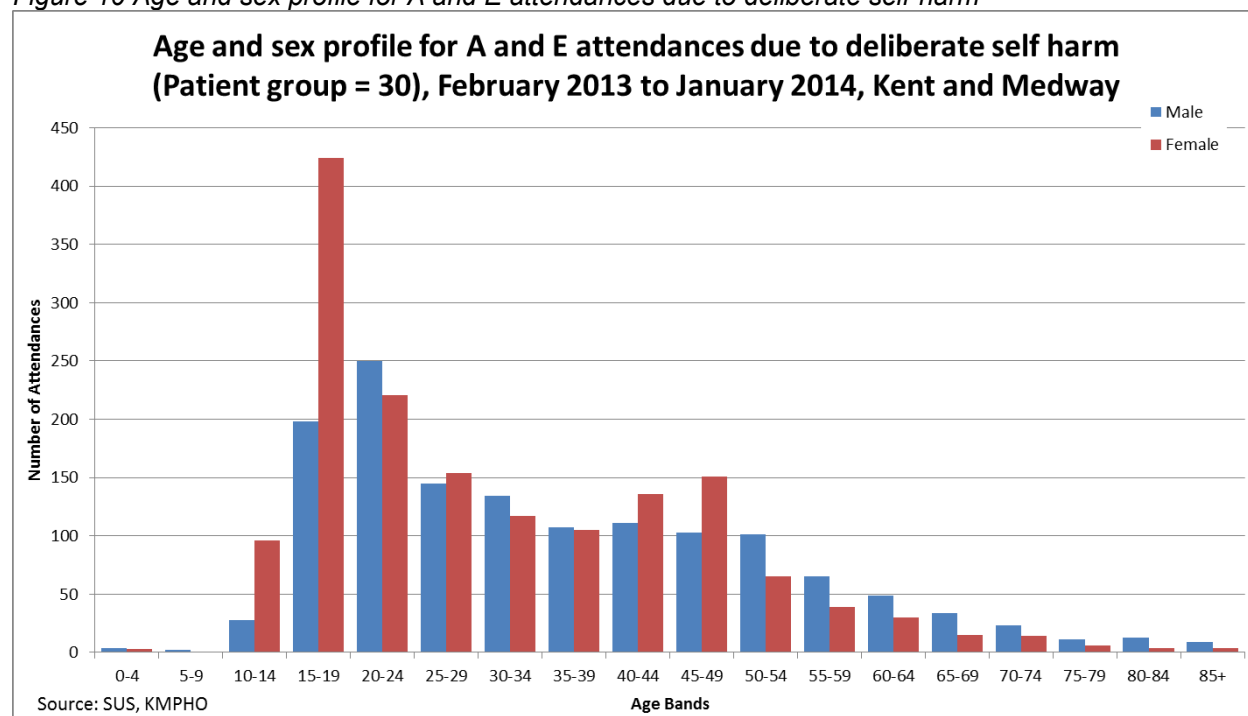
Not everyone who self-harms is suicidal, and not everyone who takes their own life self-harms first. However for some people self-harm can be an indicator that they are suffering from depression or another mental illness. Across England the average rate of admissions as a result of self-harm amongst 10-24 year olds is 346.3 per 100,000. Table 3 shows that the Kent rate in the same time period was 364.2, and increased in the following year.

Table 3 Age-Standardised Rate (ASR) per 100,000 10-24 year olds for hospital admissions as a result of self-harm

Persons	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
	ASR	ASR	ASR	ASR	ASR
NHS Ashford CCG	306.7	314.7	282.0	260.7	440.9
NHS Canterbury & Coastal CCG	397.1	409.8	374.8	313.7	395.0
NHS Dartford, Gravesham & Swanley CCG	405.5	428.7	395.8	360.2	354.9
NHS South Kent Coast CCG	462.1	376.3	386.7	496.8	506.3
NHS Swale CCG	516.6	379.5	485.2	233.0	311.7
NHS Thanet CCG	541.2	627.9	618.0	473.7	475.5
NHS West Kent	479.5	399.8	376.1	365.1	439.8
Kent	443.2	415.2	400.5	364.2	416.3

4.18 Figure 10 shows that the highest number of A&E attendances for deliberate self-harm come from young women between the ages of 15 and 19.

Figure 10 Age and sex profile for A and E attendances due to deliberate self-harm



5. *Review of 2010-2015 Strategy*

5.1 The 2010-15 Kent and Medway Suicide Prevention Strategy focused on the following priorities:

- To reduce risk in key high risk groups
- To promote wellbeing in the wider population
- To reduce the availability and lethality of suicide methods
- To improve the reporting of suicidal behaviour in the media
- To ensure appropriate monitoring of suicide statistics and audit of services.

5.2 During the lifetime of the strategy, progress in relation to each of the priorities has included the following;

- **To reduce risk in key high risk groups**
 - Men's sheds, and other men's health groups, have been established across Kent and Medway to bring men together to put their practical skills to good use and encourage them to be more socially active and improve mental wellbeing
 - Primary Care Mental Health link workers have been commissioned in Kent to provide extra support to people with mental health conditions in the community
 - KMPT have developed a suicide prevention strategy and action plan. A number of actions have been completed including a ligature audit with appropriate actions implemented, a GRIST risk assessment tool (a psychological model of how people think and reason) being piloted and training on Applied Suicide Intervention Skills has been delivered
 - Kent Drug and Alcohol Action Team serious incident review panel have reviewed all cases of suicide in contact with alcohol and drug services at the time of death
 - Research has been conducted into Suicide and Older People within Kent by Canterbury Christ Church University
 - Health professionals in Kent and Medway have been offered a variety of training around self-harm awareness and suicide prevention (safe assessment, triage, providing an immediate response).
- **To promote wellbeing in the wider population**
 - Kent County Council has commissioned Sevenoaks Area Mind to deliver a series of free to access Mental Health First Aid training courses. These courses are designed to help people recognise mental health problems and encourage someone to seek help
 - Free to access psychological support is available across Kent and Medway through the IAPT 'Talking therapies' programme
 - Kent County Council and Medway Council have both launched wellbeing programmes to help people take little steps and make a big difference to their wellbeing. (Kent has Six Ways to Wellbeing, while Medway has Five Ways to Wellbeing)
 - "Help is at Hand" suicide bereavement support packs have been distributed across Kent and Medway including to GP surgeries for people bereaved by suicide
 - ASIST (Applied Suicide Intervention Skills Training) has been delivered in Medway and Kent
 - SAFE is a youth-led project delivered by Voluntary Action Within Kent (VAWK). It seeks to raise awareness of mental health, reduce suicide, break down stigma, and encourage young people to talk about their feelings, recognise the danger signs and to seek support - if and when they need it.

SAFE has been set up within three Medway schools with the help of volunteers from the Upper Years and Sixth Form.

- **To reduce the availability and lethality of suicide methods**
 - Work has been undertaken with local agencies to identify hotspots and take appropriate action to minimise further suicides. Examples include, Kent County Council working with Samaritans regarding sign installation at a bridge over the M20 in Ashford, Medway Council has put up Samaritans signage and is also considering further hardening measures at Brook car park in Chatham.
- **To ensure appropriate monitoring of suicide statistics and audit of services.**
 - Relationships with National Rail, Kent Police, KMPT and the Coroner have been developed and improved and agencies regularly share statistics (where appropriate) so that trends can be monitored.

5.3 There is potential to continue to make improvements in a number of areas through the 2015-2020 strategy including;

- More activity focussing on the issue of self-harm
- Supporting families bereaved by suicide
- Implementing the results of evidence reviews around suicide and older people

6. *Strategic priorities*

6.1 When deciding on the strategic priorities, consideration has been given to both local statistics, and national guidance. While local insight will shape how each priority is delivered within Kent and Medway, the Kent and Medway Suicide Prevention Steering Group has agreed that there is nothing particularly different about suicidal behaviour locally which would mean that national objectives would not be appropriate here. This decision was very strongly supported through the consultation process. Therefore the strategic priorities that this strategy adopts mirror the national areas for action almost exactly. They are as follows;

- i.* Reduce the risk of suicide in key high-risk groups
- ii.* Tailor approaches to improve mental health and wellbeing in Kent and Medway
- iii.* Reduce access to the means of suicide
- iv.* Provide better information and support to those bereaved or affected by suicide
- v.* Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- vi.* Support research, data collection and monitoring

6.2 More details about how each of these strategic priorities will be shaped and delivered in Kent and Medway is given below, and they form the structure for the draft action plan which is attached to this report.

6.3 Priority i. Reduce the risk of suicide in high-risk groups

The national strategy identified the following high risk groups as priorities for action:

- Young and middle aged men
- People in the care of mental health
- People with a history of self-harm

- People in contact with the criminal justice system
- Specific occupational groups such as doctors, nurses, veterinary workers, farmers and agricultural workers.

6.4 A year after the national strategy was launched, the coalition published their *One Year On* report which identified that middle age men (aged 35-54) were now the group with the highest suicide rate. The *One Year On* report also suggested that Children and Young People should also now be a particular focus for national prevention work.

6.5 Having considered the nationally identified high-risk groups, as well as local data and the results of the public consultation, the Kent and Medway Suicide Prevention Steering Group have identified the following groups as being of particular concern in Kent:

- Those in contact with mental health services
The 2014 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness found that between 2002 and 2012 suicides by people known to secondary mental health services accounted for 28% of the total number of UK suicides.¹⁰ In Kent and Medway there were 36 coroner confirmed suicides in 2013 who had had contact with KMPT in the previous 12 months.

The Steering Group will continue to engage with the Mental Health Crisis Concordat Steering Group and providers of secondary mental health services in Kent and Medway to help them with their efforts to reduce suicides in this population. Specific actions to address this issue are included in the accompanying action plan.

- Those who have self-harmed
During the early stages of the consultation process for this strategy, stakeholders raised a particular concern regarding levels of self-harm. As a result, Medway Public Health hosted a consultation event focusing entirely on this issue. During the event over 70 stakeholders discussed the reasons why people self-harm and statistics relating to the local prevalence of self-harm. The event identified that more support needs to be given to people who self-harm before they reach a level where they attend A&E or are admitted to hospital. Specific actions to address this issue are included in the accompanying action plan.
- Offenders
During the development of this strategy it became apparent that there has been a sharp increase in the national number of prisoners taking their own lives while in custody. Discussions with local prison representatives and NHS England (who commission health services in prison) confirmed that this was a trend that was also being seen in Kent and Medway. The Howard League for Penal Reform identified that HMP Elmley (in Sheppey) and HMP Wandsworth (in London) had both seen four inmate suicides in 2013 which is the higher than any other prison in England.¹¹ Specific

10

actions to address this issue are included in the accompanying action plan.

- Middle aged and older men
The suicide rate for men in Kent and Medway (2011-13) is 14.5 deaths per 100,000 people. Nationally the male rate is 13.8 per 100,000. As Figure 5 on page 6 shows, middle aged and older men have the highest rates of suicide in Kent and Medway. This fits the national pattern and it is often believed that it is a result of this group not accessing support services as readily as other groups, and also because they choose more violent (and likely to complete) methods of suicide attempt. This group was a priority under the previous strategy and a number of initiatives (like Men's Sheds) have already started. Further specific actions to address this group (such as a communications campaign) are included in the accompanying action plan.
- High risk occupation groups such as construction, agriculture and road transport drivers
The research undertaken as part of this strategy development has identified that certain occupation groups have higher suicide rates than others. The Steering Group will identify the best way to work with these occupations and specific actions to address these groups will be included in future versions of the action plan.

6.6 There was a strong feeling amongst some stakeholders that the strategy shouldn't focus too heavily on particular groups in case it missed opportunities to intervene in the general population. Therefore the Steering Group will ensure that it monitors statistics and trends in all groups, as well as the general population, and will review which and how many groups it prioritises regularly.

6.7 Priority ii. Tailor approaches to improve mental health and wellbeing in Kent and Medway

Not everyone who has a mental illness will be suicidal, and not everyone who takes their own life will have been diagnosed with a mental illness. Therefore as well as ensuring that mental health services provide the best possible support to those they come in contact with, wider support to improve the mental health and well-being of other groups and the general population is needed.

6.8 The Live It Well mental health strategy is designed to improve mental health across Kent and Medway. As well as helping people stay well, it focuses on ensuring that people with mental health needs – which will be one in four of us at some point in our lives – get the care they need. It sets out a vision for promoting mental health and well-being, intervening early and providing personal care when people develop problems, and focusing on helping people to recover.

6.9 The Live it Well strategy is supplemented by a detailed website (www.liveitwell.org.uk) which is an excellent source of information, help and guidance and is designed to help people connect with their local communities. It also provides the contact details of over 400 charities, community groups and supports services which provide help to individuals with a wide range of mental health issues.

¹¹ <http://www.howardleague.org/suicide-in-prison/>

- 6.10 As part of the Live it Well strategy, Kent County Council launched the Six Ways to Wellbeing campaign and Medway Council has launched the Five Ways to Wellbeing campaign. Both campaigns are designed to raise the levels of wellbeing by helping individuals to make small actions which make a big difference to their mood and mental resilience.
- 6.11 The campaigns are based on research undertaken by the New Economics Foundation Scientific (2010). The research points to five steps that can improve mental wellbeing. They are;
- Taking notice
 - Connecting
 - Giving
 - Keep learning
 - Being active
- 6.12 Kent's Six Ways of Wellbeing also include Caring (for the planet) as an additional step.
- 6.13 Mental Health First Aid (MHFA) training is one way to increase awareness and reduce stigma about mental illness and the Steering Group will continue to promote the MHFA courses being funded by KCC Public Health, and those being delivered by Medway Public Health.
- 6.14 Raising awareness of mental illness, reducing stigma and ensuring that individuals have easy ways to access support for low level mental health conditions is an important way of reducing the likelihood that they will need more intensive support in the future. The Steering Group will continue to promote campaigns and services such as the Mental Health Matters 24hr support line and the wide range of NHS talking therapies.
- 6.15 In addition to campaigns aimed to improve the mental health of the whole population, the Steering Group and the public consultation identified that the following groups are at particular risk of poor mental health and therefore need specific activities to address their needs. The Steering Group doesn't have capacity to develop specific interventions for each of these groups, however by identifying them in this strategy the Steering Group recommends that commissioners and service providers do provide extra support wherever possible. Groups which aren't on the list will not be ignored, and the list will be reviewed regularly.
- Socially excluded and deprived groups
 - BME communities
 - Domestic abuse victims and survivors
 - Women during and after pregnancy
 - Young people leaving care
 - Children and young people
 - Students
 - Older people (especially those who have recently lost long term partners)
 - People who misuse drugs and alcohol
 - Veterans
 - LGBT
 - People experiencing financial crisis
 - People experiencing relationship difficulties

- Offenders/ex-offenders
- People bereaved by suicide
- People with new diagnosis of disability or terminal illness

6.16 Priority iii Reduce access to the means of suicide

Research has shown that work to reduce the availability and lethality of suicide methods is effective in preventing deaths. Suicidal intent can fluctuate with time and therefore actions which make it more difficult for people to take their own life can prevent deaths by deterring suicide until the level of intent subsides.

6.17 At the national level, restrictions on the amount of paracetamol products which can be bought in one transaction, and the fitting of catalytic converters on cars as standard, have been credited with reducing the number of suicides by poisoning and inhalation respectively.

6.18 At a local level, the Suicide Prevention Steering Group includes members from KMPT and Network Rail, two organisations who continue to take action to make it more difficult for individuals to take their own lives. For instance KMPT undertake regular audits of their wards to reduce the number of ligature points, and Network Rail monitor incidents on tracks and at stations and take action to make it more difficult for members of the public to access railway lines.

6.19 The Suicide Prevention Steering Group will regularly monitor statistics concerning the method and location of suicides in Kent to establish whether further action is needed to reduce the access to particular means of suicide.

6.20 Priority iv Provide better information and support to those bereaved or affected by suicide

Losing a loved one in any circumstance is difficult, losing someone to suicide can bring additional layers despair. It is not surprising that family and friends bereaved by suicide are at an increased risk of mental health and emotional problems.

6.21 This subject was the focus of a detailed session at the consultation event hosted by Kent Public Health, where over 60 stakeholders discussed what support families and friends need when they lose a loved one to suicide. These were the key points from the consultation:

- Specialist bereavement by suicide counselling should be offered rather than general counselling
- Support should be offered in an ongoing manner, rather than as a one off
- There should be better promotion of support groups such as Survivors of Bereavement by Suicide (SOBS) and Slideaway
- Family counselling needs to be available

6.22 Voluntary sector charities and organisations can be particularly effective in supporting bereaved families and GPs, primary care professionals and other agencies need to be attentive to the vulnerability of family members and aware what support is available.

6.23 Post-suicide interventions for schools have also been created by organisations such as the Samaritans and Voluntary Action Within Kent. The SAFE initiative encourages young people within their schools to consider their mental health and signpost those

who would like to seek more support. Through peer to peer support and signposting, the project aims to break down the stigma surrounding mental health.

6.24 During the development of this strategy discussions were had with a representative of the Survivors of Bereavement by Suicide (SOBS) charity who have a number of support groups running across the county. SOBS have been invited to join the Steering Group to give expert advice about how families can be supported better. Further specific actions to address this group are included in the accompanying action plan.

6.25 Priority v Support the media in delivering sensitive approaches to suicide and suicidal behaviour

The media have a significant influence on behaviours and attitudes and there is evidence that the reporting and portrayal of suicide can lead to copycat behaviour among young people and those at risk.

6.26 It is important that the media is supported to raise awareness to prevent suicides. For example, campaigns focused on World Suicide Prevention Day could be promoted each year. The media also needs to be monitored in relation inappropriate reporting of suicide and support should be given to help them improve their coverage.

6.27 The Suicide Prevention Steering Group will continue to monitor local media and aims to develop relationships with representatives of the media in order to support improved reporting of suicide coverage in the media.

6.28 While the internet can be used to provide excellent support to vulnerable individuals who would otherwise be reluctant to access services, there is growing awareness of the use of social media and websites to promote suicidal ideology and risky behaviours such as self-harm. As a local Suicide Prevention Group there is very little that the Steering Group can do to police what is available on the world wide web, but it will support the efforts of the KCC e-Safety Officer and others to raise awareness of professionals and parents about what is online and how they can help to reduce the likelihood that young people in Kent and Medway will access it. Just as importantly, the Steering Group will also support efforts to raise awareness amongst young people themselves so that friends are better able to support each other.

6.29 Priority vi Support research, data collection and monitoring

6.30 Ensuring that there is reliable and timely data on suicides and self-harm is vital when deciding how to prioritise actions. The Suicide Prevention Steering Group will regularly review and share available data on suicides in Kent and Medway to be sure that the correct priorities are being addressed.

6.31 The Group will also utilise other data sources that are not routinely or systematically reported. This is likely to include data from the coroner's office, Kent Police, Network Rail and Kent and Medway Social Care Partnership Trust (KMPT). The data should be regularly monitored by key partners and relevant actions will be taken.

6.32 Having an awareness of the research that has been conducted around suicide prevention is also fundamental to improve understanding of risk groups and developing and evaluating interventions that can be effective in preventing suicides. This awareness can be improved by utilising working relationships with academic institutions, who could disseminate relevant research, journal articles, reports and publications to key stakeholders working to prevent suicides in Kent and Medway.

6.33 For example, in 2014 Canterbury Christ Church University undertook a research project on older people and suicide. This work has been presented to the Steering Group and has been considered as part of this strategy development process.

Appendix i Suicide Prevention Action Plan

Priority 1: To reduce risk in key high risk groups

The following key high risk groups have been identified by Kent and Medway Suicide Prevention Steering Group following the public consultation:

- Those in contact with mental health services
- Those who have self-harmed
- Offenders
- Middle aged and older men
- High risk occupation groups such as construction, agriculture and road transport drivers

Action needed	Lead agency/contact	Estimated completion date
1) KMPT to implement and continually review their suicide prevention strategy	KMPT	Ongoing
2) Support and promote the Kent and Medway Crisis Care Concordat - Work with partners to implement the Concordat and associated action plan to support people in crisis due to a mental health condition	Kent Police, West Kent CCG	Ongoing
3) Kent and Medway Public Health to meet with KMPT to discuss “zero-suicide” concept	KCC, Medway Public Health and KMPT	Summer 2015
4) Suicide Prevention Steering Group members to share learning from the consultation event with the Emotional Health and WellBeing Strategy Groups and contribute to their review of the self-harm pathway	KCC and Medway Public Health	Summer 2015
5) Public Health to examine how early intervention schemes for self-harm can be rolled out across the county	Public Health	
6) Canterbury Christ Church University to review the current statistics relating to suspected suicides in Kent prisons and consider what more can be done to prevent future suicides	Canterbury Christ Church University	Summer 2015
7) KCC Public Health to develop a campaign with partners to raise awareness of mental health issues amongst men	KCC Public Health	September 2015 – May 16
8) Continue to develop a network of Men’s Sheds across Kent and Medway	Public Health	Ongoing
9) Establish contact with appropriate representatives within each high risk occupation group and consider what interventions may be appropriate to reduce the risk of suicide	Public Health	Autumn 2015

Priority 2: Tailor approaches to improve mental health and wellbeing in Kent and Medway

As well as including wellbeing interventions aimed at the whole population, the Kent and Medway Suicide Prevention Steering Group has identified the groups which may need additional support to improve their mental health and wellbeing.

- Socially excluded and deprived groups
- BME communities
- Domestic abuse victims and survivors
- Women during and after pregnancy
- Young people leaving care
- Children and young people
- Students
- Older people (especially those who have recently lost long term partners)
- People who misuse drugs and alcohol
- Veterans
- LGBT
- People experiencing financial crisis
- People experiencing relationship difficulties
- Offenders/ex-offenders
- People bereaved by suicide
- People with new diagnosis of disability or terminal illness

10) KCC and Clinical Commissioning Groups to develop a new Community and Wellbeing Service to support people with wellbeing and mental health needs	KCC and CCGs	April 2016
11) Work with Kent Police to provide frontline officers with awareness and information cards relating to local mental health services	Public Health and Kent Police	December 2015
12) Commission free to access Mental Health First Aid training	Public Health	Ongoing
13) Continue to roll out the Five / Six Ways to Wellbeing campaigns in Medway / Kent respectively	Public Health	Ongoing
14) Continue to promote NHS Talking Therapies (also known as IAPT)	Public Health	Ongoing
15) All agencies to share relevant information to enable timely monitoring and response of suicide and suicide attempts in Kent and Medway	All	Ongoing

PRIORITY 3: Reduce access to the means of suicide		
16) All agencies to work together to identify and manage hotspots for both completed suicide and suicide attempts in a timely manner	All agencies	Ongoing
17) Relevant agencies to take appropriate measures in relation to common suicide methods and at identified hotspots	All agencies	Ongoing
PRIORITY 4: Provide better information and support to those bereaved or affected by suicide		
18) Invite a representative from Survivors of Bereavement by Suicide to join the Steering Group	Steering Group Chair	Complete
19) Investigate the issue at a future meeting of the Steering Group to develop further actions	Steering Group Chair	Autumn 2015
20) Ensure that the support pack "Help is at Hand" and details of local support groups such (as SOBS) are distributed to as many frontline staff in appropriate occupations (eg health, police) as possible	Public health	Ongoing
PRIORITY 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour		
21) KCC Communications department to re-define search terms of media monitoring to ensure that coverage of suicides are analysed	Public Health	Complete
PRIORITY 6: Support research, data collection and monitoring		
22) Prepare and present regular suicide statistics and trends based on research and statistics provided from all relevant agencies, service providers and other available sources	KMPHO	Ongoing

Appendix ii Review of Responses to the Public Consultation

Consultation Process

The consultation process on the draft 2015-2020 Suicide Prevention Strategy consisted of three main features;

1) A stakeholder event focusing on the issue of self-harm (Feb 26th 2015)

Hosted by Medway PH over 70 stakeholders discussed a wide variety of issues relating to self-harm. There was a presentation given by Medway Public Health and two organisations (KCA and VAWK) discussed how they were tackling the issue in different parts of Kent. The main points to come out of the discussion were;

- The need for early identification and intervention in relation to self-harm
- Need greater use of peer support
- Need continued education for parents and staff
- Need to address the gap between school counselling and CAMHS
- Need more funding and a higher profile

2) A stakeholder event to develop the action plan relating to the draft Suicide Prevention Strategy (March 18th 2015)

Hosted by KCC Public Health, over 60 stakeholders (including service users, carers, charities, treatment providers and voluntary groups) discussed the priority groups which should be addressed by the Strategy and Action Plan, as well as prioritised some of the potential actions. Presentations were given by KCC Public Health, the Samaritans and KMPT. The main points to come out of the session were;

- There was overwhelming support for the draft priorities within the draft strategy
- There was a high level of agreement that the key groups identified by the draft strategy are the right ones to focus on. However there was a strong feeling that the strategy shouldn't focus on particular groups to the detriment of population level measures
- There was strong agreement that bereaved families and carers should be supported better, with suggestions as to how that could happen

3) An online consultation

The KCC Engagement Team hosted an online survey on the KCC website in relation to the draft strategy for approximately nine weeks. Although there were a disappointing number of responses (only 11) it was decided by the Suicide Prevention Steering Group not to extend the consultation period because:

- There was very good stakeholder engagement at the two consultation events and as part of the steering group
- The responses that were received were very supportive of the strategic approach and the draft priorities
- The online consultation was advertised widely through the Mental Health Action Groups and Healthwatch

Although there was strong support for the strategic approach a number of respondents to the online survey which criticised the care that individuals were currently receiving, particularly those in crisis.

Impact to the Strategy and Action Plan following the public consultation

Consultation response – there was virtually unanimous support for the proposal to adopt the national priorities as the framework for the Kent and Medway Strategy

Impact – The national priorities have been adopted as the framework for the Kent and Medway Strategy

Consultation response – There was widespread support for the groups identified as a) being at higher risk of suicide and b) being at higher risk of poor mental health. However there was strong feelings that “People bereaved by suicide” and “People with new diagnosis of disability or terminal illness” should be added.

Impact - “People bereaved by suicide” and “People with new diagnosis of disability or terminal illness” have been added to the list of people being at higher risk of poor mental health

Consultation response – There needs to be better early intervention support for people who self harm

Impact – An action has been included in the Action Plan which commits Kent and Medway Public Health teams to share learning with Emotional Health and Wellbeing Groups and to contribute to the review of the self-harm pathway

Consultation response – There needs to be better support for families bereaved by suicide.

Impact – A representative from Survivors of Bereavement by Suicide has been invited to join the Steering Group and the issue will be discussed in detail at a future meeting

Consultation response – Mental health providers need to provide better continuity of care to service users and need to involve service users and carers more in decisions about care plans

Impact – Service users and carers were able to make these points directly to senior members of staff within mental health providers as part of the consultation events. The Steering Group will retain close links to the Mental Health Crisis Concordat and ensure these points get picked up in the work surrounding the Concordat

Consultation response – There was a mixed response to whether the Kent and Medway Suicide Prevention Strategy should include a “Zero Suicide Ambition”

Impact – An action has been included in the Action Plan which commits Kent and Medway Public Health teams to meet with KMPT to discuss the pros and cons in more detail

Appendix iii Trends in suicide rates by CCG

Figures 11-18 show the trends in mortality from suicide and undetermined causes from between 2002 and 2013 for the different CCGs across Kent and Medway. The highest numbers are in South Kent Coast and Thanet, and the lowest in Ashford and Medway, although no CCG areas are statistically higher or lower than any others for the given time period.

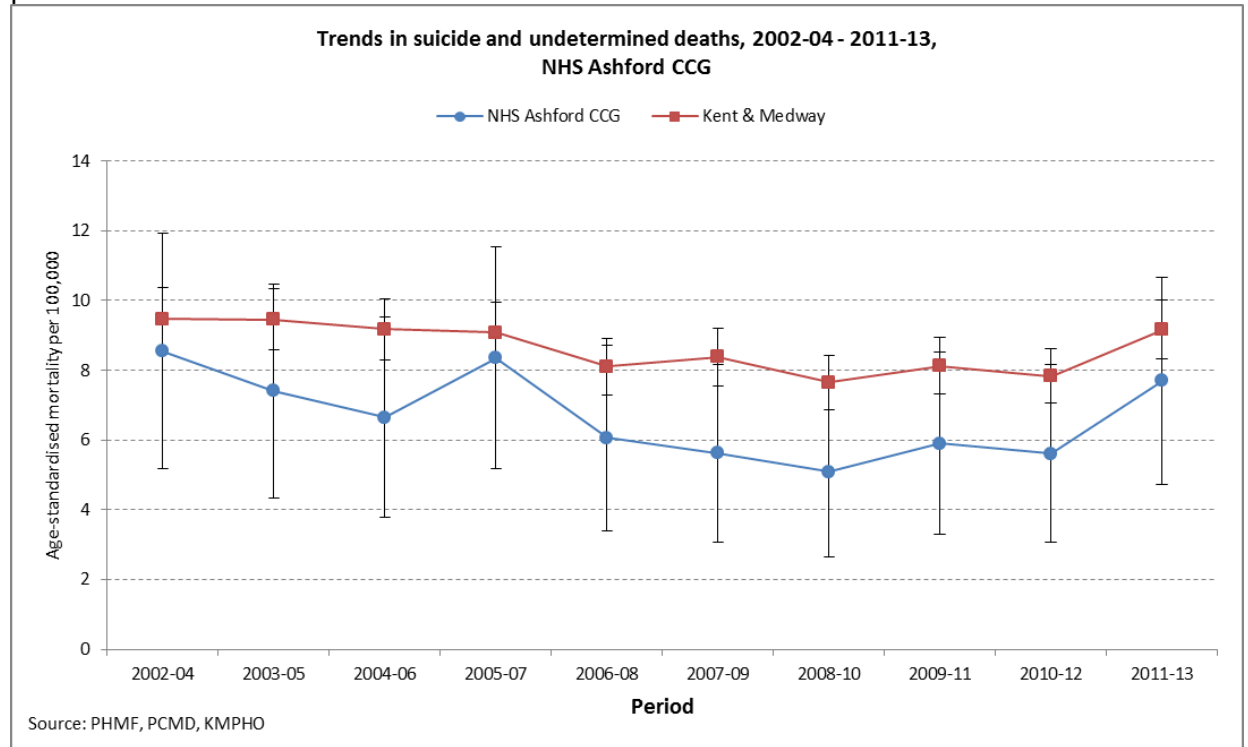


Figure 11 : Trends in mortality from suicide and undetermined causes, 2002-4 – 2011-13, NHS Ashford CCG

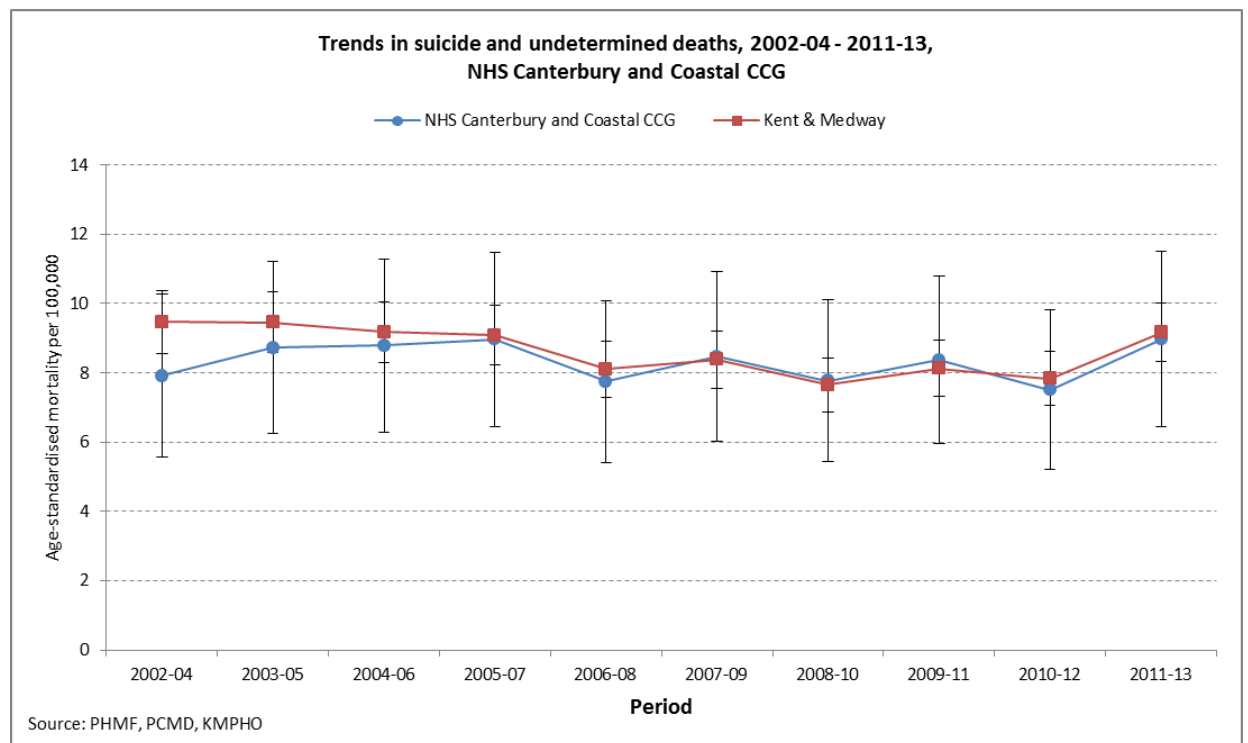


Figure 12 : Trends in mortality from suicide and undetermined causes, 2002-4 – 2011-13, NHS Canterbury and Coastal CCG

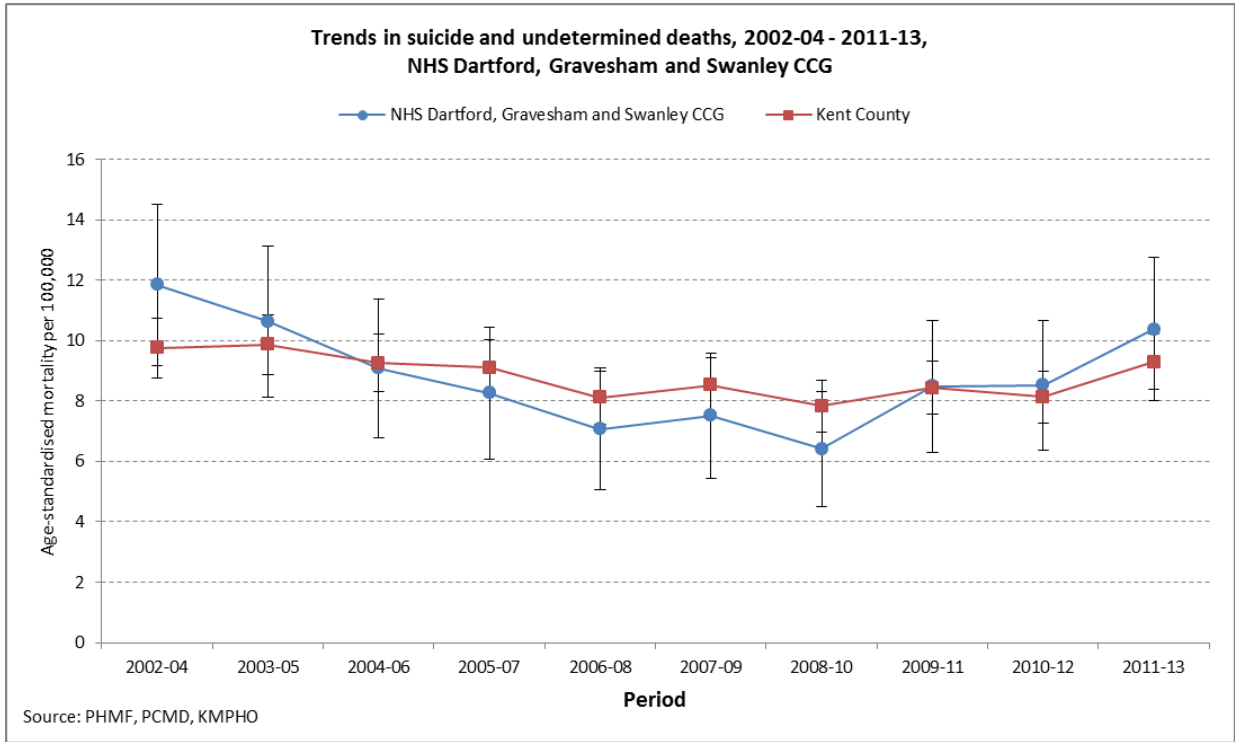


Figure 13 :Trends in mortality from suicide and undetermined causes, 2002-4 – 2011-13, NHS Dartford, Gravesham and Swanley CCG

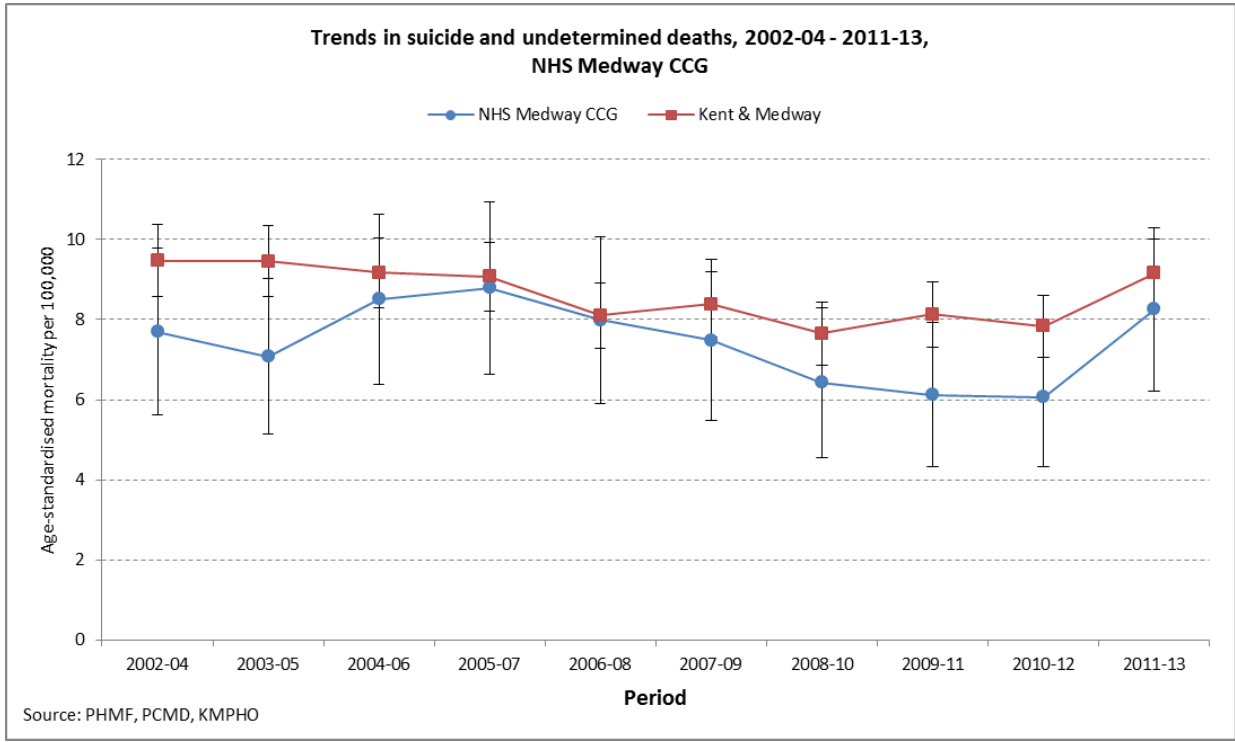


Figure 14:Trends in mortality from suicide and undetermined causes, 2002-4 – 2011-13, NHS Medway CCG

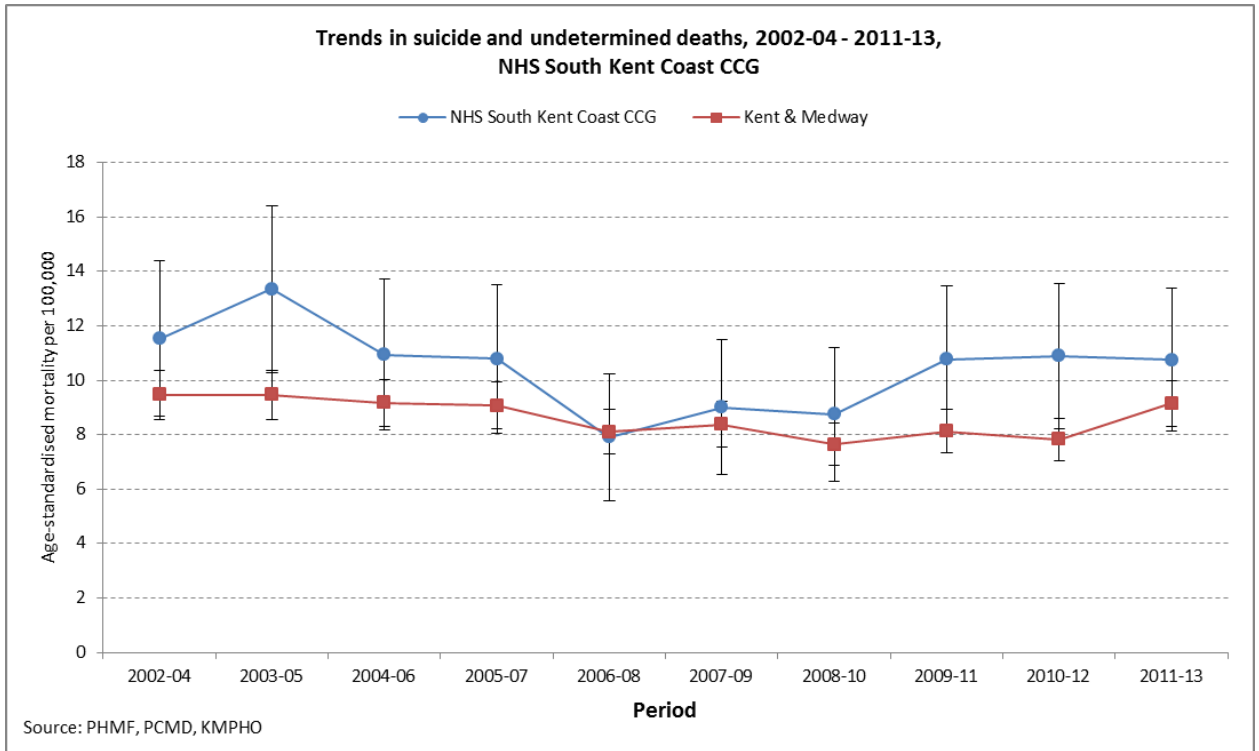


Figure 15: Trends in mortality from suicide and undetermined causes, 2002-4 – 2011-13, NHS South Kent Coast CCG

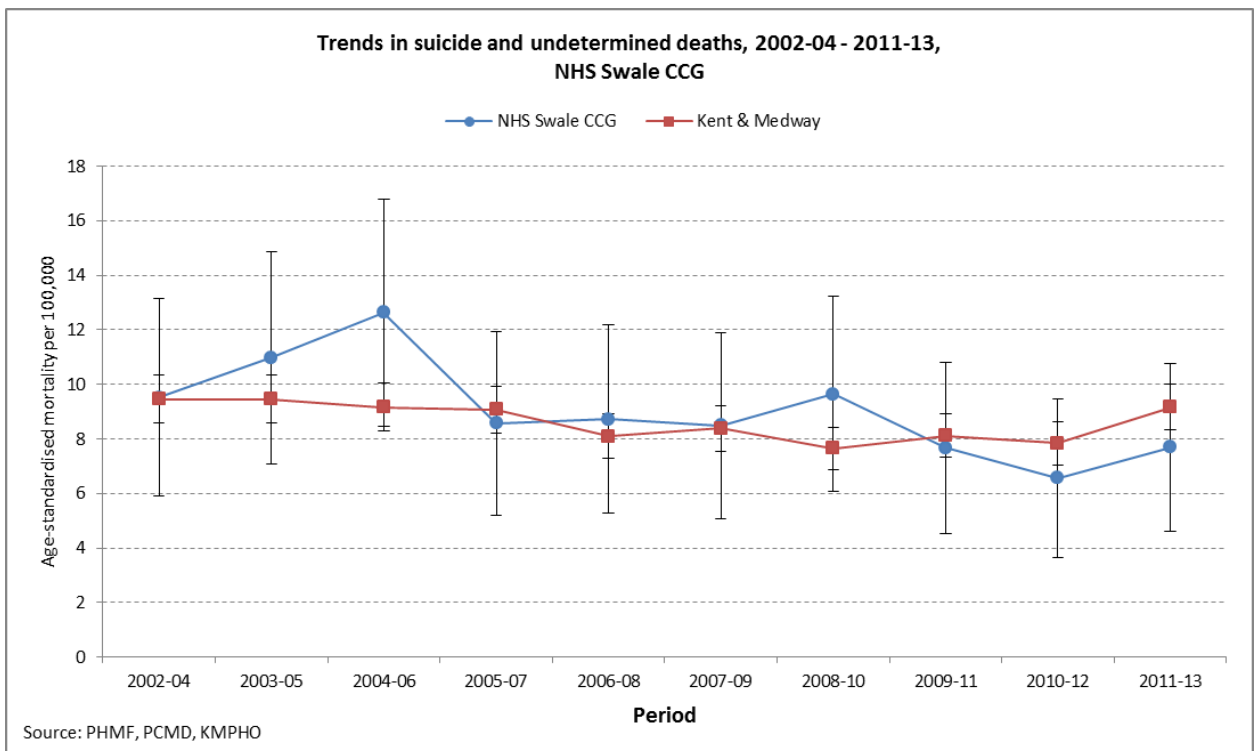


Figure 16: Trends in mortality from suicide and undetermined causes, 2002-4 – 2011-13, NHS Swale CCG

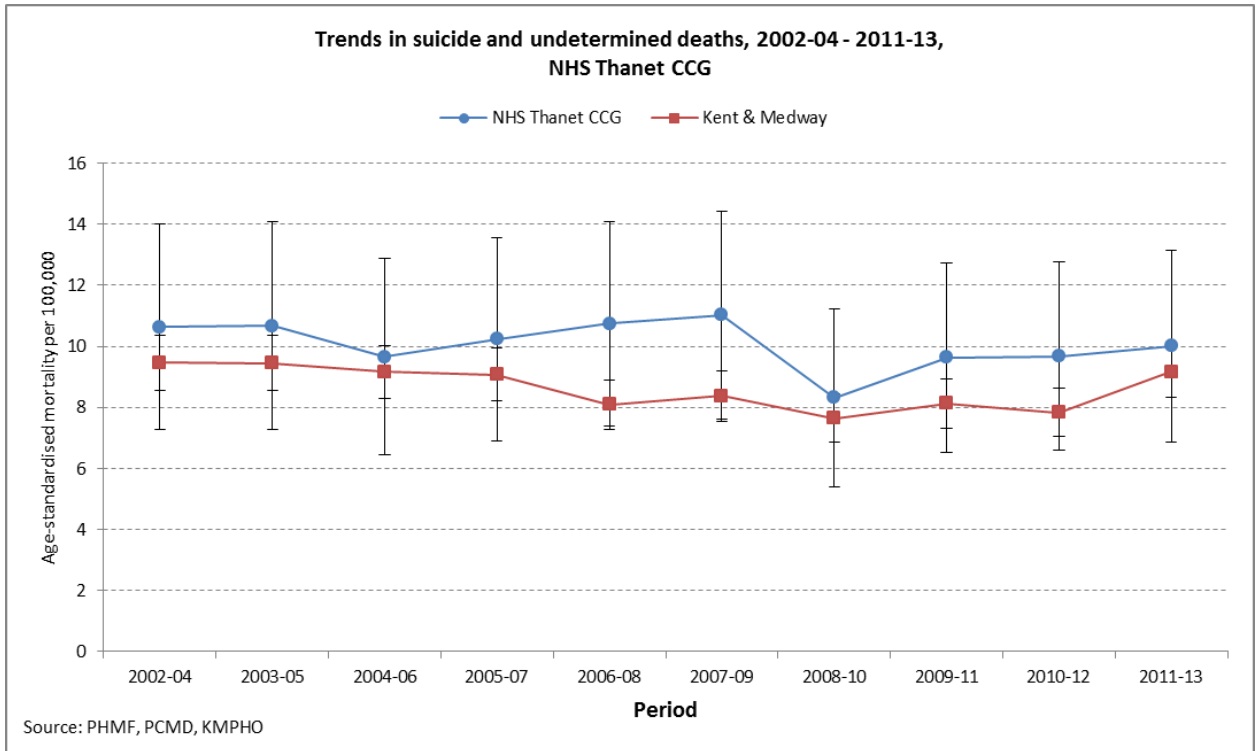


Figure 17: Trends in mortality from suicide and undetermined causes, 2002-4 – 2011-13, NHS Thanet CCG

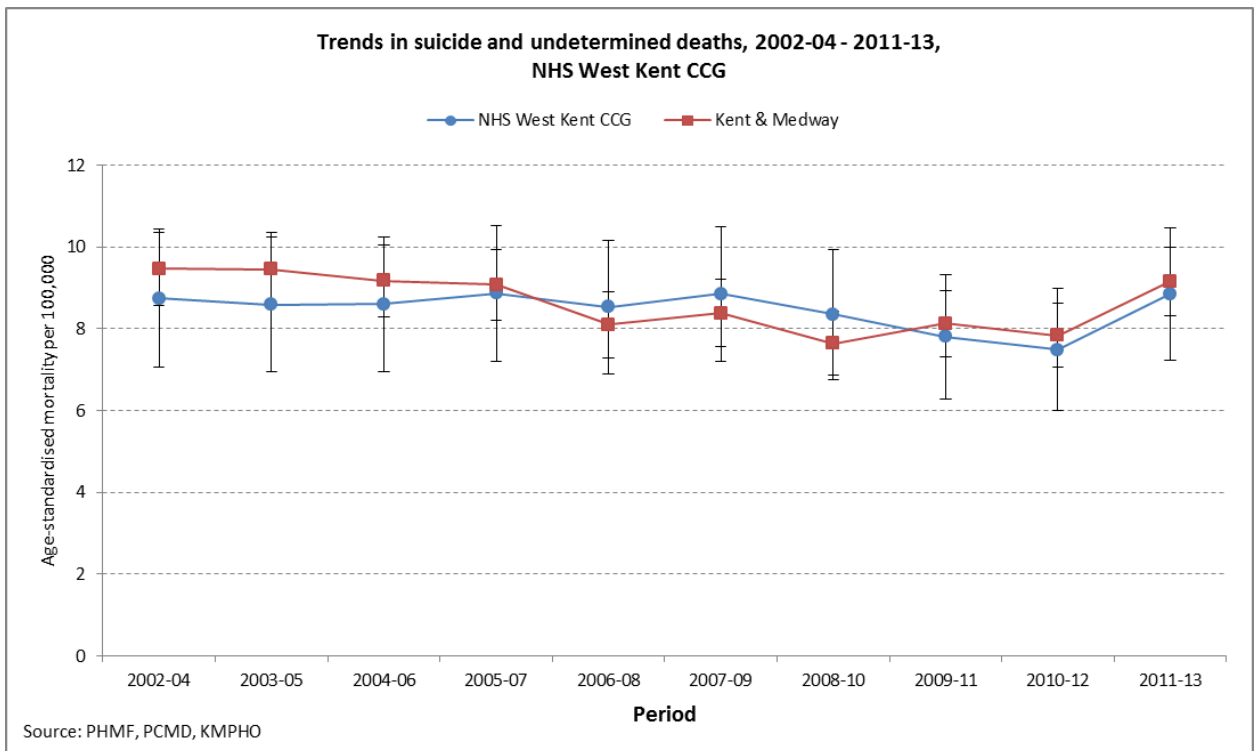


Figure 18: Trends in mortality from suicide and undetermined causes, 2002-4 – 2011-13, NHS West Kent CCG

Appendix iv Equality Impact Assessment

**KENT COUNTY COUNCIL
EQUALITY ANALYSIS / IMPACT ASSESSMENT (EqIA)**

This document is available in other formats, Please contact
tim.woodhouse@Kent.gov.uk or telephone on 07710 368080

Directorate:

Public Health

Name of policy, procedure, project or service

The Kent and Medway Suicide Prevention Strategy 2015-20

What is being assessed?

The Kent and Medway Suicide Prevention Strategy 2015-20

(This is an update of the Kent and Medway Suicide Prevention Strategy 2010-15)

Responsible Owner/ Senior Officer

Jess Mookherjee / Tim Woodhouse

Date of Initial Screening

November 2014

Date of Full EqIA :

TBC

Version	Author	Date	Comment
v.1	Tim Woodhouse	6.11.14	
V2	J Hill	5/1/15	E & D comments

Screening Grid

Characteristic	Could this policy, procedure, project or service, or any proposed changes to it, affect this group less favourably than others in Kent? YES/NO If yes how?	Assessment of potential impact HIGH/MEDIUM LOW/NONE UNKNOWN		Provide details: a) Is internal action required? If yes what? b) Is further assessment required? If yes, why?	Could this policy, procedure, project or service promote equal opportunities for this group? YES/NO - Explain how good practice can promote equal opportunities
		Positive	Negative	Internal action must be included in Action Plan	If yes you must provide detail
Age	No	Medium	Low	a) No b) No	Yes - suicide is most common in the 40-49 age group, therefore this age group is selected by the strategy as a focus for targeted interventions.
Disability	No	Medium	Low	a) No b) No	Yes – people in the care of mental health services are at high risk of suicide, therefore this group is selected by the strategy as a focus for targeted interventions. Physical illness and long-term conditions are also associated with increased risks of suicide
Gender	No	Medium	Low	a) No b) No	Yes – suicide rates for men are higher than for women, therefore men are selected by the strategy as a focus for targeted interventions.
Gender identity	No	Low	Low	a) No	Yes – the EQIA for the

				b) No	national suicide prevention strategy states that there are some indications that transgender people may have higher rates of mental health problems and self harm. The consultation for this Strategy will consider whether this group should be selected for targeted interventions.
Race	No	Unknown	Unknown	a) Yes – the coroner does not record ethnicity on the death certificate, therefore we are unable to accurately assess the ethnic breakdown of people who take their own life. The strategy commits to undertaking further work to assess whether we can gain this information in a different way. b) No	
Religion or belief	No	Low	Low	a) No b) No	The EQIA for the national suicide strategy states that there is a wide range of evidence to suggest that religious participation may be a protective factor against suicidal behaviour.
Sexual orientation	No	Low	Low	a) No b) No	Yes – the EQIA for the national suicide prevention strategy states that lesbian, gay and bisexual people are at higher risk of suicidal ideation. The consultation for this Strategy will consider whether this group should be

					selected for targeted interventions
Pregnancy and maternity	No	Low	Low	a) No b) No	Yes – the EQIA for the national suicide prevention strategy states that while the statistical risk of suicide is low for pregnant women and new mothers mental health problems are more common for those groups of women. The consultation for this Strategy will consider whether this group should be selected for targeted interventions.
Marriage and Civil Partnerships	No	Low	Low	a) No b) No	The EQIA for the national suicide prevention strategy reported that people who are married have a lower risk of suicide. It also found that any increase in higher risk amongst those in civil partnerships is likely to be associated with their sexual orientation rather than their civil partnership status.
Carer's responsibilities	No	Medium	Low	a) No b) No	Yes. Improving the support to bereaved families is a key priority of the draft strategy

Part 1: INITIAL SCREENING

Proportionality - Based on the answers in the above screening grid what weighting would you ascribe to this function?

Low	Medium	High
Low relevance or Insufficient information/evidence to make a judgement.	Medium relevance or Insufficient information/evidence to make a Judgement.	High relevance to equality, /likely to have adverse impact on protected groups

Assessment - Low

There is no evidence to suggest that the updating of the Suicide Prevention Strategy will have an adverse impact on individuals because of any protected characteristic.

The strategy has been developed to target more support at those groups within the population who are currently at increased risk.

Context

The Kent and Medway Suicide Prevention Strategy is overseen by the Kent and Medway Suicide Prevention Steering Group. The Group provides regular updates to the Kent and Medway Health and Wellbeing Boards.

Aims and Objectives

The aim of the strategy is to prevent suicides in Kent and Medway. It contains the following priorities;

- i Reduce the risk of suicide in key high-risk groups
- ii Tailor approaches to improve mental health in specific groups
- iii Reduce access to the means of suicide
- iv Provide better information and support to those bereaved or affected by suicide
- v Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- vi Support research, data collection and monitoring

Beneficiaries

The intended beneficiaries are those people in any of the groups identified as high-risk of suicide, or in need of support to improve their mental health. There are also likely to be interventions targeted at improving the wellbeing of the whole Kent and Medway population.

Information and Data

In the development of the draft strategy, the Kent and Medway Public Health Observatory has produced the following tables and charts.

Area	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
NHS Ashford CCG	13	9	3	11	7	9	4	6	7	7	5	14
NHS Canterbury and Coastal CCG	12	16	16	16	16	17	10	20	13	14	15	21
NHS Dartford, Gravesham and Swanley CCG	22	28	27	16	18	22	8	21	15	23	23	28
NHS Medway CCG	23	12	20	21	23	22	14	19	14	13	20	31
NHS South Kent Coast CCG	17	26	20	27	13	20	12	19	18	25	22	18
NHS Swale CCG	4	7	16	8	12	5	8	11	9	3	8	13
NHS Thanet CCG	9	15	15	8	12	17	11	13	8	17	14	9
NHS West Kent CCG	39	35	31	39	36	36	35	42	30	30	38	48
Kent & Medway	139	148	148	146	137	148	102	151	114	132	145	182

Source: PHMF, PCMD, KMPHO

Table 1: Annual deaths from suicide and undetermined causes, CCGs in Kent & Medway, both sexes, 2002-2013 registrations

The data in Table 1 shows the number of deaths from suicide and undetermined causes for the different Clinical Commissioning Groups (CCGs) across Kent and Medway. There was a considerable increase in the overall number of suicides in 2013 compared to any of the previous years.

Gender and age

Figures 1 and 2 show the number of deaths from suicide and undetermined causes for Kent & Medway, by age band and gender between 2002-2013 and the number of deaths from suicide and undetermined causes, Kent & Medway, by age band and gender. The data show that the suicide numbers are considerably higher in men for all age categories. The highest numbers are in men aged between 40 and 54 years old.

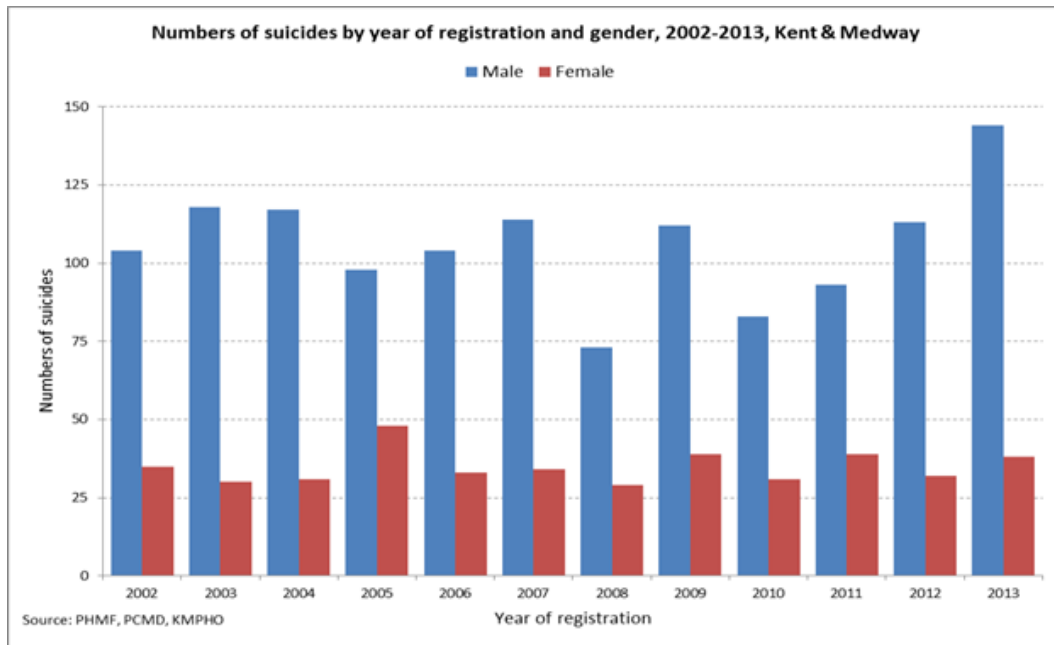


Figure 1: Numbers of deaths from suicide and undetermined causes, Kent & Medway, by year of registration and gender, 2002-2013

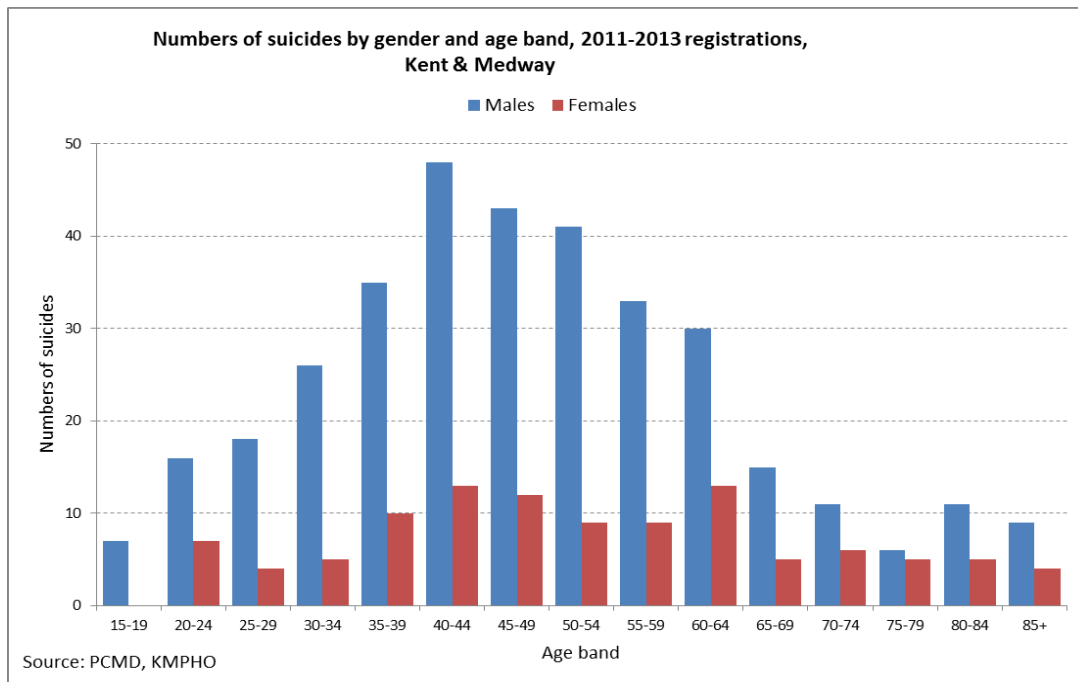


Figure 2: Numbers of deaths from suicide and undetermined causes, Kent & Medway, by age band and gender, 2011-2013 registrations

Country of birth

Coroners do not currently record ethnicity on death certificates, however they do record country of birth. While this is not a good indication of ethnicity, in order to see if there were any notable trends, the Kent and Medway Public Health Observatory has examined the country of birth of 1730 individuals in Kent who took their life between 2002 and 2013. The vast majority were born in England, and the next two most frequent countries of birth were Scotland and Wales. However eleven people born in Poland, nine born in India, and eight born in Germany have killed themselves in Kent between 2002 and 2013.

As part of the implementation of this strategy, the Steering Group will monitor suicide statistics relating to country of birth and work with other agencies (both locally and nationally) to try and improve the ability to assess the risk of suicide within ethnic groups within Kent.

Occupation

The coalition Government's 2012 Preventing Suicide in England strategy identified that "some occupational groups are at particularly high suicide risk. Nurses, doctors, farmers and other agricultural workers are at higher risk probably because they have ready access to the means of suicide and know how to use them."¹²

However it goes on to say that "Risk by occupational group may vary regionally and even locally. It is vital that the statutory sector and local agencies are alert to this and adapt their suicide prevention interventions and strategies accordingly."¹³

¹² P.19

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216928/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

¹³ Same reference as 1

It is for this reason that during the preparation of this Strategy, the Kent and Medway Public Health Observatory examined the occupation (as written by the Coroner on the death certificate) of 1730 individuals in Kent who took their life between 2002 and 2013.

The following table groups the occupations into categories, and shows that the highest numbers of suicides are within the “Professional and managerial” and the “Construction, transport and building trades” categories. It is important to note that these are *numbers* rather than *rates* and don’t take into account the different numbers of people working within these occupations in Kent. More research is needed to establish whether the comparatively lower numbers of suicides within categories such as Agriculture show increased risk within those groups given the lower number of people working in those occupations.

Occupation type	Numbers of suicides in Kent between 2002 and 2013
Professional and managerial	497
Construction, transport and building trades	462
Sales, services and administration	290
Health and personal services	105
Leisure, media and sport	74
Agriculture	50
Protection services	42
IT, Science and Engineering	41
Unknown	169
Total	1730

Suicide numbers by occupation in Kent 2002-2013 - Source KMPHO 2014

Gender by CCG

Figures 3 and 4 show the mortality rates for suicide and undetermined causes between 2011 and 2013 for males and females for the CCGs in Kent and Medway. (Full trends in mortality from suicide and undetermined causes in each CCG area can be found in Appendix 1 of the strategy).

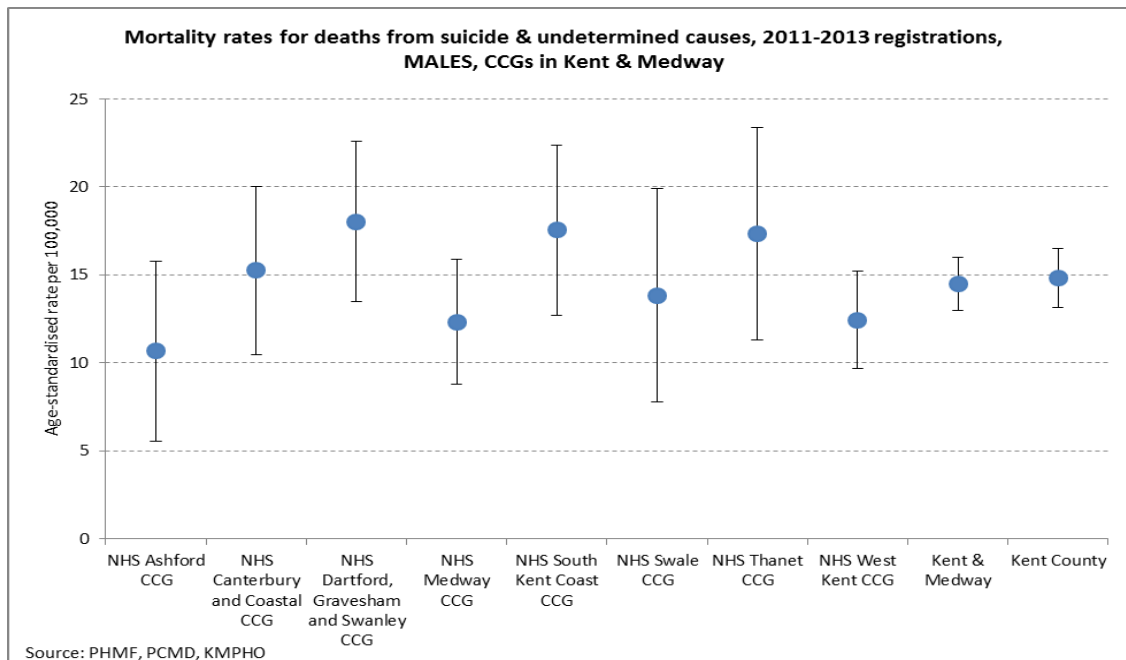


Figure 3: Mortality rates for suicide and undetermined causes, 2011 – 2013 (pooled), CCGs in Kent and Medway, MALES

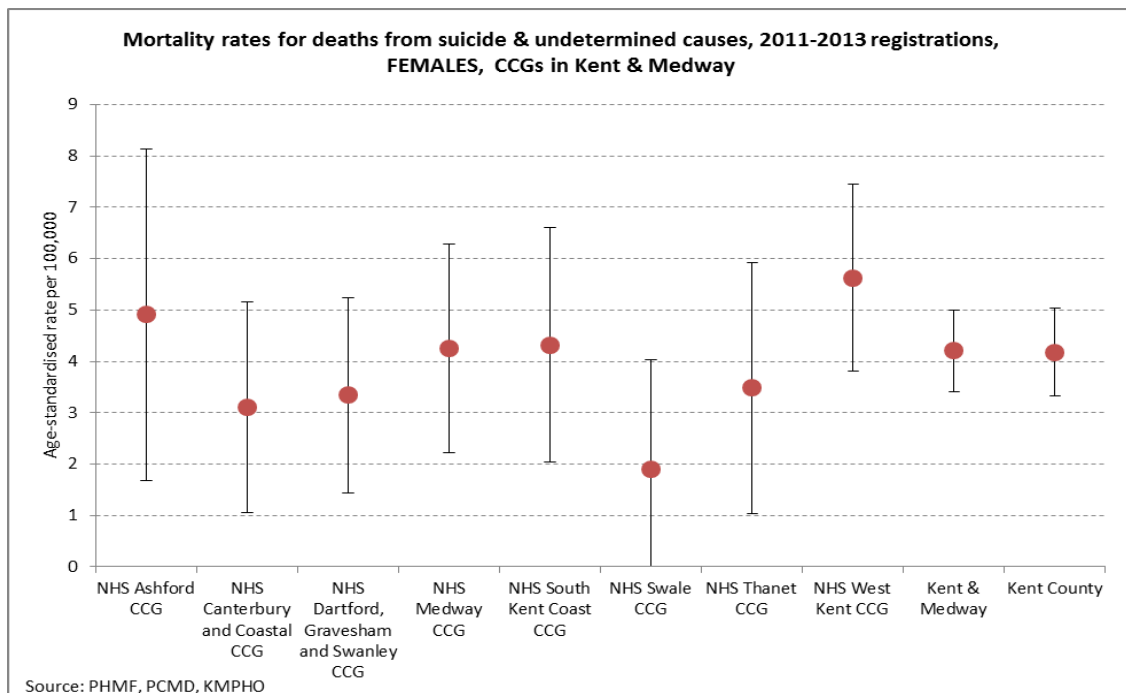


Figure 4: Mortality rates for suicide and undetermined causes, 2011 – 2013 (pooled), CCGs in Kent and Medway, FEMALES

Involvement and Engagement

We are planning to hold consultation events and issue a consultation questionnaire as part of this process.

Potential Impact

There is no evidence to suggest that the updating of the Suicide Prevention Strategy will have an adverse impact on individuals because of any protected characteristic.

The strategy has been developed to target more support at those groups within the population who are currently at increased risk.

The public consultation will help to determine which groups should be a particular focus.

Race and Religion – There is very little information regarding ethnicity or religion, mainly because the coroner doesn't record it on the death certificate. Therefore we are unable to accurately assess the ethnic breakdown of people who take their own life, or whether this strategy will have an adverse impact. The strategy commits to undertaking further work to assess whether we can gain this information in a different way.

Adverse Impact:

None

Positive Impact:

The strategy has been developed to target more support at those groups within the population who are currently at increased risk. Actions to maximise the positive impact will be included in the Action Plan for the strategy.

JUDGEMENT

Option 1 – Screening Sufficient

NO

Option 2 – Internal Action Required

YES - See action plan

Option 3 – Full Impact Assessment

YES

Although we believe there is no evidence that this refresh of the Suicide Prevention Strategy will lead to any negative impact we will undertake a full impact assessment because we are going to out to public consultation on it. (It is a KCC requirement that public consultations must be accompanied by Full Impact Assessments).

Monitoring and Review

The action plan will be monitored by the Kent and Medway Suicide Prevention Steering Group.

Sign Off

I have noted the content of the equality impact assessment and agree the actions to mitigate the adverse impact(s) that have been identified.

Senior Officer

Signed:

Name:

Job Title:

Date:

DMT Member

Signed:

Name:

Job Title:

Date:

Equality Impact Assessment Action Plan

Protected Characteristic	Issues identified	Action to be taken	Expected outcomes	Owner	Timescale	Cost implications
Race	There is very little information regarding the ethnicity of those people who take their own life. (Mainly because the coroner doesn't record ethnicity on the death certificate). Therefore we are unable to accurately assess the ethnic breakdown of people who take their own life, or whether this strategy will have an adverse impact.	As part of the strategy development process a public consultation and a review of national literature will both examine the impact of ethnicity race on suicide.	There is evidence to suggest the rates of severe mental illness are higher amongst some ethnic groups, however it isn't known whether this automatically implies there are higher rates of suicide.	Tim Woodhouse	Prior to Strategy sign off	N/A