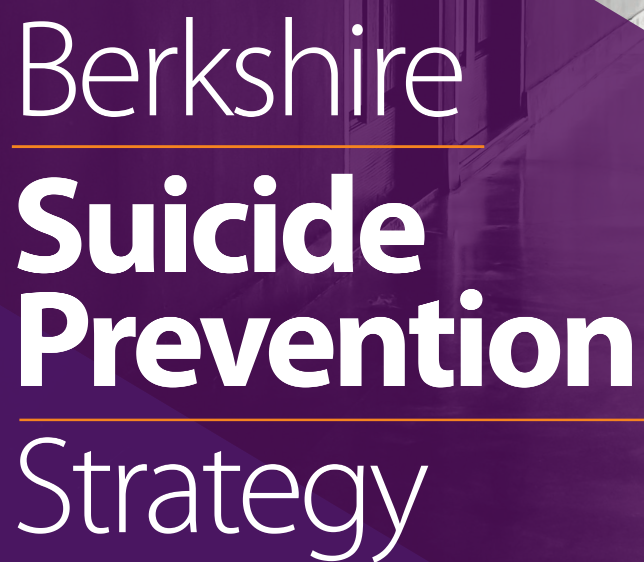

Berkshire Suicide Prevention Strategy

2021-2026

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Acknowledgements

We must particularly thank the Berkshire Suicide Prevention Strategy Working Group who led the development and content of this strategy. We must also acknowledge our colleagues on the Berkshire Suicide Prevention Steering Group who helped to navigate the strategic direction of this strategy. Acknowledgements also extend wider to additional partners who also gave up their time to contribute to the development of this strategy and action plan.

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Foreword

In England, 5,691 people tragically took their own lives in 2019[1]. Reducing this number is of upmost importance nationally and locally and remains a key public health priority. Locally we have seen an increase in female suicide rates, and growing concern over the suicide rates in younger age groups, with the suicide rate in the 20-29 year-old age group being significantly higher than all other age groups (2015-2019).

Suicide is one of the most tragic events for families, friends and communities, with life-long consequences. Those bereaved by suicide are particularly vulnerable to suicide attempts and death by suicide, therefore support for those grieving is of paramount importance.

We know that individual's health and wellbeing has been significantly affected throughout the course of the pandemic and will continue to be affected in the long-term. This strategy recognises this, and across Berkshire, partners and communities will continue to work resolutely towards mitigating the impact of the pandemic on suicide risk.
All stages of life have been considered to develop this strategy and action plan, with the acknowledgement that risk factors at all stages of life must be considered to develop a truly preventative approach. Everyone in society has a part to play in preventing suicides, whether it is a member of the public asking "Are you OK", investing in good mental wellbeing programmes, removing the triggers, supporting young people through the transitional period into adulthood, or ensuring prompt treatment from mental health services.

This strategy helps the people and professionals of Berkshire to understand some of the factors that contribute to suicide in Berkshire and raises awareness of how we can all contribute to preventing deaths by suicide.

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[1] Suicide rates in England and Wales 2019 registrations. ONS. Available Suicides in England and Wales - Office for National Statistics (ons.gov.uk). Last accessed 31/08/21

Executive Summary

Suicide prevention remains a key public health issue both locally and nationally. Strong multi-agency working, public health leadership and robust suicide prevention plans are core to this prevention. This suicide prevention strategy for Berkshire encompasses these core elements and sets out our action locally to reduce suicide and self-harm, based on local intelligence, data and strategic priorities.

There were 26.8 years of life lost per 100,000 population from suicide across Berkshire on average between 2017-19. Age specific rates are broadly in line with the England average, peaking in the 50-59-year-old age band before decreasing until the age of 80 plus years. Real time surveillance system (RTSS) data tells us that within Berkshire, female suicides have increased year on year since it started being collected in 2017.

Since the publication of our previous suicide prevention strategy, a Berkshire wide suicide audit has been undertaken (in 2018). Because of the concerns highlighted in this audit and routine RTSS monitoring a female deep-dive analysis was undertaken. NHS England also supported a 0-25 audit because of national trends reflected locally too. This local data and intelligence have been central to the development of the priorities of this refreshed strategy, and in collaboration with system partners. Research and data monitoring will continue to be a key focus for suicide prevention within Berkshire, providing opportunity to review approaches and prioritise efforts accordingly.

The COVID-19 pandemic has exacerbated existing inequalities in suicide risk and has posed new challenges for different groups within the population. The impact of the pandemic on mental health and suicide risk across the lifecourse remains largely unknown, therefore monitoring and mitigation of risk it is a priority for this strategy.

This strategy builds on the previous Berkshire Suicide Prevention Strategy (2017-2020) and serves as a refresh of that strategy, where we take forward the key underlying principles and identify new priorities. These were developed by working with our key partners across the system and making good use of local data and intelligence.

There are seven priority areas for action recommended by the national suicide prevention strategy and subsequent progress reports as follows:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring
7. Reducing rates of self-harm as a key indicator for suicide risk

This strategy principally focusses upon the second priority area – 'tailor approaches to improve mental health in specific groups', but the commitment remains to all principles and reducing suicide for all groups.

The vision for this strategy is 'To reduce deaths by suicide in Berkshire across the lifecourse and ensure better

knowledge and action around self-harm'. In order to achieve this vision, this strategy is centred upon local data, trends and action, and has 5 core priority areas agreed across the 6 local authorities, forming a Berkshire wide action plan.

1. Children and Young People; including the impact of trauma and adversity, recovery from COVID-19, neurodiversity, LGBTQ+ and transitions
2. Self-harm; as a risk factor, groups vulnerable to self-harm, hospital admissions, mental health, young people and self harm
3. Female suicide deaths; including perinatal mental health, domestic abuse, parental or carer stress
4. Economic factors; including the impact of COVID-19, debt and poor mental health, benefits, socio-economic disadvantage and gambling
5. Supporting those who are bereaved or affected by suicide; including local suicide bereavement support, specialist suicide bereavement support, and those impacted by suicide in the workplace

Recommendations

The following are recommendations for this strategy, which will form the Berkshire wide action plan for 2021-26.

Overarching recommendations:

1a) To continue to monitor the impact of COVID-19 on suicide across the lifecourse through RTSS data and respond to any identified trends.

1b) To continue to monitor the wider trends emerging from the impact of COVID-19 on people's mental health and suicide risk across the lifecourse, and to support the system to take action where required.

1c) To undertake a Berkshire suicide audit.

1d) Undertake regular reviews of information, resources and channels for people affected by suicide.

1e) Hold an annual multi-agency conference on a range of topics to share information and best practice and raise awareness to the risks for suicide.

1f) Invite additional partners across the System within Berkshire, including the voluntary and community sector to join the Suicide Prevention Group for improved cross-topic working.

1g) Set up sub-groups of the Suicide Prevention Group, informed by local intelligence and data, where there is a need to focus upon a risk factor or group within the population.

Priority area 1: Children and Young People

2a) To raise awareness of the link between trauma and adversity, and suicide across the life course.

2b) Continued investment into the Be Well campaign to encourage the importance of looking after emotional wellbeing, in addition to signposting to local mental health services and support in order to prevent self-harm and suicide in children, young people, and women.

2c) Support the system to adopt a needs-led approach for neurodiverse children and young people, particularly in the prevention and early intervention arena, e.g. in schools and the community.

2d) To explore improving data capture on sexual orientation for all ages in RTSS data and promote this across the suicide prevention system.

2e) To work with local organisations and charities who work with the LGTBQ+ community on suicide prevention.

2f) To raise awareness of the impact of the transitional period (children moving into adulthood) on the mental health impact and the risks of suicide during this period for children and young people.

2g) To link with the work across the BOB and Frimley ICS on the ease of access to shared care records across system partners for transition population (children moving into adulthood).

2h) To support higher education establishments within Berkshire, including universities to adopt a needs-led approach to neurodiversity.

Priority area 2: Self-harm

3a) Decrease the stigma related to self-harm and encourage help seeking behaviour and self-care.

3b) Help friends, family and professionals understand the physical and emotional signs of self-harm, how they can help and where they can get support.

3c) Explore the impact of self-harm on parents and siblings on their own mental health and wellbeing.

3d) Regularly review local intelligence and data on self-harm at the Berkshire Suicide Prevention Steering Group, ensuring additional relevant data from a wide range of sources are included (e.g. development of RTSS to include self-harm, ambulance service data, primary care and schools).

3e) Working with Mental Health Support Teams (MHSTs), ensure a continued focus on the prevention of self-harm by increasing resilience and general coping skills and support for those who self-harm.

Priority area 3: Female Suicide Deaths

4a) Link with the Buckinghamshire, Oxfordshire, Berkshire West (BOB) and Frimley local maternity systems on suicide risks in the perinatal period.

4b) To explore data collection on the perinatal period; risk factors and the link to suicide including data captured in the RTSS.

4c) Promote the need for clear pathways and knowledge exchange between domestic abuse and mental health services.

4d) Improve data collection of domestic abuse data in RTSS.

4e) Include domestic abuse indicators in the Berkshire suicide audit to better understand the link between domestic abuse and suicide.

4f) Provide information to domestic abuse services on how to respond to concerns where clients may be self-harming or considering suicide (whether the client is a victim, survivor, perpetrator or child or young person).

4g) Raise awareness of the information, resources and services available for parents and carers who are experiencing stress, through inputting into local campaigns.

Priority area 4: Economic Factors

5a) Work with colleagues to raise awareness of the risk between debt, mental health and suicide risk among frontline professionals and the wider public. Awareness raising needs to;
- reduce the stigma of 'being in debt' and signpost to access debt and benefit advice and support. This information also needs to be shared with frontline professionals
- encourage people in debt to reach out for help to reduce impact on mental health
- encourage people with poor mental health to reach out for debt advice

5b) Support frontline professionals to feel comfortable about talking about debt and financial problems and the link to poor mental health and suicide risk and what support is available.

5c) Support Berkshire local authorities with a single point of access information site around money matters.

5d) Ensure compassionate debt collection. Make sure the process is supportive and aims to steer residents to places that can provide help and support. Support vulnerable groups at increased risk of debt including people with long-term conditions or disabilities.

5e) Work with key partners to actively promote services that provide help around navigating the benefits system and potentially increasing people's incomes.

5f) Make sure that all parts of the health service where patients showing suicidal intent first make contact, are signposted or triaged appropriately using a process that includes debts and other economic stresses as risk factors.

5g) Work with system partners on the early identification and support of people who are at increased risk of debt and financial concerns (e.g. unemployed or people with long-term conditions) as early as possible and offer effective support to manage personal finances through appropriate referral pathways.

5h) Monitor local data and intelligence on levels of problem gambling within Berkshire and its link to suicide.

Priority area 5: Supporting those who are bereaved or affected by suicide

6a) Ensure our local bereavement offer is culturally and ethnically appropriate for different groups within communities to develop resources and services.

6b) Continued support to the volunteer led local SoBS groups to be able to continue to offer a peer-to-peer support service.

6c) Building in bereavement support to extend to wider family members, friends and communities.

6d) Continue to commission suicide bereavement support services and monitor its impact.

6e) Explore training opportunities for colleagues and workplaces impacted by suicide.

6f) Work with Thames Valley Police and other first responders to a suicide, to share appropriate resources with employers.

Background

National context

Every suicide is a tragedy. It has life changing impacts for those bereaved, and profound impacts on communities and services. Suicide is preventable, not inevitable. Strong multi-agency partnership working, suicide prevention groups and a robust strategy are key to this prevention.

The 2012 national suicide prevention strategy – 'Preventing suicide in England: A cross government outcomes strategy to save lives' (DHSC 2012)[2] alongside five subsequent progress reports (DHSC 2014, 2015, 2017, 2019, 2021) [3][4][5][6][7] sets out seven areas for priority and action, that all local suicide prevention plans should cover on a long-term basis, which are the guiding principles in this strategy:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring
7. Reducing rates of self-harm as a key indicator for suicide risk

A practical resource for suicide prevention planning produced by Public Health England (2020)[8] recommends short term actions with a co-ordinated whole systems approach for local plans, alongside the seven priority areas of the national strategy in the long-term.

The most recent national confidential inquiry into suicide and safety in mental health (NCISH) 2021 provides findings relating to people who have died by suicide in the UK between 2008 and 2018[9]. The report recommends that tackling inequalities remains a priority, areas should continue to understand the specific needs for different groups, monitor demands for mental health providers and engage with the voluntary and community sector. Plans must also address the specific needs of the populations they cover.

[2] Preventing Suicide in England: A cross government outcomes strategy to save lives. Department for Health and Social Care (2012) Available Suicide prevention strategy for England - GOV.UK (www.gov.uk) Last accessed 31/08/21
[3] Preventing suicide in England: One year on First annual report on the cross-government outcomes strategy to save lives. HM Government (2014) Available First annual report on the cross-government outcomes strategy to save lives (publishing.service.gov.uk) Last accessed 20/08/21
[4] Preventing suicide in England two years on: Second annual report on the cross government outcomes strategy to save lives. Department for Health and Social Care (2015) Available Suicide prevention: second annual report - GOV.UK (www.gov.uk) Last accessed 20/08/21
[5] Preventing suicide in England: Third progress report of the cross government outcomes strategy to save lives. Department for Health and Social Care (2017) Available Suicide prevention: third annual report - GOV.UK (www.gov.uk) Last accessed 20/08/21
[6] Preventing suicide in England: Fourth progress report of the cross government outcomes strategy to save lives. Department for Health and Social Care (2017) Available Preventing suicide in England: fourth progress report of the cross-government outcomes strategy to save lives (publishing.service.gov.uk) Last accessed 20/08/21
[7] Preventing suicide in England: Fifth progress report of the cross government outcomes strategy to save lives. Department for Health and Social Care (2021) Available Suicide prevention in England: fifth progress report - GOV.UK (www.gov.uk) Last accessed 20/08/21
[8] Local Suicide Prevention Planning: A Practical Resource. PHE (2020) Available PHE_LA_Guidance_25_Nov.pdf (publishing.service.gov.uk) Last accessed 18/08/12
[9] National Confidential Inquiry into Suicide and Safety in Mental Health. Annual report: 2021 The University of Manchester (2021). Available NCISH | Annual report 2021: England, Northern Ireland, Scotland and Wales - NCISH (manchester.ac.uk) Last accessed 20/08/21

Impact of COVID-19

The COVID-19 pandemic has exacerbated inequalities in suicide risk and has presented new challenges for different groups of the population[10], therefore monitoring impact and taking early action must be of paramount importance.

The COVID-19 Mental Health and Wellbeing Recovery Action Plan sets out a broad plan covering 2021 to 2022 in response to the mental health impacts of the pandemic, which will form the foundation for future policy development and delivery as knowledge and understanding of the impacts of the pandemic as it grows. Actions and commitments within the plan aim to support people at risk of self-harm or suicide. This includes supporting the population to take action and look after their mental wellbeing, preventing the onset of mental health difficulties and supporting specialist services to continue to expand and transform to meet needs[11].

In 2020, the NCISH Team was particularly concerned with the impact of the COVID-19 pandemic and measures to control transmission, e.g. lockdowns[12]. They published a report comparing the months pre-lockdown (January-March 2020) to post-lockdown (April-August 2020), concluding that there was no evidence of the large national rise in suicide post-lockdown that many feared. Although suicide rates appeared to be higher in 2020 than in 2019, the context was an upward trend noted pre-pandemic, alongside improvements in local data capture. An important caveat to this NCISH finding was that the national team could not rule out higher rates in some local areas or population subgroups, with the possibility of elevated rates for some being masked by suppressed rates for others. The Chair of the National Suicide Prevention Strategy Advisory Group has also recommended particular vigilance regarding data on suicide rates in younger people and in those with previous contact with secondary mental health services. Another caveat is that other data sets indicate an increase in risk factors for suicide – such as poorer mental health and increased economic pressure – linked to COVID-19, and this could lead to increased suicide rates in the longer term.

Recommendation 1a: To continue to monitor the impact of COVID-19 on suicide across the lifecourse through RTSS data and respond to any identified trends.

Recommendation 1b: To continue to monitor the wider trends emerging from the impact of COVID-19 on people's mental health and suicide risk across the lifecourse, and to support the system to take action where required.

[10] One year on: How the coronavirus pandemic has affected wellbeing and suicidality. Samaritans (2021). Available Samaritans_Covid_1YearOn_Report_2021.pdf Last accessed 17/08/21

[11] COVID-19 mental health and wellbeing recovery action plan Our plan to prevent, mitigate and respond to the mental health impacts of the pandemic during 2021 to 2022. HM Government (2021). Available COVID-19 mental health and wellbeing recovery action plan (publishing.service.gov.uk) Last accessed 17/08/21

[12] Suicide in England since the COVID-19 pandemic - early figures from real-time surveillance NCISH (2020) Available display.aspx (manchester.ac.uk) Last accessed 02/09/21

Suicide Rates in England and Wales

The definition of suicide used for National Statistics includes all deaths from intentional self-harm for persons aged 10 years and over and deaths caused by injury or poisoning where the intent was undetermined for those aged 15 or over. Figures are based on the date on which the death was registered rather than the date which the death occurred. All deaths cannot be defined as caused by suicide until certified by a Coroner following an inquest, and so the death cannot be registered as a suicide until the inquest is complete. This can take months or even years, and this delay between death, inquest, and registration will have been further increased during the Covid-19 pandemic.

In July 2018, the standard of proof used by coroners to determine if a death was caused by suicide was lowered. This may in part account for increases in the numbers of deaths recorded as suicides before and after this date, although the impact of this change appears to be relatively minor[13]. Initial findings suggest that the increases in suicide in 2018 appeared to begin prior to the July change indicating a real increase in numbers not attributable to the coding change.

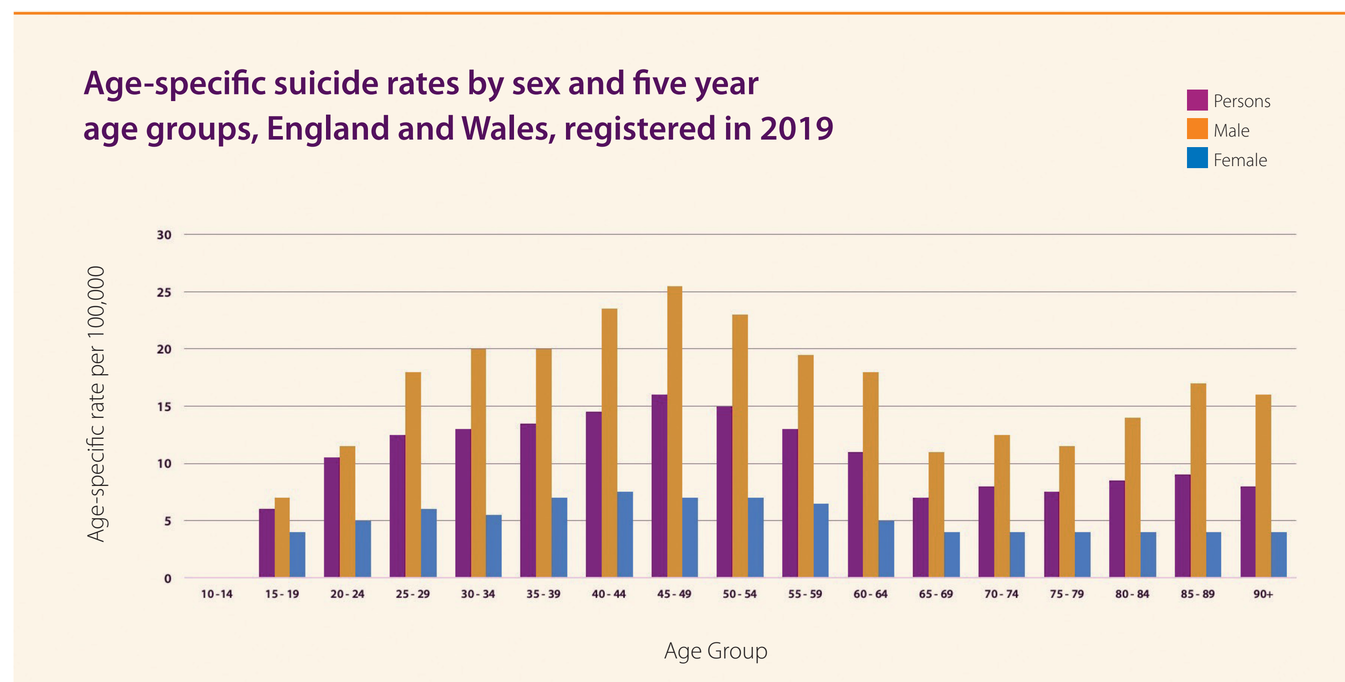
The suicide rate in England and Wales in 2019 was 11 per 100,000. Rates increased from the previous year for both males and females. Males accounted for three-quarters of suicides in England and Wales in 2019 and the male suicide rate in England was the highest seen since 2000. The suicide rate for males in the South East increased significantly to 16.8 per 100,000 from 13.5 per 100,000 in 2018.

Age and Gender England and Wales

Since the early 1980s rates in suicide by age have shown a consistent pattern, peaking among the middle-aged (40-54 years) before decreasing until the ages of 80-84, from which they begin to rise. Male suicide rates have seen a recent increase since 2017 in those aged 10 to 24 years, 25 to 44 years and 45 to 64 years although there has been an overall decrease in suicides since a peak in the late 80's. There was a marked decrease in female suicides between 1981 and the mid 1990's which was mainly driven by a decrease in rates in females aged over 44. Suicide rates in the 10 to 24 and 25 to 44-year-old age group have been historically low and stable. In 2019, the female suicide rate for those aged 10 to 24 years in England and Wales was the highest recorded since 1981. The rate has increased by 93.8% from 1.6 deaths per 100,000 in 1981 to 3.1 deaths per 100,000 in 2019. The rate among females aged 25 to 44 years saw a significant increase from 4.5 to 6.1 deaths per 100,000 between 2016 and 2019.

[13] Change in the standard of proof used by coroners and the impact on suicide death registrations data in England and Wales - Office for National Statistics.

Figure 1: Suicide patterns by age



Source: Office for National Statistics – Suicides in England and Wales 2019

Nationally, the percentage of suicides caused by hanging, strangulation and suffocation has increased in recent years. These account for 62% of suicides among males and 47% of suicides among females. The second most common method of suicide is poisoning, accounting for 16% of male suicides and 33% of female suicides.

Suicide Rates in Berkshire

Table 1 shows the number of deaths in Berkshire local authorities due to suicide over a rolling three-year time period. There was a total of 198 deaths from suicide in Berkshire between 2017 and 2019. This translates to an age-standardised rate of 8.7 per 100,000 population. There has been a non-statistically significant increase in the rate from 2016-18[14].

In 2017-19, rates were highest in Reading and West Berkshire. Wokingham has the lowest rate of suicide. There were 26.8 years of life lost per 100,000 population from suicide across Berkshire on average between 2017-19. West Berkshire has the highest average life years lost at 33 per 100,000 population. However, this is not significantly higher than the South East or England average.

It is important to note that it is difficult to make clear comparisons between areas due to the random fluctuation that can be seen in statistics calculated from small numbers. None of the differences between areas described above or seen in table 1 are statistically significant.

Table 1: Suicides in Berkshire

	Number of deaths			Age-standardised rate per 100,000			Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3-year average)		
	2015-17	2016-18	2017-19	2015-17	2016-18	2017-19	2015-17	2016-18	2017-19
England	**13846**	**14047**	**14788**	**9.6**	**9.6**	**10.1**	**30.8**	**31.3**	**33.0**
South East Region	**2230**	**2194**	**2299**	**9.4**	**9.2**	**9.6**			
Bracknell Forest	32	27	28	10.4	9.1	9.1	28.4	23.6	26.3
Slough	30	38	31	7.7	10.1	8.9	29.8	34.2	25.7
Windsor and Maidenhead	33	33	32	8.5	8.5	8.0	34.3	32.2	25.4
Reading	33	28	38	8.0	7.2	9.9	23.9	18.6	26.2
West Berkshire	35	35	40	8.4	8.5	9.7	26.8	28.8	32.9
Wokingham	35	29	29	8.1	6.7	6.8	22.9	21.4	24.0
Berkshire	**198**	**190**	**198**	**8.5**	**8.3**	**8.7**	**27.7**	**26.5**	**26.8**

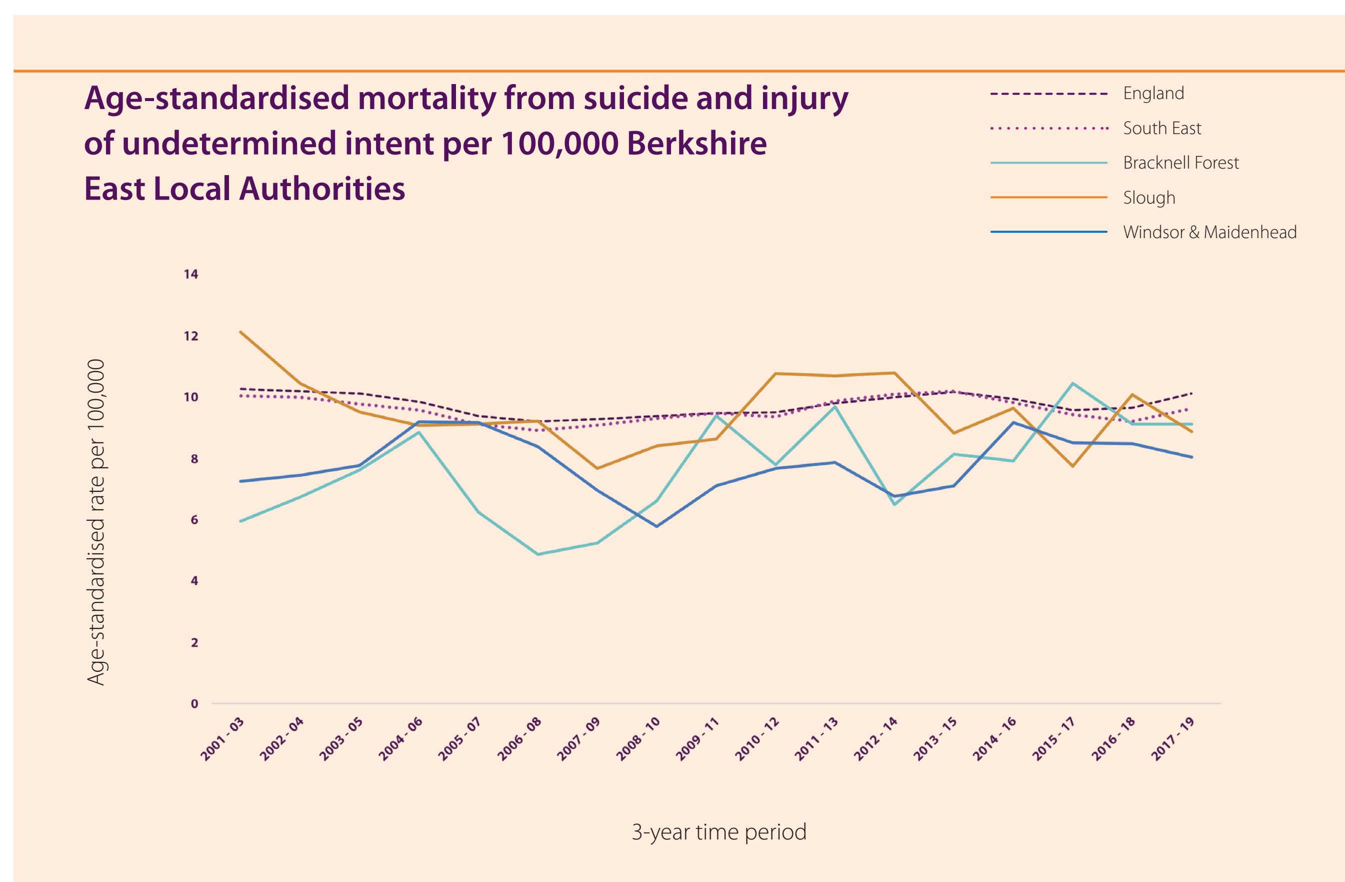
Source: Public Health England Suicide Prevention Profile

[14] ONS, analysed by Public Health

When looking at this data over time, the rates of suicide across Berkshire have remained relatively stable since 2001-03.

Rates in Slough have stayed close to the national and regional averages since 2001-03. Rates in Windsor and Maidenhead decreased significantly below national and regional averages in 2008-10 and 2012-14, but are now in line with the national and regional averages (2017-19). Rates in Bracknell Forest similarly dropped significantly below national and regional averages for the two consultative time periods of 2006-08 and 2007-09 and then again in 2012-14, but again are now in line with the national and regional averages in the time period up to and including 2017-19.

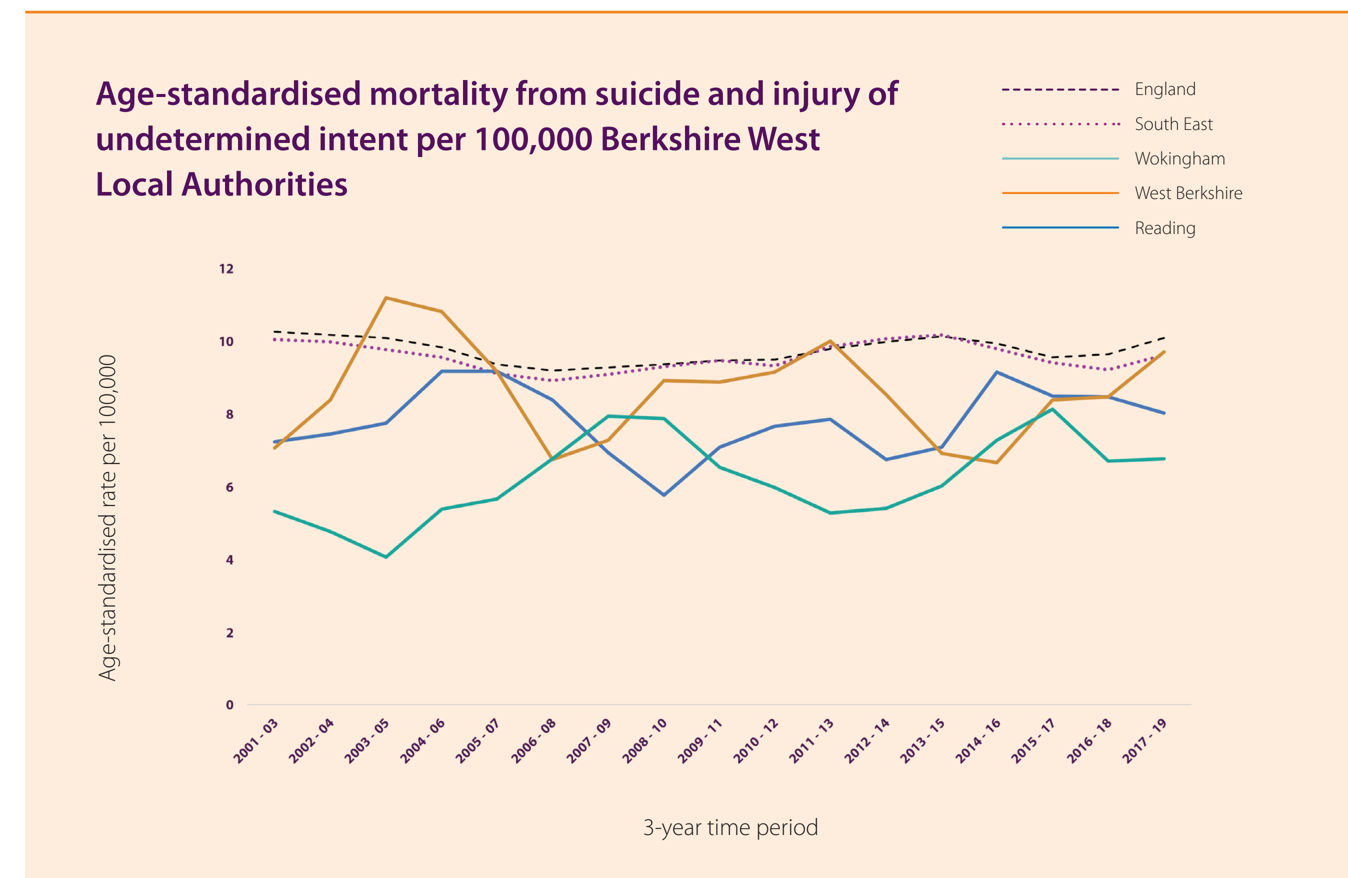
Figure 2: Suicide rates in Berkshire East Local Authorities



Source: Public Health England Suicide Prevention Profile

Rates in Reading have stayed close to the national and regional averages since 2001-03. Rates in West Berkshire dropped significantly below national and regional averages for the two consecutive time periods of 2013-15 and 2014-16, but are back in line with national and regional averages in the time period up to and including 2017-19. Rates in Wokingham are consistently below the regional and national averages, being significantly lower between 2001 and 2007 and again between 2010 and 2015. They remain lower in the time period up to and including 2017-19 although the difference is no longer significant.

Figure 3: Suicide rates in Berkshire West Local Authorities

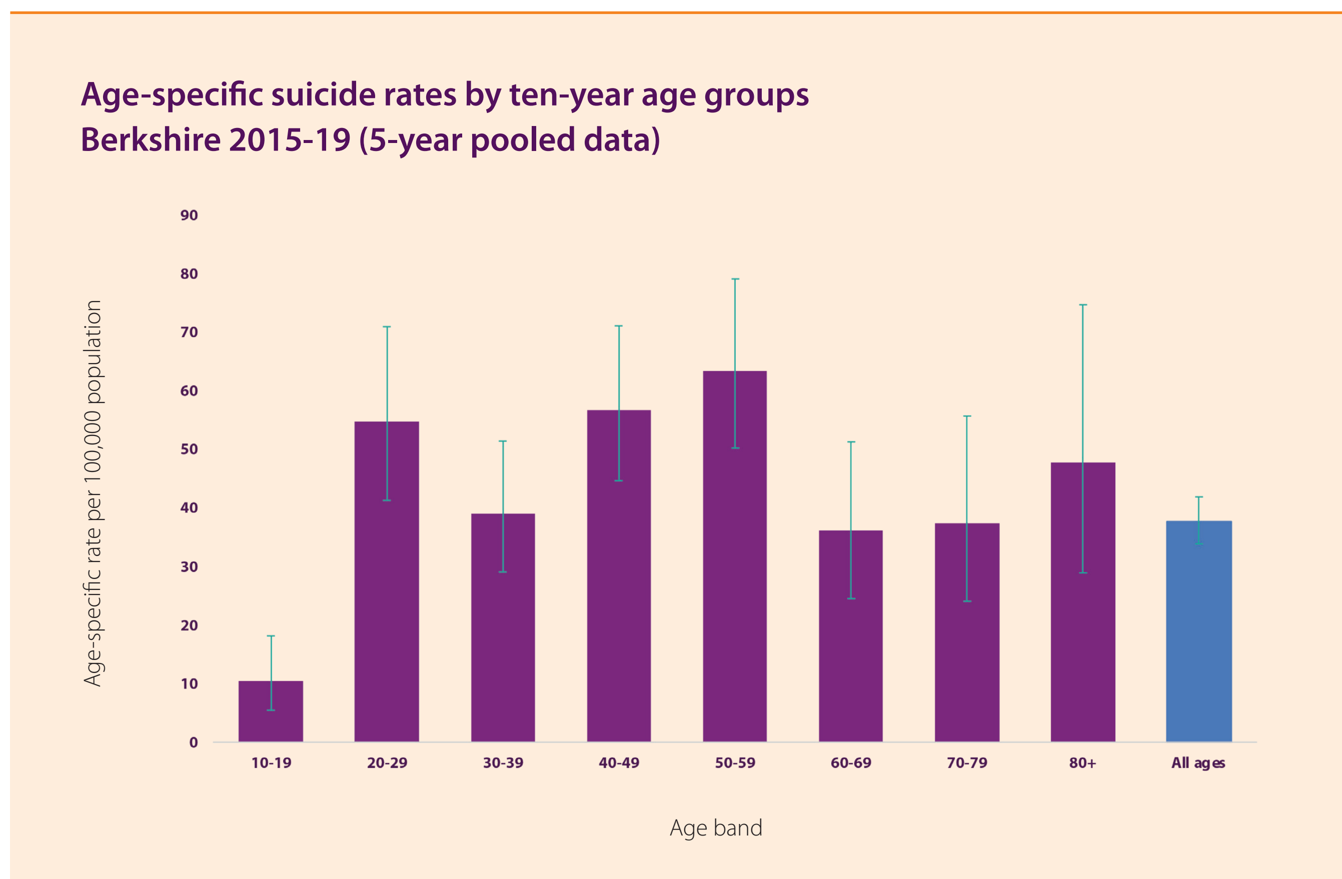


Source: Public Health England Suicide Prevention Profile

Age and Gender Berkshire

Since the 1980s age-specific suicide rates in England have shown a consistent pattern, peaking among the middle-aged (40-54 years) before decreasing until the ages of 80-84, from which they begin to rise. In order to assess age-specific suicide rates in Berkshire, it is necessary to pool together five years' worth of data. This is done to reduce the chance of identifying differences that have occurred at random within the data, which is more likely to happen when numbers are relatively small. It allows identification of statistically significant differences between groups.

Figure 4: Age-specific suicide rates



Source: ONS Civil Registrations Data provided under license by NHS Digital

Age-specific suicide rates in Berkshire generally show a similar pattern to the national picture. They peak in the 50-59-year-old age band before decreasing until the age of 80 plus years. In Berkshire, suicide rates in the 40-49-year-old age group (57 per 100,000) and in the 50-59-year-old age group (63 per 100,000) are significantly higher than the average for all age groups (37 per 100,000). Nationally, suicide rates in males aged 10 to 24 years, and 25 to 44 years have been increasing since 2017. In 2019, the suicide rate among females aged 10 to 24 years in England and Wales is the highest recorded since 1981. In Berkshire, the suicide rate in the 20-29-year-old age group is significantly higher (55 per 100,000) than the average for all age groups.

In England, three quarters of all suicides are male suicides. In Berkshire between 2017 and 2019, the male age-standardised suicide rate was 14.1 per 100,000 which is lower than the rate for England (15.5 per 100,000) and similar to the rate for the South East (14.6 per 100,000). The proportion of suicides that were male suicides for Berkshire local authorities between 2017 and 2019 range from 69% in Windsor and Maidenhead to 90% in Slough. Age-standardised rates for male suicides range from 11.1 per 100,00 in Wokingham and Windsor and Maidenhead, to 16. 6 per 100,000 in Bracknell Forest. Numbers are too small to detect any statistically significant differences between Berkshire local authorities, or between Berkshire local authorities and the regional and national averages but do suggest some variation between areas in both the male suicide rate and the proportional of all suicides that are male suicides.

Table 2: Male suicides

	Male deaths			Male age-standardised rate per 100,000			Proportion of all deaths by suicide that are male deaths		
	2015-17	2016-18	2017-19	2015-17	2016-18	2017-19	2015-17	2016-18	2017-19
England	**10392**	**10592**	**11145**	**14.7**	**14.9**	**15.5**	**75%**	**75%**	**75%**
South East Region	**1643**	**1606**	**1707**	**14.3**	**13.9**	**14.6**	**74%**	**73%**	**74%**
Bracknell Forest	30	24	24	19.7	16.9	16.6	94%	89%	86%
Slough	26	34	28	13.0	17.9	16.0	87%	89%	90%
Windsor and Maidenhead	20	21	22	10.7	11.1	11.1	61%	64%	69%
Reading	27	20	28	13.2	10.4	13.8	82%	71%	74%
West Berkshire	27	28	32	13.5	14.0	15.8	77%	80%	80%
Wokingham	25	19	23	12.0	9.1	11.1	71%	66%	79%
Berkshire	**155**	**146**	**157**	**13.7**	**13.2**	**14.1**	**78%**	**77%**	**79%**

Source: Public Health England Suicide Prevention Profile

The numbers of female suicides at a local authority level are very small. There were 41 female suicides across all Berkshire local authorities between 2017 and 2019. Age-standardised rates can only be calculated for Reading, and Windsor and Maidenhead local authorities for this time period, as these are the only local authorities with 10 or more female suicides. The 2017-19 female suicide rate for Reading is 5.5 per 100,000 and the rate for Windsor and Maidenhead is 5 per 100,000. These figures are both in line with England (4.9 per 100,000) and the South East Region (4.8 per 100,000).

Occupation Group

Office of National Statistics (ONS) death registration statistics categorise a person's occupation using the Standard Occupational Classification (SOC) 2010. The analysis below looks at the Major SOC Group of people who have died from suicide or an injury of undetermined intent who were resident in Berkshire and who died between 2015 and 2019. Anyone aged less than 16 has been excluded. 'Student' is not included in the SOC so this category has been added based on the occupation recorded on the death registration. This resulted in 237 deaths being included in the analysis based on data on deaths registered between 2015 and 2019.

Table 3: Major Occupation Groups

Major Occupation Group	Deaths from suicide and injury of undetermined intent 2015-19	% of all deaths from suicide and injury of undetermined intent	Lower limit	Upper limit
Administrative and Secretarial Occupations	*	*	*	*
Associate Professional Occupations	31	13%	9%	18%
Caring, Leisure and Other Service Occupations	18	8%	5%	12%
Elementary Occupations	**26**	**11%**	**8%**	**16%**
Managers, Directors and Senior Officials	**22**	**9%**	**6%**	**14%**
Process, Plant and Machine Operatives	20	8%	6%	13%
Professional Occupations	30	13%	9%	17%
Sales and Customer Service Occupations	*	*	*	*
Skilled Trades Occupations	61	26%	21%	32%
Student	14	6%	4%	10%
Total Deaths	**237**			

Source: ONS Civil Registrations Data provided under license by NHS Digital

In Berkshire, between 2015 and 2019, a quarter of people dying from suicide had an occupation group of 'Skilled Trades Occupations' (26%).

Seasonal Variation

A count of the number of suicides in Berkshire by the season in which death occurred does not reveal any seasonal variation, ranging from 70 in the Winter to 95 in the Autumn (see Joint Strategic Needs Assessment (JSNA).

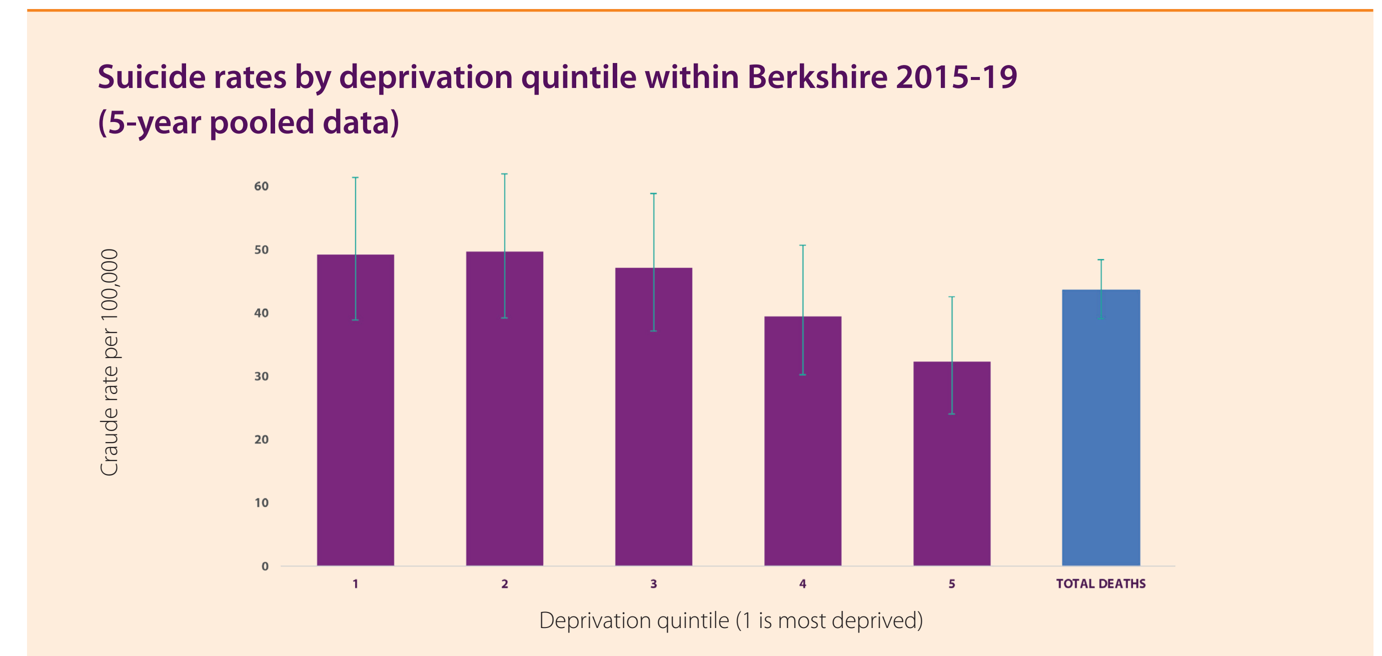
Deprivation

The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation in England. It is an overall measure of deprivation experienced by people living in every Lower Super Output Areas (LSOA), or neighbourhood, in England. All neighbourhoods are ranked according to their level of deprivation and are grouped into 10 equal groups (deciles). These groups describe each area based on which decile of the IMD it falls into. Group 1 being the most deprived 10% and group 10 being the least deprived 10%.

Neighbourhoods in Berkshire are not evenly distributed across these 10 national deciles with neighbourhoods in some Local Authority areas in Berkshire being heavily skewed towards the least deprived deciles. Therefore, to assist in looking at suicide data in Berkshire by deprivation, Berkshire neighbourhoods have been ranked in order of deprivation when compared to all other neighbourhoods in Berkshire. They have been split into 5 equal groups (quintiles) in order to describe each neighbourhood in terms of how deprived it is in relation to all other Berkshire neighbourhoods. Group 1 neighbourhoods are the least deprived in Berkshire, group 5 neighbourhoods are the most deprived in Berkshire.

Suicide rates are lowest amongst people living in the least deprived areas (32 per 100,000 in quintile 5) and higher amongst those living in the more deprived areas (49 per 100,000 in quintiles 1 & 2), although this is not statistically significant.

Figure 5: Suicide rates by deprivation



Source: ONS Civil Registrations Data provided under license by NHS Digital

Real-Time Surveillance System Data

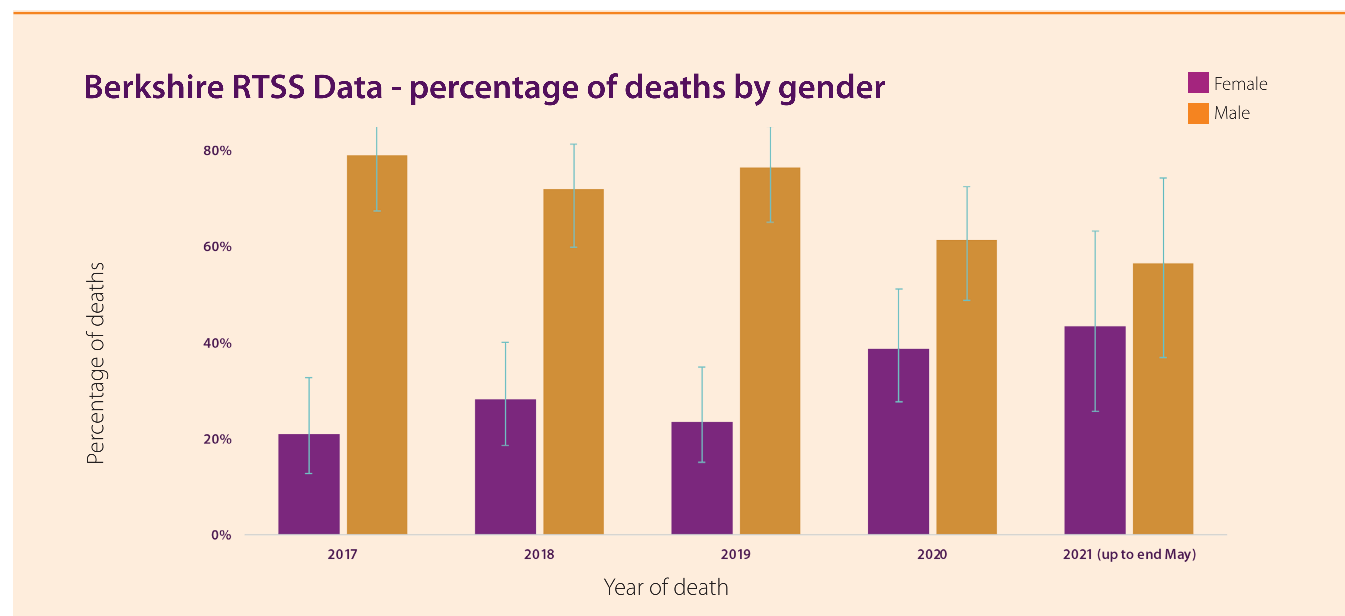
Because of the delay between a death by suicide being counted in the ONS data, Local Real Time Surveillance Systems (RTSSs) have been developed to allow early data capture and sharing of information amongst key partners working on suicide prevention. This means that ahead of a formal verdict, organisations involved in suicide prevention work can review incidents so that trends or patterns can be spotted and acted on quickly, e.g. in terms of enhanced surveillance or additional promotion of support to groups at higher risk.

Details of suspected suicides are usually gathered by a police officer attending the scene of a sudden death, but sometimes by a coroner's officer receiving a sudden death report, or by a member of hospital staff. What information is available regarding an individual's background and circumstances is very much dependent on what relatives or close friends are available to share, and how well informed they may be.

In addition to demographic information such as gender and age, the RTSS in Berkshire captures marital status, occupation, local authority area of residence, GP details, known contact with mental health services, and any other information on circumstances which appears may be relevant to the suicide at the time of compiling the initial report. Since March 2020, any known impacts of the Covid-19 pandemic on the individual are also noted, e.g. reduced access to support, impact of isolation, additional economic or other stresses.

280 suspected suicides were recorded in the Berkshire RTSS between 1st January 2017 and 27th May 2021. Two thirds were male. However, the gender difference in suicides recorded in the RTSS notably reduced in 2020 with 39% of all suspected suicides being female suicides. This can be compared to 21% of all suspected suicides being female suicides in 2017. The gender difference became no longer statistically significant in 2020 and this trend appears to be continuing into the early part of 2021. Suspected suicides amongst females have increased year on year since Berkshire RTSS data began been collected in 2017

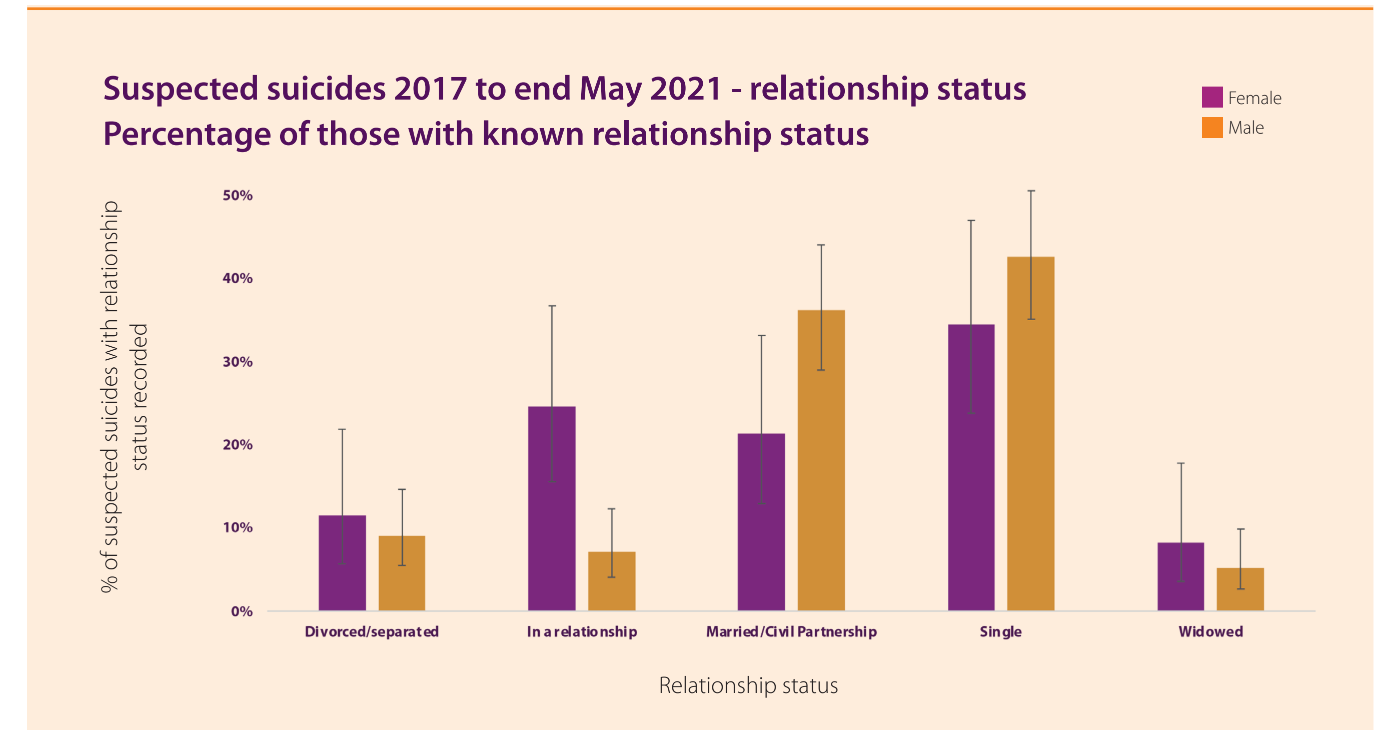
Figure 6: Suspected suicides by gender



Source: Berkshire Real Time Suicide Surveillance Data

Almost 80% of suspected suicides had information detailing relationship status collected via the RTSS. Of those with known relationship status, 40% were single (35% of females and 43% of males). Relationship status varies by gender with females been significantly more likely to be in a relationship (not including marriage and civil partnerships) than males.

Figure 7: Suspected suicides by relationship status and gender



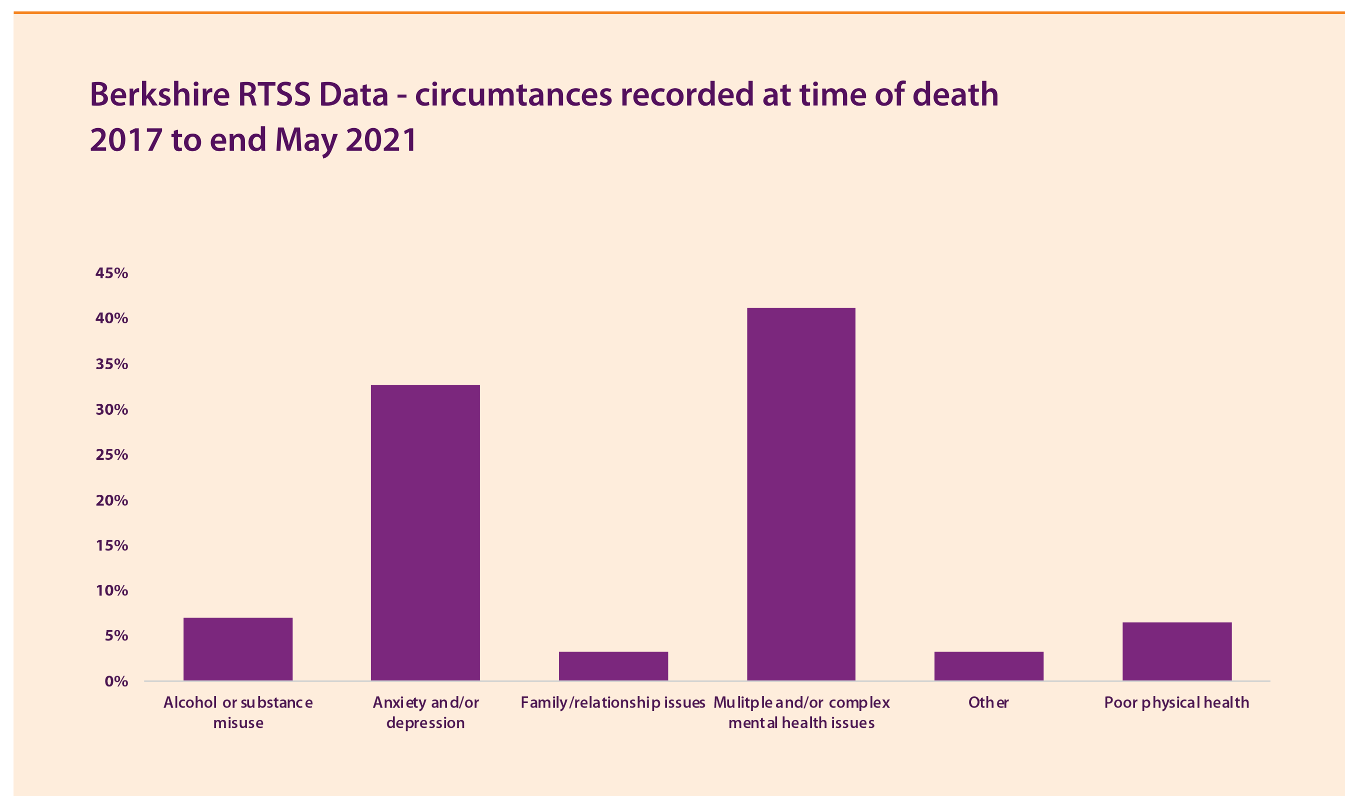
Source: Berkshire Real Time Suicide Surveillance Data

67% of suspected suicides occurred in a person's own home, 20% occurred in a place accessible by the general public and the remainder occurred in a communal establishment or hotel. Analysis of method of suicides indicate a similar pattern to the national picture with hanging, strangulation, and suffocation recorded for 66% of suspected suicides and poisoning recorded for 20% of suspected suicides.

As part of RTSS, information is collected on medical history of the individual including known illnesses, contact with health services, and anything else that may be relevant. There is also a section for describing the circumstances leading up to the death. These are extracted and summarised to provide a description of any individual circumstances that may be relevant to the potential suicide. For the purpose of this strategy, these circumstances have been grouped into 10 categories. This will not be a full and complete picture of the circumstances leading to individual deaths but will be indicative of patterns at a population level that may warrant further investigation.

From the 187 potential suicides where information was provided around the relevant medical history and/or the circumstances leading to death, 41% had multiple or complex mental health issues. A further 33% have a history of anxiety and/or depression. Other reported factors included alcohol or substance misuse in the absence of any other recorded mental health issue (7%) and poor physical health (6%). Previous suicide attempts were mentioned in relation to 22 deaths (12%). Direct links to the Covid-19 pandemic were flagged in 8 suspected suicides.

Figure 8: Suspected suicides by circumstances recorded at time of death



Source: Berkshire Real Time Suicide Surveillance Data (data with underlying numbers of <5 have been suppressed)

It is likely that this data will be skewed towards the more immediately apparent factors with other, indirect contributing factors only coming to light through further investigation into the death. At inquest, for example, additional information is usually reported regarding the circumstances and personal characteristics of the person who died, although there is some variation between coroners' courts and in how much information it is possible to confirm in individual cases.

Berkshire Audits and Deep-dive Analyses

The purpose of suicide audits is to review coroner court reports to gain richer demographic, risk and protective factor intelligences than can be derived from the ONS data sets or from RTSS data. Deep-dive analysis is done where audit or RTSS data indicates concerns that require further investigation.

Berkshire Suicide Audit (2018)

The most recent Berkshire Suicide Audit covered coroner verdicts across the period 1st April 2014 through to 31st March 2018 and included a review of 241 hearings.

- The Berkshire profile broadly matched the national profile in terms of gender.
- Some age variations were noted but not at a statistically significant level.
- No statistically significant difference was found between suicide rates in areas of relative deprivation in Berkshire.
- The majority of people included were either in full-time work (24%), unemployed (20%) or retired (18%).
- 80% of all of those who were employed had a job title recorded and 43% of these worked in a skilled trade.
- 6% of all people included were recorded as being in education at the time of death.

The 2018 Audit highlighted the following personal and social factors as seen on a recurring basis in inquest reports:

- Relationship difficulties (67%)
- One or more mental health diagnosis (63%)
- One or more physical health condition (61%)
- History of self-harm (21%)
- Work-related stress (20%)
- Financial issues (19%)
- Involvement with police or courts (15%)
- Bereavement by suicide (6%)

This information is helpful in identifying risk factors which can help to target local interventions and signposting to support services to work towards preventing deaths by suicide.

The 2018 Audit included a review of which services individuals were known to have been in contact with.

- 10% of all individuals were known to substance misuse services in their lifetime. 20% had a documented history of alcohol misuse and 17% had documented history of drug misuse.
- 51% of those who died and who were registered with a GP had seen their GP within 1 month prior to the date of death (compared to 45% nationally).
- 36% of all deaths occurred to people known to mental health services (compared to 33% nationally), and 31% of individuals had been in contact with mental health services in the 12 months prior to their death (compared to 30% nationally).

This information is particularly useful in identifying which agencies to target for suicide prevention activities such as awareness training for staff, as well as potential locations for signposting material. It should be noted that the 2020-21 deep dive analysis of female suicides (see below) suggests some changes in health support seeking behaviour since this audit was completed.

Recommendation 1c: To undertake a Berkshire suicide audit.

Recommendation 1d: Undertake regular reviews of information, resources and channels for people affected by suicide. This action is applicable to all areas of this strategy.

Berkshire 0-25 Audit (2020)

NHS England has co-ordinated a series of reviews into deaths from suicide by children and young people, including a Berkshire audit of people aged 0-25 who died by suicide in the period 2015-20. This focused work helps to mitigate against the risk of issues particularly pertinent to young people getting overlooked in an all-age approach, within which deaths by younger people are a minority.

For the Berkshire 0-25 Audit, information was drawn from the Child Death Overview Panel (CDOP), Berkshire Healthcare Foundation Trust, Thames Valley Police, and the Coroner's Office. A total sample of 35 young people were included in the analysis. Analysis around ethnicity; and wider experience of adversity, trauma, and socio-economic risk factors were based on the CDOP qualitative sample of 7 young people. Key findings of the audit are highlighted below with an acknowledgement that caution needs to be given when deriving patterns from a relatively small sample size.

- Females were over-represented by comparison with national data (a trend mirrored in the female deep-dive analysis summarised below)
- The Berkshire age profile did not align with the national picture, but indicated local peaks in the 15-19 and mid 20s age ranges
- Young people from black or minority ethnic groups were over-represented by comparison to national data
- Data on faith, gender identity and sexuality were difficult to source
- Adverse childhood experiences (which includes domestic abuse, parental separation, involvement with criminal justice, poverty within this audit) – were noted in 71% of cases
- Neurodiversity was an identified risk factor
- Postvention support for young people following a suicide attempt was indicated as an area for development.

Berkshire female deaths deep-dive analysis (2021)

RTSS data had highlighted an increase in the proportion of all suicides which are female suicides from 21% in 2017 to 39% in 2020. Female suicides have shown a small but steady increase from 13 in 2017 to 24 in 2020. Whereas male suicides have not followed this increasing pattern but have overall decreased from 49 in 2017 to 38 in 2020. There is a continuing unusual pattern in the numbers of females dying by suicide in Berkshire, by comparison with previous years and by comparison with patterns in the RTSS data for other parts of the Thames Valley.

The Berkshire Suicide Prevention Group agreed in 2020 that the number of female suspected suicides in Berkshire was sufficiently unusual to convene a response group to look at cases in more depth. A sub-group was therefore formed to carry out a deep-dive review.

This deep-dive was based on RTSS data and further supplemented by further enquiries of GP practices, secondary mental health care (particularly Serious Incident Review findings), and of bereaved families where appropriate and possible, without re-traumatising. Further information from families was also gathered via contact with Berkshire's specialist postvention service, where families elected to take up this service. Information was obtained from GP records for 80% of the women whose deaths were considered as part of this analysis. In most cases, however, little information was available from primary care sources to supplement what was already captured within the RTSS. Several GPs volunteered that the patient had not been seen by the practice for some time prior to death. Given the findings from the 2018 Berkshire audit that around half of the people included in that review had seen their GP within a month of their death, this may indicate a change in health supporting seeking behaviour during the COVID-19 pandemic, a pattern which has been observed from other surveys over this period.

Across the period January 2020 to May 2021, female deaths were highest in Slough and Reading of the six Berkshire unitary areas, accounting for 26% and 37% of all female deaths respectively. Up until the age of 60, there is an increasing trend in the number of suicides by age. When considering 10-year age bands, deaths are highest in the 40-49 and 50-59 year-old age groups, with these two groups accounting for 49% of deaths by suicide in females.

Although the numbers are too small to identify statistically significant themes, several issues were identified for more than one of the women who died:

a. A mental ill-health diagnosis and /or history of contact with mental health services (found to be the case for all women where it proved possible to obtain further information from GP records)
b. Adverse Childhood Experiences - most often related to sexual abuse, but also loss of or separation from parents
c. History of self-harm
d. History of alcohol or substance abuse
e. Parenting / carer stress
f. Financial stress
g. Domestic abuse
h. Workplace stresses and adjustment challenges, particularly for those in a health, care or other frontline role (including childcare and police)
i. Neurodiversity
j. Bereavement and grief
k. History of disordered eating
l. Denial of suicidal intent at the time of last contact with services

Although clear and direct links to the impact of COVID-19 appear in only a small number of the cases considered so far, there may be other and more subtle links, such as have come to light where it has proved possible to have further discussion with bereaved relatives. As the pandemic and associated control measures have disrupted access to services for many people, this makes it more difficult to gather information about people's circumstances just prior to death, e.g. via enquiries of primary care. The impact of COVID-19 remains an issue to consider.

Local development of this strategy

Our previous Berkshire Suicide Prevention Strategy 2017-2020 mirrors the national 2012 strategy, and so remains current as there has been no national update. This strategy is therefore a refresh of the previous strategy, using local data and intelligence to prioritise our efforts across Berkshire to reduce suicide risk.

Methodology

This strategy has been developed with the view that it builds on and takes forward the information, knowledge and action that is covered in the Berkshire Suicide Prevention Strategy 2017-2020. In this sense, it is a refreshed strategy that benefits from utilising the expertise of members of the long-established Berkshire Suicide Prevention Steering Group that has been in place for over five years.

Whilst there has been no formal public consultation, as was done previously, this strategy has a local focus and contains the perspectives from professionals working in the statutory, private and third sector organisations. Colleagues who support people who have been directly affected by suicide have also been involved, who have worked with sensitivity to engage this group with this strategy. The strategy reflects the commitments of the Berkshire Suicide Prevention Steering Group who worked together on identifying the key priorities, which have been derived from reviewing local data, intelligence, and information.

A small subgroup of the Berkshire Suicide Prevention Steering Group was responsible for further defining the content for each of the priorities and providing regular updates to and receiving feedback, from the main steering group.

Principles

This strategy is a refresh of our previous strategy, in that our priorities last time, and the priorities of the national strategy, are now our guiding principles to how we work to prevent suicide across Berkshire. The 7 guiding principles for this strategy are;

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring
7. Reduce rates of self-harm as a key indicator of suicide risk

Vision

The suicide prevention group have acknowledged that there is a need for a more personalised strategic direction in how we prevent suicide locally, and that we need to consider risk factors across the whole lifecourse to truly prevent suicide.

Vision: To reduce deaths by suicide in Berkshire across the lifecourse and ensure better knowledge and action around self-harm.

Priority areas for action

Rather than the 6 action plans from the last strategy across each local authority, there has been an agreement to agree common priorities for action across Berkshire.

Based on the local data, and what is happening locally, we have agreed to focus on 5 core priority areas. These principally address the national priority to tailor approaches to improve mental health in specific groups, but we remain committed to all our principles and reducing suicide rates across all population groups. Our local intelligence has demonstrated a need to focus on the following key areas;

1. Children and Young People
2. Self-harm
3. Female suicide deaths
4. Economic factors
5. People bereaved or affected by suicide

Whilst these are our agreed strategic priorities across Berkshire, there will remain a need to monitor trends and risk factors, particularly from the impacts of COVID-19 and to respond to latest changes.

Governance

Our suicide prevention steering group is a well engaged group of stakeholders across the Berkshire system, including public health colleagues across the 6 local authorities, Clinical Commissioning Group (CCG) colleagues across the 2 CCG areas, representation from those bereaved suicide, and the voluntary sector. This group has worked to the evidence base and has responded flexibly to meet the changing patterns in deaths by suicide to prevent suicide.
Leads will be identified for each priority area, and working groups established to take these recommendations forward. The suicide prevention group will continue to have overall responsibility of the delivery of the recommendations set out in this strategy.

Recommendation 1e: Hold an annual multi-agency conference on a range of topics to share information and best practice and raise awareness to the risks for suicide.

Recommendation1f: Invite additional partners across the System within Berkshire, including the voluntary and community sector to join the Berkshire Suicide Prevention Steering Group for improved cross-topic working.

Recommendation1g: Set up sub-groups of the Berkshire Suicide Prevention Steering Group, informed by local intelligence and data, where there is a need to focus upon a risk factor or group within the population.

Priority Area 1: Children and young people

The UK has a relatively low rate of suicide by children and young people compared to other countries, however suicide is one of the leading causes of death in children and young people in the UK[15]. There has been growing concern over the rising rates of suicide and self-harm in children and young people[16]. Childline has reported that the number of referrals their counsellors have made to external agencies due to suicidal concerns has seen a steep increase since 2009/10 to 2018/19, from 283 to 3,518 referrals[17].

The Royal College of Paediatricians and Child Health's 2020 report into the State of Child Health notes that suicide in children and young people may be associated with many factors, including poor mental health; self-harm; academic pressures or worries; bullying; social isolation; family environment and bereavement; relationship problems; substance misuse; or neglect. Adverse childhood experiences, stressors in early life and recent events also contribute to the risk. Suicide represents the extreme end point of mental ill-health in children and young people, there are many more that experience suicidal ideation, attempt suicide and an even higher number self-harming. Although most children and young people who self-harm may not take their own life, it is a strong risk factor for suicide in the future[18]. A retrospective study found that for every suicide death in the age range of 12 – 17 year olds, it is estimated that there are 100 and 1000 times more hospital attendances for self-harm for males and females respectively[19]. This is discussed in more detail within the self-harm chapter of this strategy.

Good mental health and emotional wellbeing in children and young people can help build resilience, and in turn become a protective factor against suicide. The NHS five-year forward view recognises that children and young people are a priority group for mental health promotion and prevention. Early intervention and quick access to good quality care is vital – especially for children and young people. Waiting times should be substantially reduced, significant inequalities in access should be addressed and support should be offered while people are waiting for care[20].

The NCISH 2017 report on suicide by children and young people highlighted themes that should be specifically targeted for prevention[21];

- Support and management of family factors like mental illness or substance misuse
- Childhood abuse
- Bullying
- Physical health
- Mental ill health
- Alcohol or drug misuse

[15] Royal College of Paediatrics and Child Health (2020) State of Child Health. London: RCPCH. Available at: stateofchildhealth.rcpch.ac.uk Last accessed 10/08/21
[16] Samaritans (2019) Suicide Statistics Report – Latest statistics from the UK and Northern Ireland. Surrey: Samaritans. Available at SamaritansSuicideStatsReport_2019_Full_report.pdf Last accessed 10/08/21
[17] Royal College of Paediatrics and Child Health (2020) State of Child Health. London: RCPCH. Available at: stateofchildhealth.rcpch.ac.uk Last accessed 10/08/21
[18] Bould H, Mars B, Moran P, Biddle L, Gunnell D. Rising suicide rates among adolescents in England and Wales. Lancet 2019; 394: 116–7
[19] Geulayov G, Casey D, McDonald KC, et al. Incidence of suicide, hospital-presenting non-fatal self-harm, and community-occurring non-fatal self-harm in adolescents in England (the iceberg model of self-harm): a retrospective study. The lancet Psychiatry 2018; 5: 167–74
[20] NHS Five Year Forward View. NHS (2014). Available Five Year Forward View (england.nhs.uk) Last accessed 02/09/21
[21] NCISH Suicide in Children and Young People. NCISH (2017) Available NCISH | Suicide by children and young people in England - NCISH (manchester.ac.uk) Last accessed 12/08/21

Groups highlighted to be at increased risk of death from suicide included young people who are bereaved, students, looked after children, young people who identify as LGBT. Previous self-harm was a crucial indicator of risk with around half of young people who had died by suicide having previously self-harmed.

Within Berkshire, children and young people's mental health and wellbeing is a strategic priority across the system. It is therefore important that this strategy and the work of the suicide prevention group collaborates with the system to ensure complementary action. This includes the Berkshire West Health and Wellbeing Strategy for Reading, West Berkshire and Wokingham for which priority 4 is to 'Promote good mental health and wellbeing for all children and young people'. Each of the three local authorities in the East (Bracknell Forest, Slough, and Windsor and Maidenhead) also have a strategy addressing children and young people and/or mental health as a priority for their areas.

CCGs with system wide partners refresh their Children and Young People's Mental Health and Wellbeing Local Transformation Plans (CYP MH&WB LTP) and LTP's cover investment within prevention, postvention and bereavement support for children and young people.

Key data relevant for the work of this strategy are presented under each priority area for action. A full list of local data around the risk factors in childhood and adolescent are presented in the suicide data deep-dive analysis JSNA.

Five areas for action have been identified for Berkshire based on local data and intelligence;

- Experience of adversity or trauma
- The impact of COVID-19
- Neurodiversity
- Lesbian, Gay, Bisexual, Transgender, Queer, Questioning and Ace (LGBTQ+)
- Transitions

Experience of adversity or trauma

The 0-25 suicide audit (2020) identified that adverse childhood experiences (ACE's) were present in 71% of the cases (CDOP sample of 7 young people). In addition, the female suicide deaths deep-dive analysis (2021) found that ACE's were a theme common to more than one of the women who died. There is no universally agreed definition of ACE's, but studies addressing issues have converged on the list below, as outline by the Early Intervention Foundation[22]:

- physical abuse
- sexual abuse
- psychological abuse
- physical neglect

[22] Adverse childhood experiences What we know, what we don't know, and what should happen next. Early Intervention Foundation (2020). Available: adverse-childhood-experiences-summary (1).pdf. Last accessed 02/09/21

- psychological neglect
- witnessing domestic abuse
- having a close family member who misused drugs or alcohol
- having a close family member with mental health problems
- having a close family member who served time in prison
- parental separation or divorce on account of relationship breakdown.

ACE's occur before the age of 18, however the effects are often experienced over the lifecourse. A toxic stress response can be triggered by these experiences in the acute phase. Adversities can affect development in numerous ways, with early exposures that are persistent over time more likely to lead to lasting impacts[25]. There is strong empirical evidence that links ACE's with suicide across the lifecourse[23 24].

Although there isn't data available specific to ACE's on a localised level, data relating to the numbers of Children in Need give an indication of the numbers of children experiencing trauma and adversity across Berkshire. On the 31st March 2020, nearly 7,000 children were identified as being in need across Berkshire, as shown in the table below. The most common primary need, accounting for over half of cases, was abuse or neglect. This was followed by family dysfunction and family being in acute stress which, combined, accounted for over 1,440 cases[25].

Table 4: Children in need by primary need at initial assessment, Berkshire 2020

Local authority	All cases	Abuse or neglect	Child disability or illness	Parents disability or illness	Family in acute stress	Family dysfunc-tion	Socially un-acceptable behaviour	Low income	Absent parenting
Bracknell Forest	879	486	72	49	65	104	47	0	10
Reading	1451	713	111	68	225	131	44	c	c
Slough	1589	1190	129	54	29	65	68	10	29
West Berkshire	930	397	100	12	136	198	38	0	49
Windsor and Maidenhead	883	421	73	21	128	194	13	0	33
Wokingham	1039	519	96	52	124	49	c	0	35
Berkshire Total	**6771**	**3726**	**581**	**256**	**707**	**741**	**210**	**10**	**156**

Source: Department for Education

[23] Adversity in childhood is linked to mental and physical health throughout life BMJ 2020; 371 doi: https://doi.org/10.1136/bmj.m3048 (Published 28 October 2020)
[24] Ports KA, Merrick MT, Stone DM, et al. Adverse Childhood Experiences and Suicide Risk: Toward Comprehensive Prevention. Am J Prev Med. 2017;53(3):400-403. doi:10.1016/j.amepre.2017.03.015
[25] NHS Digital calculated using ONS mid-2020 population estimates

Many children and young people who have experienced ACE's go on to lead healthy and productive lives. Protective factors, such as having a stable and caring child-adult relationship and feeling connected with others can build resilience. An enhancement of these factors has been shown to mitigate negative outcomes[26]. Across Berkshire there are a wealth of services and interventions in place to prevent and mitigate the impact and reduce harm for children and young people who are at risk of or have experienced trauma and adversity. This work is happening across schools, police, NHS and voluntary sector organisations. Our role is therefore to complement this workstream and highlight the link between ACEs and suicide risk.

Recommendation 2a: To raise awareness of the link between trauma and adversity, and suicide across the lifecourse.

Recovery from the COVID-19 Pandemic

The impact of the COVID-19 pandemic and subsequent lockdowns has raised concerns that children and young people's mental health will be adversely affected and will need to be closely monitored[27]. It has been noted that outbreaks of suicidal thoughts have increased during lockdown, especially among young adults[28]. Additional stressors during the pandemic may include fears that a family member or oneself will develop COVID-19, the impact of bereavement, isolation, loneliness and loss of social supports, disruptions to care and support and fears about accessing it, school closure and exam disruption, and exposure to domestic violence and family tensions[29]. Many of these stressors are documented risk factors for suicide in children and young people and have potentially increased the risk of children experiencing ACE's, therefore the impact must be monitored.

A COVID-19 flag has recently been introduced for RTSS data locally for Berkshire. Since this has been introduced, no suicide cases have been flagged within the cohort of 0-25 as related to COVID-19, however there is a need to continue to record and monitor this.

In response to the impact of the pandemic and concerns around mental and emotional wellbeing of children and young people, all Berkshire local authorities have committed to a mental wellbeing campaign "Be Well: Berkshire Emotional Wellbeing". The campaign aims to mobilise younger residents and women at risk of suicide across Berkshire to access support services, to help them stay mentally well during the Covid-19 pandemic and as we recover. Mental health support is also offered through Kooth, an online counselling and emotional wellbeing platform. Within Berkshire, the top presenting concerns in the year 2020/21 have been anxiety and stress, suicidal thoughts and self-harm. There is a need to both ensure increased access to support as we recover from COVID-19 and ensure we link with the wider system to prevent suicide risk.

Recommendation 2b: Continued investment into the Be Well campaign to encourage the importance of looking

[26] The evidence behind Adverse Childhood Experiences. Available: Evidence-based early years intervention - Science and Technology Committee - House of Commons (parliament.uk) Last accessed 10/08/21
[27] BMA. The impact of COVID-19 on mental health in England; Supporting 1 services to go beyond parity of esteem. 2020 Available [bma-the-impact-of-covid-19-on-mental-health-in-england.pdf] Last accessed 10/08/21
[28] Covid-19: Suicidal thoughts increased in young adults during lockdown, UK study finds BMJ 2020Available at]Covid-19: Suicidal thoughts increased in young adults during lockdown, UK study finds | The BMJ Last accessed 02/09/21
[29] Holmes EA, O'Connor RC, Perry VH, et al. Multidisciplinary research priorities for the COVID19 pandemic: a call for action for mental health science. The Lancet Psychiatry 2020; 7: 547– 60

after emotional wellbeing, in addition to signposting to local mental health services and support in order to prevent self-harm and suicide in children, young people, and women.

Neurodiversity

Neurodiversity was identified as a risk factor for suicide in the 0-25 suicide audit (2020), with further qualitative analysis recommended of the impact of waiting for an autism assessment on children and young people's mental health and suicide risk. Neurodiversity refers to the different ways the brain works and interprets information. It is often used as an umbrella term for a spectrum of conditions such as autism, attention deficit hyperactivity disorder (ADHD), dyslexia, dyspraxia, tourette syndrome and complex tic disorders. It is estimated that 1 in 7 people (approximately 15% of the UK population) are neurodiverse[30].

It is well documented throughout literature that neurodiverse conditions can increase the risk of suicide, for both adults and children and young people. NICE guidance recognises that people with autism are at higher risk of suicide[31]. Research also shows that late diagnosed adults appear to be at the highest risk of suicidal thoughts and behaviours, demonstrating the importance of identification and addressing needs at the earliest opportunity[32].

Data on the number of children and young people with a statement of special educational needs (SEN) or education, health and care (EHC) plan for 2020/21 by primary need for pupils enrolled in schools and nurseries in Berkshire[33] gives an indication of the number of children that are neurodiverse. The most consistent pattern to emerge is for children with a primary need of Autistic Spectrum Disorder, with the majority of local authorities having higher rates of children with SEN support and or/statements/EHC plans with this as their primary needs than the regional average. The full local data on SEN and EHC plans can be found in the JSNA.

There are a number of neurodiversity projects taking place within Berkshire. This includes a service redesign for East Berkshire Healthcare Children and Young People autism and/or ADHD services with a core focus to reduce waiting times for assessments and thus access to support. In Berkshire West all referrals are triaged at the BHFT CAMHs Common Point of Entry and referred to services as appropriate. Across Berkshire we have a wraparound offer of support with the provision of pre-assessment and post-diagnosis support; in the East through GEMS and in the West this is through Autism Berkshire, a voluntary sector organisation. There also exists a virtual Helpline, "SHaRON" that provides support for parents and carers of neurodiverse children and young people in Berkshire.

A needs-led rather than diagnosis led approach has been adopted throughout Berkshire, which means that families without diagnosis are also supported. This approach to neurodiversity allows for pre-diagnostic support to be put in place for children and young people once needs become apparent, through interventions such as changing environments to be more neurodiversity friendly and accessing peer networks. This support potentially reduces the risk of suicide for neurodiverse children and young people as interventions can be put in place as soon as needs are apparent and can reduce isolation experienced.

[30] Autism and.. Oxford Health (2021). Available Autism and.. - Oxford Health NHS Foundation Trust. Last accessed 26/08/21
[31] NICE (2018). NICE guidance on preventing suicide in community and custodial settings [NG105]. National Institute for Health and Care Excellence. Available: https://www.nice.org.uk/guidance/ng105. Last accessed 04/08/21
[32] Supporting autistic children and young people through crises: Autistica. Available: https://www.autistica.org.uk/downloads/files/Crisis-resource-2020.pdf Last accessed 17/08/21
[33] Figures are for state-funded nursery, primary, secondary and special schools, non-maintained special schools and pupil referral units. They do not include independent schools

Recommendation 2c: Support the system to adopt a needs-led approach for neurodiverse children and young people, particularly in the prevention and early intervention arena, e.g. in schools and the community.

Lesbian, gay, bisexual, transgender, queer, questioning and ace (LGBTQ+)

Data on the LGBTQ+ community at a local level is very limited and there is a reliance on national survey data to understand the needs of this group. Experimental statistics were published in May 2021 by the ONS looking at sexual orientation in the UK in 2019 using data from the Annual Population Survey. Younger people (aged 16 to 24 were most likely to identify as lesbian, gay or bisexual (6.6% of all 16 to 24-year olds). Facts and figures presented by Stonewall, a UK based LGBTQ+ charity include the following findings which are particularly relevant to the topic of suicide in young LGBTQ+ people:

- Half of LGBTQ+ people said that they've experience depression in the last year
- 2/3 bisexual women and just over half of bisexual men having experienced anxiety
- Nearly half of LGBTQ+ pupils are bullied for being LGBTQ+ in Britain's schools
- More than 4/5 transexual young people have self-harmed
- 3/5 lesbian, bisexual, and gay young people who are not transexual have self-harmed
- More than 2/5 transexual young people have attempted to take their own life
- 1/5 gay, lesbian and bisexual young people who are not transexual have attempted to take their own life.

The lack of local level data and intelligence surrounding the needs of LGBTQ+ children and young people makes this group a priority for action, to better understand their needs, and reduce suicide risk.

Recommendation 2d: To improve data capture on sexual orientation for all ages in RTSS data and promote this across the suicide prevention system.

Recommendation 2e: To work with local organisations and charities who work with the LGTBQ+ community on suicide prevention.

Transitioning from childhood to adulthood

A key transitional period in the life course is when we transition from childhood to adulthood (aged 16-25). This period is often characterised by changes and adjustments as young people are often expected to make key life changing decisions as they move into higher and further education, employment and their living situations. This may also be a time of new challenges, particularly around increasing independence and responsibility, and developing self-esteem.

During this period, young people may also transition with regards to their mental health treatment, from children's mental health services to adult mental health services. Consequently, this can mean changes to treatment, support workers and where they access services[37,38]. This can also increase the likelihood of young people not attending and

disengaging from services. There is therefore an increase of worsening mental health, and thus increased suicide risk during this period. It is therefore of importance that this transition is managed carefully and effectively so that the correct support and service is accessed and engaged with at the correct time.

University and work all present children and young people with new opportunities and challenges. For children and young people that face added risk factors at an individual level, such as those who have experienced trauma, or have special educational needs, they can be particularly vulnerable to experiencing a challenging transition[34]. A successful transition can help build resilience, self-confidence and self-esteem[35] which in turn can act as protective factors for mental ill health and suicide risk.

Locally, The University of Reading can be used as an example to demonstrate these complexities. . The University's student services run a variety of programmes to aid the transition for students. However, the university reports that the change from a home environment to campus life is sometimes a difficult transition, and is consequently a top reported student concern. Moving from one locality to another means a loss of support systems and friends, and can result in isolation.

There are additional complexities around transitioning medical care, if a student has existing difficulties, to a new locality and being able to access assessments for neurodiversity, where diagnosis was not arranged before arrival, in order to access the correct level of support.

Recommendation 2f: To raise awareness of the impact of the transitional period (children moving into adulthood) on the mental health impact and the risks of suicide during this period for children and young people.

Recommendation 2g: To link with the work across the BOB and Frimley ICS on the ease of access to shared care records across system partners for transition population (children moving into adulthood).

Recommendation 2h: To support higher education establishments within Berkshire, including universities to adopt a needs-led approach to neurodiversity.

[34] Bilsen J. Suicide and Youth: Risk Factors. Front Psychiatry. 2018;9:540. Published 2018 Oct 30. doi:10.3389/fpsyt.2018.00540
[35] Improving transition from children to adult mental health services Learning, messages and reflections from the LGA conference. Available at: https://www.local.gov.uk/sites/default/files/documents/39.2%20Improving%20transition%20from%20children%20to%20adult%20mental%20health%20services%20WEB.pdf. Last accessed 09/08/21

Priority area 2: Self-harm

Self-harm has been identified as a key priority and it's an area that the Berkshire Suicide Prevention Steering Group have wanted to explore for a while, due to the high rates in some areas. Self-harm is defined as an intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent. It is often difficult to say whether the self-harm act is suicidal as a person's reasons and intentions when self-harming can change over time. According to the Samaritans, self-harm is often not suicidal but is a risk factor for later suicidality and young people who self-harm are more likely than others to die from suicide[36]. Self-harm covers a wide range of behaviours that can cause injury or harm in some way, including isolated and repeated events. These can include[37];

- cutting with sharp or blunt instruments (e.g. razor blades, broken glass, plastic utensils)
- taking excessive amounts of over the counter medicines or prescribed drugs
- poisoning or ingesting
- scratching (with fingernails or other objects)
- banging, hitting or punching themselves to break bones and bruise themselves
- hair pulling,
- causing bruises to the body,
- interfering with wound healing,
- sticking sharp objects into the body
- inhaling substances (e.g. glue, aerosols, lighter fuel etc)
- swallowing inappropriate objects (e.g. razor blades)
- burning or scalding with hot water.

Every episode of self-harm is different, and people will experience it in different ways. Whatever method is used, the underlying feelings and distress underlying the behaviour must be taken seriously.

Self-harm and suicide attempts can also be detrimental to an individual's long-term physical health for example, paracetamol poisoning is a major cause of acute liver failure. Overdosing in particular is extremely dangerous as it is difficult to predict how your body will cope and can be impossible to reverse. Self-cutting can result in permanent damage to tendons and nerves. Many actions to prevent and reduce suicide will have physical health benefits for those who self-harm.

Self-harm is an important public health issue and often people keep self-harm a secret because of shame or fear of it being seen or being labelled or judged. They may cover up their skin in order to avoid discussing the problem. Sometimes there are psychological scars that are difficult to cope with, often unseen by others. Self-harm is not typically an attempt at suicide but self-harm is an important risk factor for suicide.

[36] Samaritans: Pushed from pillar to post (2020). Available https://media.samaritans.org/documents/Samaritans_-_Pushed_from_pillar_to_post_web.pdf. Last accessed 16/09/21
[37] https://wirralchildcare.proceduresonline.com/p_self_harm_suicide.html

Young people and self-harm

Public Health England (PHE) has also evidenced the continued increase in incidence of self-harm in the UK over the past 20 years, unlike trends in completed suicide[38]. Levels of self-harm among young people in the UK are among the highest rates in Europe. Trends in self-harm rates show that there has been an increase in self-harm, especially among young women where self-harm is more common. According to PHE, those who self-harm in mid-late adolescence potentially face increased risk of developing mental health issues.

Analysis of data from the Health Behaviour in School-aged Children survey for England (aged 11-15 years) conducted in 2014 found that 22% of 15 year olds reported that they have ever self-harmed. In addition, nearly three times as many girls as boys reported that they had ever self-harmed (32% of girls compared to 11% of boys). Findings from this survey also found that the likelihood of self-harming varied by socioeconomic status and structure of households, with incidence of self-harming associated with lower family influence[39].

Establishing an accurate prevalence of self-harm is difficult to precisely determine. This is because there is a "hidden" population of young people who self-harm in the community but do not present to local services for treatment. This is illustrated in the Iceberg model of self-harm, in that for every young person that presents to hospital for self-harm there are at least 10 further individuals who do not present at hospital for self-harm. At the tip of the iceberg are suicides, which are highly visible, beneath are higher rates of hospital-treated self-harm and at the base are very common but hidden self-harm (Hawton, 2019).

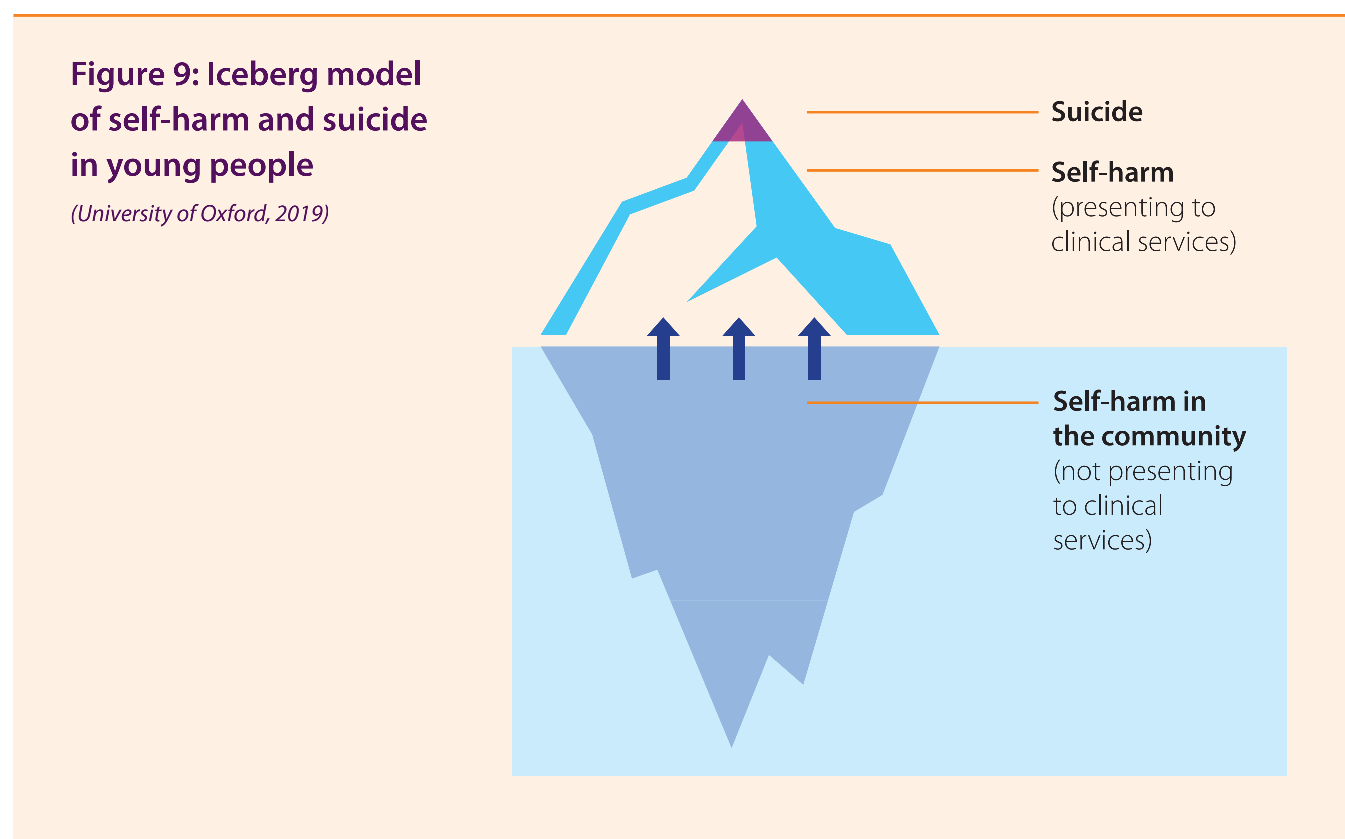


Figure 9: Iceberg model of self-harm and suicide in young people

(University of Oxford, 2019)

[38] Public Health England definitions
https://fingertips.phe.org.uk/search/self%20harm#page/6/gid/1/pat/6/par/E12000001/ati/102/are/E06000047/iid/21001/age/1/sex/4/cid/4/tbm/1

[39] https://www.gov.uk/government/publications/health-behaviour-in-school-age-children-hbsc-data-analysis

Only a small proportion of young people who have harmed themselves report seeking help from medical or psychological services. There needs to be a greater understanding on where people can get appropriate and timely support for self-harm, as well as fully understanding what may prevent this group from accessing support.

NHS England continues to work to ensure that every person who presents at an emergency department for self-harm receives a psychosocial assessment and is directed to appropriate support. And within South Central Ambulance Service (SCAS) a steering group is in place to evaluate training from an expert reference group to adapt and adopt content to different audiences, including universal clinician, social care and voluntary sector.

Understanding self-harm and its link to suicide risk

Those who repeat self-harm are at significantly greater risk of completing suicide than those who have a single episode. It can be difficult to differentiate behaviours where there is an intent to die (e.g. cutting with suicidal intent) from those where there is a pattern of self-harm with no suicidal intent (e.g. habitual self-cutting). Any intentional harm to the body counts as self-harm. 'Minor' self-harm can lead to progressively become more serious or frequent. Sometimes people harm themselves in ways that are dangerous, and they might accidently kill themselves (e.g. cutting too deep on certain parts of the body or overdosing). Young people in particular may lack judgement about the level of self-harm they have applied and this could lead to irreversible harm or accidental death.

The Berkshire Suicide Audit found that 21% of people who died by suicide had a history of self-harm, and previous self-harm is flagged in local RTSS data as a feature in the relevant medical history of those who have died.

For these reasons, it is important to address concerns around self-harm early, support people to find alternatives and distractions to self-harm and identify what triggers self-harm. People who self-harm can also be supported to stay safe if they do self-harm (e.g. having a self-harm first aid kit available and pain relief, avoiding certain parts of the body etc) as well as when to avoid self-harming (e.g. when tired, or under the influence of alcohol). It might not be possible for someone who self-harms to stop doing so immediately, but they should be encouraged to get help.

Recommendation 3a: Decrease the stigma related to self-harm and encourage help seeking behaviour and self-care.

People self-harm for a range of reasons, for some it is a way of coping with difficult or distressing feelings, but research has shown that long term self-harm does not help to reduce that distress. Some of the typical reasons why someone may self-harm are shown in table 5 below.

Table 5: Reasons for self-harm

Reason	Examples
Social problems	Being bullied, having difficulties at work or school, having difficult relationships with friends or family, coming to terms with sexuality, coping with expectations, wanting to have a break from difficult things in life, money worries, being in contact with the criminal justice system, housing, loneliness, excessive screen time, cyberbullying, lower family income, family breakdown, student debt
Trauma	Physical, emotional or sexual abuse, grief after death of a close family member or friend, having a miscarriage, have lost a loved one through suicide
Psychological causes	Having repeated thoughts or voices telling them to self-harm, disassociating (losing touch with who they are and with their surroundings), borderline personality disorder, a way of punishing themselves, low self-esteem, struggling with stress, anxiety or depression
Express difficult feelings	Trying to feel in control, reliving unbearable tension

Source: Health Service Executive Ireland and Mental Health Foundation

Although the data shows that the majority of self-harm occurs among people aged under 18 and is strongly associated with puberty, especially in girls, self-harm can affect people of any age, social status gender identity, sexuality, race or culture. People who self-harm may have a diagnosable mental health condition or they may have none. There are many people at risk of self-harm and these include:

- Women
- Young people
- Older people
- People who have or are recovering from drug and alcohol problems
- People who are lesbian, gay, bisexual or gender reassigned
- Socially deprived people living in urban areas
- Women of South-Asian ethnicity
- Individual factors (e.g. personality traits, family experiences, life events, exposure to trauma, cultural beliefs, social isolation and income)
- Societal factors (e.g. education, housing, unemployment rates).

Source: Public Health England, 2021

There are some young people who are at more risk of self-harm (e.g. victims of abuse) because they are more at risk of anxiety and depression. And although self-harm appears to be less frequent in adults, self-harm can continue into adulthood, and certain methods of self-harm are associated with a greater risk of later suicide (Hawton 2012).

Recommendation 3b: Help friends, family and professionals understand the physical and emotional signs of self-harm, how they can help and where they can get support.

Recommendation 3c: Explore the impact of self-harm on parents and siblings on their own mental health and wellbeing.

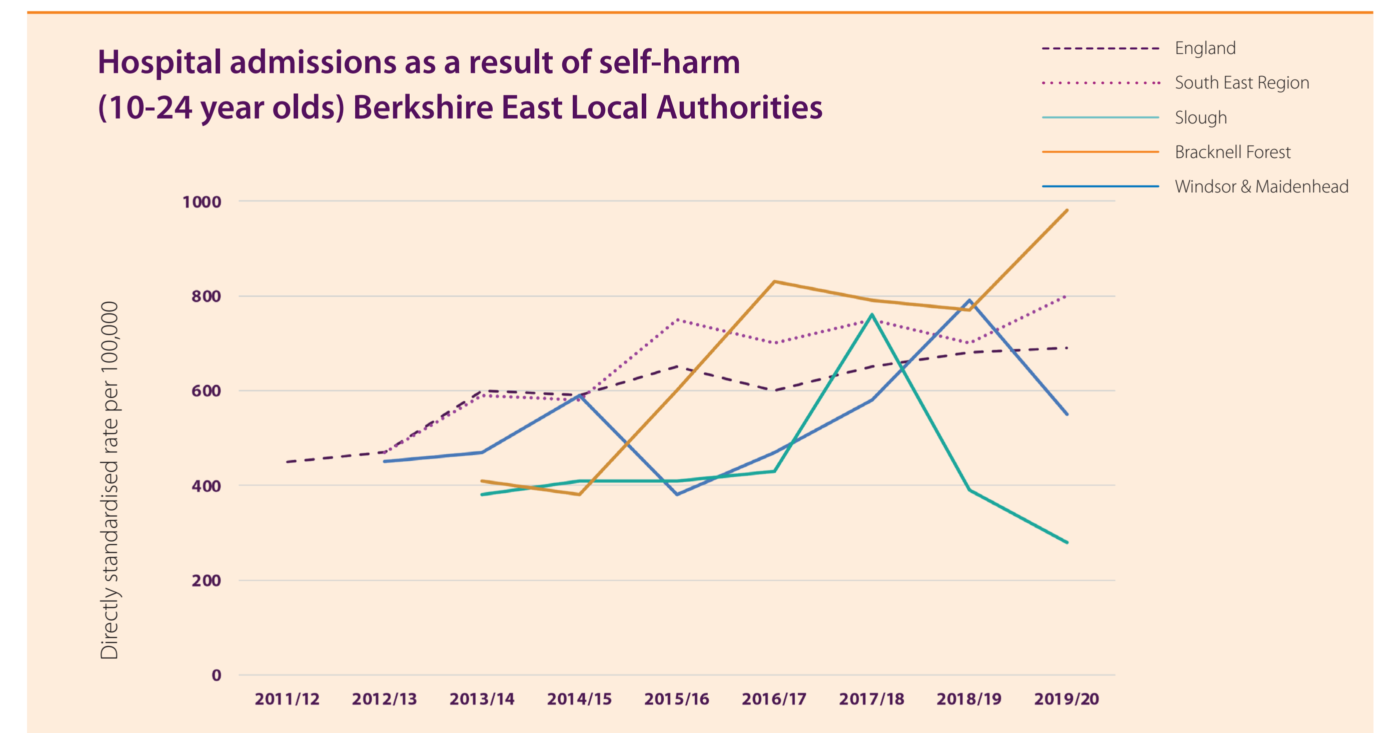
Hospital admissions for self-harm

Self-harm is one of the top five causes of acute hospital admissions in the UK (PHE, 2021). PHE state that those who self-harm have a 1 in 6 chance of repeat attendance at A&E within the year and one study showed a subsequent suicide rate of 0.7% in the first year which is 66 times the suicide rate in the general population[40]. This means that someone who has self-harmed is more likely to die by suicide compared to someone who has never self-harmed.

The data below looks at the number of young people aged 10 to 24 who were admitted to hospital as a result of self-harm (primary reason for admission). This counts number of admissions and not persons, a person may be admitted on multiple occasions during each time period. Indicators based on hospital admission may be influenced by local variation in referral and admission practices as well as variation in incidence. Data does not include attendances at Accident and Emergency which do not result in an admission.

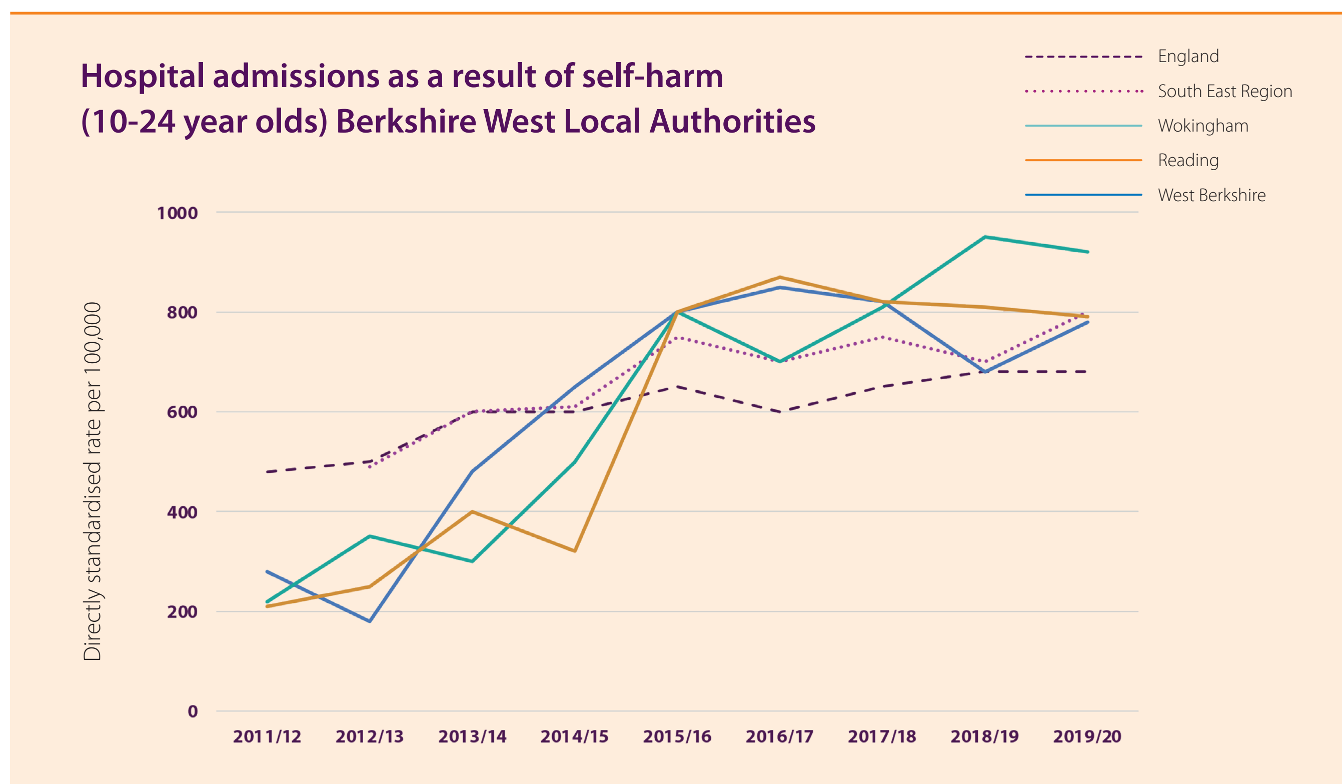
During 2019/20, there were 705 admissions of children and young people from Berkshire to hospital as a result of self-harm. Rates for each local authority since 2011/12 can be seen in the charts below. Rates of admission were significantly lower than the regional average for children and young people living in Slough, and Windsor and Maidenhead. Rates were higher than the national average but comparable to the regional average in Bracknell Forest and Wokingham. In Bracknell Forest, rates jumped from 2014/15 to 2015/16 and have risen again between 2018/19 and 2019/20. Rates in Wokingham, however, have continued to remain above the national average. Rates in Reading and West Berkshire show a similar pattern to each other, increasing up to a peak in 2016/17, prior to falling back in line with national and regional averages.

Figure 11: Hospital admissions for self-harm (10-24-year olds)



Source: Public Health England

[40] Fingertips https://fingertips.phe.org.uk/search/self%20harm#page/6/gid/1/pat/6/par/E12000001/ati/102/are/E06000047/iid/21001/age/1/sex/4/cat/-1/ctp/-1/cid/4/tbm/1



Source: Public Health England

Data since 2011/12 has shown that admissions are highest in the 15-19-year-old age band, accounting for 54% of admissions (380 admissions) during 2019/20.

Recommendation 3d: Regularly review local intelligence and data on self-harm at the Berkshire Suicide Prevention Steering Group, ensuring additional relevant data from a wide range of sources are included (e.g. development of RTSS to include self-harm, ambulance service data, primary care and schools).

Mental health and self-harm

Mental health problems such as anxiety, depression, ADHD and eating disorders are common in young people who present at hospital for self-harm or who die by suicide[41]. Other important factors present in this cohort are; alcohol misuse, emerging personality disorder, low self-esteem, poor problem solving and perfectionism.

Recommendation 3e: Working with Mental Health Support Teams (MHSTs), ensure a continued focus on the prevention of self-harm by increasing resilience and general coping skills and support for those who self-harm.

[41] https://www.psych.ox.ac.uk/news/self-harm-in-children-and-adolescents-a-major-health-and-social-problem-of-our-time

Priority area 3: Female suicide deaths

Within England and Wales, there has been a growing increase in female deaths by suicide. In 2019, the suicide rate among females and girls was 5.3 deaths per 100,000, up from 5.0 in 2018 and the highest since 2004[42]. Risk and protective factors for suicide can affect men and women differently, therefore understanding the relationship between gender and these risk factors is of importance for effective suicide prevention. For example, risk factors such as domestic abuse disproportionally affect women[43].

Within Berkshire, male suicide rates are higher, but importantly have been decreasing, while the female rates have increased. The increase of female suicides seen locally is detailed above. Throughout the strategy there is due attention to males throughout the other principles and priorities, and many of the actions discussed within this section are also applicable to males.

The findings of the females deep-dive review have informed this priority, identifying three key areas for recommendation based on local need and gaps in intelligence – the perinatal period, domestic abuse and parental/carer stress. Other risk factors identified through the female suicide deep dive are covered within this strategy in the other four priority areas.

Perinatal mental health

In Berkshire, the female deep-dive and the work of the suicide prevention group has highlighted a gap in our knowledge on the perinatal period.

The perinatal period refers to pregnancy and the first year following the birth of a child. Perinatal mental health problems are mental health problems that occur during this period. They affect up to 20% of new and expectant mothers and include a wide range of conditions including depression, anxiety, and psychosis. If left untreated, perinatal mental health issues can have significant and long-lasting impacts on the woman, the child, and the wider family. The latest confidential enquiry into maternal deaths in the UK and Ireland (2019) found that suicide is the second largest cause of direct deaths in mothers occurring during or within the 42 days at the end of pregnancy[44].

Research has shown that in some mental disorders, such as postnatal depression, bipolar disorder and postnatal psychosis, there is an increased risk of suicidal ideation, suicidal attempt, or suicide[45]. Prevalence of mental illness varies by maternal age, with many studies finding a significant correlation between young age and depression or anxiety during pregnancy. Some studies have also found high rates of mental illness amongst older mothers[46] . Agencies across the maternity system involved in the care of expectant and new mothers must carefully monitor and early identify suicide risk and potential risk factors, to reduce suicide risk within this group.

[42] Saving lives, improving mothers' care 2019 report (2019) Available MBRRACE-UK Maternal Report 2019 - WEB VERSION.pdf (ox.ac.uk). Last accessed 02/09/21
[43] Orsolini, Laura et al. "Suicide during Perinatal Period: Epidemiology, Risk Factors, and Clinical Correlates." Frontiers in psychiatry vol. 7 138. 12 Aug. 2016, doi:10.3389/fpsyt.2016.00138
[44] Biaggi A, Conroy S, Pawlby S, Pariante CM. Identifying the women at risk of antenatal anxiety and depression: A systematic review. J Affect Disord. 2016 Feb;191:62-77. doi: 10.1016/j.jad.2015.11.014. Epub 2015 Nov 18. PMID: 26650969; PMCID: PMC4879174.
[45] Orsolini, Laura et al. "Suicide during Perinatal Period: Epidemiology, Risk Factors, and Clinical Correlates." Frontiers in psychiatry vol. 7 138. 12 Aug. 2016, doi:10.3389/fpsyt.2016.00138

Recommendation 4a: Link with the BOB and Frimley local maternity system on suicide risk in the perinatal period.

In guidance for commissioners of perinatal mental health services, the Joint Commissioning Panel for Mental Health, drew together data from various research into the prevalence of perinatal mental health conditions to provide the overview of prevalence shown in the table below. By applying the national prevalence estimates to the total number of maternities in Berkshire, we can estimate numbers at a local level. These estimates do not consider socioeconomic factors or any other factors that may cause local variation in prevalence. We cannot estimate the overall number of women in Berkshire with a perinatal mental health condition, as some women will have more than one of these conditions.

Table 6: Rates of perinatal psychiatric disorder per 1,000 maternities

Condition	Rate per 1,000 (Joint Commissioning Panel for Mental Health report)	Berkshire maternities (ONS, 2019)	Estimated number of women in Berkshire with condition
Postpartum psychosis	2	713	21
Chronic serious mental illness	2		21
Severe depressive illness	30		311
Mild-moderate depressive illness and anxiety states	100-150		1,037-1,555
Post-traumatic stress disorder	30		311
Adjustment disorder and distress	150-300		1,555-3,110

Source: Joint Commissioning Panel for Mental Health, 2012/Office for National Statistics 1

Women who lack social support have been found to be at increased risk of antenatal and postnatal depression. Having a poor relationship with a partner is also a risk factor for postnatal depression[46]. The number of births which were outside of marriage or civil partnership and sole registered (by one parent only) in Berkshire during 2019 was 375. Risk factors outlined are likely to have been further affected by COVID-19 and the lockdown measures, and thus the potential to increase suicide risk, therefore should be monitored going forward.

Recommendation 4b: To explore data collection on the perinatal period; risk factors and the link to suicide including data captured in the RTSS.

[46] NICE (2020) Postnatal and Antenatal depression – what are the risk factors? Available Risk factors | Background information | Depression - antenatal and postnatal | CKS | NICE. Last accessed 26/08/21

Domestic abuse

The female deep-dive analysis for Berkshire also highlighted a gap in our knowledge on the links between suicide and domestic abuse locally. The Domestic Abuse Act 2021 came into force on the 30th April 2021, making vital changes to the act, going beyond criminal justice and encompassing family courts, housing and health, acknowledging the impact of domestic abuse on victims and survivors lives[47]. It is widely evidenced that domestic abuse victims and survivors are more at risk of suicide and suicidal thoughts. ONS figures estimate that approximately 2.3 million adults aged 16 to 74 years within England and Wales experience domestic abuse in the last year (ending March 2020); the true scale of this however remains unknown. Research focussing upon more than 3,500 women supported by Refuge, a charity supporting victims of domestic abuse, has shown that almost a quarter (24%) of those supported by the charity had felt suicidal, and 83% reported feelings of hopelessness and despair. Domestic abuse and suicide risk are clearly linked, therefore mental health services and those working with victims of domestic abuse should work together to mitigate this risk.

Recommendation 4c: Promote the need for clear pathways and knowledge exchange between domestic abuse and mental health services.

Transforming Health and Social Care in Kent and Medway partnership (STP) have researched the link between domestic abuse and suicide in their county. They found that suicide victims were categorised into four cohorts - current victims of domestic abuse, those who had historically experienced domestic abuse, perpetrators, and young people living in households where domestic abuse was occurring[48].

Children witness to or living in a household where domestic abuse is present is a highly traumatic experience and can lead to lasting harms and risk-taking behaviours throughout the lifecourse. Perpetrators, as found in Kent, are also at risk of suicide, where the perpetrator is currently under investigation, or is being convicted of the abuse. It is clear therefore, that domestic abuse has a profound impact for those experiencing, witnessing and perpetrating, increasing risk immediately, and throughout the life course. Within Berkshire, further data collection is required locally in order gain a greater understanding of the links between domestic abuse and suicide for those impacted.

Recommendation 4d: Improve data collection of domestic abuse data in RTSS.

Recommendation 4f: Include domestic abuse indicators in the Berkshire suicide audit to better understand the link between domestic abuse and suicide

Recommendation 4g: Provide information to domestic abuse services on how to respond to concerns where clients may be self-harming or considering suicide (whether the client is a victim, survivor, perpetrator or child or young person)

[47] Domestic Abuse Act 2021. Womens Aid. Available Domestic Abuse Act - Womens Aid. Last accessed 07/09/2021
[48] Highlighting the relationship between domestic abuse and suicide: Progress and next steps (2021) Transforming Health and Social Care in Kent and Medway

Parental or carer stress

Parental or carer stress has been identified through the female deep-dive audit as a key risk factor for suicide. Anecdotal feedback within acute hospital teams in 2020 found that these stresses are particularly pertinent when parenting neurotypical children, and suicide attempts amongst older people are often linked to carer strain.

Parental stress, anxiety and depression has also been found to have increased over the period of the COVID-19 lockdown. The key concerns highlighted by parents in this report was around struggling with competing demands of meeting their child's needs, home-schooling and work commitments. Data has shown that the parents and carers from single adult households, and lower income families (<16,000 p.a), and those who have children with special educational needs and/or neurodevelopmental differences have been particularly vulnerable to elevated mental health symptoms[49]. It is widely accepted that mental ill health is a risk factor for suicidal ideation and behaviour, therefore this increase in mental health symptoms must be acknowledged and monitored[50].

There are a wide range of services within Berkshire that support parents and carers. Family information services are available, which provide free and impartial information and signposting for families. Easily accessible resources and information around available services are key for parents and carers accessing the support they need at the correct time, and the work of this strategy should consider this forum as a means to prevent suicide risks in this group.

Recommendation 4h: Raise awareness of the information, resources and services available for parents and carers who are experiencing stress, through inputting into local campaigns.

[49] [1] Parental mental health worsens under new national COVID restrictions (2021). Available Parental mental health worsens under new national COVID-19 restrictions | University of Oxford Last accessed 26/08/21

[50] Samaritans research briefing: Gender and Suicide (2021). Available ResearchBriefingGenderSuicide_2021_v7.pdf (samaritans.org) Last accessed 02/09/21

Priority area 4: Economic factors

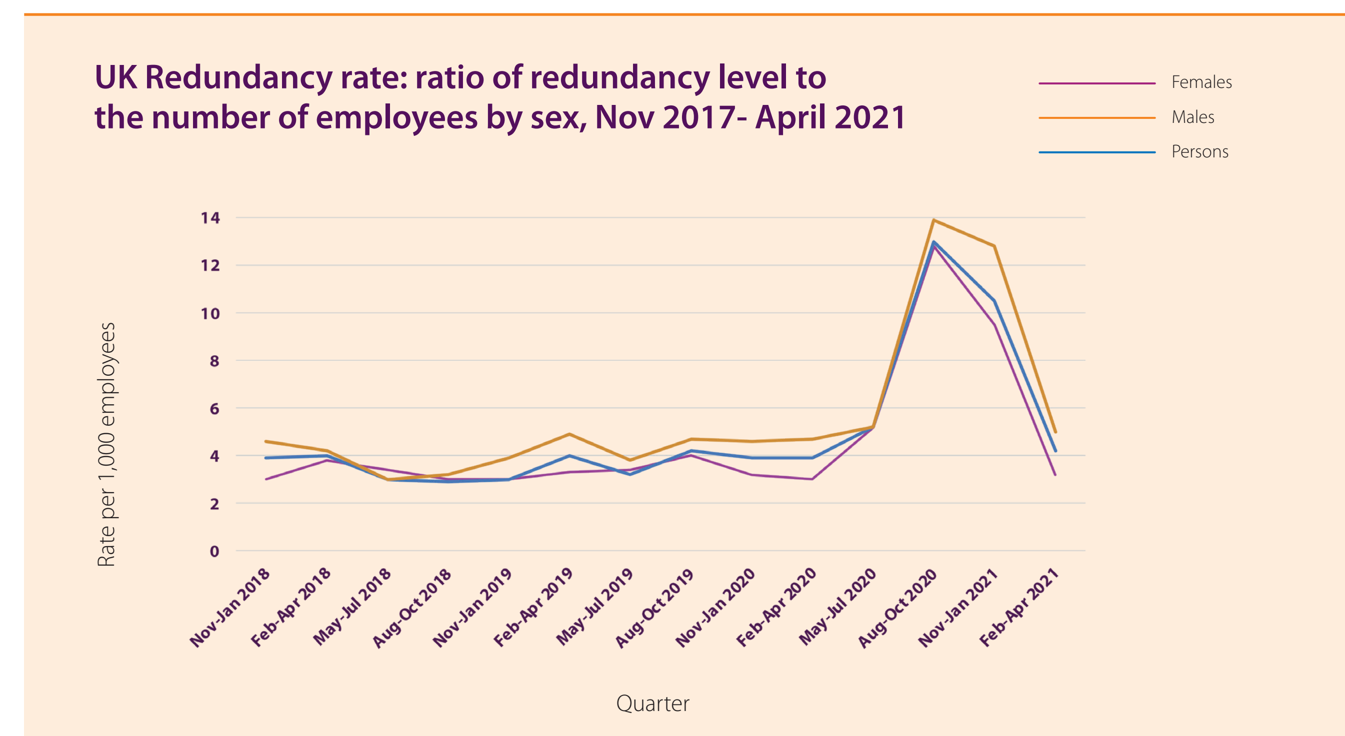
Impact of COVID-19

Some people are more economically or financially vulnerable than others, and this number is on the rise. Individuals who are young, low-paid, Black, in self-employment and those with low education levels or live in large families have been disproportionately affected by the current COOVID-19 pandemic. These groups are more likely to have lost their jobs, not be working any hours or had their pay cut[51].

During the COVID-19 pandemic in 2020, the number of people with low financial resilience (e.g. people with high levels of debt, low savings or erratic earnings) has increased by a third from 10.7 million to 14.2 million, representing more than a quarter of the UK adult population[52]. The COVID-19 pandemic has had a huge impact on employment and income, with some survey respondents expecting to struggle to make ends meet and experience financial hardship. They may need to rely on foodbanks or take on additional debt in order to meet the shortfall. In comparison, some other workers have been able to work from home and save money on commuting costs. Around 48% of adults have not been financially affected by COVID-19 and 14% have seen improvements to their financial position.

The chart below illustrates how the redundancy rate (persons) has risen from 3.9% in Feb-April 2020 to 5.5% in May – July 2020, a sharp rise to 13.3% between Aug-Oct 2020 and a slight drop to 11% between Nov 2020 and January 2021 in the UK. The redundancy rate is the ratio of the redundancy level for the given quarter to the number of employees in the previous quarter, multiplied by 1,000.

Figure 12



Source: PHE Wider Impacts of COVID-19 on health (WICH) monitoring tool

[51] COVID-19 recession is having a disproportionate impact on most vulnerable. LSA (2020) Available: https://www.lse.ac.uk/News/Latest-news-from-LSE/2020/h-August-20/COVID-19-recession-is-having-a-disproportionate-impact-on-the-most-vulnerable Last accessed: 09/09/21

[52] Financial lives 2020 survey. FCA (2020) Available: https://www.fca.org.uk/publications/research/financial-lives-2020-survey-impact-coronavirus Last accessed 09/09/21

In the past, periods of economic uncertainty have seen increases in suicide rates, particularly among men. Economic factors, particularly unemployment have been shown as strong risk factors of suicide (e.g. Lewis G and Sloggett A, BMJ 1998; 317:1283). Suicide rates increased from a record low in 2006 post the economic recession suggesting the national recession could have been an influencing factor in the increase in suicides. Studies have found that local areas with greater rises in unemployment had also experienced higher rises in male suicides[53].

The government's furlough scheme has helped employers to pay peoples wages in order to reduce financial insecurity during the pandemic and period of economic upheaval. On the 30th March 2021, 49,700 jobs were furloughed across Berkshire and there has been a total of 164,500 jobs furloughed in total since 23rd March 2020 across Berkshire. The cumulative number of jobs on furlough across Berkshire local authorities ranges from 25,800 for people living in Windsor and Maidenhead to 31,400 in Slough. Figures are based on the local authority of the business and not residence.

Table 7 Cumulative number of jobs on furlough at 31st March 2021 (local authority of business)

Local Authority	Cumulative number of jobs on furlough
Bracknell Forest	23,100
Reading	31,300
Slough	31,400
West Berkshire	26,700
Windsor and Maidenhead	25,800
Wokingham	26,200
Berkshire total	**164,500**

Source: HM Revenue and Customs

During the first national lockdown, women and young people were more likely to be furloughed and are more likely to face financial difficulties as recovery progresses (Women's Budget Group, 2020, IFS, 2020, IFS 2020a). In the lowest earning 10% of employees, 80% were employed in a sector that was shut down or are not able to work from home, compared to 25% in the highest earning 10% (IFS) - (*Note this excludes key workers).

[53] Barr et al BMJ 2012; 345:5142

Debt and poor mental health

Unmanageable debt is a risk factor for suicidal behaviour, with those in debt three times as likely to consider suicide than people not in problem debt (Mental Health Policy Institute (MMHPI), 2018). Unemployment, unmanageable debt and job insecurity are also risk factors for suicidal behaviour.

Across England, more than 1.5 million people are experiencing both problem debt and mental health problems. An estimated 46% of people in problem debt also have a mental health problem. Almost one in five (18%) people with a mental health problem are in problem debt. Financial problems are a common cause of stress and anxiety with people in this position not asking for help due to stigma around being in debt. Suicide can be seen as a way out of debt for some people who are struggling and more than 100,000 people in England attempt suicide while in problem debt each year (MMHPI) (2018)[54].

Long-term factors such as persistent poverty and financial insecurity can put people at an risk of becoming suicidal, as can sudden triggers like the intimidating and threatening letters people receive from lenders. Providing debt management advice and support to people in debt will help to reduce an individual's risk of death by suicide, especially if they are experiencing poor mental health. There is a lot of support and help available for people, but awareness can be low.

Recommendation 5a: Work with colleagues to raise awareness of the risk between debt, mental health and suicide risk among frontline professionals and the wider public. Awareness raising needs to;

- reduce the stigma of 'being in debt' and signpost to access debt and benefit advice and support. this information also needs to be shared with frontline professionals
- encourage people in debt to reach out for help to reduce impact on mental health
- encourage people with poor mental health to reach out for debt advice

Recommendation 5b: Support frontline professionals to feel comfortable about talking about debt and financial problems and the link to poor mental health and suicide risk and what support is available.

Recommendation 5c: Support Berkshire local authorities with a single point of access information site around money matters.

People who had a long-term condition or disability were three times as likely to have fallen behind on paying their council tax, compared to those without. People who receive an income-related benefit (e.g. universal credit) were almost four times as likely to have fallen behind on council tax compared to those not receiving benefits.

Recommendation 5d: Ensure compassionate debt collection. Make sure the process is supportive and aims to steer residents to places that can provide help and support. Support vulnerable groups at increased risk of debt including people with long-term conditions or disabilities.

[54] A silent killer. Money and mental health (2018) https://www.moneyandmentalhealth.org/wp-content/uploads/2018/12/A-Silent-Killer-Report.pdf Last accessed 09/09/21

Benefits

National government data shows that there is over £15 billion pounds of unclaimed benefits, in addition to unclaimed Universal Credit available. This could mean that many individuals and families are living on less money than they need to be and unnecessarily finding it difficult paying priority bills (e.g. heating and food). Barriers preventing people claiming the benefits they are entitled to include;

- a lack of awareness about what benefits are available and the claims process.
- a perceived stigma around benefits creating a reluctance to consider them. This has particularly affected people who have recently been struggling financially during COVID-19 pandemic.
- a lack of access to or no IT skills which are necessary to access services online (e.g., digital applications)

The proportion of the population aged 16 to 64 across Berkshire who were claiming benefits during May 2021 was just under 5%. This is the same as the figure for the South East Region as a whole. There is some variation between Berkshire Local Authorities with the claimant counts being higher in Slough (8.4%) and Reading (6.4%).

Table 8: Berkshire Benefit claimants May 2021

	Bracknell Forest	Reading	Slough	West Berkshire	Windsor and Maidenhead	Wokingham	South East
Benefit claimant count	3,145	6,845	7,965	3,545	3,775	3,135	274,810
Percentage of 16-64 year old population	4	6.4	8.4	3.7	4.1	3	4.9

Source: ONS Crown Copyright Reserved [from Nomis on 2 July 2021]

Recommendation 5e: Work with key partners to actively promote services that provide help around navigating the benefits system and potentially increasing people's incomes.

Recommendation 5f: Make sure that all parts of the health service where patients showing suicidal intent first make contact, are signposted or triaged appropriately using a process that includes debts and other economic stresses as risk factors.

Socioeconomic disadvantage and suicidal behaviour

The Berkshire suicide audit 2018 found that the majority of people with financial issues prior to death had 'other debts', such as student loan, loans and credit cards. Other reasons for financial issues included utility bills/rent, work related issues (business accounts, sick pay stopped), drug debt, gambling, bankruptcy and being the victim of a scam. The Berkshire Suicide Audit also showed that between 2007 and 2018, the percentage of suicides that were amongst people who were unemployed ranged from 11% to 38%. If we consider this against the fact that 4% of the overall population in Berkshire are unemployed, then people who are unemployed are over-represented in the number of suicides in Berkshire.

Figure 15: Financial issue (s) prior to death across audit years

	Percentage					
	2007 - 2009	2008 - 2010	2009 - 2011	2012/13 - 2013/14	2014/15 - 2015/16	2016/17 - 2017/18
Total	9%	6%	<5%	24%	27%	13%

Source: Berkshire Suicide Audit (2018)

It is well recognised that the reasons why people die by suicide are complex, arising from a wide range of psychological, social, economic and cultural risk factors. People who are socioeconomically disadvantaged or who live in areas of socioeconomic deprivation have an increased risk of suicidal behaviour. Features of socioeconomic disadvantage include; low income, unmanageable debt, poor housing conditions, lack of educational qualifications, unemployment and living in a socioeconomically deprived area[55]. What is more, poor mental health makes it harder to deal with money problems and vice versa[56].

Recommendation 5g: Work with system partners on the early identification and support of people who are at increased risk of debt and financial concerns (e.g. unemployed or people with long-term conditions) as early as possible and offer effective support to manage personal finances through appropriate referral pathways.

[55] Dying from inequality. Samaritans (2017). Available:https://media.samaritans.org/documents/Samaritans_Dying_from_inequality_report_-_summary.pdf. Last accessed 09/09/21

[56] Money and mental health, the facts. Money and mental health (2019). Available: https://www.moneyandmentalhealth.org/wp-content/uploads/2017/06/Money-and-mental-health-the-facts-1.pdf. Last accessed 09/09/21

Gambling

Gambling related harm is a risk factor for suicide and is a growing area of public health concern. In 2019/20, 11% of gamblers contacting the National Gambling Helpline said they had experienced suicidal thoughts, either currently or in the past[57].

Additional funding is being made available to support treatment services for problem gambling and to monitor the impact of COVID-19 on gambling behaviour. Gambling operators are putting in place additional measures to increase protections for those who might be at risk of gambling harm. These were clear themes within the National Strategy to reduce Gambling Harms[58] although there has been little progress on addressing gambling related suicide.

PHE have plans to publish an evidence review on gambling harms on the prevalence of gambling and associated health harms and their social and economic burden. This work has been put on hold due to COVID-19.[59]

The National Confidential Inquiry into Suicide and Safety in Mental Health's 2021 report on suicide by middle-age men[60] found a number of findings associating suicide with economic precursors. Overall, 57% of men were experiencing economic problems including unemployment, financial problems, or problems finding stable accommodation. Almost a third of men included in the study were unemployed at the time of death, with almost half of these unemployed for over 12 months. Twice the proportion of men were living in the most deprived areas of England (27%) compared to those living in the lest deprived areas (14%). Alcohol and drug misuse were particularly common amongst men who were unemployed, as it was amongst those who were bereaved, or had a history of violence or self-harm.

Recommendation 5h: Monitor local data and intelligence on levels of problem gambling within Berkshire and its link to suicide.

[57] Suicide awareness and prevention training.
Gamcare (2020https://www.gamcare.org.uk/news-and-blog/news/gambling-charity-and-samaritans-launch-bespoke-suicide-awareness-and-prevention-training/
[58] Reducing gambling harms. Gambling Commission (2021) https://www.gamblingcommission.gov.uk/about-us/reducing-gambling-harms Last accessed 09/09/21
[59] Progress report on the national strategy to reduce gambling harms. Gambling Commission (2021)
https://www.gamblingcommission.gov.uk/print/absg-progress-report-on-the-national-strategy-to-reduce-gambling-harms-year Last accessed 09/09/21
[60] Suicide by middle aged men. NCISH (2021). Available NCISH | Suicide by middle-aged men - NCISH (manchester.ac.uk). Last accessed 02/09/21

Priority area 5: Supporting those who are bereaved or affected by suicide

Those who are bereaved by suicide face a higher risk of mental ill-health, suicide attempts and death by suicide.[61, 62, 63] The Support After Suicide Partnership summarises the particular challenges which mean that those bereaved by suicide are less likely to receive support from family and friends than others going through a bereavement. [64] Sudden deaths can lead to a complex bereavement, with those bereaved by suicide often experiencing particularly intense shock, as well as challenges linked to the stigma of suicide.[65] These stigmatising factors can mean the bereaved person is avoided or feels judged, and connections with social and support networks are weakened. People's awkwardness in discussing death is often magnified when the death is by suicide, and this can leave the person who is bereaved feeling especially isolated. Conversely, high interest in the suicide – from communities and from the media – can make it difficult for people to grieve in private.

Experiences of bereavement affect everyone in different ways but is usually characterised by grief. Grief is a process that people go through as they gradually adjust to loss. Again, grief is experienced differently by different people with people often moving in and out of the stages of grief and the range of associated emotions. Grief is an entirely normal process and there is no time limit on how long grief lasts. However, sometimes people experience grief in a way that, rather than becoming manageable overtime, worsens and affect day-to-day living for a long time.

Throughout this strategy we have seen how bereavement can be a key factor contributing to death by suicide. Bereavement is highlighted in the Berkshire Suicide Audit, the Berkshire deep-dive into female suicides, and The National Confidential Inquiry into Suicide and Safety in Mental Health's reports into suicide amongst both children and young people and middle-age men.

Bereavement by suicide can be particularly devasting to the lives of those around the person who has died. People bereaved by suicide are at a greater risk of suicide themselves. Bereavement by suicide was highlight in 6% of subsequent suicides in the Berkshire Suicide Audit (2018).

In 2020, Suicide Bereavement UK published a report entitled 'From Grief to Hope: The collective voice of those bereaved or affected by suicide in the UK.' [66] The report lays out key findings and recommendation based on an online survey completed by over 7,000 people who have been bereaved by suicide. The number of people responding to the survey increased steadily by age band, peaking at age 45-54 before dropping off more rapidly for the 55-64 and 65+ age groups. 97% of respondents were White. Of non-White respondent, the majority (47%) reported their ethnicity as 'multiple/mixed'. 89% identified as heterosexual and 75% were in paid employment. 33% had been bereaved by more than 1 suicide. The key survey findings are summarised in the following table below.

[61] Qin P, Agerbo E and Mortenson PB (2002) Suicide risk in relation to family history of completed suicide and psychiatric disorders:
a nested case-control study based on longitudinal registers. Lancet 360: 1126–1130.
[62] Pitman et al (2014) Effects of suicide bereavement on mental health and suicide risk The Lancet Psychiatry, 1(1): 86-94 http://www.thelancet.com/journals/lanpsy/ article/
PIIS2215-0366(14)70224-X/fulltext
[63] Pitman et al (2016) Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UKwide study of 3,432 young bereaved adults. BMJ Open 6:e009948.
doi:10.1136/ bmjopen-2015-009948 http://bmjopen.bmj. com/content/6/1/e009948
[64] Finding_the_Words.pdf (supportaftersuicide.org.uk)
[65] Pitman et. Al. (2016) The stigma perceived by people bereaved by suicide and other sudden deaths: a cross-sectional UK study of 3,432 bereaved adults. Journal of
Psychosomatic Research 87:22-29.
[66] From Grief to Hope: The collective voice of those bereaved or affected by suicide in the UK Suicide Bereaved UK (2020). Available display.aspx (manchester.ac.uk)
Last accessed 02/09/21

Table 9: Key findings from Suicide Bereavement UK's 2020 report

Topic	Finding
Impact	82% reported that suicide had a moderate or major impact on their lives
	Serious adverse consequences included relationship break-up, unemployment and finical problems
	Over a third reported mental health problems with this been particularly common for women
Link to self-harm and suicide	8% reported self-harming
	38% had considered taking their own life
	8% had made a suicide attempt
	36% of those making a suicide attempt did so over a year after being bereaved by suicide
Relationship to deceased	The most common relationship reported was the loss of a friend to suicide
	Participants who had lost friends were more likely to have experienced multiple suicides and often reported feeling overlooked by services
Accessing support	60% did not access support following a suicide
	Over a third did not know what types of services were available
	62% perceived the provision of local bereavement support to be inadequate
Support requested	Immediate, proactive support is important
	Some, not always ready to receive help straight away, said that information should be presented in an easily accessible format such as a booklet or person to contact for support when they were ready
	Ongoing bereavement support should be available with a follow up at 3, 6, 12, or 18 months after the suicide occurred

Source: Suicide Bereavement UK, From Grief to Hope, 2020

Survivors of Bereavement by Suicide (SoBS) is a national charity set up to offer support to adults bereaved by suicide. It is the only organisation offering peer-to-peer support to all those over the age of 18, impacted by suicide loss in the UK. It helps those bereaved by suicide to support each other, at the time of their loss and in the months and years that follow. SoBS offers peer led support groups, online virtual support groups, a national telephone helpline, online community forum and email support. It offers a unique and distinct service for bereaved adults across the UK, run by the bereaved for the bereaved. Suicide recognises no social, ethnic or cultural boundaries and neither does SOBS. The helpline and groups are open to all survivors of bereavement by suicide aged 18 years and over.

Recommendation 6a: Ensure our local bereavement offer is culturally and ethnically appropriate for different groups working with communities to develop resources and services.

Local SoBS groups exist to meet the needs and break the isolation experienced by those bereaved by suicide. It is a self-help organisation that aims to provide a safe, confidential environment in which bereaved people can share their experiences and feelings, so giving and gaining support from each other. It also strives to improve public awareness and maintain contacts with many other statutory and voluntary organisations. Each local SoBS group needs to have 3 trained volunteers to run a group and they must have been bereaved by suicide for at least 2 years. Finding volunteers is a challenge given the commitment involved. Each group is also responsible for finding suitable premises, funding itself, and following guidelines set by the national charity. This makes the group vulnerable, and we have a role to support this group.

There is currently one SoBS group in Berkshire, in Wokingham but they often support people from further afield where there is no closer group to join. The Wokingham SoBS group has been running for over 7 years, and its co-ordinator is an active member of the Berkshire Suicide Prevention Strategy Group. Numbers actively involved in the SoBS group fluctuate, with an average attendance rate of 15 people pre-COVID-19 and an average of 12 people attending the current virtual offer. The group has many recently bereaved members, but also members who were bereaved many years ago and have not had the opportunity to talk before - usually because of the stigma which still surrounds suicide.

Recommendation 6b: Continued support to the volunteer led local SoBS groups to be able to continue to offer a peer-to-peer support service.

There is sometimes a tendency to assume that the impact of a suicide is confined to the close family and friends of the person who died, but there can be repercussions throughout wider networks, communities, places of work or study, and within services called upon to respond to a suicide in a professional capacity. In offering support to those affected, it is important not to make assumptions which limit how widely information about support is shared. People may identify with a suicide because of something they have in common with the person who died, without necessarily having had recent or frequent contact with that person. Over 7,000 individuals contributed to a study carried out by Suicide Bereavement UK, which illustrates this significant ripple effect[67].

A range of national resources for people bereaved by suicide are available and are shared by our first responders

[67] McDonnell S, Hunt IM, Flynn S, Smith S, McGale B, Shaw J (2020). From Grief to Hope: The Collective Voice of those Bereaved or Affected by Suicide in the UK. Manchester: University of Manchester. Available at: https://supportaftersuicide.org.uk/wp-content/uploads/2020/11/From-Grief-to-Hope-Report-FINAL.pdf

across Berkshire to a suspected suicide, e.g. coroners, funeral directors, police, doctors and bereavement counselling and support organisations. This includes 'Help is at Hand', a national publication which aims to provide people affected by suicide with both emotional and practical support[68], as well as several other useful resources.

Recommendation 6c: Building in bereavement support to extend to wider family members, friends and communities.

Specialist Suicide Bereavement Support

There is now specific investment in developing support for people who are bereaved by suicide within the NHS Long Term Plan. Transformation funding has been issued to enable different parts of the country at different stages to develop suicide bereavement support services, and this will reach all areas by 2023-24. Berkshire has been in receipt of NHSE funding to develop suicide bereavement support since 2019-20 as part of the Berkshire Oxfordshire and Buckinghamshire (BOB) Integrated Care System.

From the work of the Berkshire suicide prevention group we now have a specialist Bereaved by Suicide Support Service in place which provides advocacy and support for those bereaved by suicide. Current support for Berkshire residents bereaved by suicide includes the services of a Bereavement Liaison Co-ordinator within Thames Valley Police. The Co-ordinator works with officers involved in gathering RTSS data and establishes early contact (with consent) with bereaved individuals to offer a supportive presence. The Co-ordinator carries out an initial assessment of need and provides practical advice. This role has created additional capacity within the police to provide an accessible and consistent point of contact for individuals and families who may not be ready for signposting or referral into local support services at initial contact but may require such in the future.

Local and ongoing practical and emotional bereavement support is provided by a Bereavement Liaison Supporter. The Liaison Supporter will remain alongside the bereaved as they access other services, supporting referral and fast tracking as appropriate, and maintaining a good overview of working relationships with other local providers. Preparing people for media involvement and interest is a key element of this role, as well as supporting navigation through the coroner's court. Other areas of practical and emotional support are available, based on individual client need.

The Berkshire Bereavement Liaison Support Service is currently provided by Victim Support and builds on an established and successful model of support for people bereaved by homicide. Any Berkshire resident can access the service. Adults are supported directly, and the service facilitates links to specialist children's bereavement support services. A dedicated member of Victim Support staff is the primary point of contact with the service, but clients can contact Victim Support 24/7 in the event of needing to talk to someone outside of the working hours of the project lead.

[68] HIAH Booklet. Support after suicide (2021) HIAH_Booklet_2021_V5-1-2.pdf (supportaftersuicide.org.uk) Last accessed 09/09/21

A recent evaluation of the various components of the BOB-wide service found that the most valued features were:

- A mechanism that connects families with services as soon as possible after the death
- Practical support and advocacy (e.g. around inquests, collecting belongings, media interest)
- Signposting to local services and organisations based on sound local knowledge
- Emotional support to deal with loss, trauma and feelings of isolation, exacerbation of existing health problems and the emergence of mental health problems.

Suicide bereavement support will be re-commissioned from 2022 as a single service across the Thames Valley. This will generate some economies of scale, and also build in some flexibility for local co-ordinators to support one another across county boundaries to help manage peaks in demand.

The current commissioned services focus on meeting the needs of 'close relatives' of people who have died by suicide. However, the providers have offered wider community support through forums and in response to some specific requests. In re-commissioning the service, we will explore how to tap into such expertise and experience for wider community benefit in future, whilst ensuring those in need of the one-to-one practical and emotional support following a suicide can still access this in a timely manner.

Recommendation 6d: Continue to commission suicide bereavement support services and monitor its impact.

Support for those impacted by suicide in the workplace

There is recognition that staff may feel responsible for a suicide event, or not having done more to prevent it. Although these feelings are always misplaced, they can prolong the trauma if not managed effectively. Staff members may also experience anger, flashbacks and post-traumatic stress.

Recommendation 6e: Explore training opportunities for colleagues and workplaces impacted by suicide.

Recommendation 6f: Work with Thames Valley Police and other first responders to a suicide, to share appropriate resources with employers.

Glossary

Age-specific mortality rate
The total number of deaths per 100,000 people of an age group

Age-standardised mortality rate
A weighted average of the age-specific mortality rates per 100,000 people and standardised to the 2013 European Standard Population. Age-standardisation allows for differences in the age structure of different populations and therefore allow valid comparisons to be made between geographic areas, the sexes, and over time.

Registration delay
The difference between the date which a death occurred and the date which a death was registered

Statistical significance
The term "significant" refers to statistically significant changes or differences based on unrounded figures. Significance has been determined using the 95% confidence intervals, where instances of non-overlapping confidence intervals between figures indicate the difference is unlikely to have arisen from random fluctuation

Years of life lost
Years of life lost is a measure of premature mortality and gives an estimate of the length of time a person would have lived had they not died prematurely. It can be used to compare the premature mortality experience of different populations and quantify the impact on society from suicide.

Berkshire Wide Action Plan

This action plan is a continuously working document lead by the Suicide Prevention Steering Group who have the ultimate responsibility for delivery. Timeframes and specific indicators are to be defined by the group. For the purpose of this strategy the recommendations are listed below.

Priority Area	Recommendation	Outcome
1. Overarching Aims	**1.a)** To continue to monitor the impact of COVID-19 on suicide across the lifecourse through RTSS data and respond to any identified trends.	Impact of COVID-19 on suicide across the lifecourse further understood and trends responded to by the Suicide Prevention Group.
	1.b) To continue to monitor the wider trends emerging from the impact of COVID-19 on people's mental health and suicide risk across the lifecourse, and to support the system to take action where required.	Impact of COVID-19 on mental health and suicide risk further understood, support for the action taken where required across the system in place, informing the Suicide Prevention Group's approach.
	1.c) To undertake a Berkshire suicide audit.	Suicide risk and trends identified and analysed, informing the Suicide Prevention Groups focus and approach.
	1.d) Undertake regular reviews of information, resources and channels for people affected by suicide	Accurate, high quality information, resources and channels available for those affected by suicide.
	1.e) Hold an annual multi-agency conference on a range of topics to share information and best practice and raise awareness to the risks for suicide.	Knowledge and understanding of focus areas improved. Awareness raising of focus areas.
	1.f) Invite additional partners across the system within Berkshire, including the voluntary and community sector to join the Suicide Prevention Group for improved cross-topic working.	The Suicide Prevention Group benefit from further insight and knowledge from additional organisations, informing their approach, and other groups benefit from our expert input.
	1.g) Set up sub-groups of the Suicide Prevention Group, informed by local intelligence and data, where there is a need to focus upon a risk factor or group within the population.	Better understanding of, and potential reduction in suicide risk for identified risk factors or groups within the population.
2. Children and Young People	**2.a)** To raise awareness of the link between trauma and adversity, and suicide across the life course	Link between trauma and adversity across the life course is clear and understood by partners, professionals and the voluntary and community sector.
	2.b) Continued investment into the Be Well campaign to encourage the importance of looking after emotional wellbeing, in addition to signposting to local mental health services and support in order to prevent self-harm and suicide in children, young people, and women.	Emotional wellbeing improved as a preventative factor for children, young people and women's suicide and self-harm risk.
	2.c) Support the system to adopt a needs-led approach for neurodiverse children and young people, particularly in the prevention and early intervention arena, e.g. in schools and the community.	Neurodiverse children and young people pre-diagnosis and supported and adaptations made for their needs, reducing suicide risk.

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2. Children and Young People (cont...)	**2.d)** To explore improving data capture on sexual orientation for all ages in RTSS data and promote this across the suicide prevention system.	Improved understanding and insight into LGBTQ+ as a risk factor for suicide, informing the Suicide Prevention Groups focus and approach.
	2.e) To work with local organisations and charities who work with the LGTBQ+ community on suicide prevention.	Improved insight and knowledge into the LGBTQ+ community and suicide prevention and risk, informing the Suicide Prevention Groups focus and approach.
	2.f) To raise awareness of the impact of the transitional period (children moving into adulthood) on the mental health impact and the risks of suicide during this period for children and young people.	Improved knowledge and understanding on the impact of the transitional period on mental health and suicide risk for children and young people for partners, professionals and the education sector.
3. Self-harm	**3.a)** Working with Mental Health Support Teams (MHSTs), ensure a continued focus on the prevention of self-harm by increasing resilience and general coping skills and support for those who self-harm.	School pupils at risk of self-harm or self-harming have improved coping skills, support and resilience.
	3.b)Decrease the stigma related to self-harm and encourage help seeking behaviour and self-care.	Those who self-harm feel able to seek help with less fear of stigma and have improved self-care.
	3.c) Help friends, family and professionals understand the physical and emotional signs of self-harm, how they can help and where they can get support.	Friends, family and professionals are able to identify and understand self-harm, how they can help and where to get support. Those who self-harm feel better supported by professionals, their friends and family.
	3.d) Explore the impact of self-harm on parents and siblings on their own mental health and wellbeing.	Further understanding of the impact of self-harm on parents and sibling's mental health and wellbeing, allowing future interventions into how to support these groups to be well informed.
	3.e) Explore means to improve local intelligence and data on self-harm to be regularly reviewed at the Berkshire Suicide Prevention Steering Group.	The Suicide Prevention Group able to respond to trends in self-harm and take action where appropriate.
4. Female Suicides	**4.a)** Link with the BOB and Frimley local maternity systems on suicide risks in the perinatal period	Awareness raised of the suicide risk in the perinatal period for local maternity systems. Local maternity systems aware of the work of the Suicide Prevention Group.
	4.b) To explore data collection on the perinatal period; risk factors and the link to suicide including data captured in the RTSS.	Improved understanding and insight into the risk factors and link to suicide within the perinatal period.
	4.c) Promote the need for clear pathways and knowledge exchange between domestic abuse and mental health services.	Domestic abuse services and mental health services have an improved understanding of the links between domestic abuse and suicide and are confident in utilising the pathways between the services.

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4. Female Suicides (cont...)	**4.d)** Improve data collection of domestic abuse data in RTSS.	Improved understanding and insight into domestic abuse as a risk factor for suicide within Berkshire.
	4.e) Include domestic abuse indicators in the Berkshire suicide audit to better understand the link between domestic abuse and suicide	Improved understanding and insight into domestic abuse as a risk factor for suicide within Berkshire.
	4.f) Provide information to domestic abuse services on how to respond to concerns where clients may be self-harming or considering suicide (whether the client is a victim, survivor, perpetrator or child or young person)	Improved knowledge and understanding of suicide risk and self-harm for domestic abuse professionals for all groups affected. Clients within the domestic abuse services who are at risk of self-harm or suicide feel better supported and able to access the services they need.
5. Economic Factors	**5.a)** Work with colleagues to raise awareness of the risk between debt, mental health and suicide risk among frontline professionals and the wider public. Awareness raising needs to; • reduce the stigma of 'being in debt' and signpost to access debt and benefit advice and support. this information also needs to be shared with frontline professionals • encourage people in debt to reach out for help to reduce impact on mental health • encourage people with poor mental health to reach out for debt advice	The risk between debt, mental health and suicide risk is further understood by frontline professionals and the wider public. The stigma of 'being in debt' is reduced for both frontline workers and the wider public, therefore potentially increasing the number of those seeking help. Frontline professionals feel confident to signpost to debt and benefit advice and support, encourage people to reach out for help, and for debt advice, therefore potentially increasing the number of those seeking help.
	5.b) Support frontline professionals to feel comfortable about talking about debt and financial problems and the link to poor mental health and suicide, and what support is available.	Frontline professionals feel comfortable and able to talk about debt and financial problems and can link this to poor mental health and suicide, and support available. Those with poor mental health benefit from accessing debt and financial support where needed following conversations with frontline professionals, reducing suicide risk.
	5.c) Support Berkshire local authorities with a single point of access information site around money matters.	There is a single point of access for information on money matters, allowing for up to date and consistent information being accessible to all.
	5.d) Ensure compassionate debt collection. Make sure the process is supportive and aims to steer residents to places that can provide help and support. Support vulnerable groups at increased risk of debt including people with long-term conditions or disabilities.	Reduction in stress and anxiety for those who are facing debt collection. Support and help highlighted to those facing debt collection, reducing stress and anxiety.
	5.e) Work with key partners to actively promote services that provide help around navigating the benefits system and potentially increasing people's incomes.	Improved understanding of navigating the benefits system, therefore potentially increasing incomes and reducing financial stress, reducing suicide risk.

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5. Economic Factors (cont...)	**5.f)** Make sure that all parts of the health service where patients showing suicidal intent first make contact, are signposted or triaged appropriately using a process that includes debts and other economic stresses as risk factors.	Identification of debt and economic stresses as risk factors upon first contact, therefore allowing professionals to have a better-informed approach to support, signposting and guidance, reducing suicide risk. Self-help or advisors for debts and practical issues (housing, relationships) highlighted to patients, therefore potentially reducing anxiety and stress.
	5.g) Work with system partners on the early identification and support of people who are at increased risk of debt and financial concerns (e.g. unemployed or people with long-term conditions) as early as possible and offer effective support to manage personal finances through appropriate referral pathways.	Reduction in debt and financial stresses as a risk factor for suicide for those who are at an increased risk.
	5.h) Monitor local data and intelligence on levels of problem gambling within Berkshire and its link to suicide.	Improved understanding of the levels of problem gambling and its link to suicide within Berkshire, informing the Suicide Prevention Group's approach.
6. Bereaved by Suicide	**6.a)** Ensure our local bereavement offer is culturally and ethnically appropriate for different groups within communities to develop resources and services.	The local bereavement offer is available and accessible for all groups within Berkshire and has accessible resources and services. Different groups within communities feel the services are culturally and ethnically appropriate.
	6.b) Continued support to the volunteer led local SoBS groups to be able to continue to offer a peer-to-peer support service.	Those bereaved by suicide can access and benefit from a peer-to-peer support service.
	6.c) Building in bereavement support to extend to wider family members, friends and communities.	Wider family members, friends and communities are able to access bereavement support, and feel able and supported in doing so, potentially improving their emotional and mental wellbeing.
	6.d) Continue to commission suicide bereavement support services and monitor its impact.	Bereavement support services are available and accessible across Berkshire, providing consistent support for those bereaved.
	6.e) Explore training opportunities for staff impacted by suicide.	Training for staff impacted by suicide in place and being delivered where appropriate, potentially improving emotional and mental wellbeing for staff following suicide.
	6f) Work with Thames Valley Police and other first responders to a suicide to share appropriate resources with employers	Employers able to better support their staff who have been affected by suicide.

2021-2026