PUBLIC HEALTH, WELLNESS AND CULTURE SCRUTINY PANEL

POLICY REVIEW 2014/15

STRATEGIES FOR THE PREVENTION OF SUICIDE

FINAL REPORT

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Foreword

Every suicide is both an individual tragedy and a loss to society. Each one affects a number of people directly and indirectly and can have a devastating effect emotionally, spiritually and economically. Suicides are not inevitable. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides.

The number of people who take their own lives in England had been reducing in recent years; however, more recently numbers have started to rise.

In 2011 4531 people were registered as taking their own lives – that is approximately one death by suicide every 2 hours.

Through this review we hope to refresh the overview of what is known about suicide, including factors that impact on levels of suicide, identification of those who may be at higher risk and the evidence for effective prevention.

In September 2012 the national suicide prevention strategy was published. This report reflects the content of the strategy and provides an update on the focus of the local response and achievements since publication.

The number of suicides is very small compared to smoking or obesity but deaths by suicide show up the ultimate loss of hope, the ultimate loss of meaning of purpose. They may be small numbers, but they have a very big ripple impact and they may be an indicator of what is happening further down through the health support services.

The Panel wishes to extend its thanks to all the witnesses who gave up their time to attend and gave interesting insights into the work they and their colleagues do and the challenges they face.

Councillor George Howe
Lead Scrutiny Member

2. Introduction

2.1 Suicide is preventable and partners have a role in ensuring that preventing suicide becomes everyone's business. The economic cost to England was measured as £1,450,000 per case in 2009 to the Local Authority, Police, Third Sector, Coroner and NHS. In the North East there were 238 cases of suicide and injury undetermined in 2009 which totals £345,100,000.

2.2 In response, suicide prevention policy is experiencing great change. Since the publication of a national strategy to prevent suicide in September 2012[1] the government has called for a fundamental overhaul of how public services tackle suicide prevention.

2.3 Local action, in the context of this national coordination, is essential to suicide prevention. This report assesses the local response to the national strategy and the help that is available in the local area to focus on the most effective things that can be done to reduce suicides.

3. Aim of Review

3.1 To review strategies for local suicide prevention.

4. Terms of Reference

4.1 The Panel set out to :

1. Examine and help identify the main determinants of suicide in Sunderland
2. Review the adequacy of suicide prevention services
3. Assess whether existing sources of data on suicide are sufficient
4. Look at how the various statutory and voluntary agencies should work together to implement the suicide strategy.

5. Membership of the Panel

Lead Scrutiny Member, Cllr George Howe
Cllrs Louise Farthing, Fiona Miller, Julia Jackson, Rebecca Atkinson, David Errington, Richard Bell, John Cummings and Shirley Leadbitter.

6. Method of Investigation

6.1 The Scrutiny Panel met monthly to take evidence from officers within the council and support organisations in the community. They also considered information contained in national legislation, regulations, guidance and research. The Panel funded their own session of A Life Worth Living training which was held on 6 November 2014 and invitations were extended to other scrutiny members as well as frontline workers.

[1] September 2012, a cross Government National Strategy *"Preventing Suicide in England*

7. Findings of Review

Suicide Rates in Sunderland

7.1 The North East has the highest age standardised death rates from suicide and injuries of undetermined intent in both males and females aged 15 and over. The rates for males (20.4 per 100,000) are significantly higher than the England average (16.4 per 100,000).

7.2 In Sunderland, in terms of actual numbers, deaths from suicide/self-harm have gone up from 17 in 2007 to 32 in 2012. (The most up-to-date data published during the work of the Panel is attached at Appendix 1 and shows a decrease for the year 2013).

	2009	2010	2011	2012
M	15	27	23	25
F	2	9	6	7
All	17	36	29	32

7.3 The numbers are very small compared to smoking or obesity but any death by suicide shows up the ultimate loss of hope, the ultimate loss of meaning of purpose. Every death by suicide is both an individual tragedy and a loss to society. Every suicide can have a devastating effect. They may be small numbers, but they have a very big ripple impact. Suicides are not inevitable. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides.

7.4 A government report in 1999 set a target of a 20% reduction in the all age suicide mortality rate between 1996 and 2010. Both Gateshead and South Tyneside exceeded the reduction in 2007. Sunderland did not meet the 2010 target. It is also useful to consider the health inequality gap. Only in Sunderland has the health inequality gap widened. The Sunderland rate was 10% higher than the England rate in 1996 but is now 16% higher.

Local Prevention Strategy

7.5 The national strategy provides a framework which can be used by local public health teams to implement a local suicide prevention action plan.

7.6 Within Sunderland, the public health team facilitated the development of a suicide prevention action plan which is overseen by a multi-agency suicide prevention group, chaired by a voluntary sector organisation.

7.7 From a wider health strategic perspective, the health and wellbeing board is responsible the strategy which sets out how the health needs of the local population will be met. The strategy, informed by a Joint Strategic Needs

Assessment (JSNA) determines the needs of the local population including for those at risk of self-harm and suicide. The Panel was informed that a suicide needs assessment is currently being undertaken for Northumberland Tyne & Wear which will help to provide more detailed information for focused prevention strategy and wider health strategy.

7.8 The national strategy provides examples of possible interventions, many of which are in place in the city.

- Suicide prevention training for front line staff within key public services
- A&E treating individuals following an attempted suicide or act of self-harm provide a psychological assessment and follow up care
- Signs displaying contact details for Samaritans are displayed at hotspots.

7.9 Despite these local activities, with no mandatory requirement for local authorities to deliver suicide prevention and with a heavy reliance upon the voluntary sector, the Panel is concerned that there is a very real risk that suicide prevention is not high on the agenda.

7.10 There is no formal mechanism by which a local suicide prevention group would report directly to a health and wellbeing board. The director of public health may do this on behalf of the group but the Panel felt the existence of a local champion may be the determining factor in how much focus is given to suicide prevention.

7.11 While there is a connection between the suicide prevention group and the safeguarding board, it is important that the local suicide prevention group has links with decision-making bodies – specifically, the health and wellbeing board.

7.12 There is a danger that the suicide prevention group will not be able to ensure suicide prevention is a priority on the agenda and services are commissioned, which undermines their value. Also, the health and wellbeing boards will not have access to vital information to inform future strategies.

7.13 The Panel noted that focused leadership at political level would support the championing of suicide prevention as a priority, with strategic leadership and community-based solutions to drive forward the prevention plans. This lead champion role could include taking a lead role in the suicide prevention group, acting as the link between the group and other bodies within the wider health remit.

<u>Factors relevant to suicide</u>

7.14 The Panel heard that there are a wide range of factors that impact on a local suicide rate. The most obvious of these being the relative level of deprivation. A higher than average rate is not necessarily a reflection on the quality of mental health services or suicide prevention initiatives. Rather it may be a

consequence of wider issues such as higher levels of unemployment or deprivation or related to specific demographic factors

7.15 The link between suicide and difficult economic circumstances is well established. Recession has been shown to be accompanied by an increase in suicide rates with unemployed men being most at risk. A Samaritans research report published in 2012 emphasised that men in lower socio-economic position in their mid-years are particularly vulnerable to death by suicide.

7.16 The Panel was informed that men are at greater risk for a number of reasons. Many of the clinical and social risk factors for suicide are more common in men. Cultural expectations that men will be decisive and strong can make them more vulnerable to psychological factors associated with suicide. Men are more likely to be reluctant to seek help from friends and services. Linked with this, providing services appropriate for men requires a move away from traditional health settings. Men are also more likely than women to choose more dangerous methods of self-harm, meaning that a suicide attempt is more likely to result in death.

7.17 Locally, other risk factors include:

- Barriers to accessing health care (81% of people are registered with a GP. 45% have had mental health episodes, 11% were in contact with mental health care in one week). 79% of people who had attempted suicide had a known mental health condition and 25% had significant drug and alcohol problems.

- Access to the means to complete suicide - two thirds of suicides in Sunderland were by hanging (61% hanging, 14% poisoning, 9% substance overdose, 7% drowning, 7% jumping from a height.)[2]

- Conflict in people's lives – stress, discrimination, trauma, abuse

- Relationships - people living alone or people with relationship issues were in high risk categories. One third of people in Sunderland reported stress-related problems.

- Individual risk factors included people with previous suicide attempts (22% in Sunderland have a history of self–harm). Working with schools to identify risk factors such as family break ups and exams is important. Men were identified a high risk, with 35-55 year olds being the largest at risk group currently. Chronic pain is also a factor (9% of cases) and a new service for psychological wellbeing supports those in need.

[2] Data from September 2014 Audit

Case Study - Monkwearmouth Bridge

Monkwearmouth Bridge attracts more people in distress than the Alexandra Bridge and, although both have been used, the Wearmouth Bridge has been a particular hot spot in the city.

Police were called to the Bridge 222 times in three years between 2010–2013 in response to reports of people being sighted and threatening to jump. In total, there were seven deaths as a result of those incidents. The police, expert negotiators, paramedics, fire brigade, and Sunderland RNLI are often called to the scene. Samaritans signs with helpline numbers are in place on the Bridge in a bid to prevent the numbers increasing.

7.18 Public Health England will soon be publishing a guidance document for local areas on the prevention of suicides in public places (including hotspots) which will provide information on the practical steps local areas can take to reduce risks. In the meantime, a new Bridge for Sunderland is at project planning stage and the Panel expressed a view that risk factors with a specific focus on suicide prevention should be considered with appropriate safety measures incorporated at the design stage.

7.19 The Panel was informed that incidents of self-harm have increased significantly in Sunderland. We know that across the country a record number of youngsters are being admitted to hospital for self-harm, eating disorders, depression and other psychological disorders. Emergency admissions for psychiatric conditions soared to 17,278 last year, double the number four years ago. There were 15,668 admissions of young women aged 15 to 19 for cutting, burning or harming themselves, compared with 9,255 admissions in 2004. A total of 2,965 children were treated on wards for anorexia and other eating disorders, a 12% jump in one year and double the number treated a decade ago.

7.20 Experts say that exam stress, social media, bullying and the pressure to look slim and attractive are combining to make children's lives unmanageable. At the same time, the Panel heard that mental health services for children and young people in England need a "complete overhaul".

7.21 The evidence follows a review of services by a government taskforce which has found that too many young people are not getting the help they need[3].

7.22 The report recommends a five-year plan to improve services. To tackle the problems, the report is recommending a host of measures. These include:

- A comprehensive set of waiting-time targets for services
- The launch of a hard-hitting anti-stigma campaign
- One-stop shop services in the community to direct young people to places that can help

[3] Children and Young People's Mental Health and Wellbeing Taskforce published 17 March 2015

- Continued support throughout teenage years and into the early 20s to avoid the "cliff-edge of lost support" at 18
- Greater use of online tools and apps to encourage self-help
- Improved care as close to home as possible for children and young people in crisis
- Extra training for GPs and other who work with children, such as staff in schools

7.23 The Panel welcomes this national recognition of the need to make dramatic improvements in mental health services. Nowhere is that more necessary than in support for children, young people and their families. Need is rising while the services aren't necessarily keeping up.

7.24 Around half the people who die from suicide have a history of self-harm therefore increased community awareness and understanding of self–harm whilst breaking down the taboo and stigma associated with self-harm/self-injury is vital.

7.25 People with a history of self-harm are identified within the suicide prevention strategy for England. While there is no obligation for local plans to include self-harm, the Panel felt that the local plan should include measures to address self-harm prevention.

7.26 The comprehensive collection of suicide data through meaningful research is generally considered to be the foundation for the development of an effective suicide prevention plan. The Panel was informed that annual research is carried out by the Public Health Locality team to identify patterns and trends via the Senior Coroner who permits controlled and confidential access to records on request by appropriate individuals on an anonymised basis. The research has identified some trends in risk factors relating to depression, self-harm and alcohol.

7.27 The Public Health team will prioritise the use of their finite resources based on public health issues that can be identified from this local research and from the risk factors identified locally.

7.28 The Panel commented that it is of course vital to consider not just whether the data is collected but also how it is used with data being used to inform where and how resources and interventions should be targeted and to support good local action planning.

<u>Effective Support and Intervention</u>

7.29 We took evidence from those in contact with people with suicidal thoughts to see what interventions make the most impact.

7.30 The partners who work with people accessing services all reported the numbers of referrals increased. Exploration of suicidal thoughts with support workers can help and individual to access the appropriate support. This support varies from accessing debt advice, making GP appointments,

providing helpline and crisis support numbers, contacting the Initial Response Team (IRT) and on occasion contacting the emergency services.

7.31 Sunderland Samaritans are incredibly proud to have served the people of Sunderland for over 40 years. They opened in 1970 and their service is needed as much today in 2014 as it was then - every year, they take nearly 10,000 calls from people going through tough times.

7.32 The service aims to alleviate emotional distress and reduce the incidence of suicidal feelings and behaviour. It is run by volunteers and leadership is provided from the national Samaritans.

	2012-2013	**2013-2014**
Numbers of calls	9344	10854
Calls where suicide was discussed	937	1045
Calls where suicide was In progress	37	318

"Speaking to Samaritans gave me the reassurance I needed that everything would be ok."
Charlie

"The volunteer I spoke to was very kind, and within five minutes I felt completely comfortable. He let me talk and never once tried to tell me what to do."
Dawn

7.33 Washington Mind has seen the number of referrals (people accessing our services) increase. They confirmed this is likely to have a connection to economic circumstances affecting people's state of mind.

7.34 The numbers in the table below show the number of users of the LIFE Suicide Prevention Model. The numbers identify individuals who have raised concern about suicidal thinking and planning.

	Total referrals	Counselling – Use of LIFE	Face to face Support – Use of LIFE	Telephone Support Use of LIFE	Training Support Use of LIFE
April 12 - March 13	848	511	6	47	4

7.35 From the data the Panel can clearly see the demand for volunteer-led services just in just one year.

7.36 In addition to the work of the voluntary sector, the Panel recognised the role of employers and businesses in providing in-house support for employees who may be demonstrating signs of mental health problems. The Panel noted this could be achieved at an operational level with the introduction of initiatives such as Mental Health First Aiders.

Partnership working

7.37 The focus of our evidence gathering has been within the local authority as the public health lead agency but it was clearly evident from all evidence that suicide prevention strategies must have a multi-agency approach.

7.38 We were informed that public health brought together key service providers to formulate an action plan to improve a range of services which can identify and support people at risk of attempting suicide at the earliest stage.

7.39 The multi-agency group, formed in 2013, leads on the operational implementation of the local suicide prevention action plan and leads on the A Life Worth Living Campaign. The group is chaired by a voluntary sector organisation with the intention of taking a community approach. The remit of the group is to develop and implement a local action plan which supports the national aspiration goals. A three year action plan for Sunderland has been completed for 2014/15 to 2016/17.

7.40 The group reports to the New Horizons Partnership[4] which in turn, reports into the Sunderland Safeguarding Board.[5] These all have the ambition of keeping adults, particularly those who are more vulnerable, safe from the risk of abuse, harm or exploitation.

7.41 The development of the next 3 years action plan has been underpinned by a public health model of suicide prevention adopting a population based approach. This approach attempts to reduce the risk in the whole population by changing attitudes, knowledge, behaviours and norms that might predispose people to suicide.

7.42 The group identified the need for individual and multi-agency approaches including the need for those on the frontline of service delivery such as housing officers, transport staff, police, employment services and the voluntary sector to be involved as being 'fundamental' to the implementation of the strategy.

7.43 Although preventing suicide is a complex challenge, it was clear that partners are committed in having a coordinated community approach across multiple

[4] The New Horizons Partnership oversees implementation of the Sunderland Emotional Health and Wellbeing (EHW) Action Plan and also receives progress on the Suicide Prevention Action Plan

[5] A multi-agency partnership made up of a wide range of statutory, independent and voluntary agencies and organisations.

organisations and acknowledge that this is fundamental to making a difference.

7.44 A Third Sector organisation (Washington Mind) was commissioned by the Public Health Team to design a local campaign and deliver training under the campaign brand, 'A Life Worth Living' (ALWL). The programme aims to train people who are best placed in the heart of communities to offer support and information to people who are experiencing suicidal thoughts.

CASE STUDY - A Life Worth Living

A community focused training programme which aims to train people who are best placed in the heart of communities to offer support and information to people who are experiencing suicidal thoughts.

It supports local people to identify 'a life worth living' and equip local workers and volunteers with the confidence, skills and knowledge they need to offer support and information to a potentially suicidal person and provide them with the knowledge to signpost to local services and access the relevant pathway of support; to reduce suicides.

The training places an emphasis upon how attitudes to suicide across societies can hinder suicide prevention and how by taking moral judgements out of the equation we can have open and honest conversations with a person who is contemplating taking their life as a realistic option to ending their pain.

"Attending the training has enabled me to be more open about the subject of suicide. I feel I can now support my customers through periods of change in their life"

"The training highlighted for me the importance of asking a difficult question and the need to talk about suicidal thoughts."

"The training proved beneficial to me to have the information and resources to actually make a difference."

"The training offered a valuable insight to helping those in real need."

7.45 At the time of the review, funding for the training had been renewed for a further 18 months with the likelihood that this would become part of the Health Champions Training, which is a positive development.

7.46 The Panel commissioned its own training session and the councillors who took part commented that it was a valuable session for all community leaders and recommended that all councillors make the time to take the training. A request has been made during the review for the ALWL Suicide Prevention Training to be incorporated into the member's development training programme so that all councillors have the opportunity to take part.

The Role of the Senior Coroner

7.47 If a Senior Coroner has reason to suspect a suicide in England and Wales there is always a public hearing - the Inquest. At the end of an Inquest hearing a Senior Coroner can give a number of conclusions, including death due to suicide, unlawful killing, drug related, alcohol related. To record a conclusion of suicide the Senior Coroner must be satisfied beyond reasonable doubt so as to be sure that the deceased has taken their own life and intended to do so. The Senior Coroner may record an open conclusion to reflect that there is insufficient evidence to support any other conclusion available.

7.48 The Panel was informed that people bereaved by suicide may see the inquest as an important opportunity to find out what happened to their friend or relative and to publicly state their version of events. This may be their one opportunity to ask questions about how a relative died.

7.49 The Senior Coroner in Sunderland investigates approximately 2,000 deaths per annum. Types of death that are investigated are those of unnatural cause, cause unknown, violent deaths, deaths in State Detention. The Coroner does not have to have a role in suicide prevention but has expressed views where this is relevant (the coroner is part of the regional public health suicide prevention group).

7.50 The Senior Coroner's office confirmed at present there is a tendency for more mature males with debt related issues to be amongst the suicide numbers. The Senior Coroner's cooperation is not well practised across the country and is a useful approach to add to the research material in Sunderland.

7.51 The Coroner has the power to issue a Regulation 28 – Report to Prevent Future Deaths. This is where the Coroner believes that future deaths may be avoided if preventative action is taken. Chief Coroner's Guidance No. 5 refers https://www.judiciary.gov.uk/wp-content/uploads/JCO/Documents/coroners/guidance/guidance-no5-reports-to-prevent-future-deaths.pdf

CASE STUDY – Regulation 28 report

Mr PG was a 51 year old male. The conclusion of an inquest was that he killed himself. The circumstances leading to the event were set out in a report to the Secretary of State for Health. Mr PG experienced multiple presentations to a number of professionals and agencies within a 72 hour period and had three mental health assessments, all of which placed him at low risk. Matters of concern reported under Regulation 28 on this case included: there appeared to be no mechanism to break the cycle of referrals and take him to a safe place for more detailed assessment; there were limitations upon the GP in being able to make a referral which would have required a further visit to the mental health team rather than the GP being able to make an admission to a place of safety, even if only for a limited period.

7.52 The Regulation 28 Report is a 'lessons learned' system - it can safeguard against future problems and can be the trigger for a review. The implications would be more serious however if a further similar death occurred and there had been no response to the Coroner's report. The Panel would recommend that these reports are also assessed in the local public health research.
https://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/pfd-reports/

8. Conclusion

8.1 In this report, we set out the context of suicide prevention nationally and actions in relation to the local preventative activity.

8.2 Recent Parliamentary research considers that there are three main elements that are essential to the successful local implementation of the national suicide strategy:

- Carrying out a "suicide audit" which involves the collection of data about suicides that have occurred locally from sources such as coroners and health records in order to build an understanding of local factors such as high risk demographic groups.
- The development of a suicide prevention action plan setting out the specific actions that will be taken based on the national strategy and the local data, to reduce suicide risk in the local community.
- The establishment of a multi-agency suicide prevention group involving all key statutory agencies and voluntary organisations whose support is required to effectively implement the plan throughout the local community.[6]

8.3 It also highlights how public health staff must ensure that services are joined up to respond to particular issues:

6

The All-Party Parliamentary Group (APPG) on Suicide and Self-Harm Prevention Inquiry into the State of Local Suicide Prevention Plans in England, January 2015

- Recession – knowledge of the options for those at risk of suicide because of economic difficulties, from debt counselling to psychological therapy.
- Self-harm – ensure there are supports for young people in crisis who are at risk of self-harm.
- Men – ensure information about depression and services is available in "male" settings.

8.4 The Panel was thankful for the commitment of those dedicated individuals in the community who work with those most at risk. However, local suicide prevention is fragile; often relying upon the commitment of dedicated individuals.

8.5 The Panel would conclude that local suicide prevention depends upon several inter-connected factors including leadership and local champions, suicide prevention being treated as a priority, availability of resources and the sustainability and commitment of a suicide prevention group.

9. Recommendations

9.1 The Panel's recommendations to the Cabinet are outlined below:

1. The Health and Wellbeing Board should receive a report annually from either the director of public health (representing a suicide prevention group) or a representative of the group on delivery of the suicide prevention action plan.

2. There should be evidence that a Suicide Needs Assessment has informed a suicide prevention action plan in the city.

3. There should be evidence that the Suicide Prevention Action Plan is informed by the most relevant up-to-date intelligence specifically in relation to:
    - Measures to address self-harm prevention
    - Lessons learned from suicides in Sunderland

4. Appoint a Councillor Champion who would have the role of: facilitating communication between the suicide prevention group and other groups and bodies including the health and well-being board; facilitating regular communication about the work of the suicide prevention.

10. Acknowledgements

The Panel is grateful to all those who have presented evidence during the course of our review. We would like to place on record our appreciation, in particular of the willingness and co-operation we have received from the below named:-

(a) Gillian Gibson, Public Health Consultant
(b) Jackie Nixon, Promoting Health Engagement Lead, Public Health Team

(c) Karen Lounton, Bereavement & Registration Services Manager
(d) Brian Patterson, Director, Sunderland Samaritans
(e) Ellen Rowley, Chair, Sunderland Samaritans
(f) Jacqui Reeves, Services Manager, Washington MIND
(g) Kathy McKenna, LIFE Coordinator, Washington MIND

11. Background Papers

11.1 The following background papers were consulted or referred to in the preparation of this report:

(a) Preventing Suicide in England – A cross-government outcomes strategy to save lives' September 2012
(b) Sunderland Suicide Prevention Action Plan
(c) All-Party Parliamentary Group on Suicide and Self-Harm Prevention Inquiry into the State of Local Suicide Prevention Plans in England, January 2015
(d) Office for National Statistics: Suicides in the UK

12. Appendix 1 Trends in mortality rate due to suicide and injury of undetermined intent