The Association of Directors of Public Health

ADPH submission to Commons Select Committee on Suicide Prevention.

What actions are necessary to prevent suicide?

Suicide is a major social and public health issue. It is a cause of early death and increased mortality rates, and is seen as an indicator of underlying rates of mental ill-health. The impact on family and friends can be devastating and it carries a huge financial burden for the local economy and contributes to worsening inequalities.

The factors leading to someone taking their own life are often complex, however they are all amenable to change. The prevention of suicide has to address this complexity. No one organization is able to directly influence all factors, it is vital that services, communities, individuals and society as a whole work together to help prevent suicides.

Local authorities and partner organisations, including police, transport police, the rail industry, fire services, schools, youth services, and drug and alcohol services

Leadership and Collaboration on a shared footprint

In 'Preventing Suicide: A global imperative' (1) the World Health Organization call for a systematic response to suicide and making prevention a multisectoral priority involving not only health care but education, employment, social welfare, the judiciary and others. Leadership that adopts a whole system approach amongst key partners can facilitate strategic planning and sustained change at a scale that has meaningful impact.

Directors of Public Health and public health teams in local authorities, working with local Health and Wellbeing Boards have a central role in coordinating local suicide prevention efforts (2). A local multi-agency suicide prevention group can put action plans in place tailored to the specific needs, strengths and opportunities of their local communities.

Nevertheless, investment, resources, capacity and expertise may be limited in each local area. Collaboration across local authority boundaries may be a more efficient approach where authorities share such services as healthcare, police forces, coroners and transport providers. Collaboration on a sub-regional or regional footprint provides for integrated strategic planning, combined intelligence and commissioning interventions at scale that could be prohibitive for one local area to instigate. Prevention at scale can reduce costs through saved lives, collaborative productivity and reduced duplication. Cheshire Merseyside and Greater Manchester are sub-regions in the North West where this model is being adopted.

The Cheshire Merseyside Suicide Reduction Network

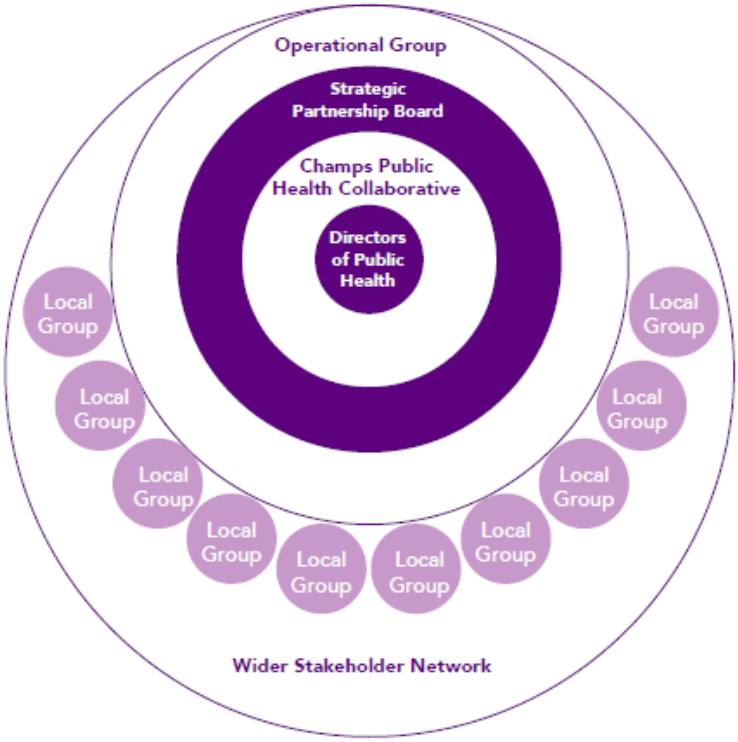
The Cheshire Merseyside Suicide Reduction Network (CMSRN) was formed in 2008 to seek greater co-ordination of responses to and understanding of patterns of suicide. In 2013 the CMSRN came under the collective leadership of the Cheshire Merseyside Directors of Public Health. CMSRN consists of four components: a Partnership Board, an Operational Group, Local Suicide Prevention Groups and a Stakeholder Network. The four components take an integrated approach to a strategic direction and the systematic implementation of action plans and robust provision of effective prevention, treatment and crisis services.

In 2015 the NO MORE Zero Suicide Strategy (3) was published with the key aims of developing Suicide Safer Communities, for healthcare to transform to achieve zero suicides, to support those bereaved and ensure the efforts of the network are sustained.

Outcomes from Year 1 of the strategy are:

- Joint CM Suicide Audits have provided the evidence for shared action planning
- AMPARO, a suicide liaison service, has been jointly commissioned
- 3 Mental Health Trusts have transformed their partnership working
- Primary Care suicide prevention training is being delivered at scale

The Structure of the Cheshire Merseyside Suicide Reduction Network:



The value of data collection for suicide prevention, and the action necessary to improve the collection of data on suicide.

Over recent years the number of deaths due to suicide and unintentional injury has been increasing, both nationally and locally (4882 deaths in England 2014/ 8.9 per 100,000 2012-14) (4). Services to prevent suicide and support family members are therefore of high importance and good intelligence on suicide is essential for service development and ensure good use of resources. The nationally available data should be looked at alongside local data and information to ensure local needs are addressed.

Suicide Surveillance Group: The role of a 'Suicide Surveillance Group' is to oversee suicide audits, real time surveillance and action learning. Representation on a suicide surveillance group may come from public health, mental health trusts, Primary Care Services, from Accident & Emergency and psychiatric liaison services, from the CDOP (Child Death and Overview Panel), from police, fire and ambulance services, from the Street Triage teams, from Network Rail, the Highways agency and the RNLI and from wider support services.

Public Health Intelligence Analysts are well placed to lead suicide surveillance groups and collaborations beyond local authority boundaries at a sub-regional level, providing for greater numbers, identification of trends and shared issues.

Suicide Audits: The function of suicide audits is to collect and analyse local data on the number of suicides,

the context in which they occur, the groups most at risk and how the picture is changing over time and is critical for effective suicide prevention work. This local intelligence informs the development of the suicide prevention strategy, provides an evidence for action and the means to monitor and review progress

Improvement in data collectionData collection from coroners' offices varies greatly in relation to public health auditors gaining access to the records, the detail that is recorded and whether the information is held in paper files or is electronic. A systematic and digital recording process would provide a more effective and efficient system.

Real Time Surveillance (RTS): A system or partnership agreement that enables any death where the circumstances suggest suicide may be the cause, to be notified and where appropriate responded to in a timely way. This builds on the collaboration and information sharing agreements between police, coroners and public health. *Durham has been running a Real Time Surveillance pilot linked to suicide bereavement support 'If U Care Share' (5).* RTS can be used to instigate a Community Response Plan (6). The purpose of a Community Response Plan is to prevent further suicides through use of intelligence and planning, provide a rapid response in protecting lives, provide a coordinated response from all sectors of the community and reduce anxiety and trauma.

Action Learning: Action learning is a mechanism for periodically reviewing trends, incidents and cases anonymously and reflecting on lessons learnt. Sharing information across organisational and professional boundaries may be challenging, nevertheless it is paramount to ensure effective co-ordination and integration of services.

Cheshire and Merseyside Joint Suicide Audit Report 2015 (7)

An objective of the Cheshire Merseyside NO MORE Zero Suicide Strategy is: A joint standardised suicide audit process for Cheshire Merseyside is developed.

A Sector Led Improvement approach was utilised for suicide audits to underpin the systematic collection and analysis of data. Shared suicide audit guidelines, data collection proforma and excel analysis were all shared at a learning workshop to ensure consistency across the sub-region.

Building on collaboration between local authorities, public health intelligence and the three coroners' offices a joint report was produced for the nine local authorities across Cheshire Merseyside for 2015.

Joint Audit Report:

- Combines local authority suicide audits
- This allows insight that would be missed at a local level due to small numbers.
- It improves coverage for when a resident completes a suicide in a different local authority area.
- Allows more detail to be examined than nationally published data
- 248 suicides and deaths due to UI in Cheshire and Merseyside is highest since 2002
- 200 cases for 2015 summary
- Rate per local authority varied from 8.4 to 11.9 per 100,000

Key issues similar to national trends:

- Three out of four deaths in the audit were male
- Three in ten had alcohol or substance misuse history
- Relationship problems recorded in 30% of cases
- 22% receiving care from MH services

Key issues for local area not previously known from national data: By using the same audit proforma across all areas and increasing data sharing, it has been possible to go into much more detailed analysis and to put minimum figures on some key issues that were previously unknown.

1. In the three months before they died, 30% of all people in the audit had specifically visited their GP for a mental health reason. (Where recorded 159 cases)

2. 38% of cases had a previous suicide attempt recorded
3. 16 cases had a previous suicide of someone close to the person recorded in notes. At least five of these were in the previous year
4. Domestic violence was recorded in 7% of cases (either victim or perpetrator)
5. Only three in ten were employed
6. Hanging/strangulation now most common method for women, 50% (previously self-poisoning)
7. Eastern European- Five people were born in Eastern Europe, all males aged 20-39 years
8. Benefit impact; benefits and welfare reform were mentioned in open notes in seven cases (4%)

The factors influencing the increase in suicide rates, with a focus on particularly at-risk groups

Access to means

Hanging/ strangulation is the most common method for both men and women and may be a reason for the increase in deaths by suicide for women. Actions to address this are challenging when the means are so easily available. Restrictions to the environment within mental health trusts and prisons have been effective, however there are still lessons to be learnt to eliminate such deaths. The three mental health trusts in Cheshire Merseyside, Mersey Care, Five Boroughs Partnership and Cheshire Wirral Partnership, are working openly and collaboratively through facilitated action learning to tackle deaths from ligatures.

Network Rail and the Samaritans are collaborating on exemplary work to protect passengers and train staff, who themselves are at increased risk through exposure to suicide. However, the electrification of the rail network poses an added challenge. www.suicidepreventionprogramme@networkrail.co.uk

Deaths due to inhalation of helium have increased in recent years, although numbers are small along with the ease of buying helium gas canisters and helium kits via the internet, it suggests that this may need to be an area for further action.

Vulnerable groups

People who have previously attempted suicide and/ self-harm are at heightened risk. People who frequently present to hospital following self-harm are a particularly vulnerable group (8). The process of follow-up, referral into services and safety planning could be improved.

The use of drugs and alcohol is strongly associated with suicide in the general population, particularly in those with a mental health diagnosis (9).

Financial concerns are a risk factor and the impact on those receiving benefits and/or undergoing welfare capability assessments is noted in suicide audits.

The Mental Welfare Commission for Scotland (MWCS) undertook an investigation into a death by suicide following a Work Capability Assessment (WCA) of a female claimant. Psychiatrists reported additional demands on their services due to the ways in which the WCA had distressed and destabilised clients. 40% had at least one patient who self-harmed after the WCA. 13% reported that a patient had attempted suicide, and 4% stated that a patient had taken his/her own life. 35% said that at least one of their patients had been admitted to hospital as a consequence of the WCA, and 4% reported a patient being detailed under the Mental Health (Care and Treatment) (Scotland) Act 2003. (10)

The measures necessary to tackle increasing suicide rates, and the barriers to doing so

To be effective suicide prevention strategies and interventions need to be multi-disciplinary, combining a range of integrated interventions that build individual and community resilience and target groups of people at heightened risk of suicide.

The Canadian 'Suicide Safe Communities' (11) model has been adopted by Cheshire Merseyside, Greater Manchester and Brighton and is gaining traction across the UK. The 'Suicide Safer Communities' model has

nine pillars that incorporate this multi-disciplinary approach: leadership, intelligence, awareness, training, community interventions, clinical interventions, support for those bereaved, evaluation and sustainability.

Awareness

'Time to Change' led by MIND is the awareness campaign that has a national profile and most widely adopted.

MIND gave support to a Merseyside campaign 'Time to Talk' in St.Helens #10000minutes. The aim of this localised programme was to change public perception of mental health by encouraging community members to spread healthy mental health messages to friends, family, colleagues and service users. The target was 10,000 minutes on mental health over a 12-week period. Using the live Google mapping, it was possible to see the saturation of conversations in targeted areas where deprivation associated with mental health problems are higher. The original aim of 10,000 minutes was surpassed after 6 weeks and the goal increased to 20,000; the final number of recorded minutes was 20,245.

Charities and sporting organisations do much to raise awareness. Rugby League clubs have taken the lead with such campaigns and the CALM charity have conducted awareness campaigns for over 15 years such as 'Being Silent Isn't Being Strong', #mandictionary www.thecalmzone.net . World Suicide Prevention Awareness Day, 10th September, is a focus for local campaigning and in 2016 the NSPA are providing campaign materials for their members #ITS OK TO TALK http://www.nspa.org.uk/home/about-us/

A national campaign specifically on suicide that challenges myths and encourages behaviour change has not been researched, implemented or robustly evaluated.

Training

The positive impact of suicide prevention training is evidenced at differing levels, such as specialist mental health workforce, healthcare workforce and community (12). Training programmes appropriate to the differing levels are available: The East of England Zero Suicide Strategy sets out a useful summary https://www.centreformentalhealth.org.uk/zero-suicides

To have impact training needs to be delivered at scale across the health care sector; mental health trusts, IAPT providers, hospitals and primary care. Examples of good practice can be found in Oxford Health NHS Foundation Trust, East Anglia and Cheshire Merseyside.

Community Gatekeeper Training is recommended focusing training resources upon those individuals who would most benefit from the newly acquired skills Suicide awareness and prevention training would be advantageous for staff in the Department of Work and Pensions who undertake WCAs and such agencies as the Citizens Advice Bureau. Other community services where such training is offered are: community drug & alcohol services and domestic violence services.

The availability of training and its costs can limit the scale of the uptake, particularly in the community and voluntary sector is particularly where financial restrictions.

E-learning for professionals, community members and the public is increasingly being utilised as an option, however it is not always appropriate for all groups. http://www.rcgp.org.uk/learning/online-learning/ole/suicide-prevention.aspx

Community Prevention Interventions

Community prevention interventions are wide-ranging, the basis of them is to improve knowledge and understanding of emotional wellbeing and enhance resilience skills in the target population. Community prevention interventions need to be informed by national and local data on demographics, risks and vulnerable groups

75% of those who take their lives are men and men's lack of accessing and taking up services is well documented. Innovative programmes should provide alternative and innovative ways for men to gain information and support.

CALM as a national charity has been highly successful in targeting men, developing a recognised national CALM brand and in delivering an attractive website, helpline and text service. Its creative collaborative campaigns have involved leading national and international figures with the entertainment industry, media and the arts.

Professional sporting organisations have taken the lead in targeting men from a wider age-range. For example; State of Mind Rugby League and Opening Up Cricket that delivers 'mind and body' sessions. Community Sports Partnerships are now liaising closely with MIND to encourage more areas to take up the 'Get Set Go' mental health & physical activity programme.

State of Mind

The State of Mind (13) programme was established in 2011 with the aim of improving the mental health, wellbeing and working life of rugby league players and communities. We want to get people talking about it. Our team of mental health and sport professionals deliver comprehensive education sessions at no cost throughout the UK in super league, championship and amateur clubs as well as colleges and community groups, aimed at raising awareness of mental health issues within sport

Suicide prevention goals

- We aim to enhance wellbeing and resilience by involving individuals in sport, enable a sense of purpose, increase their connection, encourage personal responsibility and promote physical activity
- We seek to promote a better understanding of mens' culture, concepts of masculinity, their beliefs and concerns, in those responsible for public health strategies and those involved in service delivery
- Be a catalyst and encourage clinical teams to consider the option and benefits of sport in care and support plans
- Also in addressing stress, depression isolation and where appropriate, anger management

Primary Care

Consultation behaviour of patients in primary care prior to suicide has been identified (14-19)

- Patients who die by suicide consult more frequently in primary care than controls but risk is also increased in people who do not consult
- Patients with a psychiatric diagnosis consult more frequently than controls in the month prior to suicide
- Depression is the most common psychiatric disorder and is a robust risk factor for suicide
- Substance misuse is a common diagnosis for individuals who have died by suicide
- There is a strong association between elevated suicide risk, chronic physical illness and depression
- Approximately one third of patients do not consult in primary care in the year leading up to suicide
- Patients who did not consult with their GP were more often young, male and have lower rates of psychiatric diagnosis

The challenges facing GPs have been identified:

- Assessing suicidal risk in primary care
- Education and training of suicide prevention in primary care
- The management of patients in primary care prior to suicide
- Referral pathways between primary care and mental health services
- The challenges GPs face when managing suicidal patients
- Service user needs in primary care prior to suicide
- GP Support following patient suicide

Systematic multi-level interventions across CCGs has been adopted in East of England and adoption across other localities is to be recommended.

Secondary Care

Aiming for Zero Dr. Coffey's innovative work on "Perfect Depression Care" has been widely cited as a model for eliminating suicide and transforming health care. This quality improvement model in mental health care has reduced suicides by 75% in Detroit. The Zero Suicide approach sets out to be aspirational, innovative and bold. It has been adopted in the East of England, South West England and Merseyside. www.zerosuicide.com

Mersey Care NHS Trust have developed a broad and innovative suicide prevention programme which involves training for all staff, personalised safety plans for every service user with a history of intent or self-harm, rapid post-suicide reviews and the creation of Safe from Suicide Team as part of the new assessment and immediate care service.

The social and economic costs of suicide and attempted suicide

Costs of bereavement by suicide

Suicide is an individual tragedy, life-altering for those bereaved and a traumatic event for the community and local services involved. Effective and timely emotional and practical support for individuals and families bereaved or affected by suicide is essential to help the grieving process, prevent further or longer-term emotional distress and support recovery. There may be a risk of "copycat" suicides in a community, particularly among young people, if another young person or a high-profile celebrity dies by suicide.

- People bereaved by suicide are at greater risk of attempting to or taking their own lives by suicide by up to 300% (20).
- The Cheshire Merseyside Suicide Joint Audit Report 2015 noted 16 cases where the person had been bereaved by suicide in 2014. The economic costs of each suicide are estimated at £1.67 million. If the 16 deaths in 2014 had been prevented, this would have equated to £26.72 million being saved.
- Economic costs are 'saved' when an individual beneficiary receives postvention support; principally reduced healthcare costs, reduced absenteeism and presenteeism. Cost-effective analysis of a service in Australia (21) provides the equivalent of a £512 saving per beneficiary after accounting for service costs.
- It is estimated that a minimum of six people will suffer a severe impact as a result of each individual suicide, which would indicate 4,212 people were affected within the Cheshire and Merseyside region during 2012-14. Postvention support for all those affected would provide a potential saving of £2.1 million

AMPARO

A strategic objective of the NO MORE Strategy is 'Support is accessible for those who are exposed to suicide'

Joint commissioning through the Champs Public Health Collaborative of a suicide liaison service, AMPARO, builds upon the partnerships with the Cheshire and Merseyside coroners and police forces and non-statutory organisations such as SOBS (Survivors of Bereavement by Suicide). AMPARO, the coroners and police have a data sharing agreement with secure communication systems.

In Year 1, 2015-2016, referrals came from 154 deaths by suicide, with 132 bereaved people benefitting from the service. The key aims of the service are:

- Alleviating the distress of those exposed to or bereaved by suicide
  32 beneficiaries completed the sWEMWBS wellbeing questionnaire pre and post intervention; 21 (66%) showed a meaningful positive change, however these small numbers should be interpreted with caution.

- Reducing the risk of imitative suicidal behaviour
  This has not previously been measured systematically and is difficult to assert after just 12 months of a pilot service, however to date there have been no beneficiary suicides.
- Reducing the risk of suicide clusters
  The service has been alerted to two potential clusters/ notable deaths in a community during 2015-16 and was able to implement the CM Community Response Plan.
- Reducing the economic costs of suicide
  The service cost in the first 12 months equates to £871 per client, it is envisaged that with increased referrals this will reduce to approximately £575 in Year 2.
- Based upon the Australian research AMPARO would have contributed £67,584 savings to the Cheshire Merseyside economy in Year 1

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