

09 January 2018

Agenda Item:

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

OVERVIEW OF ARRANGEMENTS FOR SUICIDE PREVENTION

Purpose of the Report

1. To outline arrangements for preventing suicides in Nottinghamshire County.

Information and Advice

2. For the period 2014 -16, the age-standardised incidence rate of suicide in Nottinghamshire County was 8.2 per 100,000 population, which is slightly lower than the average for England (9.9 per 100,000). This equates to approximately 58 suicide deaths per annum of which about three quarters occurred in men aged between 21 and 49 years.

Further information on the Nottinghamshire suicide rates, trends and risk factors refer to [Appendix 1](#).

3. Effective prevention of suicide requires a whole system approach involving Nottinghamshire County Council, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide.
4. The House of Commons Health Committee Suicide Prevention report¹ recommends that local suicide plans should be developed and implemented in line with the [Public Health England's \(PHE\) suicide prevention planning guidance for local authorities](#) (2016). The structure of this report broadly reflects that of the PHE planning guidance and includes
 - Applying the national policy context to the local Suicide Prevention Framework for Action and action plan
 - Multi-agency suicide prevention partnership
 - Use of suicide data sources
 - Evidence-based multiagency suicide prevention strategy and action plan

National policy context and Nottinghamshire multi-agency suicide prevention steering group

5. The Nottinghamshire (combined with Nottingham City) Suicide Prevention Steering Group was reformed in 2013. The main responsibility of the group was the development of a multi-agency

¹ [House of Commons Health Committee Suicide Prevention](#) report (March2017)

Suicide Prevention Framework for Action Nottinghamshire (2015-2018) and the implementation of the accompanying action plan (attached in [Appendix 2](#)).

6. The group comprises stakeholders from the following organisations;
- Public Health (Chair and meeting facilitator)
 - Nottingham City Coroner's Office
 - Nottinghamshire Police
 - NHS Mental Health services (Children, Young People and Adults)
 - CCG Mental Health Commissioners (Children, Young People and Adult)
 - Substance Misuse service providers
 - Quality and safety leads (CCG and NHCT)
 - Primary Care GP mental health leads
 - Network Rail
 - British Transport Police
 - East Midlands Ambulance Service
 - University of Nottingham (Researchers)
 - Student Counsellors (University of Nottingham and Trent University)
 - Third Sector Organisation, such as; Samaritans offering bereavement support and Harmless offering support for people who self-harm
7. The Framework for Action is aligned to national guidance and current best practice for mental health and suicide prevention guidance and clinical evidence². The key suicide prevention priorities and actions includes;

Priority 1: Identify early those groups at high risk of suicide and self-harm and support effective interventions

Actions Completed:

- In 2015, Public Health undertook the Nottinghamshire Coroners Suicide Audit to review all Nottinghamshire suicide deaths in 2013 and 2014. The audit findings showed that the majority of suicides deaths were in men aged 49 years and younger, which is similar nationally. To reduce the number of suicide deaths in this group, the Nottinghamshire Suicide Prevention Steering group agreed to target this high risk group in 2017/18. (Refer to [appendix 3](#) for the 2017/18 action plan).
- Awareness campaigns targeting men have included;

• ² **Preventing suicide in England: a cross government outcomes strategy to save lives (2012)** details the national objectives and actions are outlined in preventing suicide in England by;

- **No health without mental health: A cross-government outcomes strategy for people of all ages (2011)** is key in supporting reductions in suicide amongst the general population by improving access to effective mental health services
- **Five Year Forward View (2016)** to address gaps in mental health services
- **Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis** was published by the government in February 2014. The concordat outlines a vision for health, social care and emergency services work together to deliver a high quality response when people of all ages with mental health problems including suicidal behaviour, urgently need help.
- **Future in Mind (2015) targeting children and young people** in promoting resilience, prevention and early intervention and improving access to mental health effective support
- **Mental Health Crisis Concordat (2014)** outlines a vision for health, social care and emergency services work together to deliver a high quality response when people of all ages with mental health problems including suicidal behaviour, urgently need help.
- **National Institute for Health and Care Excellence (NICE) guidelines**
 - Depression in adults. The treatment and management of depression in adults (2009) NICE clinical guideline 90
 - Depression in adults with a chronic physical health problem: recognition and management. (2009) NICE clinical guideline 91.
 - Depression in children and young people: identification and management (2005) NICE clinical guidelines 28.
 - Self-harm in over 8s: long-term management (2011). NICE clinical guidelines 133

- [Campaign Against Living Miserably \(CALM\)](#) awareness
- National Suicide Prevention awareness campaigns such as '[It's okay to Talk](#)'. Public Health have developed a local pamphlet to support this campaign which aims to develop a culture where people are feel comfortable talking about suicide and are able to have a difficult conversation with someone they are worried about
- Public health mental health awareness delivered through the Workplace Health schemes supports employers and employees in promoting good mental wellbeing which has positive impact on reducing mental health problems and preventing suicides
- Improved access to support for young people in mental health crisis through the establishment of a CAMHS Crisis Resolution and Home Treatment Service providing mental health support in the community, and in acute hospitals, with a liaison function in A and E being rolled out at QMC and King's Mill.
- Improved access to Adult Mental Health crisis services through the commissioning of Rapid Response Liaison Psychiatry (RRLP) service in acute hospital and the Police Mental Health Triage service

Actions Ongoing (2018/19):

- In 2016, there were ten suspected suicides on Nottinghamshire railways. Public Health in partnership with Network Rail, British Transport Police and the Samaritans are working to prevent any further suicides. The local Samaritans target those rail hotspot areas with suicide awareness signage and awareness raising that encourages passengers to notice what may be suicide warning signs. In 2017, there has been a 20% reduction Nottinghamshire Network Rail suicide deaths

Priority 2: Review of timely suicide and self-harm data and be informed by national and local evidence based research and practice in order to better understand the local needs

Public Health undertakes reviews of national and local suicide trends so that at risk groups are identified early and evaluates the effectiveness of suicide prevention interventions.

Actions Completed:

[Suicide Prevention Joint Strategic Needs Assessment](#) (2016)

Self-harm Joint Strategic Needs Assessment (due to be published December 2017).

Actions Ongoing (2018/19):

- Coroner's Office suicide verdict data
- Public Health Suicide Profile data
- Hospital Episode Statistic data
- Office of National Statistics annual suicide data
- Review of British Transport Police Network Rail suspected suicide daily incidents

Priority 3: Access effective support for those bereaved or affected by suicide

Actions Completed:

- At the time of a suicide death, Nottinghamshire Police give the families of the deceased person the Samaritans 'Help is at Hand'³ that offers advice and where to get support

³ Samaritans 'Help is at Hand' (2015) <https://www.gov.uk/government/news/you-are-not-alone-help-is-at-hand-for-anyone-bereaved-by-suicide>

- Coroner's office also provide relatives with the Samaritans 'Help is at Hand' at the coroner's inquest
- A research grant-funded 2 year pilot is in place and delivered by a third sector provider (Harmless). The pilot is assessing the impact of offering families affected by a suicide early access to bereavement counselling in reducing depression. This project ends the October 2018. Continuation of the project depends on ongoing CCG funding.
- Network Rail offer suicide prevention awareness and training to all rail staff. The training offers skills in ways of detecting those at risk of suicide and intervening to support the person to access mental health interventions

Actions Ongoing (2018/19):

- Samaritans target railway stations where a suicide death on the railway has occurred. Samaritan counsellors offer advice and support to those that have witnessed a railway suicide.

Priority 4: Engage with media personnel to agree on sensitive approaches to reporting suicide and suicidal behaviour

Actions Completed:

- Nottinghamshire County Council Communication team has implemented the Samaritans guidance for the media on the reporting of suicide:
www.samaritans.org/media_centre/media_guidelines.aspx
- This local suicide prevention communication plan promotes responsible reporting of suicide in the media and ensures effective local responses to the aftermath of a suicide

Actions Ongoing (2018/19):

- Where there have been incidences of irresponsible media reporting, the communications team of Nottinghamshire County Council has supported the local media to improve their reporting, using the Samaritans media guidance
- Where there has been irresponsible reporting, Public Health alerts local stakeholders and services of the possibility of raised levels of suicidal behaviour

Priority 5: Improve the understanding and care for people at risk of suicide and self-harm through training of frontline staff to deal with those at risk of suicide and self-harm behaviour

Actions completed:

- 2016 - Public Health Division committed £92k for the delivery of Mental Health and Suicide Prevention awareness and training, to equip frontline staff in the NHS, Police, Emergency Services and Third Sector with skills to detect those at risk of suicide and prevent suicides. The 18-month contract ended in March 2017.
- Rushcliffe CCG are running Suicide Response Training for GPs in Primary Care. The training equips GPs the skills to ask patients about their suicidal thoughts that equips GPs in putting in a safety plan to reduce the risk of suicide.
- A training programme for secondary schools has been jointly developed by CAMHS, Educational Psychology and the Healthy Families Team, and will be delivered through 8 sessions in the Spring term.
- The Primary Mental Health Team has been commissioned as part of CAMHS to provide training and case consultation to universal practitioners working with young people who express emotional health needs. Additionally, Nottinghamshire has become part of a pilot

project through the Anna Freud Foundation, aimed at strengthening the links between schools and CAMHS.

8. Implementation (Quality and Governance)

Progress and updates against the suicide prevention action plan are reported to:

- Nottinghamshire Health and Wellbeing Board (2016)
- Nottinghamshire Integrated Mental Health Commissioning Group
- CCG Quality and Safety Committees
- Nottinghamshire Healthcare NHS Trust (local Mental Health Trust) conducts a monthly suicide prevention audit. This audit is part of the “Monthly Audit Tool” taking place across all Adult Inpatient Services. Each month all in patient areas undertake a self-audit on their records. Part of the audit considers a series of standards based on the National Audit for Suicide Prevention: Ward Audit.
- In 2015 Nottinghamshire Health NHS Trust produced a 3 – year ‘Signup to Safety Plan’. The plan aims to ensure processes are in place so that the target of no incidents of suicide (or suspected suicide) among people with recent clinical contact and a 50% reduction in overall severity of self-harm incidents by 2018 is reached.
- Substance misuse services have governance and quality procedures in place to review all cases of patient/service users suicides and make recommendations on actions to prevent any further suicide deaths.
- The Nottinghamshire Suicide Prevention Steering group meet quarterly and review progress against the suicide prevention action plan.

9. Funding

- CCGs have funded suicide prevention. Public health and CCGs together have invested in mental resilience programmes in schools to prevent and improve children and young people’s mental health problems. Additionally CCGs have invested in the CAMHS Crisis Resolution and Home Treatment Service.
- The provision of government funding to the NHS for suicide prevention that is guaranteed for 2018/19-2020/21 is still to be allocated.
- The Council invested £92K of the public health ring-fenced grant to fund Suicide Prevention awareness and training between October 2015 to March 2017. The expiration of this contract and lack of funding leaves a significant gap in the training of frontline health, social care and emergency services in early identification and support for people at high risk of suicide and in the management of mental health crisis.
- On the 11th of December 2017, the ASCH and PP Committee agreed £50k from the Public Health grant to be allocated to Mental Health and Suicide Prevention awareness and training.

Statutory and Policy Implications

10. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

11. No financial implications

RECOMMENDATION/S

- 1) That members to comment on the information provided and to consider whether there are any actions they require in relation to the issues contained in the report.

Barbara Brady

Director of Public Health

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Constitutional Comments (LMC 14.12.2017)

12. The Health Scrutiny Committee is the appropriate body to consider the contents of the report and for members to consider whether there are any actions they require in relation to the issues contained within the report.

Financial Comments (DG 13.12.2017)

13. The financial implications are contained within paragraph 11 of this report.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- 'None' or start list here

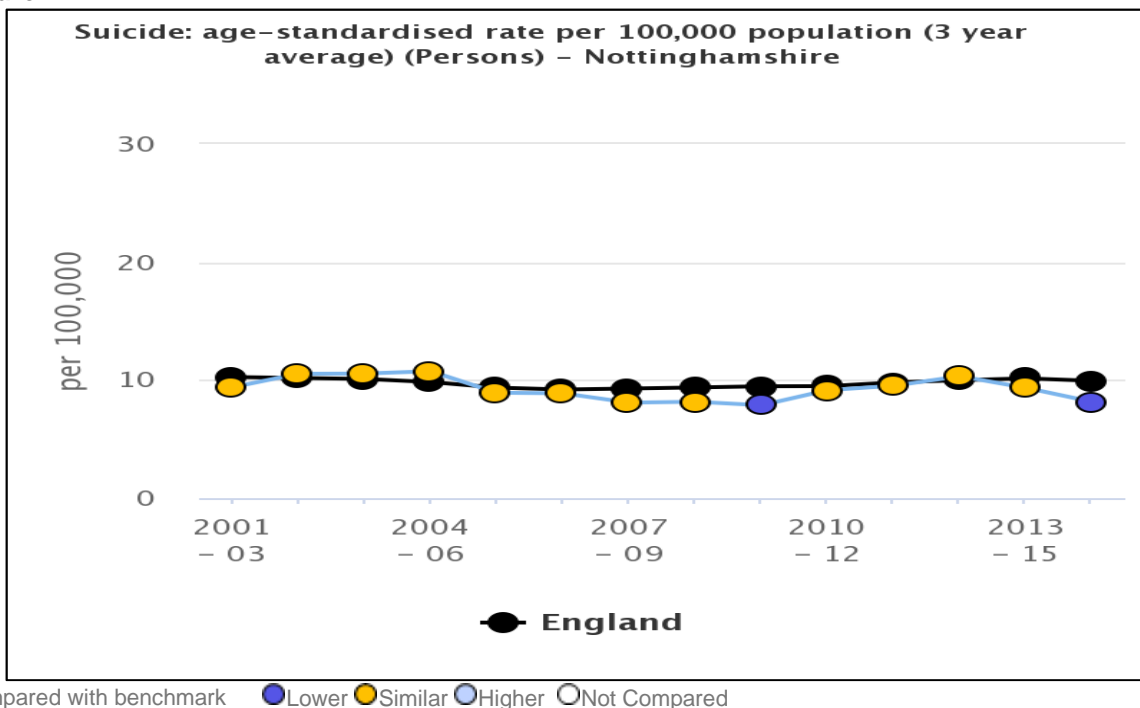
Electoral Division(s) and Member(s) Affected

- 'All' or start list here

Appendix 1: Nottinghamshire Suicide Prevalence Rate and Risk Factors

Figure 1 below illustrates that since 2001, Nottinghamshire rate of suicide deaths are similar to national average. With the exception in 2009/11 and 2014/16, Nottinghamshire was lower than the national average.

Figure 1:



In 2014/16, there was 176 suicide deaths which equates to approximately 59 deaths per year during that period (see Table 1)

Table 1: Suicide: age-standardised rate per 100,000 population and number (3-year average) (Persons) - Nottinghamshire

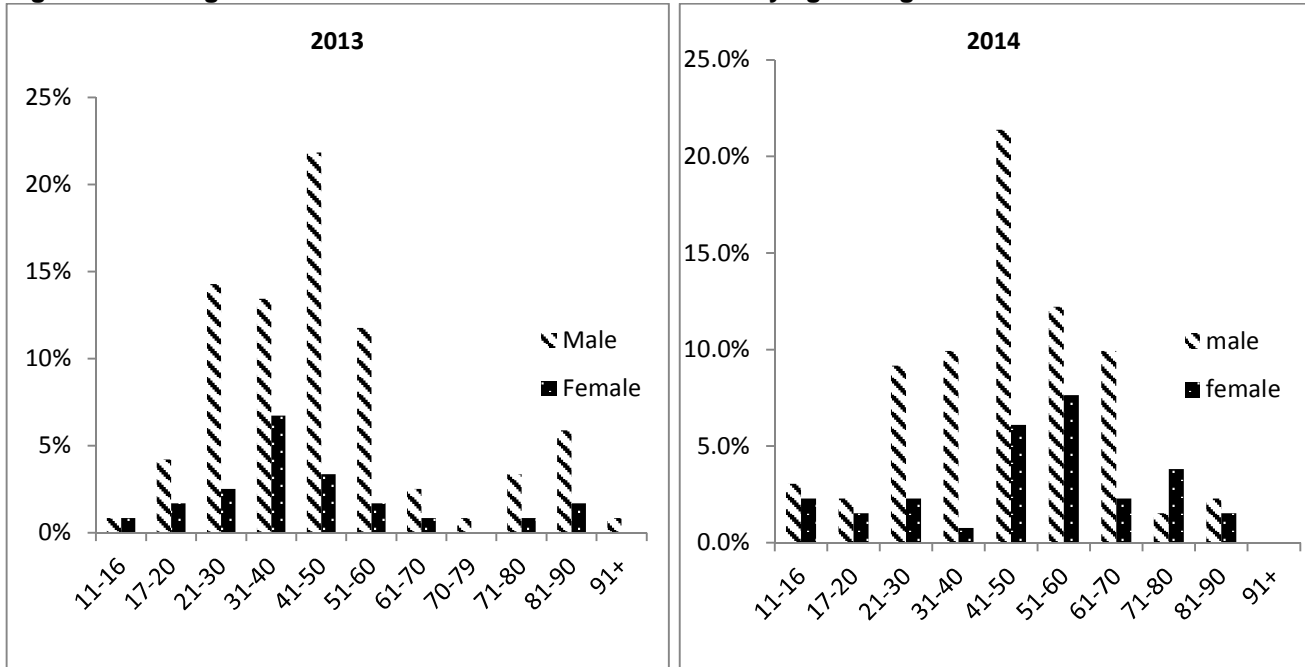
Period	Count	Standardised rate per 100,000 population	East Midlands	England
2001 - 03	184	9.4	10.2	10.3
2002 - 04	206	10.5	10.1	10.2
2003 - 05	209	10.6	10.0	10.1
2004 - 06	218	10.8	9.7	9.8
2005 - 07	184	8.9	9.2	9.4
2006 - 08	183	8.9	8.9	9.2
2007 - 09	166	8.1	8.9	9.3
2008 - 10	169	8.2	8.7	9.4
2009 - 11	164	7.9	8.9	9.5
2010 - 12	191	9.1	8.9	9.5
2011 - 13	200	9.5	9.4	9.8
2012 - 14	219	10.3	9.8	10.0
2013 - 15	200	9.3	9.9	10.1
2014 - 16	176	8.2	9.5	9.9

Source: Public Health England (based on ONS source data)

Nottinghamshire Coroner's Suicide Audit results

In 2015, Public Health undertook a Nottinghamshire Coroners Suicide Audit to review all Nottinghamshire suicide deaths in 2013 and 2014. As shown in figure 2 the majority of suicides deaths were in men aged 49 years and younger, which is similar nationally, whereby three in four deaths by suicide are by men.

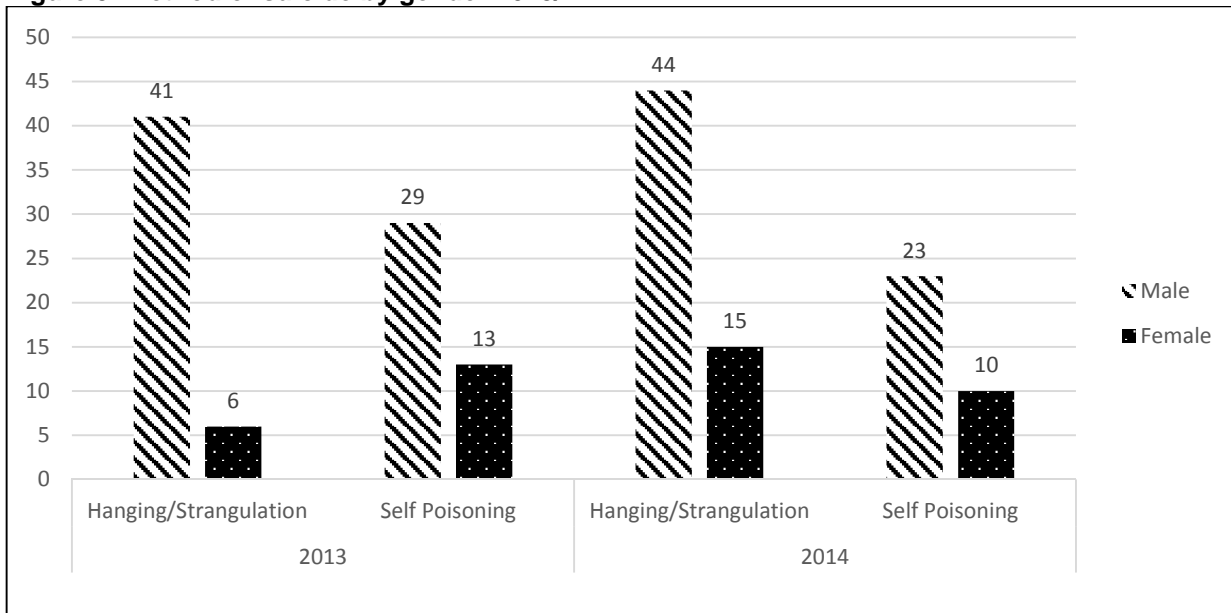
Figure 2: Nottinghamshire Coroner's Audit Suicide Deaths by age and gender – 2013 and 2014



Source: Nottinghamshire Coroner's Audit

In Nottinghamshire, hanging and strangulation rated as the highest method of suicide of men in 2013/14 and women in 2014 as shown in figure 3.

Figure 3: Method of suicide by gender 2013/14

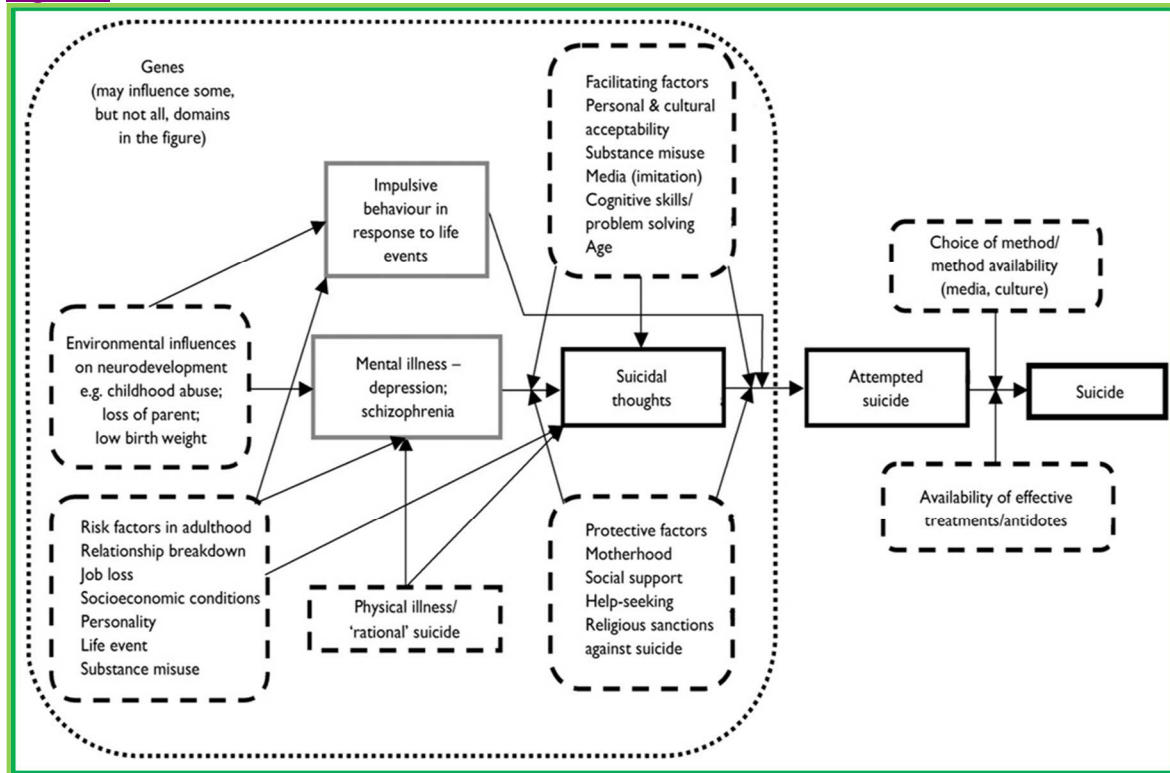


Source: Nottinghamshire Coroner's Audit

Suicide Risk Factors

There are a wide variety of factors that can contribute to suicide and self-harm as shown in [figure 4](#), below. These include distal factors (e.g. genetic influences, family history and early trauma) and proximal factors (e.g. psychiatric disorder, physical illness, relationship breakdown and other life events). Changes in socio-economic environment are important, as is exposure to suicidal behaviour by others, including through the media. Availability of suicide methods can contribute to risk, and the danger of the method will partly determine whether an act is fatal or non-fatal.

Figure 4: Life course influences on suicide and self-harm.



Source: Gunnell D, Lewis G. Studying suicide from the life course

The 2013/14 Coroners Suicide Audit indicated that relationship/family problems and physical illness/disability rated the highest risk factors for suicide deaths in Nottinghamshire, as shown in figure 5.

Figure 5: Physical and Social Risk Factors – Coroners Audit 2013/14

