

Suicide Prevention in NHS GG&C

Recommendation

Paper for information.

Purpose of Paper:- 1.

This paper provides a summary of recent trends in suicide for the Health Board area, and summarises the multi-agency action plan to prevention suicide.

Key Issues to be considered:-

A continuing decline in suicide rates across the Board area, in response to a range of influences.

Any Patient Safety /Patient Experience Issues:-

Suicide prevention is a critical patient safety issue, principally for mental health services, but including all aspects of health care.

Any Financial Implications from this Paper:-

n/a

Any Staffing Implications from this Paper:-

n/a

Any Equality Implications from this Paper:-

Suicide rates differ by age, gender, disability, ethnicity and sexual orientation.

Any Health Inequalities Implications from this Paper:-

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:-

No

Highlight the Corporate Plan priorities to which your paper relates:-

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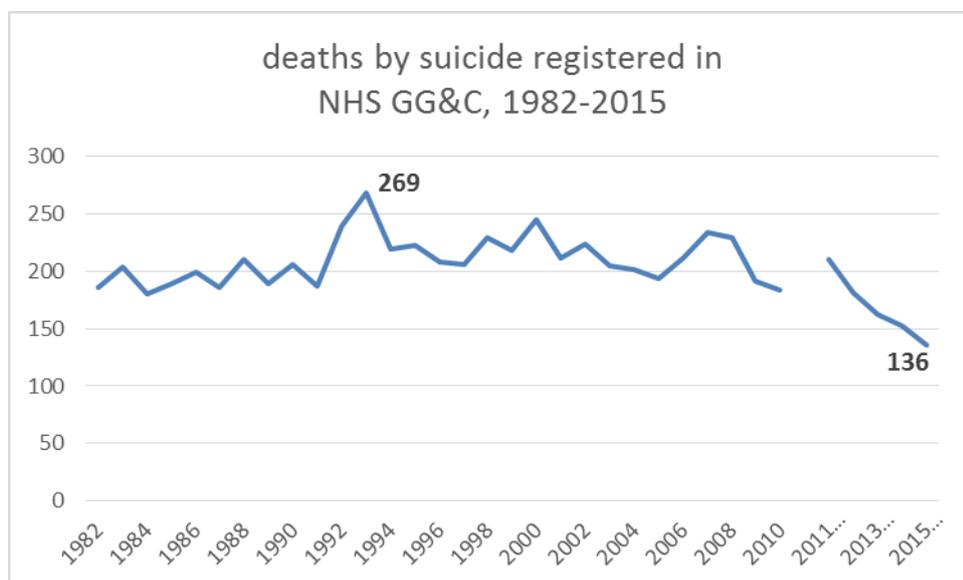
1. This paper provides a summary of recent trends in suicide for the Health Board area, and summarises the ongoing multi-agency prevention work that continues in keeping with a 5-area action plan.

1.1 Death through suicide is not only a tragic loss of life for individuals affected, but also has a devastating impact on family and friends as well as on wider social networks. Suicide makes made a significant contribution to the excess mortality experienced in the Board area.

2. Death by suicide in NHS GG&C

2.1 The latest data on suicide was released by Information Services Division (ISD) of the Scottish Government in August 2016, and includes all deaths by suicide in 2015.

2.2 One hundred and thirty-six Board residents died by suicide in 2015, the lowest in more than 30 years, as shown in the graph below. Deaths by suicide are now at 51% of the level seen in 1993, when mortality by suicide peaked at 269 deaths. (The reduction in deaths by suicide in Glasgow City has been more pronounced, from 174 deaths in 1993 to 69 in 2015 – a 60% reduction).

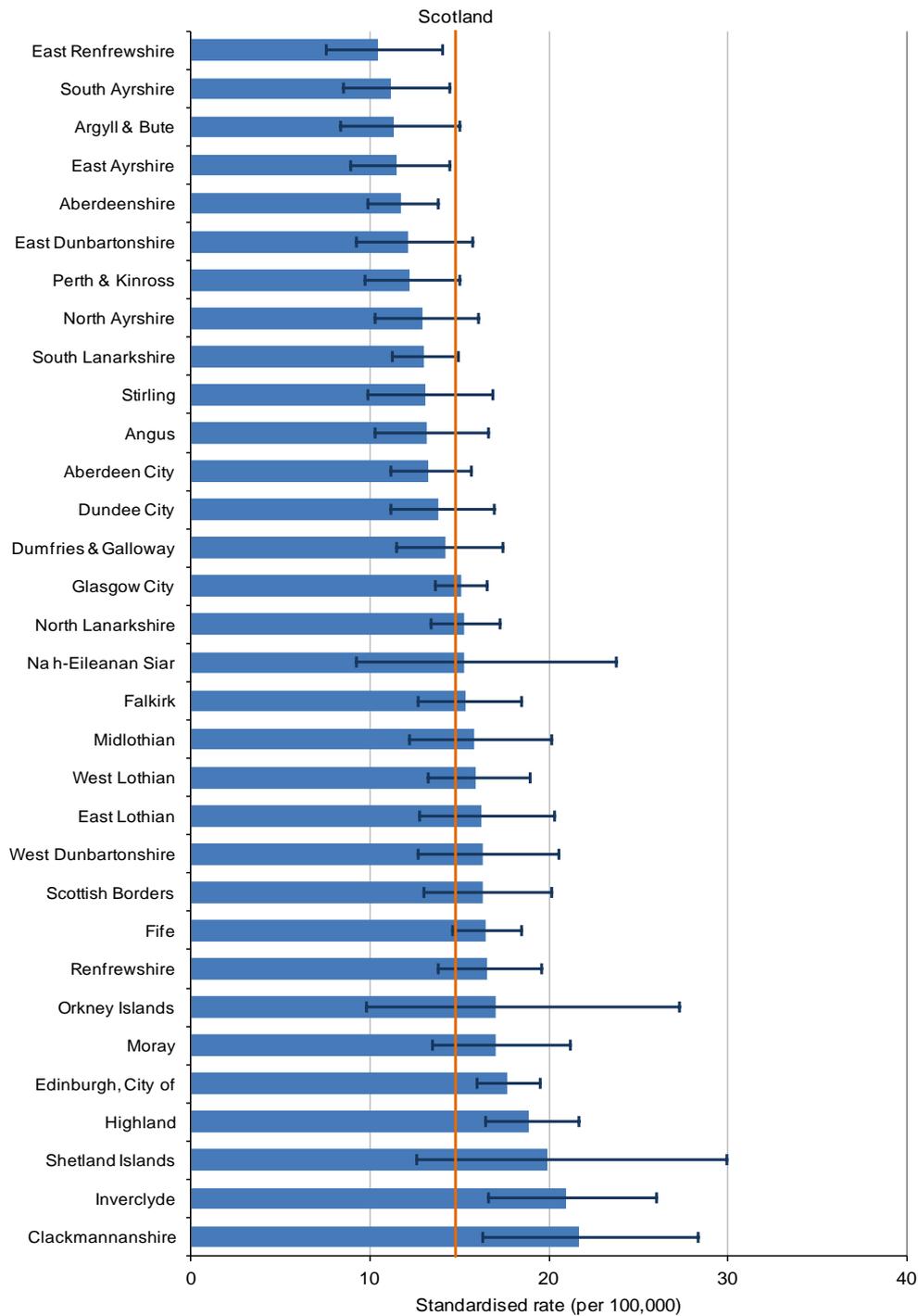


NB In 2011, the National Records of Scotland changed their coding methodology to make it consistent with WHO standards. A small number of deaths that would previously been coded as “mental and behavioural disorders” are now coded as suicide. The net effect of this change increases the number of deaths considered to be suicide. The break in the graph marks the change between these two methodologies.

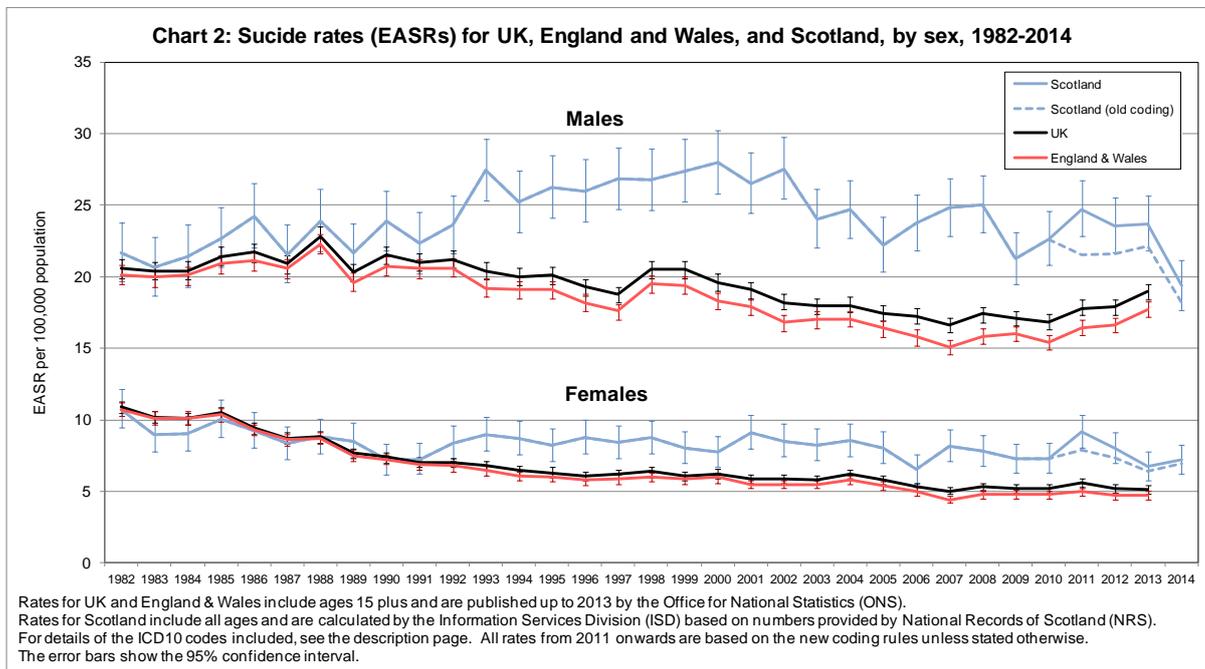
2.3 This welcome drop in the absolute number of deaths by suicide is also reflected in a large fall in the age- and sex- adjusted suicide rate: in other words, the reduction is not solely the result of natural changes in our population.

2.4 The chart below shows deaths in Local Authority Areas across Scotland. Glasgow City deaths are almost exactly at the average for Scotland, but deaths by suicide in Inverclyde are second highest in the country. Given the close correlation between deprivation and suicide rates, this suggests that Glasgow's suicide rates are significantly lower than might have been expected.

CHART 1 - European age-sex-standardised rates per 100,000 population: suicide deaths by local authority, 2011-15 (Persons - all ages)



The Scottish suicide rate continues to fall, but it is increasing in the other countries of the UK. The chart below compares the Scottish rate to that in England and Wales (a similar pattern is evident in Northern Ireland). Recession and austerity in England were accompanied by an increase in the male suicide rate from 2008, a pattern not evident in Scotland, and it is not clear why this difference should have emerged.



Data available through the Scottish Suicide Information Database (ScotSID)¹ provides more detailed demographic information:

- The suicide rate for males in 2015 is more than two-and-a-half times higher than that for females. However the rate for men is falling, whereas that for women has remained almost unchanged.
- In 2011-15, the suicide rate was more than three times higher in the most deprived tenth of the population (decile) compared to the least deprived decile. Compared to 2001-05, suicide rates have decreased in every decile, but the reduction is most marked in deprived areas. For example, the suicide rate in the most deprived decile fell from 31.6 to 22.1 deaths per 100,000 population, compared to a reduction from 7.8 to 7.3 in the least deprived decile.
- The highest rate of suicide for both men and women is seen for ages 35-54 years. The lowest rate for men is 65-74 years, and for women 75+ years.

Glasgow-based researchers² have investigated the pattern of deaths by suicide since the 1950s, and detect evidence for a “cohort effect” of increased suicide risk most apparent for people born between 1960 and 1980, with the cohort 1965–1974 being most affected. This

¹ <https://www.isdscotland.org/Health-Topics/Public-Health/Publications/2016-08-10/2016-08-10-ScotSID-Report.pdf>

² Parkinson J, Minton J, Lewsey, J, Bouttell J & McCartney G. Recent cohort effects in suicide in Scotland: a legacy of the 1980s? *J Epidemiol Community Health* doi:10.1136/jech-2016-207296

effect was largely driven by men and those living in the most deprived areas. This effect is consistent with exposure to economic and political changes during the 1980s.

ScotSID also provides information about service use by people who subsequently die by suicide. 59% of people who died by suicide were taking a psychotropic drug (of which 82% took an antidepressant, and 63% a sedative or sleeping tablet) at the time of death, implying recognition of distress or mental health problems in primary care. However only about 1/5 of deaths took place in people with a psychiatric admission and/or outpatient appointment in the previous five years. Contact with Acute services (admission or A&E attendance) was about three times higher than that with MH services.

	At time of death	Up to 30 days before death	Up to 1 year before death	Up to 5 years before death
Taking a psychotropic drug			59.0% ³	
Discharged from Acute hospital		7.4%	30.6%	58.1%
Discharged from MH inpatient care		4.8%	12.5%	21.0%
Last psychiatric outpatient appointment		6.3%	20.2%	20.7%
A&E attendance		26.7%		
Known to specialist drug services	6.0%			

2.4.1 Every death that occurs in patients known to Mental Health services and for up to one year after discharge is considered a Significant Clinical Incident (SCI) and is investigated. SCI investigations are shaped by families and carers, and conclusions shared with them.

2.4.2 Themes emerging from those reviews include the following:

- the need to involve families and carers more closely in risk assessment and management
- the importance of prompt risk assessment on admission and at transfers of care
- despite the importance of risk assessment, a recognition that it is not possible to predict risk in individuals with any accuracy; and furthermore that about 85% of deaths occur in patients thought to be at low risk of suicide at the last contact
- the importance of effective communication of clinical information, which should be facilitated by current progress towards a networked electronic case record
- the importance of compassion and the containment of distress in responding to people with suicidal behaviour.
- most psychiatric units now have *en suite* bathrooms for all patients, but there is a need for increased vigilance, as those areas are the commonest areas for inpatient suicide to take place.

³ This rate roughly three times higher than that in the general population

3. Responses to suicide at national and Health Board level

- 3.1 The introduction of the Choose Life strategy and action plan across Scotland from 2003 was a landmark approach that helped to coordinate multi-partner action, complementing programmes of development for mental health and allied services. Each of the Community Planning Partnership areas appointed a Choose Life Coordinator and put in place a range of partnership activity to address the challenge of suicide in Scotland, an arrangement that remains in place to-date.
- 3.1.1 There are multi-partner Choose Life programmes in place throughout this period. While it is beyond the scope of this paper to provide a detailed overview of all of the work conducted within the Choose Life programmes, examples are included in the updates below. One of the hallmarks of the suicide prevention work in Greater Glasgow and Clyde has been to forge a blend between community level prevention approaches and statutory service developments, achieving significant involvement with multiple partners.
- 3.2 Delivery of suicide prevention training to key groups sectors has continued, including staff working in mental health, addictions, emergency medicine and other clinical services, and staff in children's homes, money advice services, schools, housing and homelessness organisations, voluntary sector projects, violence against women support programmes and so forth. We would estimate that over 20,000 colleagues from multiple sectors have been trained in some form of suicide prevention skill in Greater Glasgow and Clyde over the last 13 years.
- 3.3 Additionally, the individual Choose Life programmes in the Board area have been augmented by being part of a collective Greater Glasgow and Clyde approach. Thus, there has been collaborative working and good practice-sharing across the six Choose Life programmes within the Health Board area, plus joint action on pan-Board issues, like policy and practice within Accident and Emergency Services, jointly funded research and addictions and suicide, and work on locations of concern, including the Erskine Bridge. A NHS GG&C Suicide Prevention Planning Group has assisted in this coordination and sharing task, comprised of a range of stakeholders, including clinicians from mental health and A&E, health improvement, Choose Life coordinators, the voluntary sector, service user representatives and Police Scotland. A development day was held on 14th March with Glasgow Centre for Population Health to review the strategic approach.
- 3.4 This refreshed approach has set out a set of five Key Action areas – Community Prevention; Carer and Family Dimensions; Clinical and Care Service Responses; Child and Youth Suicide Prevention; Training and Workforce Development

3.5 While not intended to be comprehensive, the table below presents a range of actions across these Key Action Areas:

Theme	Action areas
<p>1. Community prevention approaches</p>	<p>Public awareness and prevention programmes – with special focus on disadvantaged communities and linking to wider mental health improvement actions; examples include a number of locality based suicide prevention forums, such as in North East Glasgow</p>
	<p>Act on locations of concern (i.e. locations where deaths through suicide may be more prevalent) – with multi-partner action in recent past leading to successful introduction of barriers on the Erskine Bridge; a Glasgow City working group has just been established, including membership from the Emergency Services and transport authorities</p>
<p>2. Carer and family dimensions</p>	<p>Developing a shared language with and enhanced support for carers – within clinical services this is being progressed through adoption of the “Triangle of Care” model; potential to link more closely to wider carer support strategies across the Board area</p>
	<p>Learning from and supporting people bereaved by suicide, for example by hosting events. One notable stream of work has been a series of “Celebration of Life” events and activities held by Choose Life programmes, including features during world suicide prevention day; other recent work has included production of the film “Still in Our Hearts”, featuring the experiences of family members bereaved through suicide and helping to reduce stigma in this area.</p>
<p>3. Clinical and care service responses</p>	<p>Suicide prevention – development of a new clinical policy for GG&C: currently underway.</p>
	<p>Review of risk management policy and processes: a new risk assessment protocol compatible with electronic systems has been through the first phase of consultation. It will be implemented through 2017, accompanied by a significant staff training programme.</p>
	<p>Attention to the importance of compassion in health and social care, including work in GG&C delivered by a “Distress Collaborative”.</p>
	<p>Board-wide service development for people with Borderline Personality Disorder</p>

	<p>Extension of Scottish Patient Safety Programme (SPSP) to include community settings and other care groups will roll out in 2017.</p>
	<p>Continuing joint work between Mental Health and A&E Departments, supported by a new Mental Health-Acute Interface Group.</p>
	<p>Recent and Ongoing research:</p> <ol style="list-style-type: none"> 1. User and community perspectives on enhancing service responses to risk of suicide – Listen and You Might Learn report commissioned by North East Glasgow Suicide Prevention Forum provides valuable insights from community members to guide future prevention efforts; 2. The influence of Adverse Childhood Experiences on suicidal behaviour: an observational and data linkage study currently recruiting at GRI and QEUH. Funded with £43,687 from NHS GG&C Research & Development, £20,000 from Health Improvement Scotland 3. Implementation of suicide safety planning and telephone support in a UK setting. Co-investigator with Glasgow University, funded £300,000 from MQ Research.
<p>4. Child and youth suicide prevention</p>	<p>Youth suicide prevention and self-harm support in schools and community settings, linking to wider mental health improvement actions and support services – this is part of the wider strategic approach child and youth mental health improvement underway across the Health Board area. Greater Glasgow and Clyde has been at the forefront of developing innovative responses to self-harm among young people, including the pilot and implementation of a schools curricular resource on this subject and creation of an awareness course for professionals</p> <p>Looked After Children and Young People as a key priority group – this has included training a high proportion of residential care staff in SafeTalk and/or ASIST</p> <p>Exploring and utilising digital communication technologies as part of the range of responses to youth mental health issues. This includes the Health Board’s leading role in the European Union funded Aye Mind collaborative programme (www.ayemind.com) which has worked with 13-21 year olds to create new resources and approaches</p>

	<p>Undertake development work to address ACES (adverse childhood experiences, including trauma), as a recognised major risk factor for suicide. Partners include GCPH, Health Improvement Scotland and the Scottish Government.</p>
	<p>Focus on LGBT young people as a priority group, where almost 2/3rds of LGBT community members have self-harmed; actions underway include promoting adoption of LGBT Youth Charter mark, enabling staff to be able to better respond and meet the needs of young people as they deal with their sexuality and gender.</p>
<p>5. Training and workforce development</p>	<p>Delivery of training in suicide awareness and prevention training and of self-harm awareness, plus allied mental health training to key staff in multiple sectors, as an integral element to the above priority delivery areas (examples include training staff in agencies where clients are frequently in distress, such as money advice services, youth work agencies and those supporting people in the criminal justice system)</p>
	<p>Develop appropriate policies, protocols and staff support arrangements to back up training delivery and suicide prevention efforts – work is underway to scope the detailed delivery requirements and trainer capacities to further embed suicide prevention skills across key workforces in the Board area, working in conjunction with key national agencies, like NHS Health Scotland as appropriate.</p>

4. Summarising progress and recommendations for further development

- 4.1 In the years since the launch of the 2003 Choose Life Strategy, has taken forwards an active, multi-agency Choose Life programme, complementing allied developments within clinical services. Mass delivery of suicide prevention training (such as SafeTalk and ASIST) have been a major feature of the Glasgow City approach, linking closely with a diverse range of community prevention approaches as well as clinical service development
- 4.2 Contrary to some of the international suicide trends, the suicide rate for Scotland as a whole and Greater Glasgow and Clyde in particular has declined over the previous decade (particularly among males). This is despite a well-recognised association between deprivation and suicide rates.
- 4.3 While this decline in rate is welcome, all partners involved in suicide prevention work wish to see the rates continue to decline, and remain keen to maintain a planned approach to

suicide prevention, drawing on the expertise and resources of multiple partners

- 4.4 In conclusion, we would ask Health Board members to note the encouraging downward trend in suicides within Greater Glasgow and Clyde and also to endorse the multi-partner approach to suicide prevention that has been adopted, focused on continuing to work towards further reductions in suicide rates, including a continued focus within each of the Health and Social Care Partnerships within Greater Glasgow and Clyde and within wider Community Planning Partnership approaches.