CX/11/03

Health & Adults' Services Scrutiny Committee
20 January 2011

Suicide prevention

A review by the Health & Adults' Services Scrutiny Committee, January 2011

Contents

Foreword from the Chairman

On behalf of Devon County Council's Health & Adults' Services Scrutiny Committee I am delighted to publish this report. It follows an in-depth investigation into the services designed to help prevent suicides in Devon carried out by the suicide prevention task group previously set up by the Committee. I would like to thank all those who participated in the process, for their time and effort and continued commitment to helping to shape this review and recommendations for improvement. I would also particularly like to thank our expert contributors for the detailed evidence they gave to the task group.

People very sadly take their lives when they feel they have no hope or no future, at times of family breakdown, accumulating debt, repossession of properties, imprisonment or being charged with criminal offences. Every suicide is an indescribable tragedy. The loss of life is combined with the emotional trauma family, friends and staff of support organisations endure. Carrying out this review and investigating the matter in objective and rigid terms has been very hard for exactly those reasons. However, in order to review information and arrive at suggestions for improvements, the task group had to engage in those terms, for example when investigating cost implications. It is in the nature of the subject that some readers might find the content of the report distressing.

Conducting this piece of work has been very worthwhile and has engaged a large number of people. We have been able to look at the issues involved in depth and it has been wonderful to see such a high level of dedication and enthusiasm from everyone involved. If we continue to work together and develop even stronger partnerships, we will be able to help people even more at the most vulnerable times in their lives.
Cllr Richard Westlake
Chairman, Suicide Prevention Task Group
Chairman, Health & Adults' Services Scrutiny Committee

Introduction

Suicide is not only a human tragedy but also a major public health problem. The World Health Organization estimates that approximately one million people die by suicide every year more than those killed by either homicide or war. In the UK, suicide rates have been declining steadily for the last 10 years. A total of 604 suicides occurred in Devon between 2001 and 2009, of which 92 were coded as injury undetermined. Devon has a suicide rate similar to the South West and England, with a clear downward trend over recent years. NHS Devon's suicide prevention strategy aimed to reduce the death rate from suicide and undetermined injury in Devon by at least a fifth by 2010 which is a reduction from a rate of about 65 deaths per year.

Early indications suggest that this target should have been achieved.
The current economic climate has significant implications for mental health and suicide risk: evidence and research suggests a possible increase in suicides as a result of the recession. The emotional impact does not only extend to family and friends but also to the number of people involved and the consequent trauma caused police officers, fire and rescue services staff, train drivers, members of the public who witness incidents etc.

Suicides also have a major financial impact on services. For example, the cost to the rail industry is estimated at 50 million a year alone. Costs have to be covered for staff employment, the coroner service, NHS as well as the knock-on effect on third parties, e.g. train operators, service closures and enabling the voluntary sector to sustain social networks.

The National Institute for Mental Health in England (NIMHE) suicide prevention toolkit indicates that 25% of people who took their lives in England and Wales had been in contact with specialised mental health services in the year before their death. This suggests that 75% had not had such contact and that people committing suicide may have been in touch only with primary care services, or with no service at all. Approximately 50% of individuals do not present to their GP within the three months prior to their deaths. "Poor social circumstances" are present in 58% of deaths recorded by Coroners as suicide and alcohol and drugs is a characteristic in 38% of deaths.

In 2005-06, the Devon Partnership NHS Trust developed and piloted guidance on suicide hotspots which include railway bridges, cliffs and high buildings. The national guidance on suicide hotspots includes suggestions such as:
- erecting physical barriers at well known spots
- placing Samaritans signs at hotspots or installing telephone helplines

- establishing "suicide patrols" of volunteers in hotspot areas
- training non-health staff to recognise people and situations of possible risk
- working more closely with the media on the reporting of suicides as evidence suggests that media coverage can increase the use of a hotspot.

Agencies have to work together to deter suicide in high-risk locations and in order to improve their efforts to reduce the likelihood of suicides occurring and deliver a more comprehensive network of services to provide pre-emptive support when and where it is needed.

Review Approach

Devon County Council's Health & Adults' Services Scrutiny Committee established a task group to review services helping to prevent suicides in July 2009 and the group commenced its work in July 2010. Members of the group were County Councillors Dennis Smith and Richard Westlake (Chairman) as well as East Devon District Councillor Christine Drew and Exeter City Councillor Laura Newton.
The review of services helping to prevent suicides in Devon combined an analysis of available national, regional and local data with hearing a wide range of contributors. At the first meeting the group agreed to conduct the work under the following headings:
i. tackling the stigma relating to severe mental health problems and suicide
ii. support for families and social networks
iii. service availability and access
iv. utilisation of existing agencies and organisations across statutory, voluntary and private sectors
v. Devon County Council's role as an employer in tackling stress, isolation and loneliness among its workforce

The task group first reviewed plans and proposals from statutory bodies in Devon in order to establish how they envisaged to improve preventative services before conducting interviews with a range of contributors. These were:

adva (Against Domestic Violence and Abuse Devon)
Devon County Council's Adult & Community Services directorate
Devon County Council's Wellbeing @ Work service
HM Coroner
HM Prison Service
NHS Devon
Devon and Cornwall Police
Devon & Cornwall Fire & Rescue Service
Devon Drug and Alcohol Action Team
Devon Partnership NHS Trust
Farm Crisis Network Devon
Network Rail
Parent carers
Peninsula Medical School
Samaritans of Exeter, Mid & East Devon
South Western Ambulance Service NHS Foundation Trust
University of Bristol Department of Social Medicine

The task group also considered the NHS Devon Suicide Prevention Strategy.

Findings

The development of a consistent suicide prevention service is only achievable if all involved agencies work in partnership because elements such as employment, housing, postnatal services, domestic violence and abuse etc, cannot be tackled in isolation. For example, research suggests that domestic violence and abuse may be the single most important cause of female suicide. In order to aid the implementation of Devon's Suicide Prevention Strategy, a multi-agency Suicide Prevention and Audit

Group was established when NHS Devon came into being which provides an integrated approach to support vulnerable people and people at greater risk. The group also acts as a forum for the consideration of the audit report, to identify and prioritise actions and to link into commissioning processes. Contributors reported that the group operated on an irregular, ad-hoc basis with limited effectiveness.

Evidence and research suggests a possible increase in suicides as a result of the recession but securing resources for research is difficult in the light of the current financial climate. The future of research will have to be secured, however, in order to monitor trends and identify best practice for implementation. Robust research can also establish which population groups to target most for support and preventative services. For example, only approximately 60% of individuals on the Care

Programme Approach (CPA) lived in settled accommodation and approximately 8% were in employment. Support could be targeted at other high-risk groups as well, e.g. farmers, fishermen, vets and elderly people who retired to Devon without family nearby. Practitioners questioned how much the findings of research are fed into planning and prevention activities.

Recommendation 1: To maintain research into suicide prevention in the current financial climate and beyond.

Recommendation 2: To translate research and intelligence into bespoke service provision and to target high-risk groups as identified by research and evidence.

Another effective measure in suicide prevention is reducing access to means, e.g. packaging of medication, identifying and managing high-risk places by erecting physical barriers, e.g. nets or fences, or Samaritans signs as well as networking with the media in order to limit coverage of suicides. Information sharing between agencies also has to be improved, e.g.
- liaison between HM Coroners and GPs
- alerting community psychiatric nurses (CPN) in time which can save police and/or ambulance operations
- improve the coordination of information in police reports and service planning
- ambulance clinicians recording concerns and information which is shared with

Devon Doctors and subsequently GPs. It is then the GPs' responsibility to follow up any concerns with their patients

- sharing of care plans in order to e.g. detect psychosomatic symptoms and not to undermine the involvement of another agency
- to address inconsistent out-of-hours services

Contributors repeatedly highlighted difficulties with the way information about suicides is recorded. First of all, data collection and logging systems should highlight attempted suicides. Currently, incidents could be recorded as mental health issues although the individual might not be known to mental health services. Secondly, service planners would benefit from a close working relationship with the HM Coroners. In one contributor's opinion, the Coroner in some cases declared an open verdict out of respect for families. Service planners need to be able to utilise accurate information, however, in order to improve and develop effective provision.

tackling stigma

Mental health services are locally provided by the Devon Partnership NHS Trust. The Trust has signed up to the national Time to Change campaign to end mental health discrimination and prejudice. The task group felt that it was the role of all organisations to work towards tackling stigma and discrimination surrounding mental health and local authorities should lead by example. Devon County Council has not been involved in the Time to Change campaign but tackling mental health discrimination and prejudice is incorporated in training courses and health promotion events, such as drop-in sessions across Devon for National Stress Awareness Day. The Wellbeing @ Work team (see page 10) also tackles any instances in practice directly.

Recommendation 3: Devon County Council to nominate a Time to Change champion among their existing staff or members in order to ensure the organisation tackles stigma and discrimination among staff and services.

People at risk can be fast-tracked to the mental health service. The depression assessment patient health questionnaire 9 (PHQ-9) routinely assesses individuals whether they had contemplated committing suicide and whether they had taken any practical steps. The task group recognises that the practice of openly and routinely engaging in conversations with people about their mental health should be commended and could remove the stigma.

One contributor highlighted that this practice would particularly benefit survivors of domestic violence and abuse. He reported that survivors repeatedly visit their GPs with health problems arising from their situations and get treatment, usually anti-depressants but are not asked what the cause is. Survivors and perpetrators also repeatedly highlight that being asked about what was happening to them would have encouraged them to confront and deal with domestic violence and abuse and health professionals were in a unique position to ask these questions. Conventional mental health services often did not tackle the real cause of ill-health arising from domestic violence and abuse.

Recommendation 4: To openly and routinely engage in conversations with people about their mental health by primary care professionals and to develop procedures to that effect.

The task group received evidence that individuals refrained from using mental health services due to the stigma attached to them and organisations providing an informal network not employing mental health professionals could fill this gap. Contributors suggested that the stigma could be removed by better integrating mental health services into community services for increased social interaction. Support networks are fundamentally important to individuals' mental health because of the informal talking and socialising they provide. One parent carer stressed that charities such as Rethink, Sane, Papyrus, CALM and Mind are under-represented in Devon and more information about mental health should be displayed at health centres and GP practices, including information on how to contact the charities. The same contributor stressed that more emphasis should be laid on getting people involved and any activities which bring them into contact with others should be explored.
Devon's Mental Health & Wellbeing Strategy emphasises the importance of early intervention as being more beneficial to individuals as well as being more cost effective. As part of this, the anxiety and depression service has been improved, to which individuals can self-refer, and 3.3m had been invested in the provision of cognitive behavioural therapies (CBT). Approximately 500 people per week were referred or referred themselves to the anxiety and depression service in Devon.

Recommendation 5: To support organisations promoting the improvement of mental health and social isolation in order to facilitate opportunities where people can meet, socialise and be supported and less isolated.

Support

The task group recognises that tackling isolation and loneliness as well as accessing appropriate support networks are two of the most important areas for improvement. In this context, a number of very positive developments have been brought to the attention of the task group. For example:
- Currently, 97% of patients discharged from acute wards provided by the Devon Partnership NHS Trust receive a follow-up visit within seven days of discharge by a community psychiatric nurse (CPN) or a psychologist. Approximately 99% of inpatients are referred via the crisis resolution service.
- So called "places of safety" for adults are available for people who attempt suicide and who are detained under section 136 of the Mental Health Act (1983). Three such places of safety were now available across Devon, funded by NHS Devon where previously survivors had to attend police stations. The majority of individuals detained under section 136 were under the influence of alcohol. Follow-up appointments are also being offered for survivors who were under the influence of alcohol.

GPs fulfil a vital role in cases of disclosures; GPs might decide to wait, refer the individual to mental health services or counselling or prescribe anti-depressant medication. One contributor highlighted that in some cases, GPs were prescribing anti-depressants without counselling. Usually, individuals disclose information at the point of crises and a more immediate response is often necessary. For example, more instant access to counselling needs to be achieved in order to reduce the waiting times and replace expensive private sessions.
In this context, the task group found an example from the HM Prison Service inspirational. Suicidal or self-harming prisoners who come to the attention of staff

trigger the so-called Assessment, Care in Custody and Teamwork (ACCT) process which included immediate support, a detailed assessment within 24 hours, medical treatment as well as regular reviews and action plans. The crisis relief followed no set timescales but depended on the involved individuals. Prisoners in crises are encouraged to resume responsibility for their situations when appropriate in order to minimise attention-seeking behaviour. All prison staff receive ACCT training to be able to identify a prisoner in crisis and to trigger the procedure and could also access various means of support for themselves. A consistent follow up of all individuals who attempt suicide and are discharged from services should be achieved as well as a more holistic approach in supporting families.

Recommendation 6: To adopt a process similar to the Assessment, Care in Custody and Teamwork (ACCT) process in health and social care in order to provide people with a more timely response to their urgent needs.

As discussed earlier, approximately 75% of people who commit suicide are not known to specialist mental health services and approximately 50% of individuals did not present to their GP within three months prior to their deaths. Therefore, recognising the importance of significant others and social networks is vital in identifying, approaching, supporting and signposting of people who feel suicidal who are not known to services. Public education campaigns are challenging, however, due to the need to decode often subtle or indirect signals, the need to make complex judgements, e.g. recognising distress as a medical problem, taking decisions about appropriate help and the negative perception of mental health services. Furthermore, individuals have to seek help themselves and professionals could not normally act on third party referrals.

Contributors highlighted that support for bereaved families and for parents whose children died is virtually non-existent and suicides reoccur within families. One parent carer highlighted that bereaved family members should be kept informed of the results of any investigations and carers should be included in the reporting process. Currently there is no provision for this in the public sector although the police, for example, supported crime victims. Information and signposting could be facilitated, for example, in court settings or the coroner's office.

Recommendation 7: To provide support to the bereaved.

Service Availabitliy and access

One parent carer who contributed to the review voiced concerns about the mental health and wellbeing of carers and families. As a result of not driving, having no family in Devon and not receiving any help from her neighbours, the carer felt isolated and suggested that agencies could have been more active in identifying support. The parent carer also had negative experiences with care professionals who, for example, reduced support hours without prior negotiation.
In this instance, the carer had discussed her difficulties with different health and social care professionals and the task group questioned how robust the link is between an individual's behaviour or disclosure, immediate mechanisms and follow-up support provided by GPs or mental health professionals. GPs in particular fulfil a vital role at the point of disclosures and they should be more aware of the community services in

the areas for signposting purposes. One contributor suggested producing a comprehensive list of local venues suitable for clients for mental health practitioners (see older people mental health task group report, CX/10/37, recommendation 9 and support for carers task group report, CX/10/95, recommendation 20). This could be coordinated through, for example, CVS.

Contributors confirmed that referrals to services from GPs were irregular and staff turnover at e.g. hospitals meant that professionals did often not know which services were available in an area. One parent carer described how her son's GP placed her son on a waiting list for counselling and how he came into contact with mental health services only after a suicide attempt. The contributor suggested that more training is needed for GPs to recognise severe mental health problems so that people can access appropriate services quicker.

Access to information is fundamentally important, both for individuals and health and social care professionals. The length of time individuals receive treatment should also be reviewed and whether a greater focus should be laid on enabling people to make sustainable changes to their lives, e.g. introducing group work and informal peer contacts as the time professionals can spend with individuals is limited. One provider organisation pointed out that that bureaucratic demands and the amount of information gathering required can also limit the time professionals were able to spend with a person to form a therapeutic relationship.

The task group found that gaining access to support services and ensuring a seamless pathway can be difficult. This depends on demographics, service availability during different times in the day and night as well as distances from hospitals and difficulties travelling back home. One contributor highlighted that people who use services do not have a 24 hour contact in the event of crises instead they are advised to call the Samaritans or Devon Doctors which was characterised as unhelpful for someone who might be suicidal. The same contributor also described how individuals who live in Kingsbridge have to catch two busses to access the community mental health team in Ivybridge for psychological therapies, for example, while community psychiatric nurses and occupational therapists travel to the person's home. Including the time for the appointment, the person needs to allocate more than half a day. People who live in Kingsbridge cannot access the service in Totnes which is only one bus ride away.

Utilisation of services

The development of a consistent suicide prevention service is only achievable if all involved agencies work in partnership because individual elements, such as employment, housing, postnatal services etc, cannot be tackled in isolation. Multi-agency working had improved through provisions such as MASH (multi-agency safeguarding hub; NHS Devon/Adult & Community Services) or the Devon Basic Command Unit (BCU). Safer custody groups are operating at prisons involving "listeners" provided by the Samaritans (please see below). Different referral avenues, e.g. MARAC (multi-agency risk assessment conference in response to domestic abuse) or safeguarding adults and/or children, mean that frontline staff need to be flexible in responding to individual cases. Establishing one central referral unit with one telephone number and point of access would further improve coordinated responses. All professionals need to be aware of one coordinated referral pathway.

A number of best practice examples have been highlighted to the task group, including
- the current collaboration between the Children's Board, Devon County Council and NHS Devon in the provision of maternal mental health as a good example of early intervention.
- Another example is the joint project between the Samaritans and Network Rail. Suicide rates on railway lines were relatively low (200 suicides/year nationally = 4%) compared to the overall number of suicide but the rates have remained relatively constant compared to decreasing numbers of suicides elsewhere. Network Rail had already introduced preventative measures such as barrier ends or fences before having started cooperating with the Samaritans in identifying hotspots and focussing preventative activities there e.g. increase signage, training for train station staff and direct access to a Samaritans phone line.

A five-year project, led jointly by Samaritans and Network Rail, with an expected budget of approximately 5m aims to reduce suicides on the railways through a range of interventions including communication campaigns, staff training, work with the media, community outreach and lobbying for more physical barriers in a blend of prevention and postvention initiatives.
- the "Listener Scheme", a peer support scheme whereby selected prisoners are trained and supported by the Samaritans to listen in complete confidence to their fellow prisoners. The Samaritans also held conversations with all new prisoners. Prisoners can telephone Crimestoppers and the Samaritans unrestrictedly from prison telephones.

The Samaritans would welcome better cooperation with more agencies. For example, the Samaritans already offer a follow-up call service through the Accident & Emergency (A) unit at the Royal Devon & Exeter NHS Foundation Trust but a high staff turnover meant it was essential to maintain regular contact to ensure continuity as A staff were not necessarily briefed on the existence of this service. The Samaritans also suggested their service could be more visible by
- all district and county council buildings as well as GP practices displaying Samaritans posters and information material
- more signage being erected along cliffs and other potential dangerous locations
- more schools being engaged.

Recommendation 8: Devon County Council to work more closely with the Samaritans to display information, erect more signage at so-called hot-spots and to engage more schools.

In order to utilise services and coordinate resources better, the possibility of establishing a public mortuary service should be scoped. Currently, the acute hospitals provided this service at a charge. A public mortuary service would require, however, suitable accommodation for storage as well as examinations. Vacant buildings owned by the County Council could be used and existing services could be better coordinated within this setting as well. For example, coroners currently holing inquests in hotels could use these premises as well as partner organisations, such as the Citizens Advice Bureau.

Devon county Council staff support

Improved awareness should be promoted amongst employers and managers to e.g. identify stress and sensitively engage with individuals. Devon County Council uses two approaches to suicide prevention measures: promoting mental wellbeing (proactive) and responding to risk (reactive). As part of the measures, stress risk assessments are used as a tool which managers can complete for employees in order to monitor an individual's situation. Managers can refer employees to the Wellbeing @ Work service for occupational health and stress management appointments. Counselling appointments can also be made on self referrals.

The task group was concerned that employees were in part reliant on their managers to take the initiative to review their stress levels and that managers were in part reliant on self-referrals. Senior managers are particularly vulnerable in the foreseeable future due to their responsibility and the stigma attached to stress as a sign of weakness.

Recommendation 9: To complete stress risk assessments for every employee at least once a year within Devon County Council and all NHS organisations in Devon without increasing the stress of service managers.

Wellbeing @ Work delivers management training on topics such as managing attendance or stress management. Attending this is compulsory in the children & young people services (CYPS) for 3rd, 4th and 5th tier managers and is currently being rolled out. The majority of managers within adult & community services (ACS) have already completed this training. Managers from other directorates could attend voluntarily. No repeat training is envisaged for managers although they could repeat any training if the need arose. There are currently only 1.5 FTE posts within the stress management service, with one FTE post half-funded by ACS and CYPS for specific interventions, leaving a 0.5 FTE post for corporate stress related work. The learning & development team also produced a framework for "Leading and Managing People through Radical Change", and have incorporated information on stress in this.

Recommendation 10: To include information on stress in the introduction to management course.

Suicidal feelings among employees mostly occurred in conjunction with dismissal procedures and the Wellbeing @ Work service can refer an individual to other health professionals, including GPs or mental health crisis resolution teams. The service also holds regular clinics in Barnstaple, Exeter, Plympton and Totnes and can use external clinicians or dispatch their professionals to different locations, resources permitting.
Conclusion

The task group hopes that by presenting this report and recommendations to contribute constructively to the improvement of services designed to prevent suicides in Devon.

Recommendation 11: To recommend to the Health & Adults' Services Scrutiny Committee to request a report on the implementation of the recommendations of the suicide prevention task group in June 2011 and at intervals thereafter.

Summary of Recommendations

1	To maintain research into suicide prevention in the current financial climate and beyond.
2	To translate research and intelligence into bespoke service provision and to target high-risk groups as identified by research and evidence.
3	Devon County Council to nominate a Time to Change champion among their existing staff or members in order to ensure the organisation tackles stigma and discrimination among staff and services.
4	To openly and routinely engage in conversations with people about their mental health by primary care professionals and to develop procedures to that effect.
5	To support organisations promoting the improvement of mental health and social isolation in order to facilitate opportunities where people can meet, socialise and be supported and less isolated.
6	To adopt a process similar to the Assessment, Care in Custody and Teamwork (ACCT) process in health and social care in order to provide people with a more timely response to their urgent needs.
7	To provide support to the bereaved.
8	Devon County Council to work more closely with the Samaritans to display information, erect more signage at so-called hot-spots and to engage more schools.
9	To complete stress risk assessments for every employee at least once a year within Devon County Council and all NHS organisations in Devon without increasing the stress of service managers.
10	To include information on stress in the introduction to management course.
11	To recommend to the Health & Adults' Services Scrutiny Committee to request a report on the implementation of the recommendations of the suicide prevention task group in June 2011 and at intervals thereafter.

Acknowledgements

The members of this task group would like to thank all contributors who gave their time to speak with the group, for their hard work to help to shape the focus of this review, for sharing their expertise and for commenting on draft recommendations.

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