Centre for Public Scrutiny

Local Government Association

Association of Directors of Public Health

Providing a lifeline

Effective scrutiny of local strategies to prevent or reduce suicide

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Providing a lifeline

Effective scrutiny of local strategies to prevent or reduce suicide

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Centre for Public Scrutiny

The Centre for Public Scrutiny's (CfPS) purpose is to improve lives and places through effective governance and public scrutiny. We work with a wide range of organisations, people and places to support them in developing a culture and ways of working which incorporate challenge, scrutiny and involvement. We also provide consultancy, training and policy support which gives people the skills, knowledge and confidence needed to design and deliver good governance.

www.cfps.org.uk

Local Government Association

The Local Government Association (LGA) is the national voice of local government. We work with councils to support, promote and improve local government. We are a politically-led, cross party organisation which works on behalf of councils to ensure local government has a strong, credible voice with national government. We aim to influence and set the political agenda on the issues that matter to councils, so they are able to deliver local solutions to national problems.

www.local.gov.uk

Association of Directors of Public Health

The Association of Directors of Public Health (ADPH) is the representative body for Directors of Public Health (DsPH) in the UK with the aim of maximising the effectiveness and impact of DsPH as Public Health leaders. ADPH seeks to improve and protect the health of the population through collating and presenting the views of DsPH; advising on public health policy and legislation; facilitating a support network for DsPH; identifying their development needs; and supporting the development of comprehensive, equitable public health policies.

www.adph.org.uk

Acknowledgement

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CONTENTS

WHY THIS ISSUE IS IMPORTANT

Key trends from the Samaritans Suicide Statistics Report 2017

- In 2015 there were 6,188 suicides registered in the UK
- Around 75 per cent of all suicides in 2015 were committed by men
- The highest suicide rate in the UK was for men aged 40–44
- Male rates remain consistently around 3 times higher than female suicide rates
- In England and the UK, female suicide rates are at their highest in a decade

Any suicide is a tragedy – not only does it represent a life lost, it has a profound impact on the lives of family and friends who themselves may subsequently need support from statutory health and care services or voluntary and community sector organisations. For every death, another 6 to 60 people are thought to be affected directly. Given this scale of human impact, it is not surprising that the economic cost is estimated to be so high. For every suicide nearly £1.7 million is lost in things like productivity and caring for those left behind. Yet suicide can be prevented.

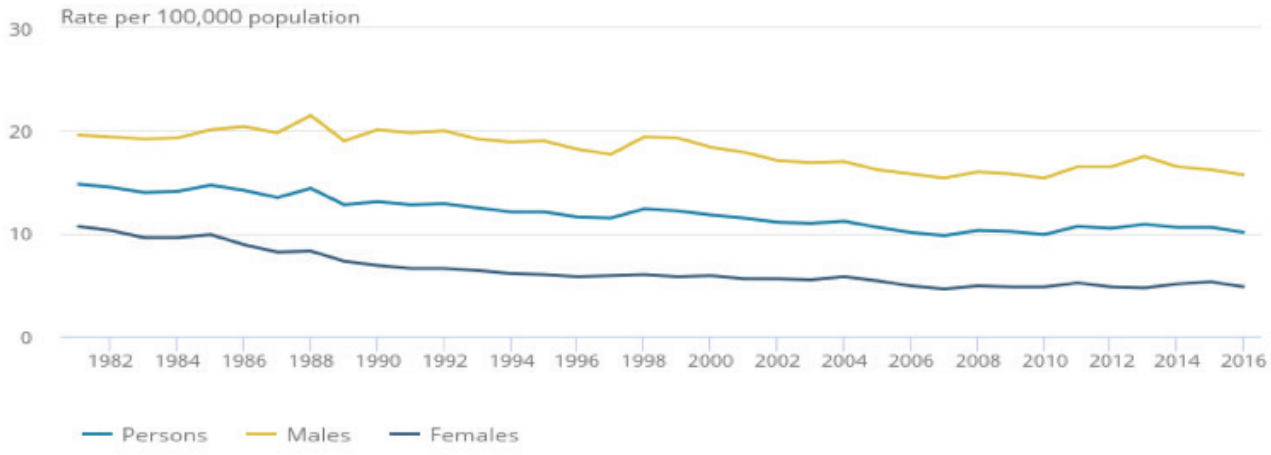
Councils have been active on suicide prevention work in recent years. Councils can help to prevent suicide through their public health role to address many of the risk factors, for example alcohol and drug misuse. They can also address the wider determinants of health such as employment and housing. There are also important and varied opportunities to reach local people who are not in contact with health services, for example through on-line initiatives or working with the third sector. [1]

Office for National Statistics figures for 2016 (illustrated below) show a 6% fall in the suicide rate in England, 245 fewer deaths, linked to suicide prevention work. The male suicide rate has fallen for three consecutive years and the recent rise in female rate has reversed. However, there were still 4,575 deaths in England, 1 every 90 minutes.

[1] https://www.local.gov.uk/suicide-prevention-guide-local-authorities

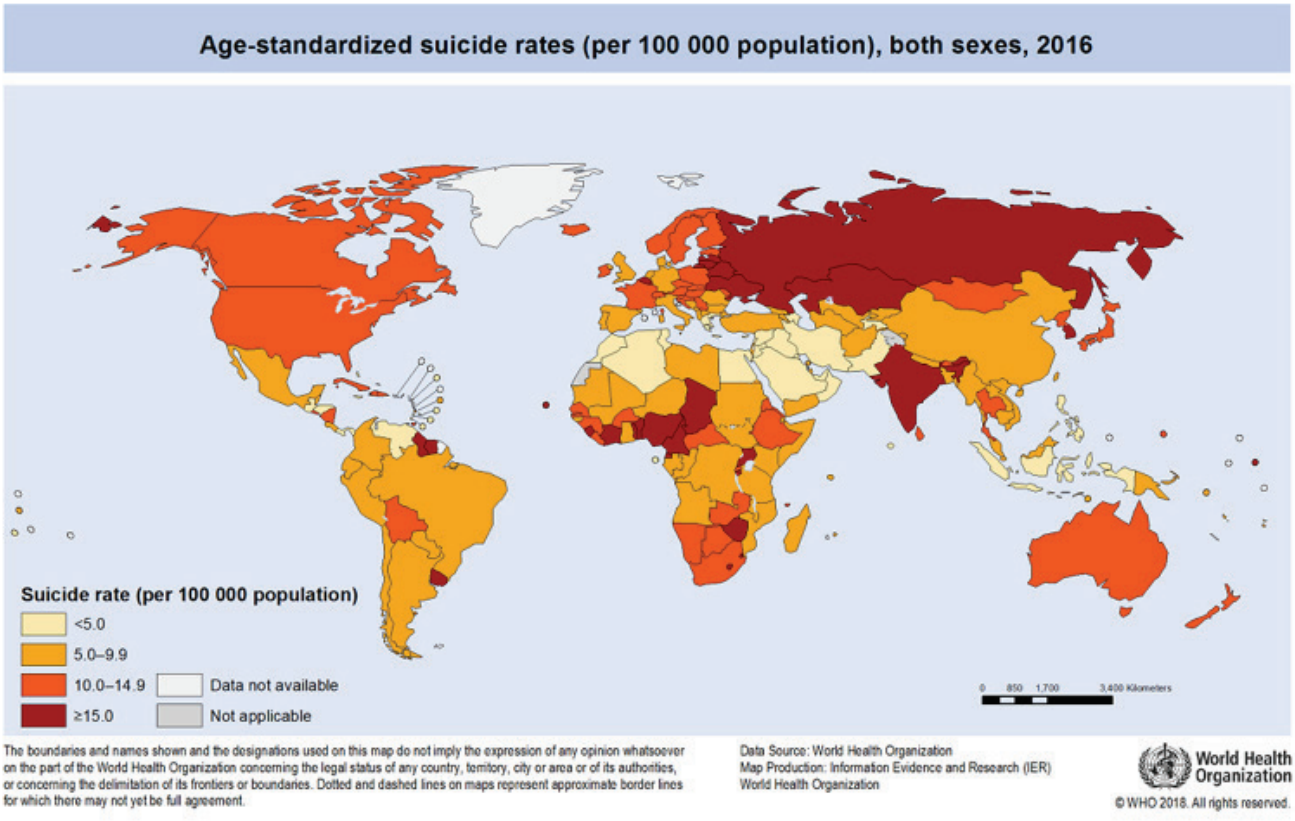
http://www.mentalhealthchallenge.org.uk/wp-content/uploads/2018/03/MentalHealthChallenge_Suicide_Prevention_briefing-1.pdf

Figure 1: Age-standardised suicide rates by sex, for Great Britain, registered between 1981 and 2016



Source: Office for National Statistics, National Records of Scotland

Below is an illustration of World Health Organisation data comparing suicide rates around the world. On this scale, the UK compares favourably – but there is no room for complacency.



National suicide prevention policy has developed and expanded considerably as concerns around suicide rates have intensified. Since 2012, action to prevent suicide in England has taken the form of an integrated government strategy 'Preventing Suicide in England: a cross-government outcomes strategy to save lives'. The principal aim of the strategy has been to prevent people from taking their own lives. Since 2017, it has included a commitment to reduce suicide rates nationally by 10% in 2020/21, compared to 2016/17 levels. The current iteration of the strategy operates across government, involving a range of policy areas. A new cross government delivery group has been set up to oversee implementation of the strategy.

The latest progress report on the strategy was published in January 2017 and the House of Commons Health Select Committee has published two reports from its suicide prevention inquiry which took place during 2016-2017. In 2016, the Committee published an interim report on suicide prevention to help inform the Government's updated suicide prevention strategy. The Committee published a final report in 2017, welcoming many of the initiatives proposed by government but concluding that more needs to be done across health and care services, criminal justice, workplaces, schools, transport, the media, employment, the armed forces and in society itself to prevent suicide by recognising and tackling the underlying causes, spotting the early signs of suicide risk and making effective interventions that help people deal with mental health issues such as depression, anxiety and suicidal thoughts.

The Committee recognised that local scrutiny of suicide prevention strategies can add value to implementation, interventions and outcomes. With the help of CfPS, the Chair of the Health Committee, Sarah Wollaston MP, wrote to all health overview and scrutiny committees in 2017 encouraging them to make local suicide prevention plans part of their work programme.

This guide aims to help councillors and local scrutiny committees to build their knowledge and understanding about the context of suicide risk, prevalence and prevention. It suggests questions that they can ask commissioners, providers and other stakeholders to make sure that local plans and strategies are comprehensive and are delivering better outcomes for people at risk of suicide. Talking about suicide can be a very sensitive issue, but councillors and scrutiny committees may find hearing about the experiences of local people and families insightful when they are reviewing local strategies and plans.

CONTEXT AND RELEVANCE FOR SCRUTINY

Key points

- Local suicide prevention plans in England are not a legal requirement, but have been recommended by several national reviews and reports
- The ADPH, LGA, Department of Health and Social Care and Public Health England have agreed to work together to support councils to address suicide prevention in England through a sector-led improvement approach
- All councils are encouraged to publish their suicide prevention plans and take them through their overview and scrutiny or health scrutiny processes
- A national voluntary self-assessment exercise started in the autumn of 2018. All councils are encouraged to take part in the self-assessment exercise and scrutiny can be involved

Local suicide prevention plans in England are not legal requirements but have been recommended by several reviews and reports, including in the recent NHS England publication 'Five Year Forward View for Mental Health'. The guidance published by Public Health England 'Local Suicide Prevention Planning - A Practice Resource and Support after Suicide: A Guide to Providing Local Services' provides advice for councils in continuing to reduce and prevent suicides.

In the government's response to the Health Committee report on suicide prevention in 2017, the Department of Health (now Department of Health and Social Care) proposed a quality assurance process for councils' suicide prevention plans. The Health Committee was also clear that it wanted scrutiny of local plans to be part of local assurance processes.

ADPH and LGA have been working with DHSC to refine the approach to assurance and ensure that it is compatible with a sector-led improvement ethos and DHSC has given Ministerial endorsement to this way of working.

In December 2017, PHE undertook a stock-take of progress towards all local areas having suicide prevention plans in place. Out of 152 upper tier councils, 148 now have plans in place and the remainder are working towards having a plan. Whilst a comprehensive plan is important, councils without plans may also be leading effective interventions through other strategies or agreed local approaches.

The support of scrutiny committees in establishing suicide prevention as part of a wider public mental health agenda is crucial. Scrutiny committees should look to assess the extent to which suicide prevention is a priority for their area and test how well the plan will deliver the prevention and reduction of suicide needed to achieve national ambitions.

Because scrutiny has a 'whole system' remit, it can look across all the environments where action to prevent or reduce suicide can be effective, making it a valuable and influential improvement function.

Key sectors for scrutiny to consider

- Armed forces
- Coroners' service
- Criminal justice
- Education
- Employment
- Health services
- Housing
- Media and social media
- Police
- Prisons
- Railways and transport
- Social care (including safeguarding)
- Universities and higher education settings
- Welfare

QUALITY IMPROVEMENT AND THE ROLE OF SCRUTINY

Local suicide prevention plans are at different stages of development and implementation and there is an opportunity to share good practice and areas for improvement so that councils can learn from each other and external experts.

The ADPH, LGA, PHE and DHSC have agreed to work together to support councils to address suicide prevention and reduction through the sector-led improvement framework. Some regions have already begun sector-led improvement work on suicide prevention.

Three components to sector-led improvement

- **Voluntary self-assessment of suicide prevention plans**

  A self-assessment tool has been developed by ADPH to help councils identify progress with plans, actions and outcomes and identify what further support and resources could be useful. The self-assessment tool is available for councils to carry out in autumn 2018

- **Local scrutiny by overview and scrutiny committees**

  It is important for councils to be transparent about their progress on suicide prevention planning and a key way to achieve this is by involving overview and scrutiny functions in developing plans and monitoring outcomes. This guide provides advice for scrutiny committees about questions to ask as part of the local assessment and assurance process

- **National learning report summarising regional self-assessment themes**

  An expert advisory group is being established and jointly chaired by a Director of Public Health (nominated by ADPH) and Professor Louis Appleby (Chair of the National Suicide Prevention Advisory Group). The group will produce a thematic report on the national outcomes and good practice from self-assessments which scrutiny committees can use

In 2017, Business in the Community, in association with Public Health England and supported by the Samaritans, published a toolkit for employers to reduce the risk of suicide. The toolkit includes a useful 'myth buster' which is shown below.

Common myths about suicide	
Myth: You have to be mentally ill to think about suicide	**Fact:** There is a misconception that you have to be mentally ill to think about suicide, but the truth is many people do – around one in five adults say they have thought about suicide at some point. Suicidal thoughts can range from feeling that life isn't worth living anymore, to seriously considering taking your own life. Not all people who die by suicide have mental health issues. Two in three suicides are by people who are not under mental health care
Myth: Talking about suicide is bad as it may give someone the idea to try it	**Fact:** People who have felt suicidal will often say what a huge relief it was to be able to talk about what they were experiencing. Talking about suicidal feelings in an honest and non-judgmental way can help break down the stigma associated with it, meaning people are more likely to seek help and open up about how they feel. Talking about suicide will not put the idea in someone's mind, but it will help make the topic less taboo
Myth: People who threaten suicide are just seeking attention	**Fact:** People who say they want to die should always be taken seriously. It may well be that they want attention in the sense of calling out for help, and giving them this attention may save their life
Myth: If a person is seriously thinking about taking their own life, then there is nothing you can do	**Fact:** Suicide is not inevitable – it is preventable. Most people who experience suicidal thoughts don't go on to take their own life
Myth: Once a person has made a serious suicide attempt, that person is unlikely to make another	**Fact:** People with a history of attempting suicide are at an increased risk of dying by suicide. If someone has made an attempt on their life, it is essential they are given appropriate support and help
Myth: Most suicides happen in the winter months	**Fact:** Suicide rates peak in the spring, but suicidal thoughts, feelings and behaviour may happen to anyone at any time

Source: Business in the Community – Reducing the Risk of Suicide: Toolkit for Employers (2017)

10 QUESTIONS FOR SCRUTINY COMMITTEES TO ASK

Key points

In line with the national suicide prevention strategy, councils and partners should consider the impact of suicide in their area and produce an appropriate and proportionate plan to:

- prevent and reduce its impact
- address the needs of populations particularly vulnerable to suicide
- provide support for those at risk and those who attempt suicide
- provide support for those bereaved through suicide

Scrutiny committees should be looking to assess whether local suicide prevention plans, strategies or approaches are fit for purpose, proportionate to local suicide risks and rates and engage the right partners in the right actions, with ambitious but achievable outcomes. Plans, strategies or approaches to suicide prevention and reduction should form part of a broader approach to better mental health, alongside appropriate training for people involved in providing services.

1. Is there a plan, strategy or agreed approach for the area?

- Is there a suicide prevention plan, strategy or other agreed approach for the area with a clear narrative and rationale about the vision and ambition for preventing or reducing suicide?
- Has there been an analysis of the local need within the last two years, such as a suicide audit or needs assessment, drawing on the local suicide profile at least, which identifies suicide and suicide prevention proportionately as an issue?
- Does the plan, strategy or approach contain clear actions and outcomes that are proportionate to local need?
- What mechanisms are there for performance measurement, evaluation and review?
- Is the plan, strategy or approach consistent with nationally suggested good practice and guidance as set out in the national strategy and the PHE guidance?

2. Who are the partners and what are the governance arrangements?

- Is there a visible local partnership with responsibility for developing and delivering actions and being accountable for outcomes in the plan, strategy or approach?
- Do the partners meet frequently enough and are their representatives senior enough to make a difference?
- Is there a clear line of accountability from the partnership to councillors, for example to the health and wellbeing board and scrutiny committee?
- Are there effective links to the Crisis Care Concordat and the Prevention Concordat for Better Mental Health?

- How is the partnership making links with Sustainability and Transformation Partnerships (STPs) or Integrated Care Systems (ICSs)?
- Can each local agency/partner clearly articulate their role and contribution?

3. Which individuals and organisations have been involved?

- Who has been engaged in discussions about the development, delivery and outcomes of the plan, strategy or approach? For example:

Public health teams	People who have attempted and survived suicide	Clinical Commissioning Groups
Councillors	Health and Wellbeing Boards	Primary care providers
Secondary care and mental health care providers	Social care and safeguarding teams	Voluntary and community sector organisations
People bereaved through suicide	Other experts by experience	Probation services
Courts and tribunals services	Prisons and young offenders' institutions	Welfare teams (including financial vulnerability and debt advice)
Police forces and Police and Crime Commissioners	Other emergency services	Coroners' offices
Faith communities	People with characteristics protected under the Equality Act 2010, including LGBT groups	BAME communities
Schools and universities	Transport sector	Housing associations
Armed forces, their families and veterans	Sector specific inspectors and regulators	Employers and business organisations

- How are people with lived experience or other experts by experience engaged meaningfully and influentially in shaping the plan, strategy or approach, monitoring its impact and also what care is provided for them?

4. Are there specific groups in the community that need help and support?

- Are there local issues, circumstances or groups which require specific or different approaches and how are those being addressed in the plan, strategy or approach? For example, people in the lowest socio-economic groups and living in the most deprived geographical areas are ten times more at risk of suicide than those in the most affluent groups living in the most affluent areas
- In line with national guidance, specific populations and issues should be considered, for example:

	Already being delivered	For future delivery	Reason not considered for action
Reducing risk in men			
Preventing and responding to self-harm			
Mental health of children and young people			
Treatment of depression in primary care			
Acute mental health care			
Tackling high frequency locations			
Reducing isolation			
Bereavement support			
High priority cohorts (e.g. BAME, LGBT groups) (consider which populations are relevant to your area)			

- In line with the 2018 commitment from the Secretary of State for Health and Social Care [2] made at the National Suicide Prevention Alliance conference, what actions are being taken to reduce suicides in inpatient healthcare settings?

5. What support is available for people bereaved through suicide?

- Does the plan, strategy or approach build on existing specific suicide bereavement support services or commit to put these in place to proactively provide support to people bereaved or affected by suicide?
- If your council area does not have a dedicated suicide bereavement service in place are there any other forms of bereavement support available?
- Can you be assured that people are aware of the support available and are referred or able to access services?

[2] http://www.nspa.org.uk/home/news-events/nspa-conference-2018/presentations/

6. Are there any barriers to sharing information between organisations?

- Are there information sharing arrangements in place to support the ambitions of reducing and preventing suicide?
- Are there any barriers to the effective and timely sharing of information between organisations?
- How confident are local suicide prevention partners that the risk of people 'slipping through the net' has been considered and addressed?

7. What level of funding and resources exist to support the implementation of the plan, strategy or approach?

- What is the total financial resource committed to support the actions in the plan, strategy or approach?
- How have the partners decided the levels of funding that each of them will commit?
- What arrangements exist to determine the value for money or social value provided by the plan, strategy or approach?

8. Are there particular challenges and successes in the area?

- Are any particular local challenges which you are struggling with?
- Has there been any comparison, benchmarking or learning from other areas about how these challenges might be overcome?
- Are there any particular areas of success or notable practice?
- Have there been any attempts to share lessons from successes or notable practice so that other areas can learn?

9. How are ambitions for suicide reduction and prevention decided?

- How has a judgement been made about 'what success would look like'?
- How has national guidance, for example from PHE and NICE, been incorporated in to local practice?

10. Does the plan, strategy or approach represent a 'whole system' approach to preventing or reducing suicide?

- Is the plan, strategy or approach the product of innovative thinking or does it represent a collection of existing ideas?
- Is there a sense that actions to prevent or reduce suicide are 'everyone's business' - for example from organisational strategies, plans or approaches through to wider population awareness and individual action to spot risks and intervene appropriately and safely?

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