

**North East Regional  
Suicide Prevention Steering Group**

**A 5 Year Strategy for Suicide  
Reduction and Prevention: 2010 to 2015**

**Final Version  
September 2010**

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## Executive Summary

- In 1999, *Saving Lives*<sup>1</sup> established a target date of 2010 for a 20% reduction in the suicide rate in England
- As 2010 is now upon us, the suicide rate in the region stands at 8.5 per 100,000 population compared to the rate for England of 7.8 per 100,000. Significantly, the rate in the North East has reduced from the baseline figure of 9.9 per 100,000 (taken during the years 1995-1997). This equates to a reduction of 14.3%. Although these figures are encouraging more needs to be done
- A multi-agency Suicide Prevention Steering Group has been established to progress this agenda within the North East. This all-age, 5 year strategy is a product of the group's early work as well as a consultation which took place earlier this year. The strategy is split into 3 parts:
  - An overview of the data, vision and governance arrangements. In essence, why is suicide an issue and how does the region intend to reduce it?
  - The priorities for Year 1 (September 2010 to March 2011). In short, what are the must do's and quick wins?
  - The remaining priorities for April 2011 to March 2015. As suicide prevention is so far-reaching there is an extensive range of initiatives under this section. These are all important issues but will need prioritisation by the Regional Steering Group
- It is the intention of this strategy to ensure that, by 2015, the suicide rate in the North East has reduced from its current rate of 8.5 per 100,000 population to the national average for England (currently 7.8 per 100,000 population). This will not be easy but the regional steering group believes that, in partnership with other agencies, it can introduce measures which can effectively contribute to a reduction in the number of suicides within the region
- Numerically, and if we use the Office for National Statistics 2007 estimate of population for the North East (2.6 million people), this would equate to a reduction of 18 cases per year, from 221 suicides currently to 203 cases per annum by 2015
- Based on a Health Economy model developed for the Northern Ireland Suicide Prevention Strategy, where each case was estimated to cost the regional economy £1.4 million, this would mean a saving to the regional economy of approximately £25.2 million

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<sup>1</sup> Department of Health (1999) *Saving Lives: Our Healthier Nation*. London: The Stationery Office

- However, it is important to be clear that suicide prevention means so much more than reducing suicide rates or measuring the economic costs of each suicide. Behind the figures are the human stories, the crises which led each individual to take his or her own life and the impact that this had on the family, friends, wider community and work colleagues of the individual
- It is therefore important that this strategy considers the human cost of suicide in addition to the economic and social costs
- The Regional Suicide Prevention Steering Group has agreed the following priorities for year 1 of the strategy, namely September 2010 to March 2011:

**Year 1 priorities:**

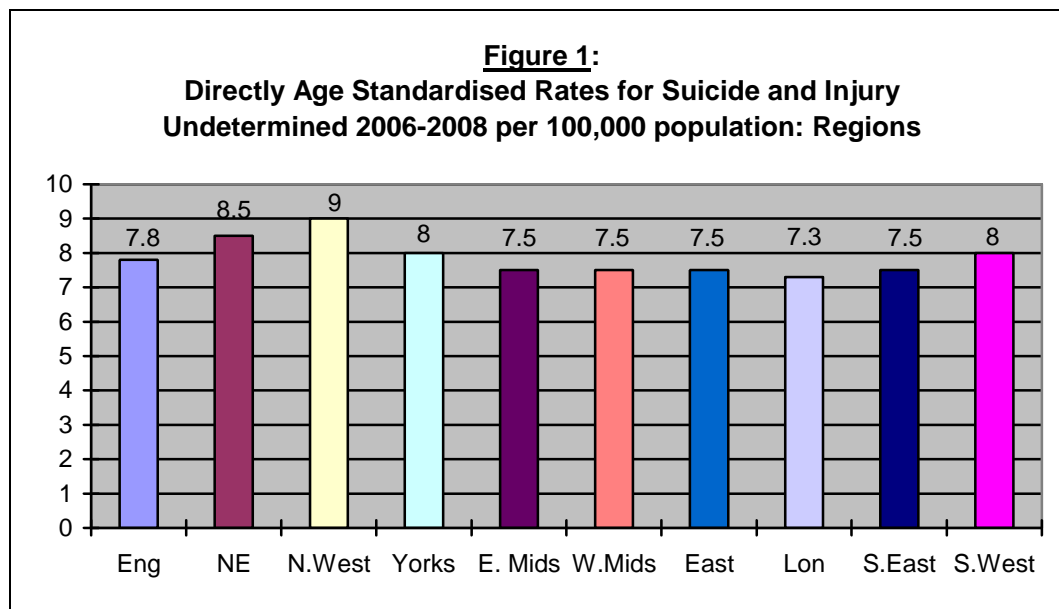
- **To ensure that multi-agency suicide prevention groups, where they exist in our region, are fully supported by the regional steering group, are representative of core agencies and community groups and are able to inform the regional agenda**
- **To improve the sharing of information between organisations on people at risk of suicide. This will include the development of multi-agency information-sharing protocols**
- **To put systems in place to prevent ‘clusters’ of suicide emerging in any one particular area as occurred recently in South Wales**
- **To develop a training model to improve access across the region to training on mental health awareness and suicide prevention**
- **To apply the Northern Ireland model to quantify the economic cost of suicide within the North East**
- **To work with the Strategic Health Authority to begin the development of a Self-Harm Pathway so that individuals who self-harm receive the best care and are supported following discharge from care**
- **To work with those prescribing medication to raise awareness of the impact that certain medicines have on rates of self-harm and suicide and reduce their availability, where appropriate**
- **To develop a ‘Gold Standard’ pathway between health and criminal justice agencies, such as the police and probation service, to ensure that people in crisis are supported effectively during and after their contact with those services**

## **PART ONE**

**WHY IS SUICIDE AN ISSUE IN THE NORTH  
EAST AND HOW DO WE INTEND TO  
REDUCE IT?**

## 1.0 Introduction

- 1.1 In 1999, *Saving Lives*<sup>2</sup> established a target for the reduction of the suicide rate by 20% by 2010. As this date is now upon us, it is conceivable that the suicide reduction and prevention agenda may begin to slip down the national, regional and local policy agenda.
- 1.2 However, *New Horizons*<sup>3</sup>, the intended replacement for the National Service Framework for Adult Mental Health, issued a warning that this should not happen. It argued that suicide prevention should remain a vital aim of public health, especially during and in the immediate aftermath of a recession. This is particularly relevant bearing in mind data from a recent Adult Psychiatric Morbidity Household Survey<sup>4</sup> where, from a sample of 13,000 adults, 16.7% reported a history of feeling suicidal and 5.6% had attempted suicide.
- 1.3 This appears to be borne out by the most recent national statistics on suicide available to us (2006-2008). Although the suicide rate in the North East has reduced by 14.3% since 1995-1997, from 9.9 per 100,000 population to 8.5 per 100,000, the region has the second highest suicide rate in England. This is shown in figure one<sup>5</sup>.



Note that these figures have been calculated by the Office for National Statistics based on ICD-10 classifications including all suicides and most open verdicts

<sup>2</sup> Department of Health (1999) *Saving Lives: Our Healthier Nation*. London: The Stationery Office

<sup>3</sup> Department of Health (2009) *New Horizons: towards a shared vision for mental health – consultation* London: Crown Copyright

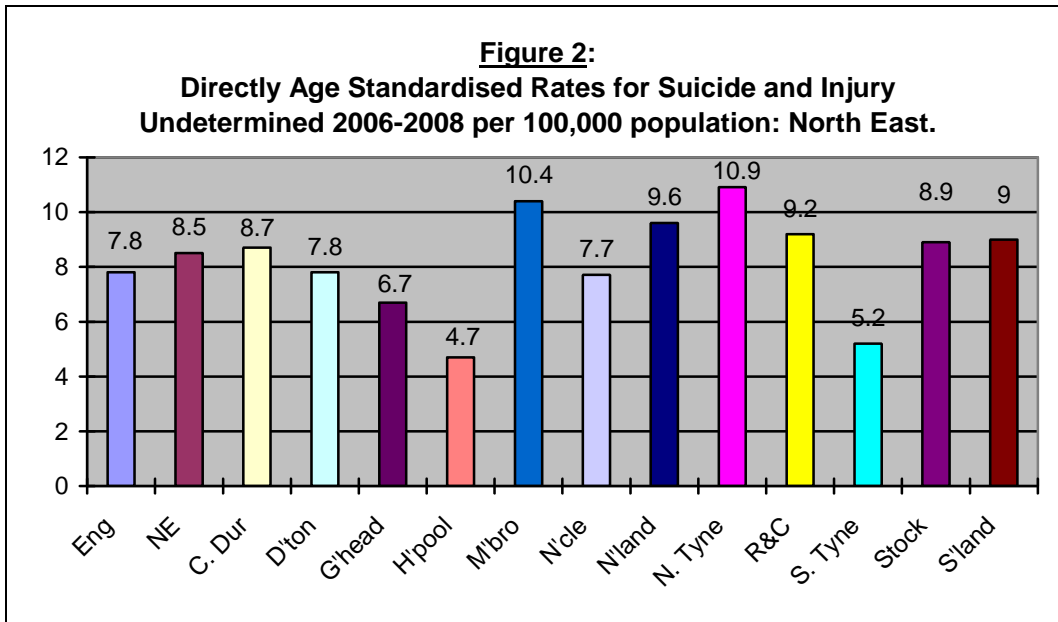
<sup>4</sup> <http://www.ic.nhs.uk/pubs/psychiatricmorbidity07>

<sup>5</sup> National Centre for Health Outcomes Development (2009) *Directly Age standardised ratios (SMR)*.

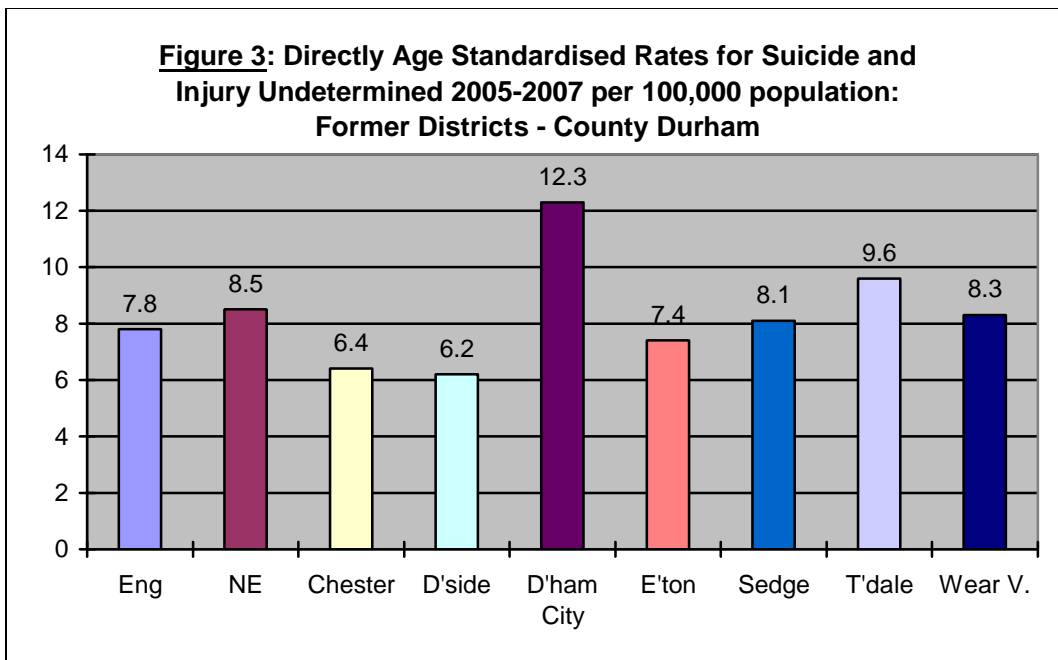
**Includes data on 95% Confidence Intervals.** Available at:

[www.nchod.nhs.uk/NCHOD/compendium.nsf/\(\\$All\)/84BBAA5EC65332F3802576D000355CA4/\\$File/31D114DR00++\\_08\\_V1\\_D.xls?OpenElement](http://www.nchod.nhs.uk/NCHOD/compendium.nsf/($All)/84BBAA5EC65332F3802576D000355CA4/$File/31D114DR00++_08_V1_D.xls?OpenElement)

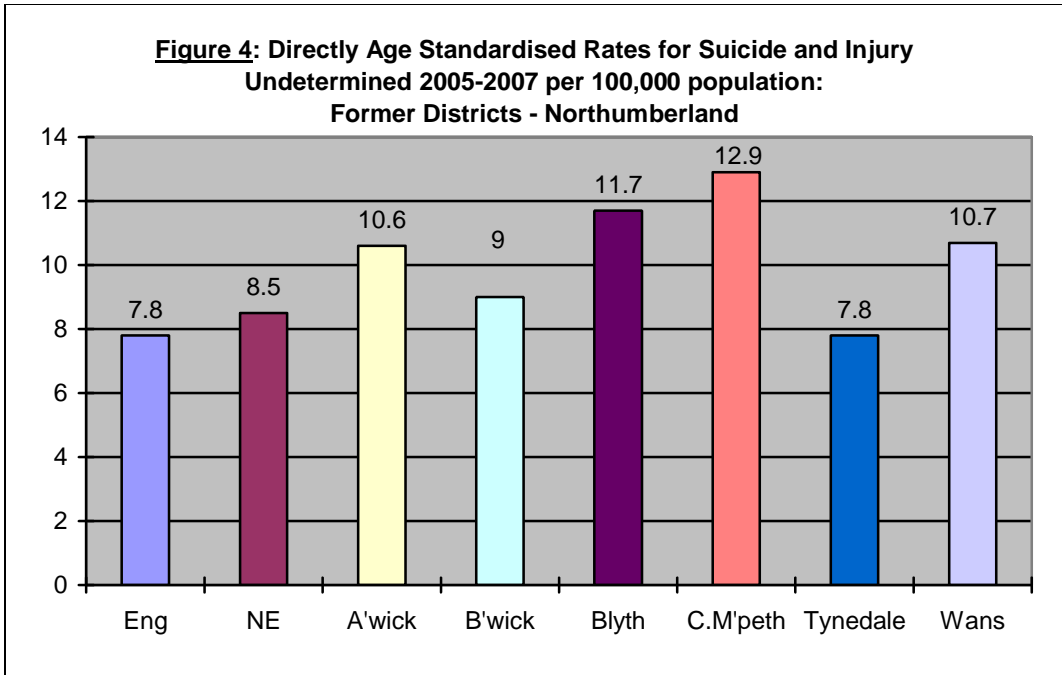
1.4 By looking at the localities within the region, there is evidence of an even greater spread. Again, based on data from the Office for National Statistics covering the years 2006-2008, these data are displayed in Figure two<sup>6</sup>



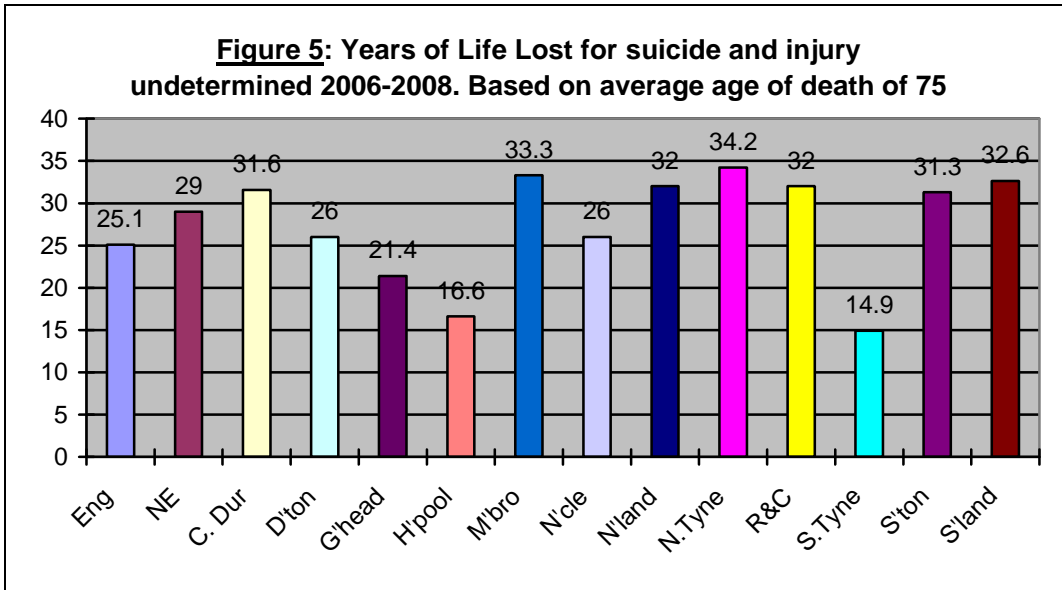
1.5 Figures 3 and 4 cover the former District Councils of Northumberland and County Durham and Darlington. Although based on districts which no longer exist and with the most recent data only being available from 2005 to 2007 they still provide some interesting comparisons



<sup>6</sup> As footnote 5. Includes data on 95% Confidence Intervals

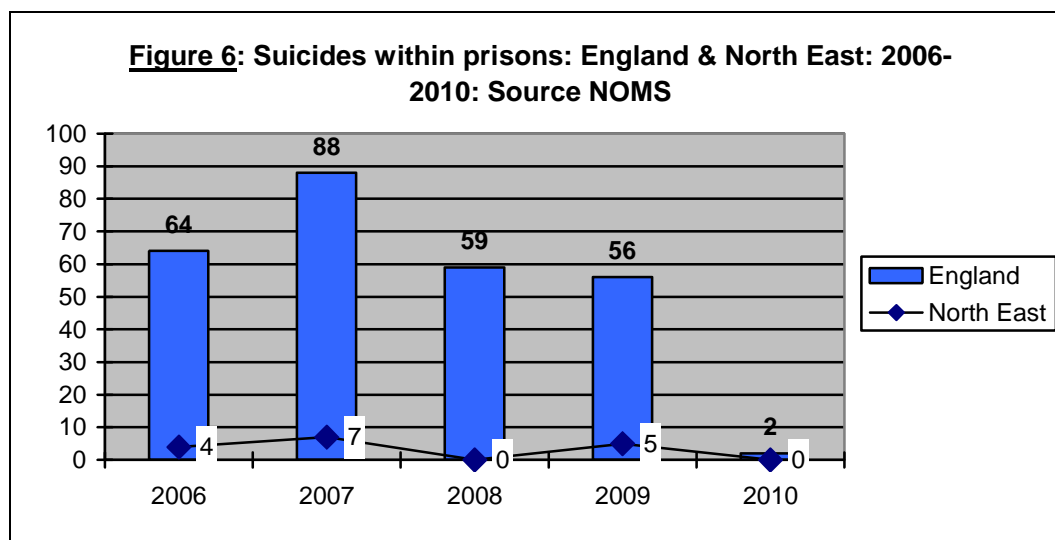


1.6 It is also interesting to look at the average years of life lost per case of suicide. Based on a nationally set figure of 75 years of age, representing the average age of death in the population, figure 5 demonstrates that, in areas such as Middlesbrough and North Tyneside, people dying as a result of suicide are dying much younger than those in areas such as Hartlepool and South Tyneside<sup>7</sup>



<sup>7</sup> National Centre for Health Outcomes Development (2009) *Years of Life Lost from suicide and injury undetermined*. Available at: <http://www.nchod.nhs.uk/NCHOD/compendium.nsf/17b8958892856d44802573a30020fcd9/bfae33dcd7cc8498652573b20016d056!OpenDocument>

- 1.7 In addition, if we look at the prison environment, Figure 6 provides an overview of suicides within the English prison estate together with those occurring within the North East



- 1.8 If we look at data on suicide and injury undetermined by *minority ethnic group* or *sexual orientation* the data are more problematic. At present, UK death certification does not record ethnic group nor sexual orientation so accurate figures are difficult to attain.

However, some research has been undertaken in both of these areas. For example, in 2007, the Care Services Improvement Partnership systematically reviewed literature on the mental health needs of lesbian, gay and bisexual people. They found that risk of suicide in these groups was 2.47 times higher than the general population (with 95% confidence intervals of 1.87 to 3.28 times the general population)<sup>8</sup>

In addition, research undertaken by University College London, also in 2007, found that for Black and Minority Ethnic Groups, women of South Asian or East African origin and people of Irish decent were at significantly higher risk of suicide than the general population<sup>9</sup>. Anecdotal evidence also shows that Gypsies and Travellers are at high risk of suicide due to an increased likelihood of depression and difficulties in dealing with bereavement<sup>10</sup>

- 1.9 Data on Self-Harm are also notoriously difficult to quantify. For that reason, local data have not been included in this strategy. However, Figure 7 provides an interesting national insight into rates of self-harm amongst the under 17 age group by region.

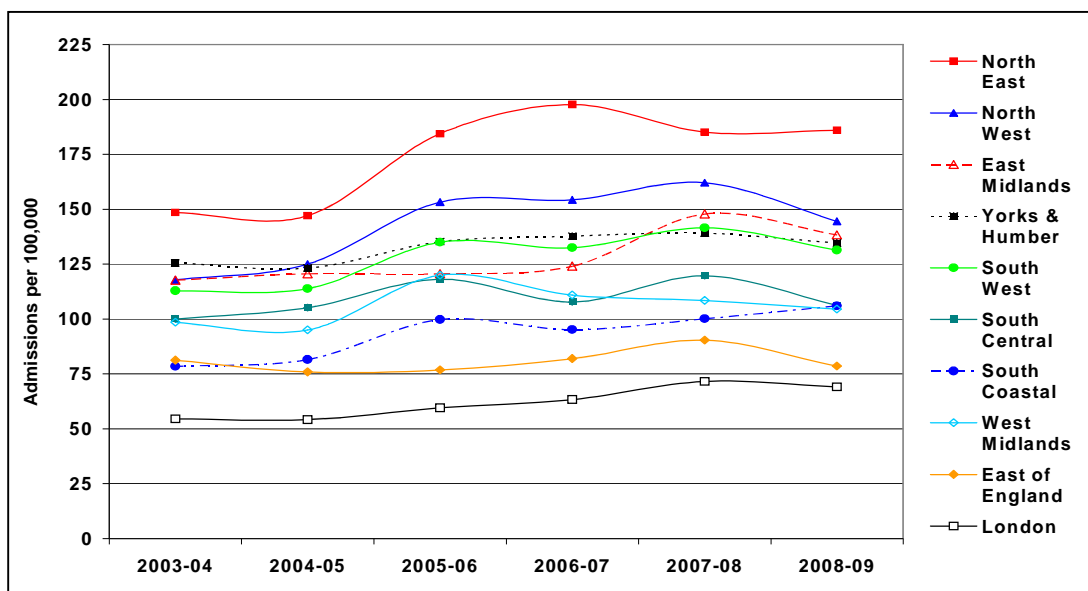
<sup>8</sup> CSIP (2007) *Mental Disorder, Suicide and Deliberate Self Harm in Lesbian, Gay and Bisexual People: A Systematic Review*. London: CSIP

<sup>9</sup> UCL (2007) *Suicide Prevention for BME groups in England: Report from the BME Suicide Prevention Project – Executive Summary*. London: NIMHE

<sup>10</sup> Cemlyn, S et al (2009) *Inequalities experienced by Gypsies and Travellers: A Review*. England: Equality and Human Rights Commission

The data, provided by the Department of Health (Hospital Episode Statistics), demonstrate how the North East has a much higher rate of emergency admissions due to self-harm, for this age group, than any other region in England

**Figure 7:** Emergency inpatient admissions caused by intentional self-harm, per 100,000 population aged 0-17, by Strategic Health Authority of residence 2008-09. Source: DH Hospital Episode Statistics



1.10 The figures outlined in this section illustrate the human cost of suicide. The Northern Ireland Suicide Prevention Strategy<sup>11</sup> has gone further to quantify the economic costs. In 2004, there were 146 suicides in the province. They calculated that this equated to 4350 life years lost at a cost of £1.4 million per case with costs based on, for example, post mortems and subsequent investigations and inquests, loss of future earnings and human costs to family, friends and community

1.11 Based on the human, economic and social costs of this data, it is therefore the intention of this North East strategy to ensure that suicide reduction and prevention remains a major health and social priority that requires multi-agency input within the North East.

## 2.0 Vision and Rationale

### Vision

2.1 Our aim is to ensure that by 2015, the North East will have reduced its suicide rate to that of the national average for England. Based on the most recently available figures (2006-08) this will necessitate a reduction from 8.5 per 100,000 in the North East to the 7.8 per 100,000 rate for

<sup>11</sup> [www.dhsspsni.gov.uk/phnисуicidepreventionstrategy\\_action\\_plan-3.pdf](http://www.dhsspsni.gov.uk/phnисуicidepreventionstrategy_action_plan-3.pdf)

England. From estimates provided by the Office for National Statistics in 2007, where the North East had an approximate population of 2.6 million<sup>12</sup>, this would equate to a reduction from 221 to 203 cases per annum by 2015.

As a secondary objective, the Regional Suicide Prevention Steering Group will work with those localities that have significantly higher rates of suicide than the regional average to reduce their rates to that of the regional average. This will accommodate those localities identified under section 1.4 in the introduction but may change as new data emerge.

We will also work with those localities which have low rates of suicide to assess the reasons behind their apparent success and, hopefully, translate that success across the region.

### **Rationale**

- 2.2 The Safety First Strategic Framework for the North East<sup>13</sup> has identified '7 NOs' that health services should seek to implement. These 'NOs' include 'No avoidable deaths, injury or illness' with a reduction in the number of suicides being a key component of that objective.

It is therefore imperative that any regional strategy on suicide prevention builds upon this principle by developing a vision that not only reflects a realistic and achievable reduction in suicide from a health service point-of-view but also reflects on the wider impact that suicide has on individuals, families and the wider community.

- 2.3 We believe that our vision is both realistic and achievable but we must work in partnership to do this. The Regional Steering Group can only do so much to influence this agenda; it must be seen to lead but it must also be seen to influence others to lead on its behalf. How we do this is explained further in the next section.

## **3.0 Governance Structures**

- 3.1 Before looking at the key regional priorities for delivery, it is important to identify the Governance arrangements that will ensure that delivery.

### **3.2 *National***

At a national level, the National Suicide Prevention Strategy has been operational since 2002. Its primary function is to secure a 20% reduction in the suicide rate in England by 2010. The strategy is therefore approaching its natural end and plans for a refreshed document have been announced.

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<sup>12</sup> Available at: <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15106>

<sup>13</sup> NHS North East (2008) *Safer Care North East*. Available from: [http://www.northeast.nhs.uk/assets/media/pdf/NW2154\\_Patient\\_Safety\\_Document.pdf](http://www.northeast.nhs.uk/assets/media/pdf/NW2154_Patient_Safety_Document.pdf)

Until recently, there were clear links between the National Suicide Prevention Programme and each of the English regions. Due to structural changes in a number of regions this is no longer the case.

Therefore, although the Regional Steering Group for Suicide Prevention plans to keep the national programme updated on progress with the regional strategy, the Steering Group is not ultimately accountable to that programme. Lines of accountability are therefore solely within our region.

Additionally, and perhaps more significantly, the recent changes in Government and the subsequent white papers and consultation documents on healthcare have suggested a move towards local determinism with less of an emphasis on regional structures<sup>14</sup>.

It is therefore likely that existing work on suicide prevention at a sub-regional and local level will be required to reflect the needs of the planned GP consortia and Local Authority Health and Wellbeing Boards.

However, it is the contention of this strategy that a Regional Suicide Prevention Steering Group can add value to these emerging structures as, by focusing on issues which are common to all organisations, it can support, guide and advise sub-regions and localities in the adoption of the most cost-effective and evidence-based interventions.

### 3.3 *Regional*

Within the North East, a Regional Suicide Prevention Steering Group has been established to oversee the development of this 5 year strategy. The group is multi-agency in membership and currently reports to the Chief Executive Officer Mental Health/Learning Disability Commissioning Group. It has also established a widespread stakeholder network to ensure that all relevant partners are updated with developments. The terms of reference of the Steering Group can be found in *Appendix A*

Additionally, a Safer Care Group on Suicide Prevention has been established. This is led by the Strategic Health Authority and is responsible for implementing the Safer Care North East Strategy (see *footnote 13*). The focus of this group is very much on preventing suicide within mental health services and therefore complements rather than duplicates the work of the Regional Suicide Prevention Steering Group.

As the Safer Care North East strategy is due to come to an end by December 2011, it is intended that any outstanding work of the Safer Care Group on Suicide Prevention will be taken forward by the Regional Suicide Prevention Steering Group. The current work programme of the Safer Care Group is located under *Appendix B*

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<sup>14</sup> Available from:  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_117353](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353)

There are two further regional strategies worthy of note: *Better Health, Fairer Health*, the regional public health strategy; and, *Our Vision, Our Future*, the regional strategy to improve clinical services. In each case, groups relating to mental health have been established, the *Regional Advisory Group for Mental Health, Happiness and Wellbeing* and the *Clinical Innovation Team for Mental Health*. Although the Regional Suicide Prevention Steering Group does not report formally through these structures, regular updates are provided through our network of stakeholders

#### 3.4 *Sub-regionally and locally*

The North East has three sub-regional suicide prevention task forces or groups: one covering the Northumberland Tyne & Wear area; one within County Durham and Darlington; and one covering the Tees-wide area (with representatives from the latter two groups meeting periodically).

These groups generally report through Primary Care and Mental Health Foundation Trust performance structures, are multi-agency and multi-professional in composition and have been established to reduce suicide rates within that sub-region. Most of these groups have strategies and/or action plans in place

Additionally, there are a series of Suicide Audit Groups in the region which tend to operate at collaborative cluster level i.e. North of Tyne, South of Tyne and County Durham, Darlington and Tees. Their role is to collate reliable data on suicide and undetermined death and ensure that this data is used to inform local suicide prevention strategies and plans.

*Appendix A* contains a diagram explaining the current governance arrangements within the region

4.0 Funding
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- 4.1 The Regional Suicide Prevention Steering Group does not have any allocated funding. It is therefore envisaged that all initiatives outlined in this strategy will be undertaken by the current membership of the steering group, in partnership with existing suicide prevention groups at sub-regional and local level

## **PART TWO**

### **OUR PRIORITIES FOR YEAR ONE - SEPTEMBER 2010 TO MARCH 2011**

## 5.0 Priorities for 2010 - 2011

- 5.1 The priorities for year 1 have been identified by the Regional Suicide Prevention Steering Group following a consultation exercise which took place earlier this year. The priorities are outlined in the following paragraphs

### **Priority 1 – Supporting Suicide Prevention Groups**

1. To ensure that multi-agency suicide prevention groups, where they exist in our region, are fully supported by the regional steering group, are representative of core agencies and community groups and are able to inform the regional agenda

#### *What this means*

- The Regional Suicide Prevention Steering Group will work with existing sub-regional suicide prevention task forces/groups to develop coterminous terms of reference
- The Regional Suicide Prevention Steering Group will work with these groups to ensure that they have representation from core agencies and groups, such as criminal justice agencies, child services, older people's services, service users and carers, Samaritans, universities, local authorities, Coroners' Officers, MIND, health and social care commissioners, Social Care and Connexions. A core aim should be to strengthen the relationship between statutory organisations and the third sector
- The Regional Suicide Prevention Steering Group will provide quarterly updates to each sub-regional group, seek updates from each of those groups and support the sharing of information between those groups

### **Priorities 2 & 3 – Multi-agency Information-sharing**

2. To improve the sharing of information between organisations on people at risk of suicide. This will include the development of multi-agency information-sharing protocols
3. To put systems in place to prevent 'clusters' of suicide emerging in any one particular area as occurred recently in South Wales

#### *What this means*

- The Regional Suicide Prevention Steering Group will work with a range of agencies to develop information-sharing protocols to enable the sharing of data on suicide, self-harm and people at risk. This process should include specific reference to the sharing of information to and from third sector organisations and include a focus on often under-reported groups such as BME communities, Gypsies and Travellers

- This will be taken forward by supporting and learning from work currently taking place in Easington concerning the establishment of systems and processes to share information between agencies:
  - On people at risk
  - On the reporting of possible suicides within a set time period, for example to inform a GP that their patient has died
  - On the management of possible suicide clusters. The intention will be to develop a protocol based on a model developed in Northern Ireland
  - On the development of a central reporting and alert system to undertake these functions
  - On the inclusion of such information-sharing, risk management, the conduct of Serious Untoward Incidents and Significant Event Audits within contract specifications

#### **Priority 4 – Training**

4. To develop a training model to improve access across the region to training on mental health awareness and suicide prevention

##### *What this means*

- A sub-group of the Regional Suicide Prevention Steering Group will develop a training model on mental health awareness and suicide prevention. This will advise partners on the availability of current training, improve bespoke training programmes within Mental Health Foundation Trusts and work with the Universities of Teesside and Northumbria to develop collaborative study days which will aim to improve skills on identifying, assessing and managing suicide risk

#### **Priority 5 – Economic Costs**

5. To apply the Northern Ireland model to quantify the economic cost of suicide within the North East

##### *What this means*

- The Regional Suicide Prevention Steering Group will work with the National Suicide Prevention Programme and the North East Public Health Observatory to establish reliable data on the economic cost of suicide within the North East

#### **Priority 6 – Self Harm**

6. To work with the Strategic Health Authority to begin the development of a Self-Harm Pathway so that individuals who self-harm receive the best care and are supported following discharge from care

### What this means

- The Regional Suicide Prevention Steering Group will work with the Strategic Health Authority-led Patient Safety Strategic Forum to develop a regional Self Harm Pathway. In the process of doing this we will:
  - Work to improve the coding of episodes of self harm in acute care settings as well as the recording of self harm on management information systems
  - Review self-harm pathways between General Hospitals and Emergency Care Departments and Primary Care, Secondary Mental Health Services and Third Sector organisations. This should include reference to alcohol, the needs of young people (including Child and Adolescent Mental Health and educational settings), the needs of older people, the work of NHS Direct and procedures for follow-up post-discharge
  - Learn from work currently being undertaken by the Care Quality Commission concerning the number of people receiving an assessment of self harm and/or suicide risk in general hospitals
  - Consider initiatives for people who repeatedly self-harm as well as issues pertaining to the transition from child to adult services
  - Consider the development of a *Cause/History/Social Background* matrix to identify those most at risk
  - Review existing good practice, including:
    - The Tees, Esk and Wear Valleys Self Harm Pathway and SAD PERSONS scale which is currently being used in custody suites and County Durham and Darlington Foundation Trust
    - Self Harm Self Help groups currently operating in North of Tyne and the Self Help Guide developed by Northumberland, Tyne and Wear NHS Foundation Trust
    - The Newcastle Child and Adolescent Mental Health Self Harm Service which is developing a training programme for schools, GPs and nurse practitioners to implement a multi-agency referral pathway

### Priority 7 - Prescribing

7. To work with those prescribing medication to raise awareness of the impact that certain medicines have on rates of self-harm and suicide and reduce their availability, where appropriate

## What this means

- The Regional Suicide Prevention Steering Group will, *in partnership with sub-regional suicide prevention groups/task forces*:
  - Work with Heads of Pharmacy within Primary Care Organisations and Mental Health Foundation Trusts, to determine whether regular audits are taking place concerning the prescribing of amitriptyline, dosulepin, venlafaxine and co-proxamol, as these medicines have been identified as being the most common in suicide deaths by overdose
  - Ensure that audit cycles for reviewing the prescribing of these medicines include the establishment of baselines, a review of Average Daily Quantities (ADQs) and Specific Therapeutic Age Related Prescribing Units (STAR-Pus), a review of Net Ingredient Costs (NICs) and an assessment of adherence to NICE guidelines on depression and guidance from the National Collaborating Centre for Mental Health on depression in adults with chronic physical health problems
  - Ensure that, where possible, audits of Tricyclic medication (TCAs) include an assessment of their use for the alleviation of neuropathic pain, bearing in mind recently published guidance on the recommended use of TCAs for first-line pain management<sup>15</sup>
  - Work with Heads of Pharmacy to identify further high risk medicines and assist them to undertake medicines reviews focusing on concordance with national prescribing guidelines
  - Ensure that prescribers of co-proxamol bear in mind declarations by the Medicines and Healthcare products Regulatory Agency (MHRA) in 2005 and the European Medicines Agency in 2009 of its recommended withdrawal
  - Work with organisations to issue prescribing memoranda on particular medicines, such as co-proxamol, and use *Scriptswitch* messaging to support adherence to depression guidelines, support decision-making and issue warnings on the use of particular medicines
  - Write to all GPs, Consultants and non-medical prescribers in acute health and mental health settings outlining current evidence on medicines commonly used in completed suicides
  - Develop waste management strategies at GP practice and Community Pharmacy level for the return of unused medication.

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<sup>15</sup> National Institute for Health and Clinical Excellence (2010) *Neuropathic Pain: The pharmacological management of neuropathic pain in adults in non-specialist settings*. Clinical Guideline 96. London:NICE

## **Priority 8 – Criminal Justice**

8. To develop a 'Gold Standard' pathway between health and criminal justice agencies, such as the police and probation service, to ensure that people in crisis are supported effectively during and after their contact with those services

### *What this means*

- The Regional Suicide Prevention Steering Group will work with representatives from Tees, Esk and Wear Valleys Mental Health Foundation Trust to review police custody records for risk factors of suicide and screen a sample of individuals in relation to their contact with other criminal justice agencies

**PART THREE**

**THE REMAINING PRIORITIES: APRIL 2011  
TO MARCH 2015**

## 6.0 Priorities for 2011 - 2015

- 5.1 The priorities for years 2011 to 2015 have been identified by the Regional Suicide Prevention Steering Group and a consultation exercise which took place earlier this year.
- 5.2 The following paragraphs amount to a substantial list of potential interventions. These will need to be prioritised by the Regional Suicide Prevention Steering Group, by year of proposed implementation, and will be based on the following criteria:
- Cost effectiveness
  - Economies of scale
  - Outcomes reflecting value for money
- 5.3 The priorities are set out in alphabetical order

### **Priority 1 – Alcohol**

- The Regional Suicide Prevention Steering Group will:
  - Work with sub-regional Suicide Audit Groups to identify the number of suicides in which alcohol has been a factor. For example, in Middlesbrough, they identified that 60% of recent cases showed the presence of alcohol in toxicology reports
  - Work with relevant partners to develop a simple, comparable alcohol screening tool for use in Emergency Care departments which will also form part of bio-psychosocial assessments

### **Priority 2 – Bereavement Support**

- The Regional Suicide Prevention Steering Group will review the availability and cultural sensitivity of existing bereavement support programmes such as the one run by Chester-le-Street MIND

### **Priority 3 – Black and Minority Ethnic Groups**

- The Regional Suicide Prevention Steering Group will:
  - Work with HM Coroners to ensure that ethnicity is always recorded at inquest (to include reference to whether or not an individual is a Migrant, Gypsy or Traveller)
  - Work with those agencies representing asylum seekers, refugees, migrant workers, international students, gypsies and travellers to establish systems to collate data on self harm and suicide

#### **Priority 4 – Children and Young People**

- The Regional Suicide Prevention Steering Group will work with representatives from Children and Young Peoples' Services to:
  - Review the promotion and prevention agenda, in particular relating to the role of the family, peer groups, schools and colleges
  - Promote the use of screening tools (such as the Suicide Ideation Questionnaire (SIQ) and Suicidal Ideation Screening Questionnaire (SIS)) to identify those at risk and the associated development needs of the children and young peoples' workforce

#### **Priority 5 – Commissioning**

- The Regional Suicide Prevention Steering Group will seek to:
  - Influence current and emerging commissioning structures concerning the delivery of suicide prevention initiatives and resource identification, especially in relation to those vulnerable groups at high-risk of suicide
  - Assess the efficacy of established needs assessments/Joint Strategic Needs Assessments in relation to suicide prevention

#### **Priority 6 – Data Quality**

- The Regional Suicide Prevention Steering Group will work with sub-regional Suicide Audit Groups to:
  - Assess whether their systems for data collection are fit for purpose and the links they have with, amongst others, Criminal Justice agencies, Primary Care and Substance Misuse services
  - Review suicide audit toolkits to assess the viability of including a data collection field on medications present at time of death, whether they are the primary cause of death or not (as occurs in Tees, Esk and Wear Valleys NHS Foundation Trust)
  - Use local suicide audit data to identify high risk groups and localities and initiate research in those areas with low rates to explain the reasons behind those low rates
  - Liaise with the North East Public Health Observatory to assess the feasibility of collating data at a regional level
  - Develop robust reporting arrangements to share data with the National Confidential Inquiry into Suicide and Homicide and submit suggestions for future topics, for example the cases in contact with Improving Access to Psychological Therapy services

- Identify those cases with no history of self harm to enable better understanding of that client group
- Work with HM Coroners to ensure the timely release of data on possible suicides. This may also entail establishing links with a number of 'spotter' Coroners to aid the early identification of any perceived, emerging problems or clusters before inquests are completed and/or to identify new and emerging methods or hotspots
- The Regional Suicide Prevention Steering Group will support the development of systems to collate more rigorous data on self-harm, including via NHS Direct

### **Priority 7 – Economic Issues**

- The Regional Suicide Prevention Steering Group will liaise with Jobcentre Plus and the Improving Access to Psychological Therapies programme to support those affected by economic hardship. This will include assessing the viability of an early alert system to assess the impact of redundancy on suicidal behaviour. In essence, monitoring whether increases in the number of economically inactive people per locality has led to a proportionate increase in the suicide rate

### **Priority 8 – Knowledge Transfer**

- The Regional Suicide Prevention Steering Group will work with its partners to facilitate the development of a regional, multi-agency, standardised approach to Serious Untoward Incidents and Significant Event Audits (thus ensuring that lessons learned from such reviews are mainstreamed into service planning and delivery). We will share learning from the current NHS County Durham project where a bespoke Significant Event Audit form is being developed for cases of self harm and suicide

### **Priority 9 – Lesbian, Gay, Bisexual and Transgender groups**

- The Regional Suicide Prevention Steering Group will seek to improve the monitoring of data on Lesbian, Gay, Bisexual and Transgender (LGBT) groups. It will do this by:
  - Having a separate focus on Transgender issues and establishing a baseline suicide rate for people undergoing gender transition
  - Extending the coverage of *Stonewall LGBT Diversity Champions* and the *Workplace Equality Index* across the region
  - Assessing the impact of the Middlesbrough *LGBT Inclusion Award*

- Reviewing the lessons learned from the Brighton & Hove LGBT Strategy (2008). In particular:
  - o Development of Mental Health training for front-line staff to challenge discrimination and the perceived pathology of LGBT as a link between childhood sexual abuse and mental health;
  - o Development of a flexible referral system;
  - o Development of routine data collection systems to monitor numbers accessing services, especially those referred from GP practices and via Emergency Care departments to mental health services;
  - o Working with schools to develop policies to tackle homophobic bullying and encourage disclosure of sexuality

### **Priority 10 – Media**

- The Regional Suicide Prevention Steering Group will work with:
  - HM Coroners to advise the media on the responsible reporting of the methods used in completed suicides, particularly where those methods are new or unusual (such as with Charcoal Burning or Helium Inhalation)
  - The media to promote the use of Samaritans' guidelines on the reporting of mental health issues and suicide
  - The media to increase the number of positive, mental health related news stories

### **Priority 11 – Mental Health**

- The Regional Suicide Prevention Steering Group will take over the role of the Safer Care Group on Suicide Prevention once the Safer Care North East Strategy comes to an end in December 2011. This will enable the steering group to take forward initiatives specifically related to mental health services

### **Priority 12 – Older People**

- The Regional Suicide Prevention Steering Group will work with representatives from Older Peoples' Services to review access to crisis services for those over 65 years of age with 'at risk' illnesses such as a long-term physical health problem

### **Priority 13 – Prescribing**

- The Regional Suicide Prevention Steering Group will, in partnership with sub-regional suicide prevention groups/task forces, work with pharmacies to:

- Supply them with contact numbers for helplines and local community mental health and crisis intervention/home treatment teams
- Assess the viability of establishing flagging/alert systems and, in turn, links to needs assessment processes, for patients on methadone displaying behaviour changes (as occurs in the Fulcrum GP Practice in Middlesbrough)

#### **Priority 14 – Primary Care**

- The Regional Suicide Prevention Steering Group will work with Primary Care Organisations to consider:
  - Developing and providing specialist training in suicide prevention and seek opportunities for cost-effective training programmes on the detection and management of depression
  - Developing Local Enhanced Services Payments for a review of all suicides in primary care
  - Reviewing the application of assessment tools such as the Beck's Depression Inventory
- The Regional Suicide Prevention Steering Group will work with Primary Care to review existing PMS (Personal Medical Services) contracts to ensure that they are structured to manage the risk of suicide. The process may involve reviewing contracts to determine whether or not GPs retain responsibility for patients at-risk of suicide following non-crisis referrals

#### **Priority 15 – Prisons, Police, Probation and Youth Justice**

- The Regional Suicide Prevention Steering Group will, in partnership with criminal justice agencies:
  - Develop information sharing protocols for vulnerable prisoners released without licence
  - Improve understanding of the factors that heighten the risk of self harm and suicide amongst the offender population and develop methods to counteract these
  - Review support and treatment opportunities and embed these into action plans
  - Increase the accessibility of training programmes such as Mental Health First Aid and ASIST (Applied Suicide Intervention Skills Training)

- Strengthen offender care pathways based on National Offender Management Service (NOMS) guidance and Safer Custody policy
- Support the NE Prisons' Suicide Prevention Forum in their development of:
  - o Regional camera cell and safer cell protocols
  - o Health checks in all prisons based on the HMP Durham review of deaths in custody
  - o Shared learning and actions from Prisons and Probation Ombudsman reports
- Develop the role of the North East Safer Custody "Champion", who will take forward the Safer Custody agenda for North East prisons in his/her capacity as chair of the Prisons' Regional Forum
- Share learning from:
  - o The HMP Low Newton *Primrose Project* for its work with female offenders who pose a risk of serious harm because of a severe personality disorder
  - o The Mental Health Commissioners/NOMS/University of Durham project on women who self harm in HMP Low Newton
  - o The CARATs (Counselling, Assessment, Referral, Advice and Throughcare for those with a Substance Misuse problem) co-commissioning model and service specifications on transfers to secure settings and to the community

#### **Priority 16 – Public Health Settings**

- The Regional Suicide Prevention Steering Group will work with relevant partners to consider developing specific initiatives within educational, home and workplace settings

#### **Priority 17 – Rural Communities**

- The Regional Suicide Prevention Steering Group will work with agencies representing rural communities, such as the National Farmers' Union, to consider relevant suicide prevention initiatives within our region

#### **Priority 18 – Service People and Veterans**

- The Regional Suicide Prevention Steering Group will work with agencies representing Service People and Veterans to consider relevant suicide prevention initiatives within the North East.

This will include sharing good practice from the Tees, Esk and Wear Valleys NHS Foundation Trust Community Veterans Mental Health Service pilot which has recently received national recognition in the form of a Military and Civilian Health Partnership Award

### **Priority 19 – Smoking Cessation**

- The Regional Suicide Prevention Steering Group will work with FRESH North East to consider the effects of tobacco on serotonin functioning and, in turn, on suicide rates as well as the availability of Stop Smoking Services for those with mental health conditions

### **Priority 20 – Suicide Hotspots**

- The Regional Suicide Prevention Steering Group will work with:
  - Sub-regional suicide prevention groups/task forces to undertake an annual review of suicide hotspots within the region and help to maintain existing signage (which include the Samaritans contact number for those in crisis)
  - Local Samaritans' offices to increase the number of posters (containing helpline information) at railway stations and introduce training sessions for staff post-incident and for staff working in railway stations to help them to recognise suicidal behaviour

### **Priority 21 – Women**

- The Regional Suicide Prevention Steering Group will work with agencies representing women to consider relevant suicide prevention initiatives within the North East

### **Priority 22 – Young Men**

- The Regional Suicide Prevention Steering Group will work with all agencies to promote better engagement with young men and improve the accessibility of their services within our region

### **Contact details for further information**

- Neil Johnson, North East Mental Health Development Unit
- [neiljohnson@nhs.net](mailto:neiljohnson@nhs.net) or 0797 948 7034

## **Appendix A: Terms of Reference for Regional Suicide Prevention Steering Group**

### **REGIONAL SUICIDE PREVENTION STEERING GROUP TERMS OF REFERENCE – FINAL VERSION (For review October 2010)**

**The Regional Suicide Prevention Steering Group brings together key stakeholders in the North East Region to develop and deliver a regional suicide prevention strategy**

In delivering this function, the key tasks of the Steering Group will be to:

- Develop a regional suicide prevention strategy which adds value to existing sub-regional arrangements and supports the delivery of suicide prevention initiatives at a local level.
- Support delivery of the content of the regional suicide prevention strategy ensuring that the objectives of the strategy correspond to planned and existing strategies and policies, for example *Better Health, Fairer Health, Our Vision, Our Future, Safer Care North East* and Local Area and Multi-Area Agreements
- Ensure that 'high risk' localities are identified and receive special focus in all Task Force activities. This should include working with HM Coroners to ensure the timely release of data on possible suicides
- Influence the NHS and Local Authority commissioning of services for people in relation to suicide prevention in the North East that will deliver the strategy and identify resources
- Identify and assess the rigour of established needs assessment procedures and support processes (including Joint Strategic Needs Assessments)
- Make recommendations on the development of suicide prevention services and advise on the prioritisation of such developments to the Local Strategic Partnership Boards as well as to Government Office for the North East and Directors of Public Health
- Draw on the experience and expertise of existing sub-regional suicide prevention task groups and other national and regional policy streams to inform and influence the suicide prevention agenda in the North East

This will entail reviewing the Terms of Reference and reporting mechanisms of existing task groups with a view to standardising reporting arrangements and adopting a common language

- Provide a quarterly update to task groups on progress against the regional strategy and seek quarterly updates from task groups on current activity
- Review how Task Groups and Suicide Audit Groups collect data in relation to suicide and unexpected death, work with the North East Public Health Observatory (NEPHO) to collate and analyse data at a regional level and ensure that there are robust reporting arrangements in place to share data with the National Confidential Inquiry into Homicide and Suicide
- Encourage an SHA-led standardised approach to the management and operation of Serious Untoward Incidents/Significant Event Audits across the region. This should include the provision of guidance on types of unexpected death (including expected suicide) and the development of a common system for ensuring that findings become part of Governance structures (including reporting routes). This should also include establishing routes of communication with HM Coroners to ensure that key professionals (especially GPs) are informed of the death of their patient(s) so that they can begin the review process
- Develop a cross-service communications plan which will include a requirement for Task Groups to share information with one another and provide guidance on managing a sudden increase in cases

In addition, the Chair of the Steering Group will:

- Ensure a strategic fit between the objectives of the steering group and existing regional strategy and policy
- Ensure that organisational representatives are aware of their responsibilities regarding communication within their own organisation and networks and the benefit of building these Terms of Reference into their organisational Governance systems
- Allocate responsibilities to each member of the steering group
- Co-opt representatives from other organisations/agencies/groups, on invitation.

Members of the Steering Group will:

- Represent agencies likely to have the greatest impact on reducing the suicide rate within the North East
- Ensure that, when identified, work is actioned
- Report back to their existing networks (geographical and/or sectoral) about progress of the steering group

- Whilst representing and contributing on behalf of their organisation, operate as independent advisers and commit to working towards the maximisation of benefits for the region as a whole

### **Accountability**

The Steering Group will report to the Chief Executive Officer (CEO) Mental Health & Learning Disability Commissioning Group and Joint Investment Partnership (JIP). It will also seek to establish connections with other stakeholder groups impacting on suicide prevention. Pages 4 and 5 provide more detail in contrasting the current structure with the suggested one.

As the work of the Safer Care NE Suicide Clinical Group will have a bearing on the work of the steering group, it is expected that meetings of both groups will take place on the same day.

### **Meeting Arrangements**

The group will meet quarterly

### **Membership**

The membership of the Regional Suicide Prevention Steering Group comprises members drawn from across key agencies within the region. Membership will include the following:

- Chair (Regional MH/LD Commissioning Team – Brian Key)
- Vice-Chair (NEHMDU – Neil Johnson)
- Safer Care NE (Delcy Wells to deputise Emma Nunez)
- Public Health representation (Sue Milner)
- Mental Health North East (Lyn Boyd)
- Service user/carer representative (currently vacant)
- Child Health representative (currently vacant)
- Older Person's representative (currently vacant)
- Sub-regional Suicide Prevention Task Forces/Groups x3 (Tony Gray, Andrew Russell, Denise Colmer/Keith Linsley)
- Police (Superintendent Barbara Franklin)
- Probation (Keith Norman)
- Prisons (Clair Hutchings-Budd)
- ADASS (currently vacant)
- NHS Direct (Dave Cutler)

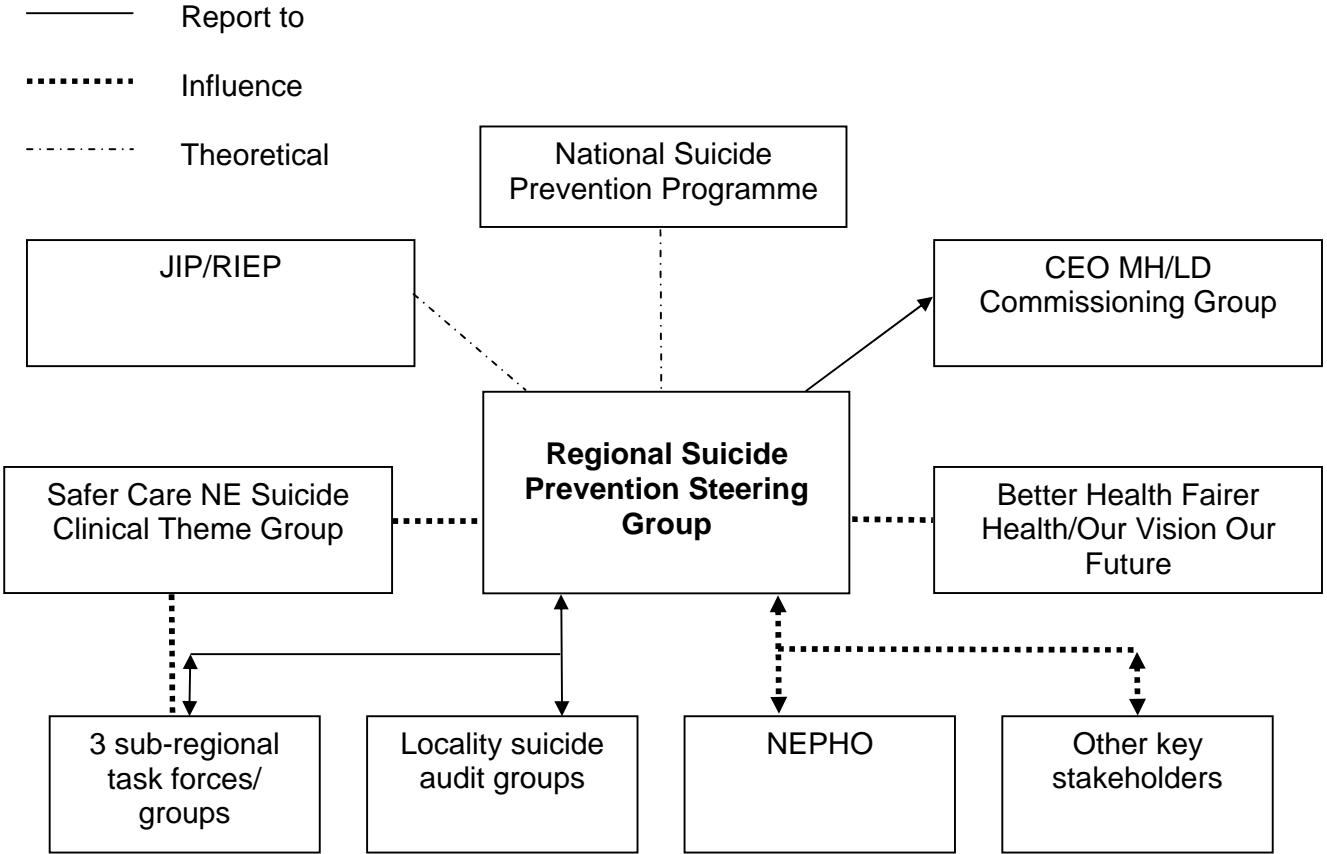
### **Co-opted members**

In addition to the core membership outlined above, the following organisations/people will attend meetings on invitation.

- Representation from Maternity Services
- Communications lead re: working with the media

- Migrant Health agenda (Alan Brice – Medical Foundation)
- Regional Pharmaceutical Committee/Heads of Medicines Management
- General Practice/Health Visiting
- Acute Care (Building Bridges – Alan Foster OR via Delcy Wells)
- Network Rail

Regional Suicide Prevention Strategy: Structure



## **Appendix B: Action Plan from Safer Care Group on Suicide Prevention**

### **OBJECTIVE**

**To reduce the number of suicides and unexpected deaths in people who are receiving secondary mental health services in the North East.**

### **GOALS**

- 1. To support local provider and commissioning organisations, and Suicide Prevention Groups in the Region, in targeted local work on suicide prevention in people who are in receipt of secondary mental health services.***
- 2. To improve the safety of care and treatment of people who are receiving secondary mental health services.***

### **INITIATIVES**

1. Agree and confirm the Terms of Reference of the Safer Care Group on Suicide Prevention and the Regional Suicide Prevention Strategy Steering Group, setting out in each details of cross membership, communication and reporting arrangements and showing how joint or linked objectives will be agreed and delivered. Similarly agree and confirm cross membership, communications and reporting arrangements with the Mental Health Clinical Innovation Team.
2. Support the Regional Suicide Prevention Strategy Steering Group as required in developing the Regional Strategy; specifically, scope existing education and training modules for staff in relation to suicide prevention, identify which modules are the most effective, and develop an education and training strategy which will form part of the wider strategy.
3. Support improvements in communications and risk assessment by:
  - a. Determining the potential benefits for managing and reducing risk in the use of the SBARD (Situation, Background, Assessment, Recommendation, Decision) structured communications and handover system, following the current pilot at Tees, Esk and Wear Valleys NHS FT.
  - b. Reviewing the functionality, coverage, usage and training for staff in relation to the IT systems operating currently in the two mental health Trusts, and optimizing multi-disciplinary communications about patients, their treatment and current risk assessment using these systems.

- c. Agreeing the elements of a Gold Standard IT system which would overcome the limitations of existing systems and optimise multi-disciplinary communications within each Trust, across Trusts (including acute Trusts and the Ambulance Trust) and with primary care and NHS Direct, and establishing effective working links with IM&T planning across the Region to ensure that these elements are understood, discussed and included in future strategic IM&T plans.
4. Review the current audit programmes in both mental health Trusts, identify potential gaps in the programmes and agree how these will be addressed by the Trusts; identify lessons emerging from the audits that are relevant to suicide prevention, monitor implementation of actions agreed, and note in future audits whether improvements have been effective and should be adopted more widely.
5. Develop a Global Trigger Tool for mental health drawing on the current national pilot in which Tees, Esk and Wear Valleys NHS FT is participating.
6. Develop a plan for the local delivery of training in situational awareness and Human Factors to crisis teams and other relevant staff; and determine whether a Train the Trainer approach would be effective. Northumberland, Tyne and Wear NHS Trust have agreed to have all their crisis teams trained in the next two years.
7. Review the safety culture audit tools available and develop a plan to audit safety culture; include in this an audit of clinician attitudes to the inevitability of suicide.
8. Review the impact of training in risk assessment in terms of the confidence achieved by staff who undertake this training in taking forward actions to mitigate risk.

## **MEASURES**

1. Terms of Reference for Safer Care Group and Regional Suicide Prevention Strategy Steering Group, showing working relationship between the two Groups (structural measure).
2. Education and training for suicide prevention reviewed by the end of March 2010 (process measure).
3. Qualitative evaluation of SBARD tool (process measure).
4. Action plan to optimise use of existing IT systems (process measure).
5. Effective links with IM&T strategic planning (structural measure).
6. Qualitative evaluation of Trust audit programmes (process measure).

7. Qualitative evaluation of Global Trigger Tool (process measure).
8. Plan for roll out of training in Human Factors (process measure).
9. Audit tool to assess safety culture, and in due course, results of audit (process and outcome measures).
10. Qualitative evaluation of risk assessment training (process measure).
11. Ongoing monitoring of Serious Untoward Incidents (SUIs) and National Reporting and Learning System (NRLS) data relating to suicide and unexpected death, and qualitative data on root causes and lessons learned (impact and process measures).
12. Annual audit of patient and carer satisfaction carried out by the Care Quality Commission (impact measure).
13. Death rates by suicide from 1995/96/97 (3 year rolling data – outcome measure).