NHS Greater Glasgow and Clyde

Board Meeting
(17th April 2012) **Board Paper No. 12/14**

Director of Public Health

SUICIDE PREVENTION IN GREATER GLASGOW AND CLYDE

Recommendations:

The Board is asked to:

- Note the contents of this suicide prevention update paper, including analysis of the scale and complexity of the challenge, the policy context and a summary of progress in addressing this issue

- Note that a new GGCNHS Suicide Prevention Group is being formed in April 2012 which will review progress and develop recommendations to strengthen the overall approach, in conjunction with the contributions of wider partners being progressed through local Choose Life Programmes.

1. Executive Summary

- Suicide is a complex and challenging public health issue which has strong association with deprivation. It requires concerted and sustained effort from a wide range of partners
- Despite some decline in suicide rates for Greater Glasgow and Clyde over the last decade, this has been modest, compared with national and international trends
- There is thus a need to review of the strengths and weaknesses of the current approaches and a refocusing of efforts in line with identified priority actions
- The paper sets out four linked areas of activity, ranging from direct suicide prevention activity within clinical services, community based prevention programmes through to action to address underlying determinants
- A new NHS Greater Glasgow and Clyde suicide prevention group will provide additional impetus to this agenda in terms of coordination of effort, linking with the Choose Life programmes that are active in each of the six Community Planning Partnerships in Greater Glasgow and Clyde

2. Introduction: nature and scale of the challenge

The purpose of the paper is to provide an overview of suicide prevention and its policy content, an update on progress across the Board area and a summary of future approaches, challenges and opportunities.

Suicide represents a major public health issue, and a complex social challenge, requiring action from multiple agencies, both locally and nationally. Suicide has a

substantial emotional impact for individuals and families affected and for staff and service providers who had been involved in caring for individuals. Across the age ranges, suicide has a disproportionate impact on men, with approximately three male suicides for every female suicide. It is well-documented[1] that a range of factors such as living in an area of deprivation, previous history of mental health problems, addictions problems or a previous history of self harm can all contribute to risk of suicide.

In a recent scientific paper, Mok *et al* have highlighted that despite some declines in the Scottish suicide rate over the last decade, the rate in Scotland is still approximately 80% higher than the rate in England and Wales[2] – with the scale of addictions problems being cited as one of the potential drivers of this difference, along with factors such as deindustrialisation.

Within Glasgow, suicide appears to be one of the complex of issues that contributes to the "Glasgow Effect" of excess mortality. This research project overseen by the Glasgow Centre for Population Health, is comparing the health experiences of 3 similarly disadvantaged cities (Glasgow, Liverpool and Manchester); a key finding is that for 0-64 years, suicide contributed 11.2% of the excess deaths experienced in Glasgow.[3]

It is well documented that the global financial crisis and economic downturn can be predicted to create an upward pressure on suicide rates, based on international studies. This may well take several years to fully express itself through routine statistics, given that the personal and family consequences of the recession may persist well after the ending of the recession at macro-economic level. For example, a study by Dr David Stuckler and colleagues published in the Lancet in 2009[4], examining trends in 26 EU Countries found that for every 1% increase in unemployment level there was a 0.79% rise in the suicide rate among people aged under 65 years.

Scottish suicide figures are released in August of each year, providing data for the previous calendar year, and standard practice is to analyse 3-year rolling averages, given the degree of fluctuation year on year.

Greater Glasgow and Clyde area has seen a significant, but modest reduction in suicide rates over the last decade. Despite significant concerted effort, the decline in rates in Greater Glasgow and Clyde has been more modest than the decline in rates for Scotland as a whole. Comparing European age standardised rates for 1996-2000 with 2006-2010, the rate in Scotland declined by 10.7%, whereas the rate in GGC declined by 5.2%. At a more local level, the picture is more complex: there has been a very mixed pattern in terms of changes of suicide rate over the last series of

[1] See for example, Review of Risk and Protective Factors for Suicide and Suicidal Behaviour: http://www.scotland.gov.uk/Publications/2008/11/28141444/0

[2] http://bjp.rcpsych.org/content/200/3/245.abstract?etoc

[3] http://www.gcph.co.uk/assets/0000/0087/Investigating_a_Glasgow_Effect_for_web.pdf

[4] Reported here: http://news.bbc.co.uk/1/hi/health/8138015.stm

reporting periods for the local authorities in Greater Glasgow and Clyde. Some show decreases, some unchanged and some show increases in rates.[5]

Table 1. Deaths caused by intentional self harm by NHS Board and time period: Persons

Numbers				
Both sexes combined				
	1991-1995	1996-2000	2001-2005	2006-2010
Greater Glasgow and Clyde	1172	1161	1087	1109
Scotland	4081	4350	4177	3973

Table 2. Deaths caused by intentional self harm by NHS Board and time period: Persons

European Age- Sex-Standardised rates				
Both sexes combined				
	1991-1995	1996-2000	2001-2005	2006-2010
Greater Glasgow and Clyde	18.6	19.1	17.9	18.1
Scotland	15.8	16.9	16.2	15.1

Data from Tables 1 and 2 available from http://www.scotpho.org.uk/health-wellbeing-and-disease/suicide/data/nhs-board

As noted above, suicides in have to be understood in the context of stark inequalities, where Greater Glasgow and Clyde performs significantly worse on practically all 41 indicators of mental health, with particularly high rates of depression in women and anxiety in men. Suicide rates also have to be understood in the context of alcohol and drug harm particularly in deprived areas. Table 3 below shows the pattern of suicides at a Scottish level analysed against the Scottish Index of Multiple Deprivation. This shows that most of the progress in Scotland in terms of reduced suicide rates has been amongst the least deprived categories of population.

Table 3. Deaths caused by intentional self harm and events of undetermined intent by Scottish Index of Multiple Deprivation 2009 Version 2: Persons

	Numbers			European age- sex-standardised rates	
Both sexes combined - Scotland					
	2001-2005	2006-2010		2001-2005	2006-2010
10 (least deprived)	192	197		7.2	7.3
9	207	182		7.8	6.4

[5] Scottish Public Health Observatory website – suicide data pages http://www.scotpho.org.uk/health-wellbeing-and-disease/suicide/key-points

8	280	275		10.8	10.2
7	304	307		11.8	11.4
6	383	361		14.6	13.3
5	391	377		15.1	14.1
4	452	441		17.3	16.8
3	489	506		19.0	19.6
2	559	568		21.9	22.6
1 (most deprived)	802	759		31.8	30.5
Unknown	118	-			
Scotland	**4177**	**3973**		**16.2**	**15.1**

Data from Table 3 available at: http://www.scotpho.org.uk/health-wellbeing-and-disease/suicide/data/deprivation

All these factors have been explored in detail in a major population mental health profile for the Greater Glasgow and Clyde (*Mental Health in Focus*[6]), produced by the Glasgow Centre for Population Health in 2011. This report shows that people living in the most deprived quintile of Greater Glasgow and Clyde experience a suicide rate 75% higher than the Health Board average.

3. National policy context

Since 2002, the Scottish Government has overseen a strategy approach to the suicide prevention agenda via the Choose Life Strategy and Action Plan, emphasising the responsibilities of Community Planning Partners to address this public health challenge, and through allied developments within the *Delivering for Mental Health* agenda. There have been significant moves to strengthen suicide prevention efforts across frontline services, including through introduction of HEAT target H5, requiring training in suicide prevention skills for 50% of key frontline staff.

In late 2010 the Government launched an updated strategic approach to suicide prevention, 'Refreshing the National Strategy and Action Plan to Prevent Suicide in Scotland'[7]. This document set out 6 priority objectives for continued action, highlighted in the table below:

Refreshing the National Strategy and Action Plan to Prevent Suicide in Scotland – 6 Priority Objectives	
Objective 1	Identify and intervene to reduce suicidal behaviour in high risk groups
Objective 2	Develop and implement a coordinated approach to reduce suicidal behaviour
Objective 3	Ensure interventions to reduce suicidal behaviour are informed by evidence from research and evaluated appropriately
Objective 4	Provide support to those affected by suicidal behaviour
Objective 5	Provide education and training about suicidal behaviour and promote

[6] http://www.gcph.co.uk/publications/284_mental_health_in_focus

[7] http://www.scotland.gov.uk/Publications/2010/10/26112102/13

	awareness about the help available
Objective 6	Reduce availability and lethality of methods used in suicidal behaviour

This document also provided a valuable summary of the progress of the national suicide prevention programme, and key landmarks over recent years. This includes summary of the conclusions of evaluations of the Choose Life programme, such as the phase 2 programme evaluation.[8]

4. Key Action Areas

Responding to suicide cannot be seen as an isolated challenge and requires a multi-agency response, plus engagement with the public. Within Greater Glasgow and Clyde, the Health Board is working closely with many partners to advance the suicide prevention agenda, embedding this in a wider body of work aimed at promoting mental health and wellbeing for the population. This activity can be categorised into four interlocking areas:

A. Direct clinical service approaches to suicide prevention
B. Dedicated suicide prevention activities in community settings
C. Wider mental health improvement programmes
D. Action on underlying determinants.

A brief note is provided below on each of these activity areas, and further details are available as required.

A . Direct clinical service approaches to suicide prevention

One of the most notable areas of action and progress among clinical and allied services has been the large scale training of key frontline staff, in line with the HEAT 5 national target. Across Greater Glasgow and Clyde nearly 4000 staff were trained in suicide prevention skills, exceeding the 50% target within the designated period (i.e. by December 31st 2010). Since then, a detailed training plan has been put in place to ensure that the numbers of staff trained remain above the 50% level, and this work is proceeding on target.

Many of the mental health service modernisations across Greater Glasgow and Clyde over the past years have brought a specific focus on suicide prevention as a core part of their rationale. Examples include the establishment of Crisis Teams, the enhancement of the range of community based services, including the establishment of Primary Care Mental Health Teams, Patient Safety Forums and critical incident review processes, adoption of recovery-oriented services, enhancements in approaches and environments for in-patient care, and services such as Esteem, providing early intervention at the onset of psychosis.

In additional to training a significant number of Accident and Emergency Services staff in suicide prevention, one new initiative in this setting is development and piloting of an information resource to support this work in a number of A&E departments in GGC hospitals.

[8] Choose Life Phase 2 Evaluation Report:
http://www.scotland.gov.uk/Publications/2010/03/30174735/0

Addictions services have played a prominent role in this agenda, often being at the forefront of delivery of training to frontline staff, and working with other services to devise better means of supporting people with co-morbidities.

There is significant further development required in the clinical services agenda to enhance suicide prevention, including further development of clinical pathways and inter-service liaison work, and the new GGCNHS suicide prevention group will be a key vehicle for progressing this agenda (see below).

Also of vital importance is staff health and wellbeing. Mental health has been designated as one of the priority issues on the Joint Staff Health Action Plan and a package of policies and support measures are in place in this regard. Mental health also forms a significant element of the Healthy Working Lives award, relevant both within the NHS and with the work with external employers.

B. Dedicated community-based suicide prevention work

Since the establishment of the national Choose Life programme, there have been multi-agency Choose Life programmes in each of the six Community Planning Partnership areas of Greater Glasgow and Clyde, representing a range of innovative approaches with communities. This body of work has recently been summarised in an information and discussion paper[9] (Annex 1). Highlights of this work include extensive delivery of training across many agencies and groups (including active support for achievement of the HEAT 5 target), community awareness raising initiatives, developments in many areas in school settings, including policy development, training, support for counselling and other services, and work on the self harm agenda.

As part of the Glasgow City programme, joint work with NHS Health Scotland created the North and East Glasgow Suicide Prevention Partnership, which has had a remit to develop a body of work focused on prevention with and for disadvantaged communities. This was in response to the identification of this area as having one of the highest rates of suicide. The programme has worked with local services, community agencies and communities themselves to devise new approaches. One of these is the NAEdrama project, working with local young people and a film production company to produce a suite of films aimed at raising awareness of suicide prevention among young people. These are now available on the NAEdrama YouTube channel, with over 2000 web hits to-date.

There is a need to consider the needs of the whole population and of the diversity of communities within the Board area in devising response to suicide risk and wider mental health needs. It is vital to work with 'local intelligence' with communities and partner agencies and utilise wider research into needs, as nationally available statistics may not always have sufficient detail to highlight areas of concern.

In this regard, there has been a strong focus on inequalities and equalities related work programmes in Greater Glasgow and Clyde, often with an overt focus on suicide prevention. This includes the work of the Compass team providing mental health care for asylum seekers and refugees, the Sanctuary programme which has also addressed the mental health needs of this population, an annual Festive Overdose Prevention campaign, which has been highly successful in reaching

[9] Suicide Prevention in Greater Glasgow and Clyde: Public Mental Health Briefing Paper, Lee Knifton and Trevor Lakey, GGCNHS, 2012

vulnerable groups at risk of both drugs overdose and suicide, providing practical support such as first aid and overdose prevention and suicide prevention inputs.

There is a clear need to continue the public awareness aspects of suicide prevention – encourage people to talk, to support those around them and to seek help. For example a poll of around 1000 adults conducted as part of the 2011 Choose Life Survey for NHS Scotland showed that 46% of people would not directly ask someone who was showing signs of considering taking their own life if they were suicidal.[10]

C. Wider development of population mental health improvement approaches
Embedding suicide prevention work as part of wider efforts to promote population mental health and wellbeing, and to build resilience, is seen as crucial. Greater Glasgow and Clyde NHS is giving increasing priority to promotion of mental health, through a variety of linked initiatives and developments. The 2011 Director of Public Health's report, *'Keeping Health In Mind'* presented at the December 2011 Board meeting, provided a major focus on mental health, emphasising the importance of this issue across the life-course, with a body of recommendations to be advanced. Earlier in the year a Strategic Mental Health Improvement Framework, *'No Health Without Mental Health'* was completed and disseminated to relevant local planning structures, to guide further development in this field.

One example of a mental health improvement programme in the Greater Glasgow and Clyde area is our initiation of and continued support for the Scottish Mental Health Arts and Film Festival[11] – with over 120 events in our Board area in 2011, and planning underway for the October 2012 festival, to be launched in Renfrewshire. Another very promising area is that of assets-based approaches to promoting mental health. One current example of this is being progressed in East Dunbartonshire, learning about the support resources and community assets that can promote recovery, directly from people who have experienced mental health problems[12].

D. Wider action to address underlying determinants (inequality dimensions to the fore)
As noted in section 1 above, wider social and economic factors have a major bearing on suicide rates. Local and national governments and many other players have roles and responsibilities to respond to the challenge of suicide. However, the NHS has a significant contribution to make to work which addresses underlying determinants of poor mental health and of suicide risk. One key task is to monitor impact of the financial climate on public health and ensure this intelligence fed into future prioritisation and planning systems to advocate for wider change. Other areas where NHSGGC is active include contributions to local community regeneration work, anti-poverty and financial inclusion programmes and employability initiatives.

This latter area is particularly relevant, given that the research of Stuckler *et al*[13] highlighted that active labour market programmes ameliorated impact of unemployment on suicide rates. GGCNHS is well placed in this area, being involved

[10] Report of Choose Life Survey from September 2011 http://www.bbc.co.uk/news/uk-scotland-14779653

[11] Details at http://www.mhfestival.com

[12] http://www.iriss.org.uk/resources/using-assets-approach-positive-mental-health-and-well-being

[13] Reported here: http://news.bbc.co.uk/1/hi/health/8138015.stm

with its partners in a range of employability programmes, including those focused on the needs of clients with mental health and addictions problems.

5. Next Steps and Further Progress

As noted above, despite significant multi-agency effort, the decline in suicide rates in Greater Glasgow and Clyde over the past decade has been modest. This highlights a need to take stock of the current approaches and evidence of their effectiveness, to address any gaps in service responses or supports, and to increase the focus on priority groups. Given the evidence summarised above, one area of further exploration will be the degree to which suicide should be considered as part of a cluster of issues linked closely to deprivation (also including impacts such as obesity, depression, low levels of exercise, addiction problems and so forth).

In order to provide overall coordination of the suicide prevention effort, the Board is establishing a new Suicide Prevention Group, which commences its work on 27th April 2012. This group will work in close partnership with the six Choose Life Programmes operating in the Board area, and with the national Choose Life Programme. Its functions will include collating and reviewing data on trends and risk factors, development of recommendations for priority actions and for coordination across relevant services, overseeing a continued programme of training for frontline staff, and disseminating good practice approaches.

The group will develop proposals for a strengthened suicide prevention approach by November 2012 and present these back to the Health Board.

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