Northumberland Multi-Agency Suicide Prevention Strategy 2017 – 2022 Refreshed Sept 2019

Northumberland Suicide Prevention Strategy was produced July 2017 and has been reviewed Sept 2019 to:

- Update data
- Reflect progress
- Reflect new guidance and publications
- Reflect new governance arrangements
- Reflect new structures in the NHS

As a result of this review, three workstreams:

- Suicide prevention
- Crisis care and
- Mental health promotion

will be brought together to form a Better Mental Health and Suicide Prevention Strategy, with three separate action plans to facilitate monitoring and reporting.

Foreword

As Elected Member Champion for Mental Health in Northumberland, I am pleased to endorse this refreshed Northumberland Suicide Prevention Strategy.

Suicide has an immense impact on family, friends, work colleagues and the wider community at both an emotional and economic level and I am pleased to report Northumberland is taking a proactive approach to mental health issues.

The refreshed strategy brings together three strands of work: suicide prevention crisis care and mental health promotion I endorse this approach so we have a co-ordinated Better Mental Health and Suicide Prevention Strategy and action plan to help protect the most vulnerable in society. Under the leadership of the Director of Public Health I look forward to supporting this important work stream.

Councillor Trevor Cessford

EXECUTIVE SUMMARY

Northumberland Multi-Agency Suicide Prevention Strategy adopts a "Zero Suicide Ambition – Every Life Matters" approach.

Suicide remains a national and local public health priority. It has an immense impact on family, friends, work colleagues and the wider community at both an emotional and economic level.

Table 1 below shows Northumberland's suicide prevention profile, produced by Public Health England in 2018. This shows Northumberland as having higher than average suicides amongst 35-64 year olds and high years of life lost. Suicide prevention is, therefore, a priority for Northumberland

Table 1.

Indicator	Period	Northum'land			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Suicide: age-standardised rate per 100,000 population (3 year average)	2015 - 17	–	66	16.6	16.8	14.7	9.0		32.1
Suicide: age-standardised rate per 100,000 population (3 year average)	2015 - 17	–	82	10.0	10.8	9.6	6.1		17.9
Suicide: age-standardised rate per 100,000 population (3 year average)	2015 - 17	–	16	3.8	5.0	4.7	2.6		11.5
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average)	2012 - 14	–	104	45.4	42.6	31.9	10.7		62.6
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average)	2012 - 14	–	85	74.6	69.9	50.2	16.4		101.6
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average)	2012 - 14	–	19	16.6	15.8	13.7	-	*Insufficient number of values for a spine chart*	-
Suicide crude rate 10-34 years: per 100,000 (5 year average)	2013 - 17	–	29	13.9	13.4*	10.5	3.3		22.2
Suicide crude rate 35-64 years: per 100,000 (5 year average)	2013 - 17	–	82	26.0	25.7*	20.1	8.0		43.6
Suicide crude rate 65+ years: per 100,000 (5 year average)	2013 - 17	–	14	8.4	10.6*	12.4	2.6		34.9

Source. Public Health England Fingertips data. Suicide prevention profile.
Note. Rows 1 - 3 and 4 - 6 and are for males, persons and females respectively.

Northumberland Public Health Team undertook a suicide audit 2018. Whilst the number of deaths audited was relatively small (29) key findings from the audit were:

- Of the 29 suicides identified from the Coroners Records, 93% were men, this reflects the national data. Suicides were highest among 45-49 year old men and 74% of the male suicides occurred among 15 - 49 year olds.

- The most common method of suicide for this audit cohort was hanging (69%). Most deaths (69%) occurred in the person's own home.
- 70% of suicide cases had a history of mental health problems, most commonly anxiety and depression. The majority had made contact with either their GP or mental health services. In some cases recent life events such as bereavement or the breakdown of a relationship had triggered episodes of severe mental health problems and people feeling they were unable to cope. In other cases people had battled with severe mental health problems over many years often dropping in and out of services. There was evidence of chaotic lifestyles; those with long histories of mental ill health sometimes also had coexisting drug and/or alcohol misuse.
- 5 of the 29 cases had a history of previous self harm or having thoughts of self harm; almost a third had attempted suicide previously.
- No deaths occurred within a prison setting.
- Information on employment and income was not consistently available so these risk factors could not be reported.

In summary, there is little from this audit that suggests the risk factors for suicide in Northumberland differ from those nationally.

The case definition for inclusion was that the case:

- died between 1 January 2017 and 31 December 2017;
- the inquest was carried out by one of the two Northumberland coroners;
- had a conclusion of suicide;
- open and narrative conclusions where the circumstances of death included the possibility that the deceased could have taken their own life;

This audit relied completely on coroners' records. Where the death is determined beyond reasonable doubt to have been intentionally self-inflicted, the coroner assigns a suicide verdict; where this cannot be established beyond reasonable doubt, an open or narrative verdict is given. The death cannot be registered until the inquest is complete. Statistics on causes of death produced by the Office for National Statistics (ONS) are based on the information provided at death registration.

Recent case law has changed the standard of proof from 'beyond reasonable doubt' (the criminal standard) to 'on the balance of probabilities' (the civil standard) and this is the approach that Coroners should now be following in practice, although the decision is currently the subject of judicial review. Some estimates suggest that this change in the standard of proof will increase deaths attributable to suicide by 30 - 50%.

Background

Suicide is often the end point of a complex history of risk factors and distressing events, but there are many ways in which services, communities, individuals and society as a whole can help to prevent suicides. A strategic approach to suicide prevention has to be multifaceted

in order to secure the best outcomes for the population. This strategic plan outlines a shared approach to preventing suicide and has a clear ambition to identify vulnerability in people and across environments; ensure effective collaborative working across agencies; and work alongside related national and local strategies such as the Mental Health Task Force's *Five Year Forward View for Mental Health*[1], and the *Northumberland Mental Health Action Plan*.

Since publication of Northumberland's strategy, a number of new documents have been published including:

- Prevention Concordat for Better Mental Health (2017)
- Strengthening the Front Line (May 2019)
- Cross-Government Suicide Prevention Workplan (Jan 2019)

This refreshed strategy reflects the recommendations and guidance included in these documents and other developments including the establishment of the Integrated Care System and its Mental Health and Suicide Prevention Workstream.

Much progress has been made with the suicide prevention action plan, additional funding through the sub-regional suicide prevention group will have a tangible impact on the provision of postvention support, training and suicide surveillance. This is accompanied by more upstream public mental health activities such as the development of emotional wellbeing and resilience in younger people; the Mental Health Trailblazer; and the development of a whole school approach to good mental health, starting with a supported network of school mental health leads.

The National Suicide Prevention Strategy prioritises: [2]

- Working in partnership with local government to embed their local suicide prevention plans in every community.
- Delivering our ambition for zero suicide in mental health inpatients and improving safety across mental health wards and extending this to whole community approaches.
- Addressing the highest risk groups including middle-aged men and other vulnerable groups such as people with autism and learning disabilities, and people who have experienced trauma by sexual assault and abuse.
- Tackling the societal drivers of suicide such as indebtedness, gambling addiction and substance misuse and the impact of harmful suicide and self-harm content online
- Addressing increasing suicides and self-harming in young people.
- Providing support for those bereaved by suicide.

[1] Mental Health Taskforce (2016). The Five Year Forward View for Mental Health. February 2016.
[2] HM Government. Preventing Suicide England: Third Progress Report of the cross government outcomes strategy to save lives (2017) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/582117/Suicide_report_2016_A.pdf

The National Suicide Prevention Strategy was updated in 2017 to strengthen delivery of its key areas for action, including expanding the scope of the strategy to include addressing self-harm in its own right. Self-harm is a key risk of suicide across community, hospital and custodial settings. Northumberland suicide prevention group members have agreed that addressing increasing levels of self-harm is a key issue for all delivery partners.

Local position

The **latest data on suicides in Northumberland** is summarised in Table 1 (pg 3). Whilst the 3 year rolling figures have fluctuated since 2001-2003, the rate has stayed roughly the same overall. However, the years of life lost through suicide is higher than the national average which reflects deaths in younger men.

There is a plethora of national guidance on suicide prevention and along with public mental health it is a key area of public health activity in the county. A county wide suicide prevention strategy and action plan is augmented by regional and sub-regional work under the auspices of the Integrated Care System (ICS) and the public health led regional Public Mental Health Network.

The Northumberland Suicide Prevention Strategy reflects the framework of the national cross-government strategy *Preventing Suicide in England. A cross government outcomes strategy to save lives.*[3] It uses the same six priority areas of action outlined in the national strategy. These priority areas have ambitions to:

1. **Reduce the risk of suicide in high risk groups;**
2. **Engineer approaches to improve mental health in specific groups;**
3. **Reduce access to the means of suicide;**
4. **Provide better information and support to those bereaved or affected by suicide;**
5. **Support the media in delivering sensitive approaches to suicide and suicidal behaviour;**
6. **Support research, data collection and monitoring.**

Using these areas for action, the strategy identifies the main issues we need to understand and manage in order to support vulnerable individuals who are at risk of suicide. The strategic plan will help to secure a whole system approach in identifying, understanding and preventing suicide and self-harming behaviours across high risk groups and improve resilience across populations.

[3] HM Government/DH (2012). Preventing suicide in England. A cross-government outcomes strategy to save lives. HMG/DH. 10 September 2012.

INTRODUCTION

"Suicide is often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity." Professor Louis Appleby CBE

What do we mean by suicide?

The ONS definition of suicide includes all deaths from intentional self-harm for persons aged 10 years and over, and deaths where the intent was undetermined for those aged 15 years and over.[4] Throughout the rest of this analysis, these deaths will be referred to as suicides. The differentiation between suicides and injuries of undetermined intent is one of intention; a death is classified as suicide when the intention to commit suicide is made plain, either by methodology or via the leaving of some form of intention (i.e. a note or verbal suggestions that a suicide attempt might be made). Injuries of undetermined intent are deaths due to injuries where the intention to commit suicide is suspected but where there is no evidence of intent. The data also includes those records coded where the cause of death is due to a condition caused by an attempt to self-harm or an injury of undetermined intent.

In England and Wales, all suicides are certified by a coroner following an inquest. The death cannot be registered, and therefore ONS are not notified until the inquest is completed. Currently, a conclusion of suicide must meet the "higher" standard of proof, that is, that the coroner or jury are sure, to the higher standard, that the person took their own life and intended to do so.

How can we better understand suicide?

A significant factor in prevention is understanding the complex interplay between a person's environment and their vulnerability, the consequence of which could be suicide. Various factors around an individual in relation to how they relate to their own sense of self, their relationships, their community and society as a whole, will influence their behaviours. This interplay is critical in relating the individual to their sense of health and wellbeing, in addition to their capacity to ask for and receive help when required.

Long term vulnerability can increase the risk of someone having suicidal thoughts and Figure. 1 illustrates how circumstances from before birth up to suicide might influence an individual's decision to attempt suicide and the outcome of an attempt.

[4] In 2016, the suicide definition was revised to include deaths from intentional self-harm in children aged 10 to 14. Deaths from an event of undetermined intent in 10-14-year-olds are not included in suicide statistics, because although for older teenagers and adults it is assumed that in these deaths the harm was self-inflicted, for younger children it is not clear whether this assumption is appropriate.

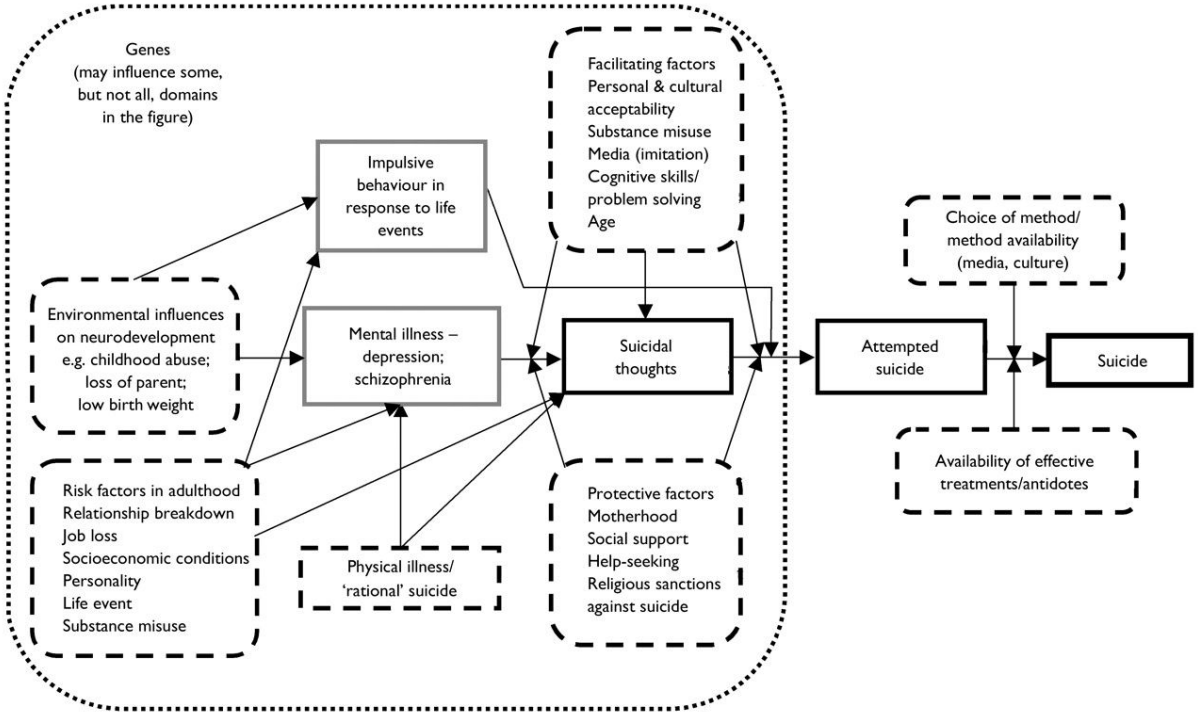

Figure. 1 Influences on suicide over the life course[5]

A collective approach to supporting these individual and broader relationships is pivotal in the context of managing vulnerabilities and behaviours.

NATIONAL STRATEGY

In September 2012 the Department of Health produced the national suicide prevention strategy *Preventing Suicide in England: A cross government outcomes strategy to save lives*. This strategy outlined an approach to suicide prevention which recognised a requirement for a multifaceted approach to suicide prevention and described an intention for collaborative cross sector innovations. The strategy offered national objectives and updated 'areas for action' as well as highlighting the responsibility for a local planning approach to be developed to implement work on suicide prevention. Subsequent to the national strategy, Public Health England published guidance on local suicide prevention planning[6] and this local strategic plan reflects the expectations of both documents.

The headline action areas to support the proposed framework for Northumberland follow the six identified headline areas of the National Strategy. These are:

- **Reduce the risk of suicide in high risk groups:** From 2011-2015, for around 7 in 10 (13,232) suicides, an occupation was provided at the time of death registration:

[5] Gunnell D, Lewis G. Studying suicide from the life course perspective: implications for prevention. BJ Psych. Sep 2005, 1887 (3) 206-208.
[6] PHE (2016). Local suicide prevention planning. A practice resource. PHE. October 2016

Males working in the lowest-skilled occupations had a 44% higher risk of suicide than the male national average; the risk among males in skilled trades was 35% higher. The risk of suicide among low-skilled male labourers, particularly those working in construction roles, was 3 times higher than the male national average.The risk of suicide in culture, media and sport occupations was 20% higher for males and 69% higher for females; risk was highest among those working in artistic, literary and media occupations.

For females, the risk of suicide among health professionals was 24% higher than the female national average; this is largely explained by high suicide risk among female nurses.

Male and female carers had a risk of suicide that was almost twice the national average.

Managers, directors and senior officials – the highest paid occupation group – had the lowest risk of suicide. Among corporate managers and directors the risk of suicide was more than 70% lower for both sexes.

Other high risk groups include:

- young and middle aged men.
- people in the care of mental health services (including inpatients).
- people with a history of self-harm; (although self harm is not necessarily a precursor to suicide).
- people in contact with the criminal justice system.

- **Engineer approaches to improve mental health in specific groups:** Specific groups are identified as vulnerable children and young people; survivors of domestic abuse or violence; veterans; people living with long-term physical health conditions; people with untreated depression; people who are especially vulnerable due to social and economic circumstances; people who misuse or have a dependency on drugs or alcohol; people identifying themselves as lesbian gay bisexual transgender questioning (LGBTQ) and people from black and minority ethnic (BAME) groups.

- **Reduce access to the means of suicide:** It is important to work collectively to recognise high risk environments or the potential ease of access to means of suicide and effectively manage these risks. The methods of suicide more easily managed through preventative interventions are: hanging and strangulation in psychiatric inpatient and criminal justice settings; self-poisoning; those at high-risk locations; and those on the rail networks. It is also important to be vigilant and respond to new or unusual suicide methods.

- **Provide better information and support to those bereaved or affected by suicide:** These are identified as those individuals who are directly affected by someone's suicide, as well as people in close relationships with the deceased. This group would also include train (and other vehicle) drivers or people witnessing people who have jumped to their deaths.

- **Support the media in delivering sensitive approaches to suicide and suicidal behaviour:** This would constitute media messages being delivered appropriately and in

a measured way which does not over emphasise the details of the death or the exact location.

- **Support research, data collection and monitoring:** This constitutes the need to ensure that all data capture is accurate and timely and is used by the appropriate bodies to deliver informed and interrogated intelligence.

The *Five Year Forward View for Mental Health* challenged areas to reduce suicide by 10 per cent by 2020/2. It reiterated the need for every area to develop a multi-agency suicide prevention plan, that demonstrates, how they will implement interventions targeting high-risk locations, and supporting high-risk groups within their population.

LOCAL CONTEXT IN RELATION TO THE NATIONAL OVERVIEW

Northumberland is the sixth largest county in the UK with an estimated population of 316,116 people. The majority of the population is concentrated around the larger conurbation physical areas of Ashington, Blyth, Cramlington, Morpeth, Alnwick, Hexham and Berwick. Whilst there are some areas of significant prosperity in Northumberland, there are also a number of areas that are very deprived and which have the attendant risks to physical and mental health and wellbeing, substance dependency and links to the criminal justice system, which are all risk factors for suicide and self - harm. HMP Northumberland is a Category C prison[7] with an operational capacity of 1348 males; the proportion of offenders supervised by probation services out numbers those serving a custodial sentence by around 3 to 1.[8] Northumberland also has a secure children's home, Kyloe House which can accommodate up to 12 young people. There are also large tracts of rural areas with small populations but high levels of social isolation and loneliness which are also contributory factors to suicide and self-harm.

The years of life lost to suicide in Northumberland were more than the years of life lost for either respiratory disease (flu, pneumonia and asthma) or cerebrovascular (stroke and some other diseases).[9]

The Public Health England Suicide Prevention Profile[10] provides a suite of indicators for suicide related risks. The risk factors for suicide are myriad and interrelated, and will be specific to each individual, but the following factors (not an exhaustive list) are known to increase the risk of suicide:

- **Age and sex.** The suicide rate for males is approximately three times higher than females for the UK as a whole.

[7] Closed prison - those who cannot be trusted in open conditions but who are unlikely to try to escape
[8] Revolving Doors Agency (2017). Rebalancing Act. A resource for Directors of Public Health, Police and Crime Commissioners, the police service and other health and justice commissioners, service providers and users. Available from: http://www.revolving-doors.org.uk/sites/default/files/Documents/Rebalancing%20Act.pdf
[9] NHS Digital. NHS Indicator portal.
[10] Available from: https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

- **Mental ill health.** There is a strong association between mental ill health and suicide. The prevalence of depression in Northumberland (as recorded on GP records) is significantly higher than that for England and the North East. The risk of suicide after self-harm may be 49 times greater that the risk of suicide in the general population.[11] During 2017/18 there were 920 admissions for intentional self-harm amongst Northumberland residents; a significantly higher admission rate than that for England and the North East.[12] The rate of maternal death by suicide remains unchanged since 2003 and maternal suicides are now the leading cause of direct maternal deaths occurring within a year after the end of pregnancy.[13] Nationally, there are higher rates of mental ill health and in particular, more severe mental ill health in the prison population and higher rates in offenders on probation and in the community.[14]

- **Substance misuse.** Substance misuse and mental health problems often occur together and there is a complex relationship between the two. The latter can be exacerbated by the former and alcohol and non-prescribed drugs can interact with medicines used to manage mental illness. In Northumberland during 2017/18 there were 2941 alcohol-related admissions[15] and 225 admissions specifically due to intentional self-harm from alcohol.[16] Substance use amongst sentenced prisoners and those on remand is higher than the rest of the population; during 2016/17 26% of referrals nationally into substance misuse services for opiate addiction originated from the criminal justice system.[17]

  In 2019 Northumberland Public Health Team completed a Healthcare Needs Assessment (HNA) on coexisting mental illness and substance misuse. This is available on request from the Public Health Team. The HNA drew on the views of those with lived experience as well as professionals working with people with mental illness and/or substance misuse. It compared local healthcare activity data with national data and guidance and also evidence from academic literature. The HNA found that there were opportunities to further strengthen the ways that the healthcare needs of people with coexisting mental illness and substance misuse are met. It made four recommendations around governance, communication and workforce, and pathways and interventions.

[11] Hawton, K., Bergen, H., Cooper, J., Turnbull, P., Waters, K., Ness, J. & Kapur, N. (2015) Suicide following self-harm: findings from the Multicentre Study of self-harm in England, 2000-2012. Journal of Affective Disorders 175, 147-51. DOI:10.1016/j.jad.2014.12.062
[12] PHE (2019). Public Health Outcomes Framework. Suicde prevention profiles
[13] Knight M, Nair M, Tuffnell D, Kenyon S, Shakespeare J, Brocklehurst P, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-14. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2016.
[14] Ibid 11 (Revolving Doors Agency).
[15] PHE (2019). Public Health Outcomes Framework. Admission episodes for Alcohol Related Harm (Narrow)
[16] PHE (2019). Public Health Outcomes Framework. Local Alcohol Profiles for England.
[17] Ibid 11 (Revolving Doors Agency).

- **Social isolation and loneliness**. Social isolation and loneliness can both lead to and arise as a result of mental ill health. Older men, people with a long term disability, those living in more deprived communities, the unemployed, excluded young people, those currently or previously in contact with the criminal justice system and a raft of other groups are likely to experience more social isolation and loneliness. At the last census (2011), there were 19,407 households with a single occupant over 65 years of age. In 17/18, 45.4% of >65 social care users said they had as much social contact as they would like, this is a decrease from the 16/17 figure of 46.5%. Amongst adult carers, however, 51.1% said they had as much social contact as they would like compared to 50.6% the previous year.[18]

- **Gender and ethnicity**. We also know that nationally individuals in the LGBTQ groups can be vulnerable to suicide. This is particularly the case for individuals who identify themselves as being transgender, either in treatment for transition or who have recently transitioned. In addition, individuals from BAME communities are also more likely to feel marginalised and disenfranchised from broader societal engagement.

- **Veterans.** Young men (under 24 years) who have left the Armed Forces may be at two to three times higher risk of suicide than the same age groups in the general and serving populations. The risk may be greater in those with a short length of service, and those of lower rank.[19]

- **Prisoners and those in contact with the criminal justice system.** The prison population and people who have been held in a police custody suite in the weeks prior to their suicide are all identified as being at higher risk of suicide than the general population. Data published in 2019 by ONS shows that 41 people committed suicide in custody in 2008 and 40 in 2016. As these data are small, data is not available for Northumberland.

- **Suicides in young people**. Are less common but nationally rates increase steeply during the late teens. Additional themes in suicide by children and young people include bullying, suicide-related internet use, academic pressures (especially related to exams) and social isolation or withdrawal.[20]

In 2017 in the UK, as in previous years, the most common method of suicide for both males and females was hanging, suffocation or strangulation (all grouped together). This accounted for 59.7% of all suicides among males and 42.1% of all suicides among females

[18] PHE (2018). Public Health Outcomes Framework. .
[19] Kapur, N., While, D., Blatchley, N., Bray, I., & Harrison, K. (2009). Suicide after Leaving the UK Armed Forces —A Cohort Study. PLoS Medicine, 6(3), e1000026. http://doi.org/10.1371/journal.pmed.1000026
[20] University of Manchester (2016). National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness. Suicide by Children and Young People in England. May 2016.

The second most common method of suicide was poisoning, accounting for 18.2% of all suicides among males and 38.3% of all suicides among females.

Alcohol was found to have been taken in 40% of cases. The majority of deaths (62%) occurred at a domestic address while the remainder (38%) occurred in other locations – potential hotspots include multi-storey car parks, railway stations/lines, isolated beauty spots and river courses.

An audit of the South and North Northumberland coronial records in relation to the numbers and methods of suicide across Northumberland was carried out in March 2017 covering the period August 2015 to January 2017. The coronial records of 16 deaths recorded as suicide across the county were reviewed.[21] The most frequent method used was hanging with only 5 people having been flagged up as at risk of suicide. Experience of members of their own family taking their own lives in the past and a history of previous suicide attempts and self-harm were recurring themes. Ages ranged from 17 and 79 years with the predominant age range being between 43 and 56 years; most of these individuals were men. These findings reflect national trends.

NORTHUMBERLAND STRATEGIC PLAN

Since 2017, a number of actions have been taken to help prevent suicide in Northumberland including promoting positive mental health for people at risk of suicide/self-harm as part of a broader mental health promotion action plan. These include:

- self-help resources have been created, in consultation with young people, to support them with early access to coping mechanisms and self- supporting skills to help them deal more effectively with the challenges they face, which could be effective in reducing the risk of escalation into crisis. The resources include how to cope when you're feeling low, anxious, stressed, angry and include coping with self harm. The resources are available here:-
  https://www.northumberland.gov.uk/Children/Looked-after/Children-s-social-care.aspx

- British Transport Police (BTP) and Network Rail have engaged with the 'at risk' workforce and identified areas vulnerable to ingress and ensured fencing has been repaired or erected. BTP and Transport for London (TFL) are delivering an initiative which enables members of the public to feel confident about alerting rail workers where they see individuals behaving in a way which is a cause for concern.

[21] These were records of those for whom the inquest had been completed during that period, as opposed to the time period during which the suicide took place.

Planning and Governance

Northumberland Suicide Prevention Strategy (2017) established a multi-agency suicide prevention group under the umbrella of the Crisis Care Condordat with the addition of a representative from Network Rail.

The group reviewed its Terms of Reference, June 2019 and agreed to include responsibility for the Prevention Concordat for Better Mental Health, a prevention-focused approach to improving the public's mental health which has been shown to make a valuable contribution to achieving a fairer and more equitable society.

Terms of reference are included at appendix 1

Integrated Care System

Since the Suicide Prevention Strategy was developed in 2017, the NHS has established an Integrated Care System (ICS) across the North East and North Cumbria.

The ICS has a suicide prevention workstream and sub regional suicide prevention partnership.

The **ICS has adopted a 'Zero Suicide Ambition - Every Life Matters' approach**. The ICS framework aims to transform the way services are delivered to people across the North East and Cumbria, supporting the provision of a more integrated approach to health and social care. The ICS provides a governance framework and supports the 3 sub-regional Integrated Care Partnerships (ICPs); Northumberland is part of the North ICP Sub Regional Suicide Prevention Partnership, (Northumberland, North Tyneside, Sunderland, South Tyneside, Newcastle and Gateshead).

The **overall aims of the ICS suicide prevention workstream** are to:

- gather and use all the available evidence of how best to prevent suicide and self harm, working together as different agencies and communities, and with people who have lived experience of self harm and suicide.
- take action to prevent self-harm and suicides and to promote wellbeing and resilience, across the North of England, so that fewer people die by suicide, including those in high risk groups.
- reduce the impact and stigma of suicide and improve support for those affected.

The ICS priorities are to:

- **develop system wide competency**. To develop a consistent, multi-agency tiered approach to, learning and development, based on Health Education England competency frameworks for self-harm and suicide prevention.
- **develop real time alerts and use data better**. To develop a consistent approach to local real time alerts process and how this is used to inform suicide prevention activity.
- **learn from deaths and near misses**. To develop a systematic process for analysing and learning from near misses and deaths by suicide/ suspected suicide which informs suicide prevention activity.
- **develop postvention support**. To develop support across all areas of the north ICP region, for people bereaved/affected by suicide including families, communities and the workforce.

The sub regional suicide prevention partnership is a multi-agency suicide prevention group. This group has been established to focus on prevention work that can be delivered at scale across the 'North' ICP area.

Priority areas agreed by the group include:

- Sharing of good practice and ensure funding and resources are shared to improve efficiency;
- Recruitment of a Suicide Prevention Coordinator;
- Recruitment of a Data Analyst to receive real time suicide data and work with other agencies to build a pathway for postvention support;
- Football/sport project targeting middle aged men;
- Development of a Northern Training Hub - to develop an evidence based training programme to enhance what local areas already have in place;
- Postvention support to be commissioned on a regional footprint to ensure cost-effective postvention support pathways and link into real time data surveillance pathway;
- Grass Roots Project funding allocation process.

Mental Health Promotion

A number of work programmes and activities have been undertaken across the County not under the auspices of the suicide prevention partnership. Examples include:

- **Mental Health Training**. Connect 5 is a mental health promotion training programme. It increases the confidence and core skills of frontline staff so that they are more effective in having conversations about mental health and wellbeing. It has

been designed to help people manage stress and distress and increase resilience and mental wellbeing through positive change. Connect 5 is a collaborative prevention toolkit and approach that promotes psychological knowledge, understanding and awareness and the development of skills, which empower people to take proactive steps to build resilience and look after themselves. It is a train the trainer model so further training will be cascaded by those who have been trained. Basic suicide awareness training is already available in Northumberland, as is Mental Health First Aid Training.

- **Health Trainers.** Health Trainers are working with individuals to identify stress and give advice on relaxation techniques and mindfulness. This is to ensure equity between physical health and mental health.

- **Mental Health Trailblazer (School Mental Health Support Teams (MHST) and 4 week waiting time pilot).** Northumberland successfully bid to become a Trailblazer Area to pilot School Mental Health Support Teams in two school partnership areas and to develop the 4 week waiting time pilot. Both of these projects are now in development with Education Mental Health Practitioners based in 4 schools in Blyth and Hexham.

- **Designated Senior Mental Health Leads.** In addition to the Trailblazer projects, Northumberland has developed Designated Senior Mental Health Leads in schools across the county, not only in the Trailblazer pilot areas. A Mental Health Leads in Schools conference was held November 2018 for the 125 schools which had identified potential mental health leads; 109 schools completed a Mental Health Audit/Survey. Consultation has taken place with 20 schools to develop further the eight principles of a whole school approach to promoting Emotional Health and Wellbeing.

- **Regional Suicide Prevention Sector Led Improvement.** In the north east, the regional Public Mental Health Network chose to participate in a self-assessment and peer challenge session. This took place in December 2018 and resulted in several actions in the Northumberland plan being revised e.g. auditing the proportion of practices/GPs that have completed the RCGP suicide prevention training.

  The three workstreams:

  - **Suicide prevention**
  - **Crisis care**
  - **Mental health promotion**

will be brought together into a Better Mental Health and Suicide Prevention Strategy and Action Plan.

Progress in Northumberland

Priority 1 - Reducing the risk of suicide in high risk groups

Northumberland partner organisations have committed to identify individuals at risk and ensure they are managed appropriately by the services they are involved in.

We have:

- undertaken a mapping exercise of mental health and suicide training to establish who is delivering what and to whom.

- engaged with regional work, led by the Health in Justice Team of Public Health England working with Her Majesty's Prison and Probation Service (HMPPS) to improve pathways to support those already identified as being at higher risk of suicide when they transition from a prison to a community setting.

- used the better Health at Work Awards, to provide advice and support to employers on workplace suicide through the promotion of the Prevention toolkit (**http://wellbeing.bitc.org.uk/spret**) and for employers having to manage a traumatised workforce post event, the Postvention toolkit (**http://wellbeing.bitc.org..uk/spostv**) developed by Public Health England, Business In The Community (BITEC) and the Samaritans specifically for employers. Employers in Northumberland are strongly and explicitly encouraged to use these toolkits.

- We have developed a mechanism to respond to sudden deaths that may have arisen from self harm, to ensure those at high risk are supported. This is being developed further into a more formal protocol, which in young people augments the Child Death and Overview Panel rapid response process.

- identified opportunities to engage with men (particularly younger men aged 15 - 34 years) in non-clinical settings to encourage them to discuss and seek help/support on the range of factors commonly associated with suicide in men. This included a leaflet drop advertising services in places where men might tend to gather, focussed on barbers, pubs & clubs as well as corner shops and other retail outlets. One to one work for depression with men explores and connects with a man's interests and values, and aims to set achievable and measurable goals for clients based on their own interests. This is done collaboratively so that the solution is elicited from the client.

We will continue to:

- review recommendations made by the National Confidential Inquiry into Suicide and Homicide in People with Mental Illness and ensure they have been implemented or considered by relevant organisations.

- ensure that current best practice relating to the identification and management of those who self-harm is being implemented.[22]

- access and raise awareness of the many national and regional support organisations ensuring information is available and highly visible in an easy read format across all public buildings around the county.

Priority 2 - Engineer approaches to improve mental health in specific groups

The pursuit of parity of esteem, which demands that people who are experiencing mental ill health should be dealt with with the same approach that they would be if they presented to health services with a physical health issue, is a significant driver to the better identification and management of people who may be vulnerable to suicide at the earliest point of intervention.

We have:

- developed and delivered training on Youth Mental Health courses and Mental Health training to residential care staff working with children and young people, Adult mental health courses, suicide awareness training, and staff have been trained to deliver mental health and wellbeing sessions. Staff trained include those in the public sector, voluntary sector and businesses. Through attendance, individuals will have knowledge of basic assessment models and developed skills to support those experiencing mental and emotional health difficulties. Staff will therefore be able to signpost to appropriate services and give information will promote positive mental wellbeing.

We will continue to:

- review and monitor the provision of suicide and general mental health awareness and mental health promotion training (particularly mental health first aid training and Connect 5 training) across the county.

[22] NICE (2004) - Self-harm in over 8s: short-term management and prevention of recurrence (CG 16);

- focus on prisons, audit the uptake of suicide prevention, mental health first aid training and contribution to the Assessment, Care in Custody and Teamwork (ACCT) process.

- use the JSNA and all relevant plans to emphasise the importance of mental health for all, including the Children and Young People's Strategic Plan to promote resilience and emotional health and wellbeing in children and young people.

Priority 3 - Strategies for the reduction of opportunity

We have previously identified hotspots and potential risk within buildings our vulnerable communities may access.

We have:

- reviewed initiatives to provide safer environments across secure settings (e.g. removal of ligature points in hospitals, police custody and prison settings).

- developed links with BTP and Network Rail to support safer rail access; promote a general public awareness raising campaign with respect to the identification of high risk rail side activity. Regular overt patrols by BTP officers, consisting of both mobile and train patrols, providing engagement to members of staff and the public in conjunction with Special Constables.

We will continue to:

- monitor incidents and respond appropriately based on evidence.

- use the suicide audit process and the Suicide Coordinator to identify any 'hotspots' and ensure that mitigating action has been put in place where possible and that training is in place for staff in that locality.

Priority 4 - Provide better information and support to those bereaved or affected by suicide:

Bereavement by, or a close connection with a suicide are themselves risk factors for suicide. It is therefore vital, as part of this suicide strategy, that bereavement and suicide support services are timely and appropriate.

We have:

- mapped interventions specifically aimed at reducing suicide and supporting the bereaved and those affected by suicide.
- reviewed the framework and pathway for service providers and evaluated local bereavement support services.
- commissioned trauma and bereavement/postvention support across the county, provided through Northumberland and North Tyneside MIND.
- commissioned Barnardo's to provide support for children and young people.

We will:

- use the real time alert system being implemented regionally to identify potential clusters and facilitate a subsequent Community Action Plan.[23]
- be part of a regionally commissioned additional postvention support service provided by If you Care Share.

Priority 5 - Support the media in delivering sensitive approaches to suicide and suicidal behaviour

It is important that media reporting of suicides is responsible and sensitive so that hotspots are not identified and the narrative is not salacious, likely to influence copycat behaviour and is respectful and non-judgemental of the individual who has died and their family. There is also a need to review and identify the potential risks and benefits that social media presents.

We have:

- undertaken a literature review of the evidence that social media has a positive or negative impact on suicide and the prevention of suicide. It concluded that there is little consensus in the available academic literature as to whether social media has a positive or negative impact on suicide and the prevention of suicide. Professionals in Northumberland working with adults at risk of suicide, or more broadly with adolescents, should ensure that they have an up-to-date knowledge of this dynamic area, both in general terms and specific to their area of work.

We will continue to:

- ensure the local media are aware of, and following, Samaritans' guidance on responsible media reporting.

- review the evidence of the impact of social media on suicide (both positive and negative) to inform future work.

[23] PHE (2015). Identifying and responding to suicide clusters and contagion. A practice resource. PHE. Sept 2015

Priority 6 - Support research, data collection and monitoring

A consistent and systematic approach to monitoring suicide incidents and being informed through robust data and research will afford Northumberland the careful thinking time to respond to the management and understanding of suicide events.

We will continue to:

- develop a suicide audit process and support the regular collection of data, the identification of trends and hotspots, and progress against the aim of the strategy to reduce suicides.

- respond to national audits and reports**.** The partnership has sought assurance from partners that the recommendations in reports around preventing suicide have been reviewed and followed where appropriate. Examples include the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2017) and 'Learning from suicide-related claims. A thematic review of NHS Resolution data' (2018).

MEASURING PROGRESS

Nationally, the **NHS Outcomes Framework,** the **Public Health Outcomes Framework** and the **Adult Social Care Outcomes Framework** all contain high level national indicators which will provide a monitoring framework against which success can be measured.

- Public Health Outcomes Framework for England 2013–2016 identifies four key indicators relevant to this plan: social connectedness (domain 1); hospital admissions as a result of self-harm (domain 2); excess under 75 mortality in adults with serious mental illness (domain 4); and suicide (domain 4).

- NHS Outcomes Framework identifies 2 key improvement areas relevant to this plan: reducing premature death in people with serious mental illness (1.5); and improving outcomes from planned treatments – psychological therapies (3.1).

- Adult Social Care Outcomes Framework indicator of social connectedness (shared with the Public Health Outcomes Framework): proportion of people who use services and their carers, who reported that they have as much social contact as they would like (domain 1) .

Both the Adult Social Care and NHS outcomes frameworks contain safeguarding domains that are relevant to work on suicide prevention (Adult Social Care domain 4 and NHS Domain 5).

Reviewed Sept 2019

Appendix 1

Northumberland Crisis Care, Suicide Prevention and Mental Health Strategic Partnership

Terms of Reference (Final) Sept 2019

Good mental health is very important to overall health. It is associated with better productivity, is a positive factor for some physical health conditions, and is a vital asset for dealing with life's stresses. Good mental health is not just the absence of a mental health problem, but having the ability to think, feel and act in a way that allows us to enjoy life and deal with the challenges it presents (Mental Health Foundation, 2017)

Aim

Prevent the onset, development and escalation of mental health problems, prevent suicide and promote good mental health by strengthening individuals and communities and reducing inequalities by ensuring effective arrangements to:

- Improve outcomes for people experiencing mental health crisis
- Develop partnerships to promote good mental health to all
- Promote well-being and social inclusion of people at risk of mental health problems

Objectives

1. Use data and intelligence, including research, effectively to understand local needs to influence commissioning and prioritise interventions
2. Work in partnership to ensure alignment across sectors and programmes of work, including: mental health promotion activities, access to support before crisis point, urgent and emergency access to crisis care, quality treatment and care when in crisis, recovery and staying well avoiding future crisis
3. Ensure mental health is integrated into relevant plans across organisations e.g. Children and Young People's Plan, JSNA, Ageing Well Programme
4. Develop metrics to measure the impact of interventions
5. Provide leadership and accountability

Membership and chairing arrangements

Clinical Commissioning Group/ Public Health – Director and Public Health Support (NCC)
Northumberland, Tyne and Wear Mental Health Trust
Northumbria Foundation Healthcare Trust
Adult Safeguarding (NCC)
Police
Elected Member Mental Health Champion (NCC)

Talking Matters Northumberland
HMP
NEAS
British Transport Police
Tyneside & Northumberland Mind
Individuals with lived experience

The meeting will be jointly chaired by the DPH and CCG representative

Quorate

The meeting will be quorate if two thirds of members are present

Frequency of meetings

Quarterly

Reporting arrangements

The group will report to the Director of Public Health, The Health and Wellbeing Board, Strategic Safeguarding Partnership and Overview and Scrutiny Committee

Links with other groups
Integrated Care System (ICS) Suicide Prevention Steering Group (across the North East and Cumbria)

North Integrated Care Partnership (ICP) Sub Regional Suicide Prevention Group (across 6 local authority areas, Northumberland, North Tyneside, Newcastle/Gateshead, South Tyneside, Sunderland)

Northumberland Mental Health Promotion And Suicide Prevention Steering Group

Northumberland Drugs and Alcohol Steering Group

Northumberland Children and Young People's Emotional Health and Wellbeing Implementation Group

Northumberland Children and Young People's Mental Trailblazer Steering Group

Northumberland Senior Mental Health Leads in Schools Group

Review of terms of reference

These terms of reference will be reviewed at least annually and/or in light of new policies/directives to ensure their relevance.