Item No: 22

Meeting Date: **Friday 9 December 2016**

Glasgow City Integration Joint Board

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DEATHS FROM SUICIDE WITHIN GLASGOW CITY

Purpose of Report:	This report updates Glasgow City Integration Joint Board on suicide statistics for the City's population and updates members on current action.

Recommendations:	The Integration Joint Board is asked to: a) note the progress being seen in deaths by suicide in Scotland and Glasgow. While the decline in deaths by suicide is very welcomed, all partners wish to see the rates continue to decline; b) note the ambition of Glasgow's Choose Life Working Group to pursue an application for Living Works Suicide Safer Community status via the Community Planning Partnership. This internationally recognised award requires applicants to evidence nine pillars of action drawn from suicide prevention strategies around the world. No other area of Scotland currently has this status, and c) note the changes evidenced in this report and to continue to support continued action and leadership by Glasgow City Health and Social Care Partnership in the Choose Life processes within the City.

Implications for Integration Joint Board:

Financial:	Ongoing commitment through multiple business areas of the Health and Social Care Partnership.

Personnel:	No change

Legal:	None

Economic Impact:	None

Sustainability:	From mainstream commitments

Sustainable Procurement and Article 19:	

Equalities:	Considered through programme development

Risk Implications:	

Implications for Glasgow City Council:	None

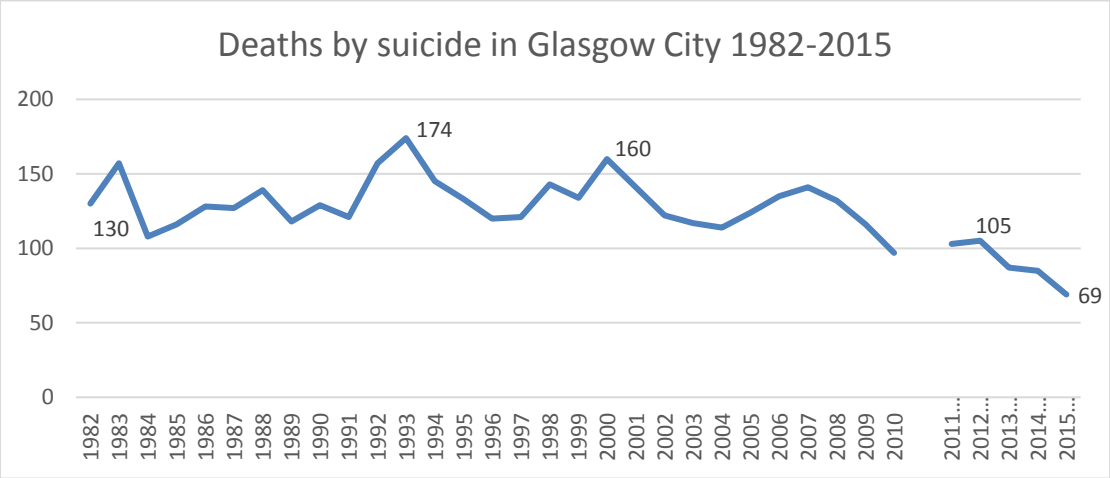
Implications for NHS Greater Glasgow & Clyde:	None

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	✓
	2. Glasgow City Council	
	3. NHS Greater Glasgow & Clyde	
	4. Glasgow City Council and NHS Greater Glasgow & Clyde	

1. Death by suicide in Glasgow City

1.1 Suicide is a tragic loss of life, with a legacy for all those affected. This report updates members on the latest figures from the Information Services Division (ISD) of the Scottish Government, released in August 2016, and the actions and plans within Glasgow to continue this downward trend.

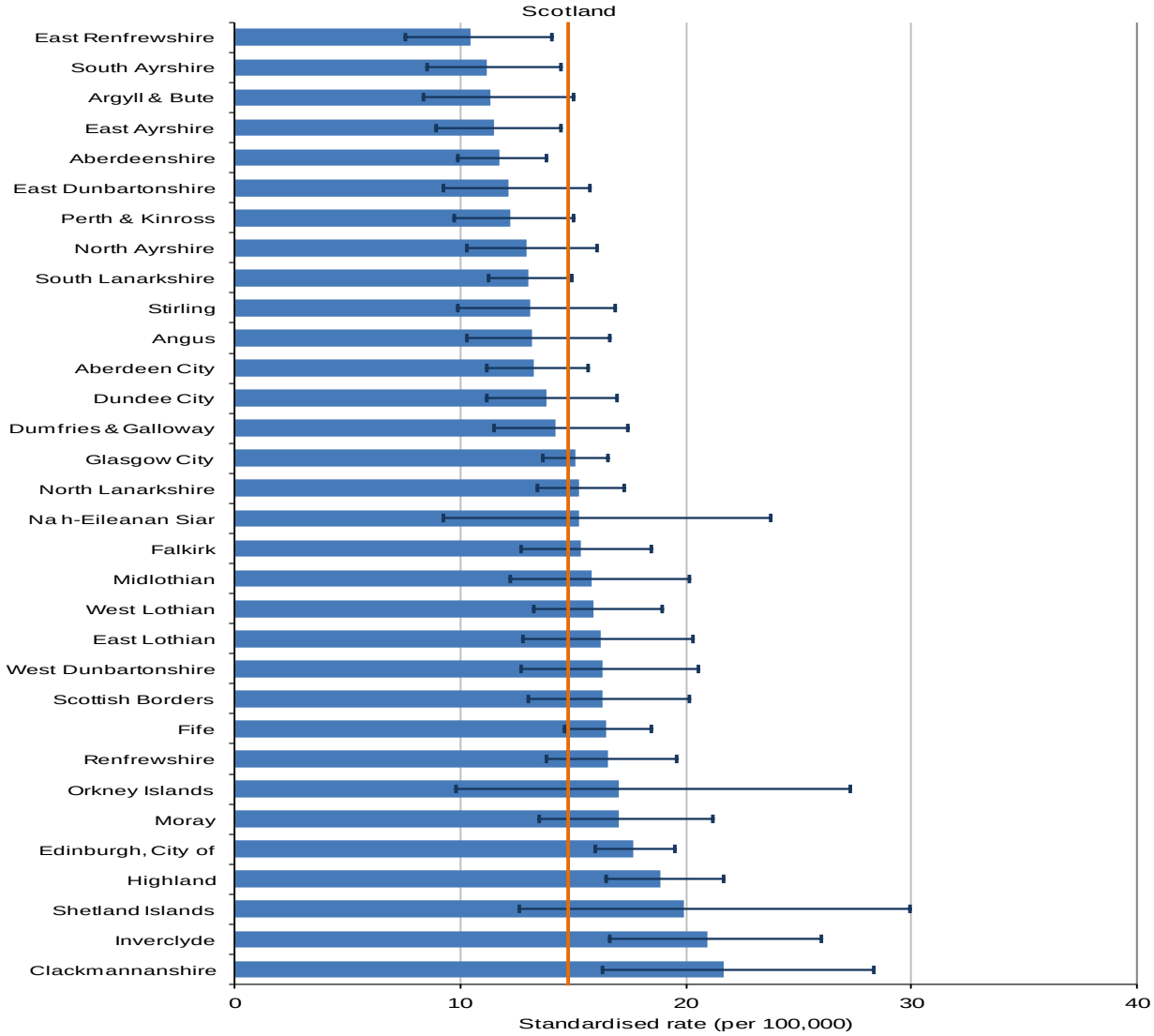
1.2 Sixty-nine residents died by suicide in 2015, the lowest in more than 30 years. For every ten deaths by suicide reported in 1993 we had four deaths reported in 2015, as seen in the graph below.



NB In 2011, the National Records of Scotland changed their coding methodology to make it consistent with WHO standards. A small number of deaths that would previously been coded as “mental and behavioral disorders” are now coded as suicide. The net effect of this change increases the number of deaths considered to be suicide. The break in the graph marks the change between these two methodologies.

1.3 Glasgow deaths are almost exactly at the average for Scotland, as shown below. Given the close correlation between deprivation and suicide rates, this suggests that Glasgow’s suicide rates are significantly lower than might have been expected.

CHART 1 - European age-sex-standardised rates per 100,000 population: suicide deaths by local authority, 2011-15 (Persons - all ages)



1.4 Just over a decade ago Glasgow had one of Scotland's five highest suicide rates. The reduction, particularly in the last five years, has been very significant indeed.

1.5 The Scottish suicide rate continues to fall, but it is increasing in the other countries of the UK. Recession and austerity in England were accompanied by an increase in the male suicide rate from 2008, a pattern not evident in Scotland, and it is not clear why this difference should have emerged.

1.6 This data also reveals that;

- the suicide rate for men in 2015 is more than two-and-a-half times higher than for women. However the rate for men is falling, whereas that for women has remained almost unchanged.
- in 2011-15, the suicide rate was more than three times higher in the poorest communities compared to the least deprived (analysing by 'deciles'). Compared to 2001-05, suicide rates have decreased in every decile, but the reduction is most marked in the lowest deciles. For example, the suicide rate in the most

deprived decile fell from 31.6 to 22.1 deaths per 100,000 population, compared to a reduction from 7.8 to 7.3 in the least deprived decile.

- the highest rate of suicide for both men and women is seen for ages 35-54 years. The lowest rate being in the older age groups.

2. Understanding what is happening

2.1 Over the last few years partners have reported anecdotally that they are responding to more people presenting as suicidal in the city, to such an extent that a 'locations of concern' working group has now been established with key partners.

2.2 Research would be required to understand this anecdotal reporting alongside the marked reduction in death by suicide figures, however it is hard to imagine how such change could have been achieved without the local multi-agency action that has taken place.

2.3 One of the hallmarks of Glasgow's approach has been to work on community level prevention approaches alongside statutory service developments. Again research would be required to determine if this has been one of the contributory factors for the city experiencing a greater decline than elsewhere in Scotland.

2.4 Local research on deaths by suicide since the 1950s[1] has also suggested an increased suicide risk for people born between 1965–1974. This effect was largely driven by men and those living in the most deprived areas and is consistent with exposure to economic and political changes during the 1980s.

2.5 Information is also available on the use of health services by those that have died by suicide (ScotSID). This shows that more than half (59%) of all those affected were taking a psychotropic drug (of which 82% took an antidepressant, and 63% a sedative or sleeping tablet) at the time of death. However only about 1/5th of deaths took place in people with a psychiatric admission and/or outpatient appointment in the previous five years. Contact with hospital services (admission or A&E attendance) was about three times higher than that with mental health services.

2.6 Every death that occurs in patients known to Mental Health services (and for up to one year after discharge) is considered a Significant Clinical Incident (SCI) and is investigated. SCI investigations are shaped by families and carers, and conclusions shared with them. Key themes that have emerged from SCI's include;

- the need to involve families and carers more closely in risk assessment and management
- the importance of prompt risk assessment on admission and at transfers of care

[1] Parkinson J, Minton J, Lewsey, J, Bouttell J & McCartney G. Recent cohort effects in suicide in Scotland: a legacy of the 1980s? J Epidemiol Community Health doi:10.1136/jech-2016-207296

- a recognition that about 85% of deaths occur in patients thought to be at low risk of suicide at the last contact, this highlights the difficulty in predicting suicide risk with any accuracy.
- the importance of effective communication of clinical information, which should be facilitated by current progress towards a networked electronic case record
- the absolute importance of compassion and the containment of distress in responding to people with suicidal behaviour.
- most psychiatric units now have *en suite* bathrooms for all patients, but there is a need for increased vigilance, as those areas are the commonest areas for inpatient suicide to take place.

3. Responses to Suicide

3.1 The introduction of the Choose Life Strategy across Scotland (2003) was a landmark in galvanising multi-partner action. All Community Planning Partnerships appointed a Choose Life Coordinator (now hosted within Glasgow City Health and Social Care Partnership) and put in place a range of implementation plans. Glasgow has an active multi-partner Choose Life programme.

3.2 Suicide prevention training has been undertaken by over 10,000 workers in Glasgow; training of Health and Social Care Partnership staff (mental health, addictions, clinical services, staff in children's residential units, school nursing etc.), money advice services, staff working in Schools, housing and homelessness organisations, voluntary sector projects, violence against women support programmes have all participated.

3.3 Additionally, the Glasgow programme has been augmented by being part of a collective Greater Glasgow and Clyde approach. Thus, there has been collaborative working and good practice-sharing across the six Choose Life programmes within the Health Board area, plus joint action on pan-Board issues. An NHS Greater Glasgow & Clyde Suicide Prevention Strategy Group has assisted in this coordination and sharing task.

3.4 A development day was held in March to review the NHS Greater Glasgow and Clyde strategic approach. This refreshed approach set out five key areas for future action;

- Community Prevention;
- Carer and Family Dimensions;
- Clinical and Care Service Responses;
- Child and Youth Suicide Prevention;
- Training and Workforce Development

3.5 A range of actions have been undertaken specifically within NHS services to reduce suicide, including:

- Development of a new suicide prevention clinical policy for NHS Greater Glasgow and Clyde: currently underway.
- Review of risk management policy and processes: a new risk assessment protocol compatible with electronic systems has been through the first phase of consultation. It will be implemented through 2017, accompanied by a significant staff training programme.
- Board-wide service development for people with Borderline Personality Disorder
- Extension of Scottish Patient Safety Programme (SPSP) to include community settings and other care groups will roll out in 2017.
- Continuing joint work between Mental Health and Accident & Emergency Departments
- Two research projects are being supported looking at the influence of Adverse Childhood Experiences on suicidal behaviour and implementation of suicide safety planning and telephone support in a UK setting.

3.6 **The Suicide-Safer Communities Award**

The Suicide-Safer Communities designation honors communities that have implemented concerted, strategic approaches to suicide prevention. The nine pillars in this designation reflect the core elements of suicide prevention strategies around the world. The designation celebrates and acknowledges those communities who have made significant progress in reaching their suicide-safer goals, and helps others understand what strategic steps they can take to prevent suicide on a community level.

The 9 pillars of action are.

1. **Leadership/Steering Committee**
2. **Background Summary**
3. **Suicide Prevention Awareness**
4. **Mental Health and Wellness Promotion**
5. **Training**
6. **Suicide Intervention & Ongoing Clinical/Support Services**
7. **Suicide Bereavement**
8. **Evaluation Measures**
9. **Capacity Building/Sustainability**

The Choose Life Strategy Group will engage with the Community Planning Partnership regarding applying for this award for the city.

4. Recommendations

4.1 The Integration Joint Board is asked to:

a) note the progress being seen in deaths by suicide in Scotland and Glasgow. While the decline in deaths by suicide is very welcomed, all partners wish to see the rates continue to decline;

b) note the ambition of Glasgow's Choose Life Working Group to pursue an application for Living Works Suicide Safer Community status via the Community Planning Partnership. This internationally recognised award requires applicants to evidence nine pillars of action drawn from suicide prevention strategies around the world. No other area of Scotland currently has this status, and

c) note the changes evidenced in this report and to continue to support continued action and leadership by Glasgow City Health and Social Care Partnership in the Choose Life processes within the City.

For help and advice for you or the person you're worried about, call **Breathing Space** on **0800 83 85 87** or **Samaritans** on **08457 90 90 90.** For further info see www.glasgow.gov.uk/chooselife