Manchester City Council
Report for Resolution

Report to: Health Scrutiny Committee – 30 June 2016

Subject: Suicide Prevention Update and development of Local Action Plan

Report of: The Director of Public Health

Summary

This report provides Committee with an update on the paper submitted in March 2015 and specifically reports on progress in the development of a Local Suicide Prevention Plan for Manchester.

The report will provide information on:

- The national and local strategic context of suicide prevention
- Key trends, facts, figures and risk factors relating to suicides in Manchester
- A summary of key areas of activity currently contributing to suicide prevention
- Our approach to developing of a local suicide prevention plan for Manchester
- Draft actions to be included in the plan and proposed governance arrangements and timescales for implementation.

Recommendations

The Committee is asked to:

- Note the contents of the report
- Consider the multiple factors that impact upon suicide rates
- Provide feedback and ideas on draft actions in the plan

Wards Affected: All

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We would like to acknowledge input to this paper from Professor Nav Kapur (University of Manchester) and Nicky Lidbetter (CEO Self Help)

Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

Prevention of suicide in Manchester. Report to Health Scrutiny Committee. 12 March 2015
http://www.manchester.gov.uk/meetings/meeting/2327/health_scrutiny_committee

Guidance for developing a local suicide prevention action plan. Public Health England. September 2014
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/359993/Guidance_for_developing_a_local_suicide_prevention_action_plan__2_.pdf

References

1. World Health Organisation Suicide Fact Sheet 2015

2. Cipriani, A., Barbui, C., Geddes, J. R., 2005, Suicide, depression and antidepressants, BMJ 2005, vol. 330, 373-4

3. Suicide by children and young people in England. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2016.

4. Projecting Adult Needs and Service Information System (PANSI), Institute of Public Care,Oxford Brookes University

5. Ness, J., Hawton, K., Bergen, H., Cooper, J., Steeg, S., Kapur, N., . . . Waters, K. (2015). Alcohol use and misuse, self-harm and subsequent mortality: an epidemiological and longitudinal study from the multicentre study of self-harm in England. Emergency Medicine Journal, 32(10), 793-799. doi: 10.1136/emermed-2013-202753

6. https://www.livingworks.net/community/suicide-safer-communities/

1. Introduction

1.1 Every suicide is both an individual tragedy and a loss to society. For every death by suicide around 60 people are seriously and negatively affected by that death including family, friends, work colleagues, health professionals, police, neighbours and so forth. Those bereaved and affected by suicide are at heightened risk of developing suicide thoughts and behaviours themselves and the economic costs are immense – it has been estimated that the cost of a completed suicide is £1.67m. For every year that a suicide is prevented, £66,797 costs are averted. For every suicide there are many more people who attempt suicide every year. A prior suicide attempt is the single most important risk factor for suicide in the general population.(1)

1.2 Whilst we know that people in the care of Mental Health Services are at higher risk of suicide than the general population, three quarters of suicides occur in people who have not been in touch with Mental Health Services within the previous 12 months. It is therefore crucial that a broad, community-based approach is taken to suicide prevention.

1.3 There is much interest and commitment from a range of agencies and organisations across sectors in the city in contributing to the prevention of suicides that can be harnessed.

1.4 Suicides are not inevitable. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides.

2. Definition of suicide

2.1 Deaths from suicide are identified from death registrations. Registration of deaths is made following a coroner's inquest, when a verdict is given.

2.2 The Office of National Statistics (ONS) definition of suicide includes deaths given an underlying cause of intentional self harm or an injury / poisoning of undetermined intent. Since 2016 the definition has been revised to include death from intentional self harm in children and young people aged 10 – 14 years. (deaths of undetermined intent continue to not be included). The numbers of deaths in this young age group is very low and the inclusion has not had a significant impact on the age-standardised rates.

2.3 There is some evidence that suicides may be under reported in national statistics where Coroners provide a narrative verdict rather than a short form verdict.

3. Strategic Context for suicide prevention work

3.1 The Government Report, *Preventing suicide in England: Two years on* highlights the importance of local action supported by national coordination in suicide prevention. The national Suicide Prevention Strategy is being refreshed and publication is expected during the Summer.

3.2 Public Health England (PHE) recommends that local authority areas develop

local multi agency suicide prevention action plans to coordinate suicide prevention activity, overseen by partnership groups. PHE published specific guidance for public health staff in local authorities to support this work in September 2014 and this guidance is currently being revised and will be published in Summer 2016.

3.3 The Greater Manchester Mental Health Strategy highlights suicide prevention as one of its key prevention priorities during the first two years. The focus is on working with the GM Suicide Prevention Executive to reduce suicide risk by reflecting the main elements of the national strategy ie men's mental health, mental health services, self-harm, young people, suicide hotspots, working with the media, early follow-up on hospital discharge, adopting NICE guidance on depression and self harm. Supporting the development of real time data and information and workforce development to support suicide prevention.

3.4 Within Manchester, suicide prevention work is underpinned by the public mental health programme and is a core outcome of the mental wellbeing priority within the Joint Health and Wellbeing Strategy.

3.5 Manchester Mental Health and Social Care Trust has a comprehensive Suicide Prevention Strategy focused on preventing suicides of those within its services and convenes a regular suicide prevention group chaired by Prof. Nav Kapur to coordinate activity and share research and learning.

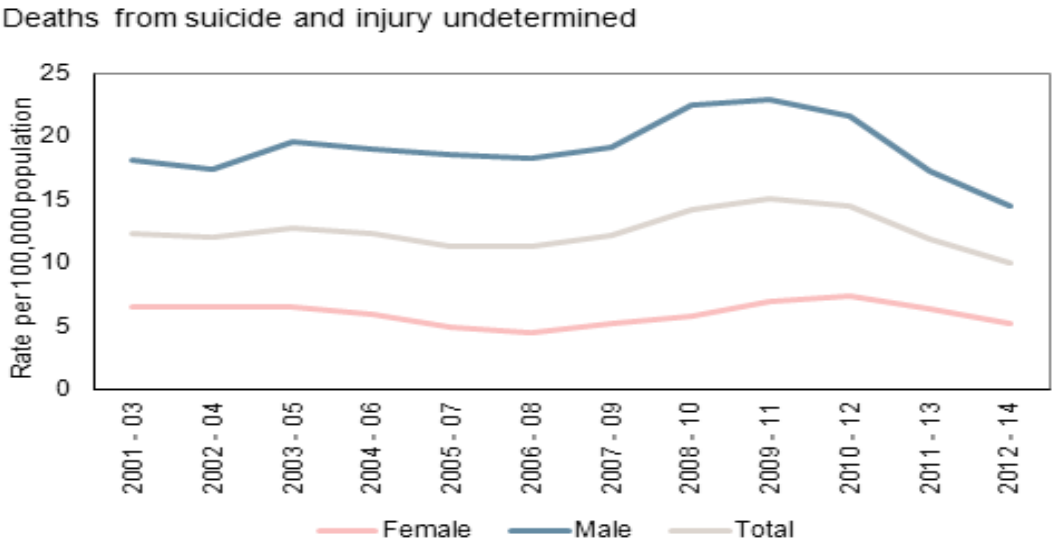
4. Summary of key facts and trends about suicides

4.1 Suicides in Manchester

The table below shows the numbers of deaths by suicide in Manchester per year:

Year	Number of suicides (all ages) and injuries of undetermined intent (15+ only)		
	Persons	Male	Female
2008	54	44	10
2009	59	45	14
2010	66	55	11
2011	65	48	17
2012	53	38	15
2013	38	30	8
2014	48	36	12

Whilst numbers of suicides increased in 2014 from the previous year it is the second lowest value since the recession in 2008. The overall trend for Manchester (based on three year averages) is downwards as shown in the chart below. This is also true of patient suicide rates which have decreased in line with general population rates.



Source: Public Health England © Crown Copyright 2016

A more detailed breakdown of suicide rates by gender and age produced by Public Health England shows how Manchester rates compare with national rates. This table highlights that Manchester is similar on all cohorts except for Males 35 – 64 years which are significantly higher than for England.

Compared with benchmark: Lower Similar Higher

Benchmark Value: Lowest | 25th Percentile | 75th Percentile | Highest

Indicator	Period	Manchester		Region	England	England		
		Count	Value	Value	Value	Lowest	Range	Highest
Suicide age-standardised rate: per 100,000 (3 year average) (Persons)	2012 - 14	138	9.9	10.3	8.9	4.5		15.7
Suicide age-standardised rate: per 100,000 (3 year average) (Male)	2012 - 14	103	14.4	16.3	14.1	7.2		25.3
Suicide age-standardised rate: per 100,000 (3 year average) (Female)	2012 - 14	35	5.2	4.6	4.0	-	Insufficient number of values for a spine chart	-
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Persons)	2012 - 14	133	35.4	38.3	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) (Male)	2012 - 14	101	53.8	60.7	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) (Female)	2012 - 14	32	16.1	16.2	13.7	0.0		26.2
Suicide crude rate 15-34 years: per 100,000 (5 year average) (Male)	2010 - 14	63	11.9	14.8	12.3	4.1		33.5
Suicide crude rate 15-34 years: per 100,000 (5 year average) (Female)	2010 - 14	-	3.8*	3.8	3.4	2.9		4.7
Suicide crude rate 35-64 years: per 100,000 (5 year average) (Male)	2010 - 14	130	31.9	23.9	20.5	7.9		33.8
Suicide crude rate 35-64 years: per 100,000 (5 year average) (Female)	2010 - 14	-	6.4*	6.4	5.9	4.9		7.1
Suicide crude rate 65+ years: per 100,000 (5 year average) (Male)	2010 - 14	13	12.4	12.4	12.4	2.1		24.5
Suicide crude rate 65+ years: per 100,000 (5 year average) (Female)	2010 - 14	-	4.4*	4.4	4.3	3.5		5.2

Further detailed data on suicide and self harm in Manchester can be found in appendix 1.

Public Health England recommend that local areas carry out regular audits of suicides in their area using Coroners records, to identify local contexts and issues that may be relevant when designing suicide prevention actions. It is some time since this has been done in Manchester due to capacity / prioritisation issues.

4.2 Risk Factors for Suicide

The causes and consequences of suicide are complex and there are many myths and misunderstandings associated with the subject. Frequently, several factors act cumulatively to increase a person's vulnerability to suicidal behaviour.

Research evidence shows the following groups to be at risk of suicide:

- **Males** – Males are three times as likely to die by suicide as females (particularly adult men under 50)

- **Age groups** – The 45 – 59 age group has the highest rates of suicides in the UK for both males and females

- **Mental Health** – a number of studies have shown that up to 90% of people who die by suicide had one or more mental illness however only around 25% of people who take their lives in the UK (and in Manchester) have been in contact with mental health services prior to their death. In the case of depression, studies have shown that, on average, the risk of suicide is about 15 times higher than the average for the general population. (2) The Mental Health Foundation estimates that 70 per cent of recorded suicides are by people experiencing depression, often undiagnosed.

- **Self Harm** – Within published literature it has been consistently shown that a history of self-harm and suicide attempts are a major risk factor for further suicide attempts and death by suicide. Self harm rates in Manchester appear to have been rising in recent years based on hospital data collected as part of Manchester Self Harm Project (see appendix 1).

- **Children and young people (including those who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system)** – although numbers of children and young people who die by suicide are low it remains the second most common cause of death in young people. According to The Office of National Statistics, in 2014 there were 476 deaths of 15 to 24 year olds from self-harm or undetermined intent in England and Wales representing a rate of 6.6 deaths per 100,000 population aged 15 to 24 years. Further one study that looked at suicides in the UK between 1997 and 2003 observed that three times as many young men as young women (15 – 19) die by suicide – mirroring the adult ratio; and 14% of young people were in contact with mental health services prior to their death, compared to 26% in adults.

Recently published research (3) examined reports from a range of investigations and inquiries on 130 people under the age of 20 who died by suicide between January 2014 and April 2015. It was found that 28% of young people who died had been bereaved and in 13% of cases there had been a suicide of a family member or a friend. 36% had a physical health condition such as acne or asthma, and 29% were facing exams or exam results when they died.

There are also strong links between childhood physical, sexual and emotional abuse and suicidal thoughts and behaviours and bullying during childhood is also a risk factor for suicide attempts in adults.

- **Students** – the number of students who took their own lives in England and Wales rose by 50% between 2007 and 2011, from 75 to 112, despite the number of students as a whole rising by only 14%. The number of student suicides at local level is not available however this is an area of concern for Manchester.

- **Survivors of domestic abuse or violence, including sexual abuse –** there are strong links between intimate partner violence and suicidal thoughts and behaviours. Manchester has higher rates of domestic violence and abuse compared to other core cities.

- **Veterans –** research has shown that veterans are at increased risk of suicide and that this risk is greater for those who leave early (as opposed to longer serving personnel), younger individuals, those experiencing post traumatic stress disorder (PTSD) and those with a history of childhood trauma.

- **People with physically disabling or painful illnesses including chronic pain and long term conditions** – The National Confidential Inquiry into suicide and homicide by people with a mental illness 2015 found that around a quarter of patients who die by suicide have a major physical illness and this rises to 44% in patients 65 and over. Manchester has high rates of people with a long term condition or disability and it is estimated that by 2030 there will be 26% more people aged 65 and over with a limiting long term illness living in Manchester. (4)

- **Alcohol and Drug Use** – Alcohol and drug use amplifies suicidal thoughts, plans and deaths. A recent UK based study found that the use of alcohol significantly increased suicide risk particularly in women.(5) Manchester has higher estimated rates for opiate and/or crack cocaine use than national estimates and a higher incidence of co-existing mental health and substance misuse issues compared to the North West and England. Local prevalence estimates for alcohol misuse are not available however applying national estimates of adults dependant on alcohol would equate to 22,670 in Manchester. A recent report by the prison and probation ombudsman into 19 deaths in UK prisons between April 2012 and September 2014 highlighted a possible link between New Psychoactive Substances and self harm and suicide.

- **Lesbian, gay, bisexual and transgender (LGBT)** – there is growing evidence of the increased risk of self harm and suicidal thoughts and behaviours amongst LGBT people. A study conducted in the UK highlighted the impact of homophobia as a key factor.

- **Black, Asian and minority ethnic groups and asylum seekers** – Studies have found self-harm and suicide to be higher amongst Asian women than other groups. Prevalence data however is limited as ethnicity is not recorded on death certificates.

- **Specific occupational groups** – doctors, nurses, vetinary and agricultural workers are at heightened risk of suicide with doctors and farmers at highest risk. A number of factors contribute to this not least easier access to the means of suicide.

- **Criminal Justice System** – The World Health Organisation and International Association for Suicide Prevention recognise that prisoners are a high risk group for suicide, as are those on remand and those recently discharged from custody. The risk is greatest in the first week of imprisonment.

- **Social and economic circumstances** – people who are unemployed are two to three times more likely to die by suicide than those who are in work. Debt and austerity measure may well increase risk. Recent research in the British Medical Journal found that Work Capability Assessment for people on disability benefits was independently associated with and increase in suicides, self-reported mental health problems and antidepressant prescribing. High levels of deprivation and health-related worklessness that persist in Manchester make this risk factor a particular concern.

- **Bereavement by suicide –** people bereaved by the sudden death of a friend or family member are 65% more likely to attempt suicide if the deceased died by suicide than if they died by natural causes. As well as the increased risk of suicide attempt, those bereaved by suicide were also 80% more likely to drop out of education or work. In total, 8% of the people bereaved by suicide had dropped out of an educational course or a job since the death.

5. What works in suicide prevention?

5.1 There are a number of evidence-based activities to prevent suicide. In summary these include taking specific steps to reduce risk for those in mental health services and criminal justice services, for example by reducing access to the means of taking their own lives, and Identifying and targeting population groups at potential risk and building resilience and support, for example survivors of domestic abuse. There is also evidence that raising awareness and improving skills of frontline professionals and members of the public to talk to and support people at risk of suicide is a key protective factor.

5.2 As Manchester has high levels of chronic illness and poverty and based on the

risk factors highlighted above there is potentially a large population of people at risk of suicide making a broad community approach essential.

6. What are we currently doing in Manchester

6.1 As already highlighted, there is currently much being done as well as more that could be done to prevent suicides in the city. Below are some examples of work being delivered by different organisations either specifically related to suicide prevention or more broadly focused on improving public mental health and wellbeing. This list is not exhaustive and specifically does not provide a detailed list of the many community projects supporting this agenda. It is intended to demonstrate the range of activities and partners engaged in this work.

6.2 **Connect 5 training:** Provided by buzz Health and Wellbeing Service, commissioned by Public Health, Connect 5 equips staff with the skills to have mental wellbeing conversations with people that they work with as well recognising and responding to suicidal thoughts and knowing where people can get help. The service has recently secured additional funding from the Office of the Police and Crime Commissioner to work across staff groups within the Criminal Justice System in Greater Manchester

6.3 **Boost resilience training:** buzz is providing 'Boost' six week emotional resilience courses to the public in each locality

6.4 **Self Help Materials**: buzz maintains the Mental Health in Manchester website which provides a guide to better mental health and getting help, including emergency contacts and help lines. They service also distributes evidence-based self help guides for people with poor mental wellbeing or who are in distress.

6.5 **Manchester City Council and Manchester CCGs:** invest in a range of local mental health support via community voluntary organisations.

6.6 **Manchester Mental Health and Social Care Trust:** Has a comprehensive strategy to reduce suicide risk and deaths within its services and convenes a bi monthly Suicide Prevention Group to oversee the strategy and ensure learning is shared.

6.7 **Child and Adolescent Mental Health Services (CAMHS) provided by Central Manchester Foundation Trust (CMFT):** Specialist Community Mental Health Services for Children and Young People and Child and Adolescent Mental Health Wards have been rated as outstanding in the latest CQC report (June 2016)

6.8 **Places of Welcome:** Places of Welcome is a network of small community organisations, including faith communities, who offer an unconditional welcome to local people for at least a few hours a week. The network is based on trust, respect and generosity. They have developed a set of guiding principles, the 5P's - Place, People, Presence, Provision and Participation.

Each Place of Welcome needs a coordinator who can manage it on a week by week basis; acting as the point of contact, supporting volunteers, connecting with the wider Places Of Welcome network, and manage signposting information. Manchester Diocese is currently setting up a scheme in Wythenshawe (along with others in greater Manchester) and hopes to support many more over the coming months.

6.9 **The Sanctuary:** Is provided by Self Help and provides mental health crisis support to adults who are experiencing anxiety, panic attacks, depression, suicidal thoughts or are in crisis. It offers space to talk and assistance with coping. (see case study appendix 2)

6.10 **Centre for Suicide Prevention (University of Manchester):** Is a leading UK centre for research into suicidal behaviour and have two major research programmes – *The National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness* and *Manchester Self-Harm Studies (MASH)*

6.11 **Network Rail:** Work in Partnership with Samaritans to reduce the incidence of suicides at its stations and lines. Their programme includes hotspot identification, social deprivation mapping, media management, Samaritans training courses made available to railway personnel and campaign materials.

6.12 **Samaritans:** Samaritans volunteers provide a 24 hour telephone, text and email service for people who need emotional support including those who have suicidal thoughts or plans. Samaritans also provides an outreach service to Manchester Prison and works in partnership with Network Rail to provide training to its staff and signage for stations.

7. Approach to developing the local plan

7.1 In order to develop a robust local action plan that is evidence based, achievable and has the support of as wide range of partners as possible the following approach / steps have been taken:

- A working group has been established of suicide prevention 'ambassadors' from a range of organisations including Manchester City Council Public Health, Self Help, Mental Health and Social Care Trust (buzz health and wellbeing service) Network Rail, 42nd Street, Manchester Mind, Samaritans, University of Manchester, person with lived experience to coordinate the development of the plan. Councillor Joanna Midgley, in her role as Mental Health Champion as also been supporting the group. The group developed following discussions about suicide prevention at the CCG / MCC Mental Health Providers Engagement Group and particularly the desire of community voluntary sector organisations to have more strategic input into this agenda.

- A Joint Strategic Needs Assessment will underpin the plan with data and research evidence relating to suicide prevention including Manchester specific data. *This document is currently in draft awaiting approval through the quality assurance process and will be made available on*

Manchester City Council website once approved.

- Working group members have carried out a series of conversations with people from a wide range of organisations to gather insights to inform the focus of a local plan, engage people in the agenda and look for opportunities for joint working. These include:

  Citywide CCG Commissioning
  Clinical lead for Mental Health (Central CCG)
  Public Health England
  MCC Homelessness
  MCC Adults Safeguarding
  Manchester Mental Health and Social Care Trust
  Manchester Diocese
  Saheli
  MCC Children's Safeguarding
  CAMHS
  British Transport Police
  Papyrus (Young Person's Suicide Charity)
  Greater Manchester Police
  Family Intervention Service
  Greater Manchester Immigration Service
  University of Manchester (Suicide, Self Harm and Postvention research areas)
  Business Leader

7.2 The plan will align to and support local delivery of the GM suicide action plan being developed as part of the GM Mental Health Strategy

7.3 The plan is being structured in line with the Living Works model for Suicide Safer Communities.(6) This is an internationally recognised framework for local areas to implement activities around and allows areas to become a 'designated' Suicide Safer Community through an application process. The Living Works Model has 9 pillars of action which have been drawn from Suicide Prevention Strategies around the world. They 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*

8. Aims and objectives

8.1 The Suicide Prevention Working Group has identified the following aims and objectives for the work:

- Reducing the misery of mental distress
- Reducing the prevalence of suicidal ideation across the lifespan
- Preventing attempted suicides and deaths by suicide
- Identifying people at risk of suicidal thoughts and behaviours who 'fall beneath the radar' e.g. people working under high performance pressure
- Strengthening initiatives to increase emotional / psychological resilience
- Ensure better support for those bereaved or affected by suicide
- Strengthening partnerships to work together to reduce suicide
- Raising awareness that suicide prevention is everybody's responsibility
- Developing creative and far reaching public engagement initiatives
- Identifying and responding to the training needs of workforces working with people who may experience suicidal thoughts and behaviours
- Reducing the stigma and blame surrounding suicide and disclosing suicidal thoughts for individuals and workers
- Engagement with the media to ensure suicides are reported sensitively
- Work with commissioners to advocate for suicide prevention as a priority
- Use evidence based practice and measures evaluate our approaches and interventions.

9. Draft action plan

Informed by the approach above, the following action areas have been identified. These will build upon and optimise work already ongoing beneath the pillars – it is clear that we are not starting from scratch and there is already a solid foundation of work to build on.

Pillar	Action Area	Partners to include
1. Leadership / Steering Committee	Building on the working group already in place, establish a suicide prevention partnership to oversee the delivery of the plan	Suicide Ambassadors Key leads for targeted actions in the plan
2. Background Summary	JSNA produced, maintained and promoted Carry out local suicide audit in line with PHE recommendations Identification of local hot spots and opportunities to reduce access to means and promote support	Led by Public Health Team, MCC Led by Public Health with resource support from partners Network Rail, GMP, Highways Agency, GM suicide prevention executive
3. Suicide Prevention Awareness	Establish a network of suicide prevention ambassadors to advocate for suicide prevention within their work areas and disseminate key messages	

	Presentations to key groups and workforces Development of key messages in respect of suicide prevention Run 'open' suicide prevention awareness sessions for workforces and the public Work with GM colleagues to develop engaging public campaigns to reduce the stigma of suicide and let people know where support is available. Make links to national suicide prevention initiatives e.g. online suicide prevention	Using Suicide Prevention Ambassadors Network
4. Mental Health and Wellness Promotion	Delivery of resilience training and workshops with the public including young people. Dissemination of mental health self help / self care resources and Self Help Services	Buzz Health and Wellbeing Service Manchester Mind Self Help
5. Training	Ensure that key staff groups who come into contact with people at risk of suicide are equipped to provide appropriate compassionate support. This should be part of core workforce training programmes.	Organisations working with people at risk e.g. Homelessness, Domestic Abuse, Drugs and Alcohol GPs / Primary Care Mental Health Services
6. Suicide Intervention & Ongoing Clinical/Support Services	Task group to explore issues about Self Harm and how this can be addressed Establish pathways into appropriate community support for people receiving mental health services and prioritising people being discharged from services	CCGs, Mental Health Trust, Mental Health Providers Forum, Self Help

	Strengthen and develop initiatives that provide support for people in distress and ensure they are promoted, including managing distressing thoughts	Self help, Samaritans, Suicide Prevention Ambassadors
7. Suicide Bereavement	Strengthen, develop and promote support available for people bereaved or affected by suicide – this could include families and friends, workplaces and schools and colleges	Survivors of Bereavement by Suicide (SOBS), CAMHS, GMP, Public Health etc
8. Evaluation measures	Evaluation framework to assess the impact of the local plan	Suicide Prevention Working Group
9. Capacity building / sustainability	Integrate suicide prevention into existing approaches to community asset building and self care	Our Manchester Leads, buzz

10. Timescales and next steps

10.1 The final plan alongside the JSNA will be presented to the Health and Wellbeing Board on 31st August 2016. The plan will be launched to a wider audience following this. A date for the launch will be confirmed following further discussion with Greater Manchester Suicide Prevention Executive to ensure it is aligned with planned activities and maximises communications opportunities but is likely to be around Suicide Prevention Day on 10th September or World Mental Health Day 10th October.

10.2 Further consultation on the plan will take place with appropriate Boards, Committees, Groups and organisations to ensure it has the right focus and engagement and is achievable.

10.3 Once the plan has been agreed delivery will be overseen through the establishment of a Manchester Suicide Prevention Partnership, formed from the existing working group with additional members.

11. Recommendations

11.1 The Committee is asked to:

- Note the contents of the report
- Consider the multiple factors that impact upon suicide rates
- Provide feedback and ideas on draft actions in the plan

Appendix 1

Suicide deaths in Manchester 1997-2013 **8th June 2016**

Summary

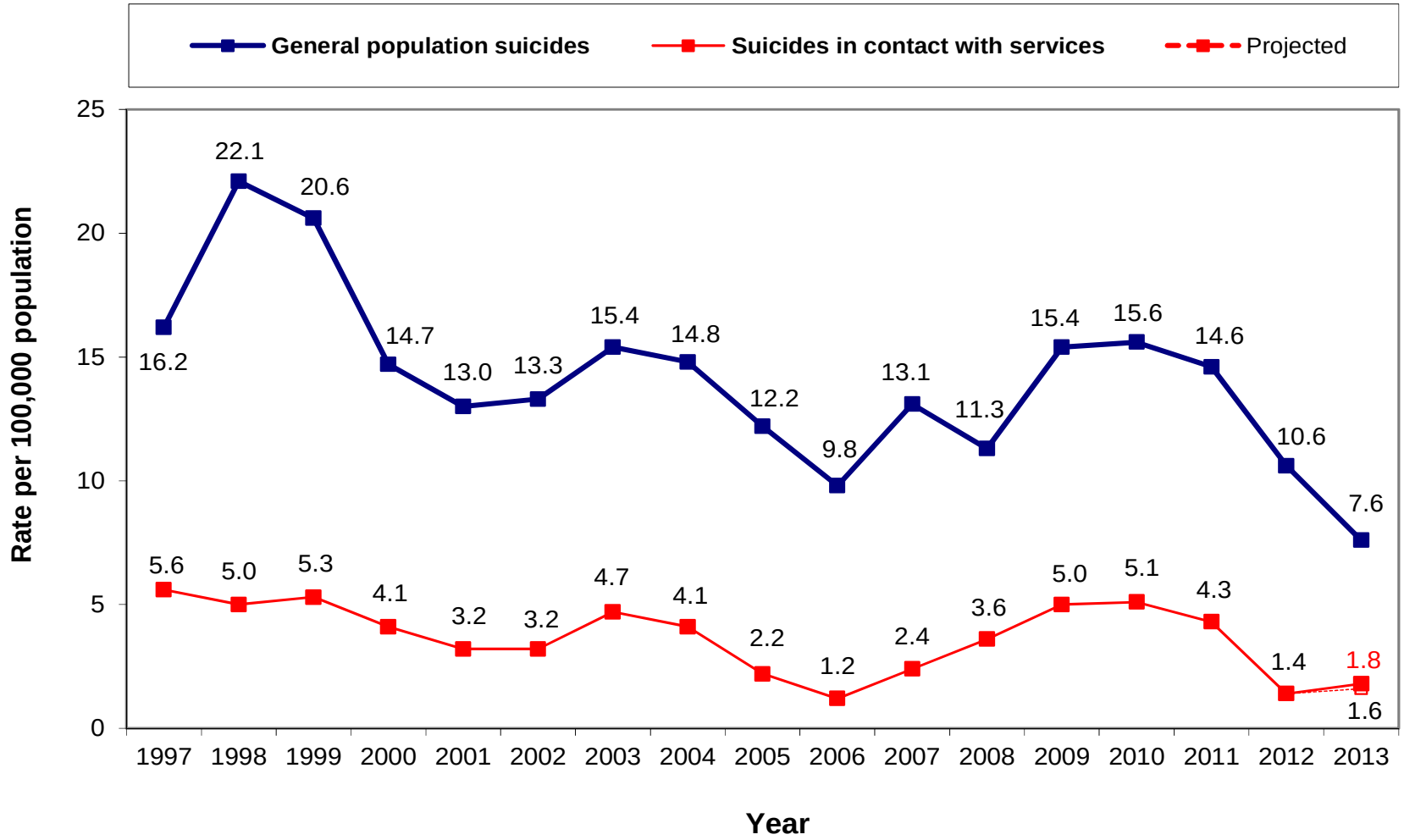
- Suicide rates in the general population in Manchester appear to have fallen between 1997 and 2013 (table 1 and Figure 1). They remain higher than the England average but are now below the average for the North West (Figure 2).
- The proportion of people in contact with services before suicide has varied over this time period, but the average proportion in contact is similar to national figures.
- From 2006 to 2010 rates in both the general and clinical populations rose. It is possible that the general population increase was associated with socioeconomic factors. The increase in the patient figures is more difficult to interpret. It could simply reflect underlying trends but could also indicate better engagement of at risk individuals by services.
- Since 2010 rates of suicide have been falling.
- The characteristics of Manchester residents who died by suicide are somewhat different to the characteristics of those who die by suicide in England as a whole. For example, Manchester residents have higher rates of death by self-poisoning; they are more often on long-term sick leave or from a black and minority ethnic group; and they are more likely to have a history of drug misuse and alcohol misuse. This is probably a reflection of differences in the socio-demographic characteristics of the underlying population as well as possible specific risk factors for suicide.
- All data are based on individuals with postcodes in the City of Manchester.
- Because the numbers are relatively small, trends will inevitably be influenced by random fluctuations.

Table 1: Suicide deaths in Manchester (1997-2013)

	General population suicides N=947 N	Contact within 12 months[A] N=245 N	% in contact[B] (26% average)	% England in contact[B] (27% average)
1997	58	20	34%	24%
1998	79	18	23%	24%
1999	74	19	26%	25%
2000	54	15	28%	26%
2001	48	12	25%	27%
2002	50	12	24%	27%
2003	59	18	31%	27%
2004	58	16	28%	28%
2005	49	9	18%	29%
2006	40	5	13%	27%
2007	54	10	19%	27%
2008	47	15	32%	26%
2009	65	21	32%	27%
2010	67	22	33%	29%
2011	64	19	30%	30%
2012	47	6	13%	29%
2013	34	8	24%	29%

A 'Individuals who died by suicide within 12 months of mental health service contact; B '% in contact' refers to the proportion of general population suicide deaths which occurred in individuals within 12 months of mental health service contact.

Figure 1: Rates of suicide per 100,000 population in Manchester



Note: Significant fall between 1997-2012 in the general population and patient suicide rate

Figure 2: Age standardised suicide rates in the North West (average rate 2012-14, based on year of registration)

4.10 - Suicide rate (Persons) 2012 - 14

Directly standardised rate - per 100,000

Area	Count	Value	95% Lower CI	95% Upper CI
England	14,122	8.9	8.8	9.1
North West region	2,147	10.3	9.9	10.8
Preston	64	16.7	12.8	21.4
Blackpool	61	15.2	11.6	19.6
Hyndburn	33	14.6	10.0	20.5
Copeland	30	14.4	9.7	20.6
South Lakeland	44	14.2	10.2	19.3
Bury	67	12.4	9.6	15.8
Pendle	32	12.3	8.4	17.4
South Ribble	39	12.1	8.6	16.6
St. Helens	61	11.9	9.1	15.3
Rochdale	72	11.8	9.2	14.9
Stockport	96	11.5	9.3	14.1
Tameside	74	11.5	9.0	14.4
Oldham	71	11.2	8.7	14.1
Sefton	88	10.8	8.7	13.4
Knowsley	46	10.8	7.8	14.4
Fylde	25	10.6	6.8	15.7
Warrington	64	10.5	8.1	13.5
Lancaster	44	10.5	7.6	14.2
Burnley	26	10.1	6.6	14.9
Carlisle	32	10.1	6.9	14.3
Blackburn with Darwen	40	10.0	7.1	13.7
Manchester	138	9.9	8.2	11.8
Wigan	94	9.8	7.9	12.0
Liverpool	133	9.7	8.1	11.6
Bolton	77	9.5	7.5	11.8
Wyre	28	9.3	6.1	13.6
Cheshire West and Chester	92	9.3	7.5	11.4

Source: www. phoutcomes.info/search/

Figure 3: Public Health England suicide rates in Manchester 2001-2014

Source: www. phoutcomes.info/search/

Table 2: General population suicide deaths in Manchester (1997-2013)

	Manchester Suicide deaths N=947		**Remaining England suicide sample N=78,055**	
	N	**%**	**N**	**%**
Age and sex				
Age: median (range)	40 (13-96)		44 (10-104) **	
Male	724	76%	58,758	75%
Method				
Hanging	372	40%	32,808	42%
Self-poisoning	326	35%	18,476	24% **
Jumping /multiple injuries	81	9%	7,817	10%
Carbon monoxide poisoning	24	3%	4,425	6% **
Drowning	33	4%	3,787	5%
Other†	104	11%	10,105	13%
Unknown/unascertainable	7	1%	640	1%

** p<0.001 * p<0.05
†includes firearms, suffocation, electrocution, burning, cutting & other specified

Table 3: Suicide in patients in contact with MMHSCT in the 12 months before death (1997-2013)

	MMHSCT Suicide deaths N=232		Remaining England patient suicide sample N=22,234	
	N	**valid %**	**N**	**valid %**
Demographic features				
Age: median (range)	40.5 (18-95)		44 (10-98) **	
Male	165	71%	14,769	66%
Not currently married	183	81%	15,276	70% **
Living alone	111	50%	9,708	45%
Unemployed	102	46%	9,071	42%
Long-term sick	62	28%	3,464	16% **
Black and minority ethnic group	32	15%	1,551	7% **
Method				
Self-poisoning	100	43%	5,926	27% **
Hanging/strangulation	70	30%	8,777	40% *
Jumping/multiple injuries	28	12%	3,302	15%
Other[†]	32	14%	4,126	19%
Priority groups				
In-patient	26	11%	2,569	12%
Post-discharge patients	29	14%	4,193	21% *
Missed last appointment	58	30%	5,189	27%
Non-adherent with medication in last month	45	23%	3,062	15%*
Clinical features				
Primary diagnosis:				
Schizophrenia	62	27%	3,945	18% *
Affective disorder	99	43%	9,890	45%
Alcohol dependence	33	14%	1,856	8% *
Drug dependence	1	<1%	955	4% *
Personality disorder	16	7%	2,008	9%

Other primary diagnosis‡	20	9%	2,854	13% *
Any secondary diagnosis	128	55%	11,402	52%
Duration of mental illness (under 12 months)	25	11%	4,452	21% **
Behavioural features				
History of self-harm	163	73%	14,701	68%
History of alcohol misuse	132	59%	9,560	44% **
History of drug misuse	93	42%	6,789	31% *
History of violence	58	26%	4,585	21%
Contact with services				
Last contact within 7 days of death	88	39%	10,780	49% *
Symptoms at last contact	158	75%	13,584	64%*
Estimate of immediate risk: low or none	172	86%	17,624	86%
Estimate of long-term risk: low or none	89	53%	10,765	60%

** p<0.001 * p<0.05

† includes CO poisoning, drowning, firearms, cutting, suffocation, burning, electrocution & other specified

‡ includes anxiety disorders, eating disorder, adjustment disorders, dementia, organic disorder, conduct disorders, learning disability and other specified.

Self-harm in Manchester 2003-2013

- Rates of self-harm in Manchester have increased since 2008/9 but fell in men in 2013.
- The increase in men was largest in the 35-54 year age group
- The increase for women was largest in the 15-24 year age group

Figure 1: Rates of self-harm by sex 2003-2013

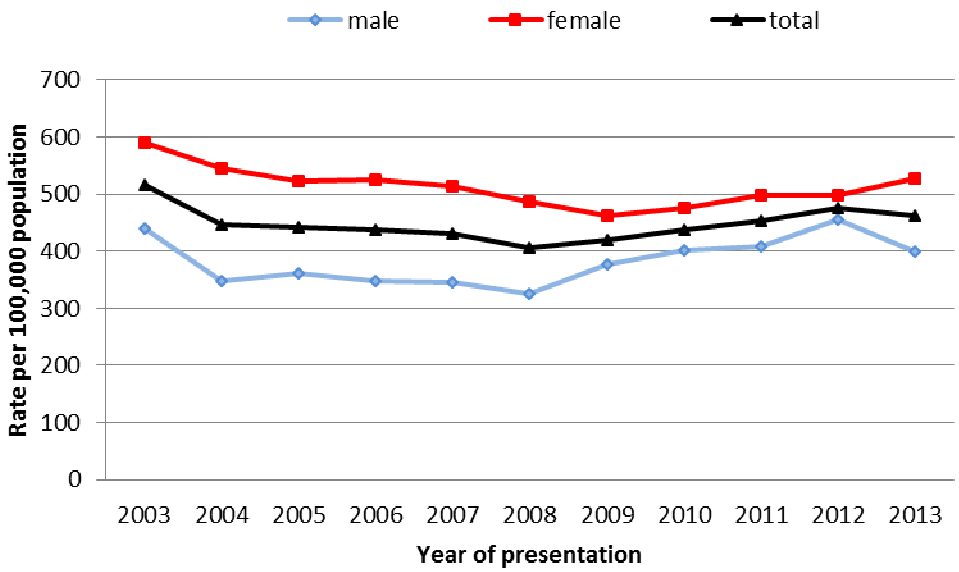
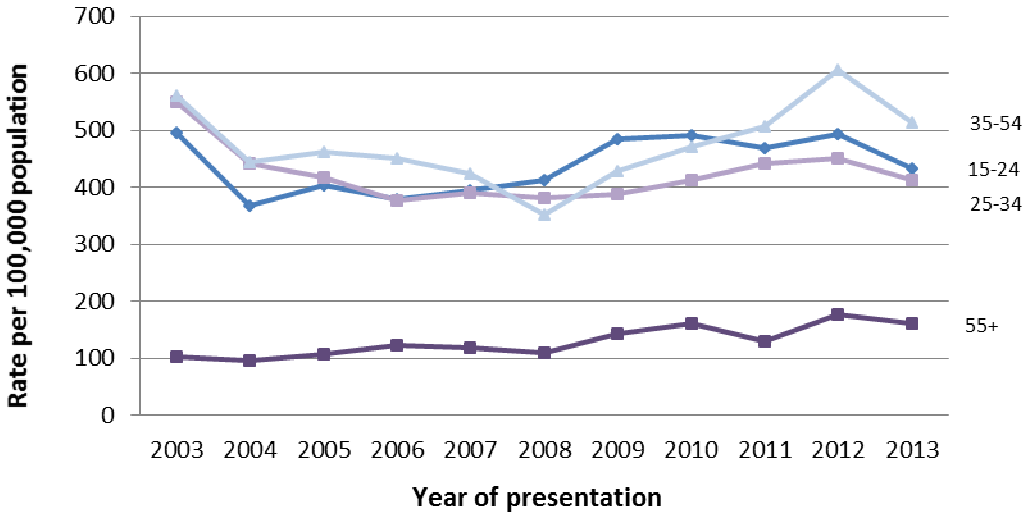


Figure 2: Rates of self-harm among males, by age group, 2003-2013



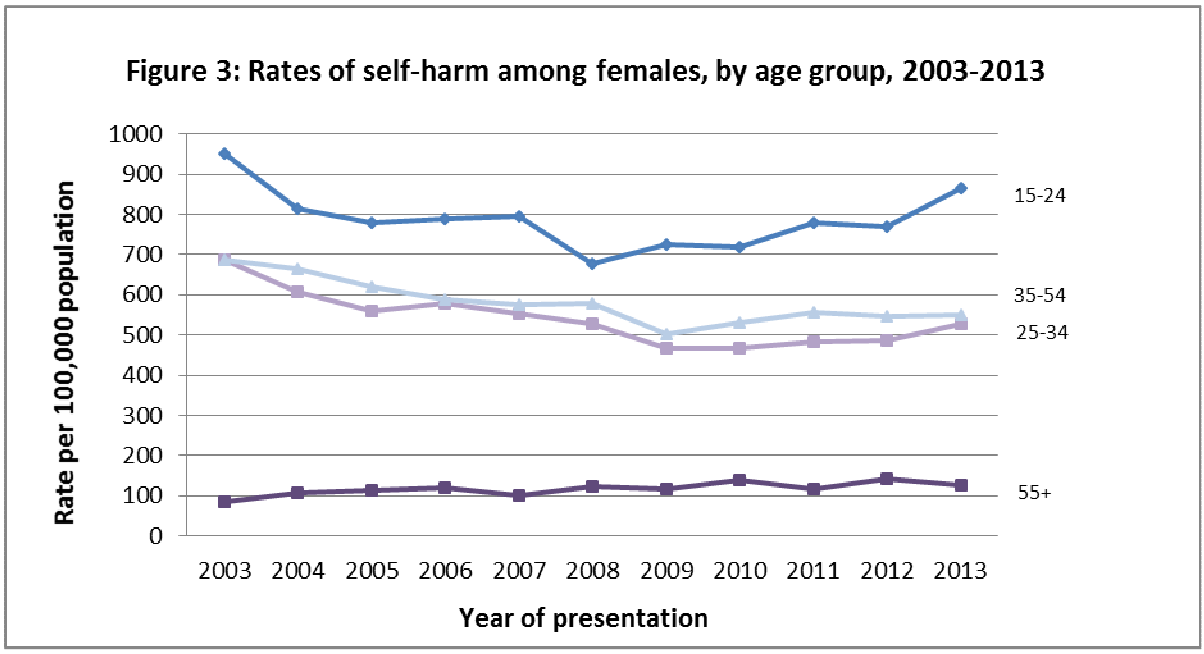


Figure 3: Rates of self-harm among females, by age group, 2003-2013
Rate per 100,000 population
1000
900
800
700
600
500
400
300
200
100
0
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
Year of presentation
15-24
35-54
25-34
55+

Appendix 2

The Sanctuary: providing the right care at the right time

Introduction

Contact the Sanctuary:

The Sanctuary 24/7 phone line:
0300 003 7029

Facebook:
www.facebook.com/SanctuarySHS

Twitter:
www.twitter.com/weareselfhelp

The Sanctuary is a nationally-recognised model of good practice in mental health crisis care, providing 24 hour support in the community for those experiencing anxiety, depression or low mood, panic attacks or suicidal thoughts, and who are in crisis.

The service, funded by local NHS commissioning groups, is community-based, and provides a timely response to those people in mental health crisis, who are sub-threshold for traditional NHS mental health crisis services.

These people would ordinarily present at A&E, only to learn that they do not meet the criteria for NHS crisis care services. In offering this provision, Self Help is enabling those people in crisis to access the right care, at the right time, in the right place.

The idea for the Sanctuary came from Nicky Lidbetter, Chief Officer and Founder of Self Help, following her experience, more than 20 years ago, where she suffered with severe panic attacks. Like many people, she rushed to A&E fearing that she was losing control, and believing that this environment would be best placed to meet her needs.

While there, she was reassured by hospital staff that there was nothing physically wrong with her, but the experience left her feeling frightened, unsure and, critically, still experiencing mental distress.

Nicky, like many others who turn to A&E in a crisis when they couldn't cope, felt that this wasn't the appropriate place to be when experiencing a crisis and that more could be done.

She was a prime example of someone whose presentation was 'sub-threshold' in terms of being eligible for support via NHS mental health crisis services, and her experience is one that thousands of people share every year up and down the country.

National recognition

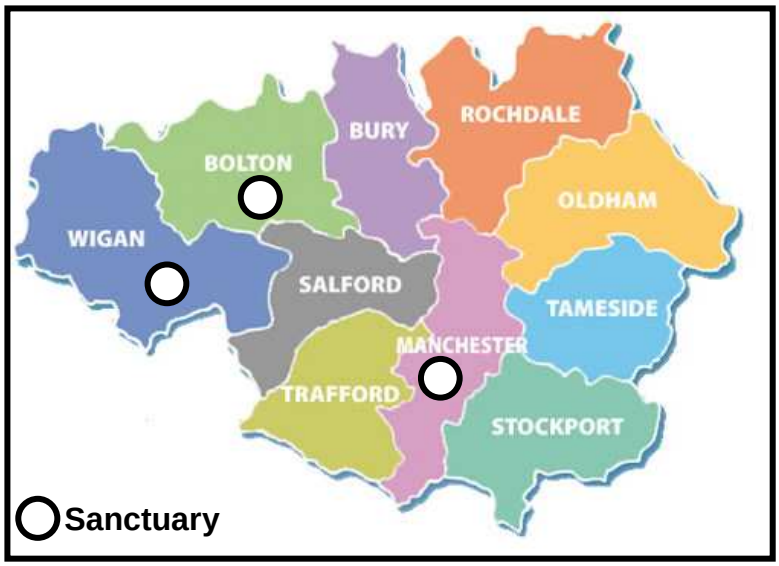
The Sanctuary is now a nationally-recognised model of best practice for mental health crisis support, with endorsement from high-profile influencers throughout the country:

Norman Lamb MP, former Minister of State for Care and Support, said: "When I first proposed the idea of a Crisis Care Concordat, I knew that I wanted to create a blueprint that could genuinely be used and adopted locally. The brilliant work you are doing in Greater Manchester is testament to that vision, and I am delighted with your progress."

Mike Penning MP, Police Minister for the Home Office, said: "Improving the way the police and health services deal with people experiencing a mental health crisis is a priority for this Government. A vital part of achieving better outcomes is the work of organisations such as the Sanctuary, which provide a crucial service at a time when many vulnerable people need the most help."

What we offer

Sanctuaries are open all night, every night from 8pm through to 6am, serving the CCG populations of Manchester, Salford, Trafford, Tameside and Glossop, Bolton and Wigan, via three physical venues.



They provide a place of safety and support, in a non-clinical environment, where clients can gain support from staff who have often had experience of living with a mental health difficulty; indeed, provision of peer-led support is central to the ethos of The Sanctuary, and differentiates the service from the NHS crisis mental health service offer.

The night time Sanctuary crisis service is supported by a 24-hour telephone crisis support line which provides telephone assessments, screening and interventions to assist people who are dealing with emotional crisis.

The Sanctuary Manchester, based at the Kath Locke Centre in Hulme, has had **3,862** interactions with service users between April 2015 and May 2016.

In order to ensure the best outcomes for service users, the Sanctuary has developed strong partnerships with key agencies such as Greater Manchester Police, North West Ambulance Service and Greater Manchester Fire and Rescue Service. This includes reciprocal referral arrangements, whereby Sanctuary staff can refer directly to their services, and vice versa.

Links have also been forged with out-of-hours services, aimed at ensuring the service user pathway is improved, and that they are signposted to the right service when they are experiencing mental health crisis.

How it helps

A University of Manchester report revealed that **seven per cent** of people who had used The Sanctuary would have self-harmed or attempted suicide if they had not had access to it.

Equally, **43 per cent** of people would have gone to A&E, called an ambulance or the Police had it not been for The Sanctuary, proving demonstrable savings for commissioners and the overall health economy.

An independent cost benefit analysis by New Economy has shown our daytime service to have a fiscal cost-to benefit ratio of **1:14**, while that rises to **1:18** for our night service.

John's story…

I've struggled with low mood for a long period of time, and recently things started to get worse as I found myself restless overnight with negative, unwanted thoughts.

Not knowing where to turn, by chance, I came across a Sanctuary emergency card and gave them a call. I needed to speak to someone desperately.

I can honestly say that the help I received that night was fantastic – it saved my life. This type of support is one of the best ideas I've ever come across to support people like me, who continuously struggle with their mental health.

The staff at the Sanctuary could really relate to my issues. Lots of them had been through similar experiences themselves and this made a huge difference in terms of the advice they were able to offer.

To put it simply, they gave me hope to continue in life. I wouldn't be here if it wasn't for the support I received the first night I called them.

Since my initial visit, the team have gone out of their way to keep in touch with me and make sure that I'm okay. One of the staff is even teaching me how to play the guitar! Something I've always wanted to learn.

They are truly going above and beyond to meet my needs and that's made a huge difference in how I feel about myself.

It's been the most helpful experience I've had with a mental health service.

Contact us

For further information about The Sanctuary, please contact Nicky Lidbetter, Chief Officer at Self Help, on 07791 560 842 or via **nicky.lidbetter@selfhelpservice.org.uk**.