Manchester City Council
Report for Resolution

Report to: Health Scrutiny Committee – 5 December 2017

Subject: Suicide Prevention Update

Report of: The Director of Population Health and Wellbeing

Summary

This report provides the Committee with an update on the paper submitted in June 2016 and specifically reports progress on the delivery of the local suicide prevention plan. This is shared in draft form with the Committee to gather feedback.

The report provides information on:

- The national and local strategic context of suicide prevention
- Key trends, facts, figures and risk factors relating to suicides in Manchester
- Findings from the Greater Manchester Suicide Audit
- A summary of key areas of activity contributing to suicide prevention
- Progress on delivery of specific actions within the local plan
- Future plans

Recommendations

The Committee is asked to:

1. Note the contents of the report
2. Consider the multiple factors that impact upon suicide rates
3. Provide feedback and ideas to support suicide prevention

Wards Affected: All

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We would also like to acknowledge input to this paper from Professor Nav Kapur (University of Manchester), Dr Isabelle Hunt (University of Manchester), Caroline Clements (University of Manchester) Nicky Lidbetter (Big Life Group) and Kay Paterson (Manchester City Council).

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.

Report to Manchester Health Scrutiny Committee – June 2016

1.0 Introduction

1.1 Every suicide is an individual tragedy and a loss to society and one suicide is one too many. When someone dies by suicide the shock is felt by families, friends, neighbours, colleagues and professionals. Suicide, in contrast to other bereavements can bring silence and stigma which can amplify the impact on those left behind. As well as the huge social and emotional costs the economic costs are considerable - it is estimated that the cost of a completed suicide is £1.67m and a significant proportion of this relates to the impact of the bereavement on others e.g. lost earnings and mental health impacts.

1.2 Whilst people who are in the care of Mental Health Services are at increased risk of suicide, the majority of those who take their own lives have not been in contact with mental health services within the previous 12 months. Often suicides occur without warning. This means that a broad-based approach that recognises the role that communities, organisations and individuals play in preventing suicide is essential.

1.3 There is much interest and commitment from a range of agencies and organisations across sectors in the city in contributing to preventing suicides that can be harnessed. Suicides are not inevitable. There are many ways in which services, communities, individuals and society can help to prevent suicides. A spokeswoman for the Office for National Statistics (ONS) recently commented: “The recent decline in the suicide rate is likely to be due to the suicide prevention work in England by the government, the NHS, charities, the British Transport Police and others.”
https://www.theguardian.com/society/2017/sep/07/drop-uk-suicide-rate-linked-prevention-work-england

2.0 Defining and reporting suicide

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

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

2.3 There is some evidence that suicides may be under-reported where narrative conclusions are provided by coroners.

3.0 Strategic context for suicide prevention work

3.1 National strategic context

3.1.1 Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives published in January 2017, strengthened the existing strategy by highlighting the following areas for action:

- Better and more consistent local planning and action by ensuring that every local area has a multi-agency suicide prevention plan in 2017, with agreed priorities and actions;
- Better targeting of suicide prevention and help seeking in high risk groups such as middle-aged men, those in places of custody/detention or in contact with the criminal justice system and with mental health services;
- Improving data at national and local level and how this data is used to help take action and target efforts more accurately;
- Improving responses to bereavement by suicide and support services; and
- Expanding the scope of the National Strategy to include self-harm prevention in its own right.

3.1.2 In October 2016 Public Health England (PHE) published detailed guidance to support local authorities to establish a suicide prevention partnership, develop a local action plan and use data and evidence effectively. NICE guidelines on suicide prevention are due to be published in September 2018.

3.2 Greater Manchester Suicide Prevention

3.2.1 A Greater Manchester Suicide Prevention Strategy was endorsed by the Greater Manchester Health and Social Care Strategic Partnership Board in February 2017. Actions within the strategy are organised around six key objectives:

- All ten Boroughs (and Greater Manchester as a whole) will achieve Suicide Safer Communities Accreditation (the 'nine pillars of suicide prevention') by 2018
- Mental Health Service Providers will collaborate to work toward the elimination of suicides for in-patient and community mental health care settings by continuous quality improvement in relation to 10 key ways for improving patient safety
- We will strengthen the impact and contribution of wider services
- We will offer effective support to those who are affected
- We will develop and support our workforce to better assess and support those who may be at risk of suicide
- We will use the learning from evidence, data and intelligence to improve our plan and our services.

3.2.2 The primary focus for the first two years of the strategy (2017/18 – 2019/20) will be to meet the challenge set out within the Five Year Forward View for Mental Health i.e. to reduce the rate of suicide by 10% by 2020.

3.2.3 The GM strategy is being overseen by the GM suicide prevention executive and Manchester is represented on the group and will continue to support the strategy both through the delivery of our local plan and leadership in project work at a GM level.

3.3 Manchester Suicide Prevention Partnership

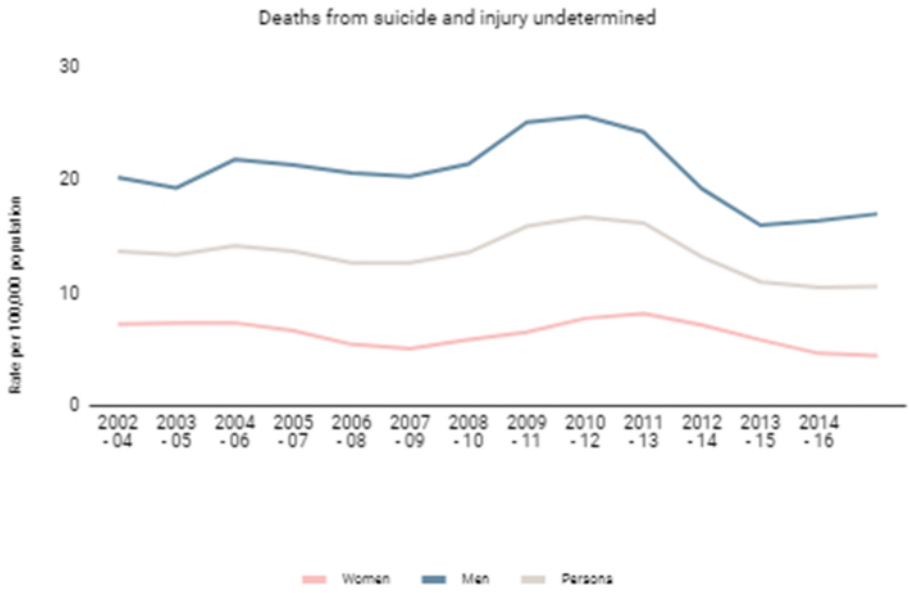
Manchester Suicide Prevention Partnership continues to be chaired by Councillor Joanna Midgley, Mental Health Champion. The partnership steering group meets regularly and oversees the operational delivery of the local plan and shapes the strategic direction of the work. Theme leads from different organisations take responsibility for different areas of the plan. The partnership held its first open forum in June 2017 to formally launch the plan and engage a broader range of partners. The next forum will be held in January / February 2018. These forums will be held twice / three times a year and tackle a range of issues important for suicide prevention. The next forum will focus on long term / painful conditions and carers. This topic has been chosen due to the findings from the GM suicide prevention audit.

4.0 Summary of key facts and trends about suicides and self-harm

4.1 Suicides in Manchester

Year	Number of suicides (all ages) (single year by date of registration - source PCMD)		
	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
2015	45	38	7
2016	38	30	8

Whilst numbers of suicides increased in 2014 from the previous year, numbers of suicides have been decreasing. 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

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 shows that for the 2011-15 male and female aged 35-64 and the female aged 10-34 cohorts, Manchester had significantly higher rates than for England.

Compared with benchmark: Lower Similar Higher Not Compared

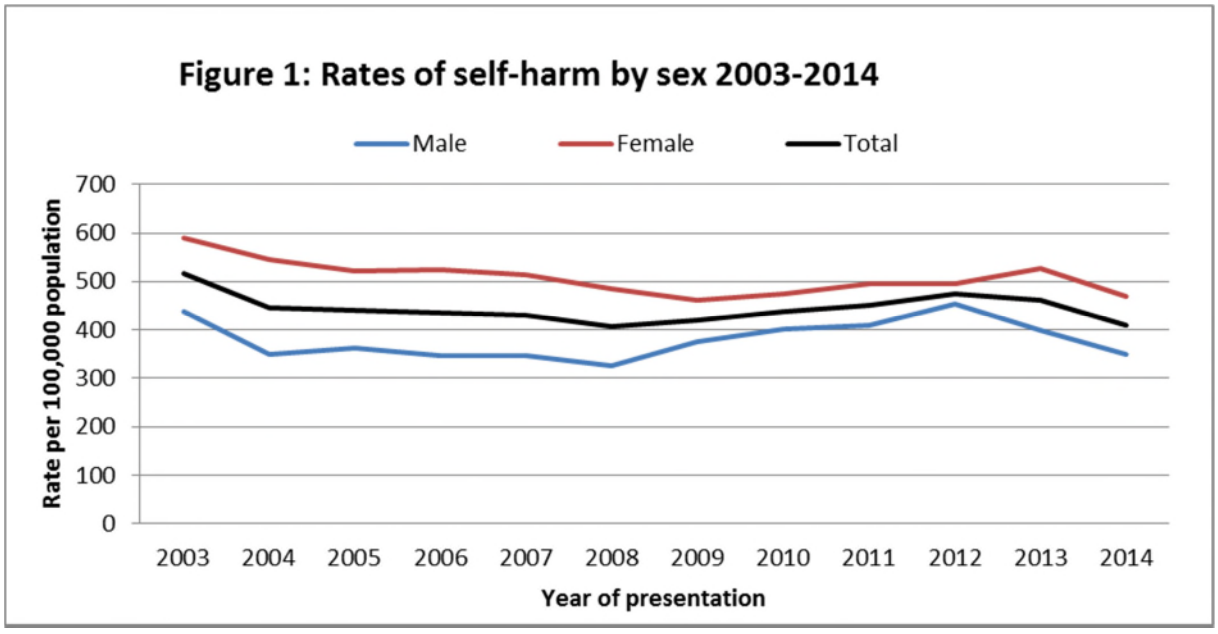
Benchmark Value: Lowest | 25th Percentile | 75th Percentile | Highest

Indicator	Period	Manchester			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Lowest	Range	Highest
Suicide: age-standardised rate per 100,000 population (3 year average) (Persons)	2014 - 16	–	131	10.6	11.0	9.9	6.1		18.3
Suicide: age-standardised rate per 100,000 population (3 year average) (Male)	2014 - 16	–	104	17.0	16.7	15.3	8.4		27.7
Suicide: age-standardised rate per 100,000 population (3 year average) (Female)	2014 - 16	–	27	4.4	5.5	4.8	2.3		11.3
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 10-34 years: per 100,000 (5 year average) (Male)	2011 - 15	–	58	9.6	12.4	10.5	4.5		25.3
Suicide crude rate 10-34 years: per 100,000 (5 year average) (Female)	2011 - 15	–	200	3.6*	3.6	2.9	2.5		4.0
Suicide crude rate 35-64 years: per 100,000 (5 year average) (Male)	2011 - 15	–	120	29.1	24.0	20.8	8.9		39.7
Suicide crude rate 35-64 years: per 100,000 (5 year average) (Female)	2011 - 15	–	462	6.6*	6.6	6.0	5.0		7.1
Suicide crude rate 65+ years: per 100,000 (5 year average) (Male)	2011 - 15	–	12	11.3	12.3	12.6	2.9		26.2
Suicide crude rate 65+ years: per 100,000 (5 year average) (Female)	2011 - 15	–	147	4.3*	4.3	4.4	3.7		5.6

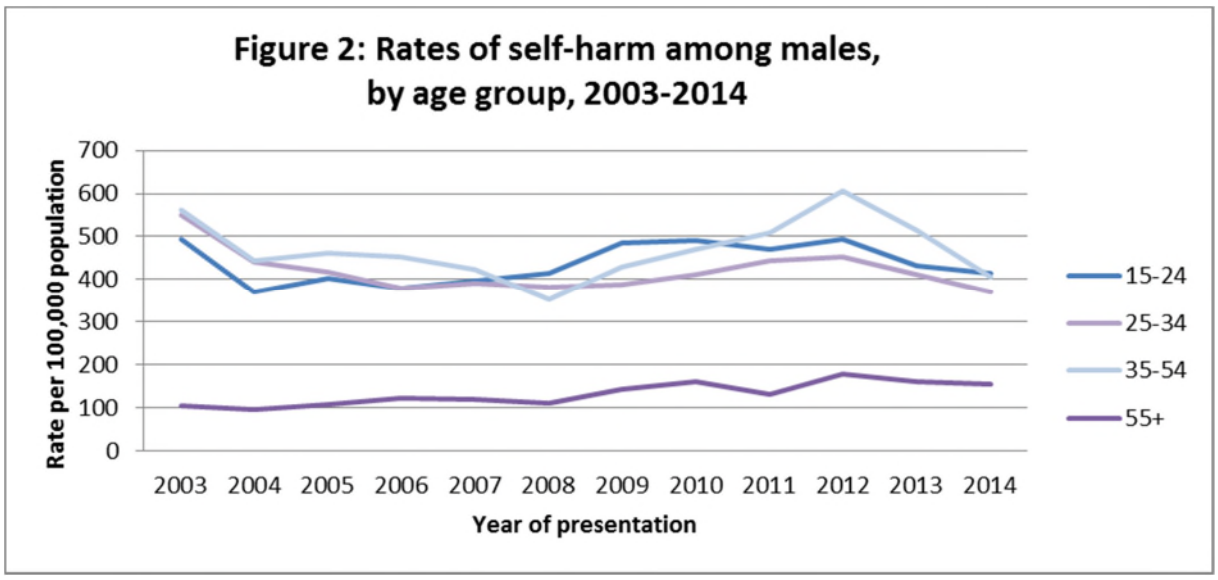
Further detailed data on suicide in Manchester can be found in appendix 1.

4.2 Self-harm in Manchester

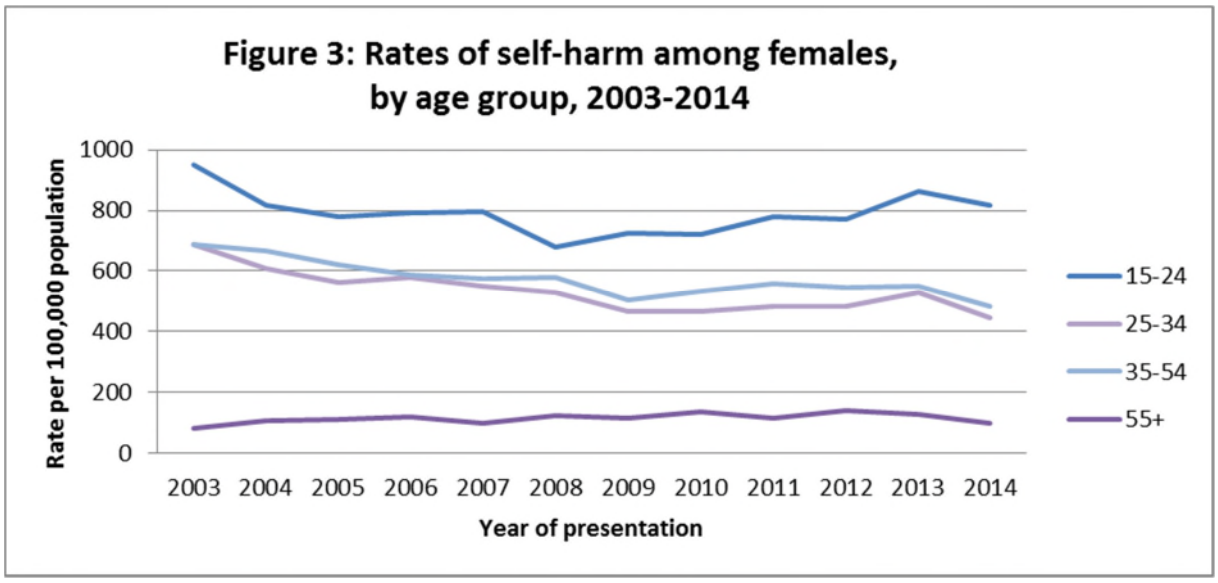
Rates of hospital presentations for self-harm by people resident in the City of Manchester (individuals aged 15 years and over)



Rates of hospital presentations for self-harm by males resident in the City of Manchester (individuals by age-group)



Rates of hospital presentations for self-harm by females resident in the City of Manchester (individuals by age-group)



4.2.1 Figure 1 shows the rates of hospital presentation for self-harm over time by people who are resident in the City of Manchester. Rates of self-harm declined overall in males and females early in the period, but began to increase again around 2008, reaching a peak male rates of self-harm in 2012 (where the gap between rates in males and females narrowed substantially), and in female rates of self-harm in 2013. From 2014 there appears to be a decline in rates of self-harm but further years of data are needed to see if this decrease is sustained over time. It should be noted however that even with the increase around 2012, rates are still lower than at the start of the period.

4.2.2 Figures 2 shows the rates of hospital presentations for self-harm by males resident in the City of Manchester, split by gender and by age group. There are important differences in rates of self-harm by age. The most notable change over time in age-based rates in men is the peak in self-harm by men aged 35 to 54 around 2012 and 2013. Previously rates fluctuated but were similar across the three younger age groups, and in contrast to the overall rates the rate for men aged 35 to 54 reached a peak in 2012 higher, at just over 600 per 100,000, than at the start of the period (around 550 per 100,000). There was also a near doubling of the rate in older males between the start and end of the period.

4.2.3 Figures 3 shows the rates of hospital presentations for self-harm by females resident in the City of Manchester, split by gender and by age group. Despite overall decline in rates over time, the youngest female age group (15-24 years) continues to have the highest rate of self-harm, with recent increases following a low of around 650 per 100,000 in 2008, peaking again at a rate of over 800 per 100,000 in 2013. The three older age groups remained relatively stable or decreased over time.

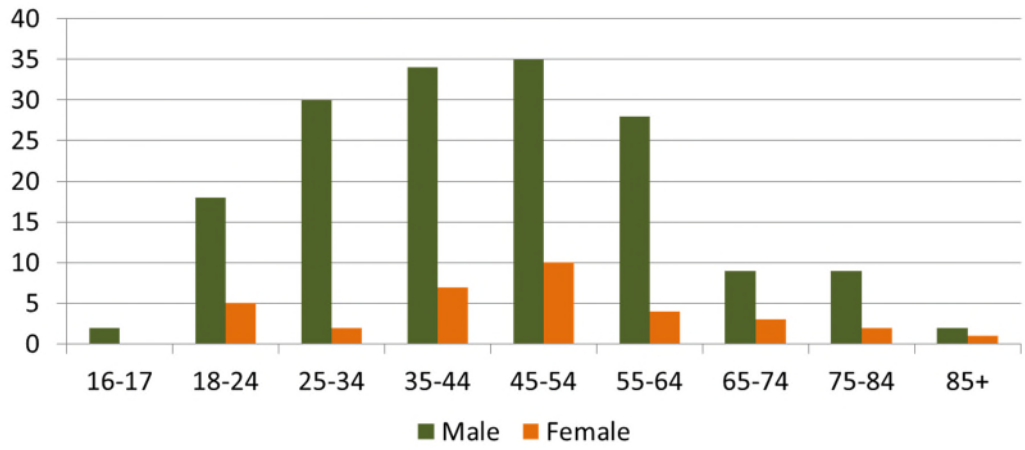
4.3 Findings from the Greater Manchester Suicide Audit

4.3.1 Introduction

Manchester participated in Greater Manchester suicide audit in 2016. Small numbers in each local area can restrict the usefulness of the data so the findings from the 36 Manchester (2015) records were combined with those from other local authorities. Coroner records were examined where the inquest had concluded that the intent for an individual to take their life by suicide was proven beyond reasonable doubt.
The aims of the audit were to identify the demographics, common themes and factors in deaths by suicide in GM. This insight can now inform the development of the Greater Manchester Suicide Prevention Action Plan as well as the local action plan for Manchester.

4.3.2 GM Suicide Audit – 2015 deaths

- Total of 201 cases, 167 men (83%), 34 women (17%)
- The highest proportion were aged 45-54 (22%) and 13% were aged 65 and over

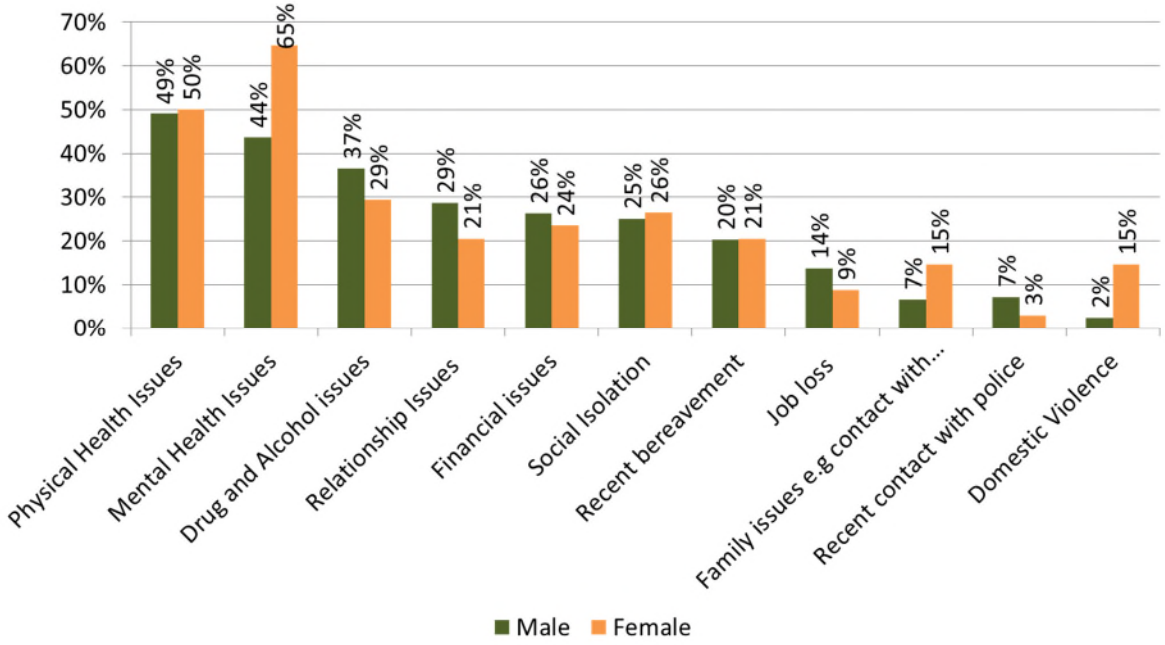


GM Suicide Audit 2015 – by Local Authority

	Total	Male		Female	
Bolton	20	17	85%	3	15%
Bury	14	12	86%	2	14%
Manchester	36	30	83%	6	17%
Oldham	12	10	83%	2	17%
Rochdale	15	14	93%	1	7%
Salford	23	18	78%	5	22%
Stockport	14	8	57%	6	43%
Tameside	18	17	94%	1	6%
Trafford	9	9	100%	0	0%
Wigan	40	32	80%	8	20%
Total	201	167	83%	34	17%

4.3.3 Key themes emerged in relation to the following areas:

- Social Isolation – lack of friendship groups, lack of close relationships, age
- Physical health issues – injuries, chronic illnesses, severe illnesses
- Occupations – including construction
- Contact with police
- Job loss and financial issues
- Bereavement and connection with suicide
- Relationship breakdown, in particular for men
- Internet



A summary of the findings can be found in appendix 2**.** It is planned for a Manchester specific audit to be carried out in early 2018 to examine the data from 2016.

4.4 Suicides by Children and Young People

Although numbers of children and young people under 18 who die by suicide are low - and within Manchester there were no cases in 2016/17 (*Child Death Overview Panel report 2017*), suicide is the leading cause of death in the UK in 10 - 19 year olds. (ONS). A recent study looked at 922 suicides by young people aged under 25 in England and Wales during 2014 and 2015. Key messages emerging from the research are that suicide in young people usually follows a combination of existing vulnerabilities and events. These stresses are common in young people and most do not come to serious harm. Themes for suicide prevention identified are support for family factors such as mental illness or substance misuse; specific support for vulnerable groups including young people who are bereaved; greater priority for mental health support within colleges and universities; housing and mental health support for looked after children; mental health support for LGBT young people.

4.5 Other risk factors relevant for Manchester

Along with local findings from the Greater Manchester Suicide Audit there is a need to be mindful of other groups known to be at higher risk of suicide including:

- **Men -** Males are three times more likely to die by suicide than females
- **Age -** The highest rate of suicide for men is in those aged 40-44 and the highest rate of suicide for women in those aged 50-54
- **Mental Health -** Although only about a quarter of people who take their own life have been in contact with mental health services prior to their death. The Mental Health Foundation estimates that 70% of recorded suicides are by people experiencing depression - often undiagnosed.
- **Self-Harm -** a history of self-harm is a major risk factor for further self-harm and death by suicide
- **Those who have experienced domestic abuse including sexual abuse -** there are strong links between intimate partner violence and suicidal thoughts and behaviours. Manchester has high rates of domestic violence compared to other core cities.
- **Veterans -** veterans are at increased risk of suicide and this risk is increased for those who leave early (as opposed to longer serving personnel).
- **History of childhood abuse** and other adverse childhood experiences
- **LGBT** - there is growing evidence of the increased risk of self-harm and suicidal thoughts amongst LGBT people and a study conducted in the UK highlighted the impact of homophobia and discrimination as key factors.
- **Black, Asian and minority ethnic groups -** Studies have found higher rates of self-harm and suicide amongst Asian women than for other groups. Prevalence data is limited however as ethnicity is not recorded on death certificates.
- **Criminal Justice System** - The World Health Organization recognises that prisoners are a high risk for suicide, as are those on remand and those

recently released from custody. The risk is greatest in the first week of imprisonment.

- **Social and economic circumstances** - People who are unemployed are 2 to 3 times more likely to die by suicide than those in work. High levels of deprivation and health-related worklessness in Manchester make this risk factor a particular concern.
- **Inequality** is another major risk factor, with people among the most deprived 10% of society more than twice as likely to kill themselves than the least deprived 10%, according to the ONS.
- **Drug and alcohol use -** Alcohol and drug use can amplify suicidal thoughts, plans and deaths. A recent UK based study found that the use of alcohol significantly increased suicide risk, particularly in women.
- **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 aged 65 and over. This was also found to be a key risk factor amongst those suicides examined for the local audit.
- **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 to prevent suicide within the population?

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.

6. Current activity in Manchester and future plans

6.1 Introduction

A summary of the range of activities taking place to reduce suicides in Manchester is outlined below. This is organised under the key themes of the local action plan. Some of this work is directly led by members of the suicide prevention steering group and other aspects are part of a broader system approach to suicide prevention in Manchester.

6.2 Data, research and intelligence

6.2.1 The Joint Strategic Needs Assessment (JSNA) is currently live on the Manchester website and available at

http://www.manchester.gov.uk/downloads/download/6672/adults_and_older_peoples_jsna_-_suicide_prevention

6.2.2 Work is in progress to obtain information about suspected suicides in Manchester as close as possible to the date of death. This is to ensure bereavement services can be made available to those affected by the death. Links made with Network Rail, British transport Police and Train Operators in September has resulted in more intelligence being made available around suspected suicide on the rail network. In addition we are exploring links with GMP to identify any suicide related data that can be shared with us. The need for 'real time' data has been identified by the Greater Manchester Suicide Prevention partnership and we continue to support these efforts across GM.

6.2.3 Manchester is a national and international leader in suicide and self-harm research through the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) and the Manchester Self Harm Project (MaSH).

6.3 Awareness, training and communications

6.3.1 As a key action in the local suicide prevention plan, suicide prevention awareness training has been delivered to a range of staff and volunteers across the city and more will be scheduled for next year. This half day training covers essential facts and figures about suicide prevalence and risk, the suicide continuum, understanding suicidal distress and building skills and confidence in talking to someone who may be suicidal. It is based on a session developed in Stockport by Public Health and Samaritans and has been further developed for Manchester. These sessions have been run without additional funding and have been delivered collaboratively by colleagues across the partnership from the population health and wellbeing team, Manchester University Hospitals NHS Foundation Trust (MFT), buzz health and wellbeing service and 42nd Street.

Due to the limited capacity within the system to deliver and very high demand (50 places for two courses delivered at Wythenshawe Hospital on November 13th were booked within a couple of days and many requests for places received) there will be a need to recruit a bigger pool of trainers and this will form part of the roll out next year.

6.3.2 A presentation on suicide prevention was given to the Manchester Housing Providers Partnership and further work is planned with the Connecting Communities group to further support housing providers' role in suicide prevention with their tenants and residents and the wider community.

6.3.3 The City Council sees supporting the health and wellbeing of its employees as a priority, including mental health. Mental health awareness training is available to all staff and managers - the training is delivered by Mind. This training is a core part of the Leadership and Management development programme for all managers and specifically addresses suicide prevention. There is also generic mental health awareness training for all staff that can be

accessed via the Learning and Events Team. The learning and development needs of Adult Social Care staff are currently being considered as part of the move to the Local Care Organisation and this will include skills and knowledge in suicide prevention.

6.3.4 The City Council also has an Employee Assistance Programme (EAP) which provides free, confidential, 24/7 advice, emotional support and counselling to all employees and their immediate family. In addition there is a proposal in the draft Employee Health and Wellbeing Strategy to introduce Mental Health/Psychological First Aid training. The proposal is to recruit and train employees to deliver psychological first aid and so enable 'in the moment support' for employees in crisis. Menopause awareness/support training is also currently being scoped and will address the physical and psychological impact of the menopause.

6.3.5 As part of the Greater Manchester Suicide Prevention Delivery Plan an online suicide prevention course is currently being developed. This will allow access to a greater number of workers and volunteers and will complement face to face training. Also, Pilot 'Safe Talk' training (accredited suicide prevention training) will be delivered in different locations in Greater Manchester aimed at barbers and hairdressers.

6.3.6 As part of World Suicide Prevention Day on 10th September 2017 a number of communications were made to the public and to staff to promote the campaign theme - *taking a minute can save a life.* This used the **ALERT** mnemonic - **A**sk if they are thinking about suicide, **L**isten and show you care, **E**ncourage them to get help, **R**ight now, **T**ell someone

6.3.7 Finally, more work will be undertaken over the next 12 months to develop a more comprehensive training and development plan to ensure training needs across the city are met.

6.4 Mental Wellbeing Promotion

6.4.1 buzz

Manchester Health and Care Commissioning (MHCC) commission buzz to provide a range of community based mental health and wellbeing support. The buzz Health and Wellbeing Service provides one to one wellbeing advisors to support the physical and mental wellbeing of individuals and provides Connect 5 training which equips staff with the skills to have mental wellbeing conversations with people they work with. This training has been extended to work specifically with staff groups within the Criminal Justice System.

Finally, buzz also provide Boost Resilience Training, a six week emotional resilience courses to the public in each locality and maintains the Mental Health in Manchester website which provides a guide to better mental health and getting help including emergency contacts and help lines. The service

also distributes evidence-based self-help guides for people with poor mental wellbeing or who are in distress.

6.4.2 **One Team Prevention Programme**

Community Links for Health (CLFH) is a social prescribing service for GPs, primary care and One Team to refer patients for support with their physical and mental health and wellbeing including the social determinants of health such as money, housing, work and skills. Enabling people to connect with social and community support through the use of the 5 ways to mental wellbeing approach - be active, connect, take notice, keep learning and give. The CLFH service for North Manchester launches shortly. The contract for CLFH North Manchester was awarded to a partnership - lead by Greater Manchester Mental Health, in collaboration with Northwards Housing, Pathways Community Investment Company (CIC) and the GP Federation. Work is underway to commission the CLFH service for South and Central Manchester and the provisional start date is for the service to go live in July 2018.

6.4.3 **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.

Adverse Childhood Experiences (ACEs)

Funding has been secured via the Manchester Investment Fund for a place-based pilot approach to addressing Adverse Childhood Experiences (ACEs) in adults. This will provide ACE awareness training to workers in Harpurhey so they can routinely enquire about ACEs with people they are working with and provide appropriate support and referral.

6.5 Clinical Support

6.5.1 Greater Manchester Mental Health Foundation Trust (GMMHT) has a comprehensive vision for suicide prevention within its organisation and convenes a regular suicide prevention group. Based on evidence and analysis of national and local data GMMH have adopted five priority areas as the key drivers for quality improvement across the organisation:

- Care provided will be evidence based, timely, safe and effective
- We will work in partnership with Service Users and their Carers
- We will support Carers and Staff when they have been bereaved or affected by suicide
- We will be a learning organisation
- We will have a competent workforce

6.5.2 A sub group has been established, chaired by Nicky Lidbetter to deliver the specific objectives within the local suicide prevention plan relating to suicide intervention and ongoing clinical/support services. The Clinical Pillar Group continues to meet (largely on a monthly basis) and has a core attendance including representatives from GMMHT, the University of Manchester, Self Help, 42nd Street, commissioners from MHCC, consultant psychiatrist from Emerge (CAMHS transition service) and a GP with specialist interest in mental health. Good progress has been made in respect of all three objectives with notable positive movement as follows:

i) **Strengthening initiatives that provide support to people in distress**
The group has developed two proposals that aim to support those experiencing suicidal ideation. The first is a proposal to deliver a pilot of a new, 'managing distressing thoughts' course that has been jointly developed by Dr Trish Gooding of University of Manchester and Self Help. Funding is now needed to support the delivery of this pilot project.

ii) The second initiative is that of a volitional self-help sheet which Chris Armitage (University of Manchester) has developed and which consists a series of 'If …. Then' statements which could be used by providers across the city when working with/supporting clients with suicidal ideation.

iii) **Strengthening of pathways between mental health crisis commissioned providers**
A workshop took place on 15th September that was attended by all commissioned providers of mental health crisis services. The event served as a useful opportunity for providers to get to know each other whilst also enabling a focussed discussion to take place around 'current barriers and blockers to working together'.

6.5.3 Finally, the Sanctuary is a mental health, MHCC commissioned crisis service that provides non-clinical support to those struggling to cope and experiencing difficulties such as panic attacks and /or depression and/or suicidal ideation. The service operates 365 nights a year from 8pm through to 6am and offers tailored and bespoke support by phone (0300 003 7029) as well as at the Sanctuary venue itself (which is located in the Kath Locke Centre, Moss Side).

6.6 Self-Harm

6.6.1 Two meetings have been held that have focussed exclusively on self-harm. At the first meeting held in June, Vanessa Craig (Consultant Psychiatrist, GMMH) presented an overview of the NICE guidelines on self-harm which are considered to be the gold standard in treatment/support for self-harm. In October, a follow-up meeting was held, attended by facilitators of the SHARE self-harm self-help group as well as colleagues from GMMH. As a result of this, strong links are now in place between both services which should give rise to a number of positive developments including enhanced service user input into relevant GMMH services.

6.6.2 A further meeting is planned for December 8th, and at which a mapping of Manchester's self-harm services against the NICE 'gold standard' will take place with the purpose of identifying gaps. Additionally, it may be that some aspects of the NICE guidelines may also be woven into provider CQUIN arrangements, where applicable.

6.7 Support for those bereaved by suicide

6.7.1 Postvention support for families and schools in the event of a suicide of a young person. Initiated by the Chair of the Sudden Unexplained Death of a Child (SUDC) panel and the General manager of CAMHS; a group was established to develop an effective pathway of support to families and the wider school community where a death of a young person by suicide happens / is suspected. This involves the production of a resource detailing local and national sources of information and support and a 'key worker' who can be a main point of contact for bereaved families.

6.7.2 Silence of Suicide: In January 2017 Manchester Suicide Prevention Partnership hosted Silence of Suicide - an organisation set up by Michael Mansfield QC and Michael's partner Yvette Greenaway following the death of Michael's daughter by suicide in 2015. This open invitation event, held at Friends' Meeting House, encouraged discourse for anyone bereaved by or affected by suicide in order to reduce the stigma and silence surrounding it. It is hoped to host similar events in the future.

6.7.3 Bereavement support GM pathway: As part of the Greater Manchester Suicide Prevention Plan a proposal has been developed for a GM suicide liaison service that provides support and signposting to anyone bereaved by suicide in the region. This service will be dependent on securing investment from the GM transformation fund.

6.8 Embedding suicide prevention into policies and plans

6.8.1 Wythenshawe Hospital has introduced a suicide prevention policy that clearly articulates the role of Trust staff in supporting patients who are identified to have suicidal ideas or have made attempts to end life. The policy details an integrated pathway on arrival at triage to being cared for in a ward and department. Attached to the policy is an Integrated Care pathway, commenced in the Emergency Department or on a ward, as well as, a standard operating procedure for ligature risk assessment and ligature cutter use. The policy identifies the role for staff in health promotion, with information about how to refer to Greater Manchester Mental Health Liaison Team for further specialist risk assessment. There are additional educational sessions that are delivered directly onto wards that have been identified as high risk areas, also being provided to areas where use of ligature or other suicidal methods have been reported. Staff as Wythenshawe Hospital and GMMHT also contributed to the local suicide prevention standards produced by Greater Manchester and Eastern Cheshire Strategic Clinical Network in January 2017.

6.8.2 Within Manchester City Council, guidelines for managers are also being proposed to support them to manage and support employees in the event of the sudden death of a colleague either due to natural causes, suicide or other reasons. The draft Employee Health and Wellbeing Strategy is due to be considered by Personnel Committee in January 2018.

7. Recommendations

The Committee is asked to:

1. Note the contents of the report
2. Consider the multiple factors that impact upon suicide rates
3. Provide feedback and ideas to support suicide prevention

Suicide deaths in Manchester 1997-2015

22nd September 2017

Summary

- Suicide rates in the general population in Manchester appear to have fallen between 1997 and 2015 (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 2009 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 2009 rates of suicide have been falling, although there was a peak in 2014.
- 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.

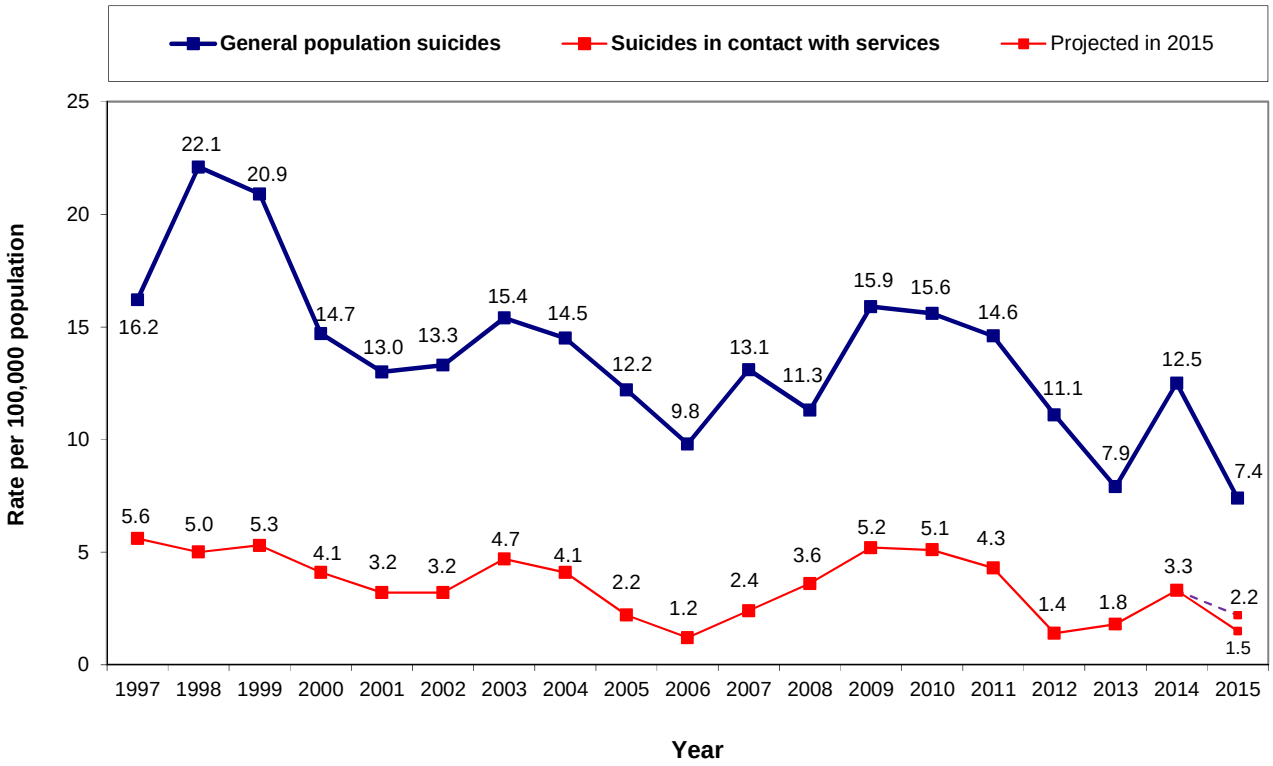
Table 1: Suicide deaths in Manchester (1997-2015)

	General population suicides N=1,042	Contact within 12 months[A] N=271	% in contact[B] (26% average)	% England in contact[B] (27% average)
	N	N		
1997	58	20	34%	24%
1998	79	18	23%	24%
1999	75	19	25%	25%
2000	54	15	28%	26%
2001	48	12	25%	27%
2002	50	12	24%	27%
2003	59	18	31%	27%
2004	57	16	28%	28%
2005	49	9	18%	29%
2006	40	5	13%	27%
2007	54	10	19%	27%
2008	47	15	32%	26%
2009	67	22	33%	27%

2010		67	22	33%
	29%			
2011		64	19	30%
	30%			
2012		49	6	12%
	28%			
2013		35	8	23%
	28%			
2014		56	15	27%
	25%			
2015		34	10	29%
	21%			

[A] Individuals who died by suicide within 12 months of mental health service contact (projected figure in 2015); [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 1997-2014 in the general population and patient suicide rate

Figure 2: Age standardised suicide rates in the North West (average rate 2013-15, based on year of registration)

4.10 - Suicide rate (Persons) 2013 - 15

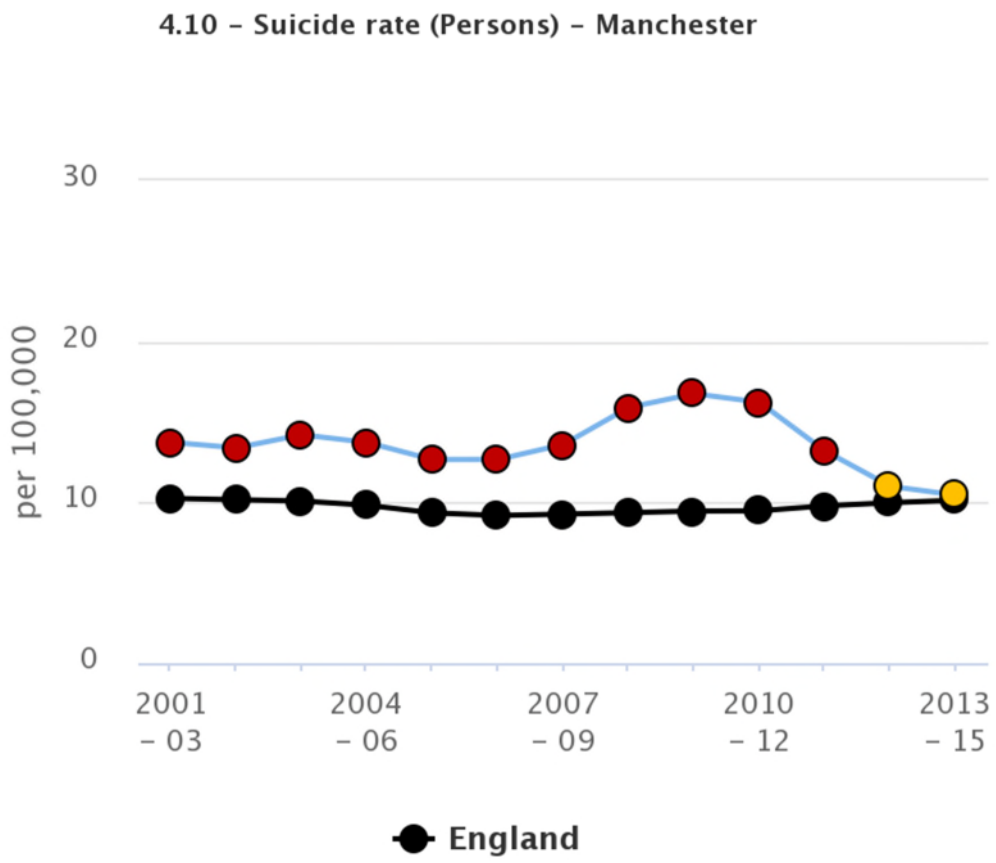
Directly standardised rate - per 100,000

Area	Count	Value	95% Lower CI	95% Upper CI
England	14,429	10.1	10.0	10.3
North West region	2,117	11.3	10.9	11.8
Blackpool	59	16.6	12.6	21.4
St. Helens	63	13.7	10.5	17.6
Tameside	75	13.2	10.3	16.5
Salford	81	13.1	10.4	16.4
Warrington	69	12.7	9.8	16.0
Sefton	91	12.6	10.1	15.6
Stockport	95	12.6	10.2	15.4
Blackburn with Darwen	45	12.5	9.0	16.8
Wigan	103	12.1	9.9	14.7
Bury	58	12.0	9.1	15.6
Cumbria	153	11.9	10.1	14.0
Lancashire	357	11.6	10.4	12.8
Cheshire East	115	11.4	9.4	13.7
Rochdale	62	11.2	8.6	14.4
Oldham	63	11.0	8.4	14.1
Bolton	78	10.7	8.4	13.4
Wirral	88	10.7	8.6	13.2
Manchester	130	10.5	8.6	12.6
Cheshire West and Chester	93	10.5	8.4	12.8
Liverpool	126	10.3	8.5	12.3
Halton	30	9.1	6.1	12.9
Knowsley	35	8.9	6.2	12.5
Trafford	48	8.1	6.0	10.8

Source: Public Health England (based on ONS source data)

Source: www. phoutcomes.info/search/suicide

Figure 3: Public Health England suicide rates in Manchester 2001-2015



Source: www. phoutcomes.info/search/suicide

Table 2: General population suicide deaths in Manchester (1997-2015)

	England	Manchester suicide deaths N=1,042		Remaining suicide sample N=87,250	
		N	%	N	%
Age and sex					
Age: median (range)	41 (13-96)			44 (10-104) **	
Male	798	77%	65,702	75%	
Method					
Hanging	426	41%	37,549	43%	
Self-poisoning	329	32%	19,713	23% **	
Jumping /multiple injuries	95	9%	8,869	10%	
Gas inhalation	38	4%	5,206	6% *	
Drowning	37	4%	4,197	5%	
Other†	110	11%	11,062	13%*	
Unknown/unascertainable	7	1%	654	1%	

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

Table 3: Suicide in patients in contact with mental health services in the 12 months before death (1997-2015)

	Patient suicide deaths N=268		Remaining patient N=24,548		England suicide sample
	N	valid %	N	valid %	
Demographic features					
Age: median (range)	41 (15-95)		45 (10-100)		**
Male	193	72%	16,259	66%	*
Not currently married	208	81%	16,859	70%	**
Living alone	127	50%	10,743	46%	
Unemployed	128	50%	10,011	43%	*
Long-term sick	63	25%	3,703	16%	**
Black and minority ethnic group	35	14%	1,710	7%	**
Method					
Hanging/strangulation	90	34%	9,908	41%	*
Self-poisoning	111	42%	6,385	26%	**
Jumping/multiple injuries	29	11%	3,642	15%	
Other[†]	36	14%	4,507	18%	*
Priority groups					
In-patient	19	7%	2,724	11%	*
Post-discharge patients	38	15%	4,500	21%	*
Under CRHT services	12	6%	2,326	12%	*
Missed last appointment	68	29%	5,635	26%	
Non-adherent with medication in last month	47	21%	3,299	15%	*
Clinical features					
Primary diagnosis:					
Schizophrenia	68	25%	4,324	18%	*
Affective disorder	100	37%	10,895	45%	*

Alcohol dependence	34	13%	1,991 8% *
Drug dependence	23	9%	1,036 4% *
Personality disorder	16	6%	2,232 9%
Other primary diagnosis‡	25	9%	3,235 13%
Any secondary diagnosis	150	56%	12,534 52%
Duration of mental illness (under 12 months)	33	13%	4,941 21% *
Behavioural features			
History of self-harm	185	72%	16,166 67%
History of alcohol misuse	150	59%	10,555 44% **
History of drug misuse	119	47%	7,574 32% **
History of violence	69	28%	5,065 21% *
Contact with services			
Last contact within 7 days of death	108	41%	11,840 49% *
Symptoms at last contact	174	71%	15,004 64% *
Estimate of immediate risk: low or none	183	84%	19,312 85%
Estimate of long-term risk: low or none	97	53%	11,848 59%

** 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

Suicide Prevention: Audit into Strategy in Greater Manchester

Andrea Fallon (Director of Public Health, Rochdale Borough Council)
Dr Rebecca Fletcher (SpR Public Health)

1. Aims

- To develop a strategy to reduce suicide across Greater Manchester
- To create a system to carry out a suicide audit across Greater Manchester (GM)
- To identify the demographics, common themes and factors in deaths by suicide in GM.
- To inform the development of the GM action plan, and local action plans for the ten boroughs of GM.

2. Background

- In 2015, 247 people took their own life in Greater Manchester. Suicide is the biggest killer of men under 49, and it remains the leading cause of death in our city region for people aged 15 to 29.
- Previously there was variation in practice across GM in terms of strategies, and audits.
- Small numbers in each local area restricted the usefulness of audits.
- Nationally, recent commitment to the usefulness of audits from PHE guidance and All Party Parliamentary Group report on Suicide and Self-harm

3. Audit Limitations

- Does not include suicide attempts or self-harm
- Not included those investigated by non-GM coroners
- Only included coroner information, and therefore limited in some areas of information
- Some information was missing in particular for isolated individuals

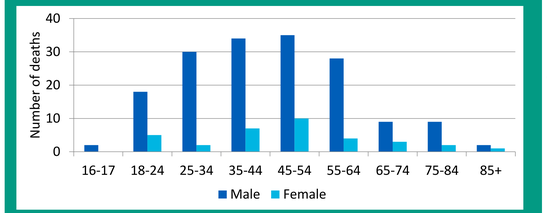
4. Audit

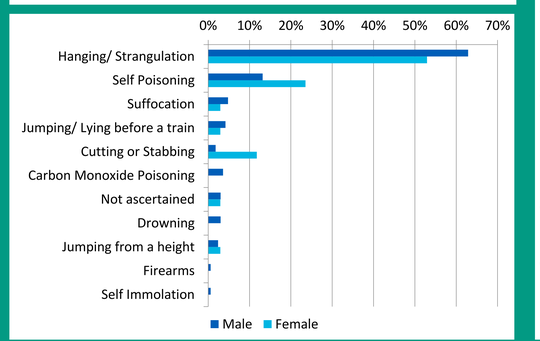
Methods

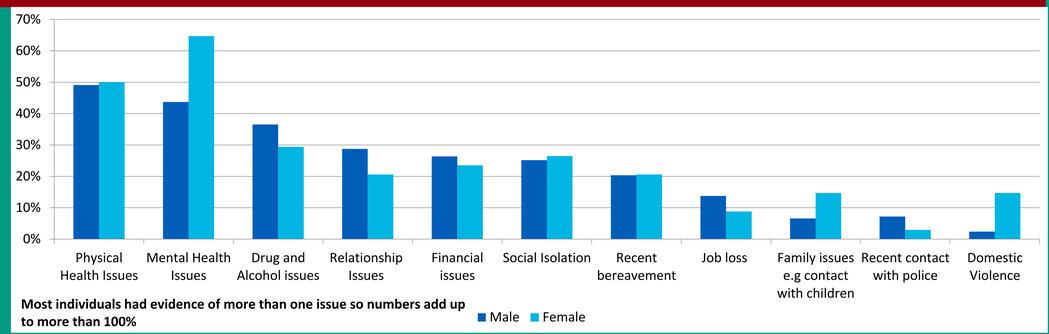
- There are four coronal areas in GM – all agreed to take part and facilitated access to the relevant files
- Inclusion: Deaths from suicide and cause undetermined in 2015 in GM residents
- Information sharing agreements were signed by the 10 local authorities and analysis carried out by Public Health SpR based in Rochdale Council
- Coroner paper files were reviewed using a standard audit tool. This data was then collated and analysed.

Cases

- A total of 201 cases, 167 men (83%), 34 women (17%), were included.







Most individuals had evidence of more than one issue so numbers add up to more than 100%

Results

- **Drugs and Alcohol**: 32% of men and 35% of women had consumed alcohol at the time of their death. 26% of men had consumed illegal drugs (35% of these had taken cocaine) and 15% of women
- **Primary Care**: GP access information was not available for 25 men and 7 women. Of those with information available, 80% of the men and 81% of the women had seen their GP in the past 6 months.
- **Medication**: 76% of women and 69% of men were on regular prescribed medications. 20% were on prescribed pain medication.
- **Police Contact**: 13 (8%) men had been arrested and charged in the past 12 months, mainly public protection offences. At least 13 (8%) men had been in prison previously.
- **Children**: 48% of men and 56% of women had at least one offspring.
- **Employment**: 31% of men and 18% of women were unemployed. 22% of women were long-term sick.
- **Mental Health**: 72 men (43%) had a mental health diagnosis, and 23 women (68%). Depressive illness was most common but bipolar disorder and schizophrenia or other delusional disorders made up 11%. 21 women (62%) and 53 (32%) of men had a history of contact with secondary mental health services.
- 80% of deaths occurred in the home.

Themes

- Social Isolation – lack of friendship groups, lack of close relationships, age,
- Physical health issues – injuries, chronic illnesses, severe illnesses
- Employment– including unemployment and working in some sectors (e.g. construction)
- Contact with police – shame and anxiety
- Job loss and financial issues
- Bereavement and connection with suicide
- Relationship breakdown, in particular for men
- Internet – and specific methods

5. Strategy

The strategy was developed and agreed by a GM Suicide Prevention Executive made up of representatives from NHS, LA, Public Health, Mental Health Trusts, Police, Transport Police, Samaritans, SOBS among others.

The strategy sets out a five year plan for reducing and ultimately eliminating suicides in GM. To do this requires our co-ordinated efforts so that suicide prevention becomes 'everyone's business'. We have included direction from the National Confidential Inquiry into Suicides and Homicides (2016), the National Suicide Prevention Strategy (2017), the Five Year Forward View for Mental Health, and the PHE local Suicide Prevention Planning resource .

The audit findings have informed the strategy, and associated action plan. The priorities for action within the strategy are :

- Reducing the risk in men,
- Preventing &responding to self-harm
- Mental health of children and young people and in pregnancy
- Treatment of depression in primary care
- Acute mental health care
- Tackling high frequency locations
- Reducing isolation and loneliness
- Bereavement support
- Media engagement

6. Ways Forward

- To establish a GM Suicide Audit Group to continue to deliver a GM wide audit
- Continue to build on the positive relationship with coroners
- Ensure that local suicide prevention plans reflect the GM wide plan and strategy.
- To deliver the strategy by continuing the commitment wide range of statutory, voluntary and community partners across GM
- To monitor progress against each of the actions as set out within the action plan, which will be refreshed each year.

7. Impact so far

- 9 presentations on the audit were delivered across GM to partnership groups.
- Positive relationships with the GM coroners have been further developed.
- The strategy has been agreed by the GM Health and Social Care Partnership

Acknowledgements

Thanks to the members of the GM Suicide Prevention Executive, and the GM coroners and their officers. Thanks also to all the staff involved in the planning, data collection and analysis of the audit.