Suicide Prevention Programme

2ND SHARED LEARNING DAY

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Welcome!

TOM AYERS

(CHAIR)

Introductions

Shared principles

- **Listen with respect and openness.** We seek to value learning from different people and stay open to new ways of doing things.

- **Confidentiality.** People may share something they wish to be kept confidential. We require everyone's agreement not to share anyone's information without their permission.

- **Collaborate.** We seek to make decisions by consensus. Everyone's input is equally valued.

- **Contribute.** We seek to share ideas, ask questions and contribute to discussions. We can also choose not participate at any stage.

- **Disagree with the point - not the person**. We seek to resolve conflicts and tensions.

- **Use plain English.** We seek first to understand, then to be understood. If possible, avoid using jargon and explain acronyms if they must be used.

Twitter…

- **You have all made excellent progress with the work so far so we know it is tempting to share …**
- **Below is the NCCMH twitter handle**
- **Wifi access codes: RCP19@w1f1**

@NCCMentalHealth
@NCISH_UK

#NationalSuicidePreventionProgramme

Housekeeping

- There are no planned fire alarm tests today. If the alarm sounds, please follow the green fire exit signs located above all doors.
- There are two ways to exit:

1) To the left of the room and take the stairwell which leads to the back of the building

2) Leaving through the main entrance

- The toilet are located on the ground floor, doors are to the right hand side as you entered the building.
- If you need to leave the room for any reason, there are some quite space located on this floor.

Agenda

- **This morning:**
- NCISH Updates, policy development, Q&A
- Introduction- evaluation of the national programme.
- Group peer review: Digital solutions, World Cafe
- **This afternoon:**
- Group peer review: Digital solutions, World Cafe
- Co-production in service development
- Action planning, next steps
- Closing reflection

Morning break:
11:35 to 11:55

Lunch:
13.05 to 13:50

Afternoon break:
15:00 to 15:15

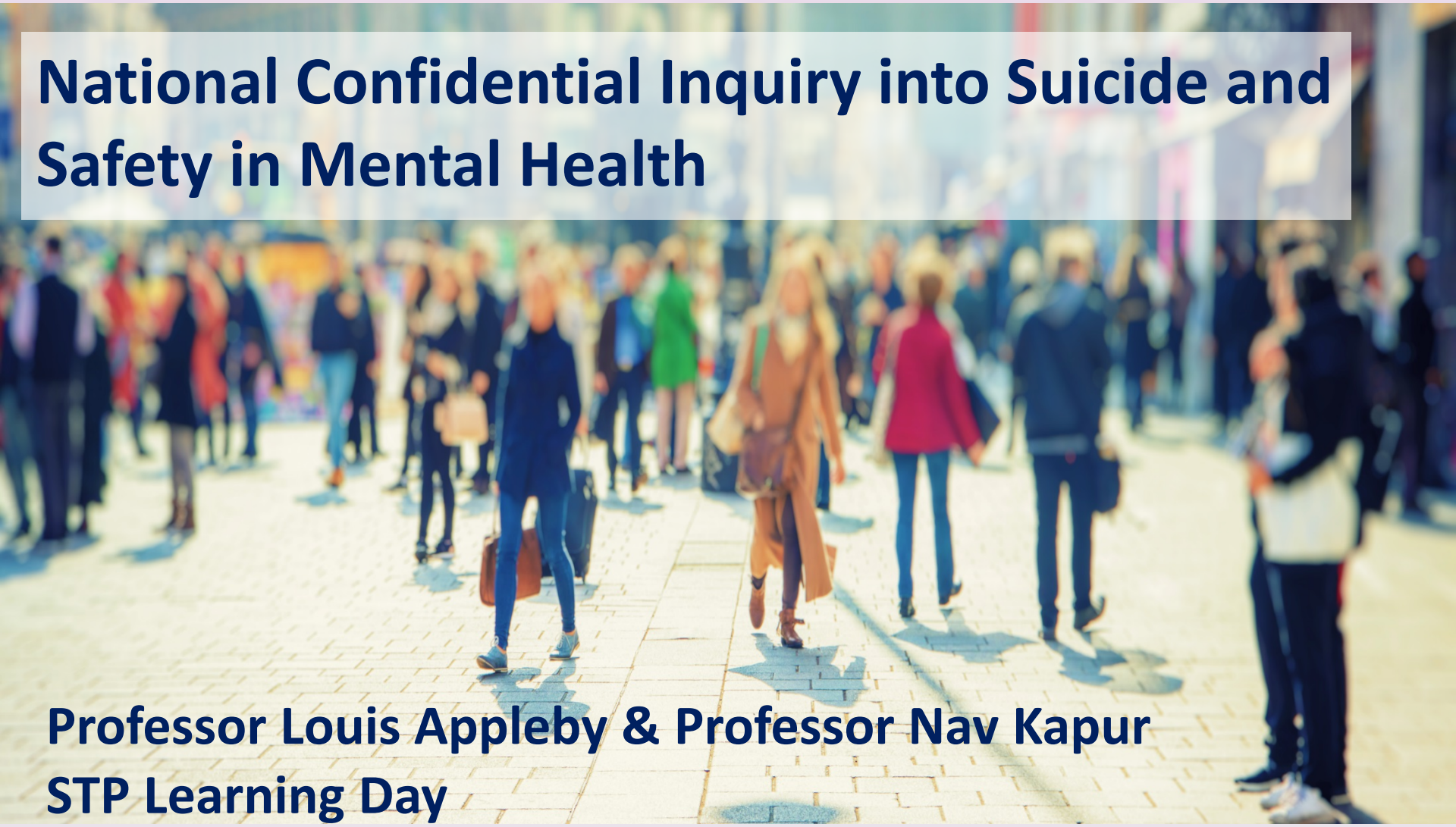
Finish:
16.30

NCISH Updates and policy developments

PROF LOUIS APPLEBY

PROF NAV KAPUR

National Confidential Inquiry into Suicide and Safety in Mental Health

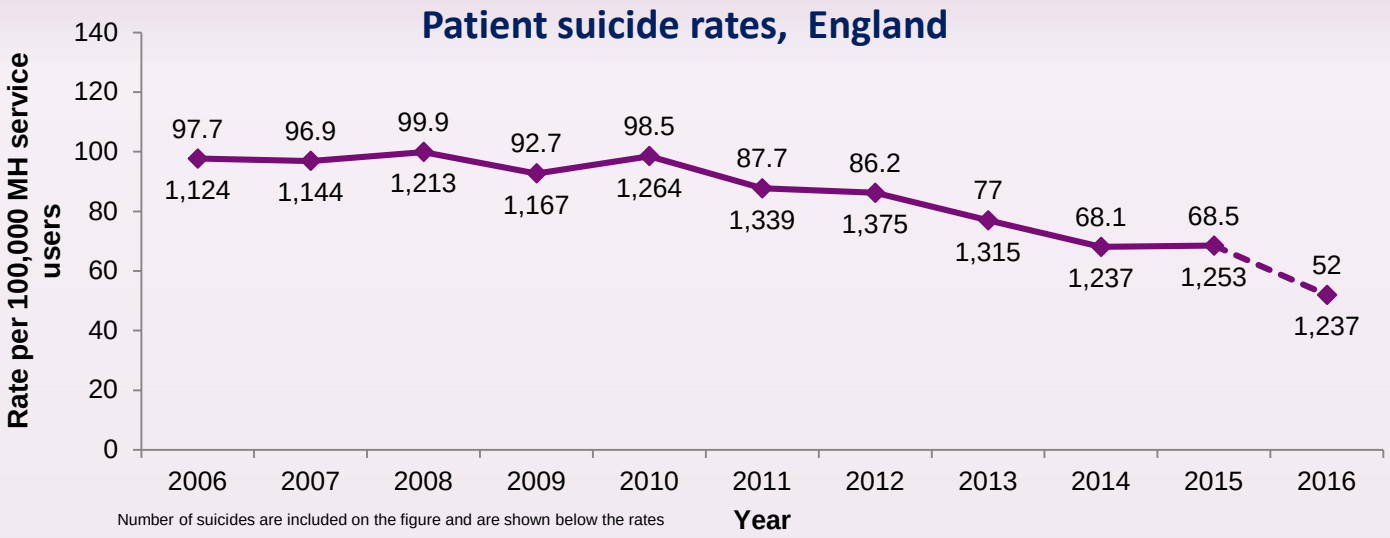


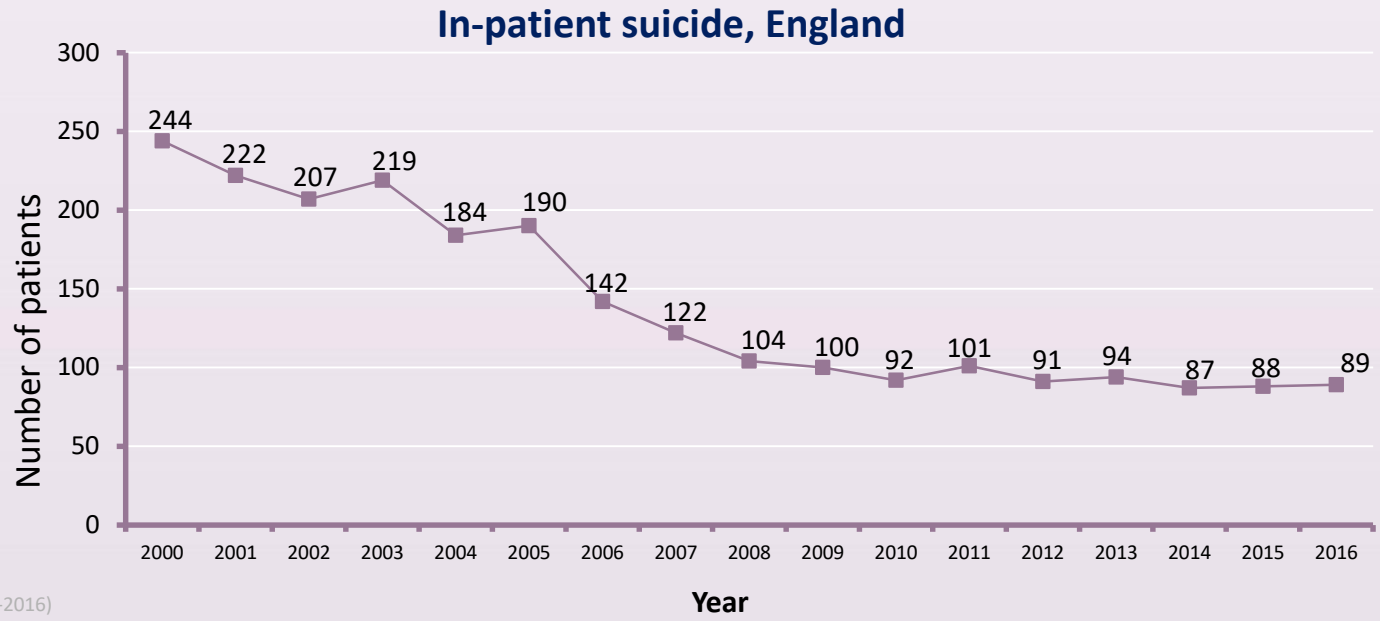
Professor Louis Appleby & Professor Nav Kapur

STP Learning Day

January 7th 2019

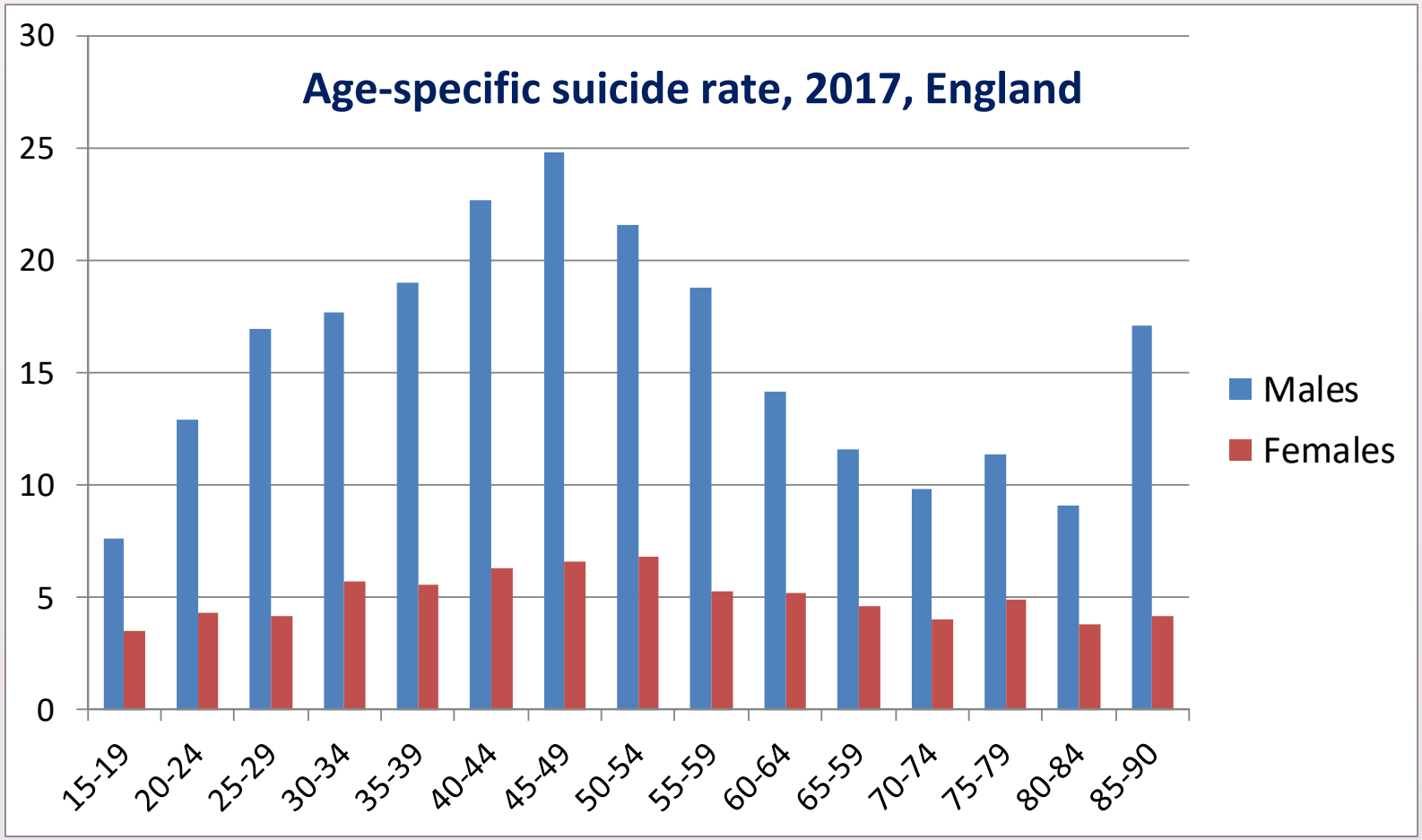
Patient suicides





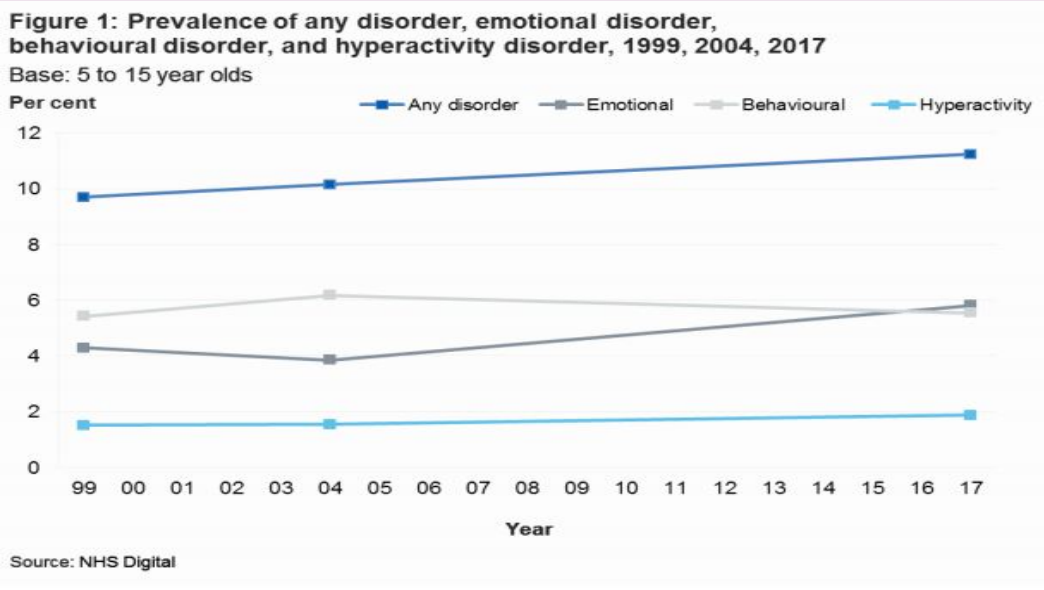
ENGLAND_SUICIDE (2006-2016)

Gender differences

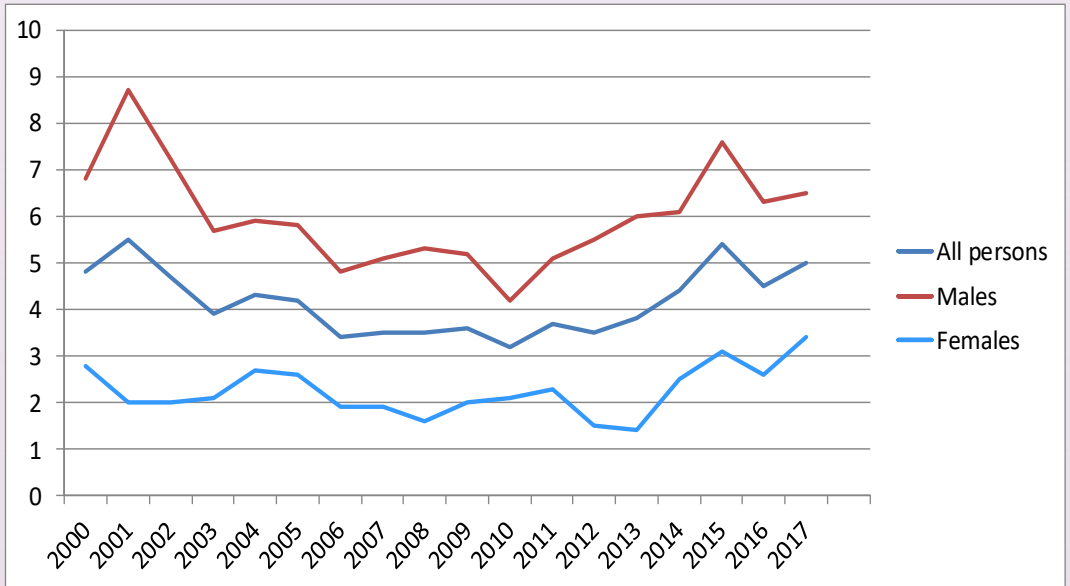


Source: ONS

Prevalence in young people



Suicide rate in 15-19 year olds, England



Source: NCISH

Self-harm in older adults

Older adults who self-harmed

Articles

Self-harm in a primary care cohort of older people: incidence, clinical management, and risk of suicide and other causes of death

Catharine Morgan, Roger T Webb, Matthew J Carr, Evangelos Kontopantelis, Carolyn A Chew-Graham, Nav Kapur, Darren M Ashcroft

Summary

Background Self-harm is a major risk factor for suicide, with older adults (older than 65 years) having reportedly greater suicidal intent than any other age group. With the aging population rising and paucity of research focus in this age group, the extent of the problem of self-harm needs to be established. In a primary care cohort of older adults we aimed to investigate the incidence of self-harm, subsequent clinical management, prevalence of mental and physical diagnoses, and unnatural-cause mortality risk, including suicide.

Methods The UK Clinical Practice Research Datalink contains anonymised patient records from general practice that routinely capture clinical information pertaining to both primary and secondary care services. We identified 4124 adults aged 65 years and older with a self-harm episode ascertained from Read codes recorded during 2001–14. We calculated standardised incidence and in 2854 adults with at least 12 months follow-up examined the frequency of psychiatric referrals and prescription of psychotropic medication after self-harm. We estimated prevalence of mental and physical illness diagnoses before and after self-harm and, using Cox regression in a matched cohort, we examined cause-specific mortality risks.

Findings Overall incidence of self-harm in older adults aged 65 years and older was 4·1 per 10 000 person-years with stable gender-specific rates observed over the 13-year period. After self-harm, 335 (11·7%) of 2854 adults were referred to mental health services, 1692 (59·3%) were prescribed an antidepressant, and 336 (11·8%) were prescribed a tricyclic antidepressant (TCA). Having a diagnosed previous mental illness was twice as prevalent in the self-harm cohort as in the comparison cohort (prevalence ratio 2·10 [95% CI 2·03–2·17]) and with a previous physical health condition prevalence was 20% higher in the self-harm cohort compared to the comparison cohort (1·20 [1·17–1·23]). Adults from the self-harm cohort (n=2454) died from unnatural causes an estimated 20 times more frequently than the comparison cohort (n=48 921) during the first year. A markedly elevated risk of suicide (hazard ratio 145·4 [95% CI 53·9–392·3]) was observed in the self-harm cohort.

Interpretation Within primary care, we have identified a group of older adults at high risk from unnatural death, particularly within the first year of self-harm. We have highlighted a high frequency of prescription of TCAs, known to be potentially fatally toxic in overdose. We emphasise the need for early intervention, careful alternative prescribing, and increased support when older adults consult after an episode of self-harm and with other health conditions.

Lancet Psychiatry 2018; 5: 905–12

Published Online October 15, 2018 http://dx.doi.org/10.1016/S2215-0366(18)30348-1

See Comment page 859

Centre for Mental Health and Safety (Prof R T Webb PhD, Prof N Kapur FRCPsych, M J Carr PhD), National Institute for Health Research (NIHR) School for Primary Care Research, Division of Informatics, Imaging and Data Sciences (Prof E Kontopantelis PhD), Centre for Suicide Prevention (Prof N Kapur), Centre for Pharmacoepidemiology and Drug Safety (Prof D M Ashcroft PhD, C Morgan PhD), Faculty of Biology, Medicine and Health, NIHR Greater Manchester Patient Safety Translational Research Centre, Manchester Academic Health Science Centre, The University of Manchester, Manchester, UK; Research Institute, Primary Care and Health Sciences, West Midlands, Collaboration for Leadership in Applied Health Research and Care, Keele

- 145 times more likely to die by suicide
- Only 12% referred to mental health services
- Over 1 in 10 prescribed TCAs
- Psychiatric disorder, physical illness, social isolation could be targets for intervention

Guidelines

NICE National Institute for Health and Care Excellence

Public Health England

NICE guideline

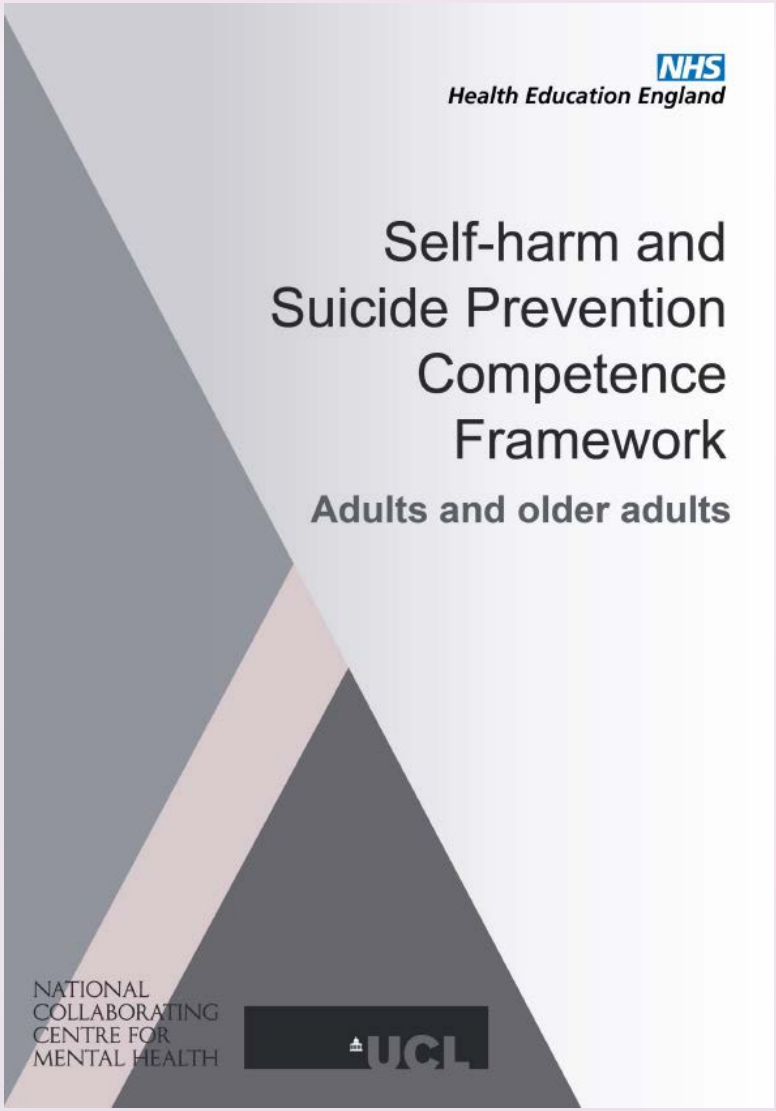
Preventing suicide in community and custodial settings

NICE guideline
Published: 10 September 2018
nice.org.uk/guidance/ng105

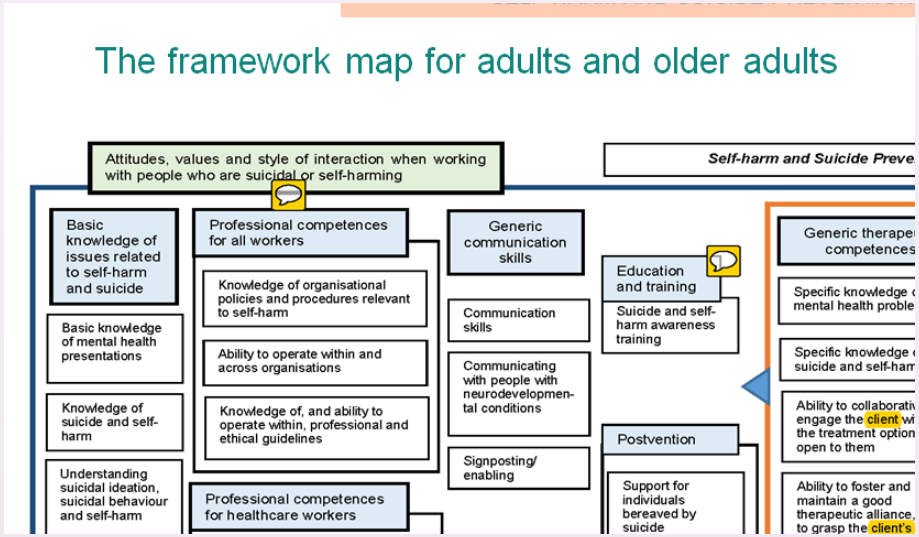
Recommendations

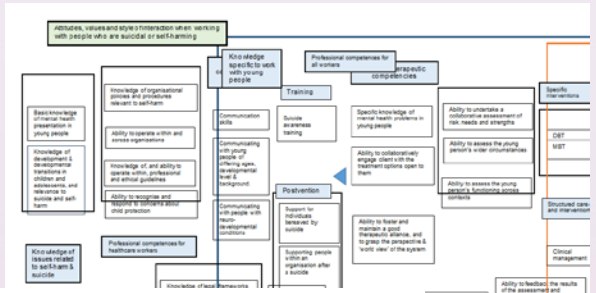
https://www.nice.org.uk/guidance/ng105

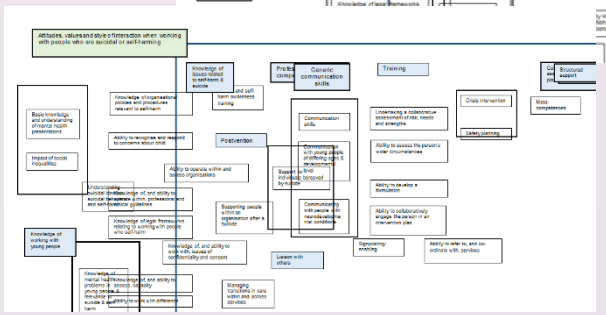
Competencies



https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks/self







www.manchester.ac.uk/ncish

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NCISH - Q&A

PROF LOUIS APPLEBY

PROF NAV KAPUR

Evaluation of the national programme

JAMES FITTON

ALEX TODD

Suicide and self-harm prevention programme
Independent evaluation

James Fitton

Our presentation today

- Introductions
- The main evaluation questions
- Reporting and feeding back
- Scope of the evaluation
- Method
- Requirements from local sites
- Timetable

Introductions

Niche are specialists in mental health evaluation. We incorporate the Mental Health Strategies team, as well as offering a range of wider experience.

Examples include:

- National evaluations of New Care Models and Community Forensic service investments
- Evaluation of Healthy London Partnership's mental health programme
- Evaluation of an 11-site mental health collaborative in the Republic of Ireland
- Evaluation of the multi-Trust MERIT programme in the West Midlands
- Three-year evaluation of integrated care in Wakefield

Our team will include mental health clinicians as well as specialist data analysts.

We are very much looking forward to working with you all!

The main evaluation questions

1. What have the eight local areas spent the transformation funding on? Why were these investments chosen?
2. What is now different as a result of the funding, in each of the eight local areas?
3. What impact was it hoped the new services/approaches would have? On what basis was it hoped that this impact would be achieved?
4. Have these impacts been achieved? Why/why not?
5. Have there been unintended consequences (either positive or negative) from the new investment? How has the programme affected relationships between organisations?
6. What lessons can be learned for the future development and implementation of initiatives intended to reduce suicide and self-harm?

Reporting and feeding back

- *Monthly*, then quarterly progress reports. These will be risk management reports as to the agreed process of the evaluation. They will be provided monthly from January to March of 2019, and then quarterly thereafter, with the final progress report planned for the autumn of 2020;

- *Six-monthly* formative reports. These will contain interim qualitative and quantitative findings, sufficient to enable detailed formative discussion;

- *Summative* report at the end of the project, drawing together all of the work undertaken, and presenting conclusions and recommendations.

Scope of the evaluation

1. South Yorkshire and Bassetlaw
2. Cornwall and Isles of Scilly
3. Kent and Medway
4. Norfolk and Waveney
5. Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby
6. Coventry and Warwickshire
7. Bristol, North Somerset and South Gloucestershire
8. Lancashire and South Cumbria

The scope will include both NHS and local authority-led initiatives. Public domain quantitative data from other STP areas will be used as part of counterfactual analysis, but only these 8 STP areas will be considered as the intervention group, and included in qualitative methods. Further national waves of this initiative are not in scope for this project.

All 8 local areas will remain part of the scope of this evaluation (on an "Intention to Treat" basis) even if they subsequently cease to be part of this programme for any reason.

Method

The evaluation will be based on the following methods:

a) Agreement of a **logic model** with each local area - the planned local actions, their intended outcomes, how their impact will be measured, and the possible barriers to their achievement.

b) Statistical analysis of data from both sites within the programme, and comparator sites – including performance against a statistical baseline prediction

c) Three cycles of **1-1 and small group direct interviews**, in spring 2019, autumn 2019, and summer 2020

d) Formative workshops to discuss emerging findings, their meaning and consequences

Requirements from local sites

For the evaluation to be successful, Niche will require the following:

- Access to details of **local implementation plans** for the programme, both initially, and updated as things change
- Support to ensure attendance at evaluation **events**, and participation in evaluation **interviews**
- Support to access **statistical data** arising from local implementation processes
- Support to **communication processes** to ensure that relevant stakeholders are aware of this evaluation, and their potential role within it

Timetable

- By March 2019
  - Agreed logic models
  - Agreed data schedule
  - Plans for first cycle of site visits
- By July 2019
  - First formative report
- Further cycles of interviews in autumn 2019 and summer 2020, followed by formative feedback
- Summative report at the end of 2020/ January 2021

Questions?

Group 1
Real time surveillance
(main room)

Group 2
Middle-aged men
(side rooms 1.2, 1.3, 1.4 groups change/rotate rooms every 22 mins)

Real-time surveillance

CORNWALL AND ISLES OF SCILLY

(OPEN DISCUSSION)

Real-time Surveillance & Postvention

Ruth Goldstein & Chris Watts, Cornwall Council

Monday 7th January 2019

one and all onen hag oll

CORNWALL COUNCIL

Real time surveillance

Why

To be able to offer timely Postvention

How

1. Info sent to Suicide Prevention inbox and then distributed to Postvention notification group
2. Postvention notification group check on their systems for relevant data and share via the group
3. May instigate a conference call if necessary
4. Data obtained is added to the suicide database spreadsheet.
5. The Coroner's Office provides register of deaths once a week and D&C Police provide a monthly list of suspected suicides/unexplained deaths. These are used to double check completeness of database

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Postvention notification

- **Public Health (Suicide Prevention inbox)**
- **CFT**
- **D&A Action Team (& Addaction)**
- **D&C Police**
- **GP Lead for Suicide Prevention**
- **OSW (IAPT)**
- **RCHT**
- **Suicide Liaison Service**
- Adult Safeguarding
- CAMHS
- Children & Families
- Education & Early Years
- MARU
- Penhaligon's Friends

- ***Those in bold are members of our Suicide Surveillance Group (SSG)**

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Purpose of postvention

- Postvention describes activities **developed** by, with, or for people who have been bereaved by suicide, to support their recovery and to prevent adverse outcomes, including suicide and suicidal ideation.

- People bereaved through suicide are at an increased risk of suicide, psychiatric admission and depression than other bereaved people.

- In addition, postvention interventions can promote community mental health awareness and resilience.

- **Postvention activities may include letters to GPs, Schools, Colleges, Workplaces and information about relevant support services being sent to those affected.**

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Ongoing Suicide surveillance

- Quarterly Suicide Surveillance Group meetings focus on:
  - Review of recent cases and management of on-going risk.
  - Identification of anything that could indicate a trend which would trigger further research/analysis.
  - Discussion of key learnings and outputs from Significant Event Audits/Serious Incident Investigations.

- Once a year Public Health hosts a longer SSG to discuss the Annual Suicide Audit in order to inform Suicide Prevention Action Plan.

- ***Used to send out a questionnaire to GPs and mental health trust but considering removing this in favour of real time surveillance***

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Challenges

- Data sharing and storage – Justified by the objective of preventing further harm/deaths but needs to comply with GDPR.
- Supporting Primary Care following a suspected suicide and working with GPs to build on learning from individual cases.
- How can we work much more closely with workplaces to prepare them in case of a staff mental health crisis/suicide?
- Safeguarding practices - reduce duplication and ensure that information is shared in a timely but secure way?
- Ensuring that bereavement services are actively signposted to and are integral to the postvention process.

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Actions & next steps

- Produce composite data collection spreadsheet
- Clarity on national/PHE data standards for the database and creation of restricted fields for data integrity and comparisons etc.
- Test new data collection process with recent case files.
- Formalise data-sharing agreements between all parties and ensure adherence to Information Governance.
- Update Coroner's Office on new processes and how to integrate with their processes, checking whether there are any additional reporting requirements of Public Health.
- Review the process in 3 and 9 months time to assess efficiency and effectiveness.

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Suicide Audit

- Public Health England provide a significant amount of data on national trends and guidance on suicide prevention. The purpose of the annual Cornwall & Isles of Scilly Suicide Audit is to build on the national picture (e.g. areas of high deprivation, management of long-term health conditions etc.) and to identify any specific trends and risk factors (e.g. high-risk job roles etc.) that require tailored interventions in C&IoS.

- A distinct project is being launched to review data on attempted suicide in C&IoS and how we can incorporate learning from these cases into our Action Plan.

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Co-production in service development

NATIONAL ADVISORS

DAN BEALECOCKS

NISHANT PRASAD

WENDY MINHINNETT

JULIE REDMOND

Action planning & next steps

TOM AYERS

Closing reflections

TOM AYERS

CLOSE

THANK YOU