Suicide Prevention Health Needs Assessment

Northumberland, Gateshead, Newcastle upon Tyne, Sunderland, North Tyneside and South Tyneside.
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1 Executive Summary

In this suicide prevention health needs assessment (HNA) the sub-regional suicide prevention group for Northumberland, Gateshead, Newcastle upon Tyne, Sunderland, North Tyneside and South Tyneside (hence forth “the Sub-Region”) seeks to describe the current level of need regarding suicide prevention in the area and make recommendations to help meet that need. This HNA focusses on what can be achieved at the sub-regional level with attention paid to possible points of integration. It considers the wider determinants of need in order to promote understanding of the local population, which in turn will help facilitate access to appropriate information and services. This HNA includes input from a number of stakeholders, including: Public Health Teams in Local Authorities; Public Health England (PHE); Health Service Providers; Voluntary organisations; Service Users; Families affected by suicide; Commissioners; and Emergency Services. This HNA has drawn information from published literature, available statistics, interviews and stakeholder meetings.

While death from suicide is still relatively rare, it is a devastating event. There is of course no single cause of suicide and the roots of an individual case will often be difficult to understand. A number of risk factors are known however, these include: social isolation; certain mental health issues; bereavement; loss of employment; substance misuse; and deprivation. Furthermore individual characteristics such as ethnicity, religion, sex (more common in men) and age may influence the risk.

In England, one person dies approximately every two hours from suicide. Within the Sub-Region there were 414 deaths by suicide and injury of undetermined intent from 2011 to 2013. Although there was variation between individual local authority areas, their suicide rates tended to be higher than the average for England. Within the Sub-Region those most at risk were men. Death by suicide was most commonly seen in the 35 to 54 year group in both genders. In some areas the Sub-Region also displays higher than the national average exposure to certain risk factors such as: self-harm; deprivation; substance misuse; prevalence of depression and anxiety.

The themes developed in this HNA centre around destigmatising discussion of suicide and better communication. This latter point is important both with service users and between organisations themselves. Furthermore the creation of inclusive media messages was seen as critical to supporting engagement with services.

Shorter, simplified pathways to obtaining help were seen as fundamental to improving service provision. It was felt that services, including those which deal with predisposing factors (e.g. debt management, benefits access) as well as those which deal with mental health, should be integrated further. The provision of clear, good quality information regarding available services and how they may be contacted was seen as highly important, as was the on-going support for those at risk.

A number of interventions which may be used in differing settings are also noted within the HNA. In line with the concept of proportional universalism it was noted that these may have to be targeted to specific groups with additional resource spent upon reaching vulnerable people within hard to reach groups.

It is hoped that the recommendations which conclude this document are useful in supporting suicide prevention work at the sub-regional level as well as being informative to organisations developing more targeted local plans.
2 Introduction

Deaths by suicide are devastating and their roots are often difficult to understand. More than 58,000 people die by suicide in the European Union every year (WHO, 2003) and in England, one person dies every two hours from suicide (HMG/DH, 2012), indeed this rate may be an underestimate. The economic costs of suicide are also high, with estimates in Ireland and Scotland suggesting average costs of 1.5 million Euros per death by suicide (Kennelly, 2007; McDaid & Kennely, 2010).

In the UK, death by suicide is more common in men than women, the risk also varying by age. From 2001 to 2012 the highest risk for men in the UK was experienced by those aged 30 to 44 years, with those 45 to 59 being the next most at risk (with some evidence of a recent increase in the rate). For women this order was reversed. In men, fewest deaths by suicide tended to be seen in those aged 60 to 74 years, although in 2006 and 2010 the age group least at risk were the 15 to 29 year olds, which has been the case for females from 2001 to 2012 (ONS, 2104).

Factors which predispose towards (or protect against) suicide are complex and differ between countries, regions and from person to person as described in the ecological model below (Leenaars, 2005). A multifaceted approach, tailored for a number of populations, is therefore required when considering appropriate preventive interventions. These of course should be evidence based. Preventive measures may focus on the avoidance of exposure to risk factors (occurrence of suicide has been linked to presence of certain mental illnesses, social isolation, physical illness, substance abuse, previous suicide attempts, family violence and access to means of suicide) (Scott and Guo, 2012) or more likely, as a recent WHO review found, upon the treatment of those risk factors already experienced.

Fig.1 Ecological model for understanding suicide

(Leenaars, 2005)
“The central characteristic of a public health model is its emphasis on prevention” (Miller et al, 2009, p. 169) and it is on prevention that this Health Needs Assessment (HNA) shall focus. Interventions are applicable throughout the life-course, there is evidence to suggest that school-based behaviour change programmes aimed at the whole school population with additional training and support for those children thought to be at risk can have a positive effect on intermediate outcomes acting to reduce risk factors for suicide. The longer term effects are as yet unknown however.

Perhaps more directly suicide rates may be limited by reducing access to means (e.g. firearms and poisons) however while this may have a great impact on individual cases, it is unclear what the size of effect is on a population level.

3 Literature review
Presented here is a brief review of available suicide prevention literature. Due to the volume of work published on this important topic, this current analysis is primarily a narrative review of reviews supplemented with additional policy documents.

3.1 Prevention
Prevention methods often seek to address one, or a number of, factors including suicidal ideation, attempts and deaths by suicide. These methods tend to fall into one of two broad categories; reducing factors which predispose towards suicidal behaviour and case finding in those thought to be at risk. In the former case the published evidence suggests that reducing the availability of lethal means as well as GP training on depression management (Isaac et al, 2009). The latter tend to be comprised of “general education campaigns, school-based and primary care provider screening programs, and gatekeeper training” (Isaac et al, 2009, p.261). There is however a lack of rigorous testing around the effectiveness of some these approaches at a population level.

Suicidal behaviour may occur proximate to negative life events or stressors (Florentine and Crane, 2010; Liu and Miller, 2014), however individuals will feel the stimulus of such events differently and so be at different risk of suicide. There are a number of models (in addition to the ecological model already discussed) that attempt to describe the physiological factors influencing this risk. This includes the arrested flight model and the interpersonal-psychological theory of suicide. The former suggests that feelings of defeat and humiliation combine with a perceived inability to escape or that things may improve in the future lead to a sense of being trapped and an overwhelming need to find an escape. The theory goes on to postulate that once negative associations have been established between experiences and mood, feelings of entrapment and suicidal ideation will become increasingly easy to trigger as time elapses, unless addressed. The model has a number of limitations however as it does not address those people who have suicidal thoughts but never act upon them.

The interpersonal-psychological theory of suicide model is based on the observations that a disconnectedness from society coupled with feeling like a burden may contribute to expressing suicidal behaviour. Furthermore this model considers that death by suicide is more likely when the individual has become accustomed to physical pain and when their experiences have led them to fear death less. This may occur through prior attempts, observing attempts of others or by experiencing other traumatic events.
Suicide is therefore the outcomes of a process which may be interrupted at several points. This has been summarised as in Figure 2 below. Broadly interventions can limit how a person thinks about suicide and/or limit their ability to access lethal means (Florentine and Crane, 2010). In limiting access to one method there is a theoretical risk that one will simply increase deaths due to other causes. This is termed substitution. There is not a one to one relationship however as a complex relationship exists between the individual and the chosen means, additionally problem solving ability may be reduced whilst someone is suicidal, meaning that selection of an alternative method may also be limited. Means themselves will also have variable levels of lethality and this too must be considered in prevention.

**Fig. 2 Possible intervention points** (Florentine and Crane, 2010)

Existential crisis is common amongst people who are suicidal as is a sense of disconnection from others, with reconnection being associated with recovery and resolution of crisis. Reforming connections is however difficult and may be problematic. It has been suggested that a given individual (a nurse is suggested in Lakeman and FitzGerald’s 2008 review paper) may act as an “emissary for humanity” (Lakeman and FitzGerald, 2008, p.122) by providing a caring contact whilst challenging some negative views the person holds about themselves. This may facilitate the process of opening up to be consoled.

### 3.1.1 National suicide prevention programmes

National suicide prevention programmes, as reviewed by Shekelle et al and reported in the WHO’s Health Evidence Network synthesis report of July 2012, are poorly described in the literature however their establishment is associated with later decreases in suicide rates.

Similarly public awareness programmes, which are commonly used, often with the aim of reducing suicide rates through general destigmatisation are poorly understood in the literature with conflicting results with regard to their impact upon deaths by suicide, but there is scope to integrate public awareness campaigns with other regional interventions (van der Feltz-Cornelis et al, 2011).

### 3.1.2 Community-based suicide prevention centres and programmes

One population based method for suicide prevention is to educate the community as to risks and signs of suicidal behaviour. It is believed that this will aid in appropriate help seeking behaviour (and the ability of the wider community to support this) and destigmatise mental health issues (Mann et al, 2005). Furthermore as underlying causes and modes of behaviour are explained and given context so the attached stigma is reduced. Whilst such education campaigns are relatively common their impact is poorly understood from a research viewpoint.
Another important gatekeeper within the community is primary care. This is a strong contender for a possible intervention point as most people who die by suicide have had contact with primary health care in the month before their death (Mann et al, 2005). Providing support to primary care physicians so that depression in their patients does not go undiagnosed and that risk of suicide is appropriately estimated may therefore be important (du Roscoät and Beck, 2013). Again the impact of this training appears to be variable, with some studies showing benefit (in UK, Australia, US and Northern Ireland) whilst others have shown no benefit (US, Brazil and UK). van der Feltz-Cornelis et al, in their 2011 review, show that improved recognition of depression by GPs and its recognition as a major risk factor for suicide was an important component within suicide prevention programmes. It has been demonstrated that GP education programmes are associated with increased antidepressant prescribing rates as well as significantly reduced suicide rates (the mechanism assumed to be better recognition and treatment of underlying mental illness).

Screening, which seeks to identify at-risk people and refer them to appropriate treatment, may also form part of community strategies and may be sited within schools (see below) young offenders’ services or be targeted at a section of the general population, such as young people (Mann et al, 2005). The use of screening tools amongst adolescents in primary care may be limited however due to rates of false positives and negatives (O’Connor et al, 2013).

In the WHO document it is noted that there were only limited data around the effectiveness of observational community-based projects and the use of 24 hour helplines, possibly as a consequence of the small number of individual studies available being of poor quality and therefore producing inconclusive results.

Better evidence was supplied by randomised controlled trials (RCTs), the first showing that providing “a collaborative care manager to primary care clinics” was associated in a reduction in suicidal ideation amongst older patients with depression. The second examined the provision of assistance to the friends and families of men at high risk of suicide. While there seemed to be benefit in this there were methodological problems as the rate of post-intervention suicide rate was not compared to a control group.

There is evidence that crisis centres and telephone hotlines are useful for identifying people at high risk of suicide and providing or referring onto appropriate services. There is however a gender bias as women have been seen to be more likely than men to call (Rihmer et al, 2004; du Roscoät and Beck, 2013). There is also evidence that in some populations helplines may be useful in reducing suicide rates amongst isolated elderly people. Within the UK a study showed that providing signage carrying the Samaritans’ phone number, placed in suicide hotspots, was associated with decreased suicide rates in the area, without a reciprocal rise in surrounding areas (du Roscoät and Beck, 2013).

Community based suicide prevention programmes tend to benefit from increased coordination with other services to optimise resource use and to have the best possible impact (Arnautovska et al, 2013).
3.1.3 **Self-inflicted Deaths by Prisoners**

Incarcerated people are at relatively high risk of dying by suicide. This risk is especially high in the first month of custody. In recent years the risk of death by suicide in prison has increased within the UK. The Prison and Probation Ombudsman recognises that there is a need for timely suicide prevention interventions where prisoners display risk factors (which should be thoroughly assessed) (Newcomen, 2015). Prisoners have should be able to expect a parity of care with the general public and therefore should expect to be given required information quickly, with referrals to mental health specialists being made in a timely fashion.

3.1.4 **Youth and School-based suicide prevention programmes**

Suicidal ideation may be relatively common in adolescence. A Canadian study estimated that the lifetime prevalence was 15.4% with the risk of an attempt of suicide being made being 3.5% (Pronovost et al, 1990 in Guo and Harstall, 2002). Young males are more likely to die of suicide however it is also estimated that young females are more likely to attempt suicide (Hider, 1998 in Guo and Harstall, 2002).

Many factors may contribute towards the death of a teen by suicide (or in them experiencing a non-fatal attempt). It has been noted that in up to 80 to 90% of cases a diagnosable Axis I psychiatric disorder (the top-level of the DSM multiaxial system of diagnosis) is present in 80–90% of young people who die by suicide (Gould et al, 2003; Cash and Bridge, 2009). The most commonly associated mental illness risk factor is depression (Cash and Bridge, 2009) (although it should be borne in mind that a significant minority of people who die by suicide or have a non-fatal attempt do not have this diagnosis). Attempting suicide in the past is also a strong predictor that the individual involved will make a subsequent attempt in the future. This seems to be even more likely for adolescent boys (Gould et al, 2003).

In 1897 Durkheim first suggested that suicide is less likely where there are high levels of social integration (what may be thought of as a component of social capital). Adolescent boys tend to be at greater risk of death by suicide than adolescent girls in western cultures. It is thought that along with “higher suicidal intent, use of more violent methods, higher prevalence of antisocial disorder and substance abuse, and greater vulnerability to stressors, such as legal difficulties, financial problems, and interpersonal loss” (Amitai and Apter, 2012, p. 987) boys may also find it difficult to communicate their problems due to social norms (Amitai and Apter, 2012). Boys and girls may show differing risk behaviours split along gender lines therefore it is possible that some interventions may be more appropriate for one gender than another (e.g. encouraging boys to talk about their feelings), although decisions must also take the individual into account. As the family background of an adolescent will play an important role in the development of coping strategies as well as in degree of ideation Amitai and Apter suggest that “[m]ental health professionals should be encouraged to try to improve functioning within the family of suicidal youth” (Amitai and Apter, 2012, p. 988).

Physical abuse, especially sexual abuse has been shown to be associated with poorer mental health outcomes and increased suicide ideation and suicidal behaviours in young people aged 16 to 25. As may be expected the risk is increased if the abuse is at the hands of a family member and/or if it is repeated behaviour. Therefore abused young people will require careful assessment and support. Amitai and Apter go on to say that “Trauma-focused cognitive-behavioral therapy was proven
effective in reducing psychological distress in these children” (Amitai and Apter, 2012, p. 989) but further stress that structures should be put in place to make it easy for children to seek help.

Young people who identify as having a same-sex sexual orientation are more at risk than their peers. The risk of suicide increases if the young person experiences a negative reaction from their family to coming out. Addressing societal issues of rejection is probably therefore an important measure here.

Allied to this is the literature showing that bullying during childhood also increases the odds of suicidal behaviour. Modes of bullying are also changing with increased online activity by both other adolescents and by adults.

Lower socioeconomic status has also been seen to be associated with death by suicide and suicide attempt risk in a number of studies. This may be expected as this group is vulnerable to a number of health inequalities across the board, additionally there may be some interaction with educational level (Guo and Harstall, 2002). Coupled with this is the observation that those children who experience adverse family situations in childhood, be that parental psychopathology, loss separation or divorce, impaired parental relationships or abuse are more likely to engage in suicidal behaviours. However the methodological limitations of the studies these observations are based upon means that the conclusions drawn must also be limited and taken with caution on this point (Guo and Harstall, 2002). A 2002 review by Guo and Harstall also suggested that young people with personality disorders (including antisocial, borderline and avoidance disorders) and other psychiatric conditions were at greater risk of suicidal behaviours than their peers.

Schools are a useful environment for providing suicide prevention interventions to children and adolescents, including anti-bullying initiatives. It can however be difficult to see the effect of these interventions as numbers may be low and outcomes variable. Furthermore the ethics of conducting RCTs in such situations may be problematic (Balaguru et al, 2013). There are limited data therefore on which to scientifically base school centred prevention programmes (Miller et al, 2009).

A number of studies, mostly delivering interventions to high school students, have been reviewed in the literature. These approaches show a high degree of heterogeneity in approach and objectives. A number focussed on skill training and social support, these were found to be useful in that they reduced the impact of risk factors whilst increasing the effects of protective ones. There were also two studies looking at behaviour change and the development of coping strategies, showing “lowered suicidal tendencies, improved ego identity and improved coping ability” (Scott and Guo, 2012, p. 8).

A systematic review by Robinson et al published recently in 2013 suggested that universal approaches (e.g. general programs delivered as part of school curriculum) increased knowledge of warning signs and risk factors for suicide within the school population, coupled with some suggestion of greater help-seeking behaviours in those at risk and lower self-reported risk.

Additional school based studies showed a mixture of outcomes. These demonstrate that school based (universal) programmes can be used to increase knowledge within pupils with some evidence that help-seeking behaviour may also be improved, both from peers and staff depending on the programme (Leenaars, 2005). While a universal approach is probably the most common form of suicide prevention programme used within schools (Miller et al, 2009) there is however limited
evidence as to whether or not these interventions meaningfully impact upon suicide rates. This is not to say that they cannot, rather that further studies are required to explicitly consider this as a primary outcome (Scott and Guo, 2012). It is likely, perhaps, that such universal schemes have their greatest impact where there has genuinely been a widespread lack of knowledge and understanding previously (Balaguru et al, 2013). A similar review by Cusimano and Sameem in 2010 also came to the conclusion that, in the literature, there is evidence that school-based programmes improve the knowledge of adolescents whilst also supporting help-seeking behaviours but that importantly there is a lack of published information regarding their impact upon actual suicide rates (Cusimano and Sameem, 2010).

Few studies have formally investigated potential harm to already vulnerable people by intervening in this general way and more research is required here. The studies which have shown possibly concerning results (especially showing that those young people who had previously attempted suicide were at higher risk of deleterious effects about discussing suicide as part of the general school curriculum) have been conducted on small populations making their findings difficult to generalise and draw conclusions from (Guo and Harstall, 2002). Other authors, such as Leenaars, are robust in their support for school based education programmes putting forward such statements as, “I believe that the statement, “Public education in schools causes suicide”, is a myth” (Leenaars, 2005, p.24) and points towards Orbach and Bar-Joseph’s 1993 study which found that students exposed to their curriculum reported fewer suicidal tendencies and greater ability to cope (although interestingly hopelessness was not affected). Importantly “[n]o students reported feeling harmed by the program” (Leenaars, 2005, p. 24). However it must be borne in mind that absence of evidence is not evidence of absence.

More targeted approaches such as screening, using validated tools (Mann et al, 2005), to identify individuals at risk, who would otherwise not come forward for help, have been seen to be successful in providing additional support to vulnerable pupils. This has both advantages, in that a number of tailored “check-ups” can be made, but also significant disadvantages in the possible generation of stigma and distress around false-positives. Importantly though “[t]here is no evidence that screening youth for suicide induces suicidal thinking or behaviour” (Mann et al, 2005, p. 2069). In order to be successful such screens, often conducted via questionnaire (Cooper et al, 2011) must pick up as many individuals genuinely at risk as possible whilst not selecting those who have only a low risk. What is considered an acceptable risk is something which must be debated before the screening tool is put in place (Robinson et al, 2013; Guo and Harstall, 2002). Furthermore in order to be of use the screening programme must be able to pass those identified into an efficient treatment or intervention which meets their needs and is acceptable to the patient and possibly in the case of children, their guardian. This therefore has obvious budgetary implications which must too be carefully thought through before the implementation of any such scheme, as to remove it early could potentially be harmful.

Another tailored approach is “Gatekeeper Education” this might include training staff or in some cases other pupils to be more aware of risk factors of suicide (Cooper et al, 2011), giving the necessary tools to change attitudes to help-seeking and destigmatising the subject matter. Gatekeepers have primary contact with those at risk. They may be for instance “clergy, first responders, pharmacists, geriatric caregivers, personnel staff, and those employed in institutional settings, such as schools, prisons, and the military” (Mann et al, 2005, p. 2067) and are trained to
look for suicide risk factors (Isaac et al, 2009). This approach works best when staff are motivated to
engage with training (Balaguru et al, 2013) and has already been demonstrated to be beneficial in
other professional groups (e.g. military, peer helpers, clinicians and aboriginal people (Isaac et al,
2009) and Robinson et al present some evidence that it is effective in the school setting also.
Appropriately skilled Gatekeepers have also been seen to be advantageous in rural settings, where
access to mental health services may be otherwise limited especially for children unable to travel
larger distances (Balaguru et al, 2013). Other individuals, who are not explicitly identified, may also
provide a Gatekeeper role. These may include clergy, recreation staff, police, coaches, teachers and
counsellors (although some of these may take on the designated role as part of their job depending
upon local arrangements). Friends and family have also been suggested as Gatekeepers (Isaac et al,
2009). Gatekeeper training is comprised of different elements and lasts for different durations
depending where it is delivered and by whom it is taught. This will be a source of variation in
outcomes of programmes. There is evidence however that if properly conducted such training can
increase knowledge, efficacy and access to services. Impact upon the rate of death by suicide is less
clear, with observed benefits being attenuated after a few years, possibly showing the need for
repeat training (Isaac et al, 2009).

For either of these latter approaches to be effective there must be clear pathways in place to refer
those in need of additional support on to services which can supply it. In addition strategies which
use a number of approaches have also been seen to be effective at delivery of objectives as well as
reaching a wider audience (Balaguru et al, 2013). These approaches therefore are illustrative of
Walker et al’s (1996) three-tiered model moving from the first universal tier to the second selected
tier with progression to a third indicated level. This final level of intervention is characterised by
highly individualised and specialist intervention for children who do not respond well to any of the
other tiers (Miller et al, 2009).

Other factors to support suicide prevention in schools reported by Balaguru et al included:

• Use of piloted and well resourced programmes
• Self reporting and anonymity
• Tailoring intervention to target group (making it culturally appropriate and adapting to an
  individual’s needs typically through face to face sessions, provision of a case manager)

Conversely factors which may limit or adversely impact suicide prevention programmes in schools
were identified as:

• A lack of peer support skills amongst pupils (this may be addressed by including within
  intervention, which need not always focus on obtaining help from adults)
• Unsustainable or resource intensive intervention / resource poor setting.

The scope of an intervention can also be limiting in some senses. For instance the universal model
has traditionally focussed on stress as an acute trigger to suicide, to the exclusion of other
contributory factors and usually of a quite short duration. Some universal programmes have been
used to destigmatise suicide and seeking help for suicidal thoughts, one way of doing this is by
deephasizing the link between psychopathology and suicidal behaviour in this context (Miller et al,
2009), furthermore if the same programme is rolled out to all pupils irrespective of their individual
risk there is less opportunity for stigmatising behaviour to be initiated.
A problem inherent to the majority (if not all) suicide prevention programmes in schools is that those most at risk are least likely to benefit as there is a trend for people with suicidal thoughts or a number of mental health issues not to engage with such preventative programmes (Miller et al, 2009).

An ideal school-based suicide prevention programme would therefore be “one that is long-term, targets all possible risk factors for suicide, engages children, parents, staff and community, and has good accessibility to mental health services” (Balaguru et al, 2013, p.137). This of course will not be universally feasible and concessions and adaptations may need to be made.

In the wider setting Dialectical Behavioural Therapy, which addresses both factors which can be changed as well as acceptance of those that cannot in its four components of: mindfulness; distress tolerance; interpersonal effectiveness; and emotional regulation, has been shown to be associated with decreasing deaths by suicide in adolescents (Mujoomdar et al, 2010). Having said this, the authors also note a lack of good quality studies in the area, especially around more subtle outcomes such as “suicidality” (a continuum from intent and planning to completion) (Mujoomdar et al, 2010, p.24). Further they note that while the technique does seem to work there is little information regarding its cost effectiveness.

While there is uncertainty around the efficacy of individual interventions to reduce numbers of deaths by suicide in young people it is judged likely that multifactorial programmes which include education, training, reduce access to methods of suicide and recognise of people at high risk of suicide and which refers adequately to depression treatments will be more effective than single interventions (Gould et al, 2003).

### Suicide prevention in later life

Suicide amongst elderly people (this relative term often being defined as 65 years or older in developed countries (Orimo et al, 2006)) is still a rare event (especially within the context of the UK) (Manthorpe and Iliffe, 2011) however as a proportion of deaths by suicide this group show a relatively high risk (worldwide this is the most at risk group). Where rates are high strategies to improve resilience; promote positive aging; and allow the increase and maintenance of social capital through family and community engagement may be beneficial (this may be through outreach programmes but may also feature the use of telecommunications). Furthermore action around the restriction of means, which will be generally beneficial in the community, will also help. Additionally giving physicians the tools to recognise risk factors, suicidal thoughts and behaviours in their older patients will also help prevent deaths especially as patients will tend to be seen more frequently as they age (Lapierre et al, 2011).

Older people with mental health problems may find it difficult to access the full range of mental health services available to younger adults (e.g. out of hours services, psychological therapies, alcohol services and crisis services) and may therefore require additional support to do so. This may be achieved through the engagement of a number of professions within both health and social services. This may include social workers forming a conduit between health professionals (e.g. primary and secondary care), the family or carers as well as being an advocate for their client (Manthorpe and Iliffe, 2011). This may be important in addressing the significant rates of untreated depressive disorders seen in over 65s who have died from suicide (Rihmer et al, 2004).
Significant reductions in deaths by suicide in older people with cancer have also been seen after the provision of palliative care, presumably as fear around the future is managed and choices provided. Community support programmes also have utility in reducing suicide rates amongst older people in living rural areas (van der Feltz-Cornelis et al, 2011).

Having noted this however there is still a paucity of information and research regarding how and which life stressors adversely affect the elderly population and more research is required (Liu and Miller, 2014).

3.1.6 Interventions for veterans and military personnel
There are a number of factors experienced by serving military personnel that influence their risk of suicide, both protective and deleterious. For example sophisticated modern armies have screening programmes for entry which may select out people with certain risk factors. Additionally there will be high social capital under certain situations supported by the strong social structures in place. There are of course stressors that are associated with the experience of warfare which may exacerbate underlying, undiagnosed conditions (Nock et al, 2013).

There is evidence to suggest that war veterans are more likely to die of suicide than the general population (and be more likely to experience suicidal ideation and suffer mental health problems) (Rozanov and Carli, 2012). One may also imagine that upon exiting active service the lack of familiar social networks would be felt keenly and the protective factor of social capital being reduced. Furthermore veterans will tend to be more familiar with the use of arms than the general population and may have reduced fear of the process of dying. They are also at greater risk of experiencing negative stimuli such as ill health due to previous trauma etc. However suicide is more common in younger veterans and soon after discharge from the armed services. Depression is considered the primary underlying disorder associated with suicide. Comorbidity with post-traumatic stress disorder (PTSD) further increases risk.

Veterans are a heterogeneous group with differing experiences and exposures to risk. The training of gatekeepers (Mann et al, 2005) has been used as a prevention measure amongst veterans and may involve screening for mental health problems, signposting appropriate treatment and support through hotlines (Rozanov and Carli, 2012).

3.1.7 Interventions targeted towards minority groups
Ethnically tailored, community-wide public health programs; video-focused educational interventions to modify family expectations regarding self-harm; and school-based initiatives to train school staff and pupils to respond to suicidal crises have been shown to be successful when used amongst ethnic minorities (van der Feltz-Cornelis, 2011; Simon et al, 2013).

Gay, lesbian and bisexual adolescents are at higher risk for mental health problems and associated risk behaviours including suicidal behaviour (Blake et al, 2001). The risk appears to be greatest during adolescence and early adulthood, diminishing as people age. Accessing appropriate mental health services may continue to be problematic however, if those in need perceive a negative stereotyping of homosexuality. Furthermore it is noted in the literature that services can be inadequately provided when they are delivered by (perceived) heterosexual staff. It should be noted however that there is some evidence of increased satisfaction with mental health services in recent years (Cochran, 2001).
There are a number of environmental factors such as victimisation experiences, social isolation and the use of substances to cope with associated stress which may explain this increased risk. Programmes that do not have suicide prevention as their primary outcome measure may still be useful in combating the behaviour if they are properly implemented. For example a study has shown that where HIV awareness and protection courses were delivered in schools, in a gay sensitive way, that pupils from those schools were less likely to display risk behaviours and were also less likely to die from suicide than children from other schools (Blake et al, 2001).

3.1.8 Restriction of access to lethal means
While reduction of suicidal ideation and intent are of course critical, they will not be sufficient in isolation in every instance. Therefore it is important to also limit access to the means of suicide, referring back to Figure 1 this can be thought of as an environmental intervention. These precautions may not stop someone who is determined to end their own life, however by limiting access to means may provide a person with the time needed to seek or receive help or may prevent them from acting during a period of acute distress (Daigle, 2005).

3.1.8.1 Firearms
Gun control can be seen as an archetypal public health intervention for preventing deaths through suicide (Leenaars, 2005) (as well as gun crime).

A number of reviews have been conducted around the impact gun control laws have on suicide rates. These have been conducted from a global (or non-UK) point of view. Several studies reported mixed effects, however reducing the ubiquity of weapons such as hand guns is associated with reduce rates of suicide. Waiting periods for the purchasing of fire arms demonstrated variable effects with some studies suggesting it may reduce suicide rates, at least by this method.

Not all responses were seen to run in the same way, with some counterintuitive effects. That is to say national regulation in Canada was associated with increased rates of firearm related suicide while another study drawing data from both the USA and Canada found that laws restricting access reduced deaths by this method but also saw a reciprocal increase in suicide by other methods. Yet other studies demonstrate a trend towards reduced suicide rates with greater regulatory laws. There is also some suggestion that greater gun control benefits younger people more than the elderly and for women rather than men (Leenaars, 2005). Therefore one may conclude that while such laws may reduce deaths by a given method additional research is required to fully understand its impact upon the suicide rate in its entirety (e.g. effects on substitution).

The Firearms Amendment Act was introduced in 1989 within the United Kingdom. It further restricted purchase of firearms and required the safe storage and registration of firearms and was linked to a significant reduction in firearm suicides and a decrease in the overall suicide rate of farmers (Florentine and Crane, 2010).

3.1.8.2 Pharmacological agents
Restricting access to and package size of paracetamol and salicylates have been shown to be associated with reduced rates of suicide. While some of the reported effect may be due to confounding with a general downward trend in suicide rates over time, other studies have also replicated these findings.
3.1.8.3 **Respiratory toxins**

Changes in fuels with lower carbon monoxide content have reduced deaths due to carbon monoxide poisoning. Historically (between 1955 and 1975) when gas in English homes was switched from charcoal gas to natural gas there was an associated decrease in the suicide rate (Florentine and Crane, 2010). There was some substitution for car exhaust as a means however the use of catalytic converters in cars may now limit their use in production of fatal levels of fumes.

Gas poisoning was a frequently used method of suicide “because it was widely considered to be highly lethal, painless, non-disfiguring and requiring little planning” (Florentine and Crane, 2010, p. 1628). It was therefore important to put this means beyond use, especially as, at the time no similar means were easily available.

3.1.8.4 **By hanging**

Hanging is a frequently used mode of suicide and sadly in England has increased since the mid-1980s (in both sexes but most markedly in males). Whilst case fatality is high those who reach hospital alive are likely to survive (80% to 90%). Prevention of hanging in the general population is problematic due to the ubiquitous availability of ligatures and ligature points. A minority (10%) of deaths by hanging occur in institutional environments such as police custody, hospitals and prisons. In 1999/2000 92% of prison suicide deaths in England and Wales were due to hanging or self-strangulation. In Suicides by hanging in police custody shoe or boot-laces were used as a ligature about a third of the time. The Home Office has recommended that shoelaces and belts etc. always be removed (Gunnell et al, 2005).

In England and Wales it is a legal requirement that “all non-collapsible frames, such as bed, shower, and curtain rails to be removed from psychiatric wards” (Gunnell et al, 2005, p. 436). Auditing of the environment is also recommended as is not using areas where “ligature points or where obstructions to the observation of patients have been identified and cannot be removed” (Gunnell et al, 2005, p. 436) for admissions or acutely ill patients. Due to the frequency of patients using items of clothing as ligatures it has also been suggested that patients within psychiatric wards be asked to wear clothes that do not require belts, laces etc. It is further noted that such discussions would have to be conducted sensitively with the patient.

3.1.8.5 **Suicide and alcohol**

There is a substantial body of work written about the relationship between alcohol (mis)use and suicide. It has been demonstrated that the relationship is further complicated by the presence of alcoholism (people with alcoholism have a relatively high life-time risk of suicide of 2.5%). Studies of suicide notes have highlighted the multifactorial aspects of this relationship. The restriction of the availability of alcohol is associated with a reduction in deaths by suicide. This has been observed as a result of prohibition and in other settings significant price increases but may also be brought about by legislation, policing and societal change (Leenaars, 2005).

3.1.8.6 **Interventions to reduce risk at hotspots**

A suicide “hotspot” is a place which is accessible (usually public) and is frequently used as a site for suicide (or has gained that reputation). Frequently they are bridges, cliffs, buildings, railway tracks as they also provide access to a means of death. Sites may also be chosen because of their secluded nature (e.g. rural car park or forest). Four main approaches may be taken, namely: restricting access to means (e.g. by denying access by installing physical barriers); encouraging help-seeking behaviour...
(e.g. signage and provision of help-line telephones); increasing likelihood of intervention (e.g. active surveillance); encouraging responsible reporting by media (see below). In some cases a structure gains the label through sensationalist reporting in the media, prompting others to seek it out (Cox et al, 2013).

Perhaps one of the more obvious strategies is to install physical barriers to prevent people falling from height. Shekelle et al, in their 2009 review, identified a single study which observed an increase in deaths by jumping from a bridge once pre-existing protective screening was removed. Cox et al identified a number of studies (concerned with falls from height or in front of trains) all of which showed decreases in death by suicide rates after barriers were built or reciprocal increases after their removal. This is not a panacea however as substitution of other means may occur (Cox et al, 2013). However a recent review of coroner files from Hong Kong concludes that the installation of physical barriers to structures from which people may jump to their death is strongly evidenced to reduced suicide rates (without substitution), however it notes that in settings where high rises are ubiquitous this presents a challenge to the installation of such barriers in the required density (Wong et al, 2014).

In their review Cox et al also note that three studies looking at “encouraging help seeking” by installing telephones (connected to organisations such as the Samaritans) at hotspots for example all saw reductions in suicides at those specific sites. Furthermore there was evidence that substitution had not occurred, meaning that lives were likely to have been saved.

Increasing the likelihood of an intervention by a third party, either by increasing resources such as putting patrols on bridges or by increasing the skills of staff already present and the resources available to them have also been demonstrated to reduce the rate of death by suicide involving the structure where they are used. For instance a reduction in the rate of deaths by suicide was seen at the Clifton Suspension Bridge after the addition of barriers, coupled with a change in protocol which saw staff monitoring incidents and the use of CCTV occur (Cox et al, 2013).

Inpatient psychiatric units are also areas where people may attempt suicide and environmental safeguards (along with staff interventions) should be used to limit any opportunity. Not only must such devices be installed but the hardware, such as breakaway bars, must be tested also and great thought paid to the removal of ligature points (or the use of specialised equipment such as suicide resistant showerheads, recessed soap dishes, specially designed sprinkler systems where they cannot be removed), especially those with a suspension distance of approximately at least a foot. Thought should also be given to the wider environment e.g. designing doors to open out so people cannot barricade themselves into rooms, and the use of non-breakable glass along with windows that cannot be opened.

Cardel et al also consider the use of cameras in their review. They note the debate that has surrounded their use but suggest that while they may be useful they should not replace “actual visual contact with the patient” (Cardell et al, 2009, p. 41) as this allows staff to more clearly see the condition of the patient and listen for breathing. Care too must be taken when using cameras that they are placed in such a way as to provide a useful vantage point and that they are not obscured by glare (which may be reduced by painting walls in matt pastel colours) or do not have sufficient light to function in.
Cadell et al also note the long list of personal belongings that are generally excluded from psychiatric units due to their potential to be used to self-harm or to take life and describe the close checks made on admittance and at routine points. Additionally scrutiny of visitors entering the environment is necessary should anything harmful be inadvertently brought in. Furthermore they recommend supervision of patients when they do use certain pieces of equipment (e.g. razors, hairdryers) for self-care.

Whilst such environments must be rendered safe through good planning and observance of robust policies they must too remain nurturing environments in order to fulfil their purpose (Cardell et al, 2009).

3.1.8.7 Restriction of media reporting of suicides

Within the UK there are well established guidelines around the reporting of deaths by suicide (specifically the method employed) by the media. These are in place to limit copycat behaviour after an initial death by suicide. There are examples in the literature which describe an increase in the rate of death by suicide during sensationalist reporting of such events occur (Cox et al, 2013) and that “the magnitude of the increase is proportional to the amount, duration, and prominence of the media coverage” (Amitai and Apter, 2012, p. 990). Ofcom’s Broadcasting Code lists a number of rules which are pertinent here, they are:

Section One: Protecting the Under-Eighteens

1.13 Dangerous behaviour, or the portrayal of dangerous behaviour, that is likely to be easily imitable by children in a manner that is harmful:

- must not be featured in programmes made primarily for children unless there is strong editorial justification;
- must not be broadcast before the watershed (in the case of television) or when children are particularly likely to be listening (in the case of radio), unless there is editorial justification (Ofcom, no date given).

Section Two: Harm and Offence

- 2.4 Programmes must not include material (whether in individual programmes or in programmes taken together) which, taking into account the context, condones or glamorises violent, dangerous or seriously antisocial behaviour and is likely to encourage others to copy such behaviour
- 2.5 Methods of suicide and self-harm must not be included in programmes except where they are editorially justified and are also justified by the context. (See Rule 1.13 in Section One: Protecting the Under-Eighteens) (Ofcom, no date given B).

The Samaritans suggest that journalists:

- Think about the impact of the coverage on their audience
- Exercise caution when referring to the methods and context of a suicide – this is due to the discussion of the method of suicide possibly acting as a prompt to vulnerable people to copy this behaviour. This observation is borne out by numerous studies, demonstrating that imitation peaks after approximately three days, tending to level off after two weeks, but
sometimes persisting for longer (WHO, 2008). Whilst including some broad description of the method used may be acceptable (e.g. saying someone was hanged) in certain contexts, giving information into types of ligature or knots used would not be. Furthermore the Samaritans recommend that no mention of the method used is made within a headline. They further counsel that care is taken around reporting novel methods as this too may promote copycat behaviours; a state which may also be promoted by over-identification with the deceased caused by an overly detailed account of their circumstances leading up to their death. Finally, within this theme, the Samaritans advise, “Never say a method is quick, easy, painless or certain to result in death. Try to avoid portraying anything that is immediate or easy to imitate – especially where the ingredients or tools involved are readily available” (Samaritans, 2013, p.7).

- Avoid over simplification
- Steer away from melodramatic depictions of suicide or its aftermath
- Aim for non-sensationalising sensitive coverage
- Consider carefully the placement and illustration of reports
- Educate and inform

These points are also reflected in the WHO’s “Preventing Suicide A Resource for Media Professionals” (WHO, 2008).

From a research literature point of view more is written about the possible adverse outcomes of irresponsible reporting than any potentially protective benefits to be gained from media black outs or changing the structure and tone of a report. There is evidence in the literature that within media reports there is a tendency to focus on deaths by suicide characterised by dramatic and highly lethal means (at least in the US where most of the reports are drawn from), a trend which also tends to be seen in film, the authors of a recent systematic review contend (Sisask and Värnik, 2012).

### 3.2 Treatment, maintenance and follow-up

The majority of those who die by suicide have had contact with primary care in the preceding year, a significantly larger group than those who attend mental health services in that period (Bernert et al, 2014). The need for clinical guidelines and training is therefore clear in this context. A number of studies have shown that the use of pharmacological treatments can significantly reduce risk of suicide (van der Feltz-Cornelis, 2011), while acute treatment may address risk during a given episode (e.g. of depression in people with unipolar or bipolar conditions) adequate longer term therapy is necessary to limit the on-going risk (Rihmet et al, 2004). There is however less evidence that psychotherapies alone are as protective. One exception is Cognitive Behavioural Therapy which has been seen to be effective (van der Feltz-Cornelis, 2011). A recent report by the British Association for Counselling & Psychotherapy concluded that “People at risk of suicide should have access to psychological interventions, including those within the cognitive-behavioural spectrum” and that “[p]sychotherapists, counsellors and other staff working with clients at risk of suicide should be provided with specific training and support systems in relation to this work” (Winter et al, 2009, p. 55).

After discharge from inpatient psychiatry or from accident and emergency (after self-inflicted injury) there is an increased risk of suicide and repeat attempts. This period is typically within a month of
discharge but with the peak in the first week (Luxton et al, 2013). Importantly “[m]any psychiatric patients who die by suicide are not found to be at high or immediate risk at their last contact with mental health providers” (Luxton et al, 2013, p. 32). This suggests that danger signs may not always be noted or indeed expressed meaning that targeting support may be difficult at this stage. Furthermore compliance with aftercare may be problematic for the individual concerned.

For those with bipolar disorder lifetime rates of attempted suicide may lie between 25 and 50 per cent with death by suicide being 60 times that of the general population. It is possible that forms of psychosocial interventions may be beneficial for people with bipolar disorder, along with pharmacotherapy (Fountoulakis et al, 2009). The literature suggests that interpersonal group therapy, cognitive-behavioural therapy, group sessions for partners of persons with bipolar disorder, and patient and family psychoeducation were effective interventions in adherence improvement and indirectly could influence the suicidal rates (Fountoulakis et al, 2009, pp. 25-26).

Within hospitals it is vital that staff are routinely trained to be competent in assessing and managing an individual’s risk of suicide. It is recommended that “all new staff should have in-depth training at the time of orientation and then routine training on an annual basis” (Cardell et al, 2009, p.42).

In a review of the literature Luxton et al showed that the incidence rate of suicide can be significantly reduced in this period by having formalised contact as part of repeat follow-ups (although a recent meta-analysis did not find any evidence to support additional psychosocial interventions following episodes of self-harm) (Crawford et al, 2007). du Roscoät and Beck similarly noted that one of the three most efficient categories of suicide prevention is “preservation of contact with the patients hospitalized for a suicide attempt after hospitalization” (du Roscoät and Beck, 2013, p.363). These contacts need not necessarily be resource intensive, indeed those studied ranged from in person / telephone to letters and postcards. An important factor in the mechanism seems to be the reassurance that connectedness brings, essentially that “someone cares about the patient” (Luxton et al, 2013, p.37). The fact that this contact occurs regardless of effort put in by the person is useful as they may already feel that they are a burden and therefore not wish to access further help themselves. Furthermore the contact does also provide details of (more clinical) help that may be available and acts as a prompt for help seeking behaviour. Similar results can be seen in the 2014 review by Brown and Green which also highlights the significant positive effects follow-ups can have.

Problem solving interventions, emergency cards, dialectic behavioural therapy, cognitive behavioural therapy and interpersonal behavioural therapy have all demonstrated beneficial associations with lower rates of self-harm (Luxton et al, 2013; Beauvais et al, 2007).

3.3 Postvention
Postvention, or acting after an event has occurred in order to have a positive or ameliorating effect, was introduced as a concept by Schneidman more than forty years ago (Leenaars, 2005). In connection to suicide it deals with the traumatic effects and grief felt by those who have lost someone to suicide (or in some cases those connected with individuals who have experienced a non-fatal attempt). Whilst postvention services seek to improve the quality of care of those who have lost someone to suicide, with evidence showing decreased mental distress and symptoms of conditions including PTSD and is primarily understood in this way, it also may limit suicide rates amongst those who have experienced the ramifications of another’s suicide. More research however is needed to better establish this latter point (Szumilas, 2010).
Within schools professionals seek, through postvention activities, to address the distress felt by those connected to someone who has died through suicide and limit the development of mental health problems amongst pupils. An overarching aim of this methodology is to make further deaths by suicide as unlikely as possible and to prevent the occurrence of clusters of deaths by suicide. The information in the literature, specifically around postvention in schools, is relatively sparse however. Common features, thought to be valuable, are: the provision of information to pupils, staff and parents; support/ counselling for pupils, staff and parents; consultation with the immediate family of the person who has died; working with the media (in order that the wishes of the family are met and that reports are not made in an unhelpful or sensationalist way but rather support safety messages).

3.4 On-going research

High quality research into the causes of and interventions for suicide are necessary to help combat this cause of death. The need to support research is recognised within ‘Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives’ (HMG/DH, 2012) and further highlighted in the recently published ‘Guidance for developing a local suicide prevention action plan (PHE, 2014). The development of research networks have been seen to be important in allowing a collective voice on suicide prevention to be heard and in promoting multi-disciplinary working to both advocate for suicide prevention as well as providing a sound platform of evidence from which to do so (Mulder, 2007).

3.4.1 National Confidential Inquiry into Suicide & Homicide by People with Mental Illness

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) was “commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of the NHS England, NHS Scotland, Welsh Government, the Northern Ireland Department of Health, Social Services and Public Health (DHSSPS) and the State of Jersey to undertake the Mental Health Clinical Outcome Review Programme” (The University of Manchester, no date given).

Annual reports are created with that for 2014 being the most recently available. Some of the key findings of this report include:

- People remain at “particularly high” risk of suicide in the first 3 months after discharge, with the greatest risk being seen within the first 1-2 weeks
- Hanging remains the most common method of suicide in both the general and patient populations, with increased numbers of people using this method
- Suicide by patients under crisis resolution and home treatment is now more common than in in-patient care, however the rate has been seen to fall “suggesting improving safety”
- “Living alone is a common antecedent of suicide by patients under CR/HT.”
- In 2008 higher rates of patient suicides were seen to be linked to the economic crisis. NCISH figures suggest that the impact of the crisis has been varied and inconsistent with differing effects seen in different age groups and between genders (The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2014)

NCISH also produce “Major UK and National Reports” as well as individual “Inquiry project reports” which go into greater detail on a given subject. Ongoing work includes:

- Features of mental health organisations and patient suicide rates
3.5 Policies

3.5.1 Policy in England

In 2012 HM Government published, “Preventing suicide in England A cross-government outcomes strategy to save lives” which was authored by the Department of Health (HMG/DH, 2012). This strategy seeks to provide an approach to prevention whilst recognising the underlying complexity. The strategy recognises the different approaches necessary for differing groups of people. For instance it draws distinction between those at high-risk of dying by suicide and those who may not be at such acute risk but need a differently tailored approach to support their mental wellbeing, giving the examples of children and those whose risk is hard to measure.

Furthermore this document considers method of suicide as well as the importance of the working collaboratively with the media to create appropriate responses. The need for both timely data collection and the evidence generated by on-going high quality research are both also outlined.

The document sets out two objectives:

- a reduction in the suicide rate in the general population in England; and
- better support for those bereaved or affected by suicide

As well as six priority areas to support the delivery of these objectives:

1: Reduce the risk of suicide in key high-risk groups – These are identified as: young and middle aged men; people in the care of mental health services, including inpatients; people with a history of self-harm; people in contact with the criminal justice system; specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

The strategy goes on to say that based on these groups, those who work with men, especially in primary care, must be vigilant of suicidal behaviour. Importantly the document also puts mental and physical health on an equal footing, acknowledging the impact this will have for 24 hour responses to mental health crises and in the management of care for people who self-harm.

It goes on to highlight the important roles that emergency departments along with primary care have in relation to self-harm, stressing the need for “good communication and follow-up” thus highlighting the on-going need for support some vulnerable people may have.

The authors also recognise that suicide risk may be context specific. They note the importance of the criminal justice system in suicide prevention and the need to continue to provide safer custody. The varying risk profile across different occupations is highlighted too. This necessitates that the statutory sector and local agencies have and adapt their suicide prevention interventions to suit their local conditions.
2: Tailor approaches to improve mental health in specific groups – The authors note that building on activities to promote the mental health of the general population will also act to reduce suicide rates and that the measures set out in, “No health without mental health” and “Healthy Lives, Healthy People” will support this. However the authors go on to delineate specific groups who require a tailored approach, these are:

- children and young people (highlighting problems such as bullying, low body image and lack of self-esteem. Recommendations to help parents to keep children safe online are also made), including those who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system;
- survivors of abuse or violence, including sexual abuse (with a focus put on timely referral of women and children experiencing abuse);
- veterans (whose mental wellbeing should be supported through the Military Covenant);
- people living with long-term physical health conditions (the authors suggest that routine assessment for depression as part of personalised care planning for people with long-term conditions, can help reduce inequalities and help people to have a better quality of life);
- people with untreated depression (as depression is a strong risk factor for suicide its prompt diagnosis and treatment is identified as a major way of reducing rates of suicide);
- people who are especially vulnerable due to social and economic circumstances;
- people who misuse drugs or alcohol;
- lesbian, gay, bisexual and transgender people;
- Black, Asian and minority ethnic groups and asylum seekers.

Factors such as: unemployment; debt; lack of social capital; family breakdown and bereavement as well as the ability of services to identify and support people who may be at risk of developing mental health problems are also important factors to consider in suicide prevention.

3: Reduce access to the means of suicide

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

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

6: Support research, data collection and monitoring.

3.5.2 NICE guidelines

NICE provides guidance on both the short term (first 48 hours of care after someone has self-harmed) and longer term treatment and management of self-harm (CG16 and CG133 respectively).

In CG16 NICE stresses that “[p]eople who have self-harmed should be treated with the same care, respect and privacy as any patient” (NICE, 2004) whilst keeping in mind the additional distress often associated with self-harm. The report goes on to outline the importance of respecting the patient and supporting their autonomy.

There are also a number of recommendations the clinical care and pain management of the individual whilst undergoing treatment. There are also sections covering the training of staff and the planning of services. Of note here are the observations (amongst others) that “People who self-harm should be involved in the planning and delivery of training for staff” and that “Strategic Health
Authorities, Primary Care Trusts (PCTs), acute trusts and mental health trusts should ensure that people who self-harm are involved in the commissioning, planning and evaluation of services for people who self-harm”.

There are also recommendations for initial management by ambulance services, some of which are operational and support faster and better diagnosis and treatment (such as the collection of any medication packaging) as well as consideration around which is the correct service to transport too (with the consent of the service user).

The guidelines also cover triage within the emergency department and also psychosocial assessment, noting that it “should not be delayed until after medical treatment is complete, unless life-saving medical treatment is needed, or the patient is unconscious or otherwise incapable of being assessed” and also that clear information about what is happening to them and any proposed treatments (where appropriate).

The majority of the rest of the guidance is given over to issues of treatment. Suicide itself is mentioned four times within CG16. That is once within the assessment of risk which states that:

“All people who have self-harmed should be assessed for risk; this assessment should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent.”

Then under the heading of “Referral, admission and discharge following self-harm” which recommends that:

“the decision to discharge a person without follow-up following an act of self-harm should not be based solely upon the presence of low risk of repetition of self-harm or attempted suicide and the absence of a mental illness, because many such people may have a range of other social and personal problems that may later increase risk. These problems may be amenable to therapeutic and/or social interventions.”

Suicide is then next explicitly mentioned in the context of “special issues for older people (older than 65 years)” where the guidance states that, “When older people self-harm, treatments will be much the same as for younger adults, but the risk of further self-harm and suicide are substantially higher and must be taken into account” and recommends that “[a]ll acts of self-harm in people older than 65 years of age should be regarded as evidence of suicidal intent until proven otherwise because the number of people in this age range who go on to complete suicide is much higher than in younger adults”.

In CG133 NICE sets out the longer-term management of self-harm. It begins with recommendations to develop trust and supportive relationships between health and social care professionals and people who self-harm. They also highlight the need to be aware of the stigma and discrimination sometimes associated with self-harm as well as supporting joint decision making and autonomy. The recommendations also note the need to maintain “continuity of therapeutic relationships wherever possible” (NICE, 2011, p.7) and sensitive communication. The guidance also covers the psychosocial assessment of the individual (which as well as problems should also consider strengths).
Suicide prevention is mentioned in the context of risk assessment within this guidance. It states that:

“When assessing the risk of repetition of self-harm or risk of suicide, identify and agree with the person who self-harms the specific risks for them, taking into account:

- methods and frequency of current and past self-harm
- current and past suicidal intent
- depressive symptoms and their relationship to self-harm
- any psychiatric illness and its relationship to self-harm
- the personal and social context and any other specific factors preceding self-harm, such as specific unpleasant affective states or emotions and changes in relationships
- specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm
- coping strategies that the person has used to either successfully limit or avert self-harm or to contain the impact of personal, social or other factors preceding episodes of self-harm
- significant relationships that may either be supportive or represent a threat (such as abuse or neglect) and may lead to changes in the level of risk
- immediate and longer-term risks” (NICE, 2011, p.8).

The guidance also states, “[d]o not use risk assessment tools and scales to predict future suicide or repetition of self-harm” (NICE, 2011, p.8).

CG133 also discusses the creation of multidisciplinary care plans in some detail and highlights the need for review and re-agreement in intervals of not more than a year. The aims of a care plan may include:

- “prevent escalation of self-harm
- reduce harm arising from self-harm or reduce or stop self-harm
- reduce or stop other risk-related behaviour
- improve social or occupational functioning
- improve quality of life
- improve any associated mental health conditions” (NICE, 2011, p.9).

NICE clinical guideline 123, ‘Common mental health disorders Identification and pathways to care’ is a third document which considers suicide prevention. Within this document is the recommendation that a competent health care professional, when carrying out a mental health assessment should ask “directly about suicidal ideation and intent” (NICE, 2011B, p.19). If there is a risk, the guidance further recommends the professional:

- “assess whether the person has adequate social support and is aware of sources of help
- arrange help appropriate to the level of risk
- advise the person to seek further help if the situation deteriorates” (NICE, 2011B, p.19).

Considering risk assessment and monitoring the guidance recommends to the health professional that:
“[i]f a person with a common mental health disorder presents a high risk of suicide or potential harm to others, a risk of significant self-neglect, or severe functional impairment, assess and manage the immediate problem first and then refer to specialist services. Where appropriate inform families and carers” (NICE, 2011B, p.20).

In a subsequent paragraph the guidance outlines the importance of on-going follow-up thusly:

“ If a person with a common mental health disorder, in particular depression, is assessed to be at risk of suicide:

• take into account toxicity in overdose, if a drug is prescribed, and potential interaction with other prescribed medication; if necessary, limit the amount of drug(s) available
• consider increasing the level of support, such as more frequent direct or telephone contacts
• consider referral to specialist mental health services” (NICE, 2011B, p.20).

From the NICE guidance we therefore see a picture develop of where preventative interventions may be made, furthermore the fact that suicide prevention is a multidisciplinary priority is shown through its integration with a number of pathways and clinical guidelines.

3.6 Conclusions
Suicide is the result of interplay of complex and multifactorial risks. Prevention can focus on removing or limiting risks in a population (e.g. through education to reduce stigma and increase help seeking behaviours) or alternatively be targeted towards selected groups such as people who already experience suicidal ideation or who are displaying suicidal behaviours (e.g. insuring that people receive appropriate treatment and support). Individuals may be at higher risk of suicide if they belong to a vulnerable group and interventions may need to be appropriately targeted. In addition to this, modification of the environment is important at certain sites as it may put beyond use certain means, giving time for interventions to be implemented or for an acute episode to pass.

Structures such as schools, workplaces and military services may be useful settings in which to site interventions e.g. education programmes in schools or the training of Gatekeepers (staff or peers) to recognise signs and symptoms of distress that may be a precursor to suicide and be provided with the tools to possibly help.

Timely access to services is also critical, this is illustrated by the observation that the administration of appropriate medication has been seen to reduce the risk of suicide and deliberate self-harm in people with mood disorders. Furthermore psychosocial and pharmacological treatments have been shown to be of some benefit in reducing rates of repeated self-harm (Beautraise, 2007).

Deaths by suicide cannot be considered in a vacuum. Responsible reporting (or the decision not to report) of such a death in the media can have a significant effect both in terms of limiting further distress as well as limiting suicidal ideation or planning in others. Similarly postvention services can be very important in addressing the traumatic effects of losing someone to suicide and may in itself limit further risk of self-harm and suicidal behaviours in those surviving the person.

Suicide prevention therefore requires partnership working and planning, in a number of settings, as well as continuing research to increase our understanding and the evidence base around effective interventions.
4 Data Section

4.1 Area

Figure 3 below shows the geographic footprint of Northumberland, Tyne and Wear which is comprised of the Local Authorities of Northumberland, Newcastle upon Tyne, Gateshead, Sunderland, South Tyneside and Sunderland. This is subsequently referred to as “the Sub-Region”. The population sizes are given in Table 1 and their age structures are shown, separated by sex, in Figures 4 to 9 below.

**Fig. 3 Northumberland, Tyne and Wear (The Sub-Region)**

<table>
<thead>
<tr>
<th>Area</th>
<th>Population size</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>53,493,729</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>148,428</td>
</tr>
<tr>
<td>Gateshead</td>
<td>200,153</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>282,442</td>
</tr>
<tr>
<td>Sunderland</td>
<td>274,743</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>201,446</td>
</tr>
<tr>
<td>Northumberland</td>
<td>316,116</td>
</tr>
</tbody>
</table>

(*http://www.localhealth.org.uk/#z=324076,651271,191734,143913;v=map9;l=en*)
4.2 Age Structure

Figures 4 to 9 show the age structures of the populations of: South Tyneside; Gateshead; Newcastle upon Tyne; Sunderland; North Tyneside; and Northumberland. It should be noted that figures are for 2012 only.

South Tyneside shows a spike in population amongst 45 to 54 year olds, with a steady decline in proportion after this point. Gateshead has a less skewed distribution, with the proportion in age groups after 49 years declining. A substantial proportion of the population fall between 40 and 54 years. There are a higher proportion of young people than is seen in South Tyneside. Newcastle Upon Tyne has a very noticeable spike in the 20 to 24 year old age group, this is true for both sexes. The population structure as a whole is biased towards younger people. In Sunderland some biomodality is seen in the age structures of both sexes (a similar pattern is seen in both South Tyneside and Gateshead). A substantial part of the population is between 19 and 29 years old with another peak between 44 and 59 years. The population declines steadily after this. In North Tyneside the largest age groups in population terms are the 40 to 59 year olds. Finally Northumberland similarly displays a relatively even spread in numbers of people aged 0 to 39 years. There is however a relatively flat peak between the ages of approximately 40 and 69 years, with a sharp decline in numbers from this age onwards.

Fig. 4 Age Structure of South Tyneside 2012
Fig. 5 Age Structure of Gateshead 2012

Fig. 6 Age Structure of Newcastle upon Tyne 2012
4.2.1 Life expectancy

Life expectancy at birth for males born in the North East is lower than the England average (78.0 years and 79.4 respectively). In all of the Sub-Region the expectancy is also lower than the England average, although in the case of Northumberland this was not seen to be a statistically significant difference.

The difference in life expectancy can perhaps more starkly be seen when healthy rather than total life expectancy for men is considered. Comparing the North East to England average we can see that the gap widens (from 1.4 year difference in total life expectancy to 3.9 years when healthy life is considered). Again each area within the Sub-Region has a lower healthy life expectancy when compare to the England average but again Northumberland is seen as not being significantly different in a statistical sense.

As one would expect females are seen to have a longer life expectancy than males. However women in the North East can consistently expect to have a shorter life on average than the average woman in England, although this gap may be closing.

Again we see a greater gap between the North East healthy life span for females and the England average than in the case of total expected life expectancy. Similarly all the areas within the Sub-Region have a lower expectancy than the England average, although healthy life expectancy in Northumberland is not statistically significantly lower.

**Fig. 10 Life Expectancies in the Sub-Region**

![Life Expectancies in the Sub-Region](http://www.phoutcomes.info/search/healthy%20life%20expectancy)
### 4.2.2 Ethnicity

Table 2 shows the proportions of the ethnic backgrounds of residents of the Sub-Region as reported on the 2011 Census. The North East of England tends to have a higher proportion of people identifying as White than England as a whole. The only area within the Sub-Region which did not display this pattern was Newcastle upon Tyne. It had a similar proportion of people identifying as “White” to England. Furthermore Newcastle upon Tyne had a larger than average proportion of people identifying as “Asian British” as well as “other ethnic groups”.

Table 2 also shows the relatively low population turn overs and migrant registrations at GPs generally seen within the Sub-Region. Again the exception to this is Newcastle upon Tyne which shows a markedly higher turnover (perhaps due to being the major city in the area with a relatively young and mobile population). Additionally Newcastle upon Tyne has a significantly higher rate of migrant registrations with GPs.

<table>
<thead>
<tr>
<th>Area</th>
<th>Population turnover per 1000 resident population</th>
<th>Migrant GP registrations per 1000 resident population</th>
<th>Black or Black British</th>
<th>Asian or Asian British</th>
<th>White (white British, Irish or other)</th>
<th>Mixed/multiple ethnic group</th>
<th>Other ethnic group</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>92.6</td>
<td>9.6</td>
<td>3.5%</td>
<td>7.8%</td>
<td>85.4%</td>
<td>2.25%</td>
<td>1.0%</td>
</tr>
<tr>
<td>North East</td>
<td>70.5</td>
<td>5.3</td>
<td>0.5%</td>
<td>2.9%</td>
<td>95.3%</td>
<td>0.86%</td>
<td>0.4%</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>46.5</td>
<td>3.3</td>
<td>0.3%</td>
<td>2.2%</td>
<td>95.9%</td>
<td>0.63%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Gateshead</td>
<td>70.9</td>
<td>4.1</td>
<td>0.5%</td>
<td>1.9%</td>
<td>96.3%</td>
<td>0.78%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>136.0</td>
<td>18.4</td>
<td>1.8%</td>
<td>9.7%</td>
<td>85.5%</td>
<td>1.53%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Sunderland</td>
<td>51.1</td>
<td>4.8</td>
<td>0.5%</td>
<td>2.7%</td>
<td>95.9%</td>
<td>0.65%</td>
<td>0.3%</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>72.4</td>
<td>2.0</td>
<td>0.4%</td>
<td>1.9%</td>
<td>96.6%</td>
<td>0.90%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Northumberland</td>
<td>56.9</td>
<td>1.4</td>
<td>0.1%</td>
<td>0.8%</td>
<td>98.4%</td>
<td>0.54%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

**Key**
- Higher than England average
- Similar to England average
- Lower than England average
4.3 Suicide Rates

Office for National Statistics (ONS) Data were obtained from The Knowledge and Information Team of Public Health England. Data were also drawn from the Suicide Prevention Tool of the Fingertips website. Between 2011 and 2013 there were 106 deaths by suicide and injury of undetermined intent\(^1\) in Northumberland, 38 in Gateshead, 81 in Newcastle upon Tyne, 68 in North Tyneside, 36 in South Tyneside and 85 in Sunderland. Figure 11 shows that, within the Sub-Region as a whole, that those most at risk were men. Across both genders we see and increasing rate with age before a marked drop in the 55 years and over category. Death by suicide was most commonly seen in the 35 to 54 year group in both genders.

Fig.11 Deaths by Suicide in the Sub-Region (2011-13, crude rate)

![Graph showing deaths by suicide in the Sub-Region (2011-13, crude rate)]

Considering the data drawn over five years presented on the Public Health England website, the age standardised rates per 100,000 population are given in Figure 15 overleaf, from which we can see that the North East of England as a whole has a statistically significant higher suicide rate than the England average. Furthermore this pattern is replicated within North Tyneside and Northumberland; the other localities within the Sub-Region show rates not statistically dissimilar from the England average. Given the relatively large confidence intervals (a function of the fact the death by suicide is still a relatively rare event) there is little significant difference observable between the localities and the England average, however Northumberland does show a statistically higher level.

While there are the greatest numbers of suicides in the male 35 to 54 years group, rates are higher than the England average for males aged 15 to 34 years (Fig. 12) and males aged 35 to 64 years (Fig. 13). There is also variation with the area of study. In males aged 15 to 34 years there is a significantly higher rate of death by suicide in North Tyneside and Northumberland. Within this age group the

\(^1\) Number of deaths from suicide and injury of undetermined intent classified by underlying cause of death recorded as ICD10 codes X60-X84 (all ages), Y10-Y34 (ages 15+ only)
other local authorities within the Sub-Region were not significantly different to the England average. Similarly there were no significant differences in suicide rates between any local authority within the Sub-Region and the England average for males aged 35 to 64 years and males aged 65+ years (Fig. 13). In part this will be driven by the relatively large confidence intervals which are a consequence of the relatively low numbers. Similar data for women were not available due to small numbers.

**Fig. 12**

**Male suicide crude rate 15-34 years: per 100,000 males (5 year average)**

<table>
<thead>
<tr>
<th>Area</th>
<th>Value</th>
<th>Lower CI</th>
<th>Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>12.3</td>
<td>12.0</td>
<td>12.7</td>
</tr>
<tr>
<td>North East region</td>
<td>18.4</td>
<td>16.4</td>
<td>20.6</td>
</tr>
<tr>
<td>Gateshead</td>
<td>11.7</td>
<td>6.6</td>
<td>19.4</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>12.2</td>
<td>8.3</td>
<td>17.3</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>23.7</td>
<td>15.8</td>
<td>34.3</td>
</tr>
<tr>
<td>Northumberland</td>
<td>22.0</td>
<td>15.5</td>
<td>30.3</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>16.6</td>
<td>9.3</td>
<td>27.3</td>
</tr>
<tr>
<td>Sunderland</td>
<td>17.5</td>
<td>11.9</td>
<td>24.8</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics (ONS), original mortality data


**Fig. 13**

**Male suicide crude rate 35-64 years: per 100,000 males (5 year average)**

<table>
<thead>
<tr>
<th>Area</th>
<th>Value</th>
<th>Lower CI</th>
<th>Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>20.1</td>
<td>19.7</td>
<td>20.5</td>
</tr>
<tr>
<td>North East region</td>
<td>23.3</td>
<td>21.5</td>
<td>25.3</td>
</tr>
<tr>
<td>Gateshead</td>
<td>15.2</td>
<td>10.3</td>
<td>21.8</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>21.3</td>
<td>16.9</td>
<td>28.0</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>24.6</td>
<td>18.2</td>
<td>32.4</td>
</tr>
<tr>
<td>Northumberland</td>
<td>22.3</td>
<td>17.5</td>
<td>28.1</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>15.5</td>
<td>9.8</td>
<td>23.3</td>
</tr>
<tr>
<td>Sunderland</td>
<td>25.5</td>
<td>19.9</td>
<td>32.3</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics (ONS), original mortality data

When males were considered in isolation a higher rate of death by suicide is seen in each area. Northumberland was seen to have the highest rate at 20.0 per 100,000 (95% CI 16.0-24.6), significantly higher than the England average rate of 13.8 per 100,000 (95% CI 13.6-14.1). The other localities were not statistically distinct from the England average but this in part may be due to large confidence intervals.
Fig. 16 Mortality from suicide and injury undetermined: directly standardised rate per 100,000 (Male) 2011 - 13

<table>
<thead>
<tr>
<th>Area</th>
<th>Value</th>
<th>Lower CI</th>
<th>Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>13.8</td>
<td>13.6</td>
<td>14.1</td>
</tr>
<tr>
<td>North East</td>
<td>17.3</td>
<td>16.0</td>
<td>18.7</td>
</tr>
<tr>
<td>Gateshead</td>
<td>11.6</td>
<td>8.0</td>
<td>16.4</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>16.0</td>
<td>12.1</td>
<td>20.7</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>16.3</td>
<td>11.9</td>
<td>21.7</td>
</tr>
<tr>
<td>Northumberland</td>
<td>20.0</td>
<td>16.0</td>
<td>24.6</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>13.6</td>
<td>9.1</td>
<td>19.6</td>
</tr>
<tr>
<td>Sunderland</td>
<td>16.3</td>
<td>12.6</td>
<td>20.8</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics

(After http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide)

Rates were not available on the Fingertips website for females as data were suppressed due to small numbers. A data request was therefore made to the Knowledge and Information Team within Public Health England. From data received figure 17 below was constructed. It shows rates of suicide per 100,000 population by gender but is uncorrected for any other variable. Again from this chart one may see the relatively high rate experienced in Northumberland, however it should be noted that the highest female rate was seen in North Tyneside.

Fig.17
Two separate recent reports based upon police data sampled from all incidents closed and coded as ‘sudden death – not crime’ (SC1) were available (the first covered 01/01/13 to 30/06/13, the second 01/07/13 to 31/12/13). These findings will however be an underestimate as this code is only applied if a body is found (personal communication).

Between 01/01/13 and 30/06/13 the most common method was by hanging (51.8%) and the second involved a fall from a height (15.7%). Death by hanging was also the most commonly used method by males (56.3%) whilst females most frequently died from a drug overdosed (33.3%).

Between 01/07/13 and 31/12/13 it was identified that males were more likely to die by suicide than females (males making up 76.9% of deaths by suicide coded SC1). Again hanging was the most frequent method used (56.4% of those identified), the rate not having substantially changed in the since the previous six month sample (death by overdose was the next largest category observed). Furthermore it was predominantly males who used this method to end their lives; however there was a marked increase in the proportion of female deaths by suicide where this method was noted (55.6% of female deaths by suicide for 01/07/13 to 31/12/13). However it should be noted both that the time scales were short and the total number of deaths by suicide small, therefore such figures should be interpreted with caution.

4.4 Risk factors

4.4.1 Self-harm Rates

In the north east of England and across the Sub-Region rates of emergency hospital admissions for self-harm tend to be higher than the national average. The exception is South Tyneside which is seen to have a rate not statistically different from the England average. There is some variation in the rate amongst the Sub-Region with Sunderland showing a relatively high value. As these rates are for emergency admissions (rather than presentations) they are likely a significant underestimate of the true burden of self-harm in the area.

Fig.18 Emergency Hospital Admissions for Intentional Self-Harm directly age-sex standardised rate, all ages, Persons 2012/13.

<table>
<thead>
<tr>
<th>Area</th>
<th>Value</th>
<th>Lower CI</th>
<th>Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>188.0</td>
<td>186.8</td>
<td>189.1</td>
</tr>
<tr>
<td>North East</td>
<td>292.8</td>
<td>286.3</td>
<td>299.5</td>
</tr>
<tr>
<td>Gateshead</td>
<td>266.6</td>
<td>244.3</td>
<td>296.4</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>221.3</td>
<td>204.0</td>
<td>239.6</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>251.6</td>
<td>230.0</td>
<td>274.6</td>
</tr>
<tr>
<td>Northumberland</td>
<td>234.8</td>
<td>217.4</td>
<td>253.2</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>202.9</td>
<td>180.2</td>
<td>227.6</td>
</tr>
<tr>
<td>Sunderland</td>
<td>383.6</td>
<td>365.6</td>
<td>412.6</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics (HES), Health and Social Care Information Centre for the respective financial year; England, Hospital Episode Statistics (HES) Copyright © 2014. Reused with the permission of The Health and Social Care Information Centre. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS). Uncensored mid-year population estimates produced by ONS and supplied to the Public Health England. Analysis uses the single year of age grouped into quinary age bands, by sex.

(After http://fingertips.phe.org.uk/search/self%20harm#gid/1/pat/6/ati/102/page/3/pag/E12000001/are/E06000047/iid/21001/age/1/sex/4)
Considering the impact on young people (aged 10 to 24 years) one may see that they are disproportionately affected by self-harm as a group. This is evidenced by the fact that their rates are consistently higher than the full average. In Figure 19 below we see that South Tyneside still has a relatively low rate within the Sub-Region however the lowest is now seen in Newcastle upon Tyne.

**Fig.19**

<table>
<thead>
<tr>
<th>Area</th>
<th>Value</th>
<th>Lower CI</th>
<th>Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>352.3</td>
<td>350.1</td>
<td>354.4</td>
</tr>
<tr>
<td>North East</td>
<td>532.2</td>
<td>520.7</td>
<td>543.9</td>
</tr>
<tr>
<td>Gateshead</td>
<td>517.6</td>
<td>475.2</td>
<td>562.9</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>334.9</td>
<td>310.2</td>
<td>360.9</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>545.7</td>
<td>500.5</td>
<td>594.0</td>
</tr>
<tr>
<td>Northumberland</td>
<td>461.3</td>
<td>427.8</td>
<td>496.7</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>384.4</td>
<td>343.1</td>
<td>429.3</td>
</tr>
<tr>
<td>Sunderland</td>
<td>676.8</td>
<td>637.4</td>
<td>718.1</td>
</tr>
</tbody>
</table>

Ethnicity may also be a risk factor for self-harm and suicide. This may be due to social isolation, knowledge and accessibility of services and as well as other additional pressures. Office of National Statistics data were obtained via the PHE Knowledge and Information Team however due to low numbers in some of the categories it is difficult to draw conclusions from these data, other than to say that rates of self-harm vary between ethnic groups and the highest rates may be seen in people with other than white ethnicity.

### 4.4.2 Deprivation and poverty

The population of the north east of England tends to be more likely to experience deprivation than the national average, as shown in Table 3 below. Indeed in each of the local authority areas which make up the Sub-Region it is only Northumberland that is not worse than the national average in this respect. The data show, in fact, that Northumberland has significantly fewer residents living in deprivation than both the local and national averages.

<table>
<thead>
<tr>
<th>Area</th>
<th>Percentage of population living in the 20% most deprived Lower Super Output Areas in England</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>20.4</td>
<td>20.4 – 20.4</td>
</tr>
<tr>
<td>North East</td>
<td>32.5</td>
<td>32.4 – 32.5</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>40.2</td>
<td>39.9 – 40.4</td>
</tr>
<tr>
<td>Gateshead</td>
<td>39.0</td>
<td>38.8 – 39.3</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>37.6</td>
<td>37.4 – 37.8</td>
</tr>
<tr>
<td>Sunderland</td>
<td>37.0</td>
<td>36.8 – 37.1</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>24.1</td>
<td>24.0 – 24.3</td>
</tr>
<tr>
<td>Northumberland</td>
<td>15.4</td>
<td>15.3 – 15.6</td>
</tr>
</tbody>
</table>

Fuel poverty is higher in the North East than the England average (11.6% and 10.4% of households respectively). There is some variation within the Sub-Region however. The majority of areas show a higher burden than the England average, with Northumberland being the highest at 11.8% but in
North Tyneside there is significantly less fuel poverty than both the England and regional averages (9.7% of households).

<table>
<thead>
<tr>
<th>Area</th>
<th>The percentage of households in an area that experience fuel poverty based on the “Low income, high cost” methodology</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>10.4</td>
<td>10.4 – 10.4</td>
</tr>
<tr>
<td>North East</td>
<td>11.6</td>
<td>11.6 – 11.7</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>11.0</td>
<td>10.8 – 11.2</td>
</tr>
<tr>
<td>Gateshead</td>
<td>11.0</td>
<td>10.8 – 11.2</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>13.4</td>
<td>13.2 – 13.6</td>
</tr>
<tr>
<td>Sunderland</td>
<td>11.7</td>
<td>11.6 – 11.9</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>9.7</td>
<td>9.5 – 9.9</td>
</tr>
<tr>
<td>Northumberland</td>
<td>11.8</td>
<td>11.6 – 11.9</td>
</tr>
</tbody>
</table>

On the whole the North East has fewer homeless households than the England average. This pattern is replicated in the majority of local authorities within Northumberland Tyne and Wear. Gateshead has a rate which is not statistically significantly different from the England average. Only South Tyneside has a significantly higher rate of 3.9 per 1000 (compared to the England average of 2.3 per 1000 households).

<table>
<thead>
<tr>
<th>Area</th>
<th>Statutory homeless households, crude rate per 1,000 estimated total households, all ages</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>2.3</td>
<td>2.3 – 2.3</td>
</tr>
<tr>
<td>North East</td>
<td>1.3</td>
<td>1.3 – 1.4</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>3.9</td>
<td>3.4 – 4.4</td>
</tr>
<tr>
<td>Gateshead</td>
<td>2.1</td>
<td>1.8 – 2.4</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>1.4</td>
<td>1.2 – 1.6</td>
</tr>
<tr>
<td>Sunderland</td>
<td>1.4</td>
<td>1.2 – 1.6</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>1.9</td>
<td>1.6 – 2.2</td>
</tr>
<tr>
<td>Northumberland</td>
<td>1.3</td>
<td>1.1 – 1.5</td>
</tr>
</tbody>
</table>

Long term unemployment is relatively common in the North East. The rate in the country as a whole is 9.9 per 1000 but in the North East this rises to 17.4 per 1000 resident population aged 16 to 64 years. This pattern is seen throughout the Sub-Region with each of the six areas displaying long term unemployment at rates significantly higher than the national average. This is most stark in South Tyneside, where the rate is 25.3 per 1000 resident population aged 16 to 64 years.

<table>
<thead>
<tr>
<th>Area</th>
<th>Claimant count for jobseekers allowance, 16-64 year olds claiming for more than 12 months, crude rate per 1000 resident population, 16-64 year olds.</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>9.9</td>
<td>9.8 – 9.9</td>
</tr>
<tr>
<td>North East</td>
<td>17.4</td>
<td>17.2 – 17.6</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>25.3</td>
<td>24.3 – 26.3</td>
</tr>
<tr>
<td>Gateshead</td>
<td>13.8</td>
<td>13.2 – 14.5</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>14.3</td>
<td>13.8 – 14.9</td>
</tr>
<tr>
<td>Sunderland</td>
<td>17.1</td>
<td>16.5 – 17.7</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>12.8</td>
<td>12.2 – 13.5</td>
</tr>
<tr>
<td>Northumberland</td>
<td>13.1</td>
<td>12.6 – 13.7</td>
</tr>
</tbody>
</table>
4.4.3 Substance misuse

Hospital admissions for alcohol related harm occur more frequently throughout the North East than the England average. This is true for all areas constituting the Sub-Region, with Sunderland shouldering the greatest level of burden.

<table>
<thead>
<tr>
<th>Area</th>
<th>The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause per 100,000 population (age standardised).</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>637</td>
<td>635 – 639</td>
</tr>
<tr>
<td>North East</td>
<td>856</td>
<td>844 – 867</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>982</td>
<td>932 – 1035</td>
</tr>
<tr>
<td>Gateshead</td>
<td>941</td>
<td>801 – 882</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>828</td>
<td>791 – 866</td>
</tr>
<tr>
<td>Sunderland</td>
<td>1071</td>
<td>1032 – 1111</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>974</td>
<td>931 – 1018</td>
</tr>
<tr>
<td>Northumberland</td>
<td>788</td>
<td>758 – 820</td>
</tr>
</tbody>
</table>

(http://fingertips.phe.org.uk/profile/health-profiles/data#gid/1938132701/pat/6/ati/101/page/3/par/E12000001/are/E08000037/iid/91414/age/1/sex/4)

Opiate and/or crack use in the North East is more prevalent than the England average. However within Northumberland Tyne and Wear there is significant variation in the prevalence of drug misuse, with the majority of areas having a lower prevalence than the North East average. Gateshead and Newcastle upon Tyne display a prevalence statistically above the England average, whereas North Tyneside, Northumberland and Sunderland show rates statistically lower than the England average, with South Tyneside having a rate not significantly different from the England average.

The proportion of opiate users who complete drug treatment successfully and who do not relapse within six months is regrettably low. The England average is 7.8% and 6.0% in the North East. Within the Sub-Region the majority of areas are not significantly different from the England average (although the confidence intervals are large, possibly due to the low numbers of observations involved). The percentages range from 4.5% in Newcastle upon Tyne (which has a significantly poorer rate than the England average) to 9.0% in North Tyneside (although not significantly different from the England average as shown by the overlapping confidence intervals, this is significantly higher than the regional rate).

The successful recovery of non-opiate users is more likely. The North East has a statistically significant lower success rate than the England average. The majority of areas within the Sub-Region also show this difference, however Gateshead and South Tyneside are both not statistically different from the overall England prevalence.
### Prevalence of opiate and/or crack use 2011/12

<table>
<thead>
<tr>
<th>Area</th>
<th>Count</th>
<th>Value</th>
<th>95% Lower CI</th>
<th>95% Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>293,379</td>
<td>8.4</td>
<td>8.4</td>
<td>8.4</td>
</tr>
<tr>
<td>North East region</td>
<td>16,935</td>
<td>9.9</td>
<td>9.7</td>
<td>10.0</td>
</tr>
<tr>
<td>Gateshead</td>
<td>1,749</td>
<td>13.3</td>
<td>12.6</td>
<td>13.9</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>2,221</td>
<td>11.4</td>
<td>10.9</td>
<td>11.9</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>975</td>
<td>7.4</td>
<td>6.9</td>
<td>7.8</td>
</tr>
<tr>
<td>Northumberland</td>
<td>1,324</td>
<td>6.5</td>
<td>6.2</td>
<td>6.9</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>817</td>
<td>8.4</td>
<td>7.8</td>
<td>9.0</td>
</tr>
<tr>
<td>Sunderland</td>
<td>1,271</td>
<td>6.9</td>
<td>6.6</td>
<td>7.3</td>
</tr>
</tbody>
</table>

Source: Alcohol, Drugs & Tobacco Division


### Successful completion of drug treatment - opiate users: % who do not re-present within 6 months 2013

<table>
<thead>
<tr>
<th>Area</th>
<th>Count</th>
<th>Value</th>
<th>95% Lower CI</th>
<th>95% Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>12,077</td>
<td>7.8</td>
<td>7.6</td>
<td>7.9</td>
</tr>
<tr>
<td>North East region</td>
<td>648</td>
<td>6.0</td>
<td>5.6</td>
<td>6.5</td>
</tr>
<tr>
<td>Gateshead</td>
<td>67</td>
<td>6.4</td>
<td>5.1</td>
<td>8.0</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>55</td>
<td>4.5</td>
<td>3.5</td>
<td>5.8</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>53</td>
<td>9.0</td>
<td>7.0</td>
<td>11.6</td>
</tr>
<tr>
<td>Northumberland</td>
<td>57</td>
<td>6.8</td>
<td>5.3</td>
<td>8.7</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>34</td>
<td>7.3</td>
<td>5.3</td>
<td>10.0</td>
</tr>
<tr>
<td>Sunderland</td>
<td>47</td>
<td>5.7</td>
<td>4.3</td>
<td>7.5</td>
</tr>
</tbody>
</table>

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the National Drug Treatment Monitoring System

(After [http://fingertips.phe.org.uk/search/percentage%20of%20opiate%20users#gid/1/pat/6/ati/102/page/3/par/E12000001/are/E06000047/iid/90244/age/234/sex/4](http://fingertips.phe.org.uk/search/percentage%20of%20opiate%20users#gid/1/pat/6/ati/102/page/3/par/E12000001/are/E06000047/iid/90244/age/234/sex/4))
Successful completion of drug treatment - non-opiate users: % who do not re-present within 6 months 2013

<table>
<thead>
<tr>
<th>Area</th>
<th>Count</th>
<th>Value</th>
<th>95% Lower CI</th>
<th>95% Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>20.941</td>
<td>37.7</td>
<td>37.3</td>
<td>38.1</td>
</tr>
<tr>
<td>North East region</td>
<td>1.134</td>
<td>31.2</td>
<td>29.7</td>
<td>32.7</td>
</tr>
<tr>
<td>County Durham</td>
<td>240</td>
<td>37.7</td>
<td>34.0</td>
<td>41.5</td>
</tr>
<tr>
<td>Gateshead</td>
<td>76</td>
<td>32.2</td>
<td>28.6</td>
<td>38.4</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>113</td>
<td>29.4</td>
<td>25.0</td>
<td>34.1</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>57</td>
<td>25.3</td>
<td>20.1</td>
<td>31.4</td>
</tr>
<tr>
<td>Northumberland</td>
<td>37</td>
<td>19.3</td>
<td>14.3</td>
<td>25.4</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>84</td>
<td>31.9</td>
<td>25.6</td>
<td>37.8</td>
</tr>
<tr>
<td>Sunderland</td>
<td>75</td>
<td>24.4</td>
<td>20.0</td>
<td>29.5</td>
</tr>
</tbody>
</table>

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the National Drug Treatment Monitoring System

(After http://fingertips.phe.org.uk/search/percentage%20of%20opiate%20users#gid/1/pat/6/ati/102/page/3/par/E12000001/are/E06000047/iid/90245/age/234/sex/4)
## 4.4.4 Lack of Wellbeing

In the North East a greater proportion of respondents scored low for self-reported happiness than the England average. This difference is repeated throughout Northumberland Tyne and Wear but is not statistically significant in Newcastle upon Tyne, North Tyneside or Northumberland.

In line with relatively high levels of unhappiness there were also relatively high anxiety rates reported for the North East in the survey. However due to uncertainty in many of the estimates (as shown by large confidence intervals) this difference is only significant within Gateshead and the North East rate.

The North East appears to perform relatively well with regard to levels of social inclusion however. The national average of adults who use social care who have as much social contact with people as they would like is 44.5%. The North East as a region exceeds this by 4.1 percentage points (48.6% of social care users). The percentages of those satisfied within the Sub-Region also tend to exceed the England average, although in the cases of South Tyneside and Gateshead this is not a statistically significant difference. Furthermore Newcastle upon Tyne, Sunderland, North Tyneside and Northumberland exceed not only the England, but also the regional average.

When considering the possible isolation of carers we again see that the North East has a greater prevalence of satisfaction with social contact levels then the England average. Within the Sub-Region the individual areas also tend to be significantly better than the England average, the exceptions being South Tyneside and Sunderland which are not significantly different from the 41.3% England average.
However optimism must be tempered with the observation that approximately half of adult social care users and similar proportions of carers do not have much contact as they would like and therefore may become socially isolated.

Fig. 24

![Social Inclusion](http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000041/par/E12000004)

### 4.4.5 Risk Factors in Children and Young People

Child poverty is also an issue in the North East of England. Again, within the Sub-Region, it is only Northumberland that has a significantly better value than the national average (17.6% and 19.2% respectively) whilst the other five areas have a burden which is statistically significantly worse than the average.

<table>
<thead>
<tr>
<th>Area</th>
<th>Percentage of under 16s living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>19.2</td>
<td>19.2 – 19.3</td>
</tr>
<tr>
<td>North East</td>
<td>23.6</td>
<td>23.5 – 23.7</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>26.9</td>
<td>26.3 – 27.4</td>
</tr>
<tr>
<td>Gateshead</td>
<td>22.1</td>
<td>21.7 – 22.6</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>27.4</td>
<td>27.0 – 27.8</td>
</tr>
<tr>
<td>Sunderland</td>
<td>24.3</td>
<td>23.9 – 24.7</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>19.1</td>
<td>18.7 – 19.5</td>
</tr>
<tr>
<td>Northumberland</td>
<td>17.6</td>
<td>17.3 – 17.9</td>
</tr>
</tbody>
</table>

(http://fingertips.phe.org.uk/profile/health-profiles/data#gid/1938132701/pat/6/ati/101/page/3/par/E12000001/are/E08000037)
Hospital admissions as a result of under aged drinking are a concern in the North East, with rates tending to be above the national average (although confidence intervals tend to be large, possibly due to low power). Newcastle and Northumberland both display rates in-line with the national average, whilst the other areas show significantly higher rates of the results of alcohol abuse in this age group.

| Table 10 Alcohol-specific hospital admissions (under 18) 2010/11-12/13 |
|-----------------------------|---------------------------------|----------------|
| Area                        | Under 18s admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population (persons only counted once per financial year). | 95% Confidence Interval |
| England                     | 44.9                            | 44.2 – 45.6 |
| North East                  | 72.2                            | 68.1 – 76.5 |
| South Tyneside              | 99.8                            | 80.2 – 122.9|
| Gateshead                   | 71.4                            | 57.1 – 88.1 |
| Newcastle upon Tyne         | 45.6                            | 35.8 – 57.3 |
| Sunderland                  | 86.1                            | 72.5 – 101.4|
| North Tyneside              | 76.9                            | 62.1 – 94.2 |
| Northumberland              | 44.6                            | 35.5 – 55.4 |

In Figure 25 the rates of children and young people aged 10 to 18 years supervised by a youth offending team are given. Young people in the Youth Justice Service are recognised as being a vulnerable group. Only Northumberland has a rate statistically similar to the England average, the other localities within the Sub-Region showing significantly higher rate. This picture is continued across the North East as a whole.

**Fig. 25**
The graph below (Figure 26) shows rates of both children (aged 0 to 18 years) in care and those leaving care in 2013/14. Both of these groups are recognised as being vulnerable populations. Again Northumberland is the only local authority area which has rates statistically similar to the England average, the others within the Sub-Region are statistically significantly higher. South Tyneside was seen to have the highest rate in 2013/14. In terms of children leaving care Northumberland and North Tyneside have rates statistically in line with the England average, all other local authority areas within the Sub-Region having higher rates. Gateshead has the highest rates but the confidence intervals overlap with both those of South Tyneside’s and Newcastle upon Tyne’s.

Half of adult mental health problems start before the age of 14, early identification and intervention to support children and young people with mental health and emotional well-being issues is therefore very important. Difficulty scores are calculated “by local authorities through a strengths and difficulties questionnaire (SDQ) and a single summary figure for each child (the total difficulties score), ranging from 0 to 40, is submitted to the Department for Education through the looked after children return (SSDA903). A higher score indicates greater difficulties (a score of under 14 is considered normal, 14-16 is borderline cause for concern and 17 or over is a cause for concern).”
Table 11 shows difficulty scores calculated for the Sub-Region. As there are no confidence intervals available for the difficulties scores and because the data are for a relatively short time period it makes it difficult to draw conclusions from them. However we can see that the North East has the same score as the England average. Within the Sub-Region three areas had a score of below 14 and would therefore be considered normal. Due to the lack of information on the precision of this estimate it is however difficult to say how robust this observation is. Both Northumberland and Sunderland have scores in excess of 14, in the case of Northumberland it suggests borderline cause for concern but Sunderland’s score of 22.3 falls into the “cause for concern” category.

<table>
<thead>
<tr>
<th>Area</th>
<th>Total difficulties score for all looked after children, in care for at least 12 months, aged 5 - 16 years (inclusive) at last assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>13.9</td>
</tr>
<tr>
<td>North East</td>
<td>13.9</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>Suppressed due to small numbers</td>
</tr>
<tr>
<td>Gateshead</td>
<td>12.1</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>12.6</td>
</tr>
<tr>
<td>Sunderland</td>
<td>22.3</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>13.8</td>
</tr>
<tr>
<td>Northumberland</td>
<td>14.6</td>
</tr>
</tbody>
</table>

(https://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000001/are/E08000037 )

4.4.6 Mental Health

There is a markedly lower proportion of men who use secondary mental health services in the North East who are recorded living independently, with or without support than in England as a whole. This is also true throughout the Sub-Region being as low as 38% in Newcastle upon Tyne.

A similar pattern is considered when women using secondary mental health services are considered. In this instance it is South Tyneside which has the lowest percentage (Newcastle being second lowest). It is however interesting to note that in the constituent parts of the Sub-Region the proportions, while not reaching the England average, does exceed the North East average.
The data in Table 12 following was drawn from the Community Mental Health Profiles (http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp) present a range of mental health information for local authorities in England. They give an overview of mental health risks, prevalence and services at a local, regional and national level.

Within the Sub-Region rates of anxiety and depression tended to be higher than the England average. There also seemed to be noteworthy differences between the amount of depression identified via QOF and that self-reported. This may be in part attributed to differences in case mix and different definitions of diagnosis, however it may also point towards a need for increased case finding. The greatest difference (in terms of percentage point difference) was seen within NHS Newcastle North and East CCG and the smallest in NHS Northumberland CCG. A similar pattern was seen between those individuals who self-reported a long-term mental health problem and those with a recorded diagnosis, however it should be noted that these represent different age groups (over 18 and all ages respectively). The majority of CCGs also showed higher rates of bed days used in secondary mental health care.

The spend on mental health in specialist services also tended to be higher, as do rates of self-harm. Sadly rates of recovery for IAPT treatment tend to be lower than the England average, the exception being within NHS Northumberland CCG (51.7% compared to 45.9% for England and 43.9% for the north east).
### Table 12 Community Mental Health Profile Data

<table>
<thead>
<tr>
<th>Area</th>
<th>Depression &amp; anxiety prevalence (GP survey 2012/13)</th>
<th>Depression: QOF prevalence (18+)</th>
<th>Gap between self-reported depression and QOF recorded depression</th>
<th>Percentage of people completing GP survey who report a long-term mental health problem</th>
<th>Patients with a diagnosis recorded</th>
<th>Patients with a comprehensive care plan in place</th>
<th>Number of bed days in secondary mental health care hospitals per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>12.0%</td>
<td>5.8%</td>
<td>6.2 percentage points</td>
<td>4.5%</td>
<td>17.8%</td>
<td>87.3%</td>
<td>4686</td>
</tr>
<tr>
<td>North of England</td>
<td>13.8%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>12.5%</td>
<td>-</td>
<td>4688</td>
</tr>
<tr>
<td>NHS South Tyneside CCG</td>
<td>16.5%</td>
<td>7.3%</td>
<td>9.2 percentage points</td>
<td>5.9%</td>
<td>12.0%</td>
<td>85.7%</td>
<td>6901</td>
</tr>
<tr>
<td>NHS Gateshead CCG</td>
<td>14.2%</td>
<td>6.8%</td>
<td>7.4 percentage points</td>
<td>5.7%</td>
<td>11.0%</td>
<td>86.0%</td>
<td>4576</td>
</tr>
<tr>
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<td>Area</td>
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<td>Carers of mental health clients receiving of assessments</td>
<td>Spend (£s) on mental health in specialist services: rate per 100,000 population</td>
<td>People on Care Programme Approach per 100,000 population</td>
<td>Emergency admissions for self harm per 100,000 population</td>
<td>Hospital admissions for unintentional and deliberate injuries, ages 0-24 per 10,000 population</td>
<td>Rate of recovery for IAPT treatment</td>
</tr>
<tr>
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</tr>
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</table>

Higher than England Average: Dark Blue
Similar to England Average: Yellow
Lower than England Average: Dark Red
4.4.6.2 Care Quality Commission Thematic Review

The Care Quality Commission (CQC) began a thematic review of mental health crisis care in late 2013. This has the explicit aim of “exploring the experiences and outcomes of care for people experiencing a mental health crisis” (Care Quality Commission, 2015). The data presented in Appendix III are drawn from the first phase data of the mental health crisis review. This includes “data from providers and other key organisations, plus analysis from service users, carers and local groups involved in mental health crisis care” and presents information where the local authority is considered an outlier (Care Quality Commission, 2015). One may see from the table that there is variation within the Sub-Region.

Across the Sub-Region the majority of local authorities were not seen as an outlier in terms of Indirectly standardised mortality rate for suicide and undetermined injury, however Sunderland showed a higher than expected rate. Across the Sub-Region the number of unnatural deaths of detained patients was higher than average.

Both Gateshead and Sunderland had higher than expected A&E attendances for self-harm and Sunderland also had a higher than expected rate of people with a mental health condition returning to A&E within a month. However South Tyneside and Northumberland both have lower than expected ratios of observed to expected numbers of emergency acute admissions for self-harm.

South Tyneside, North Tyneside and Northumberland all demonstrated a lower than average proportion of people with a severe mental health illness who also had a comprehensive care plan in place.

Both Sunderland and North Tyneside demonstrated a higher than expected emergency admission rate for people with mental health problems associated with alcohol misuse.

South Tyneside and Newcastle upon Tyne both had higher than average rates of people waiting more than 28 days for talking therapy, interestingly Northumberland displayed lower than average rates. Conversely concern as to the acceptability of care given (as assessed by answers to carer and group surveys) to those in crisis was noted for Northumberland. Across the sub-region the proportion of emergency admissions to specialist MH provider that are gate-kept by crisis resolution home treatment teams was higher than average however.

Although wait for talking therapies was noted in some parts of the Sub-Region South Tyneside and Sunderland both showed shorter than average times between referral and first contact with specialist mental health (MH) services, with Gateshead showing much shorter than average times. Additionally throughout the Sub-Region there were higher than average rates of respondents who said that they had been told who was in charge of organising their care.

In terms of places of safety for those in crisis providers tended to see the provision as adequate, however in Gateshead, Newcastle upon Tyne, Sunderland and North Tyneside a negative score was seen against the question “How often has someone not been able to access place of safety because it was occupied?” indicating that the system may reach capacity quickly on some occasions. Across the Sub-Region however places of safety do not tend to be used for purposes other than their
intended use. There was also variation in the proportion of S136 assessments that led to a hospital admission across the Sub-Region.

4.4.7 Quantitative Data Summary

Life expectancy in the North East is lower than the England average, as is the healthy life expectancy. Between 2011 and 2013 there were 414 deaths by suicide and injury of undetermined intent within the Sub-Region, with men being most at risk. There was a steady increase in risk with age until the age of 55+ years. As a standardised rate deaths by suicide were seen to be more common in the North East than the England average. It is however difficult to see significant differences between each of the local authority areas (both one to another and to the England average) due to wide confidence intervals (a marker of the low precision of the estimate due to death by suicide being a relatively rare event). The age structure of a community may however contribute to the overall risk of suicide. With the exception of Newcastle, the Sub-Region has a population skewed towards older age groups. Newcastle upon Tyne however has a high proportion of people in their early 20s resident within it.

Concerning potential risk factors hospital admission for self-harm were seen to be more common than the England average in the North East and also through the Sub-Region itself (with the exception of South Tyneside), these rates being markedly increased in young people. The rates of admission to hospital for alcohol-related cause were similarly elevated. Individuals living in the Sub-Region are also tend to be more likely to experience deprivation than the England average, similarly the proportion of people living in fuel poverty tends to be higher than the England average in the majority of the Sub-Region. Long term joblessness is also more likely than the England average within the Sub-Region. Importantly Community Mental Health Profile data suggests that within the Sub-Region rates of anxiety and of depression tend to be higher than the England averages and rates of recovery for IAPT treatment lower.

In terms of the social inclusion of people using social care and of carers the Sub-Region performs relatively well compared to the England average however there is still room for improvement. Additionally data were not available to measure the isolation of other vulnerable groups. Individuals using secondary mental health services were less likely to be living independently within the Sub-Region when compared to England however.

In summary then we can see from the data that suicide rates tend to be higher within the Sub-Region than the England average. Additionally individuals living in the Sub-Region may be more likely to be exposed to a number of risk factors than elsewhere in England.
4.5 One to One Interviews

4.5.1 Background

Semi-structured interviews were conducted with people who had been bereaved by suicide or who had identified themselves as previously being suicidal. Two concerned postvention after the individuals lost children to suicide. A third interview was conducted with a pair of siblings who had lost another sibling to suicide and a fourth with an individual who had lost family and friends to suicide. A fifth interview was had around support for transsexual people. Finally two interviews centred on prevention with individuals who had previously attempted to end their own lives.

Additionally, a one to one interview was conducted with a local GP with an interest in mental health and finally an interview was conducted with a LGBT Youth Development Worker. The group interviewed were drawn from across the Sub-Region and had been pre-selected by the If U Care Share foundation (with the exception of the GP interviewed). The semi-structured interview templates can be seen in Appendix IV.

Transcripts of each interview were thematically analysed. Emergent themes are presented below.

Whilst this is a very small sample and may not be fully representative of the greater population from which it was drawn useful qualitative information and insights were given.

4.5.2 Emergent Themes from Pre- and Postvention Interviews

- Four people spoken to regarding postvention all immediately replied “none” to the initial question about what services were available in their local area. One interviewee was however able to identify a number of services in their area that they were aware of before their attempt. This was seen as being largely due to previous contact of other family members rather than outreach on their part.
- Feelings of anxiety, embarrassment and fear of stigmatisation at coming forward for help.
- The impact that isolation can have was also explored. Both in the context of rurality and in belonging to a minority group, societal reactions and portrayal in media. The point was strongly made that in order to engage with services people need to see themselves reflected in them. Any promotional material must therefore bear inclusivity in mind. Perhaps more importantly this must be carried through in the working culture of the service, with attention paid to type of language used. These points were primarily made within the context of the LGBTQI experience, however the point holds for any minority group.
- Specifically thinking of transsexual people it was felt that there were no clear pathways available, with individuals being passed between services or expected to access specific clinics. Again feelings of stigma and isolation were expressed, one example being mis-pronouncing by health professionals. This was seen as a barrier to coming forward for help when needed.
- It was felt by at least one interviewee that the system as a whole promotes an overall tone of willingness but lacks a real understanding when a community has been left behind.
- It was also expressed that there were a number of good services available but that interventions may need to be targeted to vulnerable or minority groups and promoted through bodies which are seen to represent them.
• It was also felt that there needs to be greater integration of services so that individuals would have their various needs met, irrespective of which service was first approached.
• It was felt that services should openly stress their inclusive nature.
• The point was also made that resilience can be built in schools, especially by teaching children how to support each other and to prevent bullying. Furthermore it was seen as important that young people know at least the first steps to obtaining help.
• The need to destigmatise help seeking by training people such as hairdressers, taxi drivers etc. in mental health first aid was raised.
• Perceived lack of empathy in mental health professionals.
• The recognition that those working with vulnerable people may themselves need support. The point was made that such organisations should have clear plans in place to react if necessary.
• Feelings of being dealt with in a “tick box” fashion after a perfunctory telephone conversation. This was seen as a significant barrier and additionally may have contributed to further suicidal ideation due to making the individual feel powerless and worthless.
• The need for a tailored approach, appropriate for the individual’s circumstance.
• There was a strong preference for being able to self-refer into support services.
• The need to have regular slots for follow-up with GP and teaching of coping strategies.
• The need to remove delays in getting help when in crisis was commonly and strongly raised. A number of interviewees felt that immediate action was necessary to reduce acute risk.
• There was a strongly expressed need to remove repetition in giving details around incidents of suicide or suicidal ideation and to avoid being passed between a series of organisations.
• Improved communication between services and between service and service user and to follow through when consultations were promised.
• Improved communication between families and health services so that concerns may be passed on and acted upon in a timely fashion.
• Perceived lack of knowledge or ability to signpost from GP to other services.
• Variation in what organisations are present in different areas e.g. availability of bereavement and mental health charities.
• Variation of practice of organisations – information not being provided in a timely manner, organisations advising that contact would be made without follow-up.
• Concern over lack of budget for postvention services.
• Concern over availability of resource and the ability to hold of beds for those on home visits or similar (in case they need to return to suddenly return to hospital).
• Sense of desperation around not knowing where to obtain help from.
• Relief at finding postvention services and continuing support.
• Benefit of understanding shown by people who have shared similar experiences, promoting further engagement with support services.
• The need for people who have lost loved ones to suicide or who have been suicidal to be included in decision making and delivery of services from start to finish.
• Need for support to be delivered by people from a mix of backgrounds (medical professionals and lay people).
• More support within hospitals with work done to address underlying causes. It was felt that too many people who overdose “get checked out and sent home” without having underlying causes addressed.
• The need for on-going support or follow-up after discharge from services was strongly conveyed.
• It was strongly expressed that supportive follow-up during waiting periods for treatment or therapy would be useful. It was felt that if contact was made to say how long it would be until they were seen and that they had not been forgotten about people would feel more supported.
• The need for a simplified and integrated pathway (with increased integration of GP and other services such as talking therapies) to obtain needed help and support. The current system was seen as difficult to navigate.
• The need for an integrated system to address differing aspects leading to suicidal ideation or behaviour in order to holistically treat the person.
• A number of times it was stressed how useful it was to have someone (named) that could be talked to by text, phone or drop in.
• Awareness around possible suicides within hospitals (palliative care, ideation, staff not knowing where patients were).
• Those who had been in touch with Crisis Teams spoke positively of them and also noted that they knew how to contact them if needed.
• It was felt that the work of the voluntary sector should be recognised and become more integrated with NHS work.
• The need to be able to fill days e.g. going to the hairdressers regularly, fitness, dog walking.
• Broadly it was felt that suicide prevention should be talked about more within society and families without ascribing blame. There also needs to be increased knowledge of where to go for help. This was seen as a current gap. One interviewee suggested that the community mental health teams may be able to help fill this gap. Regarding survivors of suicide it was felt that they should be able to be able to link in with someone who has a mentoring role within groups patterned after the AA. It was felt that while the mentor would not necessarily have an NHS background the scheme could be supported by NHS, local authority and businesses (the later to support people into employment).

4.5.3 Emergent Themes from Interview with a Doctor
A one to one interview was also conducted with a GP with mental health interests in the area. They described their initial approach when someone who may be suicidal presents to their clinic. The multifactorial risk factors that may have triggered the suicidal feelings or behaviours were briefly discussed. Depending on the level of suicidal intent examples of different treatment options were given e.g. counselling, medication, housing support and/or referral on to more specialist services such as the Crisis Team for a full psychiatric history to be taken and assessment made.
Themes arising from the interview are presented below in-line with the approach taken for discussions with others:

- The resilience and effort needed by patients to present themselves to a GP to ask for help around dealing with suicide and suicidal thoughts was recognised.
- The importance of spending time with patients, being compassionate and providing empathy was stressed.
- The need to take a detailed history and the resource, primarily in terms of time, that this may represent was highlighted. As was the possible onward impact to waiting times for other patients.
- It was recognised that to do this effectively will take longer than the standard ten minute GP appointment slot, due to the complex needs of the patient.
- A fear was raised that this may limit the thoroughness of assessments made of individuals.
- It was pointed out that approximately ten years ago mental health workers were embedded within the practice in which the GP worked. These mental health workers could meet with patients face to face and, anecdotally, had significantly shorter waiting times than some current support services.
- A juxtaposition was also made between people who are actively suicidal, who will be referred to the crisis team and individuals who have other needs which if addressed can quickly deescalate the situation e.g. a housing need.
- Signposting to other bodies (e.g. Citizens Advice Bureau, housing, talking therapies) resources and lack of feedback were also identified as issues. A major gap was seen in the waiting times to receive, for example, for grief counselling.
- It was observed that even where services are available it may be difficult for vulnerable individuals to access them unaided due to the involvement of low self-esteem and low confidence. This was also linked to the observation regarding mental health workers having previously been embedded within a GP practice.
- This in turn may add to the stress felt by the individual and increases the load on primary care as the patient will need monitoring and review in the interim period.
- The mechanism of booking GP appointments was also raised. The example of practices which only allow on the day booking was given; this was seen as an extra barrier to efficient follow-up of patients needing on-going support.
- Furthermore an analogy was drawn between services available for suicide prevention and what was available for dementia. It was noted that support was becoming “more mainstream” and groups such as Dementia Friends were seen as having a positive and normative effect. It was felt that other aspects of mental health should have parity with this.
- The point was made that non-mental health services are very reactive and services for people at risk of suicide should be just as reactive. For example if someone has a broken leg they get seen straight away and an X-ray is taken, the patient being seen the following day in a trauma clinic. Mental health should be on a par with this.
- The need for multiagency working and support for individuals was raised and the importance of effective triage was stressed. A further theme emerged that this may be best placed within primary care in some situations.
- That support could be given to people, where appropriate, to address stressors such as debt management, benefits, housing or a need for counselling in a coordinated and timely
manner by locating CPN, housing, social services etc. within the same structure was also suggested. This would address the perceived need to shorten pathways between presenting at a GP’s office and getting the advice necessary to deescalate the situation as signposting to other bodies with lengthy waits would be avoided.

- The provision of places of safety that individuals can access (out of hours) was also raised, the examples of crisis housing and sanctuaries being given.
- Outside of health and upstream of acute need, a discussion was had on the roles of employers and schools in suicide prevention. The example of the Mindful Employer initiative was given and the need to partake in similar training.
- In schools it was felt that education around the recognition of stress and what to do about it should be made part of the normal digest of pupils. It was felt that this would be best delivered to year groups rather than individuals so that additional stigma was not created. This was recognised as complex however as there must be the facilities to take up stress reducing activities.
- Common between education and employment (and with wider society) were themes around reducing stigma and reducing fear of coming forward for help, as well as providing more training to peers in order that people may be better able to see signs and symptoms of potential mental health problems and know how to help someone.
- The point was made that “there’s no one fix” for all and therefore approaches must be tailored to the individual.
- Finally the point was made that, “suicidal need is not just a psychiatric one”.

4.5.4 Emergent Themes from Interview with LGBT Youth Development Worker

During the discussion the interviewee outlined their work supporting young LGBT people. The majority of the discussion centred around the experience of transsexual young people, however many of the points made would also apply to other young people generally and those from vulnerable groups in particular.

- It was noted that a proportion of those young people that were in contact with the Youth Worker were also supported by CYP services and so could access services such as CAMHS more easily.
- It was felt that there is a gap in support for individuals who are not currently acting on suicidal thoughts or are acutely ill.
- Uncertainty at the point at which services will act was also expressed.
- Concern was expressed at waiting times and lack of support in this period.
- Discussion was had around the role of schools in resilience building. While it was recognised that there are supportive teachers it was felt by the interviewee that some school’s policies were not supportive of transsexual people. Additionally it was noted that there was scope in some schools to more actively promote existing services.
- It was felt that interventions within schools should be broad and include the majority of pupils but also have more targeted services available for those requiring additional support.
- In addition to supportive policies it was felt that additional training was required for teachers as well as clear pathways to support teachers in obtaining help for young people.
- It was further felt sharing standardised information regarding support services between GPs and pastoral workers would also be beneficial.
• It was felt that information and training (especially around body dysphoria) amongst services for children and young people.
• A need for better co-ordination and marketing of existing services was expressed.
• It was felt that a central point of contact for young people seeking help or others seeking help for young people would be useful. This observation was made regarding the needs of LGBT young people.
• A number of other points were made about mispronouncing of transgender young people by health professionals and a need to listen carefully to young people in order to support holistic treatment of them. A need for more support for children under 14 years of age was also expressed.
• It was felt that youth work could be increased through the Sub-Region. Examples given were building resilience into school curriculum, providing classes or drop-ins at lunch time and having an online presence.

4.5.5 Summary of One to One Interviews
While drawn from a small sample the responses given in interview were remarkably consistent. They tended to centre around needing immediate triage and appropriate help, but in a setting that felt supportive and from compassionate individuals who are in a position to offer help in a timely fashion. Being passed between organisations, or indeed any pathway with multiple steps was seen as something to be avoided as it tended to make individuals feel powerless and not valued. A number of other themes were shared between interviews, these included that:

There should not be delays, help should be offered in first few hours not weeks to years.

Two of the interviewees also mentioned the pastoral care and activities provided by the foundation in addition to talking therapies. For example one still attends regularly for aromatherapy and values the structure of knowing they have a set day to attend. A different interviewee also spoke of taking part in boxing initially and finding positive things to fill days with; dog walking, fitness etc.

All interviewees also highlighted the need for GPs to be better placed to sign post to therapeutic or support services, with one suggesting that they should be embedded.

All spoke of a need to improve communication between services and the massive barrier posed by constantly having to restate (and therefore relive) their experiences.

Two of the interviewees expressed the view that their experience of a lack of support and counselling by GPS had made them less likely to seek medical help for that or other conditions.

There was also a clear and repeated theme relating to a need around improving communication around mental health and suicide prevention. That is a number of interviewees did not feel listened to by health services and were not confident that their concerns had been listened to initially.
5 Thematic Analysis of Responses to Local Authority Framework

A framework questionnaire (see Appendix V) was created and sent out to the local authorities within the Sub-Region to capture work know by the Las to already be on-going. Five out of six of the local authorities requested to complete and return the framework did so by time of writing.

Only a minority (2/5) of local authorities who responded to the request to complete the framework currently had an active suicide prevention plan in place. The remainder all stated that they had plans in place to address this. Three out of five of the respondents indicated in involvement of local strategic or stakeholder groups, which are used to inform the monitoring of on-going plans and the development of new ones. The need for strong strategic input was highlighted.

One of the local authorities stated that collaboration with neighbouring local authorities was an explicit part of their suicide prevention plans, however it should be noted that each of the local authorities consulted sends representatives to the sub regional Northumberland, Tyne and Wear suicide prevention group. This point was highlighted by the majority of respondents (3/5).

The degree to which stakeholders are engaged in suicide prevention plans varies across the region. This ranges from local stakeholders being part of the strategy group and able to take an active part in the setting of priorities with ‘introductory training provided to GP education sessions’ to more limited consultations between the local authority and the third sector (with some areas not directly including primary health as a formal stakeholder but recognising the need to review this). Additionally a second local authority recognised the importance of engaging with primary health care through Time In Time Out (TITO) events. Stakeholders mentioned by respondents include: local authority; third sector; GP; and CCG although this should not been seen as an exhaustive list and it should also be noted that not all local authorities mentioned the same groups. Difficulties in arranging attendance of some key groups was noted.

Only a minority (2/5) of local authorities indicated that suicide audits were performed routinely, one specifying on a yearly basis the other not specifying the period between audits. Two respondents also said that retrospective audits had been conducted for the period covering the last three years, additionally a single local authority reported that their last audit was completed approximately three years ago, with a retrospective audit being a commitment for this year. One respondent replied that routine suicide audits are not conducted any more. One local authority notes that it is currently working to standardise their audit process with others within the north east of England.

When asked about how barriers to carrying out routine suicide audits could be removed the most commonly given answer was the need to understand responsibilities and how data can be shared. Two respondents explicitly raised the point of resource and analysts’ time being a determining factor. Conversely another said that they experienced no barriers pointing to an “excellent working arrangement with the Coroner”. Finally standardisation of data to be collected was also seen as a method by which routine audit could be supported. Key themes therefore seem to be data flow and capacity to analyse it.

To the question regarding whether or not local authorities have access to an ‘early alert system’ warning of possible deaths by suicide, two local authorities replied that this was within their development plans. One other noted that Community Safety receive alerts on possible drug related deaths but that suicide was “not included at this time”. Two other local authorities simply stated
that they had no early alert system in place (this should not necessarily be interpreted as one not being considered however). Therefore in summary none of the responding local authorities currently have an early alert system in place, although some are actively considering this as a possible action.

The collection of data in such a way as to support research and monitoring was identified as a gap by two local authorities. One local authority noted that the CCG had access to information and that NECS also has “a suicide management protocol”. It was noted that this forms a standard dataset but the public health teams within local authorities do not have routine access to it nor influence what data is captured.

Three other local authorities do indicate that they at least receive some information systematically. One noting that data is limited to that provide by the Coroner, one which states that data “are received in arrears and are considered when they are refreshed” but the source and type of data are not noted. Only one local authority noted the use of an audit tool (implying standardisation – however data captured was again not outlined) and a report to the Director of Public Health.

Regarding finance and staffing to support suicide prevention initiatives a number of local authorities noted the importance of partnership working to make mental health and wellbeing part of everyone’s normal working. Staff awareness of signs and symptoms was also seen as intrinsic to supporting this work. The majority of respondents also noted public health’s role in leading in this area, four identifying that a public health lead was in place, one of these noting that this function was within the remit of an identified public health consultant.

Two respondents noted sources of funding for training (ALWL for frontline workers and a training contract to deliver one session per month to identified target groups). This latter respondent also noted the use of CCTV and bereavement services within this section.

Engagement with media (to support a sensitive reporting approach) is recognised as an area for development. Council plans are in place in a number of areas and will develop as further suicide prevention work is done. The need to work collaboratively between council communications, public health and media is explicitly recognised in one response. Other areas focus on a general approach to promoting messages to support positive mental health.

The approach to identifying high-risk groups varies between local authority areas. The number of services engaged in this effort ranged from a null reply to a list of twenty. The total list of services given by any local authority can be seen overleaf:
### Table 13 Services to Identify High-risk Groups

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<td>Public health</td>
<td>Steering group of partners</td>
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<tr>
<td>MIND</td>
<td>Charity</td>
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<tr>
<td>Tyneside Women’s Health</td>
<td>Charity</td>
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<td>PH drug &amp; alcohol service</td>
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<td>Charity</td>
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<td>IDVA services LA</td>
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<td>NTW – crisis team</td>
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<td>Mental health services for children and adults, DWP, Samaritans, Police</td>
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The majority of areas listed no, one or three services to identify high-risk groups only. One area did however awareness raising work being carried out with primary care, mental health services for children and adults, DWP, Samaritans and Police.

Similarly the listed available services which provide tailored approaches to improve the mental health of specific groups (see question 12 in the Local Authority framework, Appendix V for details of groups) also showed variation. Responses included it being the responsibility of the Wellbeing network, arts for health and MHFA and YMHFA training, to fuller answers outlined overleaf:
<table>
<thead>
<tr>
<th>Service name/description</th>
<th>Commissioned by</th>
<th>Provided by</th>
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<tbody>
<tr>
<td>Social isolation group of the Health and Wellbeing Board looks at approaches to target specific groups. Their role is to develop ways to work together to reduce social isolation in vulnerable groups.</td>
<td>Stakeholders commissioned by Council and CCG, as well as charity funded.</td>
<td>The Social Isolation Group has key stakeholders from: Age UK, Housing, Adult Social Care, Foundation Trust, DWP, welfare agencies and racial equality forum links.</td>
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<tr>
<td>bait – arts for health – people at risk of mental health problems</td>
<td>Arts council and public health</td>
<td>Bait – Woodhorn Museum – Ashington</td>
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<td>MHFA and YMHFA training</td>
<td>Public Health</td>
<td>Specialist Health Improvement Team in Northumbria Healthcare Trust</td>
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<tr>
<td>CAMHs Adult mental health services</td>
<td>CCG</td>
<td>NTW NHCFT</td>
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<tr>
<td>MESMAC Drug and alcohol services</td>
<td>LA</td>
<td>Newcastle City Council NTRP</td>
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<td>Tyneside Womens Health – women</td>
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<td>Evolve (CRI) Drug and alcohol service</td>
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<td>NTW – enduring MH conditions and crisis care</td>
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<tr>
<td>Fullfilling lives – complex cases mainly drug / alcohol</td>
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<td>MESMAC - LGBT</td>
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<td>Samaritans - all</td>
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<tr>
<td>Wellbeing network</td>
<td>Public health</td>
<td>Steering group of partners</td>
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</table>
These recognised the individual needs of LGBT people, women, those with dependency issues and those with diagnosed mental health conditions and those in crisis. Thinking about the wider determinants of health, work to combat social isolation was mentioned by one respondent. This was led through a subgroup of the Health and Wellbeing Board and recognises a wide range of stakeholders i.e. Age UK, Housing, Adult Social Care, Foundation Trust, DWP and welfare agencies. It also has racial equality forum links. Recently this has expanded membership to organisations which represent Health and LGBT people.

The majority of returned frameworks also noted work to educate the local community to risks of suicide and signs of suicidal behaviour. These included community programmes commissioned by public health teams in local authorities (delivered by others including charities). Other areas point to previous and current specialist training “for organisation” highlighting that the on-going work will be done by the Wellness service and possibly other training offers currently under review. Another area highlights partnership working in this regard, with strategy group updates presented to public as well as partnership fora. Training is again highlighted, in this instance around awareness raising. Only one local authority did not record any current work in this area.

Three of the five respondents gave details of how social integration is supported in their areas. This included programmes to give health and wellness checks (with an online presence) and projects to support the wider determinants e.g. social prescribing, free or reduced price for sporting activities, local authority community centre services and also work with the third sector on community projects. Furthermore attention was drawn to the importance of health and social care staff working collaboratively to support a social navigator role. This was seen as an essential part of offering preventative services to promote self-care and to limit further increases in health problems.

Again there is variation in the degree to which schools have been involved in the delivery of suicide prevention messages and support (from a local authority Public Health Team point of view), with one area reporting no current activity. Two respondents noted the work of mental health charities (Washington Mind and the Samaritans) into schools. These consisted of CYP training of adults and work expressing feelings, resilience building and education around signs and symptoms respectively. The Samaritans’ contact details also being promoted within schools’ websites and literature. Other approaches included the health and wellbeing of school nurses. One area reports a recent review of emotional wellbeing initiatives within schools with recommendations and consistent messages currently being rolled out. This is seen in the context of the Health School Standard programme.

Three of the five respondents provided information regarding the support of positive aging and social capital amongst elderly people. Age UK was seen as a main partner as this charity provides befriender services; brokerage projects; home from hospital schemes and support for the digitalisation agenda amongst other activities. The Older Peoples assembly was identified as an important stakeholder group and Live Well was seen as providing services in other areas.

Regarding support and follow-up for individuals post mental health crisis this was generally seen as the responsibility of health services, dependent upon patient choice.

The majority (3/5) of respondents noted factors to restrict access to means of suicide locally. One may expect for these to differ between settings according to need and for example geography. Placement of CCTV and signage (with pertinent help numbers such as the Samaritan’s listed) at
relevant places, including bridges, were noted. As were 24 hour help lines. One area noted the information given to new university students (within accommodation), another highlighting the important work of NTW/police in street triage.

Responses concerning postvention services focussed on the provision of information leaflets. The Help at Hand booklet was recognised as a resource given via GPs; Bereavement Services; Funeral Directors and the Coroner. Council Bereavement Services as well as mental health services, counselling and IAPT were all recognised as important, as was appropriate signposting to such services.

There was a recognition however that those affected by suicide may have differing needs to those who have suffered a bereavement through another means. At least one local authority is considering this and the help needed from support agencies.

A number of councils have suicide prevention work and mapping exercises underway currently.

In summary there is understandable variation across the Sub-Region as each local authority pursues suicide prevention within the context of its own population needs. A number of streams of work may however be supported at the sub-regional level. For example there is currently variation around data capture, sharing and audit. It may be beneficial to standardise this by using gold standard, verified instruments and comparable time periods between areas so that up to date comparisons can be made and to facilitate a better understanding of the burden of suicide at the sub-regional level. Furthermore a similar approach could be taken to employing standardised early alert systems across the sub-region (especially as people or clusters may cross local authority area borders). This may be beneficial in allowing timely response to changes in suicide rates and allowing one to see the impact of area specific and sub-regional suicide prevention initiatives.

A need which seems to have been identified and acknowledged is that of improving integration with the media to provide preventative messages around suicide, both in a general sense and when dealing with a particular death. This may suggest that a unified communications strategy at a sub-regional level may be useful.

There has also been variation in the involvement of schools in suicide prevention within the Sub-Region. It may be useful therefore to share approaches which have worked well in a given area into those which currently have little such activity. A similar approach could be taken with the support of older people and indeed those in at risk groups.
6 Thematic Review of Expert Stakeholder Events

6.1 Background and methodology
An expert stakeholder event was run three times within the Sub-Region. Each day was open to expert stakeholders from across the sub-region. These events were kindly hosted by Gateshead, South Tyneside and North Tyneside local authorities.

Expert stakeholders were invited by cascading a flyer out from the sub-regional suicide prevention group. Additionally colleagues within local authorities and within the third sector were also encouraged to send out the flyer to their contacts. Additionally invitations were also sent out via the Mental Health, Dementia and Neurological Conditions Network (part of the Strategic Clinical Network). In this way the opinions of as large as possible cross section of expert stakeholders was gathered. The organisations stakeholders represented may be seen in Appendix VI.

The stakeholder events took the form of facilitated group discussions (group sizes being approximately 5 to 8 persons). The session was split into three sections. In the first stakeholders were invited to consider themes which had been drawn from the rest of the HNA (i.e. from the literature review, data and previous one to one interviews). Stakeholders were asked to sense check the themes and propose any additional ones that should be considered at the sub-regional level. Next stakeholders were given ~5 themes per table to discuss in their groups. A facilitator recorded potential barriers to meeting these themes as well as enablers to aid putting them in place. This was written into a provided framework. Finally the groups were asked to present back on points they rated as the most important so that some group learning could be shared between all attending the event.

6.2 Themes presented and responses

6.2.1 De-stigmatising help seeking
Stigma was seen as being based upon a lack of education and awareness, leading to fear. While it was recognised that public attitudes are shifting it was also acknowledged that this work must be maintained in order to normalise help seeking. It was noted that there are taboos around openly talking about suicide or in some cases even using the word. It was also noted that there are other taboos and stereotypes at work, such as male stereotypes, which may have to be overcome before suicide and suicide prevention can be openly talked about.

An enabler that was suggested to, in part, counter this was to tap into mechanisms to engage males, the examples given being football and sports clubs. Celebrities were also suggested as being useful in promoting destigmatising campaigns. Other suggestions made were the promotion of arts exhibitions and campaigns across job centres, council offices, libraries and other public spaces.

Lack of budget and inconsistent or short term funding of campaigns was also seen as a possible barrier. A perceived need to work with younger people was noted as was a lack of youth services in this area. It was also felt that campaigns targeted at key groups could be supported at the Sub-Regional level. Furthermore it was suggested that work could be done across the sub-region to support the use of positive preventative messages within the local media.
Peer support workers were seen as a key enabler to help destigmatise help seeking behaviour, as was appropriate training to support peer-led intervention. The work of the Initial Response Team (NTW NHS) was also noted as having a remit for increased access and reducing stigma. It was also suggested that provision of training is something which may be supported across the Sub-Regional footprint.

### 6.2.2 Increasing social capital

Social capital was seen as being adversely affected by lack of employment, lack or recourse and lack of connectedness. This may also be compounded by fewer home visits with a greater focus on telephone contacts. There was also concern that short term housing rental may also lower capital, presumably due to churn of neighbours and a perceived destabilising effect within a community. It was also noted that in order to effectively raise social capital individual issues around drug and alcohol misuse may also need to be addressed.

The point was made that those bodies which support social capital may also be able to provide help to or identify those in crisis. In this way help seeking could be increased beyond formal services. This may be especially beneficial to those in a cycle of crisis and may also serve to provide help to those not in the formal mental health system. It is therefore essentially that staff are trained to respond appropriately and are given all relevant information. Social capital should also be viewed against the background of austerity. It was also suggested that there should be an additional focus on those who remain in stressful work situations.

It was noted that the built environment may not be conducive to the maintenance of close communities. It was suggested that housing (particularly social housing) should be built in such a way as to promote community cohesion. This may also address the barrier to building social capital represented by a lack of affordable and/or social housing in certain areas leading to people being moved away from their established social networks.

Within communities it was recommended that champions be identified and investment made into local community resources and projects. Volunteering was also seen as a useful way of increasing an individual’s connectedness. This could usefully be built into wellbeing pathways.

### 6.2.3 Education of community about risks and signs of suicidal behaviour

A major barrier to increased education within the community was seen as the taboo around speaking about suicide and mental health issues openly. There may be also, unfounded, fears around causing suicidal ideation by allowing people to talk about the subject.

Other points of consideration were the cost implication and the need to identify partners to deliver this education. The point was also made that being able to recognise risks and signs will not in itself significantly impact upon suicide rates if individuals do not also know what to do or where to get additional help.

Enablers were seen as the provision of a broad and local public health message with investment. Additionally it was stressed that media messages presented (in print or otherwise) must be inclusive and allow individuals to recognise themselves in them. Promotional literature also needs to be culturally appropriate. Social media were seen as possible conduits for such campaigns.
Piggybacking of education around suicide and mental health onto extant events in order to be more cost effective was also suggested. Similarly existing “champions” within communities could be identified and used to disseminate positive messages. A further point was made that educational messages must be sustained and revisited and that information about mental health, risks of suicide and coping mechanisms should be built into regular health education programmes e.g. health education in schools. It was also noted that campaigns could be headed by a celebrity in order to gain attention.

Joined up working between local authorities, CCGs and locality groups was also listed as an important enabler within this theme.

Attention was also drawn to the Applied Suicide Intervention Skills Training (ASSIST) programme. Promotion of this was seen as a way of providing training to the general public and making mental health part of everyone’s business.

6.2.4 Providing support to General Practice to address the needs of patients
It was recognised that within primary practice there are tight constraints on both time and money. It was noted that primary care could be supported by greater inclusion of service users.

It was felt that GPs need to ask directly about suicidal thoughts that may be experienced by their patients, if they suspect that this may be an issue. It was also recognised, however that GPs also need to be provided with clear information about what additional services (e.g. legal, debt or benefit advice) are available depending upon the needs of the patient. This would support efficient signposting. The point was also raised that there are obstacles to sharing information between GPs and other services. Furthermore the importance of a good risk assessment was again highlighted. Additionally it was felt that clear and inclusive literature should be freely available and that this should also be available online.

Due to the close links between CCGs and primary care it was felt that a strong enabler to support suicide prevention within general practice is to ensure that suicide prevention forms part of CCGs’ agenda.

The Life Worth Living training was raised a number of times and was seen as a valuable resource for those who may come into contact with people who are at risk of suicide.

It was also felt that important learning could be had from and improvements put in place after significant event audits which should be embedded within the practices of primary care.

It was also noted that some GPs are very good and possess good skills regarding the treatment of mental health issues and also in dealing with suicidal feelings. It was felt that useful education sessions could be had between GPs, other NHS staff, services like Streetwise to share experiences and any learning points as well as best practice (perhaps at TITO meetings). This may also be facilitated by identifying practice leads for mental health on a centralised list.
6.2.5 Identification of at-risk people

Early identification was seen as critical. There was concern about budgetary cuts in this, especially around schools. It was felt that to find at risk people a number of services will need to work together in an integrated way. It was recognised that money and resource may be a barrier here.

Mental health first aid training was viewed as an important resource to give people the tools to identify those at risk. It was felt that this training should be taken up more widely. The example of bank staff triggering referrals when “abnormal” behaviour was noted was given.

It was noted that there may be a need to increase resources spent in rural areas. This would recognise the prevalence of at risk groups as well as the fact that there may be limited services running in large geographic areas and that people may be limited in their ability to get to them (perhaps due to lack of public transport or just the time needed to go to nearest town or city).

Attention was also drawn to those who may be at risk of suicide through having been bereaved previously and those who have had a life changing diagnosis (e.g. cancer or dementia). It was felt that these risks should be better quantified by recording these details. A similar point was made around veterans, as the north east is a traditional recruiting ground this may be of particular interest over the the Sub-Region area.

Discussion was also had around patterns of self-harm as a risk factor for suicide. It was recognised that this is an area that is difficult to address and that definitions are broad. It was also felt that there was a training need around self-harm.

Logistically, good relationships must be supported between A & E departments, liaison services and bodies such as Street Triage and the Initial Response Team and emergency services were seen as critical to identifying those at risk. This could be further supported by sharing the same language between services, or at least being aware of the differences between professions. A common language may also help to facilitate improved data quality. Examples of this may be if the person belongs to one of the groups recognised to be at greater risk of dying by suicide, whether they have made previous attempts or not or are showing patterns of self-harm.

6.2.6 Promotion of existing services

The point was made that consideration should be given to how to promote services to the most marginalised groups within our communities (in line with the concept of proportional universalism). This would include asylum seekers and refugees. It was recommended that existing services be consulted on how best to do this. Risk assessment within children and young people’s agencies was also seen as important.

Lack of funding and capacity were seen as a barrier to the promotion and marketing of existing services. Additionally it was felt that “constant changes” within organisations added to these difficulties. Differences in commissioning approaches over the sub-region were also noted as possible barriers.

Social media were seen as a resource which could be used more to promote existing services. The need to provide links between the websites of services so that information can be efficiently shared was also stressed. The work of bodies, such as NHS marketing programmes, that may be able to support work over the wider area was also noted.
It was noted that there is no central hub to co-ordinate efforts. If one were to be identified it would make the promotion of materials and services easier.

6.2.7 Preventative interventions targeted towards key high risk groups

Again the point was made that interventions should be targeted towards the most marginalised groups within society. Schools were identified as being important structures for building young people’s resilience. Mindfulness training was seen as being potentially beneficial to both young people and teachers.

LGBT communities were recognised as being able to benefit from target approaches. It was felt that these are currently not prevalent as they could be. The example of transgendered individuals was given. This group may have access to specialist health providers but links to suicide prevention were seen as lacking. It was noted that continued liaison with the regional LGBTQI steering group via Pride in Mind / MESMAC would be go some way to improving responsiveness of services to these groups.

People who live in (possible isolated) rural areas were also seen as an at risk group. Additionally men were seen as a group who may benefit from tailored interventions as they have been perceived as a group which seeks help late if at all.

It was thought that a number of barriers could be addressed by raising the general awareness levels. Again it was felt that this could be achieved through the proactive use of social media. Additionally it was suggested that professional groups may also be able to assist in this. The National Farmers’ Union (NFU) was seen as a body which may be useful here, as farmers have shown increased suicide rates in the past (Gregoire, 2002). Additionally the NFU was considered to be a well-resourced organisation.

Also it was felt that more could be done with events such as Pride and organisations such as MESMAC in order to reach LGBTQI individuals.

Attention was also drawn to the need to support younger people moving from child to adult mental health services. The fear expressed was around the rigid boundaries of services, a fear that has been expressed in the past is that individuals may be too young or not meet the clinical criteria for adult mental health services at the point they leave child mental health services. This should be addressed by robust transition pathways, it was felt. Furthermore the work of the Intensive Community Treatment Service, available in some areas, was seen as important in supporting young people with complex mental health needs.

A general point was made that generic services need to be able to support people from at-risk groups appropriately as they serve a broad range of people.

6.2.8 Support for older people

Lack of funding was again raised as a barrier to action, as was the increasing fracturing of communities (leading to increased isolation and possibly decreased social capitol). In line with this it was also noted that variation in the availability and quality of (public) transport across the area may also contribute to this isolation. Additionally a lack of transport would also limit older people’s access to services, even if they wished to use them.
In order to support older people and address some of these barriers it was felt that initiatives which enable social capital should be supported. These could include social activities and interventions to encourage people to remain active longer. Furthermore it was felt that corporate social responsibility should be encouraged and funding streams from local authorities explored.

It was noted that there may be an opportunity to assess mental health and wellbeing of older people when they are being assessed for carers’ allowance.

It was noted that this group may be more likely to suffer risk factors such as loneliness, bereavement and a loss of physical health, it was also noted that exposure to these risks may lead to substance misuse. Social prescribing was seen as one method by which this may be reduced.

Overall it was felt that the over 65s should have parity of care with those in younger age groups. This may necessitate increased support within crisis services.

6.2.9 Role of education and schools

Barriers to the education system supporting suicide prevention work were primarily seen as curriculum and time pressures, often caused by a need to reach specified targets. There may therefore be limited resources and capacity to deliver external material.

It was noted that early and continued (4 to 19 years) promotion of self-resilience and emotional health, to understand triggers, signs and symptoms of stress and anxiety within schools would increase the abilities of pupils to deal with such negative emotions. Furthermore support around certain stressful events, such as exams was seen as beneficial. Additionally a whole school approach to bullying, sensitive to groups such as LGBT, was seen as important.

Finally it was suggested that pre and after school activities could be used to deliver supportive interventions. The need for spaces for young people to access services and programmes as well as broadening their social interactions was also noted.

Teacher training was also an important area of discussion. It was felt necessary that teachers know both what to look for but equally know where to obtain appropriate help from. It was felt that these pathways should be as short and simple as possible. Additionally it was felt that more staff (e.g. catering and support staff) could be usefully trained in at least recognising signs and symptoms. Similarly it may be possible to reduce some of the stress and anxiety felt by some school pupils by installing a “buddy” system to encourage older pupils to support younger school mates. Useful input could also be had from Youth Councils and also from Health Visitors perhaps.

The feelings of parents must also be addressed and recognised by schools. There may be opportunity to provide information and education to parents also, which may in turn facilitate the inclusion of positive messages in schools.

There is also the opportunity to support mental wellbeing rather than simply reacting to instances of suicide. This may include identification of and the offer of support to young carers.

Pastoral care in schools, as well as being useful to those actively seeking help and providing resources to the wider school population may also be useful in the early identification to people at risk of suicide.
6.2.10 **Simplifying pathways for referral in order to find help**

Complexity of referral pathways was seen as being propagated through “disparate funding streams” as well as different organisations using different systems. Additionally different organisations operate in different areas (or protocols are different depending upon postcode or degree of rurality). Another complication noted was that of providing services to rural areas. Generally it was felt that pathways were too complex and contained too many steps where the person in need of help could be lost or disengage, especially when coupled with waiting times that are perceived as too long. Furthermore it was noted that language may be a barrier. This may be seen in a number of contexts. First there is the possible barrier to getting help if a person is not literate in English and therefore promotional material is not understood. Secondly different organisations will use different types of professional language. It was also noted that substance misuse could also complicate matters.

A strong barrier was around meeting criteria for a certain pathway, there may be for example resource for people who were actively suicidal but less for those who do not meet a recorded definition of crisis (despite being in a great deal of distress).

There was a felt need for strategic oversight over what is available where and what services are commissioned to do. Additionally this should be supported by additional staff training around appropriate pathways and ways to assess (so that it does not feel like a data gathering tick box exercise to the patient or client). It was noted in discussion that local authorities may be a useful structure to co-ordinate and market available services, perhaps through appropriate use of social media.

6.2.11 **Co-ordination of community services and suicide prevention programmes**

Co-ordination was seen to be limited by differing IT systems that were not designed to integrate with each other. Professional and legal tensions around data sharing were also raised as a potential barrier. A more general point was made that not all services have equal publicity and that they may not be aware of each other.

It was suggested that systems to allow transfer of information between services be explored. The example of NHS mail was used. This however would not be available to all parties. Community mental health hubs were also raised as a possible answer to problems of co-ordination and integration. It was further suggested that this could be supported by a named individual with a remit for system leadership in suicide prevention.

How services are commissioned and the targets they are set to work to was seen as a potential source of limited flexibility. It was felt that this may be addressed by supporting conversations between commissioners across boundaries. The integration of health and social care was also seen as a potential enabler for this theme, as well as building upon the work of existing partnerships e.g. welfare reform group.
6.2.12 Identification and training of gatekeepers
The ownership of the training to be delivered was raised as a main barrier. Young carers were also considered to be a vulnerable group who may not be aware of training and support available.

Teachers within schools were identified as potential gatekeepers. It was felt that early intervention to promote social and emotional health in schools would be beneficial. It was felt that this should form part of the normal curriculum. It was also suggested that teachers be given training as part of teacher training. An audit of current activity in schools was suggested so that opportunities to build upon current practice could be found.

Faith leaders were also seen as another important group of gatekeepers to be engaged around discussions of suicide prevention (including work to destigmatise the subject).

6.2.13 Restriction of access to lethal means
This was recognised as being difficult to achieve and affect directly. However it was suggested that hotspots for suicide be recognised and interventions appropriately placed (e.g. cameras, signs with helpline numbers and telephones). Care must also be taken so that increased activity to safeguard at hotspots is not used to highlight the areas association with suicide. There may be media implications here therefore.

It was felt that additional resource may be necessary within rural areas where such means may be more freely available. Close monitoring of prescribing was also seen as an important safeguard, as was the inclusion of family and friends in order to supply local support and to detect changes in behaviour or symptoms earlier.

6.2.14 Communications and Working with the Media
A need for clear concise messages was noted, as was the need for a simple pathway to getting help which could be promoted positively through the local media (including local and community radio). It was recognised that work would need to be done to get the correct messages in the right places and further that these messages should form part of a sustained strategy rather than a one off.

The increasing role of the internet was raised. A barrier was noted that the prevailing attitude is that it is difficult to block access to websites which give information regarding lethal means. This may necessitate working with internet providers to ameliorate this risk. Additionally online positive messages need to be marketed more. It was also felt that positive messages and access to information could be provided through media presented at festivals in the region.

Generally it was felt that although some media may sensationalise stories and convey unhelpful messages there is some good practice in certain areas. It was felt that this could be built upon to provide good, clear myth busting information to reduce the social taboo around discussing suicide.

6.2.15 Regular follow-up of people thought to be at immediate risk
A lack of clarity around the current pathway was noted. A major barrier noted was that unless a person has a diagnosed mental health issue they may not be as aware of available help and may not have the same degree of on-going contact with services, there may in fact be silent sufferers whose risk may not be seen by services. Additionally if an individual moves around a number of services it may be difficult to keep track of them.
The importance of commissioning was also highlighted in addressing this overall theme. Again there as a suggestion to review and simplify pathways to make it easier to provide support after assessment. It was recommended that peer support groups be utilised to aid in on-going support. It was suggested that these could be anonymous and patterned after Narcotics or Alcoholics Anonymous. The current work of crisis teams and self-harm liaison were also recognised by discussion groups.

6.2.16 Support for those in mental health crisis
Capacity of services was identified as a barrier for increased support for those in mental health crisis. As was identification of what should appropriately be referred to secondary services. The threshold for access to crisis teams as well as differing definitions of the term “crisis” (e.g. between professional services as lay public) were also seen as barriers. Individuals may also not know if they can self-refer and information may not be readily available to those who are not currently using other services. Further the point of commissioning, its complexities and difficulties in identifying responsibility were also raised.

The street triage model was seen as an important enabler in allowing efficacious access to crisis care, the police being recognised as an important partner in supporting people in mental health crisis. Furthermore attention was drawn to the Sunderland domestic violence pilot which addresses the needs of a vulnerable group members of which may require mental health crisis care.

A need to identify safe spaces to go to and alternatives to A&E was raised and the opening of crisis houses in the community suggested. Additionally it was felt that information key cards would be a useful resource.

The hope that the transformation planned as part of Principal Community Pathways may help with identifying the right person, in the right place at the right time.

6.2.17 Improvement of intra-service communication
In order to support this, questions of consent and data protection would have to be answered. Other barriers noted included needing a timely reply and having access out of hours. A lack of resourcing for out of hours and weekend support was also generally noted.

Differing IT systems between organisations were also seen as a barrier to improving communication. This therefore impacts upon the ability to share risk assessments, history and data around management, especially across areas and borders. There was also a concern that voluntary organisations may not be seen as part of the care team and therefore not be integrated into the system as a whole. The Multi-Agency Safeguarding Hub in Gateshead was given as an example of a structure which could be used to support such integrated dialog between bodies.

Good communication between the police and first responders was seen as a key issue for enabling a better service. It was also felt important that communication take place “in real time”. Furthermore the crucial point that clarity is needed around what information needs to be recorded and shared. These include basic details which make offering help much more efficient.
6.2.18 Delivery of postvention materials in a timely manner
An initial point was made which noted that there needed to be greater understanding around when it is timely to offer postvention support. It was felt that there was a lack of resource in terms of bodies which deliver postvention across the Sub-Region, although the work of a number including: If You Care Share Foundation, Washington Mind’s Surviving Suicide Group and a regional self-injury support group was recognised. Furthermore the long waiting lists, that are perceived to be a consequence of this, were seen as a barrier to use. It was also noted that to deliver the breadth of support needed (e.g. peer, professional and literature) for sustained periods of time at the required intensity would take considerable resource. Additionally it was felt that more should be done to educate people in how to access the services that are available.

It was felt that learning from the Durham surveillance pilot and IUCS evaluation could be utilised to better understand when postvention should be delivered and to whom. Furthermore it was felt, in line with other one to one discussions, that the Coroner’s office and police liaison officers could be a conduit for giving out (written) postvention information. The requirement to have promotional material for postvention services available at the point of need was stressed.

It was suggested that there should be more oversight of what pathways different agencies use, with greater promotion and integration as well as inter-agency sharing of best practice. Similarly a directory of up to date contact details, which could be used to support individual support plans was suggested. It was stated that this would best be held (or at least be available) at the first point of contact, such as GP surgeries. It was also felt that learning could be taken from the drug related deaths process and from Child Death Overview Panels, which could also be used as a route to deliver postvention messages to those bereaved.

Nationally learning could be taken form bodies such as papyrus, especially when targeting younger people. The point was made that any material given must be age appropriate.

It was felt that Coroners and their offices as well as churches and funeral directors may be appropriate places to provide information through.

6.2.19 Involvement of Coroner’s Office in delivering Postvention materials
Discussion was had around appropriate sites for the delivery of postvention materials. The Coroner’s Office was seen as one setting through which appropriate information may be given, as bereaved families will tend to have some contact with them and their staff are experienced in dealing with people during times of distress.

6.2.20 Standardisation of terms and data collection methods
It was recognised that figures on deaths by suicide may be an underestimate with some falling into narrative verdicts etc. It was also noted that the ONS data presented by PHE only includes those aged over 15 years.

The variation of engagement with coroners was seen as a barrier to the efficient collection of data. However it was recognised that there are financial, spiritual and emotional impacts to delivering a verdict of suicide. It was felt that variations in data collection methodology (seen as a barrier) could be addressed by agreeing a common set of verdicts and by setting up real time surveillance of deaths by suicide with robust fields which are consistent across the sub-region. This real time
programme should be updated more frequently than a typical audit. It was also suggested that relationship building and understanding colleagues’ roles is an important part of data sharing and collection.

Regarding types of data collected during an investigation or audit of suicide it was felt that more could usefully be routinely recorded. The focus of the discussion was around recording the deceased sexuality. Additionally it was felt that whether or not the deceased had suffered a recent loss should be included.

6.3 Additional Themes Suggested by Group

Young (18 to 25 years) male veterans were identified as an at-risk group. Additionally it was noted that LGBT groups may be isolated or otherwise bullied. The inclusion of cultural and religious differences and groups was also noted as an important feature of preventative measures.

Consideration was also given to predisposing factors such as alcohol and substance misuse.

It was also felt that the awareness of suicide/suicide prevention should be generally raised within the public eye in order to reduce stigma and encourage help seeking behaviour. Online resources such as the “Big White Wall” and “Silver Cloud” were seen as useful both in raising awareness and in giving people useful coping tools.

It was felt that suicide audit should be carried out by each local authority area.

Also it was felt that more should be done to promote services targeted towards young people who self-harm.

In general an open culture of understanding and acknowledgement should be fostered; where this is not in place or services are not accessible this should be appropriately challenged. The courage it takes for someone to come forward and discuss their fears or suicidal ideation was recognised in discussions, as was the need to involved and listen to family and friends where appropriate.

Mental health should have parity of esteem with physical health. Additionally the promotion of mental health and wellbeing rather than focussing on a particular illness was seen as important.
7 Overall Recommendations to Support Suicide Prevention throughout the Sub-Region

7.1 Overarching recommendations
It is recommended that:

- Commissioners benchmark local services against national standards.
- Local Authorities develop a local suicide prevention action plan with reference to national documents whilst also maintaining ties to sub-regional group.
- A structure which links multiple agencies (e.g. health, psychological therapies, housing, debt management, third sector) to support those who identify themselves as being in crisis is created. This would reduce the need for individuals to sequentially contact a number of bodies.
- Individuals are supported in identifying and accessing benefits and other entitlements to ameliorate some of the effect of financial and fuel poverty.
- That support is given to those seeking work through e.g. improving volunteering opportunities to improve skills, lifelong learning.
- The sub-regional group is assured that the learning from “Prisons and Probation Ombudsman investigations: self-inflicted deaths of prisoners – 2013/14” is utilised.
- Bodies, such as CCGs, are liaised with to ensure that suicide prevention is on their agenda.
- Provision of mental health first aid training is more widely explored within the community e.g. amongst taxi drivers, hairdressers and those working within suicide prevention groups.

7.2 Reduce the risk of suicide in key high-risk groups
It is recommended that:

- Initiatives targeted at treatment of depression, building resilience around anxiety, promotion of mental health, wellbeing and social inclusion should be promoted. These may include GP services, online mindfulness materials, volunteering opportunities and links to mental health and wellbeing strategies.
- Individuals with substance misuse problems (this may predominantly be alcohol misuse) have their mental wellbeing supported and have contact details of appropriate services supplied to them.
- Support children in the Youth Justice System by ensuring that appropriate mental wellbeing and suicide prevention services are offered.
- Rapid assessment of need is supported. Data from Street Triage pilots are considered and more extensive use of this model explored if indicated.
- On-going contact maintained with those waiting for services to see them and to those discharged from hospital, where appropriate.
- Engagement with groups representing vulnerable people be maintained, so that their needs may be appropriately met within local plans.
7.3 Tailor approaches to improve mental health in specific groups

It is recommended that:

- People with repeated patterns of self-harm are offered appropriate suicide prevention materials.
- Schools are engaged and supported in the delivery of resilience building and mental wellbeing material (to normalise help seeking behaviour).
- Details of training to recognise signs and symptoms and ways of obtaining help for those in need is provided to teachers.
- Work with further and higher education institutions is pursued to provide suicide prevention information widely, both to students in university accommodation and those in private lets.

7.4 Reduce access to the means of suicide

It is recommended that:

- Sub-Regional level links are made with emergency services to profile regional suicide hotspots.
- Review signage and other preventative methods at such sites.

7.5 Provide better information and support to those bereaved or affected by suicide

It is recommended that:

- Pre/post-intervention information packs for the Sub-Regional level are created for dissemination. These to contain clear contact details.
- The sub-regional group creates a directory of available services, including postvention and voluntary sector, with up to date contact details. This may also be included online in a virtual Sub-Regional hub of information.
- Coroners and Police Liaison officers are engaged in the provision of postvention materials and review material currently available.
- Schools are worked with to allow appropriate links to be made on their own websites.
- Raise awareness of suicide prevention initiatives at GPs’ TITO event.

7.6 Support the media in delivering sensitive approaches to suicide and suicidal behaviour

It is recommended that:

- Publicity is increased around available services, beginning with a Sub-Region wide campaign supported by sub-regional group (consider targeting towards at-risk groups e.g. LGBTQI, younger males, socially isolated people and/or areas of deprivation). The focus could usefully be on destigmatisation and open discussion. It is important that this not be a one-off but seen as a larger piece of co-ordinated work.
- The sub-regional group work with local partners and communications experts to create positive, destigmatising messages to be run in local media.
- High profile leaders to champion positive messages in the community are identified e.g. faith and community leaders, head teachers, councillors, celebrities.
• The use of inclusive media (e.g. age, sex, gender, sexual orientation, ethnicity) and advertising are promoted. This may be useful in settings such as GP surgeries, libraries, civic buildings etc. and at local festivals.
• Work continue with local media to further good relations and understanding regarding reporting of suicide (e.g. to Ofsted / Samaritans guidelines).

7.7 **Support research, data collection and monitoring**

It is recommended that:

• Local Authorities use standardised audit tools to perform suicide audit (e.g. Leeds tool). Consider adding fields around vulnerable groups to this tool.
• After audits are completed (and a baseline of death by suicide or possible suicide established) consider what is driving variation between local authority areas and what learning may be shared via the sub-regional suicide prevention group.
• Providers within the Sub-Regional area examine scope for secure data sharing between organisations to support suicide prevention work.
• Early alert protocols are established between local authorities, emergency services and Coroner’s office.
• Learning is shared from recent review of emotional wellbeing initiatives within schools.
8 References


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The University of Manchester, no date given B. Centre for Mental Health and Risk. National Confidential Inquiry projects [online] Available at http://www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci/projects/ [Last accessed 25/3/15].


## 9 Appendices

### 9.1 Appendix I Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAMHS</td>
<td>Child and adolescent mental health services</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive behavioural therapy is a talking therapy that can help change the way people think and behave</td>
</tr>
<tr>
<td>Confidence Interval</td>
<td>A measure of statistical precision of an estimate</td>
</tr>
<tr>
<td>CPN</td>
<td>Community Psychiatric Nurse</td>
</tr>
<tr>
<td>Dialectical Behavioural Therapy</td>
<td>A specific type of cognitive behavioural therapy</td>
</tr>
<tr>
<td>Existential Crisis</td>
<td>A point where a person questions the foundations of their life</td>
</tr>
<tr>
<td>False negative</td>
<td>When a test falsely identifies a condition as being absent</td>
</tr>
<tr>
<td>False positive</td>
<td>When a test falsely identifies a condition as being present</td>
</tr>
<tr>
<td>Gatekeeper</td>
<td>An individual who may come in contact with people considering suicide who may be trained in identification and help seeking</td>
</tr>
<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies an NHS programme rolling out services across England offering interventions approved by NICE for treating people with depression and anxiety disorders</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for health and Care Excellence - an executive non-departmental public body of the Department of Health</td>
</tr>
<tr>
<td>OFCOM</td>
<td>The Office of Communications is the independent regulator and competition authority for the UK communications industries</td>
</tr>
<tr>
<td>ONS</td>
<td>Office for National Statistics</td>
</tr>
<tr>
<td>PHE</td>
<td>Public Health England - an executive agency, sponsored by the Department of Health</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post-traumatic stress disorder - an anxiety disorder caused by very stressful, frightening or distressing events</td>
</tr>
<tr>
<td>RCT</td>
<td>Randomised Controlled Trial</td>
</tr>
<tr>
<td>Semi-structured interview</td>
<td>A method of research which while providing prompts also allows for deviation from planned questions</td>
</tr>
<tr>
<td>Socio-economic status</td>
<td>A relative measure of an individual’s standing within society based on education, income and other factors</td>
</tr>
<tr>
<td>Statistically significant</td>
<td>Outcome is considered not to be likely to have occurred by chance</td>
</tr>
<tr>
<td>Sub-Region</td>
<td>In this case “the Sub-Region” refers to are described by the local authorities of Northumberland, Gateshead, Newcastle upon Tyne, Sunderland, North Tyneside and South Tyneside</td>
</tr>
<tr>
<td>Suicidal Ideation</td>
<td>Thoughts about or an unusual preoccupation with suicide</td>
</tr>
<tr>
<td>Suicide Rate</td>
<td>Number of deaths by suicide over a given time period</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation – its primary role is to direct and coordinate international health within the United Nations’ system</td>
</tr>
</tbody>
</table>
9.2 Appendix II Literature search strategy

The literature search strategy was created with the support of Lorna Burns of PHE Libraries. The strategy search terms are presented below:

- Suicide adj3 prevent*
- Suicide adj3 reduc*
- Suicide adj3 strateg*
- AND
- Awareness
- Training
- Public health
- Health promotion
- Education
- Restrict* adj3 means / methods
- Media

Table 15 Terms Used

<table>
<thead>
<tr>
<th>Patient/Population/Problem</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Awareness</td>
<td></td>
<td>Suicide prevention</td>
</tr>
<tr>
<td></td>
<td>Training</td>
<td></td>
<td>Suicide reduction</td>
</tr>
<tr>
<td></td>
<td>Media</td>
<td></td>
<td>Suicide strategies</td>
</tr>
<tr>
<td></td>
<td>Education</td>
<td></td>
<td>Suicide programmes</td>
</tr>
<tr>
<td></td>
<td>Restriction of means / methods</td>
<td></td>
<td>Suicide ideation</td>
</tr>
</tbody>
</table>

Table 16 Limits Applied

<table>
<thead>
<tr>
<th>Age group</th>
<th>Language</th>
<th>Publication type</th>
<th>Time limit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Reviews</td>
<td>10 years</td>
</tr>
</tbody>
</table>

Table 17 Summary of Resources Searched and Results

<table>
<thead>
<tr>
<th>Source</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS EVIDENCE</td>
<td>5</td>
</tr>
<tr>
<td>COCHRANE LIBRARY</td>
<td>0</td>
</tr>
<tr>
<td>PSYCNINFO</td>
<td>198</td>
</tr>
<tr>
<td>EMBASE</td>
<td>72</td>
</tr>
<tr>
<td>MEDLINE</td>
<td>69</td>
</tr>
<tr>
<td>DARE</td>
<td>14</td>
</tr>
</tbody>
</table>
### 9.3 Appendix III CQC Thematic Review of Mental Health Crisis Care - summary of outlier measures by Local Authority

**Table 18**

<table>
<thead>
<tr>
<th>Outlier Measure</th>
<th>Indicator Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of emergency admissions via A&amp;E for a MH condition (for patients with NO history of previous MH contact) that returned to A&amp;E within 30 days (for any reason)</td>
<td>N/A N/A Lower than expected N/A N/A</td>
</tr>
<tr>
<td>% of patients admitted to an acute hospital via A&amp;E for self-harm at times when attendances for these conditions are nationally at their highest (11pm to 5am)</td>
<td>N/A Higher than expected N/A N/A N/A</td>
</tr>
<tr>
<td>% of patients admitted to an acute hospital via A&amp;E for a MH condition</td>
<td>Lower than expected N/A N/A Higher than expected Higher than expected N/A</td>
</tr>
<tr>
<td>% of patients admitted to an acute hospital via A&amp;E for a MH condition who had attended A&amp;E multiple times in the preceding 5 years</td>
<td>Higher than expected N/A N/A Higher than expected N/A Lower than expected</td>
</tr>
<tr>
<td>% of patients attending A&amp;E multiple times prior to admission that have had previous specialist MH contact and/or acute hospital admission for MH condition</td>
<td>N/A N/A N/A Lower than expected N/A N/A</td>
</tr>
<tr>
<td>% of people with severe mental health illness with a comprehensive care plan in place</td>
<td>Lower than average</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>6 month mortality rate (from all causes) among patients admitted to an acute hospital for a MH condition (not including self-harm or undetermined injury)</td>
<td>Higher than expected</td>
</tr>
<tr>
<td>Proportion of 'exceptions' recorded by GPs in QOF indicators for dementia</td>
<td>Much lower than average</td>
</tr>
<tr>
<td>Proportion of 'exceptions' recorded by GPs in QOF indicators for depression</td>
<td>N/A</td>
</tr>
<tr>
<td>Proportion of 'exceptions' recorded by GPs in QOF indicators for learning disability</td>
<td>Much lower than average</td>
</tr>
<tr>
<td>Proportion of 'exceptions' recorded by GPs in QOF indicators for severe mental illness</td>
<td>Higher than average</td>
</tr>
<tr>
<td>Ratio of observed to expected number of emergency acute admissions for Alzheimer’s disease</td>
<td>Much lower than average</td>
</tr>
<tr>
<td>Ratio of observed to expected number of emergency acute admissions for</td>
<td>N/A</td>
</tr>
<tr>
<td>MH conditions resulting from alcohol misuse</td>
<td>Ratio of observed to expected number of emergency acute admissions for other organic forms of dementia (not Alzheimer's)</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>N/A</td>
<td>Higher than expected</td>
</tr>
<tr>
<td>Lower than expected</td>
<td>Lower than expected</td>
</tr>
<tr>
<td>Lower than expected</td>
<td>N/A</td>
</tr>
<tr>
<td>Lower than expected</td>
<td>N/A</td>
</tr>
<tr>
<td>Much lower than average</td>
<td>Much lower than average</td>
</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Higher than average</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Ratio of the number of referrals for talking therapies who have waited more than 28 days from referral to treatment</td>
<td></td>
</tr>
<tr>
<td>% responses to carer survey stating they did not feel the care received provided the right response or helped to resolve the crisis for the person cared for</td>
<td>N/A</td>
</tr>
<tr>
<td>% responses to group survey stating impression of quality and effectiveness of services in responding to people in crisis is poor or very poor</td>
<td>N/A</td>
</tr>
<tr>
<td>% responses to group survey stating support available to people experiencing a crisis out-of-hours is NOT of an equal standard to that available during regular working hours</td>
<td>N/A</td>
</tr>
<tr>
<td>% responses to group survey stating that services in local area are working A little or Not at all well together to respond to people who may be experiencing a mental health crisis</td>
<td>N/A</td>
</tr>
<tr>
<td>% responses to individual survey stating they did not feel the care they received provided the right response or helped to resolve their mental health crisis</td>
<td>N/A</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>% of emergency admissions to specialist MH provider that are gate-kept by crisis resolution home treatment teams</td>
<td>Higher than average</td>
</tr>
<tr>
<td>% of emergency admissions to specialist MH provider that are NOT the main provider commissioned by the CCG</td>
<td>N/A</td>
</tr>
<tr>
<td>% responses who stated that they have been told who is in charge of organising their care</td>
<td>Higher than average</td>
</tr>
<tr>
<td>Average time taken from referral to first contact with specialist MH services</td>
<td>Shorter than average</td>
</tr>
<tr>
<td>Number of deaths within 30 days of MHMDS care spell ending</td>
<td>N/A</td>
</tr>
<tr>
<td>Number of spells for people aged 16-17 years on adult wards at specialist MH provider</td>
<td>Much lower than average</td>
</tr>
<tr>
<td>'Number of 'unnatural' deaths of detained patients</td>
<td>Higher than average</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Ratio of home treatment episodes by crisis resolution home treatment teams to people using secondary MH services</td>
<td>Positive</td>
</tr>
<tr>
<td>Are children and young people taken into Police custody for assessment if not accepted at place of safety?</td>
<td>Positive</td>
</tr>
<tr>
<td>Collect data on the reason people turned away from the place of safety?</td>
<td>Negative</td>
</tr>
<tr>
<td>Does the provider believe there is sufficient provision of health based places of safety in the local area?</td>
<td>Positive</td>
</tr>
<tr>
<td>Has an audit been completed or planned against the requirements of the Inter-Agency Policy (IAP)?</td>
<td>Negative</td>
</tr>
<tr>
<td>How many of the following data items are collected? (Age/Sex/Ethnicity/Disability/Other protected characteristics)</td>
<td>Negative</td>
</tr>
<tr>
<td>How often did the S136 Multi-Agency Group (MAG) meet in 2013?</td>
<td>Positive</td>
</tr>
<tr>
<td>How often has someone not been able to access Place</td>
<td>Positive</td>
</tr>
<tr>
<td>Question</td>
<td>2013</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>of Safety because it was occupied?</td>
<td>Positive</td>
</tr>
<tr>
<td>If staff are not always immediately available in 2013 how long on average did people have to wait with the police before they were handed over to staff?</td>
<td>Positive</td>
</tr>
<tr>
<td>In 2013 has the Place of Safety been used for another purpose which impacts acceptance of patients?</td>
<td>Positive</td>
</tr>
<tr>
<td>In 2013 has the Place of Safety had to be closed because of the need to use it as an additional inpatient bed?</td>
<td>Positive</td>
</tr>
<tr>
<td>In 2013 have people been turned away from the place of safety due to staffing problems?</td>
<td>Positive</td>
</tr>
<tr>
<td>In 2013 how often have the MHA assessments in the Place of Safety taken longer than your target time to be started or completed?</td>
<td>Negative</td>
</tr>
<tr>
<td>Number of S136 detentions admitted to hospital following assessment</td>
<td>N/A</td>
</tr>
<tr>
<td>Question</td>
<td>Column 1</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>What are the main reasons for delays in either carrying out or completing MHA assessments?</td>
<td>Positive</td>
</tr>
<tr>
<td>When police arrive are there ever delays in providing staffing levels in accordance with policy?</td>
<td>Positive</td>
</tr>
</tbody>
</table>
9.4 Appendix IV One to One Interview Templates

One to one interview plan for people who have used postvention services.

Hello my name is Keith Allan, I’m a Speciality Registrar in Public Health currently working in Public Health England. Thank you very much for agreeing to see me, I really appreciate your time. The reason I asked to speak with you is that I’m doing a piece of work looking at suicide prevention needs in Northumberland, Tyne and Wear and I want to include the opinions and experience of those who have lost someone to suicide in that.

I really just wanted to ask you a few questions about postvention and get your input on them. By postvention I mean services or groups that supported you after your bereavement. It’s absolutely fine if there are any questions you’d prefer not to answer. If there are please let me know and we can just move on or stop. It’s totally up to you.

- To begin with can you tell me a little bit about the type of support you got after your bereavement and its use to you?
  - How was that contact important to you?
  - Could you get support when you wanted it?
  - Can you tell me about any barriers to getting this support?
  - What things made it easier to get this support?

- How did you find out about these services?

- Were you aware of any other services in your area?
  - Did you use them too?
  - How useful did you find them?

- Do you think it’s better if people approach postvention or is it more helpful if services reach out to you?

- Who do you think should deliver postvention?
  - Should it be peers or mental health professionals? Both? Or does it not really matter about the person’s background?

- When you were using the services, did you get the types of information you wanted?
  - What are the best ways of giving information to take away?
    - For example brochures, leaflets, internet site

- Do you think there is anything missing from services in your area? Anything you’d like to see more of? Anything you’d like to see less of?

- Finally is there anything else you’d like to add that we’ve not covered?
Thank you so much for your time. I really appreciate it and the time you’ve taken to contribute to the Health Needs Assessment.

**One to one interview plan for people who have used prevention services.**

Hello my name is Keith Allan, I’m a Speciality Registrar in Public Health currently working in Public Health England. Thank you very much for agreeing to see me, I really appreciate your time. The reason I asked to speak with you is that I’m doing a piece of work looking at suicide prevention needs in Northumberland, Tyne and Wear and I want to include the opinions and experience of those who have lost someone to suicide in that.

I really just wanted to ask you a few questions about services and groups who can support people who may be suicidal and reduce their risk of death and get your input on them.

It’s absolutely fine if there are any questions you’d prefer not to answer. If there are please let me know and we can just move on or stop. It’s totally up to you.

<table>
<thead>
<tr>
<th>To begin with can you please tell me a little bit about any places you knew of that you could go to for support leading up to your attempt to end your life and their use to you?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>If <strong>Yes</strong></td>
<td>If <strong>None known</strong> – what do you think can be done to promote existing services?</td>
</tr>
<tr>
<td></td>
<td>Do you think there needs to be more and if so what type?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Were you able to use them?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>If <strong>YES</strong></td>
<td>If <strong>No</strong></td>
</tr>
<tr>
<td>Where did you go?</td>
<td>Can you tell me a bit about what stopped you going or put you off?</td>
</tr>
<tr>
<td>What were your feelings around this service?</td>
<td>Did you need more information?</td>
</tr>
<tr>
<td>Do you think they were able to meet your need?</td>
<td>Were you unsure if you could get in?</td>
</tr>
<tr>
<td>Could you get support when you wanted it?</td>
<td>Were you unsure where they were or how to contact?</td>
</tr>
<tr>
<td>Can you tell me about any barriers to getting this support?</td>
<td>Were you fearful of going?</td>
</tr>
<tr>
<td>What things made it easier to get this support?</td>
<td>What do you think needs to change so that people can get help sooner when they need it?</td>
</tr>
<tr>
<td>How did you find out about these services?</td>
<td></td>
</tr>
<tr>
<td>Were you aware of any other services in your area? Did you use them too? How useful did you find them?</td>
<td></td>
</tr>
<tr>
<td>What could have been done better?</td>
<td></td>
</tr>
</tbody>
</table>
• Can you tell me about the type of support you had after your attempt?
  o Can you tell me your thoughts on how your needs were met?
  o Did you feel supported and safer?
  o Did you know who to talk to for help?
• How easy was it to access this help?
• Do you think that prevention services have changed since?
  o In what way?

Overall

• Do you think it’s better if people approach services or is it more helpful if they reach out to you?

• Who do you think should deliver this help?
  o Should it be peers or mental health professionals? Both?

• When you were using the services, did you get the types of information you wanted?
  o What are the best ways of giving information to take away?
    ▪ For example brochures, leaflets, internet site

• Do you think there is anything missing from services in your area? Anything you’d like to see more of? Anything you’d like to see less of?

Finally is there anything we haven’t covered that you would like to talk about for the Health Needs Assessment?

Thank you so much for your time. I really appreciate it and the time you’ve taken to contribute to the Health Needs Assessment.
Suicide Prevention in Northumberland, Tyne and Wear

Local area information template

This template has been designed to help inform a Health Needs Assessment (HNA) looking at suicide prevention in Northumberland, Tyne and Wear. Information regarding local prevention services either commissioned/delivered by the Local Authority or delivered locally by other parties of which the Local Authority has knowledge is sought.

Please complete the questionnaire below and return to Keith.Allan@phe.gov.uk

If you have any queries please do not hesitate to email or contact Keith Allan on 0191 242 6007.
<table>
<thead>
<tr>
<th>Topic of enquiry</th>
<th>Local reflections: Please consider strengths and areas for improvement throughout.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there currently an active suicide prevention plan in your Local Authority?</td>
<td></td>
</tr>
<tr>
<td>Does this plan include provision to work with neighbouring local authorities?</td>
<td></td>
</tr>
<tr>
<td>How are stakeholders including primary care involved with local suicide prevention plans?</td>
<td></td>
</tr>
<tr>
<td>Are suicide audits routinely conducted in your area and if so how often?</td>
<td></td>
</tr>
<tr>
<td>Please specify which data are collected for and presented in the suicide audit (e.g. data which describe demography, socio-economic status, sick leave, place of birth, place and time death, manner of death, relationships, living arrangements, contact with health services, medical diagnoses, case summaries)?</td>
<td></td>
</tr>
<tr>
<td>Do you have an early alert system in place e.g. direct notification from coroners or police within 24 hours of a death that is a potential suicide?</td>
<td></td>
</tr>
<tr>
<td>What barriers could be removed (if any) to allow suicide audits to be conducted more easily?</td>
<td></td>
</tr>
<tr>
<td>Please specify what steps are taken to ensure that data regarding deaths by suicide are collected in such a way as to facilitate research and monitoring functions?</td>
<td></td>
</tr>
<tr>
<td>What financial and staffing resources are available to support local suicide prevention initiatives?</td>
<td></td>
</tr>
<tr>
<td>Do you engage with the media on suicide prevention? How are the</td>
<td></td>
</tr>
</tbody>
</table>
media supported in delivering a sensitive approach to suicide and suicidal behaviour?

<table>
<thead>
<tr>
<th>What services are in place to identify high risk groups* and reduce their risk of suicide locally?</th>
</tr>
</thead>
<tbody>
<tr>
<td>*e.g. young and middle aged men; people in the care of mental health services, including inpatients; people with a history of self-harm; people in contact with the criminal justice system; specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What services which tailor approaches to improve mental health to the needs of specific groups* are in place and where may they be accessed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>*e.g. elderly people, children and young people, survivors of abuse or violence, people who misuse substances, people with disabilities, people who belong to minority ethnic groups, LGBT people, veterans, people living with long-term physical health conditions, people with untreated depression, people who are especially vulnerable due to social and economic circumstances, Black, Asian and minority ethnic groups and asylum seekers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What factors are in place to restrict access to the means of suicide locally (e.g. barriers, CCTV, patrols, helpline information, telephones)?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>What steps are taken to educate the community locally to risks and signs of suicidal behaviour?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Are schools involved in the delivery of suicide prevention messages and the support of help-seeking behaviours, if so how?</th>
</tr>
</thead>
</table>
How is social integration promoted in your area?

Please detail initiatives to support positive aging and social capital amongst elderly people.

What services are available to follow-up and support individuals post-mental health crisis and/or after suicidal behaviour?

How is information and support delivered to those bereaved or affected by suicide?

Please add any further comments here...

Thank you very much for your time in completing this questionnaire. Please return it to Keith.Allan@PHE.gov.uk
9.6 Appendix VI Stakeholder Organisations Represented at Expert Stakeholder Events

- Tyneside and Northumberland Mind
- Newcastle Public Health Team
- Centrepoint
- Salvation Army
- PHE
- Crossroads Carer Services
- Newcastle Hospitals Community Health
- Gateshead Community Treatment Team
- Northumberland, Tyne and Wear NHS Foundation Trust
- Planned Care Directorate
- Personality Disorder Hub Team
- NTW NHS FT
- Crisis Resolution and Home Treatment Team
- Gateshead
- Community Services Group
- Northumberland Tyne and Wear NHS Foundation Trust
- Richmond Fellowship
- Community Psychiatric Nurse
- Community Treatment
- Crisis
- Nurse Consultant Ex-Military Mental Health NTW FT
- Northumbria Police
- Liaison Psychiatry
- Gateshead Crisis Services / Initial Response Team
- Streetwise Young People’s Project
- North East Together
- Social Justice Partnership Manager, DWP
- South Tyneside Talking Therapies
- Public health Locality team
- Sunderland City Council
- South Tyneside Locality
- Community Services Group
- Turning Point
- Monkwearmouth Hospital
- Washington Mind
- Nursing & Quality Directorate
- Cumbria, Northumberland, Tyne & Wear Area Team
- NHS England
- Tees Esk and Wear Valleys NHS Foundation Trust
- Teesside Liaison Psychiatry
- Early Intervention in Psychosis NTW FT
• Tyneside Mind
• Access to housing Sunderland Local Authority
• Communities & Partnerships Manager
• Middlehaven Police Office
• South Tyneside Happiness and Wellbeing Network
• Service User Development - South Tyneside Mental Health User Voice / GMHUV
• Sunderland Crisis Services
• Mental Health Concern, Insight Healthcare
• North Tyneside Local Authority Public Health
• Tyneside Women’s Health
• Northumberland County Council Public Health
• Liaison Psychiatry & Self-harm Team (Northumberland)
• Community Mental Health Nurse NTW
• Ward Councillor
• Cabinet Member North Tyneside
• Welfare Officer
• Northumberland County Council
• LAUNCHPAD
• Northumberland Recovery
• Sunderland Care and Support
• South Tyneside Foundation NHS Trust Gateshead Talking Therapies
• Marketing Officer
• North Tyneside Council
• Quality and Safety Cumbria CCG
• Community Support
• Sunderland Care and Support
• Planned Care/Community Services Group
• St Nicholas Hospital
• Quality and Risk - Tees, Esk and Wear Valleys NHS Foundation Trust
• Early Intervention in Psychosis Team – NTW FT
• North Tyneside Community Services Planned Care NTW FT
• N/T CAMHs, NBHS and PMHW
• Northumbria Healthcare NHS Foundation Trust
• Tyneside & Northumberland Mind
• Suicide Prevention Project
• Tarncroft
• Lanchester Road Hospital
• CMHN Team GHNFT
• Gateshead Health
9.7 Appendix VII Health Needs Assessment Steering Group

- Clare Bethell  Public Health Programmes Co-ordinator Newcastle Hospitals Community Health
- Wendy Burke  Acting Director of Public Health North Tyneside Council
- Tony Gray  Head of Safety and Patient Experience, Local Security Management Specialist, Northumberland, Tyne and Wear NHS Foundation Trust
- Adam Lindridge  Business Manager Community Safety, Gateshead Council
- Dawn Scott  Principal Consultant in Public Health, Newcastle Upon Tyne Council
- Shirley Smith  If U Care Share Foundation
- Caroline Warburton  Deputy Director, Outreach, Samaritans of Tyneside