ITEM No …9……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD - 26 FEBRUARY 2019**

REPORT ON: **NATIONAL SUICIDE PREVENTION ACTION PLAN: EVERY LIFE MATTERS**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB2-2019**

1.0 PURPOSE OF REPORT

1.1 This report provides information about the National Suicide Prevention Action Plan: Every Life Matters and arrangements in place to enable its implementation across Dundee.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the content of the report and the National Suicide Prevention Action Plan: Every Life Matters and National Suicide Prevention Leadership Group Delivery Plan at Appendix 1 and progress in preparing for its commencement as described in Section 4.2.5.

2.2 Notes the Tayside Multiagency Suicide Review Group (TMARSG) Annual Report 2017 at Appendix 2.

2.3 Notes the intention that a Dundee Suicide Prevention Strategic Plan will be submitted to Dundee Integration Joint Board for endorsement by June 2019.

3.0 FINANCIAL IMPLICATIONS

3.1 A local review of financial and resource implications resulting from the National Suicide Prevention Action Plan: Every Life Matters is being undertaken. This review will inform an investment plan as part of the development of a Dundee Suicide Prevention Strategic Commissioning Plan.

4.0 MAIN TEXT

4.1 Overview of the National Suicide Prevention Action Plan: Every Life Matters

4.1.1 The Scottish Government's vision is of a Scotland where suicide is preventable; where help and support is available to anyone contemplating suicide and to those who have lost a loved one to suicide. Suicide prevention is everyone's business.

4.1.2 The National Suicide Prevention Action Plan: Every Life Matters was published on 9 August 2018 and sets out the Scottish Government's actions to achieve those objectives. A key objective of the Plan was to set up and fund a National Suicide Prevention Leadership Group to deliver upon the National Suicide Prevention Action Plan.

4.1.3 The National Suicide Prevention Leadership Group was established in September 2018 and subsequently published a delivery plan on 20 December 2018. The Delivery Plan is attached at Appendix 1.

4.1.4 The Delivery Plan sets out a timeline and expected delivery partners by which Scottish Government priorities in relation to Local Action Plans, Training, Public Awareness, and Support for Those Affected by Suicide, Crisis Support, Digital Technology, At Risk Groups, Children & Young People, Data Evidence and Review will be achieved.

4.2 Local Implementation of the National Suicide Prevention Action Plan: Every Life Matters

4.2.1 As with Scottish Government in Dundee we believe that no death by suicide should be regarded as either acceptable or inevitable. We also recognise the significant impact of suicide on family members or carers affected by suicide.

4.2.2 To ensure we maintain this focus, the Dundee Suicide Prevention Strategic Planning Partnership (the Partnership) has drafted a Suicide Prevention Strategic Plan (the Plan). This Plan is for all persons in Dundee, including young people and adults affected suicide. It will set out the approach, model and actions by which the Partnership will deliver on our vision, improve outcomes for citizens of Dundee and deliver on the National Suicide Prevention Action Plan: Every Life Matters.

4.2.3 Consultation on the Suicide Prevention Strategic Plan is taking place between February and April 2019. The feedback from the consultation will then inform final development of the Plan with a view that the Strategic Plan is submitted to Dundee Integration Joint Board and Dundee Chief Officer Group for endorsement by June 2019.

4.2.4 The Strategic Plan and local action has been informed by the recommendations from Tayside Multi – Agency Suicide Review Group (TMARSG). The purpose of the TMASRG is to review all completed suicides in Tayside to determine common demographic, social, health, service use and other factors that have contributed to each suicide. This information is used to determine recurring themes which can be used to develop priorities for local suicide prevention activity. The TMARSG Annual Report 2017 is appended at Appendix 2.

4.2.5 In addition to drafting the Suicide Prevention Strategic Plan the Partnership has progressed a number of actions linked to the National Suicide Prevention Action Plan: Every Life Matters, priorities to prepare for its commencement as detailed below.

Suicide Prevention Training	A Dundee Suicide Prevention Training Plan will be implemented by June 2019 to reflect Local and National Requirements and Targets. Suicide Prevention The Plan aims to build upon training arrangements already established across Dundee through DHSCP, NHS Tayside and national opportunities.
Public Awareness	A Dundee Suicide Prevention Communications and Engagement Group was established during 2018 to coordinate local communications and engagement activity relating to Suicide Prevention. Through the group targeted campaigns to promote awareness and reduce stigma have taken place during 2018. This has include promoting Suicide Help App, Samaritans Good Practice Guide and Tay Road Bridge Factsheet.
Support for those affected by suicide	Through the Dundee Carers Partnership and Suicide Prevention Partnership investment has been made in supporting carers, family members and young people affected by suicide and bereavement. Information and advice on life after caring is available through DHSCP and Carers of Dundee websites.
Crisis Support	Through a strategic alliance with the Mental Health Strategic Planning Group, provision of crisis support has been prioritised which has included extending Social Prescribing to all GP surgeries in Dundee, expanding the Do You Need to Talk Service to include support from the age of 13 upwards and developing a responding to Distress Framework.
Digital Technology	Through the SmartCare Strategic Plan and Independent Living Partnership, digital technology and technology enabled care is promoted. In particular a City of Recovery Website is in development which will provide information and support about how to access recovery orientated support in the city.

Prevention -At Risk Groups	The Dundee Suicide Prevention Strategic Plan outlines key risk factors, drawing on local and national evidence and data, relating to a higher risk of suicide and identifies priorities to focus on upstream prevention and policy change through targeting of high risk communities and early years. This includes informing the Substance Misuse, Sexual Health, Mental Health, Older People and Homelessness Redesigns currently underway in the city and through a partnership with the Older People Strategic Planning Group a focus on reducing social isolation.
Children and Young People	A Mental Health Strategy for Children and Young People is being developed by the Tayside Health & Wellbeing Priority Group (HWPG) – 1 of 5 priority groups to deliver on the Tayside Plan for Children, Young People and Families (C, YP & F) 2017-2020.

4.2.6 The focus of the Strategic Planning Group during 2017 - 2018 has been to build capacity so that we maximise resources available to prevent suicide in Dundee. This has focused on reviewing contractual arrangements, gaining an evidence base in order to target interventions and developing a range of partnerships.

4.2.7 In addition**,** the Dundee Suicide Prevention Partnership recognised that workforce development, communications, and quality assurance arrangements are key infrastructure requirements to prevent suicide and deliver upon the National Suicide Prevention Action Plan: Every Life Matters. To support this, the following will be implemented during the period 2019 - 2020:

- A workforce development programme focused on suicide prevention.
- A balanced scorecard which evidences impact of the Strategic Plan on preventing suicide, delivery of the National Action Plan and an ongoing focus on continuous improvement.
- A Multi-agency toolkit which will provide good practice guidance.
- A communications strategy to raise ongoing awareness about suicide prevention aligned to national delivery arrangements.

4.3 Costs Associated with Implementing the National Suicide Prevention Action Plan: Every Life Matters

4.3.1 To maximise use of resources to prevent Suicide in Dundee, the Partnership strategic intent is to build capacity by working in partnership with a range of partners so that Suicide Prevention is regarded as everyone's responsibility and with that it is embedded within all strategic planning activity across the City.

4.3.2 As part of the development of the Strategic Plan, an integrated budget statement has been developed. Once the Strategic Plan is finalised an Investment Plan will be developed aligned to the priorities identified in the Strategic Plan and priorities identified in the National Suicide Prevention Action Plan: Every Life Matters.

4.3.3 Once the financial resource to accompany the National Suicide Prevention Action Plan: Every Life Matters has been confirmed this will be added to the integrated budget statement and will be used to inform the Investment Plan.

5.0 POLICY IMPLICATIONS

5.1 This report has been screened for any policy implications in respect of Equality Impact Assessment and Risk Management. There are no major issues.

6.0 RISK ASSESSMENT

Risk 1 Description	There is a risk that current funding will be insufficient to support provision implementation of National Suicide Prevention Action Plan: Every Life Matters.
Risk Category	Financial
Inherent Risk Level	Likelihood 3 x Impact 4 = Risk Scoring 12 (which is High Risk Level)
Mitigating Actions (including timescales and resources)	Securing multi-agency agreement on the actions required when developing the Dundee Suicide Prevention Strategic Plan.
Residual Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9 (which is a High Risk Level)
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6 (which is a Moderate Risk Level)
Approval recommendation	Given the risk mitigation actions in place the risk is deemed to be manageable and should be accepted.

7.0 CONSULTATIONS

The Chief Finance Officer and the Clerk were consulted in the preparation of this report.

8.0 DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	**Direction to:**	
	1. No Direction Required	x
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

David W Lynch
Chief Officer

DATE: 11 February 2019

Alexis Chappell
Locality Manager

INITIAL NATIONAL SUICIDE PREVENTION LEADERSHIP GROUP DELIVERY PLAN

Appendix 1

	DELIVERY PARTNERS	2018-19	2019-20	ANNUAL REPORT 2019	2020-21	ANNUAL REPORT 2020	2021-22	ANNUAL REPORT 2021
ACTION 1 Local Prevention Action Plans	COSLA Integration Joint Boards Third Sector NHS	Map existing activity Scope existing planning Develop best practice guidance	Identify test sites Report on test site findings by October '19	Draft guidance for local planning arrangements by Dec 2019	Recommendations on implementation and review		Support implementation	
ACTION 2 Suicide Prevention training	NHS Integration Joint Boards Scottish Government COSLA	Establish what works Establish what is needed	Online resource available by May 2019	Additional training resources available Review and refine Support rollout beyond health sector			Mainstreaming	
ACTION 3 Public Awareness	Scottish Government and Partners	Establish Public Awareness Reference Group Agree principles for collaboration	Identify information and awareness needs and what works	Recommend public awareness and information strategy	Support implementation and evaluation			
ACTION 4 Support for those affected by suicide	Scottish Government COSLA and Partners	Review existing practice and evidence including lived experience	Recommend support pathway to be implemented by end 2019	Additional support mechanisms to meet range of needs Support evaluation of pathways				
ACTION 5 Crisis Support	NHS Integration Joint Boards Third Sector COSLA	Map existing provision and identify gaps Establish evidence base Learning from Distress Brief Intervention	Recommendation to develop and test a framework	Support the roll out of agreed Framework across Scotland Support evaluation of Framework				
ACTION 6 Digital Technology	Public, Private and Third Sector	Establish Digital reference group	Review existing activity and identify people's needs	Identify and recommend options for product for development	Support product development, testing and roll out		Support Evaluation	
ACTION 7 At Risk Groups	Public, Private and Third Sector	Focused engagement with seldom heard groups Identify evidence, good practice and gaps	Develop Framework for at Risk Groups and make recommendations	Support implementation Review and Refine				
ACTION 8 Children and Young People	Children & young people, public, private and third sector	Establish conversations with young people	Ensure needs of Children and Young People are embedded in every action Link to Children and Young People's Mental Health Taskforce and Youth Commission on Mental Health					
ACTION 9 Data, Evidence and Improvement	Scottish Government COSLA NHS Integration Joint Boards	Establish conversations with People with Lived Experience Establish Academic Advisory Group	Ensure experience, other evidence and improvement methodology are embedded in every action Recommendations to Scottish Government on monitoring and evaluation of Suicide Prevention Action Plan					
ACTION 10 Reviews	National and Local Partners	Develop and test review methodology	Recommendations on roll out of reviews across Scotland	Recommend process(es) for disseminating learning across Scotland				

Local Prevention Action Plans
Children and Young People
Equalities and Inequalities
At Risk Groups

TARGET
Reduce suicide rate by 20% by 2022

VISION
Suicide is preventable, suicide prevention is everyone's business, anyone contemplating suicide, or whose life has been touched by suicide, receives the support they need.

COSLA – Convention of Scottish Local Authorities

Tayside Multiagency Suicide Review Group

Annual Report 2017

TAYSIDE MULTIAGENCY SUICIDE REVIEW GROUP (TMASRG)

ANNUAL REPORT 2017

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ACKNOWLEDGEMENTS

The information and analysis presented in this report is the result of collaboration between a wide range of agencies who have undertaken to share information in cases of completed suicide in order that lessons can be learned from these tragic events. The Chair and Co-ordinator of the Tayside Multiagency Suicide Review Group would like to thank all members of the Review Group (see Appendix 1), all staff in the agencies across Tayside who have been involved in contributing to data collection and the case review process and Gillian Robertson for invaluable administrative support to the group.

We are grateful for funding of the review process from Angus, Dundee and Perth & Kinross Councils and NHS Tayside.

In addition, this year, we are extremely grateful to Dr Fiona Moore from the University of Dundee and MSc Psychology students Eva Bohlert, Gabriele Misgirdaite, and Nicole Wolf who have undertaken additional analysis of a subset of TMASRG data.

EXECUTIVE SUMMARY

Information is provided for the 126 suicide deaths in Tayside from 2016 and 2017:

- Dundee City had the highest proportion (49%) which is in keeping with the strong association between socio-economic deprivation and suicide.
- Males outnumber females 3:1.
- The peak age is 40-49.
- Hanging was the most common method.
- 52% were unemployed.
- 52% had had contact with Mental Health services in their lifetime.
- The suicide rate increased during the summer months.

Sub-populations

Half of the deaths from 2016 and 2017 fit into the following four sub-populations:

- Male opiate users (mean age 40): overlap with the drug related death population.
- Males (mean age 31): poor employment history, substance misuse (excluding opiates) and unstable relationships.
- Retired individuals: poor physical health, history of mental health disorder.
- Males (mean age 53): previous employment and relationships but who have experienced loss of employment and/or divorce and are socially isolated.

Other common factors

- Bereavement (particularly in women)
- Harmful use of alcohol
- Adverse childhood experiences
- Criminal history
- Physical health problems
- Infertility

Key risk times

- Following an additional loss/stress e.g. relationship breakdown, loss of employment, criminal charge.
- Following a change or commencement of antidepressant medication.

Outputs

- The TMASRG provides co-ordinated and timely information sharing around suicide deaths in Tayside to inform local suicide prevention activity.
- The TMASRG has identified areas for service improvement across agencies.

Recommendations

- Prevention should begin upstream with organisations taking a public health approach to reducing socio-economic inequalities in all areas e.g. environment, housing, employment, education.
- There should be a national agreement for information sharing around suicide.
- Information about suicide prevention and access to training courses should be promoted universally with organisations, communities and individuals. The Suicide? Help! App supports this.

- Suicide prevention activity should target services who are in contact with individuals at high risk times e.g. redundancy, financial issues, divorce, bereavement.
- Support should be offered proactively to those bereaved by suicide.

Conclusion

The TMASRG is improving knowledge around suicide deaths in Tayside to inform local suicide prevention activity and is identifying cross-organisational service improvements to promote and protect mental health.

However, it is important to highlight that despite improved local knowledge around suicide all the identified risk factors are common to a large number of people. Reducing the stigma associated with mental health conditions and encouraging engagement with support are also essential if we are to prevent suicide.

BACKGROUND

Every death by suicide is one too many. Scotland continues to have a higher suicide rate than the rest of the UK mainland and there is a strong association between suicide and socio-economic deprivation. It had not been standard practice to review all suicide deaths despite their gravity. However, Scotland's Suicide Prevention Action Plan 2018 now includes the recommendation that all suicides are reviewed by a multiagency group. The Tayside Multiagency Suicide Review Group was set up in 2016 and is jointly funded by NHS Tayside and Angus, Dundee City and Perth & Kinross Councils.

PURPOSE OF THE TMASRG

The purpose of the TMASRG is to review all completed suicides in Tayside to determine common demographic, social, health, service use and other factors that have contributed to each suicide. This information is used to determine recurring themes which can be used to develop priorities for local suicide prevention activity.

Suicide prevention activity is led by the three local Suicide Prevention groups in Angus, Dundee City and Perth & Kinross. In addition, lessons learned in terms of services and pathways, and recommendations based on findings, are made to the relevant governance and review structures within the NHS or to other organisations.

The TMASRG Annual Reports are presented to each of the local Suicide Prevention Strategic Planning Groups for discussion to inform its recommendations as commissioners and ensure local connection. Local planning for improvement will be carried out through the local Suicide Prevention Strategic Planning Groups.

GOVERNANCE

The TMASRG is led by the NHS and governance within the NHS is provided by the Adult Protecting People Committee. Other organisations are supported by their own governance structures.

METHODS

Definition of a suicide

For the purposes of the TMASRG, suicide deaths are those that are determined by Police investigation and categorised by the Crown Office and Procurators Fiscal Service (COPFS) as being an apparent suicide death.

Data Collection

Written Primary Care case summaries and Post Mortem reports including toxicology are obtained for all cases. Additional verbal reports are obtained were possible from Police Scotland on criminal history, secondary care Mental Health services on mental health and substance misuse history and from Social Services. Verbal reports are provided by the relevant service at the TMASRG meeting. This arrangement has been made for pragmatic reasons to encourage information sharing where those contributing have no resource or capacity to provide written summaries. Where it is apparent that additional information is relevant this is

obtained where possible, for example, from Scottish Ambulance Service, Housing Support Services and Third Sector. The data collected is therefore not complete (see Data Completeness and Reliability section later in report).

2013-17 SUICIDE RATES TAYSIDE

The mean number of suicide deaths per year by each local authority area can be seen in Table 1. It is of note that men in Dundee City currently have the second highest mean rate in Scotland at 29.2.

Table 1: 5 year suicide rates by local authority area[1]

Area	Total Numbers 2013-17			European age-sex-standardised rates per 100,000 population		
	Persons	Males	Females	Persons	Males	Females
Angus	73	52	21	13.2	19.4	6.9
Dundee City	131	100	31	19.0	29.2	8.7
Perth & Kinross	96	71	25	13.2	19.6	6.7
Scotland	3571	2623	948	13.5	20.2	6.9

One of the main factors causing variation in suicide rates between areas is the strong association between deprivation and suicide. In Scotland from 2013-17 the rate of suicide in the most deprived decile was around three times larger than the rate in the least deprived decile (21.9 deaths per 100,000 population compared to 7.6 per 100,000).[2]

2017 SUICIDE STATISTICS TAYSIDE

The number of suicide deaths in Tayside in 2017 was 55, 48 males and 7 females.

Table 2: Number of suicide deaths in 2017

	Angus	Dundee City	Perth & Kinross	Tayside
Total	**12**	**25**	**18**	**55**

20 of the 55 deaths have had a formal review by the TMASRG to date. 32 of the deaths are undergoing review by the NHS Tayside Local Adverse Event Review process as the individuals had had contact with Mental Health services in the year prior to their death. Information necessary for a review is still outstanding for the three remaining cases.

For all suicide deaths in 2017 the available records have been reviewed to obtain detailed information on the circumstances surrounding each death. For those deaths

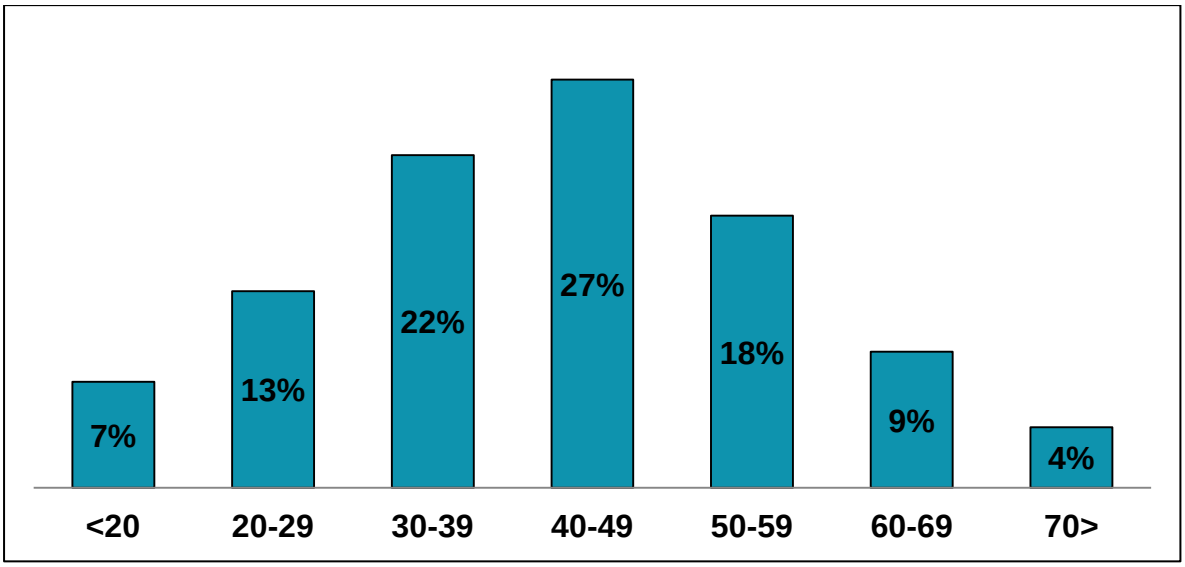
that have been reviewed by the TMASRG, additional verbal information has been recorded from case records held by member organisations.

Demographics

Age

- 67% were aged between 30-59.
- 27% were aged 40-49

Figure 1: Suicides by age demographic



Nationality

- All were Tayside residents at the time of death.
- 93% were of UK origin.
- 3.5% were of Eastern European origin and 3.5% were of other non-UK origin.

Gender

- 87% were male.

Employment

- Of the eligible workforce (excluding students, retired, disabled, unknown: 10 individuals) 40% were employed (compared to 68% in Scotland suicide deaths[2]) of whom 12% were on sick leave.
- 60% were unemployed (including 2 recent redundancies).

Table 3: Suicides by eligible workforce

	Tayside (eligible workforce)	Angus	Dundee	P&K	Scotland[2]
Employed	40% (42)	67% (9)	13% (21)	67% (12)	68%
Unknown (figure)	7%	0	1	3	<1%

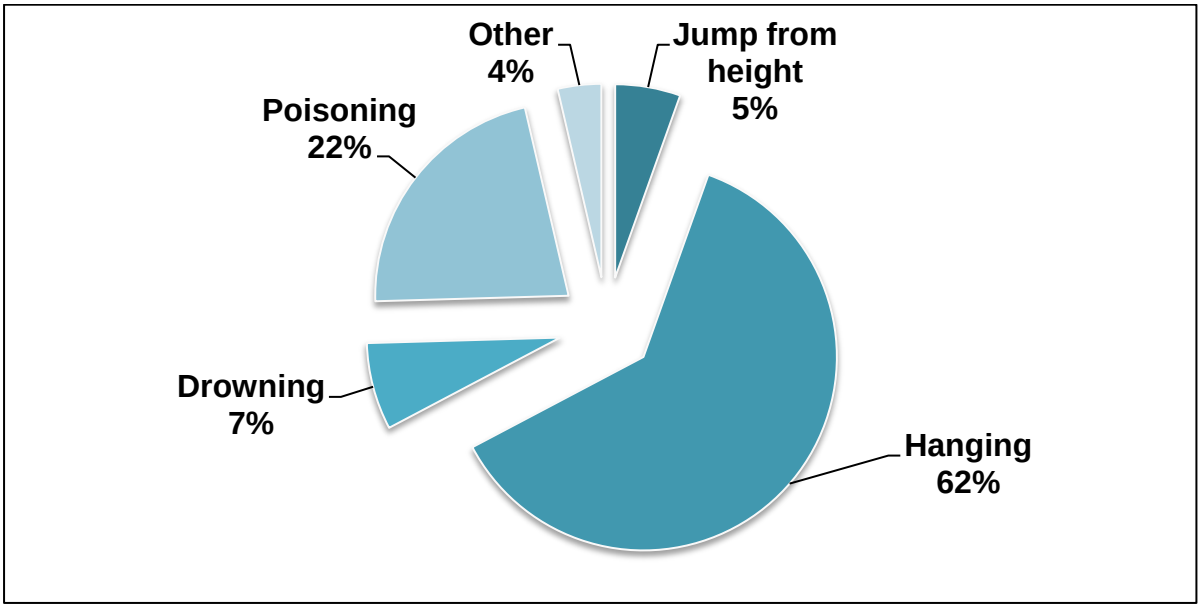
The main reason for the difference between Tayside and Scotland can be seen when the figures are divided by Local Authority area; where Dundee is the population that is different with 13% employed.

Social Circumstances

- 42% lived alone.
- 31% were either divorced/separated or had had a recent relationship breakdown.
- 25% were married or living with a partner.
- 11% lived with parents.

Method (following ScotSID definition of causes)

Figure 2: Suicides by method



- 68% of men used hanging/strangulation/ suffocation (compared to 50% in Scotland suicide deaths[2]).
- 43% of women used hanging/strangulation/ suffocation (compared to 32% in Scotland suicide deaths[2]).
- 43% of women and 17% of men used 'poisoning'.
- Other causes include drowning, jumping from a high place and laceration.
- 11% took place at a recognised location of concern.

Mental Health Services

- 69% have had recent or past contact with mental health services (including substance misuse services).
- 58% had had contact with mental health services (including substance misuse) in the year before death (compared to 26% for Scotland suicide deaths[2]).
- 29% had had a Mental Health inpatient admission in the past.
- None were inpatients at the time of death.

Mental Health Diagnoses, Symptoms and Medication

- 73% had had a diagnosis of depression by a medical professional at some time in their life.
- An additional 11% were observed to be low in mood by others or had expressed suicidal thoughts.
- 49% had a history of self harm.
- 60% were prescribed an antidepressant.
- 21% of those prescribed an antidepressant had either been commenced on it or had had a change to their prescription within the previous month.

Substance Misuse

- 40% (all male) were documented to have used illicit drugs at some time in their life.
- 25% (all male, mean age 40) were known to have used illicit opiates such as heroin.
- 16% (all male, mean age 31) were known to have used other non-opiate illicit drugs.
- 13% (mean age 40) were recorded as having problematic use of alcohol but no use of illicit drugs.

Substance Misuse Services

- 33% had been seen by substance misuse services at some time in their life (compared to 11% for Scotland suicide deaths[2]). This included:
    - 78% who used opiates,
    - 60% of those where harmful use of alcohol was documented, and
    - 22% of those who used non-opiate illicit drugs.
- 28% had only had contact with substance misuse services and had not had contact with mental health services as well. All of this population were in contact with substance misuse services in the year prior to death.

Other health services and conditions

- 87% had had contact with Primary Care ('contact' includes ordering a repeat prescription) in the year prior to death.
- 7% attended A&E in the year prior to death.
- 36% had a chronic physical health condition

Social Factors

- 24% had suffered significant bereavement: in 31% of cases this was bereavement by suicide and in 8% it was a drug related death.
- Adverse childhood experiences such as abuse, neglect, divorce or bullying were documented in 25% of cases. This included childhood sexual abuse in 24% and physical abuse in 18% of this population.
- 24% had a history of offending.
- 16% had a history of violence.
- 15% were known to have spent time in prison.
- 18% were documented as having financial issues/issues with benefits.
- 16% were estranged from family.

2016 & 2017 SUICIDE STATISTICS TAYSIDE

The total number of completed suicides in calendar years 2016-17 was 126 as determined by Police Scotland and COPFS fatalities unit, through investigation. Of these,

- 71 have been reviewed in detail by the TMASRG.
- 46 have undergone a Local Adverse Event Analysis by Mental Health services.
- One case has been excluded as the person was not resident in Tayside at the time of death and there was no contact with local services or organisations.
- The remaining eight cases have been delayed due to either late notification, as the suicide was not immediately apparent, or there are other investigations to be concluded in order for COPFS to finalise their determinations. These deaths will be progressed through the TMASRG process when finalised.

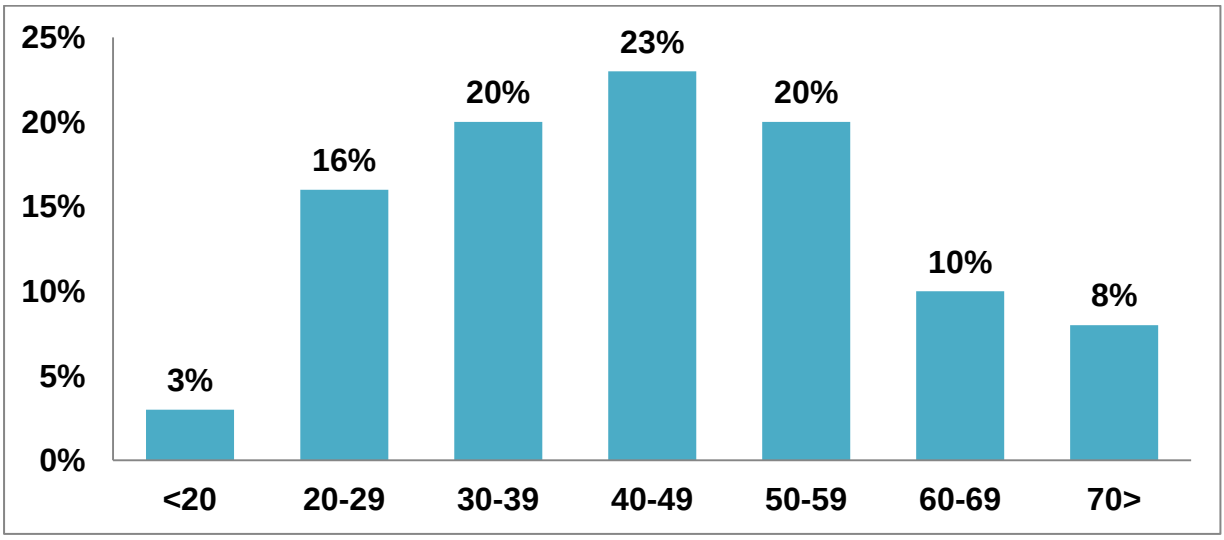
Analysis has been performed on the available information for the included 125 cases.

Table 4: Number of completed suicides 2016/17

	Angus	Dundee City	Perth & Kinross	Tayside
Male	18	45	32	95
Female	9	16	5	31
Total	**27**	**61**	**37**	**125**

Age The mean age was 44 with the most frequent age band being between 40-49.

Figure 3: Suicides by age 2016/17



Nationality

All were UK residents at the time of death with all but three from Tayside. 93% were of UK origin, 5% were of Eastern European origin, 2% other non-UK.

Employment

Of the eligible workforce (excluding students, retired, disabled: 26; unknown: 8), 48% were employed (14% on sick leave) and 52% were unemployed (including 9% recent redundancies).

Table 5: Suicides by eligible workforce 2016/17

	Tayside (eligible workforce)	Angus	Dundee	Perth & Kinross	Scotland (2009-15)[2] (working age population)
2016/17 Employed	48% (92)	61% (18)	40% (47)	54% (27)	68%

- In 2016 the proportion of the eligible workforce in employment was 54% in Tayside.
- In 2017 the proportion of the eligible workforce in employment was in 40%.

Retired

- 13% were retired - mean age 71.
- 100% of those who were retired had been diagnosed with depression at some time in their life.
- 20% had been seen by mental health services within the last year.

- 5/10 of the retired men had had a previous inpatient admission to mental health services but none of these had had any contact with mental health services in the year prior to death.

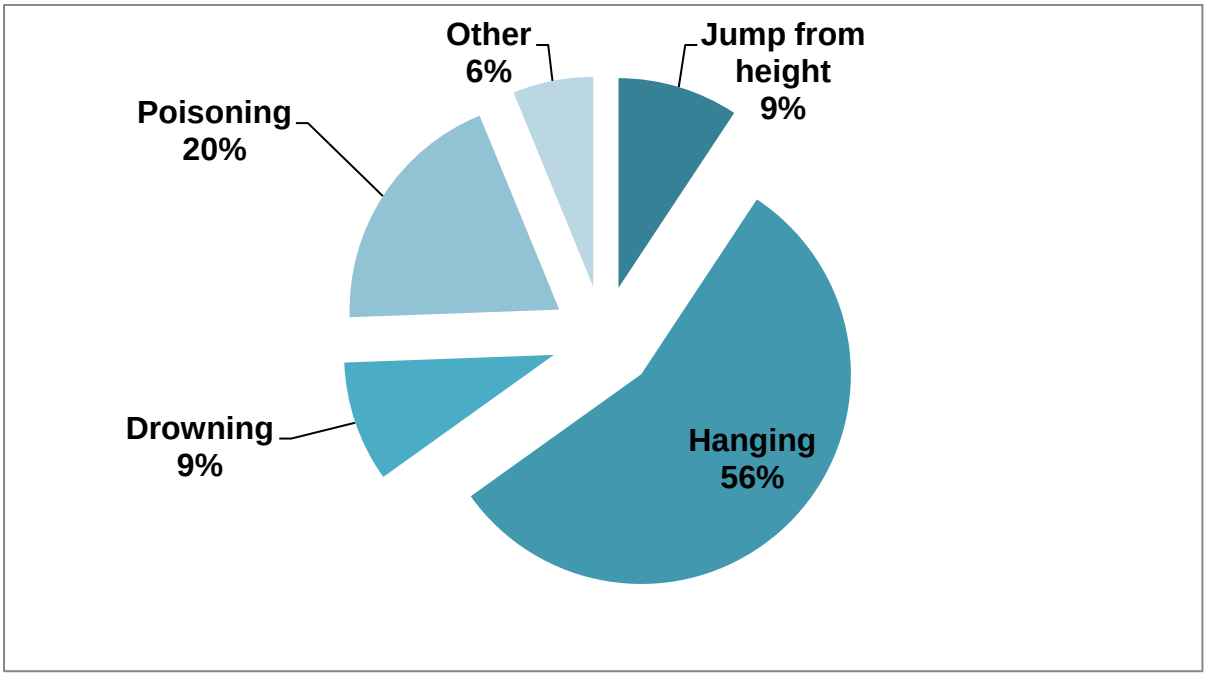
Social Circumstances

- 42% were living alone.
- 28% were married/living with a partner.
- 25% were either divorced/separated or had had a recent relationship breakdown.
- 12% lived with parents.

Method (see figure 4)

- Hanging/strangulation/ suffocation was the most common method used by 56% (23% of females, 65% of males), followed by poisoning which includes overdose.
- 15% took place at a recognised location of concern.
- 35% had alcohol in their body at the time of death.

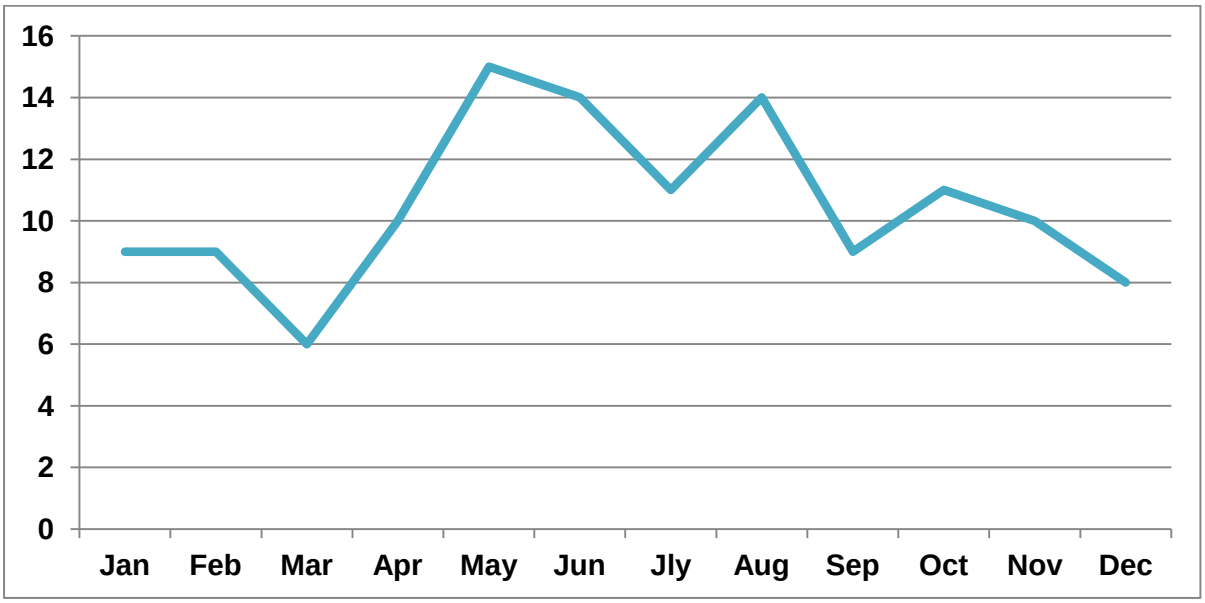
Figure 4: Suicides by method 2016/17



Timing

The rate of suicide increases in the summer months and reduces between November and April (see figure 5).

Figure 5: Suicide rates by month



Mental Health Services

- 52% had had contact with Mental Health services in their lifetime.
- 37% had had contact with Mental Health services in the year prior to death (compared to 26% for Scotland suicide deaths[2]).
- 24% had had a Mental Health inpatient admission in the past.

Mental Health Diagnoses, Symptoms and Medication

- 69% had had a diagnosis of depression by a medical professional at some time in their life.
- An additional 14% were observed to be low in mood by others or had expressed suicidal thoughts.
- 50% had a history of self harm.

Substance Misuse

- 15% were known to use illicit opiates such as heroin.
- 27% were documented to have used any illicit drugs at some time in their life.
- 24% (30% of females and 22% of males) were recorded as having problematic use of alcohol; 20% of whom also used illicit drugs.

Substance Misuse Services

- 20% had been seen by substance misuse services at some time in their life (compared to 11% for Scotland[2]). This included:
    - 74% who used opiates,
    - 28% of those where harmful use of alcohol was documented.

Other health services and conditions

- 78% had had contact with Primary Care (contact includes collecting a repeat prescription) in the year prior to death.
- 9% attended A&E in the year prior to death.
- 40% had a chronic physical health condition which increased to 71% of those aged 60 or over.

Social Factors

- 30% had suffered significant bereavement (43% of females, 17% of males):
    - 10% had suffered bereavement by suicide. (13% of females, 8% of males)
    - 20% had suffered other significant bereavement. (30% of females, 9% of males).
    - 4% had suffered bereavement by suicide and another significant bereavement.
- 9% had a history of sexual abuse (7% of females 2% of males).
- 6% were confirmed/alleged perpetrators of sexual abuse (all male).
- 19% had a history of offending (2% of females, 17% of males).
- 14% had a history of violence.
- 6% had a history of domestic abuse.
- 6% had spent time in prison.
- 18% were documented as having financial issues/issues with benefits (4% of females 14% of males).
- 18% were estranged from family (2% of females, 16% of males).
- 2% were known to have had significant caring responsibilities.
- 2% had problem gambling.

Key Risk Times/Predictors

- Qualitative information highlights that an additional loss or stress is often present, for example loss of relationship, loss of a job, financial issues or a new criminal charge.
- Qualitative information highlights that for many there are life experiences and/or personality factors that may have led to a pattern of poor coping with losses and difficulties.
- The period where antidepressant medication is commenced or changed is a time of increased risk for suicide shown by research evidence and TMASRG data.

Previous self harm and social factors

A more detailed analysis was undertaken by Dr Moore and students from the University of Dundee on 36 sequential cases from 2016 (see appendix 2). This analysis highlights that:

- Change in method between previous self harm and completed suicide is usual.
- As many as 83% may have had a recent change in a relationship.
- Over 75% had only one or two social groups/circles.
- A third may have personality traits which increase the likelihood of suicide.

Analysis was undertaken to assess the relationship between individual characteristics and help seeking behaviour but no associations were found in this small sample.

SUB-POPULATIONS AND THEMES

Combined information from the years 2016 and 2017 has given a large enough dataset to identify some sub-populations and themes to help inform targeted suicide prevention activity.

Sub-populations

The number fitting into sub-populations was 62, approximately half the total population. Therefore just as many cases do not fall into any of these sub-populations and the more common themes for this group are listed. Suicide prevention activity should always be universal as well as targeted towards high risk groups.

a) **Male opiate users** (n=19) (mean age 40): This population has the same mean age as the 2016 Tayside drug death population.[3] There is significant overlap between both populations and it is often difficult to determine whether a death is an accidental overdose or suicide. 79% resided in Dundee, 21% in Perth & Kinross. The key issues identified in this population by the TMASRG reviews included chronic physical health conditions, depression, relationship breakdowns, bereavement, financial issues, history of offending and unstable accommodation.

b) **Younger males – unemployed/poor employment history, substance misuse** (n=18) (mean age 31): Typically, this population had high consumption of alcohol, cannabis, cocaine or other substances and intermittent low mood for a number of years. They also tended to have poor relationships with family, minor offending history and financial issues. A recent loss or event was the most likely precipitant such as loss of a relationship, new criminal charge, worsening financial issues or a bereavement.

c) **Retired** (n=17) (age range 54-84): In this population nearly all had a chronic physical health condition and most have been known to the mental health services at some time in their life.

d) **Males – with families and employment history** (n=8) (mean age=53): This population has typically experienced recent losses such as divorce/relationship breakdown, loss of employment. These men tend to be socially isolated, some have harmful use of alcohol and family/friends identify low mood. One further loss or event is often the precipitant to suicide.

Common Themes

Women: the most common factors include bereavement (43%), harmful use of alcohol, chronic physical health conditions/terminal illness, adverse childhood experiences, sexual abuse in childhood or adulthood and infertility.

Men: the most common factors include harmful use of alcohol, significant criminal history including perpetration of abuse, bereavement, psychotic or organic brain conditions, history of sexual abuse, Eastern European, ex-military, Autistic Spectrum Disorder.

DATA INTERPRETATON

In any analysis where the sample size is less than 100 interpretations can be problematic due to small numbers and there is a risk of over-interpretation. The interpretations that can be made from this report therefore are limited in their wider applicability due to the small numbers involved.

The most reliable interpretations can be made from the full data set available for the combined years of 2016 and 2017. However, when that sample is divided into smaller groups such as local authority areas or employment status any interpretation becomes much less reliable.

Comparisons with Scotland suicide deaths from ScotSID[2] are in relation to the time period 2009-2015 therefore any differences may be due to the difference in time period. For example, it is known that the use of hanging as a method has been increasing over time and increasing in young women and this may be the cause of a greater proportion using this method in the Tayside figures.

DATA COMPLETENESS AND RELIABILITY

The TMASRG has no legal mandate to support collection of information and this remains a challenge. Data collection relies on the good will of partners in providing information to the review process either in written format and/or by attendance of a representative at meetings. As this was a new process there has been variation in the extent of information provided from 2016 and 2017. However, the TMASRG has now improved standardisation of the information obtained across Tayside particularly from Police Scotland and Primary Care.

When cases are reviewed by TMASRG additional verbal information is provided where possible from the detailed written records held by individual agencies. These records are not shared otherwise. However, this detailed qualitative information is often invaluable. For example, COPFS collects information from close family and this can provide detail around recent stressors and personal circumstances. Similar qualitative information is also usually available for cases that have been through the LAER process.

It is of note that where services are under pressure and a representative is unable to attend the TMASRG meeting, or when there are staff changes in organisations that provide information, the extent of information collected can reduce. The extent of information held on each individual also varies significantly and in cases where the individual was not in close contact with family or health services additional qualitative information can be sparse.

When the TMASRG is aware that there has been contact with social services or 3rd sector organisations information is sought from these organisations but whether any information is received has been very variable.

Due to these limitations it is likely that many of the data fields are an under-recording of their true presence in this population. For example, it is likely that there are greater levels of Childhood Adverse Experiences than are recorded in our data. Similarly there is likely to be an under –recording of those who can't work due to disability, those who have financial difficulties and those who are on benefits and other social factors.

The qualitative data that is collected after the death is provided by family or friends and the deceased individual may have had different perceptions of his or her circumstances than that of their family.

OUTPUTS FROM THE TMASRG

A) LOCAL SUICIDE INFORMATION

The TMASRG provides regular reports to the local Suicide Prevention Groups in each Local Authority area. This information is based on both Tayside wide suicide deaths and more detailed information around local suicide deaths. This data is used to inform the work of the Suicide Prevention groups and local authority action plans. For example:

- **Timely preventative activity**: Information is now provided as soon as possible to local Suicide Prevention co-ordinators following any suicide in order to allow timely local preventative/supportive action and early identification of any suicide clusters. The purpose is to reduce the risk of an increase in suicide and self harm by those in that community or location that can follow a suicide.
- **Timely knowledge of suicide deaths for services:** Prior to the TMASRG, there was no consistent or timely means for NHS and other services to be informed of a patient's death due to suicide. The TMASRG now informs all services of a suicide death. This ensures that services can respond sensitively and take appropriate action to support family in these difficult circumstances and instigate review processes where appropriate**.**
- **High risk local populations**: For example, the unemployed, recently redundant and those with financial difficulties. Additionally, carers and supporters are an identified key support for those vulnerable to suicide whilst also being vulnerable themselves.
- **High risk locations**: Locations of concern, or locations where a suicide may have a significant effect on the community.

B) SERVICE IMPROVEMENT RECOMMENDATIONS

General

- Prevention should begin upstream with organisations taking a public health approach to reducing socio-economic inequalities across all areas e.g. environment, housing, employment, education.
- There should be a national agreement for information sharing around suicide.
- Information about suicide prevention and access to training courses should be promoted universally with organisations, communities and individuals. In Tayside the Suicide? Help! App supports this.

Specific

The TMASRG reviews are used to identify any system failures or service issues in individual agencies or between services where lessons can be learned. For example:

- **Bereaved by suicide:** It was identified that bereaved families/friends have a need for support. Perth & Kinross offer this service and it has evaluated well. A working group set up by the TMASRG undertook a needs assessment for this population and a recommendation paper has been submitted to the Local Suicide Prevention Groups (see Appendix 3).
- **Recommendation for multiagency Significant Clinical Event Analysis:** One case highlighted potential multiagency issues where it appeared opportunities were missed to provide intervention that might have reduced the risk of suicide. A local Significant Clinical Event Analysis was recommended, involving all relevant agencies, to examine the case and identify the service improvements required to protect vulnerable individuals.
- **Ambulance mental health support:** It was identified that Tayside ambulance staff do not have access to mental health records or advice. This can mean that the most appropriate care is not provided. In contrast, Police Scotland are able to obtain telephone support from Mental Health service staff which includes access to mental health records. This issue has been raised with the Mental Health management team and a response is awaited.
- **Financial pressures & welfare reform advocacy:** A number of cases have highlighted the impact of issues around benefits in potentially contributing to local suicide deaths. This information is being collated by Public Health and will be used to advocate for changes to reduce socio-economic inequalities and poverty.
- **High risk situations:** Suicide prevention activity should target services associated with high risk situations e.g. redundancy, financial issues, divorce, bereavement.
- **Primary Care assessment:** Primary Care staff should ask everyone with low mood/distress about suicidal thoughts, discuss safety planning, arrange review where appropriate and document the discussion.

C) LOCAL AND NATIONAL STRATEGY DEVELOPMENT

The TMASRG provides information and evidence to inform local and national strategy development. For example providing input to the Scottish Government Suicide Prevention Action Plan, Police Scotland Mental Health strategy, the National Public Health priorities and local strategy and service developments across Tayside.

Local Education and Awareness Raising

The TMASRG works in partnership with the local suicide prevention co-ordinators to provide education and knowledge around suicide and the work of the TMASRG. This has been provided to NHS colleagues, particularly Primary Care and other partners including the Procurator Fiscal's office, Local Authorities and Dundee University.

Education around the TMASRG process to other Health Boards

The TMASRG has been the first group of its kind set up in Scotland and we have provided information to other Boards on the work of the group and the challenges to be addressed in order to develop similar groups.

CONCLUSION

Suicide is a premature death which can be classed as the most serious form of adverse event. However, it has not been routine to have multiagency reviews of these deaths. The TMASRG has developed a process for collation of information and review of these deaths and the value of this learning is now emerging. For example, it has been possible to highlight local sub-populations at higher risk and local areas of variation from national data.

The TMASRG has also had an important role in highlighting the importance of suicide prevention and in identifying cross-organisational service improvements to promote and protect mental health.

It is important to highlight that despite improved local knowledge around suicide all the identified risk factors are common to a large number of people. Individual suicide deaths therefore remain extremely difficult to predict and each suicide death will have profound impacts on the families and professionals involved. Reducing the stigma associated with mental health conditions and encouraging engagement with support are essential if we are to prevent suicide.

FUTURE ACTIONS

- The sub-populations and themes identified will be used to consider a multiagency partnership approach to improving the targeted component of suicide prevention activity in collaboration with the local Suicide Prevention groups.
- At national level the learning from the TMASRG process will be shared with the new National Suicide Leadership group and this will include advocating for a national approach to information sharing between organisations to facilitate data collection for all suicide deaths.
- The TMASRG local data set will be combined with the ScotSID dataset for 2016 when it is released later in 2018. This will improve the reliability of data which has a standardised national collation process; such as secondary care attendance and employment status. This process will also allow an estimate of the reliability of the current TMASRG data collation process.
- Research around self-harm presentations to Ninewells, undertaken by Dr Moore and Dundee University students, will be reviewed with a view to considering whether the TMASRG could be used to improve the surveillance of and response to self-harm.

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APPENDIX 1

MEMBERSHIP OF THE TMASRG

- Mr Robert Bain, Clinical Team Manager (Learning Disabilities), NHS Tayside
- Ms Pamela Banks, Team Leader, Criminal Justice Service, Perth & Kinross Council
- Police Constable Lynsey Boyle, Preventions & Performance Hub, Police Scotland
- Dr Jane Bray, Consultant in Public Health Medicine, NHS Tayside *(Chair)*
- Ms Ruth Brown, Mental Health Networking Co-ordinator, Dundee Voluntary Action
- Mrs Claire Burnett, Child and Adolescent Mental Health Services Occupational Therapist, NHS Tayside
- Dr Roberto Cotroneo, Consultant Psychiatrist, Tayside Substance Misuse Service
- Dr Fiona Cowden, Consultant Psychiatrist, Tayside Substance Misuse Service
- Dr Stephen Curran, Consultant Psychiatrist, General Adult Psychiatry, NHS Tayside
- Ms Jackie Daly, Head of Nursing (Community), Psychiatry of Old Age, NHS Tayside
- Ms Donna Davidson, Procurator Fiscal Depute, Scottish Fatalities Investigation Unit, Crown Office and Procurator Fiscal Service
- Mr Martin Dey, Senior Manager, Criminal Justice Service, Dundee City Council
- Ms Carla Donnachie, Area Service Manager, Scottish Ambulance Service
- Ms Susan Duncan, Development Officer (Suicide Prevention and Violence Against Women), Protecting People, Angus Council
- Sergeant Derek Elder, Police Sergeant, British Transport Police
- Dr Tim Elworthy, Consultant Psychiatrist, Tayside Substance Misuse Service
- Ms Rhian Ferguson, Development Officer, Protecting People Team, Dundee Health & Social Care Partnership

- Mrs Jillian Galloway, Head of Prisoner Healthcare, Out of Hours and Forensic Medicine Services, NHS Tayside
- Mrs Grace Gilling, Head of Service/NHS Tayside Lead for Adult Protection, NHS Tayside
- Ms Lex Greig, Social Work Team Leader, Criminal Justice Service, HMP Perth/Perth & Kinross Council
- Ms Laura Henderson, Senior Health Promotion Officer (Mental Health & Wellbeing/Substance Misuse), NHS Tayside
- Mr Paul Henderson, Service Manager (Mental Health, Drug & Alcohol), Housing & Community Care, Perth & Kinross Council
- Mrs Val Johnson, Head of Inpatient Mental Health & Learning Disabilities Services (Tayside), NHS Tayside
- Mr Scott Kane, Nurse Consultant, Liaison Psychiatry, NHS Tayside
- Mr Brian Kidd, Clinical Senior Lecturer in the Psychiatry of Addiction, Tayside Substance Misuse Service
- Mr Colin MacDougall, Suicide/Self Harm Prevention Co-ordinator, NHS Tayside
- Mr Piers McGregor, Inpatient Services Manager, General Adult Psychiatry, NHS Tayside
- Mr Adrian McLaughlin, Chair of Angus Suicide Prevention Collaborative, Angus Council
- Dr Fhionna Moore, Senior Lecturer in Psychology, University of Dundee
- Ms Mary Notman, Adult Protection Co-ordinator, Perth & Kinross Council
- Mrs Tracey Passway, Clinical Governance & Risk Management Team Leader, NHS Tayside
- Professor Kevin Power, Director of Psychology, Area Psychological Therapy Service, NHS Tayside
- Mrs Marliese Richmond, Planning & Policy Officer, Perth & Kinross Council
- Mrs Gillian Robertson, Personal Assistant, NHS Tayside
- Ms Nicola Rogerson, Service Manager, Community Safety Service, Perth & Kinross Council
- Ms Irene Sharkie, Lead Clinical Pharmacist (Mental Health), NHS Tayside
- Sergeant Andrew Sheppard, Safer Communities, Police Scotland

- Mr Craig Thomson, Station Manager, Prevention and Protection, Scottish Fire & Rescue Service
- Mr Bill Troup, Head of Mental Health Services, Angus Health & Social Care Partnership
- Mr Stephen Valentine, Hath Behaviour Change Co-ordinator, Learning & Development, NHS Tayside
- Ms Sara Vaughan, Team Leader, Perth & Kinross Intensive Home Treatment Team, NHS Tayside
- Dr Michelle Watts, Associate Medical Director, Primary Care Services, NHS Tayside

APPENDIX 2

DETAILED ANALYSIS OF A SUBSET OF TAYSIDE COMPLETED SUICIDES

The Public Health Department has been fortunate to be able to collaborate with Dr Moore from the University of Dundee whose MSc Psychology students have undertaken an in depth analysis of a small proportion of the TMASRG case records.

The TMASRG case records of 36 consecutive deaths from 2016 were scrutinised in greater detail as part of a research study. This sample consisted of 24 suicide deaths from Dundee, seven from Angus and five from Perth and Kinross. There were 22 males and 14 females.

Overview:

- 67% had a history of previous self harm/suicide attempts
- 47% had communicated suicidal thoughts to someone prior to their death.
- 83% had had a negative change in a relationship.
- Social groups/circles: 34% had one, 43% had two and 23% had three or more social groups.
- 42% had had a major change in financial state recorded.
- 58% had had a major change in the health or behaviour of a family member documented.
- 25% had a history of adverse childhood experiences for example; sexual abuse, witnessing physical abuse, loss of a parent, neglect.
- 33% were assessed to have personality traits which may increase the likelihood of suicide for example high levels of impulsivity, internalising of emotional distress, introversion or dependency.

Self Harm History

67% had a history of previous self harm/suicide attempts. For this group hanging was the most common method used by 54%. However, this was only used by 17% in previous self harm/suicide whereas 71% of previous self harm/suicide were self poisoning. In women the only previous method used was poisoning. In these completed suicides only 13% used poisoning as the method. This is in keeping with research evidence that indicates 57-65% of people who have self harmed/attempted suicide modify the method when they complete suicide.[5,6] The main change in method is that those who have previously undertaken poisoning or cutting then change to a more lethal method to complete suicide. In contrast, where previous attempts have used a more lethal method such as hanging or jumping completed suicide is undertaken by the same means.[7]

In this population 83% had experienced a negative change in a relationship prior to competing suicide. This definition includes arguments, major conflict and ending of a relationship. Strains on, or changes in relationships can cause a loss of connection with social groups affecting the feeling of 'belonging' and increasing feelings of 'being a burden' or that one is not needed in society.[4]

57% of this population who had had a relationship change had also had a recent change of accommodation/living arrangements shortly before death. 70% were prescribed medication for a mental health disorder at the time of their death and 67% had had been noted to have had a recent worsening of their mental health.

Over 75% were estimated to only have one or two social groups/circles. Having a greater number of social group identifications has been associated with a reduced likelihood of depression.

A further analysis was undertaken on this sample to assess the relationship between individual characteristics and help seeking behaviour. No significant factors were identified in this small sample. However, it confirms the need for further research in risk assessment. This is keeping with a meta-analysis of suicide prevention initiatives for GPs which found that these could not be recommended currently due to equivocal results.[8]

APPENDIX 3

BEREAVED BY SUICIDE (POSTVENTION) SUPPORT: RECOMMENDATION PAPER

SUMMARY

Situation
The Tayside Multiagency Suicide Review Group identified a potential unmet need for support for those bereaved by suicide in Tayside.

Background
People bereaved by suicide are at increased risk of complex grief and suicide. Currently the only local provision of postvention support is in Perth and Kinross.

Assessment
A short life working group of the Tayside Multiagency Suicide Review group (TMASRG) was set up to examine whether there was a need for postvention support across Tayside. Local and national evidence indicate that there is a need to provide support to this population.

Recommendation
Each Local Authority area should undertake to provide a postvention support service.

NEEDS ASSESSMENT

Local Evidence of Need

Anecdotally statutory and 3rd sector colleagues were aware of an unmet need for support for people bereaved by suicide. In 2016/17, 8% of suicides reviewed by TMASRG had experienced bereavement by suicide in someone close to them.

The Perth and Kinross Bereaved by Suicide Initiative, a joint initiative between Police Scotland and Social Work, has been providing a service to local people since November 2013. This followed a number of linked suicides between people who had been bereaved by suicide in 2012. Following a referral from the Police, and ensuring consent has been obtained from the family/friend, an initial phone call is made to the bereaved family/person. If requested, Bereaved by Suicide Support Packs are sent out to family members and/or friends of people who have completed suicide. The packs contain different sources of information on emotional and practical issues to support people during the aftermath of a completed suicide. If they wish, the Access Team continue to provide support either on a short or long term basis.

There has been considerable learning from this project which could be applied to a Tayside-wide Bereaved by Suicide Project:

- Good working relationships and referral processes are essential in order that the bereaved person is contacted in an appropriate, sensitive and timely manner.
- The bereaved person should be given a named person who they can contact for information and/or support.
- *Packs and letters should be personalised, with initial contact made by phone.*
- Linking with other services on specific issues such as child protection is important.
- Support should be available over an extended period of time, and follow up contacts made after 3 – 6 months.
- ASIST and Bereaved by Suicide Training is essential in up-skilling those providing the support, in terms of understanding the risk of suicide to the person bereaved, the complex grief process, the stigma attached to death by suicide, and the isolation the person can feel.

In Dundee, Ruth Brown from Dundee Voluntary Action co-ordinated the collection of detailed information from local people who have had lived experience of bereavement by suicide. The key findings from this were:

- Those bereaved by suicide would find it very beneficial to be offered support.
- Support should be available as soon as possible after the death.
- This support would help initially in acknowledging what has happened and if needed to provide ongoing support.
- Support from someone who has knowledge of the processes, procedures and practical issues that arise following a suicide would be helpful.
- Help in accessing statutory services if required would be helpful.
- Feedback from those bereaved by suicide was that it would be preferable for support to be provided by an independent, non-statutory agency.
- Local community hubs or similar venues would be useful points of delivery for support.
- Others require support too, not just the immediate family.
- Children and young people in particular require support.
- Community support might be beneficial where suicide has affected many community members.
- Family and friends can be important in providing support, but some people don't have this.
- Information packs on where support is available are useful.
- Sensitive handling of bereaved families by Police of people can help prevent additional distress.
- Primary Care varies in how well they manage those bereaved by suicide.

Research Evidence of Need

Public Health England has said that research suggests there is a substantial unmet need for support and it is important that all are aware of the range of resources and services available.[(1)] A UK survey of young adults found that friends and relatives of people who die by suicide have a one in ten risk of making a suicide attempt.[(2)]

Close family members are the most vulnerable after a suicide but support should be available to people throughout the deceased individual's social network, as well as to health professionals and others affected by the suicide.[1]

A systematic review of suicide risk following bereavement by suicide identified several negative outcomes including an increased risk of suicide in partners bereaved by suicide; of admission to psychiatric care in parents bereaved by suicide of offspring; of suicide in mothers bereaved by an adult child's suicide; and of depression in offspring bereaved by suicide of a parent. The range of kinships affected suggests that all members of the immediate family might need screening and appropriate support. Gaps in knowledge about the effect of peer suicide should be addressed, and investigators should delineate how extensively to offer support within the deceased's social circle. [3]

The cost of a suicide has been calculated as £1.67m, with 70% of that figure representing the emotional impact on relatives. Although we do not yet have estimates for the effect that postvention programmes could have on social functioning, stigma, mental health, physical health and mortality in England, existing evidence suggests the potential for health and economic benefits.[1]

Local Quantitative Estimate of Need

In Tayside there is a 6 year cumulative mean of 50 suicide deaths per year. An average of 4 people will suffer intense grief after each suicide[3] and a conservative estimate is that 10 people will be directly affected by each suicide death.[1] If 4 –10 people is used as the estimate for numbers who would benefit from postvention support after a suicide then in Tayside this equates to 200 – 500 people annually. The Local Authority estimates are:

- Angus 50 – 125 people per year,
- Dundee City 100 – 250 people per year,
- Perth and &Kinross 50 – 125 people per year.

REVIEW OF RESEARCH EVIDENCE FOR POSTVENTION SUPPORT

Models of service provision

Public Health England has identified a variety of different models of support including local suicide bereavement support groups, one-to-one support, family support, online resources telephone help lines, individual and group counselling or psychotherapy. Evidence based training has also been developed to guide GPs and mental health professionals to support parents bereaved by suicide.[1] Specialist support is needed for children who have been bereaved by suicide.

A systematic review of research evidence for postvention programmes undertaken in 2010 found 49 studies of which only 16 were of sufficient methodological equality to be included in the review.[4] Evidence in this field is therefore limited but the following programmes showed the most potential benefit:

- Gatekeeper training for proactive postvention was effective in increasing knowledge pertaining to crisis intervention among school personnel.
- Outreach at the scene of a suicide was found to be helpful in encouraging survivors to attend a support group at a crisis centre and seek help in dealing with their loss.
- Contact with a counselling postvention service for familial survivors (spouses, parents, children) of suicide generally helped reduce psychological distress in the short term.
- Results of studies of group-based counselling suicide postvention programs for certain survivor groups suggest that these should be made available to those individuals who indicate a need for them (e.g., individuals experiencing more severe or prolonged mental distress or psychological symptoms).[4]

The issue of stigma in relation to suicide death has been highlighted in a number of studies. A systematic review of studies to help explore the consequences of this demonstrated that suicide survivors experience stigma in the form of shame, blame, and avoidance. 'Suicide survivors showed higher levels of stigma than natural death survivors. Stigma was linked to concealment of the death, social withdrawal, reduced psychological and somatic functioning, and grief difficulties'.[5]

Service user preferences for postvention support

The systematic review of postvention support points out that 'the views of participants were noticeably absent from the studies; their views on the interventions received were generally not obtained and it was unclear whether the support given was viewed as helpful and appropriate to their needs'.[4]

However, one qualitative study has investigated the support needs of British young adults bereaved by suicide and it had the key finding that there is 'the need for proactive offers of support from family, friends, and professionals after suicide'.[5] It was also highlighted that this offer of support should be repeated regularly, in case a bereaved person does not feel ready for support early on. People said they felt less comfortable asking for help from professionals and many felt let down by GPs who did not intervene to help them access support, or failed to pick up on cues that support was needed. It was recognised that it was particularly in the immediate aftermath of the loss, where people reported feeling too distressed to seek help on

their own or act on any information provided, that proactively offering support would have been most helpful.[6]

An Australian study of parents who had lost a child to suicide identified three key themes in parental responses to suicide bereavement: searching for answers and sense-making; coping strategies and support; and finding meaning and purpose.[7]

'Coping strategies and levels of support varied considerably among parents in our study. A range of both maladaptive and adaptive strategies were described-from avoidance (not discussing the death, excessive work and alcohol use) to maintaining physical and mental health, and rituals such as writing letters and celebrating birthdays to ensure continuing bonds with the child. Where the prevailing thought was once that grief should be resolved by disconnecting from the deceased, new models of grief and loss allow for ongoing relationships and emotional connections, for example supporting ongoing rituals and marking of special occasions. Research now suggests that continuing bonds with a loved one may have an adaptive function through the maintenance of a psychological rather than physical bond. [7]

'In our study, parents found it important to maintain psychological bonds with their child through rituals. This study supports previous research indicating that support groups may play a crucial role in suicide-bereaved parents' ability to make sense of their loss and reconstruct their lives in a helpful way. An important issue identified through studying individual parents' bereavement experiences was that a number of parents had difficulties in sharing their feelings and/or talking about the loss of their child with their partner. Suicide-bereavement support groups may also offer opportunities for individuals in this situation to share their feelings in a supportive and understanding environment'. [7]

Scottish Government Guidance Postvention Support

Scotland's Suicide Prevention Action Plan, 2018, in action four states that 'the time following a death by suicide or a suicide attempt represents a critical time for compassionate, high quality care. Good and timely support and information need to be available to people who have been directly affected by suicide'.

Good Practice Guidance Postvention Support

Health Scotland (2017): Supporting people bereaved by suicide
http://www.healthscotland.com/documents/20648.aspx

Public Health England (2016): Support after a suicide: A guide to providing local services
A practice resource
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/590838/support_after_a_suicide.pdf

CONCLUSIONS

- There is a need for postvention support following bereavement by suicide as indicated by local and national evidence and Scottish Government Guidance.
- It is estimated that 200 – 500 people in Tayside per year are likely to need this support.
- Postvention support should be offered pro-actively because of the particular issues of stigma and complex grief in this population and ideally the offer of support should be repeated.
- Provision by a non-statutory agency was preferable to the small number of people surveyed. However, this cannot be assumed to be essential and timely provision of a service is more important.
- Police, Primary Care and other agencies would benefit from training/education around how to best support those bereaved by suicide.

RECOMMENDATION

Each Local Authority area should undertake to provide a postvention support service.

Dr Jane Bray
Chair, Tayside Multiagency Suicide Review Group
August 2018

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