# TAYSIDE MULTIAGENCY SUICIDE REVIEW GROUP (TMASRG)

## FIRST YEAR REPORT: MARCH 2016 – MARCH 2017

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Executive Summary

Suicide is a preventable cause of death and a leading cause of death in young people. The Tayside Multiagency Suicide Review Group (TMASRG) was set up as a pilot project in 2015 with the objective of working collaboratively to reduce suicide deaths.

From March 2016 to March 2017 the group analysed 39 deaths from a total of 70 suicide deaths in 2016. The National Records of Scotland detail 74 deaths for Tayside in 2016. However, this is due to the inclusion of some deaths which on investigation by TMASRG have been not thought to be an apparent suicide.

Deaths are analysed when all information has been collected and any other reviews have been completed. The areas of residence of those analysed were:
- Angus: 10
- Dundee: 21
- Perth and Kinross: 8

There should be caution around interpretation of the data due to the small numbers.

Findings were that:
- The highest rates of suicide were in the 30-59 year olds
- The ratio of men to women was 3:1
- Hanging was used by 69% of men
- 49% lived alone
- Alcohol misuse, bereavement, relationship/family breakdown and unemployment were common factors
- Less than 40% had ever had contact with mental health services
- 64% attended their GP in the year prior to their death

The group has used the in depth knowledge obtained to inform co-ordinated, multiagency, suicide prevention actions and service improvements across Tayside. The first year has shown that this approach is:
- increasing knowledge and awareness around suicide;
- improving co-ordinated interagency partnership working;
- pioneering a timely, evidence based approach to suicide prevention activities; and
- improving services and care pathways across Tayside for those potentially at risk of suicide

Policy Context

‘The current rate of suicide is "unacceptable", leading MPs have said.’ (The Herald, Scotland, 17 March 2017)

- **Scottish Government Suicide Prevention Strategy (2013-16):** The five key themes include developing the evidence base, supporting change and improvement and improving the NHS response to suicide.¹
- **Health Improvement Scotland (2016):** Multiagency suicide reviews are required to inform service improvement.²
- **House of Commons, Health Committee Report on Suicide Prevention (2016-17):** There must be a clear, effective quality assurance process and implementation of suicide prevention plans at local and national level.³
Background

The WHO and Scottish Government Suicide Prevention Strategy 2013-16 have a target to reduce suicide deaths by 10% by 2020. Scotland’s suicide rate has declined over the last decade, likely due to national suicide prevention efforts. However, the Scottish suicide rate remains higher than that of mainland UK. Currently in Scotland high-level regional data around suicide is collected by the Scottish Suicide Database, but more detailed individual and local service level information is lacking.

In order to reduce suicide rates, population-based strategies aimed at actively reducing risks among the whole population are thought to have greater impact than clinical strategies targeting those thought to be at high risk of suicide. The reason is that suicide results from a complex interplay of biological, socio-cultural, psychological, and behavioural factors. Although there are a number of predictive factors, such as self-harm, these are common to many people.

The aim of the TMASRG is to work collaboratively to reduce suicide deaths through the:

- collation of information and detailed analysis of all suicide deaths in Tayside;
- surveillance of patterns of suicide and self harm; and
- development of co-ordinated multiagency plans to improve suicide prevention.

The TMASRG is a three year pilot project and this is the one year interim report. The TMASRG Progress Report (April 2016) details the background to this project and can be accessed via the Suicide Prevention page on Staffnet.

Anonymised Case Vignette

Craig was a 41 year old father of two who was employed as a catering assistant in a commercial kitchen. He had separated from his wife two years prior to his death and had found the breakup of his relationship very difficult. Two months prior to his death he had moved in with his parents and had seemed more withdrawn and was drinking more alcohol at the weekends. Aged 19 he had been seen once by mental health services following an overdose. He had not attended his GP or health services in the year prior to death.

The night before his death he had been out with friends in the pub. On returning his parents heard him arguing with his ex-wife on the phone. He did not appear the next morning and his parents found that he had completed suicide. Craig’s father has found it hard to accept the loss of his son and is being treated for a severe depressive illness. Craig’s children are struggling and their school work has suffered. Each life lost to suicide has a profound and long-lasting impact on families, friends and communities.

Suicide Statistics

The mean number of suicide deaths per year in Tayside is 50 (13.3 per 100,000). This report presents data on the 39 deaths, from a total of 70 suicide deaths in 2016, that have been analysed by the group up to March 2017 (see figure 1).
The majority of deaths by suicide occurred in those in the 30-59 age bands
74% were male
44% were in employment, 21% were unemployed, 18% were retired
51% occurred at the home address and 10% occurred at known high suicide risk locations
49% lived alone, 28% lived with a partner (with or without children)
31% included a communication about the suicide - note, text or social media posting
13% were Eastern European

The circumstances of death were recorded for 38 of the 39 deaths and are displayed in figure 2. Hanging was the method used by 69% of males and 22% of females.
Potential Risk Factors

Figures 3 and 4 show factors potentially associated with suicide in this group. Caution should be taken in interpretation as the numbers examined are small and the extent of missing information is unknown. For example, the information on financial problems is what had been recorded by the police, based on information from the family, and therefore may be an under recording. Factors identified include:

- Living alone, alcohol/drug misuse, and issues of loss; for example, bereavement and family estrangement were common.
- Financial problems were reported for 15%, benefit problems for 10%.
- Less than 40% have ever had contact with any form of Mental Health service.
- 64% attended their GP in the year prior to death.
- Many of these GP attendances were not related to low mood.

Figure 3: Potential risk factors associated with suicide

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violence to others</td>
<td></td>
</tr>
<tr>
<td>Imprisonment/recent police custody</td>
<td></td>
</tr>
<tr>
<td>History of trauma or abuse</td>
<td></td>
</tr>
<tr>
<td>Recent life changing circumstances</td>
<td></td>
</tr>
<tr>
<td>Unemployment/redundancy</td>
<td></td>
</tr>
<tr>
<td>Estranged from family</td>
<td></td>
</tr>
<tr>
<td>Financial issues</td>
<td></td>
</tr>
<tr>
<td>Bereavement - suicide</td>
<td></td>
</tr>
<tr>
<td>Bereavement - any</td>
<td></td>
</tr>
<tr>
<td>Relationship breakdown</td>
<td></td>
</tr>
<tr>
<td>Alcohol/drug misuse</td>
<td></td>
</tr>
<tr>
<td>Living alone</td>
<td></td>
</tr>
</tbody>
</table>

General factors potentially associated with suicide
Knowledge generation and preventative actions: discussion

Prior to commencement of the TMASRG the only suicide deaths which underwent a formal review were those that had had contact with Mental Health services in the year prior to death or cases where Primary Care judged that a review would be beneficial. Of the 70 suicide deaths recorded in 2016, 24% were known to Mental Health services in the year prior to their death and underwent a Local Adverse Event Review by the Mental Health service. One case underwent a formal review by Primary Care. The focus of these reviews is the individual service involved and there is rarely involvement of other services/agencies.

The case reviews undertaken by the TMASRG have generated detailed knowledge around suicide. This includes personal and social information as well as information on contact with services. Comprehensive examination of an individual’s contacts with services, particularly in the few months prior to death, has been instrumental in identifying opportunities to provide a more co-ordinated and appropriate response across agencies. The level of detail obtained has been critical both to inform, and to gain the necessary multiagency support required for action. The strategic level of members within their organisations has been important in implementing change that could not be achieved by local suicide prevention groups. For example,

- partner agencies are taking forward awareness raising and actions to improve suicide prevention across their organisations; and
- a working group is addressing the issue of how to support those bereaved by suicide, who themselves are subsequently at high risk of suicide.

A particular advantage of the multiagency group is that it is improving interagency understanding and partnership working. For example:

- pathways between services have been improved;
- a co-ordinated approach to reducing risk at specific areas of the rail network has been implemented; and
- a multiagency protocol for responding to potential suicide clusters has been developed.

A more detailed illustration of recommendations and actions from the TMASRG is given in Appendix 2.
Development and work of the TMASRG

**Leadership, membership:** The TMASRG was set up by NHS Tayside Public Health Department and is chaired by a consultant in Public Health. The TMASRG has a broad membership, listed in Appendix 1. Over time trust in the membership and the review process has been built and an open learning culture has developed. The group uses research evidence around suicide prevention and the local knowledge obtained from examination of all suicide deaths, to inform recommendations. The group also undertakes local suicide/self harm surveillance.

**Funding:** The only specific funding for the group is from the three local authority areas to fund a co-ordinator for the TMASRG, supported by NHS Tayside. The role of the TMASRG co-ordinator has been to develop the group, to obtain and collate data on individual suicides and to provide support to Tayside wide suicide prevention activity. Local suicide prevention activity is led by the Suicide Prevention Collaborative and suicide prevention co-ordinator in each local authority area.

**Tayside wide suicide surveillance:** Prior to the TMASRG it was not clear where responsibility for Tayside wide suicide surveillance and response lay. The TMASRG now provides this, for example, providing a timely review and response to a recent suicide location of concern and leading the multiagency response to a recent suicide cluster.

**Real time suicide knowledge:** In Scotland there is no robust or agreed process for partner agencies to learn of suicide deaths within their own locality. The TMASRG has instigated a process to ensure timely knowledge of suicides across agencies. The TMASRG co-ordinator is immediately informed of all potential suicide deaths in Tayside by Police Scotland and the Procurator Fiscal. This information is then shared with local suicide prevention co-ordinators to allow an immediate response. The information is also shared with NHS Mental Health, Substance Misuse and Primary Care services to ensure a timely response in terms of providing family support and undertaking internal service reviews.

**Tayside wide co-ordinated suicide prevention:** A local suicide prevention co-ordinators forum has been established which incorporates the four co-ordinators for Angus, Dundee, Perth &Kinross and TMASRG. This group is improving suicide prevention activity across Tayside through sharing of knowledge and best practice, pooling of resources and co-ordination of activities.

**Suicide as a priority area:** The TMASRG is bringing greater prominence to suicide as a priority area for action for local services and preventative measures around suicide are considered within the local context. For example, a member of TMASRG sits on the NHS Mental Health Clinical Risk Management group facilitating implementation of learning and recommendations from TMASRG within Mental Health services.

**Expertise for Scotland:** The TMASRG is the first of its kind in Scotland and learning is being shared through local engagement and presentations at national meetings:
- NHS Health Scotland ‘Choose Life’ suicide prevention co-ordinators event.
- NHS Health Scotland ‘Scottish Suicide Information Database’ event.
- Police Scotland ‘Strengthening Partnerships’ event.
Challenges faced during the development of the TMASRG

**Information sharing:** An initial Information Sharing protocol was developed which was sufficient to allow the group to function but did not include all the partners required. Developing a protocol which is fit for purpose and which includes all partners has been time consuming. However, there is now broad agreement and consensus around a new protocol, which, when complete, will incorporate all the information sharing requirements of the group in one document.

**Engagement with partners:** Our experience is that developing trusting relationships with partners has been the key to information sharing and partnership work across agencies and that this process takes time. One factor which has facilitated relationship building between the NHS and Police Scotland/Procurator Fiscal’s office is that the TMASRG co-ordinator was previously employed by Police Scotland. This has been beneficial for both agencies in terms of improving understanding around cultures, expectations and internal agency processes.

**Data Collection:** In contrast to the Drug Death review process the TMASRG has no mandate for acquiring information and there are some potential limitations in terms of the extent and accuracy of the information collected.

**Evaluation of TMASRG by its membership**

A brief electronic questionnaire survey was issued to members to canvas opinion on the work of the TMASRG in its first year. The response rate was 9/24 and the responses suggest that it was predominantly answered by core attendees of the group. 66% found the group very useful and 33% found it quite useful. 100% would like the group to continue. Responses to fixed questions indicate that the group has been most valued as a means of supporting a more strategic/co-ordinated approach to suicide prevention activity and increasing knowledge of other agencies (see figure 5).

**Figure 5:** What effect has the TMASRG had in its 1st year – questionnaire feedback

<table>
<thead>
<tr>
<th>Statements about the TMASRG</th>
<th>Rating average</th>
</tr>
</thead>
<tbody>
<tr>
<td>(sliding scale: 0=strongly disagree, 5=strongly agree)</td>
<td></td>
</tr>
<tr>
<td>Increased my knowledge around suicide.</td>
<td>3.40 3.50 3.60 3.70 3.80 3.90 4.00 4.10 4.20</td>
</tr>
<tr>
<td>Increased my knowledge of other agencies.</td>
<td></td>
</tr>
<tr>
<td>More suicide prevention work undertaken.</td>
<td></td>
</tr>
<tr>
<td>More co-ordinated suicide prevention.</td>
<td></td>
</tr>
<tr>
<td>More awareness of need for suicide prevention</td>
<td></td>
</tr>
<tr>
<td>Increased the profile around suicide.</td>
<td></td>
</tr>
<tr>
<td>Suicide prevention work has improved</td>
<td></td>
</tr>
</tbody>
</table>
Free text responses also highlighted that members have valued:

- working with a wide range of partners from across Tayside;
- the collaborative way of working of the group;
- improved information sharing across agencies;
- a more evidence based and co-ordinated approach to suicide prevention activity;
- a Tayside wide group with partners who can’t attend local Suicide prevention groups and the information they provide, such as the Procurator Fiscal;
- the strategic weight the TMASRG can add to support implementation of suicide prevention recommendations; and
- the wider lens across Tayside in terms of protocol development and sharing of good practice.

A concern raised was whether the TMASRG might be a potential risk to local Suicide Prevention groups.

**Next Steps**

- Finalise the Information Sharing Protocol.
- Develop the database to facilitate research and knowledge sharing around suicide.
- Increase suicide prevention work undertaken based on local knowledge.
- Develop an improved response to those bereaved by suicide across Tayside.
- Progress surveillance and knowledge around self-harm in Tayside.
- Evaluate the work of the TMASRG.
Appendix 1

Partners

- NHS Tayside
  - Public Health
  - Mental Health services
  - Tayside Substance Misuse service
  - Primary Care
  - Pharmacy
- Suicide Prevention Co-ordinators – Angus, Perth & Kinross, Dundee City
- Social Work Department/Criminal Justice Officers – Angus, Perth & Kinross, Dundee City
- Health & Social Care - Angus, Perth & Kinross, Dundee City
- Housing Department– Angus, Perth & Kinross, Dundee City
- University of Dundee – Research Psychologist
- Procurator Fiscal
- Police Scotland
- British Transport Police
- Scottish Fire and Rescue service
- Ambulance services
- HM Prison health service
- Third Sector Interface Representative
Appendix 2

The following is an illustration of activity currently taking place, based on local need, and should not be taken as guidance for suicide prevention activities.

Multiagency Actions

The Tayside Multiagency Suicide Review Group has a close working relationship with the Suicide Prevention Steering Groups/Collaboratives in Dundee, Angus, and Perth and Kinross. These groups are key in taking forward many of the recommendations of the review group, either seeking to develop further existing initiatives or putting into place new ways of working.

Sharing and Development of good practice

The review group has provided a forum for the 3 local Suicide Prevention Co-ordinators to meet and to share good practice which is taking place within their areas:

- Bereavement by suicide – The reviews highlight the need for people bereaved by suicide to be supported. A working group set up by TMASRG will develop a model for Tayside wide support, using learning from the successful Perth & Kinross model.
- Suicide Prevention Co-ordinator Meetings – There are regular meetings between the Suicide Prevention Co-ordinators, to discuss taking forward some of the recommendations of the TSMRG.
- Tayside Suicide Cluster Guidance – The review process provided the evidence, multiagency input and momentum to finalise the draft Tayside Suicide Cluster Guidance.
- Development of a communications strategy to promote the Tayside Suicide Help App.

Suicide Prevention Training

The review group has helped to shape the existing suicide prevention training programmes in the three local areas.

- The reviews indicated it could be effective to increase the uptake of training by the general public, and in particular, aides/supporters. An action plan is now in place to increase uptake of training among non-professionals.

High Risk Populations

The review process has identified additional high risk populations, alongside those high risk groups highlighted nationally.

- Redundancy – local suicide prevention co-ordinators already work with local employers and business gateways on suicide prevention campaigns and initiatives for employees. They will be developing this work to recommend provision of signposting/support for employees in the event of redundancy.
- Servicemen/Ex-servicemen – police now screen in the custody suite and signpost to supports. Suicide prevention co-ordinators are highlighting services in their areas.
- Domestic abuse – awareness raising of the association with suicide/self harm and signposting to services.
- Eastern European population – local suicide prevention groups will build on work already undertaken to improve engagement of these populations with NHS and other services.

Locations with high suicide rates – Locations of Concern

The review process provides evidence of particular locations of concern which has led to a range of new initiatives and on-going work.
- Standardised suicide prevention signs to be put in place in all high risk locations, for example, Arbroath cliffs, sections of the rail network.
- High risk locations – Specific locations of concern have been targeted with a co-ordinated multiagency approach, including the Suicide Prevention Co-ordinators, British Transport Police, Samaritans, to reduce risk in locations with high rates of suicide.

Social Media
In some cases, the role of social media has potentially been a factor in a person’s suicide, and the review group provides a forum to discuss counteractive measures.
- Knowledge sharing and review of potential interventions to reduce suicide - The suicide app/website was developed for Dundee and Angus in November 2012 by the Dundee and Angus Coordinator on behalf of the Dundee and Angus Suicide Prevention Collaboratives. This was revised and updated in September 2016 by the 3 locality coordinators with the support from the 3 locality Suicide Prevention Collaboratives. This then became a Tayside app/website as Perth and Kinross decided to be represented and provide financial support. This piece of work is not related to the work of TMASRG as it is a locality action. However, where the TMASRG can have a significant impact is in assisting the locality Collaboratives regarding enhancing opportunities for promotion through its multiagency connections.

Suicide/Self Harm Surveillance
The review group has provided the staff presence, links to data sources and level of authority to provide on-going surveillance of suicides and self harm incidents.
- The TMASRG provided the leadership in response to a recent suicide cluster, including monitoring of patterns of behaviours and a co-ordinated response involving local stakeholders.
- The TSMARG Co-ordinator provides up to date information on recent completed suicides in the local areas, to ensure appropriate support is activated.

Individual Agency Actions
Members from individual agencies consider measures that might improve suicide prevention within their service.

NHS
- Awareness raising with Primary Care: identification of risk factors for suicide, recommend low threshold for discussion with Mental Health Crisis Team, highlighting of resources such as the Tayside Suicide Help app.
- Mental Health, A&E, Primary Care services to consider ways of ensuring there is identification of alcohol problems and improved access and engagement with treatment as recommended by clinical guidelines.
- Review and improve referral pathways into and between Mental Health services, to reduce likelihood of individuals being lost to services.
- Reinforce the recommendation for controlled dispensing of prescriptions in high risk populations, to reduce the potential for stockpiling.
- Recommend development of specific Adult and Children’s Mental Health services protocols for responding to a suicide.

Local authorities – Suicide Prevention Co-ordinators, Social Work, Criminal Justice
- Recommendation to implement support for criminal justice and other local authority staff around suicides.
- Awareness raising around suicide and risk factors, signposting to services.
• Improve and develop care pathways— for example, a new pathway has been developed between criminal justice and care of the elderly mental health services.

Police
• Policy review now underway in relation to those with mental health disorder/history of self harm in custody.
• Development of inter-agency links to improve real time communication around suicide/self harm in order to improve preventative responses.
• Work taking place with Police Scotland to develop an Information Sharing Protocol to support suicide prevention work across the whole of Scotland.
• The police data recording system around individuals at high risk of suicide has been improved to ensure this information is recorded in all their systems and can be shared across agencies.

Procurator Fiscal
• Improved liaison with other agencies via TMASRG to improve post suicide support

Ambulance, Fire service
• Awareness raising plan in development to for staff around suicide/self harm, the Suicide Help app and signposting to services.
References


Acknowledgements

We are grateful for funding from Angus, Dundee and Perth and Kinross Councils and NHS Tayside and for the committed work of all our members.