Public Health England

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National Real-Time Suicide Surveillance Pilot

January 2021

Tammy Coles
Head of Mental Health Delivery

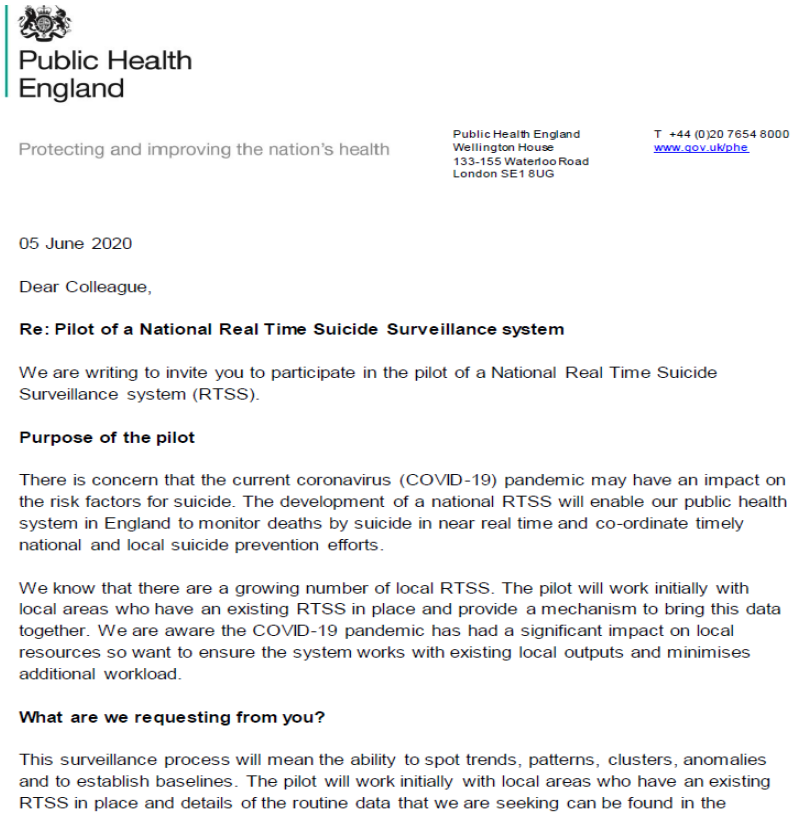
Arvinder Kaur Duggal
Public Health Intelligence Analyst, National Mental Health Intelligence Network

Barney Thorne
Suicide Prevention Lead, Leicestershire Police

Background

- Pilot in response to concerns about potential increase in suicides as a result of COVID-19 measures
- No national system: national data relies on Office for National Statistics (ONS) data which has a time delay
- No nationally agreed minimum dataset
- Local systems in place
- Lots of interest to participate; keen to not add any additional burden
- Accelerating PHE's intention to explore setting up a national system

Invitation to participate



Public Health England

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Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG

T +44 (0)20 7654 8000
www.gov.uk/phe

05 June 2020

Dear Colleague,

Re: Pilot of a National Real Time Suicide Surveillance system

We are writing to invite you to participate in the pilot of a National Real Time Suicide Surveillance system (RTSS).

Purpose of the pilot

There is concern that the current coronavirus (COVID-19) pandemic may have an impact on the risk factors for suicide. The development of a national RTSS will enable our public health system in England to monitor deaths by suicide in near real time and co-ordinate timely national and local suicide prevention efforts.

We know that there are a growing number of local RTSS. The pilot will work initially with local areas who have an existing RTSS in place and provide a mechanism to bring this data together. We are aware the COVID-19 pandemic has had a significant impact on local resources so want to ensure the system works with existing local outputs and minimises additional workload.

What are we requesting from you?

This surveillance process will mean the ability to spot trends, patterns, clusters, anomalies and to establish baselines. The pilot will work initially with local areas who have an existing RTSS in place and details of the routine data that we are seeking can be found in the

- Local systems invited to participate – pilot till 31st March 2021
- 27 positive responses

Pilot requirements

- Agree to collect (non-identifiable) and share (secure email) agreed minimum dataset at weekly intervals
- To have a Data Sharing Agreement (DSA) in place between data owners and PHE

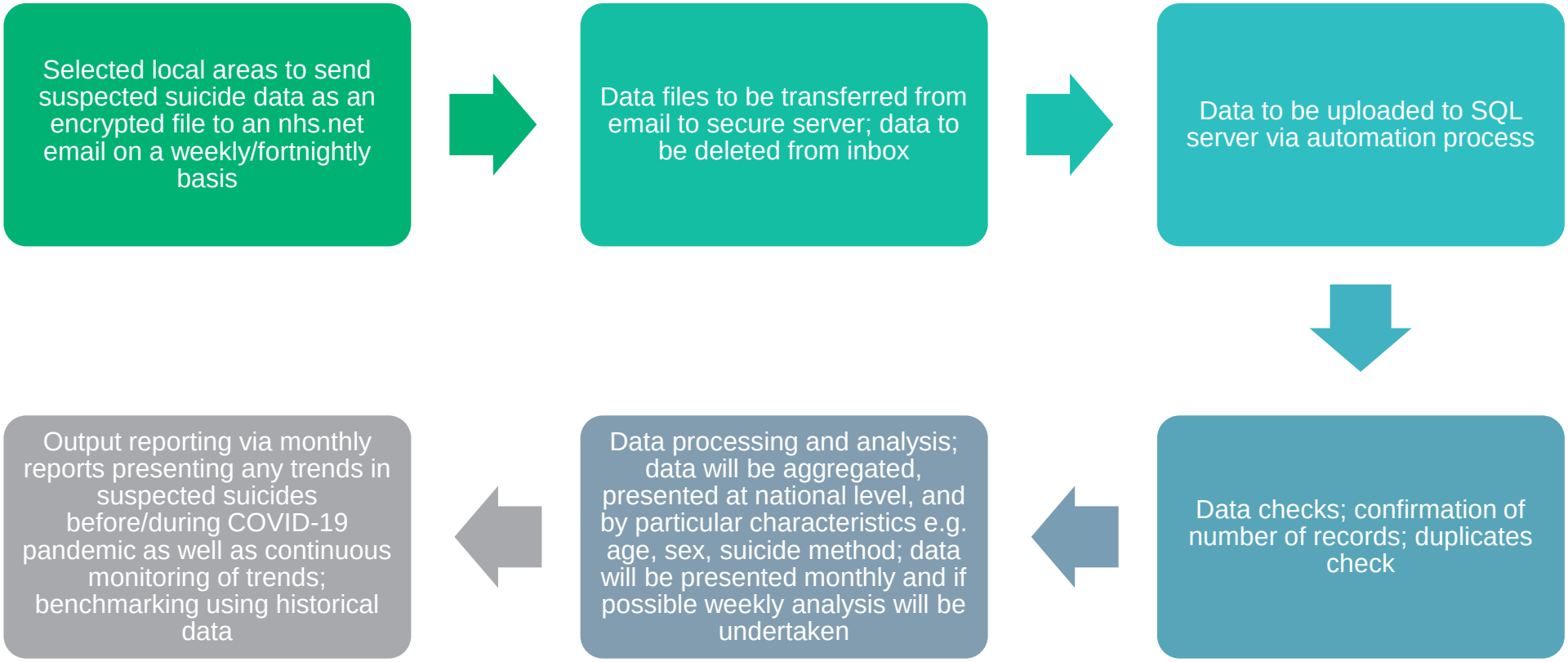
Minimum dataset

Unique ID
System (police/coroner led)
Age range at death
Gender
Ethnicity
Date of death
Suicide location type
Suicide method
Employment status
Occupation
Physical health condition
History of mental health
Known to mental health services
UTLA of residence/residence
Sexual Orientation

System setup

Protocol	• Outlines background, purpose, details of data collection/processing, and planned outputs
Local systems	• Local areas, mixture of police and coroner led systems • Tammy and Kate (PMH team) leading on correspondence with areas
DSA and other IG	• PHE has developed a data sharing agreement for receipt of data • Data collection has been recorded as an information asset • Risk register
Data processing	• Data from local areas will be emailed as secure files to nhs.net email • Download data from emails to secure drive • Aim is to set up an automation process for uploading data into the lake
Data analysis	• Developing benchmarks • Refer to data flow diagram for more details
Reporting	• Routine reporting- Planned reporting is 4-weekly reports based on local areas submitting every 2 weeks • Historical reporting - initial reporting will include analysis of historical data- pre and post-lockdown

Data flow and processing



Coverage to date

- Additional areas:
  - South Yorkshire & Bassetlaw
  - Kent and Medway

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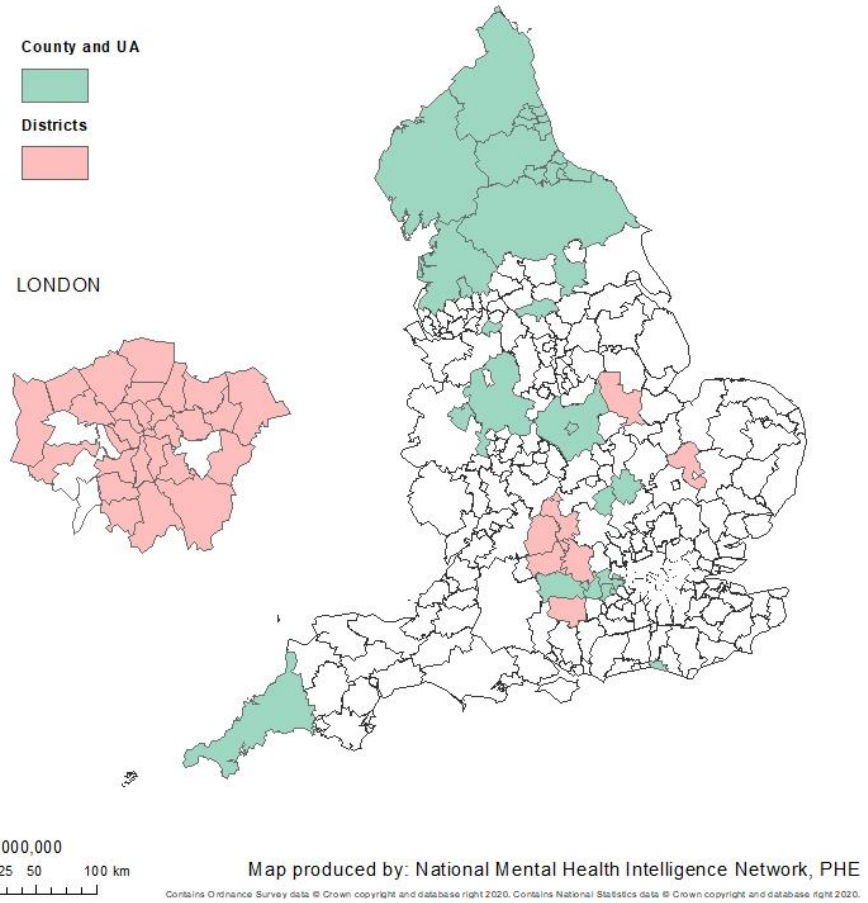
National Real-Time Suspected Suicide Surveillance: coverage to date

Last updated: 07 October 2020
Source: Local systems



Progress to date

- Data advisory group established
- Data outputs being agreed
- Pilot process evaluation being developed
- RTSS Working group established
- Developing minimum standards
- Developing protocol for staff working with traumatic data

Learning to date

- Different purpose for RTSS **- referral system, enhanced surveillance or both**
- Minimum dataset
- How ‘real time’ is the data?
- Data sharing agreements
- Data quality
- Local area capacity
- Developing case studies/peer learning

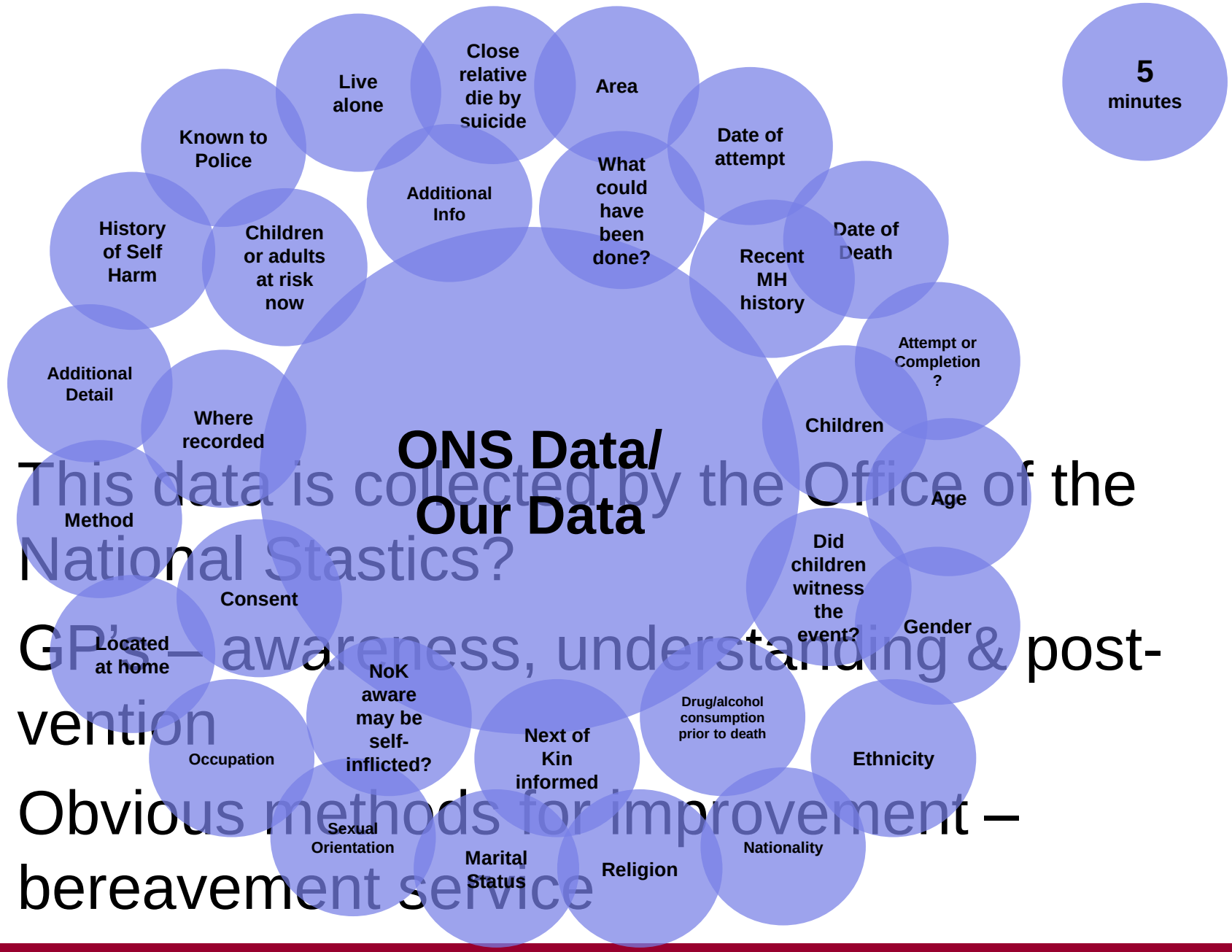
Next steps

- Evaluation process – After Event Review methodology
- Spending Review Bid for next phase

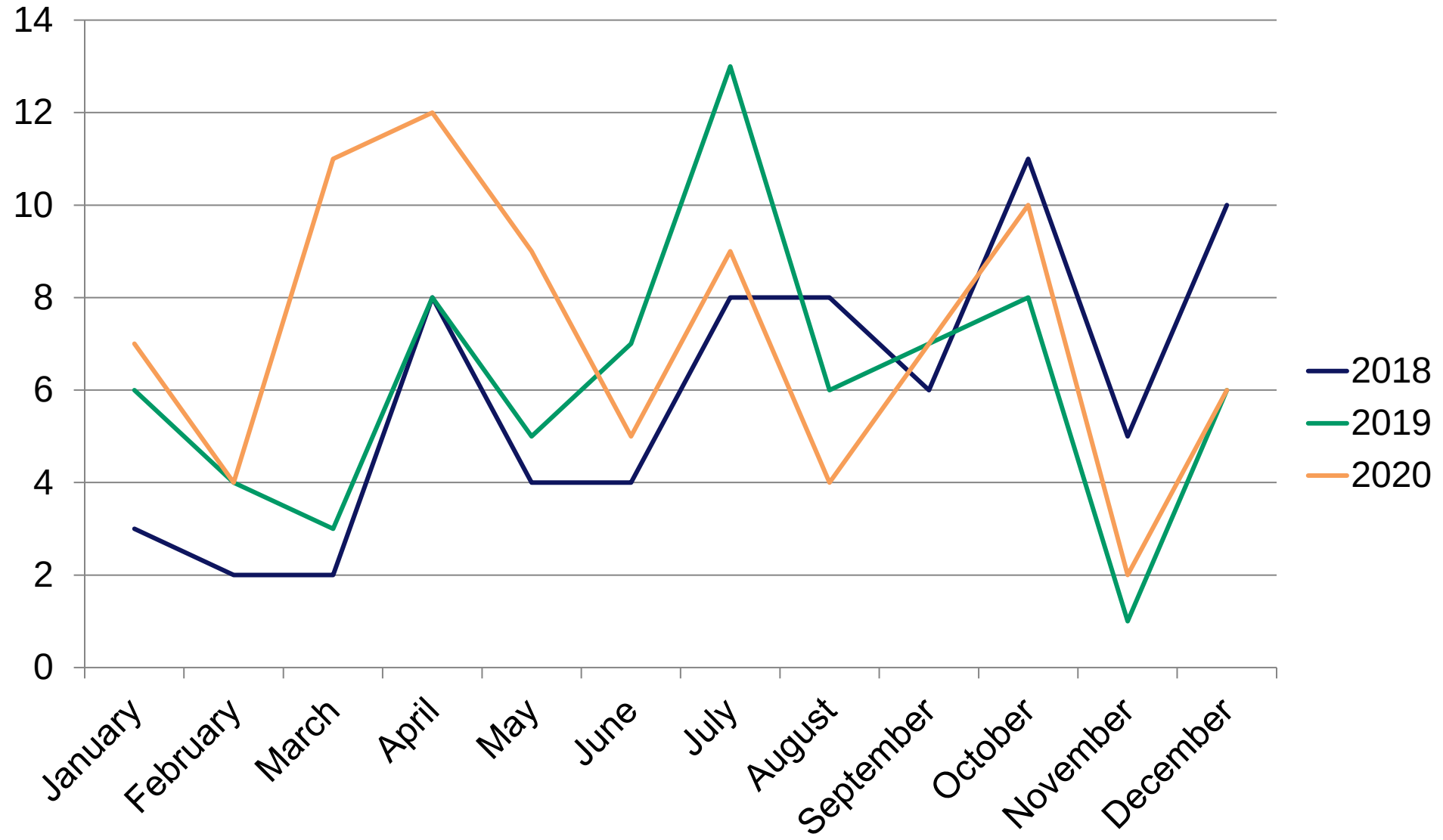
Leicestershire Police

Protecting our communities

Local Real-Time Surveillance



- This data is collected by the Office of the National Stastics?
- GP's – awareness, understanding & post-vention
- Obvious methods for improvement – bereavement service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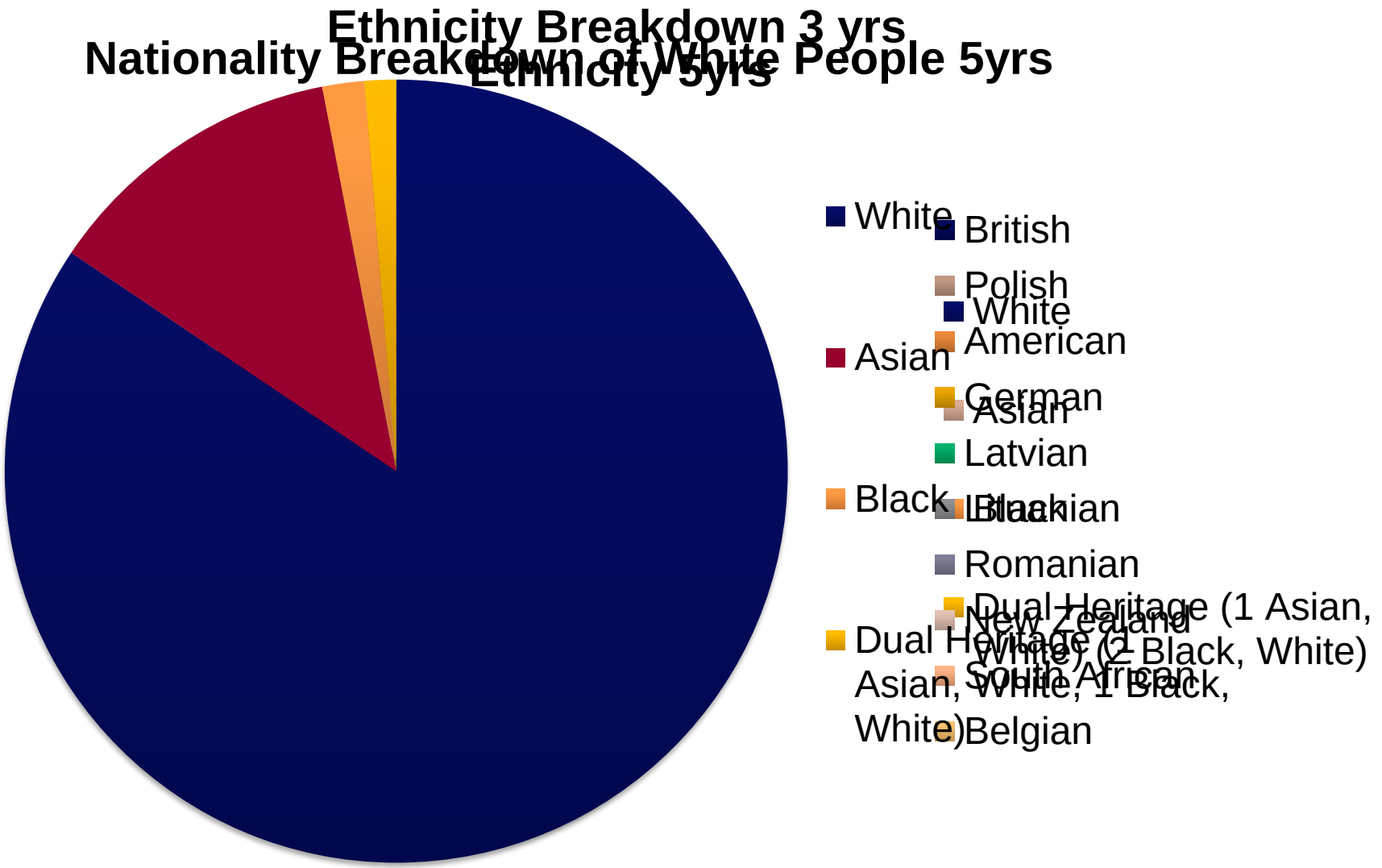
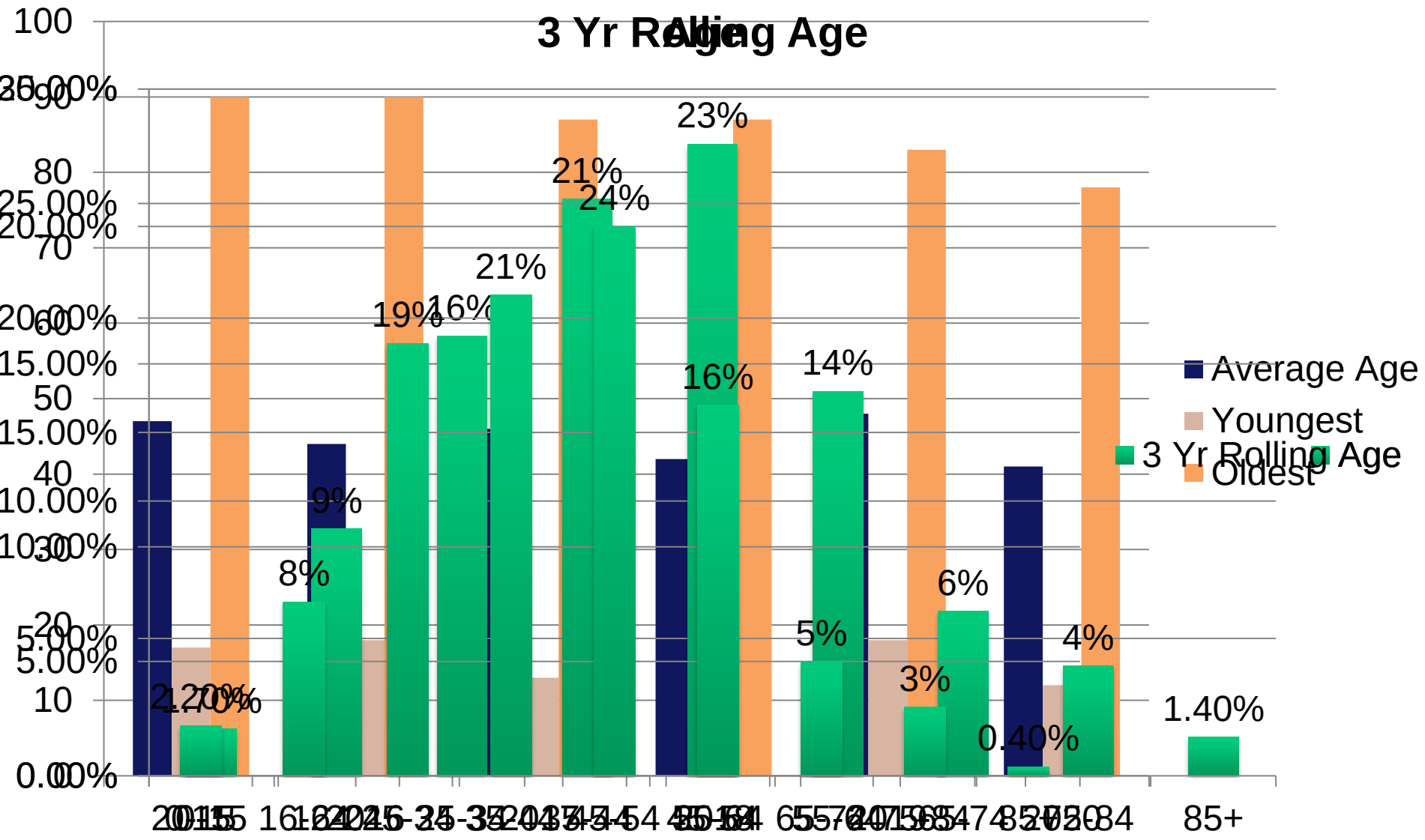

Ethnicity Breakdown 3 yrs
Nationality Breakdown of White People 5yrs
Ethnicity 5yrs
White
Asian
Black
Dual Heritage (1 Asian, White, 1 Black, White)
British
Polish
White
American
German
Asian
Latvian
Black
Romanian
New Zealand
South African
Belgian
Dual Heritage (1 Asian, White) (2 Black, White)


3 Yr Rolling Age
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3%
4%
0.40%
1.40%
85+

Collaboration

The LOSST LIFFE Model
A practical approach for operationalising strategic objectives of national suicide prevention policy

Barney Thorne
Safeguarding Partnership Manager/Suicide Prevention Lead
Wigston Police Station
Bull Head St
Wigston
LE18 1WX

&

Michelle O'Reilly*
Associate Professor of Communication in Mental Health and Chartered Psychologist in Health
School of Media, Communication & Sociology and School of Psychology
University of Leicester
107-111 Princess Road East
Leicester
LE1 7LA
Mjo14@le.ac.uk
*author for correspondence

Could go for the *journal of public health* – make sure you cite a couple of suicide papers from there

Back up option is *Journal of Public Mental Health* – impact factor – not known – word count – 4000-6000 including tables and references
Another back up option is *Journal of Community Health* - manuscript should not exceed 5000 words

Journal of public health guidelines

Please provide an abstract of 150 to 250 words. The abstract should not contain any undefined abbreviations or unspecified references.
Please note that the abstract of original articles must be structured. The following structure shall be used:

- Aim:
- Subject and Methods:
- Results:
- Conclusion:

Please use colons after each item.

Keywords

Please provide 4 to 6 keywords which can be used for indexing purposes.

a. Use a normal, plain font (preferably 10-point Times New Roman with a 1.5 line space) for text.
a. Use italics for emphasis.
a. Use the automatic page numbering function to number the pages.
a. Do not use field functions.
a. Use tab stops or other commands for indents, not the space bar.
a. Use the table function, not spreadsheets, to make tables.

Introduction

In 2013 the World Health Organization (WHO) put forward their Mental Health Action Plan (2013-2020) in which suicide prevention was described as a crucial priority because suicide is preventable and yet represents a serious global public health problem (WHO, 2014). To address the goal of suicide reduction, it was noted that national responses to suicide are necessary and these require comprehensive multisectoral strategies. Consequently, in 2015 Sustainable Development Goals (SDGs) were adopted by the UN General Assembly, with the prevention of suicide being a core indicator, as this is beneficial to the wellbeing of society and the economy (WHO, 2018). Thus, it is now a global public health goal to reduce suicide rates (Jacob, 2016). In England, suicide prevention has risen on the political agenda, with public health officials taking a strategic approach to suicide prevention (HM Government, 2019a). To address the challenge of suicide prevention and reduction, HM Government (2019a) produced a national policy which highlighted several core strategic objectives, including; to target high risk groups; promote positive mental health in vulnerable groups; reduce access to means; improve support for those bereaved by suicide and; support research, data collection and monitoring. While England has done well in reducing suicide rates (WHO, 2018), for the first time in five years suicide rates have increased (Gayle, 2019). To some extent this may be explained by the new ruling for suicide that requires the standard of proof for the conclusion of suicide to be the 'balance of probabilities', changed from the previous 'beyond reasonable doubt' (Appleby et al., 2019), and yet the rise in some groups, such as adolescents and middle-aged men, is a cause for concern.

For national policies and strategies to be effective, they must be translated and implemented at local levels (Butler and Allen, 2008). Such a translation of strategic objectives is not linear, but iteratively transformed through multiple distributed agencies communicating with each other and through organisational practices, which means that policy content is reshaped through the incorporation of knowledge from practice (Sausman et al., 2016). Notably, it has been recognised that the English suicide prevention strategy needs to be multisectoral, and tailored to local cultural and social contexts, with clear objectives, targets, indicators, responsibilities and budget allocations (WHO, 2018). Indeed, Public Health England (PHE) produced an online suicide prevention atlas of suicide data for each Local Authority to support implementation (Simms and Scowcroft, 2018), recognising that research and evaluation must learn lessons through a balance of national data with community-specific data (WHO, 2014). For Local Authorities to successfully implement national strategic objectives it is necessary for the different agencies involved to take a coordinated interdisciplinary approach and have available methods of implementation that work at a local level. In this paper, we propose a practical model for the operationalisation of national objectives by focusing on how one primary agency (the police) work with other local agencies to collate data, initiate support processes, and meet wider objectives. The foundational principles of the model are translatable for any local domain (at least in high-income countries) for key stakeholders to interpret and transform for use in practice. We demonstrate this through a case-study design.

Literature review and context

A fundamental challenge for Governments in setting strategic objectives, and local agencies addressing them, lies in the tensions of defining suicide. Over a decade ago there were more than 27 definitions (Silverman, 2006), and this challenge still hinders our understanding, response and reporting (Silverman, 2016). Broadly, suicide tends to be defined as an action that directly or indirectly results in a 'self-inflicted death', and utilising this type of definition, statistics show that globally, every 40 seconds a person dies by suicide (Ilgin et al., 2019). This is especially concerning given that for each person who dies by suicide, it is estimated that 20 more have attempted suicide (WHO, 2014). It is clearly important to recognise the risk factors for suicide. There is a significant research literature on suicide across the lifespan, with much focus on the aetiological factors that contribute to suicide decisions and behaviour. In a recent review, research illustrated a range of factors associated with suicide attempts and suicide capability (Klonsky et al., 2017), recognising that risk factors are multidimensional and overlapping, including physical or mental illness, stress, alcohol and substance use, family issues, and economic challenges (Pirkowski and Hartmann, 2019). Arguably the most substantive risk for death by suicide, was identified as the presence of a mental health condition (Randall et al., 2014), particularly depression (Hasan et al., 2020) and related issues like self-harming (reference). Problematically, though, there is a significant amount of unmet mental health need globally, and in England (reference).

While suicide has a significant economic cost (Kinchin and Doran., 2017), the personal cost is unquantifiable as suicide has a significant long-lasting impact on families and friends (HM Government, 2019a). Research shows that bereavement by suicide is devastating, and this cause of death can result in guilt, stress, anger, shame, and anxiety in family members and friends (WHO, 2014), elevating the risk of suicidal ideation and completion in these grieving individuals (Van Orden et al., 2010). This is especially problematic in younger persons, as research shows that 13% of those under the age of 20-years who died by suicide had previously been bereaved by suicide (University of Manchester, 2016). Consequently, the National Institute of Clinical Excellence (NICE, 2019) as part of a series of quality statements, have included the necessity to promote tailored support for individuals bereaved by suicide as a mechanism of early identification and risk reduction. In part, at least, these members need to be identified and offered support.

Across the broad range of public sectors there are different professionals who encounter people who are at risk of suicide. However, research shows that practitioners from many officers and other public service professionals need support in developing knowledge and key competencies through suicide prevention training (HM Government, 2019b).

The police, particularly, are an important group of public sector professionals as their role is multi-directional, in the sense that they are often first attenders to an attempted and/or completed suicide, communicate with families and other agencies, and therefore are in a unique position to address suicide prevention. The police contribute to suicide prevention both directly, through action at an attempt scene or responding to family members following a completion, and indirectly, by working with individuals in crisis, with high risk factors for suicidality such as those who use substances or engage in antisocial behaviour (Sher, 2016). However, while police officers are typically first responders to individuals in crisis and their families, they rarely have much training for this role and yet training in suicide prevention is usually well received by police officers as it helps build their confidence and knowledge (Marzano et al., 2016). Furthermore, Marzano et al noted that training in terms of suicidality can also increase their awareness and recognition of impacts to their own mental health and personal emotional responses to suicide. This is crucial, as police work has hidden psychological dangers as the occupation is imbued with stress and trauma, yet police culture and stigma may lead to officer's resisting help-seeking (Violanti, 2018).

Ultimately, suicide is *preventable*, and the police are instrumental in understanding local issues, enacting local responses, and collating local data. In this paper, we therefore report a theoretical model that accounts for how systemic principles are operationalised through a flow-process that is systematic and detailed to ensure provision of the core strategic directives of the PHE suicide prevention plan. The model was iteratively co-created by engaging local inter-disciplinary knowledge and expertise from the police, mental health services, local authorities, charities and academics, utilising policy directives, evidence from research literature and local information and expertise. Such a dialectical pluralist approach to thinking (see Johnson, 2017) and action promotes mixing of epistemics, integration of experience, and acknowledgement of wider political ideology.

Method

We utilised a case study design to develop, co-produce and iteratively shape and build the model. It is this process that is reported through the case study detail. For qualitative research, case study work is one of the major traditions (Creswell, 1998) and often located within the interpretative paradigm. Case study designs are valuable for research problems that are complex, intersecting and/or poorly understood. Case studies designed to explore study designs enable researchers to explore core issues at stake across cases to transfer the findings to build theory (Yin, 2003). Such designs are committed to studying the complexity of real-world situations in depth, accounting for varied perspectives related to it (Simons, 2009) and benefitting from prior expert knowledge (Yin, 2003).

Data collection and building a model

The model reported in this paper was co-produced and created via three stages. First, through engagement with the research evidence, policy directives and local police expertise and experience, the initial template of the model was created. This early view recognised the value and importance of collating data on self-inflicted deaths at the point of the event, and in a way that extended traditional police data collection approaches. In other words, a method of data collection was our starting point, with the creation of demographic details via a spreadsheet collected over a five-year period and continuing (Jan 2015-August 2020). Second, consultative dialogue with different agencies was conducted over time, including engagement with PHE, social care, education, mental health, local authorities and local charities (particularly the Samaritans and bereavement charities), which created opportunities to develop the model through a greater interdisciplinary lens. This was undertaken at the police-practice level, through organisational business and was integrated with a continued engagement with academic literature. The new strategic plan (HM Government, 2019) and its primary objectives were mapped against the model and refinements made to ensure it was fit for purpose. At this point in the process, several real-world cases were collected of deaths by suicide to examine the intricacies, personal details, and where available suicide notes, and the model was further defined with more academic input. These cases form the data collection reported in this paper. Third, to identify gaps in the model and recognise any barriers to implementation, we interviewed fifteen police officers who attend self-inflicted deaths, representing different ranks, collected regular diary entries from them, and interrogated the collated demographic data to improve process, recognise resource challenges, and find strategic ways to meet the objectives in the national plan at local levels.

Ethics

Ethical governance procedures were followed, and approval granted by the university of (anon) ethics committee. Due process was adhered to through the internal police structures and approval provided. The police approved and released the secondary data (demographic spreadsheets), suicide notes, and case study material to the team. Police officers engaged in the interview and diary aspect of the study provided full consent to participate with due

Care agencies

No one can be prepared for a sudden death, and for many it can leave a feeling of devastation and being unable to cope.

Family and friends may be the main support, especially in the immediate period after someone has died. Support or guidance is also available through the following organisations:

Local specialist support

START A CONVERSATION SUICIDE is preventable

For residents of Leicester, Leicestershire and Rutland affected by suicide.

www.startaconversation.co.uk

THE TOMORROW PROJECT

Specialist suicide bereavement service offering 1:1 support.

www.thetomorrowproject.org.uk

SAMARITANS

Support for people who are angry, depressed and suicidal any time – night or day.

116 123 (freephone)

www.samaritans.org

jo@samaritans.org

citizens advice

There can be concerns regarding debt following a bereavement. Citizen's Advice can support you.

Leicester 0300 3301 025

Leicestershire 0300 3302 111

Charnwood 03444 111 444

Rutland 01572 723494

National specialist support

WINSTON'S WISH

Giving hope to grieving children

A national grief support programme for bereaved children.

08452 03 04 05

www.winstonswish.org.uk

WAY Widowed & Young

Support for young widowed men and women as they adjust to life after the death of their partner.

0300 012 4929

www.widowedandyoung.org.uk

Cruse Bereavement Care

A confidential bereavement service.

01242 252518 or

0844 477 9400

www.cruse.org.uk

SURVIVORS OF BEREAVEMENT BY SUICIDE

Emotional support, help and information in a number of ways, including local SOBS support groups.

0300 111 5065

www.uk-sobs.org.uk

THE COMPASSIONATE FRIENDS

Support for bereaved parents and their families after a child dies.

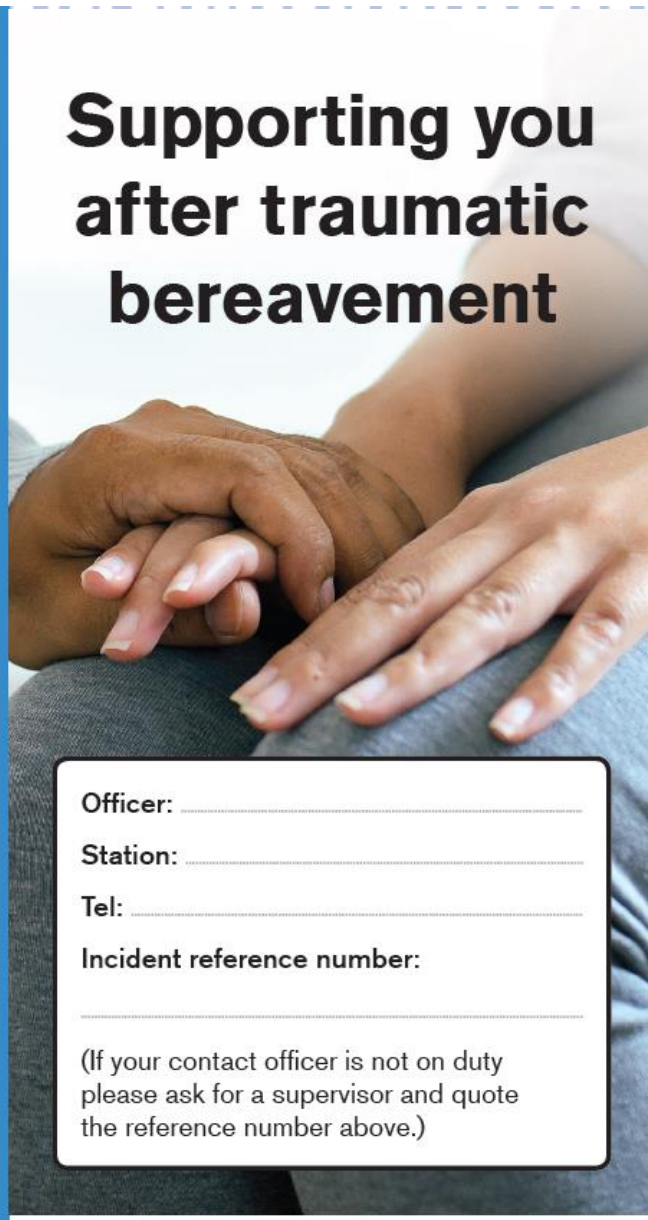
0845 123 2304

www.tcf.org.uk

Health support

Your GP is there to support you – think about making an appointment to see your GP very soon.

Supporting you after traumatic bereavement



Officer: .....

Station: .....

Tel: .....

Incident reference number:

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(If your contact officer is not on duty please ask for a supervisor and quote the reference number above.)

POLICE & CRIME COMMISSIONER for Leicestershire

Prevention | Partnership | Protection

Leicestershire Police

Protecting our communities

Public Health England

Protecting and improving the nation's health

Any questions?

tammy.coles@phe.gov.uk
arvinder.duggal@phe.gov.uk
RTSS.system@phe.gov.uk
barney.thorne@leicestershire.pnn.police.uk