Renfrewshire Council

NHS Greater Glasgow and Clyde

To:	**Renfrewshire Integration Joint Board**
On:	**29 January 2021**
Report by:	**Interim Chief Officer**
Heading:	**Mental Health Strategy**

Direction Required to Health Board, Council or Both	**Direction to:**	
	1. No Direction Required	**X**
	2. NHS Greater Glasgow & Clyde	
	3. Renfrewshire Council	
	4. NHS Greater Glasgow & Clyde and Renfrewshire Council	

1. Summary

1.1 Renfrewshire IJB have previously been updated on the NHS Greater Glasgow & Clyde (NHSGGC) Mental Health Strategy 2018-23. This strategy spans across both Adult Mental Health inpatient and community services to ensure services are modern, patient focused, effective and efficient. The strategy takes a whole system approach, linking the planning of services across NHSGGC, incorporating the planning priorities of the six HSCPs, and is aligned with delivery of the Scottish Government's Mental Health Strategy 2017–27. The strategy has a range of workstreams that report to a Programme Board.

1.2 NHSGGC Chief Officers and the Chair of the Mental Health Strategy Programme Board have commissioned a refresh of the Mental Health Strategy to ensure the focus of the Strategy and the implementation plan reflect progress and the impact of COVID-19.

1.3 As part of the national Mental Health Strategy 2017-27, the Scottish Government made a commitment to provide funding to support the employment of 800 additional mental health workers to improve access in key settings. This funding is referred to as Action 15.

1.4 National Records Scotland (NRS) publish an annual report of the probable suicide deaths in Scotland. There were 833 deaths by probable suicide in Scotland in 2019, representing a 6% increase on 2018. In Renfrewshire there were 16 deaths by probable suicide in 2019, which was an increase from 13 in 2018. Deaths in Renfrewshire in 2018 saw a significant drop from the previous year. In 2017 there were 23 deaths.

1.5 A significant priority of the Strategy and the day-to-day work of Mental Health Services in Renfrewshire is suicide prevention. Renfrewshire have utilised some of the Action 15 monies to strengthen our suicide prevention work.

2. Recommendation

It is recommended that the IJB:

- Note the refresh of the Mental Health Strategy is underway and that a further update will be provided to the Board as this work is progressed;

- Note the progress of Action 15;
- Note that the Head of Mental Health, Addictions & Learning Disability Services will continue to work in partnership with the other 5 GGC HSCPs in progressing the board-wide proposals, and lead our Renfrewshire only proposals; and
- Note the suicide prevention work that is underway in Renfrewshire and the commitment from the HSCP to prevent these tragedies.

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3. NHSGGC Mental Health Strategy 2018-23 Refresh

3.1 Work on the Mental Health Strategy was commenced in 2017 as a key part of the NHSGGC Moving Forward Together programme. The Adult Mental Health Programme Board was set up that year by HSCP Chief Officers led by Glasgow City HSCP. The Programme Board includes clinical, managerial and staff representatives from across the mental health system from all six HSCPs, with specific workstreams focusing on:

- Bed modelling and site impact;
- Recovery planning;
- Workforce planning;
- Capacity, effectiveness and efficiency of community services;
- Unscheduled care;
- Financial framework; and,
- Engagement & involvement.

3.2 Regular progress reports have been made available to Chief Officers. In recent months a specific focus has been reviewing and refreshing the strategy in the light of our response to the COVID-19 pandemic and the lessons learnt. A key assumption on our recovery planning is that demand for mental health services and support will increase post the pandemic and the scale of this is difficult to quantify at this juncture.

3.3 A number of new ways of working were adopted during the pandemic and the refresh of the Strategy will allow for these to be considered as we move forward.

3.4 A Refresh Steering Group has been established and is being led by Glasgow City HSCP as the host HSCP for Mental Health planning responsibilities. Renfrewshire HSCP's Head of Mental Health is a member of this steering group. It aims to refocus the strategic principles, goals and outcomes of the Mental Health system across HSCPs. It will consider what structures are required to ensure transformation, provision and delivery of mental health services can best be delivered in light of current demands and constraints.

3.5 The refresh will be concluded in the Spring before a period of stakeholder engagement. Older People Mental Health Strategy is being progressed separately and an update of this will be provided to the IJB in due course.

4. Action 15

4.1 Action 15 is one of the 42 commitments in the national Mental Health Strategy 2017–27. The Scottish Government provided funding to support the employment of 800 additional mental health workers across Scotland to improve access to mental health services for those in need. The goal was to 'Increase the workforce to give access to dedicated mental health professionals to all Accident and Emergency departments, all GP practices, every police station custody suite, and to our prisons.' This has since been redefined to

employ additional mental health workers that will impact/re-direct demand away from these key settings.

4.2 Renfrewshire was allocated a share of these monies with a target of establishing an addition 27.2 mental health workers by the end of the 4 year period. Appendix 1 provides details of posts and progress. The pandemic has delayed some of this recruitment as the nature of the Action 15 criteria means that most posts are newly developed roles, as such they require new job descriptions which need to be submitted to the Job Evaluation Panel to establish banding. This panel was paused during the pandemic which has delayed recruitment to a small number of posts within Renfrewshire. Many of the Mental Health Strategy developments are being delivered on a board-wide basis with Renfrewshire contributing. These are detailed in Appendix 1, alongside the Renfrewshire only developments.

The Action 15 financial allocations for Renfrewshire over the coming years are outlined in the table below:

Allocation by HSCP	Renfrewshire HSCP NRAC Share %	Renfrewshire NRAC Share £
2018 – 2019 share of 11 million total	3.40%	£373,503
2019 – 2020 share of 17 million total	3.40%	£577,233
2020 – 2021 share of 24 million total	3.40%	£814,917
2021 – 2022 share of 32 million total	3.40%	£1,086,555

5. Probable Suicide Deaths in Scotland 2019 Report

5.1 NRS publish an annual report of the probable suicide deaths in Scotland (Appendix 2). There were 833 deaths by probable suicide in Scotland in 2019, representing a 6% increase on 2018. In Renfrewshire there were 16 deaths by probable suicide in 2019 which was an increase from 13 in 2018. Deaths in Renfrewshire in 2018 saw a significant drop from the previous year. In 2017 there were 23 deaths.

5.2 **Scotland**

- There were 833 probable suicides registered in Scotland in 2019, 6% more than in 2018 and the highest annual total since 2011 (889).
- The increases in 2018 and 2019 followed a generally downward trend since the early 2000s.
- Men accounted for nearly three quarters (74%) of probable suicides in 2019, a similar proportion to every year since the late 1980s.
- Nearly a third (32%) of all probable suicides were of people aged between 45 and 59. Over the latest five years, the proportion of probable suicides was largest in the 45-49 age group (12% on average). This is a shift in age group from the late 1990s when the largest proportions were for people in their late 20s and early 30s.

5.3 **Renfrewshire**

- There were 16 (12 male/4 female) probable suicides registered in Renfrewshire in 2019 in comparison to 13 (11 male/2 female) in 2018.
- The 5-year rolling average continues to show a downward trend.

5.4 The following table shows figures for comparison across the 6 Local Authority areas making up Greater Glasgow & Clyde Health Board area:

Annual Registered deaths by Probable Suicide: Number of Persons	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
East Dunbartonshire	11	14	5	12	5	15
East Renfrewshire	5	7	7	6	12	5
Glasgow City	85	69	91	88	99	106
Inverclyde	13	10	8	12	7	16
Renfrewshire	**24**	**21**	**16**	**23**	**13**	**16**
West Dunbartonshire	14	14	12	6	12	15
Greater Glasgow & Clyde Totals	152	136	140	147	148	173

5 Year Moving Averages	**2011-2015**	**2012-2016**	**2013-2017**	**2014-2018**	**2015-2019**
East Dunbartonshire	12	11	11	9	10
East Renfrewshire	9	8	8	8	8
Glasgow City	88	86	83	86	90
Inverclyde	15	12	11	10	11
Renfrewshire	**25**	**22**	**22**	**19**	**18**
West Dunbartonshire	14	12	12	12	12

6. Suicide Prevention

6.1 Renfrewshire HSCP continues to prioritise the prevention of suicides and the wide range of treatment and care offered provides support to individuals who have suicidal ideation. Every death by suicide is a tragedy. All suicides are investigated fully and any learning is shared. Families are invited to be involved in this process and the Head of Service and Lead Investigator meet with the family to share findings and hear any suggestions they may have about how to improve our service.

6.2 Renfrewshire has recently invested in delivering a broad reaching suite of Suicide Prevention Training Courses and Awareness raising activities e.g. Applied Suicide Intervention Skills Training (ASIST), Scotland's Mental Health First Aid, What's the Harm (self-harm awareness) and a range of bespoke courses responding to requests from teams and services. The training is available to anyone who lives and/or works within Renfrewshire and its free of charge. This approach has ensured a broad reach within Renfrewshire to statutory and third sector services, alongside community groups, DWP, and interested individuals. It should be noted that some of this training is delivered by Public Health Scotland and has been paused during the pandemic, with some having been able to switch to virtual training.

6.3 Other activity include working with colleagues within Education and Children's Services providing training and awareness raising. Working with colleagues in the third sector to raise awareness through community events e.g. No Substitute for Life: 5 a side football tournament held in Ferguslie. Working in partnership with SOBS (Survivors of Bereavement by Suicide) support group and holding an annual memorial service each year to remember those lost to suicide.

6.4 Community Safety Nurses are a new development in Renfrewshire utilising Action 15 monies, based within our Mental Health Crisis Service – Intensive Home Treatment Team (IHTT) within the whole system of Community Mental Health Services. The Community Safety Nurses form part of the Community Safety Partnership and work in partnership with Police Scotland, Gender Base

Violence, MARAC (Multi-Agency Risk Assessment Conference for Domestic Violence) and link in with School Community Link Support Workers to facilitate multi agency working in providing an early intervention service for individuals with mental health issues, physical and social care needs and help manage the clinical risks related to suicide, self-harm and harm to others within the community of Renfrewshire. Partnership working is a key component to helping those vulnerable individuals early, and by utilising effective interventions, to prevent those individuals from regularly presenting at Daily Tasking and Emergency Department services, minimising subsequent resources being utilised from other partners who are not best placed to fulfil the needs of the individual.

Implications of the Report

1. **Financial –** Action 15 allocation is being fully utilised
2. **HR & Organisational Development** – None.
3. **Community Planning** – The wellbeing of communities is core to the aims and success of Community Planning. Action 15 will contribute to support this wellbeing agenda. Ongoing engagement with people with lived experience and their carers will help to shape future services
4. **Legal –** There are no legal issues with this report
5. **Property/Assets –** property remains in the ownership of the parent bodies
6. **Information Technology –** The HSCP will require to routinely report back to the Scottish Governmnet on progress made against our plans and in particular in relation to Action 15
7. **Equality & Human Rights –** None.
8. **Health & Safety –** None.
9. **Procurement** – procurement activity will remain within the operational arrangements of the parent bodies.
10. **Risk –** There are no risks identified as this funding is recurring and implementation of the new posts is governed by a Mental Health Strategy Planning Group.
11. **Privacy Impact** – N/A

List of Background Papers – Mental Health Strategy 2017-2027 Action 15 Plan (September 2018)

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Action 15 -Renfrewshire Projects	Contract	WTE IN POST	WTE VACANT	Fixed Term end date	FY Allocation
Recovery Hub					
Peer Support - Band 3	Permanent	1.00	0.00		£29,200
Peer Support - Band 4	Permanent	2.00	0.00		£78,600
Ops Manager for recovery - Band 8a	Permanent	1.00	0.00		£30,200
Total - Recovery Hub		4.00	0.00		£138,000
Borderline Personality Disorder					
Borderline Personality Nurse - Band 6	Permanent	2.00	0.00		£58,000
Total - Borderline Personality		2.00	0.00		£58,000
Mental Health Wellbeing- Inpatients					
Band 3 Occupational Ther Serv	Permanent	2.00	0.00		£68,200
Band 3 Occupational Ther Serv	Fixed Term	2.00	0.00	May-21	£53,400
Band 3 Occupational Ther Serv	Fixed Term	2.00	0.00	Aug-21	£34,100
Total Mental Health Wellbeing - Inpatients		6.00	0.00		£155,700
Community Safety Nurses (Jointly with Police)					
Band 6	Permanent	0.00	2.00		£26,000
Total Community Safety Nurses		**0.00**	**2.00**		£26,000
Inreach Posts					
Band 6	Fixed Term	0.00	2.00	Jan-23	£34,000
Total Inreach		0.00	2.00		£34,000
Community Wellbeing					
Band 6	Fixed Term	0.00	2.00	Jan-23	£34,000
Total Communtiy Wellbeing		0.00	2.00		£34,000
Contribution to Boardwide Workstreams	Fixed Term	5.40	3.73	Various	£333,000
Training					£15,000
Social Isolation - Committed 19.20					£0
		29.40	**15.73**		£793,700

Current Budget	£570,824

Variance - Per IJB	-£222,876
Allocation with SG - Requested for release awaiting confirmation	£222,876

Test of Change

Request for funing has been made to Scottish Government and Tests of change will on commence when funding if funding is confirmed

Action 15 - Proposed Tests of Change	Contract	WTE IN POST	WTE VACANT	Duration	Total Cost
Awaiting Confirmation Funding from SG					
Recovery Hub -	Fixed Term	0.00	1.00		
Borderline Personality Disorder - Adolescent Post	Fixed Term	0.00	1.00	2 years	£95,000
Community Wellbeing Nurses (GP)	Fixed Term	0.00	2.00	2 years	£190,000
Peer Support Worker (Adolescent MH)	Fixed Term	0.00	1.00	2 years	£60,000
RAMH - Mental Health Helpline				1 year	£61,000
		0.00	**5.00**		£406,000

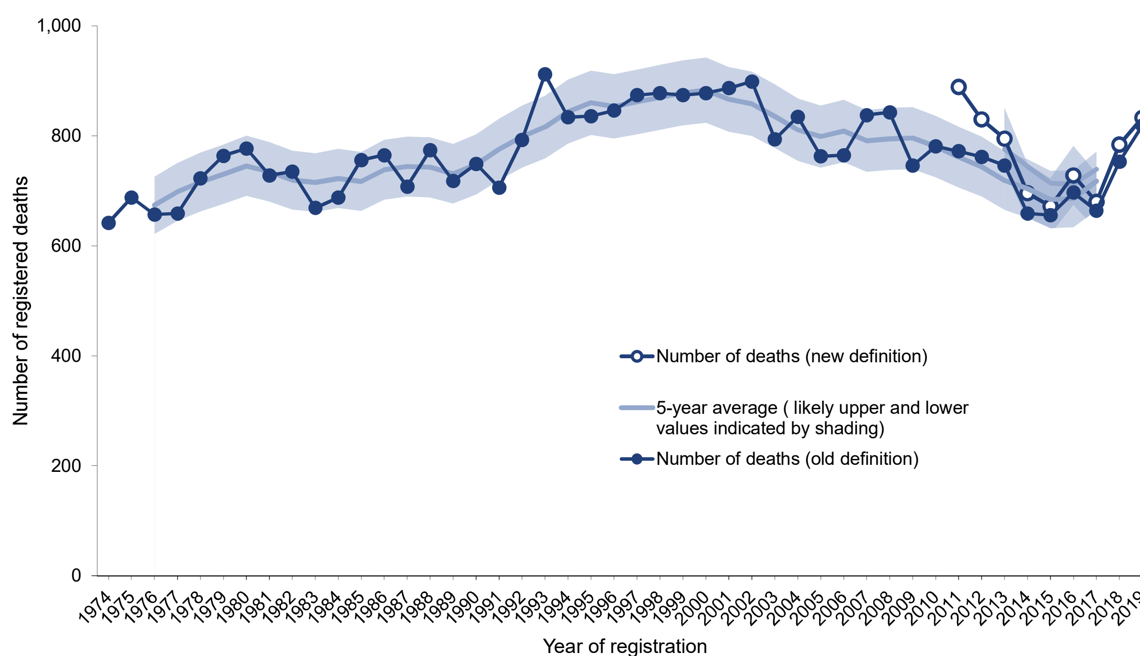
Allocation with SG - Requested for release awaiting confirmation	£406,000

Vital Events – Deaths - Suicides – 2019

Probable Suicides: main points

- There were 833 probable suicides registered in Scotland in 2019, 6% more than in 2018 and the highest annual total since 2011 (889).
- The increases in 2018 and 2019 followed a generally downward trend since the early 2000s.
- Men accounted for nearly three quarters (74%) of probable suicides in 2019, a similar proportion to every year since the late 1980s.
- Nearly a third (32%) of all probable suicides were of people aged between 45 and 59. Over the latest five years, the proportion of probable suicides was largest in the 45-49 age group (12% on average). This is a shift in age group from the late 1990s when the largest proportions were for people in their late 20s and early 30s.

Chart 1: Probable Suicides registered in Scotland, 1974 to 2019



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1. Overall number, and trends

There were 833 probable suicides registered in Scotland in 2019, 49 (6 per cent) more than in the previous year. These figures are based on the new coding rules that apply in Scotland with effect from 2011 (see the Methodology paper). It is estimated that only 819 of these deaths would have been counted as probable suicides under the old coding rules: 66 (9 per cent) more than the corresponding estimate for 2018. Further information can be found in Table 1.

Chart 1 shows the number of probable suicides in each year from 1974, using the old and new coding rules. From 2014 onwards the figures based on the old and new definitions have been very similar. The reason for the differences between the two definitions in earlier years is given in the Methodology paper (sections 2.2 and 3)

It is clear that there have been many year-to-year fluctuations. From time to time, there have been big changes, some of which have been followed by a large change in the opposite direction. However, some clear trends can be observed. Broadly speaking, the annual number of probable suicides (using the old coding rules) was roughly 650 in the mid-1970s, rose during the rest of the decade, was around 700-750 during the 1980s, increased in the 1990s to almost 900 at the start of the new century, then fell: it was about 750-800 between 2009 and 2013, then dropped to just over 650 in 2014, 2015 and 2017 (and a slightly higher figure in 2016). However, large rises in 2018 and 2019 appear to mark the end of the generally downward trend over the previous 15-or-so years. A single year's figure could be fluctuation but two consecutive large rises suggest that the trend has changed. On the basis of the old coding rules, the number of probable suicides registered in 2019 (819) was the highest since 2008 (843); using the new coding rules, the 2019 figure (833) was the highest since 2011 (889, although only slightly more than the 830 in 2012).

Because the number of probable suicides may fluctuate from year to year, the chart also shows the 5-year moving annual average, as an indication of any overall trend, and the likely range of statistical variability around it (which is explained in the Methodology paper). The 5-year moving annual average shows the trends more clearly: it rose briefly, then remained between 715 and 750 (from the period centred on 1978 to the period centred on 1990), then increased fairly steadily to a peak of slightly under 900 (in the period centred on 2000), then fell back to a level that was last seen in the early 1980s: the value of 684 (for the period centred on 2015) was

the lowest since that seen for the period centred on 1976 (which was 674). However, the latest value of the 5-year moving average (718, centred on 2017) is about 5 per cent higher, which also suggests that the downward trend has ended.

The figures for a period of a few years may not reflect the overall trend around that time because there may be large percentage fluctuations in individual years' numbers. For example, although there had been a general downward trend since around the start of the new century, year to year fluctuations during much of the first decade led to little change in the 5-year moving annual averages centred on the years from 2004 to 2009 (all were between 791 and 811). More recently, there was a clearer downward trend with the 5-year moving average (using the old coding rules for 2011 onwards) falling from 796 for the period centred on 2009 to 684 for the period centred on 2015. However, there was not much difference between the numbers of probable suicides in three of what were, at that time, the latest five years: the figures for 2014, 2015 and 2017 were, using the old coding rules, 659, 656 and 664 and the number in 2016 was only a few percent above that level (697 on the old basis). In retrospect, those figures indicate that the downward trend was ending, even though the values of moving average that were available at the time were still falling fairly steadily. Further information can be found in Table 1.

In 2009, how National Records of Scotland (NRS) obtains information about the nature of death changed. Since then, there has been a large increase in the percentage of poisoning deaths described as accidental, and a fall in those described as being due to events of undetermined intent. This caused part of the fall in the number of probable suicides after 2010: more information is available in the Methodology paper.

2. Sex and age

Roughly three-quarters of all probable suicides are men: 74 per cent in 2019 and between 70 and 77 per cent in every year from 1986 (further information can be found in Table 1).

The likelihood of suicide varies with age. In 2019, using the figures on the basis of the new coding rules, the 45-49 year old age-group had the largest number of probable suicides (96, or 12 per cent), followed by 50-54 year olds (91 or 11 per cent), and then by six age-groups which had fairly similar numbers: people aged 55-59 (81, or 10 per cent); the 35-39 age-group (79, or 9 per cent); 25-29 year olds (77, or 9 per cent); people aged 20-24 (76, or 9 per cent); the 30-34 age-group (74, or 9 per cent); and 40-44 year olds (71, or 9 per cent).

However, the number of suicides by age may fluctuate from year to year: for example, between 2018 and 2019 (on the basis of the new coding rules), there was a small fall (from 39 to 34) for 15-19 year olds and a large rise (from 57 to 76) in the 20-24 age-group. Using the figures based on the old coding rules, the largest numbers of suicides over the latest five years have been in the following age-groups: 45-49 (87 per year, on average); 50-54 (82 per year, on average); 40-44 (73 per year, on average); 35-39 (67 per year, on average); 55-59 (66 per year, on average); 25-29 (63 per year, on average); and 30-34 (62 per year, on average). The pattern has changed over the years. In the second half of the 1990s the largest numbers

were in the following age-groups: 25-29, 30-34 and 35-39, for which the annual averages (over the period from 1995 to 1999) were 108, 106 and 93, respectively. The corresponding figure for 45-49 year olds was only 78 (further information can be found in Table 3). The equivalent figures for males and females are given in Table 3M and Table 3F.

3. Area of residence

Only a couple of per cent of the probable suicides in Scotland each year are people whose usual residence was outwith Scotland (further information can be found in Table 2).

Table 4 and Table 5 give figures for each Health Board and council area, which can fluctuate markedly from year to year, so the tables include 5-year moving annual averages, which should indicate better any overall trend.

4. Method of suicide

In 2019, using the figures based on the new coding rules, the most common method of suicide was ‘hanging, strangulation and suffocation’ (57 per cent) followed by ‘poison’ (22 per cent). In addition, 7 per cent died by jumping or falling from a high place, 5 per cent by drowning or submersion, and 1 per cent used firearms or explosives. Nine per cent used another method, or an undetermined method. However, the figures for 2019 using the old coding rules have a slightly wider gap between the percentages for ‘hanging, strangulation and suffocation’ (58 per cent) and ‘poison’ (20 per cent), because fewer deaths were counted as ‘poisoning’ under the old rules.

Methods of suicide have changed over the years: in the 1970s, over half took poison, on average only about 13% hanged themselves, and almost a fifth drowned (further information can be found in Table 2).

5. Nature of death

As explained in the Methodology paper, 'probable suicides' are deaths which are believed to be due either to intentional self-harm or to events of undetermined intent. Chart 2 shows how the numbers for each of these ‘natures of death’ have changed: for example, the years from 2003 to 2017 each had between about 520 and around 610 deaths from intentional self-harm plus a number of deaths from events of undetermined intent which has fluctuated greatly in percentage terms (for example, the ‘undetermined intent’ figures for 2011 and 2016, respectively, were 245 and 94 based on the old coding rules, and were 362 and 125 based on the new coding rules). Table 2b shows the numbers for each nature of death broken down by the method of death. In the latest ten-or-so years, ‘hanging, strangulation and suffocation’ was the cause of most of the deaths from intentional self-harm, whereas ‘poison’ has usually been the main cause of deaths from events of undetermined intent. The right hand side of Table 2b shows that the main reason for the fluctuations in the figures for undetermined intent deaths over the years since 1974 is large rises and falls in the number which were due to poisoning: in comparison,

there are usually relatively few undetermined intent deaths by other methods, and their numbers have not changed as much.