**Thurrock Coalition**

**Minutes of the Mental Health Service User & Carer Forum
27th April 2015
2.00pm to 4.00pm, The Beehive**

Present: Toni Saliba (Mind), Debbie Tween (guest of Toni’s), D Hill (Mind), J Lambert (Mind), David Eyres (Mind), David Rundell (Mind), Alan Belton (SEPT – Grays Hall), Ootam Coodye (KCA Vision Thurrock Drugs and alcohol), Irene Gillan (Therapentic foster carer), Alison Petti (Together), Amanda Perry (Healthwatch Thurrock), Julie Smith (TLS), Anthony Auger (Service user), Leigh Norris (Essex Police), Steve Webster (Mind), John Sanders (Mind), Graham Carey (Adult Safeguarding), Jacqui Webster (Mind), Bryce Day (Mind), Philip Day (Mind), Charlotte Webb (Mind), Kamaljeet Gill (Mind), Sharon Goodard (Mind), Chris Holand, Sonja Dube (Mind), Brain Martin (Mind), J Richardson (Mind), Harpal Kang (Mind), David Alan (Mind), Cate Edwynn (Thurrock Council, Public Health), Leroy Richards (Thurrock Council, Public Health), Akbal Ghattram (Mind), Sophie Bayson (Mind), Lynne Evans (Mind), Michelle Dawson (Thurrock Coalition), Ian Evans (Thurrock Coalition).

1. **Welcome & Introductions**

Ian Evans welcomed everyone to the meeting - Topic of today’s meeting: suicide prevention

1. **Minutes & Matters arising from the previous Forum Meetings on Safeguarding (January 2015)**

Previous minutes agreed as an accurate reflection and record of the January meeting

1. **Presentations on Suicide Prevention Initiatives and the need for a specific Strategy in Thurrock from Speakers:
Covering Essex Police, Public Health and Safeguarding**

1. **Graham Carey: Thurrock Adult Safeguarding Partnership Board. April 2015.**

**Thurrock and suicide.**

*“Achieving a reduction in suicide involves reaching more people who may be at risk of taking their own lives; which can only be achieved by understanding which groups of individuals are particularly at risk of suicidal thoughts and behaviours”.* Samaritans

**Some facts.**

* The rate of suicide has remained fairly constant in the UK for about 20 years.
* In England, about 4,500 people (15+) commit suicide each year. That is between 11/12 people in every 100,000.
* In Thurrock we should anticipate about 18/19 deaths by suicide every year of which about 13/14 will be men because suicide is more common in men.

**ONS figures for 2012 causes of death.**

* Males aged 5-19: Suicide was the 2nd highest cause of death – 12%. (Land transport accidents highest with 18%).
* Males aged 20-34: **Suicide was the highest** cause of death – 26%. (Accidental poisoning was 2nd).
* Males aged 35-49: **Suicide was the highest** cause of death – 13%.
* Women aged 20-34: **Suicide was the highest** cause of death – 13%.
* Women aged 35 – 49: Suicide was the 3rd highest cause of death 5%.

**Three recent reports.**

The first is ***“Preventing suicide in England: Two years on. The 2nd annual report on the cross-government outcomes strategy to save lives”.***

This follows up on the take-up of the strategy and bemoans the fact that little appears to have been done in the greater London area. It is littered with good practice examples and references to further useful literature and guidance. There is particular guidance aimed at Public Health, CCG, health commissioners and providers and Police, among others.

NB: The Government consider that Health and Wellbeing Boards should be leading this with Public Health and that there are three main elements that are essential to the successful local implementation of the national strategy:

1. Carrying out a “suicide audit” which involves the collection of data about suicides that have occurred locally from sources such as coroners and health records in order to build an understanding of local factors such as high risk demographic groups.
2. The development of a suicide prevention action plan setting out the specific actions that will be taken based on the national strategy and the local data, to reduce suicide risk in the local community.
3. The establishment of a multi-agency suicide prevention group involving all key statutory agencies and voluntary organisations whose support is required to effectively implement the plan throughout the local community.

***I think that Thurrock’s Health and Wellbeing Board should be encouraged to take forward all three recommendations.***

The second report is ***the annual statistical report on suicide*** published by the Dept of Health. It provides considerable detail at a national level and much that will be of use locally, including:

* There were 4,727 suicides recorded in 2013, a rise of 214 since 2012.
* The three-year average rate for 2011-13 was 8.8 suicides per 100,000 general population
* The majority of suicides continue to occur in adult males, accounting for over three quarters of all suicides in 2013 (78%).
* **In 2012 there were 1,272 estimated suicides by people in contact with mental health services in the year prior to death**
* **The estimated figure for 2012 shows 50 inpatient suicides, however in-patient deaths are more often subject to late notification and so the estimated figure should be viewed with caution.**
* **There were 62 ‘apparent suicides following police custody’ during 2013/14 in England. This is similar to 2012/13 when there was a large rise from 2011/12. The 2013/14 figure is the highest seen in the last decade**
* There were 59 deaths mentioning helium in 2013 in England, over 5 times higher than the 11 deaths recorded in 2008 (figure 8). Although the number of deaths involving these substances is still relatively small, the large increases are of particular interest as almost all of these deaths were suicides.
* Important additional information is available from serious untoward incident inquiries, Serious Case Reviews (SCRs) and Child Death Overview Panels (CDOPs). The purpose of SCRs and CDOPs are to learn lessons to better safeguard and promote the welfare of children. Regular reports draw out key findings from SCRs. The Department for Education publishes data about preventable child deaths in England.

The third report is ***Preventing Deaths in Detention of Adults with Mental Health Conditions: An Inquiry by the Equality and Human Rights Commission.***

 “Between 2010 and 2013 367 adults with mental health conditions died of ‘non-natural’ causes while in state detention in police cells and psychiatric wards. Another 295 adults died in prison of ‘non-natural’ causes, many of these had mental health conditions. Since 2013 that number has risen considerably.

“Our Inquiry reveals that despite many reports and recommendations, serious mistakes have gone on for far too long. The same errors are being made time and time again, leading to deaths and near misses”.

More facts.

* In 2012/13 there were over 50,000 detentions in psychiatric hospitals, and this number is increasing.
* The prison service does not currently record the number of prisoners with mental health conditions. The most recent national data relates to 1997, where 92 per cent of male prisoners were reported to have one of the following five conditions: psychosis, neurosis, personality disorder, alcohol misuse and drug dependence. Seventy per cent had at least two of these.
* Statistics for England show that police cells were used as a place of safety 6,028 times in 2013/14. That equates to 115 occasions each week when someone was held by the police because of their perceived risk to themselves or to others.

The report makes 4 Recommendations:

1: Structured approaches for learning lessons in all three settings should be established for implementing improvements from previous deaths and near misses, as well as experiences in other institutions. As part of this, there should be a statutory obligation on institutions to respond to recommendations from inspectorate bodies and to publish these responses.

2: Individual institutions in the three settings should have a stronger focus on meeting their basic responsibilities to keep detainees safe including implementing recommendations, improving staff training and ensuring more joined up working. Where this is not currently the situation this should explicitly be part of the inspection regimes.

3: In all three settings there needs to be increased transparency to ensure adequate scrutiny, holding to account and the *involvement of families*. A new lever to help achieve this may be the introduction from April 2015 of a statutory duty of candour which applies to NHS bodies in England. If it proves to be effective this duty should be extended to the other settings too, particularly in investigations and inquiries into non-natural deaths.

4: The EHRC’s Human Rights Framework should be adopted and used as a practical tool in all three settings. Adopting it as an overall approach as well as ensuring compliance with each individual element will reduce non-natural deaths and should help to inform and shape policy decisions.

To conclude.

***In my view, in Thurrock we need Public Health to take the lead on Suicide Prevention and we need the Health and Wellbeing Board to oversee that work.***

“Achieving a reduction in suicide involves reaching more people who may be at risk of taking their own lives; which can only be achieved by understanding which groups of individuals are particularly at risk of suicidal thoughts and behaviours”.

1. **Leigh Norris – District Commander, Thurrock for Essex Police**

**Discussion around the Street Triage scheme.**

**What is Street Triage?**

The Department of Health is funding pilot schemes, managed by nine police forces, in partnership with local NHS organisations. In these schemes, mental health professionals provide on the spot advice to police officers who are dealing with people with possible mental health problems. This advice can include an opinion on a person’s condition, or appropriate information sharing about a person’s health history.

The aim is, where possible, to help police officers make appropriate decisions, based on a clear understanding of the background to these situations. This should lead to people receiving appropriate care more quickly, leading to better outcomes and a reduction in the use of section 136.

* Street Triage as an alternative to using Section 136.
* Part of the Mental Health crisis care concordat – partnerships around Mental Health issues
* Across Essex from 1/12/14 to 31/3/15
* 2 cars across Essex
* Friday, Saturday, Sunday nights 6pm-2am
* Out of hours – Mon – Thurs 6pm – 2am dedicated specialist helpline

**Custody demand:**

* 2013-14 187 average 16 per month detained
* 2014-15 156 average 13 per month detained
* Downward trend since pilot: average of 5.25 per month
* None taken into custody in operating hours

**Cost:**

* S136 - £1700 per detention
* Response – street triage – MH nurse and police partnerships

**Interventions:**

* Enables skilled initial assessment – 1/12/14 – NEP and SEPT
* Fri – Sun 6pm – 2am triage vehicle. Plus 4 marked cars – Harlow, Basildon, Colchester, and Rochdale

**Early benefits:**

* Improved relationships - Culture shifts – positive risk management. Police confidence in talking about Mental Health

**Question:** Why is there a weekend escalation in the Triage service?

**Answer:** Weekends are the busiest times - particularly Friday and Saturday from 4pm to midnight

**The QE2 bridge**

There were 5 suicides in 2013. Mostly people using lane 1 and jumping the barrier (There is a low barrier)

2 out of the 5 people were from the local area

**Background**

A Multi-agency approach to reducing suicide rates has built up over the years – hospital, highways, police, Samaritans, signs, and signs at services. There were no suicides from the bridge in 2014

**Question:** What training do police officers receive on Mental Health Awareness?

**Answer:** Some limited training, mainly focussing upon recognising signs of Mental Health conditions. The first priority for the police is the “Preservation of life” and the second priority is Mental Health.

* Working closer together in partnership working e.g. triage, has led to better outcomes.
* At Thurrock Mind – probation training – every Thursday.
* Mind – know the tell-tale signs
* Useful to hold and continue User-led talks and to build Public awareness, especially upon the effect of cuts and government policy – for people to get help
* Local Area Coordinators in Thurrock can pick up on issues and act/signpost
1. **Public Health presentation by Leroy Richards and Cate Edwynn**

Here today to gather issues to take back in order to inform a Suicide prevention strategy

**The Role of Thurrock Public Health -** Public Health are now Co-terminus with Thurrock Council.

**Aims:**

* To promote and protect Health & Well-being of people in Thurrock. Improving health and lifestyles
* To coproduce User led solutions
* To focus upon prevention
* Available data – following the financial downturn – suicide rates, debt, unemployment, housing repossessions all increase.

|  |
| --- |
| **Developing a Suicide Prevention Strategy****Input from the Mental Health Forum and Next Steps:*** To continue the conversation with people with lived experiences, and ensure the outcomes are user-led.
* Involve the new Director of PH in a Multi – agency approach, with people at the centre, safeguarding and the Clinical Commissioning Group (CCG).
* Do not be reactive and identify hotspots – develop user-led solutions from a preventative viewpoint.
* It has got to be easy to ask for help & to speak to someone who knows me, knows my symptoms and knows how to help
* Involve Thurrock Mind – equal value partners
* Any strategy should look at how to increase the number of interventions and preventions and not only react at the “endgame” stage when it’s too late.
* What can Public Health do to prevent suicide and to help “Be there to help us” – a call for help needs to be heard – referrals to A & E are not appropriate.
* There needs to be better awareness of indicators and risk
* All parties involved need to have the knowledge and awareness of the issues – people and professionals need to know the pathways
* Any strategy should emphasise the importance of the Crisis care concordat and involving the Police, British Transport Police and SEPT.
* Any strategy should emphasise and build, support and foster links with Support Services, such as:
* Education, Employment, Family support, Widows / widowers support, Thurrock Mind, Strengthening social networks and social inclusion, Working with the third sector on initiatives like “Bright Horizons” – (30 women, 4 men), Building awareness and social activities
* If not known to CMHT (Grays Hall) thus it’s difficult
* Improve follow up and after care – onward
* Peer support networks
* Males – limited self-referral
* Invest in preventative and support services - Hospital is costly
* Public Health would like to know what projects are being run on the ground
* Public Health have worked with Mind in the past – funding projects
* Thurrock is low in rates of suicide – we don’t know why
* One factor for suicide in Males is Employment / marriage breakdown – for men. Men will not easily engage with services
* Limitations if not already known to services: Experiences of Grays Hall – if you are not with them you do not get much help
* Limitations of the Recovery College – after training course(s), individuals experiences of just being cut off – after 6 weeks just cut off
* If Mind was closed – what would happen to us. Hospital?
* One Forum member went to Grays Hall in a bad patch was turned away till the next day – went to Basildon hospital on the bus. Arrived and explained Mental Health condition and situation and then had a negative experience of being supervised by a security guard “for staff protection”
* If Mind is shut full time – it will cost other services more money
* People need Mind it is a safe place (safety net) where would she go
* About people who know you
* Mind will be closed on a Saturday – they will signpost people
* Graham – Where people are willing to open up we could have more people and find out information if we have more of these conversations, events/workshops.
* In May, Healthwatch are running drop-in sessions on mental health, speak to Healthwatch for signposting to support services
* The council need to speak to people who can tell them what it is like (lived experience).
* Thurrock Mind as part of Thurrock Coalition could help the Public Health to Co-produce further meetings and information in June/July.
 |

1. **AOB** – none
2. **Thanks and close** - Ian and Graham thanked everyone for sharing information that has helped a great deal

**The next meeting will be July 27th 1:30pm to 4:00pm.**