Appendix 1

DRAFT Joint Cambridgeshire and Peterborough Suicide Prevention Strategy

2017-2020

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ORGANISATIONAL SIGNATORIES

To be added

ACKNOWLEDGEMENTS

The joint Cambridgeshire and Peterborough suicide prevention strategy is the result of discussions between partner organisations and individuals. We are grateful for the continuing support and input from the following:

ACRONYMS AND ABBREVIATIONS

ARC	Advice and Resource Centre
ASIST	Applied Suicide Intervention Skills Training
CAB	Citizens Advice Bureau
CAF	Clinical Assessment Framework
CCG	Clinical Commissioning Group
CEC	Clinical Executive Committee
CMO	Chief Medical Officer
CO	Carbon monoxide
CPFT	Cambridgeshire & Peterborough Foundation Trust
CR/HT	Crisis Resolution/Home Treatment
CREDS	Cambridgeshire Race Equality and Diversity Service
GPs	General Practitioners
ICD10	International Classification of Diseases version 10
LAC	Local Area Coordination
MHFA	Mental Health First Aid
MHRA	Medicines and Healthcare products Regulatory Authority
NICE	National Institute for Health & Clinical Excellence
ONS	Office for National Statistics
PCAS	Peterborough Community Assistance Scheme
QALY	Quality Adjusted Life Year
SCN STP	Strategic Clinical Network Sustainability and Transformation Plans
SUN	Service User Network

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'Keep your face always to the sunshine and shadows will fall behind you'
Walt Whitman

1. EXECUTIVE SUMMARY AND KEY RECOMMENDATIONS

The Cambridgeshire and Peterborough suicide prevention strategy 2017-2020 is a refresh of the 2014-2017 strategy with updates on national and local suicide statistics, initiatives, evidence and forward planning. Incorporated as a main thread throughout the strategy is an ambition towards ZERO suicide, as agreed through the multi-partner suicide prevention implementation board in 2017. This enhances the work already underway to prevent suicide locally, including 'STOP Suicide' and the 111(2) First Response Service (FRS) for mental health crisis.

The strategy builds on and supports the National suicide prevention strategy – 'Preventing suicide in England, Dept. of Health 2012'[1] but also includes a drive to aim for ZERO suicide, based on the National Zero Suicide Alliance. The key purpose is to ensure that there is co-ordinated and integrated multi-agency agreement on the delivery of suicide prevention services that is tailored appropriately to local need and is driven by the involvement and feedback from service users. With a focus on Zero suicide, the strategy emphasises the requirement for senior level engagement with all relevant organisations to ensure quality improvement across the pathways of care for suicide prevention.

Six priority areas for suicide prevention in Cambridgeshire and Peterborough with recommendations for actions are set out in sections 9-14 and accompanying action plan. A summary of the recommendations is provided below.

Table 1 – Summary of suicide prevention priority areas and recommendations for actions

Priority area 1 – Reduce the risk of suicide in high risk groups
Recommendations **1.1** Continue to implement suicide prevention training (STOP suicide and ASIST) to professionals, organisations and individuals in contact with people at risk of suicide. Develop and implement suicide prevention training for GPs **1.2** Continue to develop and tailor suicide prevention resources for professionals, agencies and vulnerable groups **1.3** Continue to raise awareness of STOP suicide and suicide prevention in community settings and to high risk groups **1.4** Ensure access to resources to aid self-help in those at risk of suicide **1.5** Continue to develop integrated, appropriate and responsive services for those at risk of suicide – including pathways for vulnerable groups such as those with co-occurring drug and alcohol and mental health problems. **1.6** Reassess pathways for young people and adults known by mental health services at risk of suicide **1.7** Improve pathways and support for people taken into custody and newly released from custody at risk of suicide

Priority area 2 – Tailor approaches to improve mental health in specific groups

Recommendations

2.1 Continue to work with partners who are delivering the 'Emotional wellbeing and mental health strategy for children and young people' to

- Raise awareness and campaigning around self-harm
- provide access to self-help resources that focus on building resilience in young people
- Raise awareness on preventing bullying
- Assess pathways for support for children who are at risk of self-harm , particularly in vulnerable groups of children and young people – youth offenders, children in care, children under the care of people with mental health problems
- Support initiatives that work with families to address children and young people's mental health

2.3 Promote early interventions to aid prevention of mental health problems that could lead to suicide in particular risk groups.

2.4 Promote training in mental health awareness, particularly with professional groups such as GPs to recognise mental health issues and risk of suicide

Priority area 3 – Reduce access to the means of suicide

Recommendations

3.1 In line with regulations, ensure the removal of potential ligature points – particularly in places of custody and in-patient settings

3.2 Continue to reduce the risk of suicide by jumping from high buildings accessible by the public including multi-storey car-parks and bridges

3.3 Continue work to reduce the risk of suicide on railway lines

3.4 Work with Medicines Management teams at the CCG to ensure safe prescribing of some toxic drugs

3.5 Work with health and care professionals to establish and reinforce safety plans for individuals with mental health problems

Priority area 4 – Provide better information and support to those bereaved or affected by suicide

Recommendations

4.1 Ensure bereavement information and access to support is available to those bereaved by suicide

4.2 Implement a bereavement support service and pathway for those affected by suicide

Priority area 5 - Support the media in delivering sensitive approaches to suicide and suicidal behavior

Recommendations

5.1 Encourage appropriate and sensitive reporting of suicide

- Continue to provide information to professionals on the sensitive reporting of suicide
- Continue to work with local media to encourage reference to and use of guidelines for the reporting

of suicide
Priority area 6 - Support research, data collection and monitoring
6.1 Monitor real-time information on suspected suicides as they occur. Link this information to suicide data provided on a quarterly basis by Cambridgeshire and Peterborough coroners. Include data from the Police on suicides and near suicides. **6.2** Continue to conduct an annual audit of local suicides **6.3** Continue to disseminate current evidence on suicide prevention to all partner organisations **6.4** Evaluate and report on the suicide prevention implementation plan

1.1 Zero Suicide

The ambition towards Zero suicide as the 'backbone' of the strategy requires commitment by organisations and individuals to create a cultural change in suicide prevention as summarised below.

Table 2 – Outline of the zero suicide ambition

Zero Suicide Ambition
Top level (Chief executive) engagement and commitment towards zero suicide for the main organisations involved – CCG, CPFT, PCC, CCC, Police
Improve quality - Create a learning culture not a blaming culture that will review both suicide information and information from people with lived experience to learn lessons and implement good practice.
Review and improve information sharing across agencies involved in the pathway of care of individuals with mental health problems
Strengthen the suicide prevention implementation plan with a stronger emphasis on training, campaigns and initiatives that raise awareness, educate and promote mental health across the population, but with a focus on young people

2. PURPOSE

This document sets out the strategic priorities and recommendations to prevent suicide in Cambridgeshire and Peterborough between 2017 and 2020. Accompanying the strategy is an action plan that is updated from the previous suicide prevention strategy. The action plan is intended to be used as a framework by key stakeholders for implementing the recommendations and for measuring and evaluating suicide prevention outcomes.

Suicide is a major public health issue as it marks the ultimate loss of hope, meaning and purpose to life and has a wide ranging impact on families, communities and society. Suicide is the leading cause of death for younger adults. However, the National Suicide Prevention Strategy – Preventing Suicide in England[1] states that suicides are not inevitable and many can be prevented, thus supporting a call for action to reduce suicide and the impact of suicide both at national and local level.

In line with national guidelines on preventing suicide, and to oversee the implementation of the local strategy, a multi-agency suicide prevention implementation group meets on a quarterly basis with input and membership from many organisations across public, charitable and voluntary sectors, including:

- Cambridgeshire County Council
- Peterborough City Council
- Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) - including CCG GP leads for mental health and commissioning support
- Police
- Coroners
- Cambridgeshire and Peterborough Foundation Trust
- MIND
- Lifecraft
- Service User Engagement Network (SUN)
- MindEd Trust
- Youth Offender service
- Rethink Carers
- Prison and probation service
- Samaritans
- Individuals with lived experience

The strategy is refreshed as a result of the following key considerations:

Nationally

- The National drive to prevent suicide – highlighted by the report "Preventing suicide in England - a cross-government outcomes strategy to save lives HM Government September 2012"[1] with progress reports including the most recent publication 'Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives'[2]
- Public Health England's guidance on 'Local suicide prevention planning - a practice resource'
- National momentum to aim for Zero suicide as described by the Zero Suicide Alliance
- Government commitment to improve mental health - a comprehensive package of measures to transform mental health support in schools, workplaces and communities – as announced in January 2017
- Public Health England Guidelines to develop bereavement support services for those affected by suicide: 'Support after a suicide: a guide to providing local services'

- The findings from the National Confidential Enquiry into Suicide and homicide by people with Mental Health illness – Annual report 2016[8]

Locally

- Suicide prevention is specified in the STP improvement plan within the Primary Care and Integrated Neighbourhoods (PCIN) delivery group, Mental Health Prevention and promotion of mental wellness priority. This stipulates the continued implementation of the suicide prevention strategy and findings of suicide audit.
- The five year forward view on mental health states within the key priorities for investment and focussed work 2016/17 and 2017/18 (primary prevention section): A local focus on Continued implementation of multi-agency suicide prevention strategy and findings of suicide audit (2016/17). By 2020/21 the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels.
- The Peterborough Health and Wellbeing Strategy identified five priorities to improve the health and wellbeing of everyone in Peterborough including 'to enable good child and adult mental health through effective, accessible health promotion and early intervention services'. The suicide prevention strategy includes areas that focus on mental health promotion and early intervention. The findings of the Peterborough JSNA on the mental health and mental illness of adults – 2015/2016 are also considered and help to focus the suicide prevention action plan.
- The development and implementation of a local Mental Health Crisis Concordat Declaration and Action Plan. This work is being led by the Police, but is supported by members across the partnership of organisations including the suicide prevention implementation group. The suicide prevention strategy includes recommendations that link directly to the work developed in the Crisis Concordat Action Plan.
- Feedback consistently received from individuals affected by suicide and local agencies that there is a need for:
    - better support for those bereaved or affected by suicide
    - clearer guidance where to seek help and advice for people who are worried that someone they know might be at risk of suicide, or are presented with somebody threatening suicide
    - improved information sharing across the pathway of care for people at risk of suicide
    - improvements to training for GPs and other health professionals to identify and manage those at risk of suicide

In developing recommendations and action plans for each priority area within the strategy, evidence and information is drawn from national guidance and publications on what is effective in preventing suicide. An emphasis is placed on local needs assessments and intelligence gathered from coroner data. Consultation is made with service users and other organisations or groups including British Transport Police, Probation services, Drug and Alcohol services, Public Health England and Cambridge University Student welfare officers to identify groups at higher risk of suicide and gaps in service provision.

Implementation of the recommendations and action plan are managed by a joint Cambridgeshire and Peterborough Suicide Prevention Implementation Group. Multi-agency working across all sectors, from NHS and mental health professionals to voluntary organisations, will be encouraged in order to utilise expertise from these organisations to implement the proposed initiatives. Continuing engagement with service users and their carers is expected for the successful development, implementation and delivery of initiatives in each priority area. It is envisaged that working groups will be established to address priority areas or particular recommendations and these will report to the joint implementation group. The joint implementation group will be accountable for delivering the strategy and will report progress on a regular basis as part of governance procedures to the Joint Safeguarding Executive and the Health and Wellbeing Boards in Peterborough and Cambridgeshire.

2.1 Outcomes of the implementation of the suicide prevention strategy 2014-2017

The table below lists the progress made to date as a result of the suicide prevention strategy, implementation plan and partnership working since 2014.

Table 3 – Summary of progress of the suicide prevention strategy 2014-2017

Priority area 1 – Reduce the risk of suicide in high risk groups

Suicide Prevention Training

Applied Suicide Intervention Skills Training (ASIST) Training

- Three ASIST trainers trained
- ASIST Courses delivered across Cambridgeshire and Peterborough targeting 'Gate Keeper' roles including those working with migrant communities and bereavement support workers.
- An ASIST course was funded and delivered to peer support workers in Peterborough prison.
- 258 people trained in ASIST between October 2015 and January 2017

Bespoke stop suicide training - Locally developed ½ day STOP suicide course has been developed and delivered. 21 STOP suicide workshops have been delivered reaching 236 people (From Oct 2015 to Jan 2017). These have included sessions with the following:

- CAB
- Three Homeless Charities
- Oasis Community Centre (East European migrants)
- NCS Programme (Peterborough)
- UNISON
- Junior Drs
- Carers Trust
- Cruse
- Colleges (Impington, Homerton, Huntingdon, Ely, Peterborough)

Courses are also offered to the **emergency services** as part of MIND's **Blue Light Activity**.

GP Training in suicide prevention

Funding has been secured through the STP for training of GPs across Cambridgeshire and Peterborough in suicide prevention, which will focus on the patient/GP interaction, risk identification, compassion and empathy as well as safety plans and follow-through care. Training will be implemented from the Autumn 2017

Suicide prevention resources

Since October 2015 the STOP suicide Campaign Makers, partners and other local organisations have helped us to distribute resources to at least 70 different locations across Fenland, Peterborough, Melbourn, Cambridge i.e. pubs, leisure/sport centres, community centres, local shops.

The Blue Light Programme team have also been giving out leaflets to emergency services across Cambs and Peterborough.

In addition, Great Northern agreed to display STOP Suicide resources at its key railway stations from end of July 2016 onwards

A website aimed at promoting mental health in children and young people has been developed – 'Keep Your Head' www.keep-your-head.com This includes a page designed with, and for, GPs. Crisis information and suicide and self-harm information. Wide promotion of this resource has taken place and is continuing.

A directory of Services App (MyHealth App) for the public and a professional directory of services App (Midos) are being developed. These will be available along with the directory of services produced by Lifecraft via 'Keep Your Head'.

The development of an adult version of the 'Keep Your Head' website has been agreed with funding secured from the 'Better Care Fund'. This will be developed from September 2017 with partner organisations and the Service User Network working together to create content.

Awareness raising in suicide prevention

Stop suicide website and pledge

As of January 2017 there were 1,220 personal pledges and 51 organisational pledges for STOP Suicide. In addition, STOP Suicide had 1,343 twitter followers and 394 facebook fans. The STOP suicide website has had 17,598 visitors and 45,047 page views. Approximately **3000** one to one conversations with individuals around the subjects of mental health and suicide since September 2015. The campaign has recruited a total of **10** new Campaign Makers - four in Peterborough, five in Cambridge and one in St Neots.

Promoting suicide prevention across the county:

- 'No Shame In Talking' video on **ITV News Anglia** – Fixers, 5 October 2016 http://www.fixers.org.uk/index.php?module_instance_id=11312&core_alternate_io_han

dler=view_fixer_news_video&data_ref_id=14785&news_data_ref_id=14784&video_no=1 – talk about STOP Suicide

- 'Health Secretary Jeremy Hunt visits Cambridge's 'groundbreaking' mental health services' – **Cambridge News**, 28 October 2016 http://www.cambridge-news.co.uk/news/health/health-secretary-jeremy-hunt-visits-12095230
- **CRC radio** interview – talk about current campaigns, 2 December 2016
- 'Cambridgeshire dad welcomes Theresa May's pledge to 'transform' attitudes to mental health' – **Cambridge News**, 10 January 2017 http://www.cambridge-news.co.uk/news/cambridge-news/cambridgeshire-dad-welcomes-theresa-mays-12431838
- 'Crisis cafes and community clinics among plans to improve mental health services in Cambridgeshire' – **Ely Standard**, 11 Jan 2017 http://www.cambstimes.co.uk/news/crisis_cafes_and_community_clinics_among_plans_to_improve_mental_health_services_in_cambridgeshire_1_4844482
- **Promotion of suicide prevention awareness to coincide with suicide prevention day on September 10th 2016 via a discussion hosted by radio Cambridgeshire**

Develop Integrated services for those at risk of suicide

Vanguard/Crisis Care Concordat work has been successful at creating an integrated mental health team with mental health nurses based in the police control room.

A First Response service (FRS)with crisis telephone number (111 option 2) was established in September 2016 to help prevent people with mental health crisis going to A&E and being admitted or sectioned under section 136 of the mental health act. In addition non health places of safety (sanctuaries) have been established in Peterborough, Cambridge and Huntingdon for people in mental health crisis to access via the FRS. This service has been shortlisted for the Positive Practice in Mental Health Awards in the 'Crisis and Acute Services' category. In addition, the FRS and Sanctuaries have been evaluated by the 'Service User Network' (SUN) against it's 'five values' of Empathy, Honesty, Inclusion, Personalisation and Working Together and have awarded the FRS 3 stars (good rating) and Sanctuaries 4 stars (outstanding).

Data sharing - Information Sharing Agreements are in place across organisations to support the Frequent Attenders CQUIN, in addition to MH and Acute Trusts this includes 111, ambulance service, substance misuse, primary care (Work carried out through the Crisis Care Concordat).

PRISM (enhanced primary care) service for people with mental health problems is in place for many areas across Cambridgeshire. This provides access to support and care for people struggling with mental illness through referral via the GP or through 'step down' from secondary care. The PRISM service is proving effective at reducing referrals to secondary care as people are managed in the community.

Lifeline – continues to offer a free, confidential and anonymous telephone helpline service that is available from 7.00pm – 11.00pm 365 days of the year for Cambridgeshire residents. The

Line provides listening support and information to someone experiencing mental distress or to those supporting someone in distress. Lifeline is hosted by Lifecraft in Cambridge.

Priority area 2 – Tailor approaches to improve mental health in specific groups

Anti-stigma work and mental health promotion targeting specific groups at higher risk

Funding to deliver courses to bar staff in Fenland as well as scoping work to assess feasibility of training barbers/hair dressers. A need for mental health awareness and suicide prevention for men working in the construction industry has been identified (through national data and suicide surveillance) and will be a focus for the anti-stigma/suicide prevention work commissioned from CPSL MIND

Other public engagement events through the 'anti-stigma work:

- Mental Health crisis support for young people event, Cambourne – 22 Sept
- Shelf Help launch, Huntingdon library – 28 Sept
- World Mental Health Day stand at South Cambs Council – 10 Oct
- CCG Development Day stand – 13 October 2016
- HRC Freshers' Fair – 20 October 2016
- Meeting a group of potential Campaign Makers, Wilbrahams Memorial Hall – 1 November
- Hunts Forum AGM stand – 10 November 2016
- Young people's follow up event, Cambourne – 23 November 2016
- Meeting with Cambs Football Association – 12 Jan 2017
- TASC meeting, London – 13 Jan 2017

Children young people anti stigma/bullying in schools

Between October 2015 and January 2017 CPSL Mind have engaged approximately 555 young people via workshops at Hills Road Sixth Form College, Kimbolton School, College of West Anglia, Milton, Oliver Cromwell College, Chatteris, Thomas Clarkson Academy, Wisbech and Ramsey College. Centre 33 have also been delivering mental health awareness sessions in schools. Between September 2016 - March 2017 mental health awareness sessions had taken place in 11 with sessions booked for a further 7 other schools. Across the 11 schools a total of 821 students engaged in the workshops. These sessions aim to challenge stigma and build understanding of mental health.

The Stress LESS campaign launched in April 2016, aiming to support young people to manage stress through the exam period. A range of resources were produced with over 6,500 being downloaded and 2,695 website page views. Over 130 Stress LESS Action plans were made to encourage people to 'Take 5' when revising.

Alongside the campaign a range of workshops are being run to enable school staff to deliver 'Stress LESS' sessions within their schools with pupils. As of Spring 2017 over 21 schools had been involved in this training and a further 90 individuals were being trained over the summer term. These workshops have been expanded to include information on how to respond to a young person in distress (including discussion around self-harm and suicide).

Within schools that engage in the Stress LESS workshops, small grants are available to pupils who have ideas they would like to develop to support the wellbeing of other students. These ideas are taken forward by 'Stress LESS' champions in schools.

A range of training is provided by CPFT to upskill the children and young people's workforce, this includes specific training courses on areas such as responding to self-harm as well as a 14 day CAMH foundation course. There is also tailored training for schools which includes the whole school briefing which offers an introduction to mental health with a focus on the ethos and culture around mental health in schools. Since 2015 there have been 49 schools that have held a whole school briefing, which equates to 1,616 staff.

Tackling self-harm in young people

A self-harm conference was held in 2015 in Cambridgeshire for professionals and locally a guide to 'understanding and responding to self-harm' has been produced and is freely available (download via the Keep Your Head website http://www.keep-your-head.com/CP-MHS/need-help-now/suicide-and-self-harm-support). A self-harm support group for parents has been run by PinPoint with support from local authority teams.

A range of training is provided by CPFT aimed at upskilling the children and young people's workforce in terms of mental health. Self-harm is covered within a number of courses, including specific training on responding to self-harm. This training is free to access for many professionals.

Community based youth counselling services are run across Cambridgeshire and Peterborough, with a bereavement service offered in Cambridgeshire also. These services offer face-to-face counselling and support to young people. The Kooth online counselling service for young people was commissioned in September 2016 to broaden the mental health support available for young people.

Early interventions to prevent suicide

GP training

Funding obtained through STP for suicide prevention training for GPs. Funding is supplemented by CCC Public mental health budget. A bespoke GP training package will be designed and implemented hoping to cover 20-30% of GPs or practices within the next twelve months (from September 2017) – see priority area 1. The training will help to improve GP recognition and management of mental illness and use early intervention techniques to prevent escalation to mental health crisis.

Money management/debt advice - debt prevention work is being funded with care leavers to improve money management skills and ensure vulnerable young people know where to access support if in financial trouble. A contract has also been awarded to support debt prevention and money management support to those with a severe mental illnesses in Cambridgeshire. Both of these pilot projects will be evaluated with a view to expanding provision in the future if successful.

Preventative work in schools (please see priority 2 for further details of training for school staff and mental health awareness sessions with pupils).

In 2017/18 training is being offered to schools staff to develop peer mediation skills. This work aims to support anti-bullying work locally. In addition a range of anti-bullying resources have been developed locally by the PSHE service working together with schools in Cambridgeshire. http://www5.cambridgeshire.gov.uk/learntogether/homepage/352/anti_bullying/

Drop in services for young people in Huntingdon and Peterborough and Cambridge as part of Centre 33 and local authority partnerships. Delivering broad support as well as counselling.

Priority area 3 – Reduce access to the means of suicide

Car park barriers

The 2014-2017 strategy identified a need to reduce access to the means of suicide in Peterborough carparks. There had been a number of suicides from Queensgate car park and incidences of suicide at Northminster car park, both close to the city centre. There is strong evidence for reducing access to the means of suicide in preventing suicide, particularly barriers at sights where suicide has been frequent.

The suicide prevention implementation group along with other parties including the coroner in Peterborough were successful in working with the owners of the Queensgate car parks to reach a decision to erect barriers on all the car parks they operate in the city centre.

Car park barrier construction began in 2015 and was completed in 2017. Following this, barriers have been erected at Northminster car park in Peterborough. There have been no suicides from car parks in Peterborough since the start of the barrier construction.

Suicide prevention on Railways

A range of work is being undertaken nationally as part of the railway Suicide Prevention plan – Samaritans, Network Rail and British Transport Police.

-Samaritans/Network Rail campaign on the railway including printed messages on tickets and posters at stations.

Some local stations are also displaying STOP Suicide resources.

-Staff training has been provided to railway employees to look out for and offer support to people who may be considering taking their own life on the railway (provided by Network Rail nationally).

-Rail505 app – enables other passengers/anybody to report someone they are worried about or to seek help themselves on the railway. https://www.rail505.com/

Safer medicines management

Following Child Death Overview Panel reports there was a communication to GPs regarding safe prescribing to young people, this was also re-circulated.

Priority area 4 – Provide better information and support to those bereaved or affected by suicide

Bereavement support - access to the 'help is at hand' leaflet for people bereaved as a result of suicide:

- Help is at hand booklet shared with Coroners Office (Feb15) and electronically shared with Funeral directors. Information on 'help is at hand' circulated via the GP bulletin in 2015 and 2017.
- Help is at Hand booklets circulated to all GP practices in Cambridgeshire and Peterborough with instructions on how to re-order them.

Establishing a bereavement support service for people affected by suicide

STP Funding was granted in July 2017 to set up a reactive support service for people who have been bereaved as a result of suicide. The service will be managed by a family liaison officer who will offer support to families in the first weeks after bereavement. They will also signpost people to follow-up services and peer support groups. Part of this work will be to set-up SOBS (Survivors of bereavement due to suicide) groups in Cambridge and Peterborough and connect with CRUSE counselling services.

Bereavement support resources

Bereavement support resources are promoted via the Stop Suicide Pledge website and Keep Your Head website. These resources include specific sites for young people who are bereaved.

Priority area 5 - Support the media in delivering sensitive approaches to suicide and suicidal behavior

Communication with Cambridge News on the responsible reporting of suicide, including information advice created by The Samaritans – this was initiated after a suspected suicide incident was poorly reported by the Cambridge News. CCC Coms team have been involved in this work.

Two visits were made to Radio Cambridgeshire to promote the responsible reporting of suicides. Guidelines on suicide reporting were provided to the editor.

Support research, data collection and monitoring

Surveillance: suicide audit

An annual suicide audit was undertaken in 2015 (of deaths in 2014) and 2016 (of deaths in 2015) The audits have helped to shape targeting of local work. The audit will continue to be undertaken annually, with a detailed case review of a sample of files.

Work has been carried out together with the Coroner's Office to improve the standardised regular information received on deaths throughout the year. The quality of the information received has improved.

Surveillance from British Transport Police

Data is received from BTP through an annual report and a warning system (national system).

Local, real-time surveillance system

A local real-time surveillance system has been established – This shares information from Police/Coroner to Public health on suspected suicides as they occur. This information is essential to establish a bereavement support service

The Coroner flags any notable patterns with the group or public health. The surveillance system will also help to identify any concerns in terms of geographic/temporal patterns/clusters.

Suicide rates C&P

The suicide audit for 2014 showed 65 deaths as a result of suicide or unexplained deaths in Cambridgeshire and Peterborough. A similar audit of suicides for 2015 showed there were 66 deaths.

3. NATIONAL CONTEXT

This section reviews and reflects upon nationally available data on suicides in order to place local information on suicides in context. With national reference points that include rates, trends, risk factors, suicide methods and evidence of what works to prevent suicides, a local approach for suicide prevention can be developed. This section summarises key findings from national data on suicides and is intended to be used as a guide to draw comparisons with local data and information presented in section 5.

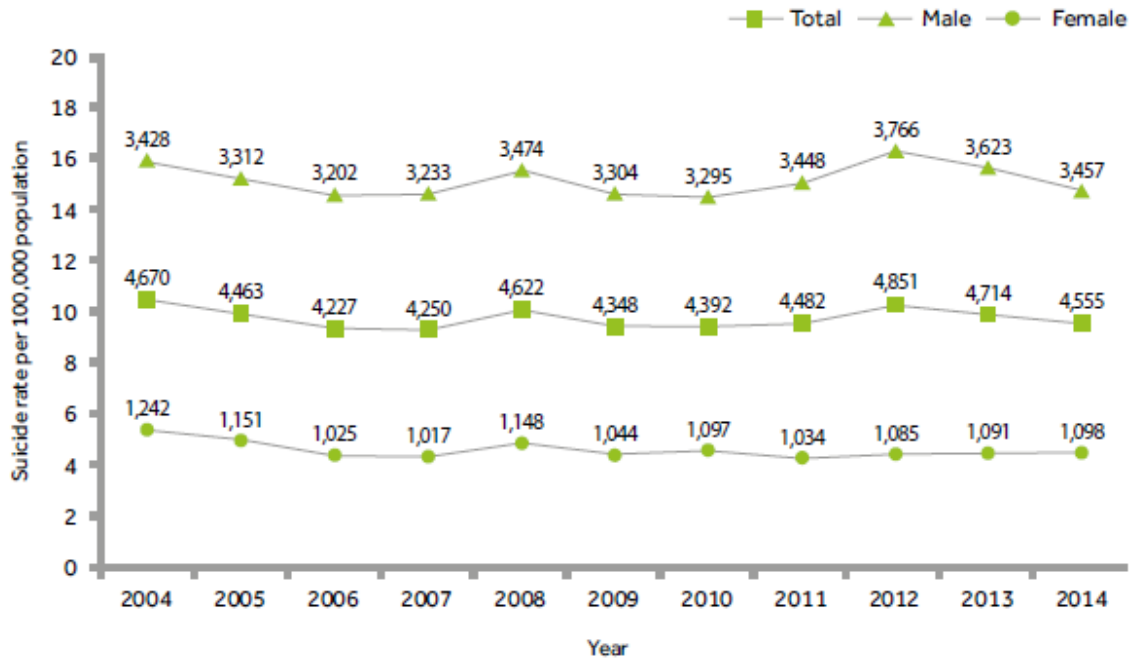
Suicide is defined in England and Wales as a death with an underlying cause of intentional self-Harm and/or an injury/poisoning of undetermined intent (ICD10 codes X60-X84 - all ages and Y10-Y34 – for ages over 15 years). It is assumed that most injuries or poisonings of undetermined intent are self-inflicted, but there is insufficient evidence to prove that the person intended to take their own life. This assumption however cannot be applied to children due to the possibility that these deaths were caused by other situations – neglect or abuse for example. For this reason, data on suicides in England only include persons aged 15 years and over for deaths from injury of undetermined intent and may under-report deaths as a result of suicide in children.

3.1 Suicide rates and Trends

Data from the Office for National Statistics (ONS) The pattern of suicide since 2004 is a continued fall from previous years, reaching a historical low in 2006 and 2007, a rise in 2008 and 2012, with intervening years being lower, influenced by under-recording of “narrative” verdicts. Suicide rates

have reduced since the peak in 2012. Suicide rates are volatile from year to year and are influenced by and reflect social and economic circumstances. Periods of high unemployment or severe economic problems have had an adverse effect on the mental health of the population and have been associated with higher rates of suicide.

Figure 1 – Rates of suicide in the general population in England, by gender.
Number of suicides included on the figure



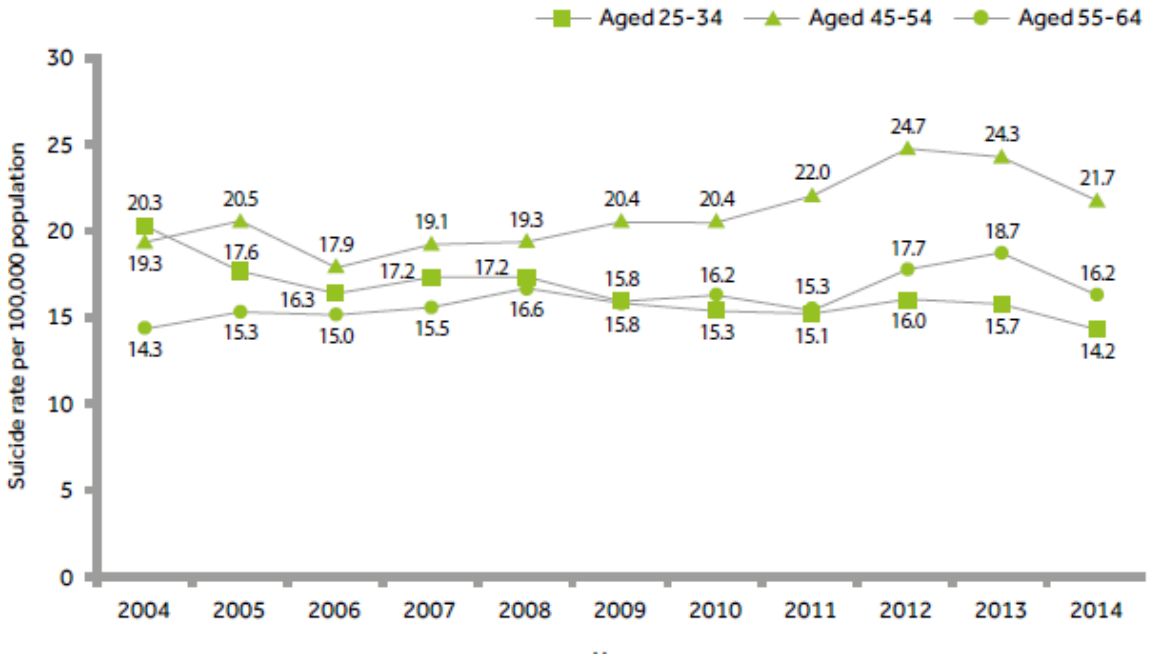
Source: National Confidential Enquiry into Suicide and homicide by people with Mental Health illness – Annual report 2016[8]

3.2 Suicides by sex and age

Suicide in males is currently about three times the rate of suicide in females across all ages in England. Of the total number of suicides in 2014, 3,457 were males and 1,098 were females.

Suicide occurs at all ages, however since 2006 the suicide rate was highest in men between the ages of 45 and 54 years and has increased by 27%. In contrast, the suicide rate in younger men, aged 25-34 has fallen since 2004 by 30% (figure 2). Middle-aged men are recognised as a one of the high-risk groups and should be a focus for suicide prevention strategies. Suicide rates fell in women aged 25-34 and rose in women aged 55-64 years.

Figure 2 – Male suicide rates in the general population in England in those aged 25-34, 45-54 and 55-64



Source: National Confidential Enquiry into Suicide and homicide by people with Mental Health illness – Annual report 2016[8]

3.3 Methods of suicide

National data from the 'National Confidential Inquiry into Suicide and homicide by people with Mental Illness" – Annual report 2016[8] on methods of suicide over the last decade show that the most common methods of suicide were hanging/strangulation, followed by self-poisoning (overdose) and jumping/multiple injuries - mainly jumping from a height or being struck by a train.

Less frequent methods were drowning, carbon monoxide (CO) poisoning, firearms, and cutting/stabbing.

Between 2001 and 2011, there were changes in method of suicide. Suicide deaths by hanging increased, whilst those by self-poisoning and jumping decreased. Of the less common methods, deaths by drowning, carbon monoxide poisoning, and firearms decreased.

3.4 Suicide Risk factors

Preventing Suicide in England, 2012[1] identifies groups of people at higher risk of suicide as follows:

- young and middle-aged men
- people in the care of mental health services, including inpatients
- people with a history of self-harm
- Physically disabling or painful illnesses including chronic pain
- Alcohol and drug misuse
- Stressful life events:
    - Loss of a job
    - Debt
    - Living alone, or becoming socially excluded or isolated
    - Bereavement
    - Family breakdown and conflict including divorce and family mental health problems
    - Imprisonment
- Specific occupational groups, Low skilled male labourers, particularly construction workers, building and finishing trades - plasterers and painters and decorators. Artistic, media and literary occupations presented higher risk, particularly in females. Health professionals and carers were at increased risk as were primary and nursery school teachers

Middle-aged men are identified as one of the high-risk groups and a priority for suicide prevention. A recent report by the Samaritans suggested that middle-aged men, especially those from poorer socio-economic backgrounds are particularly at risk of suicide due to a combination of factors. These include social and cultural changes (for example, rising female employment and greater solo living) that have particularly impacted on the lives of the cohort of men who are now in mid-life[9]

However, the greatest risk of suicide is found in people known to mental health services and particularly in people during the four week period following discharge from psychiatric hospital care[8,21]. It is important that the strategy focuses on identifying weaknesses in the system of care for people with mental health problems and works towards reducing risk in these groups – See section 9 and 9.9 for details.

4. LOCAL CONTEXT

4.1 Local suicide rates

Analysis of suicide rates at a local level for national purposes, uses pooled data on suicides over three year periods to provide a more consistent format to analyse suicide rates and trends when small numbers are given annually. Standardised rates are used in order to make comparisons with other regions.

4.2 Local suicide rates as measured by Public Health Indicator 4.10

The Public Health Outcomes Framework – 2013-2016[11] sets out the opportunities to improve and protect health across the life course and to reduce inequalities in health. The Outcomes Framework includes the Public Health Indicator 4.10 'Suicide Rate' and reflects the importance to keep the

suicide rate at or below current levels.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216159/dh_132362.pdf

A baseline suicide rate (deaths by suicide and injury of undetermined intent) is set for the period 2009-2011 using pooled three year average data. It is expected that each area will report and compare the suicide rate on a yearly basis based upon pooled three year data.

4.3 Trends in local suicide rates

Data on pooled three-year rates for suicide are published on the Public Health Outcomes Framework website: http://www.phoutcomes.info/ and show current indicators as measured against England rates as well as recent trends in suicide rates. . The suicide rate in Peterborough has decreased steadily since 2010-2012 when the rate was significantly above both the England and East of England rates and is now similar to the England average. The suicide rate in Cambridgeshire has remained similar to or slightly below the England average for the last five time periods. When the data for Cambridgeshire is broken down to smaller local authority areas, all districts have recently had rates of suicide which are similar to the England average, although in the past Cambridge City and Fenland have both had periods of statistically higher suicide rates than average. No data is shown for East Cambridgeshire due to small numbers.

Figure 3 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for PETERBOROUGH compared with England

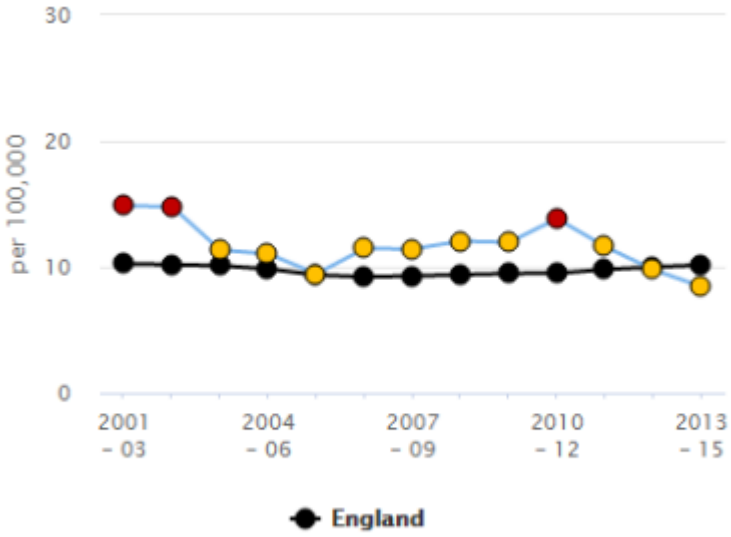


Figure 4 - Peterborough suicide rates (2013 -2015) with nearest CIPFA comparators

4.10 - Suicide rate (Persons) 2013 - 15 — Directly standardised rate - per 100,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	14,429	10.1	10.0	10.3
Bedford	–	12	32	7.5	5.1	10.6
Luton	–	10	40	7.7	5.4	10.6
Peterborough	–	-	42	8.4	6.0	11.5
Milton Keynes	–	3	54	8.6	6.3	11.3
Swindon	–	2	53	9.3	6.9	12.2
Coventry	–	4	83	10.0	7.9	12.5
Derby	–	6	65	10.2	7.8	13.0
Bolton	–	5	78	10.7	8.4	13.4
Telford and Wrekin	–	7	50	11.0	8.1	14.5
Oldham	–	11	63	11.0	8.4	14.1
Rochdale	–	8	62	11.2	8.6	14.4
Thurrock	–	1	47	11.3	8.3	15.1
Medway	–	9	83	11.7	9.3	14.5
Bury	–	15	58	12.0	9.1	15.6
Calderdale	–	13	71	12.9	10.1	16.3
Stockton-on-Tees	–	14	68	13.6	10.5	17.3

Although not significantly lower than the England rates, Peterborough has lower suicide rates than most of the CIPFA comparators for the latest data collection time period (2013-2015). Comparators are chosen as nearest and most similar local authority areas in terms of demographics and socio-economic information.

Figure 5 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for CAMBRIDGESHIRE compared with England

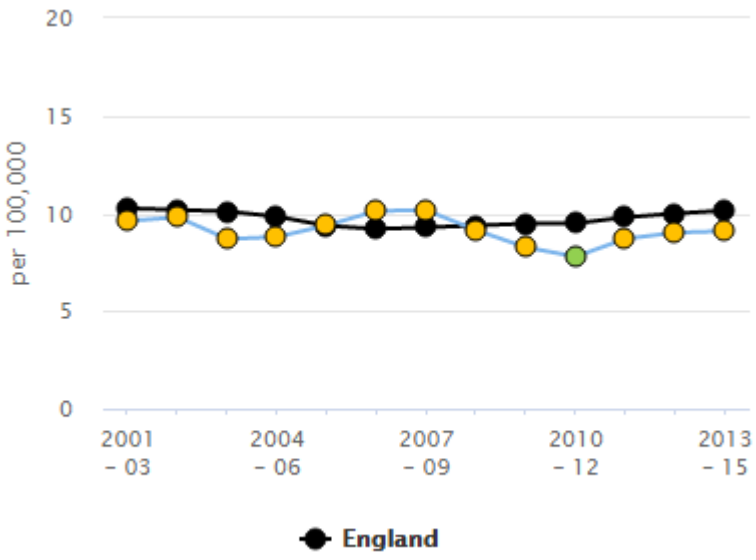


Figure 6 -Cambridgeshire suicide rates with nearest CIPFA comparators

4.10 - Suicide rate (Persons) 2013 - 15 — Directly standardised rate - per 100,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	14,429	10.1	10.0	10.3
Hertfordshire	–	14	197	6.6	5.7	7.6
Buckinghamshire	–	7	113	8.5	7.0	10.2
Hampshire	–	8	313	8.7	7.7	9.7
Cambridgeshire	–	-	155	9.1	7.7	10.6
Suffolk	–	5	181	9.3	8.0	10.8
Leicestershire	–	4	164	9.3	7.9	10.9
Oxfordshire	–	1	164	9.4	8.0	10.9
North Yorkshire	–	13	164	10.0	8.5	11.6
West Sussex	–	15	220	10.1	8.8	11.5
Worcestershire	–	6	152	10.1	8.5	11.8
Staffordshire	–	11	240	10.4	9.1	11.8
Essex	–	12	394	10.4	9.4	11.5
Gloucestershire	–	3	171	10.6	9.0	12.3
Northamptonshire	–	9	197	10.6	9.2	12.2
Somerset	–	10	165	11.6	9.9	13.5
Warwickshire	–	2	175	11.8	10.2	13.7

Source: Public Health England (based on ONS source data)

Although not significantly lower than the England rates, Cambridgeshire has lower suicide rates than most of the CIPFA comparators for the latest data collection time period (2013-2015). Comparators are chosen as nearest and most similar local authority areas in terms of demographics and socio-economic information.

Figure 7 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for CAMBRIDGE CITY compared with England

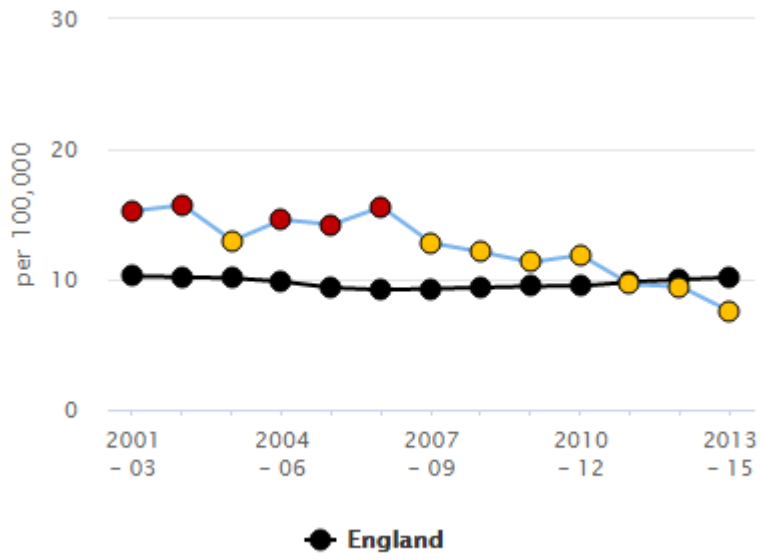


Figure 8 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for FENLAND compared with England

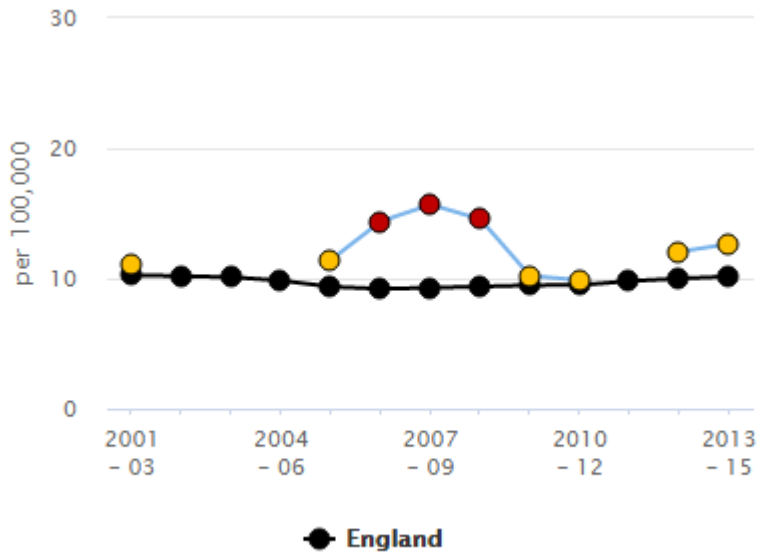


Figure 9 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for HUNTINGDONSHIRE compared with England

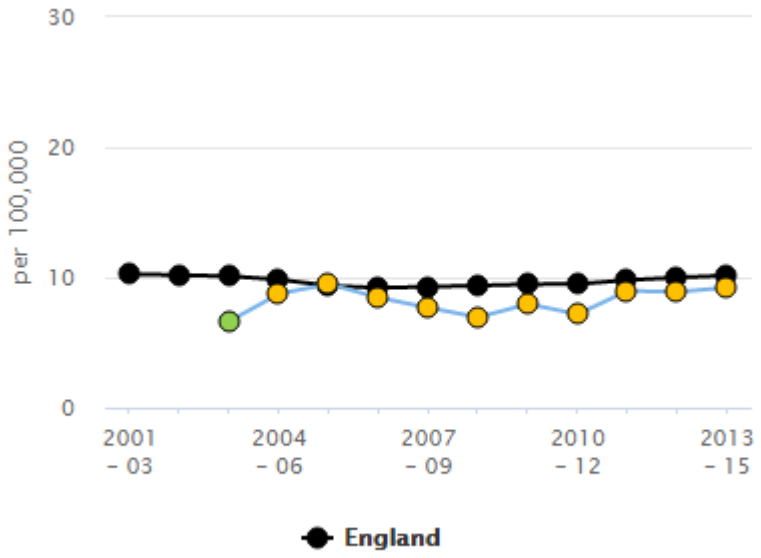
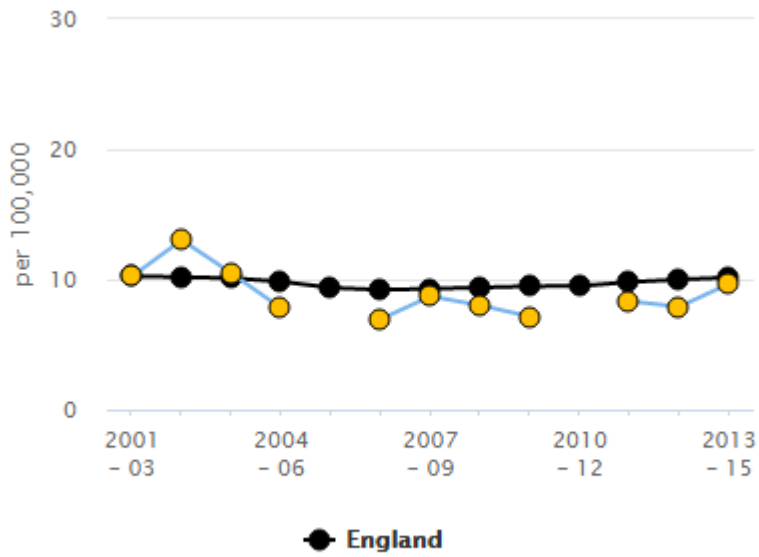


Figure 10 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for SOUTH CAMBRIDGESHIRE compared with England



Source: Figure 10 data is taken from The Public Health Outcomes Framework information on indicator 4.10 – suicide rate. Rates are based upon pooled data for the three year periods shown.

Rates are age- standardised and show the number of deaths per 100,000 population from suicide and injury undetermined - ICD10 codes X60-X84 (all ages) and Y10-Y34 (for ages 15 and over) registered in the respective calendar years, aggregated into quinary age bands (0-4, 5-9,…, 85-89, 90+). Counts of deaths for years up to and including 2010 have been adjusted where needed to take account of the ICD-10 coding change introduced in 2011. The detailed guidance on the implementation is available at http://www.apho.org.uk/resource/item.aspx?RID=126245.

4.4 Local annual suicide audit

A recommendation in the 2014-2017 strategy was to conduct a local suicide audit annually for monitoring purposes and to inform the suicide prevention implementation group of any information about concerns, or risk factors that could help focus the prevention work. Two full local suicide audits have taken place so far – for 2014 and 2015 and an audit of suicides for 2016 is expected to be initiated early in 2018. It is important that the annual audit continues, particularly as interventions are focused as a result of audit findings. This will allow data to be gathered to understand effectiveness of interventions and where gaps and need may present. With 'zero suicide' as an overall ambition, the suicide audit will become embedded in the learning culture as case notes are examined for lessons to be learned on a regular basis.

The local suicide audit for 2014 and 2015 showed there were 65 and 66 suicides and unexplained deaths, respectively for these years in Cambridgeshire and Peterborough.

The main findings from the 2014 and 2015 Suicide audits are summarised below. Due to the sensitive nature of the information, details cannot be published.

In Peterborough there were 19 deaths in 2014 and 18 deaths in 2015 classified as suicide or unexplained. The majority of suicides or unexplained deaths were by males (67%). 63% (2014) and 42% (2015) had current or previous contact with mental health services and 30% in 2015 had contact within six months of death with mental health services.

In 2015, there was a noticeably high number of deaths in under 30 year olds in Peterborough and Eastern European populations were overrepresented.

The 2015 audit results for Cambridgeshire & Peterborough showed:

- In males the highest number of deaths was in under 25 year olds and 50-59 year olds.
- In females the age pattern was more mixed, with highest numbers in 30-39 year olds and 70-74 year olds.
- The highest rate locally was in Peterborough, but Fenland and South Cambridgeshire also have high rates compared to the Cambridgeshire and Peterborough average. None of the areas were statistically significantly above that of Cambridgeshire and Peterborough as a whole though.
- Around 30% had been in contact with mental health services within the 6 months prior to death.
- Where a mental illness diagnosis was recorded in the audit records, almost three-quarters mentioned depression, as well as 29% with recorded anxiety.
- Two thirds of people had been in touch with primary care in 2015 or within a maximum of 6 months prior to death.
- 19 people were found to have physical health problems, including 12 with long term conditions (such as diabetes).
- Alcohol misuse was noted in 9 records and 7 mentioned drugs, such as cannabis, cocaine, amphetamine and crystal meth.
- Bereavement was noted in 10 records.

4.5 CPFT Suicide Audit report 2013/14 and 2014/15 data

In 2015, a comprehensive audit on all suicides and possible suicides reported by the CPFT 'Datix' system during the period 2013/14 and 2014/15 was completed by the Trust. This covered suicides and possible suicides of people who have been in contact with care of secondary mental health within twelve months prior to death.

The audit identified 29 deaths in 13/14 with a 3:1 ratio of men to women. 32 deaths were identified in 14/15 with a 1:1 ratio of men to women. Nationally, there is a 3:1 ration of men to women who have died due to suicide, known to mental health services and therefore the 14/15 CPFT data shows a divergence from the national trend.

For men the highest risk factors in both years were being single, unemployed, living alone and experiencing relationship problems. For women, the highest risk factors were being unemployed,

and/or experiencing relationship problems. Behavioural risk factors included a history of self-harm and previous suicide attempts.

31% (13/14 data) and 25% (14/15 data) had had contact with CPFT within seven days prior to death. In both years, the majority of suicides were *nCPA* (Care Programme Approach) patients (55% in 2013/14 and 59% in 2014/15).

In 2013/14 14% had been referred to CPFT and were awaiting assessment at the time of death, another 14% had been assessed as not requiring CPFT services, and another 14% had been assessed and refused CPFT services. In 2014/15, the proportion was smaller for those who had been referred to CPFT and were awaiting assessment at the time of death or had been assessed as not requiring CPFT services. However, in 2014/15, 41% had been discharged from CPFT at the time of death.

National data has shown an increase in suicides from CRHT services and as of 2013 there were three times as many suicides in CRHT services as in inpatient care in England. CPFT audit data also reflects this national information.

5. NATIONAL AND LOCAL PUBLICATIONS AND GUIDANCE RELEVANT TO SUICIDE PREVENTION

The local suicide prevention strategy must reflect the latest national information, evidence and guidance on improving mental health and preventing suicide for the population. In addition, the suicide prevention strategy must reflect, support and build upon other local strategies that support mental health. This section summarises the latest national and local publications that underpin the suicide prevention strategy.

5.1 No health without Mental Health

Suicide prevention starts with a better understanding of mental health and improving the mental health of populations, particularly those at high risk of mental health problems. No *health without mental health*, published in 2011[10], is the government's mental health strategy. Published alongside this is an implementation framework to set out what local organisations can do to turn the strategy into reality, what national organisations are doing to support this, and how progress will be measured and reported.

5.2 Cambridgeshire and Peterborough CCG Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016[2]

Our local Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age provides detailed information on the commissioning intentions and objectives for the next three years. Four key priority areas are identified and within these, priority objectives are listed. Many of the objectives are relevant to suicide prevention in our local area and are listed in table 2 below – extracted from the Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016[2].

Table 4 – Extract from 'the Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016' showing key priority areas and objectives that are relevant to suicide prevention

Key Commissioning Priority Area	Objectives relevant to suicide prevention
1. Prompt Access to Effective Help	• Introduce a **single-point of access** Advice and Resource Centre (ARC) to local mental health services for referrers, carers and service users CCG-wide. • Seek to expand the range of treatment options available – including self-help, online resources, counselling, etc. for people experiencing **mild-to-moderate** mental health problems that could be effectively helped without the need to access specialist mental health services; • Improve the help and support offered throughout the CCG to **offenders** with mental health problems • Ensure more equal access to voluntary sector services throughout the CCG.
2. The "Recovery" Model.	• Improve support for **Carers** and engagement in care planning of loved ones. • Robust **discharge planning** processes • Ensuring there is access to a specialist community-based **forensic** mental health service for former offenders throughout the CCG. • Improved partnership working between primary care, secondary services, and voluntary organisations to strengthen the local response to people who may be at risk of **suicide** • Ensure that there is appropriate **training** in mental health for key stakeholders such as GPs
3. The Inter-Relationship between Physical Health and Mental Health	• Support the introduction of **Liaison Psychiatry** Services at Hinchingbrooke and Peterborough hospitals. • Ensure people with **Dual Diagnosis** promptly receive the help they need for both their mental health and substance misuse problems
4. Improve Our Commissioning Processes	• Ensure that the services we commission are safe, effective and value-for-money

5.3 Preventing suicide in England[1]

Preventing suicide in England is the national strategy intended to reduce the suicide rate and improve support for those affected by suicide. The strategy builds on the successes of the earlier strategy published in 2002. The overall objective of the strategy is to reduce the suicide rate in the general population in England and to better support for those bereaved or affected by suicide. It sets out key areas for action and brings together knowledge about groups at higher risk as well as effective interventions and resources to support local action.

The main changes from the previous national suicide prevention strategy are the greater prominence of measures to support families - those who are worried that a loved one is at risk and those who are having to cope with the aftermath of a suicide. The strategy also makes more explicit reference to the importance of primary care in preventing suicide and to the need for preventive steps for each age group.

The Six key areas for actions to prevent suicide are listed as follows:

- Reduce risk of suicide in key high risk groups
- Improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

The strategy outlines a range of evidence based local approaches and good practice examples are included to support local implementation. National actions to support these local approaches are also detailed for each of the six areas for action.

The inclusion of suicide as an indicator within the Public Health Outcomes Framework - 4.10[11] will help to track national and local progress against the overall objective to reduce the suicide rate.

5.4 Key findings for England from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016[8]:

This report analyses data on deaths by suicide and undetermined cause in people known to mental health services. Data is compared with that obtained for the general population. Factors leading to or contributing to suicide are analysed and recommendations for service improvements are made as a result of these findings.

The main findings on suicides by people known to mental health services are:

- During 2004-14, 18,172 deaths (28% of suicides in the UK general population) were by people under mental health care
- In the UK in 2014, around 460 patient suicides were recorded - in acute care settings – in-patient and post-discharge care and crisis teams.

[1] http://www.dh.gov.uk/health/files/2012/09/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

- In-patient suicides have continued to fall with a decrease of around 60% during 2004-14. This fall is partly attributed to the removal of ligature points to prevent deaths by hanging but there has been a reduction in suicides on and off the ward by all methods. However, despite this success, there were 62 suicides by in-patients in the England in 2014.
- There are three times as many suicides by patients under the care of the Crisis Resolution Home Treatment service CHRT - in the community, as there are in in-patients.
- Of the patients who died by suicide who were under the care of CRHT services, a third were known by the service for less than one week and a third had recently been discharged from hospital. 43% of those who died by suicide lived alone. The report suggests that CRHT may not be a suitable setting for their care and raise concerns that CRHT has become the default option for acute mental health care because of pressure on other services, particularly beds.
- Suicide risk is high in the first three months post discharge with highest risk during the first two weeks. Deaths are associated with preceding short term admissions and lack of care planning. However, there has been a fall in post-discharge deaths occurring before first service contact, and this points to a recognition of the need for early follow-up.
- Of the patients who died by suicide, over 50% had a history of alcohol or drug misuse.
- Hanging, followed by self poisoning were the most common methods used for suicide in patients. However, jumping from a height or in front of a train was the third most common method . Suicide prevention initiatives by mental health services should consider how to address the physical safety of their local environment
- Economic challenges were seen to have an impact on patient suicide as 13% of patients who died by suicide had experienced serious financial difficulties in the previous 3 months.
- New migrant status is noted in 5% of patient suicides - people who had been living in the UK for less than five years. 20 deaths over a four year period were recorded in people who were seeking permission to stay in the UK

Recommendations made by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016[8]

The following table is taken from the National Confidential Inquiry report and lists recommendations for safer patient care to avoid suicide:

Table 5 – Recommendations by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016[8]

Key elements of safer care in mental health services:

1. Safer wards
   - — Removal of ligature points
   - — Reduced absconding
   - — Skilled in-patient observation
2. Care planning and early follow-up on discharge from hospital to community
3. No 'out of area' admissions for acutely ill patients
4. 24 hour crisis resolution/home treatment teams
5. Community outreach teams to support patients who may lose contact with conventional services
6. Specialised services for alcohol and drug misuse and "dual diagnosis"
7. Multidisciplinary review of patient suicides, with input from family
8. Implementing NICE guidance on depression and self-harm
9. Personalised risk management, without routine checklists
10. Low turnover of non-medical staff

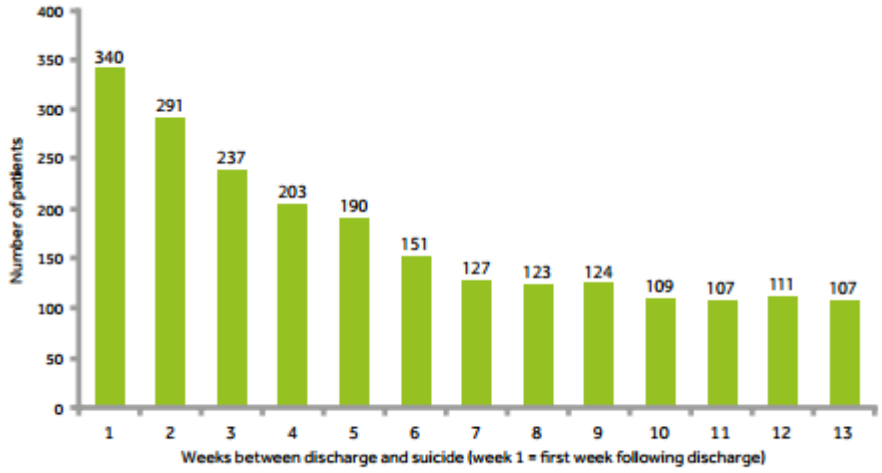
Key elements of safer care in the wider health system:

1. Psychosocial assessment of self-harm patients
2. Safer prescribing of opiates and antidepressants
3. Diagnosis and treatment of mental health problems especially depression in primary care
4. Additional measures for men with mental ill-health, including services online and in non-clinical settings

Source: the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016[8]

The findings above are used to strengthen recommendations for local interventions as part of the action plan that accompanies this strategy.

Figure 11 - Number of patient suicides by week following discharge, England?, 2004-2014



Source: the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016[8]

5.5 Cambridgeshire and Peterborough Emotional well-being and mental health draft strategy for children and young people 2014-2016[6]

The suicide prevention strategy takes account of recommendations made in the Cambridgeshire and Peterborough CCG 'Emotional well-being and mental health strategy for children and young people 2014-2016'. This document recognises that the mental health and wellbeing of children and young

people is everybody's business and by partnership working, more efficient use of resources to provide the right intervention at the right time to the right people will result.

The specific areas for action listed in this draft strategy are:

1. The commissioning of mental health services will be outcome-focussed, maximising the capacity of statutory and voluntary sector organisations
2. Mental health support will be everyone's business, all partners will understand the role they can play and support will be co-ordinated, integrated, evidence based and cost effective.
3. There will be clear pathways of care across agencies, with the right level of expertise and a shared professional knowledge
4. Services will be available for all levels of need, maximising the opportunities for early intervention and prevention, whilst also providing for those with severe and enduring mental health problems
5. Ensure that children and young people's mental health needs are identified early and support is easy to access and prevents problems getting worse
6. Standardised principles of practice will be adopted across all organisations

5.6 Mental Health Crisis Concordat – Improving outcomes for people experiencing mental health crisis – February 2014[12]

The Mental Health Crisis Care Concordat is a national agreement between 22 national bodies involved in the care and support of people in crisis and includes health, policing, social care, housing, local government and the third sector. The concordat sets out how partners will work together to ensure that people receive the help they need when they are in mental health crisis.

The Concordat focuses on four main areas:

- **Access to support before crisis point** – making sure people with mental health problems can access help 24 hours a day and are taken seriously.
- **Urgent and emergency access to crisis care** – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- **Quality of treatment and care when in crisis** – people are treated with dignity and respect, in a therapeutic environment.
- **Recovery and staying well** – preventing future crises by ensuring that people are referred to appropriate services.

Although the Crisis Care Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention. This strategy includes and reflects some of the key messages and recommendations from the concordat, aiming to reinforce a commitment by partners to work together in preventing and managing crises. To this end, members of the suicide prevention strategic group will support the development of the mental health crisis care concordat declaration and action plan to ensure a joined-up approach to effective crisis management and prevention.

5.7 Annual Report of the Chief Medical Officer 2013 – Public Mental Health Priorities: Investing in the Evidence

The report from the Chief Medical officer focuses on epidemiology and the quality of the evidence base for public mental health and includes a chapter on suicide prevention[13]. The report highlights the recent increase in both the suicide and self-harm rates (since 2006/7), and suggests that the economic recession is the most likely cause for the increase. The risk of suicide in the year following self-harm is much greater than that of the general population. In addition, risk of suicide is high in people who are admitted for psychiatric treatment and remains high in the immediate post-discharge period. However, around three quarters of suicides occur in people not known to psychiatric services.

Suicide prevention should be based on evidence of what is effective. To improve safety of mental health services, access to 24 hour crisis services, policies for patients with dual diagnoses (drug/alcohol problems in combination with mental illness) and multidisciplinary reviews after suicide are effective strategies. Suicide prevention in the general population should focus on restricting of access to means of suicide, population approaches to reduce depression and improvements in detecting and managing psychiatric disorders with increased voluntary sector and internet based support. It is also recommended that work is carried out with media and internet providers to ensure responsible reporting of suicide. Self-harm should be followed up with a psychosocial assessment and access to psychological therapy upon discharge and screening for dual diagnoses. Importantly, it is recommended that surveillance should be in place to ensure that information about changes and trends in suicides are identified to enable public health action.

This strategy learns from the recommendations made in the CMO report, and this is reflected in the details contained within the accompanying action plan.

6. LOCAL ACTIVITY TO PREVENT SUICIDE - MAPPING SUICIDE PREVENTION SERVICES PROVIDED IN CAMBRIDGESHIRE AND PETERBOROUGH

It is important to understand the current services and pathways with regard to suicide prevention in order to form a map of available interventions with which to identify any gaps and weaknesses in the system. A summary of the available services is provided in the following sections:

6.1 Services for people with mental health problems

NHS Cambridgeshire and Peterborough CCG currently commissions services for people with mental health problems on a pathway basis from the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). In addition, NHS Cambridgeshire and Peterborough CCG along with Cambridgeshire County Council and Peterborough City Council commission mental health services from a range of local independent and voluntary sector organisations. Some mental health services are commissioned as part of the mental health Crisis care work that includes Police. In addition, there are voluntary sector organisations that provide mental health support in Cambridgeshire and Peterborough with funding outside the statutory sector.

- Cambridgeshire and Peterborough Foundation Trust (CPFT) Locality Teams; Psychosis, Affective Disorders, Assertive Outreach

- **Improving Access to Psychological Therapies (IAPT)** services (through CPFT) – providing psychological or talking therapies for people experiencing common mental health problems. **Group Therapy Centre** (http://www.grouptherapycambridge.org.uk/) in Cambridge and **Oakdale** in Peterborough - commissioned by Cambridge & Peterborough NHS to provide therapy groups for local people experiencing emotional and mental health worries.
- Acute Care Pathway (including crisis resolution and home treatment (CRHT) and Psychiatric Intensive Care Pathway). The acute pathway may include contact with liaison psychiatry services
- **111 (option 2)** mental health crisis telephone line with First Response Service (FRS) support into the community.
- Community **Sanctuaries** (in Cambridge, Peterborough and Huntingdon) for people to be referred to by the FRS if in mental health crisis
- **CAMEO** (NHS service that provides specialised assessment, care and support to young people experiencing a first episode of psychosis)
- **Lifecraft** – a user-led organisation for adults in the Cambridge area who have experience of mental health difficulties in their lives. Lifecraft offers a wide range of free services to help and support its' Members in their wellbeing and recovery. Lifecraft have produced a Mental Health Handbook that serves as a directory of services for people with mental health problems
- **Lifeline** is provided for people in Cambridgeshire and offers telephone support to people experiencing mental health crisis
- Cambridgeshire, Peterborough and South Lincolnshire Mind (**CPSL MIND) -** provide a wide range of services across the county to support those recovering from mental health challenges, promote positive mental health and tackle mental health-related stigma and discrimination within our communities. CPSL MIND also hosts the STOP Suicide campaign and website
- **Talking therapies** are available through 3Ts to 11-17 year olds. This will shortly be changing (1st January 2018) and the service will be expanding to include provision for under 11s in Peterborough. In Peterborough the service will cater for up to 18 year olds, in Cambridgeshire the service will go up to 25 year olds.
- Drop in counselling sessions for children and young people run by **Centre 33**. This is provided on Saturdays 11am -1pm in Cambridge, on Thursdays 2pm-5pm in Wisbech, on Monday 4pm -6pm and Thursday 4pm – 7pm in Ely, on Thursday, 4pm-7pm in Huntingdon and 'Here Now' Drop-in on Fridays, 2-5pm at Central Library, Peterborough
- **Kooth** (www.kooth.com) - an online counselling and emotional well-being platform for children and young people (aged 11-25), accessible through mobile, tablet and desktop. Kooth users have access to trained counsellors available until 10pm, 365 days a year, peer-to-peer support through moderated forums, and a range of self-help materials
- **Keep Your Head website** for children and young people - http://www.keep-your-head.com/ - provides information on mental health and wellbeing, including services that are available as well as self-help guides and professional resources
- **Centre 33** offers a range of support for young people (up to the age of 25) in Cambridgeshire. They can help with a range of issues from housing, to family problems and bullying.

6.2 Independent and Voluntary Sector Services

Voluntary sector organisations play a significant role in local mental health service provision, often for people who may struggle to access the "mainstream" services

- **Cambridge and Peterborough Samaritans** - provide confidential emotional support to people in distress or despair in the local area. Support is provided over the telephone or by email. Cambridge Samaritans in Emmanuel St takes callers at the door from 10am until 10.30pm. Peterborough Samaritans in Lincoln Rd, Millfield takes callers at the door on Mondays (10am - 4pm) and all other days from 7am – 4pm.
- **PINPOINT** (https://www.pinpoint-cambs.org.uk/) offers parent-to-parent support for children with additional needs including mental health problems, particularly around self-harm
- **Choices** in Cambridge - Offers a confidential counselling service in Cambridge and surrounding areas for women and men whose lives are affected by childhood sexual abuse. - https://www.choicescounselling.co.uk/
- **Relate** relationship counselling
- **The Richmond Fellowship -** a specialist employment service providing support for people recovering from mental health problems to find paid employment, voluntary work, education and training or to retain their current employment
- **Rethink Carers -** The Cambridge and the Peterborough and Fenland Groups help the carers of those with severe and enduring psychotic illnesses including schizophrenia
- **Bereavement services – CRUSE bereavement** - provide bereavement support to anyone who needs it. This includes a Cambridge based group specifically for people affected by suicide.

6.2 Gap analysis in suicide prevention service provision – information from the 2014-2017 strategy

Service user feedback is crucial in determining where the gaps in service provision lie for suicide prevention across Cambridgeshire and Peterborough

NHS Cambridgeshire and Peterborough CCG Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016[2] consulted with service users, carers, HealthWatch, GPs and the Patient Experience Team to identify gaps in service provision relevant to suicide prevention as follows:

- Raising awareness and mental health promotion to ensure better access to services, and linking between physical and mental health services. Make the best use of existing campaigns to raise awareness
- Improved information and services for carers
- Improved crisis support
- Prompt access to appropriate services
- Prompt and appropriate response by services – particularly in crisis
- acknowledge the role of carers in supporting people with severe and enduring mental illness

- Commissioners and providers review practice to ensure recipients of mental health support services always have details of who they can contact when in distress 24 hours a day.
- greater emphasis throughout services upon prevention, early intervention, support and self-management
- prompt access for GPs to obtain advice and effective help for patients presenting at surgeries in distress or "crisis"
- partnership working across local service providers (including the voluntary sector) in order that patients receive an integrated and seamless service across all interfaces

These issues were used to inform the suicide prevention implementation plan 2014-2017. Some of the needs are being addressed through workplans initiated in the last few years and details can be found in the implementation plan and summary of suicide prevention work to date. However, many of the needs are still relevant and additional needs are identified through consultation work through the suicide prevention implementation group

- Access to sanctuaries during mental health crisis in all areas of Cambridgeshire, including an unmet need in Fenland
- Better working relationships between and across the statutory services and third sector agencies to ensure sharing of information and timely and appropriate response to those requiring mental health support and crisis resolution
- Faster access to therapy, particularly for those with depression.
- Support for drug and alcohol users with mental health problems who do not meet the threshold for treatment under the dual diagnosis pathway
- Walk in centres – there is a lack of walk in voluntary centres that offer support and help to people at risk of suicide. Cambridge has Lifecraft and Centre 33 (for people aged below 25 years). No similar walk in centres exist in Fenland, Peterborough or Huntingdon.
- Bereavement support services for people bereaved as a result of suicide
- Mental health promotion targeted to men at higher risk of suicide
- Online information for adults with mental health problems – self-help resources and services that are available (similar to the children and Young people's Keep Your Head site)

7. A STRATEGIC LOCAL PARTNERSHIP APPROACH TO SUICIDE PREVENTION IN PETERBOROUGH AND CAMBRIDGESHIRE

In line with National guidelines on preventing suicide, and in recognition that an effective local public health approach is fundamental to suicide prevention**,** a multi-agency local suicide prevention group was established to provide input and recommendations to develop and refresh this strategy. The group is formed from partner organisations and stakeholders and includes representatives from the NHS – GPs and clinical commissioners, public health, mental health trusts, police, coroners and charitable organisations –such as The Samaritans, Lifecraft and CPSL MIND (see section 2 for details). An important aspect to developing a local strategy for suicide prevention will be engagement with 'service users' – those who have been affected by suicide or at risk of suicide. With service user input

and feedback, the strategy should reflect what is needed and what would work to minimise suicide risk in the population.

Note: service user and stakeholder consultations on this strategy and action plan are scheduled for December 2017 and January 2018

8. THE ZERO SUICIDE AMBITION

There has been national and local interest to embrace what is termed as a 'zero suicide initiative'. Zero suicide was conceived through the 'Detroit model' for suicide prevention[15], which has been successful in America - creating a cultural shift in how patients with mental health problems are cared for with the emphasis on an ambition to achieve a zero rate of suicides as a core responsibility of the 'caring' organisations. The core principles and values of the 'Detroit model' are based on six dimensions and ten rules for perfect care:

Table 6 – Six dimensions and ten rules of perfect care according to the 'Detroit Model'

Six Dimensions of Perfect Care	**Ten rules of perfect care**
1. Safe 2. Effective 3. Patient Centred 4. Timely 5. Efficient 6. Equitable	1. Care is relationships 2. Care is customised 3. Care is Patient centred 4. Share knowledge 5. Manage by Fact 6. Make safety a system priority 7. Embrace transparency 8. Anticipate patient needs 9. Continually reduce waste 10. Professionals Cooperate

Nationally, the Zero Suicide Alliance (http://zerosuicidealliance.com/) was launched in November 2017. This focuses on improving support for people contemplating suicide by raising awareness of and promoting FREE suicide prevention training which is accessible to all.

The suicide prevention group has also agreed to endorse the Detroit principle to aim to work towards zero suicides in our local area. This will form the overarching principle for all suicide prevention as outlined in this strategy. Zero suicide requires high level commitment by all partner organisations and support by individuals to drive through the cultural change required to make this a success.

A Workshop in July 2017 consulted key stakeholders on the zero suicide ambition and what this means locally to support the suicide prevention implementation plan. The themes that emerged are presented in the box below.

As Cambridgeshire and Peterborough have already established the 'STOP suicide campaign' , which is now recognised widely across the county and has the support of all major organisations involved

in mental health care, the ambition towards 'zero suicide' will not be viewed as a new initiative but embedded as the core principle for the local strategy and STOP suicide campaign. In addition, the Cambridgeshire and Peterborough suicide prevention implementation group will endorse and promote the national Zero Suicide Alliance initiative through the partnership.

Table 7 – Local goals for the zero suicide ambition

Zero Suicide Ambition – Main goals for implementation locally
Top level (Chief executive) engagement and commitment towards zero suicide for the main organisations involved – CCG, CPFT, PCC, CCC, Police
Improve quality at the organisational level- Engagement with organisational workforce to create a learning culture not a blaming culture. Part of this process will involve reviewing both suicide information and information from people with lived experience to learn lessons and implement good practice.
Improve quality at the individual level – win over 'hearts and minds' for zero suicide so it is at the forefront of peoples' minds during day to day organisational business and becomes part of life.
Review and improve information sharing across agencies involved in the pathway of care of individuals with mental health problems
Strengthen the local STOP suicide campaign and suicide prevention implementation plan with a stronger emphasis on campaigns and initiatives that raise awareness, educate and promote mental health across the population, but with a focus on young people
Promote the Zero Suicide Alliance resources and information including free online training in suicide prevention

9. SUICIDE PREVENTION PLAN

The zero suicide ambition will provide the main thread for suicide prevention and its work will be embedded in all areas within the plan. The suicide prevention plan is divided into six priority areas based upon the national guidance 'Preventing suicide in England, 2012[1]:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behavior
6. Support research, data collection and monitoring.

In tackling each priority area, evidence and information is taken from national guidance and publications on what is effective in preventing suicide, but an emphasis is placed on local needs and information gathered from the suicide audit and stakeholders that identify groups at higher risk of suicide and gaps in service provision. In all areas there will be encouragement of multi-partnership working across all sectors from NHS and mental health professionals to voluntary organisations that

will utilise expertise from these organisations to implement the proposed initiatives. Continuing engagement between the dedicated members of the Cambridgeshire and Peterborough suicide prevention group and service users and their carers is essential for the successful design, development, implementation and delivery of initiatives in each priority area.

The plan includes recommendations from the CPFT zero suicide strategy and cross reference to the Trust's strategy and action plan will be made to ensure a joined up and comprehensive approach to suicide prevention locally.

Each priority area is discussed in detail and recommendations for action are made in the following sections of this strategy document.

10. PRIORITY 1 - REDUCE THE RISK OF SUICIDE IN KEY HIGH-RISK GROUPS

Data presented in 'Preventing suicide in England[1]' identified particular groups at higher risk of suicide – see section 3.4. It is important to compare and contrast the high risk groups identified nationally with local data on suicides as well as local information based upon health and wellbeing needs assessment in order to focus suicide prevention resources appropriately to those in greatest local need.

10.1 Identifying People at higher risk of suicide

The suicide prevention strategic group includes Peterborough and Cambridgeshire coroners who are providing comprehensive local suicide data to the group on a regular basis. Analysis of the local data on suicides has enabled the identification of local suicide risk factors and emerging issues. In particular, men from Eastern European migrant populations – Polish and Lithuanian nationals residing in Peterborough and Fenland regions are emerging as a high risk group for suicide. In addition, unemployment, bereavement, drug or alcohol use are factors that have been recognised through the local suicide audits as potential risk factors. Groups of people, such as middle aged men (particularly those working in building and construction or IT), people in custody, gypsies and travellers and homeless are also identified as at increased risk of mental health issues and suicide.

Cambridge has a higher proportion of students in the population compared with similar sized cities as it is home to both the university of Cambridge and Anglia Ruskin University. Although the risk of suicide in the Cambridge student population has not been established, ONS data has shown a substantial increases in both male and female suicides in the student population from 2007-2011[7]

Based upon the evidence above of people at high risk of suicide both nationally and locally, the following groups of people will form the basis for targeted interventions (table 3):

Table 8 - Groups at high risk of suicide – Cambridgeshire and Peterborough

- New migrants – Polish and Lithuanian people
- People in contact with mental health services – including people recently discharged from psychiatric hospital care
- Unemployed people and those in financial difficulties
- Students
- Middle-aged men
- Gypsies and travellers
- Young offenders
- People in custody
- People who self-harm and have had a history of self-harm
- Alcohol/drug users
- Bereaved people and those bereaved by suicide
- Veterans
- Gay, lesbian, transsexual people
- Children with mental health problems at risk of self-harm

The strategy recognises that individuals may fall into two or more high-risk groups. Conversely, not all individuals in the group will be vulnerable to suicide. Other risk factors, such as loneliness, social circumstances and physical illness, must also be considered within the wider context or risk *Preventing suicide in England, Department of Health, 2012*[1]

10.2 Creating tools and resources to aid suicide prevention in high risk groups

The evidence base for suicide prevention highlights particular interventions that have been shown as effective in reducing risk or raising awareness of suicide. The best suicide prevention strategies use a combination of tools and interventions.

Based on the evidence of what is effective in preventing suicide, the following tips have been developed to aid the development of the suicide prevention strategy:

- Emphasise self-help and provide solutions for self-help
- Emphasise that suicide is preventable - there are preventative actions individuals can take if they are having thoughts of suicide or know others who are at risk of suicide.
- The impact of mental illness and substance abuse as risk factors for suicide can be reduced by access to effective treatments and strengthened social support.
- Don't glorify or romanticize suicide or people who have died by suicide. Vulnerable people, especially young people, may identify with the attention and sympathy garnered by someone who has died by suicide.
- Teach people how to tell if they or someone they know may be thinking of harming themselves and how to protect them from this harm.

10.3 Recommendations to prevent suicide in high risk groups

This strategy reflects what is known from the evidence base on suicide prevention and uses knowledge of local gaps in service provision to make the following recommendations for actions in preventing suicide in high risk groups:

1. Suicide prevention training – for professionals and other front-line workers in contact with vulnerable groups at risk of suicide
2. Develop suicide prevention resources for professionals in contact with vulnerable groups and for self-help
3. Promote awareness raising campaigns to prevent suicide
4. Ensure integrated, appropriate and responsive services to those at risk of suicide
5. Reassess pathways for people known by mental health services at risk of suicide – ensure follow-up provision of care upon discharge from services.
6. Improve pathways and support for offenders and people taken into custody at risk of suicide.

Each of these recommendations for action is discussed in detail below, highlighting how they will reach out to the target groups at high risk of suicide across Cambridgeshire and Peterborough

10.4 Recommendation 1.1 - Suicide Prevention Training

The recommendation is to enable mental health and suicide prevention training throughout Cambridgeshire and Peterborough for professional groups and third sector organisations in regular contact with adults who are at risk of suicide. The training will equip people in recognising the signs and symptoms of mental health problems and suicidal behaviour in people they encounter through the work they do. Moreover, it will give them the skills and confidence to respond appropriately to affected individuals – to support and refer them appropriately.

From 2017 -2020 suicide prevention training will continue after initial funding in 2014 from the Strategic Clinical Network. This helped to set-up the local STOP suicide initiative, that included training. From 2015, funding for suicide prevention training was provided by Cambridgeshire County Council (CCC) with support funding from Peterborough City Council (PCC) to continue the work of the STOP Suicide initiative. MIND in Peterborough and Cambridgeshire with support from Lifecraft in Cambridge deliver the suicide prevention training on behalf of the partnership.

Training in suicide prevention aims to reach beyond “traditional” models of suicide prevention by engaging with a much wider range of agencies, including voluntary organisations and faith groups who are likely to come into contact with the two thirds of suicides who are not in contact with mainstream mental health services.

Suicide prevention training is provided from a recognised and evidence-based source such as ‘Applied Suicide Intervention Skills Training’ **(**ASIST)[16]. ASIST is a two-day suicide prevention course that aims to help both professionals and lay people to become more willing, ready and able to recognise and help persons at risk of suicide. ASIST is intended as ‘suicide first-aid’ training, and is focused on teaching participants to recognise risk and learn how to intervene effectively to reduce the immediate risk of suicide. A study by the London School of Economics estimated the cost-

effectiveness of implementing ASIST training to GPs and concluded that the cost per QALY (Quality Adjusted Life Year) saved was £1,573 – extremely cost effective in terms of medical interventions

A bespoke, half day 'STOP suicide' suicide prevention training course has been developed by MIND and Lifecraft and is offered as an alternative to the two day ASIST training.

In addition, Cambridgeshire County Council continues to support Mental Health First Aid (MHFA)[17] training, in order to promote general mental health awareness in professional groups and organisations likely to be in contact with people with a broad range of mental health needs is recommended.

CPFT also offer suicide prevention training as do Samaritans and free online suicide prevention training is available through the Zero Suicide Alliance.

Suicide prevention training will be targeted to individuals and organisations who are most likely to encounter people at risk of suicide, with priorities given to people working with those with recognised risk locally, for example, Eastern European migrants or men working in the building/construction industry.

In order to create a culture that encourages an understanding and appreciation of the roles and responsibilities of other agencies, suicide prevention training, where possible will be offered to mixed groups of professionals. This would promote partnership working between agencies and deliver consistent messages on suicide prevention across the professional groups. Mixed groups will also facilitate a better understanding of each other's roles and responsibilities when dealing with people in crisis.

GP Training in suicide prevention

Funding has been secured through the STP with some support from CCC and PCC for training of GPs across Cambridgeshire and Peterborough in suicide prevention. GPs are most likely to have contact with people at risk of suicide in many of the 'high risk' categories listed in Table 3.The 2015 audit of suicides and deaths from undetermined intent for Cambridgeshire and Peterborough found that two thirds of people had been in touch with primary care in 2015 or within a maximum of 6 months prior to death. Suicide prevention training for GPs can potentially enable greater identification of those at risk, and earlier referral to evidence based treatment services (Suicide in primary care in England 2002-2011[18]. Training will focus on the patient/GP interaction, risk identification, compassion and empathy as well as safety plans and follow-through care. Training will be implemented from late 2017.

10.5 Recommendation 1.2 - Develop suicide prevention resources for professionals in contact with vulnerable groups and for self-help

Different professional groups and organisations with direct contact with people at risk of suicide will have differing responsibilities towards these people. Often there is a lack of clarity or understanding about what is appropriate in terms of responding to a person who may be suicidal or in signposting that person to sources of self-help. In order to bridge this gap, it is recommended that resources be developed for professional groups and organisations that will act as protocols and provide signposting information in any circumstances where professionals are in contact with people at risk

of suicide. Resources will help to empower organisations with information to help vulnerable people in mental health crisis. Examples of suicide prevention protocols for GPs and for people working for MIND are provided in Appendix 1

A variety of resources and information was developed and collated as a result of the 2014-2017 suicide prevention implementation plan. These included the development and promotion of the STOP suicide initiative, including the STOP suicide website: http://www.stopsuicidepledge.org/. The development of the local 'Keep Your Head' website with resources and information aimed at young people, their carers and professionals: http://www.keep-your-head.com/CP-MHS. Wide promotion of the Crisis (111/2) service has been undertaken by the partnership. The suicide bereavement support leaflet has been distributed via GPs, police, coroners and will be promoted on a regular basis.

There has been support and agreement by partners involved in suicide prevention work to create an adult version of the 'keep your head' website, which will contain information, resources and self-help guides for people experiencing mental health problems or suicidal thoughts. This work will be initiated in the Autumn of 2017, with funding in place to support (through the Better Care Fund).

A directory of services has been produced by Lifecraft in Cambridge and a professional and service user App (MiDos and MyHealth), are being created to contain information about mental health support and services with funding through the Mental Health Delivery Board. These will be promoted through the various websites mentioned above.

An opportunity exists to work with professionals to develop care plans for people known by mental health organisations to ensure up-to-date self-help resources and contact information is included to help prevent escalation of mental health problems into crisis. This can be facilitated through the proposed GP training.

10.6 Recommendation 1.3 – Awareness-raising campaigns and the Cambridgeshire and Peterborough Pledge to reduce suicide

The 2014-2017 suicide prevention strategy recommended the development of a range of awareness raising initiatives and campaigns in collaboration with service users through focus group feedback. Service users representing particular high-risk or hard to reach groups should be sought to ensure resources and advocacy services are developed appropriately. Resources will need to be translated into other languages, including Polish and Lithuanian and be culturally appropriate if they are to reach out to all vulnerable groups.

In addition the development of the 'Cambridgeshire and Peterborough STOP suicide Pledge' to reduce suicide was recommended. The pledge is intended to raise awareness in individuals and organisations about responding to the risk of suicide by encouraging self-help and helping others. Development and roll-out of the 'Peterborough and Cambridgeshire Pledge' to reduce suicide was initially supported by funding from the SCN Pathfinder programme and is now receives continuing support and funding from CCC and PCC.

As of January 2017 there were 1,220 personal pledges and 51 organisational pledges for STOP Suicide. In addition, STOP Suicide had 1,343 twitter followers and 394 facebook fans. The STOP suicide website has had 17,598 visitors and 45,047 page views. Approximately 3000 one to one conversations with individuals around the subjects of mental health and suicide since September 2015. The campaign has recruited a total of 10 new Campaign Makers - four in Peterborough, five in Cambridge and one in St Neots.

The Samaritans run a national campaign 'We're in your corner' that raises awareness of the issue of men and suicide and encourages these men to seek help – see https://www.samaritans.org/media-centre/our-campaigns/were-your-corner. It would be beneficial for local campaigns targeted at reducing suicide in men (such as STOP suicide) work with the Samaritans to share idea and resources in order to maximise benefits.

Continuing support for campaign work and promotion of the STOP suicide pledge is recommended.

It is recommended that awareness-raising will be supported by promotion of 'World Suicide Prevention Day' each year on September 10th and world 'mental health awareness day on October 10th in addition to local initiatives throughout the year.

10.7 Recommendation 1.4 – Aspire to develop integrated, appropriate and responsive services to those at risk of suicide

This work is the backbone to suicide prevention with an aspiration to create a seamless pathway of care that has no cracks for people to fall between. Service improvement and driving up quality of care is the key theme behind the zero suicide ambition. A first step to achieving this is to create a culture of learning across the system. Learning from case reviews of suicides is recommended as a pilot but also learning from people with 'lived experience' to determine what works as well as what has gone wrong.

The last year has seen the implementation of initiatives to improve the pathway of care for people in mental health crisis (through the work of the Crisis Care Concordat partnership). The suicide prevention strategy endorses and continues to support this work:

- Continue support for Integrated Mental Health teams – Mental health nurses in police control rooms
- Continue support for Crisis 111(2), First Response Service and the continuing roll-out of sanctuaries or places of safety in the community for people in mental health crisis to use.
- Ensure suicide prevention initiatives link to Crisis Concordat work and include pathways of care for people pre crisis, during crisis and post crisis
- Develop and expand data sharing agreements and protocols (see recommendation 1.6 below)

A recent audit of drug and alcohol related deaths highlighted the high rate of mental health problems in people who have died as a result of drug and/or alcohol abuse. Likewise, the suicide audit highlighted drug and/or alcohol problems in a proportion of deaths. It is clear that there are gaps in services that do not cater sufficiently for people who do not meet the thresholds for a 'dual diagnosis' of concurrent drug/alcohol abuse and severe mental illness. These may be people who are substance or alcohol users with common mental health disorders such as depression. They may be

treated for their substance use but their mental health needs are overlooked. A recommendation in this strategy is to encourage and facilitate systems that allow engagement with other services where appropriate – particularly with drug and alcohol teams.

Other recommendations in this section include:

- The development of guidance for GPs and primary care – resources, sign posting and self-referral as well as safety plans and links with PRISM
- Develop bereavement support services for those affected by suicide – see Recommendation 4.1
- Improve data sharing between agencies– The Vanguard and Concordat work has required data sharing protocols. Data flow following a bereavement is being reviewed.
- Continue work to map and update pathways and ensure all partners are aware of contacts and resources for self-help as well as pathways and how they operate
- Encourage professionals and organisations to work together in identifying gaps and opportunities in pathways to prevent suicide – particularly at points where services meet when a person is transferred from one service to another

10.8 Recommendation 1. 6 - Reassess pathways for people known by mental health services at risk of suicide

Approximately 30% of people who die as a result of suicide are known to the mental health services. People recently discharged from psychiatric care are the group with the highest risk of suicide, particularly within the first two weeks post discharge[8]. A retrospective case control study showed that 55% of suicides by people known by psychiatric services, died within a week of discharge from a psychiatric unit[21]. The study concluded that factors associated with increased suicide risk during this period included hospitalization of less than 1 week, recent adverse events, older age, and comorbid psychiatric disorders. Factors associated with decreased risk included patients receiving enhanced aftercare. Based on these findings, work should be conducted in partnership with CPFT to identify gaps or weaknesses and areas for improving the care of people upon discharge from psychiatric care.

To assess and improve pathways of care for people known to mental health services, it will be important to work in partnership with CPFT, through the CPFT zero suicide strategy group and the Mental Health Crisis Care Concordat Working group. To this end, the following are recommended:

- Ensure Crisis Concordat work aligns with this priority area. Pathways of care to be assessed include those pre crisis, during crisis and post crisis. Explore models for strong community and joined-up support at locality level for people pre and post crisis as part of the 'Neighbourhood model'.
- Assess pathways to ensure that information is shared across agencies in the patient's best interest
- Assessment of pathways for people who are discharged from psychiatric care. This would include ensuring that careful and effective careplans and follow-up arrangements are in place. Link with PRISM as a 'step down' or 'step up' process in community settings. Ensure that carers, families and significant others are always involved in care planning, including the identification and mitigation of risk.

- Ensure that every CPFT patient has a comprehensive flexible risk management strategy that results from a specific risk focused conversation and that the strategy is consulted, considered and reviewed at every contact.
- Ensure that CPFT patients who's mental state is deteriorating are picked up early and offered objective review and increased support
- Engage with Rethink Carers group – for carers of people with mental health illnesses – understand concerns about pathways of care and provide information to carers in order to support them in their care role for someone at risk of suicide
- Engage with service users to establish the strengths and weaknesses in pathways of care in response to crisis – including a review of the use of Police section 136 and the use of places of safety
- Encourage development of pathways that are comprehensive and organised around the patient – particularly where organisations meet during transition points – acute sector transition into the community, for example
- Enable ongoing support for people with mental health issues and for those people in the community who do not meet the threshold for secondary mental health services – through links with PRISM. CPFT will ensure that it has a pathway for the care of patients with drug and alcohol problems that explicitly manages their risk of suicide and provides them with more not less active treatment

10.9 Recommendation 1.7 - Improve pathways and support for people taken into custody and newly released from custody at risk of suicide.

Prisoners and people taken into custody have been identified as a group with specific requirements due to the nature of the crisis that has increased their risk of suicide. To this end, the following is proposed:

- Liaise with NHS England and Public Health England to work with probation, prison and police staff to understand the screening risk assessment procedure at court and upon reception of prisoners and people taken into custody to include risk of suicide/self-harm.
- In partnership with NHS England, liaise with prison managers to promote the use of prison listeners to prevent suicide.
- Assess pathways of care for people in police custody and working with NHS England, assess pathways of care for people in prisons at risk of suicide. Review self-help advice and information, screening and risk assessment upon reception into custody
- Promote access to the Samaritans in custody suites.
- Continue to support suicide prevention training of prison staff and prison listeners (section 9.4).
- Promote access to support from drug and alcohol services for people in custody with mental health and drug/alcohol problems.
- Assess discharge pathways for people who have been in custody, including a review of care plans for people with mental health problems. Recognise the need to promote joined-up services with an understanding of the roles and responsibilities of other organisations including the probation service.

11 PRIORITY 2 - TAILOR APPROACHES TO IMPROVE MENTAL HEALTH IN SPECIFIC GROUPS

The Preventing Suicide in England strategy identified specific groups of people for whom a tailored approach to their mental health is necessary if their suicide risk is to be reduced:

- children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system
- survivors of abuse or violence, including sexual abuse
- veterans
- people living with long-term physical health conditions
- people with untreated depression;
- people with autism or Asperger's spectrum disorders
- people who are especially vulnerable due to social and economic circumstances
- people who misuse drugs or alcohol
- lesbian, gay, bisexual and transgender people; and
- Black, Asian and minority ethnic groups and asylum seekers.

The Cambridgeshire and Peterborough CCG Commissioning Strategy for Mental Health and Well-being of Adults of Working Age 2013-2016[2] sets out an implementation plan with four themes as follows:

Theme 1 – Easier and prompt access to effective help

This includes a section on addressing the barriers to access to 'main stream' services for marginalised groups

Theme 2 – The Recovery Model

Theme 3 – The inter-relationship between physical health and mental health

Theme 4 – Improve our commissioning processes

The National publication 'No health without mental health' 2011 set out six mental health objectives:

- More people will have good mental health – this included a statement to continue to work to reduce the national suicide rate
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm – includes fewer people self-harming and safeguarding children and young people and vulnerable adults
- Fewer people will experience stigma and discrimination

11.1 Recommendations to improve mental health in specific groups

Recommendation 2.1 Assess pathways of care for children and adults who self-harm

Emergency admissions for self-harm in young people remains a concern in Cambridgeshire and Peterborough with data showing rates of admission above those for England and the East of England. It will be important to work in partnership highlight strengths, gaps and weaknesses within the pathways of care for children and adults who self-harm and identify areas for improvement, particularly with respect to follow-up care for people discharged from services.

- Monitor admissions to the Accident and Emergency departments for self-harm to assess any impact on service developments. Repeat admissions of people who self-harm would be particularly useful to monitor as the strategy should focus on the best interventions to prevent repeat episodes of self-harm
- assess pathways for support for children who are at risk of self-harm , particularly in vulnerable groups of children and young people – youth offenders, children in care, children under the care of people with mental health problems
- Promote the 'Keep Your Head' website for children and young people to professionals including liaison psychiatry to highlight resources and directory of services for self-help and signposting
- Develop an adult version of the 'Keep Your Head'website to contain information about resources, services and self-help guidance for people with mental health problems
- Ensure follow-up care plans are robust for people discharged from services
- Assess plans for people who self-harm if mental health services are not involved. Link this work to the PRISM service (Enhanced primary care service for people with mental health issues).

11.2 Recommendation 2.2 Work with partners who are developing the 'Emotional wellbeing and mental health strategy for children and young people' to promote the following:

- Continue to raise awareness and campaigning around self-harm
- Continue to provide access to self-help resources that focus on building resilience in young people, including the 'Keep Your Head' website
- Continue work that raises awareness and develops resources aimed at preventing bullying and promoting mental wellbeing in schools and colleges- see 'beat bullying' teaching resources – www.beatbullying.org/dox/resources.html
- Support and promote the projects that work with families to address self-harm, for example Pinpoint.
- Develop a 24 hour crisis response for children.

11.3 Recommendation 2.3 – Promote early interventions to aid prevention of mental health problems that could lead to suicide

Prevention interventions to promote good mental health and avoid decline towards suicidal tendencies are essential to this strategy:

- Review access to support in the community before crisis situations arise.
- Work with communities and community liaison teams to raise awareness of sources of help, for example, debt management, relationship counselling, housing organisations parent/children centres

- Promote Information and provide training to health professionals including GPs and health visitors to encourage use of signposting, advice and self-help resources (through the Keep Your Head websites, for example
- Engage with service users and public to understand gaps in service provision and focus efforts on improving the system to support individuals where appropriate
- Review the potential to provide a tangible presence of a mental health drop-in facility in Peterborough city centre

11.4 Recommendation 2.4 - Promote training in Mental Health Awareness

For detailed information – see section 9.4. Continue to roll-out training that promotes mental health awareness and prevention of mental health problems that could lead to suicide. Implementation of bespoke training packages in mental health awareness and suicide prevention began in 2014. This work is continuing to be funded as well as additional training in suicide prevention aimed at GPs. Training for General Practice staff should include awareness around risk assessment for mental health issues by assessing patient histories, particularly around a past history of self-harm.

12 PRIORITY 3 - REDUCE ACCESS TO THE MEANS OF SUICIDE

The 2014-2017 strategy reported that the most common method for suicide was hanging but there was considerable concern about information on deaths as a result of multiple injuries associated with falling from height from car parks in both Peterborough and Cambridge. The strategy made clear recommendations to help address these issues but vigilance is still required and more work can be done as follows:

12.1 Recommendation 3.1 – In line with regulations, ensure the removal of potential ligature points – particularly in places of custody and in-patient settings

Most suicides are the result of hanging. It is therefore important to remove potential ligature points in places likely to have people at high risk of suicide – including places of custody, prisons and hospitals in line with national regulations and guidance -
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/117555/safer-detention-guidance-2012.pdf
http://www.rcpsych.ac.uk/pdf/AIMS-PICU%20Standards%20-%20Second%20Edition%20-%20FINAL%20new%20template.pdf

Regular audit of potential ligature points should continue as good practice in places of safety including psychiatric hospitals and places of custody taking into account recommendations made by coroners.

12.2 Recommendation 3.2 Reduce the risk of suicide by jumping from high buildings accessible by the public including multi-storey car parks

Preventing access to the means of suicide by physical barriers in locations where people may choose to jump is one of the most effective mechanisms for preventing suicide[22,23]. There is no evidence to suggest that people will find an alternative mechanism for suicide if one method is made inaccessible[23]

The suicide prevention implementation group fully endorses the erection of barriers at all multi-

storey car parks in Cambridge and Peterborough to ensure safety by preventing access to any area with a sheer drop that could lead to a suicide attempt. This would make a clear statement and showcase Peterborough and Cambridge as places that take positive steps to prevent suicide.

The suicide prevention implementation group is delighted with progress to date; barriers have been erected on all the Queensgate shopping centre car parks in Peterborough. No deaths have been reported as a result of jumping from car parks since the work began to construct the barriers. In Cambridge, the Queen Anne car park in Cambridge should to be reviewed in terms of protective measures to prevent people from jumping from the building.

Training in suicide prevention has been provided to staff working at both Peterborough and Cambridge shopping centres by the Samaritans. Similar training should be considered for all staff working in the multi-storey car parks in Peterborough and Cambridge.

12.3 Recommendation 3.3 – Reduce the risk of suicide on railway lines

A range of work is being undertaken nationally as part of the railway Suicide Prevention plan – involving Samaritans, Network Rail and British Transport Police. There have also been local initiatives to support this work:

- Samaritans/Network Rail campaign on the railway includes printed messages on tickets and posters at stations. Some local stations are also displaying Stop Suicide resources.
- Staff training has been provided to railway employees to look out for and offer support to people who may be considering taking their own life on the railway (provided by Network Rail nationally).
- The Rail505 app – enables other passengers/anybody to report someone they are worried about or to seek help themselves on the railway. https://www.rail505.com/

Continuing implementation of these initiatives is supported by this strategy

In addition, the annual suicide audit will be used to assess whether there are any 'black spots' for suicide on railway lines locally. An assessment of any requirements for physical barriers should be made at any location with heightened risk of suicide.

12.4 Recommendation 3.4 – Work with Medicines Management team at the CCG to ensure safe prescribing of some toxic drugs

Self-poisoning accounts for about a quarter of deaths by suicide in England and is the second most common method for suicide in men and women. Safe prescribing regulations were introduced in 1998 to limit the size of packs of paracetamol, salicyates and their compounds sold over the counter, supported by guidance on best practice in the sale of pain relief medication (MHRA, 2009[25]).

The National Institute for Health and Clinical Excellence (NICE) will be developing a quality standard on safe prescribing, as part of a library of approximately 170 NHS Quality Standards covering a wide range of diseases and conditions.

The suicide prevention implementation group should work with the CCG Medicines Management team chief pharmacist to ensure that there is a focus on suicide prevention as part of implementation of forthcoming NICE guidance – quality standard on safe prescribing. Further

consideration needs to be given to the prescribing of some toxic drugs, where safer alternative medicines are available[26]

Promotion of suicide prevention through pharmacies and with pharmacists is recommended to raise awareness of suicide risk due to some forms of prescription medication.

12.5 Recommendation 3.5 - Whenever possible, medical professionals should be reinforcing safety plans for individuals with mental health problems

Promote the adoption of personal safety plans for people with mental health illness, or who have previously suffered from mental illness and/or are at risk of suicide as identified by GPs and other health professionals. This includes those who have never been in Secondary Care services.

Personal safety plans are essential as part of the process of care and need to cross over organisational boundaries and be person held. There is an opportunity to promote the use of safety plans with GPs and other health professionals through the suicide prevention training from the autumn of 2017 (funded with STP money). Included in the safety plan is an assessment of access to means of suicide and dialogue should be promoted between the health professional and patient about how to eliminate access to the means of suicide. This should include exploring and adopting best models for reducing hanging in the community.

Educational resources and information for GPs will continue to be disseminated by engagement with GP leads and clinical networks through the CCG.

13 PRIORITY 4 - PROVIDE BETTER INFORMATION AND SUPPORT TO THOSE BEREAVED OR AFFECTED BY SUICIDE

It was recognized in the 2012 Preventing Suicide in England strategy that bereavement by suicide was an area poorly covered by previous suicide prevention strategies.

Public Health England have published a suite of recent guidelines on supporting people after suicide. These highlight the need for change to ensure all suicide prevention strategies include postvention (activities for people bereaved by suicide to support their recovery and prevent adverse outcomes). The guidelines include several case studies of reactive approaches to postvention support as well as information on how to implement and evaluate similar initiatives.
https://www.gov.uk/government/publications/support-after-a-suicide-a-guide-to-providinglocal-services
Locally, no specific bereavement support service exists for people and families who have been affected by suicide. Bereavement is in itself a risk factor for suicide and a conservative estimate is that 10 people are directly affected by each suicide death. Friends and relatives of people who die by suicide have a 1 in 10 risk of making a suicide attempt after their loss. When compared with people bereaved through other causes, those bereaved by suicide are also at an increased risk of psychiatric admission and depression.

There are several bereavement charities and organisations, some of which specialize in helping

those affected by suicide.

- CRUSE – a charity dealing with bereavement in general – supported by the CCG
- Survivors of bereavement by suicide
- Compassionate Friends – a charity dedicated to helping families of children who have died

In addition, The 'Help is at hand' booklet produced by the Department of health[27] is designed for people affected by the loss of a loved one through suicide.

13.1 Recommendations to support those who are bereaved and bereaved as a result of suicide

Recommendation 4.1 Ensure bereavement information and access to support is available to those bereaved by suicide

Funding has been approved through the Systems Transformation Programme (STP) to implement a local, county wide suicide bereavement support service (approved in July 2017). A pathway will be developed so that bereaved individuals will be asked whether they would like to be contacted by a support officer upon initial contact (usually by a police informing the family of the death by suicide of a loved one). If they consent to be contacted, this information will be passed to the family support officer and they will make contact with the family or bereaved individual within the first week after bereavement to offer support and signposting to services (such as CRUSE a charity to help bereaved people) and self-help resources. It may be important to ascertain whether there are any other individuals outside the family context (friends, colleagues for example) who may be affected by the suicide.

The bereavement support service will also help facilitate the setting up of local 'Survivors of Bereavement due to Suicide (SOBS) groups, that will be run as friendship or 'peer support' groups for people affected by suicide.

Information for those bereaved as a result of suicide will continue to be made available through professionals and other organisations in first contact with bereaved people (Police Officers, coroners, GPs, death registration professionals and funeral directors).

- Continue to distribute 'help is at hand' leaflets to these professionals.
- Provide details of local bereavement charities if not included in 'help is at hand' leaflet. A local bereavement support leaflet should be developed to signpost people to locally available services and resources for self-help. This should be provided to individuals who have been affected by suicide.

The families of people who have died as a result of suicide who are known to mental health services may be particularly vulnerable after bereavement. It will be important to review and map the processes in place to ensure that appropriate support is available to families and close contacts after bereavement. Any gaps in the services should be highlighted and recommendations made to improve outcomes.

14 PRIORITY 5 - SUPPORT THE MEDIA IN DELIVERING SENSITIVE APPROACHES TO SUICIDE AND SUICIDAL BEHAVIOR

It is known that the reporting of suicides by the media can promote other suicides – particularly using the same method or at the same location and that responsible reporting of suicide or reduced reporting can decrease suicides at 'hotspot' locations[28].

There are media guidelines on the reporting of suicide from 'The Samaritans'[29] that set out clear instructions and recommendations on what an article should contain when it reports a death by suicide.

14.1 Recommendation 5.1 – Encourage the appropriate and sensitive reporting of suicide

- Ensure all professionals in contact with the media are aware of guidelines for reporting suicide. Some professionals such as coroners and police may be contacted by journalists after a suicide in order to obtain details for an article to report the suicide.
- Continue to work with local media to encourage reference to and use of guidelines for the reporting of suicide. Work with Communications teams within the local authorities to encourage responsible reporting of suicide by the local newspapers.
  Highlight the following:
    - Media guidelines produced by Samaritans
    - Encourage a positive report on the deceased person
    - Do not sensationalise the suicide or suicide method
    - Protect bereaved families from intrusion – press complaints commission
    - Use of language by the media - Avoid referring to suicide in the headline of a story – it is more sensitively reported in the body of the story.
    - Avoid terms such as "successful", "unsuccessful", or "failed".

15 PRIORITY 6 - SUPPORT RESEARCH, DATA COLLECTION AND MONITORING

Suicide prevention relies on information about local suicides to determine who is at risk of suicide and where and how suicides happen locally. This data is important in order to focus resources. It is also important to monitor local suicides and reports of self-harm by assessing up-to-date information. This will enable appropriate response to any changes in rates of suicides and self-harm and will help to understand the impact of implementing the recommendations set out in this strategy.

To this end, the following recommendations are made:

15.1 Recommendation 6.1 Continue to collect detailed suicide data on a quarterly basis and carry out an annual audit of local suicides

Data should continue to be collected from Cambridgeshire and Peterborough coroners and include information on age, sex, nationality, occupation, marital status, contact with mental health services, contact with primary care services and in particular services in two weeks prior to death, place of death, resident address, method of suicide.

A suicide audit will be conducted on an annual basis and used to inform development of initiatives targeted to people at risk locally. The information contained in the audit will also be used as part of the evaluation process for this strategy.

Real-time suicide surveillance has been implemented that sends information on suspected suicides as they occur from police to public health. This enables the suicide prevention implementation group to react if necessary to any concerns, for example linked suicides, or suicide in young people that may affect other young people at school or colleges.

In addition, and as part of the Zero suicide ambition, it is proposed that a sample of suicide case files be reviewed on a quarterly basis to learn lessons and identify preventative actions that could be implemented locally.

All data is held securely by public health analysts as part of the suicide prevention partnership.

In addition to the above, CPFT will ensure they have a comprehensive, clinically rich, searchable data set collating every suicide of a patient in contact with the trust. The data from this database will be freely available to staff, patients and carers and actively used to educate staff patients and carers.

15.2 Recommendation 6.2 Disseminate current evidence on suicide prevention to all partner organisations

As evidence emerges on the best practice interventions and measures to reduce the risk of suicide, there should be a mechanism for ensuring that this is disseminated to all partner organisations working to prevent suicide. This may be facilitated through the suicide prevention group meetings with an assigned person responsible for checking the evidence base on a regular interval.

15.3 Recommendation 6.3 Coroners should notify the Suicide Prevention Strategic Group about inquest evidence that suggests patterns and suicide trends and evidence for service development to prevent future suicides

Coroners are best placed to review and assess evidence during the year as inquests to suicides occur. This may provide opportunities to identify concerns about local suicides – patterns or trends, for which action may be required. In addition, coroners may highlight concerns about services or opportunities to improve services where failings have occurred.

16 EVALUATION – HOW WILL WE KNOW WE ARE MAKING PROGRESS? Recommendation 6.4 - Evaluate and report on the suicide prevention implementation plan

Evaluation is an important component to this strategy and will provide essential information and evidence on what is effective in suicide prevention and what areas require more work or are ineffective.

A set of Key Performance Indicators will be developed to monitor the progress against the strategy and aligned with the suicide prevention implementation plan 2017 - 2020.

Public health outcome indicator 4.10[11] expects suicide rates to be reported annually based on three year rolling average rates for local populations. A baseline has been set as the average rate of

suicides for the period 2009-2011 and this should be used to compare future statistics and the impact of implementing this strategy.

Evaluation should also include surveys of various groups for effectiveness of particular actions or interventions.

- Survey of GPs
- Survey of mental health professionals
- Survey of people trained in suicide prevention
- Survey of service users

Soft data should be used as part of the evaluation – data collected by each implementation sub-group. For example; actions taken, resources disseminated or used and numbers of people reached by the initiative.

16.1 RESOURCES FOR IMPLEMENTING INITIATIVES TO PREVENT SUICIDE AND SUSTAINABILITY

The implementation of the strategy will require a mixture of input and work from partner organisations, cultural and organisational change and funding for the delivery of specific initiatives.

Implementation of the recommendations and action plan will be managed by a joint Cambridgeshire and Peterborough Suicide Prevention Implementation Group. Multi-agency working across all sectors, from NHS and mental health professionals to voluntary organisations, will be encouraged in order to utilise expertise from these organisations to implement the proposed initiatives.

Continuing engagement with service users and their carers is expected for the successful development, implementation and delivery of initiatives in each priority area.

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APPENDIX 1

Examples of Suicide Prevention Protocols for specific professional groups

1. **Suicide Prevention Pathway developed by Peterborough MIND -**Peterborough and Fenland Mind Suicide Protocol

mind for better mental health | Peterborough and Fenland

Who should you call is you are faced with a Suicidal Person (SP)?

Rarely a SP may behave out of control on in a way suggesting harm to themselves or others. If this is the case you should call the Police on 999. See *point 1* if this is the case.

Normally the SP will speak of thoughts or plans of suicide alone and appear distressed. If this is the case see *point 2* for the key questions you need to ask.

Point 1
The police are able to detain someone under the Section 136 of the Mental Health Act if they believe the SP to have a 'mental disorder' and are in need of immediate need of care and control.

They will first remove the SP to a place of safety, preferably a hospital or police station where they will be held until approved by an Approved Mental Health Professional. One or two doctors will also assess the SP for up to 72 hours.

Point 2
If you feel the person is distressed and can be spoken through what they are experiencing you should stay calm, show interest and concern, not show judgement or shock. You should be positive that the right help they can feel better.

You should then encourage them to see their GP as a matter of priority whilst still addressing non-medical concerns. The agreed response you need here is for the person to let you contact their GP. The SP may suggest this is pointless but nevertheless it should be the first port of call unless consent is firmly withheld. If you are given consent see point 4, if you are not see point 3.

Point 3
If the SP refuses for you to get in contact with their GP then you must respect their request for confidentially. You should then offer the SP a 'Feeling on the Edge' leaflet and tell them they can return to you if they decide they want help from the service to access their GP. The expectations to this strict rule are (a) Imminent threat of self- harm, then call the police (b) Vulnerable Adult such as Dementia, Learning Disability or Abused Domestic Violence when a SOVA approach is required.

Point 4
If you are given consent you should then ring the GP and explain to the receptionist who you are, who the SP is and why you are calling. They should use a password (perhaps a Suicide Prevention Alert) and ask to speak to the Duty GP.
The GP will speak to you and they should use their professional judgement and personal knowledge to decide on the best pathway which will often result to a same day appointment. If the GP cannot speak to you immediately then you are to ask for a ring back and an urgent same day appointment for the SP.

If the surgery is uncooperative or unresponsive and you feel they are still carrying the risk then they should log the experience and feedback to the Administrators as a possible Quality Issue and also ring ARC for assistance.

Appendix 1

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