Joint Cambridgeshire and Peterborough Suicide prevention strategy

2014-2017

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Creating a safer Cambridgeshire

Peterborough and Fenland mind for better mental health

NHS Cambridgeshire and Peterborough Clinical Commissioning Group

mind in Cambridgeshire for better mental health

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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
CMET	Clinical and Management Executive Team
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	Strategic Clinical Network
SUN	Service User Network

CONTENTS

1. EXECUTIVE SUMMARY AND KEY RECOMMENDATIONS

The Cambridgeshire and Peterborough suicide prevention strategy supports the National suicide prevention strategy – 'Preventing suicide in England, Dept. of Health 2012'[1]. The key purpose of the strategy 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.

Six priority areas for suicide prevention in Cambridgeshire and Peterborough with recommendations for actions are set out in sections 9-14 of the strategy document and accompanying three year 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** Implement suicide prevention training to professionals and organisations in contact with people at high risk of suicide **1.2** Develop suicide prevention resources for professionals and agencies in contact with vulnerable groups **1.3** Implement awareness raising campaigns and roll-out 'the Cambridgeshire and Peterborough pledge' to reduce suicide **1.4** Ensure access to resources to aid self-help in those at risk of suicide **1.5** Aspire to develop integrated, appropriate and responsive services to those at risk of suicide – including pathways for children and young people as well as adults **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** Assess pathways of care for children and adults who self-harm **2.2** Work with partners who are developing 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 the projects that work with families through the 'BOUNCE' project in Peterborough

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

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

3.3 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 Whenever possible, medical professionals should be reinforcing 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

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

- Provide information to professionals on the sensitive reporting of suicide
- Liaise 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

Recommendations

6.1 Collect detailed suicide data on a quarterly basis from Cambridgeshire and Peterborough coroners. Include data from the Police on suicides and near suicides. Carry out an annual audit of local suicides

6.2 Disseminate current evidence on suicide prevention to all partner organisations

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

6.4 Evaluate and report on the suicide prevention implementation plan

Complementary to the recommendations listed above, the Cambridgeshire and Peterborough Suicide Prevention Strategic Group on behalf of the Clinical Commissioning Group (CCG) was

successful in obtaining funding through the Strategic Clinical Network (SCN) Pathfinder Programme for suicide prevention for one year from April 2014. This funding has facilitated the launch of a local STOP SUICIDE campaign that supports the following initiatives:

1. Assessment of local suicide prevention pathways and development of a suite of professional resources including a pathway map to provide advice on how to respond to a suicidal individual in the community.
2. Provision of suicide prevention training to select groups of professionals and personnel within organisations most likely to be in direct contact with people at high risk of suicide.
3. The development and promotion of the 'Peterborough and Cambridgeshire pledge to prevent suicide'.
4. The development of a website with resources to support the STOP SUICIDE initiative – see www.stopsuicidepledge.org

Details of the SCN Pathfinder programme and STOP SUICIDE campaign are provided in section 16.

2. PURPOSE

This document sets out the strategic priorities and recommendations to prevent suicide in Cambridgeshire and Peterborough between 2014 and 2017. Accompanying this strategy is a three year action plan to be used as a framework by key stakeholders for implementing the recommendations and for measuring and evaluating the 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. Suicides more frequently occur in the younger age group, and account for a larger proportion of years of life lost compared to deaths from other causes. 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, a multi-agency local suicide prevention strategic group was formed to develop the strategy with lead input from public health. Members of the group include the following public and third sector organisations:

- Cambridgeshire County Council
- Peterborough City Council
- Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) - including CCG GP leads for mental health and commissioning support
- Coroners
- Cambridgeshire and Peterborough Foundation Trust
- Service User Engagement Network (SUN)
- Police
- Youth Offender service

- Local Voluntary Organisations – including Lifecraft, MIND, Samaritans, Richmond Fellowship, Rethink Carers among others

Importantly, the strategy is the response to the following recent developments:

- the publication of the document "Preventing suicide in England - a cross-government outcomes strategy to save lives HM Government September 2012"[1]
- the priority identified in the Commissioning Strategy for the Mental Health and Well-being of Adults of Working Age 2013-2016[2] to 'improve partnership working between primary care, secondary services and voluntary organisations to strengthen the local response to people who may be at risk of suicide'
- the feedback consistently received from 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 commit suicide, or are presented with somebody threatening to commit suicide
- The recognition that Peterborough, Cambridge City and Fenland districts have had higher than average suicide rates in some recent years

The suicide prevention strategy will not operate in isolation, but will support and complement other relevant strategies and developments. The strategy takes account of the respective JSNAs for Cambridgeshire and Peterborough[3,4], the local priorities agreed by the respective Health and Well-Being Boards, the suicide prevention strategy developed by CPFT[5], the emotional well-being and mental health strategy for children and young people[6] and our need to respond to key national policies.

Recently, there has been a move to establish the development of a local Mental Health Crisis Concordat Declaration and Action Plan. This work is being led by the Police, but is supported by members of the suicide prevention strategic group. The partnership should ensure that the objectives in the suicide prevention strategy around pathway design before, during and after mental health crisis are reproduced in the Crisis Concordat Action Plan.

The suicide prevention strategy will also be used and referred to during the development of the Cambridgeshire Public Mental Health Strategy and the Cambridgeshire and Peterborough CCG Five Year Mental Health Strategy, both to be developed in 2014/15. Both mental health strategies are being developed by members of the suicide prevention strategic group. The Public Mental Health Strategy will complement the suicide prevention strategy and the CCG Five year Mental Health Strategy will reinforce some of the recommendations made in the suicide prevention strategy, enabling more effective implementation of the action plan, particularly around crisis management and community support for those known by mental health services.

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 will be managed by a joint Cambridgeshire and Peterborough Suicide Prevention Implementation Group from September 2014. 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 an annual basis to the various partner organisations; Peterborough Adult Mental Health Stakeholder Group, Public Health Board and Health and Wellbeing Board in Peterborough, the Health Committee in Cambridgeshire and CMET of the CCG.

3. NATIONAL CONTEXT

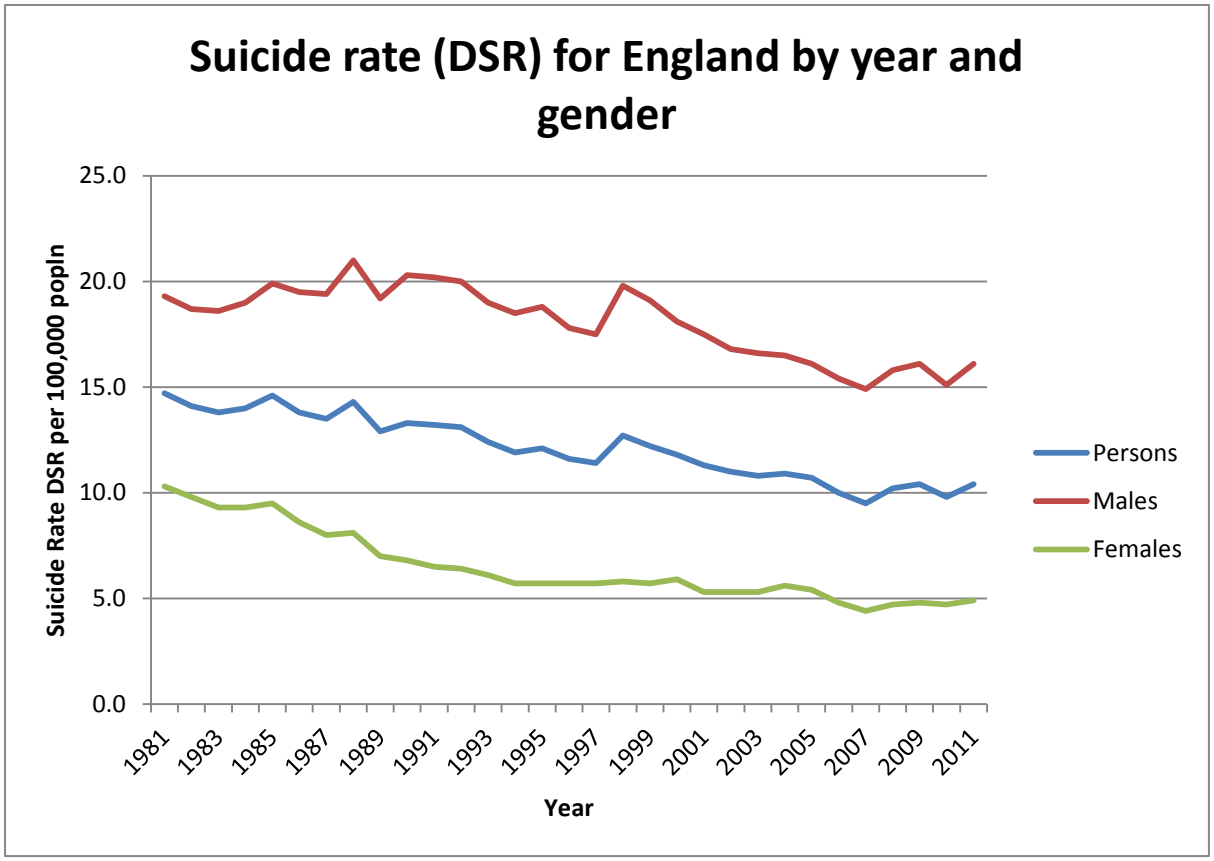
It is important to review and reflect upon nationally available data on suicides in order to place local information on suicides in context. With national reference points that include rates, trends, risk factors, suicide methods and evidence of what works to prevent suicides, a local approach for suicide 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 kill themselves. 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) shows that suicide rates have been declining for most of the last decade until 2008 when they reached a historical low. However, since 2008, suicide rates have increased (Figure 1). However, in 2011 there were 6,045 suicides in the UK and the suicide rate was significantly higher compared with 2010 (11.8 and 11.1 deaths per 100,000 population respectively), and was the highest rate since 2004. This highlights the need to be vigilant. 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 – Directly age-standardised suicide rates by sex and year, England, 1981-2011



DSR – Directly age-standardised rate. ICD10 codes – X60-X84 and Y10-Y34

Source : Office for National Statistics[7]

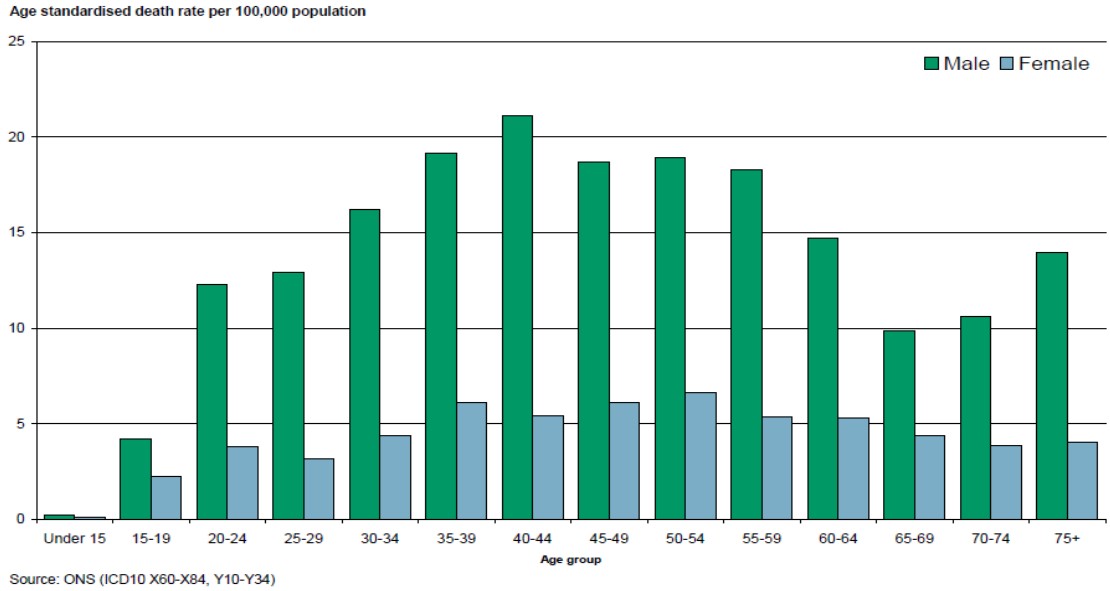
3.2 Suicides by sex and age

Suicide in males is currently about three times the rate of suicide in females across all ages (Figure 2). Of the total number of suicides in 2011, 4,552 were males and 1,493 were females, producing age-standardised suicide rates of 18.2 and 5.6 per 100,000 population for males and females respectively.

Suicide occurs at all ages, however between 2001 and 2011 the suicide rate was highest in men between the ages of 30 and 44 years. In recent years there has been a significant increase in suicides in slightly older men (those aged 45 to 59) and in 2011, middle-aged men are recognised as a one of the high-risk groups and should be a focus for suicide prevention strategies.

The suicide rate in older men (those aged 75 and over) has shown the opposite trend to middle-aged men, as the rate declined between 2004 and 2011. Moreover, those aged 75 and over were the only age group where the suicide rate fell slightly in 2011 (from 14.8 suicides per 100,000 population in 2010 down to 13.8 in 2011).

Figure 2 – Directly age-standardised suicide rates by sex and age group, England, 2011



3.3 Methods of suicide

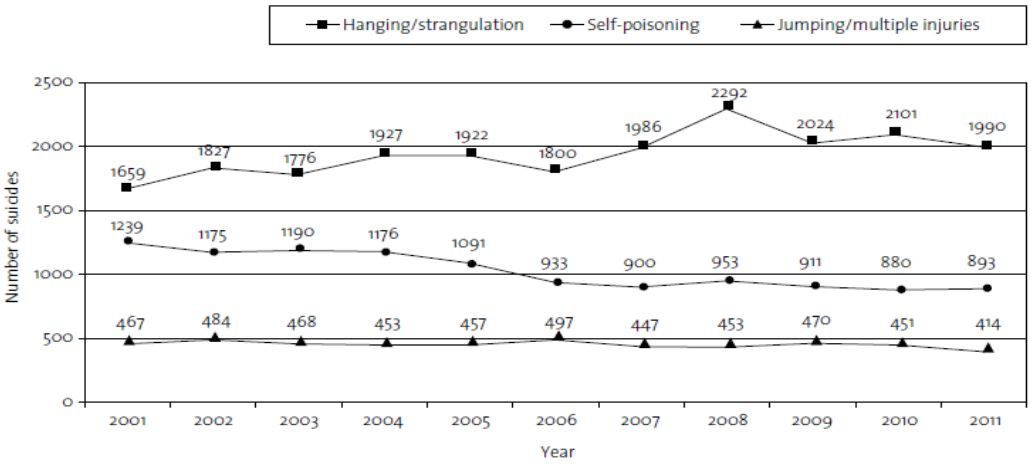
National data from the 'National Confidential Enquiry into Suicide and homicide by people with Mental Health illness – Annual report 2013[8] on methods of suicide over the last decade show that the most common methods of suicide were hanging/strangulation, followed by self-poisoning (overdose) and jumping/multiple injuries - mainly jumping from a height or being struck by a train (Figure 3A).

Less frequent methods were drowning, carbon monoxide (CO) poisoning, firearms, and cutting/stabbing (Figure 3B).

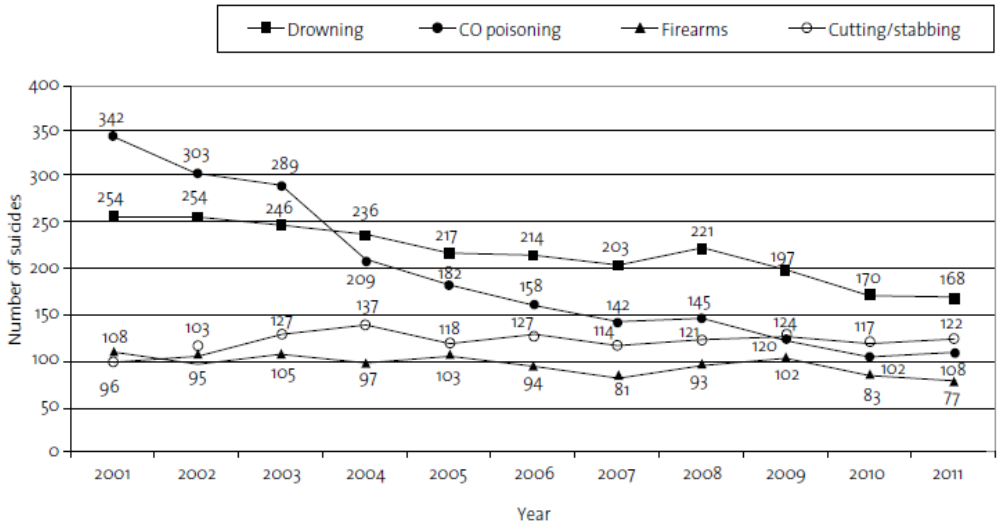
Between 2001 and 2011, there were changes in method of suicide. Suicide deaths by hanging increased, whilst those by self-poisoning and jumping decreased. Of the less common methods, deaths by drowning, carbon monoxide poisoning, and firearms decreased.

Figure 3 – Suicide in the general population by cause of death, England?, 2001-2011

3A. Most common causes of death



3B, Other causes of death



Source: National Confidential Enquiry into Suicide and homicide by people with Mental Health illness – Annual report 2013[8]

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, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

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. 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.

4.1 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.

4.2 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 2 – 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

4.3 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.

4.4 Key findings for England from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, July 2013[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.

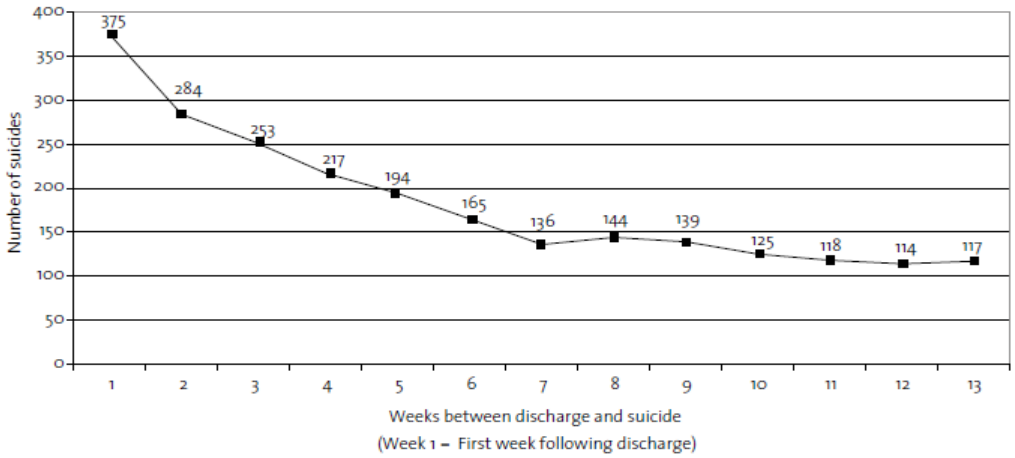
The main findings on suicides by people known to mental health services are:

- During 2001-2011, 13,469 deaths (28% of general population suicides) were identified as patient suicides, i.e. the person had been in contact with mental health services in the 12 months prior to death.
- In-patient suicides show a sustained fall over the last decade

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

- A substantial fall in in-patient suicides following absconding
- Deaths under crisis resolution/home treatment are now more frequent than under in-patient care
- There was an overall increase in the number of suicides under crisis resolution/home treatment services
- A fall in the number of patient suicides following refusal of treatment or care.
- There are few suicides by patients refusing treatment or care while under a community treatment order
- There has been a decrease in the number of patient suicides by overdose of tricyclic antidepressants (attributed to safer prescribing of psychotropic drugs)
- 54% of patient suicides had a history of either alcohol or drug misuse or both, an average of 641 deaths per year.
- 15% of patient suicides had severe mental illness and co-morbid alcohol or drug dependence/misuse (dual diagnosis),
- Post discharge suicides remain a problem, although there has been a drop in the number of suicides post discharge over the last ten years.
- Post-discharge suicides were most frequent in the first week after leaving hospital (Figure 4)
- The most common methods of suicide by patients were hanging, self-poisoning, and jumping/multiple injuries.

Figure 4 - Number of patient suicides by week following discharge, England?, 2001-2011



4.4.1 Recommendations for services based upon the findings from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, July 2013

The following recommendations relevant to suicide prevention in people known to mental health services have been made as a result of the findings by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness:

- maintain services for dual diagnosis patients
- address the economic difficulties of patients who might be at risk of suicide, ensuring they receive advice on debts, housing and employment
- improve safety in crisis resolution/home treatment (CR/HT) as a priority for suicide prevention in mental health care; particular caution is needed with patients who live alone or refuse treatment and when patients are discharged from hospital into CR/HT
- be vigilant about the suicide risk from opiates, currently the main self-poisoning method; clinicians should check patients' access to opiates
- continue the successful safety focus on wards, including measures to prevent absconding and ensure safe detention. Strengthen specialist services and risk management for patients who are misusing alcohol or drugs
- use Community Treatment Orders more effectively to address treatment refusal and loss of contact in patients at risk of suicide
- ensure that all in-patients, including younger in-patients, are included in reviews of physical health and polypharmacy
- introduce or maintain assertive outreach services

4.5 CPFT Suicide Prevention Strategy

Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) have produced a suicide prevention strategy (May 2013-May 2016)[5] and as a partner organisation for the development and delivery of this strategy, findings and recommendations within the CPFT strategy are considered.

The CPFT suicide prevention strategy lists eleven specific key actions based upon the six priority areas identified in the national strategy for suicide prevention[1.] There is much overlap in the eleven key CPFT actions and the recommendations produced in this strategy that will facilitate an on-going working partnership to deliver the aims of both strategies.

4.6 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

4.7 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.

4.8 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.

5. LOCAL CONTEXT

There are around 50 suicides in Cambridgeshire and Peterborough annually although this number fluctuates from year to year making comparisons and analysis difficult to interpret. Pooled data on suicides over three year periods provides a more consistent format to analyse trends when small numbers are involved. Standardised rates are used in order to make comparisons with other regions and over time where population structures may be different.

5.1 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.

5.2 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 data shows that the suicide rate in Peterborough has increased in recent years and for 2010-2012 is significantly above both the England and East of England rates (Figure 5a). By comparison, the suicide rate in Cambridgeshire has dropped in recent years and is below the England average for 2010-2012 (Figure 5B). However, when the data for

Cambridgeshire is broken down to smaller local authority areas, it is evident that there have been higher rates of suicide in both Fenland and Cambridge City in recent years, although the very recent trend is a decrease in suicide rates (Figure 5C). Huntingdonshire, East Cambridgeshire and South Cambridgeshire have lower suicide rates than England averages (data not shown).

Figure 5A – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for Peterborough

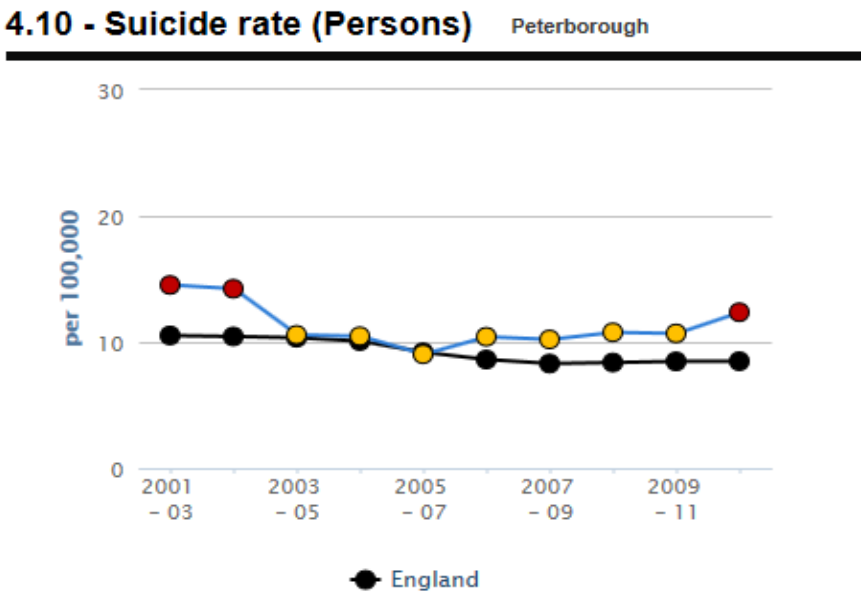


Figure 5B – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for Cambridgeshire

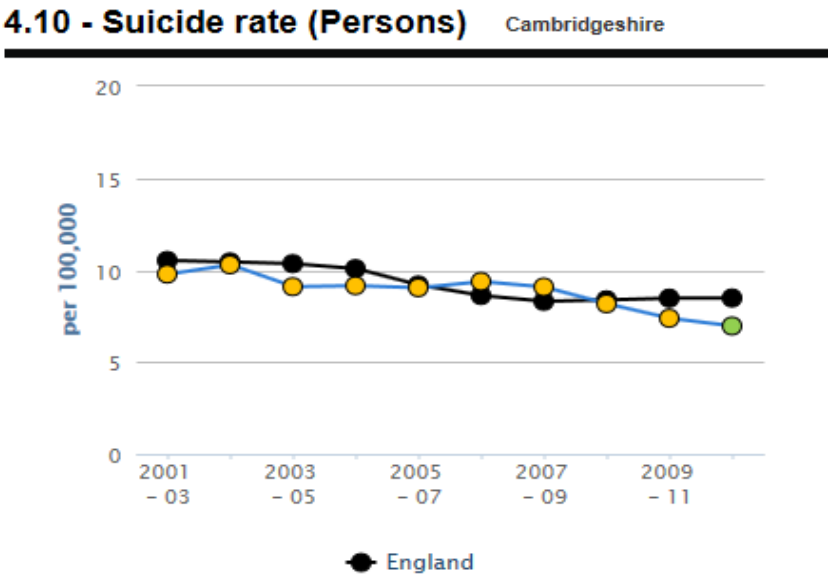
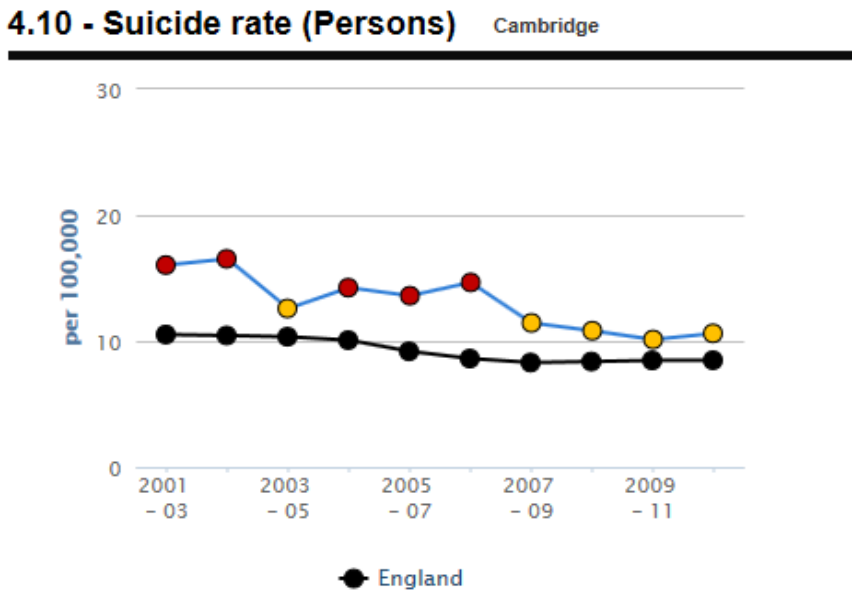
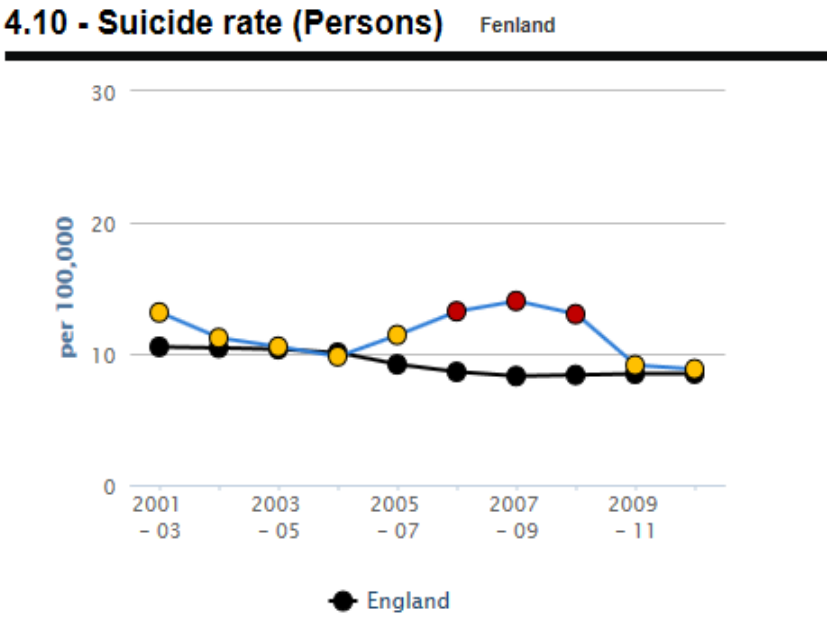


Figure 5C – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for Cambridge City and Fenland Local Authorities





Source: Figure 5 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.

5.3 Suicide methods – local data

Information on local suicides in 2012/13 provided by coroners has facilitated some analysis of methods used in suicide. Consistent with national data, the most common method for suicide in Cambridgeshire and Peterborough was hanging. Other methods of suicide including drowning, use of firearms, multiple injury, including injury as a result of jumping from a height and drug overdose were less frequent (Data not shown).

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 local adults with mental health problems on a pathway basis from the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). The pathways commissioned for adults are:-

- Advice and Referral Centre – ARC (a single-point-of-access to specialist mental health services, commenced in Peterborough in August 2012, and being rolled-out in stages across the CCG)
- Locality Teams; IAPT, Psychosis, Affective Disorders, Assertive Outreach
- CAMEO (NHS service that provides specialised assessment, care and support to young people experiencing a first episode of psychosis)
- Acute Care Pathway (including crisis resolution and home treatment and Psychiatric Intensive Care Pathway);

NHS Cambridgeshire and Peterborough CCG along with Cambridgeshire County Council and Peterborough council commissions mental health services from a range of local independent and voluntary sector organisations.

Third sector organisations involved in supporting people known to have mental health problems and suicidal risk include:

- MIND in Cambridgeshire
- Group Therapy Centre
- Cambridge Counselling Services
- Choices
- Oakdale
- Relate Counselling

- LIFECRAFT
- The Richmond Fellowship
- Rethink Carers

6.2 Services for people at risk of suicide not known by mental health services

- **The Advice and Referral Centre (ARC**) acts as a source of advice and a single-point-of-access for local GPs wishing to refer a patient to local NHS mental health services.
- **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
    - Samaritans
    - Lifecraft
    - Lifeline
    - MIND
    - Richmond Fellowship
    - Bereavement services – CRUSE bereavement

6.3 Gap analysis in suicide prevention service provision

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] have consulted with service users, carers, HealthWatch, GPs and the Patient Experience Team to identify gaps in service provision, some of which are 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

In addition to the list of gaps in service provision provided above, the suicide prevention group

highlights the following unmet needs:

- Better working relationships between the CRISIS resolution team and third sector agencies to ensure sharing of information and timely and appropriate response to those in crisis
- Swifter and appropriate referral to mental health CPFT, ARC
- Faster access to therapy. Currently waiting lists for 1:1 therapy exceed 3 months
- 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.
- Accident and Emergency psychiatry liaison services differences between Peterborough, Hinchingbrooke and Cambridge hospitals
- Use of ARC as a single point of access by people not known by mental health services

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

In line with National guidelines on preventing suicide, and in understanding that an effective local public health approach is fundamental to suicide prevention**,** a multi-agency local suicide prevention group has been established to provide input and recommendations for 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 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.

A recent conference that showcased the 'Detroit model' for suicide prevention[15] has provided some core values and principles that the Cambridgeshire and Peterborough suicide prevention partnership would like to adopt. The 'Detroit model' for suicide prevention has been particularly successful in America by 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 recommended for adoption by the Cambridgeshire and Peterborough suicide prevention board are represented by the following:

Six Dimensions of Perfect Care

1. Safe
2. Effective
3. Patient Centred
4. Timely
5. Efficient
6. Equitable

Ten rules of perfect care

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

The suicide prevention group has also agreed to endorse the Detroit principle to aim to work towards zero suicides in our local area.

8. PRIORITIES FOR SUICIDE PREVENTION

To achieve our goal to work towards zero suicides, the suicide prevention group agreed the following six priorities, 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 assessments that identified 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.

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

9. 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.

9.1 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 is emerging as a local risk factor as well as isolation and rural location (suicides in Fenland). Local knowledge also puts vulnerable and marginalised groups such as alcohol and drug users, gypsies and travellers and homeless people at increased risk of suicide. An annual audit of local suicides will enhance this knowledge and focus resources for implementing the strategy to those with greatest need (see section 14 for more details).

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, recent 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 3 - 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
- Farmers and rural workers in Fenland
- Gypsies and travellers
- Young offenders
- People in custody and those under investigation for criminal offences, particularly sex offences
- People who self-harm and have had a history of self-harm
- Alcohol/drug users
- Bereaved people and those bereaved by suicide
- Veterans
- Asylum seekers
- 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]

9.2 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.

9.3 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 and agencies in contact with vulnerable groups
3. Promote awareness raising campaigns – Poster and leaflet campaign aimed at either 'the helper' or 'the person in need' and targeted at specific high risk groups.
4. Adopt and roll out 'CRISIS cards' and 'CRISIS App' developed with the help of service users
5. Ensure integrated, appropriate and responsive services to those at risk of suicide
6. Reassess pathways for people known by mental health services at risk of suicide – ensure follow-up provision of care upon discharge from services.
7. 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

9.4 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 them and refer them appropriately. Funding to support this area of work is agreed through the SCN pathfinder programme for one year from May 2014 (for more details see section 16)

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 should be 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.

In addition to 'ASIST' – type suicide prevention training, the continuing roll-out of 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.

9.4.1 Suicide Prevention Training - Priority Groups

The professionals and third sector agencies identified as priority groups for suicide Prevention training are listed in table 4 below and are based upon local needs assessment of groups of people identified as high risk of suicide and the organisations most likely to have direct contact or involvement with them. Of particular note is the intention to engage with and offer suicide prevention training to employers of eastern European workers and faith groups and social organisations for Polish and Lithuanian people, ensuring that the content of the training is culturally appropriate with an understanding of how suicide risks and mental illness is perceived in the countries of origin. This is in line with the aim of Peterborough Social Services to reach out into the community to offer prevention initiatives to hard-to-reach groups through the development of Local Area Coordination (LAC) and Asset Based Communities.

It is recognised that there is a need to increase awareness of the risk of suicide in primary care settings. GPs are most likely to have contact with people at risk of suicide in many of the 'high risk' categories listed in Table 3. There is an opportunity to provide training and/or information to GPs in

order to help them recognise some markers of suicide risk including a history of self-harm (Suicide in primary care in England 2002-2011[18]). Training of GPs and mental health professionals is important to highlight the importance of safety plans for patients with mental health problems, particularly around restricting access to the means of suicide.

In addition, the Independent Commission on Mental Health and Policing report highlighted in the Mental Health Crisis Concordat[12] concludes that mental health is a core business for the Police, who should be trained to be aware of the vulnerabilities people may have. As such, police are a priority group for training in suicide prevention.

Further refinement of the list of priority groups for suicide prevention training (Table 4) will be made upon advice obtained from engagement with service users through a series of focus groups at an early stage in the implementation process.

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 should 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.

Depending on funding, training packages would be commissioned from accredited agencies to deliver training or by 'in-house' training of trainers to deliver the programme locally. Some expertise in suicide prevention training is established within the Cambridgeshire and Peterborough suicide prevention group. Similar training packages have been successfully developed and implemented by Cambridgeshire Youth Offender Services and Samaritans. Some mental health first aid training is commissioned by Cambridgeshire County Council – currently to professionals in the public sector. MHFA training can also be provided by MIND.

In order to ensure sustainability, and depending on funding, we recommend training two - three people within the Cambridgeshire and Peterborough suicide prevention group to deliver suicide prevention training long term.

In addition, we will be continuing our support to The Samaritans as they deliver training in suicide prevention to some of the groups identified in table 4.

Table 4 – Professional groups and voluntary sector organisations identified for suicide prevention training and the groups at higher risk of suicide likely to benefit as a result of training of professionals

*****This table will be regularly checked and updated according to the availability of local information about groups requesting or in need of suicide prevention training

	Professional Group	Target High Risk Group
1	Nurse team for gypsies and travellers	Gypsies and Travellers
2	LINKUP groups – Key members/organisers? Service user	Drug and Alcohol users

	group for DAAT and homeless/vulnerable One group in Wisbech at the Ross Mini Centre (used by Eastern Europeans) One group in Cambridge – St Barnabas church – St Andrew's Street	New migrants
3	Addaction Service - community based service that offers free support for individuals with alcohol problems in local areas in settings such as GP Surgeries, Libraries, local pharmacies, and others	Drug and Alcohol users
4	Inclusion Cambridgeshire – engages with Adult drug users: http://www.inclusion-cambridgeshire.org.uk/	Drug and Alcohol users
5	Drug Services Aspire - Peterborough	Drug and Alcohol users
6	Alcohol Service Drink sense - Peterborough	Drug and Alcohol users
7	CASUS (Young Person's treatment service)	Drug and Alcohol users
8	Police – including those working in custody suites, police working with sex offenders – all localities	Offenders/ people in custody Drug and Alcohol users
9	Bereavement services	Bereaved people
10	Primary care – GPs, Receptionists? - targeted to areas with higher rates of suicide – rural Fenland	Farmers and rural workers New migrants Unemployed people and those in financial difficulties Middle aged men
11	Rethink Carers – carers of those with mental health problems	People in contact with mental health services
12	CREDS team. Home school liaison officers who work very closely with families from both Gypsy and Traveller and eastern European communities.	New migrants Gypsies and Travellers
13	Teams who work with children: Locality team workers – (Multi-agency teams that respond to and meet needs of young people identified through CAF) School pastoral leads (particularly in PRUs)	Young people who self-harm

	Youth club facilitators Staff that work with looked after children Staff that run supported housing for young people (such as railway house)	
14	A and E/hospitals Hinchingbrooke? Peterborough	People who self-harm Alcohol/drug users People in contact with mental health services
15	CAB Staff	Unemployed people and those in financial difficulties
16	Job centre plus Staff	Unemployed people and those in financial difficulties
17	Debt crisis PCAS Peterborough Community Assistance Scheme http://www.peterborough.gov.uk/housing/housing_benefit/welfare_reform_changes/pcas.aspx	Unemployed people and those in financial difficulties
18	Prison staff and Probation Officers– Offender Health provided by Care UK	Offenders, people in custody, people released from custody
19	Other local voluntary organisations including people working in organisations for homeless people, refuges and chronically excluded adults • Network Peterborough (faith based food bank) • Richmond fellowship staff • Social Cohesion Projects including Operation Can Do – Peterborough • Refugees Red Cross (Peterborough) • REACH service user group – cambsreach@gmail.com	Vulnerable adults New migrants Drug and alcohol users Middle aged men
20	Health visitors – In Fenland, Cambridge City and Peterborough	Unemployed people and those in financial difficulties
21	Social services community staff	Various
22	Housing association staff – Rural fenland, Peterborough and Cambridge	Unemployed people and those in financial difficulties

23	Car park and shopping centre staff in Peterborough and Cambridge	Various
24	Rail staff	Various
25	Relate Staff	People with relationship problems
26 **27**	Youth group leads and teachers involved in pastoral care Staff viewing CCTV cameras, especially along waterways	Young people with mental health needs/ at risk of self-harm

9.4.2 Suicide Prevention Training - Key Outcomes

Suicide prevention training should achieve the following:

- Training select groups of front-line workers from professional and third sector organisations in recognising the signs and symptoms of mental health problems and suicidal behaviour in people encountered as a result of the work they do.
- Equip people who are most likely to encounter people with mental health issues or suicidal thoughts with the skills and confidence to support them and to enable them to seek professional help
- Increase mental health awareness in the population
- Improve mental health outcomes and reduce the risk of suicide in the population
- Help the development and planning of services, encourage multi-agency working and information-sharing between agencies

9.4.3 Evidence Base for suicide prevention training

A study by the London School of Economics calculated the average cost of a complicated suicide as £1.67M (2009 prices)[19]. The same study 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

ASIST training is used widely in Scotland after a roll-out in 2004. The Scottish Government has evaluated the ASIST initiative and concluded that the implementation of ASIST had raised awareness of suicide, reduced stigma and fear, given a range of people the knowledge and skills they need to help those at risk of suicide, helped develop and plan services, encouraged multi-agency working and information-sharing practices between agencies, helped develop policies and practices within agencies and helped to establish more supportive management and supervisory relationships[20]

9.5 Recommendation 1.2 - Develop suicide prevention resources for professionals and agencies in contact with vulnerable groups

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 a suite of resources be developed for particular professional groups and organisations that will act as protocols 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

Resources should be developed for the same professional groups listed in section Table 4. In addition, resources should be reviewed and developed for charitable organisations as appropriate, including 3rd sector members of the suicide prevention board.

It is recommended that the suite of professional resources be used in addition to and alongside suicide prevention training (Section 9.4).

Funding to support this area of work has been agreed through the SCN Pathfinder programme for one year from May 2014 (See section 16).

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

In order to aid self-help as a means to prevent suicide and to raise awareness of how to access help, the suicide prevention strategy recommends the development of a range of resources – posters and leaflets aimed at either 'the helper' or 'the person in need' and targeted at specific high risk groups.

Awareness raising poster or leaflet campaigns should be developed 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.

Content for awareness raising posters should be agreed as follows:

- Appropriateness for target audience – high risk group
- Posters for awareness raising for 'helper' or 'person at risk'
- Strap-Lines and content
- Images
- Locations for display – for example, Job Centres, CAB, Libraries, Leisure Centres, Pubs/clubs, community centres
- Accessibility to families and children

In addition to resources to aid self-help, the suicide prevention group endorses a pilot piece of work to develop the 'Cambridgeshire and Peterborough Pledge' to reduce suicide. 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 is supported by funding from the SCN Pathfinder programme (Section 16).

Awareness-raising will be supported by promotion of 'World Suicide Prevention Day' each year on September 10th and through local initiatives and in partnership with Communications teams and local media – see the three year action plan for more details.

9.7 Recommendation 1.4 - Resources to aid self-help in those at risk of suicide

Some excellent work has already taken place by the Service Users Network (SUN) to create a CRISIS card and CRISIS 'App' - developed with the help of and for the use of service users. These provide information and self-help solutions for service users to aid them to manage their thoughts and feelings and to reduce the risk of a decline towards suicidal ideation. The CRISIS card and App are supported by the suicide prevention board and they are recommended for wider distribution after the successful first implementation phase. It will be important for the suicide prevention board to work with the SUN to achieve this goal.

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

Resources for self-help for children and young people should be developed in line with recommendations in 'Emotional well-being and mental health strategy for children and young people 2012-2016'[6]

9.8 Recommendation 1.5 – Aspire to develop integrated, appropriate and responsive services to those at risk of suicide

As mentioned in section 5 of this strategy, it is important to map the current service provision for people at risk of suicide and to ensure analysis is performed to identify weaknesses in the services or pathways, gaps in the system and opportunities to develop good practice and joined up working with continuity of care.

Consultation with service users and children has highlighted the need for integrated services. To this end, it is recommended that a gap analysis of services is undertaken that involves all partners in suicide prevention from professional bodies to third sector organisations. This work should be undertaken in collaboration and with support from CPFT and should incorporate findings from the Mental Health commissioning strategy and the 'Emotional well-being and mental health strategy for children and young people 2014-2016[6]'. The work should be supported and promoted through collaborations with the Mental Health Crisis Care Concordat Working group.

- Map 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

- Support the Police in responding to people with mental health problems by promoting pathways enabling contact and rapid access to other agencies that are able to provide advice and support
- Develop a cultural view that it should be everybody's expectation that people receive appropriate and timely services
- Refer to Crisis concordat recommendations on partnership working and the gathering and sharing of information about a person in crisis
- Encourage systems that allow engagement with other services where appropriate – particularly with drug and alcohol teams
- Endorse recommendations from coroner's reports on deaths as a result of suicide

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

It will be important to work in partnership with the Mental Health Crisis Care Concordat Working group and CPFT with reference to the joint commissioning strategy for adult mental health and well-being in order to assess pathways for people known to mental health services at risk of suicide.

To this end, the following processes 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.
- 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. 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. This would include ensuring that careful and effective careplans and follow-up arrangements are in place.
- Explore models for strong community and joined-up support at locality level for people pre and post crisis as part of the 'Neighbourhood model'. This could be based in Peterborough, Cambridge and Fenland.
- Suicide prevention audit of Accident and Emergency Departments – a toolkit for an audit of this type has been developed by the NHS Mental Health Network – NHS Confederation – see: http://www.nhsconfed.org/Documents/Preventing-suicide-toolkit-for-emergency-departments.pdf
  The suicide prevention board will need to work with managers within the Accident and Emergency Departments of Addenbrooke's hospital, Hinchingbrooke hospital and

Peterborough hospital in order to implement the audit and identify areas of strengths and weaknesses in the care pathway.

- 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
- Assess the single point of access (ARC) and identify gaps around risk identification and pathways used by GPs and ARC staff. Training to GPs, ARC and CRISIS resolution team on pathways and risk identification
- Link up suicide prevention strategic group to influence the development of the 5 year mental health strategy to ensure 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

Successful delivery against recommendation 1.6 will be strengthened by ensuring that links are established between the suicide prevention implementation group and the newly formed Mental Health Crisis Concordat Working Group, which has overlapping objectives.

9.10 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.
- Provide access to the Samaritans in custody suites.
- Suicide prevention training of custody staff – working with NHS England to bring a bespoke package of suicide prevention training to prison staff and prison listeners (section 9.4).
- Work with prison and police staff to understand the screening risk assessment procedure upon reception of prisoners and people taken into custody to include risk of suicide/self-harm.

- Promote access to support from drug and alcohol services for people in custody with mental health and drug/alcohol problems.
- Suicide prevention training of probation and custody staff and aspire to train prison listeners
- 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.
- Build on the work done to establish forensic services in Peterborough (ONE service). Assess links with partner organisations and discharge pathways.

10. 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

In recent responses to 'No health without mental health', local mental health strategies have been written to specifically focus on children and young people, adults, older people and people with learning disabilities.

10.1 Recommendations to improve mental health in specific groups

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

Work in partnership with CPFT and Accident and Emergency Departments and with reference to the CPFT suicide prevention strategy to assess pathways of care for children and adults who self-harm. Highlight strengths, gaps and weaknesses within the pathways and identify areas for improvement in the pathways, particularly with respect to follow-up care for people discharged from services.

- Results from suicide prevention audit at Accident and emergency departments
- Monitor admissions to the Accident and Emergency departments for self-harm to assess any impact on service developments. Reports of self-harm in Accident and Emergency Departments should be regularly monitored to assess any impact on service developments. Repeat admissions of people who self-harm would be particularly interesting to monitor as the strategy should focus on the best interventions to prevent repeat episodes of self-harm
- Directory of services to signpost and share at the point of contact (through liaison psychiatry)
- Review the use of follow-up care plans for people discharged from services
- Assess plans for people who self-harm if mental health services are not involved
- Review good practice in resources to help people who self-harm or have a history of self-harm, for example; 'Harmless' http://www.harmless.org.uk - a national organisation based in Nottingham

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:

- raise awareness and campaigning around self-harm
- provide access to self-help resources that focus on building resilience in young people
- raise awareness and develop resources aimed at preventing bullying and promoting mental wellbeing in schools and colleges- see 'beat bullying' teaching resources – www.beatbullying.org/dox/resources.html
- 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
- assess pathways for teenagers and young adults who have attended A&E due to self-harm, particularly upon discharge

- Support and promote the projects that work with families through the 'BOUNCE' project in Peterborough – working with families through workshops to encourage health and wellbeing including mental wellbeing

Partnership working between the local authorities, health, mental health organisations, schools, colleges and community agencies to promote mental wellbeing in children and young people will be endorsed by the suicide prevention implementation group, which will support and provide input to help develop the proposed public mental health strategy for Cambridgeshire.

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
- Information to health professionals including GPs and health visitors to promote advice services
- 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

Recommendation 2.4 - Promote training in Mental Health Awareness

For detailed information – see section 9.4. Training that promotes mental health awareness and prevention of mental health problems that could lead to suicide. The development of bespoke training packages in mental health awareness and suicide prevention are recommended for particular organisations that have contact with people at risk of developing mental health problems. Training for health professionals including General Practice staff and people working within the mental health services is recommended. 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

11. PRIORITY 3 - REDUCE ACCESS TO THE MEANS OF SUICIDE

A local audit of methods used in suicides concluded that the most common method was hanging. Other methods, such as use of fire arms, poisoning and drowning were less frequent. In addition, recent local data reports deaths by suicide as a result of multiple injuries associated with falling from height from car parks in both Peterborough and Cambridge. As a result of this local information, the following recommendations are made:

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.

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 strategic 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. The strategic group hopes that such a move would make a clear statement and showcase Peterborough and Cambridge as places that take positive steps to prevent suicide.

Training in suicide prevention is currently 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.

Recommendation 3.3 – Reduce the risk of suicide on railway lines

The Samaritans and British Transport Police are currently running an awareness campaign called ' we are in your corner[24]' and are placing posters on sites of access to railway lines in the region – see http://www.btp.police.uk/latest_news/supporting_samaritans.aspx The suicide prevention board endorses this campaign and its continuing roll-out.

Suicides do occur on railway lines in Cambridgeshire and Peterborough and it will be important to access whether any suicide 'black spots' for suicide are identified. An assessment of any requirements for physical barriers should be made at any location with heightened risk of suicide.

Training in suicide prevention should be offered to national railway staff, particularly those working in stations.

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.

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 education and training. 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 could be disseminated by engagement with GP leads and clinical networks through the CCG.

12. 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. Bereavement is in itself a risk factor for suicide. In addition, those affected by the loss of a loved one through suicide will have specific needs.

Bereavement services for Cambridge and Peterborough are under review. The suicide prevention group will ensure they are part of this process by joining the group discussions for bereavement services.

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.

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

12.1 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

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

- Distribute 'help is at hand' leaflets to these professionals.
- Provide details of local bereavement charities if not included in 'help is at hand' leaflet. People bereaved as a result of suicide should be signposted to organisations best able to help them:
    - CRUSE bereavement services
    - Survivors of bereavement by suicide
    - Compassionate friends – a charity dedicated to help in families of children who have died

In line with the national strategy – to provide more support for families affected by suicide, opportunities should be identified to work with neighbouring suicide prevention groups in the Eastern region to develop a self-help support group or network for people affected by suicide. It would be worth taking the opportunity presented through the Strategic Clinical Network Pathfinder programme to engage with other local suicide prevention groups interested in establishing self- help groups or networks for people affected by suicide.

People bereaved as a result of suicide may access help through organisations such as CRUSE (a charity to help bereaved people). It will be important to ensure suicide prevention training is offered to personnel working for CRUSE in Cambridgeshire and Peterborough.

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.

13. 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.

13.1 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.
- Liaise 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".

14. 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:

Recommendation 6.1 Collect detailed suicide data on a quarterly basis and carry out an annual audit of local suicides

Data should be collected from Cambridgeshire and Peterborough coroners and include information on age, sex, nationality, occupation, marital status, contact with mental health services, contact with services in two weeks prior to death, place of death, resident address, method of suicide. Collation of data and analysis to provide information on suicide trends, hotspots, risk groups and indicators. Police data on suicides and near suicides should also be used for analysis of suicide rates and methods, particularly around 'hotspot' locations.

The suicide data and statistics should be audited on an annual basis by public health analysts and be used to inform a report to the health and wellbeing board in relation to public health outcome 4.10 (suicide rate)[11]

Data should be held by public health analysts as part of the suicide prevention partnership

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.

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.

15. 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. These are summarised in the table that follows and are discussed again in the accompanying document 'Joint Implementation Plan for Suicide Prevention in Cambridgeshire and Peterborough, 2014-2017'

The department of Health performance management of suicide has been based on the Our Healthier Nation target set in 1999[15]. The target was to reduce death from suicide and injury undetermined by at least one fifth by 2010 from a baseline of 1996.

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.

An annual audit of suicide data should be carried out (recommendation 6.1) and this should be comprehensive in order to determine groups at risk of suicide and any changes to means of suicide and risk of suicide over time. The audit should be designed in parallel with the action plan for suicide prevention in order to present data relevant to any specific recommendation aimed at reducing risk of suicide by particular means or within particular risk categories.

Evaluation should also include surveys of various groups for effectiveness of particular actions or interventions. Where surveys are recommended, these are listed in table 5. It would be useful to run several surveys aimed at various stakeholder groups:

- 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, numbers of people reached or informed.

Table 5 – Summary of recommendations with Key Performance Indicators if appropriate and data to be collected in order to measure and monitor performance

Recommendation	KPI	Data to be collected
Recommendation 1.1 - Suicide Prevention Training	In 2014-2015 200 people trained in Mental Health Awareness and suicide prevention training 50% of priority organisations receive training 80% Satisfaction with training	Numbers of people trained List of organisations receiving training and numbers of staff trained within each organisation Survey of people trained in suicide prevention
Recommendation 1.2 - Develop suicide prevention resources for professionals and agencies in contact with vulnerable groups	50% of priority organisations receive resources	Number of resources disseminated and list of organisations receiving resources
Recommendation 1.3 – Awareness-raising campaigns and Peterborough and Cambridgeshire Pledge to reduce suicide	Posters disseminated 1% of people in Peterborough sign pledge 5% or organisations in Peterborough sign pledge	Number of posters disseminated Number of individuals signing pledge Number of organisations signing pledge
Recommendation 1.4 - Resources to aid self-help in those at risk of suicide		Number of Crisis cards disseminated and CRISIS App downloaded. Number of posters to aid self-help displayed
Recommendation 1.5 – Aspire to develop integrated, appropriate and responsive services to those at risk of suicide		Survey of service users on integrated pathways for suicide prevention
Recommendation 1. 6 - Reassess pathways for people known by mental health services at risk of		Report to suicide prevention group

suicide		
Recommendation 1.7 - Improve pathways and support for people taken into custody and newly released from custody at risk of suicide	Reduction in suicides in people in custody – baseline 2009-2011	Report on pathways and support for prisoners and people taken into custody. Recommendations considered according to the report (above)
Recommendation 2.1 Work in partnership with CPFT and Accident and Emergency Departments and with reference to the CPFT suicide prevention strategy to assess pathways of care for children and adults who self-harm	Admission rates for self –harm reported to suicide prevention group Trends in admission rates recorded	Report on pathways available to children and adults who self-harm Including recommendations for improvements
Recommendation 2.2 Work with partners who are developing 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 • 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	TBC	
Recommendation 2.3 – Promote early interventions to aid prevention of mental health problems that could lead to suicide	Resources (information and mental health awareness training) are made available to communities and agencies – such as CAB	
Recommendation 2.4 – Promote	At least 100 people provided with	Number of people trained in

training in Mental Health Awareness	Mental Health Awareness and suicide prevention training	Mental Health Awareness and suicide prevention
Recommendation 3.1 – In line with regulations, ensure the removal of potential ligature points – particularly in places of custody and in-patient settings	Audit of potential ligature points is conducted annually in inpatient wards and places of custody Potential ligature points removed or made safe	Audit is carried out
Recommendation 3.2 – Reduce the risk of suicide by jumping from high buildings accessible by the public including multi-storey car-parks	Training of car park and shopping centre staff in suicide prevention Posters displayed in car parks and shopping centres to aid self-help Achieve zero suicides at car parks in Cambridge and Peterborough Barriers erected on public buildings with history of suicides by jumping and at risk of further suicide attempts	Number of staff trained in suicide prevention Number of posters displayed Barriers erected on multi-storey car parks with risk of suicide by jumping
Recommendation 3.3 – Reduce the risk of suicide on railway lines	Training of rail staff in suicide prevention Posters available to aid self-help in railway locations Achieve zero suicides on railway lines	Number of network rail staff trained. Number of posters displayed
Recommendation 3.4 – Work with Medicines Management teams at the CCG to ensure safe prescribing of some toxic drugs	Deliver recommendations in NICE guidelines on Safe Prescribing	
Recommendation 3.5 - Whenever possible, medical professionals should be reinforcing safety plans for individuals with mental health problems	All GP practices in Cambridgeshire to be offered general training over a 3 year period Target of 50% uptake over 3 years At least 4 GPs per LCG to receive bespoke training in suicide prevention and use of safety plans with the expectation they attempt to disseminate the learning throughout their LCG Information on use of safety plans sent to GPs through the CCG GP clinical network	Audit of training provided by implementation group Survey of GPs and health professionals to include question about the use of safety plans

Recommendation 4.1 - Ensure bereavement information and access to support is available to those bereaved by suicide	Help is at hand leaflets are available to police, coroners, funeral directors and GP practices Establishment of a self-help group or network with partner suicide prevention groups Bereavement services offered suicide prevention training	Number of 'help is at hand' leaflets disseminated to organisations in contact with people bereaved as a result of suicide Number of people trained from bereavement services
Recommendation 5.1 – Encourage appropriate and sensitive reporting of suicide	Sensitive and responsible reporting of suicide by local media against guidelines	Information on the responsible reporting of suicide has been provided to local media reporters and editors Media reports collated for evaluation report
Recommendation 6.1 Collect detailed suicide data on a quarterly basis from Cambridgeshire and Peterborough coroners and carry out an annual audit of local suicides	Reduction in suicides year on year Reduce the rate of suicide in the population Public Health Indicator 4.10 – Baseline period = 2009-2011 Achieve 10% reduction in suicide rate for 2014-2016	Data collated by public health analysts and shared confidentially with suicide prevention board Report on suicide rates to health and wellbeing board in relation to public health outcome: Reduce the rate of suicide in the population Suicide statistics on three year rolling basis
Recommendation 6.2 Disseminate current evidence on suicide prevention to all partner organisations		Implementation group meeting minutes and email records
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	Annual report on suicide prevention implementation plans to include evidence reported by coroners	Annual report on suicide prevention implementation plans

16. 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 and overseen by the strategic group from September 2014. 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.

16.1 Strategic Clinical Network (SCN) Pathfinder project for suicide prevention in Cambridgeshire and Peterborough (STOP SUICIDE campaign)

The suicide prevention strategic group on behalf of Cambridgeshire and Peterborough CCG have recently been successful in obtaining funding through 'Improving Mental Health Outcomes: Application to the East of England Strategic Clinical Network Pathfinder Programme' in order to implement some specific work on suicide prevention for one year from April 2014.

The vision of the programme is to improve outcomes for mental health service users, reduce risks of suicide and self-harm, and to widely disseminate the learning from the exemplar projects selected to become pathfinder sites. To this end, the Peterborough and Cambridgeshire 'Pathfinder' application emphasises and encourages multi-partnership working across all sectors from NHS and mental health professionals to voluntary organisations and will utilise expertise from these organisations to implement some specific initiatives for suicide prevention. Continuing engagement between the dedicated members of the Cambridgeshire and Peterborough suicide prevention group and service users and their carers will be essential for the successful design, development and delivery of the initiatives.

The proposal is influenced by the recent publication by NHS England and Public Health England 'A call for Action: Commissioning for Prevention' [30]. The World Health Organisation states in its publication 'For which strategies of suicide prevention is there evidence of effectiveness?'[31] that 'suicide is a result of complex interactions of various risk factors and protective factors. Consequently, a combination of suicide preventive interventions addressing different risk factors at various levels in different populations may be required'.

In recognition of this, the Pathfinder initiative proposes a multi-pronged suicide prevention approach as follows:

1. Assessment of local suicide prevention pathways and development of a suite of professional resources including a pathway map to provide advice on how to respond to a suicidal individual in the community.
2. Provide suicide prevention training to select groups of professionals and personnel within organisations most likely to be in direct contact with people at high risk of suicide.
3. Create and promote the 'Peterborough and Cambridgeshire pledge to prevent suicide'.

4. Development of a website to contain the proposed local suicide prevention initiatives (www.stopsuicidepledge.org)

The proposed initiatives have overlap with recommendations made in this document and will aid the implementation and delivery of recommendations made here.

Implementation of the Pathfinder initiative is being jointly led by MIND in Cambridgeshire, LIFECRAFT and MIND in Peterborough with support from the Cambridgeshire and Peterborough suicide prevention group and governance by the CCG. Overseeing the project is the East of England Strategic Clinical Network

17. REFERENCES

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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

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.

This power cannot be used to detain someone if they are on private premises.

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.

You are to record all contacts of SP anonymously to gather important data.

2. Example of suicide prevention protocol for GPs

Cambridgeshire and Peterborough
Clinical Commissioning Group

GP Suicide Prevention Guide – Cambridgeshire & Peterborough

Resource	*Organisation*	*Contact*	*Information*
Self-help organisation	Samaritans	0845 790 9090 jo@samaritans.org	24/7 A 24 hour helpline service which gives you a safe space where you can talk about what is happening, how you are feeling, and how to find your own way forward
Self-harm pathway	NICE	http://pathways.nice.org.uk/pathways/self-harm	Summarises both short and long term self-harm guidance using a flowchart based approach
Local Mental Health Provider	CPFT	http://www.cpft.nhs.uk/	
Suicide Prevention Toolkits	NPSA	www.nhsconfed.org/Publications/briefings/Pages/Preventing-suicide.aspx	The toolkits support clinicians and managers to understand what they can do to reduce the suicides.
Self-Harm Top Tips	NHS Cambridgeshire and Peterborough CCG		 Top tips - Self Harm.pdf
Risk Assessment Top Tips	NHS Cambridgeshire and Peterborough CCG		 Top tips - Risk Assessment.pdf
The National Self-Harm Network	Self-Harm	0800 622 6000 (7pm-11pm Thursday-Saturday, 6.10pm-10.30pm Sunday) support@nshn.co.uk http://www.nshn.co.uk/	A forum and resource for those who self-harm and their families, and for professionals who support them.
Handbook on CAMH self-harm	CHIMAT	www.chimat.org.uk/resource/view.aspx?RID=105602	The National CAMHS Support Service produced a self-harm in children and young people handbook and an e-learning package, to provide basic knowledge and awareness of self-harm in children and young people, with advice about ways staff in children's services can respond.
Self-help organisation	PAPYRUS Hope Line UK	0800 068 4141 (Monday – Friday 10am-5pm & 7pm-10pm, Weekends – 2pm-5pm) pat@papyrus-uk.org http://www.papyrus-uk.org/	Papyrus aims to prevent young people taking their own lives.

Self-help organisation	Get Connected	0808 808 4994 Open from 1pm - 11pm every day Text 80849 for free - Texts will usually be answered within 24 hours http://www.getconnected.org.uk/	Offers help by telephone and e-mail to those under 25 who self-harm.
How to respond to suicide risk in older clients info sheet	The Staffordshire University Centre for Ageing and Mental Health	http://www.staffs.ac.uk/assets/Suicide_and_older_people_tcm44-32414.pdf	The Staffordshire University Centre for Ageing and Mental Health has developed a set of information sheets to help health and social care providers respond to suicide risk in older clients
Rural Stress Helpline	Rural Stress	Helpline 0845 094 8286 (Mon-Fri 9am-5pm); email help@ruralstresshelpline.co.uk	Offers a confidential, non-judgemental listening service to anyone in a rural area feeling troubled, anxious, worried, stressed or needing information.
Bereavement Resources			
Help is at Hand		http://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf or order from www.orderline.dh.gov.uk	A resource for people bereaved by suicide and other sudden, traumatic death. This provides advice and information for anyone directly affected by suicide. It also has advice for people in contact with those bereaved through suicide, either because of their work or because they are part of the same community
The Inquest Handbook	INQUEST	http://inquest.gn.apc.org/website/help-advice/the-inquest-handbook	A guide for bereaved families, friends and their advisors. This booklet includes specialist sections dealing with deaths in police or prison custody and when detained under the Mental Health Act 1983.
SOBS (Survivors of Bereavement by Suicide)		0844 561 6855 (open 9am – 9pm every day) sobs.admin@care4free.net http://www.uk-sobs.org.uk/	Meet the needs and break the isolation of those bereaved by the suicide of a close relative or friend.
E-learning			
E-learning on Domestic Violence	RCGP	www.elearning.rcgp.org.uk/course/view.php?id=88	To enable them to identify and respond to victims of domestic violence more effectively.
Websites			
www.selfharm.co.uk	A project dedicated to supporting young people who are affected by self-harm		
http://www.getselfhelp.co.uk/			