Suicide and Self Harm Risk Reduction in Berkshire
Final draft Strategy

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With many additions from a wide range of stakeholders in:

- **Commissioners**
- **Primary care**
- **Secondary care**
- **Local authorities**
- **Voluntary organisations**

Acknowledgement
This draft strategy drew on frameworks developed by the Bolton and SPIN (Thames Valley) suicide reduction alliances.

Executive summary
This is a draft strategic framework for reducing suicide and self-harm risk across Berkshire. It key elements are:

- Many stakeholders have contributed to this draft strategy and now recommend it to the CCGs in the east and west of Berkshire.
- Stakeholders have made recommendations for the objectives and membership of a Steering Group – comprising senior staff from the main organisations (Council, NHS, voluntary groups) to actively implement the strategy across East & West Berkshire.
- Stakeholders recommend that the CCGs and the Steering Group use the ‘Whole Picture’ Public Health framework (Figure 1) as the basis for their ongoing work in reducing and preventing suicide and self harm, and recommend any necessary actions to CCGs and Health & Wellbeing Board for improving preventive support to people at risk.
- Steering Group should ensure that a multi-agency confidential continuous audit of suicide and self-harm in the county informs their work.
- CCGs will wish to commission services accordingly.

Figure 1 – Comprehensive Public Health Framework for Reducing Suicide and Self Harm Risk

ECONOMIC & SOCIAL DETERMINANTS	PREVENTION	SCREENING, DETECTION, AWARENESS	PRIMARY CARE	SECONDARY CARE	SOCIAL CARE, EMERGENCY SERVICES, SERVICE USERS…
Targeted help in debt & unemployment	Improve mental health and behaviour in schools and at work	Set up active multi-agency audit and review group	Awareness training for GPs & other primary care staff	Implement Open Dialogue approach across Berkshire	Awareness training for front line staff
Target isolated, lonely, distressed groups	Use continuous audit to identify groups at risk	Identify children & adolescents at higher risk	Improve reception for people in distress	Ensure high quality self-harm service in A&E	Make bereavement support rapid and well-coordinated
Increase educational attainment for the most disadvantaged	Councils actively mitigate impact of economic & benefit changes	Train front line staff in awareness, assessment and sign posting	Map disability & chronic illness of those with mental health problems, liaise with providers, inc IAPT	Identify the barriers to vulnerable people using services	'No blame' debrief for staff affected by suicides, inc emergency services
Help mentally ill people to stay in employment and education	Initiatives for groups at higher risk: Looked After Children, Lesbian, Gay, Bisexual and Transgender	Involve agencies in touch with people at high risk	Improve referral routes for people at risk	'No blame' debriefing within secondary care	Target information to groups at risk about support in crisis
Increase access to social justice	Implement Open Dialogue approach for people with schizophrenia	Support people who know someone at risk	Reduce barriers to health-seeking behaviour among people at risk	Crisis support and Home response services	Influence bigotry, bullying, discrimination
Targeted help when at risk of losing home	Targeted support to families to prevent violence, emotional neglect	Run Berkshire conference on suicide, self harm and adolescents	'No blame' debriefing within primary care	Awareness training for front line staff including ambulance staff	Reduce access to the means of suicide
Liaison with criminal justice system, forensic team, court diversion team	Training for all staff in stakeholder organisations				
	Access to on-line and other resources				

1.0 The wider background

1.1 Suicide is a devastating event. It is an individual tragedy, a life-altering crisis for those bereaved, and a traumatic event for communities and services. The impacts are immediately and profoundly distressing. We thus need to be sure that in the Clinical Commissioning Groups (CCGs) and Local Authorities in Berkshire, an alliance of stakeholders takes preventive and ongoing action covering the main risks. The 2012 national strategy (‘Preventing Suicide in England’) sets us two major objectives: reducing the suicide rate in England, and giving better support to people bereaved or affected by suicide. Those objectives are thus given priority in this draft strategy. Self harm is inextricably linked with suicide and its prevention has been incorporated here.

1.3 Suicide is not inevitable. Preventing suicides is a complex and challenging issue, but there are effective solutions for many of the individual factors which contribute towards the risk of suicide. Suicide Prevention work is cost-effective when conducted in accordance with evidence of effectiveness, and by working in partnership. Local Government, statutory services, the third sector, local communities and families each have a role to play.

1.4 While self-harm and suicide have a big negative wellbeing impacts on family, friends, colleagues, they also have a huge economic impact. The average cost of a single completed suicide of a working age individual in England was estimated in 2012 to be more than £1.5 million. This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as waged and unwaged lost output, public service time and funeral costs. Non-fatal self harm also has major – potentially avoidable - cost implications for public services, particularly A&E and acute inpatient services and psychiatric follow-up.

2.0 Local background

2.1 In 2014, the CCGs asked Public Health to recommend a strategy for reducing suicide risk across Berkshire. This draft is the result of a study of national research and recommendations plus recommendations of many local stakeholders from a range of organisations.

2.2 This draft proposes co-ordinated prevention across all the elements influencing suicide and self harm, from the wider determinants of distress and escalating desperation, and poor mental health, through coordinated local preventive action spanning local authority and voluntary services, and primary and secondary care.

3.0 Aims and objectives of the suicide prevention strategy

3.1 The aims of this draft strategy are

- To reduce the suicide rate in local authority areas in Berkshire and give better support to people bereaved or affected by suicide.
- To reduce the local self-harm rate and ensure good support to people who have harmed themselves.

3.2 Objectives

1. Agree to take comprehensive action across social and economic determinants, prevention, risk assessment and identification of groups at higher risk, while ensuring health services, local authorities and voluntary services provide good quality support; establish a very active self-harm and suicide prevention steering group for Berkshire, to lead this work.
2. Develop continuous multi-agency audit of both self-harm and suicide (including any emerging trends or patterns) across Berkshire in order to inform and implement the aims and objectives.
3. Translate local and national intelligence and research findings into useful local action, especially commissioning, training and service quality improvement.
4. Focus on individuals and groups at high risk and continuously develop local interventions to support them in reducing their distress; ensure that barriers to support are reduced (these actions will be co-ordinated between local authorities, NHS and voluntary groups).
5. Ensure that people bereaved and affected by the suicide or self harm of others receive a rapid and automatic offer of support
6. Develop effective action, both preventive and responsive, for people who harm themselves.

4.0 Objective 1

4.1 Recommendation - Agree to take comprehensive action across each CCG on social and economic determinants, prevention, risk assessment and identification of groups at higher risk, while ensuring health services, local authorities and voluntary services provide good quality support. Establish a steering group to lead this.

4.2 Figure 1 shows the main factors influencing suicide and self harm, and key local ways to address them.

4.3 It can be seen from Figure 1 that if only part of the 'spectrum' is tackled, vital elements will be missed. For example, if action concentrates mostly on secondary mental health services, then people in severe distress because of issues like impending homelessness or the loss of a loved one (but who have no contact with mental health services) would not be helped. This would probably preclude them getting any preventive help to avoid getting into difficulties in the first place, and thus professionals would only be

able to intervene when the client is already in a rapidly-escalating crisis. Similarly, if our action was to concentrate just on primary care, or on A&E, major opportunities to prevent bullying in schools and at work will be missed, and the later mental health consequences on self harm and suicide will not have been prevented.

4.4 Unless action is also taken to strengthen community cohesion, a strategic opportunity would be lost to address the big risk factors of isolation, loneliness and depression (and their mental health and suicide risks) of older people, people with physical impairments, chronic disease and those isolated by discrimination.

4.5 Local Authorities have major potential to influence mental wellbeing, whether through housing, social care, employment conditions, support to children and young people at risk, support to parents or many other services. Mental health services can have major impacts on people with severe mental illness (often at higher risk) and can, by working with local authority services, have a major impact on their ability to cope with stressful factors.[1] IAPT and other primary care services help people with depression, but it can often be non-clinical 'gate-keeping' staff who can make the difference between whether patients with escalating distress feel they will get help from services or not.

4.6 While the numbers of suicides each year in Berkshire are unlikely to be especially high (because of the relative affluence of the county) every suicide is a major tragedy and missed opportunity to have helped. And each one has major impact on friends, families and colleagues. They also have major impact on people in services, such as police, social care, mental health services, Primary Care. Each time someone harms themselves and ends up in A&E, other people are similarly affected. Local Authority staff who were working with a young person who harm themselves can be profoundly distressed. And the knowledge that someone you know has been talking about suicide as a possibility is enormously worrying for friends, families and professionals. The steering group should thus use Figure 1 to address this wider impact.

4.7 All these factors may be more, or less, relevant in Berkshire. The first key actions to implement this strategy are therefore

- **to agree to establish an active steering group, with membership to include Social Care, GP, acute services, mental health services, Public Health, voluntary group, emergency services and perhaps Urgent Care Board to oversee this work on behalf of the CCGs, and,**
- **for a Steering Group to review the local situation using Figure 1 as a checklist to ensure that all the main factors are being addressed, and to recommend action where they are not**.

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[1] For example, social care, housing and mental health staff already work together to support people with mental illness, but may need to work with employers and colleges to enable them to stay in work. In the UK there is high unemployment among people with psychoses, whilst in Finland, 75% of them are supported to remain in work and to live at home.

4.8 There will be many good opportunities for this group to spot opportunities and to address them, and for CCGs then to commission for better quality, more coordinated support for people at risk.

4.9 We recommend that the initial objectives of the Berkshire Steering Group should be:

1. Audit and monitor the epidemiological patterns of suicide risk in Berkshire; (this should be linked with Serious Incident Case Reviews (SIRIs) where appropriate, and avoid duplication of effort)
2. Translate local and national intelligence, research and policy into locally meaningful recommendations
3. Focus on action to reduce suicide risk across the whole spectrum (Figure 1) as the key outcome, and develop methods of measuring progress
4. Maximise opportunities to recognise and reduce risk by engaging a network of key stakeholders, statutory Safeguarding links, service leads and service user representatives in that 'whole picture' action
5. Prioritise the setting up of rapid bereavement support for those affected by others' suicide or self harm
6. Ensure that training is offered to large numbers of local authority, NHS and voluntary personnel who can influence the 'whole picture'
7. Make recommendations for action to the Safeguarding Board and the Health & Wellbeing Boards; these recommendations could include suggestions about how to drive down local numbers, and whether suicide should be regarded as a 'never event' rather than pursuing a more pragmatic 'have a go' aspiration. They should be linked to the relevant Outcomes Frameworks.

4.10 The Steering Group would also need to ensure they use the Government's national recommendations in carrying out their work. Those are:

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 behaviour
6. Support research, data collection and monitoring
7. Develop effective action, both preventive and responsive, for people who harm themselves.

Most recent guidance issued by Public Health England (PHE gateway number 2014346, 1 Oct 2014) recommends the following actions for local areas:

- If not already in place, local areas should consider a local suicide prevention action plan that is kept up to date and fits local circumstances.
- Local Directors of public health are well placed to lead the local data monitoring/surveillance function.
- Local areas consider creating local forums to monitor suicide trends, rising threats (e.g. social media) respond to incidents, co-ordinate and deliver the suicide prevention strategy locally.
- Engage with local media regarding suicide reporting.
- Work with transport and other partners in health and wellbeing boards on mapping suicide hot spots and take appropriate actions.
- Working on local priorities to improve mental health. Both promotion of good mental health and prevention

5.0 Objective 2

5.1 Recommendation - Develop continuous *multi-agency* audit of suicide (including any emerging trends or patterns) across Berkshire in order to inform and implement our aims.

5.2 In order to have useful information about risk factors (and hence groups and individuals potentially at risk of suicide), the Steering Group would need good local intelligence.

5.3 Traditionally, mortality files (which contain very basic data extracted from death certificates) provide local information about age, gender, occupation and cause of death. This gives a useful – but rudimentary – local picture of numbers and methods of suicide. It may enable local authorities to identify, for example, 'hot spots' for suicide. But it gives no clues about motive, risk factors, life events, illness, or anything about whether the deceased got or tried to get help from services.

5.4 The suicide prevention alliance needs data that might enable preventive action to be taken, and should gain this by the Steering Group developing confidential continuous multi-agency audit of self harm and – especially – suicide data. This would involve the Steering Group setting up an audit team, led by a senior local professional or clinician (for example a GP, psychiatrist, social worker or Consultant in Public Health) and including staff members from mental health, local authority (e.g. social care, children & families, housing), to gather confidential data on each death. This would include Coroner's data, and any data about any contact the deceased had with local services. This would inform local preventive action and allow the Steering Group to determine any particular local risk factors. When conducted in a sensitive and 'no blame' way, this should enable the alliance to identify possible risk factors or even 'hot spots' so that preventive measures can be considered.

5.5 Public Health and the Coroner began the first stage of this audit in September 2014.

5.6 Identifying any particular local risk factors
(As a useful example of 'local intelligence', Bolton's suicide prevention alliance's multi-agency audit enabled them to identify a specific unusual pattern of deaths among women in a particularly age group, in contrast to the 'usual' pattern of men tending to have higher risk. The Bolton alliance were able to use multi-agency audit to identify that this particular cluster had some specific high risk factors and also history of contact with specific services. This is the kind of local data that could enable a steering group to ensure that specific help is developed.)

5.7 Drug overdoses are a fairly common means of self-harm and suicide, and stakeholders recommended examining whether pharmacists could be engaged in reviewing access to over-the-counter medicines.

5.8 The Steering Group could also recommend how the local Joint Strategic Needs Assessment should be developed so as to provide useful epidemiological data to assist all this ongoing work. While the JSNA only provides non-confidential information, nevertheless, local data relating to any of the risk factors for suicide and self harm (for example, epidemiological analyses of disadvantage and deprivation, mental health, disability, distribution of chronic illness) can assist the suicide risk reduction work in the short and medium terms.

6.0 Objective 3

6.1 Recommendation - Translate local and national intelligence and research findings into useful local action, especially commissioning, training and service quality improvement

6.2 The CCG could ensure that the Steering Group would use local and national information to recommend action. The CCG could commission accordingly. One good example of how to reduce suicide risk can be found in Bolton's strategy, and it can easily be seen how a very similar approach could be used in Berkshire:

> 'General Practices can make a big difference to suicide rates. GPs regularly encounter people with many of the known factors for higher risk of suicide, for example long-term physical health problems, self-harming, drug and alcohol misuse and mental health problems. GPs are the first point of contact for many people who are experiencing distress or suicidal thoughts and who may be vulnerable to suicide. GPs can help by providing information on sources of support and are also the key gatekeepers to specialist services. Primary Care staff may also be the first point of contact for people who are bereaved or affected by the suicide of family members, friends and colleagues.'

> Health visitors, midwives and other community staff may be in contact with children, young people and families and be the first to be aware of mental health problems or other difficulties developing. They can therefore provide direct support and also refer speedily to other services. *(Bolton Council (2013). Acting on evidence: A strategic framework of evidence based recommendations for preventing suicides in Bolton (2013-16))*

6.3 Local stakeholders have made the following recommendations for coordinated preventive awareness training to improve mental health and behaviour in schools:

6.4 Stakeholders consulted in drafting this strategy recommended using a coordinated approach for comprehensive awareness training about self-harm and support for all relevant local professionals who work with children and young people, including those working in:

- Perinatal mental health (midwives, maternity care, health visitors)
- Schools and early years settings
- Children's Centres'
- Youth workers
- Voluntary and PVI sector
- School nurses
- Community leaders/faith leaders
- Primary care staff including GPs
- Youth offending teams
- Looked After Children's teams
- Social care
- Family nurse partnership practitioners.

Note: It will be important, when approaching self harm among young people, to coordinate this work with inclusion and CAMHS initiatives. The relevant CAMHS pathway is included as Appendix 4.

7.0 Objective 4

7.1 Recommendation - Focus on individuals and groups at high risk and continuously develop local interventions to support them in reducing their distress; ensure that barriers to support are reduced (these actions will be co-ordinated between local authorities, NHS and voluntary groups)

7.2 Many people who take their own lives are believed to have found themselves facing multiple difficulties all at once in their lives. While we may cope well if we face one or two, if we then encounter more, we can quickly become very distressed. If our usual ways of coping with difficulties don't seem to work anymore, we can rapidly face severely escalating distress. If we try to get support, but services seem inflexible, it is easy to become hopeless.

People who live with disadvantage are more likely to already have to cope with more difficulties (risk factors). Disability, lack of money, constant difficulty in trying to ensure your family have decent housing, all these are stressful. Sudden changes – especially things like loss of employment and its consequences for debt – make a huge difference.

7.3 Some residents already face multiple difficulties that may not go away. Losing a partner after many years, or a series of losses, having been a Looked After Child, having a major physical or mental impairment, being old and having no social contacts any more, and especially having a severe and enduring mental illness, all weight the scales heavily against wellbeing. Stakeholders recommended that loneliness be taken very seriously as a risk factor. If someone already has more than one of these factors, encountering other severe life events can more quickly lead to escalating distress and hopelessness.

7.4 Individuals facing these difficulties may not be able to see a way out of it. But an alliance of local services actively working to ensure no-one faces too many without support could anticipate and prevent some of the likely risk and harm. Figure 1 thus gives us a potential framework for seeing how local services could act as effective buffers – and in some cases potential life-savers – for people encountering multiple risk factors for suicide. But their effective use by the Steering Group may also rely on the Steering Group having identified local 'groups' at risk. (To do this the Steering Group will need to audit suicide and self harm data from the past few years to see if any patterns appear.)

7.5 National research suggests that many of the following are risk factors for suicide:

- Socioeconomic deprivation
- Social isolation, living alone, loneliness
- Depression/stress
- Long term and/or distressing physical health conditions
- Relationship problems
- Bereavement
- Domestic violence
- Problems at work
- Recent unemployment, redundancy
- Facing discrimination or bullying
- Drug and alcohol problems[2]
- Criminal suspicion or conviction which has the potential to significantly disrupt life

[2] Stakeholders recommended that the Steering Group should actively examine the extra risk placed by increased access to alcohol (for example, 24-hour selling and home delivery of alcohol) and drugs, and propose action on local alcohol licensing, for example.

- History of suicide attempts (especially)
- Self-harm (It will be very important for the Steering Group to distinguish – where possible – between those who self harm in a very serious attempt at suicide and those whose self harm may be less driven by strong intent to die and perhaps more as a more regular means of obtaining temporary relief from unbearable feelings. Stakeholders emphasised that 'We especially need to capture repeated self harm. We may need a more effective system for recording self harm and also for ensuring effective help is given. Need to be able to differentiate between more habitual lower-level self harm and serious attempts that are potentially dangerous. Need to do a trawl of the data, especially in primary care and ambulance services, as well as A&E data. We should not neglect this group.')

7.6 It can easily be seen how mental illness, for example, may also increase the likelihood of an individual experiencing unemployment, low income, having housing problems, having relationship difficulties, and finding themselves isolated. And how much greater the risk might be if they are older and living alone, being exploited, having language barriers… Not all of these will be so relevant in Berkshire, but each of these that a person encounters increases their risk of suicide. There are many services, groups and projects locally which regularly encounter people experiencing one or more of these risk factors and hence their interactions provide opportunities to detect and reduce risk.

7.7 The actions of others can also influence vulnerability to risk, for example through bullying, harassment, stigma and prejudice. Local authority action to support communities to maintain and increase inclusivity and neighbourly support not only has the potential to reduce risk of suicides but, like so much of this work, can reduce distress and improve wellbeing for all. Initiatives that aim to decrease isolation and help people in 'higher risk groups could become important protective factors increasing resilience and reduce risk. The Steering Group could examine whether these are in place.

7.8 Alienation and the feeling of being an 'outsider' develop in adolescence or earlier, and is compounded when peers ridicule apparent differences. Anti-bullying, anti-stigmatising and mental wellbeing improvement measures in schools cannot be emphasised enough here.[3]

7.9 Similarly, when adults facing major barriers to good mental health are bullied at work, this can push them into crisis. Bullying at work is more widespread in UK public and private sectors than is often acknowledged, and has a strong negative impact on mental wellbeing. This is one of the wider determinants of stress and self harm (see Figure 1) and is an important issue for stakeholders to influence.

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[3] Stakeholders suggested that the Steering Group should make recommendations based on the report: Department of Education (2014) Mental health and behaviour in schools: departmental advice. London. UK Government.

7.10 The second part of this recommendation is to ensure that support is readily available to people facing multiple risk factors. Stakeholders said: ‘We need to identify the points in the ‘system’ where patients in crisis can get lost, fall through the net. There are missed opportunities to share information. People move around so we may need to share current info of their whereabouts’. It is not enough to say ‘services are available’. There is good evidence that the more disadvantaged a person, the harder it is for them to find and make good use of health and other services. People in distress and especially those who are very disadvantaged will tend to find it much more difficult to use services. They face many barriers and will be easily discouraged. Stakeholders said: ‘If only a few people with suicidal intent get as far as mental health services, then are we screening properly? People who are fine on Thursday but feel dreadful by Friday need good quick access to effective support’. We must ensure that services are sensitive to the needs of people facing escalating suicide risks and offer help quickly. This is especially true of services that are set up to offer support in times of emotional distress (mental health services, helplines, self-help groups, peer support groups, psychological support) but can be equally relevant to the places where people may present during difficult or vulnerable periods (Citizens Advice Bureau, General Practice, job centres, welfare agencies, food banks). Police, justice services and forensic services should be consulted or involved in this work. There may be a group of people with mental health difficulties in contact with court diversion services, and so on.

7.11 Commissioners of local services need thus to be responsive to needs and also pro-active towards barriers to access faced by vulnerable people. This sometimes requires research and consultation with people who access support or those who may face extra barriers, to ensure they do not quickly decide that there is nowhere to turn. This may involve commissioning active outreach services. The quality of the experience of people using support services is as important as accessibility, in terms of suicide risk reduction. Access often requires vulnerable people to overcome significant personal concerns and reservations about the quality of the service they will receive and the impact it will have. Initial contacts with a service (such as general practice) are often where vulnerable people will make instant judgements about how helpful the support is going to be, and are therefore pivotal in identifying opportunities for support and in identifying risk. (In this context we can more easily see how the attitudes and skills of non-clinical staff are vital since they are often the first point of contact with a service for someone in distress.)

7.12 The Steering Group should work with service users and voluntary organisations and make recommendations accordingly to the CCG and other commissioners about actively ensuring that good support is rapidly available to people facing multiple suicide risk factors.

7.13 Good local information may already be available about the support-seeking behaviours of very vulnerable groups. The Steering Group may wish to recommend how it can be developed more comprehensively so that it informs the suicide prevention approach shown in Figure 1.

7.14 Figure 1 can also be used as a checklist. If the Steering Group wishes to ensure that good comprehensive support is put in place, members can take many of the recommendations in the table and ask themselves: “Does this currently work for someone encountering multiple risk factors for suicide?” “Would someone with a long history of difficulty feel that these services were working and helpful to them?” If the answer is “No” then the Steering Group and the commissioners have an immediate target for improvement.

7.15 As an example of how the Steering Group should approach this, we can try to imagine the following groups who were identified in the National Strategy as high-risk groups who are priorities for prevention, and consider whether we think local services would respond effectively to them is they present with escalating distress due to multiple losses:

- Young and middle-aged men
- People in the care of mental health services, including inpatients
- People with a history of self-harm
- People in contact with the criminal justice system

Would they be likely to get help quickly and easily, particularly at a time when they might be feeling increasingly desperate, isolated and hopeless? Figure 1 might be used as the checklist for this. Similarly, while one service may be helpful, it may not always be easy to ensure smooth referral and quick access between services.

7.16 The Steering Group may want to recommend improving care pathways between key services. For example, how do we imagine those four groups (see bullet points above) might experience coordination between:

- Emergency departments
- Primary Care
- Secondary Care
- Inpatient care
- Community care
- On hospital discharge?

7.17 Bolton Suicide Prevention Strategy lists many pages of comprehensive action lists for action and for multi-agency long-term prevention. This list will be very useful to the Steering Group once their work is underway.

7.18 Stakeholders involved in drafting this strategy recommended examining whether people from any particular cultural backgroups appear at higher risk locally, and if so, whether the Steering Group should recommend action to increase awareness among local faith and/or community leaders.

7.19 Stakeholders recommended that the Steering Group could examine any harmful influences of internet websites providing information on ‘DIY means of suicide’, bullying, trolling etc. (This would be dependent on whether local audit reveals any such influences).

7.20 Stakeholders also recommended examining whether self-harm and suicide risk was elevated among armed forces veterans locally.

8.0 Objective 5

8.1 Recommendation - Ensure that people bereaved and affected by the suicide or self harm of others receive a rapid and automatic offer of support

8.2 It will be very important for the Steering Group to recommend effective action to ensure that friends, family member, colleagues and service providers likely to be affected by someone's suicide are contacted very quickly so as to offer support. It will also be vital that effective support is available. While this may sound like a daunting initiative to set up, examples are available of how this is routinely done, in a sensitive and coordinated way in some areas. For example, in one area of Northern Ireland, family members of someone suspected to have died from non-natural causes will, apparently, automatically be contacted and offered support. Bereavement support should be based on assessment of need.

8.3 Other possibilities include:

- Ensuring that GPs and Primary Care practitioners are aware of the potential vulnerability of family members when someone takes their own life, and how to respond well;
- Providing a system of emotional and practical support for families bereaved or affected by suicide;
- Providing bereaved families with explanation of policies on investigation of patient suicides, opportunity to be involved and information on any actions taken as a result.

9.0 Objective 6

9.1 Recommendation - Involve other local commissioners and stakeholders in the strategy and action, using the 'whole picture' (Figure 1) approach to ensure co-ordinated action at all levels.

9.2 The Steering Group will need to inform the work of the Health & Wellbeing Board, firstly with recommendations on reducing inequalities in mental wellbeing relating to suicide and self harm, but also with recommendations about meeting mortality targets. For example, the Public Health Outcomes Framework (January 2012) includes the suicide rate as an indicator. Further indicators with direct relevance to suicide prevention are '*self-harm and excess under 75 mortality in adults with serious mental illness'*. The indicator on excess mortality is also contained in the NHS Outcomes Framework. Within the Health and Social Care Outcomes, suicide prevention supports '*Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm'.*

9.3 Similarly, *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages* is the latest Government mental health policy, and has an associated implementation framework. The strategy pushes for heavier focus on the mental wellbeing of the population and on early detection and prevention of mental health problems in addition to improvements in services for people with mental health problems. '*No health without mental health'* recommends that local commissioners work towards reductions in suicide rates, especially amongst vulnerable people in mental health services.

9.4 Local authorities and mental health services can between them take effective action to reduce the means of suicide. Suicide can often arise out of impulsive action in response to a sudden crisis or extremely difficult circumstances. Under these circumstances, one of the most effective ways to prevent suicide is to reduce access to high-lethality means of suicide to increase the possibility that the suicidal impulse may pass.

9.5 According to evidence, the suicide methods most amenable to intervention are:

- Hanging and strangulation in psychiatric inpatient and criminal justice settings
- Self-poisoning
- Those at high-risk locations

9.6 It is also important to be vigilant of, and respond to new or unusual suicide methods or patterns. Research and timely audit and monitoring of suicides in local areas can provide useful intelligence on emergent trends and cluster events. Just as local resilience and emergency planning groups can plan highly effective and well-coordinated prevention of disasters, so can local authorities and suicide prevention alliances can seek intelligence from police following initial investigation of the death or through the coroner's office following the police report to the coroner. The media also has an important role in preventing the circulation of detailed information concerning high-lethality suicide as detailed reports may increase the number of fatal suicide attempts. The internet is also a source of information on lethal methods.

10.0 Objective 7

10.1 Recommendation - Develop effective action, both preventive and responsive, for people who harm themselves.

10.2 It is important to ensure that in Berkshire, self-harm is taken very seriously, and that good quality support services are provided rapidly to anyone attending A&E from this cause. Many people who harm themselves are – despite some persistent negative stereotyping – experiencing very severe distress. (See Appendix 1 for examples). Anyone who harms themselves then has a much higher risk of shorter life expectancy because their risk of later suicide becomes a lot higher than the rate in the general population. Men who self-harm are more than twice as likely to die by suicide

as women and the risk increases greatly with age for both genders. It was estimated as long ago as 1994 that one-quarter of all people who died by suicide would have attended a general hospital following an act of self-harm in the previous year.

10.3 About one in six people who attend an emergency department following self-harm will self-harm again in the following year; a small minority of people will do so repeatedly. Many individual episodes of self-harm are indeed a definite attempt to end life, though some may instead be an attempt to get help or support from others. In all cases, they are a very serious attempt to obtain relief from awful and overwhelming situations or emotional states. And in fact the purpose of some acts of self-harm may be the person's attempt to preserve their life (as illustrated by vignettes 3 and 5 in Appendix 1). People who harm themselves as a way of relieving distress (through cutting, for example) may be doing this as their own coping and suicide prevention strategy (as with the person mentioned in vignette 5, Appendix 1). They are likely to continue to need to do this until they receive appropriate and sufficient psychotherapeutic interventions and support, and hence good quality effective psychological support for them is vital.

10.4 Given the big pressures on health and social care, it can be hard for a service to do more than 'patch up' someone who has sought their help. Services – such as crisis intervention – may not be able to do much preventive work. But if the Steering Group promotes a more co-ordinated network of support then Berkshire could have preventive, treatment and support services working actively to provide coordinated and comprehensive suicide risk reduction.

10.5 Self harm is not uncommon among children and young people. A survey of parents published in 2002 of 12,529 children and young people aged 5 years to 15 years reported that 1.3% had tried to harm themselves. In the same year, a survey in schools reported that 13% of young people aged 15 or 16 had self-harmed at some time in their lives and 7% had done so in the previous year. Teachers, parents and school nurses may not know how to respond to young people at risk. The Steering Group could promote a local conference to provide comprehensive information on self harm and suicide risk and prevention for a combined audience of these and other associated groups.

10.6 Self-harm is more common among people who are disadvantaged in socio-economic terms and among those who are single or divorced, live alone, are single parents or have a severe lack of social support. Poverty, childhood experiences of abuse, and experiences of domestic violence are all associated with a wide range of mental disorders, as well as self-harm.

10.7 Studies in the early 1990s showed that self-harm was also much more common among prisoners than among the general population. One-half of female remand prisoners had self-harmed at some time in their lives and more than one-quarter did so in the previous year. The corresponding figures for men were about half of those. Up to 10% of prisoners would self-harm

during their term, and risk increased with length of time in custody. The highest rates were found among sentenced female prisoners who had spent two or more years in prison, 23% of whom self-harmed during their sentence.

10.8 This high rate was largely explained by the fact that, among the prison population, there were much higher levels of the factors associated with self-harm. For example, between 12% and 21% of prisoners had at least four mental disorders simultaneously (including drug and alcohol dependence, personality disorder, neurotic disorder and psychosis); between 35% and 52% were dependent on opiates, stimulants or both; 20%–30% were severely dependent on alcohol; about one-half of female prisoners had suffered domestic violence; 10% of men and 33% of women reported previous sexual abuse.

10.9 Life events are strongly associated with self-harm in two ways. First, there is a strong relationship between the likelihood of self-harm and the number and type of adverse events that a person reports having experienced during the course of his/her life. These include having suffered victimisation and, in particular, sexual abuse. Second, life events, particularly relationship problems, can precipitate an act of self-harm. Many people who self-harm have a physical illness at the time and a substantial proportion of them report that this was the factor that precipitated the act.

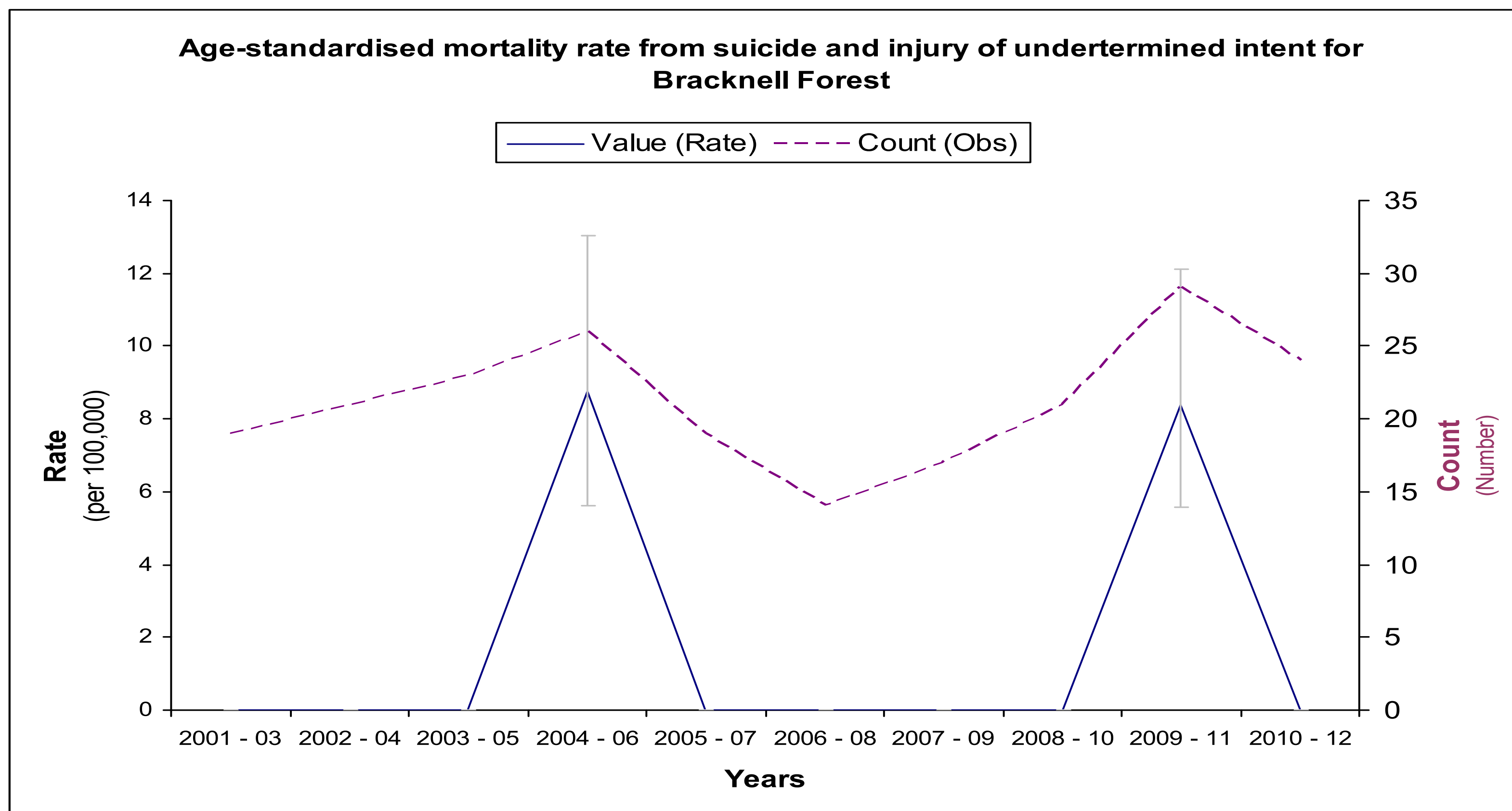
10.10 These research findings imply that local authority programmes can be planned so as to have a preventive impact on pivotal stress and life events among people at risk. For example, elected members in one London Local Authority led collaboration between their Housing, Employment, Public Health, and Children & Families Teams and the mental health services to identify residents at risk from benefit and housing changes and cuts in social care, and planned mitigating support for them. They had identified that mental health service users affected by ‘bedroom tax’ were harming themselves and attending A&E Self-harm occurs in all sections of the population but is more common among people who are disadvantaged in socio-economic terms and among those who are single or divorced, live alone, are single parents or have a severe lack of social support.

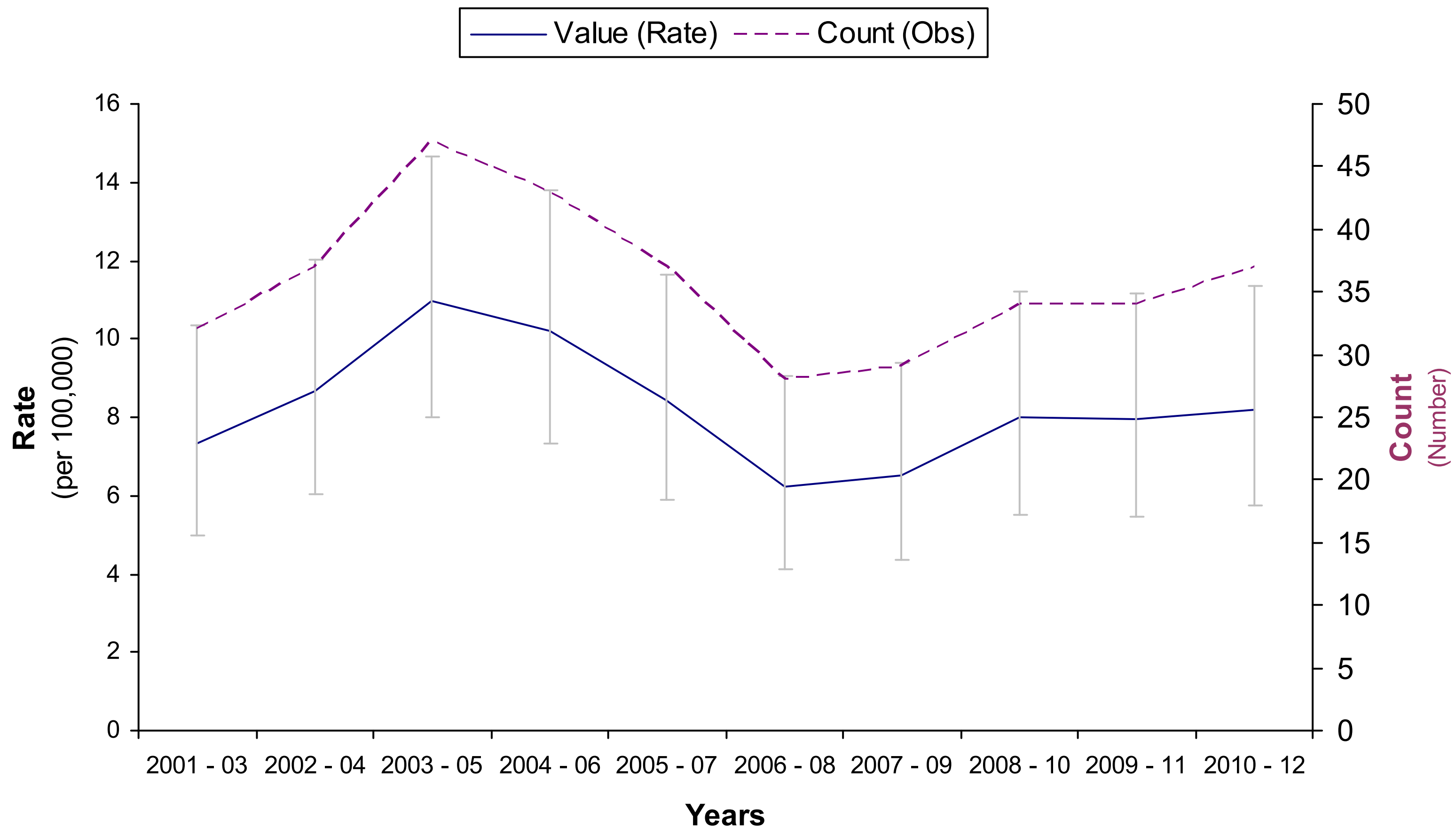
Appendix 1 - Five vignettes to illustrate the diversity of self-harm that falls within the remit of the guideline, and which highlight the seriousness of self-harm. (Source: Extracted from British Psychological Society. (2004). Self-Harm: The Short-Term Physical and Psychological Management and Secondary Prevention of Self-Harm in Primary and Secondary Care.
NICE Clinical Guidelines, No. 16. Leicester. National Collaborating Centre for Mental Health.)

1. A 55-year-old bank manager, married for 30 years and a mother of three children. She has had no recent major adverse life events. At age 30 she suffered a severe depressive illness that responded to ECT. She had been well and on no treatment for 23 years until she became depressed again 'out of the blue'. She became highly agitated and developed the depressive delusion that she was evil and would be responsible for the death of her children. To prevent this she drove to a secluded spot and took 100 tablets of her antidepressant.
2. A 19-year-old student who has no previous history of mental health problems or of self-harm. Towards the end of a party the young man, who had drunk 8 cans of lager, had an argument with his partner, went into the bathroom and swallowed a handful of aspirin tablets. He almost immediately regretted his action and told a friend who phoned for an ambulance which took him to the local emergency department.
3. A 22-year-old unemployed man who was raised in a series of children's homes. He was subjected to repeated abuse as a child and has a history of substance misuse. He has cut his arms since the age of 14 at an average frequency of about once every three weeks. This gives him relief from intense feelings of emptiness and despair. He presents to an emergency department for the third time in a month with superficial cuts to his forearm. He does not describe persisting low mood.
4. An 8-year-old boy, who was conceived when his mother was raped, was brought up by his mother and a stepfather whom the mother quickly married to avoid the shame of an illegitimate child. The boy was nevertheless called 'the bastard' by the stepfather, who also repeatedly sexually abused the boy from when he was about 4 years old. The mother was subject to frequent episodes of domestic violence at the hands of the pathologically jealous stepfather who attacked her for having a child by another man. The mother became depressed and began drinking heavily to 'escape' the beatings. When very drunk, the mother told the boy that her life was a misery and it was all because he had been born. In desperation the boy drank a bottle of bleach believing this would kill him and save his mother. He survived and was diagnosed as being depressed.
5. A woman in her thirties who was sexually abused by her father from the age of 2 until the age of 16. She has taken an overdose on two occasions with suicidal intent, and received life-saving hospital treatment. She also self-harms by cutting her arms and body as a relief from the experience of excruciating emotional pain, and as an alternative to attempted suicide. She describes herself as compelled to do this, and regards it as an act done to herself by herself which inflicts physical wounds with the intention paradoxically of helping herself rather than killing herself.

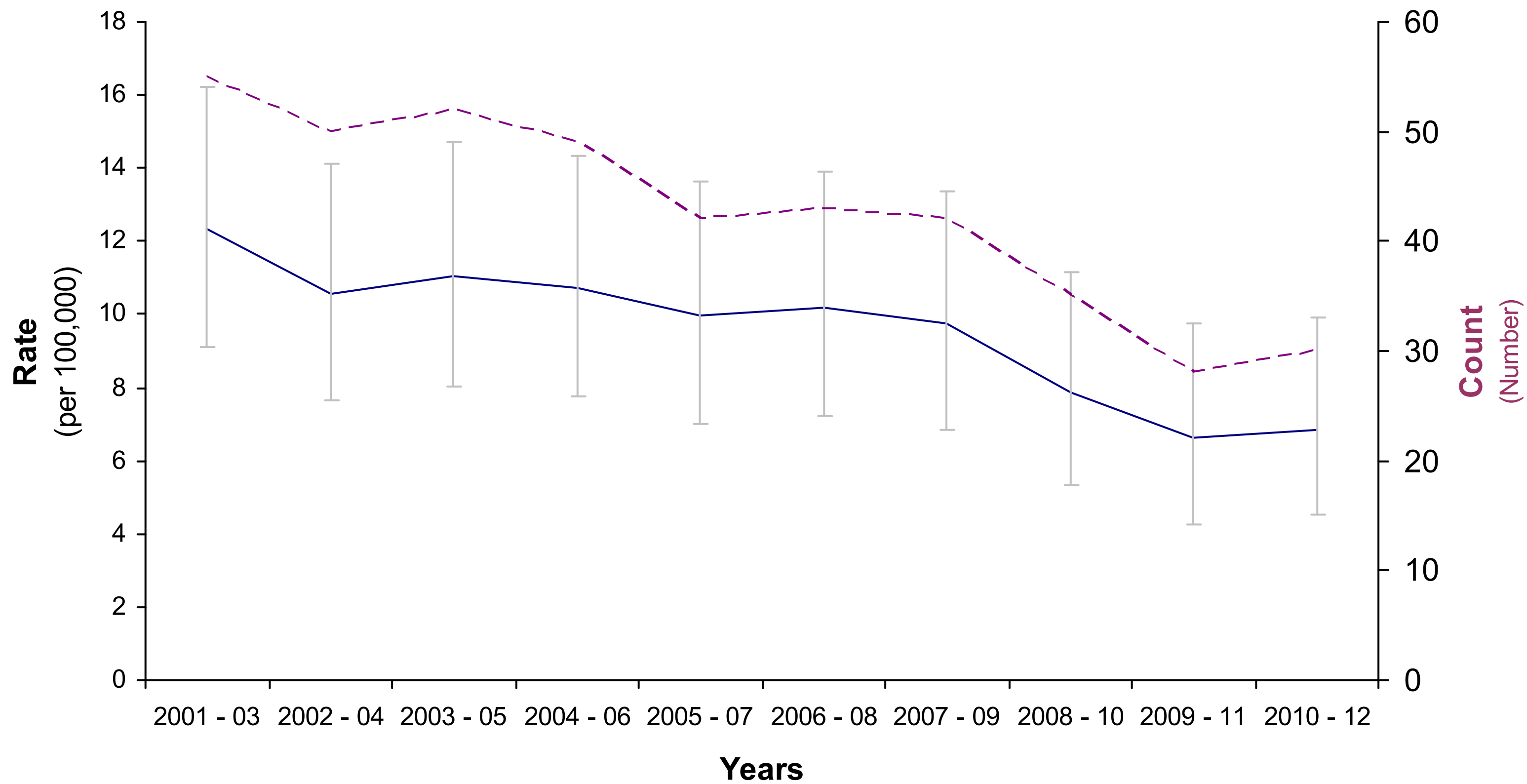
Appendix 2 - Trends in Suicide and injury of undetermined intent for Berkshire local authorities
Source: Public Health Outcomes Framework 4.10 - 2014

NOTE: Where there is no rate value it is because the Value cannot be calculated as number of cases is too small

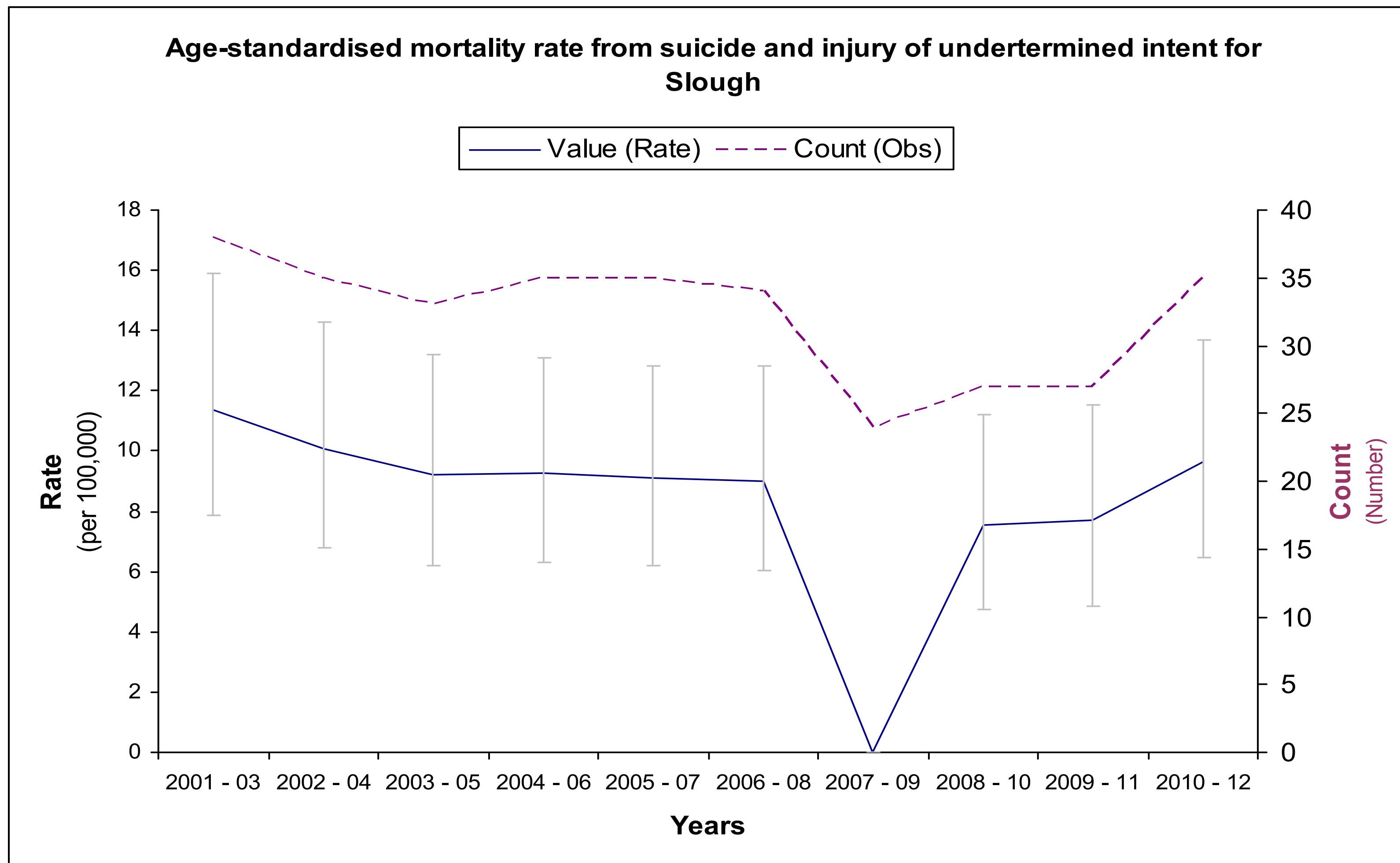




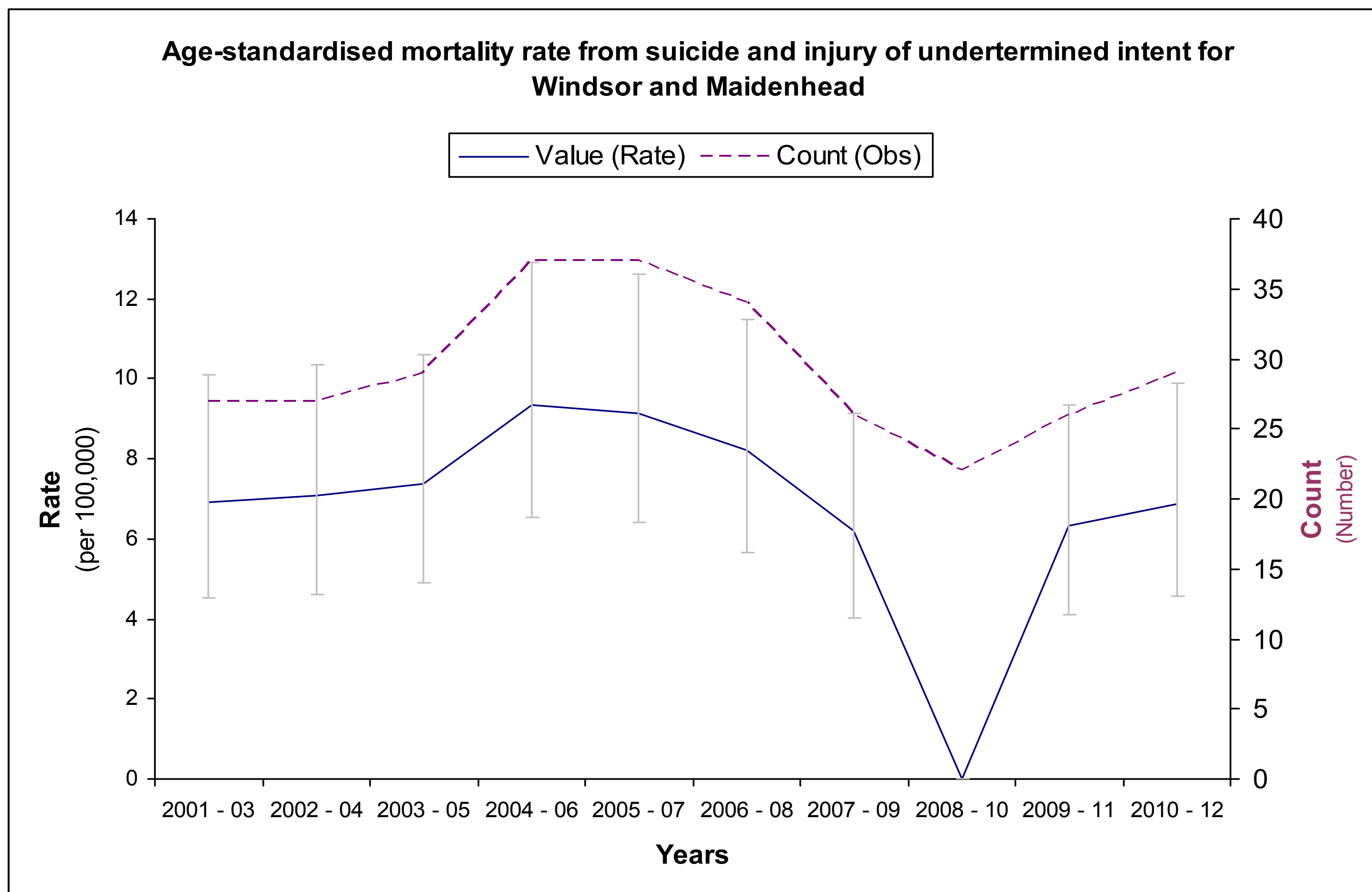
Age-standardised mortality rate from suicide and injury of undertermined intent for West Berkshire
Value (Rate)
Count (Obs)
Rate
(per 100,000)
Count
(Number)
Years
16
14
12
10
8
6
4
2
0
50
45
40
35
30
25
20
15
10
5
0
2001 - 03
2002 - 04
2003 - 05
2004 - 06
2005 - 07
2006 - 08
2007 - 09
2008 - 10
2009 - 11
2010 - 12


Age-standardised mortality rate from suicide and injury of undertermined intent for Reading
Value (Rate)
Count (Obs)
18
16
14
12
10
8
6
4
2
0
60
50
40
30
20
10
0
Rate
(per 100,000)
Count
(Number)
2001 - 03
2002 - 04
2003 - 05
2004 - 06
2005 - 07
2006 - 08
2007 - 09
2008 - 10
2009 - 11
2010 - 12
Years

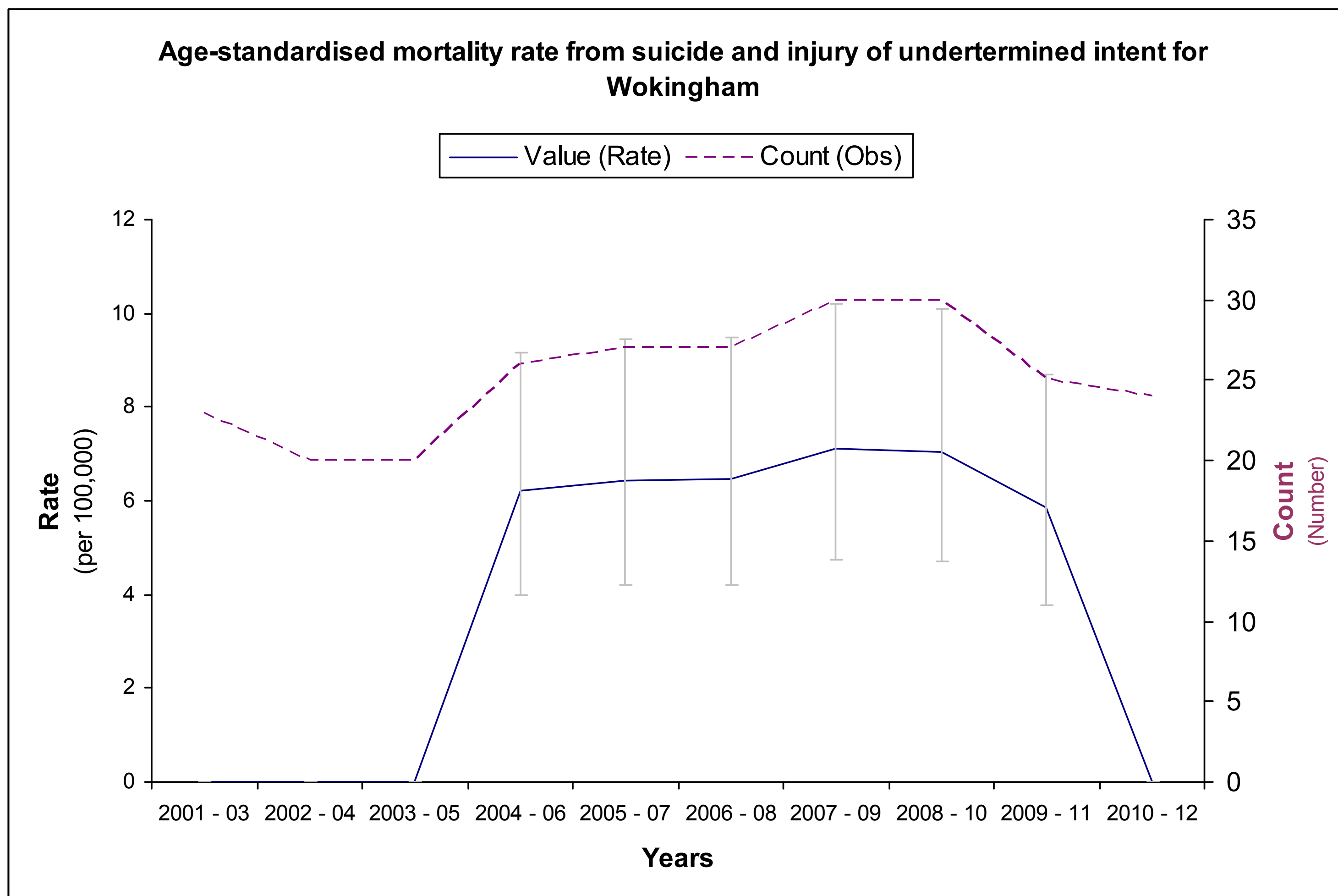
NOTE: Where there is no rate value it is because the Value cannot be calculated as number of cases is too small



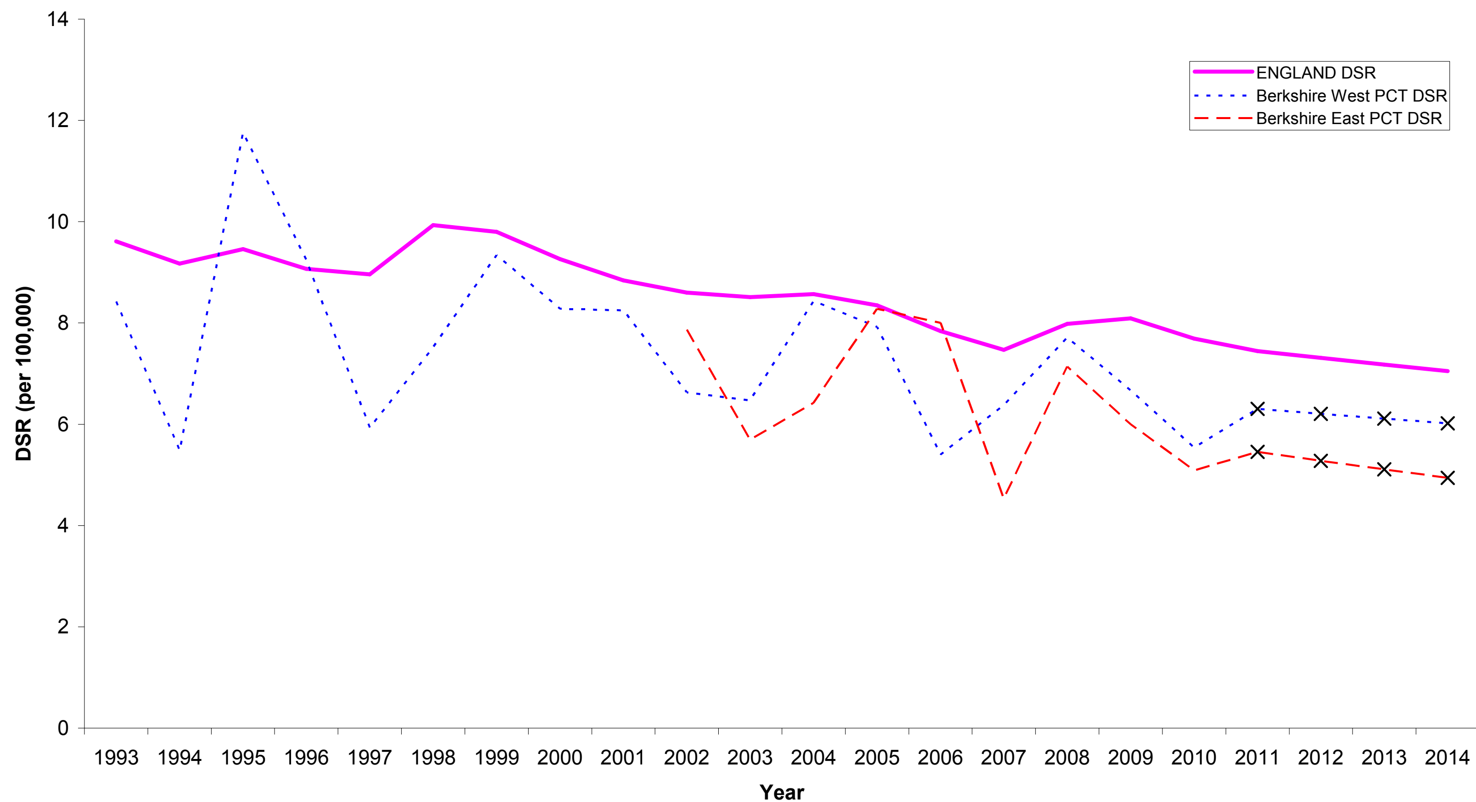
NOTE: Where there is no rate value it is because the Value cannot be calculated as number of cases is too small



NOTE: Where there is no rate value it is because the Value cannot be calculated as number of cases is too small

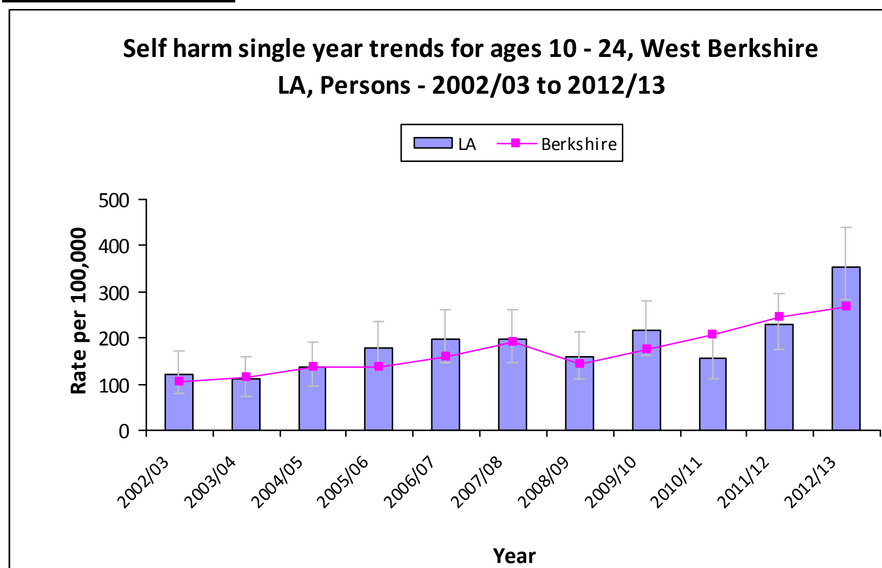


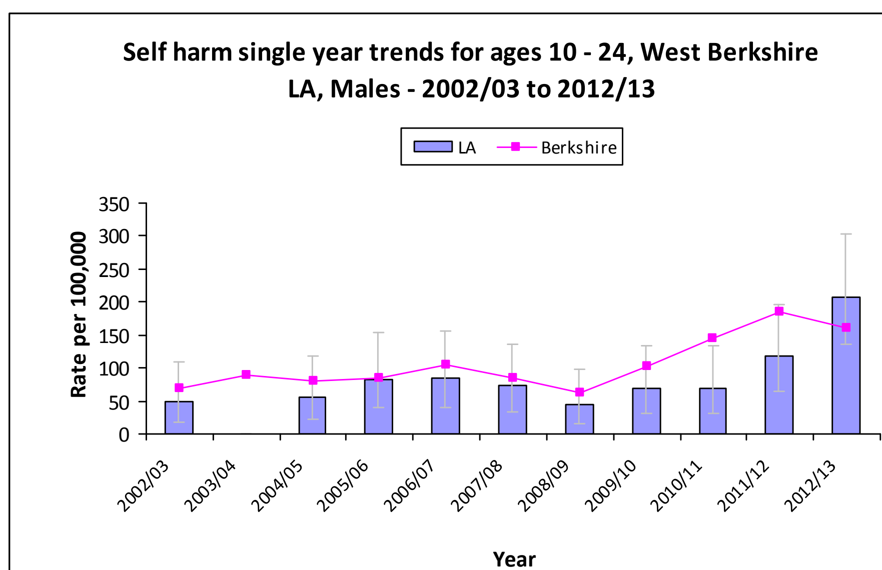
Suicide and injury of undetermined intent for Berkshire PCTs
Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base - 2012

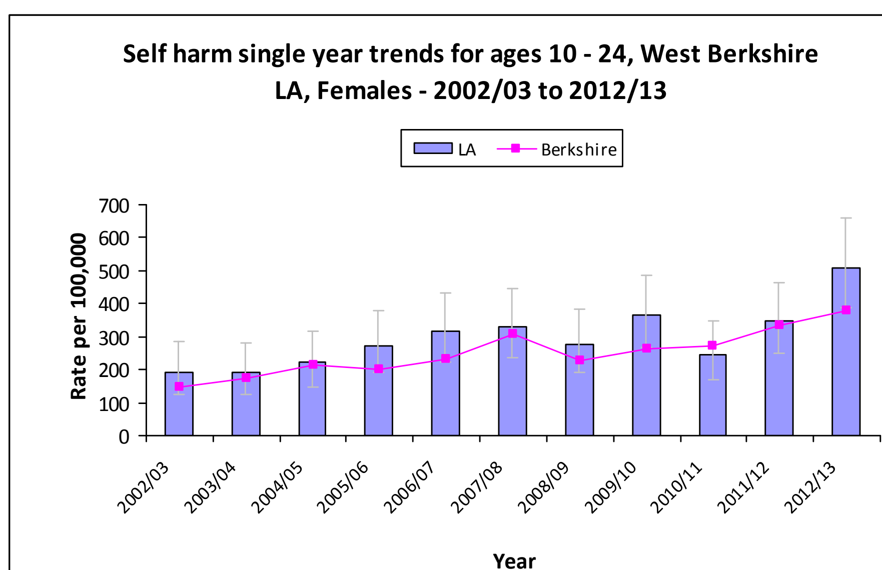


Appendix 3 – Self-Harm Charts

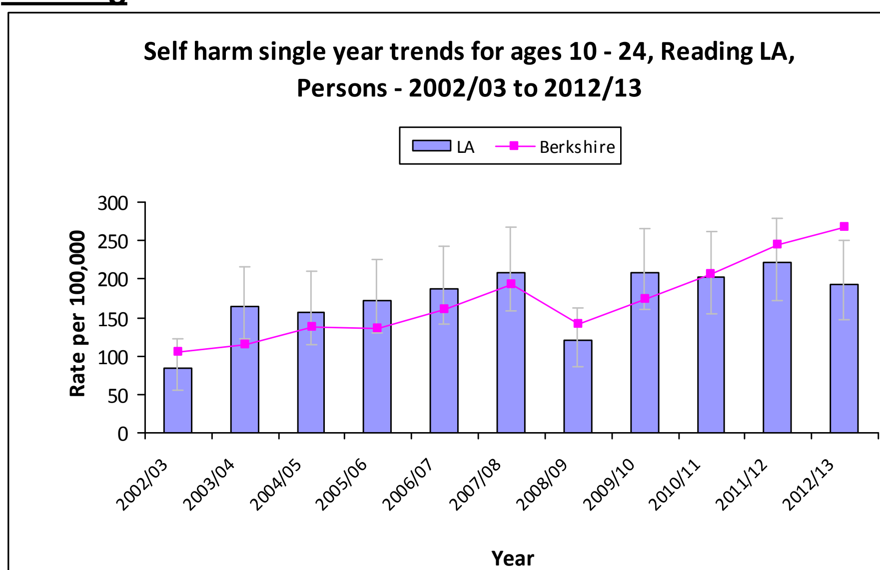
West Berkshire

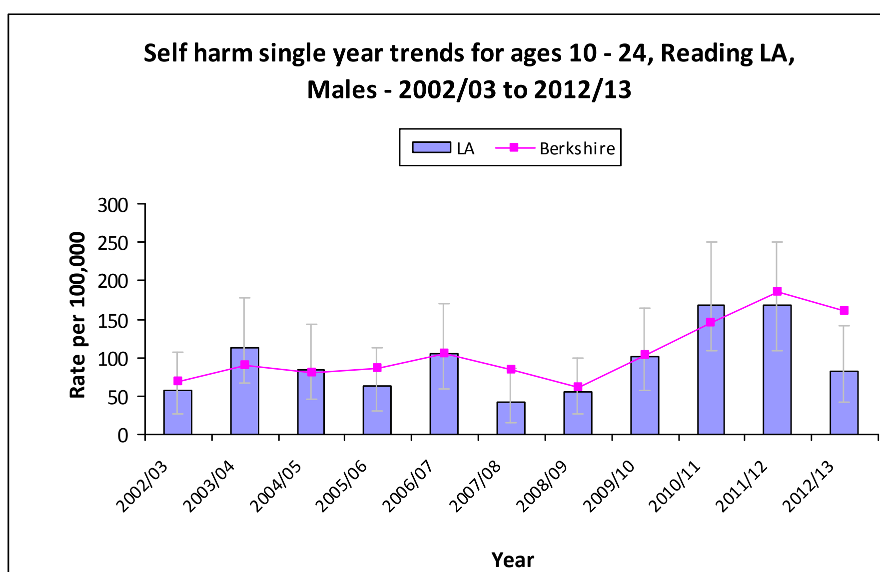


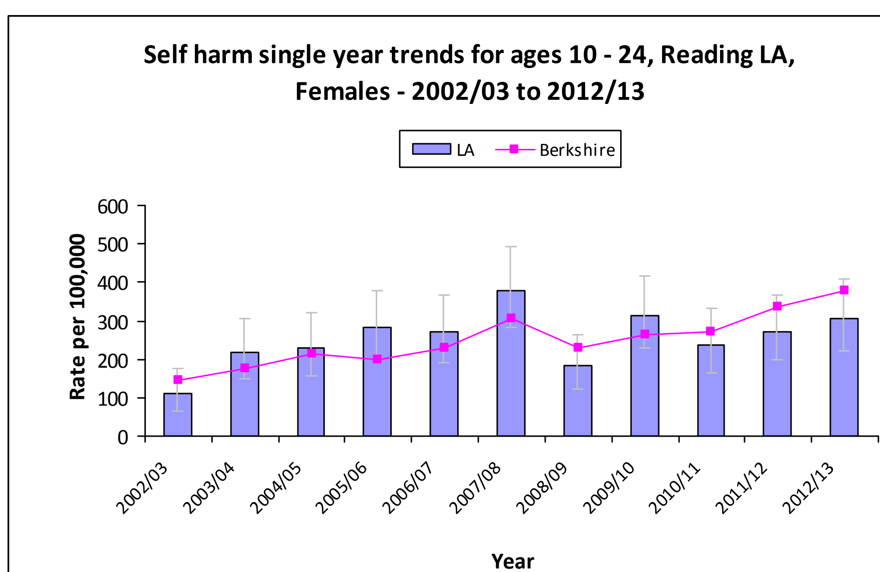




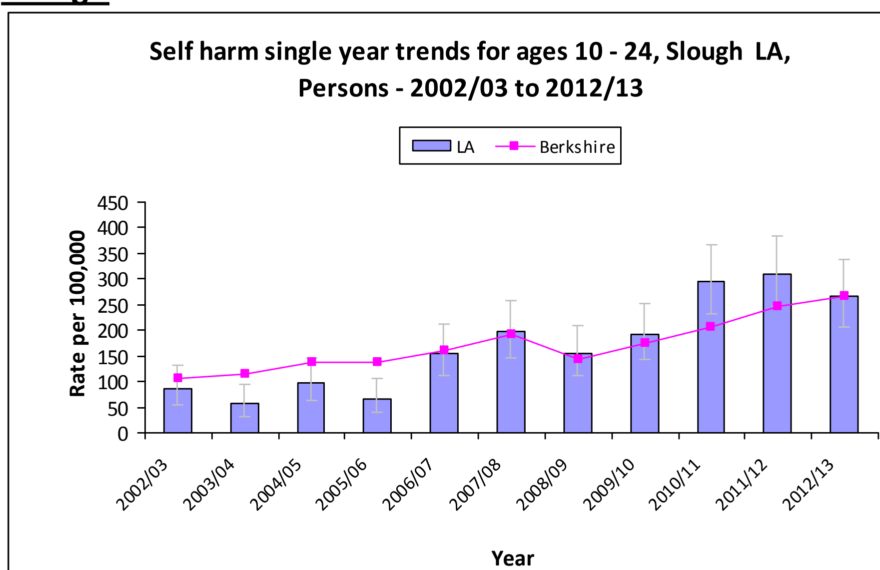
Reading

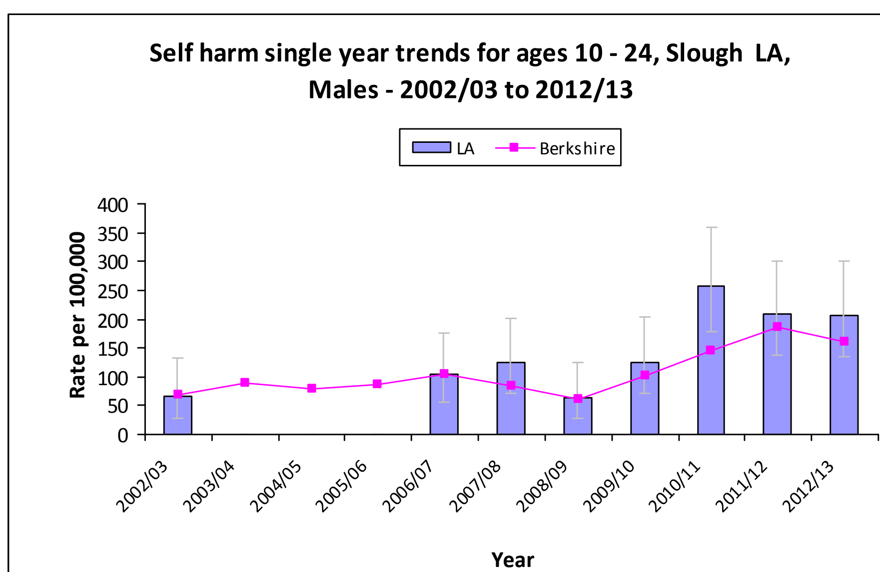


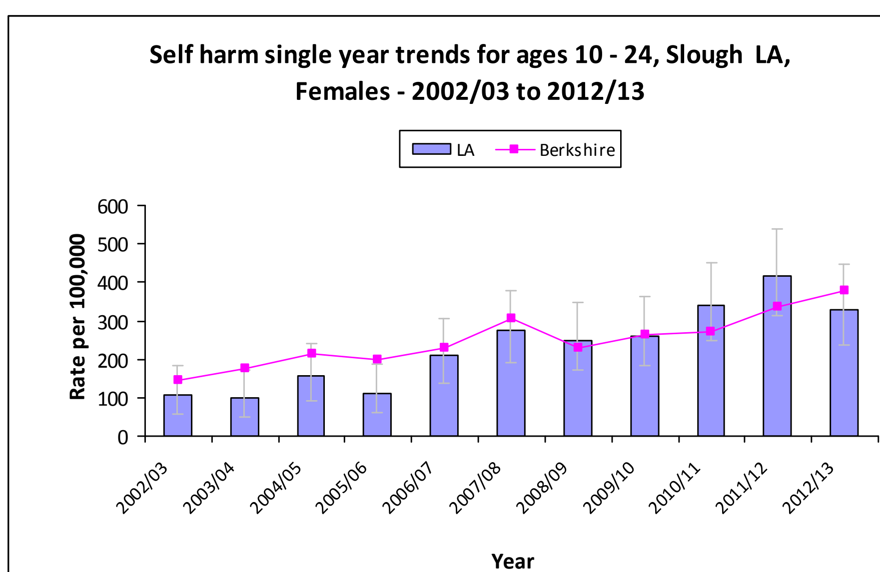




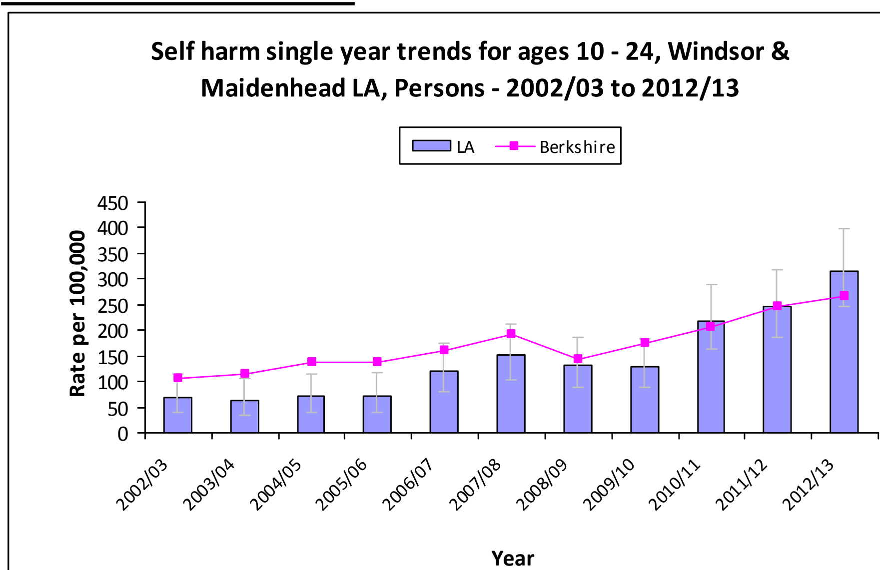
Slough

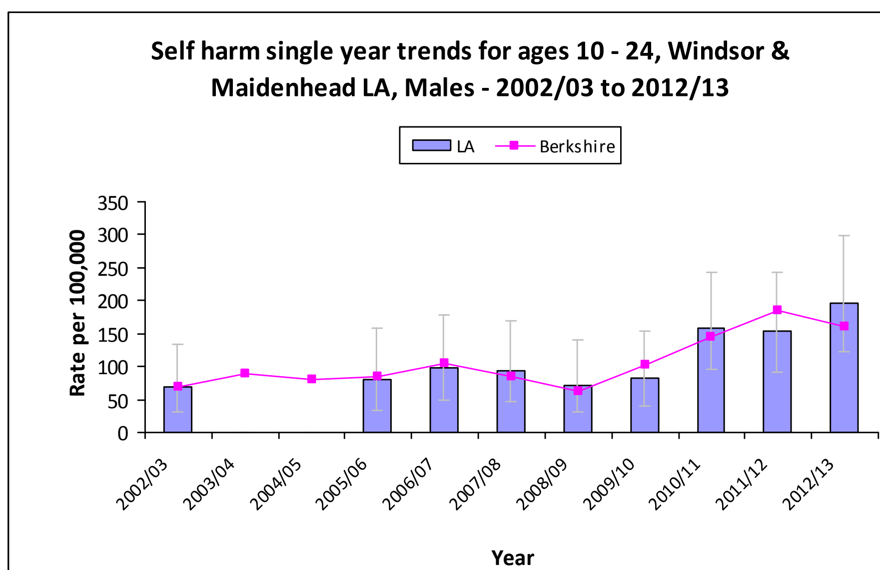


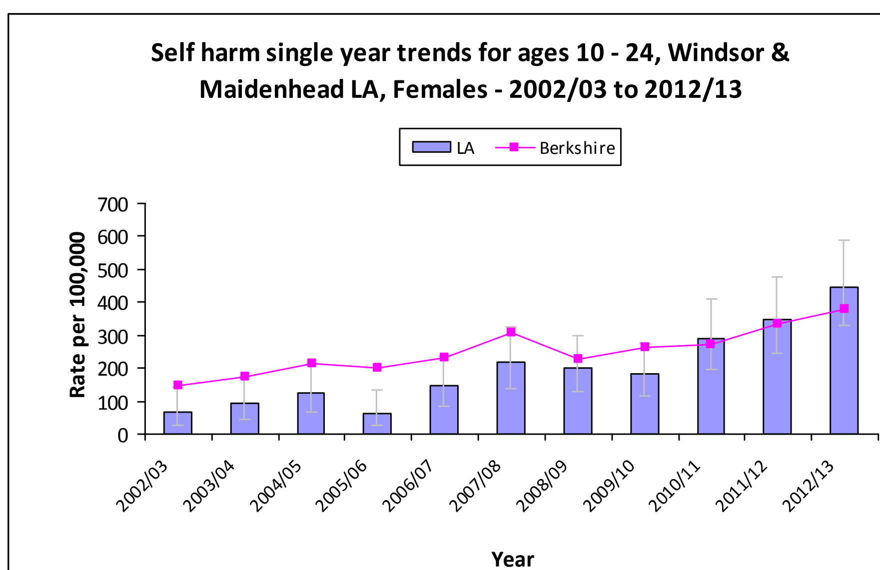




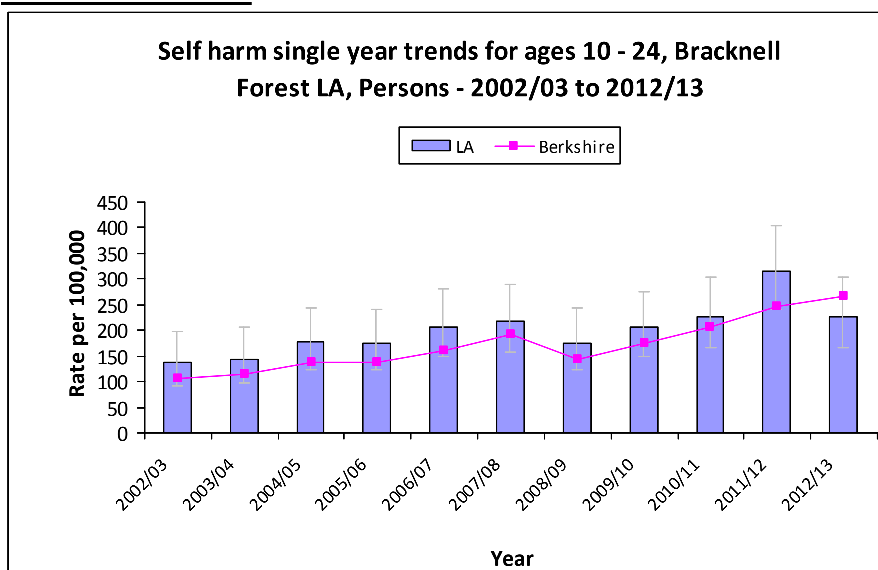
Windsor & Maidenhead

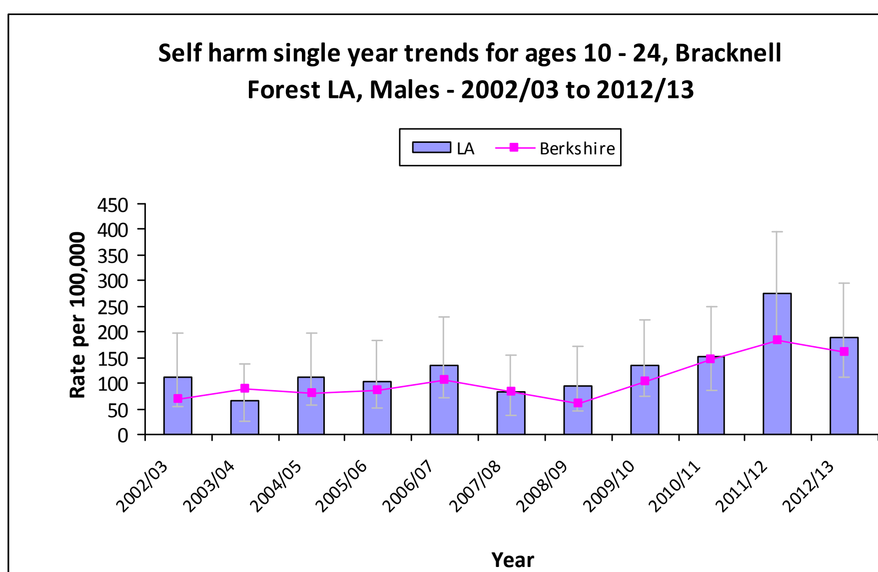


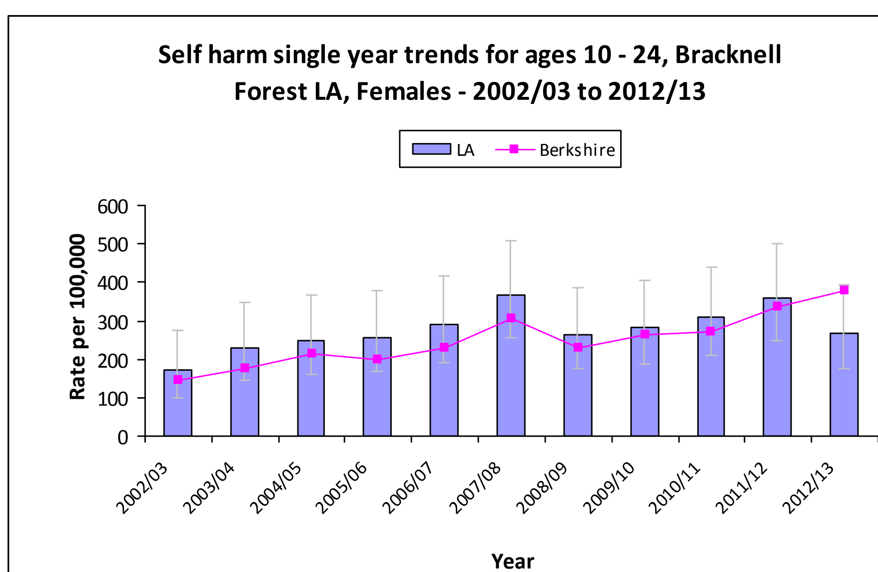




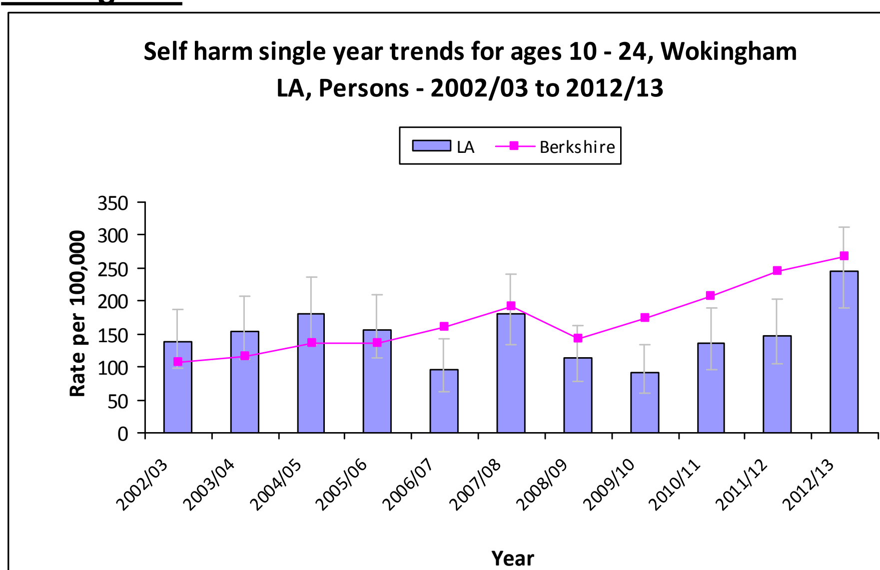
Bracknell Forest

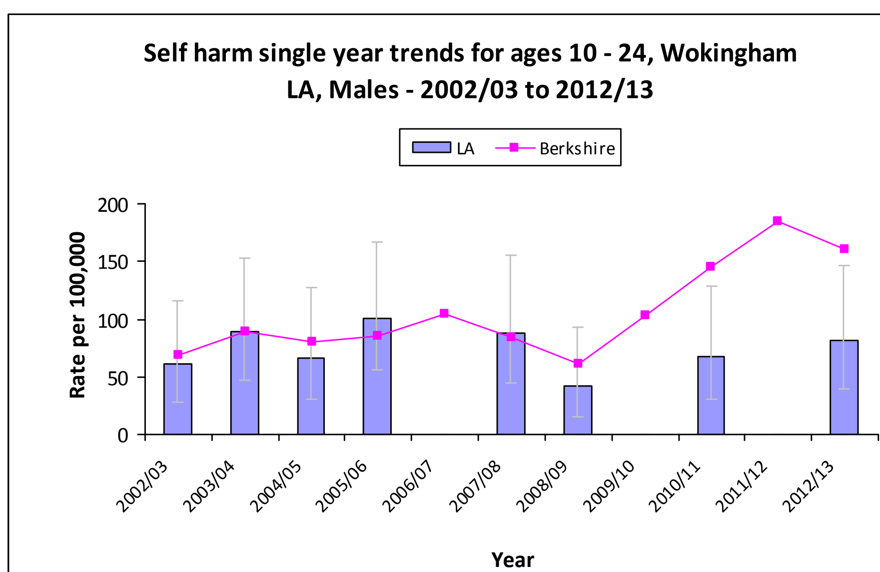


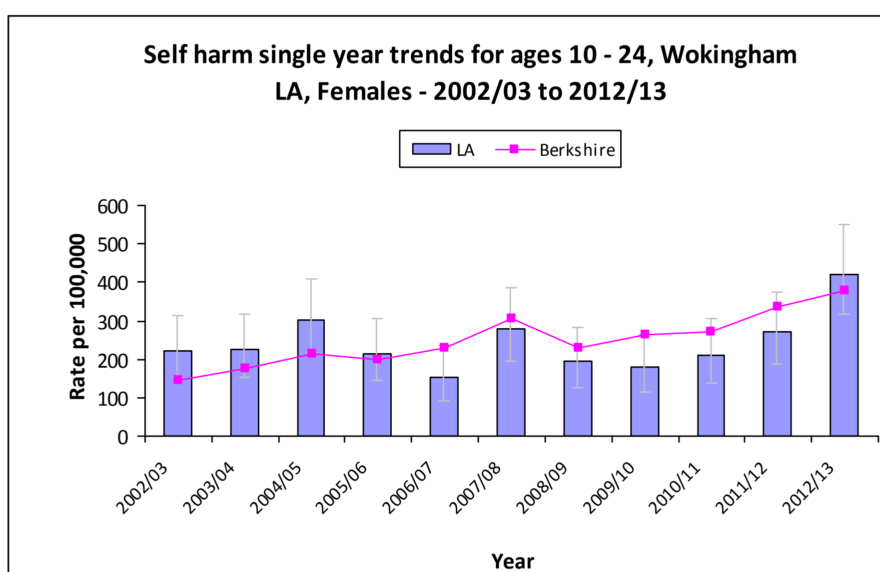




Wokingham



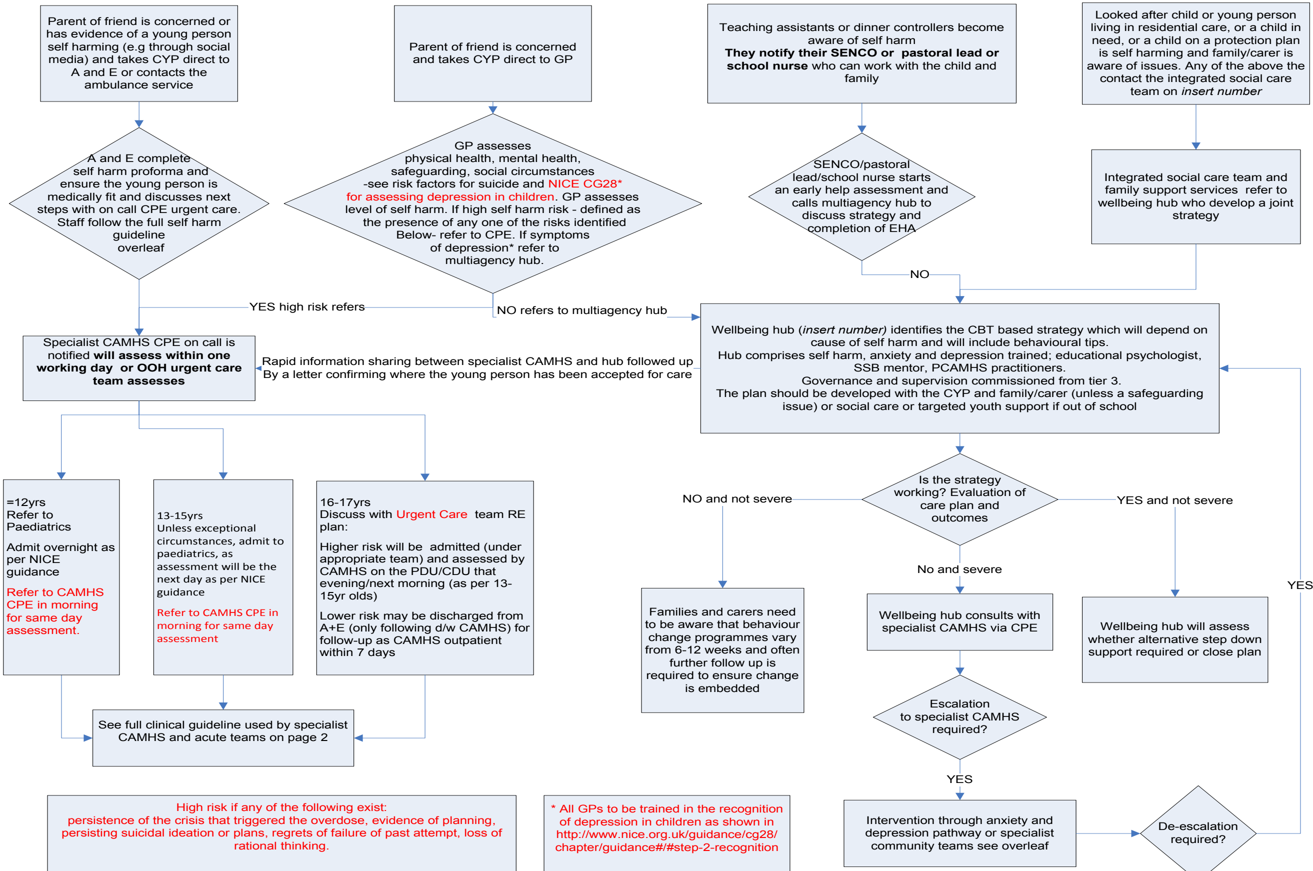




Appendix 4 – CAMHS Self-Harm Pathway to pilot with the Slough Wellbeing app 01.09.14

Self assessment of self harm includes:
Type, frequency, duration, triggers, strengths and resilience, suicidal thoughts, low mood, sleep deprivation, low self esteem and whether safeguarding issues are relevant.
Care plans should be developed by: school nurses, wellbeing PCAMHS services, and tier 3 with the aim of breaking the cycle through building resilience, regulation of feelings, thought management, developing a significant other person who can help, increasing personal safety awareness, body awareness and other activities to distract thoughts .

NB A confidential, PHE supported, Slough wellbeing app will be piloted and available on www.puffell.com from January 2015 to increase awareness of triggers, the importance of keeping a mood diary with options for promoting protective behaviours or escalation as required



Self harm is a coping mechanism for underlying distress which may arise' in family disputes, from anxiety in parents/carers, from the young persons own anxiety or depression or learning difficulties, or from bullying or in relation to perceived performance at school.

Primary school children rarely present with self harm rather they may present as anxious or misbehave or say 'I don't want to be here (at school)'. Copycat self harm behaviours can occur at younger ages. Secondary school age young people are more likely to not talk to anyone and self harm in response to a range of difficulties.

Self harm is common and 12% of 14-16 year olds and 15% of 15-16 year olds will attempt this at some point,

Parents/carers and CYP older than 14 years should be offered a self help guide either app based or on line .
See the Northumberland, Tyne and Weir self help guides at http://www.ntw.nhs.uk/pic/selfhelp/
A self help guide can be found in the Slough Wellbeing app which will also link the person to the anxiety and depression pathways. The goal should be developing life skills which can include increasing assertiveness, Mindfulness, building resilience, developing positive friendships, reducing safeguarding problems, help for parents with mental health problems etc. and a series of links to wellbeing websites

NICE guidance PH012 and PH020 on social and emotional wellbeing in schools apply at http://www.nice.org.uk/GuidanceMenu/Settings-and-environment#/Guidance/Settings-and-environment/Schools-and-other-educational-settingst

Schools should review their anti bullying policies regularly and training should include how to deal with on line bullying and the Chair of Governors should champion this.
See case studies at https://www.gov.uk/government/case-studies/talking-about-and-responding-to-school-cyberbullying

Each school needs a lead person trained in the multiple causes of self harm and how to deliver effective interventions. Ideally every headteacher, school nurse, practice nurse, GP, dinner controller, teaching assistant and youth worker should be trained in emotional literacy and self harm

Teaching assistants deal with issues daily and have listening skills and nurturing skills. The training must address their own response to seeing self harm as it can be emotive when a problem solving approach is required to establish what should be done

The lead educational psychologist for the school should ensure that staff are trained and have a range of behavioural tips (provided by the behavioural, emotional and social support team) to use.

All staff require competencies in self harm appropriate to their level As an initial training resource a lesson plan might include the Bucks guidance for schools at http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Self_Harm_Guidance.pdf . NB the final pages are likely to be more accessible by young people

On line free learning for all for all adults working with young people is available at Minded's e-learning site at http://rcpsych.ac.uk/usefulresources/minded.aspx.

Royal College of Psychiatrists leaflets are available for many conditions in different languages at: http://rcpsych.ac.uk/expertadvice.aspx

Supervision structures in the school can be augmented by the wellbeing hub who can offer family therapy (Friends for Life) or escalate at any time to early help or Tier 3. The wellbeing hub will develop a personal care plan from mood diaries created within the app

The hub will include dedicated educational psychologists who can advise re CBT and other problem solving interventions and can train staff in emotional literacy and management techniques within PSHE or nurture groups.

CBT approaches are very effective for anxiety or depression id these are causes of self harm. Strategies to build problem solving skills that are effective are CBT or DBT based although the latter is not yet commissioned across Berkshire.
A CBT trained person within the school should support front line staff to develop their nurturing and listening skills.
Emerging evidence for more vulnerable subgroups includes the use of music therapy..
The local offer will state what additional services are on offer in each local school.

An escalation through the early help assessment process may be required if sexual abuse is suspected and post traumatic stress disorder is suspected,.

If the cause is parental separation signpost to national charities such as Relate for on line counselling or consider other local options

Appendix 5 – Risk factors in children and young people which the strategy should

Table 1: Risk factors for mental disorder in children and young people (from DH Public Mental Health review 3)

Risk factor	Impact on risk of mental disorder	Prevalence in population
Use of alcohol, tobacco or drugs during pregnancy	Increased risk of a wide range of poor outcomes including long-term neurological and cognitive-emotional development problems[10]	
Maternal stress during pregnancy	Increased risk of child behavioural problems[11] Impaired cognitive and language development [12]	
Low birth weight	Associated with increased risk of common mental disorder[13] 4-5 fold increased risk in onset of emotional/conduct disorder in childhood[14]	
Poor maternal mental health		5.7% of mothers experience depression 2 months post-natally, 6.5% at 6 months and 21.9% at 12 months[15]
Unemployed parent	2-3 fold increased risk of emotional/ conduct disorder in childhood[16 17]	1.9 million children live in a workless household[18]
Poor parenting skills	4-5 fold increased risk of conduct disorder in childhood[19]	
Parents with no qualifications	4.25 fold increased risk of mental health problem in children[20]	
Deprivation – children in families with lower income levels	3 fold increased risk of mental health problems between highest and lowest socioeconomic groups (15% vs 5%)[21]	In 2007/8, four million (30%) children living in relative poverty (less than 60% median income)[22]
Four or more adverse childhood experiences (ACEs)[23]	12.2 fold increased rate in attempted suicide as an adult 10.3 fold increased risk of injecting drug use	15% of females and 9% of males experience four or more ACEs

Risk factor	Impact on risk of mental disorder	Prevalence in population
	7.4 fold increased risk of alcoholism 4.6 fold increased risk of depression in past year 2.2 fold increased risk of smoking	
Child abuse (physical, emotional and/or sexual abuse and/or neglect) [24]	15.5 fold increased risk of minor depression as a child 8.9 fold increased risk of suicidal ideation 8.1 fold increased risk of anxiety 7.8 fold increased risk of recurrent depression as adult 9.9 fold increased risk of adult PTSD 5.5 fold increased risk of substance misuse/ dependence	16% of children (1 in 6) experience serious maltreatment by parents[25]
Adolescent dating violence (ie. physical or sexual abuse by a dating partner)	8.6 fold increased risk of suicidality[26]	8.9% of women and 1.2% of men aged 16 to 19 sexually assaulted in previous 12 months[27]
High level use of cannabis in adolescence	6.7–6.9 fold increased risk of developing schizophrenia[28]	9% of children aged 11– 15 report cannabis use in last year, 7% of 15-year-olds report frequent drug use[29]

Source: NO HEALTH WITHOUT MENTAL HEALTH: A cross- Government mental health outcomes strategy for people of all ages Analysis of the Impact on Equality (AIE) Annex B - Evidence Base, DH Feb 2011

Suicide Risk and Self-Harm Reduction in Berkshire

Stakeholder Consultation

List of People who have commented/attended consultation meetings

Names	Job Titles
Andy Beckingham	Locum Consultant in Public Health, Public Health Services for Berkshire, (Bracknell Forest)
Belinda Dixon	Service Day, Maidenhead
Christine Price	Alzheimer's Dementia Support, UK.
Clare Stafford	Chief Executive, Charlie Waller Memorial Trust
Daren Bailey	Clinical Nurse Specialist, Prospect Park Hospital, (Reading)
Darrell Gale	Consultant in Public Health, (Wokingham Borough Council)
Dr Adrian Hayter	Chair, WAM CCG
Dr Angus Tallini	GP Partner, Falkland Surgery, Chair of Council of Member Practices, Mental Health GP Lead, Newbury & District CCG
Dr Chris Allen	Consultant Clinical Psychologist
Dr Katie Simpson	Mental Health Clinical Lead CCG Federation, (East Berkshire)
Dr Rosemary Croft	Mental Health Clinical Lead CCG Federation, (West Berkshire)
Dr Sue McLaughlin	Nurse Consultant, Prospect Park Hospital, (Reading)
Eugene Jones	Locality Manager Community Mental Health Team, (RBWM)
Jason Jongali	Interim Head of Mental Health & Learning Disabilities Commissioning, NHS Central Southern Commissioning Support Unit
Mark Evans	Head of Children's Services, (West Berkshire Council)
Nick Davies	Head of Strategic Commissioning for Adult Social Care & Housing (RBWM)
Ornella Veltri	Public Health Business Support (RBWM)
Pat Barlow	Mental Health Carer from the MH Partnership Board
Phil Dale	Information & Advice Officer, Berkshire Carers Service, Maidenhead
Adanna Nwanguma	Public Health Team, (Reading)
Rutuja Kulkarni	Head of Public Health (RBWM)
Sally Murray	Head of Children's Commissioning Support Berkshire NHS Central Southern Commissioning Support Unit, (Reading)
Shahbano Razvi	Public Health Programme Officer (RBWM)
Susanna Yeoman	Deputy Locality Director, Slough
Tandra Forster	Head of Adult Social Care, (West Berkshire Council)
Tony Dwyer	Locality Manager (Bracknell) Adult & Older Persons Mental Health Services Berkshire Healthcare NHS Foundation Trust & Bracknell Forest Council
Kate Jahangard	Education & Children's Services, Reading
Sally Grant	Team Manager, SEAP Org UK – (Support Empower Advocate Promote)

August/September 2014

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Department of Health. Feb 2011 Preventing Suicide in England – A cross government outcomes strategy to save lives. Assessment of impact on equalities. Annex B Evidence Base. dh 125514

Acting on evidence: A strategic framework of evidence based recommendations for preventing suicides in Bolton (2013-16)) http://www.boltonshealthmatters.org/sites/default/files/BOLTON%20SUICIDE%20PREVENTION%20STRATEGIC%20FRAMEWORK%202013-16%20DRAFT%20FOR%20CONSULTATION.pdf