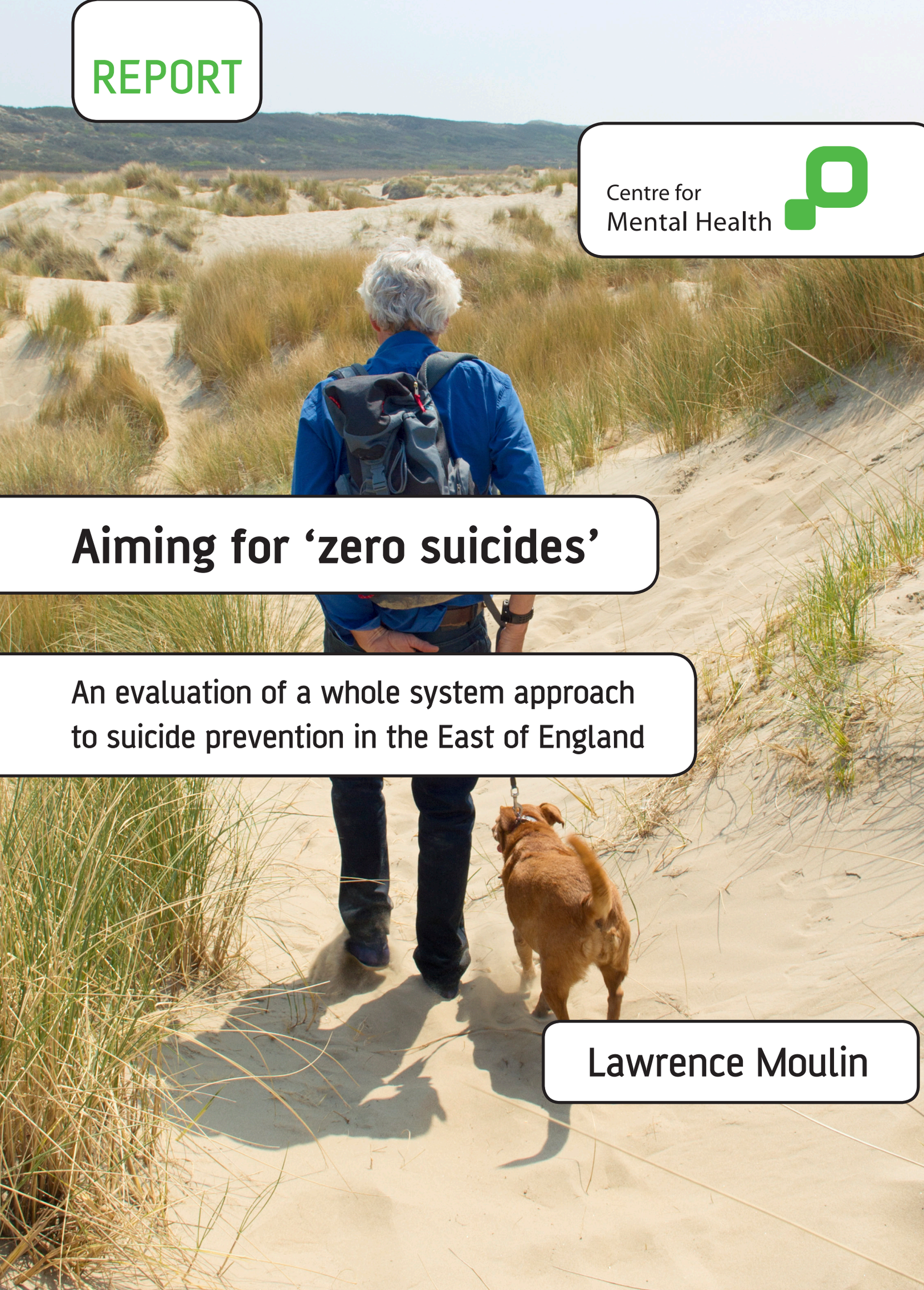
REPORT

Centre for Mental Health



Aiming for ‘zero suicides’

An evaluation of a whole system approach to suicide prevention in the East of England

Lawrence Moulin

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Contents

"Last Friday, I was in A&E with my son and partner and there was a lady in a lot of distress there. I waited a while to see if anyone was with her but no one sat with her. She was sobbing her heart out.

I went over, introduced myself, said I was concerned about her, and if she minded me coming over and if she wanted to talk. She opened up and said she just wasn't coping and didn't know what to do. We chatted for quite some time and I even heard myself saying the words about being 'safe for now'...

It was really emotional but I hope I did OK. I didn't think I'd be putting the training into practice quite so soon and outside work. Just wanted to let you know how the training has helped."

(Follow-up email from training participant)

Executive Summary

"Yesterday was a day like no other; I saved a man's life using the skills you taught us on the course.

I cannot find words to properly express the gratitude I have for that. Without the training I would have been in bits.

It was a very public place, packed with people – but, to onlookers, we [must have] just looked like two blokes sitting on a bench talking."

Course participant

"Very useful training. I'll use these skills in my practice.

I like the approach - it helped me to understand that I don't have to sort out their problems, just listen. THANK YOU."

Course participant

The majority of people who take their own lives are not in contact with specialist mental health providers at the time of their death. The programme described in this report has focused on those people and how to engage and energise community support to reduce their number.

The 'zero suicide' programme

This report is an evaluation of a programme which was set up to develop services and became more focused on supporting those people not in touch with services. In 2013, the East of England Strategic Clinical Network (SCN) set up a programme to aim for 'zero suicides' in the region. Four CCGs were chosen to run pathfinder sites to improve outcomes for individuals and their carers, with a particular interest in partnership working, and that addressed clear gaps in services or the transition between services, and that demonstrated a commitment to engage 'hard to reach' patient groups and patients from ethnic minorities. The work was launched in the context of the shared vision and a 'zero suicide' ambition created in the launch workshop, led by Dr Ed Coffey from Behavioural Health Services in Detroit. This was focused on each area setting 'Wildly Important Goals' (WIGs) and stretching targets with optimistic and ambitious expectations, and building on approaches developed in the US.

The four projects are notable in their ability to engage with the 'unusual suspects'. They took 'bottom-up' approaches and included coroners, librarians, gym staff, housing association staff, publicans, social care assistants, paramedics, faith groups, Football Association staff, CCG employees, private security staff and the British Transport Police. In addition, the recruitment of local community champions was a really exciting innovation, putting local people at the heart of the developments. The real success of the programme has been in changing people's attitudes.

Common themes

There are common themes throughout the four sites that give an overview of how such projects can be implemented:

- With a clear and shared vision and a challenging ambition (zero suicides) and given the capacity, local groups can develop and deliver creative and effective local approaches to suicide reduction.
- A real partnership between community groups, the third sector and the statutory sector can unlock previously unrecognised social capital and local knowledge.
- Integrating services with web and social media communication can be a core part of any such programme, and can play a more central role than simple information sharing.

Recommendations

We were very impressed with the work carried out in the East of England. The projects showed creativity, vision and commitment to reducing suicide and proved their approaches to be very successful. Our recommendations for other sites wanting to take this work forward are:

There is very significant need for more training as part of a range of changes that need to be made across the whole system:

- Health Education England needs to assess the types of training required to deliver this work, and ensure this is built into the core professional training and Continuing Professional Development for all staff working in the NHS, delivered on a multi-disciplinary basis.
- Other training bodies with responsibility for staff in the police and local authorities, among others, similarly need to build this into the core of all professional training and development.
- Awareness training for wider groups also needs significant support, with clarity about levels of training and ongoing support needed.

Coroners can be partners in suicide reduction; Public Health England should ensure it works with them to regularly carry out suicide audits.

Research and data remain ongoing challenges. Without timely, accurate and reliable data it is not possible to evaluate the effectiveness of programmes such as these.

Sites were clear that to deliver this work **they needed passion, but also capacity** in terms of money, people, and commitment from other services.

1. Introduction

Centre for Mental Health was engaged to carry out a review of the 'Zero Suicide' Programme initiated by the Strategic Clinical Network (SCN) for the East of England. This report considers the development of the programme and highlights of the work undertaken and describes some of the underlying evidence and the learning from the work carried out. It then summarises the work done by each site and draws some final conclusions.

The Centre's researchers were very impressed by the work that was carried out in the East of England, the creativity, commitment and vision of all the people involved across the sites, and the many successes. We commend everyone involved for what they have achieved.

Overview of the programme

In October 2013, a regional conference was held by the East of England Strategic Clinical Network (SCN) to launch the 'Zero Suicide East of England SCN programme'. Dr Ed Coffey (from Behavioural Health Services in Detroit) brought vision and energy to the launch workshop, a focus on moving towards 'zero suicides' a strong focus on local development, and suggested how to create space for local initiatives to develop through a joint public and third sector approach.

This programme was trying to replicate the overall vision of the work in Detroit and the resulting culture that it established, including setting 'Wildly Important Goals' (WIGs) and stretching targets with optimistic and ambitious expectations. Through discussions with Dr Coffey, this was distilled into two key elements that guided the direction of this programme:

1. Everybody should have an openness, willingness and the confidence to explicitly talk about suicidal thoughts.
2. Any subsequent intervention should include a removal of access to the means of suicide and a focus on establishing alternative options (i.e. a safety plan).

Applications to be a pathfinder site were invited from Clinical Commissioning Groups (CCGs). Every area in the East of England made an application, and four were chosen.

The objectives of the programme were to improve outcomes for individuals and their carers, with a particular interest in sites founded on partnership working, that addressed clear gaps in services or gaps in the transition between services, and that demonstrated a commitment to engage 'hard to reach' patient groups and patients from ethnic minorities.

The programme management was undertaken by the SCN, with CCG sites established through a formal competitive application process. The programme was overseen by a Board comprising key stakeholder groups and expert external advisors. It worked as a learning and improvement collaborative - all the project sites worked broadly to the same timetable and were supported by the SCN and by each other.

Aims

Programmes were expected to contribute to:

- Reducing risk of suicide and self-harm,
- Improving outcomes,
- Rapid access to evidence-based treatment
- Improving quality and experience of depression care,
- Increasing the efficiency of services, and
- Smoothing the access to services for patients and referrers.

Objectives

The specific objectives of the 'Zero Suicide' programme were:

- To establish up to four successfully-completed CCG-led whole-system service improvement projects of 12 months duration;
- To establish a regional learning and improvement collaborative consisting primarily of the pathfinder programme projects, but also including other health systems, and to disseminate learning from the programme;
- To undertake appropriate evaluation of the pathfinder programme as a whole as well as of the individual projects;
- To support co-production throughout the programme, particularly between patients, carers, and patient-led organisations;
- To demonstrate and publish the impact of service improvements, including care pathway changes, practice improvements, skills and role developments;
- To ensure sustainability so that projects are taken forward and embedded within mainstream services.

The work was carried out drawing from other national documents and initiatives such as the National Suicide Prevention Strategy (DH, 2012) and the All Party Parliamentary report (2015), and other local programmes such as the Grassroots Suicide Prevention work in Brighton (see http://www.prevent-suicide.org.uk). (There is a list of other resources at the end of this report.)

Brief overview of the evidence

There is clear evidence that there are medical and psychological interventions which can be very helpful to individuals who have considered or attempted to end their own lives.

However the evidence of effective interventions designed to reduce the overall suicide rate across a whole population is sparse and largely inconclusive.

The HEN *Review of the Evidence for Effectiveness of strategies of suicide prevention* (Scott & Guo, 2012) assessed some promising interventions. It notes that:

- Evidence is scant and equivocal on the effectiveness of community-based suicide prevention centres and national suicide prevention programmes for reducing rates of suicide and suicidal ideation.
- School-based suicide prevention programmes that focused on behavioural change and coping strategies in the general school population and skill training and social support for at-risk students had beneficial effects on intermediate outcomes, such as suicidal tendencies and risk factors for suicide; however, the effect of these interventions on suicide rates is not known.
- There is limited evidence that multi-faceted suicide prevention programmes based on risk factor identification and educational and organisational changes reduced the rates of suicide and attempted suicide among military personnel.
- Restriction of access to lethal means (e.g. firearms and pharmacological agents) may reduce the rate of cause-specific suicide in the general population, but its effect on the overall suicide rate was unclear.
- The administration of lithium reduced the risk of suicide and deliberate self-harm in patients with mood disorders.
- Psychosocial and pharmacological treatments, such as problem-solving therapy, provision of a card for emergency contact, cognitive behavioural therapy and administration of flupenthixol, were promising in reducing rates of repeated self-harm among those who attempt suicide.

Knox and Caine (2004) described the apparent success of two interventions.

The first was implemented on the Swedish island of Gotland, where primary care physicians were trained to recognize and treat depression. Subsequently, reductions in depression-related morbidity were observed.

Researchers found a transient, statistically-significant reduction in the suicide rate based solely on reductions in female suicides. There has been discussion about whether this outcome was due to the intervention, or simply a statistical fluctuation, which disappeared if a five-year rolling mortality average was used.

The second was the US Air Force's large-scale approach to suicide prevention. In response to an increase in suicide rates during the mid-1990s, it was mandated that suicide prevention would be addressed as a community-wide Air Force responsibility, not solely a medical problem. A significant and sustained drop in suicide rates was observed following a dissemination programme. Key components of the programme were an ongoing commitment from leadership, consistent and regular communication around suicide prevention, de-stigmatisation of seeking help for a mental health problem, improved collaboration among community prevention agencies, and the identification and training of 'everyday' gatekeepers.

In the UK, there have been some notable approaches taken. The restriction of the size of Paracetamol packs, introduced in 1998, correlated with a reduction by 43% in the number of people dying from paracetamol poisoning between 1993 and 2009 (Hawthorn *et al*., 2013). It also covered a period of a nationally reducing rate of death by suicide. As ever, the analysis is one of correlation, and proving causation is very difficult.

Barriers installed at the Clifton suspension bridge in Bristol in 1998 halved the number of deaths between the periods prior to installation (1994–1998) and the years following it (Bennewith *et al*., 2007). 90% of the suicides from the bridge were by males, and there was no evidence of an increase in male suicide by jumping from other sites in the Bristol area after the erection of the barrier.

In the light of inconclusive evidence, Yip (2011) writes '... one size doesn't fit all', and there is 'no silver bullet'. He suggests we must develop culturally-attuned, locally-relevant, and evidence-based suicide prevention programs. In addition, all programmes need to be evaluated.

Where we do not have the necessary evidence, we must simultaneously implement novel approaches and rigorously evaluate them. A holistic and integrated approach is needed to make the suicide-prevention programme focused and sustainable.

Just such a range of holistic, integrated and novel approaches have been implemented in the East of England.

Cost analysis

While any attempt to put a value on the benefit of suicide reduction in monetary terms is clearly problematic, estimates of the monetary value of a prevented fatality are used in other public sector contexts such as the appraisal of transport safety measures. These estimates suggest a figure of around £1.5 million per case, based mainly on evidence of people's willingness to pay for small reductions in the risk of death or injury.

As the average age of suicide is broadly the same as the average age of a road fatality, it would seem reasonable to use a figure of this magnitude, without any further adjustment, as a measure of the potential benefit of suicide prevention.

Set against the relatively low cost of the measures discussed in this report, the obvious implication is that even a modest degree of success, e.g. preventing one suicide a year, would be sufficient to demonstrate that the measures in question are highly cost-effective. (For more information on the economics of suicide prevention see Knapp *et al*., 2011.)

2. Overall learning

Context of learning

The majority of people (up to 75%, some studies suggest) who take their own lives are not, at the time of their death, in contact with specialist mental health providers. On that basis, while it is clearly crucial to continue to improve core mental health services, in this programme the sites largely focused on that majority. In this context top-down strategies are necessary but not sufficient, and the sites seized the bottom-up development opportunities.

The work was launched in the context of the shared vision and a zero suicide target created in the launch workshop, led by Dr Ed Coffey. This was focused on each area setting 'Wildly Important Goals' (WIGs), stretching targets with optimistic ambitious expectations, and building on approaches developed in Detroit. The four sites in the East of England were then given some resources and the space to develop. They responded by engaging with a very broad range of stakeholders, and developed and delivered an impressive mix of varied, creative, and innovative approaches to reach people.

As a lay member of the steering group said, this work was about 'making space in the NHS machine so that together we can stop suicide'.

Vision and creativity

The four projects are notable in their ability to engage with the 'unusual suspects'. These included coroners, librarians, gym staff, housing association staff, publicans, social care assistants, paramedics, faith groups, Football Association staff, CCG employees, private security staff and the British Transport Police. In addition, the recruitment of local community champions was a really exciting innovation, putting local people at the heart of the developments. The real success of the programme has been in changing people's attitudes.

An observation from sites who have engaged with staff such as privately employed security guards, is that they too deal with a significant number of people who are threatening to take their own lives, and it had led to a sense that there is considerable unmet need in different parts of our communities, of which the statutory services are largely unaware.

All sites developed a web and social media presence, and in places it has been tied together in an elegant model where there is cross-referencing and interplay between social media, web pages, and local services so people can connect to one part or all of it, and access services directly if they need to.

A number of sites have also developed a structure for organisations and individuals to sign up to a stop suicide pledge. The organisational pledges were very successful, gaining support from a range of services including local authorities and police forces. It proved more difficult to get individual pledges, possibly due to stigma, and also possibly due to a lack of clarity about what it meant for an individual to have signed the pledge.

Some areas put energy into developing a local 'brand' for the programme, others built on existing voluntary sector recognition, for example the Samaritans. Each has its merits. It is also notable that while the initial focus was on suicide prevention, sites have begun to consider whether a broader focus on wellbeing would be the most effective future direction for work.

One site is in discussion with local newspapers, asking them to put an 'if you have been affected by anything in this article you can contact....' after potentially distressing articles. There may be two beneficial effects here, one is the support it offers to distressed individuals, but the second is to raise awareness among local newspaper staff of the potential impact of articles and the need to respect the editor's code of practice. This is already best practice as advised by the Samaritans (2013), but is rarely observed.

Training

One of the most exciting areas of work across all sites was the delivery of training to the broadest range of people. Sites identified the need to understand the levels of training required by people with different roles.

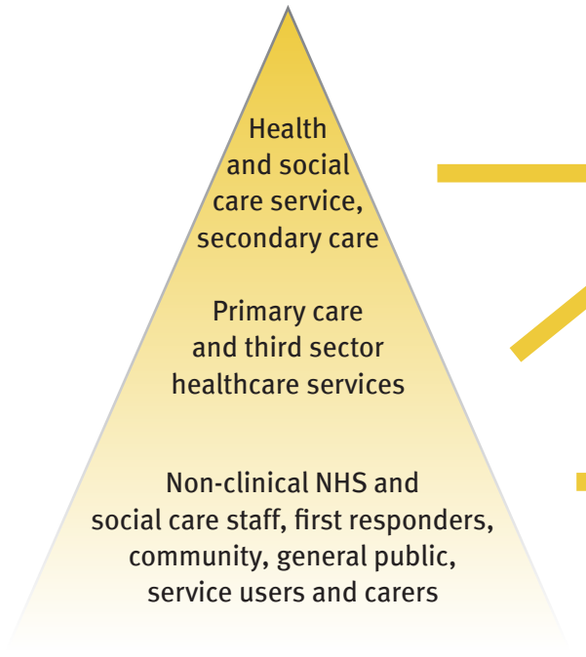
The organisation Connecting with People, which advised the steering group for the programme, has looked at training at three levels and identified some training courses to meet requirements at each level, as illustrated in Fig 1, below.

This provides a very helpful structure to understand and plan how training can be delivered.

There is no doubt that when following strategies which involve very broad training of mixed groups, it is also crucial to be clear about the expectations of participants, and about how to ensure ongoing support for people who have been trained. It was suggested that suicide discussions should become like first aid, something in which people from all walks of life are trained.

Fig 1. Suicide and self-harm mitigation programmes

This diagram illustrates which programmes are **most suitable** for people in each group.



Programme	Duration
CwP modules 1-7	2 hours each
CwP modules 1-7	2 hours each
ASIST	2 days
USI	1 day
Samaritans	3 hours
SafeTalk	1/2 day
CwP modules 1, 4, 5, 7	2 hours each

CWP – Connecting With People - http://www.connectingwithpeople.org/

ASIST - Applied Suicide Intervention Skills Training - https://www.livingworks.net/programs/asist/

USI - Understanding suicide intervention - http://www.suicidesaferlondon.org.uk/training/understanding-suicide-intervention-city-and-guilds-endorsed

Samaritans training - http://www.samaritans.org/your-community/workplace-staff-training

Safe Talk - https://www.livingworks.net/programs/safetalk/

Please note that Connecting with People (CwP) modules 2 and 3 (Suicide response parts 1 and 2) are **only suitable** for practitioners.

There are a number of effective training packages available, but for large-scale roll out the cost and time commitment can be a challenge, and some sites were considering briefer and less costly options, for example 'training the trainer' models.

We identified that training should be multi-disciplinary to ensure that any new initiatives bring staff together, and develop a common language and approach to ensure the training has maximum impact.

In some areas, it was suggested that the training was so highly valued there because it met some of the basic training needs of front-line staff working with people with complex needs, and this training was making up for a lack of core training. If there is a risk of this then it is important to think through a broader framework of staff development to enable them to do their work effectively. This zero suicide element of work is essential, but is likely to be only part of the training and support staff need.

Beyond bespoke training packages, sites sought ways to build this training into the core syllabus for different professions, as an essential element of Continuing Professional Development (CPD). There is a national challenge for Health Education England to take this forward across all professional training.

In addition to broad training approaches, one site set up a system to enable closer working with GPs. People who were referred to secondary care services by GPs and identified as having urgent needs were reviewed and clinicians developed a system to feed back to and discuss the cases with the GPs. This has the potential to develop mutual learning between GPs and secondary care services.

Risk assessment

There was a debate about risk assessment. One view was that it should be a formal procedure triggered at key points during the process of care, and a number of useful tools were being developed to support that. The SAFE Tool being developed by Connecting with People, is a good example.

The alternative view was that formal risk assessment makes a judgement at one point in time, but at any time after that, the risk level could change completely. On that basis, risk should always be presumed, and that by ensuring the individual and their safety is at the centre of the process, including families and carers throughout, removing means of harm, and ensuring speedy access to evidence-based treatment, risk can be actively managed.

It is not clear that this is an either/or discussion, but both approaches can be followed.

Engaging with coroners

Historically there have been concerns about the timeliness and the consistency of coroners' verdicts. One site worked through a complicated and time-consuming manual review of coroners' data to develop a robust local data set on suicides. It was suggested that a common data set to be used by coroners would be very helpful, and that public health suicide audits should be a central part of developing this process.

However in another site, a coroner has championed suicide reduction, and is working with local providers in the audit and reviewing deaths to achieve that. Clearly an active programme of engaging coroners can be a major asset.

Data

There were consistent issues across all sites to do with data. There were problems with its timeliness, quality and usefulness. The lack of such data means that it is not possible to assess the direct impact of this work on the reduction of suicides in each site.

We understand that Public Health England and the Association of Chief Police Officers have carried out three real time data/suicide surveillance projects in England that are currently being evaluated. The rapid evaluation and national roll-out of this work is crucial.

Research on effectiveness

Despite the wealth of innovative, creative and inspiring work carried out within this programme, due to the short time span of the programme to date and the poor quality of data nationally, it is not possible to be clear about its impact on people's lives. Where we do not have the necessary evidence, we must simultaneously implement novel approaches and rigorously evaluate them.

A major objective both for this work and for other national work must be aligned data sets, capacity for research, and a thorough evaluation of effectiveness.

"The person in question got into the car and I started talking to her. After roughly 10 minutes she said that she had to go. I asked the direct question as to whether, if she drove away, it was her intention to kill herself. She said yes.

"From then it was the talk down. I was with her for approximately 20 minutes until the NHS crisis team turned up and took over."

Police Officer

3. The sites and their initiatives

In order to summarise the work done across the sites, we have used a slightly developed version of the framework by the Health Evidence Network at the World Health Organisation (Scott & Guo, 2012). The initiatives fit under the following headings:

Prevention: Universal – for example, making changes to media reporting, means to access restriction, national prevention programmes.

Prevention: Selective (including awareness raising) – for example, general awareness courses for the general public, running stalls at events.

	Mid Essex	Hertfordshire	
Prevention - Universal		Analysis of suicide in Hertfordshire carried out by going back to source coroner's data and carrying out a manual analysis.	
Prevention – Selective (including awareness raising)	Developing training programme for third sector and voluntary organisations.	Programme to educate general public. Team have attended over 40 events, health and wellbeing workshops, council events etc. Looking at how to get posters placed in pharmacies, and how to integrate ideas into all NHS staff training. General training programme for schools and CCG staff. Development of website and social media presence.	
Prevention Indicated – (training)	Training community nurses, primary care staff, GPs, police, British Transport Police, drugs and alcohol staff, and paramedics	Very significant programme to educate GPs and practice staff, job centre staff, drugs and alcohol staff.	
Prevention – Indicated		'Hot spots' programmes with the British Transport Police, sharing maps of suicides in sites across the county with the British Transport Police. Approach developed to review GP referral of people with urgent need, which increases opportunities for more discussion between clinicians and GPs.	
After care			

Prevention: Selective (training) – for example, training GP or practice staff in specific skills and actions required, community-based suicide prevention training programmes.

Prevention: Indicated -- for example, prevention where risks have been identified, gatekeeper training, telephone-based suicide prevention services.

After care – Support for families or siblings.

	Bedfordshire	Cambridgeshire and Peterborough
	Work with local press to put an 'if you have been affected by any of the issues raised in this article contact ...' note against possibly distressing stories.	
	Focused awareness training sessions for a range of stakeholders including pub landlords, university staff and the local Football Association. Programme to train library staff.	Training over 188 people including housing association staff, counsellors, police, paramedics, and voluntary sector workers. Development of very strong group of community champions. Development of website and social media presence, integrated into an effective system. Developed pledges for individuals and organisations, with a sign up from over 640 individuals and organisations.
	Training GPs and local authority staff.	Training primary health staff, paramedics, police voluntary sector workers and members of the public.
	'Hot spots' programs with the British Transport Police. Top tips development for GPs, and computer assessment formats. Coroner working with providers to audit and review deaths	Significant work with local shopping centre about its car park barriers. Pro-active campaign within community to raise awareness of warning signs and encourage individuals to talk about suicidal thoughts.
	Four pilots have been funded to support people affected by suicide, two for adults and two for children.	Relationships established with local Cruse (bereavement charity).

Example of activity carried out

Cambridgeshire and Peterborough has carried out the following work:

- More than 1000 sets of self-help resource distributed
- 605 personal STOP Suicide pledges made
- More than 1000 face-to-face conversations held on the subject of suicide
- 33 organisational STOP Suicide pledges made
- 25 community events and meetings attended
- 77 people trained as ASIST 'first aiders'
- 111 people trained in basic suicide awareness (SuicideTALK)
- 12 active campaign makers recruited

Figure 2: How well do you feel you understand suicide prevention?

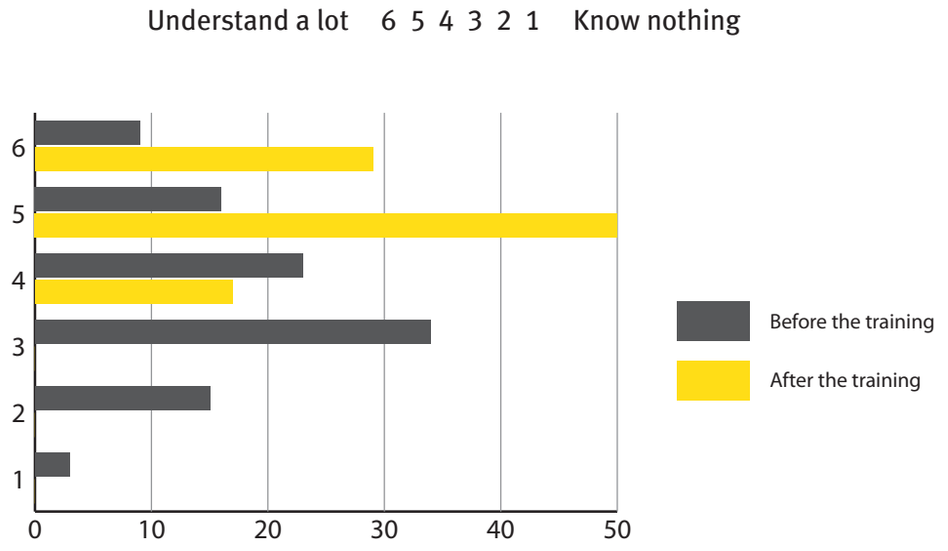
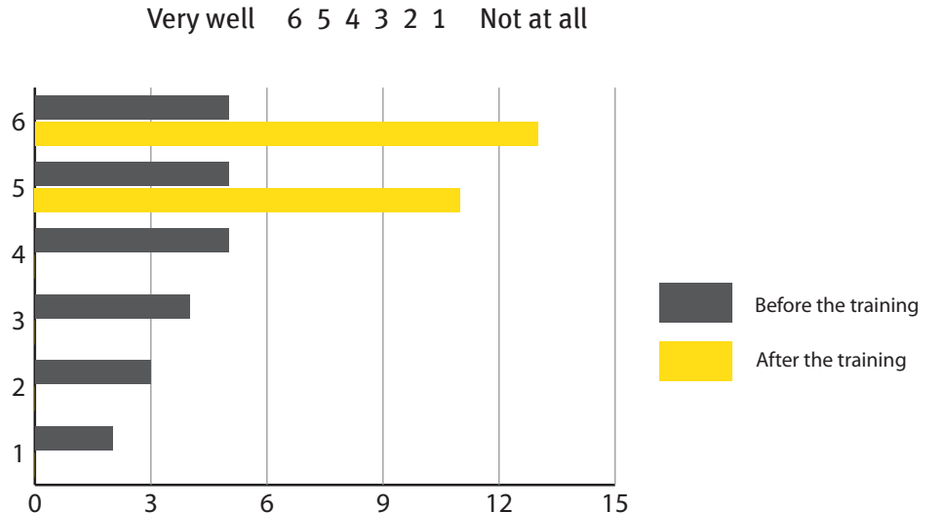


Figure 3: How well would you know what to do if you believed someone was feeling suicidal?



The data in these charts is from the feedback after the suicide awareness training held in Mid Essex.

MID ESSEX

Initial Plan

- To reach out to depressed individuals and make it easier for them to access the health care system with a proactive early intervention approach.
- To develop services that are high quality and recovery-focused, patient-centred and that 'wrap around' the individual who is in need, even going to the individual if that is what they need.

This would be done through:

- Suicide prevention education in primary care – GPs and practice nurses,
- Ensuring a single point of access for service users and agencies,
- Culture change –thinking and working collaboratively and collectively around patients' needs, and about integration of care across services.

Deliverables

This approach would be integrated to:

- Improve patient outcomes,
- Establish a protocol to assign patients a level of risk for suicide, each of which requires specific intervention,
- Implement a protocol for removing weapons from patients' homes,
- Join up care pathways,
- Reduce risk through shared risk assessments,
- Establish co-production between partners in the care pathway,
- Have a greater long-term sustainable impact,
- Capture people who fall between services – who don't meet the criteria for crisis services but still have a need,
- Offer a structured service for carers to provide an awareness of crisis planning and their role and the support they provide to people they care for.

Training would include:

- Mental health first aid for receptionists
- Refresher courses for doctors who completed training over five years ago
- Joint GP and psychiatrist education in both mental health and physical health

What was delivered?

- Suicide prevention education for a very broad group including community nurses, primary care staff, GPs, police, British Transport Police, and drugs and alcohol staff. The training has been very positively received with participants feeling much more positive about identification and comfortable with discussions and knowing what to do.
- Development of a training the trainers programmes.
- Connecting with the Cambridgeshire and Peterborough pilot programme with the intent of developing the local programme to encompass elements of the STOP suicide campaign including websites, leaflets and pledge cards. In addition, it will offer telephone support, project management and monthly statistical feedback.

Learning

- It was a challenge to get robust and useful data. It was not possible to get A&E data, partly due to data definition issues, also due to the major pressures on A&E and the lack of A&E consultants. It was difficult to get accurate baseline data, and it did not correlate with expected suicide levels. Coroners' verdicts seem variable, while the British Transport Police data seemed to be the most robust.
- Breadth of focus – as an alternative or in addition it may have been appropriate to focus on services in contact with high risk groups like middle-aged men or post-natal women, or immigrants arriving through Stansted.
- There was a discussion about whether to take a broad 'train everyone you can' approach, which would have included social workers and unqualified staff who may have more time talking to different groups of vulnerable services users.

Next steps

- Training the trainers module, using Safe Talk,
- Making this a core part of the GP training programme,
- Focus on high-risk groups rather than a generic approach,
- Potential focus on engaging with the Ambulance Trust, as they are a key part of the care pathway.

"Very applicable for all - everyone's business. All practitioners should have this training!"

Essex training participant

"Thank you so much. Brilliant and very informative. I'm very grateful that, as a student, I was able to come. I'll take [what I've learned] with me throughout my training and career."

Essex training participant

HERTFORDSHIRE

Initial Plan

Areas identified for improvement in the treatment of depression included:

- Detecting depression in those in contact with primary care services,
- Increasing referral of people with depression to enhanced primary mental health services (EPMHS),
- Developing a more co-ordinated approach to care between GPs and EPMHS in the provision of comprehensive packages of depression care,
- Developing more consistent and responsive management of the risk of suicide in the context of depression care,
- Ensuring effective communication takes place between the two agencies (including Hertfordshire Partnership Foundation Trust (HPFT)'s single point of access) around urgent care to ensure each individual who may be at risk of suicide receives the care and treatment they need.

Aim to:

- Reduce the risks of suicide and self-harm amongst those with depression,
- Improve the outcomes for these service users and their families, and (through reducing self-harm and suicide events) reduce levels of trauma experienced,
- Improve the quality and experience of depression care through provision of more accessible, more clinically effective and more consistent services,
- Increase efficiency of these services by introducing standard checklists,
- Smooth access to the trust's services for GPs and their patients.

What was delivered

- Very significant level of training delivered (over 100 GPs and 100 practice staff with this expected to double), with a very positive GP response. It was developed with and through the GP mental health leads. It involved a slightly briefer training programme, and was developed in conjunction with the Herts MIND network. Evaluation by GPs before and after training showed a very positive increase in confidence. Of those GPs trained, 96% found the session useful, 98% found it relevant and 96% rated the content of training as "good or excellent".
- An approach was developed to analyse GP referral patterns, which created the opportunity for greater discussion between clinicians and the GPs on the support needed. This has the potential to create a really fruitful mutual learning programme between GPs and the services.

    - Two groups were used to evaluate the changes in referral patterns of GPs to HPFT Wellbeing Team following the training; a control GP group and a trained GP group. The trained GP group in North & East Hertfordshire (Stevenage and Stort Valley & Villages) was trained in early 2015 with the bespoke training as part of the programme. The untrained control GP group was in North & East Hertfordshire (North Herts and Lower Lea Valley). Comparisons of self-referrals and GP referrals were made using five months pre- and post-referral data.

- Self-referrals to Wellbeing Services within the trained GP group showed a similar rate as the untrained GP group (26% referral increase for trained GPs, 23% for untrained GPs). However, GP referrals in the trained group showed a referral increase of 17%, compared with a 9% decrease in referrals for the untrained GPs in the same timeframe.

- Whilst the trained GP group showed a significant increase in referrals, there was notable variation in the referral patterns between the two localities (Stevenage and Stort Valley & Villages) and this is being further explored with the GP mental health leads.

Table 1: Average increase of referrals from September 2014 to July 2015

	Control Group	Trained Group
Self referral	23%	26%
GP referral	-9%	17%

- Training and education are developing, with the intention to work across the Hertfordshire Valley CCG area, with police and job centre staff, and broadening training to drug and alcohol staff and schools. Also there is a plan for an awareness training session for CCG staff.
- Very interesting work on 'hot spots' with the British Transport Police, including sharing maps of suicides in different sites across the county and a list of high-risk, high-profile sites.
- The team have attended over 40 events talking about this work, including health and wellbeing workshops and council events.
- Development of the website, use of twitter and a building number of both organisational and individual pledges.
- An analysis of suicides in Hertfordshire has been carried out, based on a manual analysis of coroners' data. A standard data set from coroners would be very helpful.
- Plans are being developed to put posters and leaflets in pharmacies, and how to integrate some of the training material into all NHS staff training is being considered.
- Now looking at developing models of community change makers.

Learning

- Work which requires the development of a brand and the intensive use of social and other media creates significant demand on communications departments, it is crucial that that there is clarity, capacity and expertise available.
- The delay in recruiting a project manager slowed the process down.
- With hindsight, it would have been good to have focused on community champions from the start.
- Individuals avoid making pledges, possibly because of stigma or lack of clarity about what will be required, whereas organisations seem quite happy to pledge. Models need to be developed to support individuals who sign the pledge.
- The CCGs could have an enabling role in linking this work to the commissioning plans for all providers.

CAMBRIDGESHIRE AND PETERBOROUGH

Initial Plan

The initial plan was to:

- Establish robust referral pathways for people at risk of suicide, that would be available and responsive 24/7 at times of crisis;
- Improve mental health outcomes and reduce the risk of suicide in the population;
- Encourage partnership working between organisations to ensure better management of people with depression and suicidal ideation;
- Raise awareness of suicide prevention and openness about suicide within communities - particularly those at high risk of suicide;
- Reduce the stigma attached to mental health problems;
- Provide access to sources of self-help and resources for people to help others who may be at risk of suicide;
- 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 people who take their own lives but who are not in contact with mental health services;
- Use intelligence from local needs assessments that have identified groups at higher risk of suicide, including men in rural areas and migrant workers from Eastern Europe, and to design specific interventions targeted at reducing the risk of suicide in these groups;
- Commit to 'mindful employer' principles as part of the Peterborough Pledge by raising awareness of mental health problems and suicide prevention across multiple organisations and businesses;
- Ensure sustainability of suicide prevention beyond the scope of the proposal and throughout the Cambridgeshire and Peterborough CCG.

The Peterborough Pledge was designed and piloted in such a way as to be a model for other areas of Cambridgeshire to adopt and adapt for themselves. Evaluation of the effectiveness of the pledge will be important. It is anticipated that by signing the pledge, individuals and organisations would:

- Increase awareness of suicide prevention and openness about suicide in the population;
- Increase mental health awareness and openness and to reduce stigma in the population;
- Equip people with some basic knowledge on how to respond to and help someone they are concerned about;
- Equip people with information on how to help themselves at times of crisis;
- Improve help-seeking behaviour.

What was delivered

Because 75% of people who take their own lives are not in contact with mental health services, the focus was designed to be broad:

- The first challenge was to embed the project in the community. Intensive work was done to develop a brand and a product, mostly done on a voluntary basis, and the work was launched on World Suicide Prevention Day. There was significant engagement with key community groups as a major part of the process of getting community champions. This created a strong, clear focus, which enabled clarity and the delivery of a coherent message.
- A comprehensive network has been built between face-to-face services, the website and social media, so that tweets connect and refer to web-based material, which connects to local services, which in turn links back to web-based material and tweets.

- There was a focus on training non mental health professionals including paramedics, police, housing association staff and voluntary sector workers/volunteers who worked with high risk groups. There is a broader aim to embed suicide prevention messages in all the mental health awareness training offered.
    - In the focus group, it appeared that one of the possible benefits of the training was supporting front-line staff working with people with a range of complex problems. It was not clear how it connected with any in-house training, support or supervision staff received.
- The police in Peterborough have now signed up for every officer to go through the training.
- Organisations were very positive about signing up to the pledge. Getting the police authority and local authority to sign up created a strong launch. Individuals were more hesitant to sign up as people were not sure what it meant and what to do if someone was considering suicide.
- There was a strong awareness of the need for crucial aftercare, supporting those affected by suicide, not only families but also friends and colleagues.

There was a very strong sense from Cambridgeshire and Peterborough that thousands of conversations have taken place, hundreds of people have been engaged, and through these people's actions, lives have been saved.

Learning

- In the future, it will be crucial to make sure that all key players are involved in developing the initial bid with resources built in for staffing.
- The analysis using data was helpful, but the small numbers made it hard to map areas of concern.
- To deliver this work programme, sites need passion, but also capacity in terms of money, people, and commitment from other services.

Next steps

There was a sense that the real work has yet to happen and a lot of excitement around the campaign maker model, developing a focus on schools and Child and Adolescent Mental Health Services, and supporting and strengthening primary care.

BEDFORDSHIRE

Initial Plan

Bedfordshire aimed to reduce suicides amongst two target groups:

- Patients treated only in primary care,
- Hard to reach groups who may not seek any help or treatment.

There were three strands to the project:

1. **Suicide prevention stakeholder events**

   The aims of these events was to:

   - Launch the campaign for 'zero suicide' in Bedfordshire,
   - Present the annual suicide audit,
   - Listen and learn from local people,
   - Gather information about different problems and perceived gaps in service.

   There will be a second event after a year to report on the progress made.

2. **Reducing suicides in primary care**

   Raise awareness and providing more education about suicide risk by:

   - Rolling out a series of educational events in each locality delivered in the same way as a previously held, very successful, session by a local consultant psychiatrist and the Samaritans;
   - Producing a 'Top Tips' sheet for GPs to prompt interventions and provide the right support for patients;
   - Encouraging practices to publicise the Samaritans through posters in the waiting room, information in the practice leaflets and prominent links on their websites

3. **Tackling the hard to reach groups**

   Extend work with the Samaritans to target those who are 'never seen' and do not go to their GP or anywhere else to get help and support by:

   - Running an awareness campaign locally, including posters about the support that is available from the Samaritans and Mind, in places where those people identified in the target groups may go (such as football and rugby grounds, student events, libraries, toilets);
   - Providing focused awareness training sessions, for example for pub landlords, university staff and the local Football Association;
   - Working with the Samaritans and local authorities to ensure that all of the known and possible local places and 'hot spots' have information at the location;
   - Making use of newspapers and social media;
   - Setting up a support group to help those bereaved by suicide;
   - Setting up a clear pathway of support for children bereaved by suicide.

What was delivered

- The work was built on an already existing suicide prevention group, which 'moved up a gear'.
- Training was delivered in the context of a major change in the mental health provider, and this was an opportunity for a one-off session with 90 GPs. The effectiveness of the workshop was assessed by looking at GP confidence before and after the session, and there was an average two point rise in confidence after the work. There have been two stakeholder events which were very useful, and which will be repeated next year.
- There was also a broad training programme for local authority staff in areas such as libraries about recognising risk, mental health first aid training, and suicide awareness.
- A major piece of work has been developing a template with Top Tips to go on GP IT systems, it has a structure of drop down boxes and directions for how to respond.
- For people who are hard to reach, the work has involved connecting with the British Transport Police to look at 'hot spots' such as railways.
- Four pilots have been funded to support people affected by suicides, two for adults and two for children.
- There has been very interesting work done with the local press to encourage them to put a signpost in the style of 'if you have been affected by these issues, contact the Samaritans' after potentially distressing articles. This is as advised by the Samaritans, but is rarely done.
- There are very interesting developing discussions about how much the focus should be on broad wellbeing versus suicide reduction specifically. The focus may shift to become broader. 'Suicide prevention' can be seen as a 'negative' label for branding events. They may be moving towards having a separate wellbeing group, with a public health lead.
- It was decided from the start to develop the work under the Samarians 'brand'. It was felt that this was well known, there was confidence in the local services, they had a strong set of material to distribute, and also the Samaritans run a 24/7 phone line.
- One site showed how coroners can champion suicide reduction, with one coroner aspiring to zero suicides in his area, and working with local providers so they could achieve it.

Learning

- It would have been helpful to have a dedicated project manager from the start.
- It would also have been useful to have started the broader engagement with areas like the local authority earlier in the work.

Next steps

For the future, the programme might look at children and young people and self-harm, and also at removing means, better management of medication, and training the trainers.

4. Conclusions

The 'zero suicide' programmes in these four areas proved to be very inspiring. Each site has diffferent learning points, but overall the conclusions are:

- With a clear and shared vision and a challenging objective (zero suicides) and given the capacity, local groups can develop and deliver creative and effective local approaches to suicide reduction.
- A real partnership between community groups, the third sector and the statutory sector can unlock previously unrecognised social capital and local knowledge.
- Integrating services with web and social media communication can be a core part of any such programme, and can play a more central role than simple information sharing.

"I would like to say how grateful I am to you for getting me on the course, I really enjoyed it and feel positive that I can help veterans who feel in a bad way."

Ex-veteran and course participant

Recommendations

There is very significant need for more training as part of a range of changes that need to be made across the whole system:

- Health Education England needs to assess the types of training required to deliver this work, and ensure this is built into the core professional training and Continuing Professional Development for all staff working in the NHS, delivered on a multi-disciplinary basis.
- Other training bodies with responsibility for staff in the police and local authorities, among others, similarly need to build this into the core of all professional training and development.
- Awareness training for wider groups also needs significant support, with clarity about levels of training and ongoing support needed.

Coroners can be partners in suicide reduction; Public Health England should ensure it works with them to regularly carry out suicide audits.

Research and data remain ongoing challenges. Without timely, accurate and reliable data it is not possible to evaluate the effectiveness of programmes such as these.

Sites were clear that to deliver this work **they needed passion, but also capacity** in terms of money, people, and commitment from other services.

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Resources

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Healthier Scotland - Suicide Prevention Strategy 2013-2016. Available at: http://www.gov.scot/Publications/2013/12/7616

STOP suicide Cambridge and Peterborough *Pathfinders Impact Report*, 2015. Available at: http://www.stopsuicidepledge.org/wp-content/uploads/2015/06/stopsuicidimpactreport_FINAL.pdf

Connecting with people resources - http://www.connectingwithpeople.org/resources

Peer networks/peer support models http://www.nsun.org.uk

Canada's Centre for Suicide Prevention report https://suicideinfo.ca/AboutUs/AnnualReport.aspx

US – American Association of Suicidology http://www.suicidology.org

International Association for Suicide Prevention https://www.iasp.info

Suicide Prevention Australia http://www.suicidepreventionaust.org/about

Suicide Prevention Resource Centre http://www.sprc.org/bpr/section-i-evidence-based-programs

Zero Suicide South West (England) http://www.zerosuicide.co.uk/index.html

Zero Suicide US http://www.zerosuicide.sprc.org

http://www.davidwcovington.com/zero-suicide

http://www.stormskillstraining.co.uk/

https://www.livingworks.net/programs/asist/

Aiming for ‘zero suicides’

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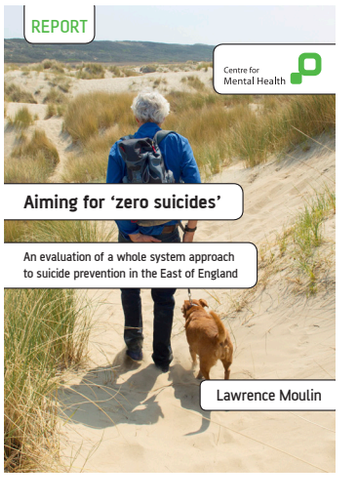

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