Public Health Services for Berkshire

Berkshire Suicide Prevention Strategy

2017-2020

DRAFT V7

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NB: All comments in red are instructions to help guide the final drafting and formatting.

Front cover to be designed

Contents

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and of course all past and present members of the Berkshire Suicide Prevention Steering Group.

Executive Summary

To be introduced by Strategic Director and finalised at the end of the final editing process.

The NHS Five Year Forward View for Mental Health sets a target on all NHS agencies and partners to reduce the current level of suicide by 10% by 2020. This is a laudable and hopefully readily achievable aim. However as discussions across the range of organisations which have contributed to this strategy have progressed, it appears to many, that this aim is not challenging enough. Zero Suicide should be our aim; as it is in the gift of the combined efforts of these organisations, and on society at large, to put in place the policies and services which protect people from mental distress, and to ease the factors which cause that distress. This strategy therefore forges ahead with a stretch target to reduce suicide by at least 25% by 2020, thus ensuring that this becomes a shared priority across organisations and areas. We recognise that a Berkshire without suicide is the true aim to work towards.

Many stakeholders have contributed to this strategy and it should now be adopted as a joint strategy by each CCG, Local Authority, and Health and Wellbeing Boards in Berkshire. It should also be reflected in other plans and strategies when they are drafted or re-written, to ensure suicide prevention becomes a pursuit common to all agencies and professions. The strategy will be formally launched once it has been endorsed by all health and wellbeing boards in Berkshire and this will give the opportunity to report back on the delivery of many of the actions detailed herein.

RECOMMENDATION

Launch this strategy at a multi-agency suicide prevention summit, by October 2017.

Recommendations

The following recommendations are the principle strategic objectives for Berkshire as a whole. These link through into more detailed action plans for Berkshire-wide work and for local authority areas. In line with the national suicide prevention strategy, the main outcomes of this strategy are to reduce suicides in Berkshire by 25% by 2020, and to provide better support for those bereaved or affected by suicide. The national strategy has identified six priority areas and the recommendations linked to these are outlined below, following those relating to the overarching aims.

Over-arching Recommendations

RECOMMENDATION
That this Steering Group revisit their terms of reference and membership and become known as the "Berkshire Suicide Prevention Steering Group", with the aim of providing the governance to this strategy and its action plans.

RECOMMENDATION
That organisations represented on the Berkshire Suicide Prevention Steering Group consider nominating a suicide prevention champion from within their membership.

RECOMMENDATION
That all agencies represented on the Steering Group commit to an annual Action Plan of their own which can then be brought together to create a Berkshire-wide Action Plan for each year of the Strategy.

RECOMMENDATION
Sign off / endorsement of this strategy by all Health & Wellbeing Boards in Berkshire.

RECOMMENDATION
Launch this strategy at a multi-agency suicide prevention summit, by October 2017.

RECOMMENDATION
Ensure strategic fit with the action plans of the Berkshire Crisis Care Concordat.

Priority Areas

1. Reduce the risk of suicide in key high-risk groups;

RECOMMENDATION
Implement the NICE guidelines on self-harm, specifically ensuring that people who present to Emergency Departments following self-harm receive a psychosocial assessment.

RECOMMENDATION
Evaluate the Berkshire CALMzone and recommission targeted suicide prevention work for younger men and middle aged men.

2. Tailor approaches to improve mental health in specific groups;

RECOMMENDATION
Work to provide and commission interventions which improve the public's mental health. These may include: awareness of mental health and peer support in young people; anti-bullying campaigns in schools; addressing stigma and social isolation in older people; workplace health promotion and support with local business; working with police on mental health literacy; and addressing issues relevant to the local population.

3. Reduce access to the means of suicide;

RECOMMENDATION
That local authority public health teams take the leadership for liaison with any Escalation Process in their area, and report on progress to the Steering Group.

RECOMMENDATION
That the Steering Group seek a named Highways England officer to act as a liaison link and group member, and to share real-time intelligence of highways network incidents.

RECOMMENDATION
That local authority public health teams work with other council departments such as car parks and open space services to identify local actions to prevent suicide including staff awareness training.

4. Provide better information and support to those bereaved or affected by suicide;

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

5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour;

RECOMMENDATION
Liaise with local media to encourage reference to and use of guidelines for the reporting of suicide through a summit with local press and media organisations, and to provide information to professionals on the sensitive reporting of suicide. By 20 July 2017

6. Support research, data collection and monitoring.

RECOMMENDATION
Develop working relationships between individual coroners and local public health teams ensure local plans are evidence based and responsive. Coroners can be invited to become formal members of any local suicide prevention groups or networks

Coroners can also inform the local authority or Director of Public Health if they identify particular areas of concern, e.g. locations used for suicide, possible clusters of suicide, increase in a particular method or new and emerging method of suicide.

Refresh the Berkshire-wide Suicide Audit for deaths in the period 2014-16 to include new categories based on best practice.

Background

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 strategy.

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.

Whilst suicide causes a vast negative wellbeing impact on family, friends, colleagues, and wider contacts, 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.

Suicides are not inevitable and are a major issue for society as well as being a leading cause of years of life lost. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides. Government and statutory services have a role to play in building individual and community resilience. Vulnerable people in the care of health and care services can be supported and kept safe from preventable harm. Interventions can be provided quickly when someone is in distress or in crisis and for vulnerable people in the wider community, practical measure such as debt advice services can make all the difference.

Public Health England (PHE) has recently published a guide to local suicide prevention planning (2016). In it, they identify ten things that everyone needs to know about suicide prevention. These are re-produced here in full, and with kind permission of PHE. Simple to follow and understand, these form the basis of raising awareness of suicide prevention across Berkshire services and populations.

10 Things Everyone Needs To Know About Suicide Prevention

1 Suicides take a high toll

There were 4,882 deaths from suicide registered in England in 2014 and for every person who dies at least 10 people are directly affected.

2 There are specific groups of people at higher risk of suicide

Three in four deaths by suicide are by men. The highest suicide rate in England is among men aged 45-49. People in the lowest socio-economic group and living in the most deprived geographical areas are 10 times more at risk of suicide than those in the highest socio-economic group living in the most affluent areas.

3 There are specific factors that increase the risk of suicide

The strongest identified predictor of suicide is previous episodes of self-harm. Mental ill-health and substance misuse also contribute to many suicides. Suicide prevention strategies must consider and link to programmes of early identification and effective management of self-harm, mental ill-health and substance misuse.

4 Preventing suicide is achievable

The delivery of a comprehensive strategy is effective in reducing deaths by suicide through combining a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide. Directors of public health and health and wellbeing boards have a central role. Their involvement is crucial in coordinating local suicide prevention efforts and making sure every area has a strategy in place.

5 Suicide is everybody's business

A whole system approach is required, with local government, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide having a role to play. Suicide prevention can also be part of work addressing the wider determinants of health and wellbeing.

6 Restricting access to the means for suicide works

This is one of the most evidenced aspects of suicide prevention and can include physical restrictions, as well as improving opportunities for intervention.

7 Supporting people bereaved by suicide is an important component of suicide prevention strategies

Compared with people bereaved through other causes, individuals bereaved by suicide have an increased risk of suicide and suicidal ideation, depression, psychiatric admission as well as poor social functioning.

8 Responsible media reporting is critical

Research shows that inappropriate reporting of suicide may lead to imitative or 'copycat' behaviour.

9 The cost of suicide justifies investment in suicide prevention work

The economic cost of each death by suicide of someone of working age is estimated to be £1.67 million. This covers the direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering.

10 Local suicide prevention strategies must be informed by evidence

Local government should consider the national evidence alongside local data and information to ensure local needs are addressed.

Strategy Aims

In 2014, the seven Berkshire CCGs and six local authority public health teams across Berkshire began work to refresh the suicide audits previously undertaken and to recommend from this a strategy for reducing suicide risk across Berkshire. This strategy is the result of a study of national research and recommendations plus recommendations of many local stakeholders from a range of organisations.

This strategy proposes co-ordinated prevention across all the elements influencing suicide, 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.

The overall aim of this strategy is:

- To outline how partners across the county will work to prevent suicide in Berkshire.
- To outline the governance structure for Suicide Prevention work in Berkshire.
- To make clear how the public, partners and other stakeholders can deliver the actions outlined herein.

The objectives and six priority areas to meet this aim are also drawn from the National Suicide Prevention Strategy – "Preventing Suicide in England" (DH, 2012), and are intended to be met through coordinated multi-agency actions, under the governance of the Berkshire Suicide Prevention Steering Group.

The objectives of this strategy developed from the national strategy are:

- To reduce suicides in Berkshire by 25% by 2020;
- To ensure better support is provided for those bereaved or affected by suicide.

The priority areas of this strategy drawn from the national strategy 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.

These six priority areas have become the golden thread which runs through this strategy and the action plans which support it. These action plans are for the year 2017/18, whilst the strategy is for the years 2017-2020, taking this to the year when the overarching aim to reduce suicide by 10%, as stated in the Five Year Forward View on Mental Health and incorporated into the Sustainability and Transformation Plans produced by groups of CCGs. There are other recommendations around process and which address the overarching aims and/or a combination of the priority areas.

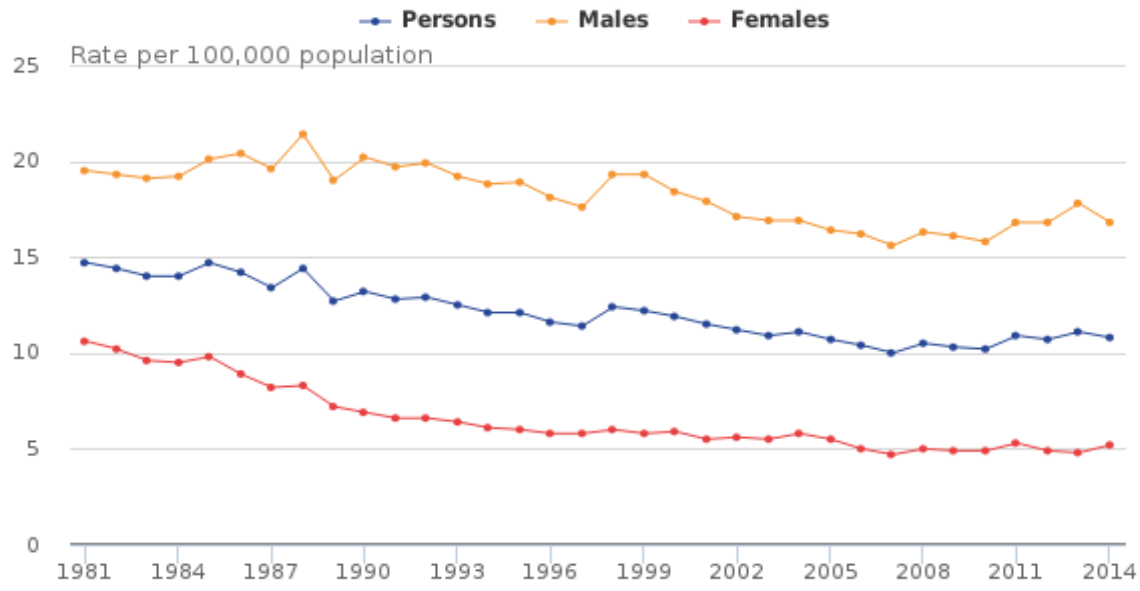
National Context

Nationally available data on suicides can help place local information on suicides in context. From the national references which include rates, trends, risk factors, suicide methods and evidence of what works to prevent suicides, a local approach for suicide prevention can be developed. This section presents the national data on suicides and is intended to be used as a guide to draw comparisons with local data and information from the Berkshire Audit.

The Office for National Statistics (ONS) provides figures on deaths by suicide, available publicly on its website at: www.ons.gov.uk. Data can be downloaded which shows numbers and rates of death by suicide per 100,000 population. Rates are important as they account for the age and size of populations, so it is more reliable when comparing suicide across age groups and areas.

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

Figure 1: Age-standardised suicide rates by sex, deaths registered between 1981 and 2014, United Kingdom



Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency. 2016.

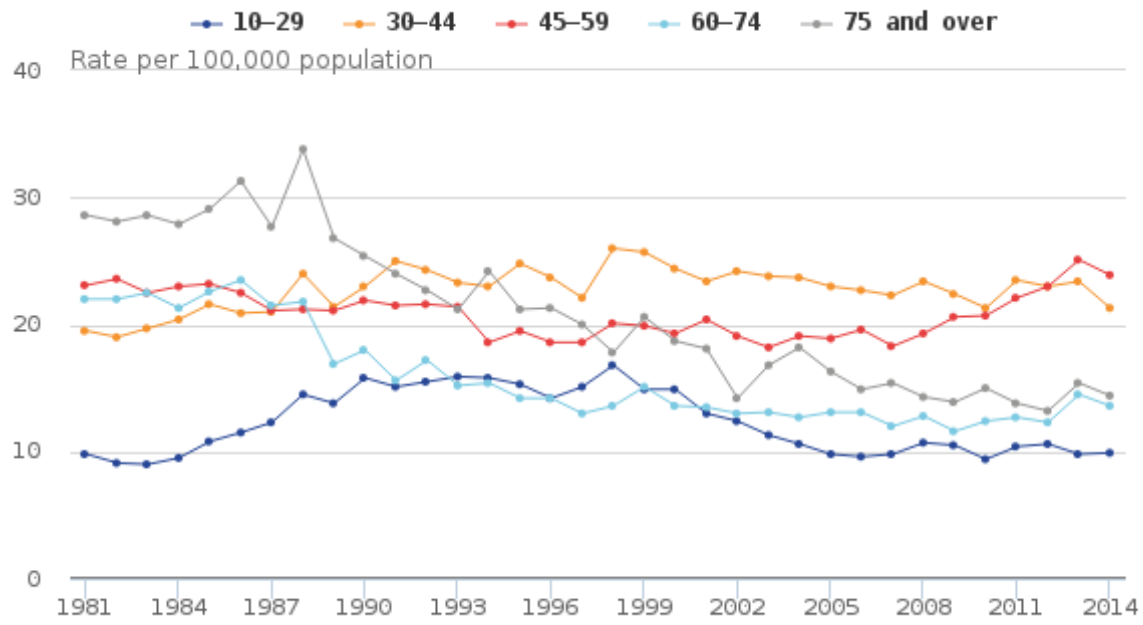
Figure 1 above shows the age standardised suicide rates for the UK since 1981. A generally downward trend in suicide rates was observed between 1981 and 2007, with a decrease from 15.6 to 10.6 deaths per 100,000 population (see figure 1). There has been a slight overall increase in suicide rates since 2007, to 10.8 per 100,000, which is part of an upward trend since 2007 for both sexes.

Suicide continues to be more than three times as common in males. The male suicide rate in 2013 was the highest since 2001. The lowest male rate since the beginning of the data series, at 16.6 per 100,000, was in 2007.

The highest suicide rate in the UK in 2014 was among men aged 45 to 59, at 23.9 deaths per 100,000, slightly lower than the record high seen in 2013. This age group also had the highest rate among women, at 7.3 deaths per 100,000 population.

Men aged 45 to 59 had the highest suicide rate in 2014 for the second year in a row with a rate of 23.9 deaths per 100,000 population. Between 2000 and 2011, the rate in this age group was the second highest, behind men aged 30 to 44. Since 2007, the rate in the 45 to 59 age group has been increasing.

Figure 2: Age-specific suicide rate, males, deaths registered between 1981 and 2014, United Kingdom

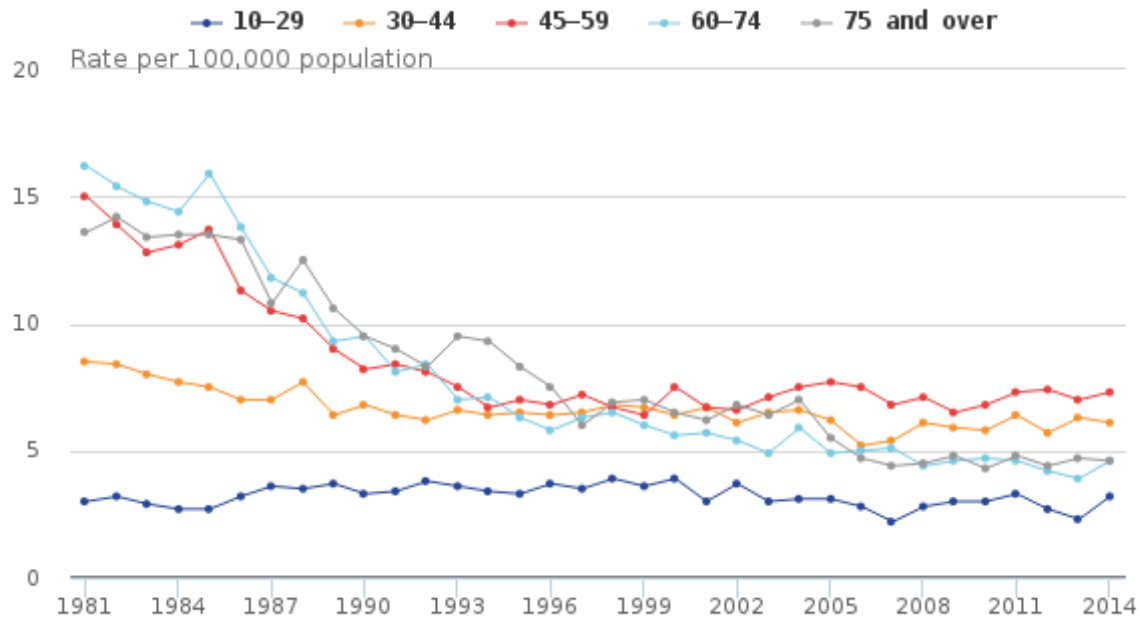


Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency. 2016.

Female rates have stayed relatively constant since 2007. In 2014, the age group with the highest suicide rate for females was 45- to 59-year-olds, with a rate of 7.3 deaths per 100,000 population (see Figure 3). This has been the case since 2003. Analysing this data by 5 year age group shows that females aged 50 to 54 have the highest suicide rate at 8.0 per 100,000 population. Between 1981 and 1994, female suicide rates decreased across all broad age groups apart from 10 to 29 year-olds. Suicide rates for

women under 60 have remained relatively constant since 2008, and for women aged 60 and over continue to show a broadly decreasing trend,showing the biggest reduction since 1981.

Figure 3: Age-specific suicide rate, females, deaths registered between 1981 and 2014, United Kingdom



Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency. 2016.

A time trend analysis in England suggested that the recent recession in the UK could be an influencing factor in the increase in suicides. The study found that local areas with greater rises in unemployment had also experienced higher rises in male suicides (Barr et al 2012). A review by the Samaritans (2012) emphasised that middle-aged men in lower socioeconomic groups are at particularly high risk of suicide. They pointed to evidence that suicidal behaviour results from the interaction of complex factors such as unemployment and economic hardship, lack of close social and family relationships, the influence of a historical culture of masculinity, personal crises such as divorce, as well as a general 'dip' in subjective wellbeing among people in their midyears, compared to both younger and older people (Office for National Statistics, 2014).

Suicide in mental health inpatients had almost halved since 1997 and deaths had also fallen among prisoners. The most recent National Confidential Inquiry into Suicide and Homicide annual report (July 2013) shows a rise in overall patient suicide, probably reflecting the rise in suicide in the general population, which has been attributed to current economic difficulties. There are twice as many suicides under crisis resolution / home treatment compared to in-patients. Hanging, strangulation and suffocation account for the largest number of suicides in males, at 60% of the total. In females hanging and drug related poisoning are the joint most frequent methods, 38% *(Preventing suicide in England: 1 year on, 2014).*

Strategic Context

Local suicide prevention planning is the responsibility of local authority public health teams to deliver with clinical commissioning groups (CCGs), health and wellbeing boards and a wider network of partners. Very recent guidance to inform this strategy has been developed by Public Health England (2016) in partnership with the National Suicide Prevention Alliance.

The need to develop suicide prevention strategies and action plans at a local level and which engage with a wide network of stakeholders in reducing suicide is set out in the government's national strategy for England, Preventing Suicide in England, a cross government strategy to save lives (HM Government, 2012). It is also reinforced by the Mental Health Taskforce's report to NHS England, *The Five Year Forward View for Mental Health* (NHS England, 2016).

Two key objectives are laid out in the national suicide prevention strategy:

- to reduce the suicide rate in the general population, and
- to provide better support for those bereaved or affected by suicide.

This national strategy in turn set out six key areas for action:

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

Responsibility for suicide prevention action plans and strategy lies with local government through health and wellbeing boards. Local authorities report on the quality and success of initiatives to improve the health and wellbeing of their populations, using national indicators set out in the Public Health Outcomes Framework. Indicators relevant to suicide prevention include suicide rate, self-harm and excess mortality in adults aged under 75 years with serious mental illness

Around half of people who die by suicide have a history of self-harm, and self-harm is a sign of serious emotional distress in its own right. Mental health promotion, prevention and early intervention are essential to help reduce self-harm in the community that does not present to health services. The effective assessment and management of self-harm by NHS services where people do present with self-harm, particularly in Emergency Departments, represents a huge opportunity to reduce repetition of self-harm and future suicide risk. In June 2013, NICE published a new quality standard to improve the quality of care and support for people who self-harm. The Spending Review (2013) committed to every Emergency Department having constant access to mental health professionals and Public Health Outcomes Framework published in (2013) includes the definition of the new indicator on self-harm. This makes clear the priority given to the prevention and management of self-harm across local authority and NHS services.

Evidence Base in Suicide Prevention

The Government published its review of the suicide strategy, *"Preventing suicide in England: Two years on Second annual report on the cross-government outcomes strategy to save lives"* (Department of Health, 2015). This section summaries this, the latest evidence and best practice as identified within the report.

Men and Economic Crisis

A recent study found that men in different age brackets had different suicide risks during the recent recession. Those aged between 35-44 years old experienced increased suicide rates corresponding to economic decline. The study also found the halt in the downward trend in suicide rates amongst men aged 16-34 may have begun before the 2008 economic recession (Coope, et al, 2014).

Self-Harm and Alcohol

There was a higher rate of alcohol-related deaths for those presenting at emergency departments with self-harm for both males and females. Local areas need to ensure that those presenting to hospital with self-harm should be assessed for alcohol problems to identify issues early and get treatment (Bergen, et al, 2014). This is in line with NICE guidelines. In the year following self-harm the risk of suicide is raised 49-fold in the year, this increases with age at initial self-harm (Hawton, et al).

Crisis Resolution

Crisis resolution home treatment services have a key role to play in suicide prevention. Approximately 180 suicides each are patients who are under crisis resolution home treatment services, with approximately 80 among in-patients (Hunt, et al; NCISH 2014).

Primary Care Patients

Both frequent attendance and non-attendance at GP surgeries is linked to increased risk of suicide. For young men, non-attendance is a particular risk factor (NCISH 2002-20012).

Discharge Processes

The first 3 months following discharge from a mental health inpatient episode remains a high risk, with the highest risk at 2 weeks discharge. Community Care reforms which recommend a 7 day follow up have shown positive results although progress has stalled recently (Psychiatry Online).

Self-harm in Prisons

There is an association between self-harm and suicide within the prison setting. Prevention and treatment of self-harm should be part of the suicide prevention efforts within prisons (Hawton, et al, 2014).

National Best Practice in Suicide Prevention

These case studies were reported in, *"Preventing suicide in England: Two years on Second annual report on the cross-government outcomes strategy to save lives"* (Department of Health, 2015).

U Can Cope

The U Can Cope film and online resources were designed for people in distress and those trying to support them, to instil hope, promote appropriate self-help and inform people regarding useful strategies and how they can access help and support. They have been endorsed by the International Association of Suicide Prevention: www.connectingwithpeople.org/ucancope

Social Media

Emerging findings from the research study on Understanding the role of social media in the aftermath of youth suicides (COSMOS), commissioned in support of the suicide prevention strategy, are that:

- Suicidal tweeters show a high degree of reciprocal connectivity (i.e. they follow each other), when compared with other studies of the connectivity of Twitter users, suggesting a community of interest.
- A retweet graph shows that users who post suicidal statements are connected to users who are not, suggesting a potential for information cascade and possibly contagion of suicidal statements.
- The reaction on Twitter to the Hayley Cropper Coronation Street suicide storyline was mostly information/support and debate about the morality of assisted dying, rather than statements of suicidal feelings.
- Tweets about actual youth suicide cases are far more numerous than newspaper reports and far more numerous than tweets about young people dying in road traffic accidents. This suggests that suicide is especially newsworthy in social media. In newspapers there is no significant difference between the two types of death, in terms of number of reports per case.

Nottinghamshire Healthcare NHS Trust and Connecting with People

Nottinghamshire Healthcare NHS Trust is implementing an innovative approach to suicide prevention to improve both patient care and clinical governance. The Trust has developed a team of in-house trainers to deliver suicide and self-harm awareness and response training across the Trust. They are also piloting a web-based App to help to consistently record individual assessments. The App is integrated securely within the NHS system and is based on peer-reviewed clinical tools.

Other Trusts are also involved in the pilot of the App in partnership with the social enterprise *Connecting with People*. The approach being taken:

- Is evidence based and uses peer reviewed clinical tools. It combines compassion with sound clinical governance.

- Is proactive, emphasising safe triage and the co-creation of immediate safety plans for all patients with suicidal thoughts, irrespective of risk. It documents evidence on level of risk and actions agreed to mitigate the risks.
- Has been developed by healthcare practitioners, third sector organisations and service users, for delivery to health and social care practitioners in primary and secondary care and in third sector organisations.

It is an example of how the third sector can work effectively in partnership with the NHS to improve patient care in specialist areas, forming part of the RCPsych OnSite training.

Safety Collaboratives in Mental Health

The South West of England has had a safety collaborative in Mental Health since 2010. This work spread across the South of England in 2013. It involves the majority of Mental Health Trusts in the region. Work streams include getting medicines right, improving physical health care and delivering safe and reliable care. This includes reducing absence without leave from inpatient units and reducing suicides.

North Essex Partnership University NHS Foundation Trust and Samaritans

Three Samaritans branches together with the North Essex Partnership University Foundation Trust have signed a partnership agreement to develop a range of opportunities for patients and staff to benefit from the knowledge, experience and complementary services offered by Samaritans in support of emotional wellbeing and suicide prevention. This will include:

- NHS staff organising for a patient (with their consent) to receive a call from Samaritans.
- Training for non-clinical NHS staff on handling challenging contacts, suicide awareness and emotional well-being.
- Establishing referral pathways between Samaritans and GPs in the area.
- Samaritans presence in Emergency Departments.

This partnership is an example of how the voluntary sector and NHS can deliver better support to people by working together more closely.

Healthtalk Online for parents whose child is self-harming

Drawing on research with families, this website enables parents to see and hear parents and other family members of young people who self-harm share their personal stories on film. The films cover issues such as why young people self-harm, discovering that a young person is self-harming, how they helped their young person, living with self-harm, support and treatment, and what helped them cope. www.healthtalk.org/peoples-experiences/mental-health/self-harm-parents-experiences/topics

Staying safe if you're not sure life's worth living

A new online resource developed by the Royal College of Psychiatrists, Connecting with People, Samaritans, Grassroots Suicide Prevention, State of Mind, leading academics, people with lived experience and their carers.

Staying safe if you're not sure life's worth living includes practical, compassionate advice and many useful links for people in distress:

www.connectingwithpeople.org/StayingSafe .

Local Context

In Berkshire, the trends in suicides broadly reflect the national trends, and the results from the most recent local suicide audit, carried out in 2015, are shown below.

Of note:

- more males completed suicide than females
- 70% of the deaths recorded between 2007-2014 were in age group 30-59 years
- The percentage of deaths among the unemployed rose from 13% in 2007 to 38% in 2014
- The most common method for suicide was hanging/strangulation.

Local Suicide Audit Results

During 2015, Public Health Teams in Berkshire undertook an audit of suicide and undetermined deaths during the 2012-2014 period. This audit provides an analysis of the most recent audit and includes comparative data from previous audits. The audit defined suicide as a death where the coroner has given a verdict of suicide (based on evidence that the intent was to cause death or take own life) or where an open verdict was reached in a death from injury or poisoning. The definition comprises suicides and open verdicts coded as ICD10 X60-X84 and Y10-YY34.

Data for the audit was collected from Berkshire Coroner Office case notes for people who died from suicide or undetermined injuries during 2012-2014. The audit only includes Berkshire residents who died in the County. It is important to note that there can be a substantial delay between the date of death and the date of registration for suspected suicides, so it is likely that not all deaths from 2014 were included in this audit.

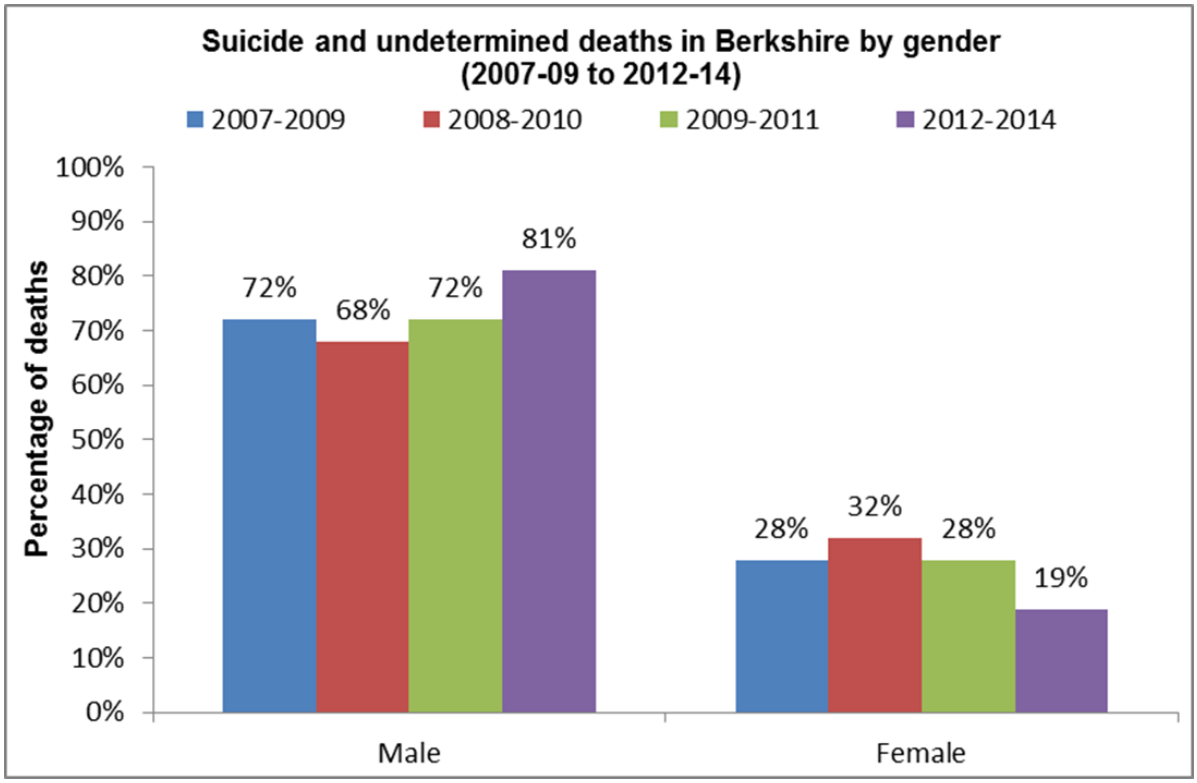
The analysis of suicide data is based on small numbers and is likely to show differences over time or between different groups that are due to random occurrence. However, the analysis of this data can give some indication as to local patterns in suicide deaths. Data from the audit is presented as averages over a three year period to reduce some of the random variations that occur when analysing small numbers. For confidentiality reasons, figures under 5% have been supressed and data is shown at a Berkshire level, rather than by individual local authorities.

120 deaths were included in the Berkshire suicide audit for 2012-14. 70% of these were classified as suicide by the coroner and the other 30% were undetermined deaths / open verdicts.

Gender

Data from all recent audits show that males have a higher suicide rate compared to women in Berkshire. This is consistent with national figures.

Figure 4: Suicide and undetermined deaths in Berkshire by gender (2007-09 to 2012-14)



Age

70% of the deaths recorded in 2012-14 were for people aged 30-59.

Age group	2012-2014
10-19	*
20-29	13%
30-39	23%
40-49	23%
50-59	24%
60-69	*
70-79	*
80-89	7%

Ethnicity

The majority of people dying from suicide or an undetermined death in Berkshire are White-British. This is largely representative of Berkshire's population. In 2011, 73% of Berkshire's population were from a White-British background, ranging from 35% in Slough to 80% in West Berkshire. The majority of deaths from other ethnic groups (Asian/Asian-British and White-Other) were Slough residents and this also reflects the Borough's population profile. It is important to note that 15% of the cases included in the 2015 audit did not have an ethnic origin recorded in the audit. This is a higher proportion than the previous audit and will therefore have affected the validity of the analysis for 2012-2014 data.

Ethnicity	2007-2009	2008-2010	2009-2011	2012-2014
White-British	77%	75%	77%	61%
White-Other	10%	15%	13%	13%
Asian/Asian-British	<5%	<5%	<5%	12%
Black/Black-British	<5%	<5%	<5%	0%
Not Known	<5%	<5%	<5%	15%

Diurnal and Seasonal Variation

The following tables illustrate the day of the week and seasons in which deaths from suicide occurred in Berkshire during 2007-2011 and 2012-2014.

Day of the week	2007-2009	2008-2010	2009-2011	2012-2014
Monday	19%	21%	21%	20%
Tuesday	16%	17%	17%	13%
Wednesday	16%	11%	10%	9%
Thursday	10%	10%	15%	16%
Friday	8%	9%	7%	14%
Saturday	19%	14%	15%	13%
Sunday	14%	17%	15%	13%

The data shows a relatively even spread across the whole week, with no particularly 'common' day.

Season	2007-2009	2008-2010	2009-2011	2012-2014
Winter (Dec-Feb)	24%	23%	27%	28%
Spring (Mar-May)	29%	30%	27%	31%
Summer (Jun-Aug)	25%	21%	21%	21%
Autumn (Sept-Nov)	21%	26%	28%	18%

Figure 5: Suicide and undetermined deaths in Berkshire by day of week (2007-09 to 2012-14)

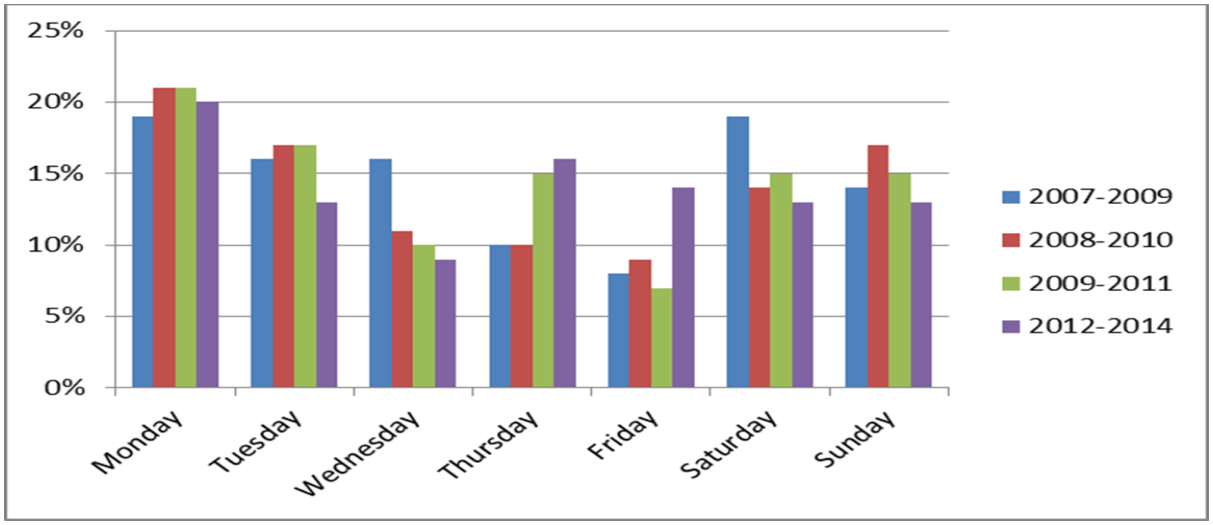
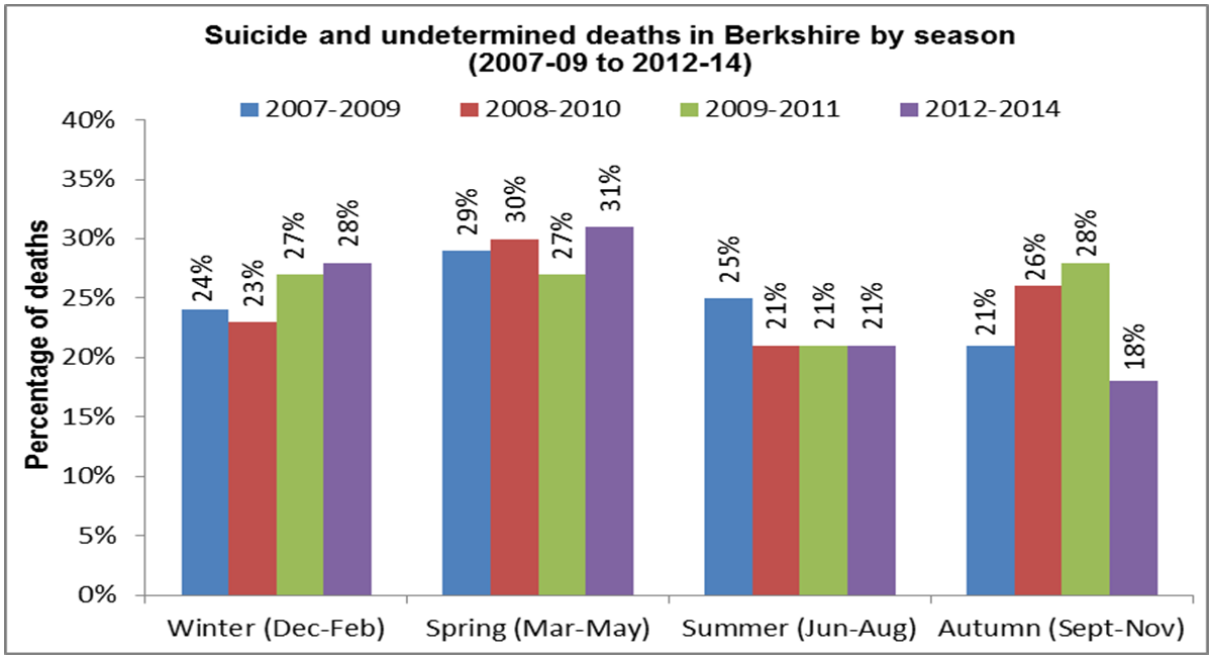


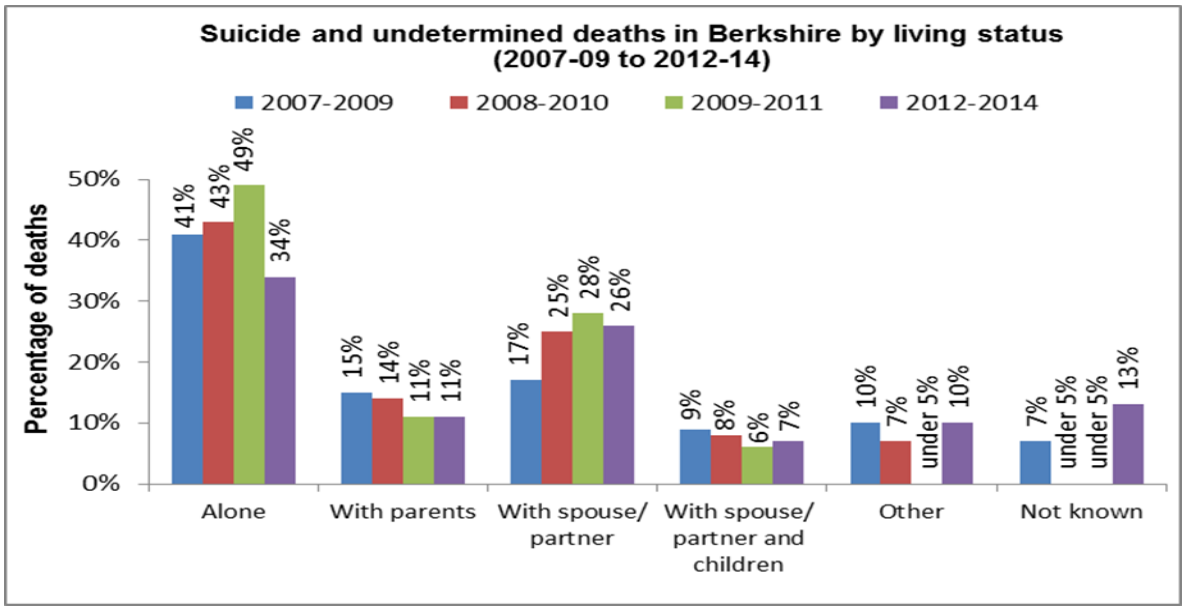
Figure 6: Suicide and undetermined deaths in Berkshire by season (2007-09 to 2012-14)



Marital and Living Status

Recent data from the Office for National Statistics shows that 13% of usual residents in England and Wales were living on their own in 2011. The table below indicates that those living alone in Berkshire are therefore over-represented in suicide deaths. This percentage has reduced from 49% in 2009-2011 to 34% in 2012-2014, however it is still the main living status recorded. It is important to note that the number of people with a living status not recorded or not known is higher in 2012-2014 (13%), which makes comparisons of data difficult.

Figure 7: Suicide and undetermined deaths in Berkshire by living status (2007-09 to 2012-14)



The table below shows that there were more deaths from single people in the two audit periods, ranging from 39% to 45%.

Marital status	2007-2009	2008-2010	2009-2011	2012-2014
Single	45%	39%	39%	40%
Married	23%	29%	30%	29%
Divorced	14%	13%	13%	8%
Separated	10%	7%	7%	<5%
Widowed	4%	6%	7%	<5%
Co-habiting	<5%	<5%	5%	10%
Not stated	<5%	<5%	<5%	6%

Employment Status

Some studies have indicated that there is a strong independent association between suicide and individuals who are unemployed (Lewis and Sloggert, 1998). Unemployment in the Thames Valley is low, although there has been some fluctuation between 2007 and 2014. The lowest level of unemployment during this time was 3.4% in Jul-07 to Jun-08, with the highest rate of 6.1% in Apr-09 to Mar-10.

Data from the 2012-2014 Berkshire audit shows that 38% of people dying from suicide and undetermined deaths were unemployed. This is an over-representation of the population, considering that only 4-5% of people were unemployed during that time period. This is also a notable increase on the figures from 2007-2011, which ranged from 11%-14%. This change may be down to a random occurrence, due to small numbers.

Employment status	2007-2009	2008-2010	2009-2011	2012-2014
Full Time	46%	51%	55%	36%
Part Time	5%	<5%	<5%	<5%
Unemployed	13%	11%	14%	38%
Student	6%	6%	<5%	<5%
Retired	18%	17%	17%	11%
Long-term illness/ disability benefits	<5%	<5%	<5%	<5%
Housewife/husband	<5%	<5%	<5%	<5%
Not known	8%	5%	<5%	12%

Suicide Note

The table below shows the proportion of deaths where a suicide note was left.

Left a suicide note?	2007-2009	2008-2010	2009-2011	2012-2014
Yes	29%	32%	40%	36%
No	71%	68%	60%	54%
Not known	0%	0%	0%	10%

Housing Status

A large number of the cases included in the 2012-2014 audit did not capture the housing status for people, which means that the data cannot be presented in this analysis.

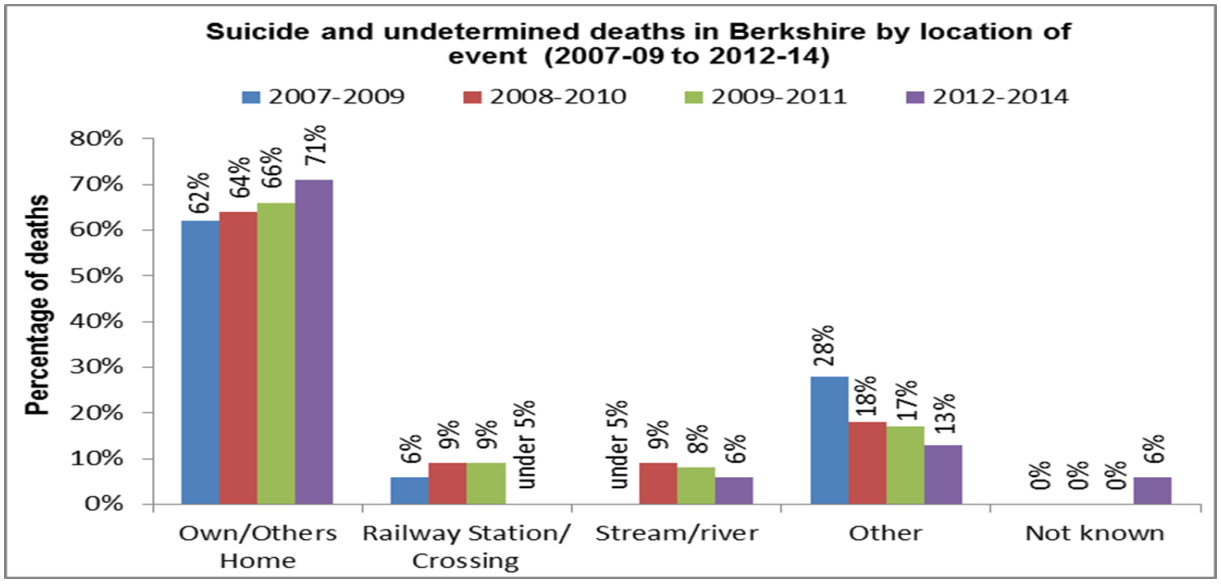
Housing status	2007-2009	2008-2010	2009-2011	2012-2014
Owner/Occupier	46%	46%	52%	35% of these cases did not have a housing status recorded and therefore this data cannot be presented
Privately Renting	41%	33%	25%	
Council House/ Housing Association	5%	9%	11%	
With Parents	<5%	<5%	<5%	
Supervised Hostel	<5%	<5%	<5%	
Unsupervised Hostel	<5%	<5%	<5%	
Other	<5%	<5%	<5%	
Not Known	<5%	<5%	<5%	

Location of event

The majority of deaths identified in the local audits took place in the person's own home or another person's home. This proportion has continued to increase from 62% in 2007-2009 to 71% in 2012-2014.

Location of event	2007-2009	2008-2010	2009-2011	2012-2014
Own/Others Home	62%	64%	66%	71%
Railway Station/ Crossing	6%	9%	9%	<5%
Stream/river	<5%	9%	8%	6%
Other	28%	18%	17%	13%
Not known	0%	0%	0%	6%

Figure 8: Suicide and undetermined deaths in Berkshire by location of event (2007-09 to 2012-14)



Methods Used

Suicide methods can be classified as either ‘active’ or ‘passive’. Active methods are quick and effective allowing little time for reconsideration. Such methods are hanging, shooting, jumping in front of a train or from a height. Among the general population hanging, strangulation and suffocation has been identified as the most common cause of suicide for men. Passive methods are less violent and allow some time for reconsideration or intervention (e.g. self-poisoning, carbon monoxide). Hanging/strangulation has been the most common cause of death over 2007-2014.

Methods used	**2007-2009**	**2008-2010**	**2009-2011**	**2012-2014**
Hanging / Strangulation	54%	47%	48%	49%
Carbon Monoxide Poisoning	8%	<5%	<5%	<5%
Jumping / laying before a train	6%	9%	9%	<5%
Jumping from a height	11%	11%	8%	<5%
Self-Poisoning	10%	9%	12%	0%
Drowning	<5%	7%	7%	6%
Other	7%	12%	14%	38%
Not known	0%	0%	0%	<5%

Alcohol and drugs taken at time of death

The audit of people dying from suicide and undetermined deaths during 2012-14 identified whether alcohol or prescribed drugs were detectable in the deceased. This data was not collected in the previous audit. The tables below show that at least 36% of people who died in 2012-14 had taken alcohol prior to their death and at least 42% had taken prescribed drugs, and outlines those drugs that were implicated in suicide deaths.

Alcohol present?	**2012-2014**	
At intoxicating level	23%	
At non-intoxicating level	13%	
No alcohol detected	54%	
Not known	11%	
Prescribed drugs present?	**2012-2014**	
At fatal level	14%	
At intoxicating level	8%	
At therapeutic level	20%	
No prescribed drugs detected	43%	
Not known	16%	
Drugs implicated	**Male**	**Female**
Antidepressants	✓	✓
Paracetamol	✓	
Coproxomal or similar	✓	✓
Benzodiazepine	✓	
Other hypnotic		
Anti-psychotic	✓	✓

Other substances implicated in suicide deaths in 2012-14 were:

Other substances	Male	Female
Amphetamines	✓	✓
Ecstasy	✓	
Crack/Cocaine	✓	
Ketamine	✓	
Heroin	✓	✓
Opiates	✓	
Methadone	✓	✓

Personal, Social and Health Factors associated with deaths from suicide

The following factors were identified from records at the Coroner's Office as being associated with suicide:

Factor identified	2007-2009	2008-2010	2009-2011	2012-2014
Relationship problems	14%	6%	<5%	29%
Financial problems	9%	6%	<5%	24%
Depression	25%	42%	51%	67%
Low self esteem	<5%	<5%	<5%	Not collected
Other Mental health Issues	8%	8%	<5%	Not collected
Pending Police Investigation	<5%	<5%	<5%	12%
Family bereavement	<5%	<5%	<5%	12%
Physical Health	8%	<5%	<5%	33%
Job related	<5%	<5%	<5%	17%
Not Stated	15%	13%	20%	-

Local Governance Structures

In order to facilitate the production of this strategy and to steer the Berkshire-wide audit of suicides, a strategic group was convened with representatives from organisations across county. This worked under the identity of the Berkshire Suicide Risk & Self Harm Reduction / Prevention Steering Group. During 2015/16 as key staff changed, the group has lost some of its membership and had become less strategic. The original terms of reference state that the group:

> "*will provide public health leadership and advice to support a joint approach to achieve real change in the prevention of suicides and self- harm through actions taken by member organisations. It will facilitate the bringing together of clinicians, professionals and organisations, with the patient's voice, to deliver surveillance data to support projects / programmes to prevent suicides and offer support to those who are bereaved*."

Public Health England (2016) suggests that the membership of suicide prevention partnerships is made up of representative working with adults, children and young people. The following diagram suggests the range of partners who may be included.

The Berkshire Steering Group will need to own this strategy, and the membership should be updated to ensure a closer fit with the groups suggested above. The membership of the current group as at December 2016 is detailed in Appendix 8.

RECOMMENDATION

That the Berkshire Steering Group re-visits their terms of reference and membership and become known as the "Berkshire Suicide Prevention Steering Group", with the aim of providing the governance to this strategy and its action plans.

There are other groups for whom this strategy and its action plans are an important issue, and these include commissioning boards in the East Berkshire and West Berkshire Confederations of CCGs; Health and Wellbeing Boards; Health Overview and Scrutiny Committees; Adult Safeguarding Boards; and Community Safety Partnerships. In order to get full endorsement of this strategy and for organisations to commit to their action plans, the terms of reference should ensure that the links to these other structures are robust and transparent.

Members of the Steering Group could be asked to act as suicide prevention champions. These are individuals who get involved in specific pieces of suicide prevention work – and might include people who have been bereaved by suicide or those with a special interest or expertise. They can be pivotal in raising issues regarding suicide awareness locally, and drive forward the action plans of their agencies. A specific initiative to engage the elected members of councils as Mental Health Champions may provide an opportunity for them to also speak out on suicide prevention. Details of this initiative are available here: http://www.mentalhealthchallenge.org.uk/the-challenge/

RECOMMENDATION
That organisations represented on the Berkshire Suicide Prevention Steering Group consider nominating a suicide prevention champion from within their membership.

Monitoring & Evaluation and Progress

This is a pan-Berkshire and multi-agency Strategy and the action plans for this strategy which are overseen by the Berkshire Suicide Prevention Steering Group are set out below.

Individual Borough action plans for each of the six Berkshire Unitary Authorities are also included and are set out in appendices 2-7. These give a more local set of priorities and respond to the particular geographical issues, population structures and general health needs of the Authorities.

Other agencies which are part of the Steering Group may have their own action plans and an objective of this strategy is to bring these into one combined action plan as far as possible and to share openly the actions plans of all agencies in order to learn from one another; to avoid un-necessary duplication of effort or resources; and to encourage co-production of outcomes.

Links to Other Local Strategies

This is the first comprehensive Berkshire-Wide Suicide Prevention Strategy and action plans have been produced for the year 2017-18. One of the objectives is to ensure that this strategy, its aims and objectives are shared and upheld in the strategies, action plans and objectives of all those groups across Berkshire who are committed to improving health outcomes, promoting wellbeing, removing the stigma associated with mental health and preventing suicides.

Local Joint Health and Wellbeing Strategies and their action plans should endorse this Strategy and Health and Wellbeing Boards are key to the governance of this Strategy and the Steering Group. Through tightly-knit joined up thinking, organisations, individual and communities across Berkshire can come together to make the progress necessary to reduce suicides in our populations.

RECOMMENDATION

That all agencies represented on the Steering Group commit to an annual Action Plan of their own which can then be brought together to create a Berkshire-wide Action Plan for each year of the Strategy.

Local Best Practice in Suicide Prevention

Thames Valley Suicide Prevention and Intervention Network (SPIN) CALMzone

The Campaign Against Living Miserably (CALM) was originally a Department of Health helpline project on suicide prevention particularly targeting younger men using marketing methodology and images to specifically engage with this audience on issues surrounding mental distress and social alienation. The resources produced directed men to a special helpline, and latterly to web-based resources. In 2000, a partnership of six areas in the North-west of England commissioned this work for young men in Merseyside, which continued when CALM transferred into a national charity. There is a local CALMzone Coordinator who promotes CALM across Merseyside in collaboration with the local community – pubs and clubs, venues and universities, sports teams and clubs – to encourage them to join and promote the campaign.

In 2015, the local authorities across the Thames Valley through SPIN funded a Thames Valley CALMzone, and employed a coordinator undertaking similar promotions as in Merseyside. CALM have provided local commissioners with anonymised reports on numbers and trends of calls and web chats across the Thames Valley. As well as providing funding to support the helpline, the commissioners ensure CALM has an up-to-date local database of agencies which local callers can be referred to. Berkshire local authorities have continued to fund the helpline until June 2017, although the local coordinator post is no longer funded.

RECOMMENDATION
Evaluate the Berkshire CALMzone and recommission targeted suicide prevention work for younger men and middle aged men.

Real Time Suicide (and near fatal self-harm) Surveillance

It is important to have a real time overview of self-inflicted deaths/suspected suicides and near fatal self-harm in order to provide timely support for those bereaved and affected, pick up community risks of contagion or suicide clusters and identify public places where suicides/incidents of near fatal self-harm appear to occur with increasing frequency. All of these activities contribute to suicide reduction and prevention in line with national and local strategy. Thames Valley Police (TVP) and the Thames Valley Suicide Prevention and Intervention Network (SPIN), supported by funding from the Thames Valley Strategic Clinical Network are collaborating to build on the supportive signposting for people bereaved by suicide work and develop a robust real time surveillance process.

In simple terms this process is as follows:

- TVP identifies and collates suspected suicides on the Gen 19 sudden death form.
- Coroner's officers send Gen 19s of suspected suicides to a central TVP email for monitoring.
- Details of the incidents in real time are thereby collated and are available for analysis, reporting and provide the ability to respond.

- Details of families who consent to 'Supportive Signposting' are sent to a central NHS England suicide bereavement address.
- Supportive literature and referral signposting links to organisations and charities are provided to relatives.

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

Further data is being collated from the following sources;

- NHS England monitor the strategic executive information system database for suspected suicides and near fatal self-harm.
- Links are being established with British Transport Police to monitor suspected suicides and near fatal attempts on the railways
- Links are being established with prisons to monitor prison suspected suicides and near fatal attempts.
- Links are to be established with the general hospital psychiatric liaison services to monitor incidents of near fatal self-harm.

All of this information will be reviewed by the TVP and SPIN leads and figures and concerns will be communicated to local public health suicide prevention leads for consideration within the local multi-agency suicide prevention action groups. A hub of SPIN comprising TVP, public health, NHS and the University of Oxford Department of Psychiatry Centre for Suicide Research has been established to maintain oversight of the regional prevalence of suicide with the aim of collaborating where indicated, in order to respond to issues that concern the whole geography, for example contagion and clusters.

Berkshire Healthcare Foundation NHS Trust (BHFT) Zero Suicide Programme

Reducing suicide for BHFT means early identification of people who may be at risk of taking their own lives and putting into place crisis plans so that patients and carers know what to do in a crisis. This can only be achieved by the early identification of individuals who are particularly at risk of suicidal thoughts and behaviours. The key objective of the BHFT Zero Suicide programme is to develop a culture of zero suicide where patients, families and carers feel supported to manage illness when in crisis.

By March 2018:

- BHFT staff will have received suicide prevention training and feel confidence in their practice. In the event of a suicide occurring, they will feel they had done everything in their power to avoid that outcome.
- BHFT will have risk management and safety plans which patients and carers recognise, understand, and consider being valid and useful.
- BHFT will have the evidence to demonstrate the same.
- BHFT will have identified local and national resources aimed at helping people who feel suicidal.

Benefits to be realised through the Zero Suicide programme are as follows:

- Staff have confidence in their practice and ability to work with patients in crisis.
- Patients and carers will know what to do in a crisis.
- Potential reduction in suicide.
- Potential for reduction in waste (via QI methodology) as patients become more able to cope with periods of crisis.
- Staff will feel more supported by the organisation to do their work effectively (including less exposed to criticism).
- Staff will have access to a broader range of resources that can assist them in their work.

Through 2016 – 2018 BHFT will be running targeted promotional campaigns to raise awareness with key at risk groups and provide signposting to local resources.

Areas of High Frequency

Due to their geography, design or operational use, there are places which present easier access to the means of suicide than others. This could be as a result of their isolation from staff operating their functions; because they are more generally isolated from crowds and the general public: or because life-threatening hazards exist which are generally mitigated by normal operation. They may have become known as places where suicides have occurred previously, either via media reports, or word of mouth.

The Railway Network

The railway network, mostly operated by Network Rail, is in places associated with higher frequencies of suicides, injurious attempts at suicide and suicide attempts and other incidents of people in hazardous positions which do not cause physical injury. The rail network in Berkshire includes a section of the main Great Western Railway routes from London to Wales and the South West, as well as sections of suburban rail lines and minor branch lines. The Great Western lines feature high-speed trains, and is presently being electrified by means of overhead cables. Most of the suburban rail lines are electrified using a third rail system. As well as a high volume of passenger trains, most local lines also feature freight trains operating throughout the day and night.

On average there are 255 suicides on the network per annum. Rail staff particularly drivers, are likely to be severely traumatised by these events and some may never return to work and therefore might need to access support services because of that. Network Rail operates a comprehensive programme of suicide prevention, working to reduce the potential for suicides to occur on the rail network and the industry sees its potential as going beyond that by seeking to do all it can to prevent suicides in its neighbouring communities. In 2015 Network Rail, together with British Transport Police, and The Samaritans agreed a process whereby any location that experienced three suspected suicide or injurious attempt incidents (or a combination of the two) would be subject of an escalation process. This would mean that enhanced working would be taken by all three parties in order to prevent further incidents at that that location. In Berkshire, there are locations where this process has been enacted. Actions taken at these locations include engineering solutions, such as the replacement of crossing with overbridges; or the fencing off of platforms on non-stopping fast lines; and the placement of Samaritans posters across the location.

RECOMMENDATION
That local authority public health teams take the leadership for liaison with any "Escalation Process" in their area, and report on progress to the Steering Group.

The Motorway and Roads Network

Most motorways and trunk roads (the strategic road network) are the operational responsibility of Highways England, with most other roads being the responsibility of local authorities, whilst some roads and byways are in private ownership. In Berkshire, the main London to South Wales Motorway, the M4 passes through the length of the county through all of the six unitary authorities and is managed by Highways England,

whilst the adjoining A329(M) motorway is the responsibility of Wokingham Borough Council. The speed of traffic on these roads and other major roads together with their overbridges provide places which can give access to the means of suicide. In 2013, the Highways Agency Traffic Officer Service attended 293 of 652 suicide/attempted suicide incidents on the strategic road network. Between April 2013 and December 2014, there were over 1,500 incidents which were brought to the attention of a Traffic Officer (Sutherland, 2015). Definitions in this area are not clear, but this does seem to indicate an increase in the reporting of road network incidents, if not in the number of incidents themselves.

RECOMMENDATION
That the Steering Group seek a named Highways England officer to act as a liaison link and group member, and to share real-time intelligence of highways network incidents.

Car Parks and Tall Buildings

Berkshire towns feature a number of multi-storey car parks of which some in the management or ownership of the Local Authorities. There are also many other tall buildings both residential and commercial, and together these locations can sometimes provide an access route to a means of jumping from a height.

The Horsham branch of The Samaritans is working with a local shopping centre and car park where suicides have occurred. They offer sessions for the car park attendants who are generally the first on the scene. They also have an arrangement with the shopping centre to call Samaritans if there is an incident, either to support the staff involved or to support shoppers/shop workers more generally if the incident was widely witnessed. (Sutherland, 2015). This is a simple intervention in which suicide prevention training could be incorporated.

Local Authority Settings

Local authorities may be responsible as owners, operators or managers of other facilities and locations where suicides may take place. This may be because of their isolation or due to their inclusion of specific means of suicide within them. Generally the local authorities in Berkshire look after many hectares of open space; parkland; and woodland, some of which may be managed as part of the highways network; but with most likely to be part of an open spaces portfolio. There is also significant waterside public realm managed or owned by the authorities. The risks at these sites include strong, tall trees as a means of hanging; access to water features such as lakes, rivers and canals which pose a risk of drowning; and dense undergrowth which could allow a person to die through neglect and exposure. Council staff and contractors may have an enhanced role to play in identifying suicide risks and in supporting people who appear to be in distress

RECOMMENDATION
That local authority public health teams work with other council departments such as car parks and open space services to identify local actions to prevent suicide including staff awareness training.

Mental Health Crisis Care Concordat

The Mental Health Crisis Care Concordat is a national agreement between 22 national agencies involved in the care and support of people in crisis and includes health, policing, social care, housing, local government and the third sector. It sets out how these agencies will work together better to make sure that people get the help they need when they are having a mental health crisis. Local areas have submitted declarations and developed action plans for the improvement of local mental health crisis care for their areas.

The Concordat focuses on four main areas:

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

Although the Crisis Care Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention. This strategy includes and reflects some of the key messages and recommendations from the concordat, aiming to reinforce a commitment by partners to work together in preventing and managing crises.

The local Crisis Care Concordat has, common to this strategy, been set at Berkshire-wide level, and has a comprehensive action plan, and certain actions include specific suicide prevention actions. These relate to the work of British Transport Police and the escalation process and staff training issues. They are more detailed than the recommendations and actions set out in this strategy, but there is strategic fit. There is a need to ensure full reference to this strategy in the Crisis Care Concordat action plans, and for further synergies to be explored.

RECOMMENDATION

Ensure strategic fit with the action plans of the Berkshire Crisis Care Concordat.

Gap Analysis and Emergent Berkshire-Wide Concerns

A gap analysis was undertaken by members of the Steering Group to identify the areas of the National Strategy which were not seen to be adequately addressed across Berkshire, taking into account the results of the local Suicide audit and the demography of the six unitary authorities. Some emergent concerns have also been captured which reflect discussion on the audit findings.

High Risk Groups

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

Berkshire is home to the University of Reading and other higher and further education establishments. Although the risk of suicide in the student population locally has not been established, recent ONS data (ONS, 2012) has shown a substantial increase nationally in both male and female suicides in the student population from 2007-2011.

Carers and people with long-term conditions have been highlighted as a local population at particular risk and this has been reinforced by the investigations into domestic homicides where a partner had subsequently taken their own life or attempted to. Adult Social Care and Public Health Outcomes Frameworks record measures of carer social interaction and that of people receiving care which give an insight into the vulnerabilities of these groups, and these are highlighted in the PHE Suicide Prevention Profiles. Not all people with a long-term health condition will be captured within these data, however; and the impact of symptoms such as chronic pain and reduced mobility, and access to certain medicines make this a group with heightened risk and access to means of suicide.

Berkshire no longer contains a prison. People in the criminal justice system will be imprisoned in neighbouring counties, which could make access visits more difficult for family and friends leading to increased isolation for the imprisoned.

Self-Harm continues to be an important risk factor for suicide and growing evidence to support using self-harm as an outcome measure for suicide prevention work with evidence showing that hospital presentation following self-harm is a clear risk factor for suicide (Hawton et al. 2012). There are around 200,000 episodes of self-harm that present to hospital services each year in England, although the true scale of the problem is not known as many people who self-harm do not attend A&E, or seek help from health or other services. Around 50% of people who die by suicide had a history of self-harm, in many cases with an episode shortly before their death, and around 15% of those who die by suicide have carried out an act of self-harm leading to presentation at hospital in the year before their death (PHE 2016).

The table below shows the rates of self-harm and suicide in the six authorities in Berkshire from the PHE Suicide Prevention Profiles (PHE, 2016A). All authorities have lower rates than England, although there is quite some variation across the authorities. It is important to ensure implementation of the NICE standards and pathways CG16 and CG133 for managing patients who self-harm.

Indicator	Period	England	SE England	Bracknell Forest	Reading	Slough	West Berkshire	Windsor & Maidenhead	Wokingham
Hospital stays for Self-Harm	2014-15	191.4	193.1	118.3	130.0	162.2	127.0	150.6	91.1
Suicide Rate persons	2013-15	10.1	10.2	8.1	11.0	8.8	7.0	7.1	6.0
Suicide rate (male)	2013-15	15.8	15.9	*	19.0	14.8	*	*	*
Suicide rate (female)	2013-15	4.7	4.8	*	*	*	*	*	*

Source: PHE Prevention Profiles. 2016

RECOMMENDATION
Implement the NICE guidelines on self-harm, specifically ensuring that people who present to Emergency Departments following self-harm receive a psychosocial assessment.

Tailor approaches to improve mental health in specific groups

Work on detailed Mental Health Strategies is underway across the Berkshire East and Berkshire West health systems. It will be important to ensure a good strategic fit between this strategy and those that are developed. Mental health and wellbeing promotion will remain important objectives of both strategies.

RECOMMENDATION
Work to provide and commission interventions which improve the public's mental health. These may include: awareness of mental health and peer support in young people; anti-bullying campaigns in schools; addressing stigma and social isolation in older people; workplace health promotion and support with local business; working with police on mental health literacy; and addressing issues relevant to the local population.

Support research, data collection and monitoring

With real-time surveillance giving information on suicides and many near fatal self-harm events, there is concern that not all events will be recorded, for instance those attempted suicides which occur on the highways network.

There is further analysis of Coroner's case notes that is recommended as good practice, such as the last contact with a GP which have not been captured in the last local audit. A new audit should be run with this new category for deaths in the period 2014-16, beginning as soon as practicable. This can then be appraised alongside data received through real-time surveillance; gaps identified and protocols and policies put in place to

ensure that data can be confidentially shared for the purposes of identifying trends and clusters in order to take appropriate preventative actions.

RECOMMENDATION

Develop working relationships between individual coroners and local public health teams ensure local plans are evidence based and responsive. Coroners can be invited to become formal members of any local suicide prevention groups or networks

Coroners can also inform the local authority or Director of Public Health if they identify particular areas of concern, e.g. locations used for suicide, possible clusters of suicide, increase in a particular method or new and emerging method of suicide.

Refresh the Berkshire-wide Suicide Audit for deaths in the period 2014-16 to include new categories based on best practice.

Berkshire-Wide Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:	Delivery Lead
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire.	1 April 2017	Lead Consultant Mental Health
		All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners.	1 April 2017	Local PH Mental Health Leads
		Launch of strategy at multi-agency suicide prevention summit.	15 Oct. 2017	Strategic DPH
		Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies.	15 Oct. 2017	Local PH Mental Health Leads
		Develop Berkshire-wide information sharing protocols to best utilise real time surveillance of suicides and near misses, in order to respond promptly to local trends and risks to reduce risk of clusters, and inform future service delivery.	30 July 2017	Lead Consultant Mental Health
		The Steering Group revisit their terms of reference and membership and become known as the "Berkshire Suicide Prevention Steering Group", with the aim of providing the governance to this strategy and its action plans.	1 April 2017	Steering Group Members
		Ensure strategic fit with the action plans of the Berkshire Crisis Care Concordat.	1 April 2017	Lead Consultant Mental Health
National Strategy				
1. Reduce the risk of suicide in key high-risk groups	Men	Evaluate the Berkshire-Wide CALMzone initiative and agree Berkshire-wide commissioning of specific support services for men for future years. To include future commissioning of CALMzone for younger men; and services for middle aged men and older men.	15 Oct. 2017	Lead Consultant Mental Health
	People who self-harm	Ensure agencies have plans to Implement the NICE guidelines on self-harm	15 Oct. 2017	Lead Consultant Mental Health
	People who misuse substances	Ensure local strategies and contracts for DAAT services include suicide prevention objectives.	Ongoing work	Local PH Mental Health Leads

	People in mental health care	Support BHFT in its Zero Suicide Approach	Ongoing work	Steering Group Members
	People in contact with the criminal justice system	Through Community Safety Partnerships, identify local actions to prevent suicide in those in contact with the criminal justice system.	30 July 2017	Local PH Mental Health Leads
	Occupational groups	Ensure local health trusts and providers can demonstrate actions to prevent suicide and promote metal wellbeing amongst their staff.	30 July 2017	Steering Group Members
		Identify particular local action plans for those in agricultural / land-based industries.	30 July 2017	Local PH Mental Health Leads
2. Tailor approaches to improve mental health in specific groups	Community based approaches	For the Steering Group to assess community-based interventions which may be best delivered at scale across the county.	Ongoing work	Steering Group Members
	Suicide prevention training	Coordinate a database on evidence based suicide prevention training programmes and providers across the county.	Ongoing work	Steering Group Members
	People vulnerable due to economic circumstances	For the Steering Group to solicit data from each LA on key indicators that may highlight risk: e.g. number of homelessness presentations.	Ongoing work	Steering Group Members
	Pregnant women and those who have given birth in last year	To undertake a needs assessment of this group in relation to suicide prevention.	30 July 2017	Local PH Mental Health Leads
	Children and young people	Through LSCBs, identify local actions to prevent suicide in children and young people.	30 July 2017	Local PH Mental Health Leads
3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work.	Ongoing work	Steering Group Members
		Investigate suicides on council owned land and properties, and agree a local action plan.	15 Oct. 2017	Local PH Mental Health Leads
		Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work	Local PH Mental Health Leads

		The Steering Group seek a named Highways England officer to act as a liaison link and group member, and to share real-time intelligence of highways network incidents.	1 April 2017	Lead Consultant Mental Health
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources).	Ongoing work	Steering Group Members
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide	20 July 2017 20 July 2017 Ongoing work 1 Sept 2017 1 April 2017	Lead Consultant Mental Health Local PH Mental Health Leads Local PH Mental Health Leads Local PH Mental Health Leads Local PH Mental Health Leads
6. Support research, data collection and monitoring		Refresh Berkshire-wide suicide audit to include deaths during 2014-2016 to include data on GP consultations. To update data on the JSNA summary on suicide.	30 July 2017 As per JSNA timetable	Local PH Mental Health Leads Local PH Mental Health Leads

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To be checked and formatted

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Office for National Statistics. Suicides in the UK in 2014. London: Office for National Statistics; 2016.

Public Health England (PHE). Local Suicide Prevention Planning, A Practical Resource. Public Health England; 2016.

Samaritans. Men, Suicide and Society: Why disadvantaged men in mid-life die by suicide. Ewell; The Samaritans; 2012.

Sutherlands, R. PACTS: 26th Westminster Lecture for Samaritans on 'Working together to reduce suicide in transport'. 2015.

Preventing Suicide in England: 1 year on. 2014.

Appendix 1: Resources available

These need adding to and amending

Factsheet on managing suicide risk in Primary Care
http://www.connectingwithpeople.org/sites/default/files/SuicideMitigationInPrimaryCareFactsheet_0612.pdf

A free booklet on debt advice is available from:
http://www.moneysavingexpert.com/credit-cards/mental-health-guide#collect

Guide for health and social care workers to support people with debt and mental health problems written by the Royal College of Psychiatrists and Rethink Mental Illness:
http://www.rcpsych.ac.uk/pdf/FinalDemandcf.pdf

Primary Care Guidance on Debt and Mental Health from the Royal College of GPs and Royal College of Psychiatrists, due to be updated shortly:
http://www.rcgp.org.uk/clinical/clinical-resources/~/media/Files/CIRC/Mental%20health%20forum/Mental%20Health%20Page%20Sept%202013/PCMHF-Guidance-Debt-Mental-Health-Factsheet-2009.ashx

Leeds Bereavement Forum has produced a short document with details of local and national support services available.
http://www.leeds.gov.uk/docs/Bereavement%20leaflet%202013.pdf

Grassroots Suicide Prevention Brighton & Hove Suicide Prevention Strategy Group provides an excellent website full of practical suicide prevention expertise.
http://prevent-suicide.org.uk/suicide_safer_brighton_and_hove.html

RAID service saves money as well as improving the health and well-being of its patients.
http://www.bsmhft.nhs.uk/our-services/rapid-assessment-interface-and-discharge-raid/

NHS Cornwall and Isles of Scilly, in partnership with Outlook South West
http://www.outlooksw.co.uk/suicide-liaison-service

Children and Young People's Mental Health Coalition Resilience and Results:
http://www.cypmhc.org.uk/resources/resilience_results/

State of Mind is a Rugby League mental health and wellbeing initiative which aims to raise awareness and tackle stigma. The organisation aims to reach men who may not normally contact health and social care services, and signpost them to where support is available. A round of Rugby League fixtures is dedicated to State of Mind, which maximises the publicity. The focus is on promoting player welfare and resilience in local communities. Super League players act as ambassadors reaching fans and amateur players through presentations, meetings and social networking, with positive messages being specially commissioned and tweeted. Films with specific themes are available at www.stateofmindrugby.com

Samaritans Media Reporting Guidance:
http://www.samaritans.org/media-centre/media-guidelines-reporting-suicide

Appendix 2: Bracknell Forest Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire. All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners. Launch of strategy at multi-agency suicide prevention summit. Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies.	1 April 2017 1 April 2017 15 Oct. 2017 15 Oct. 2017
National Strategy			
1. Reduce the risk of suicide in key high-risk groups	Men People in mental health care Occupational Groups Carers (including young carers) Socially isolated	Promotion of CALM to a wider audience Support BHFT in its Zero Suicide Approach Work with local Carers' support groups to highlight Mental Wellbeing issues and risk factors Multi agencies approach to identify individuals and sign posting for support/ local befriending service/ other services Increase local befriender 's awareness of Mental Wellbeing issues and Risk factors	1 June 2017 Ongoing work
2. Tailor approaches to improve mental health in specific groups	Community based approaches People vulnerable due to economic circumstances	Work with local Domestic Abuse Forum and Executive Group to provide support and information on suicide prevention To share local Suicide Prevention strategy/action plans/supporting materials with IAPT/Job Centre and other employment support agencies Increase agencies awareness of Mental Wellbeing issues and Risk factors	

3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work 15 Oct. 2017 Ongoing work
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources).	Ongoing work
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide.	20 July 2017 20 July 2017 Ongoing work 10 Sept. 2017 1 April 2017
6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide.	As per JSNA timetable

Appendix 3: Royal Borough of Windsor and Maidenhead Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire. All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners. Launch of strategy at multi-agency suicide prevention summit. Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies. Establish a multi-agency steering group: terms of reference to be agreed. Group will also be responsible for reviewing communication between primary and secondary care including risk assessment and escalation protocols	1 April 2017 1 April 2017 15 Oct. 2017 15 Oct. 2017 Locally determined
National Strategy			
1. Reduce the risk of suicide in key high-risk groups	Men Carers; The unemployed; Those who misuse substances Persons with a mental health diagnoses.	Build on existing local voluntary and community group programmes e.g. men in sheds. Promotion of Calm Support BHFT in its Zero Suicide Approach Ensure clarity for the dual diagnosis referral pathway with reference to Drug & Alcohol Service providers. Ensure adequate arrangements are in place for follow-up after discharge from secondary care Consider strengths and issues arising from the Berkshire crisis concordat relating to the Royal Borough of Windsor and Maidenhead.	Ongoing work Locally determined Ongoing work Ongoing work Ongoing work
2. Tailor approaches to improve mental health in specific groups		Map evidence of coverage by sector/organisation of self-harm and suicide prevention training.	Ongoing work

		Explore opportunities to deliver MHFA training to high risk group leads. Explore funding opportunities with HEE for Suicide prevention & Self Harm training.	
3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work 15 Oct. 2017 Ongoing work
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources). Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide. Map existing bereavement support and pathways.	Ongoing work Locally determined Ongoing work
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide.	20 July 2017 20 July 2017 Ongoing work 10 Sept. 2017 1 April 2017

6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide. Work with steering group members to review data about current levels of population need and service provision Work with steering group members to map areas of high risk through information on locations of deaths and attempts. Take action to reduce suicide enablers (e.g. install signage, barriers) in line with evidence base Undertake mapping relating to local suicide prevention and self-harm services.	As per JSNA timetable Locally determined Locally determined Locally determined

Appendix 4: Slough Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire. All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners. Launch of strategy at multi-agency suicide prevention summit. Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies.	1 April 2017 1 April 2017 15 Oct. 2017 15 Oct. 2017
National Strategy			
1. Reduce the risk of suicide in key high-risk groups	Men People who misuse substances People in mental health care Occupational Groups	Promotion of CALM to a wider audience To partner with the drugs and alcohol team on reviewing the referral pathway for dual diagnosis. To ensure that information on how to access DAAT services and seek help are readily available for young men. Support BHFT in its Zero Suicide Approach To support SME business on the Slough Trading Estate on incorporating mental health and wellbeing in their policies and advise on how to improve staff well-being; i.e.; promote resilience training	Locally determined Ongoing work
2. Tailor approaches to improve mental health in specific groups	Community based approaches Suicide prevention training	To work with the community development team - to build community cohesion, etc. To identify and work with Housing and unemployment teams on MHFA training for staff To deliver MHFA training to managers of SME businesses in Slough To partner with NEET young people's	

	People vulnerable due to economic circumstances Children and young people	team and train staff on MHFA To design a service information leaflet for new migrant arrivals and to ensure that all frontline services have an access to the leaflet. To partner with young people service to design an intergenerational programme addressing loneliness and social isolation	
3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work 15 Oct. 2017 Ongoing work
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources) To conduct a mapping of services available for those that have been bereaved by suicide Contact Samaritans SBCCG in order to identify Slough residents assessing the service and where they refer them to Contact the community mental health team to ensure all frontline staff have the information required to signpost patients to bereavement services To identify other local stakeholders and provide better information and support to those bereaved or affected by suicide	Ongoing work Locally determined
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the	20 July 2017 20 July 2017

		local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide To identify 'keywords' relating to suicide and how many hits are coming from Slough	 Ongoing work 10 Sept. 2017 1 April 2017 Ongoing work
6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide.	As per JSNA timetable

Appendix 5: Reading Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire. All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners. Launch of strategy at multi-agency suicide prevention summit. Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies. Establish local oversight arrangements for development and delivery of Reading suicide prevention plan; including local links with Reading Mental Health Steering Group around local oversight of action plan delivery.	1 April 2017 1 April 2017 15 Oct. 2017 15 Oct. 2017 Locally determined
National Strategy			
1. Reduce the risk of suicide in key high-risk groups	Men People in mental health care	Promotion of CALM to a wider audience Support BHFT in its Zero Suicide Approach	1 June 2017 Ongoing work
2. Tailor approaches to improve mental health in specific groups	Community based approaches Suicide prevention training Children and young people	Promote existing local voluntary and community group programmes e.g. via Reading Services Guide Delivery of Adult Mental Health First Aid Training Delivery of Youth Mental Health First Aid Training	

3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work 15 Oct. 2017 Ongoing work
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources) Promote effective signposting for those bereaved by suicide, e.g. via Reading Services Guide.	Ongoing work Locally determined
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide.	20 July 2017 20 July 2017 Ongoing work 10 Sept. 2017 1 April 2017
6. Support research, data collection and monitoring		Update Reading JSNA module on suicide and self-harm Work with Reading Mental Health steering group members to review data about current levels of population need and service provision Ensure local data and evidence is fed through to Berkshire level to support identification of wider trends and to share learning.	As per JSNA timetable

Appendix 6: West Berkshire Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire. All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners. Launch of strategy at multi-agency suicide prevention summit. Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies. Set up local quarterly meetings to review the action plan	1 April 2017 1 April 2017 15 October 2017 15 October 2017 Quarterly interval
National Strategy			
1. Reduce the risk of suicide in key high-risk groups	Men People who self-harm People who misuse substances People in mental health care	Further development of "Pie and a pint" interventions Promotion of CALM to a wider audience Monitor levels of self-harm Liaising with local substance misuse services Support BHFT in its Zero Suicide Approach	Ongoing work Ongoing work Ongoing work
2. Tailor approaches to improve mental health in specific groups	Community based approaches Suicide prevention training Children and young people	Improve public awareness of suicide Link with West Berkshire Emotional Health Academy Delivery of Adult Mental Health First Aid Training Delivery of Youth Mental Health First Aid Training and MHFA Schools Training	

3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work 15 October 2017 Ongoing work
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources) Seek views of those with lived experience on draft action plan Promotion of Newbury SOBs group	Ongoing work Locally determined Ongoing work
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide	20 July 2017 20 July 2017 Ongoing work 10 Sept. 2017 1 April 2017
6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide. Develop infographics to share with public. Link to W Berks mental health strategy Link to W Berks health and wellbeing strategy	As per JSNA timetable Locally determined

Appendix 7: Wokingham Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire. All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners. Launch of strategy at multi-agency suicide prevention summit. Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies.	1 April 2017 1 April 2017 15 Oct. 2017 15 Oct. 2017
National Strategy			
1. Reduce the risk of suicide in key high-risk groups	Men People in mental health care Occupational Groups LGBT groups Carers (including young carers) and People with LTC People who misuse substances	Promotion of CALM to a wider audience Support BHFT in its Zero Suicide Approach Awareness raising and training for local businesses on identifying early signs and how to respond. Working with local services such as TVPS. Work with local carer groups to raise awareness of Mental Health risks and prevention, promote local befriending and support groups. Work with the local treatment provider to ensure that risk of suicide and mental health are part of the assessment.	1 June 2017 Ongoing work
2. Tailor approaches to improve mental health in specific groups	Community based approaches Suicide prevention training	Engage with local groups such as faith groups and befriending services. Wellbeing work with tenants services Plan and prioritise a programme of suicide prevention training and integrate into MECC work stream.	

3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work 15 Oct. 2017 Ongoing work
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources). Review the availability of support for families and communities bereaved by suicide and affected by near misses. Promote the local Wokingham SOBS group, working with them to identify gaps.	Ongoing work Locally determined Ongoing work
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide	20 July 2017 20 July 2017 Ongoing work 1 Sept. 2017 1 April 2017
6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide.	As per JSNA timetable

Appendix 8: Membership of the Berkshire Suicide Prevention Steering Group as at December 2016

Angela Baker	Deputy Centre Director	PHE South East
Angus Tallini	GP	Newbury & District CCG (West)
Anthony Barrett		NHS
Belinda Dixon		RBWM
Caroline Attard		Berkshire Healthcare Foundation NHS Trust
Chris Allen		NHS
Colin Bibby		SEAP
Daren Bailey		Berkshire Healthcare Foundation NHS Trust
Darrell Gale	Consultant in Public Health	Public Health, WBC
Debbie Daly	Director of Nursing and Quality	NHS West
Eugene Jones		Berkshire Healthcare Foundation NHS Trust
Geoff Dennis		Berkshire Healthcare Foundation NHS Trust
Gillian McGregor		Reading Council
Gwen Bonner		NHS
Helen Ranasinghe		Samaritans
Helena Fahie	Public Health Support Manager	PHE South East
Jason Jongali		NHS West
Jillian Hunt		Bracknell Forest
Jo Baskerville		NHS West
Jo Greengrass		NHS
Jonathan Groenen		Thames Valley Police
Julia Wales,		Slough Council
Kate Ford		Thames Valley Police
Kate Jahangard		Reading Council
Katie Simpson	GP	NHS East
Ken Hikwa		Berkshire Healthcare Foundation NHS Trust
Kim McCall		Reading Council
Lesley Wyman	Consultant in Public Health	West Berkshire Council
Lisa McNally	Consultant in Public Health	Bracknell Forest
Lise Llewellyn	Strategic Director of Public Health	Public Health Services Berkshire
Natalie Mears	Public Health Programme Officer	RBWM
Mark Spencer		Thames Valley Police
Sally Murray		NHS West
Nadia Barakat		NHS East
Nick Davies		RBWM
Rachel Johnson	Public Health Programme Officer	West Berkshire Council
Ramesh Kukar		Slough Council of Voluntary Services
Reva Stewart		Berkshire Healthcare Foundation NHS Trust

Rukayat Akanji-Suleman	Public Health Programme Officer	Slough Council
Sarah Bellars		NHS
Sue McLaughlin		Berkshire Healthcare Foundation NHS Trust
Susanna Yeoman		Berkshire Healthcare Foundation NHS Trust
Tandra Forster		West Berkshire Council
Tanya Demonne		Royal Berkshire Hospital Foundation NHS Trust
Timothy Foley		SEAP
Tony Dwyer		Berkshire Healthcare Foundation NHS Trust
Trudi Sams		

Back Cover to be designed and add contact details of Shared Team etc.

URL of Strategy