Suicide Prevention
Lincolnshire Local Action Plan
2016
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>p3</td>
</tr>
<tr>
<td>1 Aims and objectives</td>
<td>P3</td>
</tr>
<tr>
<td>2 National Context</td>
<td>P4</td>
</tr>
<tr>
<td>3 Lincolnshire Context</td>
<td>p4</td>
</tr>
<tr>
<td>4 Impact of Suicide</td>
<td>p6</td>
</tr>
<tr>
<td>5 Risk Factors</td>
<td>p8</td>
</tr>
<tr>
<td>6 Suicide and Self Harm</td>
<td>p11</td>
</tr>
<tr>
<td>7 Local Action Plan</td>
<td>p12</td>
</tr>
<tr>
<td>8 Developing a local Plan for Lincolnshire</td>
<td>p12</td>
</tr>
<tr>
<td>9 Bibliography</td>
<td>p13</td>
</tr>
</tbody>
</table>
Lincolnshire Strategic Local Action Plan for Suicide Prevention

Executive Summary

The national strategy, Preventing Suicide in England 2012,[1] identifies six key areas for action:

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

The multi-agency Lincolnshire Suicide Prevention Steering Group (LSPSG) was formed in September 2015, building on previous work of the multi agency 'Choosing Life' group and the 2012 national strategy.[1] Lincolnshire’s Suicide Prevention Steering Group was established to develop a whole system approach to suicide prevention by providing a process for key stakeholders to create and own a Lincolnshire wide evidence based suicide prevention action plan that is both meaningful and achievable. Members are drawn from across all sectors, including representation from users of mental health services1. It is a strategic group, tasked with formulating a Lincolnshire Local Action Plan, with an agreed aim of reducing levels of suicide in Lincolnshire. The LSPSG is chaired by a Consultant in Public Health, and coordinated and supported by Public Health staff. However, its progress to date is as a result of the collaboration and hard work of many stakeholders.

We know that the reasons that lead someone to take their own life may be extremely complex. No organisation or single programme can address all the factors that may contribute towards a suicide, hence the need to develop further a model of collaborative working.

1. Aims and Objectives

This strategic plan aims to confirm our understanding of local suicide data and patterns in order to shape local decisions and priorities around suicide prevention.

The objective of the Local Action Plan is to implement a suicide prevention plan for Lincolnshire, and reduce the number of completed suicides in Lincolnshire.

1 See Appendix 1 for a full membership list of the LSPSG.
2. The National Context

A wide range of national policies and strategies to improve mental health in the UK have been implemented in recent decades. Some are specific to mental health:

- No health without mental health: A cross-government mental health outcomes strategy for people of all ages;[2]
- Closing the Gap: Priorities for essential change in mental health;[3].

Others are broader health policies and strategies that include objectives specific to improving mental health, for example:

- Public Health Outcomes Framework for England;[13]

Together, these documents provide a ‘way-forward’ for improving the nation’s mental health and wellbeing, identifying good practice and key indicators that can be used to measure progress. An overarching aim is to give mental health the same importance as physical health and improve the health care experience of people with mental ill health. Through mental health promotion (starting early to promote mental wellbeing and prevent problems from developing) and ensuring access to effective services for people with mild and severe mental illness, the Government’s strategy aims to ensure fewer people will suffer avoidable harm, stigma and discrimination, and more people will recover from mental health problems. These policies aim to reduce premature mortality in people with serious mental illness and improve the quality of life for people with mental health problems.

The Government has developed a separate policy specific to preventing suicide. Suicide is a leading cause of years of life lost and the 2012 Suicide Prevention Strategy for England [5] aims to reduce the suicide rate in the general population in England and better support those who are bereaved or affected by suicide.

3. The Lincolnshire Context

The effects of suicide can be devastating. Many people – friends, family, professionals, colleagues and wider society will feel the impact. There are also significant financial costs associated with a suicide. The average cost of a completed suicide of a working age adult in the UK is estimated to be £1.67m. The 2014 Annual Report from the Director of Public Health for Lincolnshire [6] identified that death from suicide or undetermined causes is the third biggest cause of years of life lost in Lincolnshire. Recommendations arising from the report include:

- Continued monitoring of suicide and death by undetermined causes to enable the identification of causes and delivery interventions that could save lives. Development of a suicide surveillance system, incorporating appropriate information sharing and reporting.
• More people trained to raise awareness of how to talk to someone that might be at risk of completing suicide.
• Create an action plan for suicide prevention, working together to help people and making sure frontline staff have the skills and information to help people at risk.

Improving mental health and reducing mortality from suicide have been identified as public health priorities in Lincolnshire. Mental health is embedded as a cross-cutting theme in the Joint Health and Wellbeing Strategy for Lincolnshire 2013-2018 [7]

Deaths due to Suicide in Lincolnshire

Figure 1.1. 2 Number of deaths due to suicide (ICD10 X60-X84) in Lincolnshire, calendar years 1995 to 2014. Source: Public Health Outcomes Framework, November 2015 (9)

Source: HSCIC Indicator Portal [8]
Figure 1.2. Mortality due to suicide and injury undetermined (ICD10 X60-X84, Y10-Y34) in Lincolnshire, 3-year pooled data, directly age standardised rate per 100,000 population, calendar years 2008-2014.

Source: HSCIC Primary Care Mortality Database [9]

Figure 1.2 shows that Lincolnshire has a higher rate of male suicide than England. The rate for females shows the trend as being the same as the rate for England.

The Mental Illness Health Needs Assessment [10] identifies that between 2011 and 2013, 184 people aged 15 years and older died from suicide and injury undetermined in Lincolnshire. The age-standardised suicide and undetermined injury mortality rate (per 100,000) in Lincolnshire is 7.0, comparable to the East Midlands rate of 6.8 and lower than the England rate of 7.9 mortality rate is lowest in Lincolnshire East and South Lincolnshire at 7.5 and 7.6 respectively and highest in Lincolnshire West at 10.4.

4. The Impact of Suicide in Lincolnshire

The mental illness health needs assessment (2015)[10] was developed to inform the development of a suicide action plan for Lincolnshire. However, it is important to remember that not all people who complete suicide are in contact with mental health services; indeed on average it is estimated that fewer than half of adults and a quarter of children and young people who complete suicide had previous contact with mental health services. As such, it is important to consider the mental health needs assessment alongside other key evidence on suicide and risk factors for suicide in Lincolnshire.

Over the last 10 years, the death rate for suicide has decreased from 9.13 per 100,000 people in 2000 to 8.13 in 2010, but in Lincolnshire this equates to 60-70 people every year who take their own life.
The majority of suicides continue to occur in middle aged men. The mortality rate for suicide and injury undetermined in Lincolnshire PCT area 2008-2010 is 9.69 per 100,000 people. During this 3 year period, 151 males and 57 females died. The death rate of 25.82 per 100,000 population for male suicide in Lincoln City and 12.41 for females in East Lindsey is significantly higher.

Nationally and locally, the most common method of suicide for men and women is hanging, strangulation and suffocation with self-poisoning as the second most common method.

In Lincolnshire, the ratio of deaths at Home: Elsewhere is 2:1.

Although a higher number and rate of suicides occurred in the most deprived areas of Lincolnshire, they were not statistically significantly different compared to the county as a whole. The majority of deaths by suicides were people living within an urban area; however analysis found that this is not statistically significant.

Suicide is the leading cause of death in young people. Risk factors include male gender; up to three times as many men than women complete suicide, and mental health problems. (18) Young people who complete suicide are less likely to be in contact with mental health services compared with adults (14% vs 26%). Young men, who are more likely to complete suicide, are less likely to be in contact with mental health services than young women.

In Lincolnshire between September 2011 and January 2014 there were 4 confirmed cases of suicide and 2 suspected cases of suicide among young people aged under 18 years of age.

Figure 1.3. Mortality due to suicide and injury undetermined (ICD10 X60-X84, Y10-Y34), 3 year pooled data, age-specific crude rate per 100,000 population, calendar years 2012-14.

Source: HSCIC Indicator Portal.[8]
Figure 1.3 shows that the majority of deaths in Lincolnshire due to suicide and undetermined injury, were amongst those aged 40-44, while in comparison, rates were lowest amongst those aged 15 - 19.

**Figure 1.4.** Mortality from suicide and injury undetermined (ICD10 X60-X84, Y10-Y34) by district of residence, 3-year pooled data, directly age standardised rate per 100,000 population, calendar years 2011-3.

<table>
<thead>
<tr>
<th>Area</th>
<th>Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston</td>
<td>12.6</td>
</tr>
<tr>
<td>East Lindsey</td>
<td>10.3</td>
</tr>
<tr>
<td>Lincoln</td>
<td>14.5</td>
</tr>
<tr>
<td>North Kesteven</td>
<td>13.5</td>
</tr>
<tr>
<td>South Holland</td>
<td>10.7</td>
</tr>
<tr>
<td>South Kesteven</td>
<td>8.1</td>
</tr>
<tr>
<td>West Lindsey</td>
<td>11.4</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>8.1</td>
</tr>
<tr>
<td>East Midlands</td>
<td>9.9</td>
</tr>
<tr>
<td>England</td>
<td>10.4</td>
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</tbody>
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Source: HSCIC Indicator Portal, November 2015 [8]

Figure 1.4 indicates that in the three year pooled data period, the highest rate of suicide was in the City of Lincoln District (at 14.5/100,000). Within Lincolnshire, South Kesteven District has the lowest rate of suicide at 8.1/100,000.

**5. Risk Factors for Mental Ill Health and Suicide**

Certain population subgroups are more likely to experience mental ill health or attempt to complete suicide. Risk factors or vulnerabilities may operate in isolation or interact within individuals to further increase risk (e.g. unemployment and deprivation). The Mental Illness Health Needs Assessment[10] identified key risk factors for mental ill health including:

- **Deprivation:** people from the most deprived areas are at higher risk poor mental health and of developing mental health problems, as are their children

**Figure 1.5.** Mortality from suicide by quintile of deprivation of residence, 3-year pooled data, crude rate per 100,000 population, calendar years 2011-2013.
Figure 1.5 illustrates the link between death by suicide and deprivation, and shows that within Lincolnshire suicide rates are higher in the most deprived quintile of deprivation, than in the least deprived quintiles.

- **Homelessness**: the prevalence of common mental health problems among people who are homeless is more than twice that in the general population. Serious mental illness is often accompanied by alcohol and/or substance misuse problems, with most studies suggesting that around 10-20% of the homeless population fulfil the criteria for dual diagnosis.

- **Financial exclusion**: Financial exclusion can lead to social exclusion, debt and poverty. People with five or more separate debts have a 6-fold increased risk of mental ill health. Difficulty repaying debt is a risk factor for suicide.

- **Unemployment**: Unemployment in Lincolnshire is lower than the national average. Between April 2014 and March 2015, 4.9% of the population of Lincolnshire was unemployed, compared with 5.3% in the East Midlands and 6.0% in England. However, across the county there are pockets of long-term unemployment and seasonal employment. Unemployment among younger adults (aged 18-24 years) is higher than the national average (12-month job seekers allowance 0.5% in Lincolnshire, 0.3% in the East Midlands and England). Further, a higher proportion of those people who are economically inactive in Lincolnshire, are inactive due to long-term sick leave (25.7%) compared with the East Midlands (23.0%) and England (21.6%).

- **Substance misuse**: substance use and mental health problems often co-occur, with a complex relationship existing between substance misuse and mental health. Substance use can exacerbate the symptoms of mental ill health and may interact with medications used to treat conditions such as mood stabilisers and anti-depressants.

- **Loneliness and social isolation**: it is estimated that between 5% and 16% of over 65 year olds nationally have reported loneliness, while 12% report social isolation. There is no current data to identify loneliness or social isolation in Lincolnshire, we can provide an approximate estimate using national rates. Of the 159,953 over 65 year old residents living in Lincolnshire, we can estimate that between 8,000 (5%) and 25,500 (16%) are lonely, with a further 19,200 who feel isolated.

- **Mental ill health** is a risk factor for suicide. In addition, a number of population subgroups that are at increased risk of completing suicide have been identified in the Lincolnshire Mental Illness Health Needs Assessment 2015.[10]

- **Minority ethnic groups**: risk of suicide in minority ethnic groups is difficult to measure as place of birth, rather than ethnicity is recorded on death certificates. At the 2011 census,
2.4% of the population of Lincolnshire was non-White, an increase from 1.4% at the 2001 census. This is much lower than the proportion of the population of England that is non-White (14%) nationally. The majority of recently arrived international migrants come from Eastern and Central Europe, and tend to be younger and more economically active than the UK-born residents of Lincolnshire.

- **People in institutional care or custody:** the national rate of self-inflicted deaths in prisoners in the period ending September 2014 was 1.0/1,000 prisoners (n=87). This was a 38% increase on the same period in 2013 and is the highest annual number of deaths since 2007. The rate of suicide and self-harm is much greater in the prison population that the general population (7.9/100,000 people). There are two prisons in Lincolnshire: HMP North Sea Camp (NSC) and HMP Lincoln.

- **Data** on rates of suicide and self-harm among asylum seekers in the UK is scant. However, using data that is available from Immigration Removal Centres, coroner’s records and the Prison Ombudsman’s reports, there are high levels of self-harm and suicide among detained asylum seekers compared with the UK prison population

- **People with post-natal depression:** suicide is the leading cause of maternal death in England. Key risk factors for maternal suicide included severe onset of mental illness soon after childbirth, older age and being free from social adversity (22)

- **People of sexual minorities:** lesbian, gay, bisexual and trans (LGBT) self-identified people are at higher risk of suicidal behaviour, mental disorder and substance misuse and dependence than heterosexual people. If estimates of 5-7% are accurate for Lincolnshire, this suggests that between 36,575 and 51,205 people self-identify as LGBT.

- **Veterans:** Young men who leave the armed forces (particularly those with a short length or services and of lower rank) are 2-3 times more likely to complete suicide than members of the general population. For ex-servicemen aged 30-49 years the risk of suicide is lower than in the general population. Lincolnshire has a large number of ex-armed forces personnel. However, data on this cohort is currently very limited, so it is difficult to provide accurate estimates.

- **People bereaved by suicide:** research supports an increased risk of suicide in mothers bereaved by the suicide of an adult child and partners bereaved by suicide, as well as an increased risk of a range of other mental health outcomes for people bereaved by suicide. Ensuring mental health services are able to support those people who are bereaved by suicide may help to reduce future burden of mental ill health and suicide mortality.
6. Suicide and self-harm

Figure 1.6. Hospital admissions due to self-harm in Lincolnshire, directly age standardised rate per 100,000 population, financial years 2010/11 - 2013/14.


Figure 1.6 shows a net increase in the number of hospital admissions in Lincolnshire due to injury by self harm between 2010/11 and 2013/14. There has been a statistically significant increase in hospital admission between 2012/13 and 2013/14 due to self harm.

Figure 1.7. Hospital admissions due to self-harm in Lincolnshire, age specific crude rate per 100,000 population, pooled financial years 2012/13 - 2013/14.


Figure 1.7 shows that the City of Lincoln has the highest rate of hospital admission due to self-harm.

Self-harm is a key risk factor for suicide. In the UK, a 30-fold increase in risk of suicide, compared with the general population, was observed for a cohort of people aged 10-92 years of age who had attended an emergency department following deliberate self-harm. Suicide rates were highest in the first 6 months after presentation for the self-harm episode. In Lincolnshire, hospital admissions as a result of self-harm in people ages 10-24 years in 2013/14 were significantly higher than the national average.

A healthwatch [12] survey of 1,251 young people in Lincolnshire identified that 20.5% (n=257) have self-harmed. Reasons for self-harm included being bullied (40.2%), anxiety/hopelessness (46.7%),
difficulties at school/college (52.1%), family problems (58.7%), depression (61.8%) and loneliness/isolation (38.2%). Almost two-fifths of young carers stated that they self-harm.

**People who have self-harmed:** there is an increased in risk of suicide following self-harm episodes. Among a national cohort of almost 8,000 emergency department self-harm attendees followed up over a four-year period, there was a 30-fold increased risk of suicide compared with the general population.(26) Suicide rates were especially high in the 6 months after the index self-harm episode suggesting that early intervention after an episode of self-harm may be important to reduce suicide risk.

In Lincolnshire, between 2011 and 2013 there were 2,448 emergency admissions for intentional self-harm. This is a population in which timely intervention might reduce future suicide risk.

7. LOCAL ACTION PLAN FOR SUICIDE PREVENTION IN LINCOLNSHIRE

The HM Government 'Preventing Suicide in England' report 2014,[1] and the 'Preventing Suicide in England' Strategy 2012 [5] cite that 'much of the planning and work to prevent suicides will be carried out locally'. From April 2013, local responsibility for coordinating and implementing a local suicide prevention action plan, became an integral part of local authorities' public health responsibilities.

8. Developing the Lincolnshire Local Action Plan

The effectiveness of a programme to support the reduction of completed suicides is dependent on exemplary partnership working. We formed a strategic group, the Lincolnshire Suicide Prevention Strategic Group, in order for organisations to work together across Lincolnshire to achieve our vision. This plan sets out our approach to achieving this goal.

**The process to date**

- Formed a Lincolnshire wide cross sector multi agency Strategic Suicide Prevention Group. Some organisations had experience and expertise from the 'Choosing Life' group, which had previously extended awareness of suicide and suicide prevention in Lincolnshire by sharing information and enabling organisations to work together on agreed actions to meet priority areas of highest risk.

- Reviewed the National Strategic Plan [5] and the six key areas contained within it. We used these as a basis for developing a Lincolnshire plan. We also searched for local action plans in other areas in England to understand what best practice was being implemented elsewhere.
Developed an initial draft of the Local Action Plan for Suicide Prevention in Lincolnshire which was based on the six national objectives, but also included an additional objective identified within a recent Mental Illness Health Needs Assessment for Lincolnshire.[10]

Convened a wider stakeholder day, in order to refine the draft Local Action Plan. This included additional representation from wider stakeholders, including Voluntary & Faith sector providers and District Councils.

Suicide Prevention Stakeholder Event Recommendations

The suicide action plan detailed below, has been shaped through an iterative, multi-agency and cross-sectoral process. The core development took place at a stakeholder event on 22nd January 2016, in which 45 representatives from over 25 organisations across the community and voluntary sectors, private sector, CCGs, the local authority and district councils, came together to:

- Discuss key actions that could be included in the action plan. This included considerations across a range of domains: preventing access to the means of suicide; reducing the risk of suicide in high risk groups; timely support based on needs; tailoring approaches to improve mental health in specific groups; providing better information and support to those bereaved or affected by suicide; research and data collection. This group exercise generated approximately 35 separate activities that were perceived could reduce suicide locally.

- Prioritise actions identified during those discussions. We created an interactive task that enabled people to prioritise the individual actions that they perceived to be most important within a Lincolnshire Suicide Prevention Action Plan. Each individual was enabled to prioritise up to 14 activities.

- Cluster prioritised activities into themes based on the stakeholder prioritisation exercise. From the interactive exercise above, similar actions were clustered into themes. Six themes were identified:
  - raising community awareness of self-harm and suicide, and how to spot vulnerabilities;
  - suicide prevention training (e.g. increase awareness and understanding, including what to do when);
  - crisis care, including a broad range of crisis services in the community, a listening service, and timely access to mental health crisis care;
  - conduct risk assessments for people diagnosed with long-term conditions to identify people who may be at risk of poor mental health;
  - coordination of resources (e.g. trained people and organisation which provide services);
  - data collection and sharing, including recording data on attempted suicide, data of key risk groups, and protocols for sharing data across organisations.

- Discuss key themes identified. Stakeholders subsequently discussed each of these themes in turn, identifying key activities within each theme as well as who should lead on coordinating the delivery of each theme. However, during this process it became clear that:
o some themes, although well supported in the prioritisation exercise, were either not aligned to the groups vision for a suicide action plan in Lincolnshire; or
o we risked overcomplicating the plan with too many themes.

- **Reframe the key themes.** Following a lively discussion between stakeholders from across a range of organisations and sectors, the following key themes (which are a simplified version of the six themes identified earlier in the day) were agreed:
  
  o Awareness*
  o Prevention*
  o Crisis Care
  o Data & Monitoring

- **Identify key actions and lead organisations for each theme.** A set of key actions were identified from each theme, and we agreed to identify lead organisations to take ownership of driving forward each theme at the next Suicide Prevention Board Meeting, where all of the key stakeholders would be represented.

  - *Awareness defined as ‘educating communities on the issue of suicide, including key risk factors, signs and symptoms, how to respond and where to go for help’
  - *Prevention defined as ‘upskilling members of the community and healthcare professionals to respond appropriately to individuals believed to be at risk of suicide, for example through basic and advanced training programmes to support people identified as at risk’

**The Way Forward**

In order to progress the Local Action Plan, a number of actions are required:

- Finalise the specific actions within each key area in collaboration with key stakeholders
- Identification of a number of lead partners who will lead/develop a specific Action Plan Work Programme for that particular area of work
- Development of a number of key task & finish groups
- Identify/allocate partners to join/own appropriate task and finish groups. Some of these may be selected from the wider stakeholder group who attended the event
- Prioritisation of each area of work programme action plans within each task & finish group
- Agree timescales and objectives and outcomes for implementation
- Initial coordination by Public Health

The Suicide Prevention Stakeholder event identified that the key area of priority was to develop a 'Suicide Awareness Tool Kit'.

This will:

- Increase factual knowledge of the symptoms of mental ill health
- Increase factual knowledge of the complex issues that lead to suicide
- Increase skills in order to recognise the warning signs of suicidal ideation
• Increase skills/knowledge of how to respond
• Increase skills/knowledge of intervention pathways for crisis support

Many of the other actions identified during the stakeholder event are dependent on this first step.

Figure 1.8 below illustrates the broader vision for the Lincolnshire Suicide Prevention Action Plan.

**Figure 1.8: A vision of Lincolnshire’s Suicide Prevention Action Plan**

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**Implementation of the Lincolnshire Local Action Plan**

The Lincolnshire Suicide Prevention Local Action Plan was agreed at the Strategic Suicide Prevention Steering Group in May 2016. It will be offered for approval at a number of executive level Boards during May and June 2016.

The Local Action Plan incorporates the recommendations both from the Mental Illness Health Needs Assessment (10) and from the Annual Suicide and Undetermined Injury Review 2015(16).
It sets out the key priorities and key tasks for both adults and children and young people in the four identified areas: prevention, awareness, crisis care and data, monitoring and research. It also notes a number of proposed actions for implementation.
Appendix 1

Recommendations from the Mental Illness Health Needs Assessment (November 2015)\(^{10}\)

Six broad recommendations for Lincolnshire have been identified from this work.

1. **Identification and recording of mental ill health**
   Work should be undertaken to ensure that health professionals can correctly and consistently identify and record the signs and symptoms of all forms of mental ill health. Consistent data collection across services is required in order to gain common understanding of issues and characteristics, and therefore this also includes the recording of common demographic and characteristic data. Work should also be carried out to ensure that the mental health register is fully populated in a consistent manner, and recording should not be limited to the specific illnesses referred to in the Quality and Outcomes Framework (QOF).

2. **Timely access to mental health services based on needs**
   People in Lincolnshire should have timely access to mental health services based on their needs. Whilst most adult outpatients are initially seen within the 18 week target, timely access to specific services such as IAPT and dynamic psychotherapy could be improved.

3. **Data Sharing between different organisations**
   In order to provide a better experience for patients, particularly if they need to access a variety of services, or consult a number of professionals, the sharing of data between different organisations needs to be improved. This should also ensure that essential data is available for analysis of risks and associations, understanding various need, service review purposes and investigating health equity. This includes improved data sharing between local providers but also between national data controllers and local intelligence teams of data such as the Mental Health Minimum Dataset, Hospital Episodes Data, GP patient demographic data and, eventually, data from the Care Data programme. The effective sharing of information is vital during the transition of patients between children’s and adult services, and this is also an area of concern.

4. **Awareness of Services and Support**
   More should be done to comprehensively bring together information on mental health services and support networks in one place, so that both the public and professionals are clear on what is available and how it can be accessed. This should then be promoted as the primary source of information to, and by, all agencies. This would help to raise awareness, signpost to the most appropriate services and manage expectations for children and adults services.

   Further, whilst a number of crisis care services are currently available (e.g. specialist mental health crisis resolution and home treatment services), developing a clear, comprehensive network of information on the support available for people in crisis will enable the better signposting of people in crisis to the appropriate support.

5. **Service User Consultation**
   Service user feedback is important for understanding and improving the experience of service users. Providers should seek feedback from those who contact or use all mental health services and support networks. Although the nature and scale of this may vary, for example between commissioned services and community support networks, feedback is essential in order to review and improve. Service evaluation processes, reporting and monitoring should form a standard
requirement of contracts with a commitment from providers and commissioners to act upon findings. Standard frameworks should be developed to aid organisations in engaging service users and collecting feedback, along with provision of appropriate advice.

6. **Professional Skills**

Training provided for front-line staff working in mental health services should be improved and made more consistent. It should cover topics such as listening skills, empathy, respect and building of trust, and should adopt a holistic approach in their treatment of those suffering from mental ill health, rather than attempting to treat the mental illness in isolation. Opportunities for joint local training should be considered (potentially linked to the LHAC programme) alongside in-house awareness training, with advice from commissioning and exemplar organisations and extension of existing mental health awareness training to include wider aspects of attitudes and communication styles.
BIBLIOGRAPHY

[8] Health & Social Care Information Centre
[9] HSCIC Primary Care Mortality Database
[12] Healthwatch Lincolnshire; 'Service Users, patients and Carers Views on Mental Health Services; Interim report 2014
[14] Department of Health; 'A mandate from Government to NHSE'. April 2014
Suicide prevention action plan

1. PREVENTION

Strategic Aim: 'Reduce Suicide in Lincolnshire, by timely and appropriate intervention'

PRIORITIES:

- Identify clear pathways of support, in relation to suicide prevention awareness for dissemination to all professionals.
- Identify systems/networks of support for those at risk of self harm and suicide, to promote wellbeing resilience
- Develop coordinated training packages for suicide prevention awareness

KEY TASKS:

- Establish systems that ensure knowledge of common pathways and goals
- Develop resources that identify networks of support for wellbeing resilience
- Identify resources to undertake a complex mapping process in respect of prevention and crisis care

Proposed Actions for Implementation

| Identify/Develop clear pathways of support for dissemination to all professionals. | Use reporting systems to develop a share and learn approach, particularly relating to users experiences of response and access. |
| Identify coordinated Training packages to include provision of training/guidance for staff/individuals in bereavement support. | Coordinate current pathways/resources. Liaise with stakeholders to better understand pathways. |
| Develop coordinated Training packages to include provision of training/guidance for staff/individuals in bereavement support. | Share skills of all Suicide Intervention trained people initially to SPSG e.g.: negotiators. Coordinated training packages aimed at reducing stigma & raising awareness in the general public and front line staff develop MECC model. Develop info/ training models in order that those who encounter a distressed person will make that contact |
**CHILDREN & YOUNG PEOPLE**

**PREVENTION**

Strategic Aim: 'Reduce Suicide in Lincolnshire, by timely and appropriate intervention'

**PRIORITIES:**

- Develop processes and systems that ensure knowledge of the pathways to support
- Develop processes for implementation of a common language to help remove stigma
- Develop coordinated training packages
- Develop a programme of evidence based interventions

**KEY TASKS:**

- Commission an emotional wellbeing service to support children and young people who require supportive interventions
- Interpret the evidence base to understand successful interventions that prevent children and young people completing suicide

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<thead>
<tr>
<th>Count.</th>
<th>Introduce mandatory staff training for suicide awareness for all staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop networks of support. Identify peer support systems/initiatives.</td>
<td>Develop Team Around the Adult – use general risk assessment &amp; develop effective response systems/pathways. Develop networks of support (including local 'hubs of support', as an alternative to A&amp;E). Develop/use active/passive listening tools/skills</td>
</tr>
</tbody>
</table>
2. Awareness

Strategic Aim: 'To raise awareness of suicide prevention in Lincolnshire, including causes, symptoms and how to help'

PRIORITIES:

- Develop a Task & Finish Awareness Group
- Develop a county wide Suicide Prevention Charter
- Develop a communications strategy for suicide prevention in Lincolnshire

KEY TASKS:

- Develop consistent messages and use them in suicide prevention awareness campaigns
- Develop a targeted Suicide Awareness Campaign using a best practice model

Proposed Actions for Implementation

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
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<tbody>
<tr>
<td>Develop consistent messages and use them in awareness raising campaigns.</td>
<td>Develop effective use of social media including websites to disseminate core messages.</td>
</tr>
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<td></td>
<td>Use opportunities such as ‘World Suicide Day’/‘World Mental Health Day’/ ‘Time to Change’ e.g. for coffee mornings (community, etc.) Add suicide awareness strapline to email signatures.</td>
</tr>
<tr>
<td>Establish Countywide Suicide Prevention Protocol</td>
<td>Encourage organisations include suicide prevention in their training plans. Develop materials for organisational use for local training to include risk assessment knowledge</td>
</tr>
<tr>
<td>Develop Communications Strategy charter.</td>
<td>Develop social media campaign targeted to workers and users. Develop/agree to use a common language/help remove stigma</td>
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</tbody>
</table>
CHILDREN & YOUNG PEOPLE

Awareness

Strategic Aim: 'To raise awareness of suicide prevention in Lincolnshire, including causes, symptoms and how to help'

PRIORITIES:

- Develop targeted suicide awareness campaign
- Deliver effective intervention to reduce the risk of suicide amongst women experiencing post-natal depression

KEY TASKS:

- Commission services that improve the early identification of post-natal depression
- Research interventions and tools that have a strong evidence base and specify their use in commissioned services
- Ensure funding available as part of commissioned services to train staff to deliver interventions
- Ensure requirement is part of service specification for children's health services 0-19
3. CRISIS CARE

Strategic Aim: 'Recognising risk for those who present in crisis, ensuring robust and timely support and clear pathways to professional care.'

PRIORITY:

- Develop pathways for coordinated collaboration with the Lincolnshire Mental Health Crisis Concordat Board

KEY TASKS:

- Establish systems to transfer the Strategic Suicide Prevention Group priorities to the Mental Health Crisis Concordat work programme
- Establish systems that ensure joint representatives & effective reporting mechanisms to each Board

CHILDREN & YOUNG PEOPLE

CRISIS CARE

Strategic Aim: 'Recognising risk for those who present in crisis, ensuring robust and timely support and clear pathways to professional care.'

PRIORITY:

- Ensure access to a range of appropriate crisis services

KEY TASKS:
• Identify existing range of Crisis services

4. Data, Monitoring & Research

Strategic Aim: 'Develop efficient systems to access & use data to understand strategy and improve service provision'

PRIORITIES:

• Develop an Adult Suicide Overview Panel
• Develop a Suicide Prevention Data Review sub group

KEY TASKS:

• Develop information sharing protocols between organisations
• Developing reporting systems to develop a share & learn approach

Proposed Actions for Implementation

| Establish a Data Review Task and Finish Group to learn from Para Suicides or near misses. Establish systems of collation. | Identify risk triggers from this data. |
| Develop detailed audit methodology using a confidential enquiry approach. | Develop information sharing agreements with partner organisations. |
| Develop Data Sharing Protocols. Extend existing partner data sharing protocols to other partners, to improve speedy access to crucial information. | Using a confidential inquiry approach as is currently in place for maternal deaths and for child deaths. National developments relating to Peer Reviews may be useful. Gather learning from established system in Derbyshire and elsewhere |
| Develop triangulation system with health/education/prison/ etc. in order that a complete story is available in Lincolnshire | Analyse and interpret data to understand trigger points for suicide |
| Identify contributory factors towards the risk of suicide and self-harm, | |
including deprivation and depression. attempts.

<table>
<thead>
<tr>
<th>Information Sharing Protocols between Police, Acute Services and Police Negotiators</th>
<th>Ensure ISA’s are in place to allow information exchange between services to allow better pathway for service users. Develop 4 monthly reporting mechanisms and establish Adult Suicide Overview Panel. Establish Data review Task and Finish Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage with East Midlands Suicide Prevention network</td>
<td>Invite leads from other areas to SPSG. Keith Waters – Regional Adviser on Suicide would be helpful in supporting us to develop actions – a number of other LA’s have successful elements of their plans already in place. Keep abreast of research to understand better the reasons for self-harming</td>
</tr>
</tbody>
</table>

**CHILDREN & YOUNG PEOPLE**

**Data, Monitoring & Research**

**Strategic Aim:** 'Develop efficient systems to access & use data to understand strategy and improve service provision'

**PRIORITIES:**

- Develop systems to enable the sharing of learning from other areas
- Establish systems and protocols to enable regular information sharing and updates from the Coroners Service

**KEY TASKS:**

- Invite leads from other areas to SPSG
- Provide Coroner with all necessary equipment including PPE and cameras