Consultation on the Suicide Prevention Strategy 2018 - 2021 -summary of findings and implications

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1. Background and purpose of report

The consultation on the Suicide Prevention Strategy was conducted between the 10 September World Suicide Prevention Day and 22 October. This involved an online survey, and engagement with a key Healthwatch forum the Mental Health Task Group. This report summarises the findings and implications.

2. Survey Structure

The survey was undertaken in survey monkey using a similar format to the consultation used for the Health and Well Being strategy. Questions were asked in relation each of the five priority areas for action in the strategy;

1. Early intervention and prevention
2. Improving help for those in crisis
3. Identifying the needs of vulnerable people
4. Addressing training needs
5. Communications and awareness

For each priority it asked the following questions (rationale for priority and proposed outcomes were set out in text)

- How important is this priority to you?
- Do you agree with the aims?
- What do you think we can do to deliver on these aims?

We also asked further questions regarding the overall approach of the strategy to understand

- Did they agree with the approach?
- What other priorities did they consider we should focus on?

– To identify any risk groups that we should be focusing on.

3. Survey Results

54 of the 87 respondents agreed to provide monitoring data. The majority 67% were people living in Tower Hamlets.

52 persons provided information on where they worked, 43% were responding on behalf of an organisation, most frequently the Health and Voluntary Sector. 26% were not responding on behalf of an organisation. The age range of respondents was 16-64 with the most frequent age of 45-54 – 65% of respondents were aged over 45. 56% identified as white British or white Irish, with 17% being white other, and 13% Bangladeshi.

The findings indicated strong agreement that the priorities were important or very important and largely agreed that the aims set out in the document were the right ones albeit with some slight adjustments proposed.

Table 1 Summary of responses for importance of priority

How important is this priority?	Response rate	Very importa nt	Importa nt	Respons e rate	Very importa nt	Impor tant
	(n)	(n)	(n)	%	%	%
1. Early intervention and prevention	87	73	13	100	75	20
2. Improving help for those in crisis	78	66	12	64	73	22
3. Identifying the needs of vulnerable people	73	62	9	63	75	18
4. Addressing training needs	72	57	14	62	87	11
5. Communications and awareness	70	52	17	61	80	17

Table 2: Summary of responses for agreement with aims

Do you agree with these aims?	Response rate	Agree with all	Agree with some	Disagre e with all	Respons e rate	Agree with all	Agree with some	Disagr ee with all
	(n)	(n)	(n)	(n)	%	%	%	%
1. Early intervention and prevention	87	65	17	5	100	75	20	6
2. Improving help for those in crisis	77	56	17	4	64	73	22	5
3. Identifying the needs of vulnerable people	72	54	13	5	63	75	18	7
4. Addressing training needs	71	62	8	1	62	87	11	1
5. Communications and awareness	70	56	12	2	61	80	17	3

Agreement with the aims was high with between 73-87% agreeing with all of the aims. Those that agreed with some/or disagreed with all the aims ranged from between 13-27%. There were extensive comments supplied by many respondents, including those that agreed fully with the aims suggested changes to the strategy wording. The comments have been reviewed and the following changes are proposed and set out in the table below.

3.1. Summary of Qualitative Feedback on Strategy

For all priorities, there were also a number of qualitative responses on the question around how we could deliver outcomes. This is elicited a very detailed responses and offered useful information that should assist with informing the approaches of the Suicide Prevention Steering Group and action plan moving forward. Prevailing themes were:

Table 3: Summary of qualitative feedback

Theme	Current Action/Gap
Improved mental health and crisis intervention services – Need to protect funding, to improve access, availability and patient experience of crisis intervention and mental health services.	– Comments are relevant to the actions and priorities of the Mental Health Programme Board and Mental Health Strategy Action Plan. For example, many of the issues highlighted are being addressed in the current review of crisis services led by the CCG.
Schools/Children's Centres/Youth – Need to build resilience and challenge stereotypes with a focus on children and young people, particularly in terms of prevention.	– Strategy recognised that children and young people as a priority vulnerable group.
Awareness raising/tackling stigma – Need to raise awareness about suicide and mental health, and to tackle stigma, particularly in religious communities and amongst high risk groups such as men.	– Tackling stigma is recognised in priority 5 alongside a need to support local and national awareness campaigns. Other strategies such as the Health and Wellbeing Strategy and the Mental Health Strategy recognise a need to address the broader issue of mental ill health stigma.
Alternative/preventative approaches – Need to focus on prevention by providing access to a range of holistic services such as for massage, coaching, peer support, exercise, mindfulness etc.	– Whilst the strategy identifies a need to build resilience at an early age, there are no specific actions to increase access to holistic services specified. However, these are addressed more appropriately through other strategies, including the Health and Wellbeing Strategy which recognises and encourages asset based community development approaches to health.
Service information and promotion – Need to provide clear signposting and information of services available and to promote widely.	– There are specific actions in priorities 1 &2 of the strategy to improve signposting of existing services. People knowing where to access help is also a key measure of success in the strategy.
Training – Need to provide suicide prevention and awareness training to frontline staff as well as training for wider issues such as drugs, alcohol and mental health and that training should be	– This priority is clearly recognised in the strategy alongside the roll out of other training such as for Making Every Contact Count. These comments can help to shape the delivery of the training offer to frontline clinical and non-clinical staff

Theme	Current Action/Gap
delivered by people with lived experience.	going forward.
Primary Care – Primary care was identified as a good location for alternative place to A&E, to provide drop in and walk in clinics, and that primary care should include preventative services such as support groups, access to psychology and debt and housing advice. The need for more funding and training of staff was also often mentioned.	– Training for GPs? – The roll out of the borough wide social prescribing programme – Specialist clinics/access to psychological therapy
Organisational approaches – Need to invest in the mental health of the wider workforce, suggestions included centralised telephone support number, buddying and support arrangements, access to psychology as well as regular training, supervision and support.	– Support for the mental health and wellbeing of staff is recognised both in the Health and Wellbeing Strategy and the Mental Health Strategy by encouraging and supporting employers to adopt the Healthy Workplace Charter which incorporates the Time to Change Pledge.
Wider determinants – Need to provide access to non-clinical support such as for debt, benefits, housing, job advice, volunteering and addressing drug and alcohol issues – preferably within a single service.	– These are recognised and addressed through other strategies including the Health and Wellbeing Strategy and the Substance Misuse Strategy.

3.2. Proposed Changes to the strategy

Table 4: Summary of proposed changes to the strategy

Priority 1 - Wording in prevention strategy [Page9]	Proposed changes and reason
– **access appropriate services in the early stages of mental illness**	Feedback in the consultation – *To include reference to 'awareness of services'* – *Respondents commented on the importance of services being non-judgement.* – *To add emotional distress to reflect the broader definition of suicide risk not being wholly attributable to mental ill health – as the aims currently suggest.* Proposed change – **To be aware of and have access to appropriate services in the early stages of mental health need or emotional distress**
– **be assessed for my mental illness at the stages of their life when they are most at risk of suicide**	Feedback in the consultation – *Further to the comments above, recommend that the word 'mental illness' be removed so aim is not limited to mental ill health* Proposed change – **be assessed for mental health at the stages of life when people are most at risk of suicide**

Priority 2 – Wording in strategy [Page 10]	Proposed changes and reason
– **Know how to access help when they need it**	Feedback in the consultation – *Respondents commented on the importance of an ability to be able to recognise that there is a need to seek help, particularly when in crisis.* Proposed change – **Are able to recognise when in need of support and how to access help when they need it**
– **Be able to access mental health services in an appropriate setting**	Feedback in the consultation – *Propose to remove the reference to 'mental health services' and replace with 'crisis service'* Proposed change – **Be able to access support in a crisis in an appropriate setting**

Priority 3 – Wording in strategy [Page 11]	Proposed changes and reason
– **Frontline staff to feel confident in supporting service users and to recognise signs of mental illness**	Feedback in the consultation – *To replace the word 'illness' with 'distress' to reflect the broader definition of suicide risk as not wholly attributable to mental ill health* Proposed change – **Frontline staff feel confident in recognising signs of emotional distress and are able to provide appropriate support**
– **Frontline staff to have a range of referral options for service users**	Feedback in the consultation – *Proposed add 'and are clear on what these are' in response to comments that being clear on what was available was as important as having a range of options* Proposed change – **Frontline staff to have a range of referral options for residents** – **Frontline staff have the right information to make an effective referral**

Priority 4 - Wording in strategy [Page 12]	Proposed changes and reason
– **Ensure that suicide prevention is embedded in the wider community.** – **Ensure non-clinical frontline staff who are confident in recognising and assisting those in mental health crisis are retained.** – **Ensure that training needs for clinical and non-clinical staff are met.** – **Ensure that frontline staff have appropriate support in the workplace to protect their personal wellbeing and mental health**	Feedback in the consultation – *Proposed to change the wording in the strategy to reflect that training is prioritised alongside other organisational approaches to support staff mental health and wellbeing such as the implementation of the Healthy Workplace Charter –* Proposed change – **Ensure that frontline staff have provisions available in the workplace to support their personal wellbeing and mental health**

3.3. Proposed changes to the 'Zero Suicide' approach

The consultation explored views on a zero suicide approach whereby, it is understood that all suicides are preventable. Instead of setting a target for reduction, every suspected suicide or suicide attempt is treated as a preventable death or injury. Lessons will be learnt from every unexplained death or suspected suicide attempt to prevent future deaths.

All suicides are preventable	Response rate	Agree with this approach	agree to some extent	Disagree with all
Do you agree with this approach?	69	50	17	2

Table 5: Zero Suicide Approach - proposed changes

Zero Suicide Approach (page 8)	The approach all suicides are preventable
– **In Tower Hamlets we take the view that every suicide is a preventable death** – *of those that disagreed with this approach to some extent or to all, tended to disagree that all suicides are preventable and provided a range of reasons for this including; that suicide may happen despite the best efforts of professionals and family, that we risk creating a culture of blame with this approach, and that we should respect and acknowledge people's right to die.* –	Feedback in the consultation – *Proposed that the strategy wording be changed to reflect that the intention is to prevent every suicide without suggesting that all suicides are preventable* Proposed change – *Propose to change the strategy wording* **(page 3) ' to take out 'we believe that suicide is avoidable, and this is at the core of our prevention strategy.** *Propose to change the strategy wording* **(page 8) '** – **from : In Tower Hamlets we take the view that every suicide is preventable** – **in Tower Hamlets we are committed to preventing every suicide and suicide attempt**

At-risk/priority groups

Respondents were invited to comment on any particular 'at risk' groups that they considered to be a priority of focus. These are presented in the table below according to the frequency of citation. It is important that the action plans for the steering group include actions for those groups frequently cited on this list.

Table 6: At risk priority Groups

(n)	Priority Groups	Summary
11	Homeless	People that are homeless or have insecure living arrangements
9	Financial distress	People in financial distress
8	People living with MH illness	People living with mental ill health or who have experienced trauma.
8	Young adults	Young adults such as parents, young men. Vulnerable young people and women experiencing cultural conflict.
8	Substance misuse and addiction	People with drug and alcohol addiction. Young people addicted to gambling and/or substances and those that care for them.
5	LGBT	Lesbian, gay, bisexual and trans people
4	Men	Men, single men and middle aged
4	Asylum seekers	Asylum seekers including victims of trafficking
3	Elderly people	Elderly and bereaved
3	Students	GCSE and Uni
2	Survivors of suicide	Survivors of suicide[1]
2	Learning disabled	Autistic adults, learning disabled
2	Ex-prisoners	Ex-prisoners and recently released
1	Other	Domestic Violence, Veterans, lonely people, early years

4. Stakeholder meetings

The Mental Health Task Group a sub group of Healthwatch were consulted on the 21st of September. The feedback from the task group was reflective of the themes that emerged in the wider consultation. Comments included a need to focus on children and young people, the needs of those most vulnerable such as those affected by welfare reforms. They provided insight into issues and experiences with crisis intervention and mental health services that have been reflected in the wider consultation. They also commented on training, training needs and identified specific groups to target for training such as the community pharmacists. The task group also provided feedback on the media, and useful ideas such as how to imbed suicide prevention training such as including it in Health and Safety advice for construction workers, or interventions with citizen's advice. Similarly to respondents in the consultation there was agreement with the approach but contention with the term zero suicide.

[1] Those bereaved by suicide

5. Conclusion

The results of the consultation demonstrate high levels of agreement with the priorities and aims set out in the strategy. People provided a lot of feedback and comments throughout the consultation and whilst these have been summarised for the purposes of presentation [Appendix 1], they provide very rich insight that can and should inform the approaches of the multiagency suicide prevention steering group. Further work in the steering group is required to determine if the identified themes are indeed addressed, or whether there are gaps that require further action.

Where people have provided feedback on the aims, these have been summarised and reflected where feasible in the proposed changes to the strategy wording in table's 3 & 4 for consideration. The changes tend to reflect comments on suicide being relevant to people with and without mental ill health, to recognise that some people may need support in identifying when they need to access help. That it is important that frontline staff have a range of options available for referral but that they also have the right information to make an effective referral. The changes also incorporate comments that whilst training is important, that it needs to be provided alongside organisational approaches that support the mental and emotional needs of frontline staff.

Finally, whilst there were high levels of agreement with the approach to treat every suicide or suicide attempt as a preventable death or injury, of those that commented, most had difficulty for a with the term 'zero suicide'. It is proposed that the wording be changed to reflect that the intention is to prevent every suicide without suggesting that all suicides are preventable.

6. Appendix 1

For each of the priorities the main themes and ideas have been heavily summarised and are set out in the order of the most often cited.

Priority 1: Early intervention and prevention (64 Comments)

Improved service provision for mental health	– To improve service provision for mental health by ensuring that services are well funded, offer longer term support, and are available and accessible at an early point and following a single assessment
Schools/Children's Centres	– To work in schools to build resilience, raise awareness and tackle stereotypes
	– To provide support for children families, and improve the linkage between mental health and schools/children's centres
Youth	– To provide more youth group activities for young people and whole systems approaches to addressing self-harming
Awareness raising/ addressing stigma	– To raise awareness in the community on mental ill health and suicide and address the stigma of accessing help by promoting national and local campaigns – Work with professionals and the community to address stigma to improve support for people in mental and emotional distress and enable them to access help
Accessible crisis intervention services	– For people at risk of suicide to be aware of the services available, who to contact in a crisis and to access them in a suitable environment
Alternative/preventatives	– For people to have access to a range of holistic preventative services such as for: massage, coaching, peer support, exercise, mindfulness or social clubs that include targeted interventions for high risk groups
Organisational approaches	– To work with multi agency partners wider than health to implement evidenced based approaches whilst also considering the mental health needs of staff
Primary Care	– Primary care services to include access to support groups and specialist clinics for CMD alongside training for practice staff and access to debt, housing and benefit advice
Service information and promotion	– Better promotion and signposting of available services and access points for help
Staff training	– Organisational approaches to train frontline staff to assess risk, listen, signpost and have conversation about mental health and/or drugs and alcohol
Wider determinants	– To provide access to non-clinical support i.e. for debt, addiction, benefits, housing, job advice and opportunities preferably in one service
Psychological services	– To provide brief psycho education facilities and better access to talking therapies
Personalised approach	– A personalised approach based on what people identify as their need

Priority 2: Improving help for those in crisis (43 Comments)

Improved service provision for mental health	– To improve the environment and services in A&E by consulting patients, increase and ensure long term funding for services. – Lower the threshold for access and tailor access to suit different needs/preferences i.e. online or group vs individual therapy. – Focus on prevention by improving support for people with stress and depression and providing non-clinical intervention for people in mental distress.
Accessible crisis intervention services	– Improved and accessible crisis intervention services that are community based and available 24 hours, provided in a better environment such as a crisis café with a crisis support and all services accessible to those to those in mental distress.
Alternative/preventatives	– To provide alternative and preventative therapies for mind, body and spirit that includes work with families and addressing trauma.
Awareness raising/ addressing stigma	– Raise the profile and awareness of suicide, normalise the issue and work in the community particularly with faith groups and anti-stigma work aimed at men
Primary care	– Primary care walk-in/drop in clinics as an alternative to A&E and in an emergency

Staff training	–	Training for frontline staff and community services in understanding mental ill health, signposting and how to talk about suicide
Service information and promotion	–	Clear signposting and information of where to access help
Outreach	–	increased outreach for homeliness and vulnerably housed
Psychological services	–	Psycho education/life skills services in crisis intervention services

Priority 3: Identifying the needs of vulnerable people (45 Comments)

Staff training	–	People commented a lot on the need to provide ongoing suicide prevention and awareness training for frontline staff delivered by people with lived experience. Make use of technology and services open out of hours such as Idea Stores.
Improved service provision for mental health	–	A centralised screening and referral to services such as CMHTs and Home Treatment Team that is well-funded, carefully commissioned and streamlined. That also provide home assessments for the most vulnerable
Organisational approaches	–	Invest in the mental health of the workforce i.e. centralised telephone number for support, facilitated staff groups with therapist, buddying and support arrangements, address knowledge and skills gap.
Accessible crisis intervention services	–	better staffed A&E & easier CMHT access
Alternative/preventatives	–	To promote peer support and create spaces for parents to meet and talk and promote the needs of carers
Service information and promotion	–	provide information on services and publicise widely through a range of mediums – encourage the public to access
Staff training	–	Help people to promote their life chances through volunteering, education and employment and campaign against cuts/benefits changes.
Improved service provision for mental health	–	Raise awareness across all services
Organisational approaches	–	identify vulnerable hidden groups such as children living with parental substance misuse
Accessible crisis intervention services	–	Increase spending for mental health in primary care

Priority 4: Addressing training needs (25 Comments)

Staff training	–	To make suicide prevention training compulsory for frontline staff
Organisational approaches	–	To provide training to people in housing, insecure housing, multidisciplinary groups and delivered by people with lived experience.
Alternative/preventatives	–	To take a whole organisation approaches for suicide prevention through regular training, supervision, support i.e. support line for staff.
Improved service provision for mental health	–	Whole person approaches mind/body/spirit medication as a last resort
Accessible crisis intervention services	–	non clinical staff unable to refer into clinical services
Stigma	–	A CALM Tower Hamlets Facility
Staff training	–	to address the stigma regarding suicide

Priority 5: Communications and awareness (21 Comments)

Media	–	People felt that social media was an important factor for young people in terms of impact on suicide risk but also in reaching them. – There was agreement for a need to have responsible reporting; that some communications would need to be tailored for hard to reach groups and that the councils' website needed improvement.
Awareness raising/ addressing stigma	–	That there is a need to improve education and awareness, to campaign in different communities to address stigma re: suicide and in workplaces

Staff training	–	To provide suicide awareness training that is informed by people with lived experience
Improved service provision for mental health	–	To improve the communication systems in health care and better co-ordination of services including adequate staffing
Learning lessons	–	To share lessons learned and details of improvements made
Primary Care	–	Improve communication between GP/Support Workers and Families
Service information and promotion	–	accessible information available offline

Any other priority areas of focus (34 Comments)

Survey respondents were also asked of any other priorities they considered important;

Improved service provision for mental health	–	An improved patient experience where patients feel heard when in crisis and received in a suitable environment where issues are tackled at an early point
	–	To receive services without judgement particularly for those with high needs .e. substance misuse with a smooth transition between services (including clinical/non-clinical)
	–	To improve the support provided to staff when investigating suicide and to apply a whole systems approach to suicide prevention which includes support for families and carers, including support after trauma.
Schools and Children's Centres	–	To build resilience in children from an early age by training teachers to discuss suicide and raise awareness in schools, to address suicide risk among parents through children's hubs such as nurseries.
Youth	–	To build self-resilience among young people by giving access to youth activities such as scouting. Supporting them through a difficult transition to adulthood in the face of cuts to services.
Alternative/preventative	–	To take a community development approach that focuses on connection, self-love and access to mental health promoting therapies i.e. mindfulness, yoga etc.
Wider determinants	–	Prevention by improving quality of life by providing social support and access to opportunities for work, education, housing for those with mental ill health and to address issues of alcohol abuse.
Stigma	–	Tackle the stigma associated with suicide and improve social cohesion and reduce religious intolerance
Psychological services	–	Provide access to counselling for survivors and reduce the waiting times for CAMHS
Targeted approach	–	Take a targeted approach for high risk groups