Community Response Plan

April 2016

For Merseyside and Cheshire

Community Response Plan

Phase 1 Preparedness

Multi-Agency Suicide Prevention Group

Phase 2 Postvention

Activate CRP - mobilise local support services - Suicide Response Team Rapid Response Team

Phase 3 Follow up

De-activation and review at 6 weeks

Purpose of this document

1. To set out how the Suicide Liaison Service: AMPARO, and the Cheshire Merseyside Suicide Prevention Network can prevent further suicides through the use of intelligence and planning (See Appendices for further information on these organisations)
2. To advocate for local multi agency suicide preventions groups (LMSPG) to provide rapid response in protecting lives
3. To outline the process of identifying potential clusters and the prompt implementation of community response plans
4. To establish parity of esteem for mental health whereby contagion by suicide is provided with the same health protection, resources and expediency of action that occurs with contagion by physical disease, such as swine flu.

This document should be read and used in conjunction with the PHE Guidance 2015. *'Identifying and responding to suicide clusters and contagion'.*

Introduction

One of the major concerns around suicides is the "cluster" effect, a process whereby one suicide can trigger a number of similar suicides. This can relate to geography, gender, age grouping, ethnic grouping and social connections.

The revised definition of a suicide cluster is as follows:

'A series of three or more closely grouped deaths which are linked by space or social relationships. In the absence of transparent social connectedness, evidence of space and time linkages are required to define a cluster. In the presence of a strong demonstrated social connection, only temporal significance is required'.
'Identifying and responding to suicide clusters and contagion' Public Health England Sept. 2015
https://www.gov.uk/government/publications/suicide-prevention-identifying-and-responding-to-suicide-clusters

Evidence suggests that people who know someone who has died by suicide are at greater risk of attempting to or taking their own lives by suicide by up to 300%.[1] For each individual suicide it has been estimated that at least a further six people on average suffer a severe emotional impact as a result of the death.

The Cheshire Merseyside Joint Audit Report 2015 shows that out of 200 deaths by suicide in 2014 sixteen cases recorded a previous suicide of a friend or family

[1] Lukas C. and Seiden H (1897) Silent Grief: Living in the wake of suicide. Jessica G Publishers, London UK, 2007.

member. These deaths were prior to the commencement of the AMPARO Suicide Liaison Service in April 2015.

Different types of cluster include:

- **Point clusters**: a greater number of suicides in specific locations and time periods
- **Mass clusters**: a greater number of suicides may occur in a specific time period and be spread out geographically.
- **Echo clusters**: areas at greater risk of suicide occurring repeatedly related to particular characteristics of the area or population which increase vulnerability.
- **Multiple suicides**: when more than one suicide has occurred with evidence of contagion i.e. that one individual has been influenced by the behaviour of another, must be established before a cluster can be confirmed.
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Contagion may be influenced by:

- **Horizontal transmission:** suicide involving a person who was very similar to others who have died by suicide
- **Vertical transmission:** the suicide of an influential celebrity occurs
- **The emergence of different methods of suicide**

Local Multi-Agency Suicide Prevention Groups (MSPG)

To prevent further suicides it is important that potential clusters are identified at the earliest opportunity and an early intervention response put in place to halt contagion. Forward planning is essential to ensure an effective **Community Response Plan (CRP)** can be triggered at any time if necessary.

Local authorities should establish local, multi- agency suicide prevention groups to co-ordinate suicide prevention with operational links to the Cheshire Merseyside Suicide Prevention Network
PHE practice resource on MSPG is due to be published later in 2016

The Local MSPG has the responsibility to establish a CRP with preparedness for action. A response to any potential cluster is about civic and community leadership to mobilize people, provide information, resources and support to address areas of concern through a CRP to potential suicide clusters.
A CRP will involve wide representation from all sectors of the community who have the local knowledge to be able to address the problem.
While undoubtedly a CRP will require some input from Public Health and the Social Care sector that has specific knowledge in the area, the success of the plan is dependent on the commitment of a wide range of agencies.

Any enquiries or interventions offered should be mindful of cultural, religious or faith issues and be sensitive to those who decline support. Information and sources of support can be offered for future reference.

Purpose of implementing a Community Response Plan (CRP)

After a significant loss there is often shock, disbelief and confusion within a community. A template for action is helpful in order to maintain a sense of calm and clarity regarding the way forward and to help to contain anxiety within the locality.

The purpose therefore of a CRP is:

- To provide a co-ordinated response from all sectors of the community
- To facilitate early detection of clusters
- To prevent the development of clusters occurring after a notable death by suicide
- To reduce anxiety and potential for vicarious trauma.

Identifying a cluster or contagion

Local suicide intelligence can be instrumental in the swift identification of a cluster within a region.

Public Health England recommends a **Suicide Surveillance Group** or **SSG**, should be in place in every region to closely monitor evidence of contagion. A group should meet on a regular basis to review real-time data of local suicides and known self-harm.

Every regional SSG group should consist of:

- the public health suicide prevention lead,
- the mental health trust suicide prevention lead,
- the police suicide prevention lead
- and a local expert in reviewing mortality data.

PHE states reviewing data should be collected via the NHS England serious incident reporting system.

Identifying and responding to suicide clusters and contagion PHE Sept. 2015 p15

CMSPN has a Suicide Audit & Intelligence Group equivalent to the SSG that has the potential to work with the coroners, AMPARO and other key services in establishing Real Time Surveillance and inform local MSPG of clusters and potential contagion (contact Champs for further information)

Community intelligence is invaluable and training to increase awareness of contagion within all public, health and social care services is essential.

Localised hot spots may develop within vulnerable social groups – social media helps with the monitoring of young people. Hot spots are areas such as bridges, railway lines, cliff edges and so on that are known already to be high risk should be closely monitored. Network Rail is proactive in suicide prevention and is working closely with Samaritans.

Guidance for developing a local suicide prevention action plan, PHE Sept. 2015 p8

A Community Response Plan will include 3 Phases:

Phase 1: Preparedness

Key groups and agencies should previously be identified with a named individual in a position of authority –this may be the Multi-Agency Suicide Prevention Group, with any additional members as deemed necessary.

MSPG's in each geographical area to include the following key stakeholders – list is not exhaustive:

- Director of Public Health
- Chief Executive Local Authority
- Local Clinical Commissioners
- Amparo suicide liaison workers
- Police
- Coroners/assistants
- Education lead
- Safeguarding lead adults
- Safeguarding lead children
- CYP mental health leads
- Mental health leads
- Prison/probation leads
- Clergy
- Any other relevant agencies/services e.g. local funeral directors
- Families of the deceased
- The voluntary and community sector

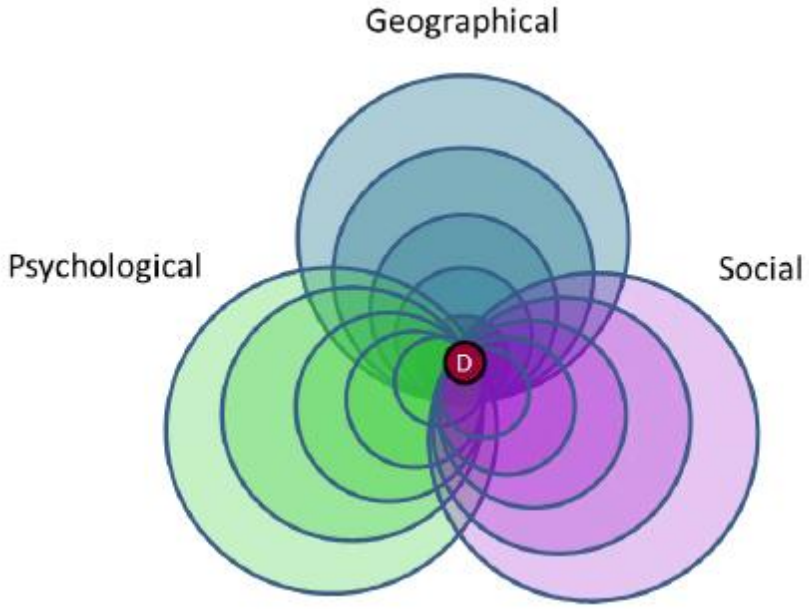
Amparo suicide liaison workers are well placed for early intervention by providing an effective triage service for key groups of individuals who would be identified as at greater risk than other

As services vary between regions the CRP provision may differ. The regions of Merseyside and Cheshire include Cheshire East, Chester and Cheshire West, Halton, Warrington, Knowsley, St Helens, Liverpool, Wirral and Sefton (the latter does not commission AMPARO).

Identifying clusters and potential contagion

The SSG will act on intelligence from Real Time Surveillance, police, coroners and other key local agencies and utilise intelligence tools to plot frequency and distribution of suicides.

A **vulnerability matrix approach** can be used for mapping of psychological, social and geographical proximity of individuals and groups, starting with those closest to the deceased to those identified as more distantly connected.



Blank vulnerability matrices (Appendix 5) are available in appendix 1 of the PHE practice resource *Identifying and Responding to suicide clusters and contagion 2015.*

Phase 2: Postvention

Criteria for activating a CRP:

- More than one linked suicides occur within a short space of time within a community.
- A single *significant* suicide occurs
- Statistical information confirming the emergence of a cluster for example from coroners/mental health leads/Amparo
- Unusual circumstances surrounding the death
- Potential for media interest
- Public perception – for example to address and alleviate public anxiety, hostility or distress.

The lead of the MSPG - the Chief Executive Officer or the Director of Public Health at the local authority where the event has taken place takes the initial decision to start the CRP in response to incoming information from SSG (or equivalent group).

Timely response:

The timing of activation must be carefully considered in order to minimise the risk of panic or heightened anxiety within a community. The timing of a CRP should take into account the type of setting in which the suicide has taken place and the level of risk of contagion or cluster.

Activation of a CRP should be within 5 working days or earlier depending on the perceived level of risk to vulnerable individuals within a given community or nationally.

Activation of a CRP within a school or university community should be within 72 hours or earlier if logistically possible or necessary depending on the perceived level of risk and vulnerability of the community and the impact of social media. –

The MSPG can activate the CRP for a specified length of time. This would depend on the known facts and variables within the region such as the number of suicides already taken place, the size of the population likely to be at risk and so on.

The MSPG/ CRP Group can define how each individual or group is at risk then plan for the appropriate support or intervention for example by signposting to relevant services and agencies.

- The PHE guidance document sets out the following approaches:
    - Whole population approaches
    - Targeted Approaches
    - Individual approaches
    - Examples of interventions
    - Social Media

- Mental Health Service Input
- Schools / Colleges (See Appendix 4)

Amparo suicide liaison workers can provide effective triage for members of the family and the wider community either working individually or with groups

A useful publication for those bereaved by suicide is 'Help is at Hand' which should be offered by police and coroners as the first contact after a death. This contains a wealth of information and advice for the bereaved.
http://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf

Governance and accountability

Recording actions:

Confidentiality is a key issue and should be respected unless there is clear evidence of safeguarding issues and imminent risk of suicide. It is vital that all communications made and actions taken by those involved with the CRP are recorded securely. The circumstances and information surrounding a death by suicide can be very sensitive and families in particular should be protected. The CRP committee will discuss and agree procedure and governance for information sharing and protecting confidentiality.

Monitoring of beneficiaries is essential throughout the early stages of the intervention and up to inquest. If inquest is delayed then periodic contact will be maintained by the Amparo suicide liaison worker, if consent for contact is obtained. Monitoring of suicide patterns will be ongoing for a period of time realistically approximately 4 weeks or more to ensure the threat of contagion has significantly reduced or disappeared.

Information about support services, helplines and internet resources should be given to those at risk

Training in models such as local suicide prevention training, Connecting with People, ASIST and STORM is advisable for those closely involved in supporting bereaved or affected individuals.

It is important to keep the details of the death to a minimum to reduce media interest and the Samaritans Media Guidelines should be used and recommended. The CRP committee will work with the local authority press team to ensure consistent messages to relevant media agencies.

Phase 3: Follow up

De-activating a CRP

This must be a co-ordinated decision made by the MSPG involved in delivering the CRP.

The criteria for de-activation include:

- Positive engagement of beneficiaries in local services
- Effective management of media coverage
- Statistical information re the suicide rate in the community
- Reduction in identifiable risk factors
- Clear evidence that the community concerned is calmer.

Learning experiences:

Every time a CRP is activated, a learning process will begin.

The CRP is open to adaptation depending on specific circumstances as every suicide will be unique. It is vital that actions are recorded for future reference and provision is made after de-activation for a meeting of the co-ordinating committee to discuss the CRP in its entirety.

Stepping down support

Once agreement has been reached about the reduced level of risk of contagion or cluster, communication of the decision must be clear to all parties involved and ongoing support services offered.
Increased vigilance around significant dates such as anniversaries is important as feelings will be running high.
The SSG will continue to monitor the possibility of further suicides in the region to prevent echo clusters occurring.

Contact:
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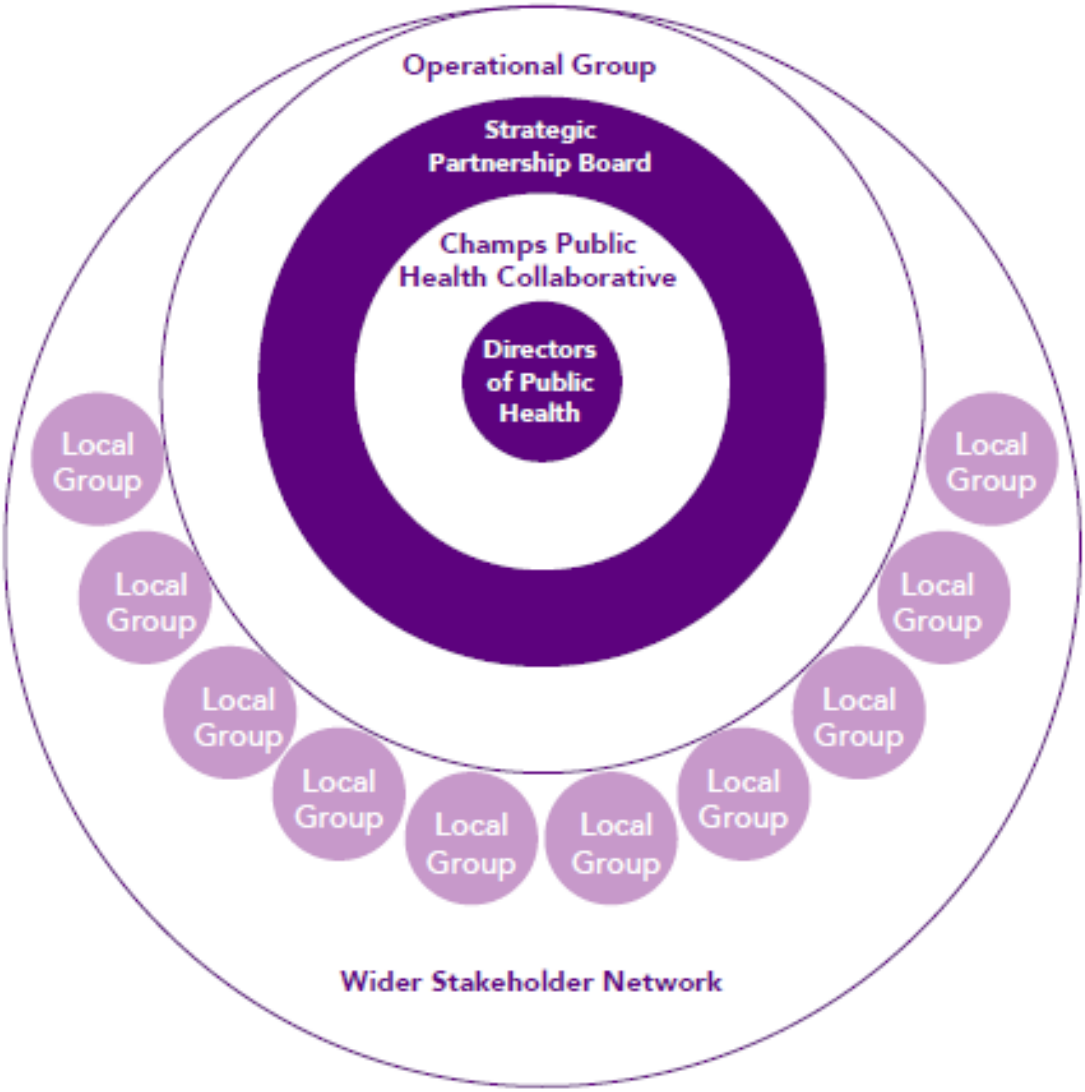
Pat.woodhouse@listening-ear.co.uk

Pat Nicholl
Champs Mental Wellbeing Lead
0151 666 5123 / 07810630522
patnicholl@wirral.gov.uk

Appendix 1: Cheshire and Merseyside Suicide Prevention Network



Appendix 2: NO MORE Strategy

Click here to access the NO MORE Strategy or alternatively download via the NO MORE website www.no-more.co.uk

Appendix 3 – AMPARO

AMPARO
support following suicide

AMPARO provides support for family members in Merseyside and Cheshire, following suicide. Support is provided 1:1 and our staff can assist with a range of practical matters such as dealing with Police and Coroners, helping with any media enquiries, help with overcoming isolation experienced and contacting and signposting to other local support services.

The Coroner will offer families access to AMPARO, immediately following a death by suicide. We can also accept self-referrals using the details below and our service is completely confidential.

Appendix 4: Schools Document

Managing Death In the School Community

The document can be downloaded from the Champs website http://www.champspublichealth.com/key-documents

Appendix 5: Blank vulnerability matrices templates

GEOGRAPHIC PROXIMITY Individuals discovering the deceased or exposed to the aftermath			
Circles of Vulnerability: Individuals or Groups	**Description of risk**	**What has been done to help this person?**	**What remains to be done?**

SOCIAL PROXIMITY Identification with, relationship to or connection to the person who died			
Circles of Vulnerability: Individuals or Groups	**Description of risk**	**What has been done to help this person?**	**What remains to be done?**

PSYCHOLOGICAL PROXIMITY Identification with, relationship to or connection to the person who died			
Circles of Vulnerability: Individuals or Groups	**Description of risk**	**What has been done to help this person?**	**What remains to be done?**