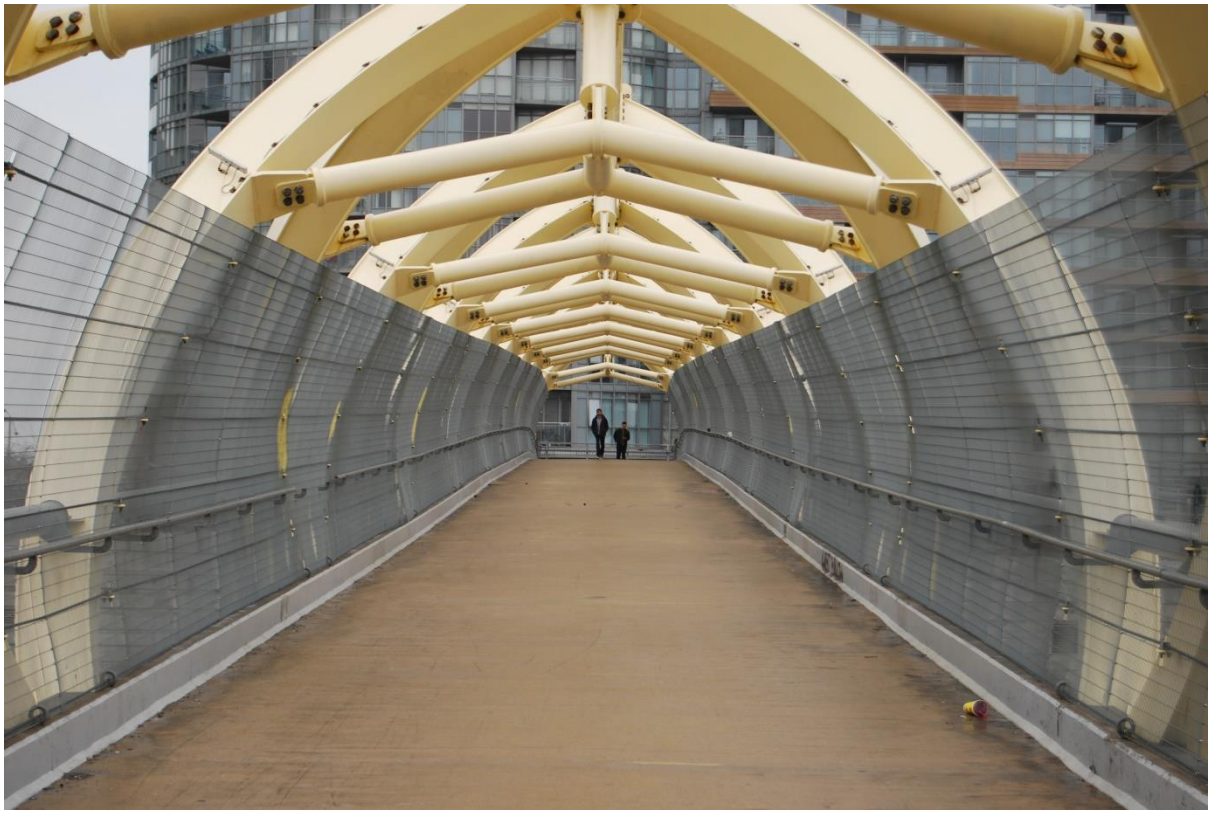
Suicide Prevention

at

High Risk Locations



WINSTON CHURCHILL MEMORIAL TRUST

Bob Blemmings

Churchill Fellow / 2019

SAMARITANS

"I don't like standing near the edge of the platform when an express train is passing through. I like to stand back and, if possible, get a pillar between me and the train. I don't like to stand by the side of the ship and look down into the water. A second's action would end everything. A few drops of desperation."

Sir Winston Churchill

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Foreword

Firstly, I would like to thank the Winston Churchill Memorial Trust, and The Samaritans, for the opportunity to take part in my travels to research and learn on the subject of suicide prevention.

My personal career history includes training and working as a registered adult nurse for 3 years and a police officer for 26 years thereafter, for which in the last 10 years I have held the role of a Hostage and Crisis Negotiator. I have talked people in crisis off bridges and cliffs, observed colleagues and friends who have done the same and thought long and hard about why, when, and how people get to the point in their lives that they believe suicide is the option for them.

I recall one instance in the middle of the night when I was called to a person in crisis on the wrong side of the railings on the Sandleford Bridge in Coleraine. I was the on-call Negotiator and the closest responding officer to the scene. On my arrival, I was met by a young male who was emotionally distraught. He had climbed over the railings of the bridge and was standing on a 3" ledge of concrete with his back to the railings. The police officers at the scene had attempted to communicate with him but had been forced to step back as the young man threatened to jump if they came any closer. The first officer at the scene told me, "We can't get closer to him; he says if we try and talk to him he will jump". Knowing the risks and understanding that this young man and the responding officers were also in a state of crisis, I said to the officer, "If we don't talk to him, who will?"

I walked to the centre of the carriageway and asked the young man if I could sit down and talk to him. It took some time, but I developed trust and a rapport with this man whom I had never met before and was able to successfully bring him to the safe side of the railings, he was subsequently taken to the care of waiting family members. My act of sitting down in the roadway, presenting no threat and offering the promise of help and understanding allowed this man to come back from the brink of suicide and receive the support he required in order to move forward.

I look around and see beauty and wonder, all that there is to enjoy in this world; but I also see, from my experience, the horrifying ways that individuals end their lives. The bridges, monuments and natural features that many enjoy are also locations that others use as a means to their end; it is a terrible truth that where some of us see beauty, others see an opportunity to bring their lives to a close.

There is a subtle difference to how persons perceive a location, and this difference can be seen and heard when people refer to these locations. There is a common phrase in Derry when persons are in high emotional state or crisis – "I'm away to the bridges", this colloquial phrase hints at the background noise that a high-risk suicide location presents; that the means to suicide is accessible.

It is this background noise that mental health professionals, community groups and law enforcement officers must be tuned into.

I present the question, how do we change our processes, physical structures and the ethos of public design to save a life, and how many lives will it take before we start?

Introduction

In 2018 307 people in Northern Ireland took their own lives, 228 men and 79 women. Behind each life lost is a complex set of circumstances and there is no simple answer to why a suicide occurred, or what could have been done or considered to prevent it.

This is a key message, suicide is not inevitable, it can be prevented, and one way to do this is to restrict the access to means by which a person would choose to suicide. If we can intervene in someone's thoughts, their behaviours, or by removing or restricting a method of suicide we may be able to save a life, or many lives.

The effects of suicide are especially felt in Derry/Londonderry at the Foyle Bridge, the longest bridge in Ireland. A report in 2013 states 90 people have died and over 2,000 talked back from the edge or rescued from the waters, presenting a huge emotional and financial cost. As a Crisis Negotiator for the PSNI, my aim is to raise awareness of suicide prevention and find solutions to save lives. The two cities I wanted to learn from are at the forefront of suicide prevention in North America & Canada.

Derry/Londonderry is a post conflict city with high levels of deprivation and poor mental health across the population. A study identified that trans-generational trauma; a history of "The Troubles" has, and continues to impact on individual's wellbeing. The city also crucially has the "Foyle Bridge", a focal point for suicide attempts.

With this project I wanted to learn from other similarly appointed cities and find innovative and imaginative solutions to improve the understanding of suicidal and self-harming behaviours at high risk sites. The destination cities have, or are currently building bridge suicide prevention barriers and have community programs, which I can learn from to share across the U.K and R.O.I.

I want to increase early identification of at-risk individuals to prevent harm and, in doing so, increase the uptake of protective help.

San Francisco and Toronto have the experience of developing suicide prevention strategies around high risk sites similar to the problems being experienced in Derry/Londonderry. The Golden Gate Bridge and the Toronto Prince Edward Viaduct have developed a number of early intervention and physical access prevention coping strategies to manage suicide attempts both at the site, and in the wider community.

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Executive Summary

Bridges, multi-storey buildings, monuments and natural features present an area from which to jump or fall with tragic and often fatal consequences.

These are all locations from which people choose to suicide and we need to consider, at each and every site, the potential benefit of a form of suicide deterrent system.

When does a location become a place to which people go to suicide, and when this occurs, what is our response to that location? There are countless locations wherein a person can end their life, but there are locations which we know have crossed the definition from: "a place where someone *can* suicide - to become a place where people *go to* suicide." At the point of this subtle change in definition I contend that this is when we need to put in place suicide deterrent systems, and/or a Crisis Intervention Plan.

In order to identify these high risk locations, we need to consider the information available from those persons; statutory, voluntary and indeed members of the public who act as initial responders to the person in crisis and at risk of suicide.

Blue light responders, in the main police officers, but also private security at some sites, tend to be the first official persons tasked with reporting a person in crisis. In Derry/Londonderry, the Foyle Bridge is a high-risk location which currently has CCTV installed to identify persons in crisis to which police officers are regularly tasked with intervening. This use of CCTV is an important step in identifying at-risk persons, but if this location continues to be a location to where person's suicide, this CCTV alone is insufficient.

It is important to state that even the installation of the most secure barrier or fencing will not deter all suicides, but the signage, physical barriers and public awareness of a location will help to increase the opportunity to restrict the individual, who is in that moment of desperation, the ease of access to a site. It will also allow critical time to provide the opportunity for an intervention, whether that be the physical act of rescuing a person, or the opportunity of time to de-escalate a person in crisis and hence save their life – this time of opportunity I term, "The Intervention Gap".

Such measures can include:

- Warning Signage
- Supplementary lighting
- Installation of an emergency contact phone line
- CCTV linked to remote observers
- Barriers and fencing
- Awareness raising at the site to encourage public intervention
- Public information programs to assist in rebranding a site to remove the negative connotation

Alongside all of these possible site interventions, we must work in partnership to address current issues and bring forward new designs of public architecture which have suicide prevention measures built into future structures.

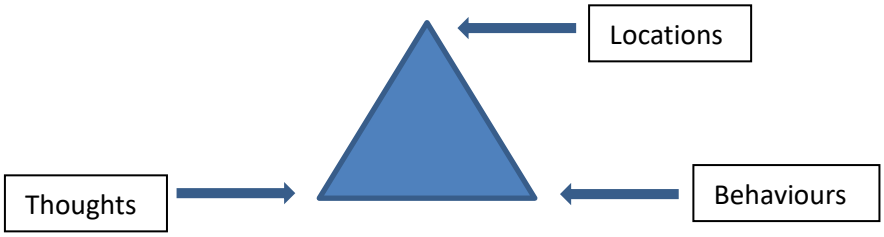
I would argue that there is no such thing as good suicide prevention design. There is only good thoughtful design, which considers the site in question and contains an awareness of the possibility of suicide and has proper safety and deterrence built into it.

As a multiagency community with public safety and suicide prevention at our core, we need to follow a principle which I term:

"SIT DOWN"

The ethos of SIT DOWN is a collaborative approach between the public and law enforcement to work together to take action against suicide in and around high-risk locations.

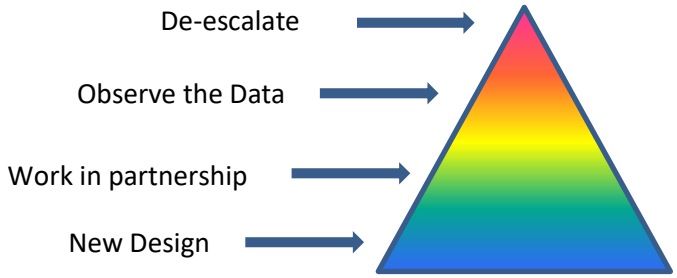
SIT: Suicide **I**ntervention **T**riangle:



Similar to the fire prevention or crime prevention triangle, I see 3 points of intervention to being able to intervene in a pre-suicide crisis

1. Thoughts – de-escalate the crisis moment
2. Behaviours – Provide a safety centred response to the person in crisis to prevent and address pre-suicidal behaviour
3. Location – Introduce suicide deterrent measures at high risk locations

DOWN: **D**e-escalate, **O**bserve the data, **W**ork in partnership & **N**ew design.



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The following 4 actions will help to return the individual from a crisis state and provide an intervention gap at high-risk locations:

1. **D**e-escalation training and awareness can help return the individual from a state of crisis.
2. **O**bserving, identifying and recognising previous suicide sites will identify where measures are required.
3. **W**orking in partnership with statutory and voluntary bodies can bring individuals into recognised pathways of care, and reduce the current blue light response and the oftentimes resultant criminal justice detentions of person in a mental health crisis.
4. **N**ew and more carefully considered design of public architecture must be included in both future and current high-risk locations and structures and consideration given to retrofitting suicide deterrent systems on these sites.

In terms of agency engagement with persons in crisis and pre-suicidal behaviour at high risk locations; blue light responders have a unique opportunity to save lives. They can add information and critical data to statutory and voluntary agencies promote multiagency working and highlight learning to public design.

These responders should be made aware of their opportunity to contribute in these areas, trained appropriately to carry out this role and be aware that their knowledge and experiences can be shared with planners and designers to better inform the purpose of public architecture.

Derry City Specific Learning

I will also share within this report my observations and findings from my 2 years as a member of the senior leadership team in Derry City and Strabane in respect of the local learning and actions in response to persons in crisis at high risk locations. The effective response to persons in crisis at high-risk locations is a combination of awareness raising and education of the responding officers, liaison with support agencies and regular and effective information sharing with city centre CCTV.

What the above actions are dependent on is the effective collection, collation and assessment of crisis incidents which are used to identify times, locations and vulnerable repeat attendees at high risk locations. With this assessment in place I have developed a time and location radar for responding officers, and use the generated lists of vulnerable individuals for targeted support and intervention to reduce the potential for harm.

Findings

Northern Ireland (N.I.) has the highest rate of suicide in both the U.K. and all of Ireland; the current suicide rate is 13 persons per 100,000 of the population. There are many reasons that suicide rates are high in N.I., however, many great organisations and communities within the country are working hard to stem the loss to suicide and show people at risk of suicide how to protect themselves from this insidious cause of death.

Within my research, I travelled to Canada and the USA to learn from 2 locations that have, and are, putting in place suicide deterrent systems (SDS) at high-risk locations. These SDS's are currently in place at the Bloor Street Viaduct (AKA Prince Edward Viaduct), in the Canadian city of Toronto, and on the Golden Gate Bridge in the U.S. city of San Francisco, which is currently putting in place a SDS. These are in response to the specific risk related to these locations. The basic premise of these SDS's is to restrict the access to a means of suicide that these locations provide, namely, a fall from height.

Within my current role in the PSNI I am privileged to work in Derry/Londonderry, a great city with an impressive, but at times challenging past. Derry City and its residents have accomplished and suffered a lot; through the partition of Ireland, a significant and strategic impact on the civil rights movement across all of the U.K., and the ongoing impact of "The Troubles". The history of this city is intertwined with its residents and the desire to make the city and its environs a forward-looking and creative location for its residents to reside and thrive in, peacefully and safely.

In Derry City there are 3 bridges, including the Foyle Bridge. Being the longest bridge in Ireland, it links both halves of the city with a 4 lane dual carriageway and footpaths on both directions. The bridge has been the location of a number of suicides over the years, and a great number of reports of vulnerable persons in crisis. The Foyle Bridge regularly appears on searches for greatest numbers of suicides across Europe, with Wikipedia recording that there have been more that 90 suicides from this location since 1984. Presently, there are ongoing discussions and plans in order to determine which SDS should be constructed at the location.

The Samaritans are an internationally renowned suicide prevention organisation and have identified a key value of human life in the context of financial loss to the economy as £1,670,000. This financial cost is of course arbitrary compared to the personal cost which individuals, families and the wider community endure, but it does indicate some of the financial burden placed on society within this context for the value of suicide prevention work and projects.

A greater cost, one could argue, is the cost of doing nothing when a location is identified as a high-risk location and continuing to choose not to implement suicide deterrent systems. This choice and it is a choice, to ignore the both morale and ongoing financial cost of suicide by failing to implement deterrence and prevention systems and processes is unsustainable and I argue unjustifiable.

Within this paper I will focus on:

- The construction and installation of restriction of means linked with suicide from high-risk locations and structures; including signage, CCTV, reducing access and Suicide Deterrent Systems.
- Collection of data to map vulnerability and target supportive action to high-risk individuals or groups
- De-escalating persons in crisis and focusing these persons on pathways of care outside of the criminal justice system.
- Managing vulnerability of populations at risk of suicide by inter-agency cooperation across law enforcement and health and social services.

I believe that there is cause and justification to install SDS's at specific high-risk locations, that this is both morally and financially a correct response to the risk posed by these locations. In these high-risk locations, the structures have progressed from a location where someone suicides to a location where people go with the intention of suiciding, however, not always following through**.**

The underlying current of:

Thoughts + behaviours + access to means

These are the area of activity that we need to be focussing our attention on.

The Suicide Intervention Triangle (SIT), which shows the process of providing aid to a person in crisis, is the key to successful intervention. Similar to the fire triangle, or the crime prevention triangle that many law enforcement and fire departments use to respond to risks, the Suicide Intervention Triangle, combined with the activities of De-escalation, Observe the data, Work in partnership and New Designs (DOWN), will work effectively to help persons in crisis and reduce the risk of future suicides.

"I argue that once this effective tipping point has been reached for any location to become a place <u>where</u> people go with the intention of suicide, this is the point that restrictions of means need to be considered"

Bob Blemmings C.F. 2019

The SDS's cannot, and will not, be effective in preventing all suicides. However, they will restrict the means of a person in crisis being able to suicide, and allow for an increased intervention gap to help the individual, restricting the immediate suicide risk and allow help to be focused on the individual in immediate crisis.

Within this report I will look at a number of bridge case studies to show what current activity is being implemented and assessed in these locations.

Restricting means of suicide, however, is only one aspect when considering suicide prevention. We also need to focus activity and thoughts on:

- Effective crisis intervention and de-escalation, guiding people into assessed pathways of care; combining the best of law enforcement and health and social care at the point of need.
- Safer design of public and large-scale civil works projects to help prevent locations and public works projects from being susceptible to the possibility of becoming a high-risk suicide location.

There is no one solution to tackling the problem of suicide; it is often a multi-layered set of circumstances and conditions that cause persons to consider suicide but if we identify suicide risk locations, and we do know these, then we need to start developing solutions around both the location and focus activity on the persons who may wish to utilise it within their suicide plan.

On my travels I have had the opportunity to speak with many individuals and team who are working in the fields of mental health provision and suicide prevention, and there are many conversations that have informed my considerations, and as such my recommendations. One such individual is Dr Mark Sinyor, psychiatrist at Sunnybrook health sciences centre in Toronto, as we discussed suicide prevention at high risk locations. He stated to me:

"The majority of suicidal impulses are fleeting – that is why restrictions to the access of means work."

Dr Mark Sinyor, 2019

Case Study 1

- Location – Toronto
- Date – April 2019
- Bridges visited – Prince Edward viaduct, Millwood Bridge, Pearson Street Bridge, Burgoyne Bridge.

The Luminous Veil deterrence System, on The Prince Edward Viaduct.

C/Insp Blemmings (R) with Chris Riegert of the Emergency Task Force

Toronto is a very populous city with a number of high risk locations, probably the most well know of these is the “Prince Edward Viaduct”. This location has long been associated with suicide and suicide attempts and has a deterrence system in place known as the Luminous Veil. There are number of well researched and available articles relating to this structure and its impact on suicide prevent across the city of Toronto, I will not go into further detail on these in this paper but they are readily available for further reading on the subject.

At the location, the barrier is the most obvious feature but there is also signage in place providing the number for the Toronto Distress centre.

Crisis line signage, Prince Edward Viaduct

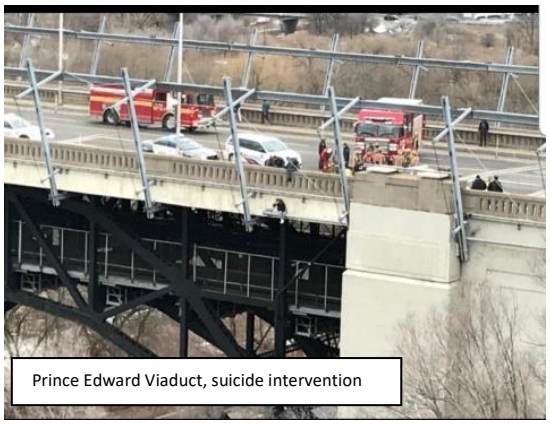
As I previously mentioned no deterrence system can restrict access to all individual as is evidenced by the repair work carried out to the barrier system seen in the pictures below:


Luminous Veil cut to allow access to subject in crisis


Luminous Veil repair, Prince Edward Viaduct

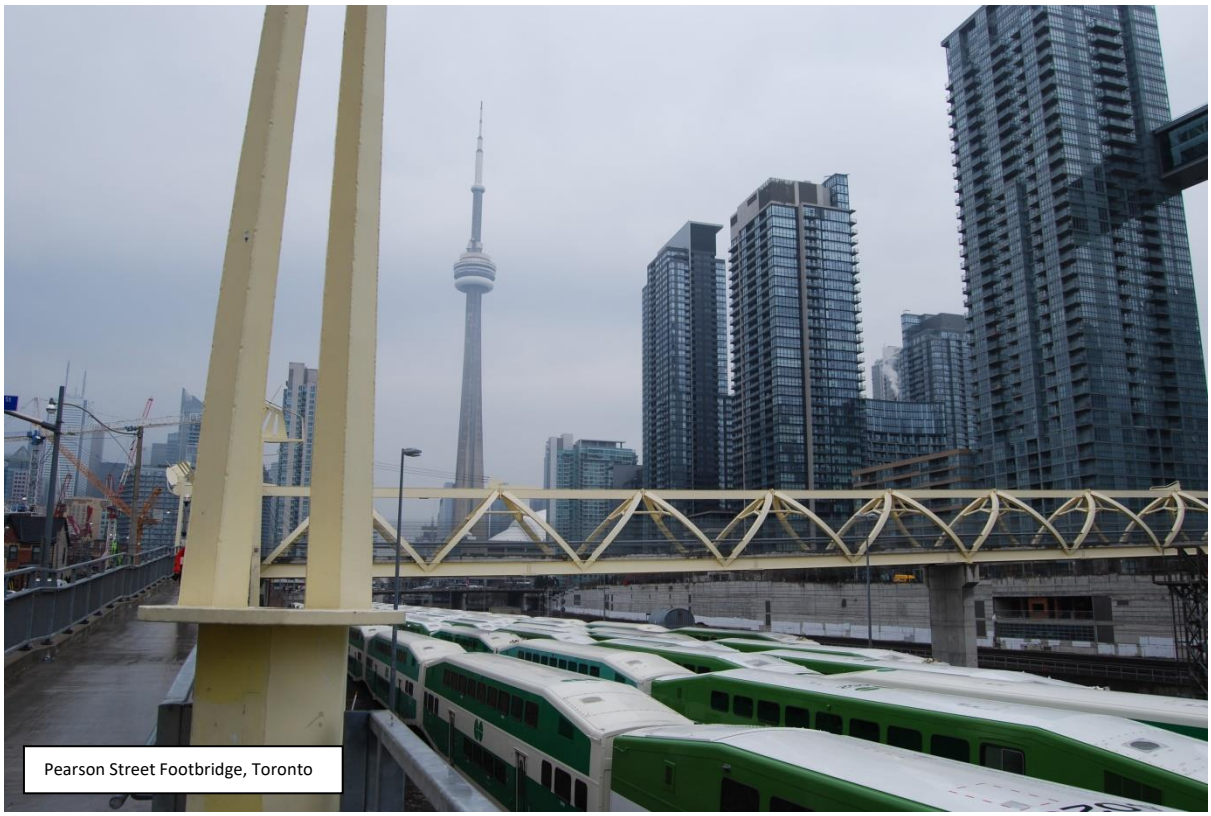
This repair was due to a male who climbed over the wall at the end of the bridge and who then climbed across the exterior of the barrier to the beginning of the bridge archway. This male was positively engaged with by crisis negotiators and recovered safely by cutting through the steel rods. This incident evidences that a system designed to deter and restrict ease of access to persons in a state of crisis who may choose a location in a moment of desperation, may be circumvented by a determined individual. It also leads us to the conclusion that systems placed must be able to be

readily accessed by emergency services to recover persons as required. I will show in further detail a simple system in place at the Foresthill Bridge where this is in use.



Prince Edward Viaduct, suicide intervention

The Pearson Street Bridge in Toronto is an example of an appealing bridge with a considered SDS in place. This bridge spans a major train line junction and would have been a high risk location but for the design of the bridge. The structure has been used in the T.V. series, “The Handmaid’s Tale”, and is an example of good design and an appealing location which has now attracted the attention of the T.V. and film industry.



Pearson Street Footbridge, Toronto

Pearson Street Footbridge, Toronto

There remain other locations within the city, such as the Millwood Bridge, from which person's suicide. In some of these locations where the repeated nature of suicide is observed some initial measures are installed as observed below.

The Millwood Bridge, Toronto

This signage combines both the ability to raise awareness for members of the public, it also acts as a message to the individual in crisis highlighting the services available.

Another example is the Burgoyne Bridge, which constructed in 2017 has also been identified as a high risk location for suicide. The initial bridge construction had a further section of screening retrofitted after construction to deter suicide with signage installed to promote access to crisis services.

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The Burgoyne Bridge, St Catherines


The Burgoyne Bridge, St Catherines

Retrofitted Suicide Deterrence Netting at the Burgoyne Bridge, St Catherines.

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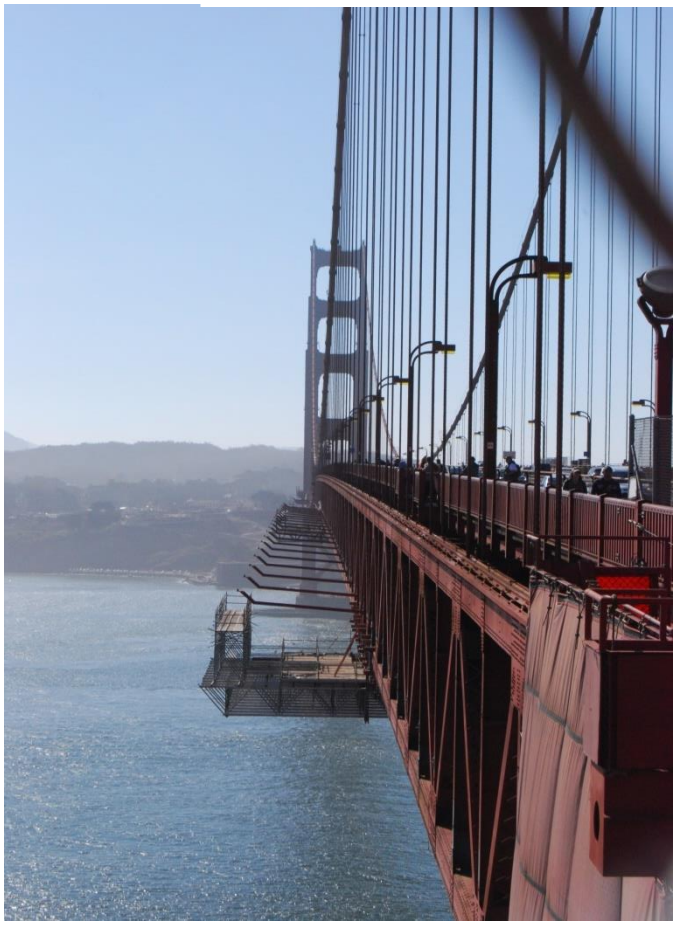
Case Study 2

- Location – San Francisco
- Date – October 2019
- Bridge visited – Golden Gate Bridge

The Golden Gate Bridge, San Francisco

The Golden Gate Bridge in San Francisco, probably the most iconic bridge in California if not the entire United States.

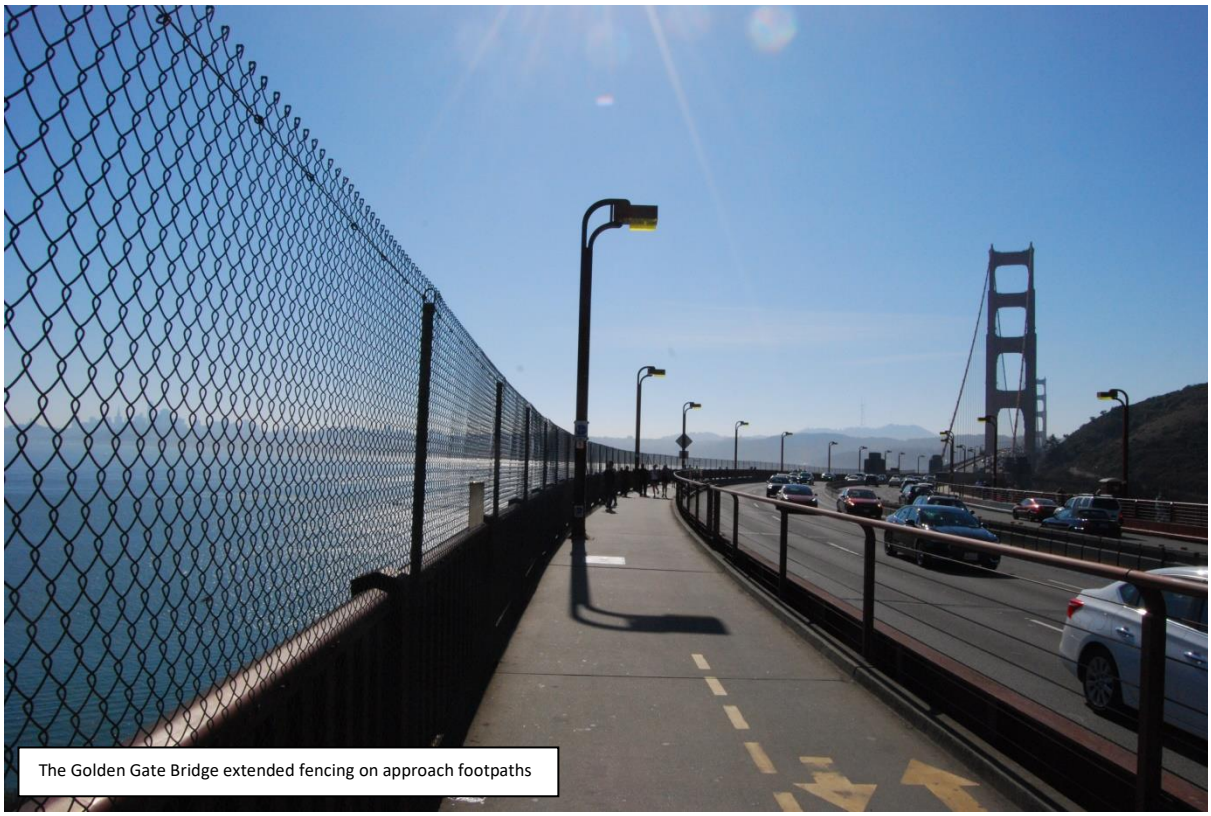


The Golden Gate Bridge Suicide Deterrence Netting

The Bridge presently has a number of restrictions of means facilities in place such as crisis lines, signage and fencing.

A new addition is the suicide prevention net to deter individuals from jumping but which will also allow the recovery of persons from the netting.

The Golden Gate Bridge helpline signage



The Golden Gate Bridge extended fencing on approach footpaths

Extended fencing alongside the pathway to the Golden Gate Bridge.

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The Golden Gate Bridge helpline signage

Crisis counselling signage is placed at various locations across the site. This sign is on the fencing which encloses the pathway under the bridge which takes pedestrians from one side of the bridge to the other pathway.

"I look around and see beauty and wonder, all that there is to enjoy in this world; but I also see, from my experience, the horrifying ways that individuals end their lives. The bridges, monuments and natural features that many enjoy are also locations that others use as a means to their end; it is a terrible truth that where some of us see beauty, others see an opportunity to bring their lives to a close."

Bob Blemmings C.F. 2019

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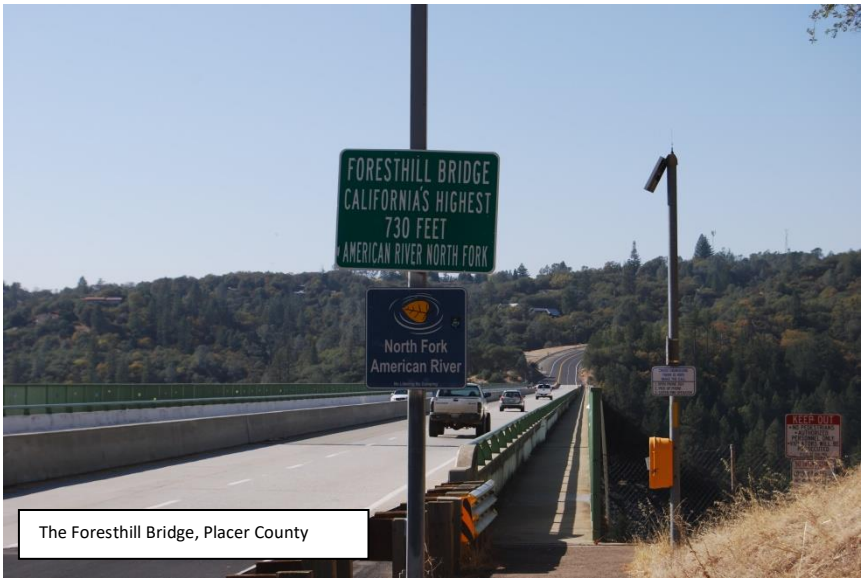
Case Study 3

- Location – Placer County
- Date – November 2019
- Bridge visited – Foresthill Bridge

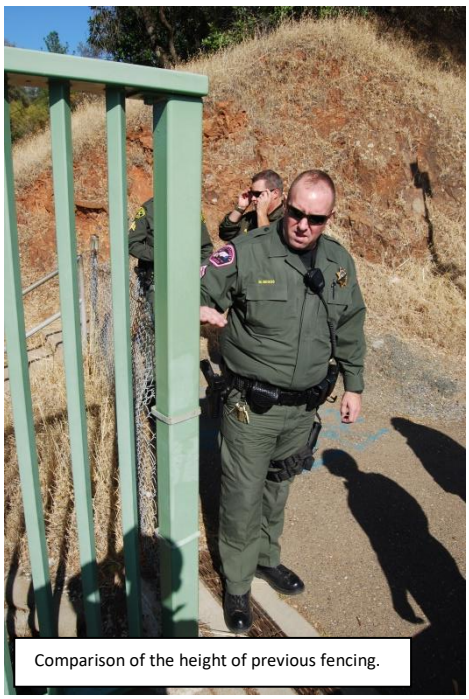
The Foresthill Bridge, Placer County

The Foresthill Bridge in Placer County north of San Francisco has been the location of a high number of suicides in recent years. The highest bridge in California at 730 feet, the barrier fencing was increased in height due to the number of suicides. Local officers showed me the height of the previous fencing compared to the new panels.



The Foresthill Bridge, Placer County

Placer County Sergeant indicating the previous height of the barrier fencing compared to the existing structure.



Comparison of the height of previous fencing.

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The Foresthill Bridge extended height fencing and crisis line.

The bridge has signage and a crisis phone line installed. On most panels of the fencing messages of hope are placed indicating the local knowledge of the use of the bridge to suicide and attempts by persons to intervene and show care to persons in crisis.

"Suicide is not inevitable, it can be prevented, and one way to do this is to restrict the access to means by which a person would choose to suicide. If we can intervene in someone's thoughts, their behaviours, or by removing or restricting a method of suicide we may be able to save a life, or many lives."

Bob Blemmings C.F. 2019

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The Foresthill Bridge, evidence of fencing removal

The barrier panels are built and installed in 6 foot sections which can be removed to allow access to the exterior of the bridge structure.

These photographs show evidence of these panels having been removed to gain access to individuals who had climbed over the barrier, and who had been prevented from falling by intervening members of the public and emergency services.

C/Insp Bob Blemmings (C) with members of Placer County Police and Negotiators. As we took this photograph a report came in of a person in crisis attempting to climb over the Foresthill bridge suicide deterrence barrier. Local parks police attended alongside the reporting member of public and prevented a suicide, taking the person into care.

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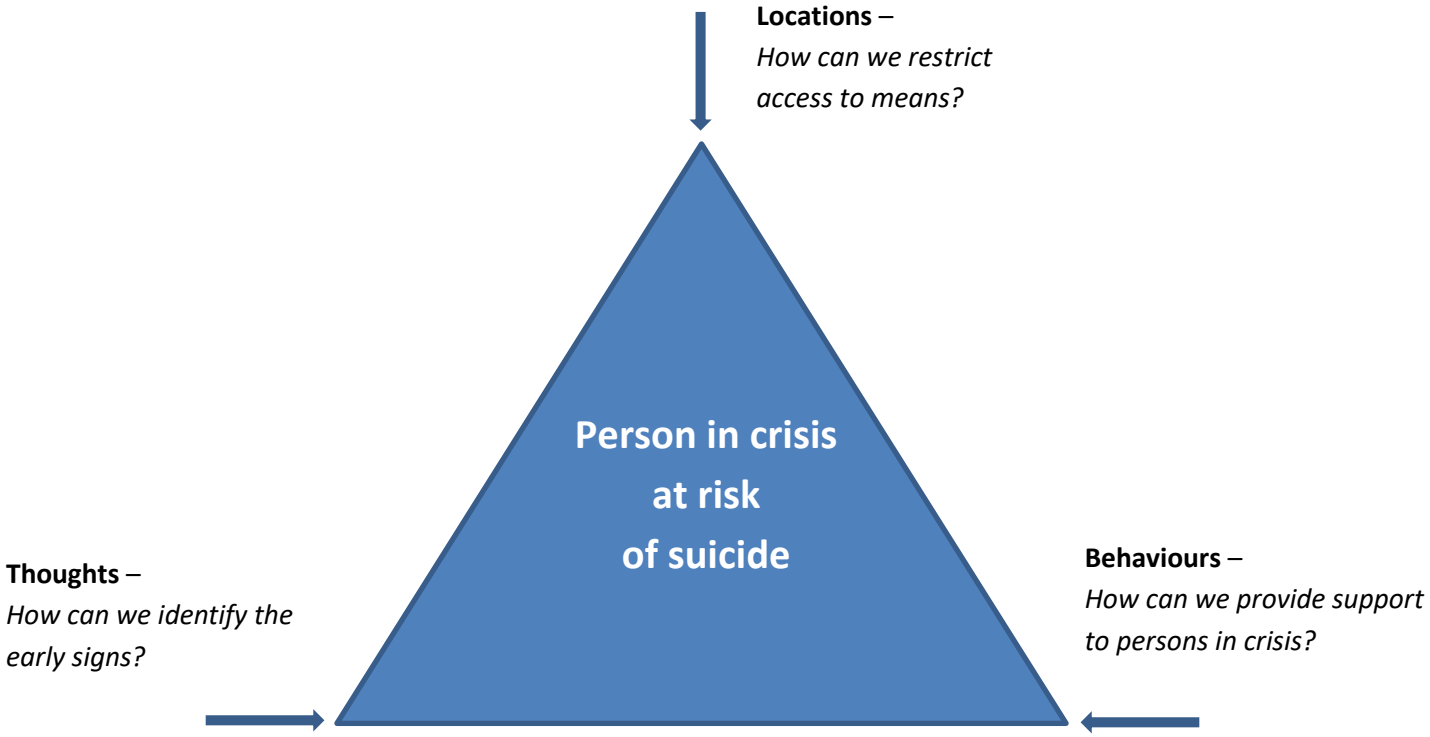
The Suicide Intervention Triangle (SIT)

The Suicide Intervention Triangle is a model designed to show how the removal of one element of suicidal activity, whether that be the thoughts, the behaviours, or the access to means of suicide, can help to save a life.

The underlying current of: thoughts + behaviours + access to means, is the area of activity that we need to be focussing our activity on. This triangle of processes is a key to successful intervention and is similar to the fire triangle or the crime prevention triangle that many law enforcement and fire departments use to respond to risks.



"There is a common phrase in Derry when persons are in high emotional state or crisis – "I'm away to the bridges", this colloquial phrase hints at the background noise that a high-risk suicide location presents; that the means to suicide is accessible."

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Extending the Intervention Gap

Time is critical.

Having negotiated with people in crisis in domestic situations, criminal barricades, international kidnappings, and individuals in suicide crisis which has led to me talking people off bridges and cliffs; I have seen that the opportunity to intervene either physically, or verbally, with the individual in crisis can be the split second action that has saved a life.

Through my 2 year review of persons in crisis in Derry/Londonderry I have seen many occasions of successful, and some unsuccessful interventions. I have seen the occasion where the benefit of that split second has saved lives.

I have seen officers run to people in crisis, jumping road barriers to grasp at men and women trying to jump off railings. I have witnessed members of the public stop and recognise the signs of a person in crisis and engage with them prior to the arrival of police and search and rescue services. I have also seen officers running to a person on the wrong side of the railings on the Foyle bridge, and the anguish on their faces as there just didn't get there in time to make that live saving hold on a person who suicided.

I have seen a car stop on the Foyle Bridge and counted the 6 seconds that it took for the driver to leave his vehicle, step over the road/pathway barrier and simply vault over the waist high railing falling river below.

As we become more aware as individuals and a nation of the pressures of modern life, and the awareness that mental health issues can and does affect everyone then I argue that we need to extend that opportunity of intervention in the physical realm of high-risk locations.

These incidents may have been prevented, or delayed by making the access to this means just that little bit harder.

The difference of a waist high barrier being raised to head height makes it that much harder to access the means of tragic death.

It allows those few seconds, and that is all it takes, for a member of the public to speak to the person, to allow blue light responders time to approach, to allow that fleeting desperation to pass.

When we identify and study high risk locations, we need to look through the eyes of a person in that moment of fleeting despair and put in place those steps to prevent the harm that can't be taken back. Each missed opportunity to do this fails to extend the intervention gap and makes it that much harder to save a life.

De-escalation, Observe the data, Working in Partnership and New Design (DOWN)

De-escalation

A state of Mental Health Crisis can be defined as "An event or experience in which the individual's normal coping mechanisms are overwhelmed, causing them to have an extreme emotional, physical, mental and/or behavioural response. Individuals experiencing a mental health crisis may or may not be affected by mental illness."

Mental health Crisis can also be associated with feelings of despair

As a Negotiator, I have spoken with persons whose language use indicates feelings of despair many times. The use of the 8 "lesses" is a clue to this internal suffering and sense of suffering alone and in pain:

1. Hopeless
2. Helpless
3. Powerless
4. Useless
5. Worthless
6. Purposeless
7. Meaningless
8. Pointless

De-escalation can commence with the individual in crisis. If the person has been in a Mental Health Crisis on a previous occasion and has received help, they may have been presented with a self-help strategy or safety plan for future situations.

One such model is the coping card I saw in use in Sunnybrook Health Sciences Centre in Toronto. This simple tri-fold pamphlet is provided to the user and presents 4 questions to assist the user in de-escalating their crisis:

1. What are my warning signs? – (Sad thoughts or feelings; behaviour – social withdrawal; physical symptoms – sleep problems).
2. How can I distract myself? – (Listening to music, watching TV or a movie, spending time with a pet, exercising and journaling).
3. What skills can I learn to lower my distress? – (Breathing exercises, progressive muscle relaxation, meditation, create a hope kit, visit mental health websites).
4. What can give my life meaning? – (People, places, activities, values, dreams).

The final page is designed to be completed by the individual, where they write down the name and number of such persons described below:

- Who I can call for distraction?
- Who do I trust to share my distress and ask for help?
- Who can I contact in my expert support system?

This simple card is a good example of a first stage, self-de-escalation mechanism and includes the safety reminder to encourage people to "Remember to check your environment and make sure it is safe. Stay away from objects or people that could put you at risk. For example, if you have an alcohol problem, avoid having alcohol in your home."

De-escalation considerations for police responders

De-escalation techniques are of use to police officers as the create time and space to increase the intervention gap when dealing with a person in crisis, and they decrease the likelihood of the incident ending with the use of force or violence.

These opportunities for a calmer and peaceful outcome therefore decreases the likelihood of the use of arrest powers, and gives opportunities to look for alternative outcomes rather than those criminal justice outcomes of arrest and detention.

The arrest of the individual in crisis risks further compounding that person's negative feelings and beliefs of themselves; it risks compounding that sense that they are wrong or an offender in some way and stigmatizing them to friends, family or community.

De-escalation of the individual in crisis can remove the need for emergency assessment and reintroduce them into a standard pathway of care and appointments which will allow for a more cost effective treatment regime.

De-escalation as a policing principle – Section 32 of The Police (Northern Ireland) Act puts in legislation the duties of a police officer, the first of these is:

"To protect life"

Therefore as police officers we can and should always use some basic principles to de-escalate a situation, and indeed an individual, we should always make de-escalation a primary tactic.

De-escalation principles:

- Space – do not crowd an individual in crisis, approach calmly and be alert to verbal and physical cues such as flinching backwards
- Time – Slow down communication and give space to the individual to develop rapport
- Listen – The most important of all. Allow the person to explain their feelings and thoughts, and vent emotion if needed

- Respect – Trust is critical, never be dismissive to a subject in crisis, as once lost trust is very hard to regain

As a police negotiator, and a trainer of negotiators, I have used and continue to use the national training of the behavioural change staircase and recommend this to first responding officers and stator professionals. We engage effectively with the person in crisis using the above principles to be able to work from initial interaction to the goal of behavioural change and bringing the subject to safety. The stages of progression are summarised as follows:

- Empathy
- Rapport
- Influence
- Behavioural change

The communication skills that allow trained negotiators to proceed up the behavioural change staircase can be summarised with the mnemonic MORE PIES:

- Minimal encouragers (mmm, uh-huh)
- Open Questions (What, how)
- Reflection (AKA echoing, repeat the last few significant words)
- Emotional labelling (You sound…..id an emotion)
- Paraphrasing (Short summary)
- I messages (I feel, when you…)
- Effective use of pauses (give time to talk and absorb important points)
- Summary (Ok, so what you have felt or experienced is, outline in order as subject stated)

De-escalation does not prevent or restrict officers from performing the arrest of a subject, or the use of the power of detention for assessment under the Mental Health Order/Act. It can allow the need for detention or arrest to be considered alongside other options such as:

- Provision of self-help guidance and coping cards to further reduce crisis and increase safety
- The reduction of immediate risk and agreement of professionals, with the individual that the period of crisis is over to allow the person to enter into agreed pathways of care through normal appointment processes
- Emergency services carrying out a warm handover to voluntary crisis intervention charities or supported mental health support bodies

What is key is that officers/staff and volunteers are given training to de-escalate and that there is considered provision for alternatives to detention or the use of A&E as a 1st resort. We need to develop options to allow the de-escalated person to remain personally safe, and also remain in control of their care pathways, and that services continually assess options for care rather than the one size fits all often criminal justice led pathway of arrest and detain. The act of arresting the individual in mental health crisis, restraining them and placing them in the back of a police vehicle can only cause further anguish and risks not only stigmatising the individual but risks exposing them

to offences of assault on police, attempted criminal damage to property or possible public order offences.

Criminalisation of the individual will not occur on all occasions, but if we continue to try and arrest our way out of mental health calls and reports of concerns for safety, the risk will remain; we need to find a better way to approach these incidents and give blue light responders pathways which focus on help rather than hold.

Observe the Data

As professionals across statutory and voluntary bodies we have access to a wide range of data concerning persons in crisis, we need to ensure we are critically considering the sources of data to assess if they are sufficient to provide an insight into the problem of suicide at high risk locations.

We need to develop professional curiosity at the local and national level and be prepared to listen to the background noise of desperation evident in colloquial phrasing such as in Derry/Londonderry. We need to actively investigate our towns and cities to ensure we have as full a picture as possible for not only suicide locations, which can be identified through current recording mechanisms such as the police SD1 form (Suicide) or from coroners reports, but also places and locations where blue light agencies and volunteers are responding to persons in crisis or those who are exhibiting pre-suicidal behaviours.

Once this information is available through agreed memorandums of understanding (MOU) or Information sharing agreements (ISA's) we need to consider how best to approach each and every location that people go to, or where people complete suicide.

This data set of locations and observable behaviours must then be shared with council planners and other architects, designers and civil engineers to inform their thinking around designing in or requiring the consideration and provision of suicide deterrence systems in public accessed projects.

As you will see further in this report through studying the available data of persons in crisis in Derry/Londonderry there are clear patterns of behaviour and attendance at high risk locations. This data can be analysed and used to provide services to those sections of the community, it can direct focussed support to repeat attendees, and it can allow both statutory and voluntary services to direct their resource to the areas and location of concerns according to the times and dates that the data identifies as key.

Work in Partnership

Working in partnership and interoperability of police officers, the health service and social services reduces the criminalisation of the individual in crisis; it smooths interaction between services which will help to maintain persons on agreed pathways of care reducing the need to push people towards accident and emergency departments. One such model I observed was the creation of Mobile crisis intervention teams (MCIT) which allow police responders to patrol with social workers or nurses. In each city I visited these teams were recognised as providing not only a very high quality of service to the individual in crisis but worked to direct the individual away from hospital care and the use of very busy accident and emergency departments into their own agreed pathway of care and treatment.

Working in Partnership; Mobile Crisis Intervention Teams (MCIT)

Leena and Paul: MCIT on patrol, Toronto.

One of the MCIT teams on patrol in Toronto. Police officers and nurses patrol together and respond to a variety or mental health related calls providing options for both the individual in crisis but also the first responders.

I have observed the MCIT model in practice in Toronto, St. Catherine's and San Francisco. In each of these locations it is clear from the officers I have spoken to that this model of police practice alongside nurses or social workers is seen as a benefit to the persons in crisis, and to the service as a whole.

The goal is to get the individual the right help from the initial interaction with services. The added benefits are to reduce the time we spend with the person in crisis whilst getting them the help they need, they reduce the criminalisation of the individual in crisis, to reduce the stigmatisation of mental health and promote wellbeing across all services.

In Toronto the Emergency Task Force officers (ETF), who deploy as emergency responders to a range of serious life at risk incidents, acknowledge the benefit of this multiagency frontline approach.

The MCIT are sent to assist primary responders where there is an element of mental health crisis, they deescalate and provide diversionary and treatment options to the officers in primary response roles. Where urgent hospital assessment or treatment is required they can ease the pathway of care by providing legitimate and qualified pre-arrival assessment of the individual.

MCIT is a transition from police custody to a pathway into either hospital or community care. Partnering with hospitals through MCIT allows better awareness of partners systems; it allows an opening up of access to differing streams of care bespoke to the needs of that community or location.

The roles we train for in our work lives generally focus us on our own services powers and policies when presented with challenging situations. In the case of police officers they generally arrest out of public safety considerations, when teamed up with nurses or social workers they can identify concurrent conditions which not only allow for options around identifying the underlying issues. Using the power of de-escalation at the scene allows for emergency room pre-screening to ease access to hospital facilities and gives the confidence to consider and use community treatment options.

MCIT officers in Toronto attend not only occurrences where there is a suspected or reported mental health crisis, but also:

1. Incidents where drugs/alcohol are precipitating factors
2. Domestic abuse related incidents
3. Incidents involving young persons who are presenting with Autism or Asperger's
4. Incidents where dementia, or Alzheimer's may be a factor

The MICT model raises the knowledge and awareness of mental health issues in the individual officers and in their colleagues and wider teams. Officers in the units have seen individuals in crisis directed away from criminal justice outcomes towards health service outcomes. This provides the additional benefit of reducing the time officers attend A&E units reducing the demand on these services.

The benefits of MCIT can be listed as follows:

1. Directs help to those in need as opposed to pushing them into the criminal justice system
2. Reduces the costs of police detention, court time and prison accommodation
3. Reduces the cost of officer time waiting in A&E
4. Reduces the demand on A&E units
5. Reduces the risk of violence of violent outcomes between the individual in crisis, community and police
6. Increases the knowledge of mental health issues within the police service
7. Nurses attending calls with police can allow focus on help, as opposed to blame and fault and divert from hospital into standard appointments and agreed pathways of care
8. Social workers attending can assess vulnerability and engagement with services to address underlying issues

9. Good relations and understanding of roles and partners procedures can ease admissions when required by making the admission assessment process more efficient and effective

The MCIT model is clear in its desire to give the best and most appropriate frontline options to the person in crisis or where the individual's mental health may be a factor in the incident being responded to. It is also clear that any criminal offending elements are not dismissed or ignored. The inclusion of the MCIT within the policing response can allow for better consideration of alternative outcomes such as diversionary disposal and in the more serious offences can inform the public prosecution service in applying the tests for prosecution and may indeed result over time in the provision of mental health specific courts. These courts can be constituted similar to courts specific for offences involving domestic violence, the court can become specialised and more informed about the precipitating factors in the offending and sentencing can then be directed to such outcomes and mandatory assessment and treatment options.

MCIT as a joint service is a highly visible partnership approach to the far reaching effects of suicide and crisis intervention. It will show that services are sensitive and informed and that they are focussed on bringing care to individuals in need. MCIT acts to divert individual from criminalisation and stigmatisation, we can be socially informed and societally sensitive to the needs of the individual, families and the community.

New Design

Good design considers all aspects of a planned structure, and includes the awareness that some structures and locations may present the opportunity to suicide.

In the case of the Bloor Street Bridge, the question started being asked: "Why are we not installing a restriction of means barrier. Is it only about the money?"

When I met with Mr John O'Grady of the TTC (Toronto Transit Commission) we discussed the number of suicides that occurred across the transit network, from the trains, subways and bus routes. In the case of the subway system the highest number of suicides occurs as the train enters the platform area. At this time the train is proceeding at speed and the train operator has less time to apply any braking. Once design structure being implemented is the use of platform edge doors, this secures the area and prevents an individual access to the train line. This alone will act to restrict access to means within the TTC subway system but prior to installation a number of other schemes are in place. The TTC has been in partnership with Toronto Crisis link since 2011 and on every platform in the system there is a phone with a direct dial number for the crisis line. The platforms also have crisis line signage to promote a positive message of help to persons in need.

As John O'Grady stated when discussing the ongoing investment in suicide deterrence systems:

"This is not a business decision based on cost – benefit analysis. This is a humanity issue. This is a demonstrable way to show we care for individuals".

Application of Data Observation and assessment in Derry/Londonderry

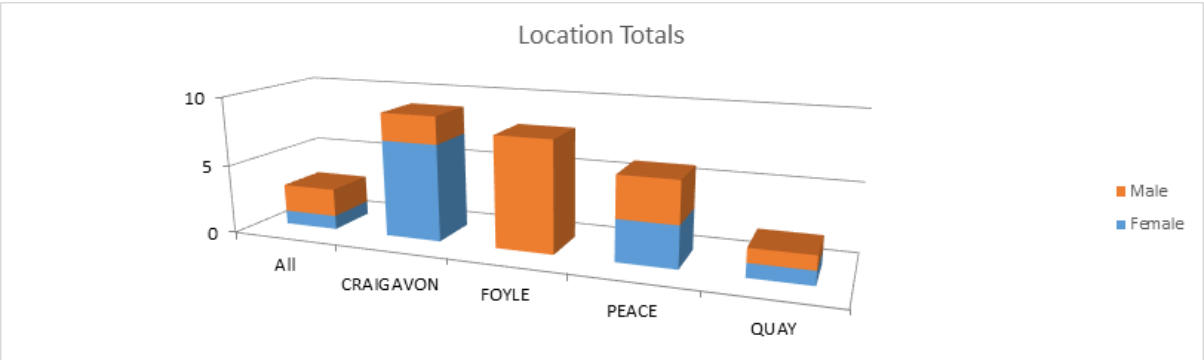
Through an analysis of data relating to persons in crisis in Derry/Londonderry from the period September 2019 – August 2020 as provided by City Centre CCTV observations and records we identified:

- There were 414 CCTV bridge incidents reported from 01 September 2019 until 31 August 2020 in the City. These numbers includes actual suicides, persons in water, incidents where persons noted looking distressed, or persons who were being restrained by persons to stop them entering the water at the bridges in the City.
- Of the 414 incidents, 5 deaths occurred following persons entering the water. A further suicide occurred on 11th November; male jumped from Peace Bridge in early hours of the morning.
- A further 9 incidents involved persons submerged in the water either at Craigavon or Foyle bridges.

The information provided for these incidents showed some observable trends in times and locations with a quarter of all incidents occurring on a Sunday between 22:00hrs and 02:00hrs, this gives a clear opportunity for emergency responding officers to pro-actively patrol high risk locations to provide early identification of persons in crisis and the ability to provide a lifesaving intervention.

Significantly in terms of locations where death by suicide occurs; of the 6 deaths recorded in Derry/Londonderry during this period, 5 were as a result of falls from the Foyle Bridge. This gives a clear indication during this observed period that a suicide deterrence system should be considered for the Foyle Bridge and that an extension in the height of the side rails of this bridge would be effective in allowing an intervention response from either emergency services or members of the public.

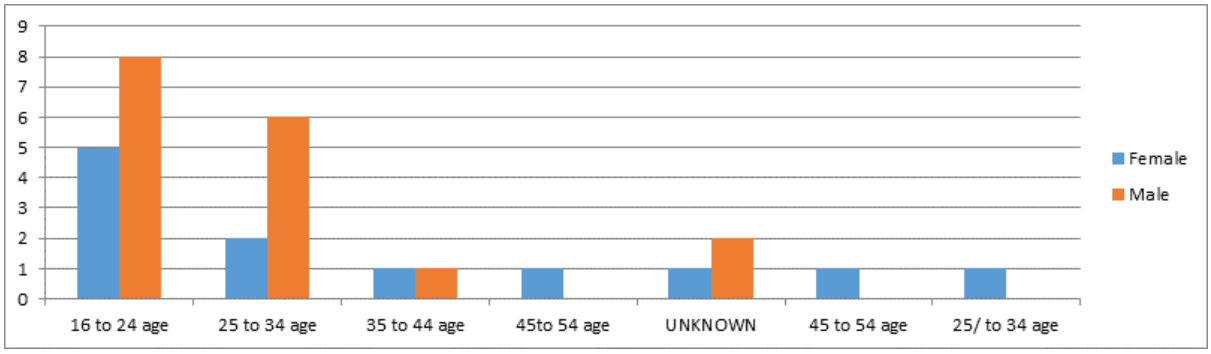
Locations:



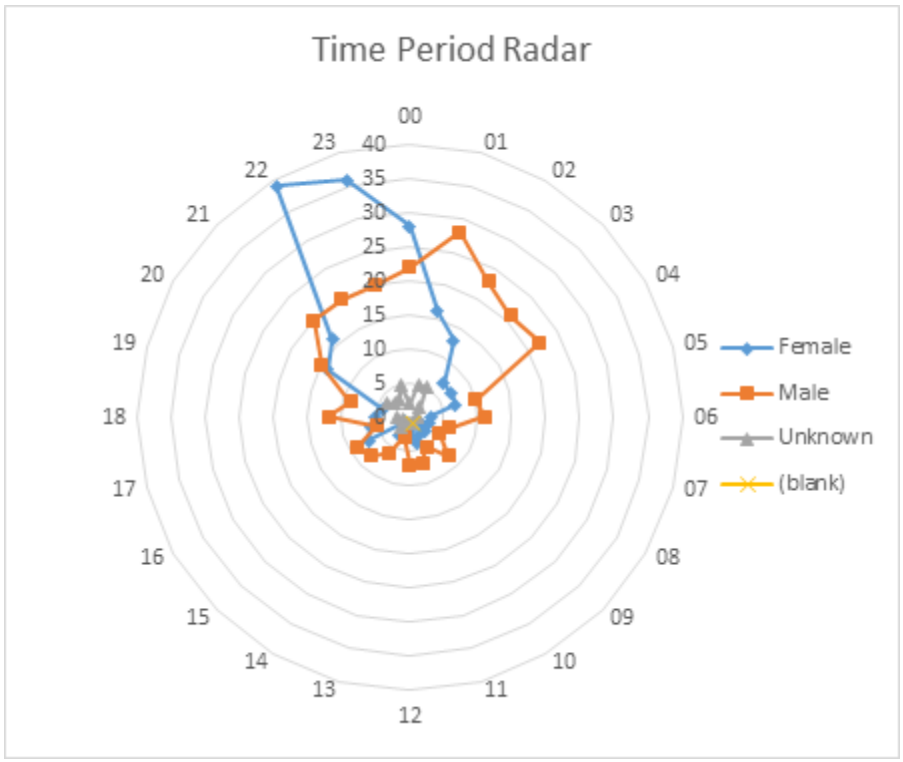
To contact the Samaritans Helpline call free on 116123.

To contact the Police you can use the non-emergency 101 number, or in an emergency 999.

Age range of individuals in crisis:



Time radar:



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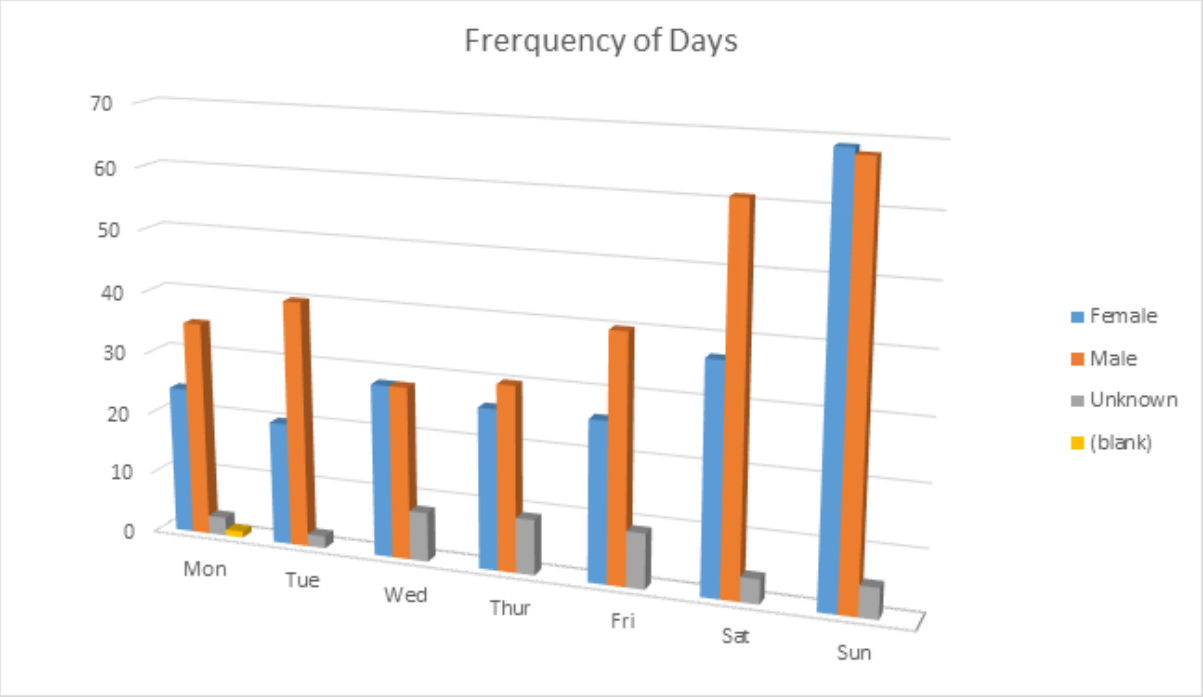
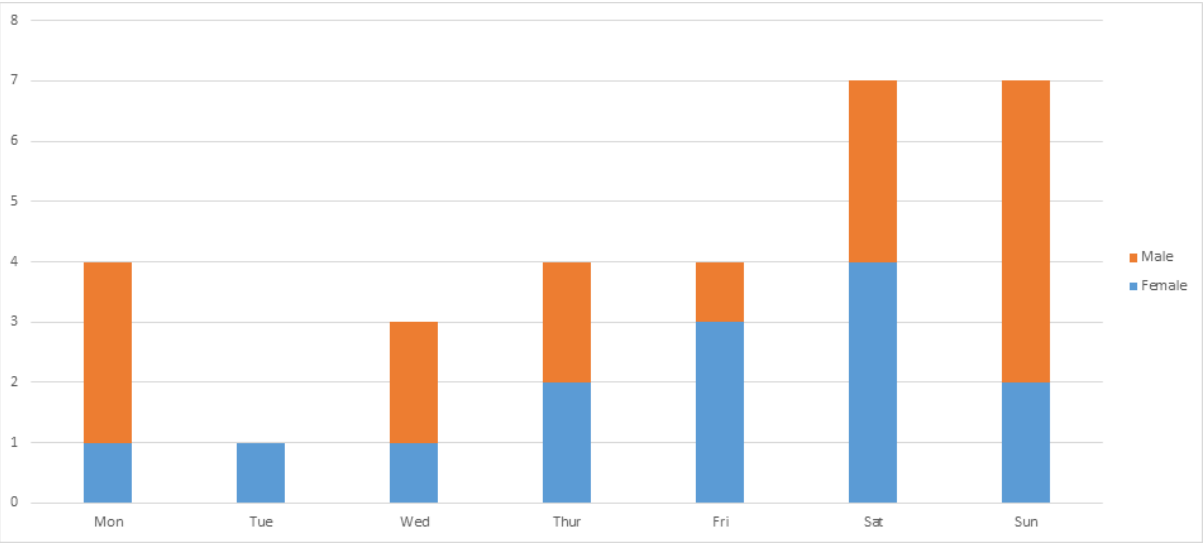
Daily Frequency:



Potentially significantly when we consider the 2021 data gathered to date, in comparison to that obtained for 2019/2020 we note that in February 2020 there were 36 incidents of crisis. For February 2021 we have 35 incidents with approximately the same amount of male to female ratios this showing the embedded nature of the issue and the year on year attendance of persons in crisis to these identified high risk locations.

The daily frequency for February 2021 shows the following:



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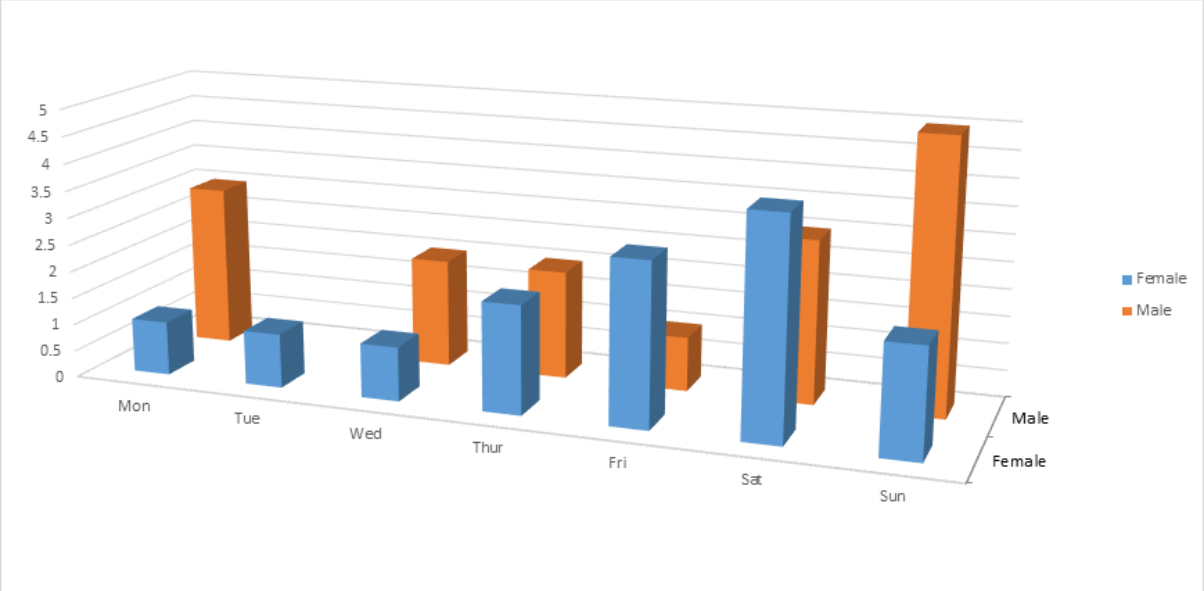

With both males and females appearing in crisis significantly increased on the weekend days with males appearing to attend more frequently on Sunday's and females on Saturdays.

Most significantly if this pattern is repeated across the next year with a similar ratio of persons in crisis to resulting suicides, we are possibly looking at a further 5 deaths from suicide in 2021/2022. If we take into account, "The Samaritans", key value of human life in the context of financial loss to the economy as £1,670,000 per individual who suicides.

A simple and terrible multiplication of the number of suicides relating to the cost to society would indicate that for a further 5 precious lives lost this equates to £8.35 million cost to the local and national economy.

This financial cost is of course arbitrary compared to the personal cost which individuals, families and the wider community but I have to ask the question at what point does the investment in a suicide deterrent system on the Foyle bridge become a financial and moral imperative.

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Conclusions and Recommendations

Suicide is a tragic end to a life. Suicide is not inevitable, it can be prevented.

I have seen emergency responders and members of the public take action and save lives, and been part of occasions where lives have been saved. Each time a life is saved or a suicide occurs we need to learn from the situation and we should be critically considering the locations where people have chosen to suicide to assess if we can put a measure in place to prevent, or restrict someone else from using that place or location.

When we consider high risk locations we need to do the following:

- Blue light services, city and town councils and voluntary agencies should adopt information sharing agreements to gather each party's information on repeat suicide, or attempted suicide locations
- Primary responders and city or town councils should create a register of high risk locations and assess if a range of restrictions of means measures are appropriate for that location or site
- Frontline first responders Police/Ambulance should be trained in de-escalation techniques
- Council planning departments should consider locations for planned public architecture through an assessment of potential for the site or structure to be a location from which suicide could occur, and be required to design in restrictions of means
- Police and health bodies should consider the Mobile Crisis Intervention Model (MCIT) as a joint agency response to persons in crisis or mental ill health, to divert persons from A&E depts. and ensure uptake of appropriate pathways of care
- Bridges, multi-storey car parks, natural features or monuments where it is know that people have suicided or attempted suicide should be assessed for placement of or retrofitting of suicide deterrent systems

"I never worry about action, only inaction"

Sir Winston Churchill

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