Public Health England

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National Suicide Prevention Alliance

Local suicide prevention planning

A practice resource

October 2016

I urge local authorities, clinical commissioning groups and NHS service providers to look beyond the headline suicide figures for your particular geographical area and avoid falling into the potential trap of thinking suicide needn't be a priority issue.

Every life lost represents someone's partner, child, friend or colleague, and their death will profoundly affect people in their family, workplace, club and residential neighbourhood.

This will impact their ability to work effectively, if at all; to continue with caring responsibilities and to have satisfying relationships. This will, in turn, significantly raise their own risk of future mental ill-health and suicide.

Suicide is preventable and we must all work together to develop community based suicide prevention plans and activities that reach out to every part of England.

I urge you to ensure that every person you represent is protected from the risk of suicide and its damaging impact on so many lives.

Hamish Elvidge
Bereaved parent and chair,
Matthew Elvidge Trust

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Foreword

Every day in England around 13 people take their own lives.[1] The effects can reach into every community and have a devastating impact on families, friends, colleagues and others. Each one of these deaths is a tragedy. Every local area, whether its own suicide rate is high or low, should make suicide prevention a priority.

Suicide risk reflects wider inequalities as there are marked differences in suicide rates according to people's social and economic circumstances with those in poorer communities more likely to be affected. Approaches aiming to protect those who are vulnerable in this way - people in debt or homeless, for example - are vital to reducing risk.

Local authorities are well placed to prevent suicide because their work on public health addresses many of the risk factors, such as alcohol and drug misuse, and spans efforts to address wider determinants of health such as employment and housing. There are also important and varied opportunities to reach local people who are not in contact with health services through on-line initiatives or working with the third sector.

However, local authorities cannot do this on their own. A local suicide prevention plan will combine actions by local authorities, mental health and health care services, primary care, community based organisations and voluntary agencies, employers, schools, colleges and universities, the police, transport services, prisons and others.

Primary and secondary health care are crucial - they will come into contact with high risk groups such as people who have long-term physical illness or are isolated or depressed. They should be key partners to local authorities and ensure that their work is integral to local suicide audit and action plans.

Although not within the scope of this resource, it is vital that suicide prevention builds on any existing strategies to promote good mental health, in particular amongst men, young people and minorities.

This document is the centrepiece to, and can be read alongside, other PHE guidance, including: *Identifying and responding to suicide clusters and contagion* and *Preventing suicides in public places*. Supporting people bereaved by suicide is a key area for action in the National Suicide Prevention Strategy and *Support after Suicide: A guide to providing local services* is a new resource to support this work.

We recognise the challenging environment facing local health and social care economies. However, in many areas, more integrated working between health and social care offers opportunities to pool resources and develop "place-based" approaches that are community-wide, community engaged and not restricted by service boundaries.

A local strategy can strengthen suicide prevention potential within existing work - for example, for new mothers or "looked after" children, targeting the energy and skills in front-line agencies to those who need them most.

This guidance aims to support the commitment and capability that we know exists in public health, local government, health services, primary care and the voluntary sector. So whether your area is starting out, needing to regain momentum or looking for ideas to accelerate your progress we hope you will find useful suggestions to shape your efforts.

Professor Kevin Fenton, national director for health and wellbeing, Public Health England and Professor Louis Appleby, chair of the National Suicide Prevention Advisory Group.

With the suicide of my best friend since childhood I essentially lost my big brother. I still do not understand why he died. I still miss him. I still think of him regularly. His death inspired me to try and help serve others. In 2002, I successfully prevented another friend taking his life. He didn't thank me at the time but he and his family and the people he manages at work now do. The fabric of human lives is precious. Suicide rends that fabric both for those who die and for we who are left behind.

Public health is about cherishing lives, especially those lives most vulnerable, marginalised, excluded or prone to preventable death and ill-health. More than ever we need to affirm the value of each and everyone of us. Building an approach to suicide reduction and prevention is an area where public health can and should excel in bringing the full range of our skills in the service of our citizens. Getting it right will challenge public health professionals emotionally, psychologically and professionally. And so it should, because our discomfort is both a growth opportunity and small beer compared to the great pain of those who feel suicide is their only or best option, and those who are bereaved.

This guidance will help and enable a properly thought through approach to suicide prevention. We each need to undertake a proper assessment of risk and protective factors and influences, an analysis of the wider situation and the engagement and influencing of stakeholders in order to deliver the necessary cross-system action plan. This guide is the best I have seen because it makes clear that preventing suicide is a jigsaw, which requires many pieces to come together. I look forward to using it, and learning from it.

Professor Jim McManus
Director of public health,
Hertfordshire County Council

Introduction

This practice resource is to support local authority public health teams to work with clinical commissioning groups (CCGs), health and wellbeing boards, the voluntary sector and wider networks of partners to develop or update local suicide prevention plans and embed work within local sustainability and transformation plans. It has been developed by Public Health England in partnership with the National Suicide Prevention Alliance.

The need to develop local suicide prevention strategies and action plans that engage a wide network of stakeholders in reducing suicide is set out in the government's national strategy for England, *Preventing suicide in England: a cross-government outcomes strategy to save lives* [2] and the Mental Health Taskforce's report to NHS England, *The five year forward view for mental health* as a key recommendation.[3]

The national strategy outlines two principle objectives: to reduce the suicide rate in the general population and provide better support for those bereaved or affected by suicide. There are six areas for action:

1. reduce the risk of suicide in key high-risk groups
2. tailor approaches to improve mental health in specific groups
3. reduce access to the means of suicide
4. provide better information and support to those bereaved or affected by suicide
5. support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. support research, data collection and monitoring

In England, responsibility for the suicide prevention action plan and strategy usually lies with local government through health and wellbeing boards. Local authorities report on the quality and success of initiatives to improve the health and wellbeing of their populations, using national indicators set out in the Public Health Outcomes Framework. Indicators relevant to suicide prevention include suicide rate, self-harm and excess mortality in adults aged under 75 with serious mental illness. See Section 1 for the national policy context.

In January 2017, PHE published an Atlas of Variation which shows suicide rates and associated risk factors for each local authority area.

This guidance is structured around the three main elements that the All-Party Parliamentary Group on Suicide and Self-harm Prevention recommends as essential to successful local implementation of the national strategy:[4]

1. establishing a multi-agency suicide prevention group involving all key statutory agencies and voluntary organisations. See Section 2.
2. completing a suicide audit. See Section 3.
3. developing a suicide prevention strategy and/or action plan that is based on the national strategy and the local data. See Section 4.

Section 5 provides updated evidence and ideas for action along with a range of supporting information in Appendix 1-7.

This document is an update to the PHE *Guidance for developing a local suicide prevention action plan* that was issued in 2014.

Priorities for suicide prevention action plans

Local areas should aim to tackle all six areas of the national strategy in the long term. Recommended priorities for short term action with a co-ordinated whole system approach are set out in the table below.

Professor Louis Appleby, Chair of the National Suicide Prevention Strategy Advisory Group.

Priorities	Quick links to further information in this guidance	Quick links to other relevant resources
1. Reducing risk in men, especially in middle age, with a focus on: economic factors such as debt; social isolation; drugs and alcohol; developing treatment and support settings that men are prepared to use	See page 48 on **Men** See page 51 on **People who misuse drugs and alcohol** See page 57 on **People who are vulnerable due to economic circumstances**	PHE guidance *Co-existing alcohol and drug misuse with mental health issues: guidance to support local commissioning and delivery of care*
2. Preventing and responding to self-harm, with a range of services for adults and young people in crisis, and psychosocial assessment for self-harm patients	See page 49 on **People who self harm** See page 58 on **Children and young people**	NICE guidelines (CG16) *Self-harm in over 8s: short-term management and prevention of recurrence* NICE guidelines (CG133) *Self-harm in over 8s: long- term management*
3. Mental health of children and young people, with joint working between health & social care, schools & youth justice, and plans to address the drastic increase in suicide risk between 15 to 19 year olds	See page 49 on **People who self-harm** See page 58 on **Pregnant women and those who have given birth in the last year** See page 58 on **Children and young people** See page 61 on **Provide better information and support to those bereaved or affected by suicide**	Department of Health and NHS England *Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing* *Local transformation plans for children and young people's mental health and wellbeing*
4. Treatment of depression in primary care, with safe prescribing of painkillers & antidepressants	See page 54 on **Community-based approaches** See page 60 on **Reducing access to the means of suicide**	NICE guidelines (CG90) *Depression in adults: recognition and management*
5. Acute mental health care, with safer wards & safer hospital discharge, adequate bed numbers & no out of area admissions	See page 51 on **People in the care of mental health services, including inpatients**	*National confidential inquiry into suicide and homicide annual report*

Priorities	Quick links to further information in this guidance	Quick link to other relevant resources
6. Tackling high frequency locations, including working with local media to prevent imitative suicides	See page 60 on **Reducing access to the means of suicide** See page 62 on **Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour**	PHE guidance *Preventing suicide in public places* PHE guidance *Identifying and responding to suicide clusters and contagion* Samaritans guidance *Media guidelines for reporting suicide*
7. Reducing isolation, for example through community-based support, transport links and working with third sector	See page 21 on **Working with the community and voluntary sector** See page 48 on **Men**	PHE guidance *A guide to community-centred approaches for health and wellbeing*
8. Bereavement support, especially for people bereaved by suicide	See page 61 on **Provide better information and support to those bereaved or affected by suicide** See page 62 on **Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour**	PHE guidance *Support after a suicide: a guide to providing local services* NSPA guidance *Support after a suicide: Developing and delivering bereavement support services* NSPA guidance *Support after a suicide: Evaluating local bereavement support services* *Help is at Hand: support after someone may have died by suicide*

10 things that everyone needs to know about suicide prevention

1 Suicides take a high toll

There were 4,882 deaths from suicide registered in England in 2014[1] and for every person who dies at least 10 people are directly affected.[5]

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

Three in four deaths by suicide are by men.[1] The highest suicide rate in England is among men aged 45-49.[1] People in the lowest socio-economic group and living in the most deprived geographical areas are 10 times more at risk of suicide than those in the highest socio-economic group living in the most affluent areas.[6]

3 There are specific factors that increase the risk of suicide

The strongest identified predictor of suicide is previous episodes of self-harm. Mental ill-health and substance misuse also contribute to many suicides. Suicide prevention strategies must consider and link to programmes of early identification and effective management of self-harm, mental ill-health and substance misuse.[7]

4 Preventing suicide is achievable

The delivery of a comprehensive strategy is effective in reducing deaths by suicide through combining a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide.[7] Directors of public health and health and wellbeing boards have a central role. Their involvement is crucial in co-ordinating local suicide prevention efforts and making sure every area has a strategy in place.

5 Suicide is everybody's business

A whole system approach is required, with local government, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide having a role to play. Suicide prevention can also be part of work addressing the wider determinants of health and wellbeing.[7]

6 Restricting access to the means for suicide works

This is one of the most evidenced aspects of suicide prevention and can include physical restrictions, as well as improving opportunities for intervention.[8, 9]

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

Compared with people bereaved through other causes, individuals bereaved by suicide have an increased risk of suicide and suicidal ideation, depression, psychiatric admission as well as poor social functioning.[10, 11]

8 Responsible media reporting is critical

Research shows that inappropriate reporting of suicide may lead to imitative or 'copycat' behaviour.[12]

9 The social and economic cost of suicide is substantial and adds to the case for suicide prevention work

The economic cost of each death by suicide of someone of working age is estimated to be £1.67 million. This covers the direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering.[13]

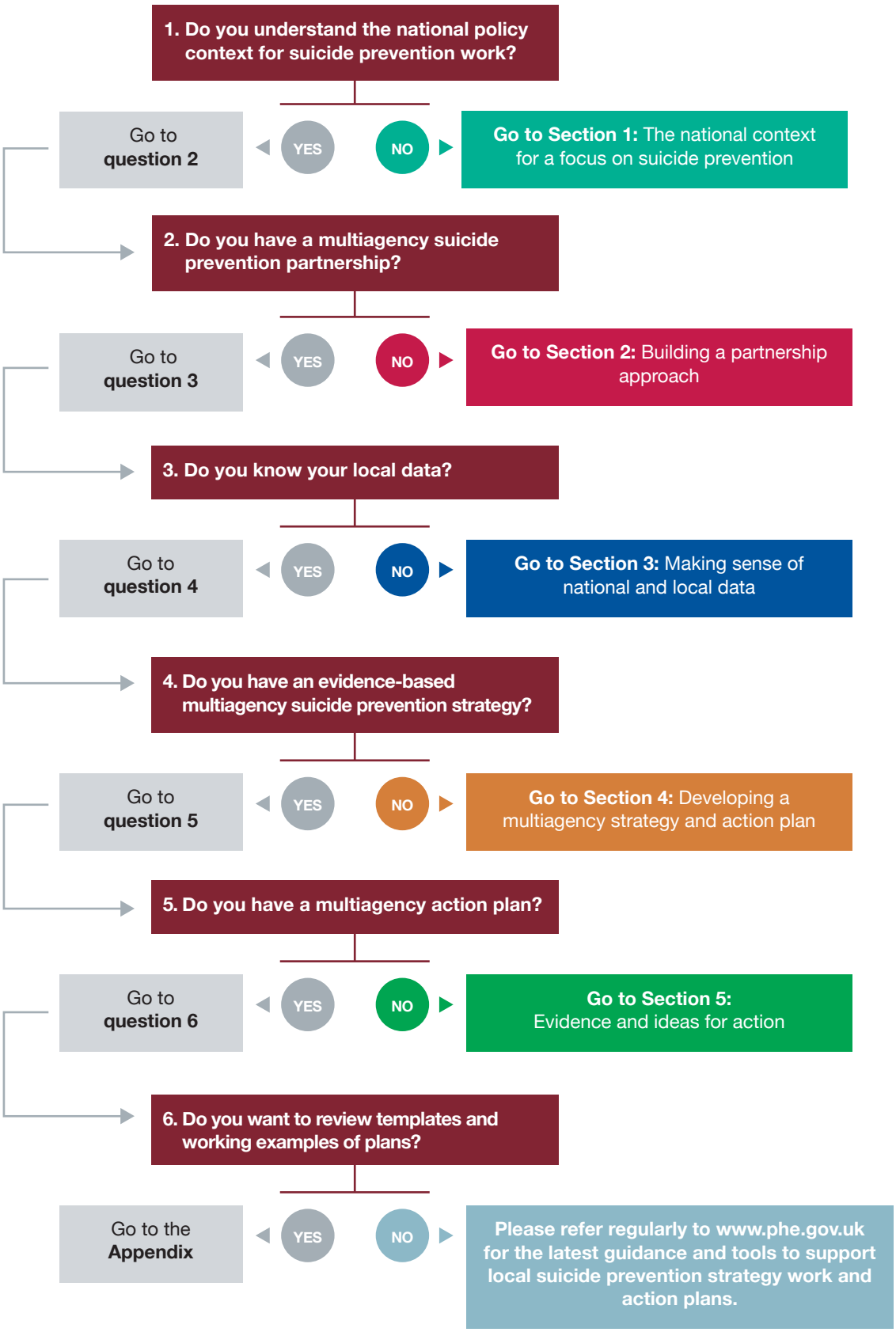
10 Local suicide prevention strategies must be informed by evidence

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

There were **4,882** deaths from suicide in England registered in 2014

Getting started

These questions will help you identify which sections of this guide will be most helpful to you.



Section 1:

The national context for a focus on suicide prevention

National policy provides the framework for local suicide prevention strategies and action plans. It is important to also consider wider public mental health and wellbeing programmes targeting adults and children.

In this section:

1.1 National suicide prevention strategy (2012)

Published in 2012, *Preventing suicide in England: A cross-government outcomes strategy to save lives*[1] focuses on preventing suicide through a public health approach and establishes the case for locally developed multiagency strategies and action plans.[1] The national strategy highlights six priority areas for action:

1. reduce the risk of suicide in key high-risk groups
2. tailor approaches to improve mental health in specific groups
3. reduce access to the means of suicide
4. provide better information and support to those bereaved or affected by suicide
5. support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. support research, data collection and monitoring

The Department of Health publish regular progress reports on the national strategy. Each report sets out current trends and outlines where progress has been made and what still needs to happen.[2, 3, 4] The *latest report* sets out the need for every local area to have a multi-agency action plan, better targeting of high risk groups, improving data and suicide bereavement support, and the expansion of the scope of the national suicide prevention strategy to include self-harm in its own right.[4]

> Directors of Public Health and Public Health teams in local authorities, working with local Health and Wellbeing Boards have a central role in coordinating local suicide prevention efforts.
>
> Preventing Suicide in England: Two Years On. Second annual report on the cross-government outcomes strategy to save lives, 2015

The Department of Health has also published *Prompts for local leaders on suicide prevention* to help establish what is happening within the local authority boundary.[5] See Appendix 1.

1.2 Outcomes frameworks

The Public Health Outcomes Framework (PHOF) and NHS Outcomes Frameworks include specific indicators for suicide as well as a range of other indicators that are likely to have an impact on suicide. These may be used to influence action to be taken by local government and health services who have a mandatory duty to report against these indicators.

Public Health Outcomes Framework (2013 – 2016)[6]

Healthcare public health and preventing premature mortality

4.10 - Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population

NHS Outcomes Framework (2015 – 2016)[7]

Preventing people from dying prematurely

1.5 Excess under 75 mortality rate in adults with serious mental illness (also in PHOF)

ii Excess under 75 mortality rate in adults with common mental illness

iii Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services (PHOF 4.10)

1.3 No health without mental health (2011)

No Health Without Mental health: a cross-government mental health outcomes strategy for people of all ages and its accompanying implementation framework advocate that suicide prevention starts with better mental health for all and that local prevention strategies should be informed by people who have been affected by suicide.[8, 9]

1.4 Five year forward view for mental health (2016)

The report of an independent task force reporting to NHS England, the *Five year forward view for mental health*[10] set a target to reduce suicides by 10% nationally by 2020 with an implementation plan published in July 2016.[11]

> The Department of Health, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017, contributing to a 10% reduction in suicide nationally. These plans should set out targeted actions in line with the National Suicide Prevention Strategy and new evidence around suicide, and include a strong focus on primary care, alcohol and drug misuse. Each plan should demonstrate how areas will implement evidence-based preventative interventions that target high-risk locations and support high-risk groups (including young people who self-harm) within their population, drawing on localised real time data. Updates should be provided in the Department of Health's annual report on suicide.
>
> Recommendation of the *Five year forward view for mental health*, February 2016

1.5 Future in mind (2015)

A report from the Children and Young People's Mental Health Taskforce, *Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing* sets out ambitions to improve mental health services for children and young people.[12] Many of its goals overlap with suicide prevention work. Examples include a new focus on reducing the stigma associated with mental ill health and improved care in a crisis. Local transformation plans to implement the report's recommendations are underway locally and suicide prevention work may need to align with these plans.

1.6 Local transformation plans for children and young people's mental health and wellbeing

In August 2015 guidance was published on the development of local transformation plans to support improvements in children and young people's mental health and wellbeing.[13] The guidance supports local geographical areas to work in partnership across local authority, health, education and youth justice to lead and manage change in line with the ambition and principles of *Future in mind*. It includes specific mention of the need to plan approaches for suicide prevention.

1.7 Mental health crisis care concordat

The mental health crisis care concordat is a national partnership agreement that seeks to ensure that anyone experiencing a mental health crisis receives high quality care 24 hours a day, no matter which public service they first encounter. It is based on statements from people about what they need when at their most distressed, as well as evidence about what interventions lead to improved outcomes and commitments from national partners. There are local multi-agency crisis care concordat groups across England who are working to deliver their local action plans.

1.8 Sustainability and transformation plans

In 2014 NHS England published the *Five year forward view* to provide a clear picture of the scale of change that local health and care systems need to deliver by 2020/21.[14] Planning guidance published in December 2015 requires 44 geographical areas, each made up of all local health and care organisations, to create a sustainability and transformation plan to set out how they will deliver the *Five year forward view*.[15] The list of national priorities for immediate action in 2016/17 includes "work with local government and other partners to develop plans for reducing suicides". In addition, the requirements for the end of the decade include "implement a suicide reduction plan together with local government and other local partners that reduces suicide rates by 10% against the 2016/17 baseline".[16]

1.9 All-Party Parliamentary Group on Suicide and Self-harm Prevention

The 2015 report *Inquiry into local suicide prevention plans in England* by the All-Party Parliamentary Group on Suicide and Self-harm Prevention details the findings from a survey of 150 of the 152 local authorities. The survey revealed variation in local implementation of the national strategy.[17]

1.10 NICE guidance

NICE guidance can inform evidence-based practice once a suicide prevention strategy has been agreed. This practice resource does not reproduce this information. See Appendix 2 for a list of relevant guidance.

Suicide prevention also includes work to promote positive mental health and prevent the development of mental illness, in particular in vulnerable groups. Although not within the scope of this guidance, it is important suicide prevention work builds upon and complements wider mental health and well-being strategies. Launching in 2017, the PHE led Prevention Concordat Programme for Better Mental Health for All will include resources to support locally tailored action. The work will complement the work of the suicide and self-harm prevention strategy.

Section 2:

Building a partnership approach

People from across all types of local communities die by suicide and most suicides are the result of a wide and complex set of interrelated factors. As a result, suicide prevention requires work across a range of settings targeting a wide variety of audiences. Given this complexity, the combined knowledge, expertise and resources of organisations across the public, private and voluntary sectors is essential. No single agency is likely to be able to deliver effective suicide prevention alone.

In this section:

Strong leadership from public health, primary care and mental health services is required to bring together and maintain a multi-agency partnership on suicide prevention. The support of elected members is also essential.

Partnership working takes place on at least two levels:

- a formal multi-agency suicide prevention group led by public health or an elected champion
- a wider network that feeds into the multi-agency group for specific projects or on specific topics

2.1 Establishing a formal multi-agency suicide prevention group

The purpose of a multi-agency suicide prevention group is to:

- understand patterns of suicide and collate data
- steer the development of the local suicide prevention strategy and action plan
- develop and co-ordinate responses to suicide and activities to reduce suicide
- make strategic links across sectors
- monitor progress towards local targets for reducing suicide and evaluate the impact of interventions
- report to the health and wellbeing board through the public health team, to influence commissioning decisions and secure funding

Membership of a multi-agency suicide prevention group will depend on local context in order to reflect a community-wide approach. The group commonly comprises a small number of core members that may include representatives from:

- public health
- clinical commissioning groups
- primary care providers
- voluntary sector organisations
- secondary mental health care providers
- emergency services
- criminal justice services

The agencies could either join the suicide prevention group, or be part of a wider partnership network. A stakeholder mapping exercise is a useful way of establishing the relevant potential members and the scope of their role.

To gain the support of the widest range of relevant potential multi-agency members it is likely to be necessary to clearly set out the case for why suicide prevention is important. Further information on building the case is provided in Section 4.

Agreeing terms of reference for the multi-agency suicide prevention group will ensure clarity regarding objectives, membership and accountability. See Appendix 3 for a sample terms of reference.

A wide range of representatives working with adults, children and young people may be brought together to contribute to a suicide prevention partnership.

2.2 Building a wider network

The work of the multi-agency suicide prevention group can be complemented by a suicide prevention network or partnership in which a wider range of representatives may engage at different levels or for specific projects, such as:

- community forums where partners can gather views from a wider network across the community and engage people in their work
- task and finish groups that oversee individual projects and areas of work
- suicide prevention champions who get involved in specific pieces of suicide prevention work – this might include people who have been bereaved by suicide or those with a special interest or expertise
- working with other organisations such as private sector companies, faith groups or education providers who bring specific skills, insights or access to at risk groups
- Regional networks which share knowledge and resources, address broader issues and support collective action towards agreed targets

Every area will have different opportunities for partnership working. In areas where responsibility for health and social care is being devolved to a local level, such as in Greater Manchester or the West Midlands, there is scope for suicide prevention to form part of a wider health and wellbeing strategy and action plan. Elsewhere, there may be scope for co-operation across local authority boundaries. In Cheshire and Merseyside, for example, nine public health teams collaborate across local authority boundaries to share data and deliver a shared suicide prevention strategy (see page 41).

The Mental Health Challenge

The Mental Health Challenge exists to encourage the active interest and involvement of elected members to support mental health and wellbeing and to influence the authority's activities and responsibilities. The challenge asks councils to appoint a 'member champion' for mental health. This could be a cabinet member, health and wellbeing board member or a 'backbench' councillor. The role is distinct from the formal responsibility of the lead member for social care, although it is possible for the same individual to do both. It could include advocating for mental health in policy development and in meetings, scrutinising local services for thier impact on mental health, building partnerships with organisations and other local leaders and involving people with personal experience. It offers an important opportunity through which to raise the profile of suicide prevention approaches. Advice and information is available, including a template motion to enable councils to promote mental health across all their business.

See www.mentalhealthchallenge.org.uk for more information and to find out the mental health champion in your area.

2.3 Working with elected members

The political engagement and support of elected members is essential to the prioritisation and progress of suicide prevention work as they will determine whether or not a council is willing to invest resources into developing a strategy and delivering an action plan, as well as scrutinising the proposed approach. It is recommended that from the outset the approach for securing and maintaining the involvement of elected members is considered. The Mental Health Challenge offers a valuable opportunity to work with the appointed mental health champions (see page 17). Providing the opportunity for elected members to meet with, and hear from, people who have been affected by suicidal ideation or bereavement by suicide can be a powerful way of engaging elected members.

Personal perspective on partnership working and the importance of engaging and involving elected members

Tim Woodhouse
Public health programme manager
at Kent County Council and **Karen MacArthur**,
public health consultant at Medway Council

The Kent and Medway multi-agency suicide prevention strategy was due for renewal in 2015. As part of the review process we took the opportunity to refresh our multi-agency steering group's terms of reference which helped to clarify responsibilities and manage expectations of steering group members.

This enabled the steering group to provide helpful comments during the drafting of our strategy and action plan before we then went out to public consultation. We also held two public engagement events, which were very important in shaping the final strategy and making sure we had taken into account the views of all stakeholders.

In terms of governance, we took the strategy and action plan to the relevant committees and boards in Kent and Medway, where we had an incredible response. This was a strategy with no budget attached that aimed to influence other budgets – and yet elected members turned out in force to check, challenge and ultimately support the strategy.

Suicide is a very powerful issue and by engaging with elected members we were able to gain their support for important elements within the associated action plan.

2.4 Involving health and wellbeing boards

Health and wellbeing boards bring together representatives from across health and local authorities in order to establish greater integration between health and social care services and develop joint health and wellbeing strategies. Gaining the support of this board can help to embed a collaborative approach to suicide prevention across public health, primary care, mental health services and other public services such as housing and education. This is vitally important given the wide determinants of suicidal risk. Health and wellbeing boards can also help to establish opportunities for joint commissioning and pooled budgets. The joint strategic needs assessment (JSNA) should include information on suicide prevention (see page 39).

2.5 Working with Crisis Care Concordat networks

There is a network of local multi-agency crisis care concordat groups across England working to improve care for anyone experiencing a mental health crisis. These groups typically involve close working between health services, ambulance services, police services, local authorities and other local organisations. Given that every area now has a mental health crisis action plan in place it is likely that many individuals and organisations that are also relevant to suicide prevention will already have been identified and have established means of partnership working. It is recommended that effective methods of data gathering and intelligence sharing are established as it is likely that there will be some overlap in the targeting of particular at risk groups, including those people who may be in the care of mental health services.

Examples of how suicide prevention work is embedded in crisis care concordat action plans are available at www.crisiscareconcordat.org.uk

The crisis care concordat multi-agency action plan for Bradford, Airedale and Craven is joined up with the work of the Suicide Prevention Group that is led by public health. It stipulates that people who have presented with suicidal ideation or self-harm are followed up and supported to reduce the risk of further crisis happening. See http://www.crisiscareconcordat.org.uk/wp-content/uploads/2015/11/Bradford-and-Airedale-Crisis-Care-Concordat-Action-Plan-V2-October-30th-2015.pdf

2.6 Working with primary care

GPs and other primary care representatives such as pharmacists are important partners in effective suicide prevention, contributing intelligence and leading on targeted interventions. This role is acknowledged in the *Five year forward view for mental health*, which calls for a new focus on primary care.[1] Ensuring there is appropriate primary care representation on the multi-agency suicide prevention group is valuable. See page 56 for information about training for primary care.

The majority of people who die by suicide are in contact with their GP in the year before their death, with 45% of people who die by suicide having seen their GP in the month before their death.[2] Suicide risk rises with increasing number of GP consultations.[3]

2.7 Involving people affected by suicide

Suicide prevention work can be greatly enhanced by engaging people who have personal experience of suicide – those who have experienced suicidal ideation or have been bereaved by suicide. The involvement of service users is an established part of national and local government policy and practice with guidance available, for example *Transforming participation in health and care.* More recently, an approach based on co-production has become more common in developing policy and services.[4, 5]

Involving people affected by suicide adds value to suicide prevention by:

- bringing personal experience to create a more complete picture of suicide and suicide prevention
- helping to identify issues that clinicians and commissioners might not be aware of
- highlighting gaps between policy and practice
- helping to ensure work is grounded in the reality of the impact of suicide and self-harm

The National Survivor User Network has developed a framework for involving people with experience of mental health issues in policy and strategy development.[6] This has been adopted by a number of local authorities, clinical commissioning groups and NHS trusts.

The NSPA resource *Support after a suicide: Developing and delivering local bereavement support services* provides useful links to organisations that support people after suicide and who can act as gatekeepers for people affected by suicide to get involved in prevention work.

Personal perspective on involving people affected by suicide

Don and Lynne Hart
Bereaved parents

There is a real opportunity for all agencies involved in suicide prevention, including local authorities, the NHS, police, fire services, community organisations and private companies, to learn from involving people with lived experience. Since the suicide of our son we've been involved in the South West Zero Suicide Collaborative and the Making Families Count initiative.

Along with others who have lost a loved one or experienced suicidal ideation, we can offer insight that helps to highlight gaps. We can also help co-produce new ways of working. There can be a perception that emotional involvement can cloud the ability to see the bigger picture. But the people we have worked with say it grounds their work in reality.

For us, while retelling our story picks at the scabs again, being involved and being taken seriously helps us to think our son's death wasn't totally in vain and other lives might be saved.

2.8 Working with the community and voluntary sector

There is a long history of public health working jointly with community and voluntary sector organisations to promote health and wellbeing, and they are a great asset to local areas. The importance of this was highlighted in a May 2016 policy report which calls for an equal partnership between health, care and the voluntary, community and social enterprise (VCSE) sector.[7]

The VCSE sector has a central role in suicide prevention partnership working. Organisations may sit within the formal multi-agency suicide prevention group, or feed into the wider suicide prevention partnership.

The National Suicide Prevention Alliance

The NSPA is an alliance of over 70 public, private and voluntary organisations in England who care about suicide prevention and are willing to take individual and collective action to reduce suicide and support those bereaved or affected by suicide. Joining the NSPA is free and members benefit from regular communications about the NSPA's work and members' activities; online access to information, reports, good practice and guidance; and opportunities to collaborate and network. www.nspa.org.uk

> We want to help people affected by suicide to make a unique contribution to prevention work through sharing experience and stories, challenging stigma and bringing resources and expertise, including about handling media around suicides and inquests.
>
> Ged Flynn, chief executive of PAPYRUS Prevention of Young Suicide

Personal perspective from the voluntary sector

Miranda Frost
Chief executive of Grassroots Suicide Prevention

Grassroots Suicide Prevention is a charity based in Brighton that supports communities to prevent suicide by teaching suicide alertness and intervention skills.

As a member of the multi-agency local suicide prevention strategy group we bring our frontline experience and knowledge of working with diverse communities and professionals. Along with other stakeholders we have helped to shape each year's action plan and we also chair a working group that focuses on building community-wide involvement in targeting high-risk groups and locations. By working together, under clear terms of reference, charities have the potential to help identify gaps in the approach, bring new ideas around suicide prevention and the capability and capacity to lead on actions.

2.9 The role of suicide prevention champions

Champions are people who speak up for suicide prevention and/or are in a position to influence political engagement/buy-in. It is important for local areas to have at least one local champion. Champions can come from a wide variety of backgrounds and fulfil different roles depending on the amount of time they want to give, their skills and interests. They can include GPs, psychiatrists and other senior mental health clinicians, university professors, comedians, sports people and local authority mental health champions. As part of the Mental Health Challenge increasing numbers of councils have elected councillors as member champions (see page 17).

Personal perspective from a suicide prevention champion

David Mosse
Chair of Haringey Suicide Prevention Group and a trustee of Mind in Haringey

Following the death by suicide of my son Jake in 2010, I met with a range of service providers and commissioners to raise awareness about suicide and the need for a suicide prevention group and action plan in the area where I live.

After networking and gaining support from individuals and the local branch of Mind, I invited a wide range of stakeholders – including statutory and voluntary sector mental health services, Haringey public health, the council, local politicians, the Metropolitan and British Transport Police, local charities and people affected by suicide – to a roundtable meeting in June 2015.

More than 30 people from a wide range of sectors attended the meeting, which featured presentations on the local data and examples of how others are approaching suicide prevention groups, plus facilitated working groups. We've agreed terms of reference, which include quarterly meetings, and work on the action plan is progressing. The group I initiated now provides leadership and momentum for suicide prevention work in the borough, sitting outside local government but bringing together statutory and voluntary agencies.

See www.havcoharingey.org.uk/networks/haringey-suicide-prevention-group for further information, including a copy of their terms of reference.

2.10 Working with other partners

A wide range of other individuals and organisations can bring important knowledge, skills and resources to local suicide prevention work. They include private sector companies such as Network Rail (see page 60), education providers, faith groups, housing associations, prisons and probation services.

Personal perspective from a partner organisation

Jo Smith

Professor of early intervention and psychosis at the University of Worcester and the *Suicide Safer* project lead

Universities can make a valuable contribution to a community-led suicide prevention approach.

At Worcester we have over 10,000 students who, on the basis of their age alone, represent a high-risk group for severe mental illness, self-harm, suicidal ideation and death by suicide. Added to that you have a population in transition who are disconnected from their family and usual social contacts, who are often having to deal with new or increased pressures of exams, managing money, living independently, emergent relationships and exposure to, or experimentation with, drugs, alcohol and sex.

We see ourselves as a joint partner committed to delivering a 'suicide safe' university, city and county. We're involved in gathering and sharing intelligence, developing strategy and implementing activities such as educating staff and students about how they can contribute to suicide safe environments, making sure people are aware of the full range of support services and helping those affected by suicide. Our facilities have been used to host events and we are also contributing to the understanding of suicide and suicide prevention through research and international collaboration.

Section 3:

Making sense of national and local data

Collecting and analysing local data on the number of suicides, the context in which they occur, the groups most at risk and how the picture is changing over time is critical for effective suicide prevention work. Local intelligence informs the development of the suicide prevention strategy, provides an evidence base for action and the means to monitor and review progress.

In this section:

3.1 How data supports effective suicide prevention work

The development of effective suicide prevention strategies and action plans requires close consideration of national data and the collection and analysis of local information. In this way data can help to identify high-risk groups, locations of concern, patterns and trends, provide evidence for targeted interventions and contribute to the monitoring and evaluation of outcomes.

Useful data and intelligence can come from a range of national and local sources, including national databases, PHE's Suicide Prevention Profile, coroners' records, primary and secondary healthcare services, social care and the criminal justice system. Further information about data sources is provided later in this section.

A note about terminology

The term suicide audit can mean different things. Some people use the term to describe the analysis of any available data on their local area. For others, a local suicide audit involves a review of coroners' records, often supplemented by collection of data from primary and secondary care and other services. Here the term is used to refer to a review of coroners' records.

3.2 Suicide data collection in practice

The public health team in the local authority has a lead role in collecting and analysing suicide data to inform the development of the suicide prevention strategy and to feed into the plans of the local health and wellbeing board.

It can be helpful to establish a Suicide Audit Group made up of partners who can provide information. See page 32 regarding data sharing agreements.

National suicide data offers a helpful starting point to establish the macro picture and to enable comparisons with the England average and upper and lower quartile rates. Important sources include the Office for National Statistics and the Public Health Outcomes Framework. The PHE Suicide Prevention Profile is recommended as the foundation tool to gather data and analysis on local populations, risk factors and contact with health services, including benchmarking against other similar local areas and national indicators. There are however limitations to the information that can be gained about a local area through the national data.

Local data provides an opportunity to gather additional information.

Local data and intelligence may be gathered by:

1. undertaking a suicide audit to gather data from coroners' reports about individual suicides (see page 29)
2. examining demographic, social and service data held by partners across primary care, health services, social care and other partners to help to understand the prevalence of risk-factors and other related issues. This includes intelligence from any relevant NHS trust patient safety Serious Untoward Incident reviews and/or other patient safety incident reviews
3. working with partners to introduce real-time suicide surveillance (see page 30)

Each area's approach to local data review and collection will be designed to meet local needs. It is suggested that local authorities focus on local data that can provide insights that are not already covered by the national data.

Local data offers the opportunity to gain important intelligence on the impact of suicide on particular populations and specific patterns and trends that may include:

- local demographics, such as particular migrant populations and protected characteristics as defined in the Equality Act, in particular those recognised as high risk groups on the basis of ethnicity and/or sexual orientation
- local context, such as a local employer making a large number of people redundant
- how individuals who die by suicide have accessed health services, including for example whether they were on mental health waiting lists
- methods used locally which might not be picked up by the national data, including high frequency locations
- issues relating to the emergence of suicide clusters

Decisions about the scope, timing and frequency of local data collection work are likely to be determined by the resources available. This work is also dependent on co-operation of partners, for example the coroners or police.

It can be helpful to start building a suicide database, enabling the collation and storage of the data collected locally from different sources, and making it easier to record data as it is updated.

Annual changes in suicide rates could be the result of natural fluctuations given the relatively small numbers. As a result it is advisable to look at a three-year rolling average to determine changes in the long-term trend.

3.3 Nationally available data

3.3.1 Office for National Statistics

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

The ONS holds suicide data from 1981 to the most recent year available for deaths registered in the UK. Note that figures are for deaths registered, rather than deaths occurring in each calendar year. Due to the length of time it takes to complete a coroner's inquest, it can take months or even years for a suicide to be registered. More details can be found in the *Suicides in the UK* bulletin.[1]

In the UK, suicide is defined as deaths given an underlying cause of intentional self-harm or injury/poisoning of undetermined intent.

Samaritans produce an annual *Suicide Statistics Report* which provides additional information about how to understand and interpret suicide statistics, because it's not always as straight forward as looking at the numbers.

3.3.2 Public Health England Suicide Prevention Profile

The PHE Suicide Prevention Profile – often referred to as the Suicide Prevention Fingertips Tool – provides data on suicides by local authority, unitary authority and CCG. The tool collates a range of publicly available data on suicide, associated prevalence, risk factors and contact with health services among groups at increased risk. It enables people involved in developing, implementing and evaluating suicide prevention work plans to profile their area and benchmark against similar populations.

The data is updated regularly and covers:

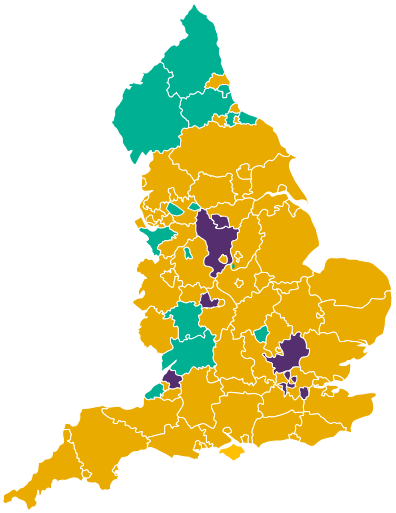
- ONS suicide data including age-standardised suicide rates for men and women
- related risk factors including rates of alcohol-related admission, domestic abuse, homelessness, unemployment, and self-reported wellbeing
- related contact with health services, including the number of patients on the quality and outcomes framework serious mental illness register, numbers receiving treatment through the Improving Access to Psychological Therapies programme, number of people in treatment at specialist drug misuse services, and emergency hospital admissions for intentional self-harm

The tool can help to answer:

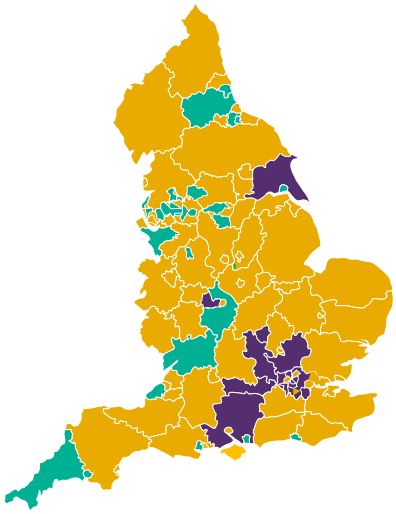
- which are the high-risk groups in an area?
- how is an area performing against risk factors compared to other areas?
- how many years of life are lost through suicide?
- how many people are using local mental health and NHS services? – for example, how many people with severe mental illness attend A&E each year with distress related to their mental health condition?
- how do the rates in one area compare with others?

These maps from the Suicide Prevention Profile indicate the local and regional variations in the male suicide age-standardised rate per 100,000

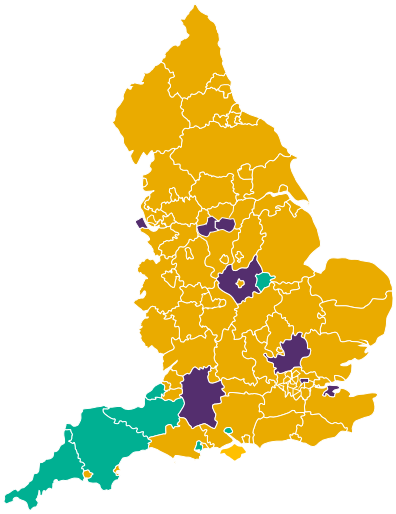
15-34 year olds



35-64 year olds



65+ year olds.



Higher **Similar** **Lower**

The Suicide Prevention Profile can be used to examine differences in the male or female suicide crude rate per 100,000. The map shows the male rate across different areas of England for three different age groups, 15-34 years, 35-64 years and 65+ years as benchmarked against the rate for England. The purple indicates lower rates than the England average, with orange indicating similar and green for higher rates. This demonstrates variations in suicide rates across the country with the highest rates of suicide in men found in the North among 15-34 year olds, local and regional differences for 35-64 year olds and in the South West for over 65 year olds.

The Suicide Prevention Profile can also be used to examine the suicide age-standardised rate per 100,000 (three year average) on the basis of deprivation and enable comparisons with statistical neighbours. The chart on page 28 demonstrates how local areas compare when benchmarked against England and similar areas of deprivation. This highlights the importance of being aware of the particular demographics in your region as well as the national averages.

This chart from the Suicide Prevention Profile indicates the variations in the suicide age-standardised rate per 100,000 by deprivation

Area	Value
England	10.0
Fourth less deprived decile (IMD2010)	10.1
Northumberland	13.3
Stockport	12.9
Warrington	11.8
Devon	11.6
Norfolk	11.5
Kent	11.4
Lincoinshire	10.8
Nottinghamshire	10.3
Trafford	9.7
Herefordshire	9.6
Northamptonshire	9.3
Derbyshire	9.0
Bedford	8.6
Thurrock	8.3
Hillingdon	6.7
Isle of Scilly	*

It is important to note the following about the Suicide Prevention Profile:

- the figures are based on the best data that is available, but there are varying levels of reliability. Each indicator has been assessed and labelled with a quality rank
- the suicide rates use ONS data with its associated limitations regarding timing and inquest conclusions
- the rates have been deliberately colour coded for 'lower', 'similar' and 'higher' and not red, amber and green, because no level of suicide is acceptable
- it is crucial to interpret results alongside local intelligence about the demography, diversity and geography of each area

See http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide for the Suicide Prevention Profile and a video guide on how to use it.

It is vital to recognise and be motivated by the fact that suicide is not inevitable and that suicides are preventable. Concerted action is therefore required across all areas. 'Low' comparative rates of suicide as compared to other areas should not be used as a justification for not taking preventative action.

3.3.3 Other sources of national data:

- Compendium of Health Indicators
- Hospital Episode Statistics
- Multicentre Study of Self-harm
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
- National Drug Treatment Monitoring System
- PHE National Mental Health Dementia and Neurology Intelligence Network Crisis Care Data Catalogue
- Primary Care Mortality Database
- Safety in Custody Statistics
- Secondary Use Services data
- The Segment Tool

Further details about each of these sources, including where to access the data, is provided in Appendix 4.

Rail industry database

The rail industry has a large database that can support local authorities investigate suicides. suicidepreventionprogramme@networkrail.co.uk

3.4 Locally sourced data

By reviewing coroners' records it is possible to gain a detailed retrospective insight into the circumstances of individual suicides.

Coroners investigate all deaths that are considered to have been sudden, violent or not due to natural causes. Deaths that may have been self-inflicted can be given one of three conclusions:

- suicide: where it can be established beyond reasonable doubt that the person took their own life
- open: if there is insufficient evidence to establish the mode of death
- narrative: in which the coroner simply sets out relevant facts

Suicide audits usually examine open and narrative conclusions as well as conclusions of suicide, to make sure they take into account all deaths that are thought likely to have been self-inflicted. The individual records provide information on the demographic characteristics of the deceased, the place of death, method of suicide, contact with secondary and primary care services and other details specific to the individual case.

There is a danger that local data collection can be undertaken without a clear purpose and no demonstrable link between suicide audit activity and suicide action plans.[2] Local authorities are advised to focus on information that is not available using national data sources, and to think carefully about how they will use it.

In those areas yet to establish suicide prevention work, it may be useful to consider whether the retrospective review of coroners files is something to aspire to over time, and whether a more pragmatic approach using nationally available suicide data and public health data can suffice as a starting point. The potential for the delay in the design and delivery of local interventions whilst any additional local data is gathered may be a consideration.

There can be concerns about the strength of local data given that the numbers of suicides in a local authority geographical area tend to be small and the changes detected through monitoring over time even smaller. Sharing the work of data collection across a wider local authority footprint might help to mitigate this risk.

A review of data will indicate the priorities for the local suicide prevention strategy and action plan. The following documents offer valuable additional information and guidance:

- Public Health England *Identifying and responding to suicide clusters and contagion*
- Public Health England *Preventing suicides in public places*
- Public Health England *Support after a suicide: A guide to providing local services*
- National Suicide Prevention Alliance *Support after a suicide: Developing and delivering local bereavement support services*

3.5 Real-time suicide surveillance

Real-time suicide surveillance, also known as real time data, is a system that enables the public health team and/or the multi-agency suicide prevention group to consider and agree if interventions are required after a death has occurred where the circumstances suggest suicide in advance of the coroners' conclusion.

The system can provide the means to offer timely support to people who have been bereaved or affected by a suspected suicide and to respond quickly to emerging patterns that could indicate clusters, increasing trends or new methods of death.

There are two potential models, one that is led by coroners, and one that is led by the police who are often the first responders at the scene of a death. Some local areas have been exploring the benefits of these different models in order to gather earlier intelligence on suspected suicides that have taken place locally. An overview of the County Durham police led real-time suicide surveillance system is provided in Appendix 5.

To be effective, either model of real-time surveillance requires the existence of a multi-agency partnership (see Section 2) that can consider the real-time data in a timely way. A system-wide response process is also needed that sets out the agreed trigger and protocol for escalating further action, what the actions will include and clear roles and responsibilities.

There are a range of potential benefits and limitations of real-time surveillance.

Potential benefits	Potential limitations
Provision of timely and appropriate support to people affected: family, community, workplace, social and virtual	Requires considerable partner engagement, information sharing protocols and effective administration, to secure timely, accurate and detailed information
Identification and response to potential suicide clusters and contagion among a particular community or area	Requires agreeing when and how to respond to changing trends and what level of variation is normal so as to ensure measured and effective responses
Identification of any increasing or decreasing suicide patterns within the area including the emergence of new methods	Notified deaths are not confirmed suicides – and may be proven subsequently not to be suicide
Responding to increasing suicides within institutions (e.g. hospitals, prisons, schools) and particular communities	
Identifying any high frequency locations within the area	
Supporting continuous quality improvement of suicide prevention strategies and action plans	

3.6 Data sharing agreements

A wide range of local organisations hold intelligence that is relevant to understanding the context and patterns of suicide. They include general practice, primary care, mental health services, ambulance services, police services, social services, prison, probation, housing, education, Network Rail and many others. This underscores the importance of establishing an effective multi-agency partnership so that useful intelligence can be gathered and shared.

Government policy places a strong emphasis on the need to share information across organisational and professional boundaries, in order to ensure effective co-ordination and integration of services.[3]

There is a consensus statement specifically on information sharing and suicide prevention available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/271792/Consensus_statement_on_information_sharing.pdf

> The duty to share information can be as important as the duty to protect patient confidentiality.

Footnote: Information: To share or not to share? The information governance review. (April 2013)

To support effective suicide prevention planning and delivery it is helpful to agree a protocol between the relevant multi-agency partners. An agreement would usually outline the need for each involved organisation to co-operate and provides the legal basis, as well as operational guidelines, for how information will be shared. It ensures that all parties have confidence in what and how the data is being used, as well as ensuring data protection measures are in place.

The value of information sharing applies not just to an individual death by suicide or suicidal crisis but also to broader community-based suicide surveillance activities.

In some areas a single agreement is used across all organisations, such as the local authority, mental health services, coroners, and the police. In others, different partners require their own agreement.

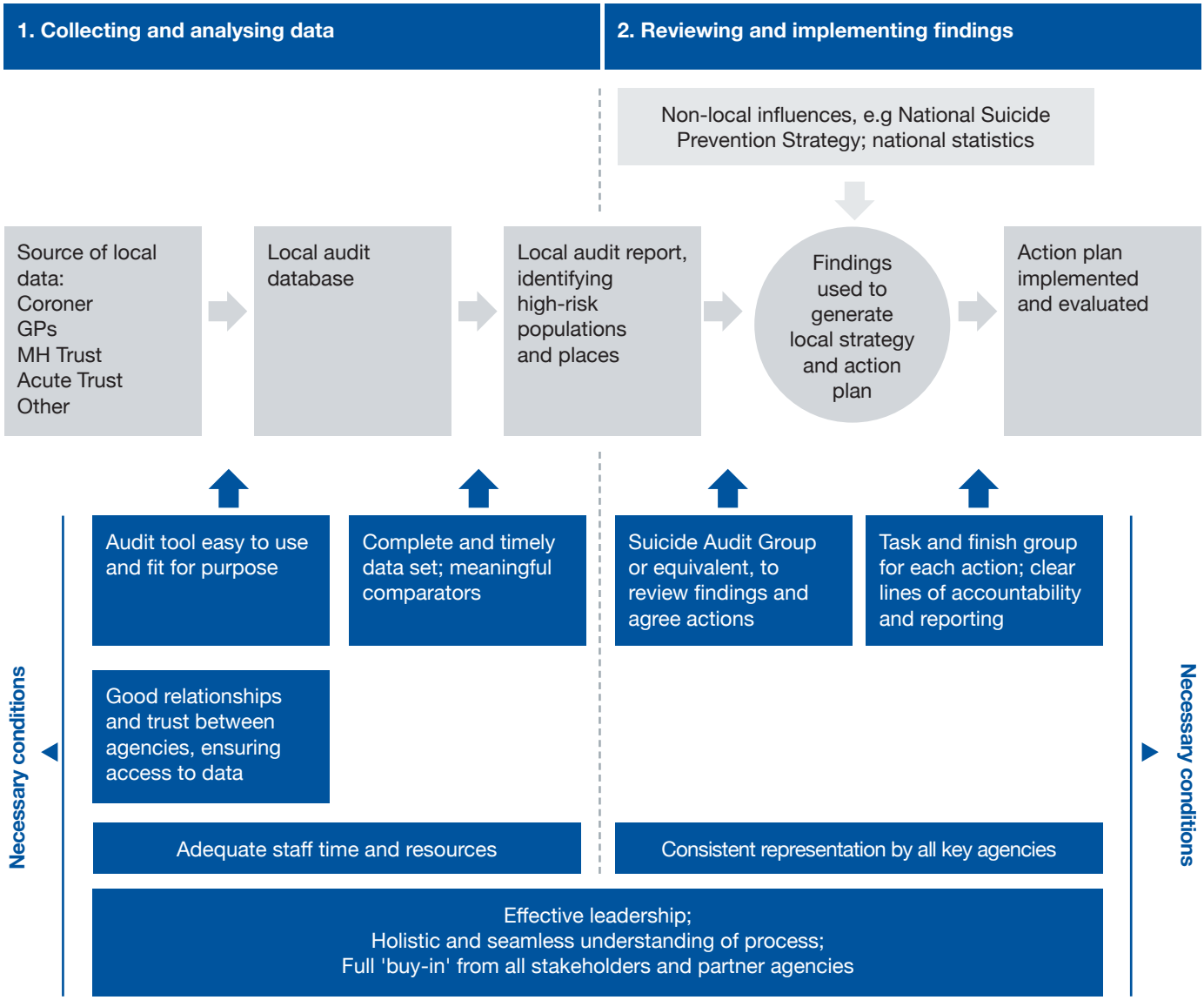
Further advice can be sought from each area's Caldicott Guardian and information is also available at: https://www.england.nhs.uk/wp-content/uploads/2014/08/info-shar.pdf

The Centre of Excellence for Information Sharing works to improve information sharing between agencies and local places. More information is available at http://informationsharing.org.uk

Organisations working across County Durham who are partners in the local suicide audit process have developed a suicide audit operational protocol. This is available at http://www.suicidesaferdurham.uk/wp-content/uploads/sites/9/2016/07/Suicide-Audit-Operational-Protocol-July-2016-v2.pdf

Local data collection: a model

In determining the approach to local data collection it may be helpful to consider the following model. It provides an example of how local data can be used to feed into the strategic planning process, and the essential elements and necessary conditions to ensuring its value.



Reproduced with permission.[4]

3.7 Building a suicide prevention database

Given the wide range of sources of relevant data it is useful to establish a database in which all information can be stored. This will help to support a continuous process of building up data from national and local sources and coroners' records in order to create a long-term view of patterns in your area, rather than seeing data collection as a one-off activity. Ongoing information is vital to ensure that the local suicide prevention strategy and action plan can be monitored and regularly reviewed.

Creating a suicide audit database

The London Borough of Bromley has developed a comprehensive system for collecting and monitoring data to inform its suicide prevention strategy and action plan. The local database collates information including:

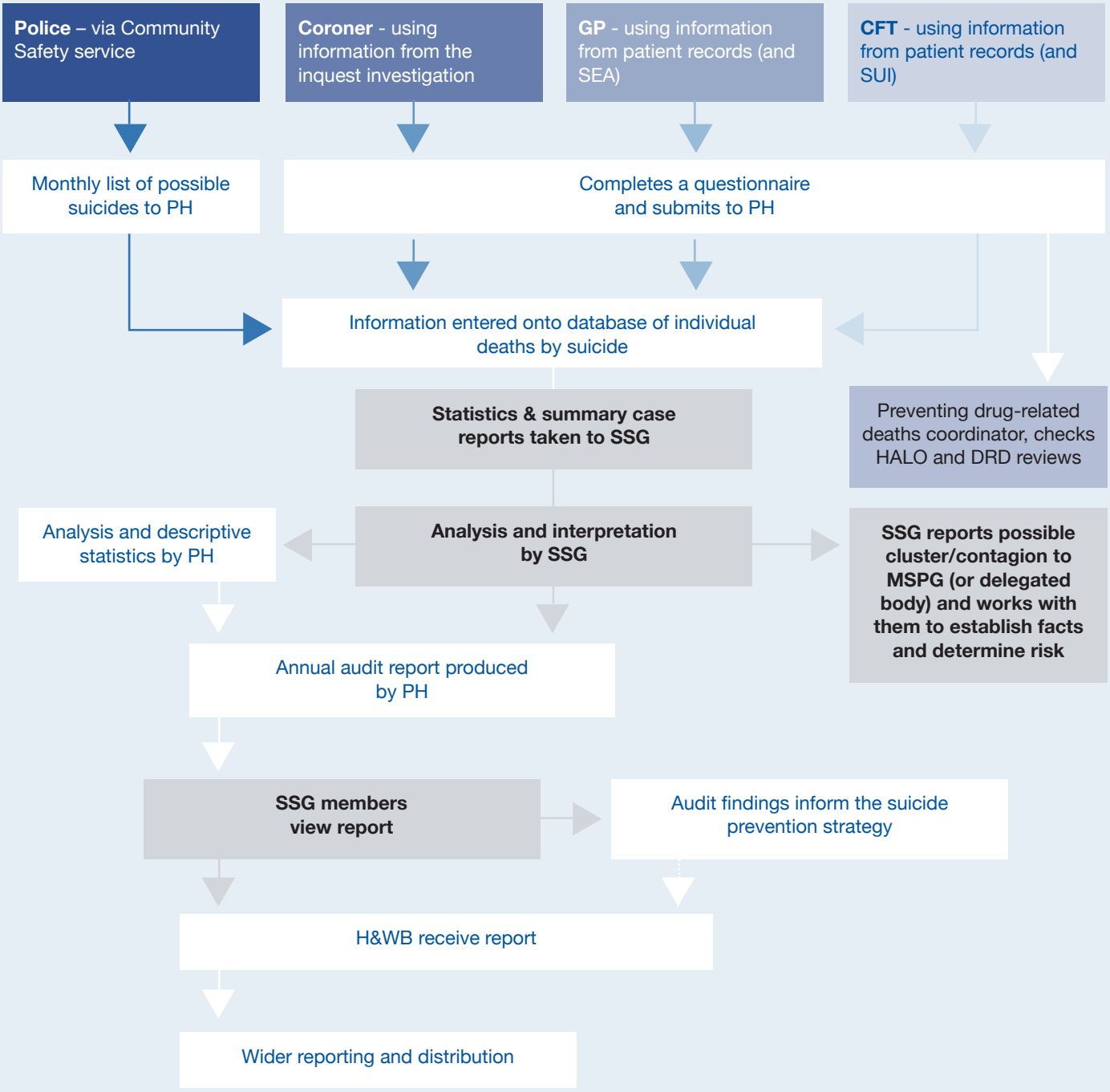
- coroner-related information such as substances specified in self-poisoning deaths
- contact with primary care services including reasons for the contact and frequency
- demographic details such as age, gender and ethnicity
- contact with acute hospital services data such as A&E attendance and psychological assessments
- psychiatric history

Information sources include mortality data from the Primary Care Mortality Database, General Practice Medical notes and history of hospital admission, as well as the coroner's records.

The public health team in Bromley produce regular reports that draw together data from this suicide database alongside national data to understand local trends. This is shared with local partners including secondary mental health services, adult safeguarding, patient safety groups and clinical quality groups.

Making information flow in Cornwall and Isles of Scilly

Cornwall and the Isles of Scilly began systematically collecting data about suicides in 2007. The team's aim is to identify factors that influence suicide risk, so that those factors can be addressed in a timely manner to prevent suicides, and to identify potential clusters or risk of contagion, so that an appropriate response can be initiated. Work is underway to develop a partnership response plan, following PHE guidance. The annual audit reports feed into regular updates to the area's suicide prevention strategy. This chart shows how information flows throughout the process.



SSG role

CFT	Cornwall Foundation Trust
DRD	Drug-Related Deaths
H&WB	Health & Wellbeing Board
MSPG	Multi-agency Suicide Prevention Group
PH	Public Health
SEA	Significant Event Audit
SSG	Suicide Surveillance Group
SUI	Serious Untoward Incident

Section 4:

Developing a suicide prevention strategy and action plan

A local suicide prevention strategy sets out the case for suicide prevention work, where to target that work and the approach through which partners agree to work.

In this section:

Developing the strategy is usually led by public health in collaboration with the multi-agency suicide prevention group and with input from the wider suicide prevention network.

The process of developing a suicide prevention strategy is important. It provides an opportunity to engage key stakeholders and create a vision for suicide prevention that is locally owned by those working in statutory agencies, the voluntary sector, people affected by suicide and communities at large.

The strategy requires the approval of elected members in order to ensure that it is resourced effectively and embedded across all relevant local authority programmes that can have an impact, such as housing and employment. Demonstrating the involvement of a wide group of stakeholders, setting out a case, and working with champions and people affected by suicide are all important for securing councillor support.

See Section 2 for more on partnership working

Local authorities have a unique opportunity to ensure the suicide prevention strategy is integrated across other programmes of work that influence the wider determinants of mental ill-health and suicide risk factors. For example this may include access to alcohol; planning of public spaces; the provision of financial and relationship information and advice; and housing and employment support for people who have been under the care of mental health services.

4.1 What to include in a suicide prevention strategy

A local suicide prevention strategy usually covers at least a three-year period. It needs to set out clear objectives and provide a framework for the action plan. It typically includes:

- a foreword from a stakeholder in a senior role, for example from the director of public health, an elected member or the chair of the health and wellbeing board
- the case for suicide prevention locally, including data and intelligence on high risk groups and/or risk factors
- a clearly stated ambition and objectives for what wants to be achieved
- the approach to monitoring and evaluating outcomes in order to determine progress
- priority areas for action based on the reinvigorated national strategy, in particular for middle-aged men, people who self harm and those bereaved by suicide (see Section 5)
- priority areas for action based on local data and needs, such as interventions focused on particular high risk locations, where the evidence base for action is increasing
- links with other strategies, such as those for mental health and wellbeing

The action plan, detailing the specific activity that is going to be delivered, is often presented together with the strategy as one document, with the action plan updated annually. See Section 5 for ideas to include in action plans.

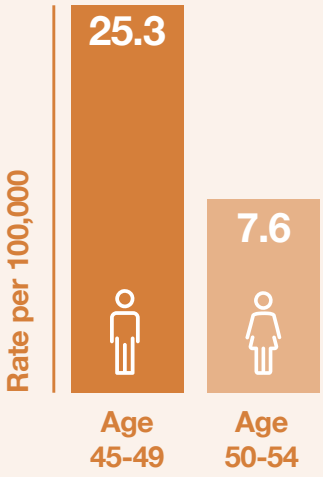
4.2 Building the case for suicide prevention work

It is recommended that the strategy includes a case for action setting out the rationale for why suicide prevention is required in the local area. Locally available data and intelligence can be presented alongside nationally available data, and insights from the existing evidence and policy base can be highlighted. There is a range of information that could include:

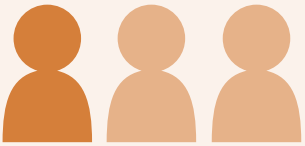
- the reasons people take their own lives, including intelligence and data about local factors
- the public health profile, including any particular populations at risk of suicide
- the financial and human cost of suicide and the cost effectiveness of suicide prevention
- the national policy context for local action
- the potential return on investment

It can be helpful to use impactful and engaging charts and diagrams to make the case for action on suicide prevention. This is an example of the use of infographics using national suicide data.[1] Lambeth Council have also taken a visual approach that can be viewed here: https://www.lambeth.gov.uk/sites/default/files/ssh-lambeth-suicide-2015.pdf

Highest suicide rates by age and gender:



Suicide and mental health:



1 in 3

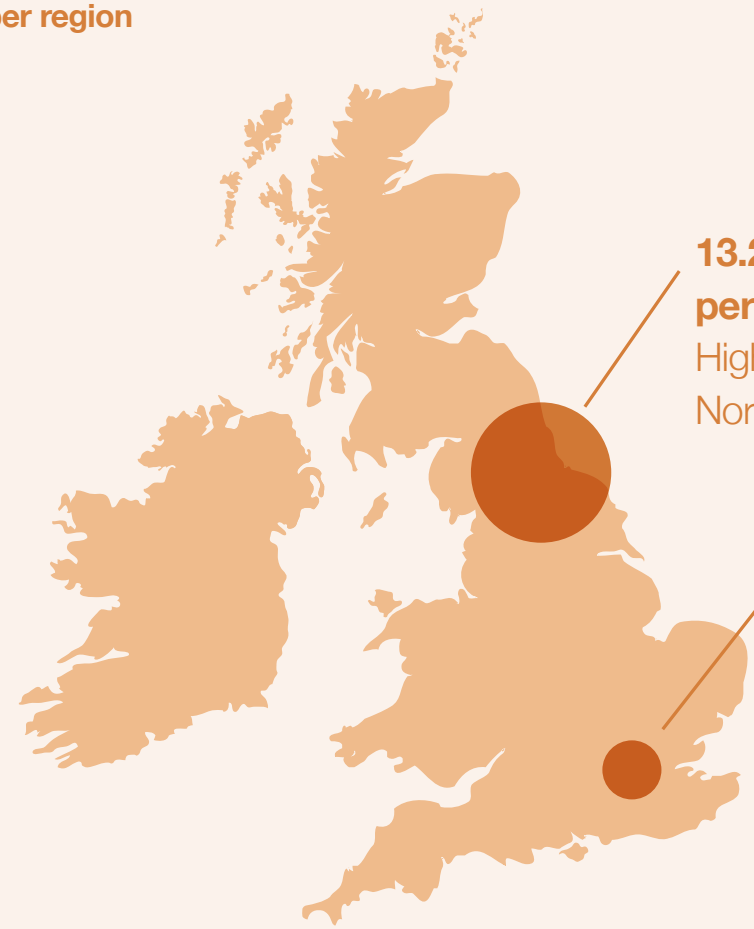
Around 1 in 3 people who die by suicide are known to mental health services

Suicide and men:

76%

of suicides are by men

Suicide rates per region of England



13.2 suicides per 100,000
Highest suicide rate: North East

7.8 suicides per 100,000
Lowest suicide rate: London

Return on investment

The economic cost of each death by suicide in England for those of working age is estimated to be £1.67 million (2009 prices).[2] This covers the direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering. Estimates vary on how many people are affected by each suicide – ranging from 6 to 60 people.[3]

A business case for suicide prevention may include broad estimates of the cost of suicide. Calculations may include multiplying the number of suicides in a particular area by an estimated cost of one suicide. Care must be taken with these estimates.

One European study found "that if an area wide suicide prevention intervention were to achieve only a modest 1% reduction rate in the number of suicides, in most scenarios this remains highly cost-effective."[4]

The Local Government Association and The King's Fund demonstrate how facts around return on investment in public health can be set out. See www.local.gov.uk/publications/-/journal_content/56/10180/6530180/PUBLICATION

4.3 Mapping the strategy to the wider health and wellbeing agenda

Suicide is a complex issue and prevention strategies need to recognise the importance of tackling factors that can lead to suicide in order to be most effective. Suicide prevention activity can be incorporated into other strategies and programmes including:

- joint strategic needs assessments
- mental health and wellbeing strategies
- local crisis care concordat action plans
- sustainability and transformation plans
- local transformation plans for children and young people's mental health and wellbeing
- commissioning of alcohol and substance misuse services

See Section 1 for further information about the wider policy context and Section 2 for Crisis Care Concordat.

Linking to the joint strategic needs assessment (JSNA)

It is recommended that local authorities map suicide prevention to the JSNA.

In Blackpool and Bolton the JSNA includes a suicide prevention section that uses public health data to describe the impact of suicide on the local community and the broad prevention strategies. See www.blackpooljsna.org.uk/Living-and-Working-Well/Health-Conditions/Suicide.aspx

4.4 Accountability

Accountability for the suicide prevention strategy and its associated action plan lies locally with the health and wellbeing board, as the body with responsibility for overseeing the planning of health services in the area. These boards can provide crucial influence and impetus to support the design and delivery of a suicide prevention strategy and enable it to be adopted under the wider health and wellbeing strategy. See page 19 for further information about involving health and wellbeing boards.

In addition to the health and wellbeing board, there may be lines of accountability to the safeguarding adults board and the children and families partnership board.

Regional collaboratives, such as the one established in Cheshire and Merseyside (see page 41) need accountability mechanisms for the regional element of any strategy, alongside local requirements, such as reporting back to their health and wellbeing board. One mechanism for this wider accountability could be to create a strategic partnership board, with local groups feeding into this central board.

4.5 Local approaches to strategy development

There are different approaches to developing and implementing local suicide prevention strategies across England. It is useful to review a selection of examples to gain useful pointers and determine the approach that best suits local need.

The *Inquiry into local suicide prevention plans in England* held by the All-Party Parliamentary Group on Suicide and Self-harm Prevention details local authorities with strategies and action plans in place.[5] Many of these are publically available by searching on the internet.

4.5.1 Suicide-safer communities

In some areas of England, a suicide-safer community approach has been adopted as part of the local strategy. This framework for action focuses on building communities that are committed to talking openly and freely about suicide, promoting wellness and mental health and supporting those bereaved by suicide. It covers nine areas that include leadership, suicide prevention awareness, training, clinical support services and evaluation.

See www.livingworks.net/community/suicide-safer-communities for more information

4.5.2 Regional collaboratives

Some strategies are distinctive in approach because of their broad geographical scope that sees neighbouring local authorities collaborating to deliver a single strategy across a region. By joining together and pooling resources these areas can benefit from economies of scale. This is the approach that has been taken in Cheshire and Merseyside (see box). The 44 identified geographical footprints that have prepared Sustainability and Transformation Plans, as well as devolution, also offer opportunities to take a wider approach.

Developing a suicide prevention strategy in Cheshire and Merseyside

The Champs public health collaborative is working towards a shared vision of eliminating suicides throughout Cheshire and Merseyside. Nine local authorities are formally signed up to a single, overarching strategy and action plan that is driving change across public health, health and wellbeing boards, primary care, secondary care and the wider community.

The NO MORE strategy has four objectives:

1. becoming a 'Suicide Safer Community'
2. the health system transforms care to eliminate suicide for patients
3. support is accessible for those who are exposed to suicide
4. a strong, integrated suicide reduction network provides oversight and governance

To support the development of the strategy in 2013 a summit was held to involve all nine local authorities and local stakeholders to help identify the gaps and discuss local activity. Wider consultation was also undertaken, including an online survey sent out to members of the Cheshire and Mersey Suicide Reduction Network. The sub-regional partnership helps achieve economies of scale by enabling the joint development of a community suicide prevention training module, joint commissioning of a suicide liaison service and a standardised approach to local data collection and the suicide audit process.

See Appendix 6 for the Champs action planning framework and www.no-more.co.uk for further information.

4.5.3 Zero Suicide

The Zero Suicide approach is a US model based on the concept that suicides in health and behavioural care settings are not inevitable. It sets an aspiration and a bold goal of zero suicides within those settings rather than planning for incremental progress. It emphasises bold leadership, training and a data-focused quality improvement approach to inform system changes.[6] It has been adopted in different ways in three areas in England: East of England, Merseyside, and South West England. Local areas are encouraged to search for the latest findings to determine the suitability of this approach for their area.

See www.zerosuicide.com for more information.

Personal perspective on a local suicide prevention strategy

Dr David Fearnley
Medical director at Mersey Care NHS Trust

Mersey Care NHS Trust wants to eliminate suicide as an option for people in contact with secondary health services by providing better care that prevents them reaching a crisis point – and offering alternatives if they do come to crisis.

We have developed a broad and innovative suicide prevention programme which involves training for all staff, personalised safety plans for every service user with a history of intent or self-harm, rapid post-suicide reviews and the creation of a *Safe from Suicide Team* as part of the new assessment and immediate care service.

Given the impact of social factors on the development of mental health problems and as a wider determinant to suicide risk, collaboration across health and social care is critical. We work closely with and through a wide variety of partners including our local crisis care concordat and with local authorities. It's encouraging how we are increasingly thinking about related areas such as housing, along with understanding what is available locally to enhance the wellbeing of our patients when they leave our care and live back in their own communities. It is by aligning multiple agendas that we have the means to deliver better outcomes for our local people at a faster pace.

4.6 Priority areas for all local suicide prevention strategies

The national suicide prevention strategy provides a ready-made framework for local strategy development.

There are six areas for action in the national suicide prevention strategy:[7]

1. reduce the risk of suicide in key high-risk groups
2. tailor approaches to improve mental health in specific groups
3. reduce access to the means of suicide
4. provide better information and support to those bereaved or affected by suicide
5. support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. support research, data collection and monitoring

Local strategies should aim to tackle all six areas in the long term, but in the short term may need to identify the focus for immediate action. The table on page 7 can help to identify the priorities. This should be considered by the multi-agency suicide prevention group alongside local data and intelligence. Some strategies and supporting action plans have chosen to concentrate on three or four areas for action where local partners believe they can make the most difference in their area. Where local prevention strategies span across all six of the areas this is often as a result of work that has developed over a long period of time.

4.7 Developing a multi-agency action plan

The local suicide prevention strategy provides the framework and sets out the overall aims and objectives and the rationale for the approach being taken. Once this is in place, the next step is to develop a multi-agency action plan to detail how the strategy is going to be achieved.

4.7.1 What to include in an action plan

The action plan sets out what will be done, by whom and by when. It usually focuses on planning activities over a one to two year period, and is monitored quarterly. It typically includes:

- what is going to be done under each objective set out in the local strategy
- target audience for the intervention
- delivery lead
- implementation partners
- resource
- timing, including milestones
- monitoring

Each action or intervention should aim to be SMART (specific, measureable, achievable, realistic, time bound), with responsibility and accountability clearly identified from the outset.

Many local areas use a table format to record their action plans: see Appendix 6 for an example.

4.7.2 Example action plans

It may be helpful to review a selection of action plans from different areas to gain useful pointers and determine the approach that best suits local need.

It is likely that some actions can be implemented quickly, with low resource implications, and others may require more planning and investment. It is useful to plan for a mixture of short, medium and long-term actions. Sometimes small low intensity actions can have a significant impact.

Section 5 provides evidence for particular target audiences and types of interventions that could be considered. It is recommended that each area identifies locally appropriate actions based on a local review of nationally and locally available data (see Section 3) and the insights of the multi-agency suicide prevention group and wider partners (see Section 2).

4.8 Monitoring and evaluating suicide prevention strategies and action plans

The suicide prevention strategy and associated action plan should consider from the outset how effectiveness and impact is going to be determined.

It is advisable to allocate a proportion of resources, including time and budget for evaluation.

> All suicide prevention programmes need to be evaluated. And where we do not have the necessary evidence, we must simultaneously implement novel approaches and rigorously evaluate them.
>
> Towards evidence-based suicide prevention programmes. World Health Organization 2010

4.8.1 Setting outcome measures

The ultimate aspiration is to see a reduction in the number of suicides and the *Five year forward view for mental health* set the ambition that by 2020/21 the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels. Contributing to this is a fundamental outcome for all areas, regardless of whether the local rate is currently comparatively high or low.

The relatively small number of suicides at a local level can make it difficult to measure a significant change in rates. The World Health Organization has said that because suicide is a relatively rare phenomenon, reductions in mortality should not be the only outcome measure for a suicide reduction programme. It has suggested that other outcomes such as decreases in suicide attempts and ideation can be used as supplementary measures.[8]

Some suggestions for monitoring include:

- local rates of suicide, attempts or self-harm
- suicide avoidance or help-seeking behaviour, such as use of telephone helplines or entry into treatment for depression
- use of and engagement with health and social care services, for example primary care and mental health services
- suicidal ideation, ranging from fleeting consideration of suicide to detailed plans to die by suicide
- changes in mental health state as assessed by validated measures
- views and experiences of professionals and people who are involved with community-based suicide prevention interventions and their families and carers. For example, less stigma attached to suicidal thoughts

Given evidence that shows the importance of depression recognition and treatment for depression, outcomes measures such as referral rates and psychiatric treatment rates could be considered.[9]

There is also growing evidence to support using self-harm as an outcome measure for suicide prevention work with evidence showing that hospital presentation following self-harm is a clear risk factor for suicide.[10]

Other measures for self-harm include the extent to which patients presenting at hospital receive assessment following self-harm in line with NICE guidelines, to enable early identification and treatment of alcohol problems, and the number of people presenting with self-harm who go on to receive cognitive behavioural therapy.

4.8.2 Setting aims and objectives

The overall objective of any strategy and action plan will be to reduce the number of suicides over a given timeframe. Additional supporting aims and objectives can also be set for individual tactical interventions detailed in the action plan.

The following table provides an illustrative approach using the national suicide prevention strategy action area 5: supporting the media in delivering sensitive approaches to suicide and suicidal behaviour.

Aims	Objectives	Specific outcome	Monitoring data
To encourage local media to report suicide and suicidal behaviour responsibly	For all editors of local media to be familiar with national guidelines for reporting suicide and suicidal behaviour	To see a measurable increase in the number of local articles adhering to national guidelines, including mentioning sources of support, over a specified time period	The number of media guidelines disseminated The number of editors engaging with the local suicide prevention lead The results of national data showing an improvement in local reporting

There is further information about setting aims and objectives and establishing a monitoring and evaluating framework for suicide bereavement services in the NSPA guidance *Support after a suicide: Evaluating local bereavement support services.*

4.8.3 Using a theory of change approach

A theory of change approach helps to map out who the services works with and why (the aims), what resources and skills are needed to provide the service (inputs), what a service will provide (outputs) and what the service wants to achieve (outcomes divided into intermediate and longer term). It is gaining increased recognition as an approach for evaluation across the health and social care sector. It can be co-produced with staff, clients and funders and it can help to:

- build and maintain a staff and volunteer team who have clarity over the aims of a service, and how outcomes can be achieved
- provide a clear way to communicate with funders and donors why selected activities are important (and need resourcing) and how they achieve the stated outcomes
- engage with potential clients so they can see what the benefits may be from the service offered
- support service reviews and innovation plans to develop the service

See http://www.thinknpc.org/publications/creating-your-theory-of-change/ for more information.

4.8.4 Reporting on evaluation

The format for presenting evaluation findings will vary depending on the audience or project. In addition to formal reports detailing the background, aims, objectives, methods, results of analysis and conclusions for improvement and development, evaluation can feed into less formal formats such as blogs, videos, presentations for conferences or reports for funders.

Points to remember

- don't reinvent the wheel. Be consistent and use established approaches where they exist. For example, use standard questionnaires to measure depression and anxiety in interventions focusing on people with depression
- don't be afraid of showing that an intervention has had no or low impact, as lessons can still be learned, especially if the study is high quality
- don't feel you need to work alone. Ask academics for help. Approach your local university to explore an evaluation partnership. Universities may be able to provide guidance on developing high quality research and evaluation studies. Psychology and psychiatric departments usually employ clinical academics who bridge practice and research

  As recommended by Professor Ellen Townsend, Director of the Self-Harm Research Group, University of Nottingham

Section 5:

Ideas for action

The most effective action plans reflect the evidence of local need (Section 3) and the priorities agreed in the local suicide prevention strategy (see Section 4) by the multi-agency suicide prevention group. This means each area's plan will differ. In suicide prevention, as noted by the World Health Organization, "one size does not fit all".[1]

In this section:

To support the design and delivery of local intervention this section provides an overview of the latest evidence for targeting particular audiences and some ideas for action; this is not intended to be exhaustive: see Appendix 6 for further ideas.

The focus is on the six priorities set out *Preventing suicide in England: A cross government strategy to save lives* and the priority areas for action outlined in 2016 in *Preventing suicide in England: Three years on*.

Some actions require the leadership and involvement of clinical services rather than local authorities, which demonstrates the importance of a multi-agency partnership to enable an integrated approach to achieving a reduction in suicides.

5.1 Reducing the risk of suicide in key high-risk groups

The first priority area in the national strategy is for all local strategies to deliver work to reduce the risk of suicide among the following high-risk groups:

- men
- people who self-harm
- people who misuse alcohol and drugs
- people in the care of mental health services
- people in contact with the criminal justice system
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers

These groups are identified as those where the suicide rate is high and there is a known statistically significant increased risk of death by suicide.

These groups are not mutually exclusive, and it is important to consider how measures to address high-risk groups consider each of the different risk factors. For example, whilst the guidance on this page regarding men focuses on encouraging help seeking, the effective treatment for depression and measures to reduce social isolation, addressing the risks associated with substance misuse or vulnerability due to economic circumstances, and in particular tackling unemployment or debt (see page 57) are also important. Taking cross-cutting and coordinated approaches to address high risk groups in each local area is critical to maximising efforts to reduce suicide and improve mental health.

5.1.1 Men

Men are at three times greater risk of suicide than women. Evidence shows:[2]

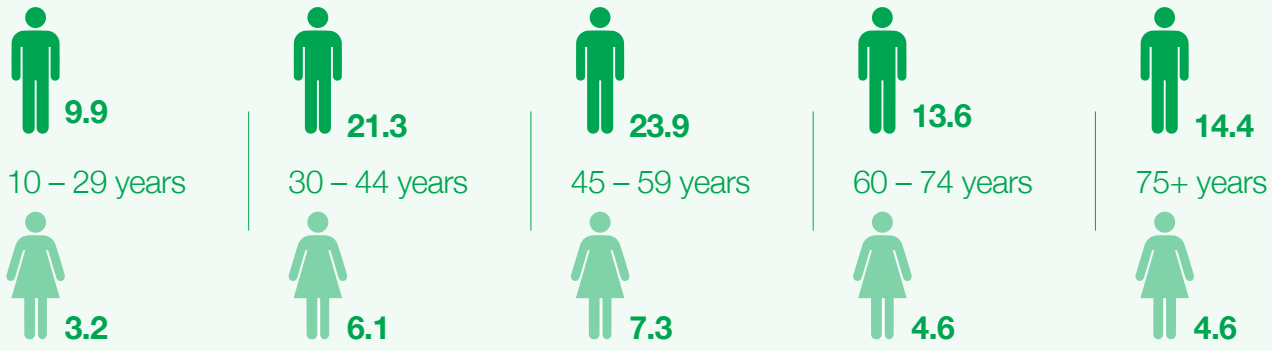
- in 2014 there were 4,882 suicides, of which 76% were by men
- men aged 45-59 have the highest suicide rates
- suicide was the single biggest killer of men aged under 50

There are a range of factors associated with suicide that are particularly common in men. These include depression, especially when it is untreated or undiagnosed, including in older people; alcohol and drug misuse; unemployment; family and relationship problems; social isolation and low self-esteem. Actions to address the impact of these risk factors and to encourage men to seek help is vital in order to effectively reach men.[3, 4, 5, 6, 7]

Initiatives that are shown to be promising for engaging with men include:[8]

- using peer communicators so that men receive information and support from trusted sources
- undertaking outreach work in community and work-based settings rather than in formal health settings

Male and female suicide rates in the UK in 2014 per 100,000 population



Personal perspective on preventing suicides among men

Gerry Cadogan

Public health principal at Torbay Council

Torbay is in the top 20% of deprived geographical areas in England, with high numbers of homeless men, young people self-harming, alcohol misuse and rates of male suicide that continue to increase.

We have undertaken an annual suicide audit using the local coroner's data since 2009 that shows that many of the men who died have experienced a change in their relationships with those close to them, either because of bereavement, relationship breakdown and/or divorce. Only around one in four of the men who died by suicide accessed mental health services. As a result, encouraging men to seek help and talk about their relationships is a priority for us.

We have a range of initiatives happening within local communities; in places where men live, work and socialise. This includes the Torbay Lions Barber Collective, and a programme of work with a pub owner, boxing club owner, taxi drivers and others which together recently won Torbay a Faculty of Public Health mental health award. We are focused on helping men to make the links between physical and emotional health by undertaking a project in partnership with the Arts Council. We also provide access to peer support groups, along with mental health training for service veterans. There is a local telephone helpline that is open most evenings and weekends and we are developing *Barbertalk* mental health and suicide awareness training to deliver in the community, including in prisons.

- providing dedicated non-clinical spaces within which safe conversations can take place, such as the CREE (men's sheds) project in County Durham, and/or where short-term respite can be provided such as Place of Calm in East Sussex

The PHE Suicide Prevention Profile can provide the suicide rate for men and for each age group in your area. See page 26.

There are various sources of information and evidence about men and suicide, including:

- the national suicide prevention strategy *Preventing Suicide in England: a cross-government strategy to save lives*
- the Samaritans report *Men and Suicide: Why it's a social issue*
- the Men's Health Forum *Delivering Male: Effective practice in male mental health*

5.1.2 People who self-harm

Self-harm, whether involving intentional self-poisoning or self-injury, is the most important risk factor for subsequent death by suicide, even though many people who self-harm do not intend to take their own life.[9] People who frequently present to hospital following self-harm are a particularly vulnerable group.[10]

While most people who self-harm do not die by suicide, the strong link between self-harm and suicide make this a matter of concern.

Evidence shows:

- there are around 200,000 episodes of self-harm that present to hospital services each year[11]
- the true scale of the problem is not known as many people who self-harm do not attend A&E, or seek help from health or other services[12]
- around 50% of people who die by suicide had a history of self-harm, in many cases with an episode shortly before their death[13]
- around 15% of those who die by suicide have carried out an act of self-harm leading to presentation at hospital in the year before their death[14]

It is important to ensure implementation of the NICE standards and pathways CG16 and CG133 for managing patients who self harm. See Appendix 2 for details.

Other relevant information is also available in the national CAMHS support service handbook. http://www.chimat.org.uk/ncss/publications

5.1.3 People who misuse alcohol and drugs

The misuse of drugs and alcohol is strongly associated with suicide in the general population, particularly in sub-groups such as men, people who self-harm and those with a mental health diagnosis. The co-existence of drug and/or alcohol misuse alongside a mental health diagnosis is termed "dual diagnosis" and is associated with an increased risk of suicidal ideation and suicide.

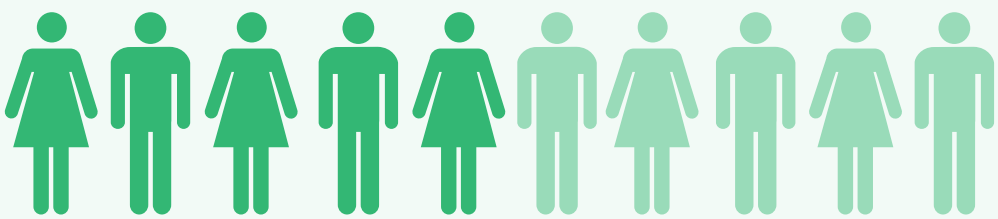
Evidence shows:

- around half (54%) of mental health patient suicides between 2003 and 2013 had a history of either alcohol or drug misuse (or both); an average of 671 deaths per year.[15]

The *Five year forward view for mental health* recommended that there should be outcome based interventions to tackle substance misuse and integrate assessment, care and support for people with co-morbid substance misuse and mental health problems.[16]

There is PHE guidance to support action *Co-existing alcohol and drug misuse with mental health issues: guidance to support local commissioning and delivery of care*

50% of people who die by suicide had a history of self-harm



5.1.4 People in the care of mental health services, including inpatients

People in the care of mental health services are a group with a high risk of death by suicide. Inpatients, people recently discharged from hospital and those who refuse treatment are at the highest risk.[17]

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) annual report provides the latest data and makes recommendations for improving clinical practice and service delivery to prevent suicide and reduce risk.

Evidence shows:[17]

- 30% of all suicides were by people who had contact with mental health services in the past twelve months
- whilst suicides by inpatients and patients recently discharged from hospital have fallen, suicides following discharge from a non-local ward have increased
- suicides by patients under crisis resolution/ home treatment (CR/HT) have increased and now account for three times as many suicides as those of inpatients. In 37% of deaths the patient had been under CR/HT less than a week
- post-discharge is a time of increased risk, with the greatest risk in the first week

Lower patient suicide is associated with specialised community teams, lower non-medical staff turnover and implementing NICE guidance on depression.[18]

Effective pharmacological and psychological treatments of depression are important in prevention as well as education of doctors.[19]

The research shows a reduction in the patient suicide rate for those organisations who implemented between seven and nine recommendations made by the NCISH. The recommendations which made the biggest impact were the provision of 24 hours crisis care and local policies on patients with dual diagnosis.[20]

Other useful sources of guidance include the National Patient Safety Agency's *Toolkit for mental health services* and *Preventing suicide: a toolkit for community mental health*.

30% of all suicides were by people in contact with mental health services in the last 12 months

5.1.5 People in contact with the criminal justice system

People in contact with prisons, probation and the courts are a high-risk group for suicide. Evidence shows that suicide risk is at its highest at transition points as people move into, within and out of the criminal justice system:

- there were 105 self-inflicted deaths in prisons in 12 months to June 2016[21]
- in 2015, 28% of self-inflicted deaths happened within the first month in prison custody, there were 25 such self-inflicted deaths[22]
- 42% of self-inflicted deaths were by prisoners on remand in 2015; this is two out of every five self-inflicted deaths[23]
- risk among recently released prisoners is at its highest within the first 28 days of release[24]

Local authorities have an important role in preventing suicide among those in contact with the criminal justice system, working with partners in multi-agency partnerships such as the National Offender Management Service and Youth Justice Board to provide appropriate services and interventions with a focus on transition times. Secure and detained settings should consider suicide awareness training for those who work in prisons, probation services and the courts. It is important to also implement measures for the prevention and treatment of self harm.

The latest data on the prison and youth justice population are included in the Suicide Prevention Profile (see page 26). Statistics for deaths in prisons are available at https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-june-2016

Personal perspective on preventing suicides among people in contact with the criminal justice system

Maria Foster
Prison support manager
at Samaritans

Samaritans works with a number of partners across the criminal justice sector to provide improved care for individuals in emotional distress. Samaritans volunteers provide phone and face-to-face emotional support to detainees in custody in geographical areas such as Norfolk and Manchester as well providing support on release from custody and through some Approved Premises.

It also provides a scheme in prisons whereby specially trained prisoners, know as Listeners, offer confidential emotional support to their fellow inmates who may have suicidal feelings or be self-harming. Listeners give prisoners who are having a tough time 24/7 access to someone they can confide in without fear of being judged or “reported”. In 2015 Listeners responded to almost 90,000 requests for support.

5.1.6 Specific occupational groups

Unemployment is a risk factor for suicide, (see page 57) and employment can be a protective factor.[25]

Evidence shows:

- certain occupational groups, including doctors, nurses, farmers, veterinary and agricultural workers remain a focus for the national suicide prevention strategy
- the relationship between occupation and suicide risk is complex

It is suggested that relevant actions should consider the following:

- having access to a means and knowledge about methods of suicide accounts for some but not all of the risk in high risk occupations[26]
- there is an association between suicide and factors such as working conditions, low job control, low social support, and high job demands[27]
- low job security has been linked to a rise in suicide risk[27]
- the link between job-related stressors and suicide appears to be particularly pronounced in manual labour jobs[28]

Encouraging employers to promote mental health in the workplace and reduce stigma may be helpful to increase help seeking, particularly among men. Campaigns such as Time to Change can support workplace based action to raise awareness of mental health issues and provide an opportunity for employers to signpost to workplace support, such as employee assistance programmes and occupational health schemes.

PHE has partnered with Business in the Community to produce a *Mental health toolkit for employers*. It includes support for line managers on how to be more aware of mental health issues and how to support staff in need.

Employers are encouraged to work with local occupational health services to strengthen the support available for employees and ensure that staff are regularly signposted to national and local support services. Relevant services include those related to domestic violence, bereavement and relationship support, financial and debt issues and local citizen advice.

Local authorities can also support employer led action through local workplace health and wellbeing accreditations schemes such as the *Workplace Wellbeing Charter* and *Better Work Award.* These aid employers of all sizes and sectors to achieve accreditation against an evidence-based set of standards on promoting health and wellbeing in their workplace. It offers a way to build improvements in workplace health, including enabling implementation of NICE guidance and the HSE *Management Standards for Stress*, and provides a mechanism to connect employers with local health improvement provision and support.

5.2 Tailoring approaches to improve mental health

The second priority area in the national strategy is to improve mental health in a range of groups:

- children and young people, with a focus on vulnerable groups such as looked after children, care leavers and those in the youth justice system
- survivors of abuse or violence, including sexual abuse
- veterans
- people living with long-term physical health conditions
- people with untreated depression
- people who are especially vulnerable due to social and economic circumstances
- people who misuse drugs or alcohol
- lesbian, gay, bisexual and trans people (LGBT)
- black, Asian and ethnic minority groups
- asylum seekers

Information is provided here on cross-cutting approaches that reach across these groups, such as community-based approaches, training, supporting people who are especially vulnerable due to social and economic circumstances and working closely with primary care. Specific suggested actions are also provided for:

- children and young people – although the numbers are small, all efforts should be made to prevent them
- pregnant women and those who have given birth in the last year – suicide is the second most common cause of death

It is important for local areas to understand the needs of people across all the protected characteristics when developing plans. This guidance contains specific sections for those groups where there is strong national evidence of heightened risk, for example middle aged men. However, national data is not routinely collected for suicide against all the characteristics, therefore local demographics need to be considered, including black and minority ethnic groups, asylum seekers and lesbian, gay, bisexual and trans people.

Further support for local areas in developing their approaches to improving mental health across their populations will be part of the forthcoming Prevention Concordat Programme for Better Mental Health for All in 2017.

The Faculty of Public Health report *Better Mental Health for All: a public health approach to mental health*, makes the case for improving mental health for everyone and preventing mental health problems. It is available at: http://www.fph.org.uk/parenting_one_way_of_improving_mental_health_for_everyone

5.2.1 Community-based approaches

Community-based awareness campaigns offer the opportunity to improve the mental health of many and to reduce associated stigma and discrimination that can make it difficult for people experiencing mental health problems or suicidal ideation to seek help.[29]

Such approaches can be most effective when supported by a clear fast-track route to treatment. It is recommended they combine general awareness raising campaigns around mental health and stigma reduction alongside targeted training of professionals and other stakeholders.[30]

In particular, education of primary care doctors targeting depression recognition and treatment has been identified as one of the most effective interventions in lowering suicide rates.[19]

Personal perspective from a community-based prevention project

Miranda Frost

Chief executive at Grassroots Suicide Prevention

At Grassroots Suicide Prevention we're leading the drive to make Brighton and Hove a Suicide Safer city. Our community work promotes open, direct conversations about suicide, and equips people with potentially life-saving suicide prevention skills. The multi-agency suicide prevention group, of which we're a member, supports this community-based approach and we lead a working group focused on targeting high-risk groups and locations of concern.

Brighton and Hove's railway and seven-mile long seafront have been identified as local geographical areas of concern for suicides. The local Samaritans, the coastal engineer for Brighton & Hove City Council and the public health lead joined forces to put up 'Talk to Us' signs in these areas, giving Samaritans' freephone number. We provided accredited training for the seafront management team, coastguards and RNLI staff to help them to respond to individuals in distress.

We also worked with Network Rail and Sussex Partnership NHS Foundation Trust to build on national work being done by Network Rail and Samaritans to prevent suicides on the railways. This collaboration included developing the *Staying Alive* mobile phone app that signposts resources and gives guidance to anyone thinking about suicide or concerned about someone.

Other suicide prevention group initiatives have included: a men's shed for retired or unemployed men; support groups for prison leavers; brief psychological interventions for anyone presenting at A&E following self-harm; training for frontline health professionals working with high-risk groups (including our local LGBTQ population); awareness-raising across social media; and undertaking community outreach work.

5.2.2 Suicide prevention training

Training programmes for suicide prevention seek to improve the knowledge, skills and attitudes of professionals, community members and friends who may have proximity to those with suicidal ideation to improve their ability to intervene and offer support. Or alternatively, they aim to reduce suicidal thoughts and death by suicide in a target population.

Broadly, there are three key approaches to training programmes:

- gatekeeper training
- general awareness and educational curricula
- skills based training

Gatekeeper training

This training is focused on specific groups of people who have the greatest opportunity to identify people at risk of suicide and then to manage the situation appropriately. Gatekeepers may include professionals, such as GPs and mental health staff, or community members who may have contact with people with suicidal intent. They include teachers, faith leaders, people working in the criminal justice system or alongside those in high-risk occupations.

In 2011, the Department of Health published a report that calculates that for every £1 investment into suicide prevention through GP training then £44 is saved.[31]

Personal perspective from a commissioner of suicide prevention training for GPs

Charlotte Gath
Consultant in public health at
Warwickshire County Council

We identified GP training for suicide prevention as one of our priority investment areas for commissioned services in our 2014-2016 Warwickshire Public Mental Health and Wellbeing Strategy.

Working closely with our three CCGs we have set out to train 75% of our local GPs because our consultation led us to believe that this number would give us a critical mass to effect real change. To date we have trained 56 GPs (around 25%) and participants have rated the training very highly. It has been a challenge to secure attendance from our local GPs but being able to fund cover while they attend the training has been very helpful. Every GP who has attended to date has rated the training as good or excellent. We have now commissioned the second wave and our CCG is timetabling the sessions as part of GPs' protected learning time.

Skills based training

Skills-based training involves building positive mental health and wellbeing by developing skills such as those required to build strong personal relationships, a personal belief system and effective coping strategies that will reduce the individual risk factors associated with suicide, amongst other things. It is an 'upstream' approach to prevention.

General awareness and educational curricula

General awareness programmes, including those in educational settings, seek to improve broad understanding of issues that impact on mental health and the factors that may contribute to suicidal ideation.

The PHE *Public mental health leadership and workforce development framework* can be used to consider competences in relation to mental health.

5.2.3 People who are vulnerable due to economic circumstances

Suicide is a significant inequality issue as there are marked differences in the suicide rates according to people's social and economic backgrounds. All staff undertaking NHS and public health functions on behalf of the Secretary of State are responsible for ensuring compliance with the legal duty under The Health and Social Care Act (2012) to have due regard to the need to reduce health inequalities.

Improving the mental health of people who are vulnerable due to economic circumstances supports suicide prevention.

Evidence shows:

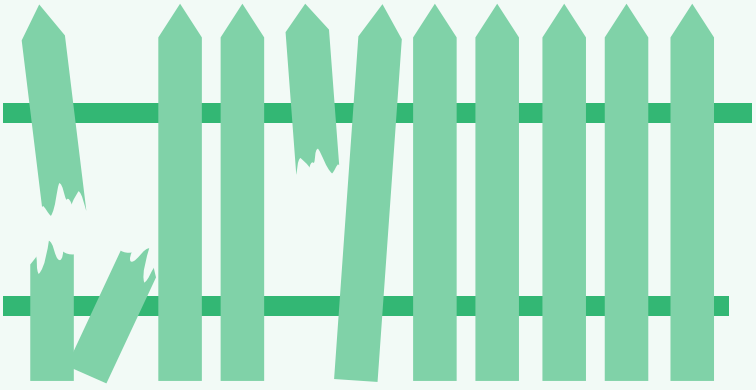
- people in the lowest socio economic group and living in the most deprived geographical areas are ten times more at risk of suicide than those in the most affluent group living in the most affluent areas[32]
- suicide is the cause of an extra 1,466 deaths for men and 262 excess deaths for women in the most deprived quintile compared to the least deprived quintile of England[33]
- men of lower socio-economic position in their mid years are excessively vulnerable to death by suicide compared to males in other age groups and compared to women of all ages[32]
- 46% of mental health services' patients who died by suicide between 2008-2012 were unemployed at the time of death[17]
- 18% of mental health services' patients who died by suicide between 2012 and 2013 had experienced serious financial difficulties in the three months before death[17]
- in 2008-2012 7% of mental health services' patients who died by suicide were in unstable housing, i.e. homeless or living in bed and breakfast or a hostel[17]

Given that reducing health inequalities and addressing the social determinants of health are a central concern for local authorities it is recommended that action to address these are explicitly linked to suicide prevention strategies.

Ideas for action include:

- collaborating with voluntary sector and community groups, such as Citizens Advice, housing associations and homelessness services to provide and promote financial and debt counselling support to vulnerable individuals
- providing suicide awareness training to frontline service providers across education, housing, employment and others
- increasing information and support services available in response to significant economic changes in any community, for instance the closure of a major employer
- providing supportive parenting training and advice to vulnerable families

People in the lowest socio-economic group and living in the most deprived areas are **ten times** more at risk of suicide than those in the most affluent group living in the most affluent areas



Building on the recommendations of the Marmot Review (2010) to reduce health inequalities, the UCL Institute of Health Equity has produced a series of practice resources that include evidence and examples of practical action that can be taken at a local level to reduce health inequalities. They are designed to support health and wellbeing boards, directors of public health and public health teams as well as people working in local authorities services that may influence health and wellbeing. The series of resources are available here: https://www.gov.uk/government/collections/local-action-on-health-inequalities-practice-resources

5.2.4 Pregnant women and those who have given birth in the last year

Local geographical areas may wish to consider specific interventions to support women's mental health during the pregnancy and post-natal period including assistance in bonding with their babies.

Evidence shows:[34]

- up to one in five women risk having a mental health condition during pregnancy and in the 12 months after childbirth
- suicide is the second most common cause of death

In 2015 the government launched a new ambition to reduce the rate of stillbirths, infant and maternal deaths in England by 50% by 2030.

5.2.5 Children and young people

Improving the mental health of children and young people, including looked-after children, care leavers and children and young people in the youth justice system is crucial to reducing deaths by suicide.

Evidence shows:

- suicide is one of the main causes of mortality in young people and for families its impact is particularly traumatic[35]
- between 2003 and 2013, an average of 428 people aged under-25 died by suicide in England per year, of whom 137 were aged under 20, and 60 were aged under 18[36]

The first phase of a UK wide investigation into suicides by people aged under-25, Suicide by Children and Young People in England, reports the following emerging themes:[36]

- family factors such as mental illness
- abuse and neglect
- bereavement and experience of suicide
- bullying
- suicide-related internet use
- academic pressures, especially related to exams
- social isolation or withdrawal
- physical health conditions that may have social impact
- alcohol and illicit drugs
- mental ill-health, self-harm and suicidal ideas

The report highlights the importance of recognising the pattern of cumulative risk and so-called final straw stresses, such as exams, that contribute to suicide in children and young people.

School based-awareness programmes have shown promise in reducing suicide attempts,[19] see the box on page 59. There are a number of PHE documents that provide useful further information:

- *Improving young people's health and wellbeing: a framework for public health*

- *Promoting children and young people's emotional health and wellbeing: a whole school and college approach*
- *A public health approach to promoting young people's resilience*

Further sources of information relating to children and young people's mental health and wellbeing are provided in Appendix 7.

The Saving and Empowering Young Lives in Europe (SEYLE) project

The SEYLE research project investigated the effectiveness of school-based interventions aimed at reducing suicidal ideation.[37] It involved 11,110 students, with a median age of 15 years, from 168 schools in 10 EU countries. It tested three interventions:

- Gatekeeper training for teachers and other school staff
- A youth mental health awareness programme targeting school pupils
- Professional screening of students considered to be at risk of suicide

The youth mental health awareness programme was found to be effective in reducing the number of suicide attempts and severe suicidal ideation.

Lesbian, bisexual, gay and trans young people

Whilst someone's sexual orientation or gender identity or expression is not a risk factor itself for suicide or self-harm, current evidence shows that lesbian, gay, bisexual and trans (LGBT) young people have a greater risk of suicidal behaviour than their heterosexual peers.

There are two PHE toolkits developed with the Royal College of Nursing to support nurses to increase their skills and knowledge around suicide prevention strategies with LGBT young people. Although aimed at nurses, the information is likely to be of value to other professionals working on suicide prevention amongst this group.

- *Preventing suicide among lesbian, gay and bisexual young people: a toolkit for nurses*
- *Preventing suicide among trans young people: a toolkit for nurses*

5.3 Reducing access to the means of suicide

The third priority area in the national strategy is reducing access to the means of suicide, which is one of the most effective ways to prevent suicide.

Evidence shows:

Since 2005, evidence for restricting access to lethal means in prevention of suicide has strengthened,[19, 38] especially with regard to control of analgesics[39] and structural interventions at high risk locations for suicide by jumping, with an overall reduction in deaths of 86% and little evidence of major substitution to other potential jumping sites.[19, 40]

Ideas for action include:[41]

- working with retailers to control the sale of dangerous gases and liquids
- working with media to restrict coverage of methods and sites associated with suicidal acts has been linked with positive changes in reporting as well as decreases in suicide levels. See page 62.

Local data gathered from suicide audits or real-time surveillance may provide insights into emerging trends with regards to locations and methods: see Section 3. PHE has produced guidance on preventing suicide at high risk locations, such as bridges and high buildings.

Further information is available in *Preventing suicides in public places*

A national resource for local authorities: The rail industry

There are around 308 deaths on Britain's railways every year and 82% of them are thought to be deaths by suicide. The rail industry led by Network Rail has responded by developing a wide-ranging suicide prevention strategy that aims to reduce these deaths – not least because deaths and dealing with their aftermath is distressing for their staff.

It is a strategy that is based on working closely with national and local partners – including British Transport Police and Samaritans to reduce the access to the means of suicide and promote help seeking behaviour. Over 11,000 rail staff – including the chief executive of Network Rail – have been trained by Samaritans in suicide awareness. In 2015/16 rail staff reported making more than 239 interventions.

Work at national level with the Samaritans has resulted in a standardised approach and resources, including training materials, which can be used at local level as well as a network of regional suicide prevention representatives. The rail industry also has a large database that can support local authorities investigate suicides.

For more information contact:
suicidepreventionprogramme@networkrail.co.uk

5.4 Providing better information and support to those bereaved or affected by suicide

The fourth priority area in the national strategy is providing information and support to those bereaved or affected by suicide. There is growing evidence that individuals and communities feel the need for support following suicides.[42] Pending trial evidence, there is also the hope that this support might serve to reduce the risk of the adverse consequences of suicide bereavement, which include poor social and occupational functioning, depression, suicide attempt, and even suicide.[43, 44]

It is important that all geographical areas include a comprehensive postvention component to the suicide prevention strategy in order to ensure that there is timely information and support provided to those bereaved or affected by a suicide, as well as the means to deliver a rapid community-based response if there is an emerging cluster.

There should also be resources made available to support those who are concerned about a family member, friend of colleague.

What is postvention?

The term postvention describes activities developed by, with, or for people who have been bereaved by suicide, to support their recovery and to prevent adverse outcomes, including suicide and suicidal ideation.[45]

Ideas for action:

- ensure all first responders have supplies of, and distribute, the *Help is at Hand* z-card
- disseminate the *Help is at Hand* booklet to affected individuals via Coroner's office, local funeral directors and voluntary sector organisations
- provide *Help is at Hand* in community settings such as libraries, primary care and community centres and through bereavement support organisations
- map current provision of bereavement support services to identify gaps to address through commissioning
- support community-response in settings such as schools, colleges and workplaces
- ensure individual approaches for anyone identified as being at risk of contagion, including rapid referral for community mental health support where needed

Relevant resources

***Support after a suicide: A guide to providing local services* is new PHE guidance that makes the case for commissioning postvention services and how this work fits into suicide prevention strategies. The NSPA resource *Support after a suicide: Developing and delivering local bereavement support services* provides a recommended framework and pathway for service providers. The NSPA have also produced *Support after a suicide: Evaluating local bereavement support services* to help suicide bereavement services evaluate their impact.**

PHE has supported the development of a guide for people bereaved by suicide called *Help is at Hand*. Materials can be downloaded from the Support After Suicide website at www.supportaftersuicide.org.

5.5 Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour

The fifth priority area in the national strategy is supporting the media to deliver sensitive coverage. Research demonstrates strong links between media reporting of suicide and imitative suicidal behaviour.[46] This risk significantly increases if the suicide method is described, if the story is placed prominently and if the coverage is sensationalised and/or extensive. While much of the work to promote responsible reporting is done at a national level, there is a place for prevention work with local media, including social media.

Ideas for action:

- ensure local media are aware of, and following, Samaritans' guidance on responsible media reporting
- provide local media with access to the designated suicide prevention lead so they can speak to them prior to running any story
- work with local media to encourage them to provide information about sources of support and contact details of helplines when reporting mental health and suicide stories

Further information is available in Samaritans' *Media guidelines for reporting suicide* and Public Health England: *Identifying and responding to suicide clusters and contagion.*

Working with the media in East Sussex

East Sussex has a suicide rate that is significantly higher than the national average.

An important aspect of the local suicide prevention plan is tackling media coverage of suicides in the area, especially those that take place in a public place. Samaritans have helped to develop a local media policy. This outlines that all media enquiries will receive a consistent response from local agencies who will:

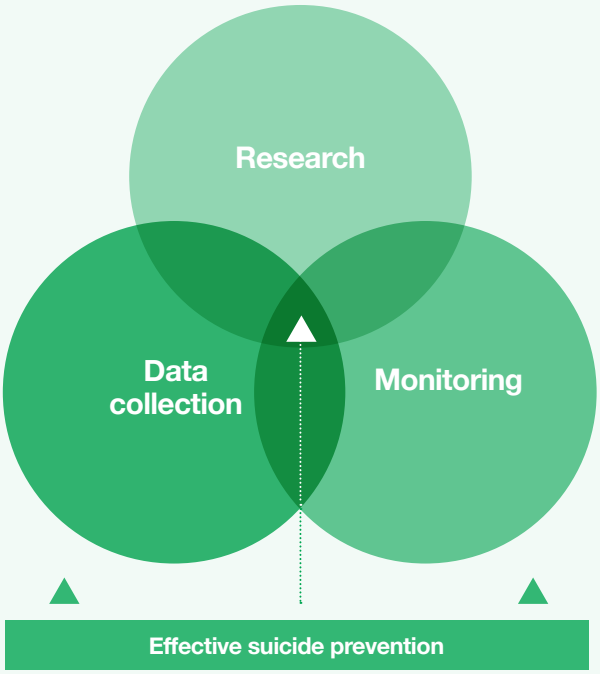
- release as little information as possible to journalists
- refer any journalists covering an incident to Samaritans' media guidelines
- highlight to the media the agencies that can provide help to bereaved families and friends

The desired outcome is that media coverage of suicides in the area will be non-sensationalist and rather will focus on tragic loss of life and impact on family and friends and include the Samaritans helpline number and local contact details for other services.

The East Sussex Suicide Prevention Action Plan 2015-16 is available at http://www.nspa.org.uk/wp-content/uploads/2015/12/East-Sussex-Suicide-Prevention-Plan.pdf

5.6 Supporting research, data collection and monitoring

The sixth area of the national strategy is supporting research, data collection and monitoring. This is an important component of any suicide prevention strategy and action plan as it underpins both the emerging national evidence base for effective suicide prevention and ensures that local action plans are monitored and evaluated.



Guidance about using nationally available data and undertaking local data collection is outlined in Section 3 and on page 44 of Section 4 there is information about monitoring and evaluation.

Beyond this, collaboration with academic partners can bring value to local action plans and on page 23 we provide a case study outlining the many benefits that kind of joint working can bring.

Suicide is preventable, we have to remember that. That's why we have to take more action to let people know their lives are important because when suicidal thoughts are at their strongest it's hard for people to see their own worth.

As someone who has attempted to take my own life, I know the importance of timely and compassionate support when it seems that all hope is lost. Until I went to stay at the Maytree Suicide Respite Centre in London I didn't think I could recover; they helped me see that I had a life ahead of me despite what had happened to me. They allowed me to talk about suicide and talking about it made me see that there was a life beyond it. They helped me save my life.

Developing effective and comprehensive local suicide prevention strategies provides the opportunity to identify and support people at risk when they are at the crux of their lives.

I'm glad my own life was saved and we can save more lives by planning and working together. We can do this.

James Withey
The Recovery Letters

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Appendix 1

Prompts for local leaders on suicide prevention

These prompts have been prepared to accompany Preventing suicide in England: A cross-government outcomes strategy for saving lives, published in September 2012.

A number of organisations will be undertaking activity relevant to suicide prevention at local level. To establish what is happening within the local authority boundary, the following questions may be useful:

- what level of understanding of suicide do local councillors, Directors of Public Health and Clinical Commissioning Groups have?
- what is the rate of suicide among the general population in the local authority area?
- is this rate higher or lower than the general population rate for England of 7.9 deaths per 100,000 population in 2008-10? What is the current trend in suicide rates showing?
- is information available on the rate of suicide among different groups and gender, e.g. middle-aged men?
- what steps have been taken locally to monitor and take action to reduce the rate of suicide within the local authority area? For example, is there a specific and agreed reduction in the rate of suicide that the local authority will aim to achieve?
- is suicide prevention included in the Joint Strategic Needs Assessments and the Joint Health and Wellbeing Strategy?
- Is there a local group or network established to oversee suicide prevention activity in the locality? If so:
  - who leads this group? Is it the Clinical Commissioning Group, local government, public health or joint arrangements?
  - is there a local councillor with specific responsibility for suicide prevention?
  - what other local agencies and partners are members of this group or network, or are consulted as part of any suicide prevention activity (eg police)?
  - does this involve GPs or other professionals working in primary care settings? If not, how do they input into activities or actions to prevent suicides locally?
  - how do these groups or work link with wider local public health and health improvement activities?
  - how do these groups or work link with local safeguarding arrangements?
  - what governance arrangements are in place?
  - does the group or network undertake a local analysis of suicide data and/or participate in local suicide audits?
  - does this include the identification of particular high-risk groups?
  - does the group or network produce an action plan on local suicide prevention activity and is this monitored?

Appendix 1 Prompts for local leaders on suicide prevention

  - does the action plan include the need to consider developing suicide prevention awareness and skills training for professionals in primary care and local government (housing, environmental health, social care, benefits, etc) and other services that may come into contact with individuals at risk of suicide? If so, what groups of front-line staff have had such training?
  - does it involve the local community?
- do joint strategic needs assessments adequately identify action to support people at risk of suicide or suicidal behaviour within the local population?
- has the local authority or other agency identified any specific locations which provide opportunities for suicide and/or where suicides/attempted suicides have occurred (such as a bridge, cliff or rail crossing)?
- what steps have been considered or taken to reduce the risk of suicide at such locations?
- what other agencies are involved in supporting this preventative action at high-risk places?
- does the local coroners' office support preventative action at local level? If so:
  - are coroners formal members of any groups or networks that exist?
  - do they provide access to coroners' records of inquests for local analysis or audit purposes?
  - do they involve or inform the local authority or Director of Public Health if they identify (at inquest proceedings or earlier) particular areas of concern, e.g. locations used for suicide, possible clusters of suicide, increase in a particular method or new and emerging method of suicide?
- what support is available within the local authority area for those affected by a suicide? What agencies provide this support?
- are any data collected on attempted suicides within the local authority area? If so by whom? Are these data shared with other agencies?

Appendix 2

NICE guidelines relevant to suicide prevention

- Self-harm in over 8s: short-term management and prevention of recurrence (2004) NICE guideline CG16
- Depression in adults: recognition and management (2009) NICE guideline CG90
- Self-harm in over 8s: long-term management (2011) NICE guideline CG133
- Borderline personality disorder: recognition and management (2009) NICE guideline CG78
- Bipolar disorder: assessment and management (2014) NICE guideline CG185
- Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (2011) NICE guideline CG115
- Depression in adults with a chronic physical health problem: recognition and management (2009) NICE guideline CG91
- Common mental health problems: identification and pathways to care (2011) NICE guideline CG123
- Antisocial behaviour and conduct disorders in children and young people: recognition and management (2013) NICE guideline CG158
- Psychosis and schizophrenia in adults: prevention and management (2014) NICE guideline CG178
- Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (2015) NICE guideline NG11.
- Mental wellbeing in over 65s: occupational therapy and physical activity interventions (2008) NICE guideline PH16
- Social and emotional wellbeing in secondary education (2009) NICE guideline PH20
- Mental wellbeing at work (2009) NICE guideline PH22
- Alcohol-use disorders: prevention (2010) NICE guideline PH24
- Looked-after children and young people (2010) NICE guideline PH28

NICE guidance on the experience of people using the NHS:

- Patient experience in adult NHS services (2012) NICE guideline CG138
- Service user experience in adult mental health (2011) NICE guideline CG136
- Medicines adherence (2009) NICE guideline CG76

NICE guidance on community engagement:

- Community engagement: improving health and wellbeing and reducing health inequalities (2016). NICE guideline NG44

Appendix 3

Sample terms of reference for a suicide prevention multi-agency steering group

1. Aim

The [your locality] Suicide Prevention Steering Group aims:

- to reduce the rate of suicide and self-harm within [your locality]
- to provide a forum for successful multi-agency partnership working at strategic and operational level

2. Objectives

To facilitate and promote joined up partnership arrangements where appropriate in ensuring effective working to reduce suicide rates across [your locality]

3. Responsibilities

- to develop and agree a multi-agency suicide prevention strategy and action plan for [your locality]
- to monitor the implementation of the suicide prevention strategy
- to review and update the strategy as appropriate
- to commission and develop specific projects and initiatives to meet the aims of the suicide prevention strategy over and above routine MH commissioning by CCGs
- to commission and analyse an annual statistical and intelligence update
- to publicise ongoing work and recent developments
- to facilitate partnership working between organisations represented on the Steering Group
- to influence the work of all agencies and individuals who could help prevent suicide and self harm, including those with lived experience.

4. Membership

To ensure that as many people and organisations are aware of, and involved in, suicide prevention this group has two types of members:

- those that regularly attend the meetings of the steering group
- those who don't regularly attend the meetings, but are on the circulation list and may attend the meetings on an ad-hoc basis.

[Include list of people who have agreed to attend regularly and a list of people to be included in the circulation list who may attend on an ad hoc basis.]

5. Accountability

[Set out how the steering group will report. This might include the Cabinet Member for Adult Social Care, the Adult Social Care and Health Committee within the County Council and/or the local Health and Wellbeing Board.]

6. Administrative support

Public Health will provide the Chair and the admin support for the Group until [insert date].

7. TOR approval and review date

Terms of reference will be reviewed every two years. The next review date will be [insert date]

8. Frequency of Meetings

Meetings of the steering group will be held [agree frequency, for example quarterly] (unless otherwise agreed by the steering group). Where possible, meetings will be held in different venues across [your locality]

Appendix 4

National public health data sources to support suicide

Compendium of Health Indicators

Hosted by the Health and Social Care Information Centre (HSCIC), the Compendium of Health Indicators gives a comprehensive overview of population health at a national, regional and local level. Sitting alongside the compendium is the Local Basket of Inequalities Indicators (LBOI). This collection of 60 indicators helps organisations to measure health and other factors which influence health inequalities such as unemployment, poverty, crime and education.

This data is available at

www.hscic.gov.uk/article/1885/Compendium-of-Population-Health-Indicators

Hospital Episode Statistics

The Health and Social Care Information Centre (HSCIC) hold Hospital Episode Statistics that provides details on all admissions, outpatient appointments and A&E attendances at NHS hospitals in England.

This data is available at

www.hscic.gov.uk/hes

Multicentre Study of Self-harm

The Multicentre Study of Self-harm in England is a collaborative research programme between the University of Oxford, University of Manchester and Derbyshire Healthcare NHS Foundation Trust. The three areas run local monitoring systems that collect detailed information on general hospital presentations by people who have self-harmed. Research from the collaboration examines epidemiology, trends and causes of self-harm, its clinical management, as well as outcomes and prevention of self-harm. It provides the most accurate and reliable information on self-harm in England.

Further information is available at:

http://cebmh.warne.ox.ac.uk/csr/mcm/index.html

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

The University of Manchester's National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) publish an annual report that examines deaths by people with mental illness. It includes information on all suicides in the UK in a preceding 10 year period. The most recent report published in 2015 is for 2004-2014 and it provides data about the rate, trends and methods of patient suicides. Each annual report presents important findings to influence local practice.

Further information is available at:

http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/

Appendix 4 National public health data sources to support suicide

National Drug Treatment Monitoring System

This system, known as NDTMS, collects and analyses information from and for those involved in the drug and alcohol misuse treatment sector.

This data is available at

www.ndtms.net

PHE National Mental Health Dementia and Neurology Intelligence Network Crisis Care Data Catalogue

The crisis care profile has local level data related to mental health crisis care. The data is presented within the five domains of: understanding need, access to support before crisis, urgent and emergency access, quality of treatment and preventing future crisis.

This data is available at:

http://www.yhpho.org.uk/resource/view.aspx?RID=232017

Primary Care Mortality Database

Also hosted by HSCIC, the Primary Care Mortality Database holds mortality data as provided at the time of registration of the death along with additional GP details, geographical indexing and coroner details where applicable. This data is for use by public health analysts in local authorities and analysts in NHS organisations who require deaths data for statistical purposes.

This data is available at:

http://digital.nhs.uk/pcmdatabase

Safety in Custody Statistics

ONS and the Ministry of Justice publish data on deaths, self-harm and assaults in prison custody in England and Wales. The latest report provides an update on statistics on assaults and self-harm up to June 2015 and statistics on deaths in prison custody up to September 2015.

This data is available at

www.gov.uk/government/collections/safety-in-custody-statistics

Secondary Use Services data

This is a single and comprehensive repository for healthcare data in England that details information about when a patient is treated or cared for. Commissioners and providers of NHS funded care can use this data for purposes other than direct or 'primary' clinical care. The data can be accessed by local clinical commissioning groups or commissioning support units.

Further information about this data is available at:

www.hscic.gov.uk/sus

The Segment Tool

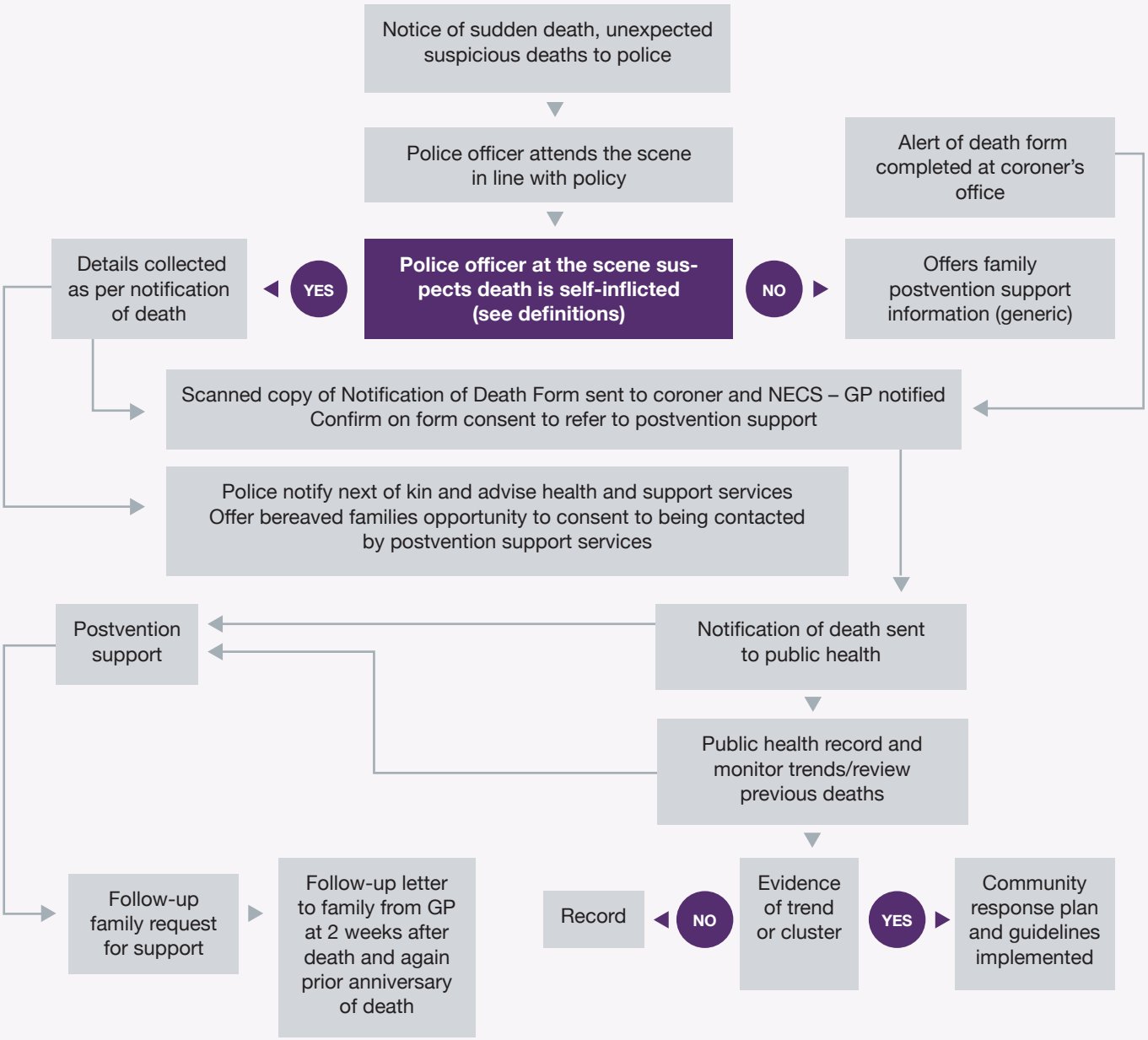
The Segment Tool has been developed by the PHE Knowledge and Intelligence teams (London and East Midlands) and provides information on the causes of death that are driving inequalities in life expectancy at local area levels. The tool uses data for 2010-12 and it is possible to view a breakdown of the life expectancy gap both within local authority areas, and between a local authority and England as a whole.

This data is available at

www.lho.org.uk/LHO_Topics/Analytic_Tools/Segment/TheSegmentTool.aspx

Appendix 5

Overview of the County Durham police led real-time suicide surveillance strategy



McGeechan G, Richardson C, Weir K, Wilson L, Newbury-Birch D (2016) Real Time Suspected Suicide Early Alert System: A Case Study Approach. Report to Durham County Council and School of Health and Social Care, Teesside University.

Appendix 5 Overview of the County Durham police led real-time suicide surveillance strategy

Real-time suspected suicide monitoring only

1. **Police including British Transport Police** should send notification of death form to patient safety team at same time as coroner. **Patient safety team** should notify GP, CCG lead and Public Health lead at the local authority. **Patient safety team** will record all suspected suicides.
2. **Police** should ensure that a reminder is printed on their notification of death form stating where the form should be sent to ensure that a suspected suicide is logged on Command and Control system.

- **Public health team**
- **Police officer**
- **Patient safety team**

Real-time suspected suicide early alert system with monitoring of clusters and trends

3. 3. When attending a suspected suicide the **attending police officer** should offer Help is at Hand and local support information booklet should be given to families and individuals advising them of support services which are available to them locally.
4. **The public health team** within the local authority should monitor suspected suicides identified via the police **Command and Control System** and notification of death forms to identify potential suicide clusters, trends and areas of interest.

   Suicide community repsonse protocol and guidelines should be followed and so appropriate action can be taken as soon as possible.

Real-time suspected suicide alert system with police led referral to support services

5. **The public health team** within the local authority should identify appropriate support services who could be involved in the real time suspected suicide early alert strategy who postvention support service can signpost clients to.
6. **Public health team to** establish steering group involving key stakeholders from local authority, CCG's, police force, and relevant support services to oversee the delivery of the strategy.
7. **Police officers** attending a suspected suicide should ask bereaved individuals for consent to pass their contact details on to postvention support service.
8. **Police officer should** log bereaved individuals consent on the notification of death form and send to **patient safety team within 24 hours.**

McGeechan G, Richardson C, Weir K, Wilson L, Newbury-Birch D (2016) Real Time Suspected Suicide Early Alert System: A Case Study Approach. Report to Durham County Council and School of Health and Social Care, Teesside University.

Appendix 6

Champs action planning framework

Introduction

Suicide[1] is a major issue for society and a leading cause of years of life lost. Every suicide affects families, friends, colleagues and others.

Suicide can also have a profound effect on the local community.

Suicides are not inevitable; however the factors leading to someone taking their own life are often complex. The prevention of suicide has to address this complexity. No one organisation is able to directly influence all factors, it is vital that services, communities, individuals and society as a whole work together to help prevent suicides.

National Policy

In 2012, the Government published its new suicide strategy Preventing suicide in England: a cross-government outcomes strategy to save lives.

The strategy focuses on two overarching objectives:

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

To support the achievement of these objectives 6 areas for action have been identified:

1: reduce the risk of suicide in high-risk groups

2: tailor approaches to improve mental health in specific groups

3: reduce access to the means of suicide

4: provide better information and support to those bereaved or affected by suicide

5: support the media in delivering sensitive approaches to suicide and suicidal behaviour

6: Support research, data collection and monitoring

Suicide rate is included as an indicator within the Public Health Outcomes Framework. This will help localities measure progress against the overall aim to reduce the suicide rate.

Action Plan Framework

The action plan is organised by the 6 objectives outlined within the Preventing suicide in England strategy. In addition actions related to wellbeing promotion are also included.

The level of intervention (local/ regional) and responsible lead are outlined, along with a red, amber, green (RAG) status.

The action plan should be reviewed annually by the local authority public health (LA-PH) suicide lead and the Cheshire and Merseyside Regional group.

An annual report based upon progress towards meeting these actions should also be produced.

References

Preventing suicide in England: a cross-government outcomes strategy to save lives. Available from: https://www.gov.uk/government/publications/suicide-prevention-strategy-launched

Public Health Outcomes Framework: Indicator 4.10 Suicide rate. Avaialble from: http://www.phoutcomes.info/search/SUICIDE#gid/1/par/E12000002/ati/102/page/0

Appendix 6 Champs action planning framework

Area for action	Standard/ Description of intervention	Standard/ Description of intervention	Lead (Responsibility)	Level (local/ regional)
1	**Reduce the risk of suicide in high-risk groups**			
1.1	**Young and middle aged men**			
a	Promote multi-agency suicide prevention work	Establish and maintain strong links between health and non-health services identified as being key to promoting young men's mental health	LA - PH/ LA	Local
b	Suicide awareness training	Training to be provided to front line staff that support young and middle aged men	LA - PH/ LA	Local/ Regional
c	Community outreach programmes	Suicide awareness messages to be promoted at traditional male settings e.g. football, rugby public houses and music venues	LA - PH/ LA/ 3rd and voluntary sector	Local/ Regional
1.2	**People in the care of mental health services**			
a	Suicide awareness training	Training to be provided to front-line staff working with high risk groups	CCG	Local
b	Risk management training	Training to be provided to front-line staff working with high risk groups	CCG	Local
c	Safe clinical areas	Ensure regular assessment of ward areas to identify and remove potential risks e.g. ligature ligatures and ligature points, access to medications, access to windows and high risk areas	CCG	Local
d	Mental health services comply with best practice on suicide prevention	Review suicide prevention practices using an appropriate tool e.g. The National Patient Safety Agency's (NSPA's) Preventing Suicide: A Toolkit for mental health services	CCG	Local
e	Improve care pathways between emergency departments, primary and secondary care	Review care pathways using an appropriate tool e.g. The National Patient Safety Agency's (NSPA's) Preventing Suicide: A Toolkit for community mental health	CCG	Local
1.3	**People with a history of self-harm**			
a	Compliance with NICE guidance	Implement NICE guidelines on self-harm (NICE CG16 & NICE CG133)	CCG/ NHS England	Local
b	Suicide and self-harm awareness training for healthcare staff	Training to be provided for staff working in emergency departments, ambulance staff and primary care	CCG/ NHS England	Local
c	Suicide and self-harm awareness training for community staff	Training to be provided for staff working in schools and colleges, care environments, and criminal and youth justice systems	LA/ LA- PH	Local

Appendix 6 Champs action planning framework

Area for action	Standard/ Description of intervention	Standard/ Description of intervention	Lead (Responsibility)	Level (local/ regional)
2	**Tailor approaches to improve mental health in specific groups**			
2.1	**Children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the YJS**			
a	Personal, social, Health and Economic (PSHE) education	Help children recognise, understand, discuss and seek help for emotional problems	LA	Local
b	Effective school-based suicide prevention	Promote awareness among staff and pupils and parents to help identify high risk signs or behaviours (depression, drugs, self-harm) and develop protocols on how to respond, ensure clear referral routes into specialist support	CCG	Local
c	Bullying prevention pro-grammes	Develop and implement bullying prevention initiatives	LA/LA - PH	Local
d	Healthy child programme 0-19	Identify children at high risk of emotional problems and ensure that they and their families receive appropriate support	LA	Local
	Safeguarding Children Board	Ensure close link between suicide preven-tion and safeguarding boards in order to ensure local provision of early help and support	LA	Local
	You're welcome quality criteria	Self-assessment toolkit to ensure services are acceptable and accessible to young people	CCG	Local
	Compliance with NICE guidance	Ensure provision of stepped-care approaches to treatment for children and young people with mental health problems	CCG	Local
2.2	**Survivors of abuse or violence, including sexual abuse**			
a	Ensure the timely and effective assessment of all vulnerable children	Ensure early identification and referral to appropriate support services. Promote the use of screening tools such as the Strengths and Difficulties questionnaire (SDQ)	LA/ Social care	Local/ Regional
b	Domestic violence training	Training and support to be provided for primary care and other front line professional staff to improve identification and appropriate referral to support services of those experiencing domestic violence	LA/ LA - PH	Local/ Regional

Appendix 6 Champs action planning framework

Area for action	Standard/ Description of intervention	Standard/ Description of intervention	Lead (Responsibility)	Level (local/ regional)
2.3	**Veterans**			
d	Improve veterans' access to support services	Create more posts for veterans therapists in NHS trusts	CCG	Local
e	Suicide awareness training	Training to be provided for GPs and other NHS staff who may come into contact with veterans with mental health needs	CCG	Local
2.4	**People living with long-term physical health conditions**			
a	Support self- management	Ensure patients feel more confident in managing their condition and take an active part in their care	CCG	Local
b	Assessment for depression	Ensure the routine assessment for depression as part of personalised care planning	CCG	Local
2.5	**People with untreated depression**			
a	through Compliance with NICE guidance	Ensure the early identification and treatment of depression – through compliance with NICE guidance	CCG	Local/ Regional
2.6	**People who are especially vulnerable due to social and economic circumstances**			
a	Join up support services	Ensure front-line agencies (primary and secondary health and social services, local authorities, the police, job centre plus) join up to maximise the effectiveness of services and support	LA/ Partnership	Local
b	Support financial capability	Commission interventions that improve financial capability e.g. Citizens advice	LA	Local/ Regional
c	Suicide awareness training for staf	Training to be provided for front-line staff who are in regular contact with people who may be vulnerable due to social/ economic circumstances	LA - PH	Local/ Regional
d	Suicide awareness raising for public	Inform people how to recognise and re-spond to warning signs in themselves and others	LA - PH	
2.7	**People who misuse drugs and alcohol**			
a	Recovery based services	Commission recovery based drug and alcohol services	LA - PH	Local

Appendix 6 Champs action planning framework

Area for action	Standard/ Description of intervention	Standard/ Description of intervention	Lead (Responsibility)	Level (local/ regional)
2.5	**People with untreated depression**			
a	through Compliance with NICE guidance	Ensure the early identification and treatment of depression – through compliance with NICE guidance	CCG	Local/ Regional
2.8	**Lesbian, gay, bisexual and transgender people**			
a	Suicide awareness training for healthcare staff	Increase awareness of staff in secondary and primary care of higher rates of mental distress, substance misuse, suicidal behaviour or ideation and increased risk of self-harm in those who are lesbian, gay, bisexual and transgender	CCG/ NHS England	Local/ Regional
b	Suicide awareness training for community staff	Increase awareness of staff in social services, education and the voluntary sector of higher rates of mental distress, substance misuse, suicidal behaviour or ideation and increased risk of self-harm in those who are lesbian, gay, bisexual and transgender	LA/ LA - PH	Local/ Regional
2.9	**Black, Asian and minority ethnic groups and asylum seekers**			
a	Suicide awareness training for healthcare staff	Increase awareness of healthcare staff to the prevalence of mental health conditions and suicide among Black, Asian and minority ethnic groups and asylum seekers	LA - PH	Local/ Regional
b	Suicide awareness training for community staff	Increase awareness of staff in social services, education and the voluntary sector of higher rates of mental distress, substance misuse, suicidal behaviour or ideation and increased risk of self-harm among Black, Asian and minority ethnic groups and asylum seekers	LA/ LA - PH	Local/ Regional
3	**Reduce access to the means of suicide**			
3.1	**Reducing the numbers of suicides as a result of hanging and strangulation**			
a	Mental health services comply with best practice on suicide prevention	See section 1.2	CCG	Local
b	Safe clinical areas	See section 1.2	CCG	Local
c	Suicide prevention in custody/ prison	Ensure safer environment for at risk prisoners eg safer cells	Police/ Probation services	Local/ Regional

Appendix 6 Champs action planning framework

Area for action	Standard/ Description of intervention	Standard/ Description of intervention	Lead (Responsibility)	Level (local/ regional)
3.3	**Reduce the number of suicides at high-risk locations**			
a	Preventative measures	Implement evidence based interventions outlined in Guidance on Action to be taken at suicide hotspots (2006) e.g. reduce risk at high risk locations through barriers, nets on bridges	LA/ Partnership	Local
b	Consider safety when designing new buildings/ structure	Work with local authority planning departments and developers to reduce suicide opportunities	LA	Local
4	**Provide better information and support to those bereaved or affected by suicide**			
4.1	**Provide effective and timely support for families bereaved or affected by suicide**			
a	Emotional and practical support	Ensure the provision of emotional and practical support to those bereaved by suicide e.g. through the use of Help is at Hand: A resource for people bereaved by suicide and other, sudden traumatic death	CCG/ LA-PH/ 3rd and voluntary sector	Local
b	Map existing bereavement services, support and pathways	Ensure the provision of local bereavement support/ groups e.g. bereavement support councillor and/ or online support	LA – PH	Local
c	Increase knowledge and promotion of bereavement support	Increase awareness among staff and public of available bereavement support services/ groups	LA – PH	Local / Regional
4.2	**Have an effective local responses to the aftermath of a suicide**			
a	Post suicide interventions at community level	Ensure post suicide intervention services are in place in schools, colleges , Universities, work places, prisons, health care services, residential care homes	Regional group/ Partnership	Regional
b	Prevent copycat suicide attempts	See section 5.1 Work with local media to encourage responsible reporting on suicide methods and locations	Regional group/ Partnership	Regional

Appendix 6 Champs action planning framework

Area for action	Standard/ Description of intervention	Standard/ Description of intervention	Lead (Responsibility)	Level (local/ regional)
4.3	**Provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide**			
a	Ensure clear contact details are provided by mental health, primary care and social services	Ensure family, carers and friends of individuals being cared for by mental health, primary care or social services know how to contact services if they become concerned about risk of suicide and are appropriately involved in care planning	CCG/ LA	Local
b	Help to navigate care system	Everyone with a care plan should be allocated a named professional who has an overview of their case and is responsible for answering any questions they or their family may have	CCG	Local
5	**Support the media in delivering sensitive approaches to suicide and suicidal behaviour**			
5.1	**Promote the responsible reporting and portrayal of suicide and suicidal behaviour in the media**			
a	Responsible reporting	Work with local media to encourage responsible reporting on suicide methods and locations	Regional group	Regional
b	Sign posting to sources of support	Work with local media to encourage them to provide information about sources of support and help lines when reporting suicide and suicidal behaviour	Regional group	Regional
6	**Support research, data collection and monitoring**			
6.1	**Build on the existing research evidence and other relevant sources of data on suicide and suicide prevention**			
a	Data collection	Ensure that local data on suicide is collected from key information sources	LA – PH (Via Regional group)	Regional/ local
6.2	**Expand and improve the systematic collection of and access to data on suicides**			
a	Ensure the routine analysis of data and development of data sources	Work in partnership to analyse data to identify emerging patterns, before data is compiled by ONS	LA – PH (Via Regional group)	Regional/ local

Appendix 6 Champs action planning framework

Area for action	Standard/ Description of intervention	Standard/ Description of intervention	Lead (Responsibility)	Level (local/ regional)
6.3	**Monitor progress against the objectives of the national suicide prevention strategy**			
a	Monitor Progress towards relevant public health outcome framework indicators	Monitor local suicide rate, self-harm rates and excess under-75 mortality	LA – PH	Local
b	Consider monitoring additional outcome measures	Consider montoring other potential outcomes and indicators e.g. rates of suicides among inpatients, the suicide rate for those in contact with specialist mental health services, the use of suicide audits by providers and commissioners	L – PH (via regional group)	Regional/ local
7	**Wellbeing Promotion**			
a	Promotion of mental wellbeing across the lifecourse	Commission multi-agency interventions to promote mental wellbeing across the life course	LA – PH	Local
b	Training in wellbeing promotion	Provide training to ensure that front line community staff are able to talk about mental health and wellbeing alongside other lifestyle issues, identify needs and sign post as appropriate	LA – PH	Local

Appendix 7

National policy documents and resources to support tailored approaches to improving the mental health of children and young people

Improving young people's health and wellbeing: a framework for public health

Published by Public Health England and the Association for Young People's Health in 2015

https://www.gov.uk/government/publications/improving-young-peoples-health-and-wellbeing-a-framework-for-public-health

Promoting young people's emotional health and wellbeing: a whole school and college approach

Published by Public Health England and the Children and Young People's Mental Health Coalition in 2015

www.gov.uk/government/publications/promoting-children-and-young-peoples-emotional-health-and-wellbeing

A public health approach to promoting young people's resilience

Published by the Association for Young People's Health in 2016

http://www.youngpeopleshealth.org.uk/wp-content/uploads/2016/03/resilience-resource-15-march-version.pdf

Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing

Published by the Department of Health and NHS England in 2012

www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Related documents can be accessed at www.gov.uk/government/publications/improving-mental-health-services-for-young-people

Local transformation plans for children and young people's mental health and wellbeing

Published by NHS England in 2015

https://www.england.nhs.uk/wp-content/uploads/2015/07/local-transformation-plans-cyp-mh-guidance.pdf

The Youth Wellbeing Directory

Provides an online directory to find mental health and wellbeing advice, help and support for children and young people up to age 25 across the UK.

http://www.youthwellbeing.co.uk/

Local transformation plans for children and young people's mental health and wellbeing.

Published by NHS England in 2015

https://www.england.nhs.uk/wp-content/uploads/2015/07/local-transformation-plans-cyp-mh-guidance.pdf

Mental health and behaviour in schools: departmental advice for schools

Published by the Department for Education in 2016

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/508847/Mental_Health_and_Behaviour_-_advice_for_Schools_160316.pdf

Appendix 7 National policy documents and resources to support tailored approaches to improving the mental health of children and young people

Preventing suicide among lesbian, gay and bisexual young people: a toolkit for nurses

Published by Public Health England in association with the Royal College of Nursing.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/412427/LGB_Suicide_Prevention_Toolkit_FINAL.pdf

Preventing suicide among trans young people: a toolkit for nurses

Published by Public Health England in association with the Royal College of Nursing in 2015

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417707/Trans_suicide_Prevention_Toolkit_Final_26032015.pdf

Quality criteria for young people friendly health services.

Published by the Department of Health in 2011.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216350/dh_127632.pdf

The practice resource development team

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About National Suicide Prevention Alliance

The National Suicide Prevention Alliance (NSPA) brings together public, private and voluntary organisations in England to take action to reduce suicide and support those bereaved or affected by suicide.

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