Preventing suicide in England

A cross-government outcomes strategy to save lives

HM Government

Publication withdrawn

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Preventing suicide in England

A cross-government outcomes strategy to save lives

Prepared by Department of Health

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HM Government

Ministerial Foreword

In England, one person dies every two hours as a result of suicide. When someone takes their own life, the effect on their family and friends is devastating. Many others involved in providing support and care will feel the impact.

In developing this new national all-age suicide prevention strategy for England, we have built on the successes of the earlier strategy published in 2002. Real progress has been made in reducing the already relatively low suicide rate to record low levels.

But there is no room for complacency. There are new challenges that need to be addressed. And at a time when we have economic pressures on the general population, it is particularly timely to revisit a national strategy that has demonstrated clear progress.

If we are to continue to prevent suicide, we also need to take specific actions, as outlined in this strategy.

This strategy supports action by bringing together knowledge about groups at higher risk of suicide, applying evidence of effective interventions and highlighting resources available. This will support local decision-making, while recognising the autonomy of local organisations to decide what works in their area.

The factors leading to someone taking their own life are complex. No one organisation is able to directly influence them all. Commitment across government, from Health, Education, Justice and the Home Office, Transport, Work and Pensions and others will be vital. We also need the support of the voluntary and statutory sectors, academic institutions and schools, businesses, industry, journalists and other media. And, perhaps above all, we must involve communities and individuals whose lives have been affected by the suicide of family, friends, neighbours or colleagues.

We have made it clear that mental and physical health have to be seen as equally important. For suicide prevention, this will mean effectively managing the mental health aspects, as well as any physical injuries, when people who have self-harmed come to A&E. It will also mean having an effective 24 hour response to mental health crises, as well as for physical health emergencies.

The strategy has been developed with the support of leading experts in the field of suicide prevention, including the members of the National Suicide Prevention Strategy Advisory Group, under the chairmanship of Professor Louis Appleby. I would like to thank all members of this group for sharing their knowledge and expertise with us. Their continued support and leadership is central to our efforts to prevent suicides in England.

Norman Lamb MP
Minister of State for Care Services

Contents

Ministerial Foreword 2
Contents 3
Preface 4
Executive summary 5
Introduction 9
1. Area for action 1: Reduce the risk of suicide in key high-risk groups 13
2. Area for action 2: Tailor approaches to improve mental health in specific groups 21
3. Area for action 3: Reduce access to the means of suicide 35
4. Area for action 4: Provide better information and support to those bereaved or affected by suicide 39
5. Area for action 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour 43
6. Area for action 6: Support research, data collection and monitoring 47
7. Making it happen locally and nationally 50
References 54

Preface

Suicide is often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity. This strategy is intended to provide an approach to suicide prevention that recognises the contributions that can be made across all sectors of our society. It draws on local experience, research evidence and the expertise of the National Suicide Prevention Strategy Advisory Group, some of whom have experienced the tragedy of a suicide within their families.

In fact, one of the main changes from the previous strategy is the greater prominence of measures to support families (action 4) – those who are worried that a loved one is at risk and those who are having to cope with the aftermath of a suicide. The strategy also makes more explicit reference to the importance of primary care in preventing suicide and to the need for preventive steps for each age group.

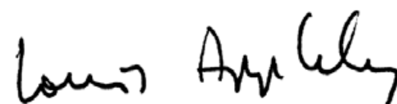
In identifying the high-risk groups who are priorities for prevention (action 1), we have selected only those whose suicide rates can be monitored – this is essential if we are to report on what the strategy achieves. However, there are also other groups for whom a tailored approach to their mental health is necessary if their risk is to be reduced (action 2). These are groups who may not be at high risk overall, such as children, or whose risk is hard to measure or monitor, such as minority ethnic communities. We have highlighted the importance of tackling certain methods of suicide (action 3) and of working with the media towards sensitive reporting in this area (action 5). We have stressed the need for timely data collection and high-quality research (action 6).

We have also had to be clear about the scope of the strategy. It is specifically about the prevention of suicide rather than the related problem of non-fatal self-harm. Although people with a history of self-harm are identified as a high risk group, we have not tried to cover the causes and care of all self-harm. Similarly, whether the law on encouraging or assisting suicide should be changed is a separate issue, outside the scope of the strategy.

No health without mental health, published in 2011, is the government's mental health strategy. An implementation framework has also been published, to set out what local organisations can do to turn the strategy into reality, what national organisations are doing to support this, and how progress will be measured and reported. This is vital, because suicide prevention starts with better mental health for all - therefore this strategy has to be read alongside that implementation framework.

The inclusion of suicide as an indicator within the Public Health Outcomes Framework will help to track national progress against our overall objective to reduce the suicide rate.

The strategy is intended to be up to date, wide-ranging and ambitious. Its publication marks the beginning of a new drive to reduce further the avoidable toll of suicide in England.



Professor Louis Appleby CBE

Department of Health, Chair of the National Suicide Prevention Strategy Advisory Group

Executive summary

1. Suicide[1] is a major issue for society and a leading cause of years of life lost. Suicides are not inevitable. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides and it is these that are set out in this strategy.

Objectives and areas for action

2. This strategy sets out our overall objectives:

- a reduction in the suicide rate in the general population in England; and
- better support for those bereaved or affected by suicide.

3. We have identified six key areas for action to support delivery of these objectives:

   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.

[1] Suicide is used in this document to mean a deliberate act that intentionally ends one's life.

Reduce the risk of suicide in key high-risk groups

4. We have identified the following high-risk groups who are priorities for prevention:

- young and middle-aged men
- people in the care of mental health services, including inpatients
- people with a history of self-harm
- people in contact with the criminal justice system
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

5. Those who work with men in different settings, especially primary care, need to be particularly alert to the signs of suicidal behaviour.

6. Treating mental and physical health as equally important in the context of suicide prevention will have implications for the management of care for people who self-harm, and for effective 24 hour responses to mental health crises.

7. Accessible, high-quality mental health services are fundamental to reducing the suicide risk in people of all ages with mental health problems.

8. Emergency departments and primary care have important roles in the care of people who self-harm, with a focus on good communication and follow-up.

9. Continuing to improve mental health outcomes for people in contact with the criminal justice system will contribute to suicide prevention, as will ongoing delivery of safer custody.

10. Suicide risk by occupational groups may vary nationally and even locally,

and it is vital that the statutory sector and local agencies are alert to this, and adapt their suicide prevention interventions accordingly.

Tailor approaches to improve mental health in specific groups

11. Improving the mental health of the population as a whole is another way to reduce suicide. The measures set out in both *No health without mental health* and *Healthy Lives, Healthy People* will support a general reduction in suicides.

12. This strategy identifies the following groups for whom a tailored approach to their mental health is necessary if their suicide risk is to be reduced:

- children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people 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 transgender people; and
- Black, Asian and minority ethnic groups and asylum seekers.

13. Children and young people have an important place in this strategy. Schools, social care and the youth justice system, as well as charities highlighting problems such as bullying, low body image and lack of self-esteem, all have an important contribution to make to suicide prevention among children and young people. Measures to help parents keep their children safe online are included in area for action 5. The call for research to support the strategy includes a focus on children and young people and self-harm.

14. Timely identification and referral of women and children experiencing abuse or violence, so that they are able to benefit from appropriate support, is of course a positive step in its own right, as well as helping to reduce suicide risk.

15. The Government is committed to improving mental health support for service and ex-service personnel through the Military Covenant.

16. In *No health without mental health* we made it clear that we expect parity of esteem between mental and physical health. Routine assessment for depression as part of personalised care planning for people with long-term conditions, can help reduce inequalities and help people to have a better quality of life.

17. Depression is one of the most important risk factors for suicide. The early identification and prompt, effective treatment of depression has a major role to play in preventing suicide across the whole population.

18. Given the links between mental ill-health and social factors like unemployment, debt, social isolation, family breakdown and bereavement, the ability of front-line agencies to identify and support (or signpost to support) people who may be at risk of developing mental health problems is important for suicide prevention.

19. Measures that reduce alcohol and drug dependence are critical to reducing suicide.

20. Staff in health and care services, education and the voluntary sector need to be aware of the higher rates of mental distress, substance misuse, suicidal behaviour or ideation and increased risks of self-harm amongst lesbian, gay and bisexual people, as well as transgender people.

21. Community initiatives can be effective in bridging the gap between statutory services and Black, Asian and minority ethnic communities, and in tackling inequalities in health and access to services.

Reduce access to the means of suicide

22. One of the most effective ways to prevent suicide is to reduce access to high-lethality means of suicide. Suicide methods most amenable to intervention are:

- hanging and strangulation in psychiatric inpatient and criminal justice settings;
- self-poisoning;
- those in high-risk locations; and
- those on the rail and underground networks.

23. Continued vigilance by mental health service providers will help to identify and remove potential ligature points. Safer cells complement care for at-risk prisoners.

24. Safe prescribing can help to restrict access to some toxic drugs.

25. Local agencies can prevent loss of life when they work together to discourage suicides at high-risk locations. Local authority planning departments and developers can include suicide in health and safety considerations when designing structures which may offer suicide opportunities.

26. British Transport Police, London Underground Limited, Network Rail, Samaritans and partners are working to reduce suicides on the rail and underground networks.

Provide better information and support to those bereaved or affected by suicide

27. Every suicide affects families, friends, colleagues and others. Suicide can also have a profound effect on the local community. It is important to:

- provide effective and timely support for families bereaved or affected by suicide;
- have in place effective local responses to the aftermath of a suicide; and
- provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide.

28. Effective and timely emotional and practical support for families bereaved by suicide is essential to help the grieving process and support recovery. It is important the GPs are vigilant to the potential vulnerability of family members when someone takes their own life.

29. Post-suicide community-level interventions can help to prevent copycat and suicide clusters. This approach may be adapted for use in schools, workplaces, health and care settings.

30. It is important that people concerned that someone may be at risk of suicide can get information and support as soon as possible. For individuals already under the care of health or social services, family, carers and friends should know who to contact and be appropriately involved in any care planning. Help is available through many outlets across the statutory and

voluntary sector for people who are not known to services.

Support the media in delivering sensitive approaches to suicide and suicidal behaviour

31. The media have a significant influence on behaviour and attitudes. We want to support them by:

- promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media; and
- continuing to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention services.

32. Local, regional and national newspapers and other media outlets can provide information about sources of support when reporting suicide. They can also follow the Press Complaints Commission Editors' Code of Practice and *Editors' Codebook* recommendations regarding reporting suicide.

33. The Government will continue to work with the internet industry through the UK Council for Child Internet Safety to create a safer online environment for children and young people. Recognising concern about misuse of the internet to promote suicide and suicide methods, we will be pressing to ensure that parents have the tools to ensure that their children are not accessing harmful suicide-related content online.

Support research, data collection and monitoring

34. The Department of Health will continue to support high-quality research on suicide, suicide prevention and self-harm through the National Institute for Health Research and the Policy Research Programme.

35. Reliable, timely and accurate suicide statistics are essential to suicide prevention. We will consider how to get the most out of existing data sources and options to address the current information gaps around ethnicity and sexual orientation.

36. Reflecting the continuing focus on suicide prevention, the Public Health Outcomes Framework includes the suicide rate as an indicator.

Making it happen – locally and nationally

37. Much of the planning and work to prevent suicides will be carried out locally. The strategy outlines evidence based local approaches and national actions to support these local approaches.

38. Local responsibility for coordinating and implementing work on suicide prevention will become, from April 2013, an integral part of local authorities' new responsibilities for leading on local public health and health improvement.

39. It will be for local agencies, including working through health and wellbeing boards to decide the best way to achieve the overall aim of reducing the suicide rate. Interventions and good practice examples are included to support local implementation. Many of them are already being implemented locally but local commissioners will be able to select from or adapt these suggestions based on the needs and priorities in their local area.

40. An implementation framework for *No health without mental health* has recently been published. The framework explicitly covers suicide prevention, and supports implementation of this strategy.

Introduction

1. Suicide is a major issue for society. The number of people who take their own lives in England has reduced in recent years. But still, over 4,200 people took their own life in 2010.

2. Every suicide is both an individual tragedy and a terrible loss to society. Every suicide affects a number of people directly and often many others indirectly. The impact of suicide can be devastating – economically, psychologically and spiritually – for all those affected.

3. Suicides are not inevitable. An inclusive society that avoids the marginalisation of individuals and which supports people at times of personal crisis will help to prevent suicides. Government and statutory services have a role to play. We can build individual and community resilience. We can ensure that vulnerable people in the care of health and social services and at risk of suicide are supported and kept safe from preventable harm. We can also ensure that we intervene quickly when someone is in distress or in crisis.

4. Most people who take their own lives have not been in touch with mental health services. There are many things we can do in our communities, outside hospital and care settings, to help those who think suicide is the only option.

5. Between July and October 2011, the Government held a public consultation on a new suicide prevention strategy for England. A summary of the consultation responses that were received, and the decisions that the Government has taken in the light of them is available from www.dh.gov.uk/health/category/publications/consultations/consultation-responses/

The challenge of suicide prevention

6. The likelihood of a person taking their own life depends on several factors. These include:

   - gender – males are three times as likely to take their own life as females;
   - age – people aged 35-49 now have the highest suicide rate;
   - mental illness;
   - the treatment and care they receive after making a suicide attempt;
   - physically disabling or painful illnesses including chronic pain; and
   - alcohol and drug misuse.

7. Stressful life events can also play a part. These include:

   - the loss of a job;
   - debt;
   - living alone, becoming socially excluded or isolated;
   - bereavement;
   - family breakdown and conflict including divorce and family mental health problems; and
   - imprisonment.

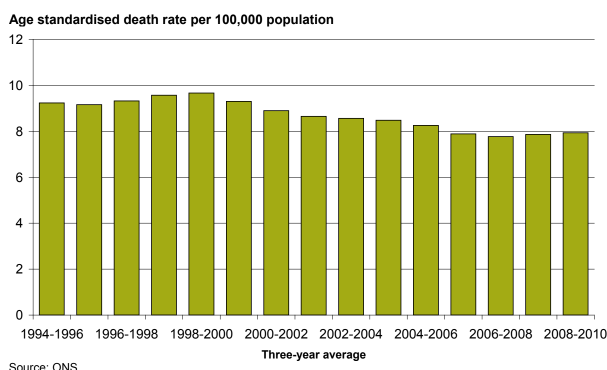
   For many people, it is the combination of factors which is important rather than one single factor. Stigma, prejudice, harassment and bullying can all contribute to increasing an individual's vulnerability to suicide.

8. Several research studies have looked at risk factors for suicide in different groups. In 2008 the Scottish Government Social Research Department undertook a Literature Review: *Risk and Protective Factors for Suicide and Suicidal Behaviour* www.scotland.gov.uk/Publications/2008/11/28141444/0. This review describes and assesses

knowledge about the societal and cultural factors associated with increased incidence of suicide (risk factors) and also the factors that promote resilience against suicidal behaviour (protective factors).

9. Suicide rates in England have been at a historical low recently and are low in comparison to those of most other European countries. In England in 2008-10, the mortality rate from suicide was 12.2 deaths per 100,000 population for males and 3.7 deaths for females.[1] The latest 15-year trend in the mortality rate from suicide and injury of undetermined intent using three-year pooled rates is shown in Figure 1.

Figure 1: Death rates from intentional self-harm and injury of undetermined intent, England 1994-2010



10. The past couple of years have seen a slight increase in suicide rates, but the 2008-10 rate remains one of the lowest rates in recent years. There has been a sustained reduction in the rate of suicide in young men under the age of 35, reversing the upward trend since the problem of suicides in this group first escalated over 30 years ago. We have also seen significant reductions in inpatient suicides and self-inflicted deaths in prison. A statistical update is being published alongside this strategy document.

11. However, we know from experience that suicide rates can be volatile as new risks emerge. The recent slight increase in the suicide rate in 2008-10 demonstrates the need for continuing vigilance and why, despite relatively low rates, a new suicide prevention strategy for England is needed.

12. Previously, periods of high unemployment or severe economic problems have had an adverse effect on the mental health of the population and have been associated with higher rates of suicide.[2] Evidence is emerging of an impact of the current recession on suicides in affected countries.[3] However, suicide risk is complex and for many people it is a combination of factors, outlined above, that determines risk rather than any single factor.

13. This suicide prevention strategy can help us reduce further the rates of suicide in England and respond positively to the challenges we will face over the coming years.

Objectives and priorities

14. Our overall objectives are:

- a reduction in the suicide rate in the general population in England; and
- better support for those bereaved or affected by suicide.

15. We have identified six areas for action to support delivery of these objectives which each have a chapter of this strategy devoted to them.

16. Much of the planning and work to prevent suicides will be carried out locally. The strategy outlines a range of evidence based local approaches. National actions to support these local approaches are also detailed for each of the six areas for action.

17. Interventions and good practice examples are included to support local implementation and are not compulsory.

Many of them are already being implemented locally but local commissioners will be able to select from and adapt these suggestions based on their assessment of the needs and agreement of the priorities in their local area.

18. We should always use cost-effective evidence-based approaches which work as early as possible. This is above all in the best interests of service users - and also enables the care services to make best use of limited resources. This means getting it right first time - improving outcomes and preventing problems from getting worse to avoid the need for more expensive interventions later on.

19. We need to tackle all the factors which may increase the risk of suicide in the communities where they occur if our efforts are to be effective. Suicide prevention is most effective when it is combined as part of wider work addressing the social and other determinants of poor health, wellbeing or illness.

Outcomes strategies and making an impact

20. Cross-cutting outcomes strategies recognise that the Government can achieve more in partnership with others than it can alone, and that services can achieve more through integrated working than they can through working in isolation from one another. This new approach builds on existing joint working across central government departments, and between the Government, local government, local organisations, employers, service users and professional groups, by unlocking the creativity and innovation suppressed by a top-down approach.

21. There are two other key strategy documents that, in combination with this one, take a public health approach using general and targeted measures to improve mental health and wellbeing and reduce suicides across the whole population.

22. *Healthy Lives, Healthy People: Our strategy for public health in England* (2010) gives a new, enhanced role to local government and local partnerships in delivering improved public health outcomes. Local responsibility for coordinating and implementing work on suicide prevention will become, from April 2013, an integral part of local authorities' new responsibilities for leading on local public health and health improvement. The prompts for local councillors on suicide prevention published alongside this strategy are designed as helpful pointers for how local work on suicide prevention can be taken forward.

23. Health and wellbeing boards will support effective local partnerships and will be able to support suicide prevention as they determine local needs and assets.

24. Public Health England, the new national agency for public health, will also support local authorities, the NHS and their partners across England to achieve improved outcomes for the public's health and wellbeing, including work on suicide prevention.

25. *No health without mental health: A cross-government outcomes strategy for people of all ages* (2011) is key in supporting reductions in suicide amongst the general population as well as those under the care of mental health services. The first agreed objective of *No health without mental health* aims to ensure that more people will have good mental health. To achieve this, we need to:

    - improve the mental wellbeing of individuals, families and the population in general;

- ensure that fewer people of all ages and backgrounds develop mental health problems; and
- continue to work to reduce the national suicide rate.

26. *No health without mental health* includes new measures to develop individual resilience from birth through the life course, and build population resilience and social connectedness within communities. These too are powerful suicide prevention measures.

27. The stigma associated with mental health problems can act as a barrier to people seeking and accessing the help that they need, increasing isolation and suicide risk. The Government is supporting the national mental health anti-stigma and discrimination Time to Change programme.

28. An implementation framework for *No health without mental health* was published in July 2012. This sets out what local organisations can do to implement the mental health strategy, what work is underway nationally to support them, and how progress against the strategy's aims will be measured. The framework explicitly covers suicide prevention, and supports implementation of this new suicide prevention strategy so should be read alongside this document.

29. During the development of this suicide prevention strategy, Samaritans have been facilitating a Call to Action for Suicide Prevention in England. The Call to Action consists of national organisations from across sectors in England taking action so that fewer lives are lost to suicide and people bereaved or affected by a suicide receive the right support.

30. Member organisations have signed a declaration on suicide prevention for England; mapped existing suicide reduction and support activity in their organisations and identified priorities for joint action.

31. We are publishing separately an assessment of the impact on equalities of this strategy.

32. Our approach in this strategy is to:

- set out clear, shared objectives for suicide prevention, and key areas where action is needed;
- state what government departments will do to contribute to these objectives;
- set out how the outcomes frameworks for public health and the NHS will require reductions in the suicide rate; and
- support effective local action by bringing together knowledge about groups at higher risk of suicide, evidence around effective interventions and highlighting research available.

1. Area for action 1: Reduce the risk of suicide in key high-risk groups

1.1 Some groups of people are known to be at higher risk of suicide than the general population. We have been able to identify these groups from research and can monitor numbers from the routine data collected. In this way we identified:

- those groups that are known statistically to have an increased risk of suicide; and
- actual numbers of suicides in these groups.

1.2 In addition, evidence already exists on which to base preventative measures in these groups. We are also able to monitor the impact of preventative measures taken using existing data collections.

1.3 The groups at high risk of suicide are:

- young and middle-aged men;
- people in the care of mental health services, including inpatients;
- people with a history of self-harm;
- people in contact with the criminal justice system;
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

1.4 There are other groups whose risk could be high, but limits on the data available mean that their risk is hard to estimate, or else there is no way of monitoring progress as a result of suicide prevention measures.

1.5 Although the strategy focuses on groups at higher risk, it recognises that individuals may fall into two or more high-risk groups. Conversely, not all individuals in the groups will be vulnerable to suicide.

Young and middle-aged men

- Men are at three times greater risk of suicide than women. Most suicides are among men aged under 50. Men aged 35-49 are now the group with the highest suicide rate.
- Older men (over 75) also have higher rates of death by suicide, which may reflect the impact of depression, social isolation, bereavement or physical illness.
- Factors associated with suicide in men include depression, especially when it is untreated or undiagnosed; alcohol or drug misuse; unemployment; family and relationship problems including marital breakup and divorce; social isolation and low self-esteem.[45]

1.6 Men aged under 35 were a high-risk group in the 2002 strategy. Although the suicide rate in men aged under 35 has fallen we are continuing to highlight young men within the strategy because suicide is the single most frequent cause of death, and their youth means that it accounts for a large number of years of life lost. This does not mean that older men should be overlooked. Rates of suicide in men aged over 75 remain high. Different risk factors, such as loneliness and physical illness, may be important in this age group.

Effective local interventions

1.7 Findings from three mental health promotion pilot projects launched in 2006

to address the raised suicide risk in young men show that:

- multi-agency partnership is key to promoting young men's mental health;
- community locations, such as job centres and young people-friendly venues, are more successful in engaging with young men than more formal health settings such as GP surgeries;
- front-line staff feel better able to engage with young men if they receive training; and
- community outreach programmes are seen by young men as more acceptable and approachable than services provided in formal healthcare settings.

1.8 We believe that this broad-based approach has improved the identification of risk by front-line agencies and contributed to the reduction in suicides in the younger male age group. These findings can be adapted and applied to all age groups. *Reaching Out*, the evaluation report of the three projects is available at www.nmhdu.org.uk/nmhdu/en/our-work/promoting-wellbeing-and-public-mental-health/suicide-prevention-resources/

1.9 Many statutory and third sector organisations have set up regional and local initiatives and projects to support men and encourage them to contact services when they are in distress. Some of these projects take their messages out into traditional male territories, such as football and rugby clubs, leisure centres, public houses and music venues.

National action to support local approaches

1.10 Samaritans has launched a five-year campaign to address suicide in men in mid-life of lower socio-economic position. This includes research to understand why this group is at excessive risk of dying by suicide compared to other groups, stimulating debate about policy and practice to reduce suicide in this group, and encouraging men to contact Samaritans.

Helpful resources

NHS Hull has produced a short fictional film to help men in the city understand depression and its effect on their lives. 'Peter's Story' aims to encourage men, particularly in the 25–50 age group, to think and talk about issues with their mental health and wellbeing. www.peters-story.co.uk

The Men's Health Forum has published *Untold Problems: a review of the essential issues in the mental health of men and boys* and a good practice guide, *Delivering Male: Effective practice in male mental health*, setting out ways to improve men's health, including strategies to prevent suicide and encourage help-seeking.

People in the care of mental health services, including inpatients

Patient safety in the mental health services continues to improve.

- The number of people in contact with mental health services who died by suicide has reduced from 1,253 in 2000 to an estimated 1,187 in 2010, a reduction of 66 deaths (5%)
- The number of inpatients who died by suicide reduced from 196 in 2000 to 74 in 2010, a reduction of 122 deaths (62%). The number of inpatients who died on wards by hanging or strangulation reduced by 54%
- The number of patients who refused

drug treatment who died by suicide reduced from 229 in 2000 to 141 in 2010 (38%). www.medicine.manchester.ac.uk/mentalhealth/research/suicide/

- People with severe mental illness remain at high risk of suicide, both while in inpatient units and in the community. Inpatients and people recently discharged from hospital and those who refuse treatment are at highest risk.

Effective local interventions

1.11 The provision of high-quality services that are equally accessible to all is fundamental to reducing the suicide risk in people of all ages with mental health problems.

1.12 Although much has been achieved by front-line staff to reduce suicides in people with mental health problems, they remain a group at high risk, so it is important that mental health services remain vigilant and continue to strengthen clinical practice.

1.13 The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI) checklist 'Twelve Points to a Safer Service' is based on recommendations from a national study of patient suicides and provides key guidance for mental health services. www.medicine.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/saferservices

1.14 A recent research study suggested that these services changes (particularly 24 hour crisis teams, policies for people with drug and alcohol problems, and reviews after suicide) were associated with a reduction in the rate of suicide in implementing NHS Trusts.[6]

1.15 Approaches identified by the NCI which can contribute to a reduction in suicide rates include:

- improving care pathways between emergency departments, primary and secondary care, inpatient and community care, and on hospital discharge;
- ensuring that front-line staff working with high-risk groups receive training in the recognition, assessment and management of risk and fully understand their roles and responsibilities;
- regular assessments of ward areas to identify and remove potential risks, i.e. ligatures and ligature points, access to medications, access to windows and high-risk areas (gardens, bathrooms and balconies). The most common ligature points are doors and windows; the most common ligatures are belts, shoelaces, sheets and towels. Inpatient suicide using non-collapsible rails is a 'Never Event'.[7*] New kinds of ligatures and ligature points are always being found, so ward staff need to be constantly vigilant to potential risk;[8]
- improving safety in new models of care such as crisis resolution/home treatment;
- service initiatives to prevent patients going missing from inpatient wards, such as those in *Strategies to Reduce Missing Patients: A practical workbook* (National Mental Health Development Unit, 2009);
- good risk management and continuity of care. The recent judgment, Rabone vs Pennine Care NHS Foundation Trust, confirmed that NHS Trusts have a duty to protect voluntary mental health patients from the risk of suicide, and

[*] Never Events are serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

highlights the importance of risk management. Aligning care planning more closely with risk assessment and risk management is important, as is the provision of regular training and updates for staff in risk management. The Department of Health guidance on assessment and management of risk[9] emphasises that risk assessment should be an integral part of clinical assessment, not a separate activity. All service users and their carers should be given a copy of their care plan, including crisis plans and contact numbers;

- innovative approaches which may be helpful: many local services have developed ways to follow up people recently discharged from mental health inpatient units using telephone, text messaging and email, as well as letters.

Helpful resources

1.16 *No health without mental health: Delivering better mental health outcomes for people of all ages* outlines a range of evidence-based treatments and interventions to prevent people of all ages from developing mental health problems where possible, intervene early when they do, and develop and support speedy and sustained recovery. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123737

1.17 NCI provides regular reports on patient suicides and up-to-date statistical data. These reports highlight and make recommendations where clinical practice and service delivery can be improved to prevent suicide and reduce risk. www.medicine.manchester.ac.uk/suicideprevention/nci

1.18 The National Patient Safety Agency's (NPSA's) *Preventing Suicide: A toolkit for mental health services* includes measures for services to assess how well they are meeting the best practice on suicide prevention. www.nrls.npsa.nhs.uk/resources/?EntryId45=65297. The NPSA also published *Preventing suicide: A toolkit for community mental health* (2011). It focuses on improving care pathways and follow up for people who present at emergency departments following self-harm or suicidal behaviour and those who present at GP surgeries and are identified as at risk of self-harm or suicide. www.nhsconfed.org/Documents/Preventing-suicide-toolkit-for-community-mental-health.pdf

People with a history of self-harm

- There are around 200,000 episodes of self-harm that present to hospital services each year.[10] However, many people who self-harm do not seek help from health or other services and so are not recorded.

- Studies have shown that by age 15-16, 7-14% of adolescents will have self-harmed once in their life.[11]

- People who self-harm are at increased risk of suicide, although many people do not intend to take their own life when they self-harm.[12] At least half of people who take their own life have a history of self-harm, and one in four have been treated in hospital for self-harm in the preceding year. Around one in 100 people who self-harm take their own life within the following year. Risk is particularly increased in those repeating self-harm and in those who have used violent/dangerous methods of self-harm.[13]

Effective local interventions

1.19 Emergency departments have an important role in treating and managing people who have self-harmed or have made a suicide attempt. There are still problems in some places with the quality of care, assessment and follow-up of people who seek help from emergency departments after self-harming.[14] Attitudes towards and knowledge of self-harm among general hospital staff can be poor. A high proportion of people who self-harm are not given a psychological assessment. Often, follow-up and treatment are not provided, in particular for people who repeatedly self-harm. In many emergency departments, the facilities available for distressed patients could be improved.

1.20 GPs have a key role in the care of people who self-harm. Good communication between secondary and primary care is vital, as many people who present at emergency departments following an episode of self-harm consult their GP soon afterwards.[15]

1.21 Work undertaken by the London School of Economics has shown that suicide prevention education for GPs can have an impact as a population-level intervention to prevent suicide. This has the potential to be cost-effective if it leads to adequate subsequent treatment. See www2.lse.ac.uk/businessAndConsultancy/LSEEnterprise/news/2011/healthstrategy.aspx

1.22 Appropriate training on suicide and self-harm should be available for staff working in schools and colleges, emergency departments, other emergency services, primary care, care environments and the criminal and youth justice systems.

Helpful resources

1.23 Clinicians can use the NICE self-harm pathway, which summarises both short and long term self-harm guidance using a flowchart based approach: www.pathways.nice.org.uk/pathways/self-harm

1.24 NICE has developed two sets of clinical practice guidelines on self-harm for the NHS in England, Wales and Northern Ireland:

- on the short-term management and secondary prevention of self-harm in primary and secondary care (see http://publications.nice.org.uk/self-harm-cg16); and
- on the longer-term management of self-harm. It includes recommendations for the appropriate treatment for any underlying problems (including diagnosed mental health problems). It also covers the longer-term management of self-harm in a range of settings (see http://publications.nice.org.uk/self-harm-longer-term-management-cg133).

1.25 The National CAMHS Support Service produced a self-harm in children and young people handbook and an e-learning package, to provide basic knowledge and awareness of self-harm in children and young people, with advice about ways staff in children's services can respond. www.chimat.org.uk/resource/view.aspx?RID=105602

National action to support local approaches

1.26 NICE quality standards are under development on self-harm in adults and children and young people.

1.27 The Royal College of GPs will focus on strengthening training in mental health as part of the GP training programme,

both within current arrangements and as they develop the case for enhanced (four year) training.

People in contact with the criminal justice system

- People at all stages within the CJS, including people on remand and recently discharged from custody, are at high risk of suicide. The period of greatest risk is the first week of imprisonment.[16] However, recent figures suggest that risk of self-inflicted death has decreased in the first week of custody (Ministry of Justice, Safety in Custody Statistics).

- Reasons for the increased risk include the following:
  - a high proportion of offenders are young men, who are already a high suicide risk group. However, the increase in suicide risk for women prisoners is greater than for men;
  - an estimated 90% of all prisoners have a diagnosable mental health problem (including personality disorder) and/or substance misuse problems; and
  - offenders can be separated from their family and friends, whose social support may help to guard against suicidal feelings.

- The three-year average annual rate of self-inflicted deaths* by prisoners in England was 69 deaths per 100,000 prisoners in 2009-2011. This has decreased year-on-year since 2004 when it was 132 deaths per 100,000 prisoners.

Effective local interventions

1.28 Details of proposals to improve mental health outcomes for people in contact with the CJS are given in *No health without Mental Health: Delivering better mental health outcomes for people of all ages*. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123737

National action to support local approaches

1.29 The National Offender Management Service (NOMS) has a broad, integrated and evidence-based strategy[17] for suicide prevention and self-harm management, and is committed to reducing the number of self-inflicted deaths in prison custody. The Youth Justice Board is taking a similar approach to reduce the number of self-inflicted deaths in the Young Person's Secure Estate. Each death is investigated by the Prisons and Probation Ombudsman.

1.30 The National Safer Custody Managers and Learning Team was established in 2009. The National Safer Custody Managers provide deputy directors of custody with advice on safer custody policies and other areas where they have a direct link to the delivery of safer custody. Strenuous efforts are made to learn from each death and improve understanding of and procedures for caring for prisoners at risk of suicide or self-harm.

1.31 Since the introduction of mental health in-reach services, the Integrated Drug Treatment System and Assessment, Care in Custody and Teamwork procedures into prisons there has been a reduction in self-inflicted deaths in prison custody.

* Prisoner 'self-inflicted deaths' include all deaths where it appears that a prisoner has acted specifically to take their own life. Approximately 80 per cent of these deaths receive a suicide or open verdict at inquest. The remainder receive an accidental or misadventure verdict.

1.32 The Department of Health, NOMS and University of Oxford Centre for Suicide Research are funding an analysis of all self-harm data based on incidents from 2004 to 2009. This will inform the development of more effective ways of identifying, managing and reducing the risk of those prisoners who self-harm.

1.33 The Health and Criminal Justice Transition Programme Board is overseeing a programme to provide police custody suites and criminal courts with access to liaison and diversion services by 2014. These services will be open and accessible to people of all ages, whether they have a mental health problem, learning disability, personality disorder, substance misuse issue or other vulnerability. They will provide early identification of individuals, allow the police and courts to understand as much as possible about the individual, and inform offender management and rehabilitation. For people in the criminal justice system with mental health needs, the aim is to ensure that they receive treatment in the most appropriate setting, whether in prison, secure mental health services, or in the community.

1.34 A study commissioned by the Independent Police Complaints Commission found that deaths in or following police custody, particularly those as a result of hanging, reduced significantly between 1998-99 and 2008-09. The study report identified improvements in cell design, identification of ligature points, risk assessments and Safer Detention guidance as all possibly contributing to the reduction.
www.ipcc.gov.uk/Pages/deathscustodystudy.aspx

Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers

- Some occupational groups are at particularly high suicide risk. Nurses, doctors, farmers, and other agricultural workers are at highest risk, probably because they have ready access to the means of suicide and know how to use them.
- Research[18] shows that these patterns of suicide are broadly unchanged. Among men, health professionals and agricultural workers remain the groups at highest risk of suicide. However, other occupational groups have emerged with raised risks. The highest numbers (not rates) of male suicides were among construction workers and plant and machine operatives.
- Among women, health workers, in particular doctors and nurses, remained at highest suicide risk.

1.35 This strategy maintains the focus on the highest risk occupational groups but recognises the potential vulnerability of other occupational groups.

Effective local interventions

1.36 Risk by occupational group may vary regionally and even locally. It is vital that the statutory sector and local agencies are alert to this and adapt their suicide prevention interventions and strategies accordingly. For example, GPs in rural areas, aware of the high rates of suicide in farmers and agricultural workers, will be well prepared to assess and manage depression and suicide risk.

The Practitioner Health Programme, funded by London primary care trusts, offers a free, confidential service for doctors and

dentists who live or work in the London area. www.php.nhs.uk/what-to-expect/how-can-i-access-php

MedNet is funded by the London Deanery and provides doctors and dentists working in the area with practical advice about their career, emotional support and, where appropriate, access to brief or longer-term psychotherapy. www.londondeanery.ac.uk/var/support-for-doctors/MedNet

Helpful resources

1.37 The Department for Environment, Food and Rural Affairs has a number of measures in place to support rural workers aimed at easing some of the stresses which are known to adversely affect farmers, agricultural workers and their families. These include specific support on bovine tuberculosis to the Farm Crisis Network. The Task Force on Farming Regulation aims to reduce some of the bureaucratic burden on farmers.

Rural Stress Helpline offers a confidential, non-judgemental listening service to anyone in a rural area feeling troubled, anxious, worried, stressed or needing information. Helpline 0845 094 8286 (Mon-Fri 9am-5pm); email help@ruralstresshelpline.co.uk

1.38 The Department of Health published *Maintaining high professional standards in the modern NHS* (2003) with additional guidance (2005) on handling concerns about a practitioner's health. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103586

1.39 In 2008, The Department of Health published *Mental health and Ill health in Doctors*. This identifies a number of sources of help and recognises that many of the issues are very similar for other health professionals. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083066

1.40 *NHS Health and Wellbeing Improvement Framework*, published in 2011, is a tool for decision makers on Boards to support them in establishing a culture that promotes staff health and wellbeing. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128691

1.41 The Police Service proactively manages staff wellbeing to try to avoid individuals becoming unwell due to mental health problems such as depression, anxiety or post-traumatic stress disorder. Police officers and staff can access services through their line management, Occupational Health Departments or often via self-referral.

2. Area for action 2: Tailor approaches to improve mental health in specific groups

2.1 As well as targeting high-risk groups, another way to reduce suicide is to improve the mental health of the population as a whole. The measures set out in both *No health without mental health* and *Healthy Lives, Healthy People* will support a general reduction in suicides by building individual and community resilience, promoting mental health and wellbeing and challenging health inequalities where they exist.

2.2 For this whole population approach to reach all those who might need it, it should include tailored measures for groups with particular vulnerabilities or problems with access to services. They are groups of people who may have higher rates of mental health problems including self-harm. These are not discrete groups, and many individuals may fall into more than one of these groups, for example, some Black and minority ethnic (BME) groups are more likely to have lower incomes or be unemployed; children and young people may also fall into several other of these groups. The groups identified are:

- children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the YJS;
- 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 transgender people; and
- Black, Asian and minority ethnic groups and asylum seekers.

2.3 For many of these groups we do not have sufficient information about numbers of suicides or about what interventions might be helpful. The requirements for improved information and research are considered further under area for action 6.

Children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the YJS

- The suicide rate among teenagers is below that in the general population.[19] However, young people are vulnerable to suicidal feelings. The risk is greater when they have mental health problems or behavioural disorders, misuse substances, have experienced family breakdown, abuse, neglect or mental health problems or suicide in the family. The risk may also increase when young people identify with people who have taken their own life, such as a high-profile celebrity or another young person.

- Self-harm is particularly common among young people.[20]

- Children and young people in the youth justice system experience many of the same risk factors as adults in the criminal justice system. Since January 2002, six young

people in custody in the Young Person's Secure Estate have killed themselves.

- Looked after children and care leavers are between four and five times more likely to self-harm in adulthood. They are also at five-fold increased risk of all childhood mental, emotional and behavioural problems and at six to seven-fold increased risk of conduct disorders.

Effective local interventions

2.4 The non-statutory programmes of study for Personal, Social, Health and Economic (PSHE) education provide a framework for schools to provide age–appropriate teaching on issues including sex and relationships, substance misuse and emotional and mental health. This and other school-based approaches may help all children to recognise, understand, discuss and seek help earlier for any emerging emotional and other problems.

2.5 The consensus from research is that an effective school-based suicide prevention strategy would include:

- a co-ordinated school response to people at risk and staff training;
- awareness among staff to help identify high risk signs or behaviours (depression, drugs, self-harm) and protocols on how to respond;
- signposting parents to sources of information on signs of emotional problems and risk;
- clear referral routes to specialist mental health services.

2.6 The Healthy Child Programme 0-19, led by front line health professionals, focuses on health promotion, prevention and early intervention with vulnerable families. Health visitors and their teams will identify children at high risk of emotional and behavioural problems and ensure that they and their families receive appropriate support, including referral to specialist services where needed. Preventing suicide in children and young people is closely linked to safeguarding and the work of the Local Safeguarding Children Boards. Professor Munro's review of child protection (2011) made 15 recommendations to reform the system. The review emphasised the importance of evidence-based early interventions and recommended that help is provided early to children and families in order to negate the impact of abuse and neglect and to improve the life chances of children and young people. In response, the Government is working with partners to reinforce the existing legislation and revise statutory guidance, and to understand better how to make progress on early help. Inspections of child protection services will assess local provision of early help.

2.7 Local services can develop systems for the early identification of children and young people with mental health problems in different settings, including schools. Stepped-care approaches to treatment, as outlined in NICE guidance, can be effective when delivered in settings that are appropriate and accessible for children and young people. The Department of Health's *You're Welcome* quality criteria self-assessment toolkit may be helpful in ensuring that services and settings are genuinely acceptable and accessible to children and young people.

2.8 The specialist early intervention in psychosis model of community care has achieved better outcomes than generic community mental health teams for young people aged 14–35 in the early phase of severe mental illness, achieving faster and more lasting recovery. The impact of early intervention on suicide is under investigation, but it is clear that suicide in young patients has decreased in recent years.[21]

2.9 It is particularly important that interventions for children and young people who offend, and for other vulnerable children and young people in the area, are both easily accessible and engaging. This requires outreach, flexible wraparound support and persistence, so that sessions can continue, even in the face of barriers to engagement.[22] In all forms of custodial or secure settings, including detention, continuous attention is needed to minimise a young person's sense of isolation from home and family and workers should be proactive in responding to their mental health needs. What young people in these circumstances value highly from professionals is knowing that someone will listen to them and be interested in their concerns.

Helpful resources

2.10 Stonewall's Education for All campaign, works to tackle homophobic bullying in Britain's schools, and has a lot of resources. www.stonewall.org.uk/at_school/education_for_all/default.asp

2.11 Beatbullying is a UK-wide bullying prevention charity, and has developed a large range of anti-bullying teaching resources to help raise awareness of bullying in all its forms and help children to keep safe. They are available free at: www.beatbullying.org/dox/resources/resources.html

National action to support local approaches

2.12 *No health without mental health* and *No health without mental health: Delivering better mental health outcomes for people of all ages* include local and national interventions to improve the mental health of children and young people. Interventions include effective school-based approaches to tackling violence and bullying and sexual abuse. They also cover effective approaches to identifying children who are at risk and the specific needs of looked after children and care leavers.

2.13 We are also extending access to psychological therapies for children and young people. Building on the learning from the Improving Access to Psychological Therapies (IAPT) initiative for adults, a rolling national programme with a strong focus on outcomes will seek to transform local child and adolescent mental health services, equipping them to deliver a broader range of evidence-based psychological therapies for children and young people and their families.

2.14 Additional investment will extend both the geographical reach and range of therapies offered through the Children and Young People's IAPT project. It will also support development of interactive e-learning programmes in child mental health to extend the skills and knowledge of:

- NHS clinicians;

- a wide range of people working with children and young people in universal settings including teachers, social workers, police and probation staff and faith group workers;
- school and youth counsellors working in a range of educational settings.

2.15 The new e-portal will include specific learning and professional development in relation to self-harm, suicide and risk in children and young people.

2.16 The Children and Young People's Health Outcomes Strategy will identify the health outcomes that matter most to children, young people and their families and set out how the system will contribute to their delivery. Children and young people's mental health outcomes – including those in relation to suicide and self-harm – was one of four key areas considered by the Children and Young People's Health Outcomes Forum. The Forum's report[23], published in July, and the system's response to their recommendations will be key components within a Children And Young People's Health Outcomes Strategy, which will be published in autumn 2012.

Survivors of abuse or violence, including sexual abuse

- One in four people in England has experienced some form of violence or abuse in their lifetime, and almost half of all children have been the victims of bullying. Women and children are most at risk of domestic and sexual violence.
- Violence and abuse can lead to a number of psychosocial problems associated with a heightened suicide risk, including: social isolation and exclusion; poor educational achievement; conduct, behavioural and emotional problems in children, and antisocial and risk-taking behaviours. Violence and abuse are also associated with a higher risk of mental health problems and suicidal feelings.
- Adverse and abusive experiences in childhood are associated with an increased risk of suicidal behaviour.[24]

Effective local interventions

2.17 Timely and effective assessment of all vulnerable children is crucial to speedy identification and referral to appropriate support services. Screening tools such as the Strengths and Difficulties Questionnaire (SDQ) can help to prioritise referrals to local CAMHS.

2.18 A training and support programme targeted at primary care clinicians and administrative staff improved referral to specialist domestic violence agencies and recorded identification of women experiencing domestic violence.
www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61179-3/abstract

Leicestershire Police have a Comprehensive Referral Desk (CRD) of specialist officers who deal with domestic abuse, child abuse and adults in vulnerable situations. Each report from front-line officers and other agencies is assessed and dealt with by referral onto other agencies or by providing an appropriate police response to any criminal allegations or safeguarding issues. The CRD has led to improved joint working with health and other agencies. Through partnership working, the CRD

tries to reduce the likelihood of the same individuals being in situations of threat, harm or risk in the future.

National action to support local approaches

2.19 *Call to End Violence against Women and Girls (2010),* a cross-government strategy, has been followed by two cross-government action plans – the latest of which was published in March 2012. It includes actions around preventing violence, provision of services, partnership working, justice outcomes and risk reduction. The Government's continued support for Independent Sexual Violence Advisers, Independent Domestic Violence Advisers and Multi Agency Risk Assessment Conferences aims to ensure that women and girls at highest risk of violence are identified and referred for specialist help. Data sharing between emergency departments and other agencies is being encouraged to improve the identification of violence.

Helpful resources

2.20 The RCGP has produced an e-learning resource for GPs to enable them to identify and respond to victims of domestic violence more effectively. www.elearning.rcgp.org.uk/course/view.php?id=88

2.21 Southall Black Sisters have developed a model of intervention on domestic violence amongst Black and Minority Ethnic women.[25]

Veterans

- There are five million armed forces veterans in the UK and around 180,000 serving personnel. The prevalence of mental disorders in serving and ex-service personnel is broadly the same as that in the general population. Depression and alcohol abuse are the most common mental disorders. The most recent research found that one in four veterans from the Iraq War experienced some kind of mental health problem and one in 20 had been diagnosed with post-traumatic stress disorder.

- In general, suicide rates among armed forces veterans are lower than those in the general population. There is no evidence that, as a whole, people who have served their country in armed conflict are at higher risk of suicide. An important possible exception is young armed-service leavers in their early 20s. One study suggests they may be at two or three times' greater risk of suicide than comparable groups.[26]

2.22 *No health without mental health: Delivering better mental health outcomes for people of all ages* outlines all the Government's commitments to improving mental health support for service and ex-service personnel.

People living with long-term physical health conditions

- Some long-term conditions are associated with an increased risk of suicide, e.g. epilepsy. There is also evidence that receiving a diagnosis of cancer, coronary heart disease and chronic obstructive airways disease is associated with higher suicide risk. For cancer, the risk of suicide increases by more than ten times in

the week after diagnosis.

- Physical illness is associated with an increased suicide risk.[27] Many people who live with long-term conditions - including physical illness, disability and chronic pain – will, at some time, experience periods of depression that may be undiagnosed and untreated. Disadvantage and barriers in society for disabled people can lead to feelings of hopelessness. People with one long-term condition are two to three times more likely to develop depression than the rest of the general population. People with three or more conditions are seven times more likely to have depression. Many medical treatments for long-term physical health conditions (for example, chronic pain medication, insulin treatment) also provide people with ready access to the means of suicide.

- While depression explains a substantial part of the increased suicide risk in people with physical health conditions, it does not explain all of the increase.

2.23 *No health without mental health* is clear that we expect mental health needs to be given equal consideration to physical health needs.

Effective local interventions

2.24 Support for self-management and self-care is crucial, for example, in managing chronic pain, so that people have a greater sense of choice over how their health and care needs are met, feel more confident to manage their condition on a day-to-day basis and take an active part in their care. Feeling in control of one's life is associated with increased mental wellbeing and resilience.

2.25 Routine assessment for depression as part of personalised care planning can help reduce inequalities and support people with long-term conditions to have a better quality of life and better social and working lives.

2.26 Suicide can occur in general hospitals. Providers need to be aware of this risk, and to make appropriate links between physical and mental health care.

2.27 *No health without mental health: Delivering better mental health outcomes for people of all ages* outlines a number of local approaches to improve the mental health care of people with physical health problems.

Helpful resources

2.28 The NPSA has produced suicide prevention toolkits for ambulance services, general practice, emergency departments and community mental health and mental health services. The toolkits support clinicians and managers to understand what they can do to reduce the suicides. www.nhsconfed.org/Publications/briefings/Pages/Preventing-suicide.aspx

National action to support local approaches

2.29 *Talking Therapies: A four year plan of action (*2011) sets out the Government's plans to improve access to talking therapies and expand provision for children and young people, older people and their carers, people with long-term

physical health conditions, people with medically unexplained symptoms and people with severe mental illness.

2.30 The Office for Disability Issues (ODI) is developing a new cross-government disability strategy in partnership with disabled people and their organisations. Together, they are identifying effective ways to remove the barriers that prevent disabled people, including those with mental health conditions, from fulfilling their potential and having opportunities to play a full role in society. In September we will publish a summary of responses to *Fulfilling Potential*, including current and planned actions across government. We will also outline the next steps based upon the issues and ideas disabled people have told us about. We will publish a strategy and action plan in 2013.

2.31 The Department of Health's long-term conditions model aims to improve the health and wellbeing of people with long-term conditions such as diabetes. The Department is also developing a Long Term Conditions Outcomes Strategy for publication towards the end of 2012 which will outline a vision for how Government can work with local bodies to improve outcomes for people with long-term conditions.

2.32 The Government has recently published the White Paper *Caring for our future: reforming care and support*[28], following extensive engagement with the care sector over recent months. This sets out the Government's vision for reform of care and support, with a renewed focus on high quality, personalised and joined up care, supporting people to maintain independence for as long as possible and have choice and control over how their outcomes are met.

People with untreated depression

- Depression is one of the most important risk factors for suicide and undiagnosed or untreated depression can heighten that risk. Most depression can be treated in primary care.

- Depression is now recognised as a major public health problem worldwide. In England one in six adults and one in 20 children and young people at any one time are affected by depression and related conditions, such as anxiety. Depression is the most common mental health problem in older people - some 13-16% have sufficiently severe depression to need treatment. But only a quarter (or even fewer young and older people) receive treatment, even though effective drug and psychological treatments are available.

- Untreated depression can have a major impact on quality of life and can cause other health and social care problems - for example, postnatal depression can be associated with behavioural problems in the child. There are also risks in the early stages of drug treatment when some patients feel more agitated.

- Depression, chronic and painful physical illnesses, disability, bereavement and social isolation are more common among older people.

Men aged 75 and over have the highest rate of suicide among older people. While suicide rates among older people have been decreasing in recent years, an increase in absolute numbers is expected in the coming decades, due to the increase in number of older people.

Effective local interventions

2.33 People recover more quickly from depression if it is identified early and responded to promptly, using effective and appropriate treatments.

2.34 *No health without mental health: Delivering better mental health outcomes for people of all ages* identifies effective local approaches to treating depression and outlines some effective approaches for 'ageing well'.

Helpful resources

2.35 NICE issued updated guidance on *Depression: Management of depression in primary and secondary care* in 2009 and *Depression in Children and Young People: Identification and management in primary, community and secondary care* in 2005. NICE has also published a quality standard on depression, including with a chronic physical health problem.

2.36 Depression Alliance has produced leaflets on depression and an information pack. www.depressionalliance.org

2.37 The Staffordshire University Centre for Ageing and Mental Health has developed a set of information sheets to help health and social care providers respond to suicide risk in older clients: www.wmrdc.org.uk/mental-health/primary-care/suicide-prevention-in-elders-project-summary

2.38 The Department of Health has funded multi-centre research on suicide prevention[29] which has produced useful recommendations for services working with older people. It found that older adults who self-harm are at high risk of suicide, with men aged over 75 years at greatest risk. Use of a violent method in the first attempt is also a predictor of subsequent suicide. Alcohol dependency is also common among older adults who attempt suicide.

2.39 *Caring for our future* sets out how supporting active and inclusive communities, and encouraging people to use their skills and talents to build new friendships and connections, are central elements to the Government's new vision for care and support. The Department of Health has supported the Campaign to End Loneliness to produce a digital toolkit for health and wellbeing boards to support them in understanding, and addressing loneliness and social isolation in their communities: www.campaigntoendloneliness.org.uk/toolkit

2.40 The Department of Health, the Royal Colleges of General Practice, Nursing and Psychiatry and the British Psychological Society have developed a fact sheet on depression in older people: www.rcgp.org.uk/mental health/resources.aspx

People who are especially vulnerable due to social and economic circumstances

- There are direct links between mental ill health and social factors such as unemployment and debt. Both are risk factors for suicide.
- Previous periods of high unemployment and/or severe economic problems have been accompanied by increased incidence of mental ill health and higher suicide rates.[30]
- Suicide risk is complex – we do need to be vigilant at this time of higher economic uncertainty, but it is important not to assume that an increase in suicide is inevitable.
- 34% of rough sleepers have a mental health need and 18% have a mental health need combined with a substance misuse issue (dual diagnosis).

Effective local interventions

2.41 A range of front-line agencies, including primary and secondary health and social care services, local authorities, the police and Jobcentre Plus, can identify and support (or signpost to support) vulnerable people who may be at risk of suicide. As the Government's strategy *Social Justice: Transforming Lives* also makes clear, for individuals and families facing multiple social or economic disadvantages, it is really important that these local agencies 'join up' to maximise the effectiveness of services and support. www.dwp.gov.uk/docs/social-justice-transforming-lives.pdf

2.42 Interventions that improve financial capability reduce both the likelihood of people getting into debt and the impact of debt on mental health. Local services include Citizens Advice, the Money Advice Service at: www.moneyadviceservice.org.uk and the Consumer Credit Counselling Service: www.cccs.co.uk/Home.aspx. Credit unions can provide affordable credit to and encourage saving by the most disadvantaged families.

2.43 Other useful approaches at a local level include:

- continuously improving the knowledge and confidence of front-line staff who are in regular contact with people who may be vulnerable because of social/economic circumstances. This is particularly relevant to DWP front-line businesses including Jobcentre Plus staff, people working in other advice and support agencies and front-line staff in the financial sector (banks, building societies and utility companies);
- providing public information to signpost people to information, support and useful contacts if they are in debt or at risk of getting into debt. Information can be provided in a number of different ways, for example online and accessible leaflets. A number of NHS trusts have developed information sheets for the local population on the impact of the economic crisis - these give advice on maintaining wellbeing during difficult times and offer guidance on where to go for further help; and
- developing suicide awareness and education or training programmes to teach people how to recognise and respond to the warning signs for suicide in themselves or in others. These can be delivered in a variety of settings (such as schools, colleges,

workplaces and job centres). There are several training programmes available including Applied Suicide Intervention Skills Training (ASIST), Mental Health First Aid, Safe Start and training carried out by Samaritans.

2.44 DWP has guidance in place to help their staff to manage suicide and self-harm declarations from customers safely and effectively, for themselves and the customer.

2.45 Businesses and other employers can help by investing in and supporting their staff, particularly during times of anxiety and change.

National action to support local approaches

2.46 *No health without mental health: Delivering better mental health outcomes for people of all ages* gives examples of effective national approaches to support people back into employment and improve their financial capability and to support employers to meet their business needs and statutory requirements for healthy workplaces.

2.47 The Government's Work Programme supports people who are out of work to gain and sustain paid employment. This includes providing tailored support for people with mental health conditions to work. Work Programme Prime providers and specialist service providers have pledged to improve support to people with mental health problems; an approach endorsed by voluntary and community organisations.

2.48 We are replacing a wider range of financial benefits with a single Universal Credit which will ensure that people are always better off in work. The new system will be much simpler to administer and easier for claimants to understand. It will help people to get back to work gradually and smooth over earnings fluctuations where hours of work and income can vary.

2.49 The Government is committed to preventing and reducing homelessness, and improving the lives of those people who do become homeless. The Ministerial Working Group (MWG) on Preventing and Tackling Homelessness is bringing the relevant government departments together to share information, resolve issues and avoid unintended policy consequences, with the aim of enabling communities to tackle the multifaceted issues that contribute to homelessness. The MWG produced its first report *A Vision to End Rough Sleeping: No Second Night Out* in 2011 and is working on its second report on preventing homelessness, to be published later this year.
www.communities.gov.uk/publications/housing/visionendroughsleeping

People who misuse drugs or alcohol

- Many people with drug and alcohol dependence problems also have some form of mental health problem.[31][32] Similarly, about half of people with mental health problems misuse alcohol and/or drugs. Dual diagnosis (co-morbidity of drug and alcohol misuse and mental ill health) is associated with increased risk of suicide and suicide attempts.

- The use of drugs or alcohol is strongly associated with suicide in the general population and in sub-groups such as young men and

people who self-harm.

- For some people, their dependence is on prescribed drugs such as tranquilisers, and they may experience agitation on withdrawal and co-morbid mental health problems which may add to their risk.

- Smoking and nicotine dependence are associated with suicidal behaviour. There is no evidence to suggest that smoking cessation increases suicide risk.

Effective local interventions

2.50 Measures that reduce alcohol and drug dependence are critical to reducing suicide. That is why the 2010 drug strategy, *Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug-free life*, put the goal of recovery at its heart. It aims to create a recovery system that is locally led and locally owned enabling prompt access to treatment, helping people to realise the goal of recovery and ensuring appropriate aftercare to help people lead fulfilling lives.

2.51 Close working between mental health teams and local NHS stop smoking services should deliver cessation treatment strategies that complement recovery. Bupropion[33] should not be used to treat people at risk of suicide and care should be taken if varenicline[34] is prescribed.

National action to support local approaches

2.52 *Reducing Demand, Restricting Supply, Building Recovery* highlights the importance of holistic support to enable people to rebuild their lives and play their full role in society. The transfer to local authorities of responsibility for commissioning treatment for dependence on drug and alcohol will help local systems to develop effective links between treatment, housing services, criminal justice bodies, training and the wider support that is needed.

2.53 The Government Alcohol Strategy (2012) is explicitly targeted at harmful drinkers, problem pubs and irresponsible shops and sets out radical plans to turn the tide against irresponsible drinking. Chapter 3 of the Alcohol Strategy sets out how local communities and services can tackle alcohol-related issues in their area.

2.54 The NICE guidelines on management of anxiety[35] and treatment and management of depression[36] state that treatment with benzodiazepine (where appropriate) should usually be for no longer than two weeks in order to prevent the development of dependence.

Lesbian, gay, bisexual and transgender people

- A review of the research literature suggests that lesbian, gay and bisexual people are at higher risk of mental disorder, suicidal ideation, substance misuse and deliberate self-harm.[37] One Danish study found the suicide risk among gay men in civil partnerships is eight times higher than in heterosexual couples and twice as high as the risk in men who have never married. However, the same study showed no statistically significant increase in suicide risk among women in civil partnerships.[38]

- Lesbian, gay and bisexual people are twice as likely as heterosexual people to self-harm. Gay and bisexual men have a particularly high prevalence of self-harm. One in ten gay and bisexual men aged 16 to 19 have attempted to take their own life in the last year.[39]
- There are indications that transgender people may have higher rates of mental health problems and higher rates of self-harm.

Effective local interventions

2.55 Staff in primary and secondary health care, social services, education and the voluntary sector need to be aware of the higher rates of mental distress, substance misuse, suicidal behaviour or ideation and increased risks of self-harm in these groups.

National action to support local approaches

2.56 PACE, the lesbian, gay, bisexual and transgender (LGBT) voluntary sector research, counselling and advocacy organisation, has published *Where to Turn*, a review of web-based mental health promotion and preventive information, support and advice services for LGBT people. www.pacehealth.org.uk/Where%20To%20Turn%20-%20Final%20Full%20Report.pdf

2.57 Local services and external partners working with LGBT groups and individuals may find the findings and conclusions in *Where to Turn* helpful when planning and delivering mental health promotion, substance misuse and other support and advice services for LGBT people.

2.58 *Working for Lesbian, Gay, Bisexual and Transgender Equality: Moving Forward* (2011) sets out specific actions that will be taken across government, including actions on health and social care issues. www.homeoffice.gov.uk/publications/equalities/lgbt-equality-publications/lgbt-action-plan?view=Binary

2.59 *Advancing transgender equality: A plan for action* (2011) sets out specific actions that will be taken across government to advance transgender equality. www.homeoffice.gov.uk/publications/equalities/lgbt-equality-publications/transgender-action-plan

Black, Asian and minority ethnic groups and asylum seekers

- The evidence on the incidence of mental health problems in Black, Asian and minority ethnic groups is complex. This term covers many different groups with very different cultural backgrounds, socioeconomic status and experiences in wider society. People from Black, Asian and minority ethnic groups often have different presentations of problems and different relationships with health services. Some Black groups have admission rates around three times higher than average, with research showing that some BME groups have high rates of severe mental illness, which may put them at high risk of suicide. The rates of mental health problems in particular migrant groups, and subsequent generations, are also sometimes higher. For example, migrant groups and their children are at two to eight times greater risk of psychosis. More recent arrivals, such as some asylum seekers and refugees, may also require mental health support following their experiences in their home countries.

- There is little evidence on suicide risks in Black, Asian and other minority ethnic groups, as information on ethnicity is currently not collected through the death registration and inquest processes. This is a major obstacle to getting reliable and accurate data on suicides and to improving the evidence base and monitoring trends.

- In 2006, *Suicide prevention for BME groups in England*, summarised the literature and identified areas for future research. The message remains that we need more and better information about prevention and risk factors among different ethnic groups. www.nmhdu.org.uk/silo/files/executive-summary-suicide-prevention-for-bme-groups-in-england.doc

Effective local interventions

2.60 The Delivering Race Equality in Mental Health Care action plan has improved understanding of BME communities' mental health needs and their attitudes towards and beliefs about mental health and mental health services. The final report on the programme describes examples of good practice in reaching out to minority ethnic groups and demonstrates the value of community initiatives aimed at bridging the gap between statutory services and BME communities. It also shows how this community development approach, working across sectors and in partnership with communities, can be effective in tackling inequalities in health and access to services.

2.61 The Count Me In 2010 census[40] showed little change from those reported for previous years. Although the numbers of mental health inpatients overall have fallen since 2005, ethnic differences in rates of admission, detention under the Mental Health Act and seclusion have not altered materially since the inception of the Delivering Race Equality action plan in 2005.

2.62 Healthcare staff coming into contact with asylum seekers and refugees should be aware of the following:

- The prevalence of suicidal behaviour, suicide and self-harm among refugees and asylum seekers is difficult to ascertain. Official statistics are not readily available and data may come from unofficial sources such as the media and personal accounts.

- Social isolation, language barriers, racism, homophobia and legal uncertainties about the future may be experienced by asylum seekers and lead to depression. Factors such as differing cultural perceptions of mental illness and stigma associated with mental illness/suicide may then stop treatment being sought.

- Some asylum seekers could be suffering from post-traumatic stress disorder and severe depression caused by their experiences in their home countries, although it is difficult to gauge the number of people who will be affected in this way. Not all mental health and suicide prevention services may be geared to meet these needs and specialised help may be more appropriate.

National action to support local approaches

2.63 A Ministerial Working Group on Equality in Mental Health has been established to ensure that equality issues directly inform strategy implementation. Its initial priority is to tackle race inequality in particular, but it also aims to ensure that the full obligations of the Equality Act 2010 are met.

2.64 Asylum applications in the UK were at their lowest in 2010 at 17,790, excluding dependents, since a peak in 2002 of 84,130. The UK Border Agency is, however, considering whether its ability to identify individuals at risk of suicide or self-harm, and to refer them to the appropriate services, could be improved.

3. Area for action 3: Reduce access to the means of suicide

3.1 One of the most effective ways to prevent suicide is to reduce access to high-lethality means of suicide. This is because people sometimes attempt suicide on impulse, and if the means are not easily available, or if they attempt suicide and survive, the suicidal impulse may pass.[41][42]

3.2 Suicide methods most amenable to intervention are:

- hanging and strangulation in psychiatric inpatient and criminal justice settings;
- self-poisoning;
- those at high-risk locations; and
- those on the rail and underground networks.

It is also important to be vigilant and respond to new or unusual suicide methods.

3.3 The media has an important role in avoiding reporting and portraying new high-lethality methods of suicide, that may increase the number of fatal suicide attempts. The internet is a ready source of detailed information concerning the use of lethal suicide methods (see area for action 5).

Reduce the number of suicides as a result of hanging and strangulation

- The most common method of suicide for men and women is hanging and strangulation.[43] Hanging and strangulation also continues to be the most common method of suicide among mental health inpatients and prisoners.

Effective local interventions

3.4 Inpatient suicides as a whole have reduced since 2004: the removal of non-collapsible fittings has resulted in no inpatient suicides as a result of hanging from non-collapsible bed or shower curtain rails, and the total number of deaths by hanging has fallen by more than half. Inpatient suicide using non-collapsible rails is a 'Never Event'[*].

3.5 Paragraphs 1.11-1.15 outline approaches which will help mental health service providers to reduce suicide risk.

3.6 Hanging accounts for over 90% of self-inflicted deaths in custody. In prison, access to certain methods will be severely restricted and this may contribute to the choice of hanging as a method. Safer cells are one example of facilities that can be used in the care of prisoners. Safer cells are designed to make the act of suicide or self-harm by ligaturing as difficult as possible, mainly by reducing ligature points. The design also takes account of the need to create not only a safer and robust environment, but also a more normalising one. However, no cell can be considered totally 'safe'. Safer cells can complement (but not replace) a regime providing care for at-risk prisoners and can reduce risks associated with impulsive acts.

[*] Never events are serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

National action to support local approaches

3.7 A recent Department of Health study[44] found that people choose hanging as a method of suicide because they mistakenly think it is quick, tidy and effective. These findings have important implications for suicide prevention work and the National Suicide Prevention Strategy Advisory Group will consider how best to respond to these findings.

Reduce the number of suicides as a result of self-poisoning

- Self-poisoning accounts for approximately a quarter of all suicide deaths in England. It is the second most common method of suicide in both men and women and was, until 2008, the most common method among women.

3.8 Significant progress has been made in reducing access to medications associated with suicide attempts, including:

- the phased withdrawal of co-proxamol, a prescription-only painkiller that was associated with 300–400 fatal deliberate or accidental drug overdoses a year in England and Wales alone. This reduced deaths from this cause, without evidence of a significant increase in deaths due to poisoning with other analgesics;[45] and

- the introduction in 1998 of legislation to limit the size of packs of paracetamol, salicyates and their compounds sold over the counter, supported by guidance on best practice in the sale of pain relief medication (MHRA, 2009).

Restricting the availability of these medicines has led to a reduction in both deliberate and accidental overdoses.[46]

3.9 However, a substantial number of deaths still occur from paracetamol overdose. The MHRA has established an expert working group of the Commission on Human Medicines to review current guidelines for the management of paracetamol overdose.

3.10 Further consideration needs to be given to the prescribing of some toxic drugs, where safer alternative medicines are available.[47]

3.11 The National Institute for Health and Clinical Excellence (NICE) will be developing a quality standard on safe prescribing, as part of a library of approximately 170 NHS Quality Standards covering a wide range of diseases and conditions.

Reduce the number of suicides at high-risk locations

- Jumping from a high place is an important method of suicide to address. Suicides by jumping almost inevitably occur in public places, have a very high fatality rate and are extremely traumatic for witnesses and people living and working in the surrounding area. Jumps also tend to attract media attention, which can lead to copycat suicides. All the world's most notorious suicide locations are jumping sites.

- Locations that offer easily accessible means of suicide include vehicle and pedestrian bridges, viaducts, high-rise hotels, multi-storey car parks and other high buildings, and cliffs.

3.12 Most areas have sites and structures that lend themselves to suicide attempts.

Suicide risk can be reduced by limiting access to these sites and making them safer.[48]

3.13 Evidence suggests that loss of life can be prevented when local agencies work together to discourage suicides at high-risk locations, including sites that temporarily become suicide hot-spots following a suicide death.

Examples of effective local interventions

3.14 Effective approaches to reducing suicides at high-risk locations or from jumping include:

- preventative measures – for example barriers or nets on bridges, including motorway bridges, from which suicidal jumps have been made, and providing emergency telephone numbers, e.g. Samaritans;

- working with local authority planning departments and developers to include suicide risk in health and safety considerations when designing multi-storey car parks, bridges and high-rise buildings that may offer suicide opportunities;

- In care and hospital settings, environmental assessments should include assessing the risk of vulnerable patients accessing opening windows or balconies (see guidance in NHS Estates Health Technical Memorandum No 55 *Windows*); and

- working with local and regional media outlets to encourage responsible media reporting on suicide methods and locations (see area for action 5).

Helpful resources

3.15 *Guidance on Action to be Taken at Suicide Hotspots* (2006) supports local suicide prevention work, enabling responsible authorities to identify local places (for example bridges, cliffs, railway stations) where people who are thinking about suicide may be tempted to go. It identifies a number of evidence-based interventions that have proved effective.
www.nmhdu.org.uk/nmhdu/en/our-work/promoting-wellbeing-and-public-mental-health/suicide-prevention-resources/

3.16 Work undertaken by the London School of Economics and the Institute of Psychiatry on behalf of the Department of Health includes a cost benefit analysis of bridge safety measures for suicide prevention, which would potentially also apply to other suicide hot-spots. See www2.lse.ac.uk/businessAndConsultancy/LSEEnterprise/news/2011/healthstrategy.aspx

3.17 *Falls from windows* provides HSE guidance to help organisations manage the risks of people using care services falling from windows or balconies.
http://www.hse.gov.uk/healthservices/falls-windows.htm

Reduce the number of suicides on the rail and underground networks

- Suicide by jumping or lying in front of trains and other moving vehicles is similarly an important method to address. While suicide rates have been falling generally, suicide deaths on the railway network have increased slightly, to about 210 people a year in England, Scotland and Wales. Most (about 80%) are men and most are in the 15–44 age range. The RSSB and the British Transport Police collect extensive information on railway deaths and incidents, including suicides and

attempted suicides.

Examples of effective local interventions

3.18 The British Transport Police (BTP) and London Underground Limited (LUL) have worked closely with local services to reduce risk at transport-related suicide hotspots. LUL has provided staff training to help them identify people who may be considering suicide and engage with them in the hope that they can persuade them not to. This approach has helped reduce incidence of suicide at one London Underground station close to a psychiatric inpatient unit. The training is currently being rolled out across the London Underground network.

3.19 The British Transport Police recognises that suicide attempts provide an opportunity for interventions aimed at preventing an individual from repeating their attempt at a later date, with the aim to reduce the number of fatalities on the railway. BTP has developed a suicide prevention plan, which is completed for every "determined" attempt at suicide. It is a comprehensive record of information about the individual and the incident, supported by a menu of potential actions which could be taken according to the information available, in order to minimise the risk that the individual poses. In particular, it captures the contact details of any friends, relatives or any individuals who have assisted in reducing the person's risk of suicide (e.g. social worker, doctor, and psychiatrist) for future reference and to enable follow up enquiries regarding the individual's progress/wellbeing.

National approaches to support local actions

3.20 Samaritans and Network Rail have established a joint, five-year training, communications and outreach programme. Through joint working with partners including train operators and the British Transport Police, they aim to reduce suicides on the national rail network by 20%. The project was launched in January 2010 and is initially focused on those stations most affected by suicide. www.samaritans.org.uk/support_samaritans/corporate_suppporters/network_rail/about_the_partnership.aspx

Respond to new methods of suicide

Effective local interventions

3.21 As well as understanding commonly used means of suicide, it is important to be vigilant and respond to new or unusual suicide methods and locations. Local services and external agencies may need to devise ways to ensure that they are provided promptly with information about the circumstances and methods of suicides either by the police following initial investigation of the death or through the coroner's office following the police report to the coroner.

National approaches to support local actions

3.22 The Government will work with the National Suicide Prevention Strategy Advisory Group to take a lead in identifying, monitoring and responding to new methods of suicide when they emerge.

4. Area for action 4: Provide better information and support to those bereaved or affected by suicide

4.1 To provide better information and support for those bereaved or affected by suicide we need to:

- provide support that is effective and timely;
- have in place effective local responses to the aftermath of a suicide; and
- provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide.

Provide effective and timely support for families bereaved or affected by suicide

- Family and friends bereaved by a suicide are at increased risk of mental health and emotional problems and may be at higher risk of suicide themselves.[49]

- Suicide can also have a profound effect on the local community. We know from studies that, in addition to immediate family and friends, many others will be affected in some way.[50][51] They include neighbours, school friends and work colleagues, but also people whose work brings them into contact with suicide – emergency and rescue workers, healthcare professionals, teachers, the police, faith leaders and witnesses to the incident.

- There may be a risk of copycat suicides in a community, particularly among young people, if another young person or a high-profile celebrity dies by suicide.

Effective local interventions

4.2 Effective and timely emotional and practical support for families bereaved or affected by suicide is essential to help the grieving process, prevent further or longer-term emotional distress and support recovery. There is some evidence that referral to specialist bereavement counselling and other bereavement support can be helpful for people who actively seek it[52], although evidence for efficacy of interventions is currently limited[53]. It is important that GPs are vigilant to the potential vulnerability of family members when someone takes their own life.

4.3 Guidance that mental health trusts will have in place on how to deal with the suicide of a patient under the care of the mental health services may include information on preparing for the inquest and dealing with the family, carers and friends of the deceased, including the impact of the suicide and the inquest on the family. The need to be sensitive in their dealings with the family will continue if the clinical team have to attend an inquest.

Helpful resources

4.4 The Department of Health has recently reviewed and updated *Help is at Hand: A resource for people bereaved by suicide and other sudden, traumatic death*. This provides advice and information for anyone directly affected by suicide. It also has advice for people in contact with

those bereaved through suicide, either because of their work or because they are part of the same community. See www.nmhdu.org.uk/nmhdu/en/our-work/promoting-wellbeing-and-public-mental-health/suicide-prevention-resources/ or order from www.orderline.dh.gov.uk

4.5 This useful resource could be publicised more widely. A recent evaluation has shown that it is well received but that access to it can be a problem.[54] The Department of Health will continue to work with partners to get the document to people at the right time.

4.6 The Government has recently published the *Guide to Coroners and Inquests and Charter for Coroner Services* which has been provided to all coroners' courts. It will ensure that people have accessible, concise information on the processes and standards in a coroner inquiry, and setting out the standards in a single document will also improve consistency across the coroner system. www.justice.gov.uk/downloads/burials-and-coroners/guide-charter-coroner.pdf

4.7 INQUEST, a charity which provides advice and support to bereaved people on the inquest process, has developed *The Inquest Handbook: A guide for bereaved families, friends and their advisors*. This booklet includes specialist sections dealing with deaths in police or prison custody and when detained under the Mental Health Act 1983.

4.8 There are other sources of support, information and advice that may be helpful both for people directly affected by suicide and also for use when training and supporting staff whose work brings them into contact with suicide. They include:

- *The Road Ahead… A guide to dealing with the impact of suicide*, published by Mental Health Matters. www.mentalhealthmatters.com
- Healthtalkonline, a website where people can share experiences of ill health and bereavement, including bereavement by suicide. www.healthtalkonline.org
- If U Care Share, a website and campaign organisation with links to sources of support. www.ifucareshare.co.uk
- Winston's Wish, bereavement support for children and young people. www.winstonswish.org.uk/
- Cruse Bereavement Care. www.crusebereavementcare.org.uk
- Survivors of Bereavement by Suicide, a self-help organisation to meet the needs and break the isolation of those bereaved by the suicide of a close relative or friend. www.uk-sobs.org.uk/
- The Compassionate Friends, support for bereaved parents and their families after a child dies. www.tcf.org.uk/

National action to support local approaches

4.9 The Independent Advisory Panel on Deaths in Custody held a listening day in September 2011 for those whose family member had died whilst detained under the Mental Health Act.

4.10 As a result of what they heard, the Panel recommended to the Ministerial Board on Deaths in Custody that Trusts with responsibility for detained patients should have procedures in place for ensuring good quality family liaison with bereaved families, and to signpost them for support and advice. Policies on investigation should be explained to families to ensure they are offered an opportunity to be involved and receive ongoing information. Trusts should also keep families informed of actions taken

to learn from their relative's death including any changes as a result of the investigation or inquest.

4.11 This good practice, particularly following the judgment in *Rabone vs Penine Care NHS Foundation Trust*, is equally applicable where a voluntary patient in contact with mental health services takes their own life.

4.12 The Department of Health recently made a grant to Survivors of Bereavement by Suicide to enable the organisation to forge productive relationships with other suicide prevention organisations so that they can continue to support bereaved families and friends in the future.

Have in place effective local responses to the aftermath of a suicide

- Suicide can have devastating effects on a community. There is emerging evidence that post-suicide interventions at community level can help to prevent copycat and suicide clusters and ensure support is available. This approach may be adapted for use in schools, colleges and universities, workplaces, prisons, mental health and other care services, drug and alcohol services and residential care homes.

4.13 Samaritans has successfully piloted a Step by Step post-suicide intervention service for schools, and is now offering this service across the UK. Samaritans branches work with schools and local authorities, offering practical support, guidance and information on the impact of suicide on school communities, and ways to promote recovery and prevent suicide clusters. This approach could also be used in other settings. www.samaritans.org

4.14 Publicity about suicide, and in particular detailed descriptions of the suicide method, may lead to copycat suicide attempts. Area for action 5 describes ways to work with the media to raise awareness of this risk and promote responsible reporting and portrayal of suicides.

Provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide

4.15 If families, friends and colleagues become concerned that someone may be at risk of suicide it is important that they can get information and support as soon as possible.

4.16 Recent qualitative research[55] indicates that there are very significant difficulties for family members and friends recognising and responding to a suicidal crisis. Signs and communications of suicidal crisis are rarely clear: they are often oblique, ambiguous and difficult to interpret. Even when it is clear to relatives and friends that something is seriously wrong, they may be afraid to intervene for fear of saying or doing `the wrong thing' and damaging relationships or even raising suicide risks. The answer is not simply to give people information about warning signs, because the blocks to awareness and intervention may be emotional rather than factual in nature. Efforts to support families and friends to play a role in preventing suicide should highlight the ambiguous nature of warning signs and should focus on helping people to acknowledge and overcome their fears about intervening.

Effective local interventions

4.17 If individuals are already being cared for by mental health, primary care or social services it is critical that family, carers and friends know how to contact the services and are appropriately involved in any care planning. Any concerns they raise should be considered carefully and responded to in a timely and appropriate way.

4.18 The NHS Future Forum reported how people often find care systems difficult to navigate, and that having a person to help coordinate their care made a significant difference to both their experience and the effectiveness of their care. The Government wants everyone with a care plan to be allocated a named professional who has an overview of their case and is responsible for answering any questions they or their family might have. *Caring for our future* sets out how we hope this can become standard practice.

4.19 There are clearly times when mental health service practitioners, in dealing with a person at risk of suicide, may need to inform the family about aspects of risk to help keep the patient safe. The Department of Health is working with a wide range of professional bodies to raise the profile of this issue and to try to reach a consensus view on confidentiality and suicide prevention.

4.20 For individuals who are not known to services help is still available through many outlets. A list of services and contacts is being published alongside the strategy. Contact details and further information about other organisations is available in *Help is at Hand*: www.nmhdu.org.uk/nmhdu/en/our-work/promoting-wellbeing-and-public-mental-health/suicide-prevention-resources/

National action to support local approaches

4.21 Samaritans has a partnership with the social networking site Facebook in the UK. Friends who are concerned about an individual will be able to tell Samaritans through the Facebook help centre. Facebook will then put Samaritans in touch with the distressed friend to offer their expert support. The Samaritans' Facebook page also has advice on how to support vulnerable friends, such as how to spot when someone is distressed and how to start a difficult conversation.

4.22 Some individuals are more likely to come into contact with people at higher risk of suicide as a result of their work, for example, staff in job centres, the police and emergency departments (see paragraph 2.38).

5. Area for action 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour

5.1 There are two key aspects to supporting the media in delivering sensitive approaches to suicide and suicidal behaviour:

- promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media; and
- continuing to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention services.

Promote the responsible reporting and portrayal of suicide and suicidal behaviour in the media

- The media have a significant influence on behaviour and attitudes. There is already compelling evidence that media reporting and portrayals of suicide can lead to copycat behaviour, especially among young people and those already at risk.[56][57]

Effective local interventions

5.2 Local services and agencies may wish to work with local and regional newspapers and other media outlets to encourage them to provide information about sources of support and helplines when reporting suicide and suicidal behaviour. Working with local media is particularly important where there is a specific location for suicide causing concern.

National action to support local approaches

5.3 In 2006 the Press Complaints Commission (PCC) added a clause to the Editors' Code of Practice explicitly recommending that the media avoid excessively detailed reporting of suicide methods. The 2009 edition of the PCC *Editors' Codebook* highlights the distress that can be caused by:

- insensitive and inappropriate graphic illustrations accompanying media reports of suicide;
- use of photographs taken from social networking sites without relatives' consent; and
- the re-publication of photographs of people who have died by suicide when reporting other suicide deaths in the same area.

5.4 It also commends the inclusion of details of local support organisations and helplines with any coverage of suicide deaths. www.pcc.org.uk/cop/practice.html

5.5 A number of other organisations and agencies, most notably Samaritans, have developed helpful guidance for the media on the reporting of and portrayal of suicide. www.samaritans.org/media_centre/media_guidelines.aspx

5.6 Samaritans plays a key role in monitoring media coverage of suicide, looking at examples of both poor and excessive reporting of suicide in the UK in national, regional and local media. It works closely with the media and regulators to support sensitive reporting

of suicide in line with its media guidelines and undertakes proactive training and outreach with the media.

5.7 The portrayal of suicide behaviour in TV programmes and film and advertising is also an important consideration. In regulating television programming and film, both Ofcom and the British Board of Film Classification take account of the risk of imitative behaviour which could encourage suicide. Advertising is subject to the Advertising Standards Authority's advertising codes, which contain a range of regulatory controls regarding the content of advertisements. We intend to consult with the regulators to ensure that their rules and guidelines remain robust and continue to provide suitable protections.

5.8 The Government is supporting the Time to Change anti-stigma and discrimination social marketing programme. The programme's media engagement work in 2012-13 will: provide an advisory service to broadcast media; pro-actively engage TV drama and news producers, scriptwriters and commissioners; hold seminars to improve the reporting and representation of people with mental health problems; and aim to secure board-level support from media companies. www.time-to-change.org.uk

Continue to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention services

- There is growing concern about misuse of the internet to promote suicide and suicide methods.[58] In particular, there has been widespread condemnation of internet sites that could help and encourage vulnerable people – particularly young people – to take their own lives. In 2005-7 there was evidence that internet use may have contributed to at least 1-2% of suicides, particularly in relation to the use of relatively unusual, highly lethal methods.
- The internet also provides an opportunity to reach out to vulnerable individuals who would otherwise be reluctant to seek information, help or support from other agencies. The internet can develop and expand the availability of sources of support to vulnerable people online and can also encourage major organisations that provide content in the most popular parts of the internet (such as social networking sites; search engine providers; and online news media outlets) to develop responsible practices which reduce the availability of harmful content and promote sources of support.

National action to support local approaches

5.9 *Safer Children in a Digital World*, the report of the Byron Review (2008), identified some confusion about the application of the law to the encouragement of suicide online. The relevant provisions of the law have since been simplified and modernised to make clear that the law applies to online as well as offline actions. The new provisions came into force on 1 February 2010.[59]

5.10 Under section 2(1) of the Suicide Act 1961 (as amended by section 59 of the Coroners and Justice Act 2009) it is an offence to do an act capable of encouraging or assisting the suicide or

attempted suicide of another person with the intention to so encourage or assist. The person committing the offence need not know the other person or even be able to identify them. So the author of a website promoting suicide and suicide methods may commit an offence if the website encourages or assists the suicide or attempted suicide of one or more of their readers, and the author intends that the website will so encourage or assist. They may be prosecuted whether or not a suicide or attempted suicide takes place. Similarly, any person making a posting to an online chat room or a social networking site which intentionally encourages another person to commit or attempt to commit suicide may be guilty of an offence.

5.11 The Director of Public Prosecutions has issued a Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide which sets out guidance to prosecutors on how to apply the law in force. The policy also provides information on the relevant evidential and public interest stages which must be considered in cases of assisted suicide. The policy is available on the CPS website.

5.12 Content providers are free to make their own policies on the publication of harmful or inappropriate material. We expect that the updated law on promoting suicide should make it easier for content providers to identify and take down any content based in England and Wales that contains potentially illegal material. However, potentially illegal material that is hosted by providers outside the UK will not be covered by these arrangements.

5.13 The Government works with the internet industry and content providers through the UK Council for Child Internet Safety (UKCCIS) to create a safer online environment for children and young people through industry self-regulation, improving e-safety education and raising public awareness.

5.14 The Government will continue to work through UKCCIS to promote active choice on domestic broadband connections and on new internet-enabled devices – prompting consumers to choose which content they wish to be able to access – enabling consumers, should they so choose, to restrict access to the most common content and sites which promote suicide. We will promote the use of default filters on public wifi networks, which could help to prevent children using public wifi from accessing adult content. Technical solutions will not offer the complete solution and UKCCIS is also working to develop greater internet safety and education tools for parents and children. We will be pressing for greater transparency from industry on their responses to the public's reporting of harmful and inappropriate content. Over the summer period, we will be seeking the views of industry, children's charities and parents on the best ways to keep children safe online.

5.15 Implemented effectively, these measures will reassure parents that they have the tools to ensure that their children are not accessing harmful suicide-related content online.

5.16 Samaritans and others have worked with search engines and social media sites to ensure that ready access is provided to trusted suicide prevention and support services. PAPYRUS, a voluntary organisation for the prevention of young suicide, has developed a leaflet *Action for Safety on the Internet*, which offers

basic advice and sources of help for anyone who wishes their child to take a safe and responsible approach to the internet; and has concerns that a young person is depressed or suicidal. www.papyrus-uk.org

5.17 See section 4.20 for a joint initiative by Facebook and Samaritans.

6. Area for action 6: Support research, data collection and monitoring

6.1 To support research, data collection and monitoring we need to:

- build on the existing research evidence and other relevant sources of data on suicide and suicide prevention;
- expand and improve the systematic collection of and access to data on suicides; and
- monitor progress against the objectives of the national suicide prevention strategy.

- Reliable, timely and accurate suicide statistics are the cornerstone of any suicide prevention strategy and of tremendous public health importance.
- Research is essential to suicide prevention. Research studies enhance our understanding of the statistical data provided by ONS to inform strategies and interventions; highlight trends and changes in patterns; identify key factors in suicide risk and enhance our understanding of risk groups; evaluate and develop interventions to reflect changing needs and priorities, and develop the evidence base on what works in suicide prevention.
- A wealth of data is already collected by different agencies in the course of their routine work, but only limited information is collected centrally or easily accessible and available to researchers or public health specialists.

Build on the existing research evidence and other relevant sources of data on suicide and suicide prevention

6.2 There is a range of existing research evidence and other relevant sources of data which are useful to inform local and regional strategies and interventions to prevent suicide. A brief description of and links to the key information sources is included in the statistical update being published alongside this strategy.

6.3 Nationally, the Government will work with the Devolved Administrations in the UK to share national and international evidence from research studies on suicide prevention and effective interventions, and identify gaps in current knowledge.

6.4 The Department of Health, through the National Institute for Health Research (NIHR) and the Policy Research Programme (PRP), has invested significantly in mental health research and will continue to support high-quality research on suicide, suicide prevention and self-harm.

6.5 A five-year NIHR programme grant to generate research evidence to underpin the implementation and evaluation of the 2002 Suicide Prevention Strategy is due to report during 2012.

6.6 The NIHR has approved a five-year programme grant on suicide prevention starting 1 April 2012. This new programme will collect and analyse data on suicide and self-harm as related to the recession; develop interventions to reduce the impact of the recession on suicides; evaluate different forms of risk

assessment following self-harm; review the literature and develop guidelines on the management of episodes of self-harm where individuals have made advance decisions on treatment; develop resources for parents of young people who self-harm; evaluate whether the use of some specific new methods of suicide is increasing; and identify medicines associated with high fatality in overdose.

6.7 The PRP will fund up to £1.5 million for new suicide prevention research to contribute to the delivery of policy.

Expand and improve the systematic collection of and access to data on suicides

6.8 The information in the national mortality statistics produced by ONS is useful for identifying national trends, but does not allow more detailed analysis. Preventative interventions and monitoring would be enhanced if more comprehensive information was more easily accessible. Additional information may be held in coroners' records and records from GPs or secondary care and mental health services, but it is not routinely or systematically reported.

6.9 Public Health England is establishing an evidence and intelligence function. This will include the role currently performed by public health observatories, and will include gathering information on suicide prevention activities and data on suicide and self-harm in order to publish the data to support the Public Health Outcomes Framework.

6.10 Scotland is currently establishing a Scottish Suicide Information Database (ScotSID) to improve the quality of information available on suicides in Scotland. The first national report is available at: www.isdscotland.org/Health-Topics/Public-Health/Publications/2011-12-20/2011-12-20-Suicide-Report.pdf?45182436705

6.11 The Department of Health will work with the National Suicide Prevention Strategy Advisory Group to consider how we can get the most out of the existing data sources in England and address the issues raised in paragraph 6.8. This will include considering options to address the current information gaps around ethnicity and sexual orientation, and will seek to learn from the Scottish experience in establishing ScotSID.

6.12 At a local level, coroners may work with health services and partner organisations and agencies to provide data that will give an early indication of emerging patterns, such as clusters or particular patterns of suicides, before data are compiled by the ONS.

6.13 At a national level the Department of Health will work with the Ministry of Justice and coroners to consider what access to coroners' records may be achievable for bona fide researchers, subject to relevant data protection and confidentiality safeguards and bearing in mind coroners' statutory duties.

6.14 The varying detail given by coroners in narrative verdicts and the increasing use of multi-category verdicts means that, in some cases, ONS find it difficult to classify intent accurately. ONS is confident that the overall picture of current suicide trends shown by national and regional statistics is reliable at present.[60] However, the variation in practice by different coroners means that local figures could be less reliable. Also,

if the rise in narrative verdicts continues at the same rate, the accurate reporting of injury and poisoning deaths may be affected in the future. ONS is working with coroners and others concerned to ensure that they are able to classify these narrative and multi-category verdicts accurately in order to monitor trends and draw comparisons over time.

6.15 In the light of this, ONS made changes to the processing of narrative verdicts for all deaths registered from 2011 onwards, and the work with coroners will not have an impact until later in that year. Accordingly, ONS will be able to look at data for 2011 when it has the annual dataset in summer 2012 to assess the impact of these changes.

6.16 The Government is reforming the coroner system under Part 1 of the Coroners and Justice Act 2009. These reforms, which involve the establishment of the Chief Coroner, will help to bring about much greater consistency of practice between coroner areas and improved services to the bereaved, as well as helping to speed up the investigation and inquest process.

6.17 National monitoring statistics depend on the data generated by the coroners' reporting system so it will be important to bear in mind the continuity of data and information when making these changes.

Monitor progress

6.18 The Government is committed to a new focus on outcomes that matter to people and their families both at national and local level. Three outcome frameworks have been developed: for the NHS, public health and adult social care. Together, these provide a comprehensive and coherent approach to tracking national progress against a range of critical outcomes.

6.19 Reflecting the continuing focus on suicide prevention, the Public Health Outcomes Framework (January 2012) includes the suicide rate as an indicator. Two other indicators with direct relevance to suicide prevention are self-harm and excess under 75 mortality in adults with serious mental illness. The indicator on excess mortality is also contained in the NHS Outcomes Framework.

6.20 *No health without mental health: Delivering better mental health outcomes for people of all ages* gives examples of outcomes and indicators for consideration by the NHS Commissioning Board and local commissioners; these include the rates of inpatient suicides.

6.21 The National Suicide Prevention Strategy Advisory Group will meet regularly to assess progress on the shared areas for action and objectives outlined in the strategy.

6.22 An update on progress in the implementation of the final strategy will be published annually online. This will summarise developments at national level, identify relevant research studies and their findings, and report detailed statistical information on suicides by gender, age, method and location.

7. Making it happen locally and nationally

7.1 A key message of this strategy is that there are many sectors, groups and individuals who can help to reduce suicide. Each priority area for action, set out in chapters 1 to 6, contains suggested local and national activities to help deliver change.

7.2 This chapter describes some of the broader context, systems and bodies, such as public health and primary care, which will support several of the areas for action.

7.3 *No health without mental health* outlines the proposed reforms to the public health, health and social care systems and how the new architecture and approach will affect planning and delivery of improved public health and mental health outcomes. It also describes cross-government actions to support the delivery of the mental health strategy. Many have direct relevance to suicide prevention; for example, the work on employment being undertaken across government and the Ministerial Working Group on Preventing and Tackling Homelessness.

7.4 An implementation framework for *No health without mental health* was published in July 2012. This sets out what local organisations can do to implement the strategy, what work is underway nationally to support them, and how progress against the strategy's aims will be measured. The implementation framework explicitly covers suicide prevention, and will support local agencies in implementing this strategy.

Public Health

7.5 Public Health England (PHE) is the new national agency for public health (from April 2013) and will support local authorities, the NHS and their partners across England to achieve improved outcomes for the public's health and wellbeing.

7.6 PHE will take a leadership role across public health services, providing expertise and support to local areas to help improve outcomes in public health and reduce health inequalities, including on mental health and suicide prevention.

7.7 An effective local public health approach is fundamental to suicide prevention. This will depend on effective partnerships across all sectors including health, social care, education, the environment, housing, employment, the police and criminal justice system, transport and the voluntary sector.

7.8 New health and wellbeing boards (HWBs) will be able to support suicide prevention as they bring together local councillors, Clinical Commissioning Groups (CCGs), directors of public health (DsPH), adult social services and children's services, local Healthwatch and, where appropriate, wider partners (such as the Police and the Local Safeguarding Children Board) and community organisations.

7.9 HWBs will assess the local community's health and wellbeing needs and assets. Improvements in population health and wellbeing, including mental health, will reduce the risks of suicide. Specific

approaches to suicide prevention could feature in an effective local health and wellbeing approach. For example, many of the locations used for suicide are under the control of local authorities and they can act to reduce this risk.

7.10 DsPH can play a key part in developing local public health approaches and in nurturing and maintaining links across the NHS and local government. They will be appointed jointly by local authorities and Public Health England. This will place many DsPH in a unique position to contribute to taking forward the suicide prevention strategy.

7.11 Some areas have established regional or sub-regional multi agency suicide prevention groups to co-ordinate activities to reduce suicides. In many cases these groups also support more localised groups or networks of suicide prevention activists. These groups could help support DsPH and health and wellbeing boards in developing assessments and strategies.

Primary care services

7.12 Most general practices will have a patient who dies by suicide only once every few years. However, GPs can make a big difference to overall suicide rates. General practices will see a lot of people with many of the known factors for higher risk of suicide, for example long-term physical health problems, self-harming, drug and alcohol misuse and mental health problems. They are the first point of contact for many people who are experiencing distress or suicidal thoughts and who may be vulnerable to suicide. GPs are also the key gatekeepers to specialist services.

7.13 Primary care staff may also be the first point of contact for people who are bereaved or affected by the suicide of family members, friends and colleagues.

7.14 Health visitors, midwives and other community staff may be in contact with children, young people and families and be the first to be aware of mental health problems or other difficulties developing. They can therefore provide direct support and also refer speedily to other services.

Commissioning reforms

7.15 The NHS Commissioning Board (NHS CB) will be committed to improving outcomes in mental health. Through its role in commissioning primary care, specialised services, prison health, military health and some specific public health services, the NHSCB will have a vital contribution to make in realising the aims of *No health without mental health* and this strategy.

7.16 The NHS CB will also have an important role in providing national leadership for driving up the quality of care across health commissioning. The Board could do this, for example, by publishing commissioning guidance and model care pathways, based on the evidence-based quality standards that it has asked NICE to develop.

7.17 NICE quality standards, defining high quality care, are relevant to both local authorities and CCGs in their commissioning roles. Existing quality standards relevant to suicide prevention include alcohol

dependence and depression in adults. Others are under development including: depression in children and young people; self-harm in adults; self-harm in vulnerable groups, children and young people; antenatal and postnatal mental health; long-term care of people with co-morbidities and or complex needs and safe prescribing. For the full list of topics referred to NICE see www.nice.org.uk/guidance/qualitystandards/QualityStandardsLibrary.jsp

7.18 Clinical Commissioning Groups will become responsible for commissioning the majority of healthcare services. In considering CCGs' applications for establishment, the NHS CB will assess whether a CCG has the capacity and capability to commission improved outcomes for the people who need support for mental health.

7.19 The National Offender Management Service (NOMS) is an executive agency of the Ministry of Justice, and brings together HM Prison Service and the Probation Service. It commissions and delivers offender management services in custody and the community as well as managing those offenders who receive hospital and restriction orders unders sections 37 and 41 of the Mental Health Act 1983. The prison population contains a high proportion of very vulnerable individuals, many of whom have experienced negative life events that we know increase the likelihood of them harming themselves such as drug and alcohol misuse, family background and relationship problems, social disadvantage or isolation, previous sexual or physical abuse, and mental health problems.

7.20 The Youth Justice Board (YJB) oversees the youth justice system in England and Wales. The YJB works to prevent offending and reoffending by young people, and to ensure that those held in custody are safe and secure.

Coroners

7.21 Suspected suicide deaths will always be reported to a coroner, who will certify the death after an inquest. Coroners have an important role in establishing via inquest proceedings the who, how and where of these deaths. The coroner's office will be able to help bereaved families to find support from local and national organisations.

7.22 The Government is reforming the coroner system under Part 1 of the Coroners and Justice Act 2009. These reforms include establishing a Chief Coroner who, for the first time, will be responsible for providing national leadership to coroners in England and Wales. He will also play a key role in setting new national standards and developing a new statutory framework for coroners including rules and regulations, guidance and practice directions within which coroners will operate. Coroners will be under a duty to inform the Chief Coroner of any investigations lasting more than a year and the Chief Coroner will be under a duty to include a summary of these in an annual report. This will help to bring about much greater consistency of practice between coroner areas and improved service to the bereaved, as well as helping to speed up the investigation and inquest process.

Central support for delivering the strategy

7.23 The Cabinet Sub-Committee on Public Health oversees the implementation of *No health without mental health*, while the Cabinet Committee on Social Justice ensures effective cross-government action to address the social causes and consequences of mental health problems. The suicide prevention strategy is a key component of *No health without mental health.*

7.24 The National Suicide Prevention Strategy Advisory Group (NSPSAG) provides leadership and support for suicide prevention initiatives including advice on monitoring and analysing trends in suicide. Membership includes senior academic researchers, voluntary sector representatives (Samaritans and PAPYRUS), representatives from NOMS, Department of Health, public health, offender health care, professional bodies such as the Royal College of Psychiatrists and a coroner. It also includes people (often family members) with direct experience of bereavement by suicide. This group will continue to provide leadership for implementation of this strategy.

7.25 The Ministerial Council on Deaths in Custody is jointly funded by the Home Office, UK Border Agency, the Ministry of Justice and the Department of Health. The Council's remit covers deaths in prisons, in or following police custody and in immigration detention; the deaths of residents in approved premises; and the deaths of those detained under the Mental Health Act. http://iapdeathsincustody.independent.gov.uk

Links across the UK and Republic of Ireland

7.26 This strategy relates to England only, as the majority of issues involved are the responsibility of the Devolved Administrations. Suicide prevention strategies have now been established in Scotland, Wales and Northern Ireland, as well as in the Republic of Ireland. Strong links have been maintained between the nations, and these links should continue to ensure a co-ordinated approach to suicide prevention, where necessary, across the UK and Ireland.

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