HM Government

Preventing suicide in England: Two years on

Second annual report on the cross-government outcomes strategy to save lives

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Contact details: Mental Health, Disability and Equality Division Department of Health Richmond House 79 Whitehall London SW1A 2NS 020 7210 5902 mh-disability@dh.gsi.gov.uk

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Ministerial Foreword

Every person lost to suicide is a tragedy, for their loved ones, their colleagues, and society as a whole. I am very concerned to see the latest figures showing a rise in suicide rates in England.

We knew that the global financial crisis could have a significant impact on suicide rates. This was why I was so keen to launch the cross-government suicide prevention strategy for England in my first weeks as a Minister. We knew that we could not afford to be complacent, because in suicide prevention, complacency kills.

With the latest challenges now becoming clear, I am calling on services, communities, and national agencies, to be more ambitious than ever before about suicide prevention. I want us to tackle, once and for all, the still widespread assumption that suicides are inevitable.

Suicide is not inevitable for people in crisis – good care can make the vital difference for people who are suicidal. Three areas have this vision already and are doing incredible things to improve and importantly save lives. I want every part of the country to be just as ambitious.

And we need to continue to tackle stigma surrounding suicide. Suicidal thoughts are far more common than people realise but we just don't talk about them. Stigma makes it embarrassing or frightening to tell another person, but this is absolutely critical to getting help. We all have a role to play. By talking openly about suicide we can remove the fear that stops people asking for help. We may feel uncomfortable or frightened of saying the wrong thing but if we tackle this stigma then we will save lives. We need people to feel free to talk to someone and access support knowing that the person they approach will listen and not judge.

Norman Lamb MP
Minister for Care Services

Message from Chair of the National Suicide Prevention Strategy Advisory Group

A global financial crisis is inevitably a time of high alert for those of us engaged in suicide prevention. It can be tempting to fall into the belief that there is nothing to be done at the local level to stop the suicide rate rising; to simply accept these are forces beyond our control.

Although the suicide rate has risen since 2008 and the financial crisis, the rise has not been as great as many of us feared. But the rates are continuing to rise despite improvement in some economic indicators. The highest rates are in the North and South West of England, the lowest in London and the South East.

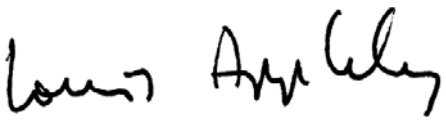
Middle-aged male rates have risen most since 2008. This group are traditionally least likely to seek help, so that presents a challenge to services to be creative about improving access. The welcome fall over the previous decade in the suicide rate among younger men has stalled, and suicide remains a leading cause of death for this group.

Local areas have a huge amount to contribute to saving lives where people are vulnerable because of debt, unemployment or housing problems.

At the national level, we are concerned to understand and work to reduce access to the means of suicide. The continuing rise in hanging as the commonest method of suicide, and the emergence of new methods such as certain gases are particular concerns.

There is also the alarming rise in self-inflicted deaths of prisoners after the previous fall. Efforts by the National Offender Management Service to address this are of great importance.

Monitoring from the Multicentre Study of Self-harm suggests recent increases in younger age groups despite an overall fall in the last 10 years - monitoring and research are at the heart of the national strategy. Self-harm is a key indicator of suicide risk and the reported rise has highlighted the need for better services and more positive experiences of care for young people in crisis. Improving the mental health of young people now is key to suicide prevention in the long term.



Professor Louis Appleby CBE

Introduction

1. On World Suicide Prevention Day, 10 September 2012, government made clear its commitment to suicide prevention by publishing a cross-government strategy for England.

2. There is a wealth of evidence that 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.[1] We knew that we needed to be prepared for possible upturns in suicide rates. Sadly, the global financial crisis of 2008 has led to a rise in suicide rates in many countries, including England. A number of studies have demonstrated an association between the areas of England worst affected by unemployment during the financial crisis and increased suicide rates.[2]

3. The UK economy is recovering from the most damaging financial crisis in generations, and the economy is now growing. Employment is at record levels and the proportion of households that are workless is at its lowest since 1996. However, there is not a simple relationship between financial crisis and suicide rates, and we know that people may still be vulnerable due to social and economic circumstances.

4. This second report on the strategy highlights the excellent work that is being done across sectors to prevent suicides, and sets out where efforts need to be concentrated for the next year. Local action, supported by national coordination, is essential to suicide prevention. The messages in this report are designed to help local areas focus on the most effective things that they can do to reduce suicides.

Current trends in suicide

5. ONS figures show 4,727 suicide deaths in 2013, an increase of 214 compared to the 4,513 deaths in 2012. The latest statistics show that:

- The rate of deaths from suicide and undetermined intent was 8.8 per 100,000 population in 2011-13. After 1998-2000 the general trend was a decrease in the overall rate of suicide. However, this tailed off in recent years, with small rises in rates in the last five years. The figure for 2011-2013 is the same as for 2004-06.
- Suicide continues to be more than three times as common in males than in females (13.8 per 100,000 for males in 2011-13, compared to 4.0 for females).

- The numbers and rates of suicide and undetermined deaths vary between age groups, with rates among males highest for those aged 40-44 years and among females highest for those aged 45-49 years.
- Hanging, strangulation and suffocation accounts for the largest number of suicides in both males and females, 57% and 41% respectively. The second most common method is drug related poisoning, accounting for 19% and 37% of suicides for males and females respectively.
- While the number of suicides in patients has been higher in recent years, there is an overall downward trend in the suicide rate. From 2002-2011, there was a 50% fall in the number of in-patients dying by suicide. The number of suicides under crisis resolution home treatment has also fallen since 2009.[3]
- Self-inflicted deaths in prisons in England and Wales increased to 84 in 2014 from 75 in 2013; the second calendar year there has been a year-on-year increase. Suicides in women prisoners remain very few. In the 12 months to September 2014 there were 24,748 reported incidents of self-harm, up by 1,508 incidents (6%) on the same period in 2013.[4]
- Helium suicide remains a concern. ONS reported 59 deaths mentioning helium in 2013, over five times higher than the 11 deaths recorded in 2008 and an increase of 16% compared with 2012. Almost all of these deaths were suicide. Due to the sensitive nature of reporting of suicide methods, particularly unusual ones, journalists are advised to follow the Samaritans' media guidelines on the reporting of suicide.[5]
- Data from the Multicentre Study of Self-harm in England show that rates of self-harm declined in both genders from 2003 until 2008 and then started rising in males until 2012. The decline in rates in females levelled off after 2008. This pattern is similar to that seen for national suicide rates over the same period. The Multicentre Study data showed a rise in self-harm in girls (but not boys) under the age of 16 years in 2010-12 compared to 2007-9. This rise was seen for both the number of self-harm episodes involving girls under 16 years (increased by 16%) as well as the number of girls under 16 years presenting with self-harm (increased by 10%), but was much smaller than the increase reported based on Hospital Episode Statistics (HES). Data on self-harm trends using HES data may be somewhat misleading and the large rise they suggest probably reflects improved data collection.

6. Further detail is included in the Statistical update on suicide published alongside this report.

New messages from research

7. Research is essential to effective suicide prevention. There have been a number of recent findings that are of practical relevance to local agencies working to prevent suicide, as well as those working at the national level:

- A study found that suicide rates in different male age groups had different relationships to the recession. Men aged 35-44 years old experienced increased suicide rates which coincided with peaks in indicators of the economic recession. The halt in the downward trend in suicide rates amongst men aged 16-34 may have begun before the 2008 economic recession.[6]
- Alcohol-related death was more frequent than expected among both males and females presenting at emergency departments with self-harm. Hospital-presenting patients should receive assessment following self-harm in line with NICE guidelines, to enable early identification and treatment of alcohol problems.[7] Suicide risk is raised 49-fold in the year after self-harm, and the risk is higher with increasing age at initial self-harm.[8]
- Crisis resolution home treatment services are a key setting for safety. There are now around 180 suicide deaths each year among patients under crisis resolution home treatment services, and around 80 among in-patients.[9][10]
- Suicide among primary care patients is linked to frequent GP attendance, increasing attendance, and also non-attendance, the latter being associated with young and middle-aged men.[11]
- Need to re-focus efforts to reduce post-discharge suicide deaths. The first 3 months post discharge remains a period of high risk - particularly in the first 2 weeks. This has been linked to short last admission of less than 7 days. Although there have been improvements over the last 15 years since this issue was first highlighted and the introduction of early follow-up recommended, progress has stalled in recent years.[12]
- Self-harm in prisons is associated with subsequent suicide in this setting, suggesting that prevention and treatment of self-harm is an essential component of suicide prevention in prisons.[13]
- The WHO report “Preventing suicide: a global imperative” highlights the worldwide burden of suicidal behaviour.[14]
- The Chief Medical Officer’s most recent annual report focused on public mental health.[15] The report looks at the epidemiology of public mental health, the quality of evidence, possible future innovations in science and technology, and the economic case for good mental health. It includes a chapter dedicated to suicide and self-harm.

8. The suicide prevention strategy is evidence-based, and the main text of this report aims to reflect the best information available from published research. But, the strategy is also dynamic and a practical tool. This report includes local case studies and innovations, which are shown in text boxes, and are presented for others to learn from and follow.

Preventing male suicides

9. The recent rises in suicide have been driven by an increase in male suicides. This means that the already three-fold difference between male and female suicide rates has increased further.

10. The high male suicide rate is seen in almost every country across the globe. This means that preventing suicide is rightly dominated by efforts to prevent male suicide. Key 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.

11. Men are at greater risk for a number of reasons. Many of the clinical and social risk factors for suicide are more common in men. Cultural expectations that men will be decisive and strong can make them more vulnerable to psychological factors associated with suicide, such as impulsiveness and humiliation. Men are more likely to be reluctant to seek help from friends and services. Linked with this, providing services appropriate for men requires a move away from traditional health settings. Men are also more likely than women to choose more dangerous methods of self-harm, meaning that a suicide attempt is more likely to result in death.

Merseyside partnership with Campaign Against Living Miserably

In 2000, a partnership of six areas commissioned CALM (at the time a Department of Health project) to provide a helpline for young men in Merseyside. The commissioning of CALM continued when CALM transferred into a national charity, and currently there is a consortium of Liverpool, Sefton, Knowsley, Halton, St Helens and Wirral signed up to the contract, managed by the Liverpool Community Health NHS Trust.

Commissioners employ a local CALMzone Coordinator to promote CALM across Merseyside in collaboration with the local community – pubs and clubs, venues and universities, sports teams and clubs – to encourage them to join and promote the campaign. CALM provide the local commissioners with anonymised reports on numbers and trends of calls and web chats within Merseyside. As well as providing funding to support the helpline, the commissioners ensure CALM has an up-to-date local database of agencies which local callers can be referred to.

In 2010 the Tri-Borough in London adopted a similar arrangement, and CALM has been commissioned locally in London since then.

Social Media

12. There is concern over the influence of social media but limited systematic evidence, despite stories of individuals who have been bullied or encouraged to self-harm. This has to be balanced against the support that vulnerable people may find through social networks. A recent systematic review of the research literature has confirmed that young people who self-harm or are suicidal often make use of the internet. It is most commonly used for constructive reasons such as seeking support and coping strategies, but may exert a negative influence, normalising self-harm and potentially discouraging disclosure or professional help-seeking.[16]

U Can Cope

The U Can Cope film and online resources were designed for people in distress and those trying to support them, to instil hope, promote appropriate self-help and inform people regarding useful strategies and how they can access help and support. They have been endorsed by the International Association of Suicide Prevention: www.connectingwithpeople.org/ucancope

13. Emerging findings from the research study on Understanding the role of social media in the aftermath of youth suicides[17], commissioned in support of the suicide prevention strategy, are that:

- Suicidal tweeters show a high degree of reciprocal connectivity (i.e. they follow each other), when compared with other studies of the connectivity of Twitter users, suggesting a community of interest.
- A retweet graph shows that users who post suicidal statements are connected to users who are not, suggesting a potential for information cascade and possibly contagion of suicidal statements.
- The reaction on Twitter to the Hayley Cropper Coronation Street suicide storyline was mostly information/support and debate about the morality of assisted dying, rather than statements of suicidal feelings.
- Tweets about actual youth suicide cases are far more numerous than newspaper reports and far more numerous than tweets about young people dying in road traffic accidents, which suggests that suicide is especially newsworthy in social media. In newspapers there is no significant difference between the two types of death, in terms of number of reports per case.

14. A lot of work has already been done by industry and government to equip parents and schools in keeping children and young people safe online. Given the global and changing nature of the internet, continuing that joint approach to better awareness through education is much more likely to be effective than an approach based solely on technical solutions.

What is happening, and needs to happen, now?

Public Health

15. Much of the planning and work to prevent suicides will be carried out locally. Directors of Public Health and Public Health teams in local authorities, working with local Health and Wellbeing Boards have a central role in coordinating local suicide prevention efforts.

16. The All-Party Parliamentary Group (APPG) on Suicide and Self-harm Prevention's recent report includes a detailed analysis of the results of their survey of local authority's suicide prevention plans. The report provides a wealth of intelligence on how the national suicide prevention strategy is being implemented at local level and details about suicide prevention work in every area in England.

17. The APPG considers that there are three main elements that are essential to the successful local implementation of the national strategy:

- Carrying out a "suicide audit" which involves the collection of data about suicides that have occurred locally from sources such as coroners and health records in order to build an understanding of local factors such as high risk demographic groups.
- The development of a suicide prevention action plan setting out the specific actions that will be taken, based on the national strategy and the local data, to reduce suicide risk in the local community.
- The establishment of a multi-agency suicide prevention group involving all key statutory agencies and voluntary organisations whose support is required to effectively implement the plan throughout the local community.

18. The APPG expressed concern that there are some areas where little or no work is being done to implement the national suicide prevention strategy, and expressed particular concern about the low level of suicide prevention activity in the Greater London area. They praised the work of sub-regional suicide prevention groups in Greater Manchester and the Cheshire/Merseyside area.[18]

19. Public Health England has an ongoing programme of work to support the suicide prevention strategy. In October, Public Health England published guidance for local authorities on how to write a suicide action plan.[19]

20. The document advises local authorities how to:

- Develop a suicide prevention action plan.
- Monitor data, trends and hot spots.
- Engage with local media.
- Work with transport to map hot spots.
- Work on local priorities to improve mental health.

21. It also highlights how public health staff could work with other organisations to ensure services are joined up to respond to particular issues:

- Recession – ensure health services know the options for someone at risk of suicide because of economic difficulties, from debt counselling to psychological therapy.
- Self-harm – ensure there are supports for young people in crisis who are at risk of self-harm.
- Men – ensure information about depression and services is available in "male" settings.

Supporting recovery from self-harm, violence, abuse and neglect

The WISH centre in Harrow has been working since 2004 to support young people, women and children who self-harm or have experienced abuse, violence and neglect.

WISH provides counselling in schools and at their Centre, group work, peer support programmes, on line and text mentoring, early intervention work, sexual violence advocacy and support for young people and has also raised awareness of the issue of self -harm and domestic and sexual violence and the capacity of schools and agencies supporting young people to integrate this into their work through training, targeted workshops and outreach work.

Referrals are made by young people themselves and from schools, Children's services, police, agencies, community groups, families and carers.

In 2013-14 they supported 217 young people each week.

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22. Reliable and timely suicide statistics are of tremendous public health importance. Public Health England is piloting "real-time" surveillance of suicides in collaboration with the police, who are usually first on the scene of suicide deaths. The primary aim of the pilots is to provide information to front line local authority and NHS staff to enable them to respond to local clusters of suicides and to provide timely support to people bereaved by suicide.

If U Care Share Foundation and pilot of Early Alert System in County Durham

If U Care Share Foundation has had a SAS (Support after Suicide) manager since 2012. Working full time and funded by Durham County Council public health the service manager works with people touched by a death by suicide, providing practical and emotional support and guidance. The service manager and those working with families have themselves been affected by suicide, and understand the complexity of the impact of such a loss.

They are now working with Durham County Council on the Public Health England pilot of the Early Alert system. Police provide information to the council's public health lead after a "suspected suicide". A CID 27 form is completed at the time of death. Police ask those affected by the death if they wish to be contacted and have access to support services and also a Welfare Rights Support Worker (if appropriate). If agreed, contact is made within 48 hours of a death by SAS Manager. Nine families have been supported since October 2014.

Durham County Council public health lead is able to map and record deaths as they happen, and where appropriate co-ordinate Community response meetings when there is more than one death in an area. This will include both statutory and voluntary agencies meeting to co-ordinate services to support those affected by the death. This is done as the deaths happen rather than waiting for published figures which may not become available until annual statistics are produced.

23. Public Health England will soon be publishing two further guidance documents for local areas. The first, on the prevention of suicides in public places (including hotspots) will provide information on the practical steps local areas can take to reduce risks. The second, on responding to potential suicide clusters, will provide advice to local areas on practical steps to take in the event of multiple suicides, where a cluster effect is suspected.

24. Public Health England has recognised the specific inequalities in self-harm and suicide affecting lesbian, gay, bisexual and trans populations and the challenges in responding to this at local government level. As part of work to respond to this need they are developing a toolkit with the Royal College of Nursing for nurses and allied health professionals to develop their skills and knowledge around lesbian, gay and bisexual young people who are at risk of suicide and recognise the wider context of their mental health in relation to their sexual orientation and identity. This will be published in spring 2015.

25. Help is at Hand continues to be available as a resource for people bereaved by suicide, with information and advice that is particularly beneficial for people in the early stages of bereavement. Free hard copies can be requested via the Health and Social Care Publications Orderline: www.orderline.dh.gov.uk/ecom_dh/public/saleproduct.jsf?catalogueCode=2901501

NHS

26. Suicide prevention is included in the NHS Mandate, the document which sets out the government's direction and ambitions for the NHS. The recently refreshed NHS Outcome Framework reflects this, by including a suicide indicator for the first time. The definition of the indicator is in development.

Mental health services

27. High quality, accessible mental health services are essential to preventing suicide. The measures that the government has put in place to improve access to psychological therapies, to reduce waiting times for treatment and to put mental health services on a level footing with those for physical health will play an important role in reducing suicide.

Nottinghamshire Healthcare NHS Trust and Connecting with People

Nottinghamshire Healthcare NHS Trust is implementing an innovative approach to suicide prevention to improve both patient care and clinical governance. The Trust has developed a team of in-house trainers to deliver suicide and self-harm awareness and response training across the Trust. They are also piloting a web-based App to help to consistently record individual assessments. The App is integrated securely within the NHS system and is based on peer-reviewed clinical tools.

Dudley and Walsall Mental Health Partnership NHS Trust, Southern Health NHS Foundation Trust and Leeds and York Partnership NHS Foundation Trust are also involved in the pilot of the App: a partnership with the social enterprise Connecting with People.

The approach being taken:

- Is evidence based and uses peer reviewed clinical tools. It combines compassion with sound clinical governance.
- Is proactive, emphasising safe triage and the co-creation of immediate safety plans for all patients with suicidal thoughts, irrespective of risk. It documents evidence on level of risk and actions agreed to mitigate the risks.
- Has been developed by healthcare practitioners, third sector organisations and service users, for delivery to health and social care practitioners in primary and secondary care and in third sector organisations. It forms part of the RCPsych OnSite training.

It is an example of how the third sector can work effectively in partnership with the NHS to improve patient care in specialist areas.

28. Good lifelong mental health starts in childhood. The Children and Young People's Mental Health and Wellbeing Taskforce brings together experts from across health, social care and education. The Taskforce started work in August 2014 and is looking at how to improve the way children and young people's mental health services are organised, commissioned and provided and how to make it easier for young people to access help and support. It will consider and make recommendations on more joined up and accessible services built around the needs of children, young people and their families, and will look at how to improve access to help and support across the sectors, including in schools, through voluntary organisations and online.

29. The key issues the Taskforce will address include the complexity of the commissioning and delivery systems and the need to clarify roles and responsibilities, the barriers to establishing more proactive joined up care, the 'cliff-edge' of transition at age 18 from Child and Adolescent to Adult Mental Health Services, the lack of visibility of existing services, the dearth of information on prevalence and improving access and reducing waiting times for children and young people. A report of the Taskforce's findings will be published in spring 2015.

30. We now have considerable evidence on what works in mental health care in reducing patient suicide.[20] To improve safety, mental health services should:

- Provide specialist community mental health services such as crisis resolution home treatment teams, assertive outreach and services for people with dual diagnosis.
- Implement NICE guidance on depression.[21]
- Share information with criminal justice agencies.
- Ensure physical safety, and reduce absconding on in-patient wards.
- Create a learning culture based on multidisciplinary review.

31. Services should consider how appropriate crisis resolution home treatment services are for patients in some circumstances. For example, living alone is associated with increased suicide risk while being cared for by crisis resolution home treatment services. Assessments should consider whether a patient with no support at home is suitable for these services.

Zero suicide ambition

This ambition has been adopted by three areas in England. It is about raising the aspiration for mental health, and challenging a culture that suicide is inevitable. It is not a target. It is not about blaming or regarding every suicide as a failure of care. This would likely be unhelpful for staff and service users. It is about learning and applying evidence.

Different areas are adopting the ambition in distinct ways:

- The **East of England** project is across four pilot areas that started work over a year ago. They have been gathering data which they are evaluating. The areas cover a population of 2.5 million and their ambition links to the crisis care concordat, prevention and recovery plans:
  - One of the main focuses in Bedfordshire and Cambridge and Peterborough are the 50% of suicide deaths which occur outside the health system.
  - Within primary care, local areas are adapting existing training methodologies to the Perfect Depression approach. The training will give police, paramedics, midwives and GPs greater confidence in talking to people who are in distress and help provide the care needed to keep them safe.
  - A new website has been set up, led by MIND, to help educate communities in Cambridge and Peterborough and raise awareness about suicide. This is now being rolled out in other locations across the region.
- Over the next five years **Mersey Care NHS Trust** aims to develop services so that they eliminate suicides while patients are in their care, including:
  - Improved training for staff, focusing on the clinical skills needed to work with patients and their families to develop a 'safety plan' – a personalised care plan with clear ways to get help 24/7.
  - Working with other providers and stakeholders to share best practice – including CALM, Samaritans and the Cheshire and Merseyside Suicide Reduction Network.
  - A dedicated Safe from Suicide team will provide advice, support, assessment and monitoring.
- The **Zero Suicide Collaborative in the South West** aims to reduce suicide to zero across the south west by October 2018, through establishing a learning collaborative focusing on the interventions that make the most impact. They are going to:
  - Work closely with Emergency Departments to better identify and support people who present with suicidal thoughts or attempts.
  - Explore ways of providing better mental health support for people once they've been discharged, regardless of which NHS service they have been in contact with.
  - Explore how to target high risk groups, such as middle aged men, with tailored support.
  - Work with other agencies, such as the police and transport services, to identify 'hot-zones' – areas where higher than average numbers of suicides occur – and understand the reasons behind these figures.

While the evidence base for Zero Suicide is currently anecdotal, the elements are grounded in research about what works, and from tried and tested health services improvement methodology. Thorough evaluation is going to be key to understanding the potential of this holistic approach.

32. Initiatives to improve the way that public services respond to people experiencing a mental health crisis are now well underway. The Crisis Care Concordat, launched in February 2014, details plans to improve emergency support for people in mental health crisis across the country. It is part of a far-reaching new agreement between police, mental health trusts, paramedics, local government, experts by experience and other community agencies. The Concordat has been signed by more than 20 national organisations in a bid to drive up standards of care for people experiencing crisis such as suicidal thoughts or significant anxiety. It aims to cut the numbers of people detained inappropriately in police cells by 50% and drive out the variation in standards across the country.

33. The Department of Health has funded 9 street triage schemes, where mental health staff, usually nurses, accompany or advise police officers when they are responding to people in mental health crisis situations. There are also another 15 schemes that have secured funding through police and crime commissioners, clinical commissioning groups, NHS England and other routes – meaning that 24 of the 39 police forces in England are involved in a scheme. Thousands of people have already been helped by the schemes to get care and support as rapidly as possible.

34. The Care Quality Commission is carrying out a review of mental health crisis care.[22] At the end of the review they will publish a national report highlighting key findings. The results will be used to improve the way CQC inspects health and care services to ensure they are responding to the needs of people experiencing a mental health crisis.

35. Sign up to Safety is a new national patient safety campaign launched in June 2014 to strengthen patient safety in the NHS by creating a system devoted to continuous learning and improvement. It aims to reduce avoidable harm by 50% over three years, and save 6,000 lives.[23]

Safety Collaboratives in Mental Health

The South West of England has had a safety collaborative in Mental Health since 2010. This work spread across the South of England in 2013. It involves the majority of Mental Health Trusts in the region. Work streams include getting medicines right, improving physical health care and delivering safe and reliable care. This includes reducing absence without leave from inpatient units and reducing suicides.

Emergency departments

36. Good management of self-harm is an essential part of the suicide prevention strategy. The first annual report highlighted the opportunity for effective assessment and management of self-harm, particularly in Emergency Departments, to reduce repetition of self-harm and future suicide risk. [24]

North Essex Partnership University NHS Foundation Trust and Samaritans

Three Samaritans branches together with the North Essex Partnership University Foundation Trust have signed a partnership agreement to develop a range of opportunities for patients and staff to benefit from the knowledge, experience and complementary services offered by Samaritans in support of emotional wellbeing and suicide prevention.

This will include:

- NHS staff organising for a patient (with their consent) to receive a call from Samaritans.
- Training for non-clinical NHS staff on handling challenging contacts, suicide awareness and emotional well-being.
- Establishing referral pathways between Samaritans and GPs in the area.
- Samaritans presence in Emergency Departments.

This partnership is an example of how the voluntary sector and NHS can deliver better support to people by working together more closely.

Primary care

37. As three-quarters of people who die by suicide have not had recent contact with secondary mental health services, there is huge potential for prevention in primary care services. Yet mental illness is frequently unrecognised in primary care patients who die by suicide.

38. For those who do access primary care, there are clear markers of suicide risk, including frequent consultation, multiple psychotropic drugs, and specific drug combinations such as benzodiazepines with antidepressants.

39. Effective treatment for depression, by implementing the NICE guidance on depression has been linked with falling patient suicide.[25] Everyone who presents with depression or anxiety should be assessed and treated and have rapid access to support and treatment, either primary care based, such as through Improving Access to Psychological Therapies, or secondary care.

40. Of course, primary care services can only treat the people they see. We need to overcome the barriers to men accessing help. Other services, including the voluntary sector, and internet based support such as silver cloud, buddy app and big white wall may be better able to engage people at risk. Raising community awareness through providing information and services in locations that men will more easily attend - sports clubs, job clubs, pubs - will enable more self-referral of younger and middle aged men.

41. NHS England has established a task and finish group with the Royal College of GPs mental health strategy group, whose goal is to identify and recommend mandatory mental health minimum standard training for all of primary care.

A number of training programmes relevant to suicide prevention are in use across England:

- ASIST
- Connecting with People
- Mental Health First Aid
- SafeTalk
- STORM

Organisations working in suicide prevention, such as Samaritans, Papyrus, Charlie Waller Memorial Trust and others, also deliver a range of training (including the programmes listed above), to a wide variety of audiences in diverse settings.

Wider public sector

Education

42. In November 2014, the Department for Education announced it will be working with the PSHE Association to help schools teach pupils about mental health and tackle the stigma which can leave young people with mental health problems feeling isolated. The government will also set out a blueprint for schools to use when delivering counselling services.

Employment

43. People come into contact with the welfare system at a time when they may be vulnerable because of unemployment and its associated consequences. The Department for Work and Pensions provides guidance and training for staff to help them identify and support people who are vulnerable, including those who may be at risk of suicide or self-harm.

44. The Department for Work and Pensions and the Department of Health are looking at how to better co-ordinate mental health and employment support services to improve recognition of employment and mental health needs, referral action and employment outcomes. They are taking forward a number of voluntary pilots based on the recommendations put forward in RAND Europe's report, Psychological Wellbeing and Work: Improving Service Provision and Outcomes, to explore the most promising and evidence-based approaches to look at how to achieve better health and employment prospects for people with common mental health problems who are in, and out of, work.

Police

45. The Association of Chief Police Officer's multi-agency working group provides guidance to the police service on suicide prevention and response issues that is aligned to the national strategies for suicide that are in place in England, Wales Scotland and Northern Ireland. Its membership includes police regional representatives, voluntary sector, academics, NHS England and Public Health England. Current work streams include:

- The project being led by Public Health England to support "real time" reporting/surveillance of suspected suicide. Three forces - Leicestershire, Durham and South Yorkshire – are involved in the pilots. Early results are encouraging, and have allowed early referral of bereaved families into support services.
- The creation of a strategic framework for the police service which supports the national strategies and includes a suite of guidance material being developed with the College of Policing.
- Looking at new intervention techniques, which will include social media.
- Looking at multi-agency referral arrangements for those vulnerable to suicide, in the context of current safeguarding work and the new Care Act.

46. British Transport Police have two joint police and health teams, one based in London and the other in Birmingham. The teams include British Transport Police officers and staff and NHS Community Psychiatric Nurses. The London team is funded by British Transport Police, London Underground and NHS England, whilst the Birmingham team has been funded during 2014-15 by British Transport Police and the Department of Health Street Triage Scheme. These teams provide advice to front line officers which can bring relevant health related intelligence into the decision making process, and also review all suicide related incidents with a view to identifying those high risk cases and placing them on care pathways which are intended to move the subjects out of crisis and into care.

Prison services

47. The National Offender Management Service (NOMS) views every self-inflicted death in prison custody as a tragedy. The possible contributory factors to the recent rise in deaths are currently being investigated.

48. All prisons are required to have procedures in place to identify, manage and support people who are at risk of harm to themselves and many prisons work closely with Samaritans, who train and support prison 'Listeners' to provide emotional support to fellow prisoners. NOMS accepts and acts on the vast majority of recommendations made by the Prisons and Probation Ombudsman in their investigations into each death, and by Coroners if they make Reports to Prevent Further Deaths. Over the past year, NOMS has put in place additional resources for safer custody work in prisons and at regional level. These staff support safer custody work in prisons and share good practice across establishments. NOMS will be conducting a review of the operation of its care planning system for prisoners

identified as at risk of suicide or self-harm ('ACCT') in 2015. The Minister for Prisons has commissioned the Harris Review into the deaths in custody of young people aged 18-24 since 2007, which will report in spring 2015.[26]

Voluntary and private sector

49. It is clear that voluntary and private sector led initiatives can, and indeed are, contributing a great deal to suicide prevention across England.

50. Network Rail and Samaritans announced plans in July 2014 for a new five year partnership to continue efforts to reduce suicides on the railways. Since the original partnership began in 2010, around 8,000 rail staff, British Transport Police officers and Network Rail front line staff have received training from Samaritans. In 2013-14 alone, rail staff, British Transport Police officers, local police and members of the public have physically prevented 631 people from taking their lives on the rail.

51. As well as training staff, the partnership has seen significant numbers of physical improvements to the rail network aimed at reducing suicide. These include mid-platform fencing, which has now been installed at 50 stations, platform hatching, trespass guards, platform end barriers and various kinds of new technology designed to help identify people in difficulties, such as smart cameras, which are being piloted.

52. The Suicide Bereavement Support Partnership, set up in early 2014, is a new hub for those organisations and individuals working across the UK to support people, who have been bereaved by suicide. This includes the Childhood Bereavement Network, Child Bereavement UK, CALM, CRUSE, IfUCareShare, The James Wentworth Stanley Memorial Fund, Manchester University, Papyrus, Survivors of Bereavement by Suicide, Samaritans and Winston's Wish.

53. The members of the Suicide Bereavement Support Partnership aim to work collaboratively to:

- Ensure all those bereaved or affected by suicide are offered and receive timely and appropriate support.
- Increase access to information about services and resources that are available.
- Improve the range and quality of bereavement support after a death by suicide.
- Reduce the incidence of suicide or attempted suicide in those who have been bereaved by suicide.

54. Samaritans and Cruse Bereavement Care are working in partnership to increase the support available for people bereaved by suicide. The work is supported by a Department of Health grant over three years. The partnership will run support

groups in 6 areas across England as well as providing signposting and resources to other sources of support.

Healthtalk Online for parents whose child is self-harming

Drawing on research with families, this website enables parents to see and hear parents and other family members of young people who self-harm share their personal stories on film. The films cover issues such as why young people self-harm, discovering that a young person is self-harming, how they helped their young person, living with self-harm, support and treatment, and what helped them cope. www.healthtalk.org/peoples-experiences/mental-health/self-harm-parents-experiences/topics

Staying safe if you're not sure life's worth living

A new online resource developed by the Royal College of Psychiatrists, Connecting with People, Samaritans, Grassroots Suicide Prevention, State of Mind, leading academics, people with lived experience and their carers.

Staying safe if you're not sure life's worth living includes practical, compassionate advice and many useful links for people in distress:

www.connectingwithpeople.org/StayingSafe

55. The Royal College of Nursing aspires to place suicide prevention as a feature of all undergraduate nursing programmes and will be piloting this in a University in Northumbria.

National coordination to support implementation

56. The National Suicide Prevention Strategy Advisory Group provides leadership and support for implementation of the suicide prevention strategy, advising the Department of Health and others.

57. The Department of Health supports the National Suicide Prevention Alliance through grant funding to bring together national and local organisations working in support of the aims of the national strategy. The Alliance is a cross-sector coalition and its mission is to get all parts of society working together to take action to reduce suicide and improve the support for those bereaved by suicide, supporting the delivery of the two objectives of the suicide prevention strategy for England. Organisations from across the public, private and voluntary sectors are invited to become members or supporters of the alliance and benefit from opportunities to share knowledge and information, pool resources and be part of a nationwide network.

58. The Alliance's new website provides guidance and support materials for local areas. The Alliance's first national conference on suicide prevention on 3 February 2015 will launch this important annual opportunity to bring all the key players together. The Alliance is funding the Suicide Bereavement Support Partnership to develop a framework that will set out the steps needed to establish effective support for those bereaved or affected by suicide. This will be based on current best practice across the country and be flexible so that it can be shaped to fit with the local environment. The Alliance is also working to reduce harmful content online and encouraging collaborations between different sectors to prevent suicide. For further information, contact info@nspa.org.uk.

59. The Department of Health works closely with Public Health England, NHS England's Strategic Clinical Networks for Mental Health and the National Suicide Prevention Alliance to collectively coordinate action nationally on suicide prevention.

What local areas can consider for next year

60. Now that new NHS structures are becoming better established, the role of Public Health England and local authorities is becoming stronger, and better partnerships are emerging between health and other agencies such as police, local services are in a strong position to lead suicide prevention.

61. The national suicide prevention strategy aims to support local services in this. The annual reports provide the national context, latest research and statistics and, in particular, examples of local initiatives that others can learn from.

62. Local actions can, and do, make a difference.

National Suicide Prevention Strategy Advisory Group

Role

The group provides leadership and support in ensuring successful implementation of Preventing suicide in England by advising the Department of Health, and other organisations, on the relevance of emerging issues for the suicide prevention strategy and discussing potential changes to priorities and areas for action.

Members

Prof Louis Appleby CBE, University of Manchester (Chair)

Steve Clarke, Department of Health
Stephen Dalton, NHS Confederation
Hamish Elvidge, Matthew Elvidge Trust
Ged Flynn, Papyrus
Vanessa Gordon, NHS England
Prof David Gunnell, University of Bristol
Prof Keith Hawton, University of Oxford
Gregor Henderson, Public Health England
Tim Hind, Local Government Association
Ian Hulatt, Royal College of Nursing
Prof Rachel Jenkins, Institute of Psychiatry
Laura McCaughan, Secretariat to Ministerial Council on Deaths in Custody
Catherine Johnstone, Samaritans
Prof Nav Kapur, University of Manchester
Debbie Large, Coroner's Officers and Staff Association
Dr Chris Manning, Royal College of GPs
Clare Milford Haven, Trustee, James Wentworth-Stanley Memorial Fund
Nadia Persaud , Coroners Society
Mary Piper, Public Health England
Christopher Barnett-Page, National Offender Management Service
Louise Robinson
Mark Smith, British Transport Police
Shirley Smith, If U Care Share
Dr Geraldine Strathdee, NHS England
Alison Tingle, Department of Health
Claudia Wells, Office for National Statistics
Prof Sir Simon Wessely, Royal College of Psychiatrists
Helen Steele, Department of Health (Secretariat)

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