Written evidence submitted by Samaritans (PHP0088)

Summary of key points:

- Public health teams within upper-tier local authorities are responsible for developing and implementing local multi-agency suicide prevention plans so that the initiatives specified in the government’s national suicide prevention strategy for England are made a reality in local communities across the country.

- But a survey conducted last year by the APPG for Suicide and Self-harm Prevention found that as many as 30% of local authorities in England have no suicide prevention plan in place at all.

- Local suicide rates are listed as one of the indicators in the Public Health Outcomes Framework but there is currently no other mechanism to ensure that local authorities implement the government national suicide prevention strategy in their area.

- We do not believe that the public health reforms have significantly reduced local suicide prevention activity but nevertheless local implementation of the national strategy remains unsatisfactory in many parts of the country.

- Public Health England needs to do more to stimulate the development of local suicide prevention plans and provide practical support to local authorities such as by gathering and sharing detailed information about local initiatives that have been effective in reducing suicide and can be replicated elsewhere.

Samaritans Vision, Mission and Values

Samaritans Vision is that fewer people die by suicide.

We work to achieve this vision by making it our mission to alleviate emotional distress and reduce the incidence of suicide feelings and suicidal behaviour.

We do this by:

- **Being available** 24 hours a day to provide emotional support for people who are struggling to cope, including those who have had thoughts of suicide

- **Reaching out** to high risk groups and communities to reduce the risk of suicide

- **Working in partnership** with other organisations, agencies and experts

- **Influencing public policy** and raising awareness of the challenges of reducing suicide

We are committed to the following values:

- **Listening**, because exploring feelings alleviates distress and helps people to reach a better understanding of their situation and the options open to them

- **Confidentiality**, because if people feel safe, they are more likely to be open about their feelings
People making their own decisions wherever possible, because we believe that people have the right to find their own solution and telling people what to do takes responsibility away from them.

Being non-judgemental, because we want people to be able to talk to us without fear of prejudice or rejection.

Human contact, because giving people time, undivided attention and empathy meets a fundamental emotional need and reduces distress and despair.

**Suicide prevention and public health**

While the availability of high quality mental health services in an essential part of reducing suicide, only 28% of people who died by suicide in England between 2003 and 2013 had been in contact with mental health services in the 12 months prior to their deaths. This means that a whole-population public health approach to suicide prevention is also required.

The Department of Health published its cross-government suicide prevention strategy for England in September 2012 which specifies that “an effective local public health approach is fundamental to suicide prevention” and that this depends on partnerships across all sectors locally. It points out that health and wellbeing boards are “able to support suicide prevention as they bring together local councillors, Clinical Commissioning Groups, directors of public health, 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”. It also highlights the potential role of Directors of Public Health in “developing local public health approaches and in nurturing and maintaining links across the NHS and local government” and notes that they are supported in some areas by multi-agency suicide prevention groups or networks that help to co-ordinate activities.

Samaritans agrees with this approach but we are concerned that there is significant variability in the actual implementation of this across England as a whole. The All Party Parliamentary Group (APPG) for Suicide and Self-harm Prevention (for which Samaritans provides secretariat support) published a report earlier this year on the issue of local suicide prevention plans.

In its report the APPG found 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 coroner 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.

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1 p.19, National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, University of Manchester (July 2015) [http://www.bbmh.manchester.ac.uk/cms/research/centreforsuicideprevention/nci/reports/NCISHReport2015bookmarked.pdf](http://www.bbmh.manchester.ac.uk/cms/research/centreforsuicideprevention/nci/reports/NCISHReport2015bookmarked.pdf)

• 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.

As part of the research for the report, the APPG conducted a survey of all 152 upper-tier local authorities in 2014 which found that:

* around 30% of local authorities do no suicide audit work.
* around 30% of local authorities do not have a suicide prevention action plan.
* around 40% of local authorities do not have a multi-agency suicide prevention group.

This means that in substantial parts of the country, there is no formal structure to coordinate the relevant local agencies to implement the suicide prevention interventions that are recommended by the government’s national strategy such as:

* the commissioning of suicide prevention training for front-line staff within key public services to ensure that those who work with identified high-risk groups are particularly alert to the signs of suicidal behaviour and know how to respond.
* that Accident and Emergency departments treating individuals following a suicide attempt or a non-suicidal act of self-harm provide a psychosocial assessment and appropriate follow-up care as recommended by NICE guidelines.
* ensure that safety measures such as barriers or signs displaying contact details for Samaritans are in place at known local high-risk locations for suicide such as bridges or multi-storey car parks.
* commissioning specialist bereavement counselling or support groups for people who have recently lost a loved one to suicide.
* engaging with local journalists to improve awareness of the need to ensure the responsible reporting of suicide.

Local suicide rates are listed as one of the indicators in the Public Health Outcomes Framework but, other that this, there is currently no other mechanism to ensure that local authorities implement the government national suicide prevention strategy in their area. In addition, some local authorities told the APPG that it was difficult to find reliable information about examples of initiatives that had been proven, with clear evidence and evaluation, to work well in a particular area and that could be replicated elsewhere.

The APPG’s recommendations in the report included that:

* all three of the main elements described above (audit, action plan and multi-agency group) should be in place in every local authority area.
* PHE should use its network of 15 local centres across England to contact public health teams in areas where this is not happening to encourage development of suicide prevention work and offer to provide practical support such as sharing of information about evidence-backed case studies of initiatives that have been successful elsewhere.
* more sub-regional groups (such as the ones that are already active in Greater Manchester and in Merseyside/Cheshire) could help to support local authority areas without active plans and stimulate new activity.
In terms of the difference that has been made by the transition of public health teams from Primary Care Trusts (PCTs) to local authorities, the proportion of areas with active suicide prevention plans has not dramatically changed. In 2012 the APPG conducted a similar survey to the one described above which found that 73% of PCT areas had an active suicide prevention plan. This compares with 69% of local authority areas with an active plan in the 2014 survey, representing a slight but not significant reduction in the proportion of local authorities doing this work.

The implementation of the national suicide prevention strategy at local level, including the involvement of all relevant local public sector agencies and voluntary organisations, is perfectly feasible under the new structures, provided that suicide prevention is prioritised and that there are sufficient funds available to support the initiatives required. Nevertheless, what we have currently remains a mixed picture with more effort required nationally to ensure that local implementation is made a reality in all parts of the country. We hope that the forthcoming report of the government’s Mental Health Taskforce will address these concerns and that Public Health England will take further action to implement the recommendations made by the APPG for Suicide and Self-harm Prevention.

The APPG for Suicide and Self-harm Prevention’s full report on local suicide prevention plans is available to view online at: http://www.samaritans.org/sites/default/files/kfinder/files/APPG-SUICIDE-REPORT.pdf

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