HM Government

Consultation on preventing suicide in England

A cross-government outcomes strategy to save lives

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Consultation on preventing suicide in England

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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 a new national all-age suicide prevention strategy for England, the Government has 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. We need to consider the changing trends in suicide rates, highlight new and emerging interventions and reflect new evidence from research. 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.

In February 2011, the Government published *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages*. This sets out a programme of local and national action to improve not only the care of people with mental health problems but also the mental health and wellbeing of the population, and to keep people well. Improving the wellbeing of our population is fundamental to preventing suicide. Implementation of the mental health strategy will be overseen by the Cabinet Sub-Committee on Public Health. But, if we are to continue to prevent suicide, we need to take specific actions, as outlined in the draft strategy in this consultation document.

The purpose of this draft strategy is for government to support efficient and effective action by bringing together knowledge about groups at higher risk of suicide, evidence around 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.

We are publishing this strategy in draft and inviting comments to make sure that we have not missed anything and to build support before implementing the final agreed strategy. We have endeavoured to make consideration of equality issues an integral part of this draft strategy, and particularly welcome comments on those aspects.

The factors leading to someone taking their own life are complex and 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.

Individual organisations and groups can take forward some of the approaches to prevention, but many others will require a multi-agency system-wide approach. This draft strategy spells out how this will be delivered locally to continue to reduce the suicide rate. The new health and wellbeing boards will become the local forum for determining local needs, bringing together local authorities, clinical commissioning groups, directors of public health, adult social services and children's services and local HealthWatch. This presents a unique opportunity for local agencies to look at the wider context and agree how best to marshal resources across agencies to have the greatest positive impact on local health and wellbeing. The draft strategy does not mandate the means of achieving the objectives. Many of the interventions and good practice examples are already being implemented locally and local commissioners will be able to accept, or leave, these suggestions based on their assessment of the needs of their local area.

We proposed in the consultation document *Healthy Lives, Healthy People: Consultation on the funding and commissioning routes for public health* that suicide prevention public health activities should be the responsibility of local authorities working with local health and wellbeing boards. We believe local authorities are well placed to support suicide prevention public health approaches, in close partnership with the NHS, social care services, the voluntary sector, communities and individuals. In our response to the consultation we will set out, in the light of the comments received, our final view of where the responsibility for suicide prevention public health activities should lie in future.

Local partnerships, and particularly local health and wellbeing boards, may take the lead but, as this draft strategy explains, we all have a role in reducing the toll of preventable deaths by suicide in our communities.

The draft 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 CBE. 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.

Paul Burstow MP
Minister of State for Care Services

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PREFACE

Suicide is often the end point of a complex pattern of risk factors and distressing events, and the prevention of suicide has to address this complexity. This draft strategy is intended to provide a broad and coherent 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 suffered 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 draft strategy also makes more explicit reference to the importance of primary care in preventing suicide, and to the need for preventative 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 final strategy achieves. However, there are also a number of 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 ethnic minorities. 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 draft 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, we do not address the issue of assisted suicide.

The draft strategy is intended to be up to date, wide-ranging and ambitious. Its publication marks the beginning of a consultation that we hope will help to improve and promote it, and make it more able to fulfil its vital purpose.

Professor Louis Appleby CBE
Department of Health
Chair of the National Suicide Prevention Strategy Advisory Group

INTRODUCTION AND EXECUTIVE SUMMARY

1 Suicide is a major issue for society. The number of people who take their own lives in England has been reducing in recent years. But 4,400 people took their own life in 2009 – that is one death by suicide every two hours.

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 also 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 the only option is to end their own life.

The challenge of suicide prevention

5 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 40–49 now have the highest suicide rate;
- mental illness;
- physically disabling or painful illnesses including chronic pain; and
- alcohol and drug misuse.

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

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

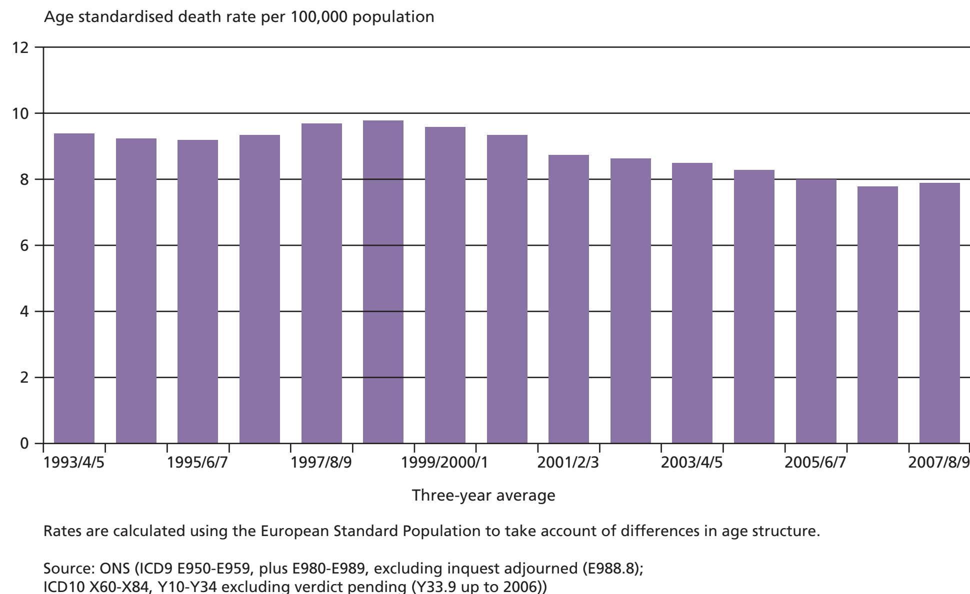
For many people, it is the combination of factors which is important rather than one single factor. Stigma, prejudice, harassment and bullying can all contribute to increasing an individual's vulnerability to suicide.

7 There are a number of research studies that have looked at risk factors for suicide in different groups. In 2008 the Scottish Government Social Research Department undertook a Literature Review entitled *Risk and Protective Factors for Suicide and Suicidal Behaviour*. 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). The review is available at: www.scotland.gov.uk/publications/2008/11/2814144/23

8 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 2007–09, the mortality rate from suicide was 12.6 deaths per 100,000 population for males and 3.8 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.

9 Over the last 10 years, progress has been made in reducing the already relatively low suicide rate to record low levels (2007 was the lowest rate on record). The past couple of years have seen a slight increase in suicide rates, but the 2007–09 rate is still no higher than the level in 2005–07. Until the past couple of years, there had also 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 25 years ago. We have also seen significant reductions in inpatient suicides and self-inflicted deaths in prison. A more detailed statistical update and analysis is included at Annex A.

Figure 1: Death rates from Intentional Self-harm and Injury of Undetermined Intent excluding 'Verdict Pending' in England, 1993–2009



Rates are calculated using the European Standard Population to take account of differences in age structure.

Source: ONS (ICD9 E950-E959, plus E980-E989, excluding inquest adjourned (E988.8); ICD10 X60-X84, Y10-Y34 excluding verdict pending (Y33.9 up to 2006))

10 However, there is no room for complacency. We know from experience that suicide rates can be volatile as new risks emerge. Figure 1 demonstrates the need for continuing vigilance and why, despite relatively low rates, a new suicide prevention strategy for England is needed. The 2007–09 three-year average suicide rate showed a slight increase on that in 2006–08, due to a small rise in the annual suicide rate in 2008 and 2009.

11 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] 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.

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

Outcomes strategies

13 This Government has a different approach to direction setting – developing strategies to achieve outcomes. Outcomes strategies reject the top-down approach of the past. Instead, they focus on how people can best be empowered to lead the lives they want to lead and to keep themselves and their families healthy, to learn and be able to work in safe and resilient communities, and on how practitioners on the front line can best be supported to deliver what matters to service users within an ethos that maintains dignity and respect.

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

15 In particular, outcomes strategies set out:

- the Government's work with the private and voluntary sectors to help shape policies, approaches and services that meet the needs of the population as a whole;
- the work across government nationally and locally that will help to deliver the broad range of public services and approaches that will meet the needs of the population and service users;
- the support that the Government will provide to these services to meet the outcomes for which they are accountable;
- the ways in which these services will be held to account for the outcomes they deliver – for example, through the public health, social care and NHS outcomes frameworks;
- our ambitions for the quality of services we want to make available to the population and service users, and to their families and carers, without exception; and
- the support, information and choices that will be offered to the public, service users, families and carers to enable them to make best use of these high-quality services.

A broad approach

16 There is no single approach to suicide prevention. It needs a broad co-ordinated system-wide approach that requires input from a wide range of partner agencies, organisations and sectors. People who have been directly affected by the suicide of a family member or friend, the voluntary, statutory and private sectors, academic researchers and government departments can all contribute to a sustained reduction in suicides in England.

17 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.

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

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

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

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

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

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

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

19 Much of the planning and work to prevent suicides will be carried out locally. The strategy outlines a number of evidence-based local approaches. A number of national actions to support these local approaches are also detailed for each of the six areas for action. Chapter 7 gives details of how local partnerships can work together to achieve suicide prevention and how this will be supported by national initiatives and actions across government.

20 In the case of local actions, it will be for local agencies working through health and wellbeing boards to decide the best way to achieve the overall aim of reducing the suicide rate. The draft strategy does not mandate the means of achieving any particular objective, so the interventions and good practice examples are to support local implementation and are not compulsory. Many of them are already being implemented locally but local commissioners will be able to accept or leave these suggestions based on their assessment of the needs of their local area.

21 The Government will establish a National Suicide Strategy Implementation Advisory Group of key stakeholders including families of those who have died by suicide. This will replace, and have a similar role to, the current National Suicide Prevention Strategy Advisory Group (NSPSAG). We will review membership of the group in the light of the final suicide prevention strategy, to ensure that the group can provide leadership and advice, and help monitor progress under this strategy. It will report to the Mental Health Strategy Ministerial Advisory Group and the Cabinet Sub-Committee on Public Health. Further details are given in chapter 7.

22 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.

23 We need to address 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.

24 There are three key strategy documents that, in combination, take a public health approach using general and targeted measures to improve mental health and wellbeing and reduce suicides across the whole population. These key strategies are:

- *Healthy Lives, Healthy People: Our strategy for public health in England* (2010);
- *No Health Without Mental Health: A cross-government outcomes strategy for people of all ages* (2011); and
- this draft cross-government all-ages suicide prevention strategy for England. This draft strategy is designed to be read alongside the other two documents.

25 *Healthy Lives, Healthy People* gives a new, enhanced role to local government and local partnerships in delivering improved public health outcomes. The creation of local health and wellbeing boards will ensure that local partnerships work effectively together. These boards will be able to support suicide prevention by bringing together elected members of local authorities, clinical commissioning groups, directors of public health (DsPH), adult social services, children's services, local HealthWatch and, where appropriate, community organisations. They will become the forum for determining local needs through Joint Strategic Needs Assessments (JSNAs) and the development of high-level public joint health and wellbeing strategies.

26 DsPH will have a key part to play in developing local public health approaches and in nurturing and maintaining links across the NHS and local government. Subject to Parliamentary approval, they will be appointed jointly by local authorities and Public Health England. We proposed in the consultation document *Healthy Lives, Healthy People: Consultation on the funding and commissioning routes for public health* that suicide prevention public health activities should be the responsibility of local authorities working with local health and wellbeing boards. This would place many DsPH in a unique position to contribute to taking forward the new suicide prevention strategy as part of their responsibility for local public health in local authorities and through their links to local health and wellbeing boards. In our response to the consultation, we will set out, in the light of the responses received, our final view of where the responsibility for suicide prevention public health activities should lie in future.

27 Public Health England, the new national public health service, will focus on improving outcomes for people's health and wellbeing locally and reducing the health inequalities experienced by individuals and specific groups within society. Improvements in the public health of the population will be supported by a Public Health Outcomes Framework. One of the proposed indicators in this framework is a reduction in the suicide rate.

28 *No Health Without Mental Health*, published in February 2011, is key in supporting reductions in suicide among 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.

29 *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.

30 Children and young people have an important place in this draft strategy. The suicide rate among teenagers continues to fall, and is below that in the general population. However, half of lifetime mental health problems (excluding dementia) begin to emerge by age 14 and three-quarters by the mid-20s, making this a crucial age group for the early identification of problems and swift and effective intervention.

Addressing equalities and assessing impact

31 The Equality Act 2010 established a public sector duty to advance equality and reduce inequality for people with nine protected characteristics. These characteristics are:

- age;
- disability;
- gender reassignment (transsexual people);
- marriage and civil partnership;
- pregnancy and maternity;
- race;
- religion or belief;
- sex (gender); and
- sexual orientation.

32 Carers of people with a protected characteristic also receive protection by virtue of their association with that person.

33 Recognition of the implications for these groups is an integral part of the draft strategy. Individuals from these groups may be at heightened risk from some of the factors identified under the first area for action. For example, lesbian, gay and bisexual people have a higher risk of mental health problems and self-harm. Different groups, including those with protected characteristics, are also considered under the second area for action: tailored approaches to improve mental health in specific groups.

34 In writing this draft strategy the lack of information about suicide risk in many groups has become apparent. Under area for action 6, we consider how we can improve information and data collection.

35 We are committed to continued engagement with people from all the protected characteristic groups. Information gathered in an early engagement event is summarised at Annex B.

Consultation questions and how to respond

36 This consultation will begin on 19 July 2011 and will run until 11 October 2011, and we welcome all comment on the contents of the consultation document. We are keen to hear your views on a number of issues, highlighted in consultation questions throughout the document. At the end of the document (Annex G) we have listed all these questions, the answers to which will help shape the final suicide prevention strategy. Please see page 90.

37 There are different ways to comment. You can:

- use the online questionnaire at: www.consultations.dh.gov.uk;
- email your completed questionnaire to: suicideprevention@dh.gsi.gov.uk; or
- post your completed questionnaire to:
  Suicide Prevention Consultation
  Mental Health and Disability Division
  216 Wellington House
  133–155 Waterloo Road
  London SE1 8UG

1. AREA FOR ACTION 1: REDUCE THE RISK OF SUICIDE IN KEY HIGH-RISK GROUPS

1.1 A number of groups are known to be at higher risk of suicide than the general population. We have been able to identify these groups from the national mortality statistics produced by the Office for National Statistics (ONS) from information supplied to them when a death is registered. 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. As routine data on gender, age, cause of death and occupation are collected we are also able to monitor the impact of preventative measures taken.

1.3 The groups at high risk of suicide are:

- people in the care of mental health services (around 1,200 suicides per year), including inpatients;
- people with a history of self-harm (around 950 suicides per year);
- people in contact with the criminal justice system (around 80 self-inflicted deaths in prison per year);
- adult men under age 50 (around 2,000 suicides per year); and
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

1.4 Although the draft strategy focuses on groups at higher risk, it recognises that individuals may fall into two or more high-risk groups.

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 1,351 in 1999 to 1,095 in 2008, a reduction of 256 deaths (19%):**

  the number of inpatients who died by suicide reduced from 214 in 1997 to 86 in 2008, a reduction of 128 deaths (60%);

  the number of inpatients who died on wards by hanging or strangulation reduced by 78%; and

  the number of non-compliant patients who died by suicide reduced from 286 in 1999 to 154 in 2007 (46%).

  Further information is available at: 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

1.5 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.

1.6 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 so that suicide rates continue to reduce. Approaches identified by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (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 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);
- a specific assessment for ligatures and ligature points. Inpatient suicide using non-collapsible rails is a 'Never Event'.[3]* The most common ligature points are doors and windows; the most common ligatures are belts, shoelaces, sheets and towels. New kinds of ligatures and ligature points are always being found, so ward staff need to be constantly vigilant to potential risk;

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

- implementing suitable measures to eliminate the risk where possible, for example:
  - installing collapsible fittings (such as shower and curtain rails) in all inpatient areas, and checking them regularly to ensure that they are working properly; and
  - ensuring that windows comply with guidance issued in NHS Estates Health Technical Memorandum No 55 *Windows* (1998);
- following the guidance in *Strategies to Reduce Missing Patients: A practical workbook* (National Mental Health Development Unit, 2009) to prevent patients going missing from inpatient wards;
- good risk management and continuity of care are essential components of high-quality care. 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, *Best practice in managing risk: principles and guidance for best practice in the assessment and management of risk to self and others in mental health services*, emphasises that risk assessment should be seen as 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; and
- innovative approaches – for example, many local services have also developed ways to follow up people recently discharged from mental health inpatient units, using telephone, text messaging and email.

Helpful resources

1.7 *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.

1.8 NCI provides regular reports on patient suicides. It also provides 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. Reports are available at: www.medicine.manchester.ac.uk/suicideprevention/nci

1.9 The 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. These are available at: www.medicine.manchester.ac.uk/mentalhealth/research/suicide/prevention/nci/about/keyfindings/saferservice

1.10 The National Patient Safety Agency's (NPSA's) *Preventing Suicide: A toolkit for mental health services* includes measures that services can use to assess how well they are meeting the best practice on suicide prevention recommended in the toolkit. It is available at: www.nrls.npsa.nhs.uk/resources/?EntryId45=65297

National action to support local approaches

1.11 The Department of Health has commissioned the NPSA to produce a community suicide prevention toolkit for primary and secondary care services. The toolkit will focus 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. The toolkit is to be published in 2011.

People with a history of self-harm

- **There are around 200,000 episodes of self-harm that present to hospital services each year.[4] However, many people who self-harm do not seek help from health or other services and so are not recorded.**
- **The most common form of self-harm in people who seek treatment is self-poisoning, followed by self-injury (cutting or stabbing with a sharp implement). More than 50% of people who self-harm have done so at least once before and a quarter self-harm again within a year.[5]**
- **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.[6] At least one in two 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[7] and in those who have used violent/dangerous methods of self-harm.[8]**
- **Studies have shown that by age 15–16, 7–14% of adolescents will have self-harmed once in their life.[9]**

Effective local interventions

1.12 Emergency departments have an important role in treating and managing people who have self-harmed or have made a suicide attempt. Research[10] has shown that 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.[11] Attitudes towards and knowledge of self-harm among general hospital staff are often poor.[12] A high proportion of people who self-harm are not given a psychological assessment.[13] 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.

1.13 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.[14]

1.14 Appropriate training on suicide and self-harm is needed 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

1.15 Simple tools and prompts for screening for risk of self-harm have been developed by some NHS trusts. For example, Greater Manchester West Mental Health NHS Foundation Trust has worked with local GP practices to devise a flagging/alert system using GP records that identifies people with a history of self-harm and other risks.

National action to support local approaches

1.16 The Department of Health has funded a multi-centre study of self-harm in England, working with research centres in Manchester, Oxford and Derby (and previously Leeds).[15] The aim of this project is to collect reliable data on national trends to inform suicide and self-harm prevention strategies, identify regional differences that may highlight important differences in approach and treatment, collect information on the costs of self-harm to health services, and provide a database that can be used to evaluate national preventative initiatives (such as National Institute for Health and Clinical Excellence (NICE) guidelines – see http://guidance.nice.org.uk/CG16).

1.17 NICE is currently developing clinical practice guidelines on the long-term management of self-harm for the NHS in England, Wales and Northern Ireland. This guideline builds on guidance published in 2004. It will include recommendations for the appropriate treatment for any underlying problems (including diagnosed mental health problems). It will also cover the longer-term management of self-harm in a range of settings. The guidance will be published by November 2011.

1.18 The National CAMHS Support Service produced a *Self-harm in children and young people handbook* and an e-learning package, designed to provide basic knowledge and awareness of the facts and

issues behind self-harm in children and young people, with advice about ways staff in children's services can respond. Available from: www.chimat.org.uk/resource/view.aspx?RID=105602

1.19 The Department of Health has commissioned the NPSA to produce a community suicide prevention toolkit (see paragraph 1.11 above for details).

People in contact with the criminal justice system

- **People in contact with the criminal justice system (CJS) are at high risk of suicide. There is evidence to show that the raised risk occurs at all stages within the CJS. Reasons for the increased risk include the following:**

  a high proportion of offenders are young men, who are already a high suicide risk group;

  a high proportion of offenders have mental health and/or substance misuse problems;

  an estimated 90% of prisoners have a mental health problem (including personality disorder) and/or substance misuse problems;

  offenders are, by definition, in a stressful situation that places them at risk of suicide; and

  offenders can be separated from their family and friends, whose social support may help to guard against suicidal feelings.

- **People at all stages within the CJS, including people on remand and recently discharged from custody, are at high risk. 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).**

- **The increase in suicide risk for women prisoners is greater than for men, although most prisoners who die by suicide are male.**

- **The three-year average annual rate of self-inflicted deaths* by prisoners is currently 71 deaths per 100,000 prisoners. This has decreased year-on-year since 2004, when it was 130 deaths per 100,000 prisoners.**

- **Some offenders have complex problems, including personality disorder with another mental health problem complicated further by alcohol and/or substance misuse, which affects 20% of people on remand in prison. In a recent nine-year review of self-inflicted deaths in prison, 51% of those who died had at least one psychiatric diagnosis recorded. Of these, 22% had a second or third co-morbid psychiatric diagnosis, indicating more complex treatment needs. The most common primary psychiatric diagnosis was drug dependence (14%). Some 56% had a history of drug misuse, 32% of alcohol misuse and 48% of self-harm, and 32% had previous NHS mental health service contact.**

- **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% of these deaths receive a suicide or open verdict at inquest. The remainder receive an accidental or misadventure verdict.

1.20 Children and young people under 18 are covered by the youth justice system, and are discussed in area for action 2.

1.21 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*, the companion document to the mental health outcomes strategy, under section 2.28–2.35.

1.22 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. Each death is subject to an investigation by the Prisons and Probation Ombudsman.

1.23 The National Safer Custody Managers and Learning Team was established at the end of 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 our understanding of and the procedures for caring for prisoners at risk of suicide or self-harm.

1.24 The Department of Health, NOMs and the University of Oxford Centre for Suicide Research are funding an analysis of all self-harm data based on incidents occurring between 2004 and 2009. The analysis will examine trends and the characteristics of those prisoners who self-harm, particularly gender, age, status, offence, sentence length, time in custody, etc. It will also provide an evidence base of factors which may increase the risk of self-harming behaviour. This in turn will inform the development of more effective mechanisms for identifying, managing and reducing the risk of those prisoners who self-harm.

1.25 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 did not reach any definite conclusions as to the reasons for the reduction, but identified improvements in cell design, identification of ligature points, risk assessments and Safer Detention guidance as all possibly contributing. Further information is available at: www.ipcc.gov.uk/Pages/deathscustodystudy.aspx

Adult men aged under 50

- **Men are at three times greater risk of suicide than women.**
- **Most suicides are among men aged under 50. The suicide rate for young men aged under 35 has fallen in recent years, following a consistent rise over the last three decades of the 20th century. Men aged 35–49 are now the group with the highest suicide rate (although rates in this age group are falling as well).**
- **Men have higher rates of other factors which may increase their risk of suicide. For example, they have higher rates of alcohol and drug misuse. Older men (over 75) also have higher rates of death by suicide, which may be because they are more likely to be socially isolated.**
- **Men's general health is worse than women's. Men are also less likely to use health services and other sources of support[18] than women and are more likely to consult anonymous sources of health advice, such as websites.**
- **Men often choose a more violent means of suicide – for example, hanging or jumping in front of a moving vehicle.**
- **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 break-up and divorce; social isolation; and low self-esteem.**

1.26 Men aged under 35 were a high-risk group in the 2002 strategy. Although the suicide rate in men aged under 35 has fallen, the fall has recently levelled out and we are continuing to highlight this age group within the draft strategy.

1.27 Although this draft strategy is focusing particularly on adult men aged under 50, this does not mean that men in other age groups should be overlooked. Rates of suicide in men aged over 75 have also not reduced. Different risk factors, such as loneliness and physical illness, may be important in this age group.

Effective local interventions

1.28 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.

1.29 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.

1.30 Samaritans has launched a five-year campaign targeted at men aged 30–50 in lower socio-economic groups, to get men to talk about their feelings to friends, family, colleagues or health professionals, or by telephoning the Samaritans 24/7 confidential helpline. The campaign was developed through research with men in this risk group.

1.31 The Campaign Against Living Miserably, CALM, is a charity focused on reducing suicide in men aged under 35. See paragraph 4.13 for information about their work.

1.32 Many other 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.

Helpful resources

1.33 *Reaching Out*, the evaluation report of three mental health promotion initiatives aimed at reducing suicides in young men, is available at: www.suicideprevention.org.uk

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.
See: www.peters-story.co.uk

National action to support local approaches

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

1.34 Information about actions to help people in debt and back into employment, as well as tackling alcohol and drug misuse, is included in area for action 2.

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. That is why the previous suicide prevention strategy targeted these occupational groups.**
- **Research[19] 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 draft strategy will maintain the focus on the highest-risk occupational groups but will recognise 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. The website has several useful telephone numbers. 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 (Defra) has a number of measures in place to support rural workers. These are not specifically aimed at preventing suicide but aim to ease some of the stresses which are known to adversely affect farmers, agricultural workers and their families. These include the specific support about bovine tuberculosis being given to the Farm Crisis Network. The Task Force on Farming Regulation aims to reduce some of the bureaucratic burden on farmers.

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

1.39 In 2008, The Department of Health published a report, *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/Publicationsand statistics/Publications/PublicationsPolicy AndGuidance/DH_083066

1.40 Dr Steve Boorman's report *NHS Health and Wellbeing,* published in 2009, made a number of recommendations about how the health and wellbeing of all staff in the NHS could be improved. The recommendations have been accepted by the Department of Health. Further information is available at: www.dh.gov.uk/en/Publicationsand statistics/Publications/PublicationsPolicy AndGuidance/DH_108799

Consultation questions

Q1 In your view, are there any additional measures or approaches to reduce suicide in the high-risk groups that should be considered for inclusion? What evidence can you offer for their effectiveness?

Q2 In your view, are there any other specific occupational groups that should be included in this section? If so, what are the reasons for inclusion?

2. AREA FOR ACTION 2: TAILOR APPROACHES TO IMPROVE MENTAL HEALTH IN SPECIFIC GROUPS

2.1 As well as targeting high-risk groups, the other way to prevent suicide is to improve the mental health of the population. 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 In order for this whole-population approach to reach all groups who might need it, it needs to include tailored measures for groups with particular vulnerabilities or issues of 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 and care leavers;
- survivors of abuse or violence in childhood, including sexual abuse;
- veterans;
- people with untreated depression;
- people who are especially vulnerable due to social and economic circumstances;
- people who misuse drugs or alcohol;
- lesbian, gay and bisexual people;
- Black, Asian and minority ethnic groups and asylum seekers; and
- other groups with protected characteristics.*

2.3 For many of these groups we do not have sufficient information about rates of suicide and also about what interventions might be helpful. The requirements for improved information and research are considered further under area for action 6. In this draft strategy we have aimed to set out the information we are aware of, to stimulate discussion and invite responses to the consultation to help fill gaps where possible. Annex B gives further details of information gained from early engagement with key stakeholders.

*The protected characteristics or groups are characteristics against which the Equality Act 2010 prohibits discrimination; they are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) and sexual orientation.

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

- **The suicide rate among teenagers continues to fall and is below that in the general population. However, young people are vulnerable to suicidal feelings. The risk is greater when they have mental health problems or behavioural disorder, misuse substances, have family breakdown 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, whether they are a high-profile celebrity or another young person.**
- **An analysis of key findings from Serious Case Reviews has suggested that in over half of the cases which involved suicide, there was recorded evidence of some prior concerns or a history of abuse and neglect, in contrast to the remaining cases where it appeared that the incident was a singular event which came without prior history or warning. The findings from child death overview panels paint a similar picture, where approximately half of the deaths recorded as `suicide/ intentional self-harm' were assessed as being preventable or potentially preventable.**
- **Self-harm is particularly common among young people.**[20]
- **Research conducted by ONS in 2008 *(Three Years On: A survey of the emotional development and well-being of children and young people)* found that children and young people who are exposed to three or more stressful life events, such as abuse, family bereavement, divorce or serious illness, are significantly more likely to develop emotional and behavioural problems.**
- **Half of lifetime mental health problems (excluding dementia) begin to emerge by age 14 and three-quarters by the mid-20s, making this a crucial age group for the early identification of problems and swift and effective intervention. Up to 80% of adults with depression and anxiety disorders first experience them before the age of 18.**
- **Children and young people under 18 who offend come under the youth justice system. Since January 2002, six young people in penal custody have killed themselves.**
- **There were 64,400 children looked after by local authorities in England as at 31 March 2010. Looked after children and care leavers are between four and five times more likely to attempt suicide 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 relationships and sex, substance misuse and mental health issues. 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 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 board. Professor Munro's Review of Child Protection has identified 15 recommendations necessary to reform the system. The review emphasises the importance of evidence-based early interventions and recommends 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. The Government will make an initial response to Professor Munro in summer 2011 and it will be important to consider the implications of this going forward.

2.6 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.

2.7 The specialist early invention 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. The early intervention approach has been shown to achieve faster and more lasting recovery.

2.8 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 easily accessible and use specific approaches that can engage them well. Outreach work is key, as is an approach which prioritises flexible wraparound support and worker 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.

National action to support local approaches

2.10 *No Health Without Mental Health* includes a number of local and national interventions to improve the mental health of children and young people. Additional interventions are outlined in the companion document *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages*. For example, it includes effective school-based approaches to tackling violence and bullying and sexual abuse (section 1.22–1.43). A number of effective approaches to identifying children who are at risk are outlined under section 5.22–5.26; and the specific needs of looked after children and care leavers are highlighted on page 15.

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

2.12 The National Advisory Council for Children's Mental Health and Psychological Wellbeing has presented its final report to ministers, *Making Children's Mental Health Everyone's Responsibility*. This work will make an important contribution to the implementation of the *No Health Without Mental Health* strategy.

Survivors of abuse or violence in childhood, 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 suicide.**

Effective local interventions

2.13 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.

National action to support local approaches

2.14 *Call to End Violence against Women and Girls*, a new cross-government strategy, was published in November 2010. The Government has committed £28 million

in Home Office funding over four years to improve local provision of specialist support services for victims of rape, sexual assault and violence. Data sharing between emergency departments and other agencies is being encouraged to improve the identification of violence.

Veterans

- **There are 5 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.[23]**

2.15 *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 at section 2.60–2.71.

People with untreated depression

- **Depression is a risk factor in suicide, and undiagnosed or untreated depression can heighten that risk.**
- **Depression is now recognised as a major public health problem in the UK and worldwide. It accounts for 15% of all disability in high-income countries. 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. Risk factors associated with depression include unemployment and social isolation, as well as bullying, sexual abuse and debt. But only a quarter (or even less among young and older people) receive treatment, even though effective treatments are available.**
- **Untreated depression can have a major impact on quality of life, and can cause other health and social care problems, and increase risk of suicide and suicidal feelings.**

- **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.**
- **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

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

2.17 Routine assessment or screening 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.

2.18 Support for self-management and self-care is also crucial, for example, to help manage chronic pain, so that people have a greater sense of choice over how their health 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.

2.19 *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages*:

- identifies a number of effective local approaches to treating depression (sections 2.5–2.15 and 4.12–4.14);
- outlines a number of local approaches to improve the mental health care of people with physical health problems (see sections 2.7–2.13 and 3.1–3.20); and
- outlines a number of effective approaches for 'ageing well' (see section 1.72–1.80).

Helpful resources

2.20 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.

2.21 Depression Alliance has produced a range of leaflets on depression and an information pack. These are available at: www.depressionalliance.org

2.22 The Staffordshire University Centre for Ageing and Mental Health has produced a set of information sheets to help health and social care providers respond to suicide risk in older clients. These information sheets are available to all services and agencies.

2.23 The Department of Health has funded multi-centre research on suicide prevention[24] which has produced some 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.

National action to support local approaches

2.24 *Talking Therapies: A four-year plan of action*, published in February 2011, sets out the Government's plans 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.

2.25 The Department of Health's long-term condition model aims to improve the health and wellbeing of people with long-term conditions such as diabetes.

2.26 The Department of Health, the Royal Colleges of General Practice, Nursing and Psychiatry and the British Psychological Society will continue to work together to improve the recognition of depression in older people in primary care. This includes developing training in identification and treatment. They have developed a factsheet on depression in older people, available at: 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.[25]**
- **Suicide risk is complex we do need to be vigilant at this time of higher economic uncertainty, but it is important not to over react or 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).**

2.27 This group includes people who are affected by periods of economic uncertainty, rising unemployment, increased debt and becoming homeless.

Effective local interventions

2.28 A number of different front-line agencies, including primary and secondary health and social care services, local authorities, Jobcentre Plus and benefit offices, can identify and support – or signpost to support – vulnerable people who may be at risk.

2.29 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 at: www.cccs.co.uk/Home.aspx

2.30 Other useful approaches at a local level include:

- developing and extending training opportunities for front-line staff who are in regular contact with people who may be vulnerable because of social/economic circumstances. This is particularly relevant to Jobcentre Plus and benefits office 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 services that may be able to 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 jobcentres). There are a number of examples of training programmes including Applied Suicide Intervention Skills Training (ASIST), Mental Health First Aid, Safe Start and training carried out by Samaritans.

2.31 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

2.32 *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages* gives a number of 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 (section 1.63–1.71).

2.33 The Government is committed to ending street homelessness and improving access to services, including mental health services, for all homeless people. A Ministerial Working Group on Preventing and Tackling Homelessness has been established.

People who misuse drugs or alcohol

- **Many people with drug and alcohol dependence problems also have some form of mental health problem. 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.**
- **More than three-quarters (75%) of people in contact with substance misuse services also have a diagnosed mental illness – most commonly depression, personality disorder and anxiety.[26] A National Treatment Outcome Research Study found that 29% of over 100 drug users questioned had thoughts about suicide before treatment. Fewer but significant numbers still experienced suicidal feelings after they started treatment.[27]**
- **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.**

Effective local interventions

2.34 Measures that reduce alcohol and drug dependence are critical to reducing suicide. That is why the new 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 and is focused not only on getting people into treatment, but also on supporting them to sustain their recovery in the long term.

National action to support local approaches

2.35 The Government published *Reducing Demand, Restricting Supply, Building Recovery* in December 2010. The strategy puts the ambition of recovery at its heart, recognising that while high-quality treatment is a vital component and the best way of tackling dependence, holistic solutions are needed to help individuals to rebuild their lives. It also acknowledges that, in line with the vision for Public Health England, systems need to be locally led and locally owned to ensure that local needs are met. As such, local areas will be free to design and jointly commission services to ensure that they meet local needs.

2.36 The Department of Health is developing an alcohol plan due for publication in 2011 and the Government is committed to overhauling the Licensing Act 2003.

Lesbian, gay and bisexual 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.[28] 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.[29]**
- **Notably, lesbian, gay and bisexual people are:**

  twice as likely as heterosexual people to attempt suicide

  at 1.5 times higher risk of depression and anxiety disorders and 1.5 times higher risk of alcohol and other substance dependence.
- **Lesbian and bisexual women are at higher risk of substance dependency and any substance use disorder.**
- **Gay and bisexual men have a particularly high prevalence of suicide attempts.**
- **The PACE report, *Where to Turn*, found that the majority of mental health service providers did not routinely record sexual orientation – only 31% of mainstream service providers compared with 89% for race and 58% for faith. The report is available at: www.pacehealth.org.uk/Where%20To%20Turn%20-%20Final%20Full%20Report.pdf**

Effective local interventions

2.37 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

2.38 PACE, the lesbian, gay, bisexual and transgender (LGBT) voluntary sector research, counselling and advocacy organisation, has recently reviewed web-based mental health promotion and preventative information, support and advice services for LGBT people. Its report, *Where to Turn*, outlines a number of findings that will need to be considered in the context of both suicide prevention and equality issues.

2.39 Published in March 2011, *Working for Lesbian, Gay, Bisexual and Transgender Equality: Moving Forward* sets out specific actions that will be taken across government, including actions on health and social care issues. It can be found at: www.equalities.gov.uk/pdf/action%20plan.pdf

2.40 Local services and external partners working with LGBT groups and individuals may find the PACE report's findings and conclusions helpful when planning and delivering mental health promotion, substance misuse and other support and advice services for LGBT people.

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 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 research, *Suicide Prevention for BME Groups in England*, was commissioned into the risk of suicide and suicide attempts among different ethnic groups. This study 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. More information is available at: www.nmhdu.org.uk/silo/files/executive-summary-suicide-prevention-for-bme-groups-in-england.doc**

2.41 The previous Government's five-year 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.

2.42 The results of the Count Me In 2010 census[30] show 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.

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

2.44 There is evidence to suggest that Irish Travellers are three times as likely to die by suicide as the general population.[31] The Government's Inclusion Health Programme focuses on improving the health outcomes of vulnerable groups, including the homeless, sex workers and Gypsies and Travellers. The strategy, supported by a published evidence pack, seeks to drive improvements through levers such as system reform and clinical leadership.

2.45 Asylum applications in the UK were at their lowest in 2010 at 17,790, excluding dependants, 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. 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 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.

Other groups with protected characteristics

2.46 In writing this draft strategy, the implications for all people with protected characteristics under the Equality Act 2010 have been considered. Suicide risk in people of different ages and sex, of different sexual orientation, of people from Black, Asian and minority ethnic groups and in disabled people has been addressed in the above sections. The needs of the families, friends and carers of people who kill themselves are considered under area for action 4.

2.47 It is clear that some of the protected characteristics reduce an individual's risk of suicide. For example, it has long been recognised that people who are married have a lower risk of suicide.[32] There is also

a wide range of evidence[33] to suggest that religious participation may be a protective factor against suicidal behaviour.

2.48 However, there are some indications that transgender people may have higher rates of mental health problems and higher rates of self-harm. The Government will publish a cross-government transgender equality action plan later this year, which will include a section on health. We need more information both about the rates of suicide in this group and also about what interventions may be helpful.

2.49 While the statistical risk of suicide is low for pregnant women and new mothers, mental health problems are more common in women during pregnancy,[34] with 13% of new mothers having depression and anxiety, rising to 22% in mothers one year after the birth. Research shows that teenage mothers have higher rates of poor mental health after birth than older mothers, and that these higher rates are evident for up to three years after birth.[35] A number of effective approaches are described in *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages* (section 1.15–1.21).

2.50 Similarly, while there is evidence of increased mental health problems among adult and young carers, we are not aware of any evidence of higher rates of suicide or attempted suicide among carers.

Consultation questions

Q3 In your view, are the most appropriate groups considered, including any groups where there are issues relating to equality?

Q4 In your view, are there any additional measures or approaches to reduce suicide in the identified groups that should be considered for inclusion? What evidence can you offer for their effectiveness?

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.[36]

3.2 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.

3.3 To achieve this we need to reduce the number of suicides:

- as a result of hanging and strangulation;
- as a result of self-poisoning;
- at high-risk locations; and
- on the rail and underground networks.

3.4 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 (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.[37]**
- **Hanging and strangulation also continues to be the most common method of suicide among mental health inpatients and prisoners.**

Effective local interventions

3.5 Inpatient suicides as a whole have reduced since 2004. In this period 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'.*

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

3.6 The following approaches may help mental health service providers to remain vigilant:

- regular inspection of collapsible curtain and shower rails on inpatient psychiatric wards to check they are still working; and
- regular environmental audits of inpatient psychiatric wards to reduce other means of suicide, including identification and removal of other potential ligature points.

3.7 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 more 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.

National action to support local approaches

3.8 A recent Department of Health study[38] found that people choose hanging as a method of suicide because they mistakenly think that it is quick, tidy and effective. These findings have important implications for suicide prevention work and the National Suicide Strategy Implementation Advisory Group will consider how best to respond to these findings over the coming months.

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.**

3.9 Some 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 deliberate or accidental drug overdoses a year in England and Wales alone. This had major beneficial effects on deaths from this cause, without evidence of a significant increase in deaths due to poisoning with other analgesics.[39] In June 2010 the ban on the use of dextropropoxyphene (the main toxic constituent of co-proxamol) was extended to the whole of the European Union; and
- the introduction in 1998 of legislation to limit the size of packs of paracetamol, salicyates and their compounds sold over the counter. Following a review

of the effectiveness of this legislation, the Medicines and Healthcare products Regulatory Agency issued new guidance in December 2009 on best practice in the sale of pain relief medication. Restricting the availability of these medicines has led to a reduction in both deliberate and accidental overdoses.[40]

3.10 However, a substantial number of deaths still occur from paracetamol overdose. The Medicines and Healthcare products Regulatory Agency has established an expert working group of the Commission on Human Medicines to review current guidelines for the management of paracetamol overdose.

3.11 A National Quality Standard for safe prescribing is being developed. This will inform both practice and commissioning.

Reduce the number of suicides at high-risk locations

- **Jumping from a high place is a relatively rare method of suicide. However, suicidal jumps 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.[41]

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 hotspots 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 the care or hospital setting, 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 resource

3.15 *Guidance on Action to be Taken at Suicide Hotspots* was published in 2006. This handbook 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 also identifies a number of evidence-based interventions that have proved effective. It is available at: www.suicideprevention.org.uk

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 also comparatively rare in England. However, while suicide rates have been falling generally, suicide deaths on the railway network have tended to increase slightly, at 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 Rail Safety and Standards Board and the British Transport Police collect extensive information on railway deaths and incidents, including suicides and attempted suicides.**

Examples of effective local interventions

3.16 The British Transport Police and London Underground Limited have worked closely with local services to reduce risk at transport-related suicide hotspots. London Underground Limited has provided training for staff to help them identify people who may be considering committing suicide and engage with them in the hope that they can persuade them not to. This approach has helped to 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.

National approaches to support local actions

3.17 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, the aim is 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. More information about the initiative can be found at: www.samaritans.org.uk/default.aspx?page=8044

Consultation questions

Q5 In your view, are there any additional means of suicide that should be considered?

Q6 What additional actions would you like to see taken to reduce people's access to the means of suicide? What evidence can you offer for their effectiveness?

4. AREA FOR ACTION 4: PROVIDE BETTER INFORMATION AND SUPPORT TO THOSE BEREAVED OR AFFECTED BY A SUICIDE

4.1 To achieve this we need to:

- provide effective and timely support for families bereaved or affected by a 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.

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

- **Every suicide affects families, friends, colleagues and others.**
- **Family and friends bereaved by a suicide are at increased risk of mental health and emotional problems and at potentially higher risk of suicide themselves.[42]**
- **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.[43] They include neighbours, school friends and work colleagues, but also people whose work brings them into contact with suicide – emergency and rescue workers, NHS and other 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 takes their own life or when 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,[44] although evidence for efficacy of interventions is currently limited.[45] 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 in one volume 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. It is available at: www.suicideprevention.org.uk or it can be ordered from dh@prolog.uk.com.

4.5 This useful resource could be publicised and distributed more widely through primary care, emergency departments, the police and emergency services, British Transport Police, the Royal Colleges, coroners' officers, funeral directors and mental health services. A recent evaluation has shown that it is well received but that access to it can be a problem.[46]

4.6 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 while detained under the Mental Health Act 1983.

4.7 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 for young people. www.crusebereavementcare.org.uk/Children.html
- 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

4.8 The Ministerial Board on Deaths in Custody (see paragraph 7.31) is arranging a listening day in September 2011 for families bereaved by sudden death in custody or while detained under the Mental Health Act. Following this, the Board will consider whether any steps can be taken to improve support for these families in 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 that 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.**

4.9 Samaritans has successfully piloted a Step by Step post-suicide intervention service for schools, and plans to roll this out to other settings. Trained Step by Step co-ordinators 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. Further information on the Step by Step service is available from www.samaritans.org

4.10 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

4.11 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. The stigma of mental health problems and suicide, concerns about unwittingly raising risks and other factors may all make it more difficult for people to talk directly to the person they are worried about. Talking to the individual is important but may not be enough, particularly if they are unwilling or unable to seek help for themselves.

Effective local interventions

4.12 If individuals are already under the care of 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.

4.13 For individuals who are not known to services, help is still available through many outlets. For example:

- local primary care;
- the Samaritans helpline 08457 90 90 90;
- the PAPYRUS HOPELineUK 0800 068 41 41. HOPELineUK is a national telephone helpline service which was launched in 2005. The service is confidential and provides a source of support, practical advice and information to anyone concerned that a young person they know may be at risk of suicide. HOPELineUK aims to support and inform parents, carers, siblings, friends and professionals who are worried about the management of a child or young person who they suspect is exhibiting suicidal behaviour, has harmed themselves or has tried to end their own life. The service can also offer support, practical advice and information to callers who may themselves be feeling suicidal. www.papyrus-uk.org;
- CALM, the Campaign Against Living Miserably, is a charity focused on reducing suicide in men aged under 35. CALM has a unique approach to engaging young men, using a distinctly non-medical inclusive approach in the way that it promotes its helpline and website. www.thecalmzone.net;
- SANE provides emotional support and specialist information to anyone affected by mental illness, including families, friends and carers. SANEline – 0845 767 8000, 6pm–11pm SANEmail – www.sane.org.uk/what_we_do/support/email SANE Support Forum – www.sane.org.uk/what_we_do/support/supportforum www.sane.org.uk;
- NHS Direct 0845 4647 www.nhsdirect.nhs.uk;
- The YoungMinds website has information for parents who are worried about their child. www.youngminds.org.uk/parents/im-concerned-about/suicidal-feelings;
- Carers Direct, the NHS Choices carers support and information online. www.nhs.uk/carersdirect; and
- if very urgent, the emergency services.

Contact details and further information about other organisations are given in *Help is at Hand,* available at: www.suicideprevention.org.uk

National action to support local approaches

4.14 Samaritans has launched an initiative with the social networking site Facebook. 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.

4.15 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 and emergency departments (see paragraph 2.28).

Consultation questions

Q7 What additional measures would you like to see to support those bereaved or affected by suicide? Please comment on how this help could be provided effectively, and appropriately funded.

Q8 What additional information or approaches would you like to see provided to support families, friends and colleagues who are concerned about someone who may be at risk of suicide? Please comment on how this help could be provided effectively, and appropriately funded.

5. AREA FOR ACTION 5: SUPPORT THE MEDIA IN DELIVERING SENSIBLE AND SENSITIVE APPROACHES TO SUICIDE AND SUICIDAL BEHAVIOUR

5.1 There are two key aspects to this:

- 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.[47]**

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.

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* includes a new section added in response to a suicide cluster among young people in Bridgend, South Wales, in 2008. This reiterates the Code of Practice recommendation, and goes on to highlight 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. For more detail refer to: 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 and suicidal behaviour. Further information and links to some of these guidelines can be downloaded from 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 also works closely with the media to support sensible and sensitive reporting of suicide in line with its media guidelines and also undertakes proactive 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 committed to challenging stigma by supporting and working actively with the Time to Change programme and others. Discussions are under way with Time to Change about the next phase of its activity, which is likely to include a media engagement project.

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.[48] 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.**
- **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 published in 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.[49]

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 chatroom 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 Government continues to support the internet industry and content provides 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. Content providers will remove content that breaks their terms of service, including illegal material on suicide and material that they consider harmful and inappropriate. We have worked with search engines and social media sites to ensure that ready access is provided to trusted suicide prevention and support services.

5.12 Content providers are free to make their own policies on the publication of harmful or tasteless material. We expect that the updated law on promoting suicide should make it easier for them to identify and take down any websites based in England and Wales that contain potentially illegal material.

5.13 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 any parent, grandparent or carer who:

- wishes their child to take a safe and responsible approach to the cyber world; and
- has concerns that a young person is depressed or suicidal.

5.14 More information is available at: www.papyrus-uk.org

5.15 See section 4.14 for a joint initiative by Facebook and Samaritans.

Consultation questions

Q9 In your view, are there any additional measures or approaches that could promote the responsible reporting and portrayal of suicide and suicidal behaviour in the media?

Q10 In your view, are there additional approaches that could be considered for the internet industry in England to maximise the positive potential of the internet to reach out to vulnerable individuals?

6. AREA FOR ACTION 6: SUPPORT RESEARCH, DATA COLLECTION AND MONITORING

6.1 To achieve this 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
- evaluate the impact of actions undertaken as part of the national suicide prevention strategy (see chapter 7).

- **Reliable, timely and accurate suicide statistics are the cornerstone of any suicide prevention strategy and of tremendous public health importance. Annex A describes in more detail the current system of data collection on suicides and an analysis of the most recently available statistical data.**
- **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 and public health specialists.**

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

6.2 Existing research evidence and other relevant sources of data which are useful to inform local and regional strategies and interventions to prevent suicide include the following:

- ONS currently produces national mortality statistics from the information supplied to the registrar on cause of death. These statistical data are used nationally and locally to identify priorities for healthcare and public policy, to measure progress, and to assess the effectiveness of health services and other interventions.
- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI) – this is a long-term study of suicides and homicides by people in the care of the mental health

services. Conducted by the Centre for Suicide Prevention at the University of Manchester, it has published a number of reports on incidence, trends, causes and recommendations for improving suicide prevention (see www.medicine.manchester.ac.uk/mentalhealth/research/suicide/prevention/nci). The Centre for Suicide Prevention is also undertaking a related study of suicides in prison.

- The Multicentre Study of Self-harm in England – this project is collecting data on national and regional trends in self-harm presenting to health services, including data on methods of self-harm, how self-harm is managed, compliance with national guidance, and self-harm in young people and in different ethnic groups. The study also collects important data on outcomes (including suicide), and risk factors.[50]
- Coroners' records from inquest proceedings can provide a wealth of information about the who, how and where of suicides, which tell us about the demographics of suicide, and may also tell us more about the motivations and causes of suicide.
- Important additional information is available from serious untoward incident inquiries, Serious Case Reviews (SCRs) and Child Death Overview Panels (CDOPs). The purpose of SCRs and CDOPs are to learn lessons to better safeguard and promote the welfare of children. Regular reports draw out key findings from SCRs.[51] The Department for Education publishes data about preventable child deaths in England.[52]
- NOMS has a system in place to monitor all deaths and other incidents in prison custody. This provides up-to-date information on each incident and those involved. Since 2009, the Ministry of Justice has published an annual statistical bulletin on deaths, self-harm and violence in prison custody, looking at trends across age, gender and time in prison custody. In addition, the Prisons and Probation Ombudsman publishes a report on every fatal incident in prison custody.

6.3 Nationally, the Government will work with the Devolved Administrations in the UK to share evidence from research studies on suicide prevention (both nationally and internationally) 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, has invested significantly in mental health research and will continue to support high-quality research on suicide, suicide prevention and self-harm. A research study has been approved under the Department of Health NIHR programme to investigate the extent to which suicide rates may be over- or under-estimated when they are based on deaths given as suicide, narrative or open verdicts.

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

6.5 The information in the national mortality statistics produced by ONS is useful for identifying national trends, but does not allow more detailed analysis. For example, a cause of death may be recorded as carbon monoxide poisoning, without specifying the precise source of the carbon monoxide. An increase in the level of detail is essential for identifying patterns and emerging trends in suicide methods.

6.6 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.

6.7 The Department of Health will work with stakeholders to consider ways to improve reporting, recording and access to data, in particular to address the current information gaps around ethnicity and sexual orientation. One option may be for coroners to collect ethnic origin and sexual orientation as part of their investigations; however, in order to make this a requirement for coroners this would require a change to regulations. This approach would potentially raise practical difficulties – for example, defining ethnicity is increasingly complex and the conventional solution is to allow people to define their own ethnicity. However, at an inquest ethnicity would have to be defined by someone other than the individual. The collection of sexual orientation information via the inquest process potentially raises issues of privacy and the acceptability of seeking such information in this way. For ethnicity, the Department of Health will also explore the feasibility of obtaining this information through linking with other datasets.

6.8 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.

6.9 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.

6.10 Scotland is currently establishing a national register of suicides and open verdicts that will record demographic and other key data shortly after the inquest, so that services and agencies can identify and respond swiftly to any emerging trends or issues at a local, national and regional level. The Government will be monitoring this national register to see if it improves timeliness and quality of data and consider whether it could be replicated in England.

6.11 ONS codes causes of death according to the International Statistical Classification of Diseases and Related Health Problems, published by the World Health Organization. In accordance with these rules, if it is not clearly stated that the death was caused by the deceased's own actions and that they intended to harm themselves, the death has to be coded as accidental. The varying detail given in narrative verdicts and the increasing use of multi-category verdicts means that, in some cases, classifying intent accurately is difficult. We need to find a way for ONS to classify these narrative and multi-category verdicts accurately in order to monitor trends and draw comparisons over time.

6.12 ONS has also established a project to assess the impact of narrative verdicts on national statistics relating to the cause of death. The results of this study were published in March 2011.[53] The study concludes that the increase in the use of narrative verdicts by coroners has not yet had a significant impact on published mortality rates in England and Wales and so no revision is needed. However, if the rise in narrative verdicts continues at the same rate, the accurate reporting of injury and poisoning deaths may be affected in due course. A review of current coding practices and the handling of narrative verdicts will be undertaken by ONS, with particular reference to deaths from intentional self-harm.

6.13 The Coroners and Justice Act 2009 replaces coroners' 'inquisitions' and 'verdicts' with 'determinations' and 'findings', although there is no practical difference between the different terms. In developing the system which underpins this, it is important that statisticians and public health specialists are able to keep accurate records of the different types of death to support tracking of data and trends over time.

6.14 See chapter 7 for proposals to evaluate the impact of actions undertaken as part of the national suicide prevention strategy.

Consultation questions

Q11 Is there additional information available that could be collected at a national and local level to support the suicide prevention strategy?

Q12 In your view, where are the gaps in current knowledge of the most effective ways of preventing suicide?

7. MAKING IT HAPPEN LOCALLY AND NATIONALLY

7.1 An effective public health approach is fundamental to suicide prevention. Locally this depends 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. Local approaches need to be supported by co-ordinated cross-government action, working with national partners such as professional and voluntary organisations.

7.2 *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 a number of cross-government actions to support the delivery of the strategy. Many have direct relevance to suicide prevention; for example, the work on employment being undertaken by the Department for Work and Pensions and the Ministerial Working Group on Preventing and Tackling Homelessness.

7.3 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; for public health; and for adult social care. Together, these provide a comprehensive and coherent approach to tracking national progress against a range of critical outcomes. In the proposed Public Health Outcomes Framework there are three indicators with direct relevance to suicide prevention. These are:

- Domain 4: rates of hospital admission as a result of self-harm; and
- Domain 5:
  - suicide rate; and
  - mortality rate of people with mental illness.

7.4 *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages* gives examples of a number of outcomes and indicators for consideration by the NHS Commissioning Board and local commissioners; these include the rates of inpatient suicides. Local commissioners (both local authorities and clinical commissioning groups) will also be able to refer to a number of National Quality Standards. These will define what high-quality care looks like in care pathways or services. Relevant quality standards under development include: alcohol dependence, depression in adults, long-term care of people with co-morbidities and/or complex needs, and safe prescribing.

7.5 Progress locally and nationally can only be effectively monitored if we have timely and relevant information. Under area for action 6 a number of actions are outlined which aim to improve information both on suicide rates in different groups and on different methods.

Local leadership and suicide prevention

7.6 *Healthy Lives, Healthy People*, the Public Health White Paper, gives a new, enhanced role to local government and local partnerships in delivering improved public health outcomes.

7.7 The creation of local health and wellbeing boards will ensure that local partnerships work effectively together. These boards will be able to support suicide prevention by bringing together elected members of local authorities, clinical commissioning groups, DsPH, adult social services, children's services, local HealthWatch and, where appropriate, community organisations.

7.8 The core purpose of health and wellbeing boards is to develop a high-level public joint health and wellbeing strategy. Improvements in population health and wellbeing, including mental health, will reduce the risks of suicide. Through assessing needs and developing plans together in health and wellbeing boards, local authorities and clinical commissioning groups can agree joint strategies and interventions to improve health. In addition, 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.

7.9 Key to developing effective strategies is the development of the JSNA. Section 5.56–5.57 of *No Health Without Mental Health* outlines the new approach to JSNAs.

7.10 DsPH will have a key part to play in developing local public health approaches and in nurturing and maintaining links across the NHS and local government. Subject to Parliamentary approval, they will be appointed jointly by local authorities and Public Health England. We proposed in the consultation document *Healthy Lives, Healthy People: Consultation on the funding and commissioning routes for public health* that suicide prevention public health activities should be the responsibility of local authorities working with local health and wellbeing boards. This would place many DsPH in a unique position to contribute to taking forward the new suicide prevention strategy as part of their responsibility for local public health in local authorities and through their links to local health and wellbeing boards. In our response to the consultation, we will set out, in the light of the responses received, our final view of where the responsibility for suicide prevention public health activities should lie in future.

Local suicide prevention groups

7.11 In a number of localities, regional or sub-regional multi-agency suicide prevention groups have been established to take forward a co-ordinated set of 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 local health and wellbeing boards in developing their local strategies.

Primary care services

7.12 Most general practices will have a patient who dies by suicide only once every few years, making it mpractical to predict that single individual and intervene directly. However, GPs can still make a very big difference to overall suicide rates, as general practice settings are the first point of contact for many people who are experiencing distress and who may be vulnerable to suicide or are experiencing suicidal thoughts. GPs are also the key gatekeepers to specialist services. People tend to visit their GP more often in the period leading up to suicide – between half and two thirds visit their GP in the month before taking their own life, and 10–40% visit their GP in the week before.

7.13 Primary care services thus have an important role in identifying and treating people with depression or other mental health problems, assessing any suicidal risk, and initiating and supporting preventative interventions. People may present to primary care services 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.

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.

7.15 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.

7.16 Information about support for the bereaved is available to primary care services. Details are given under area for action 4.

Proposed commissioning reforms

7.17 Subject to the passage of the Health and Social Care Bill, clinical commissioning groups will become responsible for commissioning the majority of healthcare services. They will be supported by the NHS Commissioning Board, which will have a vital role in providing national leadership for driving up the quality of care across health commissioning. The Board will do this by supporting clinical commissioning groups in a number of ways, including publishing commissioning guidance and model care pathways, based on the evidence-based quality standards that it has asked NICE to develop.

7.18 A programme of clinical commissioning group pathfinders has been established to test the different elements involved in clinical-led commissioning and explore how emerging groups will best be able to undertake their future functions. This includes exploring how groups can best commission services at different geographic levels, and commission some of the more specialised and complex local services such as mental health.

The role of mental health services

7.19 The draft suicide prevention strategy outlines measures that can be taken to reduce suicides among high-risk groups, including people under the care of mental health services and those with a history of self-harm. However, it is estimated that around 70–75% of suicides are by people who are not in contact with mental health services. Some may have an underlying or untreated mental illness or may have lost contact with mental health services. Research suggests that psychiatric disorders are present in at least 90% of suicides, and more than 80% are not receiving treatment at the time of death. The challenge in these cases will be to encourage people to seek help or support from a range of agencies and approaches; encourage individuals to continue or return to treatment; and encourage other therapeutic approaches, including trying to re-engage people with services.

7.20 As part of its commitment to extend choice for people using NHS services, the Government has committed to introducing choice of treatment and provider in some mental health services from April 2011, and to extending this wherever practicable. The Department of Health has recently consulted on some proposals to give people more choice of how they access mental health services and the treatment they receive, making services more responsive to people's needs. A response to the consultation will be published in due course.

7.21 The implementation *No Health Without Mental Health* is critical to delivering suicide prevention.

Criminal justice

The National Offender Management Service (NOMS)

7.22 NOMS is an executive agency of the Ministry of Justice, and brings together HM Prison Service and the Probation Service. It is responsible for commissioning and delivering offender management services in custody and the community. Caring for some of society's most vulnerable or volatile people is extremely complex. 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. Issues that increase risk include drug/alcohol misuse, family background and relationship problems, social disadvantage or isolation, previous sexual or physical abuse, and mental health problems.

7.23 NOMS works across criminal justice agencies to ensure that effective information flows to improve the continuity of care when a prisoner moves between agencies, including the establishment of a national partnership board to identify and mitigate risks associated with transferring prisoners, roll-out of a revised Person Escort Record and installation of Police National Computer terminals in prisons to improve the way information about prisoners is shared between custody providers. Effective partnership working with the Offender Health team at the Department of Health has led to improvements in access to mental health services by people in prison and effective prison clinical substance misuse services which offer assessment and needs-based treatment, including detoxification and stabilisation programmes for people in prison.

The police and other emergency services

7.24 There are a number of other key partners who come into contact with people who may be in crisis or having suicidal thoughts and engaging in suicidal actions. These include the police and the other emergency services, accident and emergency departments and of course people within communities and individuals themselves.

7.25 The police, including the British Transport Police, and other emergency services deal with suicidal people on a daily basis. They are also the first point of contact in most cases for families bereaved by suicide and have to deal with the traumatic aftermath of suicides. Communication between police and emergency services and the NHS and social care services is vital, in particular when dealing with someone who has attempted suicide. Sharing of information between emergency services and health services is essential to guide local responses when dealing with a suicidal person. Joint responses will be enhanced by the proposed local partnerships between police forces and NHS commissioners regarding services in custody suites.

Rail and underground networks

7.26 Network Rail, London Underground and the Association of Train Operating Companies are, between them, responsible for the management of the rail network, including stations. It will be important that they work together to understand the characteristics of rail suicides, and the effectiveness of industry initiatives.

Local community and voluntary groups, including local and national charities

Samaritans

7.27 Samaritans is a registered charity that provides confidential, non-judgemental emotional support, 24 hours a day, 7 days a week for people who are experiencing feelings of distress or despair, including those which could lead to suicide. The service is provided by over 15,000 active listening volunteers operating from 201 branches across the UK and Republic of Ireland. In 2009 Samaritans had 2,696,762 conversations by phone, email, SMS, letter and face to face. Samaritans also

undertakes various projects in different settings in order to reduce suicide. Further information is available at: www.samaritans.org

PAPYRUS

7.28 PAPYRUS is a voluntary organisation committed to the prevention of young suicide and the promotion of mental health and wellbeing. It was founded in 1997 by parents who have lost a son or daughter to suicide. PAPYRUS provides HOPELineUK (0800 068 41 41), a national telephone helpline service which provides a source of support, practical advice and information to anyone concerned that a young person they know may be at risk of suicide. Further information is available at: www.papyrus-uk.org

Maytree

7.29 Maytree respite centre is a sanctuary for the suicidal which opened in October 2002, taking in guests for a four-night stay. It is located in north London and provides accommodation for suicidal people in crisis. Maytree aims to reduce the suicidal thoughts of its guests through providing a calm environment in which trusting relationships can be developed, and guests can feel listened to and understood. More information is available at: www.maytree.org.uk

The Government's role in suicide prevention

7.30 The Forum for Preventing Deaths in Custody was an independently chaired body that was set up in 2005 to learn and share lessons and effect change to prevent deaths in custody. The Fulton Report of 2008 called for the establishment of the Ministerial Council on Deaths in Custody in order to bring about further reductions in the number and rate of deaths in all forms of state custody and strengthen the procedures for learning. This covers deaths that occur 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.

7.31 The three-tier Ministerial Council on Deaths in Custody officially commenced operations on 1 April 2009 and is jointly funded by the Home Office, the Ministry of Justice and the Department of Health. The first tier consists of a Ministerial Board on Deaths in Custody, which has replaced the Ministerial Roundtable on Suicide. The board has a rotating chair and, since April 2009, ministers from each of the co-sponsoring government departments have either chaired or attended the board. The board's membership is varied in order to capture a wide range of expertise and comprises senior decision-makers responsible for policy and issues related to deaths in custody from a range of government departments and voluntary sector organisations.

7.32 The second tier of the council is the Independent Advisory Panel (IAP) on Deaths in Custody, which is chaired by Lord Toby Harris and replaced the Forum for Preventing Deaths in Custody. The

IAP plays an important role in helping to shape government policy in this area through the provision of independent advice and expertise to the Ministerial Board. It also provides guidance on policy and best practice across sectors and makes recommendations to ministers and heads of key agencies to address any gaps. Some recent progress in relation to suicide prevention includes the development of workstreams on cross-sector learning from deaths in custody, improving information flows between organisations to manage risk of harm and suggested improvements to investigations of deaths.

7.33 The IAP is supported by a broadly based 'virtual' practitioner and stakeholder group (PSG), which forms the third tier of the council. There are 100 confirmed members of the PSG representing a range of organisations, including the police, prisons, the Youth Justice Board, the UK Border Agency, private sector custody providers, Department of Health/NHS secure services, inspectorates, investigative bodies and non-governmental organisations (NGOs). More information is available at: http://iapdeathsincustody.independent.gov.uk

Central support for delivering the strategy

7.34 The Cabinet Sub-Committee on Public Health will oversee the implementation of *No Health Without Mental Health*, while the Cabinet Committee on Social Justice will ensure 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*.

7.35 A Mental Health Strategy Ministerial Advisory Group of key stakeholders has been established to work in partnership to realise the aims of the strategy.

7.36 Ensuring equality and reducing health inequalities is a central issue to both the mental health strategy and the suicide prevention strategy. A Ministerial Mental Health Strategy Equalities Advisory Group is being established to ensure that this issue is appropriately and fully considered when implementing these strategies.

The National Suicide Prevention Strategy Advisory Group

7.37 The National Suicide Prevention Strategy Advisory Group (NSPSAG) was established 10 years ago to provide leadership and support for suicide prevention initiatives. NSPSAG members also provide advice on monitoring and analysing trends in suicide when data are received from ONS. Membership of the group includes senior academic researchers, voluntary sector representatives (Samaritans and PAPYRUS), representatives from NOMS, Department of Health representatives from public health (including the statistical analytical team) and offender health care, representatives from 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. The NSPSAG

is chaired by Professor Louis Appleby CBE, National Clinical Director for Health and Criminal Justice at the Department of Health and Director of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

7.38 This group has considerable expertise and the Government plans to develop its role to provide advice to the Mental Health Strategy Ministerial Advisory Group. Membership of the group will be reviewed in the light of the areas for action of the final strategy.

How will we know if things have improved?

7.39 An indicator to measure the suicide rate across England and across different groups is being considered as part of the Public Health Outcomes Framework, and the Department of Health is currently considering the responses to the recent consultation. Any indicator will draw on information available from ONS and coroners' offices, which is described under area for action 6. The proposed Public Health Outcomes Framework also included two other potential indicators with direct relevance to suicide prevention. These are the rates of hospital admission as a result of self-harm, and the mortality rate of people with mental illness.

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

7.41 All initiatives and interventions undertaken to implement the final strategy will be based on sound evidence wherever possible and will be subject to evaluation.

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

Links across the UK and Republic of Ireland

7.43 Suicide prevention strategies have now been established in Scotland, Wales and Northern Ireland and 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.

Consultation questions

Q13 Are there examples of local good practice that could be disseminated to other areas?

Q14 What other local and national approaches could be developed to ensure the implementation of the strategy?

Q15 What issues should the Department of Health be considering as we develop any potential indicators in the Public Health Outcomes Framework that are relevant to suicide prevention?

ANNEX A: STATISTICAL INFORMATION

Introduction

Most deaths are certified by a medical practitioner; however, suspected suicides must be certified after a coroner's inquest. A coroner records a verdict of suicide when they have decided that there is evidence beyond reasonable doubt that the injury was self-inflicted and the deceased intended to take their own life. Open verdicts include cases where the evidence available to coroners is not sufficient to conclude that the death was a suicide (beyond reasonable doubt) or an accident (on balance of probability). They include those where there may be doubt about the deceased's intentions.

Statistics on causes of death produced by the Office for National Statistics (ONS) are based on the information provided at death registration. These statistics are passed to the Department of Health (via the Information Centre for Health and Social Care) on an annual basis. Open verdicts are generally coded by the ONS as deaths from injury or poisoning of undetermined intent. When national statistics are presented, suicides and undetermined deaths are combined. This reflects research studies which show that the majority of open verdicts are most likely suicides, although they do not meet the high legal standard of evidence required for a coroner to record a suicide verdict. Therefore official suicide rates are measured by a definition that is much broader than the definition of suicide used by coroners.

Suicide numbers and rates

The number of suicide (and undetermined) deaths refers to the actual number of people who have died by suicide or injury (and poisoning) of undetermined intent.

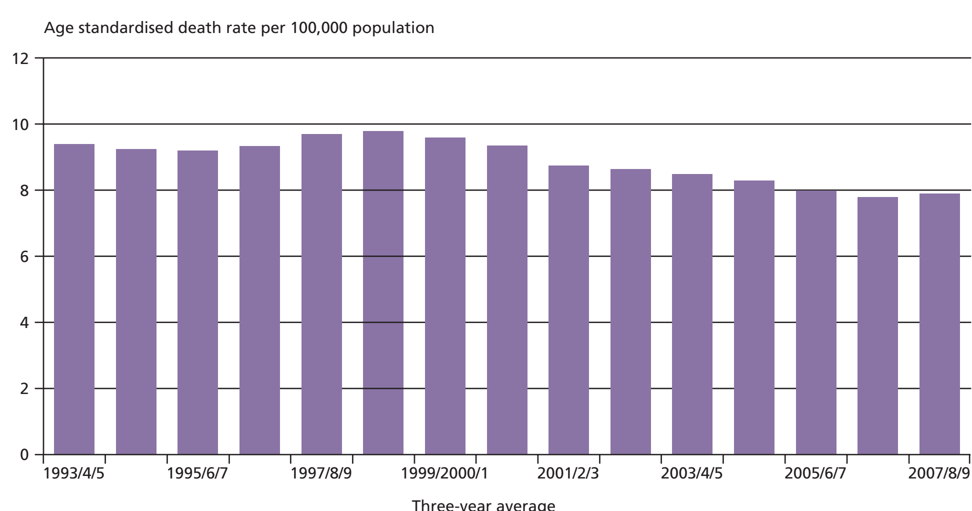
The rate of suicide refers to the frequency with which suicide occurs relative to the number of people in a defined population. This age-standardised rate takes account of changes in the size and age structure of the population to provide a comparable trend across time and across different areas.

Three-year rolling averages are generally used for monitoring purposes, in preference to single-year rates, in order to produce a smoothed trend from the data and to avoid drawing undue attention to year-on-year fluctuations instead of the underlying trend.

Current position

Since 1998–2000, the general trend has been a decrease in the rate of suicide and, despite a slight increase in the 2007–09 figure compared with the previous year, the rate is currently 14.2% lower than the 1995–97 rate.

Figure A.1: Death rates from Intentional Self-harm and Injury of Undetermined Intent excluding 'Verdict Pending' in England, 1993–2009



Rates are calculated using the European Standard Population to take account of differences in age structure.

Source: ONS (ICD9 E950-E959, plus E980-E989, excluding inquest adjourned (E988.8); ICD10 X60-X84, Y10-Y34 excluding verdict pending (Y33.9 up to 2006))

Suicide rates have tended to rise during periods of high unemployment or economic uncertainty. We are therefore entering a time when vigilance by front-line services will be needed.

The European Age Standardised Rate (EASR) for suicide for the year 2009, the most recent available, was 8.1 per 100,000 population. This was a slight increase on the 2008 figure, and the second year in a row that there had been an increase in the rate, following falls in each of the previous three years (see Figure A.2).

Table A.1: Deaths (numbers) from Intentional Self-harm and Injury of Undetermined Intent by ten-year age band and sex, England 2009

	Under 10	10–19	20–29	30–39	40–49	50–59	60–69	70–79	80 and over	All ages
Female	0	36	147	159	240	189	135	74	83	**1,063**
Male	2	93	520	688	811	586	310	190	136	**3,336**
Total	**2**	**129**	**667**	**847**	**1,051**	**775**	**445**	**264**	**219**	**4,399**

Table A.2: Death rates (per 100,000 population) from Intentional Self-harm and Injury of Undetermined Intent by ten-year age band and sex, England 2009

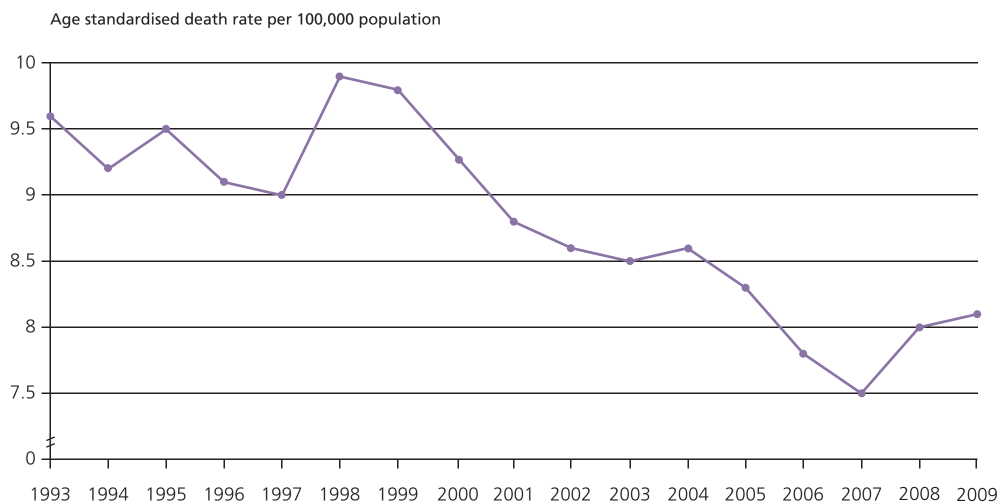
	Under 10	10–19	20–29	30–39	40–49	50–59	60–69	70–79	80 and over	All ages
Female	0	1.1	4.3	4.5	6.2	6.0	4.8	3.7	5.5	**3.8**
Male	0.1	2.8	14.4	19.7	21.3	19.1	11.7	11.1	15.6	**12.6**
Total	**0.0**	**2.0**	**9.4**	**12.1**	**13.7**	**12.5**	**8.1**	**7.1**	**9.1**	**8.1**

Source: ONS Mortality Registrations and Population Estimates

Figures A.3 and A.4 show these data in diagrammatic form.

Figure A.2: Suicide mortality – trend in single year rate

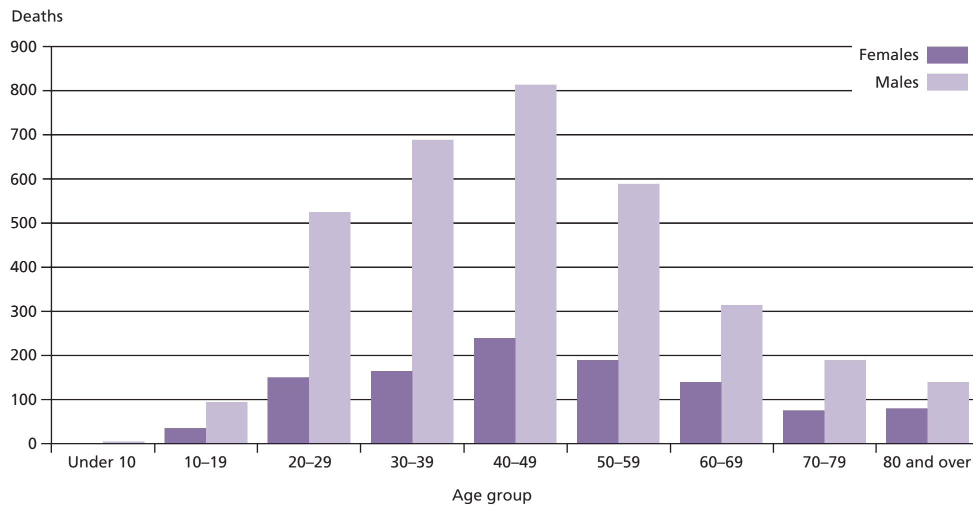
Death rates from Intentional Self-harm and Injury of Undetermined Intent excluding 'Verdict Pending' up to 2006, in England 1996-2009, all persons



Source: ONS Mortality statistics
(ICD9 E950-E959, plus E980-E989, excluding E988.8 (inquest adjourned); ICD10 X60-X84, Y10-Y34 excl. Y33.9 (Verdict Pending up to 2006 from 2007 Y33.9 no longer excluded))

The majority of suicides continue to occur in young adult males (see Table A.1 and Figure A.3) – that is, those aged under 50. In relation to women of the same age, men are more likely to take their own lives, but the difference varies by age. The peak difference is in the 30–39 age group where there are more than four male suicides for each female suicide. The average ratio between men and women of all ages is more than three male suicides to each female. Once people pass 50 years of age, the ratio is lower, with the lowest being 1.6 male suicides to each female suicide for those aged 80 and over.

Figure A.3: Deaths (numbers) from Intentional Self-harm and Injury of Undetermined Intent by ten-year age band and sex, England 2009

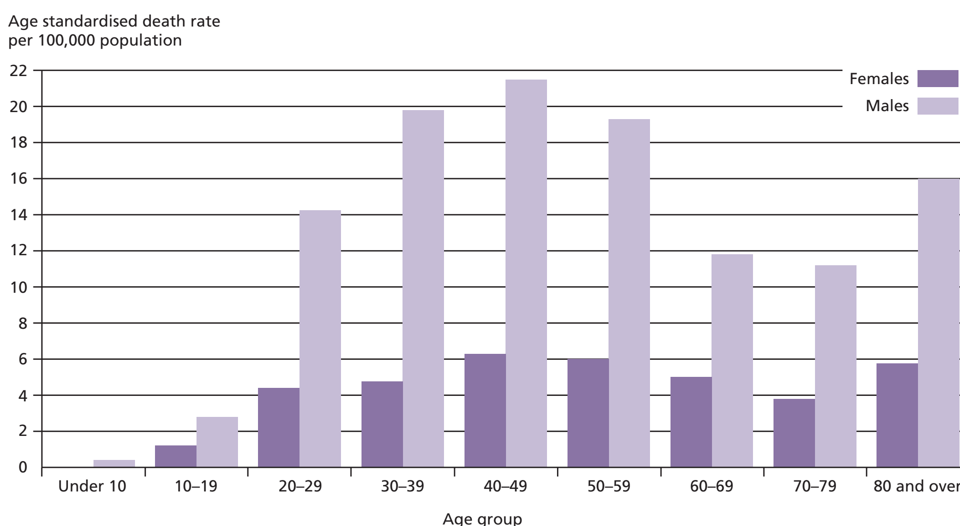


Source: ONS Mortality data

Figure A.4 below shows the death rate per 100,000 population by age and gender.

The difference between number of deaths (Figure A.3) and death rates (Figure A.4) shows up most in the 80+ age group, as the numbers are relatively small, but so is the population, so the rate per 100,000 population is relatively large, particularly for men.

Figure A.4: Death rates from Intentional Self-harm and Injury of Undetermined Intent by ten-year age band and sex, England 2009



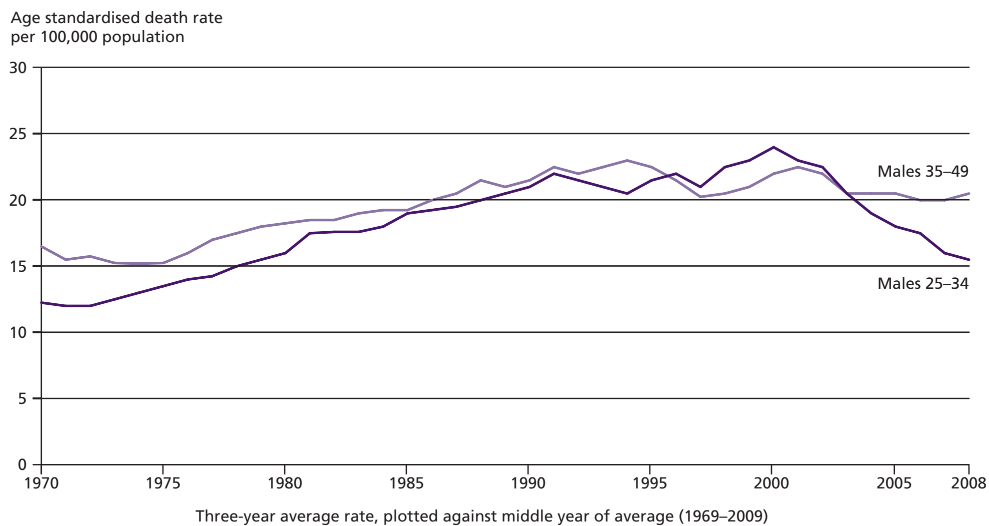
Source: ONS Mortality data

In the latter decades of the 20th century, suicide rates fell in older men and women but rose in young men. Up until a couple of years ago, there was evidence of a sustained fall in suicide among young men, although the rate remained high in comparison with the general population. However, in the most recent couple of years, this rate has risen slightly.

The suicide rate for men aged 35–49 rose gradually over the years 1970 to 1991 but in recent years this rate has levelled off (see Figure A.5 below). This age group had the highest death rates of all 15-year age bands in 2007–09.

Figure A.5: Trend in suicide rate for males (by selected age groups)

Death rates from Intentional Self-harm and Injury of Undetermined Intent, England



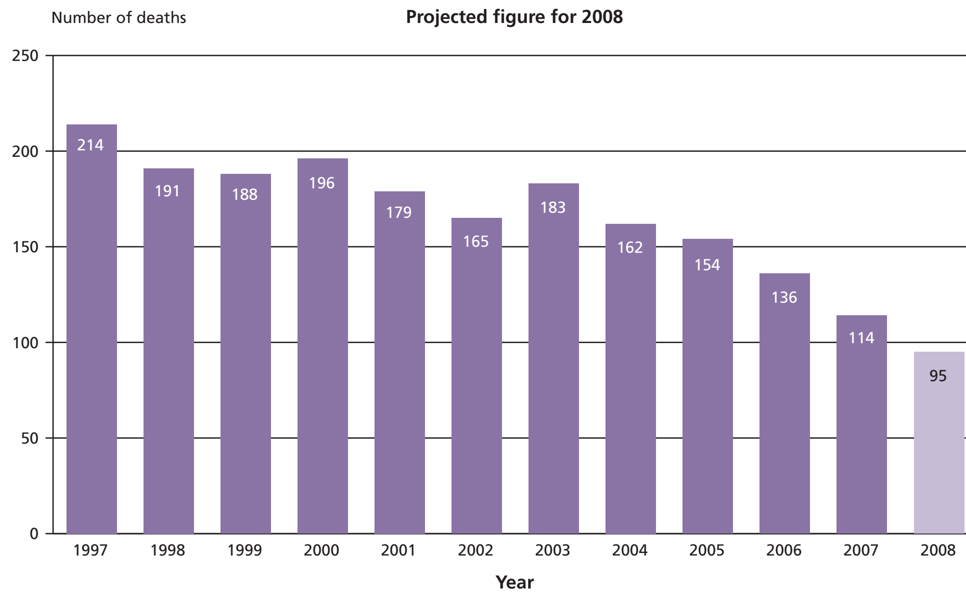
Rates are calculated using population estimates based on 2001 census.
Rates are calculated using the European Standard Population to take account of differences in age structure.
Years to 1998 and 2000 have been coded using ICD9; 1999 and 2001 onwards are coded using ICD10.

Source: ONS (ICD9 E950-E959, plus E980-E989, excluding E988.8 (inquest adjourned);
ICD10 X60-X84, Y10-Y34 excluding Y33.9 (verdict pending up to 2006 from 2007 Y33.9 no longer excluded))

The latest data, covering the calendar year 2008, show that the number of inpatients taking their own life in England has fallen from 214 in 1997 to 86 (projected) in 2008 (see Figure A.6 below).

Figure A.6: Inpatient suicides*

Persons (questionnaire), England, 1997–2008 (2008 = 89% complete)



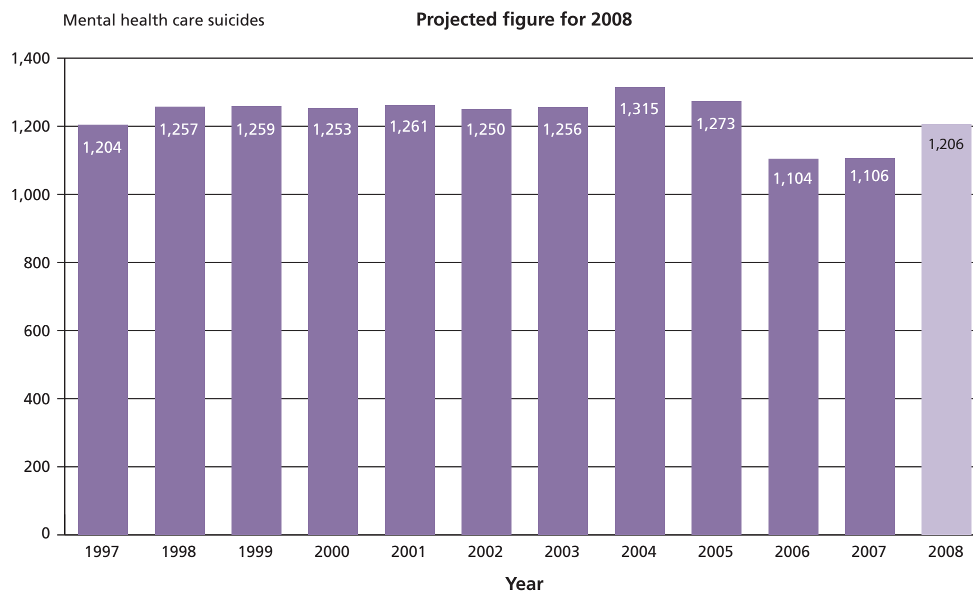
*Projected figures are shown to provide the most accurate number of cases expected for a given time period. Projected figures may vary annually according to changes in the baseline data.

Source: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, latest available data used. Inquiry started in April 1996 and first full year of data is 1997

Suicides by people in contact with mental health services in the year prior to death had decreased from a peak of 1,315 in 2004 to 1,104 in 2006. The 2007 figure and projected 2008 figure show a rise in such suicides. The projected figure is calculated from the proportion of questionnaires that have been returned on the number of cases identified in 2008 to date. The projected figure for 2008 is an estimate based upon the current 86% questionnaire response rate and will change as the questionnaire returns improve (see Figure A.7 below).

Figure A.7: Suicides by people in contact with mental health services (in 12 months prior to death)*

England, 1997–2008 (2008 = 86% completed, or 1,206 if projected)**

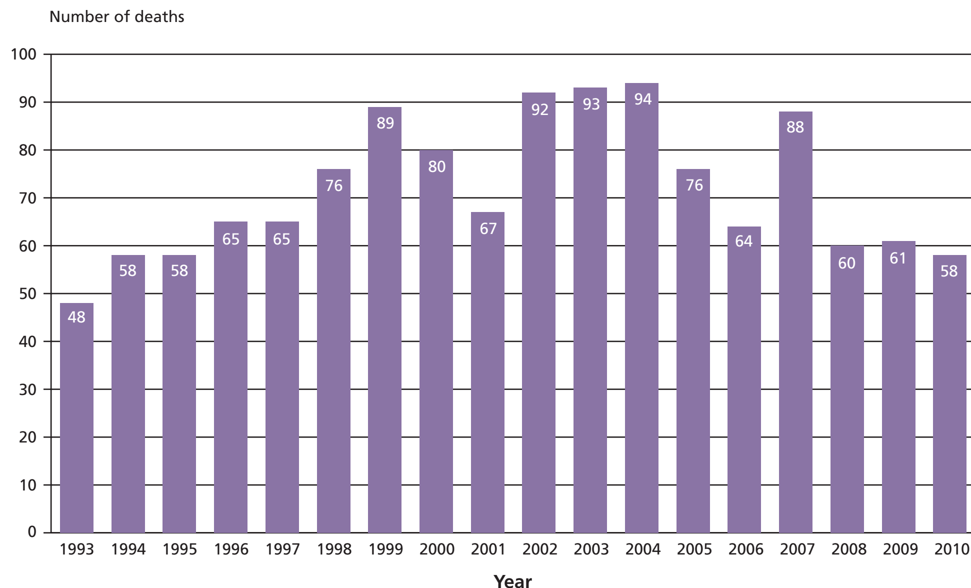


*Projected figures are shown to provide the most accurate number of cases expected for a given time period. Figures may vary annually according to changes in the baseline data.
**Projected figure.

Source: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, latest available data used. Inquiry started in April 1996 and first full year of data is 1997

Figure A.8 shows the number of self-inflicted deaths in English prisons for the years 1993 to 2010.

Figure A.8: Self-inflicted deaths in prison, England (calendar year)



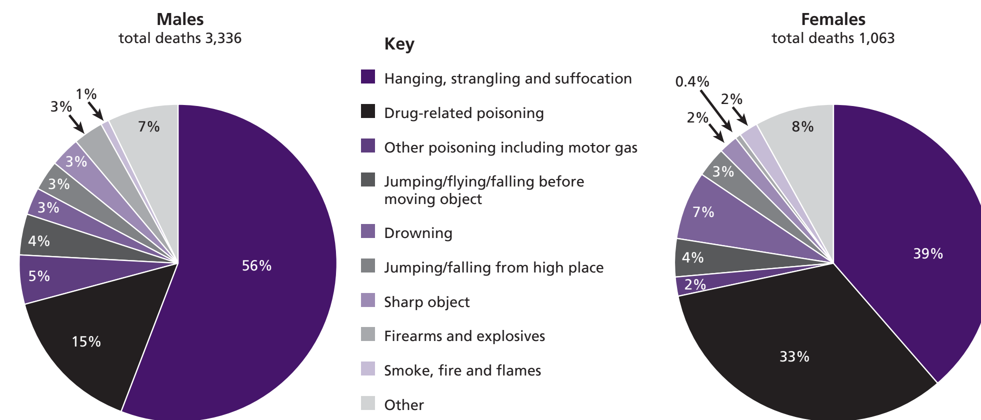
Historic figures are subject to minor changes when inquest verdicts differ from initial classification.

Source: HM Prison Service

National Offender Management Service (NOMS) statistics are based on deaths categorised as 'self-inflicted deaths'. This differs from the definition of 'suicide' quoted in the introduction. They do not only count the number of deaths that receive a 'suicide' or 'open' verdict at inquest, but also any death where it appears that the person may have acted specifically to take their own life. The classification used for apparent suicides is therefore much more inclusive than the definition used in community suicide statistics.

Among the general population, hanging, strangling and suffocation is still by far the most common method of suicide for men, accounting for more than half of all male suicide deaths. Among women, hanging, strangling and suffocation is also the most common method of suicide, with drug-related poisoning (the most common method until 2008) a close second (see Figure A.9 below).

Figure A.9: Deaths from suicide and undetermined injury by method and sex, England 2009

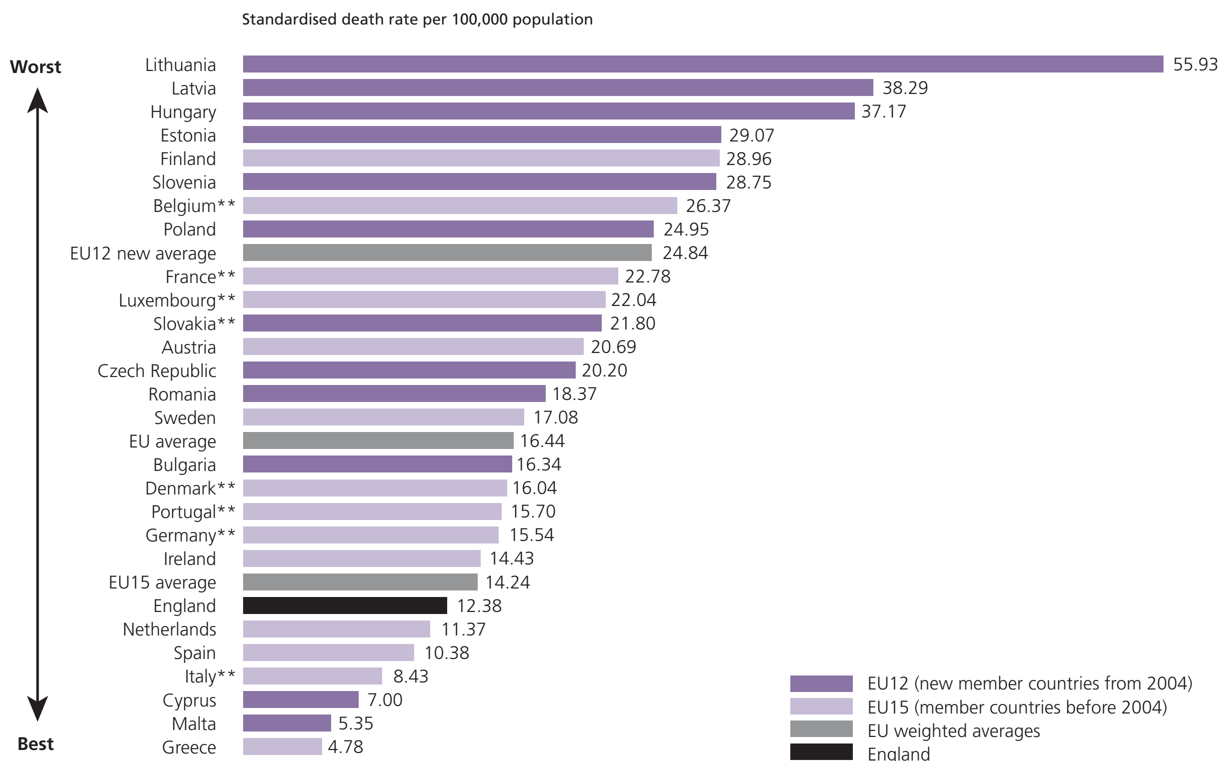


Source: Office for National Statistics

Suicide rates in England are among the lowest in the EU (see Figures A.10 and A.11 below). However, the figures use a restricted definition of suicide that does not include death from 'Injury of Undetermined Intent'. As research suggests that most of these deaths in England are also likely to be suicides, the inclusion of these in the definition could result in a deterioration in England's ranking.

Figure A.10: Male mortality from suicide*

All ages, England, EU countries and selected averages, latest data (2008**), ranked

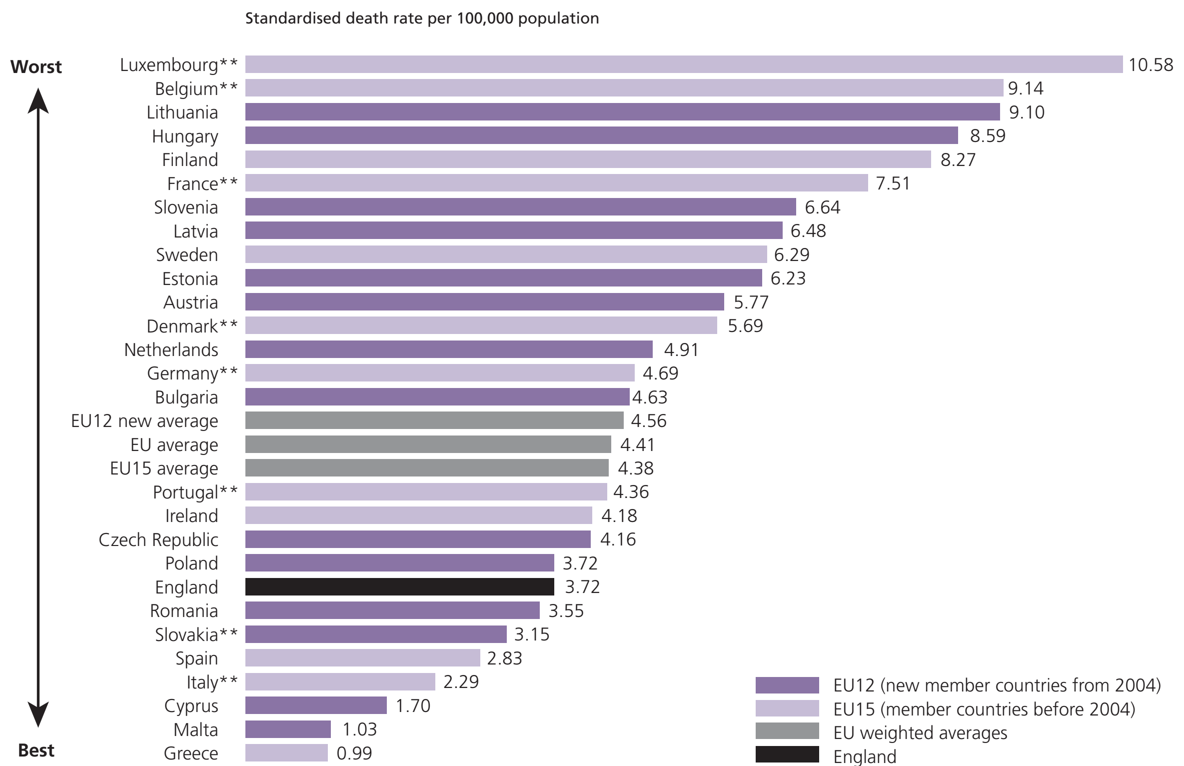


*A more restricted definition of 'suicide' than the one used to monitor the Public Service Agreement mortality target. This includes 'Injury of Undetermined Intent', which accounts for around a third of the target rate.
**Belgium, Portugal – 2004; Slovakia – 2005; Denmark, Germany – 2006; France, Italy and Luxembourg – 2007.

Source: WHO Health For All database

Figure A.11: Female mortality from suicide*

All ages, England, EU countries and selected averages, latest data (2008**), ranked



*A more restricted definition of 'suicide' than the one used to monitor the Public Service Agreement mortality target. This includes 'Injury of Undetermined Intent', which accounts for around a third of the target rate.
**Belgium, Portugal – 2004; Slovakia – 2005; Denmark, Germany – 2006; France, Italy and Luxembourg – 2007.

Source: WHO Health For All database

ANNEX B: INFORMATION FROM ENGAGEMENT WITH PROTECTED CHARACTERISTIC GROUPS

Equality workshop, 10 March 2011: Output from discussion groups

Discussion of at-risk groups

- General support for strategy direction and vulnerable groups selected, although noted that some were groups based on protected characteristics and others on risk factors.
- Urged consideration of combination of characteristics/risk factors. The vulnerable groups are not separate, there are many overlaps. Many of the vulnerable groups are disproportionately distributed across the high-risk groups and this should be considered in strategy. There are many similarities between groups, e.g. access to healthcare.
- Particular issues re stigma and discrimination in some communities.

Clearer recognition of problems for *transgender* community:

- Needs change to practice to improve medical care, e.g. including the use of hormone inhibitors which are used in US, but not available here.
- Improve experience and image of health services – make patient centred.
- Ensuring people receive the care they should would go a long way and needn't cost more – this could apply to others of our groups.
- Gender Identity Research and Education Society (GIRES) study funded by Home Office on prevalence of trans people in UK: www.gires.org.uk/assets/Medpro-Assets/GenderVarianceUK-report.pdf
- Equality and Human Rights Commission (EHRC) report on review of trans research: www.equalityhumanrights.com/uploaded_files/trans_research_review_rep27.pdf

Group diversity – recognise diversity of Black and minority ethnic (BME) groups; use Race Equality Foundation. Asylum seekers have specific and separate issues from BME groups.

Remember Gypsy/Traveller groups.

Lesbian, gay and bisexual (LGB) – PACE report was mentioned. Need to address the discrimination that people experience.

Veterans – not convinced that they are generally a group with higher risks. The exception is young leavers, who are unsupported (Army apparently gives transition support based on length of service). The early leavers are unlikely to have combat experience, and will be leaving because the armed forces are not for them. But

this is likely to be because of issues which will have made life generally more challenging for them (i.e. the problems pre-date joining forces, and probably account for their early departure).

Homeless – 'Hard to reach. Easy to ignore'. One in 100 suicide attempts at St Mungo's (their own data). At least mention in the strategy, to raise the profile in terms of service prioritisation. Compounded disadvantage experienced by homeless people makes it more difficult to access services.

Others thought to be vulnerable:

- Young carers
- Victims – effect of sustained bullying, crime, harassment – EHRC have been doing some work looking at this issue
- Carers – is there evidence from the carers' strategy?
- Socially isolated people
- Current armed forces (not just veterans).

Suggested actions/discussion points:

Better data collection

- Need for better monitoring of target groups to enable better outcome monitoring, e.g. sexual orientation. Need for coroners to collect the right information.
- Importance of research.
- Valuing qualitative information more.
- Could equality data come from other consulted sources following suicide, e.g. sexual orientation, religion/belief collated from primary care trusts (PCTs) or other services a person had been attending?
- Not just about better data collection, but how data are better used.
- Guidance on why equality data are collected – need to understand it's about assessing and not just stats – e.g. is someone's current mental distress related to stigma/harassment about their sexual orientation? Do they feel comfortable to raise this if services don't ask as part of assessment?
- Better understanding of underlying causes and awareness of risk factors – training etc. Identifying *causative factors* of suicide with actions that address these risk factors, and also *resilience factors* including mental health promotion.
- Support for specialist services and bilateral role to help better inform mainstream services (fear some expertise might be lost in funding cuts). Recognition that while there are people not using generic services there will be the need to fund specialist services.
- Ensure better engagement with at-risk groups – role of Equality Act and Public Sector Equality Duties could strengthen engagement.
- Joint Strategic Needs Assessment (JSNA) fundamental, and ought to pick up all the groups discussed – suggest that guidance on JSNA should refer to the suicide strategy.
- Central (targeted) funding streams for work with at-risk groups.

- Mainstream campaigns, e.g. Time to Change, extended to specifically target suicide prevention.
- Importance of targeted messages appropriate to different groups, not just generic messages and interventions.
- Emphasised point: importance of national interventions for smaller communities of interest – also ensuring 'local' does not just mean geographic locality but includes communities of interest which may be geographically disparate (e.g. trans, LGB).
- Services reflective of community need: example given of deaf community where deaf workers/signers are under-represented and targeted interventions non-existent.
- Initiatives to reduce stigma of identities, e.g. inclusive education – faith/belief, race, LGB, trans – recognise is a longer-term action but needs to be done to promote better understanding of difference.
- Better awareness of mechanisms of support to those suffering harassment/discrimination, e.g. support for those experiencing homophobic/transphobic bullying.
- Suggestion that services could be deemed non-compliant with equality legislation if they are not providing to all people – what compliance action can be taken? What are the mechanisms to challenge?
- Advocacy services.
- Prompt access to treatment pathways for high-risk and target groups, e.g. just commencing treatment for gender dysphoria can hugely alleviate mental distress felt prior to engagement with support services.
- Role of peer support groups – reducing isolation, promoting social engagement – very cost effective and often run by grass-roots level organisations.
- Sensitising providers in contact with people, e.g. Department for Work and Pensions, homelessness organisations, churches, criminal justice especially police, A&E, housing and revenues and benefits in local government.

Signposting

- For caseworkers – what next when you've identified someone who you think is vulnerable? What is the NHS Direct response to suicide calls?
- For general public – what to do if you're worried about someone you know? How to get the message out to the general public?
- Number of agencies have a role to improve mental health – refer back to mental health strategy.
- Use forthcoming publication of reviews of public mental health to push Directors of Public Health to address mental health.
- Monitoring attitudes of staff in organisations (if possible!), as these are so key to the experience people have when they try to access services.
- Survivors of abuse – implement recommendations of George Alberti's taskforce on violence against women and girls.
- Call to action – get organisations to buy into it, ask organisations what they are going to do in response to evidence.

- Noted that there may be common solutions for different groups.
- Importance of starting early, e.g. dealing with bullying in school.

Examples of specific interventions

MindOut (lesbian, gay, bisexual and transgender) specific peer support group for suicide prevention. By naming suicide in the group's title it made it instantly discussable by participants, whereas in other support groups raising suicidal feelings was often felt difficult. MindOut could provide further information on request.

The LGB wellbeing group in Manchester has been overwhelmed at times with people with suicidal ideation and self-harming.

In the North West there are particular issues around gay farmers and one man has set up a helpline to help them and been inundated with calls.

Organisations represented

Stonewall
Gender Identity Research and Education Society (GIRES)
St Mungo's
NHS Spiritual Care
Local Government Improvement and Development
Southall Black Sisters
MindOut
Afiya Trust
British Society for Mental Health and Deafness
The Lesbian and Gay Foundation, Manchester
Local Government Association
PACE
Irish Travellers Movement
National Suicide Prevention Strategy Advisory Group (NSPSAG)
National Mental Health Development Unit
Department of Health
Department for Education

ANNEX C: PROMPTS FOR LOCAL COUNCILLORS ON SUICIDE PREVENTION

A number of localities will be undergoing suicide prevention related activity at local and sub-regional level. To establish what is happening within the local authority boundary, the following questions may be useful in gathering information:

- What level of understanding of suicide do elected members of the council have?
- What is the rate of suicide among the general population in the local authority area?
- Is this rate higher or lower than the general population rate for England of 7.9 deaths per 100,000 population? What is the current trend in suicide rates showing?
- Is information available on the rate of suicide among different groups and gender, e.g. young men aged under 35?
- What steps have been taken locally to monitor and take action to reduce the rate of suicide within the local authority area? For example, is there a specific and agreed reduction in the rate of suicide that the local authority will aim to achieve?
- Is suicide prevention included in the JSNA?
- Is there a local group or network established to oversee suicide prevention activity in the locality?

If so:

- Who leads this group? Is it the PCT, local government, public health or joint arrangements?
- Is there an elected local authority member with specific responsibility for suicide prevention?
- What other local agencies and partners are members of this group or network?
- Does this involve GPs or other professionals working in primary care settings? If not, how do they input into activities or actions to prevent suicides locally?
- How do these groups or work link with wider local public health and health improvement activities?
- What governance arrangements are in place?
- Does the group or network undertake a local analysis of suicide data and/or participate in local suicide audits?
- Does this include the identification of particular high-risk groups?
- Does the group or network produce an action plan on local suicide prevention activity and is this monitored?

  - Does the action plan include the need to consider developing suicide prevention awareness and skills training for professionals in primary care and local government (housing, environmental health, social care, benefits, etc) and other services that may come into contact with individuals at risk of suicide? If so, what groups of front-line staff have had such training?
- Does the JSNA adequately identify action to support people at risk of suicide or suicidal behaviour within the local population?
- Has the local authority or other agency identified any specific locations which provide opportunities for suicide and/or where suicides/attempted suicides have occurred?
- What steps have been considered or taken to reduce the risk of suicide at such locations?
- What other agencies are involved in supporting this preventative action at high-risk places?
- Does the local coroner's office support preventative action at local level?

  If so:
  - Are coroners formal members of the group or network?
  - Do they provide access to coroners' records of inquests for local analysis or audit purposes?
  - Do they involve or inform the local authority or Director of Public Health if they identify (at inquest proceedings or earlier) particular areas of concern, e.g. locations used for suicide, possible clusters of suicide, increase in a particular method or new and emerging method of suicide?
- What support is available within the local authority area for those affected by a suicide? What agencies provide this support?
- Are any data collected on attempted suicides within the local authority area? If so, by whom? Are these data shared with other agencies?

ANNEX D: GLOSSARY

Commissioning:	The process of assessing the needs of a local population and putting in place services to meet those needs.
Deliberate self-harm:	See self-harm.
Clinical commissioning groups:	Groups of GPs that, in partnership with other healthcare professionals, will in future lead the commissioning of most healthcare services across England. Clinical commissioning groups are to be statutory bodies accountable for commissioning.
Mental health problems:	The phrase 'mental health problem' is used in this strategy as an umbrella term to describe the full range of diagnosable mental illnesses and disorders, including personality disorder. Mental health problems may be more or less common, may be acute or longer lasting and may vary in severity. They manifest themselves in different ways at different ages and may (for example, in children and young people) present as behavioural problems. Some people object to the use of terms such as 'mental health problems' on the grounds that they medicalise ways of thinking and feeling and do not acknowledge the many factors that can prevent people from reaching their potential. We recognise these concerns and the stigma attached to mental ill health; however, there is no universally acceptable terminology that we can use as an alternative.
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness:	A research project largely funded by the National Patient Safety Agency. Other funders are the Scottish Government and the Northern Ireland Department of Health, Social Services and Public Safety.
National Institute for Health and Clinical Excellence:	An independent organisation that provides advice and guidelines on the cost and effectiveness of drugs and treatments.
NHS Commissioning Board:	A proposed new body that will have powers devolved to it directly from the Secretary of State for Health. It will be responsible for allocating and accounting for NHS resources and for supporting clinical commissioning groups and holding them to account in terms of outcomes, financial performance, and fairness and transparency in the performance of their functions.

Protected characteristics:	Characteristics against which the Equality Act 2010 prohibits discrimination, including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
Self-harm:	The various methods by which people deliberately harm themselves, including cutting and self-poisoning.
Self-inflicted deaths:	This term is used when it appears that a prisoner has acted specifically to take their own life, i.e. before a coroner's verdict.
Self-injury:	See self-harm.
Suicidal ideation or behaviour:	Thoughts or actions of engaging in suicide-related behaviour.
Suicide:	A deliberate act that intentionally ends one's life.

ANNEX E: REFERENCES

1 Office for National Statistics and Department of Health (2010) *DH Mortality Monitoring Bulletin (Life expectancy, all-age-all-cause mortality, and mortality from selected causes, overall and inequalities)*, available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_120638

2 Gunnell D, Lopatatzidis A, Dorling D et al. (1999) Suicide and unemployment in young people. Analysis of trends in England and Wales, 1921–1995. *British Journal of Psychiatry* 175: 263–270.

3 www.nrls.npsa.nhs.uk/resources/collections/never-events/

4 Hawton K, Bergen H, Casey D et al. (2007) Self-harm in England: a tale of three cities. Multicentre study of self-harm. *Social Psychiatry and Psychiatric Epidemiology* 42: 513–521.

5 Bergen H, Hawton K, Waters K et al. (2010) Epidemiology and trends in non-fatal self-harm in three centres in England, 2000 to 2007. *British Journal of Psychiatry* 197: 493–498.

6 Hawton K, Rodham K, Evans E and Weatherall R (2002) Deliberate self-harm in adolescents: self report survey in schools in England. *British Medical Journal* 325: 1207–1211; Owens D, Horrocks J, House A (2002) Fatal and non-fatal repetition of self-harm. Systematic review. *British Journal of Psychiatry* 181:193–199; Cooper J, Kapur N, Webb R et al. (2005) Suicide after deliberate self-harm: a 4-year cohort study. *American Journal of Psychiatry* 162: 297–303.

7 Zahl D and Hawton K (2004) Repetition of deliberate self-harm and subsequent suicide risk: long-term follow-up study in 11,583 patients. *British Journal of Psychiatry* 185: 70–75.

8 Runeson B, Tidemalm D, Dahlin M et al. (2010) Method of attempted suicide as predictor of subsequent successful suicide: national long term cohort study. *British Medical Journal* 341: c3222.

9 Hawton K, Rodham K, Evans E and Weatherall R (2002) Deliberate self-harm in adolescents: self report survey in schools in England. *British Medical Journal* 325: 1207–1211.

10 Taylor T, Hawton K, Fortune S and Kapur N (2009) Attitudes towards clinical services among self-harm patients: a systematic review. *British Journal of Psychiatry* 194(2): 104–110.

11 Bennewith O, Gunnell D, Peters TJ et al. (2004) Variations in the hospital management of self-harm in adults in England: observational study. *British Medical Journal* 328: 1108–1109.

12 Taylor T, Hawton K, Fortune S and Kapur N (2009) Attitudes towards clinical services among self-harm patients: a systematic review. *British Journal of Psychiatry* 194(2): 104–110.

13 Kapur N, Murphy E, Cooper J et al. (2008) Psychosocial assessment following self-harm: results from the Multi-Centre Monitoring of Self-Harm Project. *Journal of Affective Disorders* 106(3): 285–293; Gunnell D, Bennewith O, Peters TJ et al. (2002) Do patients who self-harm consult their General Practitioner soon after hospital discharge? A cohort study. *Social Psychiatry and Psychiatric Epidemiology* 37: 599–602.

14 Bennewith O, Stocks N, Gunnell D et al. (2002) General practice based intervention to prevent repeat episodes of deliberate self harm: cluster randomised controlled trial. *British Medical Journal* 324(7348): 1254–1257.

15 Hawton K, Bergen H, Casey D et al. (2007) Self-harm in England: a tale of three cities. Multicentre study of self-harm. *Social Psychiatry and Psychiatric Epidemiology* 42: 513–521; Bergen H, Hawton K, Waters K et al. (2010) Epidemiology and trends in non-fatal self-harm in three centres in England, 2000 to 2007. *British Journal of Psychiatry* 197: 493–498.

16 Shaw J, Baker D, Hunt IM et al. (2004) Suicide by prisoners: National clinical survey *British Journal of Psychiatry* 184: 263–267.

17 The relevant Prison Service Order (PSO 2700) is available at: http://pso.hmprisonservice.gov.uk/pso2700/PSO%202700_-_front_index_and_PSO_itself.htm

18 Biddle L, Donovan J, Sharp D and Gunnell D (2007) Explaining non-help-seeking amongst young adults with mental distress: a dynamic interpretive model of illness behaviour. *Sociology of Health and Illness* 29: 983–1002.

19 Meltzer H, Brock A, Griffiths C et al. (2006) Patterns of suicide by occupation in England and Wales: 2001–2005. *British Journal of Psychiatry* 193: 73–76.

20 Hawton K, Rodham K, Evans E and Weatherall R (2002) Deliberate self-harm in adolescents: self report survey in schools in England. *British Medical Journal* 325: 1207–1211.

21 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, available at: www.medicine.manchester.ac.uk/mentalhealth/research/suicide/prevention/nci

22 Department of Health, Department for Children, Schools and Families, Ministry of Justice and Home Office (2009) *Healthy Children, Safer Communities – A strategy to promote the health and well-being of children and young people in contact with the youth justice system*, available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109771

23 Kapur N, While D, Blatchley N et al. (2009) Suicide after leaving the UK armed forces – a cohort study. *PLoS Medicine* 6(3): e26.

24 http://cebmh.warne.ox.ac.uk/csr

25 Gunnell D, Platt S and Hawton K (2009) The economic crisis and suicide *British Medical Journal*, 338: b1891.

26 Weaver T, Charles V, Madden P and Renton A (2002) *A Study of the Prevalence and Management of Co-Morbidity amongst Adult Substance Misuse & Mental Health Treatment Populations*. Research report submitted to the Department of Health, available at: http://dmri.lshtm.ac.uk/docs/weaver_es.pdf; Singleton N, Farrell M and Meltzer H (1999) *Substance Misuse among Prisoners in England and Wales*. London: Office for National Statistics.

27 Gossop M, Marsden J, Stewart D et al (1998) Substance use, health and social problems of service users at 54 drug treatment agencies. Intake data from the National Treatment Outcome Research Study. *British Journal of Psychiatry*, 173: 166–171.

28 King M, Semlyen J, See Tai S et al. (2008) *Mental Disorders, Suicide and Deliberate Self-Harm in Lesbian, Gay and Bisexual People*. London: National Mental Health Development Unit.

29 Mathy RM, Cochran SD, Olsen J et al. (2009) The association between relationship markers of sexual orientation and suicide: Denmark, 1990–2001. *Social Psychiatry Psychiatric Epidemiology* 46(2): 111–117.

30 Care Quality Commission and National Mental Health Development Unit (2011) *Count Me In 2010*, available at: www.cqc.org.uk/_db/_documents/Count_me_in_2010_FINAL_(tagged).pdf

31 Walker MR (2008) *Suicide Among the Irish Traveller Community 2000-2006*. Wicklow, Ireland: Wicklow County Council.

32 Office for National Statistics (2008) *Health Statistics Quarterly No 37*, available at: www.statistics.gov.uk/downloads/theme_health/HSQ37.pdf

33 McLean J, Maxwell M, Platt S et al. (2008) *Risk and Protective Factors for Suicide and Suicidal Behaviour: A literature review*. Scottish Government Social Research, available at: www.scotland.gov.uk/Resource/Doc/251539/0073687.pdf

34 Gavin NI, Gaynes BN, Lohr KN et al. (2005) Perinatal depression: a systematic review of prevalence and incidence. *Obstetrics and Gynaecology* 106: 1071–1083.

35 Ermisch J (2003) *Does a 'Teen Birth' have Longer Term Impacts on the Mother? Suggestive evidence from the British Household Panel Study*. ISER Working Paper 2003-32. Colchester: Institute for Social and Economic Research.

36 Florentine JB and Crane C (2010) Suicide prevention by limiting access to methods: a review of theory and practice. *Social Science & Medicine* 70(10): 1626–1632; Mann JJ, Apter A, Bertolote J et al. (2005) Suicide prevention strategies: a systematic review. *JAMA: The Journal of the American Medical Association* 294(16):2064–2074.

37 Gunnell D, Bennewith O, Hawton K et al. (2005) The epidemiology and management of suicide by hanging: a review. *International Journal of Epidemiology* 34: 433–442.

38 Biddle L, Donovan J, Owen-Smith A et al. (2010) A qualitative study of factors influencing the decision to use hanging as a method of suicide. *British Journal of Psychiatry* 197: 320–325.

39 Hawton K, Bergen H, Simkin S et al. (2009) Effect of withdrawal of co-proxamol on prescribing and deaths from drug poisoning in England and Wales: time series analysis. *British Medical Journal* 338: b2270.

40 Hawton K, Simkin S, Deeks J et al. (2004) UK legislation on analgesic packs: before and after study of long term effect on poisonings. *British Medical Journal* 329: 1076–1079.

41 Bennewith O, Nowers M and Gunnell D (2007) The effect of the barriers on the Clifton suspension bridge, England on local patterns of suicide: implications for prevention. *British Journal of Psychiatry* 190: 266–267.

42 Qin P, Agerbo E and Mortenson PB (2002) Suicide risk in relation to family history of completed suicide and psychiatric disorders: a nested case-control study based on longitudinal registers. *Lancet* 360: 1126–1130.

43 Beautrais AL (2004) *Suicide Postvention: Support for families, whānau and significant others after a suicide*. *A literature review and synthesis of evidence*. Wellington, New Zealand: Ministry of Youth Affairs; de Groot MH, de Keijser J and Neeleman J (2006) Grief shortly after suicide and natural death: a comparative study among spouses and first-degree relatives. *Suicide and Life-Threatening Behavior* 36: 418–431.

44 de Groot M, de Keijser J, Neeleman J et al. (2007) Cognitive behaviour therapy to prevent complicated grief among relatives and spouses bereaved by suicide: cluster randomised controlled trial. *British Medical Journal* 334(7601): 994.

45 McDaid C, Trowman R, Golder S et al. (2008) Interventions for people bereaved through suicide: systematic review. *British Journal of Psychiatry* 193: 438–443.

46 Hawton K, Sutton L, Simkin S et al. (2010) *Evaluation of* Help is at Hand*: A resource for people bereaved by suicide and other sudden, traumatic death*. Oxford: University of Oxford, available at: www.psych.ox.ac.uk/csr/EvaluationReport.pdf

47 Blood RW and Pirkis J (2001) *Suicide and the Media: A critical review*. Canberra, Australia: Commonwealth Department of Health and Aged Care, available at: www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/doha-suicide-media-1; Barbour V, Clark J, Peiperl L et al. (2009) Media portrayals of suicide. *PLoS Medicine* 6(3): e51.

48 Biddle L, Donovan J, Hawton K et al. (2008) Suicide and the internet. *British Medical Journal* 336: 800–802.

49 www.justice.gov.uk/publications/coroners-justice-act-encouraging-assisting-suicide.htm

50 Hawton K, Bergen H, Casey D et al. (2007) Self-harm in England: a tale of three cities. Multicentre study of self-harm. *Social Psychiatry and Psychiatric Epidemiology* 42: 513–521;

Bergen H, Hawton K, Waters K et al. (2010) Epidemiology and trends in non-fatal self-harm in three centres in England, 2000 to 2007. *British Journal of Psychiatry* 197: 493–498.

51 Brandon M, Bailey S and Belderson P (2010) *Building on the Learning from Serious Case Reviews: A two-year analysis of child protection database notifications 2007-2009*. Research Report DFE-RR040. London: Department for Education, available at: www.education.gov.uk/publications/eOrderingDownload/DFE-RR040.pdf; Brandon M, Belderson P, Warren C et al. (2008) *Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we learn? A biennial analysis of serious case reviews 2003–2005*. Research Report DCSF-RR023. London: Department for Children, Schools and Families, available at: www.education.gov.uk/publications/eOrderingDownload/DCSF-RR023.pdf

52 Department for Education (2010) *Preventable Child Deaths in England: Year Ending 31 March 2010*. Statistical Release, available at: www.education.gov.uk/rsgateway/DB/STR/d000943/index.shtml

53 Cook L and Hill C (2011) Narrative verdicts and their impact on mortality statistics in England and Wales. *Health Statistics Quarterly* 49: 81–100, available at: www.statistics.gov.uk/cci/article.asp?ID=2645&Pos=1&ColRank=1&Rank=1

ANNEX F: THE CONSULTATION PROCESS

This consultation will begin on 19 July 2011 and will run until 11 October 2011, and we welcome all comments on the contents of the consultation document.

How to respond

There are different ways to comment. You can:

- use the online questionnaire at: www.consultations.dh.gov.uk/;
- email your completed questionnaire to: suicideprevention@dh.gsi.gov.uk; or
- post your completed questionnaire to:
  Suicide Prevention Consultation
  Mental Health and Disability Division
  216 Wellington House
  133–155 Waterloo Road
  London SE1 8UG

Your views will be fed into the process of preparing the final document.

Extra copies

This document is available online at: www.dh.gov.uk/

Easy read and translated versions of this consultation document are available from the above address.

Criteria for consultation

This consultation follows the Government's *Code of Practice on Consultation*. In particular, we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible;
- be clear about the consultation process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure that the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure that consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation; and
- ensure that officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the code of practice is at: www.bis.gov.uk/policies/better-regulation/consultation-guidance

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Co-ordinator
Department of Health
3E48, Quarry House
Leeds LS2 7UE

Email: consultations.co-ordinator@dh.gsi.gov.uk

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter: www.dh.gov.uk/en/FreedomOfInformation/DH_088010

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, among other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at: www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm

ANNEX G: CONSULTATION REPLY FORM

Please reply to as many of these questions as possible. We encourage responses from anyone interested in the issues raised in this document.

We would find it particularly helpful for you to refer to any research or evaluation evidence that supports your views. We would also like to hear more about proven measures in place in your local area which bring measurable benefits to your own community.

If you need more room to answer any of the following questions, please continue on a separate sheet, clearly marking the question number.

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

1. In your view, are there any additional measures or approaches to reduce suicide in the high-risk groups that should be considered for inclusion? What evidence can you offer for their effectiveness?

2. In your view, are there any other specific occupational groups that should be included in this section? If so, what are the reasons for inclusion?

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

3. In your view, are the most appropriate groups considered, including any groups where there are issues relating to equality?

4. In your view, are there any additional measures or approaches to reduce suicide in the identified groups that should be considered for inclusion? What evidence can you offer for their effectiveness?

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

5. In your view, are there any additional means of suicide that should be considered?

6. What additional actions would you like to see taken to reduce people's access to the means of suicide? What evidence can you offer for their effectiveness?

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

7. What additional measures would you like to see to support those bereaved or affected by suicide? Please comment on how this help could be provided effectively, and appropriately funded.

8. What additional information or approaches would you like to see provided to support families, friends and colleagues who are concerned about someone who may be at risk of suicide? Please comment on how this help could be provided effectively, and appropriately funded.

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

9. In your view, are there any additional measures or approaches that could promote the responsible reporting and portrayal of suicide and suicidal behaviour in the media?

10. In your view, are there additional approaches that could be considered for the internet industry in England to maximise the positive potential of the internet to reach out to vulnerable individuals?

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

11. Is there additional information available that could be collected at a national and local level to support the suicide prevention strategy?

12. In your view, where are the gaps in current knowledge of the most effective ways of preventing suicide?

Making it happen locally and nationally

13. Are there examples of local good practice that could be disseminated to other areas?

14. What other local and national approaches could be developed to ensure the implementation of the strategy?

15. What issues should the Department of Health be considering as we develop any potential indicators in the Public Health Outcomes Framework that are relevant to suicide prevention?

Impact assessment

The following questions relate to the consultation impact assessment alongside the draft strategy.

16. What approaches would you suggest to measure progress against the objective to provide better support for those bereaved or affected by suicide?

17. Do you have any comments and evidence on the costs and benefits of targeting suicide prevention training at groups other than GPs?

18. Are you able to offer any evidence on the number of public sites in England frequently used as locations for suicide?

Any other comments

19. Is there any other information or comment you wish to add?

You do not have to complete the sections about your personal background if you prefer not to. However, the information is confidential and will only be used to assess whether the responses we receive represent a balanced cross-section of views from across society.

Name:

If you are responding on behalf of an organisation or interest group, please indicate the name of the organisation or group:

Your role within the organisation or group:

Gender

☐ Female ☐ Male ☐ Transgendered ☐ Rather not say

How old are you?

☐ Under 18 ☐ 18–24 ☐ 25–34 ☐ 35–54

☐ Over 55 ☐ Rather not say

Ethnicity:

- [ ] White – British
- [ ] White – Irish
- [ ] White – Other
- [ ] Mixed – White and Black Caribbean
- [ ] Mixed – White and Black African
- [ ] Mixed – White and Asian
- [ ] Mixed – Other
- [ ] Asian/Asian British – Indian
- [ ] Asian/Asian British – Pakistani
- [ ] Asian/Asian British – Bangladeshi
- [ ] Asian/Asian British – Other
- [ ] Black/Black British – Caribbean
- [ ] Black/Black British – African
- [ ] Black/Black British – Other
- [ ] Chinese
- [ ] Other

Other: please specify below

Do you consider yourself as a person with a disability?

- [ ] Yes
- [ ] No

If yes, please specify

Would you say that you have experienced mental health problems, either recently or in the past?

- [ ] Yes
- [ ] No

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