HM Government

Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives

Published 27 March 2021

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Ministerial Foreword - Minister for Patient Safety, Suicide Prevention and Mental Health

Each and every suicide is a tragedy, which causes devastating and permanent impacts on families, friends and broader communities. It is estimated that annually 800,000 people across the world die by suicide, with 5,316 people sadly taking their life in England in 2019. It is of the utmost importance that we do all we can to reduce this number as far as possible, so that fewer people die by suicide. But it is also of the utmost importance that when, tragically, somebody does end their life by suicide their family, friends and broader community who have been bereaved have whatever support they need in place to manage their loss. And this is what we are striving towards.

In my role as Minister for Suicide Prevention, I have met many courageous and inspiring people who have tragically been directly impacted by the suicide of somebody close to them. From each, I have heard a personal and heart-breaking story. And every time, it serves as a reminder of the significant amount of work we need to do so that as few people as possible end their life by suicide.

Since the previous progress report was published, we have continued to see a change to trends in suicide rates. Sadly, following several years of decline, the number of suicides registered in England increased in 2018 and 2019. Whilst it is too early to provide absolute figures for 2020, early indications from real time surveillance of a subset of local areas have not shown a rise in the number of suicides when comparing pre- and post-lockdown periods from January to August 2020.

However, we recognise that the past year has been incredibly tough for us all. COVID-19 has had a significant impact on everybody's daily lives as Government, including Public Health England, local public health teams, and the NHS, have taken the steps necessary to manage the outbreak. There is light at the end of the tunnel, and we have a pathway out of the pandemic. But we completely recognise the impact this year has had on some people's mental health and wellbeing. Our voluntary sector partners regularly inform us about the increase in people who have been seeking support. We also recognise the longer-term impacts that the pandemic may have, particularly on the economy and employment, that may act as a driver of mental ill health.

That is why we are doing all we can to ensure that support is available to all who need it. Within the Long Term Plan for the NHS, we reaffirmed the NHS's commitment to make suicide prevention a priority over the next decade, implementing a new Safety Improvement Programme across all mental health trusts, and setting out important measures to improve crisis care services. We have ensured that every local area has a robust all-age multi-agency suicide prevention plan in place, and I am grateful to local councils for their continued dedication on suicide prevention and to prevent and mitigate some of the most pressing impacts of COVID-19 on their local communities' mental health and wellbeing. All areas of the country will receive investment in their services, by

2023 to 2024, to further support local suicide prevention plans and establish suicide bereavement support services and I am pleased to see the progress in these services being established. These ambitions in the NHS Long Term Plan were supported by £2.3 billion of funding for mental health, with £57 million of this allocated specifically for suicide prevention and suicide bereavement.

This year, the NHS will also receive around an additional £500 million to address waiting times for mental health services, give more people the mental health support they need, and invest in the NHS workforce. Further detail on this spend is provided in the Mental Health Recovery Action Plan, published alongside this report. This wider spend on mental health will support us in our work to prevent suicides, by supporting people at risk of self-harm or suicide and to help prevent people from experiencing a crisis or suicidal thoughts.

However, and as part of this, we also recognise the pressures that our suicide prevention voluntary sector partners have faced during the pandemic, with many more people seeking help and support compared to previous years. This support is, and will continue to be, crucial, and it is important they are able to continue providing this support to anybody who requires it. We are therefore making £5 million available, specifically to support suicide prevention voluntary and community sector organisations in 2021 to 2022. As part of this funding, a grant fund will be available to help ensure that the financial gaps incurred as a result of these additional pressures are covered. Further details on the application process for the grant fund will be published shortly.

But funding alone will not deliver what we need. We also need a cross-system, collective approach to suicide prevention, with a single agreed strategy that will drive progress across all sectors of national government, local government and the voluntary sector, to reduce suicides. The annex to this report therefore includes a refreshed Cross-Government Suicide Prevention Workplan which commits us all to actions on suicide prevention, with clear responsibilities, deliverables and timescales.

So much has been done, but there remains much, much more to do, which we will be taking forward with our partners as a priority. It is vital that the data and evidence we have is timely and accurate - and work is proceeding at pace to embed a national, real-time suicide surveillance system that will provide us with the tools to identify and implement targeted support to reduce suicide numbers. Whilst high-quality, timely data is crucial, we will also ensure that we do not lose sight of the value of personal experiences, local intelligence, information and evidence from our delivery and voluntary partners.

It is also crucial that we fully tackle harmful online material that may encourage or incite self-harm or suicide. We have a Strategic Partnership in place with Samaritans and technology companies, which is adding to our understanding of what makes content harmful, and to whom. This will help to improve companies' safety policies, better identify and remove harmful content and improve support available. But we can go much further, as was set out in the Government Response to the Online Harms White Paper, to keep

people safe. Self-harm is a key workstream within the suicide prevention strategy and will remain a focus in its own right.

These are just two of multiple actions we will collectively be taking, which this report and workplan sets out. I commit to you that we will keep driving this forward, progressing this work, and implementing this agenda, as a priority, so that fewer people die by suicide, and fewer people are tragically bereaved.

Nadine Dorries MP
Minister for Patient Safety, Suicide Prevention and Mental Health

Foreword - Chair of the National Suicide Prevention Strategy Advisory Group

The last year in suicide prevention, like so much else, has been dominated by COVID-19. As the pandemic escalated, it was clear that there were potential risks to mental health - from anxiety, isolation, loss of support and disruption to care. Leaders in suicide prevention came together to consider what would be needed. They came from charities, universities, the NHS, public health – national and local - and central Government. Their contribution, their willingness to go the extra mile at a time of emergency, has been outstanding and I want to thank them for what they have done. The resulting response has several elements and follows the structure of the National Suicide Prevention Strategy - we did not start with a blank page. We identified potential groups at risk, including children and young people and those with mental health conditions. We fed into broader discussions of mental well-being and economic stresses. Information is vital: we brought together "real-time surveillance" of suicide from around the country to give an immediate picture. Samaritans continued to work with the media on sensitive reporting.

The suicide prevention task of 2020, however, did not start with COVID-19. There were already concerns about the rising rate in 2018 and 2019. Suicide in the under 20s has seen increases for a decade. The high rates in middle age and after self-harm are national priorities.

COVID-19 has exposed fault lines in society where risk of suicide is also found - inequalities based on deprivation, ethnicity, disability and stigma. The restrictions that were necessary to tackle the pandemic have brought their own risks, especially for young people whose education and opportunities have been curtailed.

The early evidence on suicide has not found a rise despite the undoubted distress reported in surveys and by charities. But we are still mid-pandemic, and this could change. Some groups or areas may be more at risk - after all, COVID-19 itself has not played out equally across communities.

Why have we seen no suicide rise in this country - and in several others? Perhaps the explanation is social cohesion, mutual support, a sense of getting through it together. Perhaps friends and families have rallied around those who are vulnerable. Perhaps the pandemic brought out the best in us.

Now we are approaching the second year and there are signs of an end in sight. As people put their lives back together, as they return to work and school, there will be new pressures. We will need economic protections, the best mental health care and sense of optimism and wellbeing. Mental health will be key to how society recovers.

Professor Louis Appleby CBE

Introduction: Suicide prevention during COVID-19

The last year has brought incredible challenges and change to each of our lives, with disruptions to our way of living and day to day life. Whilst for some people, this change has been manageable, many other people have reported feelings of worry, anxiety, frustration and loneliness – enhanced by the uncertainty that an unprecedented global pandemic brings.

Throughout, it has been our priority to ensure that people receive the support they need to manage and improve their mental health, including in circumstances where people are experiencing a crisis or suicidal thoughts. The National Suicide Prevention Strategy has been vital in shaping our response to the impact of the pandemic, helping to identify at-risk groups and develop targeted actions. The Government - both national and local - the NHS and our delivery partners – including all of the voluntary organisations up and down the country, who have done so much – have been working tirelessly to deliver this.

Importantly, mental health services for all ages have remained open throughout the pandemic and plans for 24/7 all-age open access crisis services were accelerated so that anybody requiring urgent support could access those services rapidly. The delivery of services has been swiftly amended and improved to enable continuation of care, with many services embedding digital and remote working to assess people as they are referred, in the safest way possible.

The availability of NHS services has also been promoted through the "Help Us Help You" campaign and by signposting to other sources of advice and support. Other campaigns, such as the Better Health - Every Mind Matters campaign from Public Health England (PHE), have promoted ways in which people can look after their own mental health. It is also vital that whenever people are seeking support, this support is available from whichever organisations the individual feels most comfortable. Often, this is the voluntary organisations who provide invaluable support, including running helplines and crisis lines that help any person who needs support, at any time. As part of the COVID-19 response, DHSC has provided over £10 million of funding to mental health and bereavement charities, to ensure that this support is available for anybody who is in need, at any given time. As set out in the ministerial foreword, this will be supplemented by an additional £5 million, to be made available specifically to support suicide prevention voluntary and community sector organisations in 2021-22, with part of this set as a grant fund to help ensure that the financial gaps incurred as a result of additional pressures during COVID-19, are covered. This £5 million is part of the broader £500 million package- further detail on the breakdown of this spend can be found in the ‘COVID-19 Mental Health and Wellbeing Recovery Action Plan’.

COVID-19 has brought different challenges for different groups of the population, and targeted actions and support have been important in helping people to manage this. For example, due to the pandemic, education and employment opportunities have changed, and many young people have reported feeling overwhelmed with the pressure to maintain the high standards of their work whilst adapting to a new way of learning and working, which could lead to mental ill health. As such, there has been an increased focus on the promotion of multi-agency care planning, with NHSE/I working with key children and young people mental health stakeholders, in both the NHS and local authorities, to embed this and increase awareness and accessibility of services in supporting children and young people, including those with additional vulnerabilities. NHSE/I, Public Health England and Government have also been working on the Wellbeing for Education Return programme and dedicated webinars, to support staff in schools and further education colleges to help the children, young people and families, and their own staff, to recognise and manage their understandable feelings of anxiety. Targeted actions such as this will continue to be crucial as we move forwards.

Many of these actions and commitments are contained within the Suicide Prevention Cross-Government Workplan in Annex A and Annex B, which will form the foundation for future policy development and delivery over the coming months and years. In addition to this, and alongside the Progress Report, we have also published the 'COVID-19 Mental Health and Wellbeing Recovery Action Plan', which sets out a broader plan to prevent, mitigate and respond to the mental health impacts of the pandemic during 2021 to 2022. Many of the actions and commitments captured within the Recovery Action Plan will also support people at risk of self-harm or suicide and help to prevent people from experiencing a crisis or suicidal thoughts. It is therefore important that the Recovery Action Plan is read together with this Progress Report, in order to see the breadth of commitments in place that Government and its partners will take forward.

Aside from the pandemic, much has happened and changed since the previous progress report was published. Between 2014 and 2017, there was a steady decline in the number of registered suicide deaths in England, with 2017 seeing the lowest number of deaths since 2010. Sadly, the number of registered suicide deaths increased in both 2018 and 2019. Given delays to coroners' inquests, we do not yet have a complete picture for 2020, but early indications from real time surveillance of a subset of local areas do not suggest a rise in the average number of suicides when comparing pre- and post-lockdown figures, for January to August 2020. It is, however, likely that the pandemic will have enduring effects on the general population, the economy, and vulnerable groups, and it is crucial that we acknowledge and tackle this, doing all we can to support individuals at every stage.

Therefore, we must continue driving forward this agenda to minimise the devastating impact of suicide as far as we possibly can. The National Suicide Prevention Strategy (2012) for England – a document that evolves as new challenges appear – is integral to that, and it is vital that we continue to measure and monitor progress against

implementation, and set out ambitious actions that will tackle these challenges as they arise.

This report, the fifth of its kind, will explore this, setting out the data and evidence, together with the personal stories and experiences that guide us. Crucially, it will also set out progress against existing commitments, and set out our new commitments and priorities.

1. Understanding recent trends in suicide rates (2016-19)

1.1 The Five-Year Forward View for Mental Health set a national ambition in 2016 to reduce suicides by 10 percent (equivalent to 482 suicides) by 2020 to 2021. Following years of increasing suicide rates between 2007 and 2014, this was a significant ambition, announced to focus national and local efforts across Government and communities to reverse the worrying upward trend in suicides.

1.2 The COVID-19 pandemic has had a significant impact on the recording of suicides by coroners due to delays to inquests, for example those caused by the service adapting to social distancing measures. This makes measuring progress towards the original ambition very difficult to judge as previous pre-pandemic data is no longer comparable.

1.3 Since the percentage reduction ambition was set in 2016, there have been significant changes to trends in suicide rates. Between 2014 and 2017, there was a steady decline in the number of registered suicide deaths in England, with 2017 seeing the lowest number of registered suicide deaths since 2010. Sadly, 2018 and 2019 saw increases in the number of registered suicides, with the suicide rate in 2019 being 10.8 per 100,000 people - a statistically significant increase compared to the 2016 rate of 9.5 per 100,000 people. These changes are highlighted in the graphs below.

1.4 These increases have been noticeable amongst both males and females, with a statistically significant increase in the number of suicide death registrations in England in 2019, compared to 2017. Among males, the rate of registered suicides in 2019 in England (16.7 deaths per 100,000 males) was 19.3% higher than the rate observed before the increase started in 2017 (14.0 deaths per 100,000). Among females, the rate in 2019 (5.2 deaths per 100,000 females) was 13.0% higher than the rate in 2017 (4.6 deaths per 100,000).

Table 1: Number of suicide deaths registered in England

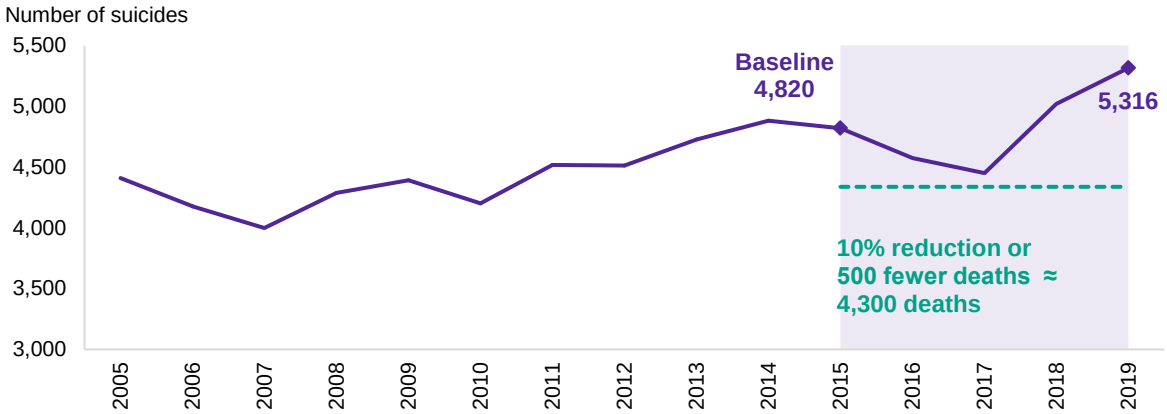
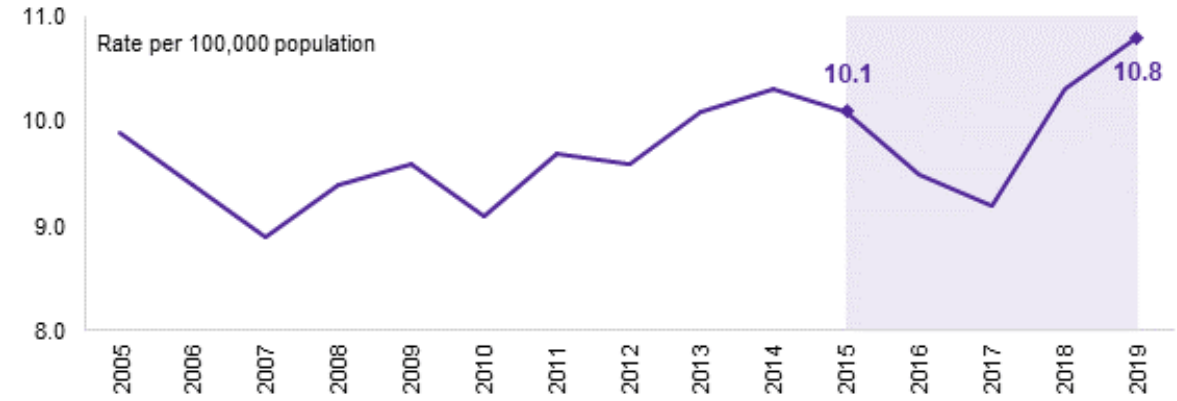


Table 2: Age-standardised rate for registered suicide deaths in England

(To note, the number of registered suicide deaths, rather than the age standardised rate, is used to monitor the reduction target outlined above)



Suicide registrations: In line with other mortality statistics, the ONS report data based on deaths registered in a particular year, rather than those occurring each year. There is a median lag of 6 months between suicide death registration and suicide death occurrence.

Statistical significance: When we conclude that the differences between two data samples are statistically significant, this means that we can say with a reasonable degree of confidence (usually 95% certainty) that the observed differences are not due to random variation. Conversely, when we do not identify any differences as being statistically significant, it means we do not have sufficient data to detect a difference. It does not mean that we are confident that no difference exists. In this report, where we have stated a difference in figures, all differences are statistically significant unless otherwise stated.

Changes to the suicide rate

1.5 For the latest year of complete data available from the Office for National Statistics (ONS), 2019, the suicide rate was significantly higher for registered deaths when compared with previous rates between 2014 and 2017. The latest annual data for 2019 showed there were 5,316 registered deaths in England.

1.6 Unlike other statistics on suicide based on the date of death registration, the following section explores deaths based on the date the death occurred, to understand the context at the exact time of these cases, with particular reference to the rise in suicide rate seen in 2018.

Changes to the standard of proof for registering suicides

1.7 In England and Wales, all unnatural deaths are investigated by coroners to establish the cause and circumstances of the death. The investigation, known as an inquest, compiles evidence such as the post-mortem, toxicology reports, and interviews with relatives and friends. Once all the available evidence has been collected, a coroner will then determine the cause of death, manner of death and surrounding circumstances.

1.8 In July 2018, the standard of proof used by coroners to determine whether a death was caused by suicide, changed. Previously, the “criminal standard” was applied, meaning that the coroner required evidence “beyond all reasonable doubt” that a death was caused by suicide. Since July 2018, the “civil standard” has been applied meaning that it must be shown on the “balance of probability” that a death was caused by suicide.

1.9 The ONS carried out an investigation into the impact of the change of standard of proof used by coroners for suicide death registrations in England and Wales. This was published in December 2020.

1.10 In summary, this investigation found that the legal change did not result in any significant change in the reported suicide rate in England and Wales- recently observed increases in suicide among males and females in England, and females in Wales, began before the standard of proof was lowered.

1.11 Given this finding, the factors behind increasing suicide rates are likely to be more complex, and beyond the legal change. Further monitoring is needed to determine the impact of the legal change compared with other influences.

Demographic factors

PLEASE NOTE: The final paragraphs of this chapter discuss changes to the reported method of suicide which may contain triggering language.

1.12 Between 2016 and 2018 in England, the male suicide rate increased significantly by 8.2% (from 14.7 to 15.9 deaths per 100,000 males), and the female rate increased by 8.9% (from 4.5 to 4.9 deaths per 100,000 females).

1.13 Age is also an important factor for understanding changes in the recent rates of suicide; in England and for at least a decade, people aged 10 to 24 years, and men aged 45 to 64 years have seen the greatest increases in suicide rates.

1.14 The proportion of suicides caused by hanging, strangulation, and suffocation in England and Wales is the highest it has been in almost 20 years, accounting for 57.6% (3,148 deaths) of all suicides in 2018. Higher suicide rates in 2018 coincide with more deaths from hanging. In England 2,830 people died by hanging (intentional or undetermined) in 2018, which is 11% higher than the average in each of the previous six years (2,549 deaths per year).

1.15 Young people, particularly women aged 10 to 24 years, have seen clear upward trends in the proportion of deaths caused by hanging in both England and Wales. In England in 2018, hangings accounted for 60.9% of all suicides - up from around 57.7% four years earlier in 2014. Increases of hanging among young people seem to coincide with increases in their rates of suicide.

1.16 2018 also saw an increase in the number of deaths caused by cutting with a sharp object in England. However, this finding is based on a relatively smaller number of deaths, so must be treated with caution. The number of deaths from poisoning, the other main cause of suicide after hanging, generally remained unchanged in 2018 when compared to recent years. Work is ongoing across Government to identify and tackle emerging methods of suicide. Further details are discussed in Chapter 4 (and Annex B).

1.17 To summarise, when looking at data by quarter and month in 2018, patterns in England are irregularly high compared to previous years. The data confirm that there have been meaningful increases among men and among young people, particularly women. The higher number of deaths seen in 2018 seem to be partly attributable to higher numbers of people dying from hanging (either intentional or undetermined intent)- with hangings increasing the most among young people.

1.18 There are many complex factors driving suicide rates and the reasons for the change seen in the national rate of suicide cannot be attributed to one factor alone.

2 Pre-pandemic suicide risk factors in vulnerable groups

2.1 The following four groups were previously agreed as particular groups we need to prioritise to reduce suicides as far as possible. Concern has grown for children and young people as the numbers of suicides have risen. Individuals who are middle-aged (particularly men), those who have previously self-harmed, and those with mental illness are not only at high risk for self-harm and suicide but also make up a large proportion of completed suicides. It is therefore important that we prioritise these groups in particular to reduce suicide as far as possible. The following section sets out pre-pandemic data trends for each of these groups and highlights the existing concerns.

Middle-aged men

2.2 In both men and women, around 40% of suicides are by people in their 40s and 50s. In 2019, 2,132 deaths were registered as suicide for middle-aged people- with this particularly pronounced for males (1,626 males and 506 females). As well as these high numbers, middle-aged men also have the highest rates of suicides.

2.3 The most recent ONS report for deaths registered in 2019 (which does not cover the period of the pandemic) shows that the group with the highest rate of suicide is men aged 45 to 49 years. The rate of suicide registrations in men aged 45 to 64 years also increased for 2018 and 2019.

People who self-harm

2.4 Each year, there are an estimated 200,000 hospital attendances for self-harm[1], and evidence suggests that around 50% of people who die by suicide have previously self-harmed.

2.5 This risk of suicide is particularly heightened in the first year after self-harm, especially the first month. It is important to note that the majority of self-harm occurs in the community and does not lead to hospital attendance- skewing the figures set out above. Rates of self-harm in the community have risen since 2000, especially in young people.[2]

Children and young people

2.6 Suicide in people under the age of 25, is also rising. In 2019 there were 565 suicides registered in this age group - one of the largest rises of the last decade. A study of suicide in children and young people in the UK by the National Confidential

Inquiry into Suicide and Safety in Mental Health (NCISH) identified antecedents such as bullying, internet use and bereavement.[3]

2.7 Outside of the pandemic, rates of suicide and self-harm in 10 to 24-year olds in England have been steadily increasing over the last decade. These increases are steepest in females, amongst whom suicide rates have doubled since 2011, although their rates still remain half of those seen in males.

2.8 There is also data reporting similar increases in Australia, Canada and the USA. Recent analysis of trends in 11 high income countries found associations between rises in the national suicide rate, and levels of income inequality and high GDP.[4] There is speculation that factors such as greater academic pressures, increasing social media use, rising rates of family instability, growing concerns about the environment, and drug dependence may contribute, but evidence on these drivers is limited. Building an evidence base to support understanding of these factors is a key priority for the sector moving forward - as is set out in the workplan in Annex A and Annex B.

People with a mental illness

2.9 There is approximately a 10-fold increase in risk of suicide for people under mental health care for mental illness. In England, there are between 1200 and 1300 patient suicides per year. However, the rate (taking into account the rising number of people under mental health care) has been falling, as has the rate in inpatient settings.[5]

Exacerbation of risk factors

2.10 We are concerned that the pre-existing risks for these four groups, as set out above, are being exacerbated as a result of the pandemic and its associated impacts.

2.11 These are unprecedented times. The mental health effects of the COVID-19 pandemic may be profound and there are suggestions that suicide rates will rise over the long term, though this is not inevitable. Suicide is likely to become a more pressing concern as the pandemic has longer-term effects on the general population, the economy and vulnerable groups.

2.12 It is emerging that there are two categories of vulnerable individuals in the context of COVID-19 – those for whom the pandemic has exacerbated existing problems, and those for whom the pandemic has resulted in significant and specific new issues, that we know are potential drivers of suicide. For example, job loss, unmanageable or mounting debts as a result of reduced income, bereavement and loneliness or social isolation.

3 Exacerbation of risk factors during the COVID-19 pandemic

3.1 Despite concerns about a steep rise in suicide during the pandemic, the most up-to-date research we have, covering a subset of the population only, indicates that there hasn't been an escalation in suicide figures. Importantly, this also tallies with international data, which can provide us with some confidence that this subset is currently accurate. However, we absolutely recognise that continued vigilance and targeted actions are vital, as previous experiences suggest that post-lockdown periods may be particularly challenging times for vulnerable individuals.

3.2 The following section sets out what we know about data during the pandemic through academic research, regular data collection, and trends noted by our voluntary, community and social enterprise (VCSE) partners.

Data during the pandemic

3.3 The latest data published by the ONS (provisional quarterly data for 2020) cannot be used to show the number of suicides with a date of death in 2020, including those that occurred during the COVID-19 pandemic. This is because there is a delay of around 6 months between a death occurring, and that death being registered as a suicide by a coroner. Only around seven in ten (68.6%) of the suicides registered to the end of September 2020 had a date of death that was also in 2020.

Real-time suicide surveillance (RTSS)

3.4 Public Health England (PHE) are piloting real-time suicide surveillance by collecting early real-time data on suspected suicides and using this to identify patterns of risk and causal factors to inform national and local responses. This will now be rolled out nationally, enabling more timely data flow and earlier interventions.

The development of RTSS

PHE have formed a National Working Group which draws upon expertise from DHSC, NHSE/I, emergency services, local government and the third sector in order to generate and oversee a national Real Time Suicide Surveillance (RTSS) system. Seed funding has been secured to assist all local areas in the establishment of real time data this year. This will significantly improve suicide monitoring, strengthen policy and investment planning, and enable more timely responses and actions. Importantly, RTSS will also facilitate the provision of bereavement support for those impacted by suicide in all local areas, as set out in the NHS Long Term Plan.

3.5 Early indications from RTSS of a subset of local areas have not shown a significant rise in average number of suicides when comparing pre- and post-lockdown periods. The study carried out by the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) research group represents a population coverage of 9 million people. It is recognised that these are provisional figures and further monitoring is essential.

Public health and international intelligence

3.6 It is vital that we have accurate data, evidence and intelligence on the impact on people's mental health and suicide risk. Public health intelligence on the impact of the pandemic (on suicidal behaviour, high risk groups, and prevention approaches) is being monitored daily through an ongoing "Living Review" of emerging findings on suicidal behaviour in relation to COVID-19,[6] and through collaborative links with 39 countries worldwide via the International COVID-19 Suicide Prevention Research Collaboration[7]. Early indications from the first six months of the pandemic are that suicide rates in other high-income countries have not risen. However, there are early signals from Japan of an adverse impact of a pandemic-related recession on suicide rates. The overall picture is complex, and effects are likely to differ within countries and across communities.[8]

Building data and evidence - the work of the Multicentre Study of Self-Harm

The Multicentre Study of Self-Harm was founded nearly 20 years ago to provide ongoing information, evidence and data on important aspects of self-harm. Using reliable and representative data from well-established general hospital self-harm monitoring systems in Oxford, Manchester and Derby, the Multicentre conduct studies on the epidemiology, causes, clinical management, trends and prevention of self-harm. This research greatly contributes to the National Suicide Prevention Strategy, as well as national and local initiatives that reduce self-harm and suicide as far as possible.

Experiences of the VCS sector

3.7 Throughout the pandemic, the VCS sector has played a vital role in supporting people with their mental health, including people who are experiencing a crisis or suicidal thoughts. This section explores some of their experiences throughout the pandemic, and what they have seen.

3.8 Mental health services across all ages evolved rapidly in the early phase of the pandemic - particularly in delivery of care. There was often a move from face to face to online and telephone delivery of care.[9] In some services and population groups,

there was evidence of reduced help seeking and service users reporting difficulty accessing help.[10]

3.9 Throughout, voluntary and community sector organisations have demonstrated significant flexibility by shifting their ways of working to accommodate individuals in need of support throughout the pandemic. Cross-organisation working also widened this support, for example NHS and community volunteers were signposted to free, online prevention training and awareness resources, such as those provided by the Zero Suicide Alliance (ZSA), PAPYRUS, Samaritans and STORM.

3.10 Partners in the voluntary sector have described an increase in the volume of calls from people seeking support during the pandemic. Samaritans have provided emotional support over 1.7m times in the nine months since the restrictions began (April 2020-December 2020). Similarly, PAPYRUS (the national charity for the Prevention of Young Suicide) has seen a 20% increase in contacts from young people aged between 11 and 25 since the start of the pandemic restrictions. Approximately 60% of these contacts identify as female.

3.11 A nine month study by the Mental Health Foundation questioned UK adults at regular intervals since the lockdown started in March 2020. It found that reports of having had suicidal thoughts and feelings within the previous two weeks, as a result of the pandemic, increased from 8 per cent of those surveyed in April to 13 per cent in November. Self-reported suicidal ideation, feelings of hopelessness and self-harm reflected rises in demand as seen across the voluntary sector, indicating the need for proactive measures to address suicide risk.

Innovative practice - adapting support and services during COVID-19 (Redcar and Cleveland Mind - the HEROES project)

Given the national lockdown meant that face to face support was withdrawn, Redcar and Cleveland Mind were finding it increasingly difficult to identify and support people that were on the verge of crisis. To mitigate this, the charity decided to innovate to ensure that people on the verge of crisis were identified and supported. They approached volunteer groups set up to provide assistance to neighbours during the pandemic and teamed up with other voluntary sector partners to create the HEROES project. Using funding from the Emergency COVID Fund and the Lottery, the charity developed training for COVID Response Volunteers who had been helping doing shopping and collecting prescriptions, to also look out for the signs of distress in their neighbours. Redcar and Cleveland Mind also delivered Zoom training for volunteers from Guisborough Bridge Association and East Cleveland Good Neighbours, in how to have positive “over the garden wall” conversations, and what to do when they come across someone that they think might be at risk. This has enabled earlier identification and more timely support, and has also helped to reduce the number of referrals, as the volunteers are able to directly promote a number of wellbeing activities to help the people they come across.

Impacts of the pandemic on groups with existing risk factors

Middle-aged men

3.12 There is little data on suicide or self-harm for those in mid-life since the onset of the pandemic. Population survey data suggest that since March, 3-4% of adults aged 30 to 59 years in the UK have reported self-harm in the previous week, with no evidence so far of a consistent trend.

3.13 Men in mid-life may be particularly vulnerable to the effect of economic adversity, with an increase in self-harm and suicide in this group particularly apparent after the 2008 recession. As part of the NHSE/I Suicide Prevention programme, all areas are asked to focus on middle-aged men as part of their multi-agency plans.

3.14 Data provided by the Samaritans suggests that during the pandemic, volunteers provided support over 700,000 times to men over the nine months since the social distancing restrictions began (April 2020 to December 2020). Three themes were identified as the key drivers, including loneliness or social isolation, concerns about the financial and economic future, and strain on existing relationships. Indeed, 30% of men raised concerns about loneliness or social isolation, compared to 26.5% the previous year, whilst multiple men also talked about feelings of fear and uncertainty about the future. In particular, losing their standard of living, a fear of loss of employment, or losing their business for those men who are self-employed.

People who self-harm

3.15 Data from two centres in the Multicentre Study of Self-harm in England (Oxford and Derby) showed a 30% decline in adults assessed in hospitals following self-harm, during the three months following the introduction of lockdown in England on 23 March 2020. This is compared with the previous weeks in 2020 and the same period in 2019. This decline was greater in females than males and occurred across all age groups.

3.16 This pattern was similar to that reported from other hospitals and other countries[11] and consistent with trends in self-harm in primary care. This is likely due to changes in help-seeking behaviour as opposed to a change in underlying epidemiology. By October, following a subsequent increase, assessment figures for adults returned to near the same level as the equivalent period in 2019. Similar figures were seen in children and adolescents, although numbers rose in August, likely coinciding with the return to schools.

3.17 Since the first lockdown, clinicians in Oxford and Derby have been recording whether COVID-19 (and the consequent public health measures) have had an influence on individuals' self-harm. During the first three months following lockdown, COVID-19 was recorded as a factor in nearly half (46.9%) of adult self-harm presentations. This was more frequent in females than males.

Children and young people

3.18 The National Child Mortality Database (NCMD) funded by NHSE/I, collects data from all 58 Child Death Overview Panels which review the deaths of all children aged under 18 years in England. With the arrival of COVID-19, NHSE/I commissioned the NCMD to provide regular reports on children and young people's (CYP) deaths and their cause.

3.19 During the first 56 days of lockdown, the NCMD saw multiple deaths from suicide, but with small numbers and significant fluctuation, it was difficult to tell whether there was a significant difference from pre-pandemic times. NHSE/I alerted clinicians and services to this possible increase, including potential risks for those with Autism Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD). In subsequent months, the incidence of suicide returned to pre-pandemic levels. Trends remain under regular review and the NCMD team are updating previous reviews of child suicides in 2021.

3.20 Amongst the likely suicide deaths reported after lockdown, restriction to education and other activities, disruption to care and support services, tensions at home and isolation were found to be potentially contributing factors. A recent UK-wide study of nearly 500 suicide deaths in young people aged 10-19 years, reported antecedents such as witnessing domestic violence, bullying, self-harm, bereavement (including by suicide) and academic pressures. Overall, 60% of those young people who died by suicide, had been in contact with specialist children's services.

3.21 Due to the pandemic, education and employment opportunities have changed over the past year, and many young people have reported feeling overwhelmed with the pressure to maintain the high standards of their work whilst adapting to a new way of learning and working. For those coming out of education in particular, the prospects of finding a job and long-term employment have been identified as a particular risk factor. Actions contained within the workplan seek to manage this.

Mental illness

3.22 Mental ill health has often been the most common concern among callers during the nine months of restrictions, affecting 47% of callers to Samaritans. Samaritans has provided emotional support to people concerned about their mental health 818,958 times over the 9 months since restrictions began, a 3% increase compared to the same period in 2020. Exacerbation of pre-existing mental health conditions and a lack of access to mental health support to address this, was also frequently raised, with these concerns often intensifying throughout the pandemic.

3.23 In summary, COVID-19 may have exacerbated existing issues or contributed to the development of new mental health problems across the risk groups of middle-aged men, those who self-harm, children and young people and those with mental illness.

By continuing to address the challenges across these areas we can respond proactively to changes in suicide risks and the impact of COVID-19.

3.24 Further actions specific to these vulnerable groups are highlighted in the cross-Government suicide prevention workplan in Annex A and B of this document.

4 Addressing the added impact of the COVID-19 pandemic on suicide and self-harm risk

4.1 In the context of COVID-19 – and given the broader societal challenges that a global pandemic brings – policies and interventions to prevent suicide and self-harm as far as possible have been a priority. To develop these, data, evidence, and information from all of our partners has been key, and there has been much research conducted (as set out in the previous chapter) which has helped to form national policy and interventions. Some of the key actions taken, and which will continue, are described below. This chapter refers to actions which have a direct impact on suicide and self-harm.

Addressing immediate risks of suicide and self-harm

4.2 Comprehensive responses to challenges should be informed by enhanced surveillance of COVID-19 related risk factors that contribute to suicidal behaviours. As described above, PHE are now collecting real-time data on suicide, and as part of the Spending Review settlement, PHE received £1.2 million for 2021 to 2022 to support roll-out of a national real-time suicide surveillance system. When rolled out fully, this will allow for more timely intervention, both nationally and locally, and help to save lives.

4.3 It is also important that we identify trends in methods of suicides as quickly as possible and put in place interventions to rapidly tackle any emerging methods identified. A process has been established with partners and across Government to rapidly signpost emerging methods and take actions through a multi-agency approach. This includes, but is not limited to, limiting access to the method, reducing or removing promotional material, and providing clearer warnings of risk.

4.4 People bereaved by suicide face emotionally complex grief, and a journey through the inquest process, which has been significantly disrupted by the pandemic. The roll-out of the NHSE/I Implementation Programme to offer support to a family within 72 hours of a death in every area of England by 2024 has continued this year. The Support after Suicide Partnership is supporting services across the country and has also provided the public with information and signposting throughout the pandemic.

4.5 The COVID-19 pandemic has also shone a spotlight on the increasing risks posed by harmful activity and content online. As set out in the Full Government Response to the Online Harms White Paper, during the course of the pandemic we have seen a spike in disinformation, misinformation and harmful content, and some people have taken advantage of this uncertainty to incite fear.

4.6 This is unacceptable, and we are working across Government, and with stakeholders, to tackle this. The Online Harms White Paper sets out a range of legislative and non-legislative measures detailing how the Government will tackle online harms, including establishing in law a new duty of care towards users, which will be overseen by an independent regulator. Companies will be held to account for tackling a comprehensive set of online harms, ranging from illegal activity and content, to behaviours which are harmful but not necessarily illegal. The Government has also set out an intention to develop a new criminal offence on incitement of self-harm online, subject to ongoing work by the Law Commission, with recommendations expected later in 2021.

4.7 We also recognise the impact the pandemic may have had on people's mental health and wellbeing. To combat this, PHE has launched psychological first aid training to help support people with the emotional impact of COVID-19, and has also relaunched the Every Mind Matters campaign to support people to take action to look after their mental health and wellbeing and help support others, such as family and friends.

4.8 It is also vital that we ensure that suicide prevention training is available to everybody, and simultaneously raise awareness of the support that is available, so that as many people as possible understand where support is available and feel able to access and signpost to it whenever they need. Doing this will ensure that people are equipped to recognise possible signs of suicidality and gain the skills to save a life. A range of suicide prevention awareness training options are available, which provide a better understanding of the signs to look out for and the skills required to approach someone who is struggling- and Government frontline workers and volunteers in particular are encouraged to complete one of the available suicide prevention awareness training options. These include from the Zero Suicide Alliance (ZSA), Samaritans, PAPYRUS, and STORM.

4.9 We have also continued work to address concerns raised by stakeholders about the promotion and embedding of the Information Sharing and Suicide Prevention Consensus Statement, which was issued by DHSC in conjunction with other partners in 2014. Through its contract with DHSC, the ZSA is developing guidance for frontline staff on how to use the Consensus Statement, which aims to support staff regarding when and how to share information about patients where this may help prevent suicide. Alongside the development of this supporting guidance, the Consensus Statement itself is also undergoing minor amendments to reflect the current legal position, following implementation of the GDPR, and amendments to the Mental Capacity Act.

4.10 We recognise the important role that the VCS sector plays in our response to supporting people's wellbeing during and following the pandemic. To this end, the Government has supported the VCS sector through £750 million in funding over the past year to ensure that key organisations can continue their vital work supporting

the country during the pandemic, including £200 million for the Coronavirus Community Support Fund. The Government donated a further £1 million to ITV's national Help our Helplines campaign. Samaritans and Campaign Against Living Miserably (CALM) received over £1 million to increase capacity for helpline and webchat services to help meet increased demand for services. Suicide prevention charities also produced specially curated COVID-19 website content and webinars for staff and volunteers to enable sharing of best practice across the sector.

4.11 As already outlined, we are also working to help ensure the sustainability of the suicide prevention voluntary, community and social enterprise sector and, in line with this, £5 million will be made available to support suicide prevention voluntary and community sector organisations in 2021 to 2022. The government recognises that COVID-19 has significantly increased the pressures on these organisations, with many more people seeking help and support compared to previous years. This support is, and will continue to be, crucial, and it is important they are able to continue providing this support to anybody who requires it. As part of this funding, a grant fund will be available to help ensure that the financial gaps incurred as a result of these additional pressures are covered. Further details on the application process for the grant fund will be published shortly.

4.12 Local councils have continued to lead on local multi-agency suicide prevention work throughout the pandemic – a vital contribution in our efforts to reach the two thirds of people who take their own life and that aren't in contact with mental health services. Local councils have also played an important role alongside partners in preventing and mitigating the impacts of COVID-19 on their local communities' mental health and wellbeing, all of which contributes to wider suicide prevention measures.

4.13 It is vital that we ensure the perspectives of people with lived experience form a core part of our response. In 2020, the National Suicide Prevention Alliance (NSPA) established a 'lived experience' network with the aim of informing local and national response to COVID-19 and suicide prevention. This comprises an online panel of people with diverse lived experience who can provide input via online surveys and polls, and a smaller group of carefully trained and supported individuals who can join focus groups, review documents and policies and join strategic groups and conversations. Moving forwards, DHSC, along with its partners, will make use of this valuable resource, to ensure policy development and implementation is shaped by people with lived experience, for example through the National Suicide Prevention Strategy Advisory Group (NSPSAG).

The NSPA Lived Experience Network:

Since its launch in September 2020 the NSPA's Lived Experience Network has recruited over 230 people to its online panel and has carefully recruited, trained and supported 17 Influencers. Their definition of lived experience is: "People who have experienced suicidal

thoughts, people who have attempted suicide, people living with or in relationships with those with suicidal thoughts, and those bereaved by suicide. This can include professionals working in this field with personal experience."

The online panel provides regular insights on people's experiences during the pandemic to NSPSAG and its COVID-19 sub-group, including from specific at-risk groups such as those who have accessed mental health services and lower-income middle-aged men. NSPA Influencers have spoken at events and will be participating in strategic discussions and groups.

Members of the online panel have provided the following quotes about their experiences of the Network and helping to shape national policy:

Dennis Baldwin:

"The Lived Experience Influencers' [network] at the NSPA has allowed me the opportunity to become part of an incredibly dynamic network of people who have such a broad spectrum of experiences as attempt and suicide survivors, that I have learnt and continue to learn from. The NSPA allows us the opportunity to share our experiences on such a scale that we would not be able to obtain ourselves, and is driving real change through our own voices that are going onto improve policy, services and saving lives being lost to suicide locally, regionally, nationally, and even internationally.

From being able to tell my story at the NSPA conference, I have seen conversations being inspired and started from my story. I was even contacted from the suicide prevention coalition in Missouri to discuss my work and lived experiences. If my lived experience can start one conversation about suicide prevention it is one step closer to saving a life being lost to suicide"

Emma Williams:

"Being part of the NSPA Influencer network has added 'weight' to my lived experience work and my Influencer role is valued by my local public health suicide prevention delivery group. Knowing that I've received the excellent NSPA Influencer training gives me (and others) confidence that I will share my lived experience safely and with a clear purpose. I am proud to be an NSPA Influencer and to use my past suicidal behaviour for the positive purpose of suicide prevention."

Ben Perkins:

"[The NSPA's] Lived Experience Influencing has been a very empowering experience so far. Through training, story sharing and networking I have gained from knowing that I am not alone in my experiences and that there are ways my story and voice can be heard. The process so far has helped to reconnect with my experiences in a positive way to

change my own self-perception and think of ways my story can influence positive change for others.”

5 Cross-government actions to address the wider drivers of suicide and self-harm

5.1 This chapter acknowledges the wider determinants for mental health and the direct and indirect impacts of these on suicide and self-harm, particularly in the context of issues exacerbated by COVID-19. This section sets out a summary of key actions taken to address these wider drivers, which are further detailed in the cross-Government workplan at Annex A and B. This list is not exhaustive and should be read alongside the 'Mental Health and Wellbeing Recovery Action Plan'.

Reducing the impact on mental health in vulnerable groups

Economic risk factors

5.2 In view of the well-documented adverse impact of periods of recession on suicide rates, an important concern is the future impact of a post COVID-19 economic recession. It is essential that policy responses to any recession include investment in active labour market programmes, particularly to support young people who are entering the labour market, and provision of adequate welfare benefits to help mitigate the impact of recession on suicide risk. Tailoring Government services (e.g. relating to food, housing, and unemployment support) to the needs and circumstances of vulnerable groups will therefore be crucial. Consideration must be given not only to individuals' current situations but also their futures.

5.3 Loss of employment and financial stressors are well-recognised risk factors for suicide, particularly relating to the vulnerable group of middle-aged men. Research suggests that there is a strong relationship between unemployment and suicide in men, with studies examining suicides during the last recession finding a 1.4% rise in suicide rates for every 10% increase in unemployment in men.[12]

5.4 Other risk factors linked to unemployment remain a concern.[13] For example, research suggests that unmanageable debt is a risk factor for suicidal behaviour, with those in debt twice as likely to consider suicide.[14] Research from Samaritans on suicide and middle-aged men found that the experience of unmanageable debt, particularly when debt spirals and leads to bankruptcy or loss of a person's home, can be both stressful and humiliating, contributing to increased risk of suicidal behaviour.

5.5 To aid businesses and employees through the next stage of the pandemic, the Government has announced it will extend the Coronavirus Job Retention Scheme and the Self-Employment Income Support Scheme for a further five months from

May until the end of September 2021. Businesses have also received billions in loans, tax deferrals, Business Rate reliefs, and general and sector-specific grants. Individuals and families have benefited from increased welfare payments, enhanced statutory sick pay, a stay on repossession proceedings and mortgage holidays.

5.6 DWP will continue to play an important role in tackling the mental health impacts of the pandemic, by continuing to pay benefits promptly and providing a range of job search support through the Plan For Jobs, which includes extra work coaches providing help for individuals to stay in or ease back into employment.

5.7 The impact of COVID-19 on people's personal finances means that more people will require debt advice or support to manage their credit commitments, including people whose mental health has been impacted. In line with this, the Government has provided additional funding to the Money and Pensions Service to commission more debt advice to support the expected rise in demand. In addition to this, the Money and Pensions Service has launched a new money guidance tool to support individuals experiencing financial difficulties as a result of the pandemic.

5.8 The Money and Pensions Service will also be publishing delivery plans that will set out how the UK Strategy for Financial Wellbeing will be delivered in each nation of the UK by 2030, comprising specific proposals to support and improve the financial wellbeing of people with mental health problems.

5.9 In October 2020, the 'Stop the Debt Threat' campaign was announced which aims to remove legalistic and intimidating language in Default Notices sent to consumer credit borrowers who are in financial difficulty, which can have a negative impact on mental health. To support these individuals, the Treasury is launching its 'Breathing Space' programme which will freeze interest, fees and enforcement action for people in problem debt, with further protections for those in mental health crisis treatment. The programme is expected to help over 700,000 people across the UK to get professional help in its first year.

5.10 The Department for Digital, Culture, Media and Sport (DCMS) is currently undertaking a review of the Gambling Act 2005 which aims to make sure that the regulation of gambling is fit for the digital age, and that appropriate protections are in place for children and vulnerable people. Alongside this, DHSC is continuing in its commitment to address access and availability of treatment for problem gambling alongside other forms of addiction and is working with the NHS and the charity GambleAware to ensure that best use is made of the £100 million of voluntary funding that will be coming on stream for gambling treatment, and that services are well-used and properly joined up.

5.11 Over the past year, the Gambling Commission has directed £8.8 million to GambleAware to ensure treatment services for problem gambling are well placed

and well-resourced to meet any increase in demand resulting from COVID-19. The Commission continues to monitor the impact of COVID-19 on gambling behaviour and problem gambling and has instructed gambling operators to put in place additional measures to increase protections for those who may be at heightened risk of gambling harm.

Social risk factors

5.12 As part of the Changing Futures programme, £46 million has been awarded through the shared outcomes fund over three years to support local areas to deliver new interventions for individuals experiencing a combination of offending, substance misuse, homelessness, domestic abuse and poor mental health. In Spring, MHCLG will announce the areas which are taking part in the programme as well as establish a national network to share positive practice on supporting adults who are experiencing multiple disadvantages. More broadly, the programme aims to improve outcomes for adults experiencing multiple disadvantage, including some of the factors set out throughout this report that may heighten the risk of self-harm or suicide.

5.13 Suicide is the second most common cause of death among people who are homeless or rough sleepers in England and Wales, with 13% of deaths among homeless people or rough sleepers in 2018 being due to suicide. Targeted support for rough sleepers is being provided through a £23 million funding package, backed by a further £52 million in 2021 to 2022, allowing vulnerable individuals to access the specialist help they need for substance dependency issues, in order to rebuild their lives and move towards work and education.

5.14 The Next Steps Accommodation programme will bring forward over 6,000 new long-term homes over 4 years. This will provide secure accommodation to support people sleeping rough to engage sustainably in mental health support and reduce the impact of rough sleeping on mental health needs. In total, over £750 million is being spent in 2021 to 2022 on homelessness and rough sleeping.

5.15 The Charter for Social Housing Residents (Social Housing White Paper) establishes a review of professional training and development to consider the appropriate qualifications and standards for social housing staff. This will include development of mental health awareness training for housing officers, with a focus on how to work with people with different mental health conditions, including in the context of suicide prevention.

5.16 Loneliness and social isolation have also been found to be particular drivers of suicide for some population groups, as demonstrated throughout this report. Following the publication of the Government's loneliness strategy in 2018, DCMS launched a major effort in 2020 to tackle loneliness during the coronavirus outbreak. The aim is to ensure that, for people of all ages and backgrounds, staying at home

does not need to lead to loneliness. This includes a public campaign to get people talking about loneliness, including guidance on supporting yourself and others safely, and a 'Tackling Loneliness Network' of high-profile charities, businesses and public figures working together to support social connection. Over £30 million of the Government's £750 million charity funding package has been allocated specifically towards reducing loneliness, and an additional £45 million has been allocated to more than 1,700 organisations who are supporting people with their mental health.

5.17 The Department for Environment, Food and Rural Affairs (Defra) is testing nature-based social prescribing through the £5.77 million cross-Government 'preventing and tackling mental ill health through green social prescribing' project. Referring people to nature-based activities can support the treatment of stress, depression, anxiety and other mental health conditions. The project will expand the broader community support offer for high-risk and vulnerable groups, including communities disproportionately affected by COVID-19. It will increase our understanding of how green social prescribing can meet the needs of people with, or at risk of developing, mental ill health and help to inform future policy development.

5.18 The above sets out just some of the key actions being taken across Government to reduce the impact of COVID-19 on suicide and self-harm. The Cross-Government workplan, as can be found in Annex A, provides a full list of new actions agreed across Government, specifically in response to the pandemic. These actions are categorised according to the group most impacted, including people who are economically vulnerable, and people who are disproportionately impacted by lockdown or restrictions. This builds on the previous workplan subsets with a categorisation which acknowledges the risks exacerbated by the pandemic for specific vulnerable groups.

5.19 Annex B contains an update on previous actions which are ongoing or have been completed, based on those published in the Cross-Government Suicide Prevention Workplan in January 2019. The two annexes together make up a national workplan to tackle suicide and self-harm across health, social and justice sectors.

Implementation and next steps

5.20 The following policies and initiatives are just a few of the key steps taken to address the drivers of suicide and self-harm, and we will continue to work across Government, both nationally and locally, and with all our partners, to provide as much support as possible to all.

5.21 Tackling inequalities remains a priority, both in the context of COVID-19 risks and across all areas of national suicide prevention strategy. There is further to go on ensuring that all communities have equal opportunity to access services they need to support their mental health. We must also consider the need for culturally

appropriate bereavement and suicide bereavement services, particularly relating to the pandemic. The Multicentre Study of Self-harm research group is prioritising research on ethnicity in its future research.

5.22 We know that there are other population groups with specific needs and characteristics, that may expose people to more risk factors for suicide- for example, autistic people. There is work underway to explore what more can be done to understand and address the specific needs of these groups. For example, on 23rd March 2021, NHSE/I published the refreshed approach to the existing LeDeR programme entitled "Learning from lives and deaths - people with a learning disability and autistic people". LeDeR aims to improve care, reduce heath inequalities and prevent premature mortality of people with a learning disability and autistic people by reviewing information about the health and social care support that people received. In addition, the new 'all age' Autism Strategy, which is due to be published this Spring, subject to Covid-19 pressures, will improve the provision of services and support for autistic people with the fundamental aim of addressing the inequalities that autistic people face. Work will continue to ensure we understand and address the specific needs of different groups, to reduce suicides as far as possible.

5.23 As part of the £57 million investment for suicide prevention through the NHS Long Term Plan, all local areas have multi-agency suicide prevention plans in place, led by local authorities. These have been reviewed by Samaritans and the University of Exeter in order to analyse the content of these plans, with areas self-assessing implementation progress. Moving forwards, plans must address the specific needs of the populations they cover, through understanding of each area's demographics including ethnicity, age, gender identity and sexuality. DHSC and NHSE/I continue to encourage local services and organisations to engage with the VCS sector on best practice in supporting specific communities.

5.24 Monitoring demands and capacity of mental healthcare providers over the coming year will be essential to ensure resources are directed to those parts of the system under greatest pressure. The NHS and local services including VCS sector organisations, must work together closely to set priorities and ensure access to services are available for those who need them.

5.25 In conclusion, the past year has been fraught with unprecedented challenges which have required services and people to come together to support each other. Everyone has been affected by the pandemic to some extent and everyone must be part of the solution on how to move forwards as we enter a recovery period, acknowledging that many challenges are yet to come. The groundwork laid by working together across multiple disciplines and addressing challenges proactively will allow for greater, more integrated cross-sector working to continue to support the most vulnerable members of our society.

Annex A – Cross-Government Suicide Prevention Workplan: new actions in the context of COVID-19

Annex A of the Cross-Government COVID-19 suicide prevention workplan sets out a list of new actions agreed across Government, specifically in response to the pandemic, as well as existing actions that have either been adapted in response to COVID-19, or continue to be of high importance in our plan to tackle suicides, particularly in the context of COVID-19. These actions are categorised according to the groups most impacted by the pandemic, including people who are economically vulnerable, and people who are disproportionately impacted by lockdown or restrictions. This builds on the previous workplan subsets with a categorisation which acknowledges the risks exacerbated by the pandemic for specific vulnerable groups.

The key vulnerable groups referenced in chapter 2 (children and young people, middle aged men, those who self-harm, and those with mental illness) are covered within these categories.

In 2020, the National Suicide Prevention Strategy Advisory Group (NSPSAG) set up a COVID-19 subgroup to look at trends in suicide during the pandemic and to focus on actions which could address the vulnerabilities of several groups of people who may be disproportionately affected by the pandemic. These groups are represented below:

People who are economically vulnerable

Action	Lead Department	Key Milestones/ Delivery Date
Reduce the adverse mental health impacts caused by Default Notices.	HMT	Completed: 'Stop the Debt Threat' Campaign was announced in October 2020. Changes to legislation were made in

Remove legalistic language and restrict the use of intimidating block capitals in Default Notices sent to consumer credit borrowers who are in financial difficulty. We have changed secondary legislation to reduce the adverse mental health impacts of the language and tone of Default Notices sent to consumer credit borrowers who are in financial difficulty. The new rules will make these letters less threatening by restricting the amount of information that must be made prominent and requiring lenders to use bold or underlined text rather than capital letters. Lenders will also be able to replace legal terms with more widely understood words and letters will clearly signpost people to the best source of free debt advice.		December 2020. Upcoming: All lenders will be required to make the changes by early June 2021.
Implement the HMT 'Breathing Space' programme. The programme includes a 60-day period where enforcement action is paused, and interest and fees are delayed (with an extension of this for people in a mental health crisis).	HMT	From May 2021, if an Approved Mental Health Professional certifies that a person is in mental health crisis treatment, they can apply to a debt advisor for a mental health crisis moratorium. The mental health crisis moratorium has some stronger protections and lasts as long as a person's mental health crisis treatment, plus 30 days. Also, from May 2021, the Money and Pensions Service will operate the single point of access to debt advice for people who have entered the 'Breathing Space Mental Health Access Mechanism'.
Improve links between money and debt advice services and	Money and	MaPS is collaborating with NHS England

social prescribing and psychological therapy services. NHS England and NHS Improvement and Department of Work and Pensions teams are working with the Money and Pensions Service to integrate signposted resources about money support and debt advice services into service delivery manuals for social prescribing link workers, and also providing training to enable employment advisers to provide financial guidance to clients with depression and anxiety receiving treatment from NHS commissioned psychological therapies services (IAPT), to ensure links are made between these services locally.	Pensions Service (MaPS), NHSE/I, DWP	and the National Academy for Social Prescribers (NASP) throughout 2021 - system-wide, regionally and locally - to systematically provide money and debt support resources to NHS Social Prescribing Link Workers. MaPS is also collaborating with DWP's Work and Health Unit to pilot the MaPS Money Guider Training with DWP funded Employment Advisers in IAPT Services, during Spring 2021.
Money and Pensions Service Money Navigator Tool. This tool was launched in June 2020 and continues to offer targeted support to people experiencing financial difficulties as a result of the pandemic, encouraging them to seek help earlier before they are in serious debt or arrears.	MaPS	Ongoing
Unemployed, low income, people or those in occupations affected by the pandemic: DWP has temporarily suspended all face-to-face assessments for sickness and disability benefits and this is being kept under review in line with the latest public health guidance. DWP is also evaluating the temporary changes to their approach to assessments and will use this to inform future improvements to the way assessments are conducted. This was referenced in the government's plan to support people's wellbeing and mental health during the COVID-19 pandemic over	DWP	Ongoing

the winter: 'Staying mentally well: winter plan 2020 to 2021', which was published in November 2020.		
Review the evidence relating to the public health harms of gambling. The scope of the review has been widened to include a rapid review of impact of COVID-19 lockdown on gambling behaviour.	Public Health England (PHE)	The revised timeline for the gambling harms review is for delivery in Summer 2021.

People in contact with mental health services

Action	Lead Department	Key Milestones/Delivery Date
Focus on all-age suicide prevention amongst mental health inpatients as part of the Mental Health Safety Improvement Programme. This is being led by the National Patient Safety Improvement Programmes team (NatPatSIP). The Royal College of Psychiatrists, and the National Collaborating Centre for Mental Health (NCCMH) are being commissioned to support the work.	NHSE/I	The programme aims to reduce the number of suicides that occur across inpatient mental health and learning disability services by: • Identifying the interventions that reduce absence without leave (AWOL) and scope interventions to reduce suicide and deliberate self-harm whilst on agreed leave by March 2021 ahead of testing and scale up • Scoping the incidence and understanding of suicide in non-acute settings by March 2021 ahead of testing and scale up

		• Scoping the incidence and understanding of the risk of suicide of staff working within the healthcare system by March 2021 ahead of testing and scale up • Supporting the assessment of ligature risks and adherence to the national guidance for ligature management from April 2021 • Considering themes from NCMD briefing published in July 2020 for children and young people
National Quality Improvement Programme National Quality Improvement Programme has been put in place for STPs/ICS sites that have received funding for their multi-agency plans. This is being led by the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), and National Collaborating Centre for Mental Health (NCCMH). Support includes a focus on reducing suicides in the community and NCISH have developed COVID-19 support for sustainability and transformation partnerships (STPs) and mental health trusts across the UK.	NHSE/I	This action is recurrent and ongoing.
Suicide Safety Plans In light of COVID-19, NHS England and NHS Improvement will be supporting mental health trusts to refresh and expand their Suicide Safety Plans to include both inpatient and community settings during 2021 to 2022.	NHSE/I	This action is ongoing and will be expanded to include both inpatient and community settings during 2021 to 2022.

Test new integrated care models across early implementer sites. NHSE/I and the NCCMH developed a new Community Mental Health Framework that encompasses the needs of people with a range of needs and diagnoses, including those who self-harm and people with co-existing severe mental health problems and substance use needs. The Framework was published in September 2019 and is being used as the basis for the testing of these new integrated care models across 12 early implementer sites supported by over £70 million of NHS Long Term Plan transformation funding to improve community-based care for adults and older adults with severe mental health problems. All STPs will be using this Framework along with further Long- Term Plan funding to implement the expansion and transformation of community mental health services over the next three years from 2021 to 2022. The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) has been commissioned to support the 12 early implementer sites to develop good self-harm care in the community.	NHSE/I	NCISH began work with the 12 early implementer sites in September 2020 and will continue up to April 2021. They recently launched an online resource with sections containing information on different aspects of care for people who self-harm. This website will be an important live resource from now for all STPs / ICSs working towards implementing their new models of community-based mental health care from 2021 to 2022.

People who are disproportionately impacted by lockdown or restrictions

Action	**Lead Department**	**Key Milestones/Delivery Date**

Support parents in conflict, below the threshold of domestic abuse. Through the Reducing Parental Conflict Programme, test a variety of interventions to reduce harmful levels of parental conflict in disadvantaged families	DWP	The programme will continue throughout 2021 to 2022, to further develop the evidence base on what works, and to support local authorities and their partners to fully embed support for families locally.
Provide targeted support for people sleeping rough – to tackle co-occurring substance misuse and mental health needs. Build voluntary and community sector and peer workforce capacity to improve integration and innovation of local services. Provide £23 million so that vulnerable individuals experiencing rough sleeping, including those with co-occurring mental health needs, can access the specialist help they need for substance dependency issues, in order to rebuild their lives and move towards work and education.	MHCLG	In December 2020, MHCLG announced allocations of the £23 million being delivered in 2020 to 2021 to 43 priority areas, as well as an additional £52 million for 2021 to 2022. This work will continue throughout 2021 to 2022.
Multiple Complex Needs As part of the Multiple Complex Needs programme, £46 million has been awarded through the shared outcomes fund over three years to support local areas to deliver new interventions for individuals experiencing a combination of offending, substance misuse, homelessness, domestic abuse and poor mental health.	MHCLG	In Spring, MHCLG will announce the areas which are taking part in the programme as well as establish a national network to share positive practice on supporting adults who are experiencing multiple disadvantage.
Develop mental health awareness training for housing officers. Focus on how to work with people with different mental health conditions and promote collaboration with relevant mental health professionals. This is included in the Charter for Social Housing Residents: Social Housing White Paper	MHCLG	MHCLG intend to establish the review during 2021 to 2022. Further work is underway to agree the start dates and timescales.

1) Training and qualifications: The Charter for Social Housing Residents: Social Housing White Paper, which was published in November 2020, committed to establish a review of professional training and development, to consider the appropriate qualifications and standards for social housing staff. The review will be informed by a working group made up of residents, landlords, professional bodies and academics, which will explore the relevance and value of professional qualifications. The review will consider the training housing staff need to increase their awareness and understanding of mental health issues. 2) Tackling anti-social behaviour: Evidence suggests that, in some cases, the perpetrators of anti-social behaviour suffer from mental health problems or have issues involving alcohol and drug use. Providing the right support and interventions can have a positive outcome in terms of preventing further offending behaviour. The Social Housing White Paper committed to establish a working group, which will help shape approaches to tackling this issue.		
Deliver a pilot project on nature-based social prescribing. Deliver a £5.77million project to test nature-based social prescribing in seven pilot locations to run national experimental work to understand its scalability, and to deliver a robust project evaluation. The project will work with communities disproportionately affected by COVID-19. This will increase understanding of how nature-based social prescribing can meet the needs of people with, or at risk of	Defra	The project will run from October 2020-April 2023

developing, mental ill health and help inform future policy development.		
Tackle social isolation and loneliness Since the beginning of the pandemic, the government has invested over £31.5 million to organisations supporting people who experience loneliness, refreshed the Let's Talk Loneliness campaign, and brought together a Tackling Loneliness Network made up of private, public and charity sector organisations who want to make a difference. DMCS will continue to work with partners to support a national conversation on loneliness, inspiring and informing the public to help themselves and each other to reduce loneliness. DCMS will also continue to engage across sectors to help inspire and inform organisations to recognise loneliness in the people they interact with, know how to combat it, and know how to consider social connection in their policy making and operational planning.	DCMS	This action will be ongoing throughout 2021 to 2022.
Combat digital exclusion To support cross-government work on digital inclusion, DCMS have asked for evidence from other government departments on the impact of digital exclusion across different departments. DCMS is also exploring how the Inclusive Economy Partnership can facilitate high-impact partnerships between government, business and civil society to tackle digital exclusion.	DCMS	Further details to be released Q2 2021

Children and young people

Action	Lead Department	Key Milestones/Delivery Date
Fund mental health advisers in each local authority to upskill education staff in responses to trauma. This will ensure teachers are equipped to identify and respond to early signs of mental ill-health in children.	DfE	This will be delivered throughout 2020 to 2021
Mental Health Support Teams (MHSTs) Creation of Mental Health Support Teams (MHSTs) for schools/colleges is ongoing. MHSTs are a new workforce of Educational Mental Health Practitioners designed to work with schools to provide mental health support for children and young people with low to moderate mental health needs.	DfE	Additional funding for MHSTs announced by the Government in March 2021. This will result in a further 216 MHSTs being established in 2020 to 2021 and 2021 to 2022, bringing the total number to around 400, and covering an estimated 3 million children and young people (around 35% of those in England), by 2023.
Implementation guidance for RSHE curriculum content The Department for Education has developed an online service featuring innovative training materials and an implementation guide to help schools in their preparations to deliver the new mandatory Relationship, Sex and Health Education (RSHE) curriculum content. This includes resources to support teaching about mental wellbeing as part of Health Education, which should help make sure children and young people are able to recognise issues in themselves and others and, when issues arise, know how to seek support as early	DfE	Schools are required to provide some relationships, sex and health education to all secondary age pupils in the academic year 2020 to 2021, and to provide some relationships and health education to all primary age pupils. Schools may choose to focus this year's RSHE teaching on the immediate needs of pupils, such as health education, before

as possible from appropriate sources.		introducing a more comprehensive RSHE programme in September 2021
Develop the University Mental Health Charter Award Scheme. The Charter (developed by Student Minds) was published in December 2019. It provides a set of principles to support universities in making mental health a university-wide priority. Student Minds are trialling the Charter at three universities to obtain and consult with the sector on how to roll out from next year (given current pressures on universities). The Award Scheme will recognise and reward universities that promote good mental health and demonstrate good practice.	DfE	The Charter Award Scheme will be developed throughout 2021
Student Space platform To support those in Higher Education, the Office for Students (OfS) have provided up to £3 million to fund the Student Space platform to bridge gaps in mental health support for students. Student Space is a collaborative mental health resource to support students at English and Welsh universities through the unique circumstances created by the coronavirus pandemic. It provides a range of information, access to dedicated support services (phone or text), details of the support available at each university, and tools to help students manage the challenges of student life.	DfE, OfS	This action is ongoing
Every Mind Matters NHSE/I has worked with partners at a national level and provided system leadership including working with Public Health England on	NHSE/I, PHE	This action is continuous and ongoing as part of the children and young people mental health response to COVID-19

the new 'Better Health - Every Mind Matters' campaign focused on children, young people, their parents and carers. The new advice available on the 'Every Mind Matters' website has been developed with leading children and young people's mental health charities and co-produced with young people		
Establish a new duty of care on how online services should deal with illegal and harmful content. The Online Harms White Paper sets out the intention to establish in law a new duty of care on companies, overseen by an independent regulator. Companies will be required to take robust action to address harmful suicide and self-harm content that provides graphic details of suicide methods and self-harming, including encouragement of self-harm and suicide.	DCMS, MoJ	The full government response to the Online Harms White Paper consultation was published in December 2020. There is also an intention to set out an offence for incitement to self-harm, with details to be worked through in early-mid 2021, subject to recommendations of the Law Commission The DCMS Media Literacy Strategy, from Spring 2021, will provide a comprehensive approach to improving user resilience and will address the links between platform design and user behaviour.
Address the lack of LGBT self-harm and suicide data. This includes: • Exploring whether 'holding difficult conversations' training for frontline professionals can be expanded or adapted to equip police first responders and coroners to ask next of kin about sexuality of an individual following suicide • Adapting the questions asked in the first 24 to 48 hours following a suicide as part of the Joint Agency Response triggered when a child dies unexpectedly • Encouraging local areas to include data on sexuality as part	PHE, NHSE/I	These areas and gaps have been explored in more detail in 2020 to 2021, and work will continue throughout 2021 to 2022.

of data collection for real time suicide surveillance The 'Mental Health of Children and Young People in England' survey also looks at the prevalence of mental disorders. Funding has been agreed to carry out a follow up survey, which will include questions on gender identity. Academics from the Multicentre Study of Self-harm in England will also be engaged on best practice in sharing information relating to protected characteristics (e.g. whether sexuality can be noted for an individual presenting at A&E with self-harm, allowing key workers to link individuals up with LGBT charities to help with recovery).		The initial prevalence survey was published in 2018. Funding has been agreed for 2021 to 2022.
Collection of NCMD data The National Child Mortality Database (NCMD), funded by NHS England, collects data from all 58 Child Death Overview Panels which review the deaths of all children aged under 18 years in England. Notification must be provided within 48 hours of the death; this can therefore be used for the real-time surveillance of child suicide deaths. Access to this early data can help local areas to better monitor suicide rates in real time and identify patterns of risk and causal factors. Trends are monitored on a continuous basis.	NHSE/I	This is a continuous, statutory process

NHS and social care staff

Action	Lead Department	Key Milestones/Delivery Date
Implement a dedicated programme of work to understand the scale of the issue of nurse suicides and support the system. The Prevention of Nursing and Midwifery Suicide Oversight Group (set up in September 2020) will monitor this programme and ensure opportunities to learn and improve are identified to further prevent nursing and midwifery suicides. A task and finish group has been set up to define project deliverables based on recommendations from an NCISH report on suicide by female nurses, published in June 2020.	NHSE/I	This work is ongoing and will continue throughout 2021.
Develop suicide and deliberate self-harm prevention training modules for blue light staff. Following a roundtable event in July 2019, Health Education England (HEE) commissioned a programme of work to scope existing suicide prevention training for 'blue light' staff given their additional and complex need to carefully look after their own psychological wellbeing whilst caring for others.	HEE	HEE are working with MindED to ensure further learning content is available by March 2021.
Supporting mental health and wellbeing of NHS staff NHS England and NHS Improvement have put in place a comprehensive package of emotional, psychological, and practical support for NHS staff available at people.nhs.uk**.** This includes: • A virtual staff common rooms for mutual support	NHSE/I	This workstream is ongoing and continuous.

• Free access to a range of well-being apps • A helpline and text service for counselling and support for the pressures they face every day during this national pandemic • Bereavement support resources • Supporting the Financial Wellbeing of NHS staff, in conjunction with the Money and Pensions Service. This is now being reinforced with a £30 million investment in mental health and wellbeing hubs which will ensure staff get rapid access to the mental health support they need, as well as enhanced occupational health.		

We are also working closely with the LGA and national partners to ensure that the mental health and wellbeing of key frontline and social care staff are supported during the pandemic and beyond:

Supporting mental health and wellbeing of key frontline and social care staff In response to additional working pressures experienced by key front line and social care staff during the coronavirus pandemic, the Local Government Association (LGA) has worked with national partners to produce a range of emotional psychological and practical support for staff and their managers. The support offered includes: • With NHSE/I, produced a comprehensive pack of wellbeing information and advice to help health and care managers support the wellbeing of staff, including in social care settings,	LGA and national partners	This workstream is ongoing and continuous.

with particular focus on supporting and responding to mental health issues. • With Our Frontline – a partnership between Shout, Samaritans, Mind, Hospice UK and the Royal Foundation of the Duke and Duchess of Cambridge – the LGA run a social media campaign and hosted a series of webinars to promote round the clock one-to-one counselling and support by call or text from trained volunteers • With the National Forum for Health and Wellbeing, the LGA have contributed to the development of a financial wellbeing guide The LGA continue to work as part of the National Social Care Wellbeing Task Force, led by Skills for Care, to monitor and plan support for the impact of stress and burnout experienced by social care staff in response to COVID and other/wider sector issues affecting the wellbeing of the workforce. The LGA will continue to monitor the wellbeing of our frontline and care workforce and amend or develop support offers over the coming months.		

People in contact with the criminal justice system

Action	Lead Department	Key Milestones/Delivery Date
Develop a new Health and Justice Information Service **(HJIS) to link prison healthcare systems to healthcare systems in the community, and to prison systems.** This will enable the sharing of GP-to-GP patient records when offenders leave prison and help to minimise delays in accessing	NHSE/I	GMS (GP) registration and GP2GP data sharing will enable patients to formally register with the prison healthcare service. This is now delayed until 2022. Phase 1 of the new national minimum data

healthcare services. Personal Demographics Service (PDS) site connections will identify patients and record their location for future use. All sites are now PDS enabled. As part of HJIS, NHSE/I is setting up a Strategic Reporting Unit which will replace the current Health & Justice Indicators of Performance (HJIPs). This will provide up-to-date and reliable data. A minimum national dataset for prison healthcare will be supplemented by Ministry of Justice (MoJ) prison statistics and PHE indicators.		set is live and extracted from the SRU on a monthly basis, phase 2 indicators are being developed for implementation. From late 2021 to 2022, electronic appointments and electronic prescribing will be rolled out.
RECONNECT The NHS Long Term Plan commits to rolling out RECONNECT (a continuity of care service) which works pre- and post-release to help people in prison reconnect to community-based health services and support people at a period of change and transition. Pathfinders will focus on the most vulnerable people (in terms of health needs) in prison.	NHSE/I	The pathfinders began roll-out in 2019 to 2020 with 100% coverage planned by 2024 to 2025. There are currently 11 sites live. Services will begin rolling out further in 2021 to 2022.
Develop a workstream to review policies and processes regarding deaths under supervision We will develop a workstream to review current HMPPS policies and processes and embed learning from deaths under probation supervision.	MoJ	This work is ongoing and will continue throughout 2020 to 2021.
Implement a suicide and self-harm prevention system in Approved Premises. We have undertaken significant work to support suicide and self-harm prevention within Approved Premises (AP).	MoJ	CARE assessments will be rolled out across England in March 2021.

AP provide accommodation and support high-risk offenders on release from prison. For example, since November 2020 following the provision of training, a new system to assess and support wellbeing (focussed on suicide and self-harm), called the Support and Safety Plan (SaSP), has been in place for all residents on arrival in AP across England. Training is underway for the additional Collaborative Assessment of Risk and Emotion (CARE), a new assessment and management approach for those at high risk of suicide, in preparation for roll-out across England in March 2021.		
Implement Roll-out of Assessment, Care in Custody and Teamwork (ACCT). ACCT is a multi-disciplinary case management system used in prisons to support people at risk of suicide and self-harm. We plan to roll-out a revised version of the ACCT case management system in the coming months, subject to any further impact of COVID-19. This should provide a better framework for supporting those at risk of self-harm through a more tailored and multi-disciplinary support model that focuses on the needs of the individual. This follows a review of the ACCT model and subsequent pilot of the changes made as a result of the review. As part of the roll-out of ACCT version 6, we are updating our ACCT training packages, as well as refreshing the suicide and self-harm prevention training that staff receive.		This work is ongoing. A revised version of the ACCT case management system is likely to be rolled out in Q1/Q2 of 2021 to 2022, subject to any further impact of COVID-19.

Maintain Prisoner Listeners Scheme. We have continued our partnership with the Samaritans by awarding a grant of £500,000 each year that supports the excellent Listeners scheme, through which selected prisoners are trained to provide emotional support to their fellow prisoners. During the pandemic we have maintained the Listener Service wherever infection control measures permit, and to provide access to Samaritans by phone when face-to-face interactions with Listeners are not possible.	MoJ	This work is ongoing and will continue throughout 2021 to 2022.
Deliver suicide and self-harm prevention campaign with staff working in prisons and probation services. 'Reach Out Save Lives' is a staff suicide and self-harm prevention campaign aimed at HMPPS employees, which is encouraging connection between colleagues and providing learning opportunities, products and other resources to raise awareness and skills around self-harm and suicide. MoJ is considering how this campaign and support for prison service users through staff training can be further linked up.	MoJ	This work is ongoing

Financial support for suicide prevention VCSE sector to manage COVID-19 pressures

Action	Lead Department	Key Milestones/ Delivery Date

£5 million will be made available to support suicide prevention voluntary and community sector organisations in 2021 to 2022. As part of this funding, a grant fund will be available to help ensure that the financial gaps incurred as a result of these additional pressures are covered.	DHSC	Further details on the application process for the grant fund will be published shortly.

Annex B – Cross-Government Suicide Prevention Workplan: Completed and ongoing actions

Annex B contains an update on actions which are either ongoing, but not specific to COVID-19, or have been completed, based on those published in the Cross-Government Suicide Prevention Workplan in January 2019. Actions are grouped using the categories set out in the 2019 publication to enable tracking of previous commitments. Actions are grouped using the categories set out in the 2019 publication to enable tracking of previous commitments.

Reducing the risk of suicide in high-risk groups

Local suicide prevention

Action	Lead Department	Key Milestones/Delivery Date
Through the NHS Long Term Plan (LTP), NHSE/I have committed to roll out transformation funding to every STP area by 2023 to 2024 to support multiagency working on all-age suicide prevention. Niche have provided an evaluation report which highlights outcomes and best practice.	NHSE/I	All areas will receive three years of funding by 2023 to 2024.
All local areas have multi-agency local suicide prevention plans in place which address the specific needs of the populations they cover, through understanding of each area's demographics including ethnicity, gender identity, age and sexuality.	Local Authorities	This action is now completed, and every local area has a multi-agency local suicide prevention plan in place. However, work by local authorities in leading and implementing those plans is ongoing.

The Department of Health and Social Care (DHSC) has provided funding to the Sector-Led Improvement (SLI) programme which provides support through regional Association of Directors of Public Health (APDH) networks in developing a delivery plan which reflects regional priorities. The SLI programme enables sharing of best practice through webinars and masterclasses and a national resource to share local learning across public health teams.	DHSC, LGA, ADPH	Year One of the SLI programme ran from August 2019 to March 2020, and discussions continue with partners on future years' SLI work.
Updated local authority suicide prevention guidance was published by Public Health England (PHE) in September 2020.	PHE	This was published in September 2020.

Men

Action	Lead Department	Key Milestones/Delivery Date
The NHS Long Term Plan committed to opening a total of 15 new specialist problem gambling clinics by 2023 to 2024. New gambling clinics have been established in London, Sunderland, Manchester and Leeds, including a pilot young person's clinic in London.	NHSE/I	Expansion of clinics continues as expected, with a review of services currently underway. An expected further roll out of services is due in 2021 to 2022.
The National Institute of Health Research (NIHR) commissioned a complementary review of the effectiveness and cost-effectiveness of existing policies and interventions for reducing gambling-related harms. The international evidence mapping review has been published. NIHR and the University of Sheffield have undertaken a further review of screening interventions and publication is expected in early to mid-2021.	DHSC, NIHR	Publication is expected in early to mid-2021.
DHSC awarded grant funding for phase 3 of the Time to Change campaign up to 2020 to 2021. This has included campaigns targeted at men such as 'in your corner' and the 'elephant in a transit' advert.	DHSC	This action has been completed

DHSC has funded Campaign Against Living Miserably (CALM) through a COVID-19 grant. The government is providing an additional £1 million for helplines in conjunction with ITV's Help Our Helplines Campaign (which will provide further funding to CALM).	DHSC	This action has been completed
As part of the Samaritans 'Real Lives, Real Stories' campaign delivered in March 2019, a radio partnership with talkSPORT was struck up which saw sporting celebrities talking about their emotional health. The campaign asked men who have been through tough times to share their stories to encourage others to seek help.	Samaritans	This action has been completed

People in contact with mental health services

Action	**Lead Department**	**Key Milestones/Delivery Date**
Mental Health Inpatients:		
Evidence from NCISH has shown that people in contact with mental health services are at highest risk of suicide in the immediate days and months following discharge (200-fold increased risk in the three months post discharge). In view of this, NHS England and NHS Improvement have amended the national post-discharge 7-day follow up standard in the NHS standard contract, to instead require all patients to be followed up within 72 hours following discharge from inpatient mental health care. This has been supported by additional funding to ensure high quality and robust post-discharge support. £50 million funding dedicated to	DHSC, NHSE/I, HEE	This action is ongoing

mental health post discharge support was allocated in 2020 to 2021 in view of the pandemic, which has resulted in reports of increasing complexity of mental health need, compounded by people losing their usual support networks under COVID-19 restrictions. Typically, the funding is being used to fund schemes that promote recovery such as step-down supported housing placements, home adaptations and support for people with daily living activities and medicines management. An additional £87 million was announced in March 2021 to provide enhanced discharge from inpatient mental health care for 2021 to 2022. Improving flow through inpatient wards by reducing delayed discharges will also ensure that beds are available for timely admission of acutely unwell patients who may be at risk of suicide/harm.		
People in crisis:		
In 2018, less than 50% of Crisis Resolution Home Treatment teams were 24/7 and were not openly accessible to the public. Now we are on track to ensuring that by March 2021 all crisis resolution and home treatment services operate 24/7 and are resourced with capacity to provide intensive home treatment for people who would otherwise require hospital admission.	NHSE/I	This action is ongoing and is due to be delivered by March 2021.
In April 2020, NHS E/I requested that all parts of the country expedite the ambition to have a 24/7, single point of access telephone line for urgent mental health support that is available to the public. This was originally expected to be delivered by March 2021 for adults but was delivered as a priority during the first wave of the pandemic.	NHSE/I	This action has now been completed

NHSE/I also asked that children and young people (CYP) and their parents/carers also have access to this functionality, either through an all ages or a dedicated CYP access point.		
Training for staff:		
In 2020 to 2021, DHSC provided up to £1million of second-year funding to the Zero Suicide Alliance (ZSA). The ZSA is building on the culture change training package for NHS trusts, and will continue to roll-out suicide prevention training to NHS organisations.	DHSC, ZSA	This action has been completed
Through its contract with DHSC, the ZSA is developing guidance for frontline staff on how to use the Consensus Statement which aims to advise staff regarding when and how to share information about patients where this may help prevent suicide. Alongside this, the Consensus Statement itself is also undergoing minor amendments to reflect the current legal position, following implementation of the GDPR, and amendments to the Mental Capacity Act.	DHSC, ZSA	This action is ongoing, with the guidance and updated statement due to be published shortly.
Health Education England (HEE) has undertaken a scoping of existing suicide training to identify gaps in provision, using the newly published competency frameworks to map against quality of training The work to conduct a synthesis of this review to inform future business planning is currently being undertake	HEE	The scoping exercise to identify gaps in provision has been completed. Work to conduct a synthesis of this review to inform future business planning is currently being undertaken.
HEE commissioned the Tavistock and Portman NHS Foundation Trust to identify key mental health training needs in primary care, in collaboration with Skills for Health. This resulted in production of the Primary Care Mental Health Frameworks Matrix, which includes links to national occupational standards and published guidelines for suicide prevention.	HEE	This action has been completed

People who self-harm

Action	Lead Department	Key Milestones/Delivery Date
NHSE/I continue to roll-out 24/7 liaison mental health teams in every acute hospital to ensure that people who present at hospital with mental health needs get the appropriate care and treatment they need.	NHSE/I	This action is ongoing. The aim is for all hospitals to have liaison mental health teams in place by 2020 to 2021, with 50% meeting the 'core 24' standard. By 2023 to 2024, 70% of liaison services are expected to have met the 'core 24' service standard, working towards 100% coverage thereafter.
NHSE/I plan to introduce a new CQUIN focused on improving the quality of care for people who self-harm and attend A&E. This is expected to require psychiatric liaison teams to ensure that 80% of self-harm referrals receive a biopsychosocial assessment in line with NICE guidelines. This is on hold due to COVID-19 pressures in Acute Trusts.	NHSE/I	The CQUIN is on hold due to COVID-19 pressures in Acute Trusts.
NHSE/I continue to support children and young people in crisis through 24/7 crisis lines and crisis services. This is in line with the original Long Term Plan commitment that all children and young people experiencing a mental health crisis would be able to access crisis care 24 hours a day, seven days a week by 2023 to 2024, with a single point of access through NHS 111. Every NHS mental health trust in England now provides 24/7 crisis helplines for those in all age groups who need urgent help in a mental health crisis.	NHSE/I	Services in place since April 2020 and will continue to be sustained moving forwards

Specific occupational groups

Action	Lead Department	Key Milestones/Delivery Date
Veterans:		
NHSE/I are working with a small number of accelerator STPs to develop pilots in relation to access to services for veterans (e.g. veteran drop in centres).	NHSE/I	There has been a delay in delivering this due to capacity issues relating to COVID-19 re-tasking. One STP accelerator site has developed a full range of materials to support suicide prevention/reduction for serving personnel, reservists, veterans and families which are now being adapted and distributed to all regions.
NHSE/I continue to expand mental health services and case management for veterans, including increasing capacity in bespoke services. NHSE/I commissioned a Veterans' Mental Health High Intensity Service (HIS) to provide both inpatient and community-based crisis response services.	NHSE/I	HIS started accepting referrals in October 2020 and all regions are expected to be live by April 2021.
The Office of Veteran' Affairs in the Cabinet Office was established in 2019. The Ministry of Defence (MoD) announced that Defence Statistics is working to improve the data on suicide and other causes of death of veterans that have served since 2001, which will include the cohorts that served in Afghanistan and Iraq. This work builds on the data on suicides and open verdict deaths among serving personnel published annually by Defence Statistics and MoD.	MoD	This action has been delayed by COVID-19 data requirements. Defence Statistics are currently working with NHS Digital and their equivalents in the Devolved Administrations to complete the processes required for MoD to receive the veteran data.
The new MoD IT system, CORTISONE, will be able to flag on NHS systems that a patient has a military GP. This could enable sharing of A&E attendance data (including self-harm) with MoD GPs. Once	MoD	A report will be published in 2020 to 2021 with the initial findings. CORTISONE delivery now delayed until the end of 2020

an individual is discharged from the UK Armed Forces their healthcare becomes the responsibility of the NHS in England and the Devolved Administrations. One of the benefits of the new system will be improved integration with the Devolved NHS Administrations and other organisations.		to 2021.
Following continued Ministerial and media interest in suicides in both serving and veteran UK armed forces personnel, the MoD and NHSE/I commissioned an update to research published in 2009 by Manchester University. The new research will focus on establishing whether there have been changes in the population risk for veterans and explore the antecedents of suicide.	MoD, NHSE/I	Updated suicide research is underway and expected to report late 2022. This was slightly delayed due to procurement and contractual issues and the additional demands of COVID-19 issues.

People in contact with the criminal justice system

Action	Lead Department	Key Milestones/Delivery Date
The Ministry of Justice (MoJ) and Her Majesty's Prison and Probation Service (HMPPS) are improving the skills and confidence of staff through training to reduce risks of suicide and self-harm (SASH) and provide appropriate support. Self-harm guidance for staff has been issued and an 'introduction to mental health awareness' module has been completed and is being delivered as part of current self-harm and suicide prevention training.	MoJ, HMPPS	This action is ongoing
MoJ and HMPPS are improving access to support for people in prisons following self-inflicted deaths, with the aim of reducing the risk of a further death. This is being achieved through a postvention support service, developed in partnership with Samaritans, which	MoJ, HMPPS, Samaritans	

has been successfully piloted in fifteen prisons and continues to operate in those prisons while options for a national rollout are developed and considered. Alongside this, support for HMPPS staff following self-inflicted deaths and other serious incidents is being improved through the implementation of Trauma Risk Management (TRiM), a peer support system designed to identify those who are experiencing adverse reactions and to refer them appropriately to post-incident care teams, occupational health support and counselling.		Postvention support service will be rolled out to all prisons during 2021 to 2022.
Develop a workstream to embed learning from deaths in custody: The Ministerial Board on Deaths in Custody has commissioned analysis on learning from Prevention of Future Deaths (PFD) reports from all custodial settings. The Independent Advisory Panel on Deaths in Custody is also scoping work to track the progress of PFDs once they are published. Her Majesty's Prison and Probation Service (HMPPS) has a process in place for collating PFD reports issued by coroners for deaths in prison custody and using the learning to inform policy and practice. DHSC completed a review of what the health system does following a death and the processes in place to respond to PFDs.	MoJ	This workstream is continuous and ongoing

Tailoring approaches to improve mental health in specific groups

Children and Young People

Action	Lead Department	Key Milestones/Delivery Date
HEE have worked with MindEd to produce online training modules aimed at children and young people in relation to suicide and deliberate self-harm prevention. Modules for adults are also available. The content provides guidance and advice to anyone who is caring for or in contact with those who have suicidal ideas, with or without self-harm, or those who self-harm, with or without current suicidal ideas	HEE	This action is now completed
University students:		
Develop a serious incident framework for use following student death: Ensure incidents are identified correctly, investigated thoroughly and learned from to reduce the reoccurrence of incidents.	Public Health England, Universities UK	This work is ongoing and will continue to be amended/refined.
The Universities UK (UUK) report 'Minding our Future' recommended setting up collaboratives with specific local areas to enhance suicide prevention practice in universities. The project aims to improve coordination of care between universities and the NHS, investigate potential barriers to accessing support, and develop a clinical risk assessment tool which can be rolled out across the UK	DfE, UUK	Student Mental Health Collaboratives have been established across an initial five university sites in the cities of Bristol, Liverpool, Manchester, London (UCL in North London), and Sheffield, with an aim to replicate this across further cities.

Black, Asian, and ethnic minority backgrounds

Action	Lead Department	Key Milestones/Delivery Date
As part of the COVID-19 response, Jobcentre operational leaders in each area are making sure that the support available meets the needs of claimants in the local community, including ethnic minorities. They are also engaging with local organisations, many of which represent ethnic minorities, to ensure all jobseekers, no matter what their background, find the right support to meet their individual needs. The government is also ensuring that ethnic minority customers have the opportunity to benefit from the package of employment support schemes announced as part of the Chancellor's "plan for jobs".	DWP	Ongoing
Improvements to data availability:		
The Office for National Statistics (ONS) has completed work on linking the Hospital Episode Statistics (HES) dataset and census mortality data (going back to 2011). This will enable analysis by protected characteristics including ethnicity.	ONS	The results will be published in early-mid 2021.
PHE continue to encourage local areas to collect adult ethnicity data as part of their real-time suicide surveillance returns. For CYP this data is robust as it is part of a statutory process.	PHE	This work is ongoing.
Suicide prevention in Gypsy, Traveller and Roma (GTR) communities:		

DHSC have engaged with a number of organisations to consider actions in this space, e.g. linking in with the Advancing Mental Health Equalities Taskforce (NHSE/I) to consider issues in this community. Ongoing work includes continued focus on improving availability of ethnicity data sources by the ONS and PHE. PHE are also encouraging local areas to reflect the specific needs of their population in their suicide prevention plans (with specific mention of local GTR communities where relevant). DHSC and NHSE/I continue to encourage local services and organisations to engage with the VCS sector on best practice in supporting specific communities.	DHSC, NHSE/I, PHE	This work is ongoing.
Improving Black, Asian and minority ethnic community experiences of care in mental health settings:		
NHS England and NHS Improvement is working with experts by experience and profession to develop the Patient and Carers Race Equality Framework (PCREF), as recommended in the independent review of the Mental Health Act 2018. The PCREF will support mental health services to provide more culturally appropriate care, informed by local priorities.	NHSE/I	The PCREF approach will be piloted in select mental health Trusts in 2021 to 2022 with a view to roll-out nationally thereafter

Reducing access to means of suicide

Action	Lead Department	Key Milestones/Delivery Date

Rail and the transport sector:		
DfT hosted a workshop in November 2020 around suicide prevention on behalf of the transport sector in order to share learning and experiences. The workshop covered an introduction to the concept of 'dissuasion' and assessment of its potential for reducing suicides across the transport network. Participants discussed research in the field through discouraging suicidal behaviour and making the transport network less appealing as a place for those in suicidal crisis to take their lives.	DfT	This action is complete.
A meeting of the Fatality Management Programme Board took place in October 2020. The Board is exploring Network Rail funding avenues to support key workstreams. The meeting process drives a 10-point action plan which includes workstreams in data quality, use of technology and other capital resources (e.g. drones, mental health triage cars), CCTV accessibility, training packages, and working with the emergency services and medical personnel (e.g. mental health nurses).	DfT, Network Rail, British Transport Police	This action is ongoing
The 'Real People, Real Stories' campaign (carried out in March 2019) was delivered by Samaritans on behalf of the rail industry. The campaign involved men sharing their mental health stories to encourage others to seek help. The campaign was targeted at males aged 20 to 59 (those most at risk of suicide on the railway).	Samaritans, DfT, Network Rail, British Transport Police	This action is complete.
New methods of suicide:		
A process has been established with partners and across Government to rapidly signpost emerging methods and take actions through a multi-agency approach. This includes, but is not limited to, limiting access to the method, reducing or removing promotional	DHSC, Home Office, DIT, DCMS	This action is ongoing.

material, and providing clearer warnings of risk.		
The ONS continues to monitor data on cause of death against new and emerging suicide methods. DHSC will link into this analytical work programme when this is next updated and will remain in regular correspondence through the National Suicide Prevention Strategy Advisory Group.	ONS, DHSC	This action is ongoing
For CYP, the National Child Mortality Database (NCMD) continues to monitor data on deaths by suicide. Notification must be provided within 48 hours of the death; this can therefore be used for the real-time surveillance of child suicide deaths. Access to this early data can help local areas to better monitor suicide rates in real time and identify patterns of risk and causal factors.	NHSE/I	Continuous, statutory process

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

Action	**Lead Department**	**Key Milestones/Delivery Date**
As part of the £57 million investment for suicide prevention through the NHS Long Term Plan, suicide bereavement support services will be rolled out across all STPs/ICSs. 18 STP / ICS areas have received all-age transformation funding to establish suicide bereavement services with all areas receiving funding by 2023 to 2024.	NHSE/I	This action is ongoing. All STPs/ ICSs will have suicide bereavement services in place by 2023 to 2024.

NHSE/I have partnered with Support After Suicide Partnership (SASP) to set up a central resource hub to support delivery of bereavement services and to deliver postvention bereavement implementation support to people of all ages. SASP continue to provide implementation support to areas in receipt of transformation funding, while also providing resources on the Central Hub to prepare systems yet to receive funding for the establishment of suicide bereavement services.	NHSE/I	This action is ongoing.
For children and young people, the local Child Death Oversight Panel ensures that there is dedicated professional liaison with each family to support them during the multiagency review of any unexplained death.	NHSE/I	Continuous, statutory process

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

Action	Lead Department	Key Milestones/Delivery Date
Samaritans Strategic Partnership: Companies committed to establishing and funding a strategic partnership with suicide and self-harm prevention experts, led by the Samaritans, to tackle harmful content and support vulnerable users of their platforms. The government invested initial seed funding of £100,000 for the partnership in 2019 to 2020.	Samaritans, DHSC	This action is ongoing.

Supporting research, data collection and monitoring

Action	Lead Department	Key Milestones/Delivery Date
Real-time suicide surveillance: PHE held a pilot of a national real time data monitoring system with a subset of local areas with existing surveillance systems in place. Access to early data can help local areas to better monitor suicide rates in real time and identify patterns of risk and causal factors. This can inform local and national responses. As part of the Spending Review settlement, PHE received £1.2 million for 2021 to 2022 to support roll-out of a national system.	PHE	This action is ongoing.
The National Child Mortality Database (NCMD), funded by NHS England and NHS Improvement, collects data from all 58 Child Death Overview Panels which review the deaths of all children aged under 18 years in England. Notification must be provided within 48 hours of the death; this can therefore be used for the real-time surveillance of child suicide deaths. Access to this early data can help local areas to better monitor suicide rates in real time and identify patterns of risk and causal factors. Trends are reviewed on a continuous basis.	NHSE/I	Continuous, statutory process
Suicide registration statistics: The ONS completed analysis of recent trends in suicide (death occurrences in England and Wales between 2001 and 2018), including factors which may have influenced the rise in suicides seen from 2018. This included sex, age, method of suicide, and region (including levels of deprivation).	ONS	Both articles were published in December 2020. The ONS will continue to review suicide data in 2021 to gain a clearer picture of any changes to rates during the pandemic - and specifically over the lockdown - at which point a greater number of completed cases will be known following delays to coroner inquests throughout

The ONS also investigated the role of the change in the standard of proof (i.e. the evidence threshold used by coroners) on the increase seen. The ONS have completed linkage of the census mortality and HES datasets. There are also plans to add GP and IAPT data to this, with the potential to look at self-harm specifically (through links between admissions data with other mental health services).		2020.

Reducing rates of self-harm as a key indicator of suicide risk

Action	Lead Department	Key Milestones/Delivery Date
Improving data and understanding of self-harm: DHSC renewed its contract for the Multi-Centre Study of Self-Harm in England for 2020 to 2021, and discussions continue on future years' work. The Multi-Centre Study continues to undertake specific research projects which will support understanding of data on self-harm in priority areas.	DHSC	This action is ongoing.
For CYP, NHSE/I is monitoring rates of self-harm through the Emergency Care Data Set data and national surveys/data sources - for example the NHS Digital survey/millennium cohort survey. NHSE/I work closely with PHE and academics to monitor rates of mental health needs and self-harm	NHSE/I	This action is ongoing
NHSE/I have accelerated plans for 24/7 all-age open access crisis services so that those who have urgent need can access it more urgently. Every NHS mental health trust in England now provides 24/7 crisis helplines for those in all age groups who need urgent	NHSE/I	Services in place since April 2020 and will continue to be sustained moving forwards

help in a mental health crisis.		

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