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Preventing suicide in England: One year on

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

Title: Preventing suicide in England: One year on First annual report on the cross-government outcomes strategy to save lives
Author: SCLGCP/ MHED / 11160
Document Purpose: Policy
Publication date: January 2014 (revised February 2014)
Target audience: Local Authority CEs, CCG CEs, NHS Trust CEs, Care Trust CEs, Foundation Trust CEs, Health and Wellbeing Boards, Directors of Public Health, Medical Directors, Directors of Nursing, Directors of Adults SSs, NHS Trust Board Chairs, Special HA CEs, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Youth offending services, Police, NOMS and wider criminal justice system, Coroners, Royal Colleges, Transport bodies
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Introduction

1. Last autumn, government made clear its commitment to suicide prevention by publishing a new cross-government strategy for England. This drew on the rich experience from the first suicide prevention strategy published a decade earlier, which had some notable successes. By 2007, suicide had fallen to the lowest rate in 150 years and there had been a marked fall in suicide in young men. Suicide in mental health inpatients had almost halved since 1997 and deaths had also fallen among prisoners.

2. But we knew that the likely impact of the financial crisis meant that we needed to be prepared for possible upturns in suicide rates. The new strategy set out very clearly what actions we can all take to reduce the toll of suicide in our society.

3. Sadly, since 2007 we have seen signs that the suicide rate has risen in England, as it has in many countries.

4. This first report on the new strategy sets out the big developments over the past year and highlights the areas where things need to be done for the next year. The strategy is intended to be dynamic and evolve in response to new trends and knowledge. It is also designed to support action at all levels, but particularly local action. The messages in this report are designed to help local areas focus on the most effective things that they can do to reduce suicide.

Current trends in suicide

5. ONS figures show 4,513 suicide deaths in 2012, very close to the number in 2011 (4,518). The latest statistics show that:

- The rate of deaths from suicide and undetermined intent was 8.0 per 100,000 population in 2010-12. After 1998-2000 the general trend was a decrease in the overall rate of suicide. However, this has tailed off in recent years with a small rise in rates in the last four years. However, the figure for 2010-2012 is 17% lower than in 1998-2000.
- Suicide continues to be more than three times as common in males (12.4 per 100,000 for males in 2010-12, compared to 3.7 for females).
- The numbers and rates of suicide and undetermined deaths vary between age groups, with rates among males highest for those aged 35-54 years and among females, highest for those aged 40-59 years.

- Hanging, strangulation and suffocation accounts for the largest number of suicides in males, 60%. In females hanging and drug related poisoning are the joint most frequent methods, 38%.
- The most recent National Confidential Inquiry into Suicide and Homicide annual report (July 2013) shows a rise in overall patient suicide, probably reflecting the rise in suicide in the general population, which has been attributed to current economic difficulties. In-patient suicide continues to fall. There are twice as many suicides under crisis resolution/home treatment compared to in-patients. Opiates are the main substance in self-poisoning.
- The patterns for both rates and numbers of self-inflicted deaths in custody closely mirror each other. Prison suicides are no longer falling after a major fall between 2004-8, with about 60 deaths each year, representing a rate of 0.7 per 1,000 individuals in custody. Suicides in women prisoners are now very few.
- There was a considerable rise in the number of apparent suicides within two days of release from police custody, with 59 such deaths, the highest number recorded over the last nine years. Almost two-thirds were known to have mental health concerns, a higher proportion than in 2011-12, and seven had previously been detained under the Mental Health Act.
- There was a rapid rise in the number of deaths caused by helium poisoning, almost all of which are likely to be caused by suicide. There were no recorded deaths in 2000 from helium, however since 2007 there has been a steady rise, with 51 deaths in England in 2012.

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

New messages from research

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

- There have now been a number of studies demonstrating an association between the areas of England worst affected by unemployment during the recent financial crisis and increased suicide rates. Between 2008 and 2010, there were approximately 800 more suicides among men and 155 more among women than would have been expected based on historical trends.¹ This was supported by a recent review of the international impact of the global economic crisis.² A rise in poor health status associated with the recession has also been found not only for the unemployed, but also among people who remained employed.³
- Much has been achieved by frontline staff to reduce suicides in people with mental health problems and our understanding of what works continues to develop. A link has been shown between specific changes to mental health

services, especially community care reforms, and lower patient suicide rates⁴. Policies recommending follow-up within 7 days of psychiatric hospital discharge and robust discharge planning appear to have been followed by reductions in hospital admission for self-harm in the immediate post-discharge period.⁵

- There is evidence that psychosocial assessments of people who have suicidal thoughts or have self-harmed are themselves helpful in preventing further suicidal behaviour.⁶ However, there continues to be a marked variation between hospitals and overall just over half of people who have self-harmed received an assessment, no better than ten years ago. Meta-analyses indicate that Cognitive Behavioural Therapy/Dialectal Behavioural Therapy reduce the risk of repeat self-harm⁷. Recent research on self-harm was included in the NICE evidence update and is available at <https://www.evidence.nhs.uk/evidence-update-39>
- There is relatively strong evidence that reducing access to means (through installation of physical barriers) can avert suicides at hotspots, and other interventions show promise.⁸
- Clinical depression is a strong confounder of increased suicide risk among physically ill people, explaining some or all of the increased suicide risk in people with a range of physical illnesses.⁹
- Lithium has been shown to be an effective treatment for reducing the risk of suicide in people with mood disorders.¹⁰
- There has been an increase in the number of suicides given an accident/misadventure death verdict, particularly for deaths involving poisoning.¹¹

8. Following the call for research to support the suicide prevention strategy, the Policy Research Programme is investing £1.5m over three years into six projects:

- Understanding and helping looked-after young people who self-harm
- Understanding lesbian, gay, bisexual and trans adolescents' suicide, self-harm and help-seeking behaviour
- Self-harm in primary care patients: a nationally representative cohort study examining patterns of attendance, treatment and referral, and risk of self-harm repetition, suicide and other causes of premature death
- Exploring the use of the Internet in relation to suicidal behaviour and identifying priorities for prevention
- Understanding the role of social media in the aftermath of youth suicides
- Risk and resilience: self-harm and suicide ideation, attempts and completion among high risk groups and the population as a whole.

What needs to happen now on suicide prevention?

Self-harm

9. Around half of people who die by suicide have a history of self-harm, and self-harm is a sign of serious emotional distress in its own right.

10. Mental health promotion, prevention and early intervention will be essential to help reduce self-harm in the community that does not present to health services. The effective assessment and management of self-harm by NHS services where people do present with self-harm, particularly in Emergency Departments, represents a huge opportunity to reduce repetition of self-harm and future suicide risk.

11. In June 2013, NICE published a new quality standard to improve the quality of care and support for people who self-harm.¹² This covers the initial management of self-harm and the provision of longer-term support for children and young people (aged 8 years and older) and adults who self-harm. Published alongside the quality standards, commissioning support tools¹³ encourage commissioners to work with clinicians and managers to commission high-quality evidence-based care for people who self-harm.

12. The Government's commitment in the Spending Review 2013 to ensure that every Emergency Department will have constant access to mental health professionals is important in ensuring that people with mental health problems get the best possible care.

13. The Public Health Outcomes Framework published in November 2013 includes the definition of the new indicator on self-harm. This makes clear the priority given to the prevention and management of self-harm across local authority and NHS services. As well as reflecting attendances at Emergency Departments for self-harm, the indicator will also capture how many attendances received a psychosocial assessment.

14. CQC is carrying out a review of emergency mental health care, including after self-harm, following recent concerns about access to appropriate treatment for people with mental health issues. CQC's findings will also be used to help them create more accurate measures for assessing if care is safe, effective, caring, responsive and well led.

What local services can do

15. Implementing the NICE guidelines on self-harm will be key to improving the experiences and outcomes for people who self-harm, in particular ensuring that people who present to Emergency Departments following self-harm receive a psychosocial assessment.

The Rapid Assessment Interface and Discharge (RAID) psychiatric liaison service, working within all acute hospitals in Birmingham, is an award-winning service which offers comprehensive mental health support, available 24/7, for people aged over 16 years with mental health or substance misuse needs who access Emergency Departments in hospitals in Birmingham and Solihull. Independent evaluation by the London School of Economics showed that the RAID service saves money as well as improving the health and well-being of its patients. <http://www.bsmhft.nhs.uk/our-services/rapid-assessment-interface-and-discharge-raid/>

Derby City and County have a dedicated CAMHS Liaison service that responds rapidly to all young people under 18 years old who present at the Royal Derby Hospital following significant self-harm, suicide attempts and severe and acute mental health concerns. They work closely with a dedicated Safeguarding Nurse. The relationship between mental health, acute health, and safeguarding services ensures that families receive effective discharge planning meetings and reduces the likelihood of readmission. Families report raised confidence that physical, social and mental health services are working together and “getting it right first time”.

16. Training for staff in general hospitals is important to address negative attitudes and lack of knowledge, that have major negative effects on the experience of people who self-harm and can be a major impediment to their care. Training of psychiatric staff in psychosocial assessment and in effective brief psychological interventions may also be needed.

17. Local Public Health teams can track local trends and provide surveillance, to inform decisions about local authority and NHS resources needed for mental health promotion, prevention, and early intervention and to deal with the assessment and management of self-harm.

Supporting mental health in a financial crisis

18. The UK economy is recovering from the most damaging financial crisis in generations, but the economy is now growing. Employment is at record levels and the proportion of households that are workless is at its lowest since 1996. However, people facing unemployment, debt or homelessness may still be at risk.

19. Suicides are not inevitable. An inclusive society that avoids marginalising individuals and which supports people at times of personal crisis will help prevent suicides. Government and statutory services have a role to play. We can build individual and community resilience. We can ensure that vulnerable people in the care of health and care services are supported and kept safe from preventable harm. We can also ensure that we intervene quickly when someone is in distress or in crisis. For vulnerable people in the wider community, practical measures such as debt advice services can make all the difference.

20. Strong mental health services have an important protective role to play. In *No health without mental health* we set out an ambitious strategy to improve mental health in England. Together, we need to make more progress, more quickly against that strategy.

21. The Department of Health, Home Office, NHS England, NHS Confederation, the police and others are currently developing a concordat on mental health crisis care, which is intended to guide local practice. This will be launched this winter. It will take the form of an agreed set of principles and will set out what support agencies need to do to ensure that people in mental health crisis get the help they need.

22. Several 'street triage' pilots have recently been funded – these are collaborations between the police and mental health professionals on the ground, by which the police get prompt advice when they are dealing with someone who may be mentally ill, so that the person receives appropriate care and support.

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

24. DWP and DH are looking at how we can better co-ordinate mental health and employment support services to improve recognition of employment and mental health needs, referral action and employment outcomes. We are currently considering proposals from RAND Europe on achieving better outcomes for people with common mental health problems who are in, and out of, work.

What local services can do

25. The annual report of the National Confidential Inquiry in July 2013, called on services to do more for patients facing debt, housing problems and unemployment.

26. Debt can cause, and be caused by, mental health problems. The need for close working between specialist services, primary care, and credit counselling agencies is recognised, and a number of resources are available to help local services support people with debt and mental health problems:

- Martin Lewis of the popular website, MoneySavingExpert.com, has teamed up with Mind, Rethink and others to produce a free booklet for people with mental health problems and those caring for them.
<http://www.moneysavingexpert.com/credit-cards/mental-health-guide#collect>
- A guide for health and social care workers to support people with debt and mental health problems written by the Royal College of Psychiatrists and Rethink Mental Illness: <http://www.rcpsych.ac.uk/pdf/FinalDemandcf.pdf>
- Primary Care Guidance on Debt and Mental Health from the Royal College of GPs and Royal College of Psychiatrists, due to be updated shortly:
<http://www.rcgp.org.uk/clinical/clinical-resources/~media/Files/CIRC/Mental%20health%20forum/Mental%20Health%20Page%20Sept%202013/PCMHF-Guidance-Debt-Mental-Health-Factsheet-2009.ashx>

The Newcastle Financial Inclusion Partnership brings together 47 agencies that provide information, advice and assistance to help people to better cope with reduced income and increased expenditure. They have developed an integrated approach to information and advice that helps people to maximise income, reduce expenditure, keep their home and access digital support.

Achievements include:

- Providing debt advice to 5,415 residents in 2012-13
- Advising 15,871 residents to secure over £24 million of unclaimed benefits in 2012-13
- Supporting moneywise Credit Union to provide over 400 more loans to vulnerable people, giving an alternative to payday loans.

The aim is to create a solid foundation for financial inclusion information, advice and support in the city, which can make a meaningful difference to local people's lives. A key element of this approach is providing consistent, coordinated information for use by all partner agencies in the city.

27. Primary care services have a crucial role in addressing mental health problems and assessing suicide risk. However, the accurate prediction of suicide is fraught with difficulties. The Royal College of GPs and Royal College of Psychiatrists have issued a helpful factsheet on managing suicide risk in Primary care http://www.connectingwithpeople.org/sites/default/files/SuicideMitigationInPrimaryCareFactsheet_0612.pdf

28. Local Authority Public Health Teams can provide support on information and data trends and effective public health approaches to support local efforts on promotion and prevention.

Grassroots Suicide Prevention is one year into delivering a three year plan that will result in Brighton & Hove achieving the internationally recognised designation of becoming a suicide safer city. The initiative is overseen by the Brighton & Hove Suicide Prevention Strategy Group. http://prevent-suicide.org.uk/suicide_safer_brighton_and_hove.html

Helping people affected or bereaved by suicide

29. The strategy places a new focus on support for people bereaved or affected by suicide.

30. Relatives and friends of people in suicidal crisis are often the first to notice that something is seriously wrong. It is important that they can get information and support as soon as possible. But they may be afraid to intervene in case they make matters worse, damage their relationship or even increase the risk of suicide. They also may be unsure about where to go for help. When help is sought, we have heard from families bereaved by suicide that medical professionals can seem reluctant to take information from families and that professionals have not communicated about a patient's suicide risk to the family.

31. Obtaining information from and listening to the concerns of family are key factors in determining risk. It is crucial that we address any confusion about how information can be shared. It is also very important to be clear that the duty of confidentiality should never be used as a justification for not listening to the views of family members and close friends who may well offer insight into the individual's state of mind which can aid care and treatment. That is why the Department of Health has worked with Royal Colleges and professional organisations to agree a consensus statement designed to promote greater sharing of information within the context of the relevant law. We want to see a change in practice, and welcome the commitment from professional bodies to address these issues.

32. Where a suicide occurs, families and friends will need effective and timely emotional and practical support. Bereavement by suicide can be particularly difficult to cope with, and many people find it hard to get the help they need. While many excellent local services exist, they are not available everywhere and people can struggle to access the services that do exist.

33. *Help is at Hand*¹⁴ is an important element of the national support for people bereaved by suicide. The Department of Health is reviewing the current resource with people who have been bereaved by suicide and organisations who can help us to reach bereaved people. Effective distribution is a recurring issue, and is something that we will be focusing on tackling through the review. The new resources should be available in 2014-15.

What local services can do

34. We know that families, friends and colleagues can be unclear how to access support that is available. An important start is for local agencies to map what support is available within the local area for those affected or bereaved by a suicide and which agencies provide this support. There are also a number of local initiatives to move towards providing support for every family affected by suicide.

Leeds Bereavement Forum has produced a short document with details of local and national support services available.

<http://www.leeds.gov.uk/docs/Bereavement%20leaflet%202013.pdf>

NHS Cornwall and Isles of Scilly, in partnership with Outlook South West, have developed a service to support people who have been bereaved by suicide. The Suicide Liaison Service provides short-term follow up and support, including referral to other statutory and voluntary services if required, for anyone who has been affected by suicide. <http://www.outlooksw.co.uk/suicide-liaison-service>

Middle-aged men

35. Men aged 35-54 years are now the group with the highest suicide rate. Understanding and addressing the factors associated with suicide in men, or working to limit their negative impact, will help to reduce population suicide risks. Key factors include depression, especially when it is untreated or undiagnosed, alcohol or drug misuse, unemployment, family and relationship problems including marital breakup and divorce, social isolation and low self-esteem.

36. Men will particularly benefit from many of the broad measures relevant to suicide prevention. Action on alcohol and drugs, the response to the recent economic uncertainty, efforts to reduce suicide and self-harm among people in contact with the criminal justice system and treating depression in primary care will all play a part in reducing suicide risk among men.

What local services can do

37. GPs can make a big difference to overall suicide rates. People recover more quickly from depression if it is identified early and responded to promptly, using evidence-based treatment.

38. Community outreach programmes into traditional male environments can also be powerful in engaging with men.

State of Mind is a Rugby League mental health and wellbeing initiative which aims to raise awareness and tackle stigma. The organisation aims to reach men who may not normally contact health and social care services, and signpost them to where support is available. A round of Rugby League fixtures is dedicated to State of Mind, which maximises the publicity. The focus is on promoting player welfare and resilience in local communities. Super League players act as ambassadors reaching fans and amateur players through presentations, meetings and social networking, with positive messages being specially commissioned and tweeted. Films with specific themes are available at www.stateofmindrugby.com

39. In April 2013, local authorities became responsible for commissioning drug and alcohol prevention, treatment and recovery services for adults and young people. For those people that have become dependent on drugs and alcohol, the aim is for them to recover from their dependency, to be in employment, have stable accommodation, look after their families, and cease committing crime. The Alcohol and drugs: JSNA support pack has been developed to support the joint strategic needs assessment process and local joint health and wellbeing strategies.

<http://www.nta.nhs.uk/healthcare-JSNA.aspx>

Children and young people

40. Improving children and young people's mental health is an important ambition, by promoting emotional resilience, good mental health and providing early and effective treatment for those who need it. The children and young people's mental health e-portal (to be delivered by 2014) will include specific learning and professional development in relation to self-harm, suicide and risk in children and young people.

41. Schools and colleges in conjunction with commissioners of mental health services have a key role to play in promoting good mental health for all children and young people and in intervening early when problems become apparent. To support more effective commissioning of mental health services by schools, the Department for Education have asked a consortium of voluntary organisations to develop new ways of tailoring and presenting the sector's offer to schools. The SEN reforms in the Children and Families Bill are intended to support better joint commissioning of education, health and care services. The new draft Code of Practice aims to ensure that schools identify underlying issues which might lead to SEN, including mental health issues, and can draw in specialist services as part of wider support plans.

42. Used well, the internet can reach out to vulnerable individuals who would otherwise be reluctant to seek information, help or support from other agencies. However, as well as maximising the benefits the internet brings, we must be aware of, and responsive to, the risks it presents. New measures announced by the Prime Minister will ensure that all internet customers will be given the opportunity to install free and easy to use filters which can block access to harmful websites such as those promoting suicide and self-harm. As part of the government's reforms to the national curriculum, from September 2014 e-safety will be taught to pupils at all key stages, from primary pupils aged five through to secondary pupils aged 16.

What local services can do

43. Local services can develop systems for the early identification of children and young people with mental health problems in different settings, including schools.

44. Local areas will be able to apply to be part of the Children and Young People's Improving Access to Psychological Therapies programme which will roll out evidence based practice and outcomes monitoring over the next few years.

The Children and Young People's Mental Health Coalition has developed guidance for schools on how to support children and young people's mental health, called Resilience and Results:
http://www.cypmhc.org.uk/resources/resilience_results/

Working with coroners

45. Suspected suicide deaths will always be reported to a coroner, who will certify the death after an inquest. Coroners have an important role in establishing the who, how and where of deaths.

46. Since the suicide prevention strategy was published, the Government has consulted on and finalised the new rules, regulations and orders to give effect to the coroner reforms. The aims of the reforms are to put the needs of bereaved people at the heart of the coroner system; for coroner services to be locally delivered but within a new national framework of standards; and to enable a more efficient system of investigations and inquests.

47. During the consultation on the reforms, the Chief Coroner joined a meeting of the National Suicide Prevention Strategy Advisory Group to hear about suicide-specific issues. This has been part of a series of discussions with organisations working on suicide prevention, and shows a welcome commitment on all sides to close working to ensure that coroner reform meets the needs of families bereaved by suicide, as well as supporting prevention of further deaths.

48. The strategy highlighted the concern that the increasing use of narrative verdicts could impact on the reliability of the national monitoring statistics produced by the Office for National Statistics (ONS). Following ONS work with coroners and to improve coding, the number of hard-to-code narrative verdicts in England fell from 3,170 in 2010 to 1,727 in 2011. This is likely to have had a positive impact on the reliability of ONS suicide statistics. The Chief Coroner will be issuing guidance to coroners, which should further improve the consistency of detail provided by coroners in narrative verdicts.

49. Respondents to the recent consultation on coroner reform commented on the most appropriate standard of proof needed for a coroner or jury to give a “suicide” conclusion at an inquest. Under current practice, coroners may return a verdict of suicide only where the criminal standard of proof has been established, i.e. that it was beyond reasonable doubt that the deceased intended to take their own life. In practice this means that a number of deaths that were probably suicides will not receive a suicide verdict. This is taken into account to some extent in the monitoring statistics we use for the purposes of the suicide prevention strategy, as ONS suicide rates include deaths given an open verdict at inquest, where the person's intent was unclear.

50. Some respondents expressed strong views on whether the current criminal standard should be replaced by the civil standard (i.e. on the balance of probabilities). Those in favour of making the change feel strongly that this change is important to address residual stigma attached to suicide. In their view, applying the

criminal standard helps perpetuate the stigma, and tackling this taboo will mean that suicidal people are more likely to seek the help they need.

51. For those against the change, a major concern was that a suicide verdict is upsetting for families and with potential negative consequences/associations, and that therefore the higher standard of proof should be required. Discussions about this issue are ongoing between Ministry of Justice, Chief Coroner, Department of Health and the National Suicide Prevention Strategy Advisory Group.

What local services can do

52. Close working relationships between individual coroners and local public health teams ensure local plans are evidence based and responsive. Coroners can be invited to become formal members of any local suicide prevention groups or networks.

53. Coroners can help by providing access to records of inquests for local data on suicide. Coroners can also inform the local authority or Director of Public Health if they identify (at inquest proceedings or earlier) particular areas of concern, e.g. locations used for suicide, possible clusters of suicide, increase in a particular method or new and emerging method of suicide.

National plans to support implementation

54. Much of the planning and work to prevent suicides will be carried out locally. Directors of Public Health and Public Health teams are now in local authorities, working with local Health and Wellbeing Boards. Local Clinical Commissioning Groups are now in place, and building relationships with provider organisations. The next year will be an important time for maintaining and developing suicide prevention in the new system. A report by the All-Party Parliamentary Group on Suicide and Self-Harm Prevention, published in January 2013, found that more than a quarter of local authorities in England did not have any specific suicide prevention strategy.¹⁵

55. Development of the cross-government suicide prevention strategy has been led by the Department of Health in our capacity as stewards of the new health and care system and the cross-Whitehall lead on health issues. The Department of Health will continue to have the lead role across government on suicide prevention. Public Health England will support local government, health and wellbeing boards and other partners, including clinical commissioning groups, in delivering local public health improvements. NHS England will provide national leadership for driving up the quality of care across health commissioning and also support national and specialist commissioning and local Clinical Commissioning Groups.

56. The Public Health Outcomes Framework includes indicators on suicide, self-harm and excess under 75 mortality in adults with serious mental illness. The indicator on excess mortality is also contained in the NHS Outcomes Framework. This attaches a clear national priority to work on suicide prevention.

57. Alongside publication of the new strategy we initiated a Call to Action for Suicide Prevention, facilitated by Samaritans. Over 50 national organisations responded to the call and declared their support. Building on this excellent work, we are supporting a new National Suicide Prevention Alliance, through a grant of £120,000 over two years.

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

59. Collectively, the Department of Health, Public Health England, NHS England and National Suicide Prevention Alliance partners plan to improve timely monitoring and surveillance of suicide and self-harm, learn the lessons from previous deaths to inform future commissioning of services and staff training/development, develop guidance to support local implementation and provide a national forum for sharing of positive and promising local practice.

What local areas can consider for next year

60. This document lists numerous actions that local services can take to reduce suicide, especially after self-harm and in people facing financial difficulties. Additional local actions could include:

- Developing, if not already in place, a local suicide prevention action plan as part of local health and wellbeing work with clinical commissioning groups and other partners.
- Local Directors of public health leading a data monitoring/surveillance function. Have local forums in place to monitor suicide trends, respond to incidents, and deliver the suicide prevention strategy locally.
- Engaging with local media regarding suicide reporting.
- Working with transport and other partners in health and wellbeing boards on mapping hot spots and taking appropriate actions.
- Working on local priorities to improve mental health. This might include: Awareness of mental health and peer support in young people; Anti-Bullying campaigns in schools; addressing stigma and social isolation in older people; Workplace health promotion and support with local business; Working with police on mental health literacy; addressing issues relevant to the local population, e.g. increasing awareness and support for young Asian women in arranged marriages.

Bolton Public Health Department have been leading collaborative work on suicide prevention for almost ten years and Bolton's multi-agency Suicide Prevention Partnership (BSPP) is moving into its sixth year. The partnership has recently published the third local Suicide Prevention Strategic Framework (SPSF) which is currently being ratified for formal adoption at the Health and Wellbeing Board. The SPSF focuses on reduction in suicide risk and risk factors universally in the general population and targeted amongst particularly vulnerable groups. The approach is strengthened by its focus on intelligence and action. Local data on the circumstances surrounding each suicide as well as routinely available local and national intelligence are combined to produce annual reports that shape the priorities of the partnership. Partners attending the BSPP report on progress towards their individual actions plans which are developed out of the SPSF. The suicide rate in Bolton has fallen from 12.9 (2008-10) to 12.0 (2009-11) in the latest official release. The latest Suicide Prevention Strategic Framework can be accessed via the online local knowledge and intelligence hub Bolton's Health Matters.

National Suicide Prevention Strategy Advisory Group

Role

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

Members

Prof Louis Appleby CBE, University of Manchester (Chair)

Prof Sue Bailey, Royal College of Psychiatrists

Stephen Dalton, NHS Confederation

Hamish Elvidge, Matthew Elvidge Trust

Ged Flynn, Papyrus

Vanessa Gordon, NHS England

Prof David Gunnell, University of Bristol

Prof Keith Hawton, University of Oxford

Gregor Henderson, Public Health England

Tim Hind, Local Government Association

Ian Hulatt, Royal College of Nursing

Prof Rachel Jenkins, Institute of Psychiatry

Claire Johnson, Secretariat to Ministerial Council on Deaths in Custody

Catherine Johnstone, Samaritans

Prof Nav Kapur, University of Manchester

Debbie Large, Coroner's Officers and Staff Association

Dr Chris Manning, Royal College of GPs

Clare Milford Haven, Trustee, James Wentworth-Stanley Memorial Fund

Assistant Chief Constable Alan Pacey, British Transport Police

Mary Piper, Public Health England

Jenny Rees, National Offender Management Service

Louise Robinson

Shirley Smith, If U Care Share

Dr Geraldine Strathdee, NHS England

Alison Tingle, Department of Health

Claudia Wells, Office for National Statistics

Dr Fiona Wilcox, Coroners Society

Prof John Wilkinson, Public Health England

Lindsay Wilkinson, Department of Health

Helen Steele, Department of Health (Secretariat)

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