HM Government

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

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| Third progress report on the cross-government outcomes strategy to save lives |

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Ministerial Foreword

Suicide is preventable. Yet suicide rates in England have increased since 2007[1], making suicide the biggest killer of men under 50 as well as a leading cause of death in young people and new mothers. On average, 13 people kill themselves every day in England. The death of someone by suicide has a devastating effect on families, friends, workplaces, schools and communities, as well as an economic cost. If we want to improve the life chances of future and current generations, we need to address this shocking reality and do more to prevent suicides.

The Prime Minister has spoken about the ambition for this Government to tackle burning injustices, including the inequalities caused by poor mental health. Addressing suicide and its prevention is a key part of that ambition, as suicides are more likely to occur in areas of low social and economic prosperity, in under-served communities and among those experiencing a range of challenges to their health, employment, finances, social and personal lives.

I want to use this 3rd progress report of the National Suicide Prevention Strategy (2012) to call for further action and strengthen the Government's response to this most tragic of issues. The Health Select Committee (HSC) inquiry into suicide prevention recently made a number of initial recommendations[2] for improving the National Strategy and this report addresses many of those recommendations. We will provide a full response to the HSC once its final report is published.

We will put in place a more robust implementation programme to deliver the aims of the National Strategy as recommended by the HSC. To achieve this, we must look at ways to connect the national policy with local delivery to drive and monitor progress with our partners and stakeholders. We will continue to work with the National Suicide Prevention Strategy Advisory Group and to provide financial support to the National Suicide Prevention Alliance (NSPA), which was formed after publication of the National Strategy in 2012 to support its delivery.

This report also sets out ways in which I am strengthening the National Strategy to drive delivery of its aims at a local level, where it matters most, to prevent further families, friends, colleagues and communities from experiencing the tragedy of suicide. I also want to increase our focus on young people in educational settings, including colleges and universities, to raise awareness of suicide risk and mental wellbeing. In order to strengthen the National Strategy, I want to take action in the following areas:

- Better and more consistent local planning and action by ensuring that every local area has a multi-agency suicide prevention plan in 2017, with agreed priorities and actions;
- Better targeting of suicide prevention and help seeking in high risk groups such as middle-aged men, those in places of custody/detention or in contact with the criminal justice system and with mental health services;
- Improving data at national and local level and how this data is used to help take action and target efforts more accurately;
- Improving responses to bereavement by suicide and support services; and
- Expanding the scope of the National Strategy to include self-harm prevention in its own right.

I welcome the independent Mental Health Taskforce recommendations in its Five Year Forward View for Mental Health to set a national ambition to reduce the suicide rate in England by 10 per cent by 2020/21 and for every local area to have in place a multi-agency suicide prevention plan[3]. Delivery of these ambitious recommendations is supported by NHS England's additional £25 million for suicide prevention from 2018/19 to 2020/21. Guidance and support for local suicide prevention planning was published by Public Health England in October 2016[4] and I wrote to every local authority Chief Executive to encourage them to develop their plans. I am delighted that 95 per cent of local authorities now have plans in place or in development. Local plans should align with local Crisis Care Concordat action plans and the ambitions we have for local prevention planning.

We have achieved significant reductions in inpatient suicides over recent years but there is more we must do. I want the NHS to go further to reduce the number of suicides by patients commonly identified at higher risk such as inpatients, those under the care of crisis resolution home treatment teams and those recently discharged from hospital. Our new investment in crisis resolution home treatment teams will help ensure that more people can be effectively and safely treated in the community. We are also investing in liaison mental health services in acute hospitals, to ensure people who present with mental health problems receive the right care, in the right place, quicker.

This is part of the Government's wider commitment to transform mental health services through additional investment of £1 billion by 2020.

The Future in Mind report[5] set an ambitious vision for transforming children and young people's mental health. To achieve this vision the Government set out additional investment of £1.4 billion for children and young people's mental health, including expanding services for eating disorders.

The central driver of the National Strategy must be that suicide is preventable. Throughout this annual report there are examples of what local areas can and should be doing to link national action to local delivery. That is the only way that we can achieve the ambition of reducing the national suicide rate by 10 per cent by 2020/21. Encouragingly, the latest data on suicide rates in 2015[1] show that there has been a small decrease in the suicide rate in England and so it is crucial that we build on this momentum. Together, we can achieve this goal.
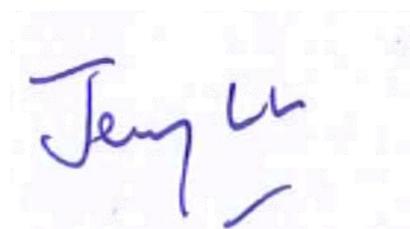
Jeremy Hunt
Secretary of State for Health

Foreword - Chair of the National Suicide Prevention Strategy Advisory Group

The 3rd annual report of the National Suicide Prevention Strategy offers a chance to consider areas where we need to increase our efforts if we are to reduce suicide rates. It is very welcome therefore that the Secretary of State for Health has set out a commitment to strengthen the National Strategy and drive forward key areas for action that will address current suicide prevention priorities.

We can see from the most recent national data that the suicide rate in England fell slightly in 2015[1], though the rate remains high in comparison to the last 10 years and it is too soon to say whether this fall is the beginning of a downward trend. For this reason we shouldn't underestimate the scale of the challenge if we are to meet the national ambition of reducing the suicide rate by 10 per cent by 2020/21. But there are positive signs. The suicide rate in mental health patients is down[6]. The rate in men has fallen for two years and this fall is found most clearly in middle-aged men whose risk has been highlighted in the National Strategy. Even so, the highest rates are still found in men in their 40s and 50s and it remains the leading cause of death in young men. At the same time, the suicide rate in women has risen, though the male rate is still three times higher[1].

The National Strategy is strengthening its focus on men, self-harm and support for bereaved families. Several reports in recent years have raised concerns about the mental health of young people, suggesting rising rates of emotional problems and self-harm. Self-harm is most common in people under 25 and although suicide rates at this age are comparatively low, the latest figures from 2015 show a small rise.

The National Strategy is based on the best available evidence. We know that, for people who have self-harmed, skilled psychosocial assessment leads to better outcomes, yet currently only around 60 per cent of patients receive an assessment[7]. We know that in mental health services, key components of suicide prevention are safer wards, early follow-up on hospital discharge and crisis resolution home treatment teams. We know that supporting young people at risk is a job for primary care, schools, the justice system and third sector as well as mental health services. Similarly, a central theme of this year's report is the need for local suicide prevention plans in every area, put together by the joint working of public health, mental health and the many agencies that support vulnerable and high risk people.

The National Suicide Prevention Strategy Advisory Group that oversees the Strategy brings together bereaved families, suicide prevention charities, professionals and academic experts - I want to thank members for their commitment and wise counsel. Patterns of suicide are constantly changing and vigilance is literally vital.

Professor Louis Appleby CBE

Introduction

1. The cross-Government National Suicide Prevention Strategy for England was published in 2012. It is now the right time to review progress and look at ways of improving our efforts. We welcome the publication of the Health Select Committee's (HSC) inquiry into suicide prevention which made five key recommendations for improving the national strategy:
    *   Improving implementation through strong leadership, clear accountability and improving transparency and scrutiny;
    *   Improving support for people most vulnerable to the risk of suicide;
    *   Raising awareness of the Information Sharing and Suicide Prevention Consensus Statement;
    *   Improving national data; and
    *   Improving the response to media reporting of suicide.

2. The Secretary of State for Health has identified five key areas for increasing our efforts on suicide prevention and this progress report sets out ways in which we are addressing these areas, including many of the recommendations made by the HSC.

3. The Government's extra investment in mental health of £1 billion by 2020 creates opportunities to address many issues that will help us in our goal to reduce suicide and to drive forward improvements. The extra investment will help improve mental health services in emergency departments and mental health crisis resolution home treatment teams in the community. We are rolling out liaison and diversion services nationally by 2020 which are ensuring that people who come into contact with the criminal justice system and who have mental health needs are diverted to appropriate services. NHS England will work with partners before setting out the funding priorities for the additional £25million investment for suicide prevention from 2018/19-2020/21.

4. This report provides progress against the key areas of action identified by the National Strategy. Central to driving delivery of the National Strategy will be implementing multi-agency suicide prevention plans locally, which will provide the co-operation and focus necessary to deliver effective suicide prevention interventions that are tailored to local needs.

5. A survey by the All Party Parliamentary Group on Suicide Prevention, published in January 2015, highlighted that 30 per cent of local areas did not have suicide prevention plans and 40 per cent did not have multi-agency suicide prevention groups. This was clearly unacceptable. Since that point, we have worked with local authorities to improve this position and a follow-up survey by Public Health England in 2016 shows that 95 per cent (146 of the 152 local authorities) now have a multi-agency suicide prevention action plan in place or in development. Though this demonstrates significant improvement, we recognise that continued strong local leadership and commitment to take action is needed to ensure we achieve the recommendation in the Five Year Forward View for Mental Health for all local authorities to have multi-agency suicide prevention plans in place in 2017.

6. We have published details, alongside this report, of local authorities which have achieved this commitment, including data on suicides in each area which will enable local areas to benchmark against national averages and other local areas. This sits alongside mental health ratings for CCGs which we published on the MyNHS website to improve transparency and drive up standards of mental health care across the country.

7. We will work with local authorities to support them in assuring the quality of their plans against Public Health England's guidance. We will ensure that the status of local plans is updated annually to drive improvement and ensure that the newest information and best practice are incorporated.

8. We have made progress on delivering the National Strategy in a number of other areas over the past year. We continue to provide financial support to the National Suicide Prevention Alliance (NSPA) which has worked with its members to develop a strategic framework for progressing areas such as help-seeking in high-risk groups and suicide bereavement. The Help is at Hand guidance, commissioned by Public Health England, for those bereaved by suicide was refreshed in 2015[8] by people who have experienced suicide bereavement. The National Offender Management Service (NOMS) has established a suicide and self-harm project which is improving staff training and developing better support for prisoners to reduce the number of self-inflicted deaths and instances of self-harm in prison.

9. Across the transport network, over 15,000 rail personnel have now received suicide prevention training and the British Transport Police launched its suicide prevention strategy. The Department for Transport has incorporated a requirement within train operating franchise agreements to adhere to the suicide prevention strategy.

10. The Samaritans has worked with Facebook to revise its suicide prevention toolkit and has been working with a range of stakeholders to address suicide prevention online. We will be exploring ways we can work with the Samaritans and the online sector to increase efforts to address potentially harmful suicidal content online. The Government also remains committed to improving online safety for children and young people.

11. However, there is much more we need to do to achieve the ambitious recommendation of reducing the national suicide rate by 10 per cent by 2020/21. We are stepping up our approach to suicide prevention in public health to improve delivery at a local level which will be driven by local suicide prevention plans.

12. This annual report sets out the ways we are addressing the key areas for improvement highlighted by the Secretary of State for Health and the HSC, as well as outlining our programme to deliver real change. It also includes updates on progress across Government and by national delivery partners.

Progress on key areas for action

13. The National Strategy committed to tackling suicide in six key areas for action, with the scope of the strategy now expanded to include addressing self-harm as a new key area:

    - Reducing the risk of suicide in high risk groups;
    - Tailoring approaches to improve mental health in specific groups;
    - Reducing access to means of suicide;
    - Providing better information and support to those bereaved or affected by suicide;
    - Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour;
    - Supporting research, data collection and monitoring; and
    - Reducing rates of self-harm as a key indicator of suicide risk.

Reducing the risk of suicide in high risk groups

The National Strategy identified the following high risk groups:

- young and middle-aged men;
- people in the care of mental health services, including inpatients;
- people in contact with the criminal justice system;
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers; and
- people with a history of self-harm.

Young and middle-aged men

14. Men remain the most at risk group and are three times more likely to die by suicide than women. Suicide is the biggest killer in men under 50 years old and a leading cause of death in young men. We must go further to address this inequality. Several campaigns and charities have been targeting specific male groups using messages and providing support in settings that are familiar and accessible to men. Initiatives such as the Men's Sheds Association and the joint campaign between the Campaign Against Living Miserably (CALM) and Lynx are raising awareness of mental wellbeing and male suicide.

15. We recognise that sporting communities are an important way to engage with young and middle-aged men; there is evidence that engagement via this route can be successful (for example, State of Mind Sport and Andy's Man Club). We will consider further engagement through the sporting community to build on the good work already taking place around the country to address these issues.

State of Mind Sport

State of Mind Sport is a mental health and wellbeing initiative which aims to raise awareness and tackle stigma, as well as encourage individuals to seek help when needed.

Awareness raising and resilience presentations are delivered by a Nurse Consultant in Mental Health and substance Misuse, and ex-professional players who have experienced mental health problems. They have delivered over 14,000 sessions over the last five years in a wide variety of settings.

Professional players selected as State of Mind Ambassadors harness their social media profiles and it is estimated the campaign has a reach of over 4 million last year. The organisation has primarily been focussed on Rugby League, but is now engaging with other sports.

http://www.stateofmindsport.org/

16. To help drive home these messages, the NSPA, through the Samaritans, worked with its members to support the "It's Okay to Talk" campaign (in conjunction with Andy's Man Club) to mark World Suicide Prevention Day in 2016. Here they used links with sport to show that it's ok for men to talk about mental health issues and suicide.

17. We know that men are less likely to seek help and so we must look at more innovative ways of targeting men, especially middle-aged men to address the barriers that prevent them from seeking help. We also need to consider which interventions and services would be most effective to meet their needs. This means taking action in all areas where men come into contact with local services, the NHS and social care services as part of local suicide prevention plans. Public Health England's guidelines on suicide prevention planning for local authorities highlights that sporting initiatives may be an effective way of targeting young men and local areas may want to engage local sporting figures, or gym/fitness professionals to become suicide prevention champions.

Cree – The County Durham Sheds Programme

Men's Sheds originally started in Australia as community-based, not for profit, non-commercial organisations to offer men a safe and friendly environment to work on meaningful projects, with a major objective to advance the well-being and health of their members.

Following a suicide audit in 2010 showing that County Durham's suicide rate was higher than the England average, Durham County Council Public Health commissioned the Cree programme. The project was based on the Australian model, and started with an initial pilot in east Durham. There was further roll out initially across east Durham in 2011, and then county wide from 2012 which has grown to nearly 40 groups across the county. Each Cree offers activities ranging from archery and paintballing, to arts, crafts and woodwork and has a champion trained in mental health first aid.

http://www.eastdurhamtrust.org.uk/index.php?option=com_content&view=category&id=73&Itemid=119
http://menssheds.org.uk/

18. It is also important to consider other factors that may impact men such as relationship problems, financial difficulties, alcohol/drug problems and other issues such as pressures on body image, especially in young men. However, for men, the stigma they can feel when it comes to talking about mental health problems remains a significant barrier to them seeking help and we must address this.

19. The latest Adult Psychiatric Morbidity Survey[7] of Mental Health and Wellbeing in England for 2014 showed that a fifth of people seek help from family, friends and neighbours following an attempted suicide. Therefore, reducing stigma in local communities is important to reducing barriers to people seeking help. The NSPA has developed a strategic framework to take forward key areas of work which includes reducing stigma, encouraging help-seeking and providing appropriate support, particularly for men.

20. The Time to Change national campaign led by Mind and Rethink Mental Illness aims to reduce stigma and discrimination relating to mental health, and is funded by the Department of Health, Comic Relief and the Big Lottery Fund. We recently announced further collective funding of £20 million to support the next phase of Time to Change which is placing more focus on addressing stigma within local communities and empowering them to develop their own local responses. To date, their work has seen a reported change in over 3.4 million people's attitudes to mental health[9].

People in the care of mental health services

21. Patient safety remains the top priority for the NHS but the Care Quality Commission's State of Care report for 2015/16[10] raised some concerns around patient safety in mental health services. Suicides by people in contact with mental health services are arguably the most preventable. Currently around a third of people who die by suicide have been under specialist mental health services in the year before they die, and two-thirds have seen their GP. The latest Adult Psychiatric Morbidity Survey of Mental Health and Wellbeing in England[7] shows that just over half of people sought help following an attempted suicide from either their GP or hospital services (26 per cent from a GP and 25 per cent from secondary mental health services).

22. The latest data shows that people who have died by suicide who have been in contact with mental health services is estimated to have increased to 1,372 in 2014[6] from 1,329 in 2013. However, the rate, taking into account the rising number of people accessing mental health care, has fallen. As part of the national ambition to reduce the suicide rate by 10 per cent by 2020, all of the NHS arm's length bodies are working to implement the Five Year Forward View for Mental Health's recommendation that deaths by suicide across NHS-funded mental health settings are learned from to prevent repeat events. We published the Five Year Forward View for Mental Health Dashboard[11] in October last year which includes an indicator at CCG level for monitoring performance on providing 7-day follow-up for people discharged from hospital. This is a vital measurement in reducing suicide risk. The NHS Planning Guidance for 2017-2019[12] and guidance for the development of Sustainability and Transformation Plans both make clear that local NHS bodies should work together with other partners to help deliver the 10 per cent reduction in suicides.

23. Following the Five Year Forward View for Mental Health[3] and the accompanying implementation plan[13] published in July 2016, NHS England's mental health programme across the life course is centred on the importance of early intervention so people of all ages have timely access to evidence-based services as close to home as possible with clear pathways to support recovery.

Primary care

24. Around 25 per cent of mental health patients who die by suicide have a major physical illness (accounting for 3,410 deaths between 2005-2013). This highlights the importance of integrating mental and physical health for people of all ages across primary, secondary and specialist NHS services, including for people with long-term physical health conditions and ensuring timely physical health assessments and follow-up treatment for people living with mental health problems.

25. NHS England is developing its overall primary and community mental health care offer including exploring new models of enhanced primary care. The national crisis care programme has highlighted the need for GPs to know the possible referral routes through to secondary services that are available to them. The Urgent & Emergency Care Review's[14] focus on the development of Integrated Urgent Care is therefore a significant opportunity for local partners to update their Directories of Services to improve their referrals.

26. Fifty NHS England Vanguard sites were launched during 2015 to develop and test new models of care and eight of these are Urgent and Emergency Care Vanguards. For example, the Greater Nottingham Vanguard is supporting people, including those with mental health problems, to access the right services in the right place so that A&E is not the first default choice. This includes connecting physical health, mental health and social care services through a clinical hub to navigate people to the right services.

27. Training for GPs and GP surgery staff in awareness of suicidality and safety planning can play a crucial role in suicide prevention, and Health Education England has been working with Public Health England to review materials such as e-learning tools and is considering how best to support this nationally.

28. Awareness training should encourage the implementation of NICE guidelines to improve the identification, treatment and management of depression in primary care.

Talking therapies

29. The expansion of the Improving Access to Psychological Therapies (IAPT) programme represents the continued transformation of care for people with common mental health problems, including depression and anxiety. The Five Year Forward View for Mental Health[3] committed to expanding access to talking therapies to 25 per cent (from 15 per cent) of people who could benefit by 2020/21. This equates to an additional 600,000 people and focuses on people with long-term conditions. Integrated and co-located psychological therapists within other settings such as primary care and employment services will both provide treatment for people with anxiety and depression and play an active role in multidisciplinary teams.

30. The General Practice Forward View[15], published in April in 2016, set out that NHS England would invest in an extra 3,000 mental health therapists based in primary care by 2020, supporting the IAPT programme.

Chiltern and Aylesbury Vale

The Chiltern and Aylesbury Vale early implementer site already has an integrated mental and physical health care pathway for respiratory disease called "Breathe Well" and has some integrated services for management of long-term conditions in primary care called "Live Well". The Live Well service will be rolled out to all GP practices and primary healthcare teams in both CCGs. Each physical health care team will have a psychological therapist linked to them – providing a single point of contact and access to all long term conditions and lifestyle management services.

Secondary and community mental health services

31. We have more than halved the number of inpatient suicides in recent years due to improvements in patient safety but the number of people who die by suicide whilst in contact with crisis resolution home treatment teams remains worryingly high. This reflects both improvements in patient safety in hospitals and the changing model of care to more provision of care in the community closer to home, and more people under secondary mental health care. But we must go further to ensure that all mental health services provide the safest care for patients.

32. These trends point to the importance of effective and evidence-based early intervention services and crisis care services in the community. This is why early last year the Government announced over £400 million to improve 24/7 treatment in communities as a safe and effective alternative to hospital and £247million for mental health liaison services in acute general hospitals over the next five years. By 2020/21 all acute hospitals will have all-age liaison mental health services in place with at least 50 per cent meeting the 'Core 24' standard for adults and older adults. New local suicide prevention plans should also dovetail with Crisis Care Concordat action plans and other relevant initiatives such as Local Transformation Plans for Children & Young People's Mental Health & Wellbeing[16].

33. NHS England has also included mortality by suicide within a new set of urgent & emergency care outcome metrics that are currently being tested by the eight Urgent & Emergency Care Vanguards to be applied across the system.

34. From 1 April 2016, the access and waiting time standard for early intervention in psychosis (EIP) services requires that more than 50 per cent of people experiencing a first episode of psychosis commence treatment with a NICE-approved care package within two weeks of referral. We are investing £40 million recurrently from April 2015 to support delivery of the new standard. New investment from 2017/18 builds over four years to support phased improvement and additional capacity reaching £70 million by 2020/21. The majority of CCGs nationally are exceeding the referral to treatment standard and NHS England has asked the Royal College of Psychiatrists' Centre for Quality Improvement to support assessment of the NICE concordance element of the standard.

35. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)[6] has recently set out 10 components of safety in mental health care that the NHS should be working towards. These components are safer wards (including removal of ligature points, reducing absconding and increase skilled in-patient observation); care planning and early follow-up on discharge from hospital to community; no 'out of area' admissions for acutely ill patients; 24 hour crisis resolution/home treatment teams; community outreach teams to support patients who may lose contact with conventional services; specialised services for alcohol and drug misuse and "dual diagnosis"; multidisciplinary review of patient suicides, with input from family; implementing NICE guidance on depression and self-harm; personalised risk management, without routine checklists; and low turnover of non-medical staff.

Consensus statement for sharing information

36. We published the Information Sharing and Suicide Prevention Consensus Statement[17] in 2014, in conjunction with the Royal Colleges and other partners, to encourage health professionals to share information about someone at risk of suicide with family members and friends.

37. We have heard from stakeholders and the recent Health Select Committee inquiry into suicide prevention that we should do more to promote the Consensus Statement.

38. The National Suicide Prevention Strategy Advisory Group (NSPSAG) is working with the Royal Colleges to explore ways in which we can improve the awareness of the Consensus Statement with their members.

People in contact with the criminal justice system

39. People in contact with criminal justice services often present with complex mental health, substance misuse and physical health problems. Nine out of ten people in prison have a mental health or substance misuse problem and 72 per cent of adult male and 71 per cent of adult female prisoners may have two or more mental disorders (e.g. personality disorder, psychosis, anxiety and depression, substance misuse); 20 per cent have four or more mental disorders.

40. There has been a sharp increase over recent years in reported deaths by suicide following police custody with the most recent annual figures standing at 60 cases in 2015/16. HM Chief Inspector of Constabulary published guidance in 2015 for protecting the Welfare of Vulnerable People in Police Custody[18] which provided advice on a range of improvements including more robust risk assessment. The Home Office launched an independent review in 2015, which will report soon, to look at issues around suicide following police custody, including processes and procedures leading up to a death, investigation of deaths and better awareness of mental health issues.

41. The Department of Health has also led work which more than halved the use of police powers to detain someone in a police cell under section 135 and 136 of the Mental Health Act 1983. In 2014/15 the number of people detained was 3,996 and this was reduced by half again in 2015/16.

42. The Government set out in the Policing and Crime Bill that no-one under 18 years old will be detained in a police cell under sections 135 and 136. In tandem with reducing those who are detained in a police cell under the Mental Health Act 1983, the Department of Health secured an additional £15m of investment and, with the Home Office, are increasing the number of hospital based places of safety.

Improving Hospital Safety in Lincolnshire

Of the £15 million to increase places of safety, one of the 45 projects is in Lincolnshire and involves a threefold approach to improved safety. Over £400,000 is being spent to develop the following:

- A new psychiatric decision making unit;
- Rapid response vehicles used for improving street triage and;
- A new CAMHS section 136 suite for children and young people.

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43. National partnership agreements have been established requiring significant work to ensure integration of care and treatment for people in contact with criminal justice services, in custody and in the community and particularly among people transitioning between settings. NHS England published a strategic direction for healthcare in the justice system 2016-2020[19] in October last year.

44. The NHS England Deaths in Custody Working Group, a sub-group of the Health & Justice Clinical Reference Group, is also producing an evidence-based report outlining its priorities and work plan to support the joint objective with the National Offender Management Service (NOMS) and Public Health England of reducing incidents of suicide and self-harm in secure criminal justice settings.

45. However, there have been increases in the number of self-inflicted deaths in prisons. In the twelve months to June 2016, there were 105 deaths provisionally classified as self-inflicted. This increase may be due to a number of factors. Prisons contain a high proportion of vulnerable individuals, many of whom have experienced negative life events that increase the likelihood of self-harm or suicide. Issues that increase risk include drug/alcohol abuse, family background, relationship issues, social disadvantage or isolation, previous sexual or physical abuse, and mental health problems. Wider factors which can influence suicide risk include access and support from family and others and the rehabilitative aspects of the prison regime and environment.

46. The Ministry of Justice is working to modernise the prison estate, improve education and empower governors, so that they can tackle issues like drugs and violence which are key to cutting re-offending and keeping staff and prisoners safe. An additional £10 million was allocated in June 2016 to prison governors to help promote safety and provided them with discretion about how to spend that money. The approach they have taken varies, but many have used it to fund additional staff, buy new equipment, or to pay for particular training or interventions.

47. NOMS has established a Suicide and Self-Harm Project, and, in conjunction with NHS England and Public Health England, is taking action to reduce self-inflicted deaths and self-harm. This includes: implementing the findings of the review of compliance and delivery of the Assessment, Care in Custody and Teamwork (ACCT) care planning process undertaken in 2015; delivering updated training to staff with prisoner contact and holding regular learning days open to all prisons; reviewing the approach to the use of safer cells; working with the Samaritans to further strengthen the long-established Listener scheme; reviewing some existing interventions and exploring additional options; improving the support provided in the early days and weeks of custody. The Health and Justice Clinical Reference Group, and its sub-group on deaths in custody, ensures co-ordination across sectors on work relevant to this agenda.

48. The Equality and Human Rights Commission (EHRC) reported its concern that there is no official data on the number of prison deaths of people with mental health conditions. Its progress review[20] strongly recommended the collection, collation and publication of this information. From April 2016, NHS England's Health and Justice Indicators of Performance will identify prisoner numbers receiving mental health assessments, mental health treatment, and those who need treatment which can only be provided through transfer to a psychiatric hospital.

49. The Prison Safety and Reform white paper[21] published in November 2016 set out the next steps for reform across the prison service. It outlines the framework being developed to deliver improvements, including improving service standards, investing in the prison estate, and improving safety and workforce.

50. In 2015, the Government announced capital funding to build nine new prisons in England which are modern, sustainable and rehabilitative. Earlier last year the Government also announced six new reform prisons which will test new freedoms around how budgets and operational freedoms over education programmes, family visits processes and rehabilitative services.

51. NHS England's Health and Justice Nursing and Quality Leads and Chief Nursing Officers have created a core set of quality indicators and standards to provide a consistent measure of the quality of commissioned services in secure settings. NHS England has developed a close working partnership with the Prison and Probation Ombudsman which includes bi-annual meetings to review and agree actions to support reduction of avoidable deaths in custody.

Specific occupational groups

52. Risk of suicide and self-harm is higher in people who are unemployed. However, evidence shows there are certain occupational groups such as doctors, nurses, veterinary workers, farmers and agricultural workers that are at higher risk of suicide and this is usually related to access to means. However, we also know that suicide risk by occupational groups may vary nationally and even locally, and it is vital that the statutory sector and local agencies are alert to this, and adapt their suicide prevention interventions accordingly.

53. It is important that we continue to monitor trends in these areas and therefore it is timely to review the data on occupational groups. The Office for National Statistics (ONS) is analysing the national data to look at suicide risk related to specific occupational groups. This analysis will be published early this year and will help to identify any underlying trends within high risk occupational groups and steer our thinking to inform better interventions in these areas. This may include working with professional bodies and industry to explore ways in which they can take action to improve suicide prevention for their employees. There are international models to learn from such as the Mates in Construction model from Australia. The Health in Construction Leadership Group launched Mates in Mind last year for the UK construction industry to encourage better mental health awareness.

54. The St John's Ambulance Service is part of Mind's Blue Light Programme, which provides mental health support for emergency services staff and volunteers from police, search and rescue, fire and ambulance services across England. We will also look at ways in which we can build on this partnership in other sectors. We know that this network has had a big impact in supporting the physical needs of people through volunteers and we want to explore how this can be extended to ensure that mental health needs are also better served through successful partnerships.

People with a history of self-harm

55. Given the direct link to suicide and increasing concerns about self-harm raised by professionals who work with children and young people, it is timely that we increase our efforts to address this issue. The latest data[22] also shows a higher prevalence of hospital admissions of girls under 17 for self-harm. The National Strategy in 2012 identified those who self-harm as a high risk group. It is now time to go further and address self-harm as an issue in its own right and to encourage young people who self-harm to seek support, advice and help. That is why we have expanded the scope of the National Strategy to include self-harm as a new key area for action.

56. Self-harm, including attempted suicide, is the single biggest indicator of suicide risk. The UK has high rates of self-harm resulting in over 200,000 hospital attendances per year in England. Approximately 50 per cent of people who have died by suicide have a history of self-harm[23], and in many cases there has been an episode of self-harm shortly before someone takes their own life.

57. There is currently a lack of high quality self-harm services across the country, although there are several areas demonstrating good practice. The latest Adult Psychiatric Morbidity Study (APMS) for Mental Illness and Wellbeing in England for 2014[7] shows that the number of people reporting to have self-harmed has increased since 2007. A fifth of young women (under 24) surveyed had reported ever having self-harmed and there were significant increases in reported self-harm in men and women aged between 25-34. However, only around 28 per cent of men and 43 per cent of women surveyed received medical or psychiatric treatment after self-harming. The Care Quality Commission's report, Right Here, Right Now[24], published in 2015 also highlighted that people who self-harm still report they experienced a lack of sympathy and other negative experiences when they come into contact with NHS professionals.

58. The National Institute for Health and Care Excellence (NICE) developed a guideline for the treatment of self-harm in July 2004 (reviewed in 2014). This guidance set out effective pathways for self-harm and in particular highlighted the importance of undertaking psychosocial assessments for people who have presented at emergency departments for self-harm. The evidence suggests this can be effective in achieving better outcomes for people who self-harm as well as being a low cost intervention that all hospitals could implement. Yet, only around 60 per cent of people receive such an assessment[25]. This is unacceptable: it is essential that everyone who attends A&E for self-harm receives and assessment that meets NICE guidelines.

59. The increase in specialist mental health expertise in emergency departments through the expansion of liaison mental health services will help to meet these aims. At the same time, in line with the recommendations of the Five Year Forward View for Mental Health, NHS England plans to draw on clinical research and service user expertise, including the NICE guideline, to develop an evidence-based treatment pathway for self-harm for people of all ages in 2017/18 and 2018/19. We will monitor progress.

60. To improve the local monitoring of people who present at emergency departments for self-harm we have introduced an indicator within the Public Health Outcomes Framework[26] to ensure all Trusts collect data on the number of people who present at emergency departments and emergency admissions to hospital for self-harm.

61. We are working with NHS England, NHS Digital, the Royal College of Emergency Medicine, NHS Providers and NHS Improvement, and the Multicentre Study of Self-harm to explore how to improve the measurement of self-harm in emergency departments and incorporate measurements of whether those presenting receive a psychosocial assessment into the new Emergency Care Data Set, which is in development. NHS England has set a new national CQUIN for 2017-2019 to improve services for people with mental health needs who present to emergency departments, including frequent attenders.

62. We have supported research which has informed development of guides for parents about self-harm in young people, in association with other bodies such as Young Minds (a leading charity for improving mental health and wellbeing in young people), the Royal College of Psychiatrists and the Royal College of Nursing which also provide a range of materials to provide help and guidance on self-harm. Last year we worked with Young Minds in partnership with the Royal College of Psychiatrists and the Charlie Waller Memorial Trust (a charity which focuses on the mental health and wellbeing of young people) to launch 'No harm done'[27], a series of films and toolkits that set out practical steps for young people, parents and health professionals to identify, understand and address self-harm. We are exploring ways in which we can build on this work.

STITCH: Improving Care in Self-Harm

The Improving Care in Self-Harm Health Integration Team (STITCH) is working to reduce the number of suicides in the Bristol area, by transforming understanding of self-harm across the health service and improving treatment and support for self-harm patients. They aim to ensure self-harm treatment and care is equitable, fully evidence based and non-stigmatising for all self-harmers, and to reduce suicides in Bristol.

The STITCH team implemented a Self-harm Surveillance Register at the Bristol Royal Infirmary (BRI), and this is now being extended to Frenchay Hospital and Bristol Children's Hospital to capture data across the city. This data collection has been the backbone of improvements:

- The BRI has created an emergency department staff training package on a rolling six-month programme and is working with other trusts across the south west to standardise self-harm training for emergency department staff.
- Two thirds of self-harmers presenting at A&E receive a psychosocial assessment, compared to just over half in 2011.
- A reduction in the average hospital length stay for patients admitted following self-harm.
- People who attend A&E more than once due to self-harm can be identified and are offered an enhanced personal plan.
- Close working between self-harm patients, practitioners and researchers to effectively and quickly evidence and implement improvements for the care provided to all those who self-harm at A&E including refinements in the psychosocial assessment and questions asked.

http://www.bristolhealthpartners.org.uk/stitch

Tailoring approaches to promote mental health in specific groups

63. The National Strategy highlighted the importance of implementing tailored approaches to improving mental health in a range of groups with specifics needs and characteristics that may expose them to more risk factors for suicide. These include children and young people, the lesbian, gay, bisexual and transgender (LGBT) community and people from Black and Minority Ethnic (BME) groups, but also people with long-term physical health conditions and people with untreated depression.

64. Progress has been made since 2012 in improving mental health services for many of these groups. We have supported the development of guidance on best practice commissioning of mental health services for people from BME groups[28]. Public Health England also published toolkits on preventing suicide among lesbian, gay, bisexual and transgender young people[29]; a collaboration with the Royal College of Nursing to support and develop the role of nurses in the prevention of suicides in the LGBT community.

65. The rest of this section provides progress on the following groups:

   - Children and young people;
   - Users of drug and alcohol services;
   - Perinatal mental health; and
   - People in receipt of employment benefits.

Children and young people

66. The suicide rate in England for children and young people between the ages of 10-29 has remained relatively stable since 2005; however the rate in 15-19 year olds has risen for the last three years.[30] We are hearing from professionals who work with children and young people that they are becoming increasingly concerned about mental health issues, including self-harm. The Department of Health and Department for Education will jointly develop and produce a Green Paper on children and young people's mental health this year, with new proposals for both improving services and increasing focus on preventative activity across all delivery partners.

67. Complex factors and events may contribute to the death by suicide of children and young people. A recent study by NCISH[6] found academic pressures, bereavement, bullying, alcohol or drug misuse and childhood abuse in many cases. More than half of those who died had a history of self-harm and 27 per cent had expressed suicidal thoughts in the week prior to death. We will look at the issues affecting young people which may be impacting their mental health such as body image and other pressures from social media, including consideration of the impact this may be having on young women and girls.

68. The Children and Young People's Mental Health and Wellbeing Taskforce set out its vision for transforming services to improve the way children and young people's mental health services are organised, commissioned and provided, and how to make it easier for young people to access help and support, including in schools, through voluntary organisations and digital means.

69. In 2015, the Government published a report of the findings of the Taskforce, Future in Mind[31]. The report established a clear and powerful consensus for change and this Government is committed to implementing this vision.

70. This vision was supported by an additional investment of £1.4billion as part of a five-year transformation programme to promote, protect and improve children and young people's mental health. Every area in the country has received an additional investment to transform their offer against the needs of their population, alongside support to deliver specialist community services for eating disorders and improving perinatal services.

71. Schools and colleges have a key role to play in promoting good mental health for children and young people. The Prime Minister announced plans this month to make further progress in relation to children and young people in educational settings, including rolling out mental health first aid in schools and expanding the pilots to establish single points of contacts for mental health to reach even more schools to improve initial support and quick referrals to specialist services.

72. The Department for Education has supported schools through a number of activities, including funding the development of Personal, Health, Social and Economic (PSHE) guidance and age-appropriate lesson plans on mental health, publishing guidance on the provision of high-quality school-based counselling and on mental health and behaviour. We know that some schools have already established close working relationships with CAMHS and this should be encouraged in other areas.

73. The Department for Education has also been looking at what good peer support for mental wellbeing looks like in schools, colleges, community groups and online.

74. It is clear that many LGBT pupils who are bullied can experience negative academic, social and mental health outcomes. The impact of this can persist into adult life. It is imperative that schools are safe, inclusive environments where pupils are able to learn and fulfil their potential. This is why the Government is funding a £2.8 million programme from 2016 to 2019 specifically to tackle homophobic, biphobic and transphobic (HBT) bullying in schools. This programme will provide support for both pupils and school staff and will transform how we prevent and address HBT bullying in our schools.

75. However, we also need to focus on other educational settings and will be analysing suicide rates of people at university to explore any lessons to be learned and increase awareness of suicide risk and mental wellbeing.

76. The successful MindEd web-based children & young people's mental health educational resources have been used by teachers. Last year the Department for Education funded a new section with materials available to all parents and families available at the MindEd website[32]. Health Education England and NHS England will further develop MindEd, and with Clinical Networks and Academic Health Science Networks will support local areas to develop new apps and digital services (such as 'Epic Friends'[33] and online forums), as recommended by *Future in Mind*.

77. NHS England is working with eight Urgent & Emergency Care Vanguards to fund and test different models of crisis and liaison mental health care for children and young people to help build the evidence base.

Users of drugs & alcohol

78. Drug and/or acohol use are major risk factors for both suicide and self-harm, and co-morbid mental health and substance misuse problems are prevalent. Eighty per cent of those in treatment for alcohol use conditions and nearly seventy per cent of people in drug treatment are thought to have co-existing mental health problems.

79. In September 2016 Public Health England finished consulting on changes to the National Drug Treatment Monitoring System to enable local areas and Public Health England to better capture information about co-occurring mental health, drug and alcohol treatment needs, and to be able to better monitor the extent to which those needs are being met. The data set changes will be implemented from April 2017.

80. There is considerable concern about the rising rates of drug related deaths, in which suicide features considerably – 28 per cent of women's deaths and 11 per cent of men's deaths registered in 2014. Public Health England has been working with academics, experts in the field and experts by experience to look at the underlying causes of drug related deaths, including suicides, and to provide practical advice on reducing these deaths. The report was published in September 2016 on the drug and alcohol legacy website.

81. Public Health England is supporting an independent expert group to update the UK-wide clinical guidelines for treating drug misuse and dependence. The guidelines include detailed advice on treating those individuals with co-existing conditions and co-ordinating their care with appropriate mental health services. The updated guidelines will be published later this year.

82. Public Health England and NHS England will shortly be issuing new national guidance which aims to improve access to services providing care for people with co-occurring mental health and alcohol/drug use problems, and are also collaborating on how to improve services, such as closer working between alcohol and care teams and liaison mental health teams in acute general hospital settings. The guidance will endorse the messages in recent NICE guidelines: Coexisting severe mental illness and substance misuse - community health and social care services[34].

83. In 2016 Public Health England announced, for the third year in a row, the successful applicants for £10 million of capital funding for services that are helping people in England with drug or alcohol problems to recover from their addiction. Over 140 projects across England, in partnership with local authorities, will have received grants from Public Health England through this scheme.

> **Leeds Recovery Academy**
>
> Developed with Public Health England capital funding, Leeds Recovery Academy provides structures support and diversional activities to those with substance misuse and mental health issues. This includes sessions developed and led by people with lived experience, promoting the strong ethos of recovery and reintegration. This community asset houses a range of statutory and third sector organisations working in partnership with a number of learning providers.
>
> www.forwardleeds.co.uk/contact/the-recovery-academy/

84. Public Health England also published guidance in 2015 to support local authorities in implementing and maintaining robust governance arrangements for the commissioning of high quality drug and alcohol services[35]. As well as this Public Health England publishes annual data packs and good practice prompts to support commissioning of effective drug and alcohol interventions which are key to preventing harm in drug and alcohol users.

Perinatal mental health

85. Suicide is now one of the leading causes of death in pregnant women and new mothers. The 2015 Mother and Babies: Reducing Risk Through Audits and Confidential Enquiries across the UK (MBRRACE-UK) report highlighted that almost a quarter of women (23%) who died between six weeks and one year after pregnancy died from mental-health related causes, and one in seven women died by suicide. That is why the Government has committed to investment of £365 million between 2015/16 and 2020/21 to provide specialist mental health support to pregnant women and new mothers.

86. NHS England is committed to improving access to high quality, timely, evidence-based care for women experiencing mental ill health during the perinatal period, through specialist support in the community and through mother and baby units for inpatient care. NHS England recognises that there is significant variation in access and provision of such services and is building a phased, five-year programme to build capacity and capability.

87. This seeks to improve outcomes for women and families, focusing on integrated pathways, earlier diagnosis, intervention and recovery, and reducing avoidable harm. It will also support delivery of the key Mental Health Five Year Forward View objective of 30,000 more women each year being able to access NICE-concordant care by 2020/21.

88. Implementing the Five Year Forward View for Mental Health, published in the summer of 2016, summarises key activities to improve perinatal mental health services. This includes the multi-year Perinatal Mental Health Community Services Development Fund launched in August 2016. The fund aims to support service development and increase the availability of high-quality care and interventions for women, their babies and families, through expansion of existing specialist perinatal community teams into a wider geography or establishing small new teams to meet the needs of the population more comprehensively.

89. Successful bids through the Fund include: Berkshire Healthcare NHS Foundation Trust, which is working with seven CCGs to expand the service and to pilot peer support, enhanced medication advice and psychological input for traumatic births; and Birmingham South Central CCG, which is working with partners to develop a comprehensive perinatal mental health community service focused on NICE-concordant care and interventions.

90. The MBRRACE-UK report also acknowledged that many women who died had multiple morbidities, as well as complex social factors, substance misuse and domestic abuse, illustrating the importance of a coherent whole public service approach to prevention.

People in receipt of employment benefits

91. We know that unemployment rates for those with mental health conditions are too high, and evidence is limited around what works to support people with common mental health conditions back into work. Based on the recommendations put forward in RAND Europe's report, 'Psychological Wellbeing and Work: Improving Service Provision and Outcomes'[36], the Department for Work and Pensions and the Department of Health are working together through the Work and Health Unit to explore these issues. Their recent joint publication "Improving Lives – the Work, Health and Disability Green Paper" sets out the Government's proposals for improving work and health outcomes for disabled people and people with long-term health conditions, and a national consultation is currently being held on these proposals where action should be taken. We are also delivering a series of trials, which will be implemented from spring this year and run for two to three years, to examine a range of models of integrated service delivery, in order to build the evidence base around what works for those with mental health conditions. Each of the voluntary trials will build that base, testing different approaches of combined health and employment support in a variety of settings.

92. We are also looking to increase the number of employment advisors based within NHS Talking Therapy services, enabling greater provision of integrated therapy and employment support to more people with depression and anxiety to help them remain in work, get back to work, and find work. These trials will run at varying pace over the next several years.

93. The Work Capability Assessment (WCA) establishes if an individual is entitled to claim Employment and Support Allowance (ESA). This is a benefit for people who are unable to work due to ill health or disability. The Department for Work and Pensions has reviewed the guidance for healthcare professionals (who carry out the WCA and provide advice to ESA decision makers) on whether substantial risk of harm (including suicide/self-harm) might be triggered by work, or work-related activity.

94. Since 2012, Departmental guidance has provided that it is mandatory to carry out a review of a case where the Department is notified that a claimant has died by suicide and there is an allegation that Departmental activity may have contributed. Peer Reviews/Internal Process Reviews are a tool for staff to look at the handling of a specific case. The purpose is to scrutinise Department for Work and Pensions handling of particular cases to identify whether processes have been properly followed and if appropriate, identify recommendations for changes to the process. It is a mechanism aimed at ensuring we learn lessons and take appropriate action, rather than about apportioning blame.

95. The Department for Work and Pensions provides a range of support for staff, including a six point plan which sets out a framework for managing suicide and self-harm declarations from customers. This sets a clear process for what staff should do in circumstances where someone may be at risk of suicide or self-harm.

96. The Department for Work and Pensions has also established a common approach to its 'Vulnerability Hub', which provides help and advice to staff when dealing with vulnerable people. It signposts them to a range of resources about specific conditions or circumstances which may increase someone's vulnerability and risk of suicide and/or self-harm.

Reducing access to means

97. Action to reduce access to means of suicide has been shown to reduce deaths by suicide. For example, there have been reductions in suicides using pain relief medication such as paracetamol and aspirin following legislative changes to the size of packets and best practice guidance on the quantity of pain relief medication that can be sold in a single transaction. We continue to monitor suicide trends for emerging and novel methods of suicide. As part of this, the Office for National Statistics (ONS) is engaging coroners to improve the level of information that is recorded during inquests so we can analyse issues around methods of suicide and improve our understanding of other factors that have led to someone taking their own life.

98. The Department of Health has been working over recent years with experts and the British gas industry to explore issues around the inhalation of gas. We will report on this work as it develops.

99. Public Health England has published guidance to support local areas to identify and understand suicide clusters[37]. The suicide clusters toolkit supports local authorities in effective responses to unexpectedly high numbers of suicides occurring in a particular period of time, a particular place or both.

100. Public Health England's preventing suicide in public places resource[38] provides guidance on a range of effective steps that can be taken to prevent public places being used for suicide and to increase the chances of last-minute intervention. This practice resource outlines the most practical and impactful actions that local suicide prevention groups can undertake.

Transport

101. There has been a long relationship between suicide and the transport network, particularly in respect of the railway network. Network Rail, the British Transport Police and the Samaritans have a long established and successful partnership for reducing the number of suicides on the rail network. The Department for Transport recognises the important and active role which the rail industry and its staff, particularly those at stations, play in reducing as far as possible the instances of suicide and the risk to vulnerable people, on the national rail network.

102. The Department for Transport fully supports both the British Transport Police's Suicide Prevention Strategy and the railway Suicide Prevention Duty Holders Group's Nine-Point Plan, and will incorporate the aims of these plans into train operating franchise agreements as the minimum standard which train operators must meet.

103. On average there is an attempted or completed suicide on the rail network every 31 hours. Samaritans' partnership with Network Rail has evolved into an industry-wide programme including British Transport Police, train operators and trade unions. In 2015, over 15,000 rail personnel were trained on Managing Suicide Contacts and Trauma Support Training courses, and a new Suicide Prevention and Support on the Railway Learning Tool was rolled out across the industry.

104. The tool comprises ten video modules that seek to inform, support and inspire staff action by bringing to life accounts from rail industry colleagues and British Transport Police officers from across England, Scotland and Wales who have saved lives, have experienced a traumatic rail incident or supported someone suffering from trauma. The number of interventions being reported has been rising steadily year on year and was over 900 last year. This work has also led to an innovative pilot launched in the south east to help identify persons at risk.

105. The Department for Transport continues to look at other ways to work with partners to develop effective mental health crisis care and suicide prevention across the rail network. One example is recognising the essential work done by the NSPA, and its constituent organisations, and the Department for Transport is in discussions with the NSPA's members and the Department of Health on how it may be able to assist partner organisations at both a strategic and delivery level, where this is appropriate.

106. We will also be looking at ways in which we can replicate the successful work of the rail industry in other areas of the transport network such as highways and waterways.

Learning & investigations within NHS settings

107. There have been significant improvements in inpatient safety over the last decade which has led to a considerable reduction in inpatient suicides. However, there is more to do and learn. NHS England issued a revised Serious Incident Framework in 2015, with additional emphasis on quality of investigation and learning lessons. NHS Improvement is now the national body responsible for patient safety. The Care Quality Commission includes deaths of detained patients in its intelligent monitoring of mental health providers. Work continues to develop the Healthcare Safety Investigation Branch to ensure parity of approach to mental health trusts in work across the NHS to reduce avoidable deaths.

108. The Healthcare Safety Investigation Branch will be an exemplar for the whole health system on how to undertake learning-orientated safety investigations, helping those in the system to improve their processes. It will also undertake some investigations itself.

109. The Secretary of State for Health also asked the Care Quality Commission to review how NHS trusts identify, report, investigate and learn from deaths of people using their services. This follows the Government's response to the report on Southern Health into the deaths of people with a learning disability or mental health problem in contact with Southern Health NHS Foundation Trust.

110. The Care Quality Commission's review[39] published in December 2016 made recommendations for improving the way the NHS identifies, reports and investigates the death of any person in contact with a health service managed by an NHS trust and pay particular attention to how NHS trusts investigate and learn from deaths of people with a learning disability or mental health problem. The report highlighted clear problems with the way that trusts identify the need for investigation into the care provided and the way in which investigations are carried out. The review made a number of powerful recommendations for improvement.

111. We welcome the Five Year Forward View for Mental Health recommendation that we ensure we learn from all deaths by suicide across NHS-funded mental health settings, including out-of-area placements to prevent repeat events. NHS England will work with Public Health England to consider the actions that health services can take to learn lessons which should then form part of the CQC's inspection regime.

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

112. The National Strategy in 2012 put improving support for those bereaved by suicide as one of its central aims. However, delivery in this area has not progressed enough to ensure that there are good quality and consistent suicide bereavement services in every area across the country. Unfortunately, those bereaved by suicide tell us they do not always receive the support and help they need and this must be addressed.

113. We continue to provide funding to support the dissemination of the Help is at Hand guide[40], which was commissioned by Public Health England and refreshed in 2015 and provides valuable and compassionate guidance and advice to people bereaved by suicide.

114. The Samaritans and Cruse Bereavement Care have been working in partnership to increase the support available for people bereaved by suicide. The Facing the Future service has been developed to support people bereaved by suicide through local support groups. The service is now covering Devon, East Sussex, Essex, London, Tyneside, West Midlands and Yorkshire. Forty five volunteers across both organisations have been trained to facilitate the groups.

115. The most recent analysis estimates that each suicide costs the economy in England around £1.67 million, although the full costs may be difficult to quantify. It is striking that 60 per cent of the cost of each suicide is attributed to the impact on the lives of those bereaved by suicide. We know that those bereaved by

suicide are more likely to experience mental health problems such as depression and anxiety and we also know that people bereaved by suicide are at a higher risk of suicide themselves. Therefore, we have a moral and economic imperative to improve the consistency and quality of suicide bereavement services across the country.

116. We encourage all local multi-agency suicide prevention groups to include support for those bereaved by suicide in all local suicide prevention plans. In October 2016, Public Health England published guidance[41] for local authorities to assist them in development of their suicide prevention plan. We will work with Public Health England to quality assure the robustness of local plans, which will include ensuring suicide bereavement support is a strong element within plans.

117. The funding that we provide to the National Suicide Prevention Alliance (NSPA) has enabled it to include suicide bereavement support as a clear workstream within its strategic framework. Public Health England, the NSPA and the Support After Suicide Partnership are have developed 'how to' resources which have been published alongside this report. These provide a framework and pathway for developing and delivering local bereavement services, evaluating local bereavement support services and a practical resource guide to providing local suicide bereavement services in local areas. This guidance should be viewed in conjunction with the guidance for local suicide prevention planning.

Grief Education Programme – Cornwall & Isles of Scilly

As part of Cornwall & Isles of Scilly's Suicide Liaison Service they have developed an 8-week Grief Education Programme. The programme is delivered in different locations across the County in order to be as accessible as possible, and enable participants to build on "social capital" within their communities. The programme is deemed suitable for people who are approximately 6 months post-bereavement, preferably post inquest and not more than 4 or 5 years post-bereavement. The courses are designed to have between six to eight participants and are delivered in two four-week blocks with a break half-way (to coincide with school term time dates).

The aims of the programme are:
- For participants to develop personal and social resources that may contribute towards their resilience; and
- To reduce feelings of isolation and stigma associated with suicide bereavement.

The programme allows participants to develop an understanding of the grief process in a safe and supportive environment, and learn health strategies for manging grief and their own wellbeing amongst a group of individuals with a shared experience of being bereaved specifically by suicide. The programme is evidence based, and in line with World Health Organisation guidelines.

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

118. The Samaritans continues to work with the Independent Press Standards Organisation to implement an Editors' Code for reporting matters on suicide responsibly. Information about this is available from the Samaritans' website[42]. Public Health England is committed to looking at ways in which it can strengthen the relationship between Samaritans, Public Health England and the Department of Health to support better monitoring of suicide reporting in the media.

119. The Samaritans also looks at other media platforms and works with technology and social media providers to help make the online environment a safer space for vulnerable people. Through its ongoing relationship with Facebook, Samaritans provided user research and communications advice to inform the revision of Facebook's suicide prevention tool, launched in the UK in January 2016. If users believe a friend's post indicates self-harm or is suicidal in nature, as well as reaching out to them directly, users are able to anonymously report the post to Facebook. The post will be reviewed by Facebook's support team, and if appropriate, the author of the post will be offered a series of options via a private message screen, including access to support lines, resources or a prompt to reach out to their friends and family for help.

120. Samaritans also undertook a six month knowledge and learning project, "Digital Futures"[43] aimed at understanding more about the online environment, and the specific needs of those who actively seek support in that space. Three multimethod streams involved people who had sought support for themselves or someone else online, professionals working in the sector and Samaritans volunteers.

121. The Samaritans continue to have a fixed "OneBox" above search results on Google UK which provides Samaritans' helpline numbers for users who have searched for suicide and self-harm related words and phrases; is a member of YouTube's Trusted Flagger programme that seeks to empower YouTube users to keep the community safe; and is an Inaugural Member of the Twitter Trust & Safety Council formed in February 2016 to make the network a safer and more secure environment for its users.

122. The National Suicide Prevention Alliance (NSPA) has published Guidance for Online Communities Moderator in Responding to Suicidal Content[44]. Led by Mind on behalf of the NSPA and in consultation with a wide range of stakeholders, the guidance enables any community moderator, regardless of forum or topic, to safely and confidently respond to people that may be expressing thoughts of suicide online and to signpost them to appropriate support.

123. The Government continues to work closely with the UK Council for Child Internet Safety which engages social media companies to make sure they are committed to protecting children who use their platforms. We have formed a Digital Resilience Working Group which has provides a range of guidance to social media companies, schools and parents and professionals who work with young to keep them safe online.

124. The Government expects social media companies, and others, to have robust processes in place and to act promptly when abuse is reported, including acting quickly to assess the report, removing content which does not comply with the acceptable use policies or terms and conditions in place and, where appropriate, suspending or terminating the accounts of those breaching the rules in place.

125. Samaritans is involved in two research projects relating to the online environment, with Bristol and Edinburgh Universities, which seek to increase the understanding of why people look online for help and support, how trust and empathy can be developed in online settings, how people who are suicidal use the internet and the impact this has on their suicidal thoughts and behaviours. The findings from these projects will be available later this year.

126. Samaritans is also working together with a number of partners across the health and criminal justice sectors to provide improved care for individuals in emotional distress. Samaritans volunteers provide phone and face-to-face emotional support to detainees in custody in areas such as Norfolk and Manchester, and in A&E departments in places such as Cornwall and Hampshire. Partnerships are also in place nationwide with GP surgeries and mental health crisis teams, and with NHS 111 in Hampshire. A successful bid to the Department of Health Innovation, Excellence and Strategic Development (IESD) programme will see all of these elements being brought together to provide joined-up emotional support across the health service. In addition, referral partnerships are now in place across a range of private and third sector organisations, including John Lewis and Action for the Blind.

Samaritans referral partnership with Action for the Blind

Action for Blind People and The Samaritans are working together to ensure blind & partially sighted people with identified needs; receive timely emotional support from the Samaritans national call service. This project is being piloted by the Action for Blind People Eye Clinic Liaison Officer service in the North of England with a view to being rolled out nationally in 2017.

Supporting research, data collection and monitoring

Research

127. To support implementation of the National Strategy the Department of Health invested £1.5m in 2012 over three years into six research projects.

128. There have been further research projects funded separately through the National Institute for Health Research (hosted by the Department of Health) in the areas of suicide and self-harm. This includes research into the feasibility of cognitive behavioural suicide prevention therapy and a recent call for research to consider projects around suicides in criminal justice settings.

129. The Department of Health is also establishing a wider mental health research programme which will inform our thinking in many of the areas which may impact suicide and self-harm prevention.

130. The six projects funded through the National Strategy are:
   - Exploring the use of the internet in relation to suicidal behaviour: identifying priorities for prevention – University of Bristol. This report is expected to be published this year.
   - The 'Listen-Up!' Project: Understanding and Helping Looked-After Young People Who Self-Harm – University of Nottingham. This report is expected to be published this year.
   - Understanding the role of social media in the aftermath of youth suicides – Cardiff University. This report was published in 2015.
   - 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 – University of Manchester. This report is expected to be published this year.
   - Risk and resilience: Self-harm and suicide ideation, attempts and completion among high risk groups and the population as a whole – National Centre for Social Research. This report is expected to be published this year.
   - Understanding Lesbian, Gay, Bisexual and Trans (LGBT) Adolescents' Suicide, Self-Harm and Help-Seeking Behaviour – University of Lancaster. This report[45] was published in 2016.

Improving data

131. The success of the National Strategy is reliant on good quality data at both national and local levels. Although the quality of suicide and self-harm data has improved over recent years, there is more we can do. Improving national data will help us to continue monitoring suicide rates and identify emerging trends within high risk groups and new methods of suicide. Improving the quality of local data will be critical in supporting local areas to develop effective multi-agency suicide prevention plans that reflect the issues in their local communities.

132. We continue to fund and support national datasets to monitor suicide and self-harm in various settings across health and justice and in the community. We are encouraging local areas to become fully engaged in collecting and evaluating their own local data through multi-agency working so they can better target local interventions.

133. Public Health England has been developing further its Suicide Prevention Profile[46] – often referred to as the Suicide Prevention Fingertips tool- which provides a range of data at a local level to support local authorities and the NHS to understand suicide trends in their areas. This tool provides valuable thematic data on local demographics which enables local areas to identify high risk groups and locations. Public Health England's revised practice resource highlights the importance of getting a sense of both national and local data to inform local suicide prevention plans and provides guidance on suicide audits.

134. Suicide prevention profiles collect and present a range of data on suicide and related issues for local organisations. The data is presented under three domains:
    - suicide data;
    - related risk factors; and
    - related service contacts.

135. It provides planners with the means to profile their area and benchmark against similar populations.

136. The National Offender Management Service (NOMS) is working collaboratively with Public Health England, NHS England and the Home Office to increase the intelligence and data available to local authorities regarding mental health needs among people in prison. This will support work at local level in a more collaborative approach to suicide prevention especially among those recently released from prison.

137. We are working closely with the Office of National Statistics (ONS) to explore better ways of analysing, improving and decreasing the time taken to record the national data. The ONS implemented a change to the national dataset to include for the first time suicide rates in people aged 10-15 years which enables us to monitor suicide risk in very young people. This is in line with what our stakeholders have asked us to do and will improve our understanding of the factors that contribute to suicide risk in this group. We are aware that self-harm is now a growing concern among professionals who work with young people and this will help us to monitor these issues in parallel.

138. In order to improve the timeliness of data, ONS now publishes provisional suicide data each quarter and has brought forward the National Statistics publication by three months. ONS is also engaging further with coroners to improve the quality of reporting of suicides.

139. The National Suicide Prevention Alliance (NSPA) is implementing a data improvement work-stream as part of its strategic framework. This includes establishing a 'data hub' so that its members and others can navigate the various national datasets on suicide and self-harm as well as encouraging its members to share their data more widely. We will continue to support the NSPA in developing this work.

The National Suicide Prevention Alliance

140. The National Suicide Prevention Alliance (NSPA) is the leading England-wide, coalition for suicide prevention organisations across the public, private and voluntary sectors and is continuing to go from strength to strength. Through grant funding from the Department of Health and the support of its membership, the NSPA works with its members to get all parts of society working together to take action to reduce suicide and improve the support for those bereaved by suicide.

141. In February 2016, the NSPA held its second national suicide prevention conference, 'Empowering Communities through Collaboration'. The conference saw the launch of the NSPA's strategic framework 2016-19. The framework is centred around seven key aims that work in support of the Government's national strategy. Aims of the strategy include reducing stigma; encouraging help-seeking; providing the appropriate support; reducing access to the means of suicide; improving data and evidence; reducing the impact of suicide and, underpinning all of this, working together. The NSPA plays a unique role, working to coordinate and facilitate action in this area, working with Government and key agencies to ensure a more joined-up and collaborative approach to suicide prevention. .

142. Over the course of the next 12 months, the NSPA will seek to continue to broaden and build its membership and its resource hub on www.nspa.org.uk.

The National Suicide Prevention Strategy Advisory Group

Role

143. This group provides leadership and support in ensuring successful implementation of Preventing suicide in England by advising the Department of Health, and other key delivery organisations and partners, 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)

Mark Smith,	British Transport Police
Louise Robinson	Bereaved By Suicide
James Parker	Chief Coroner's Office
Debbie Large	Coroner's Officers and Staff Association
Nadia Persaud	Coroners Society
Andrew Herd	Department of Health
Ellie Isaacs	Department of Health (Secretariat)
Neil Ralph	Health Education England
Shirley Smith	If U Care Share
Kish Hyde	Independent Advisory Panel on Deaths in Custody
Prof Rachel Jenkins	Institute of Psychiatry
Clare Milford Haven	James Wentworth-Stanley Memorial Fund
Hamish Elvidge	Matthew Elvidge Trust
Tim Kendall	Mental Health Intelligence Network (National Clinical Lead)
Daniel Cornelius	Metropolitan Police
Rosie Rand	National Offender Management Service
Simon Medcalf	NHS England
Frances Healey	NHS England
Claudia Wells	Office of National Statistics
Geraldine Strathdee	Oxleas NHS Foundation Trust
Ged Flynn	Papyrus
Gregor Henderson	Public Health England
Helen Garnham	Public Health England
Liz England	Royal College of GPs
Annessa Rebair	Royal College of Nursing
Prof Simon Wessely,	Royal College of Psychiatrists
Ruth Sutherland,	Samaritans/National Suicide Prevention Alliance
Prof Keith Hawton,	University of Oxford
Prof Nav Kapur,	University of Manchester
Prof David Gunnell,	University of Bristol

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