

Local Suicide Prevention Planning in England

An independent progress report

Tom Chadwick, Christabel Owens & Jacqui Morrissey

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Executive Summary

With around 4,500 lives lost to suicide every year in England (ONS 2018), suicide prevention is a public health issue which needs to be a priority locally and nationally. Every one of these deaths leaves behind family, friends and communities shattered by the loss. It is unthinkable that on average 12 people a day get to the point where they feel they have no other choice but to take their own life.

This report provides the first ever nationwide view of the breadth and depth of suicide prevention planning within and across local authorities in England. Whilst there is much activity happening nationally to help prevent suicide, local action is critical to save lives and this requires strong multi-agency groups and excellent local public health leadership with robust suicide prevention plans in place that are being delivered effectively.

Overall, an encouraging picture emerges from this report. Almost all local authority areas have established an action plan and multi-agency suicide prevention group. There is a clear commitment to collaborative working at local level, made possible by strong leadership from Public Health teams and other local agencies, and there are a wide range of actions being delivered. This work is taking place in the context of cuts to local public health budgets and cuts to provision fundamental to good suicide prevention, such as substance misuse services, and wider community services. There is an ever-stretching of thin resources. This report shows that local authorities and multi-agency groups are working hard with what they have, to try and reduce the rates of suicide and self-harm in their communities. Multi-agency partnership working is crucial in this context. Many of the resources required to effect change do not sit within local public health budgets and much of the activity taking place is delivered by other actors, including health services and the voluntary sector.

It is important to acknowledge and celebrate the wealth of ambition seen in local plans, but a note of caution is also suggested. Good planning alone does not prevent suicide. Many local plans include a large amount of activity focused on fostering partnership working, building links and trying to gain a better picture of suicide and what is happening within their local area. These are important in the early days of local suicide prevention but this preparation and planning has to move to delivery to save lives. It is essential to understand just how far local authorities have managed to move from planning to delivery in order to provide them with the most effective support going forward.

Approach

Samaritans and the University of Exeter were commissioned by the Association of Directors for Public Health (ADPH) and the Local Government Association (LGA) with support from Public Health England to conduct research into local-level suicide prevention planning in England.

Findings for this report are drawn from survey research and qualitative interviews with local suicide prevention leads, and qualitative analysis of local suicide prevention plans.

Establishing and delivering local suicide prevention

Local authorities have made good progress in establishing their local approaches and are starting to take action to prevent suicide.

Survey responses were submitted for 150 of the 152 upper-tier local authorities in England (99% response rate) and showed that:

- 99% have established or are developing a suicide prevention action plan
- 92% have a multi-agency suicide prevention group in place
- 84% have undertaken an audit of local suicide data

The following picture of plans and delivery emerges from the self-reporting of survey respondents:

Table 1.1 Planning and delivery of national strategy area actions at local level		
Area for action	Included in plan	In plan and being delivered
Reducing risk in men	97%	70%
Bereavement support	97%	71%
Improving mental health of children and young people	92%	80%
Preventing and responding to self-harm	92%	55%
Reducing risk in other populations	89%	55%
Improving acute mental health care	83%	69%
Reducing suicides at high-frequency locations	78%	65%
Reducing social isolation	69%	47%
Improving treatment of depression in primary care	66%	41%

This clearly shows that the majority of local authorities have plans which are trying to cover all the areas set out in the PHE guidance (Public Health England 2016) but some places have not managed to turn their plans into action yet. Three-quarters of plans were put in place in 2017 or 2018, with the oldest plans from 2015.

Content of plans

The actions featured in local plans are described below, organised according to the seven priority areas for action featured in the national strategy, *Preventing suicide in England: A cross-government outcomes strategy to save lives*, and annual progress reports (DHSC 2012). There is a wealth of activity happening locally which is described in more detail in the main report.

Area 1 and 2: Reducing the risk of suicide in key high-risk groups; Tailor approaches to improve mental health in specific groups

Plans contain a great deal of action involving awareness-raising, campaigning and training in relation to high-risk groups. The majority of plans recognise the importance of reaching middle-aged men as a national and local priority but relatively few plans feature substantial action on more specific high-risk groups. Some local authorities are promoting national campaigns, whereas others are investing resources in developing their own bespoke local campaigns. Overall, plans tend to have more focus on awareness-raising and other public health approaches to high-risk groups with fewer actions on mental health service related activity.

The majority of plans include training for people in contact with at-risk individuals in non-health settings. This features in almost every plan, and sometimes within almost every area of it.

Area 3: Reducing access to the means of suicide

Local plans primarily feature actions to prevent suicides at high-frequency locations. Plans in areas with no identified high-risk locations generally still include actions to monitor data for emerging locations. Actions included in plans indicate a good level of familiarity with the PHE guidance, *Preventing Suicides in Public Places*. Plans suggest that many of the simplest interventions (e.g. signs providing helpline numbers) are already in place at high-frequency locations with fewer plans covering all suggested interventions, such as physical barriers and increasing opportunity for human intervention.

There is less emphasis on reducing access to other means of suicide such as medication or firearms. Those that are in place indicate familiarity with the PHE guidance.

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

Practically every local authority's plan has recognised the importance of bereavement support with many plans including distributing the NSPA *Help is at Hand* resource (Public Health England 2015a) to people bereaved by suicide as quickly as possible following a death. This is an indication that local areas are able to deliver practical, resource light actions. Lots of plans include mention of local suicide bereavement support services with a small number delivering or considering providing services which offer 1:1 bereavement support directly after a suicide.

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

There are some plans that appear to include strong proactive communications teams, using national resources and support to try to improve media reporting locally. There is widespread engagement on this issue.

Area 6: Support research, data collection and monitoring

The majority of plans include research and data, and it appears that a wide range of data are being collected across all priority areas. Primarily, data collection is used to identify gaps in current service provision and share learning between agencies. Elsewhere, data are collected as part of monitoring and evaluation of existing actions. Monitoring and evaluation generally focuses on input and output measures, and many local authorities reported difficulty with measuring their impact on actual suicide rates. It is not possible to tell how systematically or rigorously data are being collected, or how effectively data are then being used to inform decision making.

Area 7: Reducing rates of self-harm as a key indicator for suicide risk

Most plans feature actions on this issue and many local areas are clearly committed to reducing rates of self-harm. The availability of NICE guidelines on self-harm (NICE 2012, 2004) does not appear to have significantly impacted on the content of suicide prevention plans. This may be because clinical actions are contained within other plans, and the suicide prevention plans reflect the public health approach to the issue by including training and awareness-raising activities.

Conclusions

Local authorities in England are making progress on local level suicide prevention. Multi-agency groups are widely established, and local plans are in place. Plans themselves are a testament to the diversity of actions being considered locally to develop the infrastructure for suicide prevention and help to directly prevent suicides at the local level. Such a diverse range of actions is evidence of the strong culture of multi-agency collaboration that is in place.

It is important to recognise that the national suicide prevention strategy and accompanying guidance to local authorities is wide-ranging. In the context of ongoing cuts to local authority Public Health budgets there is a danger that local authorities may spread their resources too thinly, and perhaps less effectively, in order to implement actions for all areas of the strategy. Introducing a Public Health budget that is as ambitious as the national strategy it seeks to deliver would help to mitigate this risk and ensure local authorities are able to implement effective and sustainable actions for all areas of the strategy.

The findings in this report suggest that many local areas are now well positioned to implement the actions outlined in national guidance. Going forward, it will be important for local areas to move beyond the preparation stage and begin to deliver focussed suicide prevention. By playing to their local strengths and improving the activities already taking place, it will be possible for local areas to build a sustainable and impactful suicide prevention approach that meets the needs of local populations. With nearly half of local authorities delivering the actions set out in their plans, there is a prime opportunity for harnessing the learning and resources of these authorities to provide the local authorities which are further behind with a fast track to delivery.

This report is an important first step to understanding local suicide prevention activity, but it is critical that it is followed up with a process that seeks to further understand the quality and effectiveness of local activity.

High-level recommendations

- LGA and ADPH should encourage local authorities to consider working with other local authorities to achieve economies of scale and maximise resources.
- Government needs to provide increased funding for public health services and activities by local authorities in order to support suicide prevention work.
- LAs and multi-agency groups should review their suicide prevention activities and ensure they are not 'reinventing the wheel' by spending resource on actions that are either already being delivered at the national level or where other local authorities have already worked out the best way to deliver the action.
- LAs and multi-agency groups should avoid spreading their resources too thinly by trying to cover all areas of the national strategy too soon. Those at the earlier stages of their response may benefit from embedding and improving the quality of activity already taking place rather than implementing multiple new activities. Similarly, it may be helpful to begin by playing to local strengths and focusing efforts on strategy areas where there is already effective partnership working before tackling national strategy areas that prove more difficult to implement in the local context.
- LGA and ADPH should support local areas to move past the preparatory stage of building partnerships and planning actions, and into delivery of actions themselves where this is not already happening.
- LAs should consider developing regional priorities through the SLI framework. LGA and ADPH should consider how the SLI work could support local authorities to focus their activity, in order to achieve a greater impact.

Summary of recommendations

This report provides a series of detailed recommendations for local and national actors. Given the different stages of development that local areas are at, and the different pressures they face, these recommendations should be considered in the specific context of each local area.

Table 1.2 contains all recommendations contained in the report, organised according to topic, with an emphasis on local action.

Table 1.2 Summary of recommendations		
Topic	Local / national	Recommendation
Multi-agency groups and action plans	Local	<ul style="list-style-type: none"> • LAs should consider including output and outcome measures in their monitoring and evaluation processes wherever possible.
	National	<ul style="list-style-type: none"> • DHSC and PHE should work with the National Suicide Prevention Alliance (NSPA) to support a national network for people with lived experience to better enable input and co-creation of local multi-agency plans, and to ensure this is done in a safe, consistent and meaningful way that also considers diversity. • PHE and NSPA should provide further guidance on how to measure success. • LGA and ADPH should work with PHE to agree what a “good” audit for suicide prevention looks like. • DHSC and PHE should work with the Chief Coroner’s Office to write to coroners reminding them of the crucial role they can play in suicide prevention and encouraging them to work with local multi-agency suicide prevention groups.
Area 1: Reduce the risk of suicide in key high-risk groups a) Men	Local	<ul style="list-style-type: none"> • LAs should encourage local and national organisations to work together to consider amplifying and localising national campaigns. • LAs should work with multi-agency groups to improve access to social and community support for high-risk groups of men, including use of social prescribing schemes. • All commissioners of training on suicide prevention (including CCGs, mental health commissioning boards, Public Health teams) should ensure any training that is commissioned is consistent with the Health Education England (HEE) and National Collaborating Centre for Mental Health (NCCMH) self-harm and suicide prevention competence frameworks (HEE 2018a, 2018b, 2018c, 2018d). • Multi-agency groups should support members to further develop approaches by reviewing which groups of men they are reaching through their existing plans, to ensure that there are sufficient activities designed to reach the most at-risk men.
	National	<ul style="list-style-type: none"> • PHE should consider developing a forum for LAs to share research and evidence that is informing local campaign activity, including evidence on effective messaging for men. • LGA, ADPH and PHE should initiate discussions with national organisations to better understand how national awareness-raising campaigns could be more effectively localised and how nationally conducted market research and evidence could be shared locally. • NHS England should further promote the use of the self-harm and suicide prevention competence frameworks. • NHS England should continue with its suicide prevention programme and targeted investment to local areas. It should consider evaluating care pathways for men at highest risk, covering those that are engaging with GPs as well as those only engaging with other services to help inform local action as part of its evaluation of this programme.

		<ul style="list-style-type: none"> • PHE should work with LAs to ensure that activities to reach men are being evaluated and collated nationally to help build evidence and examples of good practice around what works for men, especially those in middle age. • DHSC and PHE should explore scope to reach potentially vulnerable men and encourage help-seeking in the online equivalent of typically male spaces, such as online gambling sites.
<p>Area 1: Reduce the risk of suicide in key high-risk groups</p> <p>b) People in the care of mental health services</p>	Local	<ul style="list-style-type: none"> • CCGs, in partnership with multi-agency groups, mental health services and LA public health teams, should implement the '10 ways to improve patient safety' recommendations from National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) (NCISH 2018). • CCGs should work with LAs, frontline services and the voluntary sector to ensure acute and community services are better joined up, avoiding gaps in support during transitions and improving access for those that need it most.
	National	<ul style="list-style-type: none"> • NHS England should continue to support areas receiving targeted suicide prevention funding to consider the 'Ten ways to improve safety' as part of their local quality improvement work. • NHS England should continue promoting joined up services as part of its suicide prevention programme and through its Long Term Plan commitments to develop integrated models of primary and community mental health care.
<p>Area 1: Reduce the risk of suicide in key high-risk groups</p> <p>c) People in contact with the criminal justice system</p>	Local	<ul style="list-style-type: none"> • Multi-agency groups in the local areas that do not have actions for those in contact with the criminal justice system in their plans should consider including reference to other plans, if action is being recorded elsewhere. If action is not being undertaken, LAs, HMPPS and prison governors should work together to consider action in this area. • Actions to reduce risk for people in contact with the criminal justice system should include points of transition, including the early days of custody and the pre- and post-release period. Where they are not already in place, 'Through the Gate' services should be developed and implemented led by local Criminal Justice Boards, and HMPPS. • Plans that only include staff training in prisons should be updated by multi-agency groups to identify further possible actions.
	National	<ul style="list-style-type: none"> • LAs, HMPPS and prison governors should recognise the complex needs of this population (e.g. housing, finance, problems with addiction and mental health issues) and how these impact on their ability to access services in the community. Particular attention should be given to trying to achieve continuity of access and seamlessness of care.
<p>Area 1: Reduce the risk of suicide in key high-risk groups</p> <p>d) Specific occupational groups</p>	Local	<ul style="list-style-type: none"> • Multi-agency groups not already doing this should further consider targeting the training and awareness campaigns that they are running to ensure they reach low-income, middle-aged men in high-risk occupations.
	National	<ul style="list-style-type: none"> • PHE and NSPA should consider including more ideas for action and case studies on reaching men in high-risk occupations in its local guidance, including evidence of what has worked elsewhere.

<p>Area 2: Tailor approaches to improve mental health in specific groups</p> <p>a) Children and young people</p>	Local	<ul style="list-style-type: none"> • LAs should consider checking that educational establishments are properly represented on their multi-agency group to understand what actions are being taken in local colleges, universities and community groups to promote good mental health and wellbeing and implement clear suicide prevention and postvention plans. • LAs should consider actions to ensure that especially vulnerable children and young people, including those not in formal education or training, are being reached through their plans. • Educational establishments should consider which local partners they could engage with and what actions they can take to prepare and support young people as they transition from school into further/higher education, employment or unemployment.
	National	<ul style="list-style-type: none"> • PHE should be working with the Department for Education to ensure that multi-agency groups are aware of and taking into account the national changes designed to improve young people's mental health.
<p>Area 2: Tailor approaches to improve mental health in specific groups</p> <p>b) Other specific population groups</p>	Local	<ul style="list-style-type: none"> • Every agency working to prevent suicide should: <ul style="list-style-type: none"> ○ consider carefully how their work to promote resilience and mental health (e.g. anti-bullying plans) and suicide prevention reflects the needs of the diverse populations which they serve. ○ use Equality Profiles for their areas and services to identify key populations to reach. • LAs should consider undertaking an Equality Impact Assessment (EqIA) of their local suicide prevention plan and audit data to identify any disadvantaged or vulnerable people that their plan does not currently cover. • Senior leaders in local authorities and on multi-agency groups should ensure they are providing leadership on diversity issues and supporting colleagues to ensure that all voices are heard.
	National	<ul style="list-style-type: none"> • PHE should work with the Chief Coroner and ONS to extend the data recorded and available on suicide deaths to improve knowledge of suicide in minority groups. • NHS England should continue to provide targeted investment to local authorities for suicide prevention.
<p>Area 3: Reducing access to the means of suicide</p> <p>a) High-frequency locations</p>	Local	<ul style="list-style-type: none"> • Multi-agency groups should work with partners to draw up a site-specific plan for high-frequency locations, incorporating a broad range of actions in accordance with PHE guidance. Where signage is considered, this should be used with other interventions and avoid advertising a location as a potential means of suicide. • All local organisations should avoid using the term 'hotspot' and use 'high-frequency location' in its place. • LAs and partner agencies should consider how they can work with local media to enhance the public image of a high-frequency location and try to dispel any reputation it may have as an effective means of suicide. • Multi-agency groups should seek to engage with local representatives from the rail industry and Highways England,

		<p>as well as their local road safety departments and health and safety teams. They should have a strong system for monitoring and recording locations, interventions and incidents to help improve the evidence on what works at high-frequency locations and to inform future local action</p> <ul style="list-style-type: none"> • In areas where high-frequency locations have not been identified, multi-agency groups should consider working with the local authority planning departments and other relevant stakeholders to ensure high structures are as restricted as possible as a means of suicide.
	National	<ul style="list-style-type: none"> • PHE should consider collating a national data set using local monitoring data on high-frequency locations. This is already being done by Network Rail, and Highways England is also committed to improving the collection of data on suicides occurring on the strategic road network.
<p>Area 3: Reducing access to the means of suicide</p> <p>b) Limiting availability of other means of suicide</p>	Local	<ul style="list-style-type: none"> • Local suicide prevention groups should avoid naming new or emerging methods of suicide, such as specific gases, due to the risk of imitative suicides. Strategy and plan documentation which contain these should be edited before being published. • Local multi-agency groups should be flagging any new or emerging methods of suicide which are being identified through local monitoring activity to their PHE regional lead or to Samaritans' national office to address at a national level. • CCGs should work to ensure safer prescribing is in place and being adhered to in their local area, in order to improve and strengthen risk assessment by prescribers for people at risk of suicide and to reduce access to potentially harmful medication.
	National	<ul style="list-style-type: none"> • ADPH and LGA should ensure that the basics of suicide prevention (e.g. sensitive language use and responsible communication on methods) are included in its sector-led improvement programme. • NHS England should continue work to improve medicines management.
<p>Area 4: Provide better information and support to those bereaved or affected by suicide</p>	Local	<ul style="list-style-type: none"> • All multi-agency group members should be promoting the <i>Help is at Hand</i> resource (Public Health England 2015a), ensuring the z-cards (a credit card sized fold-out leaflet that provides advice on caring for yourself and others) and, if possible, the full resource are being given out by first responders, coroners and funeral directors. • Local multi-agency groups should consider reviewing how they are ensuring that those bereaved are receiving appropriate support in the initial weeks after a suicide, as well as ensuring they are aware of what support is available longer term. • Schools and higher education institutions should work with local authorities and multi-agency groups to ensure they know how to respond effectively in the event of a suicide to reduce the risk of further suicides within that community. • All local areas should review and develop their suicide bereavement support services against the PHE good practice guidance (Public Health England 2016).

		<ul style="list-style-type: none"> All employers should put a suicide prevention and postvention plan in place, using the BITC/PHE toolkits (BITC 2017).
	National	<ul style="list-style-type: none"> NHS England should ensure adequate funding and support is available to deliver its commitment in the Long Term Plan to put in place suicide bereavement support in every area of the country.
Area 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour	Local	<ul style="list-style-type: none"> Local authorities should consider the purpose of monitoring local media, especially if they lack the resource to act on any concerning content or if they are not using the data to measure progress. Multi-agency groups should consider the role of local communications professionals in ensuring that messages provided to local media around suicide and suicidal behaviour are responsible. Multi-agency groups should encourage local stakeholders to provide positive stories about hope and recovery to local media.
	National	<ul style="list-style-type: none"> ADPH and the LGA should consider with Samaritans national media advisory service what further work may be needed to clarify the support Samaritans can provide local authorities on working with the local media. ADPH and LGA to consider asking Samaritans to review its national monitoring data to identify any key geographical areas where reporting is particularly problematic in order to assist local responses. PHE and NSPA should update its local planning guidance (Public Health England 2016) to include more information on the importance of providing media with positive content around suicide and suicidal behaviour (i.e. stories of successful recovery). PHE should provide guidance to local authorities on actions that can be taken around social media and online content, working closely with DCMS to ensure this is integrated with national developments.
Area 6: Support research, data collection and monitoring	National	<ul style="list-style-type: none"> PHE should share findings from its pilots of real-time surveillance (Public Health England (forthcoming in Autumn 2019) with all LAs and multi-agency groups. The College of Policing and Coroner's Officers and Staff Association should review current data-sharing protocols between police and coroners to ensure that they are able to provide timely data on suspected suicides. The Chief Coroner should issue guidance to local coroners outlining their crucial role in suicide prevention, to help facilitate the establishment of real-time surveillance. A review should be undertaken by PHE of what data are being collected through real-time surveillance, in order to establish some consistency across the country. This could enable data to be collated at regional and/or national levels to provide early indication of emerging trends. The ONS should brief LGA and ADPH to ensure local authorities and partners are aware of the work it is doing to explore how to improve suicide data.

		<ul style="list-style-type: none"> If sufficient local data are being collected on specific actions, such as training, bereavement support or high-risk locations, PHE should work with ADPH and LGA to explore the value of bringing these together at a national level to add to the evidence on what works to prevent suicide.
Area 7: Reducing rates of self-harm as a key indicator for suicide risk	Local	<ul style="list-style-type: none"> LAs, CCGs and mental health services should work together to ensure that all people presenting at A&E having self-harmed are treated in accordance with NICE Guidelines (NICE 2012, 2004). LAs should ensure they are aware of guidance that exists to improve information sharing between A&E departments, mental health services and GP practices (NHS 2018) . CCGs should ensure training on good self-harm prevention is embedded in their primary care quality agenda.
	National	<ul style="list-style-type: none"> PHE should consider working with Health Education England to consider guidance on what good training in self-harm prevention would look like. NHS England should continue its work to build the mental health competency of ambulance staff to ensure that ambulance staff are trained and equipped to respond effectively to people experiencing a mental health crisis. NHS England should continue to prioritise self-harm as an area of focus for its suicide prevention programme and work to improve services for those that self-harm.
Other: Cross-cutting themes	Local	<ul style="list-style-type: none"> LAs and multi-agency groups should review their suicide prevention activities and ensure they are not 'reinventing the wheel' by spending resource on actions that are either already being delivered at the national level or where other local authorities have already worked out the best way to deliver the action. LAs and multi-agency groups at the earlier stages of their response may benefit from working through existing partnerships to embed and improve the quality of activity already taking place rather than implementing multiple new activities. LAs should consider developing regional priorities through the SLI framework LAs should ensure they are following up any partnership activity to ascertain that these partnerships have generated deliverable actions that are being implemented effectively.
	National	<ul style="list-style-type: none"> LGA and ADPH should encourage local authorities to consider working with other local authorities to move past the preparatory stage of building partnerships and planning actions, and into delivery of actions themselves. NSPA is encouraged to further develop its resources hub to help facilitate more shared learning and best practice. LGA and ADPH should consider how the SLI work could support local authorities to focus their activity. ADPH and LGA should consider including in its SLI work: <ul style="list-style-type: none"> identifying general conditions that may facilitate the translation of ambition into action.

		<ul style="list-style-type: none">○ identifying those areas with a dedicated suicide prevention lead in place to compare the difference this may make in relation to the ownership and driver of actions included in local plans.○ undertaking a series of stakeholder interviews to help identify the level of activity actually being undertaken locally, to feed into the SLI process.○ looking at whether a focus on potential “interveners” would increase impact across at-risk populations as a whole.● ADPH and LGA are encouraged to ensure that the SLI process gets closer to understanding the quality and effectiveness of local activity (rather than quality of planning), in a way which supports local authorities and multi-agency groups to use their resources to maximise effect.
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Web

samaritans.org

Email

research@samaritans.org

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