# The Future of Local Suicide Prevention Plans in England

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A Report by the All Party Parliamentary Group on Suicide and Self-Harm Prevention

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## Executive Summary

> *So when you are having a discussion about what does suicide mean, and the numbers are very small compared to smoking or obesity, what is this about, well our deaths by suicide show up the ultimate loss of hope, the ultimate loss of meaning of purpose, yet they are an indicator. They may be small numbers, but they have a very big ripple impact and they are an indicator of what is happening further down that pyramid.*

Suicide prevention policy in England is experiencing great change. A new national strategy to prevent suicide in England was published last year and the reorganisation of health and public health structures brought about by the Health and Social Care Act 2012 are due to be fully implemented by April 2013.

Statistics produced by the Office for National Statistics indicate that the suicide rate in England has been in steady decline for most of the last decade until 2008 since when there has been a small increase in the number of suicide deaths. A recent study published by the University of Liverpool suggests the economic crisis and recession are having an impact on suicide rates. Researchers calculated that more than 1000 suicides between 2008 and 2010 could be attributed to unemployment.

The All Party Parliamentary Group for Suicide and Self-harm Prevention decided in early 2012 to examine the future of local suicide prevention plans in England against this backdrop. In this Report, we set out the context of suicide prevention in England, local suicide prevention plans now and the challenges and opportunities for those plans in the future. 23 recommendations are made to Government departments and key actors identified by the Report.

The Report concludes that future of local suicide prevention plans through this period of transition depend upon several inter-connected factors; leadership and local champions, identification of suicide prevention as a priority, availability of resources and the long-term survival of suicide prevention groups. The future of local suicide prevention plans is fragile; often relying upon the commitment of dedicated individuals.

The fact that local suicide prevention plans are not a statutory requirement of the new national suicide prevention strategy is a major barrier to their survival.

The Group wishes to extend its thanks to all the witnesses who gave up their time to attend and gave interesting insights into the work they and their colleagues do and the challenges they face. The Group is also grateful to all those who responded to the Call for Evidence.

**Key findings**

*Local suicide prevention plans now*

- Throughout the lifespan of the 2002 Suicide Prevention Strategy for England, there were no specific mandatory requirements to set up a multi-agency suicide prevention group or publish a stand-alone local suicide prevention strategy. Nevertheless, many PCTs chose to do so and in our opinion this was critical in delivering progress towards the delivery of PSA objectives. [para. 22)

- The existence of local suicide prevention plans in England is patchy. 73% of respondents have a local suicide prevention plan, but a quarter of respondents reported that they have not developed a specific plan. The existence of plans is open to chance rather than determined by any national requirement. (para. 45)

- National and local leadership is vital to local suicide prevention plans. Often, leadership emerges in the form of "local champions" who exist by chance. Reliance on committed individuals is an inherent weakness of local suicide prevention plans. (para 50-53)

- Local plans are often supported by a local suicide prevention group. 51% of respondents reported the existence of a suicide prevention group. Groups provide a channel of communication and in many areas, have been instrumental in identifying sources of funding and developing programmes tailored to local needs. Suicide prevention is unlikely to receive the focus it needs in areas where no group is active. (para. 54-58)

- Regional prevention groups or networks provide a means to pool valuable resources across local authority areas. (para. 61-62)

- An analysis of Group membership showed patchy and inconsistent engagement by the police, coroners and GPs at a local level which is a great concern. 38 respondents reported police involvement, 12 reported coroner involvement and 11 reported GP involvement. Effective local suicide prevention needs the involvement and contribution all three agencies. (para. 59-60)

*Challenges and opportunities for the future of local suicide prevention plans*

- Several respondents stated that the delay in publishing the new national strategy had led to a suspension of work locally.

- The vast majority of areas appear prepared for the transition to the new structures established by the Health and Social Care Act 2012; however of those respondents who provided a reply, 86% indicated that no specific

funding had been set aside for the transition of public health responsibilities to local authorities. (para. 66-70)

- 35 respondents commented that they viewed the new structure as an opportunity, while 17 expressed concern about the uncertainty it created. (para. 66-67)

- It is difficult to conclude with any certainty how well the new structures are working in relation to suicide prevention or the true degree to which local suicide prevention plans will survive the transition to local authorities. There is no specific mandate for local authorities to implement suicide prevention strategies so there is no guarantee that health and wellbeing boards will address suicide prevention or that existing plans will survive or be replaced. Much will depend upon health and wellbeing boards being aware of suicide, through the work of the director of public health. (para. 70)

- There is particular uncertainty as to what will happen in areas where there is no suicide prevention plan or where there is no history of the director of public health taking an interest in the issue. Similarly, in areas where there is no local champion, suicide prevention maybe overlooked completely. (para. 65)

- There is no formal mechanism for suicide prevention groups to report directly to health and wellbeing boards. Without such a link, suicide prevention may not reach the agenda (vital for the commissioning of services) and groups will be working in isolation, undermining their value and ultimately jeopardising their future. (para. 73)

- 50 respondents mentioned funding for specific suicide prevention programmes. The small numbers of suicides can mean that it is overlooked in comparison to other public health issues. There is a danger that health and wellbeing boards may neglect suicide prevention when faced with other public health demands on limited resources. (para. 83)

- Engagement of the police, GPs and coroners with suicide prevention groups and plans is in many areas poor, patchy and inconsistent. (para. 91-127)

- Provision of self-harm prevention and specialist bereavement services remains poor. A third of respondents confirmed the existence of either self-harm prevention programmes or specialist bereavement services. (para. 151-157)

- Valuable work is being done at a local level and the new national strategy contains many examples of suggested best practice. The challenge, particularly at a time when budgets are constrained, is to facilitate the collation of ideas and make them available to as wide an audience as possible. (para. 147-150)

*Observations from the devolved nations (para. 128- 146)*

- The evidence from Northern Ireland demonstrated the importance of involving community organisations and the voluntary sector in suicide prevention. The existence of suicide prevention implementation group in each locality ensures that suicide prevention activity is not left to chance.

- In Wales, statements allocating responsibilities were not published or mandates passed on to local authorities, so implementation is variable. This highlighted the importance of national leadership in ensuring consistent implementation and what can result where this is not in place.

- The evidence from Scotland highlighted the strength of a coordinated national approach towards implementation of the Choose Life Strategy through the appointment of a coordinator in every local authority area. This ensured that each area has an identifiable individual with responsibility and funding for suicide prevention.

## Recommendations

The future of local suicide prevention plans through this period of transition depend upon several inter-connected factors; leadership and local champions, identification of suicide prevention as a priority, availability of resources and the long-term survival of suicide prevention groups. The future of local suicide prevention plans is fragile; often relying upon the commitment of dedicated individuals.

The fact that local suicide prevention plans are not a statutory requirement of the new national suicide prevention strategy is a major barrier to their survival.

The recommendations below are directed at the organisations at both the national and the local level which can make the most significant difference to the long-term future of local suicide prevention plans. Many of these do not necessarily require additional funding; more ensuring that existing relationships and organisations do not get lost as a result of the transition.

### National

*Department of Health*

i. Require all local authority areas to develop a suicide prevention plan led by the director of public health or senior member of the public health team and establish a suicide prevention group. Local suicide prevention plans should include provision for self-harm prevention and those bereaved by suicide.

ii. Publish and provide guidance to health and wellbeing boards to ensure that suicide prevention is specifically included in strategies beyond the Public Health Outcomes Framework requirement and the Prompts for Local Leaders by April 2013, including the local Joint Strategic Needs Assessment.

iii. Publish and provide guidance to health and wellbeing boards to formalise regular contact with the local suicide prevention group.

iv. Work with the Home Office and ACPO to facilitate police representation on health and wellbeing boards.

v. Introduce measures to monitor local progress in the absence of national target for the reduction of suicide. Reintroduce the requirement to carry out a locally based standardised suicide audit led by an experienced public health doctor and/or researcher/suicide expert and standardise the method and type of data collected. Establish a system to ensure local audits are collated and analysed at a national level.

vi. Task the National Suicide Prevention Strategy Advisory Group with establishing a vehicle to allow the sharing of innovation and ideas at a national level.

vii. Task the National Suicide Prevention Strategy Advisory Group to consider the lessons learnt from the three devolved nations and facilitate information sharing at a UK level with the possible establishment of a multi-nation policy group supported by a research group.

viii. Address the continuing concerns about the distribution of Help is at Hand.

ix. Liaise with the Ministry of Justice and Chief Coroner to address the recording of suicides, the use of narrative verdicts and the experience of families bereaved by suicide.

x. Commit additional funding beyond that identified by the Suicide Prevention Strategy to national research to ensure the Britain's leading role in suicide research is not lost.

*Home Office*

xi. Working with ACPO, the College of Policing and the Department of Health, develop guidance to improve police engagement in suicide prevention.

*Ministry of Justice/Chief Coroner*

xii. Address concerns over data collection, narrative verdicts and the needs of bereaved families as a priority.

**Local**

*Health and wellbeing boards*

i. Ensure that suicide and self-harm are addressed in the Joint Strategic Needs Assessment beyond being a measure.

ii. Ensure that the local suicide prevention plan is written into the local health and wellbeing strategy and includes provision for bereaved families.

iii. Ensure that specific measures to a) support people bereaved by suicide, and b) to address self-harm prevention, are written into in local health and wellbeing strategy.

iv. Facilitate regular communication with local suicide prevention group.

v. In areas where there is no plan or group, develop both as a priority. Using the model of Choose Life Coordinators in Scotland, designate a senior member of the public health team to undertake this.

*Directors of Public Health*

i. Seek to expand membership of suicide prevention group to include the local police force, coroner and GPs.

ii. Facilitate communication between health and wellbeing board and local suicide prevention group.

iii. Ensure local suicide prevention plans are incorporated into local health and wellbeing strategies.

iv. Investigate opportunities for developing links with neighbouring local authorities to coordinate work through a regional group that could pool resources and expertise.

v. In areas where there is no plan or group, consider development of both as a priority.

**Media**

i. The body established to replace the Press Complaints Commission must ensure the Editor's Code is enforced, particularly in relation to the existing clause 5 (ii) and the careful reporting of suicide.

ii. The body established to replace the Press Complaints Commission must be given robust powers and resources to ensure the previous work in training journalists on reporting suicide is maintained and broadened to ensure journalists working for local and regional newspapers receive the same training.

## Introduction

**1.** Suicide prevention policy in England is experiencing great change. A new national strategy to prevent suicide in England was published last year and the reorganisation of health and public health structures brought about by the Health and Social Care Act 2012 are due to be fully implemented by April 2013. The Office for National Statistics (ONS) indicate that the suicide rate in England has been in steady decline for most of the last decade until 2008, since when there has been a small increase in the number of suicide deaths[1]. A recent study published by the University of Liverpool suggests the economic downturn has had an impact on suicide rates. Researchers calculated that more than 1000 suicides between 2008 and 2010 could be attributed to unemployment.[2]

**2.** The All Party Parliamentary Group for Suicide and Self-harm Prevention decided in early 2012 to examine the future of local suicide prevention plans in England against this backdrop. The aim of this Inquiry is to make recommendations which focus on how the government, local authorities, health services and other agencies can help to ensure that the objectives of the national suicide prevention strategy are translated into tangible activities that have an impact at local level, reducing the risk of suicide in local communities.

**3.** The Group wishes to extend its thanks to all the witnesses who gave up their time to attend and gave interesting insights into the work they and their colleagues do and the challenges they face. The Group is also grateful to all those who responded to the Call for Evidence.

**4.** The report is structured as follows;

- The context - Mechanisms for delivery of the 2002 National Suicide Prevention Strategy for England
- Local suicide prevention plans now
- Future implementation
- Recommendations – specific recommendations have been drawn up for key organisations: Department of Health (DH), Home Office, Ministry of Justice (Chief Coroner), Chief Executives of Local Authorities, Directors of Public

[1] ONS statistics for mortality from suicide and injury of undetermined intent as reported in the Department of Health Mortality Monitoring Bulletin, October 2011 (p.20)

[2] 'Suicides associated with the 2008-10 economic recession in England: time trend analysis' BMJ 2012; 345 doi: http://dx.doi.org/10.1136/bmj.e5142 (Published 14 August 2012) Barr, B, NIHR research fellow1, Taylor-Robinson, D, Scott-Samuel, A, McKee, M and Stuckler, D

Health, Health and Wellbeing Boards, Clinical Commissioning Groups and GPs and the media.

- Good practice - as well as making recommendations, we have also sought to highlight examples of innovation and good practice revealed during the Inquiry. We hope that these will prove of use to practitioners looking for solutions.

## Methodology

**5.** To obtain a complete a picture as possible of the current situation with regard to suicide prevention work at a local level in England and how it will be affected by the changes in national strategy and policy, a Call for Evidence questionnaire was sent to;

- All Chief Executives of upper-tier local authorities[3] in England
- All Directors of Public Health
- All Chief Executives of Primary Care Trust (PCT) Clusters

Freedom of Information (FOI) requests were sent to authorities that did not respond. This led to an overall response rate of 98%. For the three authorities that did not reply, basic information was obtained through research carried out online.

**6.** England has 152 upper-tier local authorities (i.e. unitary or county council level) and while most of the 152 Primary Care Trusts under the old commissioning system shared the same geographical boundaries there are some areas of the country where this is not the case. The situation is further complicated by the merging of PCTs into PCT clusters and the fact that some local suicide prevention plans are implemented on a joint basis across two or more upper-tier local authority areas. For ease of reference and to minimise any confusion, replies have been allocated to the most relevant upper-tier local authority area(s) although responses came from a variety of sources. This enables us to present the data gathered from the Call for Evidence in a consistent way across the country.

**7.** In addition to the Call for Evidence, four evidence sessions were held in the House of Commons. A panel of Parliamentarians heard from local authority and NHS representatives, representatives of the administrations of the devolved nations and the voluntary sector.

[3] "Upper-tier local authorities" include County Councils in areas with a two-tier system of local government or unitary authorities in areas with a single tier.

## The Context

## Mechanisms for delivery of the 2002 National Suicide Prevention Strategy for England

**8.** Published in September 1999, the National Service Frameworks for Mental Health[4] set out a ten-year plan with national standards and service models for promoting mental health and treating mental illness. Of the national standards contained in the Frameworks, standard seven was dedicated to preventing suicide and set out service models and examples of good practice that health and social care services were expected to follow. The "preventing suicide" standard was linked to the DH document *Saving Lives: Our Healthier Nation* which had been published two months earlier and set targets to reduce death rates by cancer, coronary heart disease and stroke, accidents and suicide. The specific target for suicide was to reduce the death rate from suicide and undetermined injury by at least 20% by the year 2010[5].

**9.** The document made clear that *"local health and social care communities must translate national standards and service models into local delivery plans"*[6]. Of the seven national standards set out in the framework, two were the responsibility of public health to lead on – Standard 1 (Mental Health Promotion) and Standard 7 (Preventing Suicide). In evidence to the Inquiry, one witness said that *"we should not underestimate the power, the strength that that policy had in driving current suicide prevention and mental health promotion at work"* and that as a nationally driven strategy it came with requirements around audit and scrutiny.

**10.** The National Suicide Prevention Strategy for England, published in 2002, was intended to support the achievement of the target set in *Saving Lives: Our Healthier Nation* and reinforced in the National Service Frameworks for Mental Health - to reduce suicide by a fifth[7].

**11.** The Strategy contained six "goals" and stated that the actions and targets contained in the National Service Frameworks would contribute towards achieving these goals[8]. The six goals were:

- To reduce risk in key high risk groups
- To promote mental well-being in the wider population
- To reduce the availability and lethality of suicide methods

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[4] *National Service Frameworks for Mental Health: Modern Standards and Service Models,* Sep 1999, Department of Health
[5] Chapter 8, *Saving Lives: Our Healthier Nation,* Jul 1999, Department of Health
[6] p.83, *National Service Frameworks for Mental Health*: Modern Standards and Service Models, Sep 1999, Department of Health
[7] p.5, *National Suicide Prevention Strategy for England,* 2002, Department of Health
[8] p.10, *National Suicide Prevention Strategy for England*, 2002, Department of Health

- To improve reporting of suicidal behaviour in the media
- To promote research on suicide and suicide prevention
- To improve monitoring of progress towards the target to reduce suicides

**12.** At a national level the delivery of the Strategy became the responsibility of the National Institute for Mental Health in England[9] (NIHME), an agency established and funded by DH.

**13.** In addition to the national target of a 20% reduction in suicide, requirements were initially imposed on Primary Care Trusts (PCTs) relating to suicide audits. When PCTs were introduced in 2002 a new system of star ratings was implemented to monitor their progress against a wide range of performance indicators. Among these performance indicators was a requirement under the "Improving Health" category for PCTs to implement a local system for suicide audit. The rationale given for this was that:

> *"75% of all completed suicides involve people who are not in contact with specialist mental health services, therefore to be successful in reducing the suicide rate the development of local systems for suicide audit to learn the lessons and take any necessary action is essential"*[10]*.*

**14.** It also stated that, in addition to systematic suicide audit programmes, local services were expected to have multi-agency protocols for the sharing of information on high risk patients and to have staff competent in the assessment of risk of suicide[11].

**15.** The first set of 'star ratings', published by the Commission for Health Improvement (CHI) for the 2002/03 financial year[12], showed that of the 303 PCTs in England[13] only 193 of them had local systems for suicide audit in place. When the second set of star ratings was published by the Healthcare Commission, for the 2003/04 financial year, this figure had improved to 291 PCTs[14]. However, the star ratings system was subsequently abolished and replaced with a new "annual health check" which did not include the monitoring of suicide audits. **In our opinion, this was a great mistake.**

**16.** In response to a Parliamentary Question in January 2009, the then Minister of State for Care Services, Phil Hope MP, confirmed that information on the number of PCTs conducting suicide audits was not being collected centrally by the

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[9] p.10, *National Suicide Prevention Strategy for England*, 2002, Department of Health
[10] p.6, *Suicide Audit in Primary Care Trusts localities: A Whole Systems Approach,* 2006, Church, E., & Ryan, T.
[11] p.6, *Suicide Audit in Primary Care Trusts localities: A Whole Systems Approach,* 2006, Church, E., & Ryan, T.
[12] www.chi.nhs.uk/Ratings/Downloads/PCT.xls
[13] From 2002 there were 303 Primary Care Trusts in England but this was subsequently reduced to 152 Primary Care Trusts following a reorganisation in 2006.
[14] http://ratings2004.healthcarecommission.org.uk/Trust/results/indicatorResults.asp?indicatorId=4212

government[15]. In their 2011 report, *The Truth About Suicide*, the think-tank Demos concluded that PCTs' responsibilities for collecting data and monitoring local trends in suicide were not sufficiently clear and noted that 10 of the 147 PCTs they had approached informed them that they did not conduct suicide audits at all[16].

**17.** The Suicide Prevention Strategy for England was also linked into the Public Service Agreements (PSAs), which was the previous administration's preferred framework for performance management across government.

**18.** The Department of Health was a "Lead Department" for two PSAs which included PSA 18: *Promote Better Health and Well-Being for All.* PSA 18 (published in October 2007), stated that the government was committed to *"delivering the best possible health outcomes for everyone, helping people to live healthier lives, empowering them to stay independent for longer and tackling inequalities"*[17] and included a strong emphasis on reducing premature mortality rates with specific reference to cancer, heart disease, suicide and the effects of smoking. **This was a positive move.**

**19.** The Suicide Prevention Strategy for England was expected to contribute towards two of the five key performance indicators under which PSA 18 was measured:

- All Age, All Cause Mortality (AAACM) rate - this measured mortality from all causes of death meaning that this indicator effectively looked to achieve an increase in the overall average life expectancy. The most effective way of achieving this was by preventing premature deaths, hence the emphasis on cancer, heart disease, suicide and the effects of smoking as these are all high in the number of life years lost.

- Difference in AAACM between the national (England only) average and the 20% of areas with the worst health and deprivation indicators. This indicated the Government's expectation that health inequalities should be reduced and that the NHS should prioritise the promotion of good health in deprived areas.

**20.** PSA18 specifically noted that the Suicide Prevention Strategy for England sets out *"ways in which commissioners can reduce risk in the key risk groups*[18]*"* such as people who have recently self-harmed. PSA18 also referred to initiatives in the Suicide Prevention Strategy for England such as the provision of a toolkit for PCTs to undertake population-based suicide audits in their local areas in order to improve understanding of local trends in suicide rates and identify effective clinical interventions.

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[15]Hansard, HC Deb, 22 Jan 2009, c1625W
http://www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090122/text/90122w0013.htm#09012265002801
[16] p.72, *The Truth About Suicide,* Demos, Bazalgette, L., Bradley, W. & Ousbey, J.
[17] p.3, *PSA Delivery Agreement 18: Promote better health and wellbeing for all*, October 2007, HM Government
[18] p.9, *PSA Delivery Agreement 18: Promote better health and wellbeing for* all, October 2007, HM Government

**21.** In the latter part of the last decade, the national priorities determined by the Department of Health filtered down to the NHS through the Operating Framework and the *Vital Signs* performance management system, and to local authorities where appropriate, through local performance indicators. An indicator on the 'suicide and injury of undetermined intent mortality rate' was included in *Vital Signs*[19], meaning that it was considered as one of the national priorities for local delivery. PCTs were required to publish the local suicide rate in their area, along with a comparison to the regional and national rates, in their *Vital Signs* performance report along with data on a wide range of other national priorities. While this process generated information to support commissioning and performance management more generally, it was not a mechanism that could guarantee the full establishment and implementation of local suicide prevention plans.

**22. Throughout the lifespan of the 2002 Suicide Prevention Strategy for England, there were no specific mandatory requirements to set up a multi-agency suicide prevention group or publish a stand-alone local suicide prevention strategy. Nevertheless, many PCTs chose to do so and in our opinion this was critical in delivering progress towards the delivery of PSA objectives.**

**23.** Progress against the target to reduce suicide in England by 20% was measured from a 1995-97 baseline figure, calculated as an average of the death rate across each of those three years (because three-year averages are considered to be a more reliable indicator of trends than single-year figures). This would mean that the three-year rolling average would need to reduce from 9.2 deaths per 100,000 in 1995-97 to 7.3 deaths per 100,000 by 2009-11[20]. As illustrated in the table below, significant progress had been made towards the target by 2008-10 (the last years for which figures are available), with the rate falling to 7.9 deaths per 100,000, representing a reduction of 13.4%[21].

**24.** On 22nd January 2013, the ONS published statistics on the number of UK suicides in 2011[22]. The figures for England indicated a rise on the number of suicides per 100,000, when compared to the previous year, of just over 6%. However, these statistics measure the rate of suicides in people aged over 15 in a single year period whereas the figures previously used by DH to track progress against the national suicide reduction target was based on all age mortality statistics in the 'three-year average' format. At the time of going to print, the 2011 statistics had not been published in the latter format, meaning that they cannot yet be applied to the table below. However, it is reasonable to assume that the

[19] p.47, *Operating Framework for the NHS in England 2009/10*, Department of Health (Dec 2008)
[20] p.13, *National Suicide Prevention Strategy for England Annual Report on Progress 2008,* National Mental Health Development Unit (Jul 2009)
[21] ONS statistics for mortality from suicide and injury of undetermined intent as reported in the Department of Health Mortality Monitoring Bulletin, October 2011 (p.20)
[22] http://www.ons.gov.uk/ons/rel/subnational-health4/suicides-in-the-united-kingdom/2011/stb-suicide-bulletin.html

rise in excess of 6% in the ONS statistics for 2011 will lead to a small increase in the 2009-2011 'three-year average' figures when compared to the 2008-2010 figures. This confirms that, while the suicide rate has declined over the lifetime of the 2002 National Suicide Prevention Strategy for England, it has not achieved its objective of reducing suicide by 20%.

**Suicide rate per 100,000 in England (Three-year rolling average)**

| Three-year period | Male suicide rate per 100,000 | Female suicide rate per 100,000 | Overall suicide rate per 100,000 |
|---|---|---|---|
| 1995-1997 (baseline) | 14.1 | 4.5 | 9.2 |
| 1999-2001 | 14.4 | 4.5 | 9.3 |
| 2000-2002 | 13.7 | 4.3 | 8.9 |
| 2001-2003 | 13.3 | 4.2 | 8.6 |
| 2002-2004 | 13.0 | 4.3 | 8.6 |
| 2003-2005 | 12.9 | 4.3 | 8.5 |
| 2004-2006 | 12.5 | 4.2 | 8.3 |
| 2005-2007 | 12.1 | 3.8 | 7.9 |
| 2006-2008 | 12.0 | 3.7 | 7.8 |
| 2007-2009 | 12.2 | 3.6 | 7.9 |
| 2008-2010 | 12.2 | 3.7 | 7.9 |
| Percentage change from 1995-1997 to 2008-2010 | -13.2% | -16.6% | -13.4% |

Source: ONS statistics for mortality from suicide and injury of undetermined intent as reported in the Department of Health Mortality Monitoring Bulletin, October 2011 and the Department of Health *Statistical update on suicide*, September 2012.

**The new Suicide Prevention Strategy and Health and Social Care Act 2012**

**25.** In July 2011, the Government launched a consultation[23] on a new suicide prevention strategy for England to replace the strategy published in 2002. The consultation closed in October 2011 and the new strategy, entitled *Preventing Suicide in England: A cross-government outcomes strategy to save lives,* was published in September 2012[24]. The government's decision to proceed with the publication of a new suicide prevention strategy for England is a very welcome development and provides a valuable opportunity to renew efforts across government and across sectors to deliver evidence-based interventions that can contribute towards saving lives.

**26.** The Government fully acknowledges that the success of its national strategy to prevent suicide depends on multi-agency working and the development of partnerships across sectors. In the Written Ministerial Statement which accompanied the launch of the consultation, the then Minister of State for Care services, Paul Burstow MP, observed that:

> *"There is no single approach to suicide prevention. It needs a broad co-ordinated system-wide approach that requires input from a wide range of partner agencies, organisations and sectors.[25]"*

**27.** In the Ministerial Foreword to the new strategy the current Minister of State for Care Services, Norman Lamb MP, acknowledges that the factors which lead to suicide,

> *"are complex"* and that *"no one organisation is able to directly influence them all*. *Commitment across government, from Health, Education, Justice and the Home Office, Transport, Work and Pensions and others will be vital. We will also need the support of the voluntary and statutory sectors, academic institutions and schools, businesses, industry, journalists and other media.[26]"*

**28.** The strategy provides a good deal of information highlighting evidence around effective interventions, best practice examples and the resources that are available, with the intention that this will support local decision-making and commissioning. The strategy focuses on two overarching objectives[27] which are:

- to reduce the suicide rate in the general population and,
- to provide better support for those bereaved or affected by suicide.

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[23] http://www.dh.gov.uk/health/2011/07/suicide-prevention-strategy/
[24] http://www.dh.gov.uk/health/2012/09/suicide-prevention/
[25] Hansard, HC Deb, 19 July 2011, c103WS (http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110719/wmstext/110719m0001.htm#11071985000893)
[26] p.2 *Preventing suicide in England: A cross-government outcomes strategy to save lives,* Department of Health (Sep 2012)
[27] p.5 (paragraph 2), *Preventing suicide in England: A cross-government outcomes strategy to save lives,* Department of Health (Sep 2012)

**29.** These two objectives are intended to define what the strategy as a whole is intended to achieve, while each of the six Areas for Action set out where activity should be focused. The Areas for Actions are broadly similar to the six "goals" set out in the 2002 strategy although there have been some changes. **In our opinion, the most significant of these is that a new Area for Action has been added on providing better information and support to those bereaved or affected by suicide.**

**30.** The Areas for Action are all accompanied with supporting information and best practice examples of local interventions, but, as stated in the Ministerial Foreword, the draft strategy does not specifically mandate the means of achieving its overarching objectives at a local level. In common with much of the government's current approach, there is a strong emphasis on recognising the autonomy of local organisations in determining the approach that works in their area.

**31.** Alongside the new strategy, the Department of Health published *'Prompts for local leaders on suicide prevention,'*[28] which poses a number of questions that local leaders could consider asking about suicide prevention in their local authority area. This is a useful resource which could contribute towards increasing the scrutiny of local authorities' contribution towards implementing the national strategy. However, there is no requirement that these questions must be asked or answered nor is there an overarching implementation strategy. In asking these questions, the Department of Health recognises what is needed at a local level, but this is not supported by oversight to ensure effective implementation, or additional resources. **In our opinion, this is a grave mistake.**

**32.** As part of the Call for Evidence, respondents were asked whether they were aware of the new suicide prevention strategy. 142 of the 152 respondents confirmed that they were aware of the new suicide prevention strategy and many responses mentioned that this would be used to refresh local plans.

**33. Concern was expressed by several respondents about the delay in publishing the strategy, which had led to a suspension of work locally. This indicated an appetite for national leadership from the local level. In our opinion, the failure to provide oversight to ensure effective implementation, or additional resources will impact negatively on the success of the strategy.**

**34.** The Health and Social Care Act 2012 abolishes all SHAs and PCTs in England. Local directors of public health, previously located in PCTs, will move to upper-tier local authorities and will be responsible for implementing local policy.

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[28] http://www.dh.gov.uk/health/files/2012/09/Prompts-for-local-leaders-on-suicide-prevention.pdf

**35.** Each upper-tier local authority will establish a health and wellbeing board which will act as a local forum for determining local needs, bringing together local authorities, clinical commissioning groups, the directors of public health, adult social services and children's services and a representative of the local HealthWatch. Health and wellbeing boards therefore have the potential to play a significant role in promoting suicide prevention by working with their local director of public health and other agencies

**36.** The strategy states that,

> *"Some areas have established regional or sub-regional multi-agency suicide prevention groups to co-ordinate activities to reduce suicides. In many cases these groups also support more localised groups or networks of suicide prevention activists. These groups could help support directors of public health and health and wellbeing boards in developing assessments and strategies.*[29]*"*

**37.** Public Health England, the Department of Health's new public health agency which becomes fully operational later this year, will have responsibility for measuring performance in this area as part of the Government's new system of Outcome Frameworks. Each Outcomes Framework has a set of indicators that will act as a "dashboard' to allow for the monitoring of progress on key health outcomes. The key indicator on suicide is included within the Public Health Outcomes Framework[30] although the NHS Outcomes Framework also includes some indicators relevant to suicide prevention. Public Health England will monitor performance through the suicide data published by the Office for National Statistics. This responsibility however does not include any in-depth monitoring of the progress of local suicide prevention strategies.

**38. It is not yet clear how many existing multi-agency suicide prevention groups will survive the transition to the new structures. Nor it is possible to determine exactly how many local authorities or health and wellbeing boards in England intend to set up multi-agency suicide prevention groups or develop local suicide prevention plans, as the Department of Health has no specific requirement for them to do so.**

**39. Local agencies will be left to determine their approach to preventing suicide, with progress measured by the Public Health Outcomes Framework. While this provides local agencies with a degree of flexibility and autonomy in their approach, it does not guarantee however that local suicide prevention plans will be developed and delivered in every part of the country or that the full range of statutory agencies and voluntary**

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[29] p.51 (paragraph 7.11), *Preventing suicide in England: A cross-government outcomes strategy to save lives*, Department of Health (Sep 2012)

[30] p.15, *Healthy Lives, Healthy People: Improving outcomes and supporting transparency, Part 1: A public health outcomes framework for England, 2013-2016,* Department of Health (Jan 2012)

**groups that could have a role in preventing suicide will be engaged in a co-ordinated strategic approach in each local authority area. We consider this to be a grave mistake.**

40. **This report has sought to capture what is in existence prior to these changes being implemented and how it may be affected by the transition. Further evaluation after April 2013 will be needed to complete the picture. The All Party Parliamentary Group has therefore committed to undertake a follow-up survey in late 2013.**

## Local suicide prevention plans now

**41.** Before addressing in detail the future of local suicide prevention plans, the Group sought to establish what is happening now. Does each local area have a plan? How are local suicide prevention plans delivered locally? Who takes responsibility for the plans? How effective are they and what are their concerns for the future?

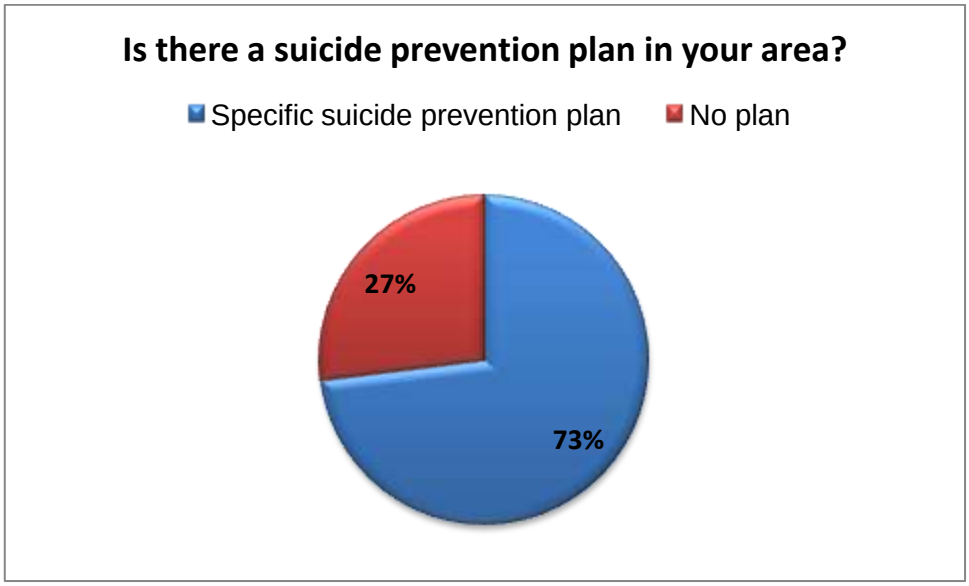
### Existence of suicide prevention plans

**42.** Most local suicide prevention plans that respondents submitted as part of the Call for Evidence follow a similar format, with priorities based upon those highlighted by the 2002 Suicide Prevention Strategy. A local suicide prevention plan will usually bring together data on the local suicide rate (based on annual audits); identify at-risk groups and measures to be taken to reduce the rate. Local plans also identify issues specific to that locality such as high risk areas including bridges and the rail network. We found several areas where local authorities or PCTs work at a regional level on suicide prevention, while retaining their own discrete plans.

**43.** As set out later in this report, the Inquiry heard evidence from various witnesses that local suicide prevention plans are vital; they give suicide prevention prominence and focus. They ensure preventative measures are linked to individuals who can be held to account for their implementation and provide a means to measure progress.

**44.** The Call for Evidence sought to establish how many areas had a suicide prevention plan producing the following response:

**Graph 1**



**45.** Ten years after the publication of the first national suicide prevention strategy; it is of great concern 27% of areas do not have a specific plan. Without a plan, it remains unclear how local authorities will know if they have a problem, where their focus of attention needs to be and what changes or partnerships could be introduced to tackle that problem.

**46.** 15 of the 41 respondents without a plan indicated that they intended to create one. Few indicated why they had decided to establish a plan. Of the respondents who did give a reason, these included the outcome of a local audit, a high profile local case of suicide, being prompted by the publication of the draft national suicide prevention strategy and the development of a plan being considered alongside the creation of a health and wellbeing strategy. While we welcome the development of plans, the variety of reasons given underlines the lack of national direction and the sense that plans are not developed to prevent problems, rather address them after they occur.

**47.** Some respondents felt that the suicide rate was so low locally that a specific plan was not required. In 16 areas, reference was made to suicide prevention being delivered as part of mental health and wellbeing strategies. This often means that suicide prevention is incorporated into mental health strategies aimed at the general population and as a result, some suicide prevention measures may not receive the direct attention and funding needed.

**48. The existence of local suicide prevention plans in England is patchy with nearly a quarter of respondents reporting that they have not developed a specific plan. At a time of transition, this has implications for the future development of plans. It is of great concern that local plans are not a requirement of the new national strategy. At a minimum, there should be a statutory requirement for each local authority area to have a local suicide prevention plan.**

## Leadership

*"And I also have to say that we have been very fortunate in xxx in that the Chief Executive of our PCT takes a personal interest in suicide prevention and mental health. So all of that top level leadership kind of smoothes the way for those of us who try to do the job. I am sure you will hear these themes from all of us, but strong partnership, because it's not something that any of us can do on our own, but I did want to say that the partnership doesn't just happen. It needs strong leadership and I think with the three representatives you have got around the table, it is where we have got strong leadership and it is personally led and facilitated and enables the various partners to come to the table and play their part."(Director of Public Health in Evidence Session)*

**49.** Prior to the 2012 reforms and following their implementation, the Director of Public Health or a senior member of the public health team would normally be expected to lead on suicide prevention. During the course of the inquiry, the existence of "local champions" emerged who may provide leadership.

### Directors of Public Health

**50.** The Call for Evidence found that of the respondents who reported having a plan, 78% are led by a director of public health or a senior member of the public health team. For some respondents, it was not possible to identify a leader. It is a concern that a significant minority of areas with plans appear not to have a designated leader. It may mean that local plans do not have the leadership vital to ensure that they are adequately resourced and effectively implemented.

### "Local champions"

*"why I'm proud of the suicide and self-harm work that's been done in xxx is that we've had two people in public health who have been passionate champions, absolutely passionate champions, and one of those sadly the xxx person is going to retire. Now I know people retire, they do that, but it's the kind of work that although it's been on the radar, it needs a passionate champion and I think that one of the local risks for us is that we need to identify the next generation of passionate champions." (NHS representative in Evidence Session)*

*"One of the things we've done is to try to work with PCTs across a wider area and we've found hugely varying degrees of priority given to suicide prevention. That's not necessarily a reflection of the levels of suicide in the area, it does seems to me a question of whether you've got someone with an enthusiasm."(Director of Public Health in Evidence Session)*

*"We particularly have trouble because our passionate champion is leaving at the time of the reorganisation. That presents an additional... I would be less worried if our passionate champion was transferring to the local authority and her business and her budget with her because she fights hard. As I say, our job is to find somebody else who will step into her shoes and that won't be easy." (NHS Representative in Evidence Session)*

**51.** The importance of what were referred to in the evidence heard as "local champions" emerged through the course of the inquiry. Local champions are individuals whose personal commitment ensures that suicide prevention is on the agenda that suicide prevention groups are formed and meet and who work hard to ensure suicide prevention programmes are developed and sufficiently resourced. This may not necessarily be the designated leader such as a director of public health, but an individual who takes a personal interest.

**52.** The Call for Evidence did not ask specifically about "local champions", and indeed the precise definition of this term is perhaps a somewhat subjective one, so it is not possible to say how many of them there are. However, what is clear is that local champions exist by chance. If local suicide prevention plans rely upon such a "local champion", their long-term survival is dependent on the commitment of that individual, which is an inherent weakness.

**53. Evidence showed that committed leadership is a vital component in ensuring local suicide prevention plans and groups have sufficient support over the long-term. Their existence however is open to chance rather than determined by any national requirement. The lack of statutory commitment to the provision and implementation of suicide strategies, plans and structures locally makes it less likely that such local champions will arise, harder for such individuals to be successful in obtaining support for their efforts, and more likely that leadership will diminish. It is essential that statutory commitment is made to ensure directors of public health are required to develop and lead a suicide prevention plan or that each area is required to appoint a local champion to develop and lead a plan. In addition, there is a need for strong national leadership, to join together local champions in order to share best practice and provide support.**

## Suicide Prevention Groups

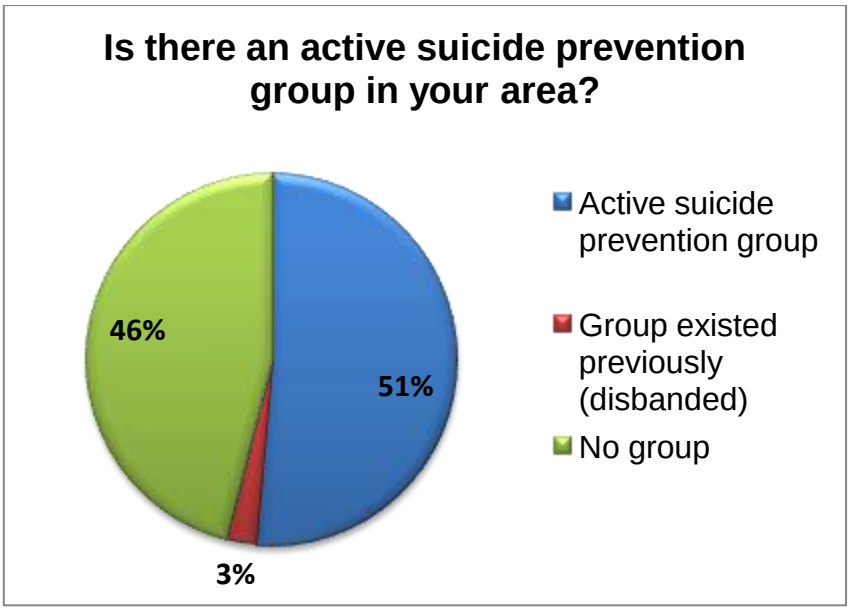
*"I sit on the xxx suicide prevention network group and as a direct result of that from talking to people around that table it was quite quickly established that there were a couple of areas in the North West that didn't have groups and very much wanted groups, or needed groups. So as a direct result of that in the last six months we've set up two support groups on the Wirral, again in response to need and a group in St Helens, Warrington and also what was great about that was that the PCT sit on that as well and what was great was that they knew there was a pot of money that could be tapped into in order to open those groups," (Representative of Support Group in Evidence Session)*

*"And I stumbled on to the Advisory group and it has been absolutely amazing for me, to help me to do what we are trying to do in xxx. It has meant that I have had access to people at the highest level in mental health. I have learnt a huge amount about structures in the NHS. I have had access to the police.*

*I just feel if there is no obligation to keep, if there is no statutory obligation towards suicide Prevention, the Group will die and those people will stop talking to each other and they will stop talking to me and that won't be very helpful." (Representative of Samaritans in Evidence Session)*

**54.** The Inquiry found that suicide prevention groups vary greatly in their composition and roles. Where they exist, they are often chaired by the director of public health or senior member of the public health team. Their role may be limited to work on an annual audit or they may oversee the implementation of the suicide prevention plan.

**Graph 2**




**55.** The value of these groups emerged clearly during the evidence sessions and through examples provided through the Call for Evidence. Groups provide a channel of communication and in many areas, have been instrumental in identifying sources of funding and developing programmes tailored to local needs.

**56.** One witness provided a written submission of what had been implemented as a result of the involvement she had had with the Suicide Prevention Advisory Group. This included the commissioning of a specialist suicide bereavement service, a weekly attendance at A&E by Samaritans volunteers and information sharing with Farmers Crisis Network.

**57.** While only a small number, it was of concern to see that 4 respondents reported that groups have been disbanded or suspended. The reasons given included the loss of key members due to redundancies and suspension while new structures are being agreed.

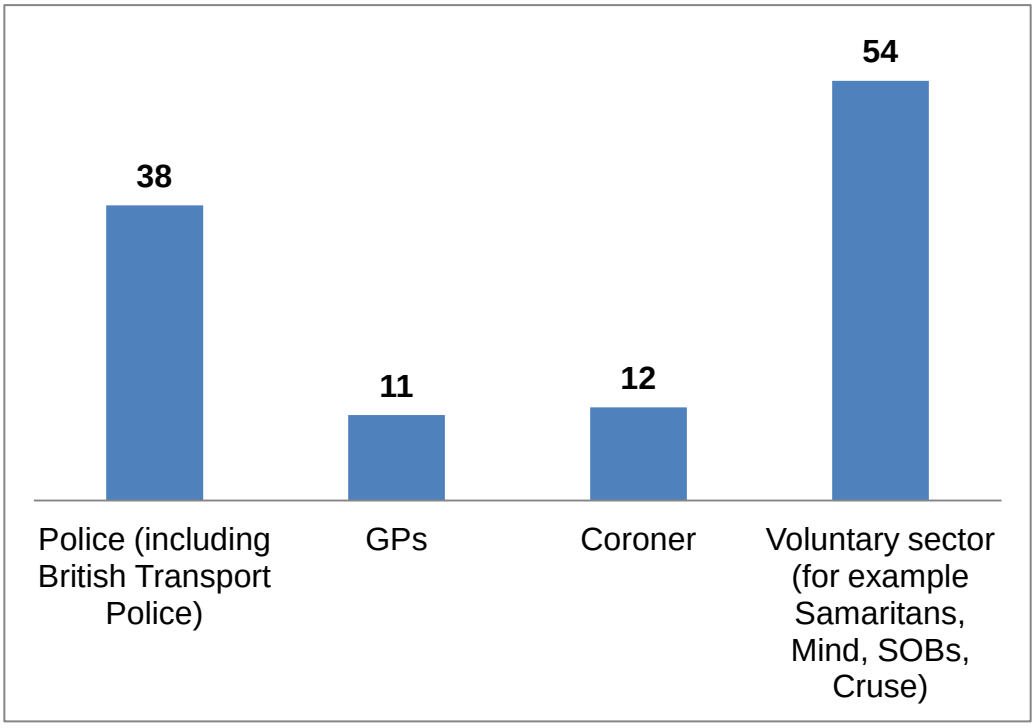
**58. In the areas where there is partnership working without the formal structure of a group, there is a danger that suicide prevention may not be considered a priority and relies even more heavily on committed individuals than would otherwise be the case with a formal group. In addition, there may be no mechanism to bring together the wider range of relevant agencies necessary to deliver coordinated action. Again, suicide prevention is left to chance, determined by the existence of interested individuals. The Government must ensure that each area has the means to establish a suicide prevention group.**

**Membership of Local Suicide Prevention Groups**

**59.** Membership of these groups varied from area to area, but usually includes representatives of the NHS Trust(s), mental health trusts, local authorities, police and voluntary groups such as Samaritans, Mind, SOBS and Cruse. Membership tends to be voluntary, with groups relying upon the commitment of individuals.

**60.** Respondents to the Call for Evidence did not always supply a membership list, but of those who did, it was felt to be helpful to highlight the composition of groups and in particular whether they included the police, GPs, coroners and the voluntary sector. All groups included representatives of statutory agencies such as the local PCT, NHS mental health trust and public health teams. Reference to the implications of this will be made in later sections.

**Graph 3**



**Regional Prevention Groups/Networks**

> *"Over the past 8 years there has been a decline in local areas publishing suicide prevention strategies, often because of reduced staffing and capacity. To try and address some of the key issues, the Cheshire and Merseyside Suicide Reduction Network was established in June 2008, to seek greater co-ordination of responses to, and understanding of, patterns of suicide in the Cheshire/Mersey region and the development of whole system approaches to reducing suicide."*

**61.** The Call for Evidence produced several examples of regional prevention groups or networks. These regional groupings may work alongside locally based groups and plans, but provide leadership and the means to pool resources and expertise at a regional level.

- In **Greater Manchester**, the regional partnership allows for the compilation of local data and joint working on suicide prevention campaigns.

- In **Teeside**, the Teeside Suicide Prevention Taskforce leads on suicide and self-harm prevention across four boroughs. It coordinates work across the four boroughs, including the commissioning of services and development of shared protocols. The four boroughs retain their own individual plans. Additionally, there is a **North East Regional Suicide Prevention Group** which coordinates the Teeside Taskforce along with task forces for Northumberland Tyne & Wear and County Durham and Darlington.

- The **Cheshire and Merseyside Suicide Reduction Network** was established by local mental health and public health leads to share data and strategies. It has a coordinating role for the majority of PCTs in the region.

**62. Regional prevention groups or networks provide a means to pool valuable resources, collaborate across local authority areas and ensure that suicide prevention is given the attention it deserves. It is recommended that information about how these regional prevention groups or networks operate is made available more widely to ensure that lessons are learnt.**

## Future Implementation

### Challenges and Opportunities for the Future of Local Suicide Prevention Plans

> *"I think just the scale of the organisational change is a challenge. This field relies on partnership working, partnership working relies on relationships and at least I think there is a risk of loss of momentum over the next few months."(Director of Public Health in Evidence Session)*

**63.** The Call for Evidence sought to establish how the new structures would affect local suicide prevention plans. Focus was given to how the transition of public health from PCT responsibility to local authorities may pose a threat or present an opportunity to suicide prevention plans, what resources, financial or otherwise are available for the transition and what impact the transition may have on existing local partnerships and relationships.

## Leadership

### Directors of Public Health

**64.** Under the new architecture, the director of public health will retain ownership for a local suicide prevention plan in areas where such a plan exists. Ideally, the director of public health, sitting on the health and wellbeing board and with a link to the suicide prevention group, (where one exists), will have a key role in ensuring that the board is aware of the need for suicide prevention initiatives. Information provided through the Call for Evidence and Evidence Sessions suggested that in the majority of cases, the director of public health would remain responsible for local suicide prevention plans, which indicates that a level of continuity is likely to exist in the transition.

**65. However, once the new architecture is in place, the Group is concerned about what will happen in areas where there is no suicide prevention plan or where there is no history of the director of public health taking a direct interest in the issue. The Government must ensure that directors of public health are required to develop a local suicide prevention plan in areas where they do not exist. The director of public health should also be required to act as the link between the health and wellbeing board and the suicide prevention group.**

## Health and Wellbeing Boards

*"The public health transition, as you probably know to local authorities, there are only five mandatory services[31] that they have to provide and suicide prevention is not one of them. So it is going to be very much about how much we can engage with the health and wellbeing board to listen as to why we need investment in this area." (Health Promotion Manager in Evidence Session)*

**66.** The Call for Evidence asked how respondents saw their role developing as a result of the creation of health and wellbeing boards eliciting a wide variety of responses. From these, a number of observations were possible.

- 143 respondents reported having either a shadow health and wellbeing Board or having a health and wellbeing board established already.
- 35 respondents made a specific comment to the effect they saw the new structure as an opportunity
- 17 respondents expressed uncertainty

**67.** The vast majority of areas appear prepared for the transition in terms of having the new architecture in place. From the data, it is difficult to conclude with any certainty how well these new structures are working in relation to suicide prevention or the true degree to which local suicide prevention plans will survive the transition to local authorities. Much will depend on how robust existing arrangements are and how well they are able to respond to change.

**68.** Amongst the 35 respondents who see the new structure as an **opportunity**, the overriding theme is the belief that health and wellbeing boards offer the possibility of greater cooperation which will benefit suicide prevention work. While this is encouraging, it is a unfortunate that they do not have a specific remit to do so.

*"Health and wellbeing boards will be in an excellent position to take a holistic view of the health and social factors that reduce suicide."*

[31] The five areas of public health that will be mandatory for local authorities to deliver are:

- Provision of appropriate access to sexual health services
- Plans in place to protect the health of the public (i.e. immunisation and screening plans)
- Ensure that NHS commissioners receive the public health advice they need
- Delivery of the National Child Measurement Programme
- Delivery of the NHS Health Check assessment

Source: p.3, *Public Health in Local Government: Local government's new public health functions* factsheet, Department of Health (Dec 2011)

*"The development of the health and wellbeing board provides an opportunity to share information and support for suicide prevention, the scope is to integrate this work throughout all organisations represented on the board."*

*"We expect the creation of the health and wellbeing boards will make inter-agency working more effective and efficient, which is likely to benefit suicide prevention work."*

**69.** Where **concerns** were expressed, these centred on the uncertainty unleashed by the transition,

*"At this time the architecture that currently supports suicide prevention is subject to change. This local architecture will remain fluid until all of the new commissioning structures are fully established and the relationships between local, sub regional and regional structures has been agreed."*

**70. Much will depend upon health and wellbeing boards being made aware of the potential for commissioning interventions that can prevent suicide. Their direct link with directors of public health, who are required by statute to be members of their health and wellbeing board, presents a clear opportunity to coordinate and generate support for suicide prevention at a local level. However, the lack of a specific mandate for local authorities to implement the initiatives set out in the national suicide prevention strategy means there is no guarantee that health and wellbeing boards will address suicide prevention or that existing plans will survive or be replaced.**

**"Local champions"**

*"We particularly have trouble because our passionate champion is leaving at the time of the reorganisation. That presents an additional... I would be less worried if our passionate champion was transferring to the local authority and her business and her budget with her because she fights hard. As I say, our job is to find somebody else who will step into her shoes and that won't be easy." (NHS Representative in Evidence Session)*

**71.** Transition in some areas may be characterised by a loss of jobs or individuals working in the suicide prevention field. It is difficult to identify the extent to which reorganisation at a local level will impact upon this, but the evidence sessions did suggest this could be an issue. As we have already seen, the existence of a local champion may be the determining factor in how much focus an area gives to suicide prevention now and in the future, but the very reliance on such a figure in transition and under the new structure is a clear weakness.

**72. In areas where there is no local champion, suicide prevention maybe overlooked completely, nor is there any guarantee that a local champion will have input into a health and wellbeing board. The Government must ensure that at the very least this role is fulfilled by the director of public health and that they have a statutory responsibility to report to the health and wellbeing board on the development of a local suicide prevention plan and its progress.**

**Suicide prevention groups**

> *"the Advisory Group is freestanding and it isn't accountable to anyone at this time, so again I think as xxx said, we need some stronger directives about making sure that these Advisory Groups sit and are accountable up to say the health and wellbeing board. Something where we know it is going to be discussed." (Health Promotion Manager in Evidence Session)*

**73.** There appears to be no formal mechanism by which a local suicide prevention group would report directly to a health and wellbeing board. A director of public health may do this on behalf of the group, but again there is no guarantee of this. It is important that local suicide prevention groups are not working in isolation and that they have links with decision-making bodies. It is of great concern that only 10 responses (of the 78 respondents with an active group) indicated that the local suicide prevention group had been given a formal role in reporting to the health and wellbeing board. In addition, it is uncertain what will happen where no suicide prevention group exists.

**74.** It is also worth noting that a small number of respondents stated that their local suicide prevention group had been disbanded or suspended. In one case, the reason for disbandment was funding, this sounds a note of caution about the future.

> *"Currently due to the economic downturn, the consequences of this included many redundancies within the statutory, voluntary and private sectors therefore impacting on the prevention group which was suspended for a while."*

**75.** Retaining leadership and relationships fostered through local groups will be important;

> *"And I think we very much believe that in these times of austerity and in knowing about the issues that need to be addressed, it is through those local partnerships that we are really going to be able to deliver the local plan, because it is a difficult issue, it is not seen as a priority for many organisations."* (*(Health Promotion Manager in Evidence Session)*

**76. Without a dedicated communication link to health and wellbeing boards, there is a danger that suicide prevention groups will not be able to ensure suicide prevention is on the agenda and services are commissioned. Without such a link, groups will be working in isolation, undermining their value and ultimately jeopardising their future. Health and wellbeing boards will not have access to vital information that will inform future strategies. The Government must address this by ensuring there is a formal requirement for health and wellbeing boards to receive reports from either the director of public health (representing the suicide prevention group) or another representative of the suicide prevention group.**

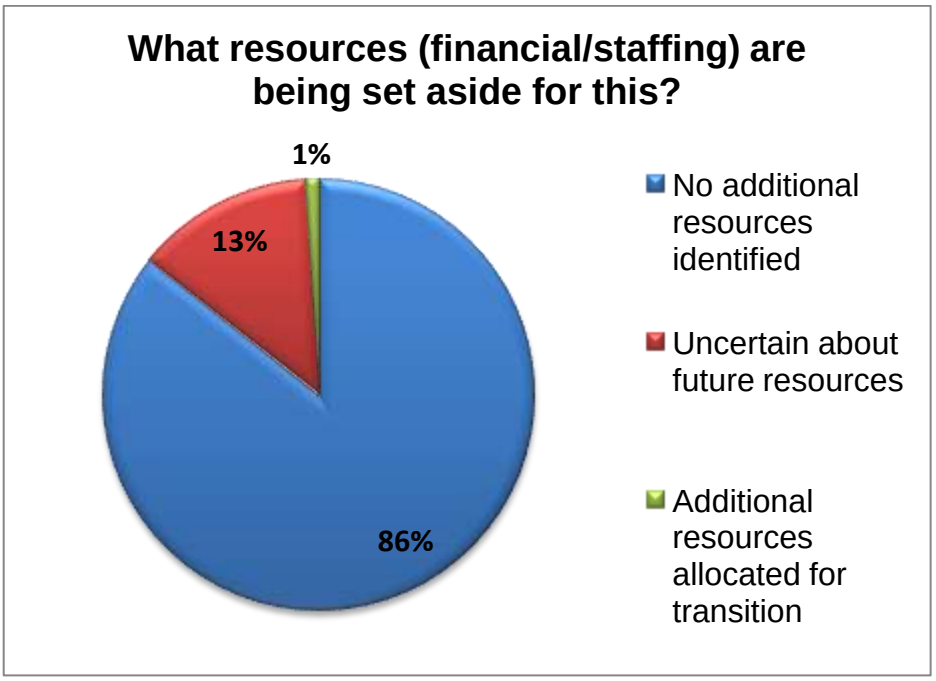
## Resources and competing priorities

*"What we are able to achieve will inevitably be impacted by the resources available which are being determined as part of the national transition of public health to local authorities."*

**77.** Besides the impact of new structures, the Inquiry sought to establish whether resources had been set aside specifically for the transition. The response provided information relating to the transition, but some respondents also provided information about funding for specific suicide prevention services.

**78.** Specifically on the transition, of those respondents who provided an answer;

**Graph 4**



**79.** Specific funding for the transfer of responsibilities from PCT to local authority may not in itself be required, because it entails the transfer of public health from one organisation to another. What may be more significant is the change from one organisation to another where there are different priorities for funding and a different process i.e. the health and wellbeing board, by which priorities are determined.

**80.** Nevertheless, the fact that the vast majority of areas do not have funding available to assist the transition suggests a degree of budgetary uncertainty. Uncertainty is also the dominant theme relating to future funding for public health.

**81.** The Department of Health's Policy Research Programme (PRP) has allocated up to £1.5m in research funding to support the new national suicide prevention strategy[32]. However, at local level there is no indication that any additional funds will be found to support local suicide prevention work. The main source of funding at local level is likely to be the ring-fenced public health budgets that will be held by local authorities from 2013/14 and are likely to be under significant pressure from a wide range of public health priorities.

*"Cash budgets for services specific to this area [public health] are under review within the overall national and local plans for transfer of responsibilities for public mental health from the NHS to local government."*

*"In terms of financial and staffing resources, this is a potential area of concern as the full impact of the NHS reforms are yet to be fully understood in relation to the total public health service resource. It is possible that financial pressures on local authorities may have a deleterious effect in the longer term on this budget."*

**82.** A substantial amount of information was offered about specific suicide prevention resources. There is a great deal of variation from area to area as to whether suicide prevention measures are funded as part of a mental health and wellbeing strategy, (with staff working in that field having a suicide prevention responsibility within their remit), or funded as stand-alone time-limited suicide prevention programmes.

**83.** During a time of transition coupled with significant budgetary pressures for local authorities and the voluntary sector (who are heavily involved in the delivery of suicide prevention programmes and suicide prevention groups), it is of concern that only one third of responses (50 respondents) mention specific suicide prevention programmes. Sustaining funding in the longer-term was raised as an on-going problem,

[32] http://prp.dh.gov.uk/2012/10/01/policy-research-programme-call-for-applications-4/

*"Voluntary sector organisations tell us that they can get money relatively easily to fund innovative first time round projects but what they struggle to do is to continue to deliver once a project has been successful so we've had suicide awareness initiatives that have been very very successful being delivered through Citizens Advice services, through Connexions services but sustaining that funding is problematic and I think as the local authority budgets have particular challenges when public health moves into the local authority that will be a problem for us and one that we're really mindful of."(Public Health Representative in Evidence Session)*

**84.** Against this background, a linked challenge for the future of local suicide prevention plans is competing priorities. Health and wellbeing boards will be responsible for identifying local priorities, including through their local Joint Strategic Needs Assessment (JSNA) which will then be used to inform commissioning decisions.

**85.** Only 57 responses specifically mentioned that mental health had been identified as a priority by the health and wellbeing board in the JSNA. Further investigation of JSNAs showed that suicide tends to be identified as an indicator, rather than an issue that requires separate attention. This is consistent with the approach of the new national strategy; suicide prevention is left to local discretion. *'Specific approaches to suicide prevention could feature in an effective local health and wellbeing approach.'*[33]

**86.** It is also important to note that mental health strategies do not necessarily equate with the provision of suicide prevention programmes. As was noted previously, few people who take their own lives have contact with mental health services beforehand.

*"the numbers are very small compared to smoking or obesity, what is this about, well our deaths by suicide show up the ultimate loss of hope, the ultimate loss of meaning of purpose, yet they are an indicator. They may be small numbers, but they have a very big ripple impact."(Director of Public Health in Evidence Session)*

**87.** Although a successful, joined-up public health strategy need to address a wide range of issues relating to both physical and mental health and wellbeing, it is nevertheless the case that suicide prevention initiatives will have to compete with other public health priorities and risk being sidelined by issues with a more visible profile such as obesity or smoking. Suicide remains a taboo subject for many and involves small numbers in comparison to other public health issues. This is compounded by the lack of a mandatory requirement for local authorities

[33] p.50-1 (paragraph 7.9), *Preventing suicide in England: A cross-government outcomes strategy to save lives*, Department of Health (Sep 2012)

to deliver suicide prevention beyond the Public Health Outcomes Framework having the reduction of suicide as a measure.

*"Looking forward in terms of the sustainability of our plans, I think we're being increasingly challenged to identify the financial return on investment and that's very challenging in an area where we've got small numbers and a limited evidence base, you're trying to demonstrate that you've achieved a negative in preventing things from happening."(Director of Public Health in Evidence Session)*

*"There are very difficult choices and prevention is often the thing that gets dropped off the agenda because the returns are in the future, not in the year that somebody is in control."(Health Promotion Manager in Evidence Session)*

**88.** Many suicide prevention actions contained in local plans involve the voluntary sector, who may deliver programmes such as support services for people bereaved by suicide. 54 respondents who confirmed the existence of a local group listed voluntary groups as members. The majority of groups from the available evidence had voluntary sector membership, underlining their importance to suicide prevention and the heavy reliance on them.

**89.** Funding pressures on the voluntary sector may threaten the long-term future of services. On the other hand, several witnesses were optimistic that their free services would be viewed positively by commissioning groups.

*"I think that local authorities will want to do well at doing public health because it is new and we want to do well at it so there is the potential for optimism there but I suppose I still remain slightly worried, particularly in our rural area that our work with the local farming community and the small charities that have helped us to make a difference to local farmers by giving them information about managing farm payments, how to access help if you're depressed and isolated and overall support for small upland hill farmers I'm worried that that might be vulnerable."(Public Health representative in Evidence Session)*

*"One is definitely, in the immediate future, is the funding issue, we can't stress enough, we are running out of money and the PCT engagement throughout our 47 support groups is sporadic to say the least." (Representative of support group in Evidence Session)*

**90. Health and wellbeing boards are intended to be the main mechanism at local level that co-ordinates the commissioning of health, social care and public health. But when faced with many demands on limited time and resources, with no mandatory requirement for local authorities to deliver**

**suicide prevention and with a heavy reliance upon the voluntary sector, there is a very real risk that suicide prevention will be neglected. The Government must take measures to ensure health and wellbeing boards include specific actions to address suicide in their Joint Strategic Needs Assessment and health and wellbeing strategy.**

## Engagement with other actors

**91.** While the focus of this report is primarily on local authorities and NHS organisations and this is where the Call for Evidence was directed, information about other actors involved in suicide prevention emerged during the course of the inquiry.

### Police

> *"There is a buy-in at a senior level, but my own observation is that we think the NHS changes managers frequently; you haven't seen anything compared to the police. I don't think I have gone through a year of strategic meetings where we haven't had a different senior police officer or manager representative at that group, believe it or believe it not, hasn't received a handover from the person who was doing it before."(Suicide Prevention Lead in Evidence Session)*

**92.** Police officers are on the frontline in dealing with people in distress and in their contact with families bereaved through suicide. A research study published in the British Journal of Psychiatry in 2007[34], drawn from a systematic analysis of suicides in County Durham and Darlington over a three-year period, found that a fifth had a documented contact with the police in the three months prior to their death. The importance and challenge of this role has been recognised in some areas with the production of an advice card for officers on how to deal with people in distress and where best to refer them.

**93.** Given this role, the engagement of the police in local suicide prevention activities is important; for instance contributing information about high risk locations and vulnerable individuals they have had contact with.

**94.** The Call for Evidence offered some indication of police representation on local suicide prevention groups. From the analysis of membership lists discussed on page 17, 38 respondents reported that representatives of the local police force (or British Transport Police) were members. This is by no means a complete picture. It is difficult to say why some police forces are engaged and others are not; it may be due to particular local conditions, but may also rest on a factor that has emerged elsewhere in this report, namely, the interested individual.

**95.** In evidence sessions, mention was made that police attendance at meetings was unpredictable and sometimes difficult to engage with. They may not attend consistently nor would the same officer attend each time.

**96.** Where police are engaged locally, valuable relationships with other groups involved in suicide prevention can be built which benefit all involved;

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[34] *Police contact within 3 months of suicide and associated health service contact,* British Journal of Psychiatry (2007), 190, 170-171, Linsley, K.R., Johnson, N., Martin, J.

*And the reason I feel I am taken more seriously is because, and it sounds terrible, but it ticks boxes for people to talk to Samaritans and I am not actually just talking about the NHS, I am talking particularly about the police who I have found quite difficult to access and they are on our Advisory Group. Sometimes more often than not, but they know that I am there too and that I am kind of on their case. (Samaritans representative in Evidence Session)*

**97.** The evidence the Group heard about police engagement reflected the same concerns that had been heard at previous meetings of the Group and raised during an adjournment debate on the investigation of suicides by the police.[35] This debate highlighted that there is no national policy for the investigation of suicide. As a result there is a great deal of inconsistency. For example, local forces may or may not examine an individual's computer for evidence of internet activity being a factor in their suicide. Equally, the training that police officers receive in their approach to bereaved families varies greatly.

**98.** The Group also received information about the role of the police in Australia in providing information to individuals and communities who have been affected by suicide. Police officers deliver information about the Standby Response Service, which can provide counselling and support. **We welcome all of these proposals.**

**99.** Separate to this, police officers in Australia are given information cards detailing how to talk to the media where there is a suspected suicide under an initiative known as Mindframe. This is in recognition of the importance of how suicide is reported and the need for sensitivity.[36]

**100.** In its response to a Freedom of Information request submitted to the Home Office following the debate, the department provided the minutes of a meeting about the investigation of sudden deaths. Concerns were expressed that there were no robust procedures available to police forces for the investigation of non-suspicious deaths in contrast to that available in the event of a suspicious death investigation. The minutes also contained the suggestion that a national protocol on coroner and police relationships be developed to improve communication and cooperation.

[35] Hansard, HC Deb, 13 March 2012, c50WH (http://www.publications.parliament.uk/pa/cm201212/cmhansrd/cm120313/halltext/120313h0002.htm#12031355000238)
[36] More information about Mindframe is available through http://www.mindframe-media.info/site/index.cfm?display=104491

## British Transport Police

**101.** The Inquiry received a submission from the British Transport Police which detailed their own suicide prevention plan and how this is implemented at a local level. British Transport Police are one of several agencies who have direct contact with distressed individuals. They are often the link between a high risk area and other agencies such as GPs and the Samaritans.

**102.** This submission questioned whether British Transport Police (and by extension Train Operating Companies or Network Rail) could sit on health and wellbeing boards or the National Suicide Prevention Strategy Advisory Group. As we have seen, the Police (including British Transport Police) are represented on 38 local suicide prevention groups.

**103. Patchy and inconsistent engagement by the police at a local level is a great concern. Effective local suicide prevention needs the involvement and contribution of the local police force. Suicide prevention groups are strengthened where there is active engagement by the local police. From the limited evidence available, this is the exception rather than the norm. In addition, the lack of a national policy for the investigation of suicides and a lack of national guidance for police officers in their interaction with bereaved families requires attention. The Home Office and ACPO must consider measures that would improve police engagement on all of these issues. The Department of Health, working in cooperation with the Home Office and ACPO must ensure that a suitable representative of each local police force (and separately British Transport Police where appropriate) be included in health and wellbeing boards.**

## Coroners

### Suicide data

**104.** The Inquiry heard evidence from several witnesses regarding the challenges of obtaining accurate detailed information about suicide deaths. Accurate statistics on suicide are essential for policy makers to understand trends and causes of suicide, identify demographic groups at high risk and identify suicide clusters.

**105.** The Department of Health supported document, *Suicide audit in Primary Care Trust Localities: A Whole Systems Approach,* published in 2006, provided information on the different sources that can be used to gather data on suicides[37] which included:

- ONS Public Health Mortality files
- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
- Surveys of local Coroner data
- Data from local prisons and probation services
- Clinical audit and significant event analyses, and
- Psychological autopsy research

**106.** Coroners offices are a particularly crucial source of information about suicides as they hold significant demographic data and details of the circumstances and method used by people who have taken their own lives. The coroners' service is currently undergoing a process of significant reform following the passing of the Coroners and Justice Act 2009. This included the establishment of a Chief Coroner who would give a degree of national leadership considered necessary to improve national standards and reduce the wide variations in regional practices.

**107.** Researchers, voluntary sector organisations, bereaved families and other stakeholders have raised several concerns in recent years in relation to the way that the coroners collect and share data about suicide and about the experience of bereaved relatives who come into contact with the system. The Chief Coroner's new role of oversight across the coroners' system, including powers to introduce national standards and training, may offer an opportunity to address some of these concerns.

**108.** The Call for Evidence gave some indication of the level of engagement of coroners with local suicide prevention groups. Only 12 respondents reported that their local coroner is involved in the local suicide prevention group. It is difficult to identify precise reasons for this low level of engagement, but in one

[37] p.9, *Suicide Audit in Primary Care Trusts localities: A Whole Systems Approach,* 2006, Church, E., & Ryan, T.

evidence session, mention was made that the local coroner had not been invited to join a group. Other witnesses highlighted the importance of the relationship they had built with their local coroner that facilitated access to data and exchange of ideas.

**109.** One of the best examples of this was a training day for coroners in the South West, linking up coroners with the NHS Mental Health Partnership Trust. This however was an isolated example. Engagement with coroners seems at best to be left to chance.

**110.** There are currently significant information gaps in the data that is collected and disseminated by coroners' offices. This includes demographic or personal data about the people who have died by suicide such as ethnicity or existing physical health conditions, but it also includes specific details about the manner of their death which might be useful for the development of suicide prevention policy such as the source of medicines used in overdoses or information about any recent episode of self-harm and how it was managed. Details such as ethnicity is vital to understanding which groups are most at risk. This is valuable information for local suicide prevention groups when conducting their suicide audits and for researchers and policy makers at national level. The public health officials that gave evidence to the Inquiry reported varying experiences of working with their local coroner.

**111.** One witness reported that his local coroner *"has been remarkable, has allowed our staff complete and unfettered access to audit which has been really positive".* The coroner attends local suicide audit meetings and lays files open to staff who can draw the information they need to fill the audit and any lessons that they may want to take back about suicide prevention and/or mental health service provision. However, the witness acknowledged that this kind of detailed work could be extremely resource intensive.

**112.** Another witness commented that in her area certain demographic data such as ethnicity is not routinely collected. The sources of information for their suicide audit were usually ONS data and Primary Care mortality data supplemented with information from provider organisations such as Mental Health Trusts' Serious Incident Reviews. While it might be possible to find a way of gaining access to data such as ethnicity through the coroner files they did not have the capacity to compile this kind of information in a systematic way.

**113.** The Group also heard from a witness who reported that in their area, there were both access and capacity issues that meant that the information they were able to gather was quite minimal. In that area, there was also a particular issue in that a much greater proportion of suicides were not known to services than might be

the case in other parts of the country as many of the people who die by suicide there are not necessarily local residents.

**114.** The inconsistencies generated by varying coroners' practices in different parts of the country highlight the challenges faced by researchers and policy-makers in obtaining accurate data needed to support and inform suicide prevention work.

**Narrative Verdicts**

**115.** At a national level, prominent researchers in the field of suicide prevention have expressed concern in recent years that the increase in the use of narrative verdicts by coroners may be having on impact on the accuracy of suicide statistics. These were originally developed to allow the coroner to provide additional information to responsible bodies that could be used to improve care and prevent further deaths. The Office for National Statistics (ONS) has stated that in some cases, it can be difficult to code the underlying cause of death from the information provided in the narrative verdict[38] and has expressed concern about the impact of this on the quality of statistics on cause of death.

**116.** All unnatural or suspicious deaths (including suspected suicides) are referred to the coroner and following an inquest, the coroner returns a verdict and registers the death accordingly. This verdict may be a "short form" verdict such as "suicide" or "accident" or it may be a "narrative" verdict by which coroners use paragraphs of text to describe the cause of death.

**117.** The Office for National Statistics (ONS) receives the death registration and text of the verdict and if this is in narrative form there is no short form text which clearly indicates a category of death. This means that the coroner's narrative verdict needs to be scrutinised on a case-by-case basis in order to assign a code manually using the International Classification of Diseases (ICD) system. The suicide rate is calculated by using the total number of "deaths from suicide or injury of undetermined intent". These statistics include two categories:

- **intentional self-harm** (ICD-10 codes **X60-X84** & **Y87.0**) – where the harm to the deceased was self-inflicted and their intention is clear.
- **injury/poisoning of undetermined intent** (ICD-10 codes **Y10-Y34** & **Y87.2**) - where harm to the deceased was self-inflicted but their intention is unclear.[39]

[38] p.4, *Narrative verdicts and their impact on mortality statistics in England and Wales,* Health Statistics Quarterly 49 (Spring 2011), Hill, C., & Cook, L.

[39] According to the ONS it is *"customary to assume that most injury and poisoning deaths, where the intent could not be determined following investigation, are those where the harm was self-inflicted, but there was insufficient evidence to prove that the deceased deliberately intended to kill themselves" (p.5 of Narrative verdicts and their impact on mortality statistics in England and Wales – see previous citation).* One of the reasons for this is the significant number of people who take their own life while suffering from a mental illness, meaning that it can be difficult to establish at inquest whether the deceased was capable of understanding the consequences of their actions.

**118.** Following the ICD rules, staff at the ONS can only code according to what the coroner has provided. Narrative verdicts may be very detailed but might still omit two crucial key points:

- whether the harm was caused by the deceased and;
- whether there is evidence that the self-harm was intentional.

**119.** If there is no clear statement on either of these factors then in many cases the death has to be classified as 'accidental' in accordance with international coding rules. This could therefore be distorting the statistics by over-counting accidents and under-counting suicides. Requiring coroners to reach short-form verdicts in addition to an optional narrative verdict would address this.

**Families bereaved by suicide**

**120.** Another important issue raised by witnesses to the inquiry and indeed from previous meetings of the APPG is the experience of people bereaved by suicide experience the system of coroners' inquests and their interactions with coroners' offices. This includes not only the way that bereaved relatives are supported as they go through the inquest process and the sensitive handling of inquest procedures but also what advice is provided to bereaved relatives about external sources of support that they could usefully be signposted to.

**121.** Bereaved families have previously reported cases that the inquest process failed to put families at the centre and that certain personal information was heard in the coroner's court without their prior knowledge and without being properly consulted. Concerns have also been expressed that bereaved families are not being appropriately supported during their contact with the inquest system. Some families report receiving little guidance about what to expect, being excluded from discussions, poor sharing of information and being handled with poor sensitivity and empathy. There can also sometimes be long delays in the process that mean an inquest may take place years after the death.

**122. Coroners have a vital role to play in suicide prevention, but this Inquiry and other work carried out by the Group has revealed a worryingly low level of engagement of most coroners and has highlighted long-standing problems related to the collection of data and recording of suicides. The appointment of the Chief Coroner is a very welcome development. The Group urges the Chief Coroner to address these issues as a matter of urgency and for his office to be given the resources and capacity to do so.**

**GPs**

*"And again we sometimes see that with GPs they won't let us go into the surgery and put up posters about the support groups because it then might plant that idea in someone's head." (Representative of support group in Evidence Session)*

**123.** GPs play an important role in the delivery of services, forming clinical commissioning groups as part of the new structure. They are a key contact point for individuals in distress. Their engagement with suicide prevention is therefore essential to the success of local suicide prevention plans. This was also acknowledged in the new national suicide prevention strategy.

**124.** In the analysis of the membership of local suicide prevention groups, it was a concern to note that only 11 respondents stated that GPs were represented on their groups.

**125.** During evidence sessions, it became apparent that currently GPs tend not to be engaged in suicide prevention and that many organisations involved in suicide prevention have encountered particular problems with GPs. These range from their willingness to provide data to distributing information about services through their surgeries.

**126.** It was suggested that this problem of engagement could deteriorate further as GPs spend more time on commissioning and that a great deal of work would need to be done to build relationships with GPs;

*"I do worry about GPs having more responsibility for commissioning mental health services because it's not seemed to be enough of a priority to many GPs in the past. Mental health therapies don't figure very largely in GP training and I think there are issues around that." (Samaritans Representative in Evidence Session)*

*"But two of the more difficult parties to come to the table are people who figure fairly highly in the future, and those are GPs and the local authority. Now while we've had some engagement it just has not been at the same degree of enthusiasm as some of the other parties." (NHS representative in Evidence Session)*

**127. The role GPs have in the new architecture will have significant implications for local suicide preventions plans and the provision of services. This Inquiry identified a lack of engagement that underlines the need for GPs to be fully informed of the issues around suicide and self-harm prevention; from accepting information about services from voluntary groups to membership of a local suicide prevention groups. The Department of**

**Health working in conjunction with organisations representing GPs must work to improve awareness and engagement, particularly to ensure that Clinical Commissioning Groups are fully informed of the local situation.**

## Devolved Nations

**128.** This report focuses on England, but one evidence session was dedicated to evidence from representatives of the devolved nations and what mechanisms are in place to deliver their national suicide prevention strategies at a local level. They were also asked about how they viewed the future of suicide prevention in their respective nations.

**129.** The Group would like to express particular thanks to the three witnesses who travelled considerable distances to give evidence. It proved to be an interesting opportunity for the exchange of ideas and information amongst the witnesses themselves and demonstrated the value of bringing people together.

**130.** While the devolved nations have different health and legal systems to England, valuable lessons about how strategies are implemented can nevertheless be learnt from their experiences.

### Northern Ireland

**131.** The Northern Ireland Suicide Prevention Strategy and Action Plan, *Protect Life*[40]*,* was published in 2006 and is the responsibility of the Northern Ireland Executive's Department of Health, Social Services and Public Safety. The strategy includes over 60 actions across a range of areas and responsibility for implementation lies with the Public Health Agency, which works in partnership with the Health and Social Care Commissioning Board and Northern Ireland's five Health and Social Care Trusts. An intersectoral suicide strategy implementation body was established to oversee and advise on implementation of the strategy and, in addition, a Ministerial coordination group meets on an ad hoc basis which includes representation from seven government departments.

**132.** Gerald Collins from the Health Improvement Policy Branch of the Northern Ireland Executive told the Inquiry that community involvement was a crucial aspect of local implementation:

*"One of the major aspects in terms of implementing Protect Life is the degree of community involvement. From the very start, Protect Life recognised that local community groups are best placed to know the issues specific to their areas and) community groups are heavily involved in the delivery and oversight of the strategy. Also within each locality there are suicide prevention implementation groups operating under the regional suicide strategy implementation body." (Northern Ireland Government representative in Evidence Session)*

[40] *Protect Life – A Shared Vision,* Department of Health, Social Services and Public Safety (2006) (http://www.dhsspsni.gov.uk/phnisuicidepreventionstrategy_action_plan-3.pdf)

**133.** More integrated working between the statutory and voluntary sectors has been identified as a key challenge for the future development of suicide prevention policy in Northern Ireland. Examples given of what a more co-ordinated approach might involve included joint bidding for funds and improved referral procedures from the statutory sector to voluntary and community organisations.

**134. The evidence from Northern Ireland demonstrated the importance of involving community organisations and the voluntary sector in suicide prevention. The existence of a suicide prevention implementation group in each locality ensures that suicide prevention activity is not left to chance. The Group recommends that the Department of Health consults with its counterpart in Northern Ireland to understand how this model of implementation works.**

**Wales**

**135.** Wales was the last of the four nations of the UK to establish its own national suicide prevention strategy. Published in 2009, the *Talk to Me*[41] action plan includes seven objectives and over 150 actions, some of which cross over other areas of government policy in areas such as child poverty, mental health, criminal justice and homelessness.

**136.** The Inquiry heard evidence from the chair of the National Advisory Group on Suicide and Self-harm Prevention to the Welsh Government, Dr Ann John, who explained that local implementation of the plan was initially, as stated in the draft consultation document, meant to be driven by local authorities (of which there are 22 single-tier authorities in Wales) and local service boards (partnership bodies in each of the local authority areas which comprise of local public and third sector organisations). In the published plan such clear statements of responsibility for implementation were removed.

**137.** The Welsh Government provides strategic leadership and Public Health Wales chairs a national advisory group to oversee implementation which includes a number of representatives from the voluntary sector. However, concern was expressed about the level of engagement of some local authorities, which highlights the importance of local and national leadership and clearly defined responsibilities.

[41] *Talk To Me: The National Action Plan to Reduce Suicide and Self Harm in Wales 2009-2014*, Welsh Assembly Government (2009) (http://wales.gov.uk/docs/phhs/publications/talktome/091102talktomeen.pdf)

*"There was no ministerial letter to give a mandate taking responsibility for driving through implementation of the plan. Equally within the plan, no direct responsibility was clearly stated and as such I believe that's why we found it very difficult to engage local authorities in the process." (Welsh Assembly Advisory Group representative in Evidence Session)*

**138.** Three regional groups have been established, in North Wales, South East Wales and Mid & West Wales in order to oversee local implementation. The different experiences in the different regions further underlines the importance of a high-level mandate:

*"Now in North Wales, the group was given a mandate by the Chief of Staff of mental health and vulnerable peoples in the Health Board and as such it has been the most effective group. The other two groups that did not have such a mandate from health boards or local authorities have run, but they have run basically because local partners are interested and as such are not sustainable. There is no adequate resourcing either so in terms of implementation that has not been sustainable." (Welsh Assembly Advisory Group representative in Evidence Session)*

**139.** While there are examples of good practice in some areas, the evidence heard suggests that local implementation is variable across Wales as a whole with suicide prevention incorporated into 15 out of the 22 Health Social Care and Well-being Strategies and only 9 out of the 22 Children and Young People's Plans. The *Talk to Me* action plan is currently undergoing a mid-term review which, as the Inquiry heard, will need to address this issue of high level national engagement enabling local implementation. It will also make recommendations for policy after 2014, once the current action plan expires as no commitment has yet been made to develop a new plan.

**140. The evidence from Wales highlighted the importance of national leadership in ensuring consistent implementation and what can result where this is not in place. The Group believes this is an important lesson for the implementation of the new strategy in England where national leadership through statutory requirements for local suicide prevention plans is currently missing. Wales also demonstrates the difficulty of engaging local authorities where there is no statutory requirement to provide a service.**

## Scotland

**141.** The Scottish Government's national strategy and action plan to prevent suicide, *Choose Life*[42], was launched in 2002 for a ten year period. This was the same year that the original Suicide Prevention Strategy for England was launched and like the English strategy it also includes a target to reduce suicide deaths by 20%. The latest three-year rolling average figures for Scotland indicate that there has been a 14% reduction in suicides from 2002 to 2010. Nevertheless, the suicide rate in Scotland remains significantly higher than the rate in England and Wales.

**142.** The *Choose Life* strategy is led by the Scottish Executive, supported by a dedicated national programme team, providing leadership and coordination, and a national monitoring group. This, as Alana Atkinson, Health Improvement Programme Manager for *Choose Life* explained to the Inquiry, is attended by stakeholders from other government departments, healthcare improvement agencies and voluntary sector organisations. Implementation at a local level is delivered by Scotland's 32 local authorities which, the Inquiry was told, have responsibility for developing and implementing their own action plans, which are usually monitored by the local Community Planning Partnership:

*"Each area has an appointed Choose Life coordinator who has different responsibilities based on that area so it's very distinct to the local area that they work in. These posts have been crucial in maintaining the local interest and focus on suicide prevention." (Programme Manager Scotland in Evidence Session)*

**143.** Allocation of responsibility for co-ordination is clear, with a named individual for each local authority listed on the *Choose Life* website, along with their contact details[43]. Up until 2007, local authorities had ring-fenced money allocated to carry out suicide prevention work. However, since then the money has become part of the main local government finance settlements, with it left to local authorities to decide how to ensure continuation of local suicide prevention plans.

**144.** In 2007 a new health target was introduced to ensure that at least 50% of key front line health staff are trained in suicide prevention by 2010. The *Choose Life* website states that this includes *"staff working in accident and emergency units, paramedics, GPs and other primary care staff as well as those working in mental health services"*[44]. The 50% target was met, and in some cases exceeded, by all NHS Boards by 2010 and they are now expected to maintain this 50% level as

[42] *Choose Life: A National Strategy and Action Plan to Prevent Suicide in Scotland,* Scottish Executive (2002) (http://www.scotland.gov.uk/Resource/Doc/46932/0013932.pdf)
[43] http://www.chooselife.et/Inyourarea/coordinatorslist.aspx
[44] http://www.chooselife.net/Policy/index.aspx

an ongoing standard. However, the Inquiry also heard that there are challenges in including GPs, primary care and emergency medicine in this agenda because,

*"they say they don't need additional training, they also say they are already trained enough yet we know that they are not identifying enough people with depression or the signs and symptoms of depression and they are certainly not asking the suicide question" (Programme Manager Scotland in Evidence Session)*

**145. The evidence from Scotland highlighted the strength of a coordinated national approach towards implementation of the Choose Life Strategy through the appointment of a coordinator in every local authority area. This ensured that each area has an identifiable individual with responsibility and funding for suicide prevention. The Group notes that this model is in contrast to the patchy existence of local suicide prevention groups and plans in England and recommends that the Department of Health consults with the Choose Life Programme to learn lessons from this.**

**146. The opportunity to bring together representatives of the devolved nations proved very valuable, not only for this report, but also for the representatives themselves from the point of view of exchanging ideas, experiences and best practice. Consideration should be given to establishing a multi-nation policy group with the possibility of including the Republic of Ireland. This could be supported by a research group.**

## Sharing information and innovation

**147.** Several issues came to light during the course of the Inquiry, that although not directly related to the transition deserve consideration and will feature in the recommendations.

> *"but there isn't actually a systematic way of sharing our learning and our experiences nationally and it really harks back to your point earlier about managing this on a much bigger scale so that would be very very helpful and if you did have this leadership that you talked about, that would make a difference so we could scale up our learning."(Public Health Representative in Evidence Session)*

**148.** The Call for Evidence and Evidence Sessions produced a wide variety of examples of innovative programmes, new ideas and good practice that had developed out of a need to respond to local issues, often through suicide prevention groups. What is not apparent is whether there is a dedicated way for suicide prevention groups and directors of public health to share their plans and ideas. There is neither a forum nor duty that would facilitate the sharing of best practice. National leadership, through the Department of Health, would be required to make this possible. The National Suicide Prevention Strategy Advisory Group could have a role in this. The All Party Group plans to host a one day summit to contribute to this.

***149. Examples of innovative programmes***

- **Somerset** - Distress Card for all police officers in Somerset that includes information on what to do if a person seems very distressed and where to refer them
- **Derbyshire** – Established drop-in health service at local agricultural market. Introduction of Citizen Advice Bureau services in GP practices
- **Wigan** – link with State of Mind Campaign – aimed at reaching men (players and supporters) through rugby league
- **Cumbria** – funding for local Survivors of Bereavement by Suicide group (SOBs) group to provide bereavement services
- **Dudley** – piloted online counselling support for secondary school pupils
- **Islington** – identified high risk locations on local rail and underground network. Worked with British Transport Police and London Underground amongst others to coordinate a local poster and information campaign and provide training for rail staff
- **Hull** – Developed local helpline card signposting sources of help

- **Bristol** – Established a self-harm register through Accident & Emergency departments. Case-by-case audits
- **Surrey** – Developed series of podcasts about issues that impact on mental health such as unemployment
- **Gloucestershire** – Commissioning of confidential self-harm helpline
- **Bath and North East Somerset** – Regional training workshop for coroners

**150. Valuable work is being done at a local level and the new national strategy contains many examples of suggested best practice. The challenge, particularly at a time when budgets are constrained, is to facilitate the collation of ideas and make them available to as wide an audience as possible.**

**Bereaved families**

**151.** The APPG has taken an interest in the availability of support for families bereaved through suicide and the Inquiry offered the opportunity to establish what provision is made in local suicide prevention plans for them.

**152.** 58 respondents made specific reference to provision for families bereaved through suicide, representing just fewer than 40% of all areas. While 24 respondents indicated that they intended to include provision in future plans (along with self-harm), which is to be welcomed.

**153.** A key resource for bereaved families is the *Help is at Hand* booklet, published by the Department of Health[45]. In the Call for Evidence, it was notable that many directors of public health/suicide prevention groups undertook to distribute *Help is at Hand* to bereaved families through GPs and coroners. There remains however a concern that its distribution is patchy and many bereaved families are missing out on this vital resource. In one evidence session, a witness commented on the difficulty of getting hard copies of the booklet.

*"we're now downloading that directly ourselves from a website and obviously that doesn't look quite as professional as a properly produced leaflet, it does look slightly home-made and of course GP surgeries don't have state-of-the-art big industrial printers so that's printing off the same machine that they might be issuing the prescriptions from. I'm exaggerating but it's not quite the same as having the leaflet so I would like hard copies of properly produced information, I think that would be very very helpful." (Public Health Representative in Evidence Session)*

[45] *Help is at Hand: A resource for people bereaved by suicide and other sudden, traumatic death,* Department of Health (2010), Hawton, K., Simkin, S. (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_115629)

**154.** The need to provide better information and support to those bereaved or affected by suicide has been recognised as an Area for Action in the new suicide prevention strategy for England, which is to be welcomed. However, without a mandatory requirement for a local plan to be established or any statutory requirement for bereavement services to be included, it is difficult to foresee how this situation is likely to improve.

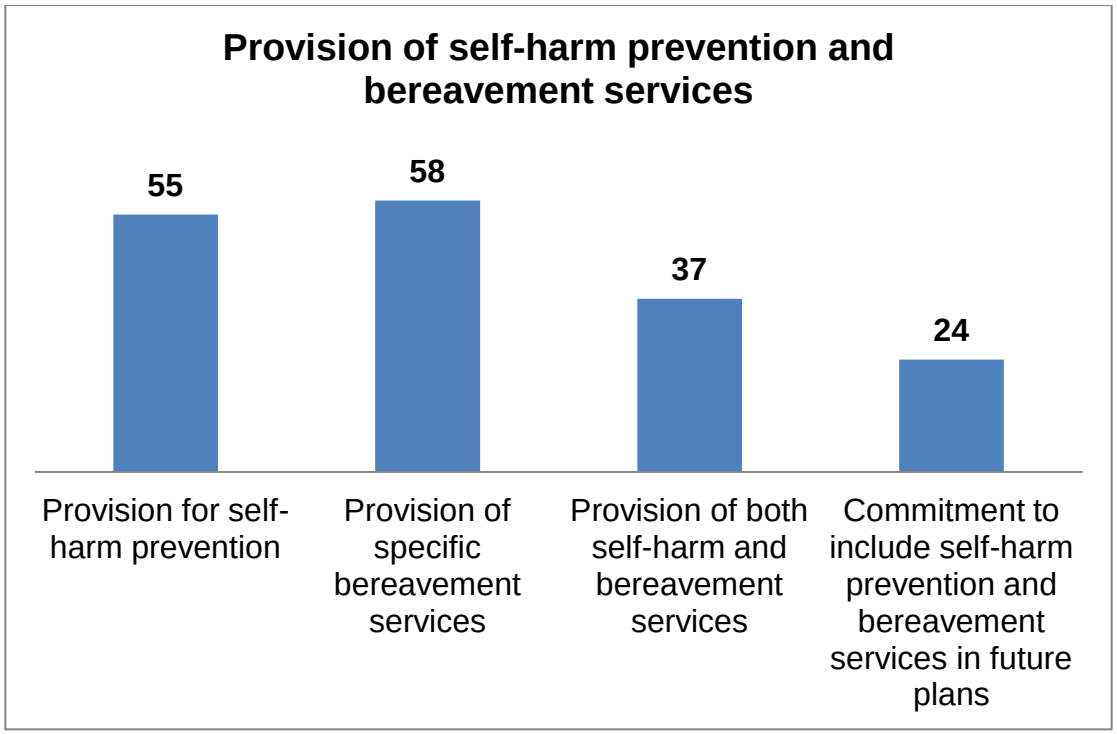
## Self-harm

**155.** In addition to asking about provision for bereaved families, the Call for Evidence also included a question about provision for individuals who self-harm. 55 respondents made specific mention of self-harm prevention programmes and support for individuals who self-harm. As mentioned in paragraph 149, 24 respondents indicated that they intended to include provision in future plans (along with self-harm), which is to be welcomed.

**156.** The need for a greater focus on self-harm was highlighted by a presentation by a group of researchers based at the Universities of Manchester and Oxford who have been working on a Multicentre Study of Self-harm in England. Their initial conclusions suggest that there are around 300,000 episodes involving 190,000 persons present to hospitals in England per year. A crude estimate suggests £132 million in general hospital costs alone per year. On top of this there are costs of psychiatric and social care, and costs to families and those who self-harm.

**157.** People with a history of self-harm were identified by the new suicide prevention strategy for England, but as with bereavement services without a mandatory requirement for a local plan to be established or any statutory requirement for bereavement services to be included, it is difficult to foresee how this situation is likely to improve.

**Graph 5**




**158. The responses the Inquiry received in relation to support for bereaved families and individuals who self-harm demonstrated that there is a long way to go to ensure that these issues receive the critical attention they need and deserve. It is welcome that both are identified in the new national strategy, but there is concern that there is no mandatory obligation contained within the strategy for local plans to include these issues. Nevertheless, those areas which have included self-harm and or bereavement are to be congratulated and much can be learnt from the work they are doing. Again, the Government should make local suicide prevention plans a statutory requirement and ensure that plans include measures to address self-harm prevention and bereavement. The APPG welcomes that the difficulties in distributing *Help is at Hand* to those who need it are acknowledged in the new suicide prevention strategy and believes the Department of Health should address this as a matter of urgency.**

## Media

**159.** The APPG has looked previously at the reporting of suicide in the media, particularly the written press and has worked closely with the Samaritans and Press Complaints Committee to address concerns. During the evidence sessions, the Group took the opportunity to ask witnesses about their relationship with the media and their views more generally about reporting.

**160.** A mixed picture emerged. In the three devolved nations, the media had been used to raise awareness, but there was also recognition of the importance of media guidelines in relation to suicide. Witnesses from other areas reported a variety of different experiences; from having a close working relationship with their local press, having a sense that standards of reporting suicide had deteriorated to no longer having the resources to monitor and work with the local media as they had done previously.

**161.** Samaritans plays a key role in monitoring the media at a national level and there was consensus among the witnesses that the media guidelines produced by Samaritans and separately by the NUJ Scotland had proved to be very helpful.

**162.** The PCC has made progress in improving the reporting of suicide and valuable work in training journalists of the risks associated with reporting.

**163. In the light of the publication of the Leveson Report in November 2012, it is important that the work undertaken by the PCC in protecting bereaved families from press intrusion and training journalists is not lost. Any future regulator must been given powers and resources to ensure this work continues.**