Local Suicide Prevention Planning in England

An independent progress report

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Chapter 1. Executive Summary

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

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

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

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

Approach

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

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

Establishing and delivering local suicide prevention

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

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

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

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

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

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

Content of plans

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

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

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

on awareness-raising and other public health approaches to high-risk groups with fewer actions on mental health service related activity.

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

Area 3: Reducing access to the means of suicide

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

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

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

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

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

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

Area 6: Support research, data collection and monitoring

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

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

Most plans feature actions on this issue and many local areas are clearly committed to reducing rates of self-harm. The availability of NICE guidelines on self-harm (NICE 2012, 2004) does not appear to have significantly impacted on the content of suicide prevention plans. This may be because clinical

actions are contained within other plans, and the suicide prevention plans reflect the public health approach to the issue by including training and awareness-raising activities.

Conclusions

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

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

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

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

High-level recommendations

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

- LGA and ADPH should support local areas to move past the preparatory stage of building partnerships and planning actions, and into delivery of actions themselves where this is not already happening.
- LAs should consider developing regional priorities through the SLI framework. LGA and ADPH should consider how the SLI work could support local authorities to focus their activity, in order to achieve a greater impact.

Summary of recommendations

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

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

Table 1.2 Summary of recommendations		
Topic	**Local / national**	**Recommendation**
Multi-agency groups and action plans	Local	• LAs should consider including output and outcome measures in their monitoring and evaluation processes wherever possible.
	National	• DHSC and PHE should work with the National Suicide Prevention Alliance (NSPA) to support a national network for people with lived experience to better enable input and co-creation of local multi-agency plans, and to ensure this is done in a safe, consistent and meaningful way that also considers diversity. • PHE and NSPA should provide further guidance on how to measure success. • LGA and ADPH should work with PHE to agree what a "good" audit for suicide prevention looks like. • DHSC and PHE should work with the Chief Coroner's Office to write to coroners reminding them of the crucial role they can play in suicide prevention and encouraging them to work with local multi-agency suicide prevention groups.
Area 1: Reduce the risk of suicide in key high-risk groups a) Men	Local	• LAs should encourage local and national organisations to work together to consider amplifying and localising national campaigns. • LAs should work with multi-agency groups to improve access to social and community support for high-risk groups of men, including use of social prescribing schemes. • All commissioners of training on suicide prevention (including CCGs, mental health commissioning boards, Public Health teams) should ensure any training that is commissioned is consistent with the Health Education

		England (HEE) and National Collaborating Centre for Mental Health (NCCMH) self-harm and suicide prevention competence frameworks (HEE 2018a, 2018b, 2018c, 2018d). • Multi-agency groups should support members to further develop approaches by reviewing which groups of men they are reaching through their existing plans, to ensure that there are sufficient activities designed to reach the most at-risk men.
	National	• PHE should consider developing a forum for LAs to share research and evidence that is informing local campaign activity, including evidence on effective messaging for men. • LGA, ADPH and PHE should initiate discussions with national organisations to better understand how national awareness-raising campaigns could be more effectively localised and how nationally conducted market research and evidence could be shared locally. • NHS England should further promote the use of the self-harm and suicide prevention competence frameworks. • NHS England should continue with its suicide prevention programme and targeted investment to local areas. It should consider evaluating care pathways for men at highest risk, covering those that are engaging with GPs as well as those only engaging with other services to help inform local action as part of its evaluation of this programme. • PHE should work with LAs to ensure that activities to reach men are being evaluated and collated nationally to help build evidence and examples of good practice around what works for men, especially those in middle age. • DHSC and PHE should explore scope to reach potentially vulnerable men and encourage help-seeking in the online equivalent of typically male spaces, such as online gambling sites.
Area 1: Reduce the risk of suicide in key high-risk groups b) People in the care of mental health services	Local	• CCGs, in partnership with multi-agency groups, mental health services and LA public health teams, should implement the '10 ways to improve patient safety' recommendations from National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) (NCISH 2018). • CCGs should work with LAs, frontline services and the voluntary sector to ensure acute and community services are better joined up, avoiding gaps in support during transitions and improving access for those that need it most.
	National	• NHS England should continue to support areas receiving targeted suicide prevention funding to consider the 'Ten ways to improve safety' as part of their local quality improvement work.

		• NHS England should continue promoting joined up services as part of its suicide prevention programme and through its Long Term Plan commitments to develop integrated models of primary and community mental health care.
Area 1: Reduce the risk of suicide in key high-risk groups c) People in contact with the criminal justice system	Local	• Multi-agency groups in the local areas that do not have actions for those in contact with the criminal justice system in their plans should consider including reference to other plans, if action is being recorded elsewhere. If action is not being undertaken, LAs, HMPPS and prison governors should work together to consider action in this area. • Actions to reduce risk for people in contact with the criminal justice system should include points of transition, including the early days of custody and the pre- and post-release period. Where they are not already in place, 'Through the Gate' services should be developed and implemented led by local Criminal Justice Boards, and HMPPS. • Plans that only include staff training in prisons should be updated by multi-agency groups to identify further possible actions.
	National	• LAs, HMPPS and prison governors should recognise the complex needs of this population (e.g. housing, finance, problems with addiction and mental health issues) and how these impact on their ability to access services in the community. Particular attention should be given to trying to achieve continuity of access and seamlessness of care.
Area 1: Reduce the risk of suicide in key high-risk groups d) Specific occupational groups	Local	• Multi-agency groups not already doing this should further consider targeting the training and awareness campaigns that they are running to ensure they reach low-income, middle-aged men in high-risk occupations.
	National	• PHE and NSPA should consider including more ideas for action and case studies on reaching men in high-risk occupations in its local guidance, including evidence of what has worked elsewhere.
Area 2: Tailor approaches to improve mental health in specific groups a) Children and young people	Local	• LAs should consider checking that educational establishments are properly represented on their multi-agency group to understand what actions are being taken in local colleges, universities and community groups to promote good mental health and wellbeing and implement clear suicide prevention and postvention plans. • LAs should consider actions to ensure that especially vulnerable children and young people, including those not in formal education or training, are being reached through their plans. • Educational establishments should consider which local partners they could engage with and what actions they can

		take to prepare and support young people as they transition from school into further/higher education, employment or unemployment.
	National	• PHE should be working with the Department for Education to ensure that multi-agency groups are aware of and taking into account the national changes designed to improve young people's mental health.

Area 2: Tailor approaches to improve mental health in specific groups
 	
b) Other specific population groups
	Local	• Every agency working to prevent suicide should:
		  o consider carefully how their work to promote resilience and mental health (e.g. anti-bullying plans) and suicide prevention reflects the needs of the diverse populations which they serve.
		  o use Equality Profiles for their areas and services to identify key populations to reach.
		• LAs should consider undertaking an Equality Impact Assessment (EqIA) of their local suicide prevention plan and audit data to identify any disadvantaged or vulnerable people that their plan does not currently cover.
		• Senior leaders in local authorities and on multi-agency groups should ensure they are providing leadership on diversity issues and supporting colleagues to ensure that all voices are heard.

	National	• PHE should work with the Chief Coroner and ONS to extend the data recorded and available on suicide deaths to improve knowledge of suicide in minority groups. • NHS England should continue to provide targeted investment to local authorities for suicide prevention.
Area 3: Reducing access to the means of suicide a) High-frequency locations	Local	• Multi-agency groups should work with partners to draw up a site-specific plan for high-frequency locations, incorporating a broad range of actions in accordance with PHE guidance. Where signage is considered, this should be used with other interventions and avoid advertising a location as a potential means of suicide. • All local organisations should avoid using the term 'hotspot' and use 'high-frequency location' in its place. • LAs and partner agencies should consider how they can work with local media to enhance the public image of a high-frequency location and try to dispel any reputation it may have as an effective means of suicide. • Multi-agency groups should seek to engage with local representatives from the rail industry and Highways England, as well as their local road safety departments and health and safety teams. They should have a strong system for monitoring and recording locations, interventions and incidents to help improve the evidence on what works at high-frequency locations and to inform future local action

		• In areas where high-frequency locations have not been identified, multi-agency groups should consider working with the local authority planning departments and other relevant stakeholders to ensure high structures are as restricted as possible as a means of suicide.
	National	• PHE should consider collating a national data set using local monitoring data on high-frequency locations. This is already being done by Network Rail, and Highways England is also committed to improving the collection of data on suicides occurring on the strategic road network.
Area 3: Reducing access to the means of suicide b) Limiting availability of other means of suicide	Local	• Local suicide prevention groups should avoid naming new or emerging methods of suicide, such as specific gases, due to the risk of imitative suicides. Strategy and plan documentation which contain these should be edited before being published. • Local multi-agency groups should be flagging any new or emerging methods of suicide which are being identified through local monitoring activity to their PHE regional lead or to Samaritans' national office to address at a national level. • CCGs should work to ensure safer prescribing is in place and being adhered to in their local area, in order to improve and strengthen risk assessment by prescribers for people at risk of suicide and to reduce access to potentially harmful medication.
	National	• ADPH and LGA should ensure that the basics of suicide prevention (e.g. sensitive language use and responsible communication on methods) are included in its sector-led improvement programme. • NHS England should continue work to improve medicines management.
Area 4: Provide better information and support to those bereaved or affected by suicide	Local	• All multi-agency group members should be promoting the *Help is at Hand* resource (Public Health England 2015a), ensuring the z-cards (a credit card sized fold-out leaflet that provides advice on caring for yourself and others) and, if possible, the full resource are being given out by first responders, coroners and funeral directors. • Local multi-agency groups should consider reviewing how they are ensuring that those bereaved are receiving appropriate support in the initial weeks after a suicide, as well as ensuring they are aware of what support is available longer term. • Schools and higher education institutions should work with local authorities and multi-agency groups to ensure they

		know how to respond effectively in the event of a suicide to reduce the risk of further suicides within that community. • All local areas should review and develop their suicide bereavement support services against the PHE good practice guidance (Public Health England 2016). • All employers should put a suicide prevention and postvention plan in place, using the BiTC/PHE toolkits (BiTC 2017).
	National	• NHS England should ensure adequate funding and support is available to deliver its commitment in the Long Term Plan to put in place suicide bereavement support in every area of the country.
Area 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour	Local	• Local authorities should consider the purpose of monitoring local media, especially if they lack the resource to act on any concerning content or if they are not using the data to measure progress. • Multi-agency groups should consider the role of local communications professionals in ensuring that messages provided to local media around suicide and suicidal behaviour are responsible. • Multi-agency groups should encourage local stakeholders to provide positive stories about hope and recovery to local media.
	National	• ADPH and the LGA should consider with Samaritans national media advisory service what further work may be needed to clarify the support Samaritans can provide local authorities on working with the local media. • ADPH and LGA to consider asking Samaritans to review its national monitoring data to identify any key geographical areas where reporting is particularly problematic in order to assist local responses. • PHE and NSPA should update its local planning guidance (Public Health England 2016) to include more information on the importance of providing media with positive content around suicide and suicidal behaviour (i.e. stories of successful recovery). • PHE should provide guidance to local authorities on actions that can be taken around social media and online content, working closely with DCMS to ensure this is integrated with national developments.

Area 6: Support research, data collection and monitoring	National	• PHE should share findings from its pilots of real-time surveillance (Public Health England (forthcoming in Autumn 2019) with all LAs and multi-agency groups. • The College of Policing and Coroner's Officers and Staff Association should review current data-sharing protocols between police and coroners to ensure that they are able to provide timely data on suspected suicides. • The Chief Coroner should issue guidance to local coroners outlining their crucial role in suicide prevention, to help facilitate the establishment of real-time surveillance. • A review should be undertaken by PHE of what data are being collected through real-time surveillance, in order to establish some consistency across the country. This could enable data to be collated at regional and/or national levels to provide early indication of emerging trends. • The ONS should brief LGA and ADPH to ensure local authorities and partners are aware of the work it is doing to explore how to improve suicide data. • If sufficient local data are being collected on specific actions, such as training, bereavement support or high-risk locations, PHE should work with ADPH and LGA to explore the value of bringing these together at a national level to add to the evidence on what works to prevent suicide.
Area 7: Reducing rates of self-harm as a key indicator for suicide risk	Local	• LAs, CCGs and mental health services should work together to ensure that all people presenting at A&E having self-harmed are treated in accordance with NICE Guidelines (NICE 2012, 2004). • LAs should ensure they are aware of guidance that exists to improve information sharing between A&E departments, mental health services and GP practices (NHS 2018) . • CCGs should ensure training on good self-harm prevention is embedded in their primary care quality agenda.
	National	• PHE should consider working with Health Education England to consider guidance on what good training in self-harm prevention would look like. • NHS England should continue its work to build the mental health competency of ambulance staff to ensure that ambulance staff are trained and equipped to respond effectively to people experiencing a mental health crisis. • NHS England should continue to prioritise self-harm as an area of focus for its suicide prevention programme and work to improve services for those that self-harm.

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Other: Cross-cutting themes	Local	• LAs and multi-agency groups should review their suicide prevention activities and ensure they are not 'reinventing the wheel' by spending resource on actions that are either already being delivered at the national level or where other local authorities have already worked out the best way to deliver the action. • LAs and multi-agency groups at the earlier stages of their response may benefit from working through existing partnerships to embed and improve the quality of activity already taking place rather than implementing multiple new activities. • LAs should consider developing regional priorities through the SLI framework • LAs should ensure they are following up any partnership activity to ascertain that these partnerships have generated deliverable actions that are being implemented effectively.

	National	• LGA and ADPH should encourage local authorities to consider working with other local authorities to move past the preparatory stage of building partnerships and planning actions, and into delivery of actions themselves.
		• NSPA is encouraged to further develop its resources hub to help facilitate more shared learning and best practice.
		• LGA and ADPH should consider how the SLI work could support local authorities to focus their activity.
		• ADPH and LGA should consider including in its SLI work:
		  o identifying general conditions that may facilitate the translation of ambition into action.
		  o identifying those areas with a dedicated suicide prevention lead in place to compare the difference this may make in relation to the ownership and driver of actions included in local plans.
		  o undertaking a series of stakeholder interviews to help identify the level of activity actually being undertaken locally, to feed into the SLI process.
		  o looking at whether a focus on potential "interveners" would increase impact across at-risk populations as a whole.
		• ADPH and LGA are encouraged to ensure that the SLI process gets closer to understanding the quality and effectiveness of local activity (rather than quality of planning), in a way which supports local authorities and multi-agency groups to use their resources to maximise effect.

Chapter 2. Background

2.1 Policy context

In 2012 *Preventing suicide in England: A cross-government outcomes strategy to save lives* was published by the Department of Health (now Department of Health and Social Care) (DHSC 2012). Shortly afterwards, in April 2013, local authorities were given responsibility for leading local suicide prevention work, in collaboration with the police, clinical commissioning groups, NHS England, coroners and the voluntary sector. This followed the transfer of public health programming from the NHS into local government.

In January 2014 the Department for Health published its first report on the national suicide prevention strategy, *Preventing suicide in England: One year on* (DHSC 2014). A year later the All Party Parliamentary Group on Suicide and Self-harm Prevention published its *Inquiry into Local Suicide Prevention Plans in England* (APPG 2015). Together the reports recommended that all local authorities in England develop:

- **a multi-agency suicide prevention group** involving all key statutory agencies and the voluntary sector

- **a local suicide prevention strategy and action plan**, in collaboration with local partners, detailing specific actions that will be taken, based on the national strategy and local data, to reduce suicide in the local area. Whilst recognising that having a suicide prevention plan is not mandatory, two key documents provide guidance to local areas on how to develop a local plan and what it should include:

The national suicide prevention strategy. *Preventing suicide in England: A cross-government outcomes strategy to save lives* (DHSC 2012), together with four subsequent progress reports (DHSC 2014, 2015, 2017, 2019), outlines seven priority areas for action that local plans should cover in the long term:

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

Public Health England guidance. *Local suicide prevention planning: A practice resource* (2016) recommends eight areas that local plans should focus on in the short term, whilst also working towards fulfilling the seven priority areas outlined in the national strategy. The eight areas for short-term action are:

- Reducing risk in men
- Preventing and responding to self-harm
- Mental health of children and young people
- Treatment of depression in primary care
- Acute mental health care

- Tackling high-frequency locations
- Reducing isolation
- Bereavement support

In February 2016 the independent Mental Health Taskforce published its report, *Five Year Forward View for Mental Health* (NHS 2016) which summarised the current state of mental health service provision in England and presented recommendations for all service areas, including suicide prevention. The report set an ambition to reduce the number of people taking their own lives in England by 10%, compared to 2016/17 levels, by 2020/21. It also included a recommendation that the DHSC, NHS England and Public Health England should support all local areas to have a multi-agency suicide prevention plan in place by 2017. Since the data were gathered for this research, NHS England has published its Long Term Plan which makes a number of commitments to help prevent suicide.

2.2   Funding and delivery context

Overall, investment in suicide prevention at the local level remains low. Alongside ongoing central government cuts to local authority public health budgets, it means there is little opportunity for significant investment in suicide prevention, without diverting funding from other areas of work.

Following the *Five Year Forward View for Mental Health* report (NHS 2016), NHS England committed £25 million for suicide prevention from 2018 – 2021, with £5 million in 2018/19 and £10 million in each of the following two years. This money is being allocated to Sustainability and Transformation Partnerships (STPs), although efforts are being made to ensure they are liaising with suicide prevention multi-agency groups on how the funding will be spent. Priorities include reducing suicide in middle-aged men, self-harm, primary care support and improving mental health services. The Long Term Plan commits to rolling out this programme across the country by 2023/24 as well as bereavement support and a new approach to longer-term management of self-harm.

2.3   Delivery of suicide prevention at the local level

Suicide prevention activities are built into the wider system of health care being delivered at the local level via STPs, the Integrated Care System (ICS) and Local Transformation Plans (LTPs). STPs bring together local healthcare leaders from councils and NHS organisations to plan for the long-term needs of their local communities. They work to make simple improvements, such as making it easier to see a GP or providing mental health support sooner to people who need it. An ICS is a closer collaboration between NHS organisations, councils and other local services. ICSs aim to streamline local services and provide more joined-up care via multiple organisations working together to better understand and respond to local needs. Finally, LTPs support the NHS to work in collaboration with all local child-related services such as schools, the youth justice system, children's care and public health to improve healthcare services for children.

In this context, suicide prevention overlaps with much of the activity taking place locally and nationally to challenge the social determinants of poor physical and mental health, such as poverty, inequality and stigma. As such, the suicide prevention agenda should be viewed as one part of this broader whole systems approach to public mental health planning. Local suicide prevention plans are not standalone documents but are part of broader efforts by a range of local government departments, including transport, culture, leisure and education, to keep people mentally healthy.

2.4   Sector-led improvement for suicide prevention

The Local Government Authority (LGA), Association of Directors of Public Health (ADPH), PHE and DHSC have signed up to a sector-led improvement collaboration for suicide prevention.

What is sector-led improvement (SLI)

Sector-led improvement (SLI) is the approach put in place by local authorities and the LGA alongside the removal of the previous national performance framework. It is the subject of a national agreement between central government and local authorities and recognises that peer-to-peer support is an effective way to make improvements. Local suicide prevention activities make up part of the SLI approach for public health.

SLI is based on the principles that local authorities:

- are responsible for their own performance and for leading the delivery of improved outcomes for local people in the area
- are primarily accountable to local communities, rather than to central government
- have a sense of collective responsibility for the performance of the sector as a whole

SLI in the public health context is designed to improve the confidence of stakeholders and the public in healthcare services, and to deliver continuous improvements in public health practice (ADPH, 2015, Public health sector-led improvement framework. www.adph.org.uk/category/phsystem/sli/).

The SLI approach may include the following activities:

- Self-assessment
- Benchmarking
- Reflecting local context
- Peer challenge
- Critical friend approach
- Measuring improvement/impact – of performance, outcomes, process, cost effectiveness
- Public health audit
- Evaluation
- Sharing learning

Information on impact and improvement is recorded and considered by the appropriate council systems (e.g. health and wellbeing boards) and made publicly available (see CfPS 2018 for published scrutiny guidance).

SLI in public health is developed and supported by the LGA, ADPH and PHE in the following ways.

- The LGA supports public health SLI and wider improvement activity through peer challenge, 'Prevention Matters' training for councillors, prevention at scale pilot programme, peer support for 'health in all policies', bespoke support and a programme of case study publications.
- ADPH provides national leadership through the ADPH SLI Programme Board, which supports and oversees the development of the SLI activity carried out in regional or sub-regional networks. Each network has a director of public health SLI lead who is responsible for coordinating annual regional SLI plans and reporting progress to the board.
- PHE provides a range of national tools and its centres give support to regional developments.

SLI: an opportunity for suicide prevention

Whilst it is recognised that local suicide prevention plans are not a statutory requirement, the SLI approach presents an opportunity for local authorities to learn from each other and from external experts. The self-assessment survey that generated data for this report (see Chapter 3) marks the first step in establishing an SLI framework for suicide prevention.

Local suicide prevention planning has advanced considerably since it became a local authority-led initiative in 2013. Taking into account the current funding context, the local and whole-systems approach, and the current national strategy and guidance documents, this report presents the progress that has been made in developing and delivering suicide prevention plans at the local level and makes recommendations to inform the SLI process. The SLI process for suicide prevention will begin in the Autumn of 2019.

Chapter 3. Research aims and methods

3.1 Research aims

The research was designed to answer three key questions about local suicide prevention in England:

1. What is the current state of local multi-agency suicide prevention action plans?
2. What actions are contained in local suicide prevention action plans?
3. What successes and challenges in suicide prevention are experienced by local authorities?

It is important to note that written plans may not be a full reflection of everything that is happening to prevent suicide locally. There may be more activity going on than is represented in the suicide prevention plan, as some of it may be included in different local plans, such as mental health or crisis care plans. A number of areas have reported this to be the case. Conversely, as well as past and present actions, plans sometimes contain future ambitions and may therefore over-represent what is actually being delivered locally. The scope of this report was limited to what is written in the suicide prevention plans and it should not be read as an audit of local actions.

3.2 Methods

Data

To answer these questions, three data sets were generated and analysed:

- **Local self-assessment survey**
  A voluntary online survey was sent to public health leads in all of England's 152 upper-tier[1] local authority areas. The survey featured a total of 60 questions provided by the LGA, ADPH and PHE. Survey questions were mostly closed tick-box questions generating quantitative data, although a number of questions featured text boxes, providing the opportunity for qualitative feedback to be provided.

  Survey questions focused on local action in the following 7 areas:
  - Multi-agency groups
  - Development of local strategy/action plan
  - Local audits and monitoring and evaluation
  - Content of plans and priority area actions
  - Good practice and challenges
  - Sector-led improvement
  - Additional support needs

  Nine local authority areas were invited to pilot the survey and comment on the question wording. Pilot feedback was used to refine the main survey. This was then distributed to all 152 upper-tier LAs in England, accompanied by a letter from ADPH, LGA and PHE.

  A total of 133 individual responses were submitted. A number of local areas collaborate on suicide prevention and in these cases respondents submitted their answers on behalf of multiple local areas. In total, the 133 responses represent data for 150 out of 152 local authority areas in England (99% response rate).

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[1] Upper tier local authorities (the 152 County Councils, Unitary Councils and London Boroughs in England) are those with public health responsibilities.

- **Local suicide prevention strategies & action plans**
  Survey respondents were invited but not required to upload their strategies and action plans (hereafter referred to as 'local plans') via the self-assessment survey or to send via email if they preferred. These documents generated in-depth qualitative data, which complemented the survey data by providing more detailed information on what was happening locally.

- **Qualitative case study interviews**
  In selected cases, telephone interviews were carried out with suicide prevention leads. Interviews focussed on what they perceived as good practice and on the challenges they were experiencing in suicide prevention. A total of 12 case study interviews were carried out.

Table 3.1 outlines the number of responses received for each data set and the total number of unique local authority areas represented for each.

Table 3.1 Summary of data collection and analysis					
	Total responses	**Local authorities represented**	**Response rate**	**Analysis**	**Sampling procedure**
Survey	133	150	98.7%	Quantitative	Census
Local plans	105	117	77%	Thematic analysis	Census
Interviews	12	12	N/A	Thematic analysis	Purposive sample

For data-protection reasons, survey respondents were able to skip questions asking for information about their local area, including region. Seven survey respondents responded anonymously (did not provide their local authority name or region). Two did not respond to the survey at all. This means that for a total of nine local authorities out of 152 (6% of the total) the data set lacks regional information.

Some regions achieved 100% response rates (e.g. North East), and in these cases exact proportions are reported for the region. However, for other regions where regional data response is below 100%, regional findings are presented as a proportional range (e.g. 80-85%). As the number of local authorities in each region of England is different, both percentages and counts are reported in the format X%; X/X (e.g. 80%; 10/12).

It should be noted that the number of local authorities in each region varies greatly. This means it is harder for regions with a large number of local authorities (LAs) such as London (33 LAs) to achieve 100% response rate than it is for smaller regions such as East Midlands (9 LAs).
Table 3.2 summarises regional response rates achieved.

Table 3.2				
Region	**Number of LAs in region**	**Number of LAs covered in survey responses**	**% response**	**Number missing**
East Midlands	9	9	100%	0
North East	12	12	100%	0
South East	19	19	100%	0
East of England	11	10	91%	1
North West	23	22	96%	1
South West	16	15	94%	1
West Midlands	14	13	93%	1
Yorkshire & The Humber	15	14	93%	1
London	33	29	88%	4
No regional data provided	n/a	7	n/a	n/a
Total	**152**	**150**	**99%**	**9**

Research timetable

The survey was piloted from 30 May to 7 June 2018, with the main survey sent out on 10 October for responses by 16 November.

3.3 Sampling procedure

The population of interest for this research was the 152 upper-tier local authority areas in England.

Survey and local plans

Our ambition for the survey and local plan data was to conduct a census of all 152 local areas. Each local area was contacted by email and invited to take part in the online survey and submit their local plan. Non-respondents were sent up to a maximum of five reminder emails throughout the survey fieldwork process.

Qualitative case study interviews

The self-assessment survey gave respondents the opportunity to opt in to being contacted about taking part in a qualitative case study interview. Participants were purposively sampled from the survey respondents who opted in, in order to achieve maximum variation. Sampling criteria are outlined in table 3.3 below. Consideration was also given to the local authority's response to survey questions and the content of their action plan if available, to allow a range of perceived successes and challenges to be explored. All interviews were conducted by telephone and lasted between 23 and 52 minutes.

During case study recruitment every effort was made to ensure diversity but local authorities from some regions were less responsive to recruitment emails and phone calls than others. This meant that some regions were not represented in the final sample. Likewise, areas not under Labour or

Conservative control were not represented because no respondents from these areas opted in to be interviewed.

Table 3.3 Sampling criteria for qualitative interviews	
Criteria	**Cases (n)**
Region	0
North West	3
North East	1
Yorkshire and the Humber	1
West Midlands	0
East Midlands	0
East of England	1
South West	3
London	0
South East	3
Urban / Rural	
Urban	8
Rural	4
Suicide rate[2]	
Higher than England average	2
England Average	9
Lower than England average	1
Local political party control	
Conservative	6
Labour	6
Liberal Democrat	0
Independent	0
Other	0
No overall control	0
Topics discussed at interview	
Local audits / research and data	4
Multi-agency group working	5
Real-time data	4
Funding and resources	4
Access to means	1
Bereavement support	1
Men	3
Sensitive media	1
Monitoring & Evaluation	1
Self-harm	2
High-risk groups	1
Local campaigns	2
Total	12

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[2] The higher/lower benchmarks are identified by ONS using confidence intervals. Where a confidence interval does not overlap from below or above the national confidence interval, a higher/lower benchmark is calculated.

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3.4   Analysis

Survey data

Quantitative survey data were analysed using SPSS to generate descriptive statistics (charts and tables) to represent findings at the national and regional level.

Local plans and case study interviews

Local plans and interview summaries were uploaded to NVivo (qualitative analysis software) and underwent a two-cycle thematic analysis (Saldaña 2009). Thematic analysis allows for the systematic organisation of qualitative data into key themes (e.g. high-risk groups) via a process of viewing, re-viewing and progressive sorting of the content. Themes were derived in two ways:

- Using pre-existing themes from national guidance documents that are used by local authorities to organise their plans (see Chapter 6)
- Inductively from the data

(Fereday and Muir-Cochrane 2006)

Across the 113 strategies and/or action plans that were submitted for this research, 117 LAs are represented (some strategies and action plans represent multiple LAs). Respondents submitted their strategies and/or action plans in one of the following ways:

- Submitted combined strategy and action plan
- Submitted strategy and action plan as two separate documents
- Submitted strategy only
- Submitted action plan only
- Submitted different versions of the same strategy and/or action plan

Additionally, different approaches were taken to the content of strategies and action plans. For example, some of those who submitted a strategy but not an action plan included a summary of local actions in their strategy. In order to capture as full a picture as possible of local planning, all actions were included in the analysis regardless of whether they were listed in strategies or action plans. Where actions were summarised in strategies and detailed more extensively in action plans, both were analysed and combined.

3.5   Limitations of the study

Local plans were submitted for 117 of the 152 local areas. This is a high response rate (77%) and whilst clear themes emerged during the analysis of these plans, it should be noted that data are missing for the remaining 25 plans, which may hold additional useful insights.

The qualitative case study findings presented in this report are drawn from a small purposive sample (n=12). Whilst clear themes were generated through the analysis, the small sample size means that the full range of themes were not captured.

Chapter 4. Multi-agency groups and action plans

This chapter examines the extent of local progress in establishing multi-agency suicide prevention groups and action plans. Survey data are presented at the national level and regional findings are presented where regional variation exists.

4.1 Multi-agency groups

A large majority of survey respondents report having a multi-agency suicide prevention group in place (92%; 138/150).

Do you have a multi-agency suicide prevention group?
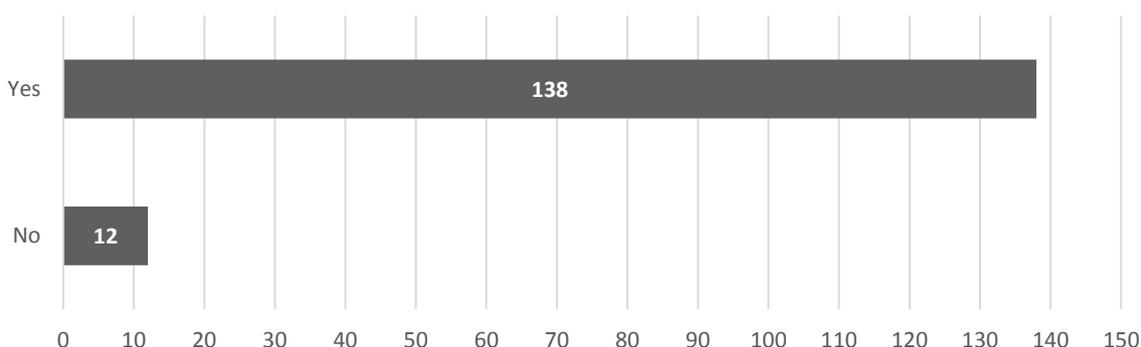
At the regional level, 100% of local areas in the North East (12/12), East Midlands (9/9) and South East (19/19) have a multi-agency group in place. Elsewhere at least 82% of local areas have a group in place. This is slightly lower in London where between 67-79% (22-26/33) have a group in place.

Of those with a multi-agency group (138/150), over half established their group between 2014 and 2017 (57%; 79/138), but a number were established more recently in 2018 (10%; 14/138), half of which were in London. In total, 16 of London's 22 multi-agency groups were established between 2017 and 2018.

The majority of respondents with a multi-agency group reported that their group holds meetings every three months (76%; 105/138). There was no relationship between region and frequency of meetings.

Multi-agency group membership is typically made up of a wide variety of organisations, agencies, and individuals from public, private and voluntary sectors (see separate technical appendix). Five key organisations and/or sectors feature in over 90% of respondent groups:

- public health (99%; 137/138)
- clinical commissioning groups (97%; 134/138)
- voluntary sector (94%; 130/138)
- secondary mental health providers (93%; 128/138)
- police (91%; 126/138).

Beyond the multi-agency group, many local respondents are also coordinating and delivering prevention activity through other means, including health & wellbeing boards (72%; 100/138), mental health commissioning boards (64%; 88/138), and the crisis care concordat (56%; 77/138).

Local areas with no multi-agency group

Twelve local areas have not established a multi-agency group (8%; 12/150). Seven of these are located in London and the remaining five are dispersed across the regions. Of these 12, ten intend to establish a group and are already collaborating with other organisations, and nine are already using their Health & Wellbeing board to coordinate their suicide prevention activities.

Case study 4.1: Building an active multi-agency group

Survey respondents and interview participants (local authority staff leading on suicide prevention) reported a number of difficulties in establishing and maintaining multi-agency groups:

- difficulty engaging new members
- difficulty supporting existing members to take part in suicide prevention
- active group members were frequently lost due to funding cuts, restructuring, or high staff turnover in their sector

Some of those who had successfully overcome these challenges shared their tactics for engaging and sustaining an active multi-agency group. One of these was that local audit findings and peer communicators were useful tools for creating and sustaining multi-agency groups, especially when trying to recruit organisations that were initially resistant or uninterested in suicide prevention. Participants found that attending the meetings of an organisation and delivering an accessible presentation of local audit data, tailored to that organisation's remit, along with emotive qualitative stories of preventable and 'relatable' suicides in their community was an effective way to help organisations understand the relevance of suicide prevention to their work and the important role they could play locally.

"I have taken suicide prevention to everybody to make sure it is on their agenda... It's all very well saying 'We need to plan suicide prevention, could you work with this high-risk group?' What I've done is I've gone to them and I've specifically said, 'This is why you could work with that group, this is why you're so instrumental."

Local data, both quantitative and qualitative, helped organisations relate to and engage deeply with suicide prevention in a way that national data sources could not. Some suicide prevention leads also found it helped to use peer communicators, for example supporting a local GP to present local data to their colleagues. Peer communicators were found to be better able to frame the work as a realistic collaboration ("This is what we can do"), rather than it being seen as a top-down instruction from the council ("This is what you should be doing"). This helped organisations to 'own the work', i.e. to identify suicide prevention opportunities for themselves that were relevant to their existing work. Others reported that the clinical language of 'suicide prevention work' and 'high-risk groups' could disengage listeners. Instead, they suggested providing a list of straightforward concrete actions linked to an organisation's existing remit and presented in lay terms. This helped to encourage organisations to move beyond 'just talking' and to take responsibility for local suicide prevention.

4.2   Action plans

All survey respondents reported that they either have or plan to establish a local suicide prevention strategy and action plan.

The following chart details the three stages of development that were reported:

Do you have a suicide prevention strategy and/or action plan?
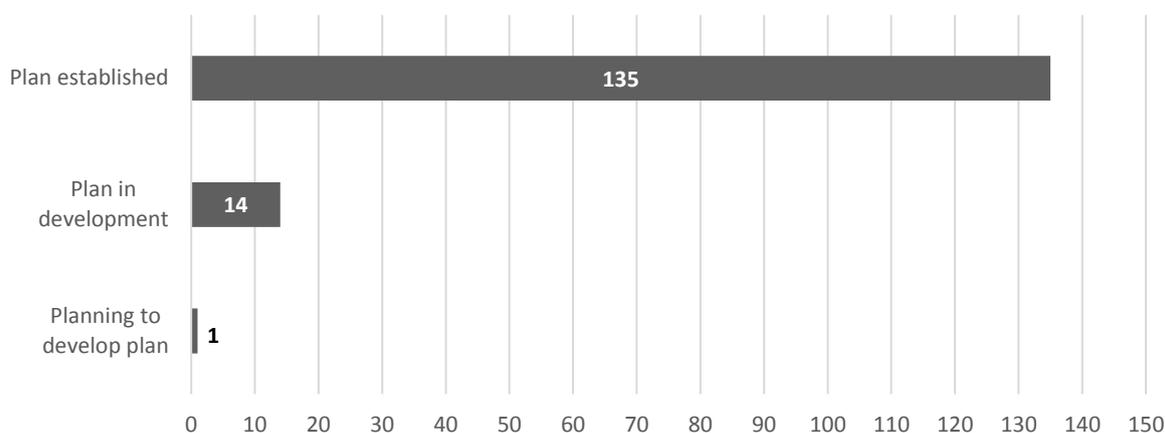
It should be noted that these findings differ from PHE data on this issue, which indicate that all but one of the 152 upper tier local authorities have a plan. This discrepancy may be due to different question wording and answer categories in the survey. There are 14 local areas whose plans are in development: London (7 plans), South West (3 plans), North West (2 plans) and Yorkshire and the Humber (1 plan)[3]. Respondents were not asked to specify the stage of development, so it is possible that some of these plans are drafted and awaiting sign off, or they could be at early stages.

Among those with an established plan and those with plans in development (149), nearly three-quarters (72% (108/149) established their most recent plan in 2017 or 2018. The oldest plans were established in 2015. Among those with an established local plan or plan in development, 72% (108/149) reviewed their plan at least once a year.

Respondents with an established local plan or plan in development (149) reported a number of different approaches to governance and consultation of local plans. Over two-thirds (68%; 101/149) developed their local plans in consultation with people who have attempted suicide and/or been bereaved by suicide.

Whilst less than half (38%; 56/149) have already submitted their plan to their Overview and Scrutiny and/or Health Scrutiny committee, among those who have not submitted their plan (53%; 79/149) nearly half (47%; 37/79) intended to submit their plan in future. Likewise, the majority of remaining areas reviewed their plan using another oversight or governance board, including Health & Wellbeing Board, Mental Health Board, and the Crisis Care Concordat.

4.3   Local audits

Suicide audits are no longer a statutory requirement and currently there is no nationally agreed view on what an audit should look like. As such, local areas may have differing views on what counts as an

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[3] The fourteenth respondent in this group did not provide information on their area name or region.

audit. The majority of respondents indicated that they have undertaken an audit of local suicide data (84%; 126/150). Most of these (70%; 88/126) completed their most recent audit in 2017 or 2018.

Of those that have not undertaken an audit (24), three indicated that they did not plan to carry out an audit in future. No follow up questions were asked of this group.

Case study 4.2: Working with local coroners and improving audit data

Interview participants who had undertaken a suicide audit found that the local data produced supported their suicide prevention work in several fundamental ways:

- Securing funding through well evidenced grant applications
- Planning effective interventions based on local need
- Building effective multi-agency groups and sustaining motivation
- Building a local culture of suicide prevention

These participants believed that their local coroner, as the gatekeeper of local data, was central to successful suicide prevention.

"The coroner has been absolutely instrumental in this […] and he's been very supportive. I think without him we wouldn't be anywhere near where we are now, and he's got plenty of ideas about where to go next."

However, participants also found that local data were of limited use in some cases. For one participant, the lack of data on ethnicity made it difficult to implement culturally and linguistically appropriate bereavement support services locally. This LA found that in some cases, data on ethnicity were being derived from country of birth leading to, for example, second generation Pakistani diaspora being recorded as white-British. This prompted further concern in this LA that potential local at-risk groups or clusters were being overlooked in their audit data for this reason. When raising the issue locally, this participant found that her majority-white colleagues were uncomfortable discussing issues of race and ethnicity for fear of 'saying the wrong thing' or being 'misconstrued as racist'. This participant found that their input was often disregarded as a 'personal agenda' as opposed to professional insight:

"When you're a person of colour and you speak up and say, 'What about race issues?' people sometimes do not distinguish between the personal and professional… they think that you're making a personal statement rather than a professional one."

It was felt that the following would help to overcome these challenges:

- Undertaking an equality impact assessment of local plans and audit data.
- Well informed senior leaders speaking openly about this issue and expressing its importance

> **Case study 4.2 continued**
>
> For interview participants who had not yet undertaken a local audit, the main barrier to doing so was an unresponsive local coroner. One participant described how they could not get a reply from the coroner despite having invited them to their strategic meetings, emailed and called the coroner's office multiple times, and even written a joint letter with partners across other local authorities. For those struggling to engage their coroner, it was felt that local coroners did not understand the important part they could play in suicide prevention. These participants repeatedly stated that national guidance to coroners about their role in prevention work could really help:
>
> *"It's just about really getting that national [directive to coroners]. Get them just so that they've got an understanding of where they are placed in the system and how important their information is in supporting on suicide prevention. Because I think that's one of the things they don't get… it's like a reactive service… they do the usual post-mortem and coroner's reports… but I think they think that's where their job finishes. I don't think they see that they could help prevent suicide."*

4.4   Outcomes and monitoring & evaluation

Survey respondents with an established local plan or plan in development (149) were asked to list up to three of the most important outcomes that their action plans were designed to achieve. After 'reducing suicide rate' (52%; 78/149), the most frequently referenced outcomes were bereavement support (40%; 60/149), awareness-raising (32%; 48/149), and research (24%; 36/149).

All respondents were asked if they have monitoring and evaluation (M&E) procedures in place for their suicide prevention actions. Most respondents do have M&E in place (76%; 113/150).

Qualitative analysis of the plans themselves revealed that M&E measures are largely made up of input measures (e.g. money spent on developing training programme for GPs). Some included output measures (e.g. number of GPs trained) and a small number of the most comprehensive plans included pre-action baseline data (e.g. GP knowledge of suicide prevention best practice before training) and outcome measures (e.g. GP knowledge of suicide prevention best practice after training).

Recommendations

- DHSC and PHE should work with the National Suicide Prevention Alliance (NSPA) to support a national network for people with lived experience to better enable input and co-creation of local multi-agency plans, and to ensure this is done in a safe, consistent and meaningful way that also considers diversity.
- PHE and NSPA should provide further guidance on how to measure success.
- LGA and ADPH should work with PHE to agree what a "good" audit for suicide prevention looks like.
- LAs should consider including output and outcome measures in their monitoring and evaluation processes wherever possible.

- DHSC and PHE should work with the Chief Coroner's Office to write to coroners reminding them of the crucial role they can play in suicide prevention, and encouraging them to work with local multi-agency suicide prevention groups.

Chapter 5. Sector-led improvement on suicide prevention

The survey was designed to inform a sector-led improvement process for suicide prevention. This chapter reports how much sector-led improvement work on suicide prevention is already taking place at the national and regional level, as well as the additional support needs identified by local areas.

5.1 Sector-led improvement

One-third (34%; 50/150) of respondents had undertaken sector-led improvement (SLI) work on suicide prevention. The remaining two-thirds had either not undertaken any SLI work on suicide prevention (49%; 74/150) or did not know whether they had done so (16%; 24/150).

Regionally, levels of SLI work were highest in Yorkshire & the Humber (60-67%; 9/15), the North West (52-57%; 12-13/23), and North East (50%; 6/12). Regions with a lower proportion of local areas undertaking SLI work include the South East (5%; 1/19), East of England (10-20%; 1-2/11) and East Midlands (22%; 2/9). Levels of certainty about whether SLI work had been undertaken were highest in East Midlands, where 100% (9/9) of respondents knew whether SLI work had taken place or not, and lowest in East of England, where around half (46-54%; 5-6/11) knew whether or not they had undertaken SLI work.

Of those who had undertaken SLI work (50), this mostly took place at the regional (62%; 31/50) or local level (60%; 30/50), with 10% (5/50) taking place at the national level and 6% (3/50) at the sub-regional level.

Examples of SLI work included:
- Cross-boundary collaboration, such as regional peer-review of plans with other local areas
- Sharing good practice at regional conferences
- Working as 'critical friends' with other local authorities in the region.

Several benefits to undertaking SLI work were reported by respondents, including:
- Improved knowledge of suicide prevention work
- Enabled data sharing
- Improved action plan quality
- Improved working relationships with group members
- More streamlined approaches to suicide prevention work.

5.2 Additional support needs

Most respondents felt they would benefit from additional support with their suicide prevention activity (78%; 117/150). Regionally, desire for support was highest in the East Midlands (100%; 9/9), South East (95%; 18/19) and Yorkshire & the Humber (80-87%; 12-13/15).

Survey respondents wishing for additional support (117) were asked to list up to three topics or issues on which they would appreciate support. The following five areas were the most frequently mentioned (see separate technical appendix for full list):

- Real-time data collection (21%; 24/117)
- Mental health services (16%; 19/117)

- Staff training (15%; 17/117)
- Children and young people (14%; 16/117)
- Funding (14%; 16/117)
- Self-harm prevention (14%; 16/117)
- Coroner co-operation (12%; 14/117)
- Reducing risk in men (12%; 14/117).

Desire for support specifically from national partners was higher still, with 88% (132/150) saying they would appreciate support from national partners such as the LGA and ADPH. Across the regions, desire for support from national partners was at 79% or higher, everywhere except in the North East (58%; 7/12).

From the list of options offered, respondents felt they would benefit most from the following three types of support (see separate technical appendix for full list):

- Case studies of good practice (72%; 95/132)
- Advice and technical advice from experts (62%; 82/132)
- Shared problem solving at the regional level (55%; 72/132)
- Shared problem solving at national level (49%; 65/132)

When asked if there was anything about current guidance that was unhelpful, a quarter of survey respondents (25%; 37/150) said yes and mentioned the following issues:

- Guidance is too broad to be achievable
- Limited resource to follow all guidance
- Too much of it: guidance updated too frequently to keep on top of
- Inconsistent terminology and changing priorities in different guidance documents leads to confusion
- Current guidance lacks specific support on:
  - Areas with complex or anomalous geographical locations or local government structures
  - Small local authorities
  - Local areas with low suicide rates
  - How to collaborate with wider region effectively.

Chapter 6. Overview and structure of local plans

This chapter is based on the qualitative analysis of local plans. It provides an overview of the main features of local action plans, their development, scope and organisation.

6.1 Strategies and plans

Strategy documents were typically well-produced, clearly written for a public audience, containing a wealth of detailed background material and often demonstrating an impressive grasp of the issues. They included some or all of the following: an overarching vision for suicide reduction/prevention, sometimes zero suicide; summary of national policy and priority areas; summaries of recent government reports, guidance documents and research evidence; national suicide statistics; local suicide statistics; local priorities or recommendations for action, and/or detailed aims and objectives. Many were illustrated with infographics. Action (or implementation) plans largely seemed to be working documents, designed for internal use by the local multi-agency group as tools for keeping track of what was happening.

Priorities listed in the strategy were not always reflected in the structure of the plan. For example, whilst a strategy may state that the priorities to be addressed in the short term are those listed in the PHE guidance, the action plan may be structured using entirely different headings, the rationale for which was not clear. In some cases, there was little or no obvious linkage between the local data presented in the strategy and the actions listed in the plan.

Apparent dissonances between strategies and plans may simply reflect the different purposes (and audiences) that these documents are designed to serve, or they may be indicative of lack of coherence and organisation in local thinking. Local authorities may find it helpful to think about how their action plan links with their strategy, using the self-assessment checklist given in Appendix 2.

6.2 Structure of plans

Local areas structure their plans in a number of different ways. Chief among these are the following.

- ***Preventing suicide in England: A cross-government outcomes strategy to save lives.*** The national suicide prevention strategy (2012) outlined six key areas for action, but its scope was subsequently expanded in 2017 to include addressing self-harm as a seventh key area. By far the majority of local authorities have chosen to structure their plan using this framework, documenting actions under each area of the strategy, either the original six or the full seven.
- ***Local suicide prevention planning: A practice resource.*** This 2016 guidance from PHE recognises that local action plans should eventually tackle all seven key areas of the national strategy but identifies eight short-term priorities. Some local authorities have used these as the basis for their current plan.
- **Livingworks: 10 pillars for building a Suicide-Safer Community.** A small number of local areas are striving for accreditation as a Suicide-Safer Community and are structuring their plans according to the assessment criteria.[4]
- **Locally identified priorities.** Some plans are structured according to locally identified priorities, although the process whereby these have been identified is not always clear. Some state that local data have been used to determine priorities, although the linkage between data and plan is not always visible. Others have conducted local stakeholder involvement processes, such as

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[4] https://www.livingworks.net/community/suicide-safer-communities/

workshops (see Box 6.1). Locally identified priorities are usually a combination of selected areas from the national strategy and broader themes that address working practices in general or cut across the strategy, such as "Joint working and commissioning to develop clear, consistent and streamlined pathways across services" or "Awareness-raising activities".

Box 6.1:   A clear description of the process of developing a plan based on local priorities
(source: Lincolnshire's suicide prevention strategy)

Developing the Lincolnshire Local Action Plan
The process to date:
- Formed a Lincolnshire wide cross sector multi-agency Strategic Suicide Prevention Group.
- **Reviewed the National Strategic Plan** [5] and the six key areas contained within it. We used these as a basis for developing a Lincolnshire plan. **We also searched for local action plans in other areas in England** to understand what best practice was being implemented elsewhere.
- **Developed an initial draft of the Local Action Plan** for Suicide Prevention in Lincolnshire which was based on the six national objectives, but also included an additional objective identified within a recent Mental Illness Health Needs Assessment for Lincolnshire [10].
- **Convened a wider stakeholder day**, in order to refine the draft Local Action Plan. This included additional representation from wider stakeholders, including Voluntary & Faith sector providers and District Councils.

Suicide Prevention Stakeholder Event Recommendations
The suicide action plan detailed below has been shaped through an iterative, multi-agency and cross-sectoral process. The core development took place at a stakeholder event on 22nd January 2016, in which 45 representatives from over 25 organisations across the community and voluntary sectors, private sector, CCGs, the local authority and district councils came together to:
- **Discuss key actions that could be included in the action plan.** This group exercise generated approximately 35 separate activities that were perceived could reduce suicide locally.
- **Prioritise actions identified during those discussions.** We created an interactive task that enabled people to prioritise the individual actions that they perceived to be most important within a Lincolnshire Suicide Prevention Action Plan. Each individual was enabled to prioritise up to 14 activities.
- **Cluster prioritised activities into themes based on the stakeholder prioritisation exercise.** From the interactive exercise above, similar actions were clustered into themes. Six themes were identified.
- **Discuss key themes identified.** Stakeholders subsequently discussed each of these themes in turn, identifying key activities within each theme as well as who should lead on coordinating the delivery of each theme.
- **Reframe the key themes.** Following a lively discussion between stakeholders from across a range of organisations and sectors, the following key themes (which are a simplified version of the six themes identified earlier in the day) were agreed.
- **Identify key actions and lead organisations for each theme.** A set of key actions were identified from each themeand we agreed to identify lead organisations to take ownership of driving forward each theme at the next Suicide Prevention Board Meeting, where all of the key stakeholders would be represented.

6.3   Level of detail in plans

There was great variation in the level of detail provided in local plans, possibly reflecting the fact that they were at different stages of development. Some were simply brief bullet-point lists of actions or aspirations, with no indication of how these were going to happen. The more comprehensive and detailed plans were tabular in format and included some or all of the following alongside each proposed action:

Rationale: why is this action being taken? Some plans include local data, established risk factors or evidence of effectiveness as justification for the action being taken.

Responsibility: who is going to do it? A key individual or organisation responsible for delivering the action is named. Some plans also indicate to whom they will report.

Start/end dates: when will it be done? A clear timeline is indicated, with key milestones and a final deadline for completing the action.

Outcome measurement: how will success be judged? Measures of success are specified.

Current status or RAG rating: how far has the action progressed? Many plans use red-amber-green (RAG) ratings, where red indicates no progress, amber indicates some progress but possible delay or further input needed, and green indicates action complete or progressing according to plan. Some also include detailed updates, including reasons for delay (e.g. staff changes), current status of work and next steps.

Links to other relevant documents. Some plans include links to national guidance documents or other local strategies/action plans, such as Mental Health or Children and Young People's plans.

Low level of detail	High level of detail
Not clear what exactly is to be done	Clear action to be taken
Not clear who is going to do it	Named person responsible for carrying out
Not clear when	Clear process and timescale
Not clear what it will achieve	Clear what it will achieve
Not clear who will monitor/evaluate	Clear reporting/monitoring procedures

Examples

"Promote awareness among young people and gatekeepers."

Objectives – "Cheshire Community Foundation has funded PAPYRUS Prevention of Young Suicide to engage the communities of Cheshire County in preventative work around suicide and self-care over a 12 month period from January 2017 – December 2017.

The project aims to:
• Deliver 20 free suicide prevention and awareness sessions for parents
• Engage with 20 young people to design and deliver a county-wide Self-Care Campaign
• Recruit and train 60 volunteers in 'ASIST' (Applied Suicide Intervention Skills Training) course free at the point of delivery. 50% of the volunteers will be aged 18 – 34 yrs old
• Support the newly trained volunteers to design and deliver at least 60 suicide prevention activities (in total) in their chosen communities."
(Cheshire West and Chester Suicide Reduction Action Plan)

"Signage at hotspots"

Progress - "Car park barriers:
The 2014-17 strategy identified a need to reduce access to the means of suicide in [city] car parks. There had been a number of suicides from [name] and [name] car parks, both close to the city centre. There is strong evidence for reducing access to the means of suicide in preventing suicide, particularly barriers at sites where suicide has been frequent.
The SP implementation group and other parties, including the [city] coroner, were successful in working with the owners of both car parks to erect barriers on the car parks.
Barrier construction began in [year] and was completed in [year]. There have been no suicides from car parks in [city] since barrier construction began." (Cambridgeshire & Peterborough plan 2017-2020)

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Chapter 7. Area 1: Reduce the risk of suicide in key high-risk groups

Chapters 7-13 that follow relate to the content of local plans and are structured according to the seven key areas of the national suicide prevention strategy. The overwhelming majority of plans document their actions under these headings.

In each chapter quantitative data derived from the survey, in which respondents were asked whether their plan included each area of action, are presented first. This is followed by a thematic summary, based on qualitative analysis of plans, of the kinds of action being taken by local authorities, some illustrative examples from local plans, and finally recommendations. The examples have been selected to illustrate either the range of activities included in plans or some particular types of action.

7.1 Men (especially young and middle-aged)

National picture

The national suicide prevention strategy (DHSC 2012) and the 2019 annual progress report, *Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives* (DHSC 2019)*,* highlight the importance of reaching young and middle-aged men. These, along with the NICE guidelines, *Preventing suicide in community and custodial settings* (NICE 2018)*; NG105)*, recognise the importance of reaching out to men at risk, encouraging help-seeking, using community locations for engagement, and training frontline staff and those most likely to come into contact with the high-risk group. STPs in receipt of suicide prevention funding from NHS England have been encouraged to implement place-based community prevention work for middle-aged men.

Unsurprisingly, the majority of survey respondents reported that reducing risk in men was included in their action plan (97%; 145/150), and nearly three-quarters said they were already implementing these actions (70% / 105/150). The five respondents that reported this was not included in their plan said they were targeting specific groups of men under other areas, for example men in the criminal justice system, or that actions for men would be included in a future plan.

Regional variation

In the North East, all respondents (12) reported that reducing risk in men was in their action plans and 83% (10/12) reported that they were already delivering these actions. Delivery was equally high in the South East (84%; 12/14) and in Yorkshire & the Humber (80%; 12/15). In London, while most respondents said they included reducing risk in men in their action plans (82-94%; 27-31/33[5]), fewer reported that they were delivering the actions (39-52%; 13-17/33).

Types of action included in plans

Qualitative analysis of local plans revealed that there is a large amount of activity going on in relation to reducing suicide risk in men. Whilst much of this is designed to reach any or all men, some plans highlight specific risk factors that may affect men, such as debt, divorce, unemployment, and

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[5] Regions with missing data are reported using a proportional range (e.g. 82 – 94%).

substance abuse, and are targeting these sub-groups. Some plans include further research work to identify local risk factors in men.

The actions being taken to reduce risk of suicide in men can be broadly categorised as follows:

- **Campaigns and awareness-raising:** Many plans include awareness-raising and campaigning activity, designed to share information about suicide and broader mental health issues, reduce stigma, promote existing sources of support and encourage help-seeking. Some LAs are planning special awareness-raising days, whilst others are making efforts to raise awareness throughout the year.

  Some LAs specify that they are promoting national campaigns locally; others have developed or are developing their own campaign messages and materials, for example "It takes Balls to Talk" or "Release the Pressure". Sometimes these are being developed and delivered in partnership with social marketing/behaviour change experts or with local organisations, such as football clubs, as part of community engagement activity. Many LAs are focusing their efforts on typically 'male' settings, using them for the distribution of information and engagement of their target audience. A variety of media channels are being used, including posters, leaflets, radio and television adverts, and social media.

- **Training for those coming into contact with potentially vulnerable men**
  - **Frontline staff:** Many plans include provision of formal training in suicide awareness and intervention skills, including ASIST, SafeTALK and MHFA, for those whose work brings them into contact with men in general or with particular groups of at-risk men. Staff groups mentioned for targeted training include those working in primary and secondary health care, social services, emergency services, education, and the voluntary sector.
  - **Specific targeting of 'male' settings:** Some LAs include training people within "male" settings to help them initiate conversations about mental health and respond appropriately. These include sports clubs, gyms, pubs, barbers, music venues, betting shops, as well as more unusual settings such as classic car rallies.

- **Improving social connectedness:** Some LAs are thinking more broadly about social connectedness, especially among middle-aged and older men, and about how they can improve it. Examples include promoting Men's Sheds, local men's clubs and other local interventions, such as 'Pie and a pint' sessions. Some of these are being made available on prescription via GPs.

- **Improving diagnosis, referrals and access to health services:** The bulk of local activity under this area of the strategy takes a public health, community-based approach. Very few plans mention any form of clinical intervention or service provision. This may be because it is included elsewhere in their plan, for example under treatment of depression in primary care, people in contact with mental health services, or drug and alcohol services. One notable exception contains a set of actions that include: reviewing GP registers to ensure all men with diagnosis of depression have been referred to psychological therapies, and increased screening of men who are showing signs of depression (e.g. loss of appetite, poor sleep, physical pain, digestive disorders, anger, reckless behaviour), with an ambition to increase male referrals to talking therapies by 5%. The same plan also includes a number of initiatives designed to promote the involvement of fathers in therapeutic work with at-risk families, and

piloting of a new fathers' group. Another plan includes auditing rates of male access to IAPT services.

Case study 7.1:   Engaging men

Local area survey respondents identified men as one priority group with which they would like more guidance and support. A group of case study interviewees echoed this sentiment, noting that they were struggling to engage men locally. Interviewees who had had more success in engaging men shared the tactics they had developed to overcome this barrier:

- **Indirect communication via partners, peers or service providers:** One participant who had wanted to conduct focus groups in order to find out what men need from local services but had struggled to recruit men to take part found that using social media to reach significant others (particularly female partners) or supportive figures such as sports coaches was more effective than approaching men directly. An oblique approach was equally useful during the focus group, in which they discovered that men responded best when asked their opinion on existing services, rather than asking them about what services they might like based on their personal experiences. Participants also noted that men were more likely to seek help from formal support services if they had been given the opportunity to 'rehearse' the conversation informally beforehand with someone they did not know well (e.g. a barber or cab driver).
- **Discreet information/resources:** Some felt that men were more likely to engage with local support services if signposting information was discreet and easily concealed. For example, a credit card sized leaflet that could be kept in a wallet and was not recognisable from the outer cover as being related to mental health or suicide prevention.

Recommendations

- LAs should encourage local and national organisations to work together to consider amplifying and localising national campaigns.
- LAs should work with multi-agency groups to improve access to social and community support for high-risk groups of men, including use of social prescribing schemes.
- All commissioners of training on suicide prevention (including CCGs, mental health commissioning boards, Public Health teams) should ensure any training that is commissioned is consistent with the Health Education England (HEE) and National Collaborating Centre for Mental Health (NCCMH) self-harm and suicide prevention competence frameworks (HEE 2018a, 2018b, 2018c, 2018d).
- Multi-agency groups should support members to further develop approaches by reviewing which groups of men they are reaching through their existing plans, to ensure that there are sufficient activities designed to reach the most at-risk men.
- PHE should consider developing a forum for LAs to share research and evidence that is informing local campaign activity, including evidence on effective messaging for men.
- LGA, ADPH and PHE should initiate discussions with national organisations to better understand how national awareness-raising campaigns could be more effectively localised and how nationally conducted market research and evidence could be shared locally.

- NHS England should further promote the use of the self-harm and suicide prevention competence frameworks.
- NHS England should continue with its suicide prevention programme and targeted investment to local areas. It should consider evaluating care pathways for men at highest risk, covering those that are engaging with GPs as well as those only engaging with other services to help inform local action as part of its evaluation of this programme.
- PHE should work with LAs to ensure that activities to reach men are being evaluated and collated nationally to help build evidence and examples of good practice around what works for men, especially those in middle age.
- DHSC and PHE should explore scope to reach potentially vulnerable men and encourage help-seeking in the online equivalent of typically male spaces, such as online gambling sites.

This plan provides an example of using national initiatives to support local action (Newcastle).

Objectives:	Actions	Measures/Outcomes	Lead Person/ Agency	Progress 2018/19	Rag rating
3.2 Promote the Time to Change message to de-stigmatise mental ill health in our community	Work with the Time to Change Newcastle / Gateshead organic hub to destigmatise mental ill health, working to uplift national campaigns focussing on: • Workplace champions • Men's Health	Number of employers signing pledges Number of workplace champions Reduce suicide rates and social isolation	All partners	High profile public sector sign ups of TTC, include Newcastle council, NTW, NUTH, PROPS, Concern group, CCG, Blue light services, Newcastle SU, Northumbria SU, Northumbria uni, NCVS, Greggs, YHN, Virgin Money Newcastle University BHAWA event held Oct 2017 – 150 representatives from 80 businesses attended to discuss workplace health 20 organisations signed up to TTC. Workplace champions recruited.	

This plan demonstrates a wide range of actions that are available to reach men at high risk of suicide (Kirklees).

Objective	Suggested steps that need to be taken	Suggested lead/ partners	Timescale (RAG)	Expected outcomes	Progress to date
1.0: Men: - with depression (esp untreated or undiagnosed) - using drugs and/or alcohol - who are unemployed - who have relationship breakdown - who are socially isolated - who have low self-esteem Men are at 3 times greater risk of suicide than women.	Use peer communicators (outside of health settings) so that men receive information and support from trusted sources. Undertake outreach work in community and work-based settings rather than in formal health settings. Support Andy's Man Clubs in Kirklees; one in North and one in South. Focus on helping men to make the link between physical and emotional health. Provide focussed support. The Basement Recovery Project – a new member of the group as of Dec 2017. Supports people in Recovery within their community.	Voluntary and community sector	G	Improved social contact Individuals better able to cope in times of distress Reduction in male suicide rate in Kirklees	Two Andy's man clubs have now been created; one in Huddersfield and one in Dewsbury. Other projects funded by Community Partnerships include: Men's Sheds, Respect Judo, Froglife, Evolve, The Brunswick centre Allotment Group, St Anne's community services, Platform 1 and Men's Talk.
	Support Kirklees to sign the 'Campaign to End Loneliness' as an approach to tackling suicide.	OPPB and Community Plus	A	Increased social connections for those people that feel lonely in Kirklees, including men.	A working group has been identified (Jan 2018) and is using the Age UK loneliness framework as a benchmarking tool.

This plan, although a little outdated, provides some examples of other actions that can be used to target a high-risk group, focusing on reducing the risk in men through health services (anonymised).

Actions	Lead	Completion Target date	RAG Status *Measure* & Update	Outcome
Increase male referrals to talking therapies by 5% through training on recognising signs of depression	CCG	December 2016	• *% of men referred to the IAPT service* • *% of men entering treatment* • *% of men completing treatment*	Increase in number of men accessing Psychological Therapies
Provide suicide prevention training primary care professionals	CCG	Ongoing (annual updates)	• *Number of primary care professionals trained* • *43 practices attended training last year 15/16. 57 GPs attended*	Good coverage of training.
Analysis of depression reviews	CCG	April 2017	• *Report on depression reviews* • *"male" add as a risk factor for review*	Increase in number of men who have been reviewed for depression

7.2   People in the care of mental health services

National picture

People in the care of mental health services are identified in the national strategy as a high-risk group for suicide and in the 2019 update the government emphasised its ambition of achieving zero suicide for in-patients. The 2018 report from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) (NCISH 2018) includes '10 ways to improve safety' in clinical services.

The majority (83%; 124/150) of survey respondents reported including acute mental health care in their action plans. Of these, 69% (104/150) said they were already implementing these actions. Those who reported that this was not covered in their local plan (17%; 26/150) mostly explained that it was included in a different local plan (e.g. crisis care).

Regional variations

At least 64% of survey respondents reported already delivering actions for people in the care of mental health services, with the highest in the South East (90%; 17/19), South West (69-75%; 11-12/16) and North West (70-74%; 16-17/23). Yorkshire & the Humber was slightly lower at 53-60% (8-9/15).

Types of action included in plans

Actions included in local plans fall into the categories below. Some of these map directly onto the NCISH '10 ways to improve safety' (NCISH 2018), whilst others are broader. A few plans mention the 'Ten ways' (one calls it '12 points to a safer service'), either listing actions under each point or reporting that they are currently using it to review local mental health care.

- **Safer settings:** Many plans mention removal of potential ligature points from in-patient settings. For some, this is the only action being considered. Relatively few mention measures to limit access to medication, either within in-patient settings or in the community, or opportunities for jumping from a height.
- **Improving risk assessment and risk management practices:** Actions include more robust or more frequent risk assessments, and further training for clinical staff in risk assessment and management.
- **Improving pre- and post-discharge procedures:** Many plans mention discharge arrangements, reflecting the importance of discharge as a high-risk time for suicide. Actions include pre-discharge planning, including ensuring adequate housing and social support, and provision of post-discharge support, including visits within 48 hours or 7 days of discharge, ongoing visits as needed, and provision of welfare advice.
- **Closer integration of acute and community services:** Some plans include broader consideration of the needs of patients and their families as they transition back and forth between in-patient and community care, or between primary and secondary care, sometimes via A&E or police settings. One includes provision of a 'step down' from secondary care, and enhanced primary care for people with mental health problems. There is mention of better communication, including out of hours, between key services (including housing and criminal justice), agencies such as British Transport Police and transport providers, especially in the event of a missing and/or at-risk patient.

- **Closer involvement of family and friends in safety planning:** A number of plans recognise the need to involve family members and friends in mental health care and safety planning and to respond to their concerns. Specific actions include dissemination of the Consensus Statement on information sharing and suicide prevention; providing families with information leaflets and details of who to contact in a crisis; and provision of a Single Point of Access crisis telephone number.
- **Non-clinical places of safety:** A number of plans include provision of non-clinical places of safety, including sanctuaries and crisis cafés.
- **Information gathering and learning from local deaths (see chapter 12):** This includes collection and analysis of information from local audits on people with a history of mental illness, as well as learning from post-incident reviews to inform future action.

Some LAs mention Zero Suicide ambitions in their broader strategy document but very few action plans mention a local Zero Suicide initiative under this area within their plan and when they do, limited information is given.

Recommendations

- CCGs, in partnership with multi-agency groups, mental health services and LA public health teams, should implement the '10 ways to improve patient safety' recommendations from National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) (NCISH 2018).
- CCGs should work with LAs, frontline services and the voluntary sector to ensure acute and community services are better joined up, avoiding gaps in support during transitions and improving access for those that need it most.
- NHS England should continue to support areas receiving targeted suicide prevention funding to consider the 'Ten ways to improve safety' as part of their local quality improvement work.
- NHS England should continue promoting joined up services as part of its suicide prevention programme and through its Long Term Plan commitments to develop integrated models of primary and community mental health care.

7.3   People in contact with the criminal justice system

National picture

The Ministry of Justice (MoJ) published a report on Prison Safety Reform in 2016 (Ministry of Justice 2016) and jointly led a Prison Safety Programme with HM Prison and Probation Service (HMPPS). All prison establishments should have local multi-agency action plans for suicide prevention and self-harm reduction, linked to local authority plans.

The self-assessment survey did not include a specific question about this high-risk group. However, the analysis of plans suggests that less than half of local plans include actions for this high-risk group. Of those that do, many focus on prisons, often including transition into the community; some only include actions around police custody and others include both.

Types of action included in plans

Actions described in the local plans fall into the following categories:

- **Safer cells:** Many of the actions involve removal of access to means of suicide within custodial settings, principally the removal of ligature points and access to sharp objects. Some plans note that this is challenging due to historic prison design.
- **Staff training:** There is frequent mention of provision of staff training, including ASIST, SafeTALK and Mental Health First Aid (MHFA), for staff in prisons and young offender institutions, probation services and the police. In some plans, this is the only action listed.
- **Listeners and peer-counselling schemes:** Many plans mention the existence of Samaritans-trained Listeners or similar peer-support schemes, which provide confidential emotional support for those in custody by others with lived experience of the criminal justice system.
- **Whole-pathway support and integration of services:** Many plans that address the needs of this group mention the need to ensure that people in contact with the criminal justice system, who may at any time be at risk of self-harm or suicide, are supported at all stages of the pathway, from police custody to prison or probation service supervision, preparation for release and post-release support. Promising 'through-the-gate' schemes, that recognise and are designed to address the immediate challenges facing those leaving prison, are in development in some LAs.[6] These schemes include individual-level release planning, covering accommodation, employment opportunities, financial advice, appointments with drug and alcohol services, and relationship/family support. Seamless support requires close integration of services, and in some cases commissioning of new services. These are included in many local plans; examples include dedicated CAMHS workers or in-reach teams to support young people in the youth justice system. One plan highlights the need for parity of health care for those in custody and people living in the community. Other joint working arrangements include provision of mental health nurses in police stations and control rooms, and street triage schemes.
- **Information sharing:** This relates closely to the previous item and is a necessary condition for it. Several plans mention arrangements (either in place or being developed) for sharing information across the justice pathway, in order to facilitate identification and timely assessment and/or referral of those at risk. Some plans mention specific groups that should receive routine risk assessment, such as young people who have been in care or in custody.
- **Therapeutic interventions for young offenders:** A few plans mention provision of "early intervention activities" or "accessible and engaging interventions" for children and young people who offend, although these are not specified. Only one plan mentions a specific intervention, namely "multi-systemic therapy".

Recommendations

- Multi-agency groups in the local areas that do not have actions for those in contact with the criminal justice system in their plans should consider including reference to other plans if action is being recorded elsewhere. If action is not being undertaken, LAs, HMPPS and prison governors should work together to consider action in this area.
- Actions to reduce risk for people in contact with the criminal justice system should include points of transition, including the early days of custody and the pre- and post-release period.

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[6] 'Through the Gate' is a flagship government policy, intended to bring about a step change in rehabilitation and thereby reduce reoffending (HMI Probation 2016)

Where they are not already in place, 'Through the Gate' services should be developed and implemented. This should be led by local Criminal Justice Boards, and HMPPS.

- LAs, HMPPS and prison governors should recognise the complex needs of this population (e.g. housing, finance, problems with addiction and mental health issues) and how these impact on their ability to access services in the community. Particular attention should be given to trying to achieve continuity of access and seamlessness of care.
- Plans that only include staff training in prisons should be updated by multi-agency groups to identify further possible actions.

7.4 Specific occupational groups

National picture

The national strategy includes those working in a number of specific occupations, including doctors, nurses, veterinary workers, farmers and agricultural workers, in the high-risk category. These are occupations in which there is easy access to means. Since the publication of the strategy in 2012, the ONS has published research showing that people working in other occupations are also at high risk of suicide, including men in low-skilled occupations such as construction and building trades.

The survey did not ask specifically about occupational groups.

Types of action included in plans

Very few plans include actions targeted at specific occupational groups. Some mention particularly vulnerable groups, such as those working in the building industry, under other headings, including 'Men'. Far more plans include actions that focus generally on workplaces and employers, perhaps reflecting the content of the PHE local suicide prevention planning guidance (Public Health England 2016).

These fall into the following categories:

- **Promoting good mental health in the workplace:** This is being done by sharing guidance such as the BiTC toolkits (BiTC 2017) on mental health and preventing suicide, as well as encouraging employers to sign up for schemes such as the Better Health at Work award, Healthy Setting agenda and Time to Change.
- **Awareness-raising and training:** As in other areas, there is a heavy focus on increasing mental health awareness, with many LAs also delivering or planning to deliver workplace-based training. Named training provision includes ASIST, MHFA and Samaritans workplace training. One LA is considering adopting the 'Mates in Mind' and 'Alright Mate' campaigns to support workplace-based suicide prevention.
- **Making links with occupation-specific organisations:** A few LAs mention that they are developing partnerships with specific with voluntary sector agencies, such as rural health networks, to support this area of work.

Recommendations

- Multi-agency groups not already doing this should further consider targeting the training and awareness campaigns that they are running to ensure they reach low-income, middle-aged men in high-risk occupations.
- PHE and NSPA should consider including more ideas for action and case studies on reaching men in high-risk occupations in its local guidance, including evidence of what has worked elsewhere.

This shows recognition of the importance of joining up work across services for those at high-risk for suicide (Blackburn with Darwen).

Priority 1: Joint working and commissioning to develop clear, consistent and streamlined pathways across services					
	Actions	Outputs	Timescale	Lead Responsible	Progress Update
All Age Groups	• Map and identify relevant mental wellbeing and suicide prevention pathways through the lifecourse • Identify any gaps • Work with commissioners and service providers to address gaps • Share the pathway with relevant agencies • Develop a self-harm/ attempted suicide pathway • Join up alcohol and drugs strategies and services with suicide prevention	• Robust pathways in place • More effective early identification of at-risk individuals of suicide • Self-harm/attempted suicide pathway developed and implemented • Suicide Prevention Strategic Plan linked in with other key strategies such as the Mental Health Concordat		Start Well Suicide Prevention Group Live Well Suicide Prevention Group Age Well Suicide Prevention Group	

Chapter 8. Area 2: Tailor approaches to improve mental health in specific groups

8.1 Children and Young People

National picture

Area 2 of the national strategy deals with improving the mental health of specific population groups. One specified group is children and young people, including those who are especially vulnerable, such as looked-after children, care leavers and children and young people in the Youth Justice System. LAs were asked in the survey if actions to improve the mental health of children and young people were included in their plan.

Nearly all survey respondents (92%; 138/150) answered 'Yes' to this. Most (80%; 120/150) reported that actions were already being delivered. The small number of survey respondents who stated that this was not covered in their local plan (8%; 12/150) explained that the mental health of children and young people was dealt with in a separate local strategy/action plan (such as a Children's Transformation Plan), and that their suicide prevention plan focused on adults only.

Regional variations

In the North East 92% (11/12) of respondents reported delivering actions to improve mental health in this group. Proportions were similarly high for the South West (88-94%; 14-15/16) North West (87-91%; 20-21/23), and South East (84%; 16/19). Conversely, in London a lower proportion of respondents reported they are already delivering these actions (64-76% / 21-25/33).

Types of action included in plans

Analysis of local plans revealed that, after men, children and young people are the most commonly referenced group. As with other areas, there are instances where children and young people are mentioned but there is no associated action, or actions are not well specified. This might be because further detail is given in other relevant children and young people's plans. In line with the national strategy, actions for children and young people tend to focus broadly on promotion of mental health and wellbeing, but with some suicide-specific activity. In addition, there are some actions focused on children and young people within Area 7 on self-harm. There is relatively little evidence in plans of targeting the especially vulnerable groups of children and young people.

Actions described in local plans fall into the following categories:

- **Development/provision of awareness resources, toolkits and training:** The bulk of activity falls into the area of awareness-raising, educating and training. Some plans are unspecific such as "Incorporate suicide awareness into schools". Others describe clear initiatives targeted at particular audiences, including the following:

- **Teachers/school staff:** Awareness/intervention training for teachers and school staff appears frequently. Many LA plans mention provision of ASIST, SafeTALK or MHFA training, or e-learning resources.
- **Parents:** There is relatively little mention of parents, but some LAs have circulated resources on mental health, suicide and self-harm awareness to parents. One reports: "500 parents trained in improving MH and resilience". Other LA plans mention support for families of children with emotional/behavioural problems, or provision of parenting groups.
- **Children/students:** This includes programmes to increase emotional literacy, build resilience in children and young people, and challenge stigma surrounding mental health issues. A small number of plans feature similar actions specifically for children and young people who are not in education, employment or training (NEET) and for university students. Some LAs are rolling out named programmes, such as Youth Aware of Mental Health (YAM), Living Life to the Full or Mindfulness; others do not specify what is being delivered. Delivery is by PSHE teachers or by third-sector organisations (e.g. MIND, PAPYRUS) working in schools. Others mention development/provision of online self-help resources for children and young people.

- **Involving children and young people as resource developers and peer educators:** Linked to the above, some LAs have initiatives to involve young people in the development and delivery of educational resources and campaigns. One mentions the Youth Health Champions programme.
- **Bullying prevention, cyberbullying and online safety:** Many LA plans include measures to prevent bullying, including cyberbullying and homophobic language/behaviour. One LA has a training scheme for school staff to improve their ability to resolve bullying issues. Others mention provision of information to parents on online safety.
- **School/college-wide models:** Some LAs have adopted named whole-school or whole-setting approaches, including: "suicide-safer schools"; "Wheel of Wellbeing approach"; "attachment-aware schools model", and "asset-based approach."
- **Universities**: Relatively few local plans mention universities or university-specific initiatives. They include generating a university mental health strategy and developing proactive mental health support for students bereaved by the death of another student.
- **Developments in clinical services:** Actions include commissioning of new services, such as children's counselling services, particularly for children and young people who do not meet the CAMHS threshold; reviewing of IAPT provision and stepped care for children; and improving pathways from CAMHS to adult services. Several LAs describe plans to improve assessment/early detection processes and crisis care planning, including involving children and young people more closely in crisis plans. One mentions the need for routine mental health assessments for looked-after children; some mention monitoring of children of parents with a mental health condition.
- **Bereavement support for children and young people (see chapter 10):** A small number of plans mention provision of bereavement support for children and young people affected by suicide, be it of a family member or peer.

Recommendations

- LAs should consider checking that educational establishments are properly represented on their multi-agency group to understand what actions are being taken in local colleges, universities and community groups to promote good mental health and wellbeing and implement clear suicide prevention and postvention plans.
- LAs should consider actions to ensure the most vulnerable children and young people are being reached through their plans, particularly those with highly complex needs.

- Educational establishments should consider which local partners they could engage with and what actions they can take to prepare and support young people as they transition from school into further/higher education, employment or unemployment.
- PHE should be working with the Department for Education to ensure that multi-agency groups are aware of and taking into account the national changes designed to improve young people's mental health.

8.2   Other specific population groups

National picture

After children and young people, the national strategy includes seven other specific groups that may have higher rates of mental health problems (including self-harm) or be vulnerable to suicide, namely:

- survivors of abuse/violence
- people with long-term physical conditions
- people with untreated depression
- people vulnerable due to social and economic circumstances
- people who misuse drugs and alcohol
- LGBT people
- Black, Asian and minority ethnic groups and asylum seekers

The survey did not ask about each of these groups individually. A single question asked respondents whether their plan covered 'Reducing risk in other high priority populations (e.g. BME, LGBT).'

The majority of survey respondents answered yes to this (89%; 133/150). Just over half of respondents reported that actions were already being delivered (55%; 82/150). Those who answered 'no' (11%; 17/150) explained that no other groups were identified in their local audit, or stated that their plan did not specifically cover any other groups but that their awareness of local risk factors informs their suicide prevention work.

Regional variations

Regions in which the highest proportion of respondents reported delivering actions for other groups were in the South East (74%; 14/19) and East Midlands (67%; 6/9). This was slightly lower in London (36-49%; 12-16/33) and the West Midlands (43-50%; 6-7/14) where less than half reported delivering actions for other high-priority groups.

Types of action included in plans

Qualitative analysis of local plans revealed that LAs are addressing the needs of a range of 'other' specific population groups, including those that are highlighted in the national strategy and others that have been identified locally. There is wide variation between plans with respect to how many and which groups they include. Compared to more generic at-risk groups (such as men), there are relatively few actions included which are designed for specific groups.

The following is a list of the groups that are mentioned in local plans and a brief outline of the types of activity taking place in relation to each.

8.2.1   Survivors of violence and abuse

A small number of plans include actions for those who have experienced domestic violence or abuse, including sexual abuse, not necessarily limited to women. Actions focus on:

- **Awareness-raising and training:** Training for GPs, healthcare staff and those working in specialist agencies (including third-sector organisations) to equip them to have conversations about mental health and suicide with vulnerable individuals and make timely referrals to mental health services.

8.2.2   People with long-term physical conditions

A small number of plans include specific actions for people with long term physical health conditions, with a wide range of actions including:

- **Routine screening for depression and suicide risk assessment** in both primary care and acute settings.
- **Safe prescribing** of painkillers and anti-depressants.
- **Provision of IAPT services and other psychological interventions** for people with long-term conditions and chronic pain. Several LAs are reviewing or expanding IAPT provision or other forms of psychological support for this group. One plan includes a psycho-educational intervention, as well as therapeutic singing groups for specific conditions.
- **Improving discharge processes** to ensure adequate support for people when leaving hospital.
- **Improving self-management/self-care skills**: Several plans mention promoting positive self-care skills and efforts to ensure patients become more confident in managing their own condition. These range from linking with a local library to promote self-help booklets and online resources, to developing a local expert patient group.
- **Improving mobility and access to transport**: One plan includes reviewing the provision of the Disabled Person's Freedom Pass, which provides free or discounted travel on a range of services across London for people living in London with certain disabilities.

8.2.3   People with untreated depression

Survey respondents were asked if their plan includes treatment of depression in primary care, which features in PHE's list of short-term priority actions, 62 respondents answered yes (41%; 62/150). Around a quarter reported that actions were in the plan but not yet being delivered (25%; 37/150) and 51 said it was not in their plan (34%; 51/150).

Actions in this area include:

- **GP training** to improve recognition and treatment of depression, including safe prescribing.
- **Early identification and treatment** through routine assessment of high-risk groups such as those with long-term physical conditions.
- **Promoting NICE Guidance** (CG90, Depression in Adults) and monitoring compliance, particularly regarding use of appropriate drug treatments.

8.2.4 *People who are vulnerable due to social or economic circumstances*

Under half of plans include actions for this group. They include:

- **Awareness-raising and training for frontline staff in relevant agencies:** Several LAs are promoting knowledge about mental health and suicide among staff in JobCentre Plus, Citizens Advice bureaux, foodbanks and hostels, as well as local authority housing and welfare advisers, and actively seeking to involve them in local suicide prevention activity. Some are providing training, such as SafeTALK or presentations by Samaritans. One LA has developed an alert system to flag up vulnerable clients to JobCentre Plus staff.
- **Provision of information and signposting for vulnerable individuals:** This includes making information on mental health and sources of support available to distressed or vulnerable individuals in settings such as those mentioned above.
- **Targeted support and advice for those experiencing poverty or financial difficulty:** One LA has developed and is rolling out a targeted service designed to address acute distress created by debt, unemployment, financial difficulties and welfare difficulties. Some include specific initiatives for people affected by recent welfare reforms, including those moving onto Universal Credit or Personal Independence Payments, or affected by benefit sanctions. No detail is provided about these services. One LA has an ongoing project specifically addressing poverty in old age, offering advice on benefits, how to get the best utility deals and how to manage debt.
- **Money management skills and debt prevention:** A few plans include more upstream prevention activity focused on promoting money management skills in vulnerable young people, helping to prevent risky borrowing habits and ensuring that they know where to seek help if they get into financial trouble.

8.2.5 *People who misuse drugs and alcohol*

Local actions for people who misuse drugs and alcohol focus heavily on the provision of high-quality statutory services with robust suicide prevention protocols and risk assessment arrangements. Several plans reference their local substance misuse strategy.

Specific local activities being undertaken include the following:

- **Suicide prevention training:** Many plans include mandatory training, including ASIST, SafeTALK and MHFA, for staff working in substance misuse services, to improve understanding and identification of those at risk of suicide.
- **Reviewing care pathways and developing services for those with dual diagnosis**. A number of plans highlight the fact that the co-existence of drug or alcohol misuse and a mental health diagnosis (dual diagnosis) is known to increase risk of suicide, and include review of service provision and care pathways for this specific group. One plan references PHE guidance *Co-existing alcohol and drug misuse with mental health issues: guidance to support local commissioning and delivery of care*.
- **Working with partners in non-clinical settings:** One plan includes working with BTP to direct people involved in drug or alcohol-related incidents on the railways into services.
- **Involvement of family members and friends:** One plan includes a project to train drug users and their friends and family to administer appropriate medication in the event of an overdose to reverse the effects of the overdose until paramedics arrive.

- **Making links and sharing learning:** A number of actions consist of building stronger links between drug and alcohol services and other parts of the system, including maternity services and prison. They also include sharing learning with groups responsible for investigating and preventing drug-related deaths.

8.2.6   Lesbian, gay, bisexual, transgender and queer people (LGBTQ)

Despite the fact that it is highlighted in the national strategy, relatively few plans include specific actions for this group. Specific actions listed within plans under this area include:

- **Awareness-raising and training:** Running groups for LGBTQ young people and their parents; social marketing campaigns to encourage help-seeking; and provision of awareness and intervention skills training for schools and organisations working with LGBT people.
- **Promoting wellbeing and positive messages:** Supporting Stonewall and PRIDE initiatives.
- **Equality and diversity in services:** For example, ensuring that all commissioned services consider the needs of LGBTQ people.

8.2.7   Black, Asian and minority ethnic groups and asylum seekers

Plans include very little specific action under this area. This may reflect local demographics; for example, one plan states that 100% of people who took their own lives in the local area were White British. Activity includes:

- **Awareness-raising:** Raising awareness about the high prevalence of mental health conditions, self-harm and suicide in these groups among a range of audiences, including health care, social services and other frontline workers; schools; voluntary sector organisations; community and faith leaders.
- **Promoting help-seeking:** Includes translation of existing leaflets or development and dissemination of culturally-specific resources, and use of radio/tv and social media channels to promote local services. Recruiting ambassadors to do the same among those who have little spoken English.
- **Identifying gaps in service provision/access:** For example, consulting young people from Black, Asian and minority ethnic groups about possible barriers to accessing CAMHS.

In addition, a few plans include activities aimed at migrants and undocumented citizens, or Gypsy, Roma and Traveller populations. These include needs assessment activity, linking up with relevant organisations and developing multi-lingual service information, with service promotion.

See case study 4.2 for insights on ethnicity and local audit data which highlights challenges experienced by a suicide prevention lead in this area.

8.2.8   Women

Although not included in the national strategy, a small number of plans include specific actions to reduce risk of suicide in women. These largely mirror the strategies that are being used for men, including:

- **Developing peer support groups for women:** These are the equivalent of Men's Sheds and other initiatives that create opportunities and safe spaces for women to talk and provide support to one another, as well as promoting social connectedness.

- **Awareness-raising and mental health promotion through female settings:** Again, mirroring the use of specific settings to disseminate information and resources on mental health and suicide to men, women are being targeted and engaged through hairdressers and female-dominated workplaces, such as nurseries and primary schools.
- **Research and interrogation of local data:** A few plans, including one for a LA which has an unusually high incidence of female suicides, include interrogating their local audit data to identify risk factors and understand female suicides. Another plan includes research into suicide among female prisoners.

8.2.9   New and expectant mothers

A few local plans include actions for new and expectant mothers designed to prevent problems with mental health before they emerge in mother and baby, and to identify and respond effectively to existing mental health problems in new and expectant mothers.

- **Mental health screening:** Ensuring women are screened for depression and anxiety at their first appointment with a midwife and that appropriate follow-up services are in place where needed.
- **Specialist midwife support:** Pairing expectant mothers with midwives with specialist skills in mental health support and substance misuse, especially for new and expectant mothers with a history of mental health problems and/or substance misuse.
- **Parenting classes:** Ensuring mental health features in all antenatal and postnatal parenting classes.

Recommendations

- Every agency working to prevent suicide should:
  - o consider carefully how their work to promote resilience and mental health (e.g. anti-bullying plans) and suicide prevention reflects the needs of the diverse populations which they serve.
  - o use Equality Profiles for their areas and services to identify key populations to reach.

- LAs should undertake an Equality Impact Assessment (EqIA) of their local suicide prevention plan and audit data to identify any disadvantaged or vulnerable people that their plan does not currently cover.
- Senior leaders in local authorities and on multi-agency groups should ensure they are providing leadership on diversity issues and supporting colleagues to ensure that all voices are heard.
- PHE should work with the Chief Coroner and ONS to extend the data recorded and available on suicide deaths to improve knowledge of suicide in minority groups.
- NHS England should continue to provide targeted investment to local authorities for suicide prevention.

This plan shows the commitment to actions to reach specific vulnerable groups (Barnsley).

Intervention	Description	Lead	Progress update	RAG
2.3 Survivors of abuse or violence, including sexual abuse:				
Ensure the timely and effective assessment of all vulnerable children	Ensure early identification and referral to appropriate support services. Promote the use of screening tools such as the Strengths and Difficulties questionnaire (SDQ)	PH People, SYP	Update	
Domestic violence training	Training and support to be provided for primary care and other frontline professional staff to improve identification and appropriate referral to support services of those experiencing domestic violence	PH Communities	Update	
2.6 People who are especially vulnerable due to social and economic circumstances				
Join up support services	Ensure front-line agencies (primary and secondary health and social services, local authorities, the police, job centre plus) join up to maximise the effectiveness of services and support	PH/ Police		
Support financial capability	Commission interventions that improve financial capability e.g. Citizens advice	PH	BPOS Bid Submitted – Successful Suicide ICS bid submitted – Successful across SY&B	
2.7. People who misuse drugs and alcohol				
Recovery based services	Outcome based interventions to tackle substance misuse and integrate assessment, care and support for people with co-morbid substance misuse and mental health problems	PH communities.	Pregnant women are managed under the 'vulnerability team' which includes substance misuse midwife and mental health midwife Plan for 2018 Suicide awareness to be included in mandatory training for all Midwives and support staff in the maternity unit.	

Chapter 9. Area 3: Reducing access to the means of suicide

Area 3 of the national strategy deals with reducing access to means of suicide. This includes: 1) preventing suicides in public places (e.g. bridges, railways, car parks), and 2) limiting availability of other means, such as medication and firearms.

9.1   High-frequency locations

National picture

PHE's *Local Suicide Prevention Planning* guidance (Public Health England 2016) prioritises tackling high-frequency locations, and in the survey respondents were asked if this was included in their plan. Over three quarters of survey respondents (78%; 117/150) answered 'yes' to this, and 64% (97/150) reported that these actions were already being delivered. Respondents who said this was not covered in their local plan (22%; 33/150) explained that they were not aware of any such locations at present and/or that they were monitoring local data with a view to identifying high-risk places and would develop actions accordingly.

Regional variations

Regions in which three-quarters or more of LAs reported already delivering action included the South East (90%; 17/19), North East (75%; 9/12) and North West (74-78%; 17-18/23).

Conversely, in the West Midlands, where 86% (12-13/14) of local areas include high-frequency locations in their plan, a lower proportion were already implementing these actions (50-57%; 7-8/14).

Types of action included in plans

Analysis of local plans suggested that, generally, there is a good level of familiarity with the PHE guidance, *Preventing Suicides in Public Places* (Public Health England 2015b). Many LAs have clearly used it to inform their plans. Some are using the framework provided in the guidance to draw up site-specific action plans and ensure they have considered the full range of interventions to reduce risk at a particular location. Some mention having a site-specific working group to plan and oversee activity in relation to a frequently-used location.

One or two plans (which may need updating) still refer to the older 2006 NIMHE guidance, *Action to be Taken at Suicide Hotspots* (NIMHE 2006)*. Many are still using the word 'hotspot', despite its inclusion in Samaritans' media guidelines (Samaritans 2013) as a term to be avoided.

The actions included in local plans fall into the following categories:

- **Analysis and sharing of data:** There is a lot of activity going on in relation to analysis of data and intelligence from a range of sources with a view to identifying and mapping high-frequency or potentially problematic locations. This includes sharing of data by agencies such as BTP, Highways England and others, suggesting that productive partnerships are developing. Some LAs with known problem locations are conducting site-specific audits to monitor deaths and suicide attempts.

Several mention the role of real-time surveillance in relation to this area of the strategy (see chapter 12).

- **Physical barriers and restricting site-access:** Relatively few plans report installation of barriers, gates and other physical obstacles to impede access by vulnerable individuals to high-risk sites, or specific areas within them. However, some LAs are working with Highways England, car park owners and other stakeholders to improve safety at high-risk sites.
- **Signs and resources to encourage help-seeking:** By contrast, installing (or updating) signs providing helpline numbers and encouraging those in distress to seek help appears in lots of plans. Some also include distributing posters, leaflets and messages on the back of tickets at high-risk places such as stations, car parks, bridges and waterfront locations. In many plans, this is the only type of action being taken.
- **Increasing capacity for human intervention:** Training and/or awareness-raising for non-health staff and members of the public are mentioned regularly. There is evidence that the Samaritans programme of training for railway staff is being rolled out widely across the country. Some LAs are making efforts to increase awareness and intervention skills among other transport providers, such as taxi and bus drivers, car park and bridge staff. This is sometimes combined with installation of CCTV for easier surveillance of sites and additional staff to monitor them. Provision of street pastors to identify and support vulnerable individuals in city streets at night is included in one plan. Some LAs mention awareness-raising campaigns for commuters and members of the public to increase vigilance and confidence to intervene. One LA has installed signage to guide members of the public who may be concerned about someone, namely: *"Put RNLI signs on embankments to contain the message, 'Dial 999 and ask for the Coastguard.'"* One LA includes provision of training for Housing Department staff who have contact with vulnerable people living in high-rise residential blocks.
- **Trauma management for affected staff and members of the public (postvention):** Some LAs have considered provision of trauma care for those who witness or are involved in suicide incidents.
- **Limiting media reporting (see chapter 11):** Only a few plans mention the role of media in connection with high-risk locations within this section, and actions are usually monitoring press coverage and promoting the Samaritans media guidelines when necessary.
- **Designing safer buildings/structures:** Many LAs are involving their planning departments, developers and the construction industry in suicide prevention. Actions include encouraging these partners to consider suicide risk when reviewing planning applications, carrying out health and safety assessments and upgrading social housing stock.

Recommendations

- Multi-agency groups should work with partners to draw up a site-specific plan for high-frequency locations, incorporating a broad range of actions in accordance with PHE guidance. Where signage is considered, this should be used with other interventions and avoid advertising a location as a potential means of suicide.
- All local organisations should avoid using the term 'hotspot' and use 'high-frequency location' in its place.
- LAs and partner agencies should consider how they can work with local media to enhance the public image of a high-frequency location and try to dispel any reputation it may have as an effective means of suicide.

- Multi-agency groups should seek to engage with local representatives from the rail industry and Highways England, as well as their local road safety departments and health and safety teams. They should have a strong system for monitoring and recording locations, interventions and incidents to help improve the evidence on what works at high-frequency locations and to inform future local action
- In areas where high-frequency locations have not been identified, multi-agency groups should consider working with the local authority planning departments and other relevant stakeholders to ensure high structures are as restricted as possible as a means of suicide.

9.2 Limiting availability of other means of suicide

Very few plans include actions to limit availability of other means of suicide. They include:

- **Controls on access to medication:** Some LAs are working with GPs, hospitals and pharmacies to promote safer prescribing practices, including limiting access to potentially lethal combinations of prescription drugs, requiring safe return of unused prescription drugs, and promoting safer prescribing for young people and people suffering from depression.
- **Firearm restrictions:** Two plans mention firearms, listing removing firearms and licences from at-risk individuals and asking about firearm ownership during routine risk assessment.
- **Retail controls:** One LA includes encouraging retailers to control the sale of dangerous gasses and liquids, and another highlights the role of suppliers of DIY materials.

Recommendations

- Local multi-agency groups should avoid naming new or emerging methods of suicide, such as specific gases, due to the risk of imitative suicides. Strategy and plan documentation which contain these should be edited before being published.
- Local multi-agency groups should be flagging any new or emerging methods of suicide which are being identified through local monitoring activity to their PHE regional lead or to Samaritans national office to address at a national level.
- ADPH and LGA should ensure that the basics of suicide prevention (e.g. sensitive language use and responsible communication on methods) are included in its sector-led improvement programme, ensuring that LAs are working to ensure all agencies are aware of the importance of these issues.
- CCGs should work to ensure safer prescribing is in place and being adhered to in their local area, in order to improve and strengthen risk assessment by prescribers for people at risk of suicide and to reduce access to potentially harmful medication.
- NHS England should continue work to improve medicines management.

This plan shows an LA that has clearly identified one high-frequency location and is taking a multi-faceted approach to the issue, recognising the importance of physical intervention, encouraging help-seeking and personal intervention, as well as monitoring activity (Bristol). Details of the specific location have been removed.

Priority area	Action	Lead partners	Timescale	KPI /outcome Progress and date
High suicide areas	[Location] Working Group to report to SPAG on key concerns and actions. This will include progress in developing additional barriers across the [Location] and wider [Location] area.

Provide emergency phone numbers at high-risk locations.

Undertake audits at different suicide locations and report into SPAG annually.

Ensure frontline staff: bridge workers, network rail staff, car park attendants and prison workers are trained on identifying and engaging people who may be considering suicide and that they are supported after traumatic events. | [Location]Working Group

Avon Coroner Audit Group

Living Works/Bristol Samaritans | 3x a year

March 2019

March 2019 | Progress in developing additional barriers across the [Location] and wider [Location] area.

Staff training in place. |

This is a clear plan, showing recognition of the need to work with developers to reduce risk in new construction projects (Staffordshire & Stoke on Trent).

3.2 Reduce the number of suicides at high-risk locations			
Description of intervention	**Timescale**	**Lead**	**Monitoring**
A. Design out suicide risk in all new developments, (esp. high rise e.g. carparks, and bridges) as per PHE and ParkMark guidance and Highways England national approach. Liaise with highways and built county teams within local authority where changes to the existing built environment may be possible to reduce risk	Guidance for development industry in use in SOT by 2019; 2018-2020	Staffordshire Police, Local authority planning departments	Progress reports to Suicide Prevention Partnership
B. Implement PHE guidance for the prevention of suicide in public places when frequently-used locations are identified – this will entail the development and implementation of site-specific action plans by a multi-agency partnership with membership appropriate to the site.	In response to emergence of priority sites	PH Staffs and SOT	Priority site task group meetings; Progress reports to Suicide Prevention Partnership
C. Implement railway specific guidelines for high-risk stations/locations identified on the network. This will entail delivery of a specific action plan for that area in order to create additional safeguards within the station/location and to understand ways in which the community can be better supported.	In response to emergence of priority sites	Network Rail and relevant partners	Network Rail internal systems; Progress reports to Suicide Prevention Partnership

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This plan shows recognition of the importance of addressing the variety of means of suicide, the need for engagement with a range of partners to achieve it, and cross-over with other areas of the strategy (Devon).

Objective	Action	Timescale	Next Steps	Monitoring - outcomes and outputs	Lead
Universal interventions					
Rise in prescribed controlled drug use as a method in suicides following the death or a partner/family member	Review CCG policies for 'Controlled Drugs' Protocols for returning unused drugs and awareness-raising with first responders/palliative care teams. Guidance for friends/family.		Part of bigger campaign encouraging return of unused medication.	Reduction in suicides involving prescribed controlled drugs. Link to Drug Related Deaths data.	Controlled Drugs LIN (CDLIN) NHSE Blue Light DEMHSG
Targeted and vulnerable populations					
Control the dispensing of certain drugs to 'at risk' groups	Consultation with LMC and LPC about safer prescribing of anti-depressants and painkillers.			Quality and Outcomes Framework – GP Practice profiles.	CCG Meds optimisation
People in contact with the Criminal Justice system	Continued 'Safer Cell' development and analysis. Removing the means and opportunity; removal of razors etc.			Safety in custody statistics.	Her Majesty's Prison Service (HMP)/Ministry of Justice (MOJ)

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Chapter 10. Area 4: Provide better information and support to those bereaved or affected by suicide

National picture

The fourth pillar of the national strategy is "Providing better information and support to those bereaved or affected by suicide." Emphasised as a priority in 2016 in PHE's local plans guidance (Public Health England 2016), and included in the recent NICE guidance (NG105; NICE 2018), and the NHS Long Term Plan, it should include:

- rapid intelligence gathering and data used to identify anyone who may be affected by a suspected suicide
- those bereaved or affected offered practical information expressed in a sensitive way
- those bereaved or affected asked if they need more help and if so, offered tailored support

The majority of survey respondents reported that bereavement support was included in their action plans (97%; 146/150). Nearly three-quarters (71%; 106/150) reported that they were already delivering these actions. Those who said that their local plan did not include bereavement support (3%; 4/150) said that they would be including this in future plans.

Regional variations

At least 90% of LAs said they were already delivering bereavement support in the South East (95%; 18/19). North East (92%; 11/12), East (91-100%; 10-11/11).

This was lower in the following regions, where around half of LAs reported delivering the bereavement support actions set out in their plans: Yorkshire & the Humber (47-53%; 7-8/15), West Midlands (43-50%; 6-7/14) and East Midlands (56%; 5/9).

Most survey respondents indicated that people are made aware of the bereavement support services available to them through direct handing out of information by coroners and emergency services (65% 97/150), or by placing publicity materials in relevant locations such as GP surgeries (63%; 94/150). The survey also asked respondents to provide details of (a) the *suicide-specific* bereavement support services they offered, and (b) the *proactive* suicide specific support services they offered. However, the survey question did not provide definitions of either suicide specific or proactive. Whilst many respondents said that they were delivering suicide specific and/or proactive bereavement support, many of the examples they provided were not considered suicide-specific or proactive according to these working definitions:

Suicide-specific: Bereavement support designed specifically for people who have been bereaved by suicide (e.g. SOBS groups), as opposed to generic bereavement services, such as Cruse.

Proactive: A proactive service is one that initiates contact with the family in the immediate aftermath of a suspected suicide and offers personal one-to-one support during the ensuing hours, days and weeks. A non-proactive service is one to which the newly bereaved may be signposted but which relies on them to make contact in their own time.

Therefore, findings from these questions are not included in the report due to lack of reliable data.

Types of actions included in plans

- **Provision of information and signposting:** The majority of plans include actions to ensure that key professionals involved immediately after a suspected suicide, such as police, ambulance services, coroners and funeral directors, are aware of and distributing information to the bereaved, with many plans mentioning *Help is at Hand* specifically. In addition, there are also more general actions concerned with raising awareness of the support that is available locally. A few local areas mention developing their own leaflets and crisis cards for the bereaved.
- **Provision of bereavement support services:** Many plans include commissioning of suicide bereavement services, promotion of existing services or improving access to them. Where particular services are named, they include SOBS, Cruse Counselling, and Facing the Future.
- **Increasing knowledge among GPs and other professional groups:** Many plans include capacity-building actions, including training, for professionals who may come into contact with those who have been bereaved by suicide. GPs are often a focus for action to improve their understanding of the impact of suicide bereavement and knowledge of support services.

Fewer plans include the following types of actions:

- **Review of service provision and identification of gaps:** A few plans indicate that a review of current provision is being conducted or is planned.
- **Proactive bereavement support:** Relatively few plans mention services that could be described as proactive. Most of these services are provided by voluntary sector organisations, such as IfUCareShare, AMPARO and Pete's Dragons. Some local areas include home visits by a police family liaison officer. A few plans suggest that LAs are exploring ways to ensure rapid response and referral, for example through real-time surveillance (see chapter 12).
- **Employer or workplace-based support:** A few plans recognise the important role that employers can play in supporting staff members who have been bereaved or affected by a suicide, or those whose work may involve responding to suicides. In relation to the latter, there are several mentions of Mind's Blue Light programme of support for those working in the emergency services.
- **School-based support:** A small number of plans include action to ensure that schools are supported in the aftermath of a suicide. The main service mentioned is *Step by Step* by Samaritans which offers advice and practical support to schools.
- **Managing clusters and contagion:** Very few plans include developing systems or protocols for identifying and responding to a cluster or minimising risk of contagion. In those that do, these actions appear to be in an early stage of development.
- **Memorial service:** One LA is planning to organise an annual memorial service for those affected by suicide, ensuring that support services are on hand at the event.

Case study 10.1: Proactive bereavement support

Interview participants reported that delivering proactive support posed some challenges. Some expressed concerns that people who are very recently bereaved are not always ready to take up immediate offers of support and may benefit more from support at a later date. It was also noted that if the offer of support is not taken up immediately, it may be difficult to repeat the offer at a later date because data protection regulations dictate that local services cannot continue to hold individuals' personal data or contact them again if they have previously refused an offer of support. For some, this highlighted the importance of ensuring that bereavement support services are highly visible, inclusive and approachable, so that bereaved people can access them easily when they are ready.

Recommendations

- All multi-agency group members should be promoting the *Help is at Hand* (Public Health England 2015a) ensuring the z-cards (a credit card sized fold-out leaflet that provides advice on caring for yourself and others) and, if possible, the full resource are given out by first responders, coroners and funeral directors.
- Local multi-agency groups should consider reviewing how they are ensuring that those bereaved are receiving appropriate support in the initial weeks after a suicide, as well as ensuring they are aware of what support is available longer term.
- Schools and higher education institutions should work with local authorities and multi-agency groups to ensure they know how to respond effectively in the event of a suicide to reduce the risk of further suicides within that community.
- All local areas should review and develop their suicide bereavement support services against the PHE good practice guidance (Public Health England 2016) .
- All employers should put a suicide prevention and postvention plan in place, using the BiTC/PHE toolkits (BiTC 2017).
- NHS England should ensure adequate funding and support is available to deliver its commitment in the Long Term Plan to put in place suicide bereavement support in every area of the country.

This plan provides a detailed set of actions, seeking to ensure a high level of support to those bereaved as well as recognising the importance of timely intelligence sharing (Leeds).

Priority	Action / Intervention	Lead Organisation	Progress (Outcomes / Milestones)	Timeline
5. Provide better information and support to those bereaved or affected by suicide	Effective provision of support to those bereaved and / or affected by suicide though Leeds Suicide Bereavement Service.			
	• To prioritise funding for postvention services by commissioning a peer led suicide bereavement service for the people of Leeds.	LCC PH	Recurrent funding confirmed and contract awarded (June 2018) and effective mobilisation / contract management in place.	Ongoing
	• To provide effective postvention service for the people of Leeds.	LCC PH Leeds Mind LSBS Touchstone WY Police	Ensure efficient contract monitoring and quarterly reporting has been met.	Quarterly
	• Contribute towards the national evidence-base and identify opportunities to promote Leeds postvention activity on a regional and national level.		Evidence of delivering workshops / speaking at national events or work citied in national guidance on postvention.	Annual
	• Ensure citywide partners are aware of the risk factors associated with suicide bereavement and advocate for early postvention interventions.	LCC PH Leeds Mind LSLCS Police	Increased referrals made by a wide range of services including the Coroner's office, primary care, police and the third sector.	Annual
	• Support the identification of potential contagion and suicide clusters within the Leeds population and act accordingly	LSBS Touchstone BTP Network Rail Forward Leeds	New clients referred into service and receiving targeted support earlier.	Annual
			Use and distribution of local and national resources e.g. "Help is at Hand" / Crisis Cards sourced from the PHRC.	Annual
	• Work closely with partners (e.g. BTP, Network Rail, Forward Leeds and LYPFT) regarding shared intelligence and early information sharing of potential deaths by suicide.	BTP Network Rail Forward Leeds	Intelligence from LSBS / police and all partners to be shared in a timely manner, ensuring local communities are supported accordingly e.g. Community Action Plan (CAP) developed at a community level.	Ongoing
			To identify potential clusters of suicide / contagion	Ongoing

Whilst a lot less detailed, this also provides an example of plan that follows good practice with a proactive, one-to-one bereavement support service (Cornwall)

Service/Delivery		High-risk group (bereaved)	Suicide bereavement support services	The Suicide Liaison Service is an adult service offering face-to-face support delivered by experienced mental health professionals following a suicide, which includes liaison with statutory and voluntary services (e.g. Cruse Bereavement Care and Penhaligon's Friends, the children's bereavement service in Cornwall), the Police and the Coroner, and assistance with the Inquest process. The service also delivers an 8-week evidence-based psychoeducation course for people who are at least 6 months post-bereavement and preferably post-inquest.

Chapter 11. Area 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour

National picture

The fifth pillar of the national strategy is supporting the media in delivering sensitive approaches to suicide and suicidal behaviour. Although there is voluntary regulation in this area, provided by IPSO's Editor's Code, the government's fourth annual progress report cites Samaritans' media guidelines (Samaritans 2013) which provide a higher set of standards. The research evidence shows strong links between irresponsible media reporting and imitative suicidal behaviour, as well as the positive impact of stories of recovery.

The self-assessment survey did not ask about this area of the strategy.

Types of action included in plans

- **Dissemination and monitoring of national reporting guidelines:** Many plans include dissemination of Samaritans media guidelines to local media outlets. There is also a lot of monitoring of local media coverage of suicidal behaviour. Not all plans with monitoring activity have clear follow-up actions associated with identifying poor coverage. Where these are included, action is either to take it up directly with local media providers or to report it to Samaritans' Media Adviser to follow up.
- **Training for local journalists:** Some LAs include actions to train local journalists, often being provided by Samaritans. One LA has convened a county-wide 'summit' on journalism and reporting standards. Others have arranged visits to local radio stations or newspaper offices to promote good practice.
- **Agreeing a standard response/local protocol:** A few plans include actions with key stakeholders to ensure a consistent and appropriate response is given in the event of media requests for information following a suicide locally.
- **Promoting positive stories of recovery:** A few plans include actions to put together positive and hopeful news stories, including personal stories of recovery, and providing these to local media outlets.
- **Monitoring social and online media:** A few plans include monitoring social media and online news content, although it was less clear where concerns would be raised or how they could be addressed. In response to the Netflix series '13 Reasons Why', one LA reports having developed a factsheet and disseminating it to parents and school staff.

Recommendations

- ADPH and the LGA should work with Samaritans' national media advisory service to clarify the support Samaritans can provide local authorities on working with the local media.
- ADPH and LGA should ask Samaritans to review its national monitoring data to identify any key geographical areas where reporting is particularly problematic and these should be reviewed against local plans.
- Local authorities should consider the purpose of monitoring local media, especially if they lack the resource to act on any concerning content or if they are not using the data to measure progress.

- PHE and NSPA should update its local planning guidance (Public Health England 2016) to include more information on the importance of providing media with positive content around suicide and suicidal behaviour (i.e. stories of successful recovery).
- Multi-agency groups should consider the role of local communications professionals in ensuring that messages provided to local media around suicide and suicidal behaviour are responsible.
- Multi-agency groups should encourage local stakeholders to provide positive stories about hope and recovery to local media.
- PHE should provide guidance to local authorities on actions that can be taken around social media and online content, working closely with DCMS to ensure this is integrated with national developments.

This plan takes a more comprehensive approach than many to working with local media, with some interesting outputs (Warwickshire), although care should be taken not to duplicate national action.

PRIORITY 5 Supporting the media in delivering sensitive reporting around suicide.				
Priority	Summary Action	Action Owner	Status	Outputs/Deliverables
	To disseminate and promote the Samaritans media guidelines to local media, and to local corporate Comms leads within public sector organisations. http://www.samaritans.org/media-centre/media-guidelines-reporting-suicide To develop a deliver a briefing workshop for senior editors within local media. To ensure agreed statement within all relevant press releases regarding Media Guidelines and signposting information. To challenge poor media practice locally and nationally. To share alerts regarding media programmes and portrayals which contain information or portrayals of suicide.			Workshop in planning stages for delivery 1 Sept. NSPA and Connecting with People response to Netflix shared. Information on social media self-harm "game" distributed to key contacts.

Chapter 12. Area 6: Support research, data collection and monitoring

National picture

Area 6 of the national strategy recognises the importance of building on the existing research evidence, improving the systematic collection of data and access to and monitoring progress.

Whilst the survey asked about data sharing agreements and monitoring/evaluation activities as part of a set of questions about the status of local plans (see Chapter x), it did not ask whether actions were being taken to address Area 6 of the national strategy.

Types of action included in plans

Research, data collection and monitoring actions feature prominently throughout action plans and across the many priority areas. Plans contain a range of actions related to research, data collection and monitoring:

- **Reviewing, monitoring data and 'gap mapping':** Many plans include actions designed to review current service provision for a group or priority area, in order to improve provision or identify gaps to be filled in future. This includes very specific actions, such as reviewing access to support for homeless/rough sleepers, or broader actions such as identifying whether veterans of the armed forces are an at-risk group. The monitoring of data also varies, ranging from the establishing of self-harm registers to monitoring local redundancies or the roll-out of universal credit. There is also some ambition within a few plans to improve data on specific groups, for example to use and review a GP audit tool, to explore the possibility of collecting data on suicide within migrant populations, or recording the incidence of self-harm in schools.
- **Data sharing:** Many plans include actions designed to implement or improve data-sharing arrangements between multi-agency group members. These are sometimes generic, for example to develop information-sharing agreement, or are being developed for a specific purpose, for example around a frequently-used location. Local plans include very little detail on how these sorts of action would be achieved. Survey and interview data suggest that this may be because local areas feel they need more support on how to develop and implement data sharing processes that are secure and compliant with data protection legislation.
- **Real-time surveillance:** Around half of local plans indicate that local multi-agency groups are exploring, developing or improving real-time surveillance systems, usually in order to ensure rapid support for the bereaved and/or to facilitate identification of emerging trends, especially with regard to particular communities or methods. Police and coroners are recognised as key to the development of these early-alert systems.
- **Sharing of evidence and learning:** Some plans include the sharing of recent published research, statistics and national guidance with members of the local multi-agency group, as well as sharing of lessons learned through practice and research undertaken by local organisations.
- **Evaluation:** Most plans include some evaluation actions. These vary from actions to put in place evaluation frameworks for the whole plan to specific actions to evaluate part of the plan, such as an awareness-raising campaign or training. There is some recognition in at least one

of plans of the need to try and ensure a consistent approach to evaluation across commissioned/funded services being provided by the voluntary sector.

Case study 12.1:   Real-time surveillance

Setting up real-time surveillance systems was identified as a major challenge by many survey and interview respondents. Of those who did have real-time surveillance in place, some reported that it had taken over two years to establish. However, once established, they found it to be highly valuable.

"Somehow the real time [data], I can't really explain it, I've just found it really, really useful. […] We haven't had to act on it but somehow, getting that, when it comes in, it's just a tiny reminder of how tough it is out there for people."

Those who had not yet been able to set up real-time surveillance systems identified a number of barriers, including unresponsive coroners, data protection regulations, organisational re-structuring, and a lack of senior leadership support. In May 2019 PHE will be publishing guidance on real-time surveillance and will make this available to all local authorities and multi-agency groups.

Recommendations

- PHE should share findings from its pilots of real-time surveillance (Public Health England (forthcoming in Autumn 2019) with all LAs and multi-agency groups.
- The College of Policing and Coroner's Officers and Staff Association should review current data-sharing protocols between police and coroners to ensure that they are able to provide timely data on suspected suicides.
- The Chief Coroner should issue guidance to local coroners outlining their crucial role in suicide prevention, to help facilitate the establishment of real-time surveillance.
- A review should be undertaken by PHE of what data are being collected through real-time surveillance, in order to establish some consistency across the country. This could enable data to be collated at regional and/or national levels to provide early indication of emerging trends.
- The ONS should brief LGA and ADPH to ensure local authorities and partners are aware of the work it is doing to explore how to improve suicide data.
- If sufficient local data are being collected on specific actions, such as training, bereavement support or high-risk locations, PHE should work with ADPH and LGA to explore the value of bringing these together at a national level to add to the evidence on what works to prevent suicide.

This plan provides a set of simple actions to ensure updated data (Durham).

6. Support research, data collection and monitoring					
Action	Outcome	Measure	Lead	Timescale	RAG rating and update
6a. Provide updates from PHE fingertips data on suicide rates and disseminate to the SPA	To provide the SPA with annual performance data	Reduction of suicides highlighted	[Name]	April 2019 & ongoing	On going
6b. Conduct a suicide audit of 3-years data (2016, 2017 & 2018)		Audit completed and findings disseminated	[Name]	April 2019.	

Chapter 13. Area 7: Reducing rates of self-harm as a key indicator for suicide risk

The 2012 national suicide prevention strategy identified people with a history of self-harm as a high-risk group for suicide, included in Area 1. The PHE local plans guidance (Public Health England 2016) included preventing and responding to self-harm in its list of short-term priorities. Subsequently, in the third annual progress report published in 2017, reducing rates of self-harm was added to the existing six areas of the national strategy, to form Area 7.

NICE guidelines (CG16 (NICE 2004)) and CG 133 (NICE 2012) provide clear standards and pathways for managing those who present to NHS services with self-harm.

National picture
Respondents were asked whether their plan included preventing and responding to self-harm. Nearly all survey respondents answered yes to this (92%; 138/150), and 55% of respondents (83/150) reported that actions were already being delivered. Those who reported that this area was not covered in their local plan (8%; 12/150) explained either that it was covered in a separate local plan (e.g. Children and Young People's plan), that self-harm was not identified as a priority in their audit data, or that actions would be included in a future plan.

Regional variation

Three-quarters or more of respondents reported already delivering actions to reduce rates of self-harm in the South East (79%; 15/19) and East Midlands (78%; 7/9).

Less than half of respondents were delivering actions around self-harm in the East of England (18-27%; 2-3/11), West Midlands (36-43%; 5-6/14), North East (42%; 5/12), and Yorkshire & the Humber (40-47%; 6-7/15).

Types of action included in plans

Many LAs note the cross-over between this and other areas of their plan, notably children and young people, and actions being taken by other groupings, such as Safeguarding Children Boards.

Actions that appear in local suicide prevention plans focus on both healthcare and community settings. They include:
- **Awareness-raising, education and training:** As in other areas of the strategy, many of the actions are concerned with raising awareness, developing and disseminating educational resources, and provision of training. These activities are targeted at particular audiences or settings:
    - **Healthcare settings:** Several LAs indicate that they are developing educational resources or delivering specific training modules designed to improve understanding of self-harm, risk assessment and management skills, and knowledge of appropriate referral pathways among healthcare staff, including in A&E departments, ambulance services and primary care.
    - **School and community settings:** Much activity is also focussed on schools, colleges, universities and workplaces. Some LAs are making efforts to reduce stigma and negative attitudes towards self-harm within the community and raise awareness of the risk of suicide

among people who self-harm. For example, one seeks to "develop a culture where self-harm is more openly discussed in non-judgemental, helpful ways to encourage help-seeking and reduce stigma", although there is no detail about how this will be achieved. Another describes an ambition to "counteract dangerous representations and myths about self-harm on social media and in young people's settings through positive messages promoting awareness, understanding and access to support", noting that this may be achievable through peer-delivered education in schools. Several plans include provision of ASIST, SafeTALK or MHFA training for staff working in schools, colleges, and universities. Some LAs are developing their own campaign materials and resources; one mentions involving people who self-harm and their families in the co-design of information, including an online resource.

- **Implementation of NICE guidelines:** Several plans mention that service audits or reviews of current clinical practice are being undertaken to assess compliance with NICE standards. One notes: "Psychosocial assessments for people who have presented at A&E for self-harm is 100%". Others are not specific, indicating only that they are making efforts to ensure high-quality, evidence-based care for people who self-harm, in accordance with guidelines.
- **Self-harm registers, surveillance and data sharing:** Several plans include designing and implementing self-harm registers or other methods of capturing data in order to monitor trends and identify risk factors for repeat episodes and possible suicide attempts. Some note the need to improve information sharing between A&E departments, mental health services and GP practices in relation to patients who have self-harmed, ensuring that risk of self-harm is clearly flagged on all medical records. One LA plan also includes learning from Serious Incident Reviews.
- **Development/delivery of specific interventions for people who self-harm:** There are relatively few of these mentioned and they are not always clearly specified, for example: "Develop tailored interventions that support those who self-harm." Interventions that are specified fall into two categories: clinical and non-clinical.
  - **Clinical interventions:** Several plans note the importance of following up on presentations for self-harm at A&E or in primary care. A few include contact-based interventions, such as sending postcards with supportive messages and signposting information, for which there is some evidence of effectiveness. Others mention provision of counselling or formal therapies, with no further detail.
  - **Non-clinical interventions:** One plan mentions a locally-developed, voluntary sector led self-harm prevention project. Another includes developing a local peer-support group for those who self-harm.

Recommendations
- LAs, CCGs and mental health services should work together to ensure that all people presenting at A&E having self-harmed are treated in accordance with NICE Guidelines (NICE 2012, 2004).
- LAs should ensure they are aware of guidance that exists to improve information sharing between A&E departments, mental health services and GP practices (NHS 2018) .
- PHE should consider working with Health Education England to consider guidance on what good training in self-harm prevention would look like.
- NHS England should work with ambulance services and Health Education England to ensure appropriate mental health and suicide prevention education is included in paramedic and other similar training. CCGs should ensure this training is embedded in their primary care

quality agenda.

- CCGs should ensure training on good self-harm prevention is embedded in their primary care quality agenda.
- NHS England should continue its work to build the mental health competency of ambulance staff to ensure that ambulance staff are trained and equipped to respond effectively to people experiencing a mental health crisis.
- NHS England should continue to prioritise self-harm as an area of focus for its suicide prevention programme and work to improve services for those that self-harm.

This plan shows an understanding of the importance of knowing what's already happening, as well as the importance of evidence and evaluation (Brighton and Hove).

Workstream: Self-harm		
	Action for 2017-18	**Target for 31 March 2018**
3.1	Conduct a Self-harm Needs Assessment and implement its recommendations as relevant.	Needs Assessment published. Action plan for 2018-19 reflects its findings.
3.2	Evaluate innovation fund projects addressing self-harm & feed learning into action plan for 2018-19.	Reports are due on 28 February 2018; findings will be fed into the planning meeting for 2018-19.
3.3	Map coverage and evaluate effectiveness of training provided: • through the Public Health Schools programme • by Grassroots Suicide Prevention – understanding self-injury course • for parents through CCG initiative & innovation fund project	Reports on outcomes to be included in the annual planning meeting for 2018-19.
3.4	A&E departments at the Royal Sussex County Hospital and the Royal Alexandra Children's Hospital: • Monitor continued provision of psychosocial assessments at A&E following self-harm and follow-up for those at risk. • Support (where evaluation shows evidence of effectiveness) the continued provision of PIT clinics at RSCH.	Monitor implementation and evaluation.

This plan shows a good range of actions in this area, with clear objectives (Doncaster).

Area for action: Preventing and responding to self-harm			
Objective	**Action**	**Specific Outcome**	**Lead Responsibility**
Improve data collection on self-harm at A & E	Identification of self-harm at A & E (coding)	Increase awareness of self-harm incidences/prevalence within Doncaster	CCG/DBH
To avoid people in crisis being sent home without follow up from A & E	Develop a formal protocol for referral from A & E into specialist service	Ensure continuity of specialist treatment for people in crisis	CCG/DBH/ SPG/RDASH
Improve skills of education staff who work with young people	To deliver a training package targeting educational staff SafeTALK & ASIST training	Improve signposting into specialist service from educational establishments	Public Health
To provide a resource for YP which addresses self-harm issues	Promote the Respect Yourself website to educational settings	Improve awareness of Respect Yourself website in educational settings	Public Health
Improve skills of all frontline staff who may encounter self-harm	Target frontline staff with SafeTALK training	Improve signposting and response to self-harm	Public Health

Chapter 14: Cross-cutting themes

This chapter looks at the actions that typically occur multiple times within individual plans and across all plans. Given the frequency at which these actions occur across plans, many of them may be suitable candidates for economy of scale savings via joined up working across local areas. These points are reflections on the quality of planning, rather than the quality of the actions or their delivery.

9.3   Making links and building partnerships

It is clear that local plans are developed by a wide range of partners, and that there is a widespread ambition across local authorities to work collaboratively. Local plans include lots of actions framed in language such as "Make links with…", "Explore opportunities to work with…" and "Engage with…", including a wide range of statutory and voluntary agencies and community groups. For plans that are at the earlier stages of development these collaborative actions represent the majority of the plan's content. Other more developed plans are building key relationships, growing their local networks and are expanding the range of suicide prevention activity. This is vitally important, both as preliminary and as ongoing work, and therefore a good sign that local government and other actors are committed to building local suicide prevention systems. However, this needs to be just the start because *in itself* it will not reduce suicides in the local area.

9.4   Aims that may still need translation into action

Many actions reflect current good practice, which indicates that local areas are aware of and using current guidance and evidence bases when developing their plans. These actions are often phrased in language such as "Ensure that…" or "Work towards ensuring…," often with no further detail, for example "Ensure that [MH Trust] patients whose mental state is deteriorating are picked up early and offered objective review and increased support." It was not possible to talk to every local suicide prevention lead and therefore it is not possible to know whether this reflects aspirations, rather than action, whether it is because the actions themselves are the responsibility of individual organisations or bi-lateral partnerships, or whether it is just the way the action has been phrased as a high level objective which then has action flowing from it.

This awareness of guidance and evidence is a positive starting point, however with around half of areas reporting not yet delivering against the actions in their plan, it's clear that there is still the need to move knowledge and ideas to actions.

9.5   Cataloguing of existing activity

Many plans indicate that multi-agency groups are aware of the complex causes of suicide and the range of approaches that are needed to reduce it. Some of these plans appear to function as "catalogues", detailing everything that is happening locally that could be linked to suicide prevention. Actions in these plans are framed in terms of "identifying" and "supporting" initiatives being undertaken by a wide range of partners and stakeholders, rather than planning new actions. Examples include, "Support asset-based approaches to men's health and wellbeing (e.g. Men in Sheds)" and "Support a range of preventative programmes to reduce the impact of the current economic crisis." Such plans are often vague about what the initiative is and how the local multi-agency group is supporting it. This may be indicative of the way the suicide prevention group conceives of its role,

namely as a hub or monitoring centre that can collate and keep track of local activity, rather than being responsible for development and delivery of new actions.

9.6   Review and audits of current activity

Audits and reviews of current activity taking place was mentioned in many plans across several areas of the strategy, often in relation to provision of services. This is a crucially important first step, in order to identify the services currently in place for a particular group and to identify gaps and unmet need. This can then be used as a basis for future action planning. Plans that are largely occupied by such actions may be an indication of relatively 'young' multi-agency groups. It is clear that local areas at this stage of development are taking this preparatory stage seriously in their action plans.

9.7   Language and communication of suicide prevention.

While many plans are using sensitive language around suicide, it is concerning that the term 'commit suicide' still appears in more than one local plan, especially when those plans also include promoting the Samaritans media guidelines, which strongly discourages use of the term. Likewise, several plans still employ the term 'hotspot' in relation to the means of suicide, and there can be a preponderance over detail on method. Language use is important because it is a window into the way people are thinking and perhaps a measure of their level of understanding of the sensitivities involved.

9.8   Activity that cuts across the structure of the national strategy or PHE guidance.

Plans often feature strong community-based activity that does not fit neatly within any single area of the national strategy. Such actions cut across multiple areas of the strategy, for example: the development of non-clinical sanctuaries for people in crisis (who may or may not be in the care of mental health services or fit into another high-risk group); initiatives to promote public involvement in suicide prevention, and recognition of the key role played by emergency services, who encounter vulnerable people at all stages of the lifespan and in all economic circumstances in their own homes. This may suggest that, as well as continuing to focus on groups of at-risk individuals, it may also be useful to start thinking in terms of groups of potential interveners and potential intervention settings. This may have the advantage of reaching a wider swathe of the at-risk population, meeting several areas of the national strategy through one activity.

9.9   Effectiveness and quality of local plans

This analysis of local plans has looked only at what is recorded in the plans themselves. The level of detail in plans varies, and may reflect that for some areas, it is simply a brief record of what is happening. Where different actors are delivering against different activities, there may be multiple other documents which contain detailed information on the aims and objectives of an activity. Some plans include links to these other documents and the existence of these documents may explain why some suicide prevention plans do not include this detail. Also, many of the plans reviewed had actions dated 2018 or before, reflecting the time when the plan was written. The length of time that some plans have been in place means there could be several years' worth of monitoring and evaluation data across the country.

9.10   Use of local audits

Local audit data are featured in the strategy section of many local plans, and in some cases these data are being used to identify local at-risk groups and other local priorities. This is further indication of local commitment to implement bespoke local suicide prevention that is responsive to the needs of

their populations. For many plans however, it is not clear how local audits have informed local actions, as many plans continue to reflect the nationally recognised high-risk groups only. It may be that local audits are most useful to achieve local ownership and partnership engagement (see Case study 4.1 for examples), but that with the increasing use of real time data, audits may not add significant information around local needs.

9.11 Recommendations

- LAs and multi-agency groups should review their suicide prevention activities and ensure they are not 'reinventing the wheel' by spending resource on actions that are either already being delivered at the national level or where other local authorities have already worked out the best way to deliver the action.
- LAs and multi-agency groups at the earlier stages of their response may benefit from working through existing partnerships to embed and improve the quality of activity already taking place rather than implementing multiple new activities.
- LAs should consider developing regional priorities through the SLI framework.
- LAs should ensure they are following up any partnership activity to ascertain that these partnerships have generated deliverable actions that are being implemented effectively.
- LGA and ADPH should encourage local authorities to consider working with other local authorities to move past the preparatory stage of building partnerships and planning actions, and into delivery of actions themselves.
- LGA and ADPH should consider how the SLI work could support local authorities to focus their activity.
- ADPH and LGA should consider including in its SLI work:
  - o identifying general conditions that may facilitate the translation of ambition into action.
  - o identifying those areas with a dedicated suicide prevention lead in place to compare the difference this may make in relation to the ownership and driver of actions included in local plans.
  - o undertaking a series of stakeholder interviews to help identify the level of activity actually being undertaken locally, to feed into the SLI process.
  - o looking at whether a focus on potential "interveners" would increase impact across at-risk populations as a whole.
- ADPH and LGA are encouraged to ensure that the SLI process gets closer to understanding the quality and effectiveness of local activity (rather than quality of planning), in a way which supports local authorities and multi-agency groups to use their resources to maximise effect.
- NSPA is encouraged to further develop its resources hub to help facilitate more shared learning and best practice.

Chapter 15: Conclusion

This report provides the first comprehensive picture of suicide prevention activity within and across local authorities in England. It shows that there is a wealth of activity being planned and delivered locally, with a wide variety of actions underway. The range of organisations and individuals working with local authorities and with each other is evidence of the commitment to collaborative working that is in place at the local level. Many local suicide prevention leads are working hard to build and sustain impactful multi-agency groups and to develop action plans with group members that are responsive to the needs of local populations. This leadership from public health professionals and others has been identified in the course of this research as critical to successful action.

In the context of declining local authority budgets and stretched resources, multi-agency partnership working is crucial. Many of the resources required do not sit within local public health budgets and much of the activity taking place is delivered by other actors, including health services and the voluntary sector.

The three data sets analysed for this research – 150 self-assessment survey responses, 117 local plans, and 12 qualitative interviews – paint an encouraging picture. Almost all local areas now have an action plan and multi-agency group in place and those plans provide a strong foundation from which to build. Across the country, some areas are further ahead than others, have more comprehensive plans and have made more progress. This provides an important opportunity that needs to be harnessed now to ensure those areas which are at an earlier stage of this work can progress more quickly, learning from others and not reinventing the wheel.

Where possible, local areas would benefit from collaborating with neighbouring local authorities at the regional and sub-regional level, where economy of scale savings could be made, and important good practice lessons shared.

Where next?

This research report and the self-assessment survey exercise that it draws from represents the first stage in the sector-led improvement collaboration that LGA, ADPH, PHE and DHSC have agreed. This collaboration is designed to support local authorities in developing, delivering and improving suicide prevention locally.

Over three-quarters of local authorities said they would welcome additional support nationally to improve their suicide prevention activities. Based on these findings and their existing experience delivering SLI on other topics, LGA and ADPH are developing a programme of SLI work on suicide prevention which may include the following:

* Bespoke national-level expert input to support individual local authorities who report facing significant delivery challenges with suicide prevention.
* Less intensive regional-level support targeted at a larger number of local authorities to help them build capacity for SLI that will help improve their already well-established approach to suicide prevention.
* A series of tools, products and events designed to make the good practice and learning points from the SLI activity widely available.

In future LGA and ADPH intend to expand this programme of SLI work into public mental health more broadly.

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Appendices

Appendix 1: content of plans by region

Regional appendices: content of plans

East of England region: Cambridgeshire, Peterborough, Essex, Southend, Suffolk, Bedford, Luton, Central Bedfordshire, Thurrock, Hertfordshire, Norfolk.

		Reducing risk in men	Reducing risk in other high priority populations	Preventing and responding to self-harm	Mental health of children and young people	Treatment of depression in primary care	Acute mental health care	Tackling high-frequency locations	Reducing isolation	Bereavement support
In plan - being delivered	Count	8	6	2	8	2	7	6	2	10
	% within Region	72.7%	54.5%	18.2%	72.7%	18.2%	63.6%	54.5%	18.2%	90.9%
In plan - not yet being delivered	Count	2	2	6	0	1	2	2	3	0
	% within Region	18.2%	18.2%	54.5%	0.0%	9.1%	18.2%	18.2%	27.3%	0.0%
Not in plan	Count	0	2	2	2	7	1	2	5	0
	% within Region	0.0%	18.2%	18.2%	18.2%	63.6%	9.1%	18.2%	45.5%	0.0%
No regional data	Count	1	1	1	1	1	1	1	1	1
	% within Region	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%
Total	Count	11	11	11	11	11	11	11	11	11
	% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

East Midlands region: Derby City, Derbyshire, Leicester City, Leicestershire, Lincolnshire, Northamptonshire, Nottingham City, Nottinghamshire, Rutland.

		Reducing risk in men	Reducing risk in other high priority populations	Preventing and responding to self-harm	Mental health of children and young people	Treatment of depression in primary care	Acute mental health care	Tackling high-frequency locations	Reducing isolation	Bereavement support
In plan - being delivered	Count	7	6	7	6	3	6	5	4	5
	% within Region	77.8%	66.7%	77.8%	66.7%	33.3%	66.7%	55.6%	44.4%	55.6%
In plan - not yet being delivered	Count	2	2	2	3	0	2	1	1	4
	% within Region	22.2%	22.2%	22.2%	33.3%	0.0%	22.2%	11.1%	11.1%	44.4%
Not in plan	Count	0	1	0	0	6	1	3	4	0
	% within Region	0.0%	11.1%	0.0%	0.0%	66.7%	11.1%	33.3%	44.4%	0.0%
No regional data	Count	0	0	0	0	0	0	0	0	0
	% within Region	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	Count	9	9	9	9	9	9	9	9	9
	% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

London region: Barking & Dagenham, Barnet, Bexley, Brent, Bromley, Camden, City of London, City of Westminster, Croydon, Ealing, Enfield, Greenwich, Hackney, Hammersmith & Fulham, Haringey, Harrow, Havering, Hillingdon, Hounslow, Islington, Kensington & Chelsea, Kingston, Lambeth, Lewisham, Merton, Newham, Redbridge, Richmond, Southwark, Sutton, Tower Hamlets, Waltham Forest, Wandsworth.

		Reducing risk in men	Reducing risk in other high priority populations	Preventing and responding to self-harm	Mental health of children and young people	Treatment of depression in primary care	Acute mental health care	Tackling high-frequency locations	Reducing isolation	Bereavement support
In plan - being delivered	Count	13	12	17	21	15	18	15	11	17
	% within Region	39.4%	36.4%	51.5%	63.6%	45.5%	54.5%	45.5%	33.3%	51.5%
In plan - not yet being delivered	Count	14	14	9	4	7	7	5	8	11
	% within Region	42.4%	42.4%	27.3%	12.1%	21.2%	21.2%	15.2%	24.2%	33.3%
Not in plan	Count	2	3	3	4	7	4	9	10	1
	% within Region	6.1%	9.1%	9.1%	12.1%	21.2%	12.1%	27.3%	30.3%	3.0%
No regional data	Count	4	4	4	4	4	4	4	4	4
	% within Region	12.1%	12.1%	12.1%	12.1%	12.1%	12.1%	12.1%	12.1%	12.1%
Total	Count	33	33	33	33	33	33	33	33	33
	% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

North East region: County Durham, Darlington, Gateshead, Hartlepool, Middlesbrough, Newcastle-upon-Tyne, North Tyneside, Northumberland, Redcar & Cleveland, South Tyneside, Stockton-on-Tees, Sunderland.

		Reducing risk in men	Reducing risk in other high priority populations	Preventing and responding to self-harm	Mental health of children and young people	Treatment of depression in primary care	Acute mental health care	Tackling high-frequency locations	Reducing isolation	Bereavement support
In plan - being delivered	Count	10	7	5	11	2	8	9	8	11
	% within Region	83.3%	58.3%	41.7%	91.7%	16.7%	66.7%	75.0%	66.7%	91.7%
In plan - not yet being delivered	Count	2	5	6	0	4	0	0	0	1
	% within Region	16.7%	41.7%	50.0%	0.0%	33.3%	0.0%	0.0%	0.0%	8.3%
Not in plan	Count	0	0	1	1	6	4	3	4	0
	% within Region	0.0%	0.0%	8.3%	8.3%	50.0%	33.3%	25.0%	33.3%	0.0%
No regional data	Count	0	0	0	0	0	0	0	0	0
	% within Region	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	Count	12	12	12	12	12	12	12	12	12
	% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

North West region: Blackburn with Darwen, Blackpool, Bolton, Bury, Cheshire East, Cheshire West & Chester, Cumbria, Halton, Knowsley, Lancashire, Liverpool, Manchester (city), Oldham, Rochdale, Salford, Sefton, St Helens, Stockport, Tameside, Trafford, Warrington, Wigan, Wirral.

		Reducing risk in men	Reducing risk in other high priority populations	Preventing and responding to self-harm	Mental health of children and young people	Treatment of depression in primary care	Acute mental health care	Tackling high-frequency locations	Reducing isolation	Bereavement support
In plan - being delivered	Count	14	12	15	20	17	16	17	12	17
	% within Region	60.9%	52.2%	65.2%	87.0%	73.9%	69.6%	73.9%	52.2%	73.9%
In plan - not yet being delivered	Count	7	7	5	1	1	1	1	6	4
	% within Region	30.4%	30.4%	21.7%	4.3%	4.3%	4.3%	4.3%	26.1%	17.4%
Not in plan	Count	1	3	2	1	4	5	4	4	1
	% within Region	4.3%	13.0%	8.7%	4.3%	17.4%	21.7%	17.4%	17.4%	4.3%
No regional data	Count	1	1	1	1	1	1	1	1	1
	% within Region	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%
Total	Count	23	23	23	23	23	23	23	23	23
	% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

South East region: Bracknell Forest, Brighton & Hove, Buckinghamshire, East Sussex, Hampshire, Isle of Wight, Kent, Medway, Milton Keynes, Oxfordshire, Portsmouth, Reading, Slough, Southampton, Surrey, West Berkshire, West Sussex, Windsor & Maidenhead, Wokingham.

		Reducing risk in men	Reducing risk in other high priority populations	Preventing and responding to self-harm	Mental health of children and young people	Treatment of depression in primary care	Acute mental health care	Tackling high-frequency locations	Reducing isolation	Bereavement support
In plan - being delivered	Count	16	14	15	16	12	17	17	13	18
	% within Region	84.2%	73.7%	78.9%	84.2%	63.2%	89.5%	89.5%	68.4%	94.7%
In plan - not yet being delivered	Count	3	3	2	2	2	0	1	0	1
	% within Region	15.8%	15.8%	10.5%	10.5%	10.5%	0.0%	5.3%	0.0%	5.3%
Not in plan	Count	0	2	2	1	5	2	1	6	0
	% within Region	0.0%	10.5%	10.5%	5.3%	26.3%	10.5%	5.3%	31.6%	0.0%
No regional data	Count	0	0	0	0	0	0	0	0	0
	% within Region	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	Count	19	19	19	19	19	19	19	19	19
	% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

South West region: Bath & NE Somerset, Bournemouth, Bristol, Cornwall, Devon, Dorset, Gloucestershire, Isles of Scilly, North Somerset, Plymouth, Poole, Somerset, South Gloucester, Swindon, Torbay, Wiltshire.

		Reducing risk in men	Reducing risk in other high priority populations	Preventing and responding to self-harm	Mental health of children and young people	Treatment of depression in primary care	Acute mental health care	Tackling high-frequency locations	Reducing isolation	Bereavement support
In plan - being delivered	Count	11	7	8	14	3	11	11	7	11
	% within Region	68.8%	43.8%	50.0%	87.5%	18.8%	68.8%	68.8%	43.8%	68.8%
In plan - not yet being delivered	Count	4	6	7	1	7	1	0	4	4
	% within Region	25.0%	37.5%	43.8%	6.3%	43.8%	6.3%	0.0%	25.0%	25.0%
Not in plan	Count	0	2	0	0	5	3	4	4	0
	% within Region	0.0%	12.5%	0.0%	0.0%	31.3%	18.8%	25.0%	25.0%	0.0%
No regional data	Count	1	1	1	1	1	1	1	1	1
	% within Region	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%	6.3%
Total	Count	16	16	16	16	16	16	16	16	16
	% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

West Midlands region: Birmingham, Coventry, Dudley, Herefordshire, Sandwell, Shropshire, Solihull, Staffordshire, Stoke-on-Trent, Telford & Wrekin, Walsall, Warwickshire, Wolverhampton, Worcestershire.

		Reducing risk in men	Reducing risk in other high priority populations	Preventing and responding to self-harm	Mental health of children and young people	Treatment of depression in primary care	Acute mental health care	Tackling high-frequency locations	Reducing isolation	Bereavement support
In plan - being delivered	Count	9	6	5	10	3	9	7	5	6
	% within Region	64.3%	42.9%	35.7%	71.4%	21.4%	64.3%	50.0%	35.7%	42.9%
In plan - not yet being delivered	Count	2	6	7	2	7	3	5	3	6
	% within Region	14.3%	42.9%	50.0%	14.3%	50.0%	21.4%	35.7%	21.4%	42.9%
Not in plan	Count	2	1	1	1	3	1	1	5	1
	% within Region	14.3%	7.1%	7.1%	7.1%	21.4%	7.1%	7.1%	35.7%	7.1%
No regional data	Count	1	1	1	1	1	1	1	1	1
	% within Region	7.1%	7.1%	7.1%	7.1%	7.1%	7.1%	7.1%	7.1%	7.1%
Total	Count	14	14	14	14	14	14	14	14	14
	% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Yorkshire and the Humber region: Barnsley, Bradford, Calderdale, Doncaster, East Riding of Yorkshire, Kingston upon Hull, Kirklees, Leeds, North East Lincolnshire, North Lincolnshire, North Yorkshire, Rotherham, Sheffield, Wakefield, York.

		Reducing risk in men	Reducing risk in other high priority populations	Preventing and responding to self-harm	Mental health of children and young people	Treatment of depression in primary care	Acute mental health care	Tackling high-frequency locations	Reducing isolation	Bereavement support
In plan - being delivered	Count	12	8	6	10	4	8	8	6	7
	% within Region	80.0%	53.3%	40.0%	66.7%	26.7%	53.3%	53.3%	40.0%	46.7%
In plan - not yet being delivered	Count	2	3	8	2	6	2	2	6	7
	% within Region	13.3%	20.0%	53.3%	13.3%	40.0%	13.3%	13.3%	40.0%	46.7%
Not in plan	Count	0	3	0	2	4	4	4	2	0
	% within Region	0.0%	20.0%	0.0%	13.3%	26.7%	26.7%	26.7%	13.3%	0.0%
No regional data	Count	1	1	1	1	1	1	1	1	1
	% within Region	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%
Total	Count	15	15	15	15	15	15	15	15	15
	% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Appendix 2: Quality criteria for self-assessment of local planning

In the course of this review of local plans, the question of quality and how it should be assessed was raised repeatedly. Whilst it was not deemed appropriate to comment on the quality of individual local plans or attempt any sort of 'grading' exercise, it was possible, based on the qualitative analysis, to identify some broad criteria that may be useful to LAs when thinking about how to improve the quality of their own suicide prevention planning.

Indicators of good planning
Use of national guidance and data: Clearly informed by latest national guidance documents and data.
Use of research evidence: Well-informed by current research literature; well-referenced, and there is clear linkage between research evidence and actions.
Use of local data: Clear linkage between data and actions; local data determine local priorities; actions clearly designed to address local context.
Use of stakeholder involvement: Involvement of local stakeholders (beyond the multi-agency group) in process of deciding local priorities.
Coherence of strategy and plan: Strategy and plan make sense when read together; identified local priorities are reflected in structure of plan.
Spread versus focus: Plan does not try to cover everything in the national strategy; actions are focused on selected high-priority areas, with recognition of areas that will need to be addressed in future plans.
Aim-oriented versus action-oriented: Clear transition from aims/objectives to actions. Uses language of action: establish, commission, develop, map, undertake.
Details of actions and accountability: • Specific action to be taken   • Named person responsible for carrying it out   • Clear process and timescale   • Clear what it will achieve   • Clear reporting/monitoring procedures

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