

**The All-Party Parliamentary Group (APPG) on  
Suicide and Self-Harm Prevention**

# **Inquiry into the State of Local Suicide Prevention Plans in England**

**January 2015**

## **ACKNOWLEDGEMENTS**

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## **EXECUTIVE SUMMARY**

This inquiry provides an analysis and evaluation of the current state of local suicide prevention plans in England, following on from All-Party Parliamentary Group (APPG) on Suicide and Self-harm Prevention's previous report on Local Suicide Prevention Plans that was published in January 2013.

The Department of Health's (DH) national suicide prevention strategy for England was published in September 2012 and responsibility for leading its implementation at local level sits with public health teams which have been based within local authorities since April 2013 as part of the recent health reforms. The APPG contacted all upper-tier local authorities in England with a series of questions and requests for data on their respective plans on suicide prevention. From the responses, we received information about over 98% of local authorities (150 out of 152).

The report is based on this survey and has two main aims:

- to provide an overall picture of the way that the national suicide prevention strategy is being implemented at local level, including policy recommendations on how local implementation could be improved; and
- to provide a detailed set of information about what suicide prevention work is ongoing in every region and local authority area in England to assist organisations with an interest in suicide prevention policy and to highlight the geographic areas where more could be done.

The APPG asked for information on whether local authorities were actively implementing local suicide prevention plans, operating multi-agency suicide prevention groups to oversee these plans, and whether regular suicide audits were carried out. Local authorities were also asked to provide details of what resources were specifically allocated to support suicide prevention, and what, if any, joint strategies were in place with neighbouring local authorities. This information was then compared with the local suicide rate and, in some cases, rates of deprivation.

The APPG considers that there are three main elements that are essential to the successful local implementation of the national strategy:

- carrying out a **"suicide audit"** which involves the collection of data about suicides that have occurred locally from sources such as coroners and health records in order to build an understanding of local factors such as high risk demographic groups.
- the development of a **suicide prevention action plan** setting out the specific actions that will be taken, based on the national strategy and the local data, to reduce suicide risk in the local community.
- the establishment of a **multi-agency suicide prevention group** involving all key statutory agencies and voluntary organisations whose support is required to effectively implement the plan throughout the local community.

The APPG's survey found that:

- **around 30% of local authorities do no suicide audit work.**
- **around 30% of local authorities do not have a suicide prevention action plan.**
- **around 40% of local authorities do not have a multi-agency suicide prevention group.**

The findings of the survey clearly demonstrate that there are significant gaps in the local implementation of the national strategy. The government has previously indicated that it is not minded to make local suicide prevention plans mandatory, preferring to allow more freedom for local decision making. However, the APPG welcomes the recent publication of new guidance for local authorities on developing a local suicide prevention action plan that was published by Public Health England in October 2014<sup>1</sup>. This is a significant step forward as the document summarises key actions that local authorities should be looking to take and provides links to useful resources and a best practice example of a suicide audit. The APPG welcomes this development and hopes that this resource can be built on through the additional actions recommended by this report and that progress can be made towards full local implementation of the national strategy.

The APPG recommends that:

- all three of the main elements described above (audit, action plan and multi-agency group) should be in place in every local authority area.
- PHE should use its network of 15 local centres across England to contact public health teams in areas where this is not happening to encourage development of suicide prevention work and offer to provide practical support.
- more sub-regional groups such as the existing ones in Greater Manchester and in Merseyside/Cheshire could help to support local authority areas without active plans and stimulate new activity.

In terms of what this support could involve, the APPG received evidence from many local authorities through the survey responses about the potential benefits of sharing evidence and information about best practice. Some local authorities felt that it was difficult to find reliable information about examples of initiatives that had been proven, with clear evidence and evaluation, to work well in a particular area and that could be replicated elsewhere. The APPG recommends that information about practical examples could be collected, evaluated and more widely shared through:

- PHE gathering, evaluating and sharing information at regional level through its local centres.
- National dissemination of evidence-backed case studies via DH's annual progress report on the national strategy or PHE's guidance for local authorities.
- Publication of information on a regularly updated national website run by either DH/PHE or a third party such as the National Suicide Prevention Alliance (NSPA).

The collection of local data can be a time-consuming task for local authorities with some obstacles often in the way of obtaining it. The APPG recommends that:

- a long-term aim should be for coroners to collect and digitalise a wider range of suicide data which is automatically made available to public health teams.
- in the short-term, PHE should issue guidance on what data should be collected locally and how it can be used. This should include the provision of an updated suicide audit tool/template.
- the Chief Coroner should issue guidelines to Senior Coroners on enabling free access to public health teams to all necessary records and data.

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<sup>1</sup> *Guidance for developing a local suicide prevention action plan: information for public health staff in local authorities*, PHE (2014)  
<https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan>

- PHE should also consider how suicide data could be pooled over wider geographical areas in order to better identify trends.

**Part One** of this report provides background information about the survey carried out by the APPG, the typical processes required to implement the national suicide prevention strategy at local level, the government's current approach to local implementation and the suicide rate in England.

**Part Two** of the report summarises the main findings of the survey, specifically on the proportion of local authority areas that have active local suicide prevention plans, local multi-agency suicide prevention group, and suicide audit (data collection) work.

**Part Three** of the report analyses some of the main themes of the responses received from local authorities on an open question about what more could be done to help support them in improving local implementation.

The detailed data provided in the **Part Four** of this report includes a section for each of the nine regions of England with charts and maps illustrating which local authorities in that region have suicide prevention plans/groups/audits, where there are joint strategies being carried out across local authority boundaries and what financial/staff resources they have available to support initiatives. This type of data has not previously been available as PHE's Public Health Outcomes Framework only monitors progress via a performance indicator which measures the suicide rate relative to the national and regional average in each local authority area.

By collecting and publishing this data, the APPG anticipates that DH/PHE, national groups such as the National Suicide Prevention Strategy Advisory Group (NSPSAG) and the National Suicide Prevention Alliance (NSPA), as well as various agencies and voluntary organisation that are members of those groups, will be able to use it to target areas where the national strategy is not currently being fully implemented and stimulate new partnerships and suicide prevention activity.

Finally, **Part Five** of the report looks at the role of the police in local suicide prevention.

## **RECOMMENDATIONS**

It is clear from the APPG's survey that there remain significant gaps in local suicide prevention work across the country and that there are some areas when little or no work is being done to implement the government's national suicide prevention strategy.

All local authorities must have in place:

- a) Suicide audit work to in order to understand local suicide risk.
- b) A suicide prevention plan in order to identify the initiatives required to address local suicide risk.
- c) A multi-agency suicide prevention group to involve all relevant statutory agencies and voluntary organisations in implementing the local plan.

Public Health England should use its 15 local centres across England to contact public health teams in local authority areas that do not have a suicide prevention plan to encourage the development of local suicide prevention plans and offer practical support.

The APPG maintains its view outlined in its previous report that the establishment of a local framework to prevent suicide should not be optional. While it seems that the government is currently unwilling to pursue this approach, there is more that Public Health England could do to stimulate local activity such as by providing support at a regional level for local public health teams.

Public Health England (PHE) and the National Suicide Prevention Strategy Advisory Group (NPSAG) should examine ways that local authorities can share information about suicide prevention initiatives that have worked well locally and could be replicated elsewhere. Ways that this could be achieved could include:

- The gathering and sharing of information between local authorities at regional level by Public Health England's local centres. This could include evaluations of existing initiatives.
- National dissemination of this information via DH's annual progress report on the national suicide prevention strategy or through updates to PHE's new guidance on local suicide prevention action plans.
- Publication of relevant case study information online, either through the website of DH/PHE or via a website run by a relevant third party such as the National Suicide Prevention Alliance (NPSA).

Future updates to PHE's guidance for local authorities on local suicide prevention action plans should also include information about how best to ensure that the local data collected through the suicide audit process can most effectively used to inform priorities for local interventions.

In the longer term, PHE and the Chief Coroner should consider whether it would be possible to ensure that a wider range of data on suicide could be routinely collected on a systematic basis and integrated electronically. If suicide data can be digitalised and made availability to public health teams and researchers, it could significantly reduce the resources currently required to collect this information manually in 152 separate areas, as well as improving the quality and reliability of the data.

**Until a better system of suicide data collection is available, PHE should issue clear, updated guidance to local authorities on the collection of suicide data from local sources including coroner offices. This should include the provision of a new suicide audit tool/template.**

**PHE should consider whether new information sharing protocols could improve access to local suicide data. In particular, the Chief Coroner for England & Wales should issue guidelines to Senior Coroners on enabling free access to public health teams to all necessary records and data.**

**Public Health England should consider whether suicide audit work could be carried out on a regional basis and how local suicide data could be pooled over a wider area in order to better identify trends.**

**Public Health England and the NSPSAG should give consideration to whether support could be provided to set up additional sub-regional suicide prevention groups across a number of local authorities similar to the existing ones in Greater Manchester and the Cheshire/Merseyside area.**

**Public Health England should urgently investigate the worrying low level of suicide prevention activity in the Greater London area and work with local authorities to establish new local plans and multi-agency groups.**



## **PART ONE – Background**

In January 2013, the All-Party Parliamentary Group (APPG) on Suicide and Self-Harm Prevention published a report on *The Future of Local Suicide Prevention Plans in England*<sup>2</sup> which examined the initiatives that statutory agencies such as Primary Care Trusts (PCTs) and local authorities were supporting to prevent suicide in their local communities. The report included results of a survey of all local authority areas in England which established that the implementation of the national strategy was highly variable across the country with comprehensive multi-agency suicide prevention action plans in place in some areas but nothing at all in others. The report made a number of recommendations for the future but also noted that with some major shifts in the health policy and commissioning environment, it would be necessary to revisit the issue of local suicide prevention through a follow-up survey a couple of years later. That follow-up survey has now been carried out and its findings are set out in this report.

The background to the original report was the recent development by the government of a new National Suicide Prevention Strategy for England<sup>3</sup>, published by the Department of Health in September 2012, to replace the previous strategy that had been in place since 2002. The other major policy development at the time was the introduction of the Health and Social Care Act 2012 which legislated for the abolition of PCTs by April 2013 with public health commissioning being transferred over to local authorities and the bulk of health commissioning including mental health services being transferred to new Clinical Commissioning Groups (CCGs).

### **Previous survey on local implementation (2012)**

In the context of these major national policy developments, the APPG was keen to explore:

- A)** how the new national strategy would be translated into action at a local level that would directly benefit people at risk of suicide; and
- B)** how the local statutory agencies with responsibility for overseeing this work would be affected by the reorganisation of commissioning that was underway.

Over the course of the summer in 2012, the APPG sought to gather evidence on the way suicide prevention work was being carried out across the country. It began by writing to the Chief Executives of all Primary Care Trusts and upper-tier local authorities<sup>4</sup> in England and inviting various witnesses involved with local suicide prevention work, including public health professionals and voluntary sector representatives, to give more detailed evidence at committee sessions at the Houses of Parliament.

Prior to the survey, the APPG was aware that, in some areas of the country, local multi-agency groups had worked to develop, coordinate and implement suicide prevention initiatives based on the aims and objectives of the national strategy. However, it was not clear how widespread this kind of arrangement was across the country. After gathering the data from the survey, the group found:

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<sup>2</sup> The Future of Local Suicide Prevention Plans in England: A Report by the All Party Parliamentary Group on Suicide and Self-Harm Prevention (Jan 2013), <http://www.samaritans.org/sites/default/files/kcfinder/files/press/APPG%20-%20The%20Future%20of%20Local%20Suicide%20Prevention%20Plans%20in%20England.pdf>

<sup>3</sup> Preventing Suicide in England – A cross-government outcomes strategy to save lives, DH (Sep 2012) <https://www.gov.uk/government/publications/suicide-prevention-strategy-launched>

<sup>4</sup> The term “upper-tier local authorities” refers to those at County Council or unitary authority level but does not include district councils.

- that 73% of upper-tier local authorities in England had an active suicide prevention strategy; and,
- that 51% of upper-tier local authorities in England had an active suicide prevention group.

The Group concluded that while there were some examples of valuable work being carried out in some areas of the country, there were clearly other areas where the development of a strategic approach to suicide prevention was being entirely overlooked. The existence of suicide prevention plans were left open to chance rather than determined by any national requirement.

The APPG also warned that with local restructuring of health commissioning imminent, the future existing local suicide prevention plans would be fragile as they often rely upon the commitment of dedicated individuals and there would be no specific requirement for local authorities or health and wellbeing boards to maintain existing plans or to develop new ones. Nor were there any kind of formal mechanisms for local suicide prevention groups to report directly into their local health and wellbeing board. The future of suicide prevention plans during this period of transition therefore depended upon several inter-connected factors including the clear identification of suicide prevention as a local priority, local leadership to champion the work needed to deliver interventions and the availability of resources to support the work. The APPG was particularly concerned that other public health issues might take precedent over suicide prevention, particularly at a time when budgets are constrained.

### **New survey on local implementation (2014)**

The data that was gathered as part of the survey in 2012 provided a snapshot of the situation at a time when the restructuring of NHS and public health commissioning was in the transition phase. The new commissioning structures were not fully implemented until April 2013 and the APPG's survey was carried out during the middle of 2012 when there was a lot of uncertainty and major changes were underway at local level. Primary Care Trusts (PCTs) were in the process of being abolished and, in some areas, temporary arrangements such as the establishment of PCT clusters were in place. This meant that although the data provided a good overview of what local suicide prevention work was in place at that time, this was a landscape that was liable to significant change within a year or two.

The follow-up survey therefore needed to be carried out after the new structures had been put in place and the new health and wellbeing boards had been given sufficient time to establish their plans and priorities. The first survey letter was sent to each of the Directors of Public Health now based at the 152 upper-tier local authorities in England in March 2014, roughly a year after the new structures had been operational. This was then followed up by a Freedom of Information (FOI) request in July 2014 to those local authorities that had not responded (just under half of the total).

The survey/FOI request aimed to gather information on the following six areas:

1. Whether the local authority area has an active **suicide prevention plan**.
2. Whether the local authority area has an active **multi-agency suicide prevention group**.
3. Whether an **annual suicide audit** is carried out in the local authority area.
4. What **financial and staffing resources** are available to support local suicide prevention initiatives.

5. Whether the local suicide prevention strategy is carried out **jointly** with neighbouring local authorities.
6. What **further support** the Department of Health/Public Health England/NHS England could provide to improve the implementation of local suicide prevention work.

### **Typical processes to implement national suicide prevention strategy at a local level**

Public health teams were transferred from the old PCTs over to local authorities in April 2013 as part of the health commissioning reforms legislated for as part of the Health and Social Care Act 2012 and it is typically these teams that would be expected to lead on local suicide prevention. The public health teams are based only in England's 152 upper-tier local authorities and each have their own ring-fenced budget.

Adult social care remains the responsibility of local authorities as under the old system, but the bulk of NHS commissioning responsibilities have been transferred to a new network of Clinical Commissioning Groups (CCGs). There are a total of 211 CCGs in England meaning that some local authority areas have more than one CCG within their boundaries. The overall strategic approach to local planning for the three areas of health, social care and public health is overseen in each area by a health and wellbeing board, the membership of which consists of senior representatives of each of the relevant statutory agencies including CCGs, public health teams, adult social services and children's services.

Each health and wellbeing board is responsible for producing a Joint Strategic Needs Assessment (JSNA) which sets out the demographic data for the local area and a profile of the health and wellbeing needs of the local population. The board is also responsible for developing a health and wellbeing strategy for their local area setting out how the health needs of the local population will be met and may include details of pooled budgets and joint commissioning arrangements. While it is usually the Director of Public Health at the local authority who is ultimately responsible for overseeing local suicide prevention planning, these structures can potentially help to support joint working and involve other key agencies at an early stage.

The responses to the first three of the APPG's survey questions (as listed above) are particularly important in understanding whether a specific local authority area has in place the basic processes required to deliver interventions to prevent suicide at local level. These processes involve the collection and analysis of information about suicide locally and then combining that information with the guidance contained in the government's national suicide prevention strategy to develop a local action plan involving key statutory agencies and voluntary organisations.

A suggested model of how these processes could work was set out in an article published last year in the *Public Health* journal entitled "*Utility of local suicide data for informing local and national suicide prevention strategies*"<sup>5</sup>. The study aimed to ascertain how suicide data was being collected in local areas across England, how the findings were being used and how the process might be improved. It focused on the practice of 'suicide audit' which the article defines as "*the systematic collection of local data on suicides in order to learn lessons and inform suicide prevention plans.*"

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<sup>5</sup> Owens C, Roberts S, Taylor J. *Utility of local suicide data for informing local and national suicide prevention strategies*. Public Health 128 (2014) 424-429 <http://dx.doi.org/10.1016/j.puhe.2014.03.004>

In the APPG's previous report we argued that the use of suicide audits are a crucial part of the development of the local information base upon which a local suicide prevention strategy can be built. While the guidance and suggested "Areas for Action" in the government's national strategy are important, it is also necessary to understand the factors relating to suicide in that geographic area as there may be different demographics and trends specific to that locality.

A suicide audit collects detailed local information that goes beyond the basic data on suicide rates and often includes additional data on the people who have died by suicide including:

- The **gender** and **age groups** of people who have died by suicide.
- The **districts** within the local authority area where there have been a high number of suicides, usually assessed using postcode areas or local government wards.
- An estimate of the **socio-economic group** of the people who have died by suicide. This can be done by categorising the occupation of the individual using the National Readership Survey (NRS) social grade scale<sup>6</sup>. Another way of measuring a possible link between suicide and social deprivation includes examining the proportion of people who died by suicide who lived in wards whose scores on the index of multiple deprivation<sup>7</sup> (IMD) fell into the bottom national 10%.
- **Ethnic background/country of origin.** Details on the ethnicity of people who die by suicide is not collected and published at a national level and so there is limited data on this. But if this data is collected locally it can help to identify groups that are potentially at higher risk than the general population.
- The **suicide methods** used by the individual to take their own life. Restriction of access to means is a key element of suicide prevention so this can help to inform potential interventions and in particular can help to identify local suicide 'hotspots' such as bridges or multi-storey car parks.
- What **contact the individuals who died had with mental health services, their GP or other statutory services.** This can help to identify whether opportunities for intervention had been missed and whether improvements in care pathways could be made in future.
- The **medical history** of the people who died by suicide. This can help to identify possible links between physical health problems and suicide, including chronic or terminal illnesses.
- The **time/day/month** that suicides took place to identify any patterns in when suicides are most likely to occur.

The data collected in a local suicide audit therefore forms the foundation on which to base the development of a local action plan as it can help local authorities and NHS Trusts to understand crucial factors such as which sections of the local population are likely to be at highest risk of suicide and whether there are any issues relating to specific services or high risk locations that need to be addressed.

However, the *Public Health* journal article expressed concern that, based on the information collected from PCTs (prior to their dissolution in 2013) as part of the study, many of the PCTs were *"unable to demonstrate that the findings of local audits had exerted a direct influence on their*

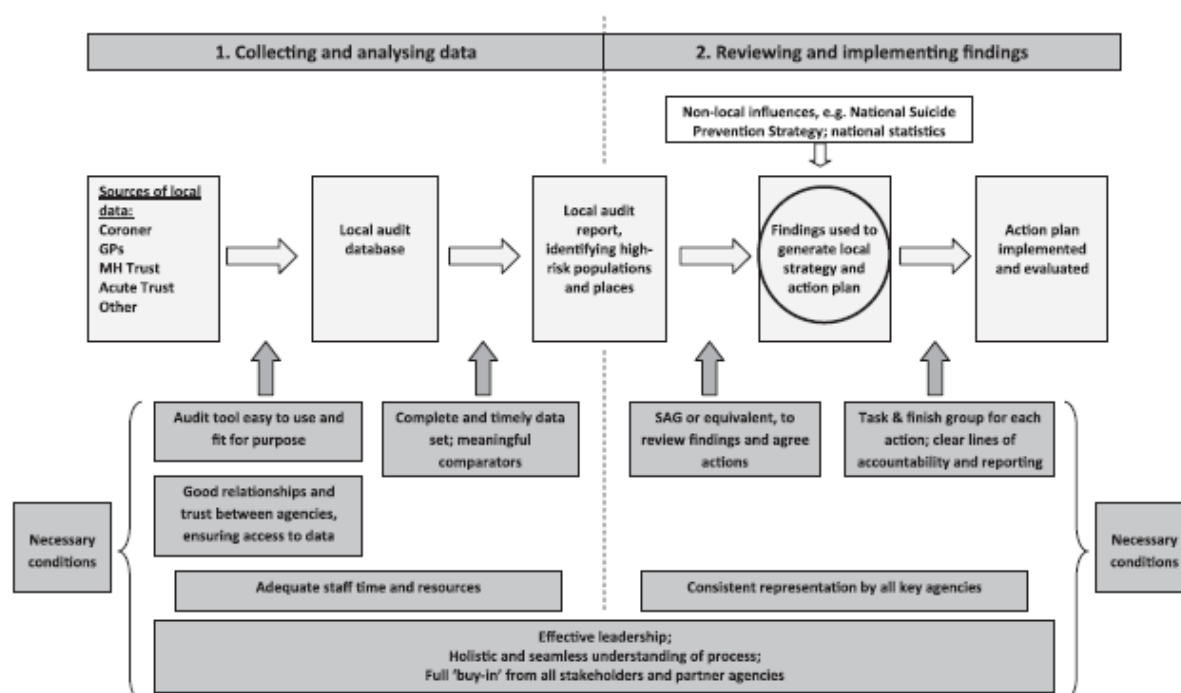
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<sup>6</sup> NRS Social Grades: <http://www.nrs.co.uk/nrs-print/lifestyle-and-classification-data/social-grade/>

<sup>7</sup> Index of Multiple Deprivation 2010, <http://opendatacommunities.org/data/societal-wellbeing/deprivation/imd-rank-la-2010>

suicide prevention plans.” The article therefore proposed the following framework illustrated in the chart below for getting the most from the audit process and the necessary conditions for each stage.

**FIGURE 1 – “Essential elements of, and necessary conditions for, the suicide audit process”<sup>8</sup>**



Source: *Utility of local suicide data for informing local and national suicide prevention strategies*, Public Health 128 (2014)

The framework sets out not only the processes required to collect and analyse the data itself (as illustrated in the first phase) but also the use of the findings to generate a local strategy and action plans (as illustrated in the second phase). The *Public Health* article suggested that the box with the circled text (highlighting the local strategy and action plan) represents the weakest link in the chain and that this is where close attention needs to be focused. This refers not just to the establishment of an action plan but also to the successful translation of suicide audit findings into specific actions that target local needs.

A typical local suicide prevention action plan is guided by the six “Areas for Actions” which are contained in the national suicide prevention strategy. The Areas for Action are:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

The national strategy provides examples of possible interventions that apply to each of these areas. There are a wide range of measures that can be employed but in practical terms they could include initiatives such as:

<sup>8</sup> Page 428, Owens C, Roberts S, Taylor J. *Utility of local suicide data for informing local and national suicide prevention strategies*. Public Health 128 (2014) 424-429 <http://dx.doi.org/10.1016/j.puhe.2014.03.004>

- the commissioning of suicide prevention training for front-line staff within key public services to ensure that those who work with identified high-risk groups are particularly alert to the signs of suicidal behaviour and know how to respond. **(Area for Action 1)**
- that Accident and Emergency departments treating individuals following a suicide attempt or a non-suicidal act of self-harm provide a psychosocial assessment and appropriate follow-up care as recommended by NICE guidelines. **(Area for Action 1)**
- early identification of children and young people with mental health problems in different settings including schools, and ensuring the availability of appropriate support such as talking therapies. **(Area for Action 2)**
- ensure that safety measures such as barriers or signs displaying contact details for Samaritans are in place at known local high-risk locations for suicide such as bridges or multi-storey car parks. Partnership work between British Transport Police, Network Rail and Samaritans is currently ongoing at rail stations across the country through a five-year training, communications and outreach programme which aims to reduce suicides on the national rail network. **(Area for Action 3)**
- commissioning specialist bereavement counselling or support groups for people who have recently lost a loved one to suicide. **(Area for Action 4)**
- engaging with local journalists to improve awareness of the need to ensure the responsible reporting of suicide. **(Area for Action 5)**

This is just a small sample of the range of initiatives that can be used locally, but the government's national strategy provides a more comprehensive guide to the measures that can be employed. In order to develop a local action plan and to ensure that the interventions that are identified can be fully implemented, it is necessary to involve the range of statutory agencies and voluntary organisations that are likely to come into contact with people at risk of suicide and are in a position to provide support. The most effective way of achieving this engagement is usually through a multi-agency suicide prevention group which meets regularly to discuss and agree on the measures that could be included in a local action plan, establish which agencies are responsible for taking the lead on specific initiatives and confirm funding arrangements and timescales for implementation. The statutory agencies and voluntary organisations referred to as members of multi-agency groups in some of the responses that we received have included representatives of:

- the local Clinical Commissioning Group(s)
- local NHS Trusts including Hospital Trusts and Mental Health Trusts/CAMHS
- the local Ambulance service
- the local authority's public health team
- the local authority's adult social care team
- the local authority's children's services team
- the local Police service
- the local Fire & Rescue service
- the local youth offending team
- Network Rail
- JobCentre Plus
- Voluntary organisations including Samaritans, MIND, CALM and Age UK

One of the main issues that the APPGs survey was aiming to obtain a clearer picture of is how many of the 152 local authority areas are carrying out the main stages of this process from beginning to end. The first three questions of the survey therefore aimed to gather data on whether each local authority has in place the basic three elements required as part of the framework illustrated in Fig 1:

- **Whether an annual suicide audit is carried out in the local authority area** (i.e. the collection of data required in phase one of the framework).
- **Whether the local authority area has an active suicide prevention action plan** (i.e. the main product required in phase two of the framework).
- **Whether the local authority area has an active multi-agency suicide prevention group** (i.e. perhaps the most important of the 'necessary conditions' in phase two of the framework as the involvement of all key agencies whose support is required to effectively implement the plan throughout the local community).

Replies were received that cover over 98% (150 out of 152) of upper-tier local authorities in England so we are now in a position to see not only to what extent this work is being carried out across the country as we did in the previous report, but also for the first time to display detailed information for each region of the country via the maps and charts in Part Four of this report.

### **Government approach to local implementation**

At present there is no specific requirement imposed by the government on local authorities to take action to implement the national suicide prevention strategy in their area. At the time of the publication of the APPG's first report in January 2013 the group recommended that the development of local suicide prevention action plans should be mandatory.

Although this is not the current government's approach, the Department of Health has produced several guidance documents on suicide prevention planning over the last few years that are relevant to local authorities. The main source of guidance is, of course, the national suicide prevention strategy published in 2012. Sections 1 to 6 of the national strategy are based on the six 'Areas for Action' (see page 9) each with sub-sections that includes detail about specific issues such as a high risk demographic group or a particular method of suicide. Under each of these sub-sections the strategy provides information about:

- **national action to support local approaches** (including initiatives being carried out by national agencies and partners as well as details of other relevant national strategies, legislation and supporting documents such as NICE guidelines)
- **effective local interventions** – (examples of local partnerships that could be considered and specific issues that local agencies should be aware of)
- **helpful resources** – (additional documents, toolkits and other resources which local agencies may find useful in developing their local approach)

Under this structure of Areas for Action and sub-sections, the national strategy therefore provides a framework which can be used by a local public health team or local suicide prevention group to help develop a local action plan. The action plan can be structured to address each of the six Areas for Action, using the information provided in the national strategy as a guide to specific information and resources which can be used to help develop action points. But while the strategy provides a lot of

detail about initiatives that are ongoing and resources that are available, it also largely leaves it up to local agencies to decide what approach to take in their area.

Section 7 of the national strategy is entitled “Making it happen locally and nationally” and while this section does outline the main mechanisms that are available for local implementation, it does not specifically prescribe how local authorities should deliver their suicide prevention plans. It does emphasise that *“an effective local public health approach is fundamental to suicide prevention”*<sup>9</sup> and that this depends on partnerships across all sectors locally. It points out that health and wellbeing boards are *“able to support suicide prevention as they bring together local councillors, Clinical Commissioning Groups, directors of public health, adult social services and children’s services, local Healthwatch and, where appropriate, wider partners (such as the Police and the Local Safeguarding Children Board) and community organisations”*. It also highlights the potential role of Directors of Public Health in *“developing local public health approaches and in nurturing and maintaining links across the NHS and local government”* and notes that they are supported in some areas by multi-agency suicide prevention groups or networks that help to co-ordinate activities.

Alongside the national suicide prevention strategy, a supplementary guidance document was published entitled *“Prompts for local leaders on suicide prevention”*<sup>10</sup> which provides two pages of questions which act as a checklist for local decision makers to consider when looking at existing suicide prevention work in their area. These include questions which take into account local characteristics such as whether the rate of suicide in the area is higher/lower than the general population rate and whether any high risk locations have been identified. It also includes questions on action being taken by local statutory authorities such as whether a local group or network has been established to oversee suicide prevention activity and whether the local Joint Strategic Needs Assessment has been used to identify action to support people at risk of suicide. As with the main national suicide prevention strategy itself, the tone of this document is to suggest issues that could be considered rather than issue firm guidance about what local agencies should or must do.

The national suicide prevention strategy states that Public Health England (PHE), as the new national agency for public health, will take a leadership role to support local authorities to improve outcomes including on mental health and suicide prevention. In October 2014, PHE published a new guidance document entitled *Guidance for Developing a Local Suicide Prevention Action Plan: Information for public health staff in local authorities*<sup>11</sup>. This short 10-page document provides advice for local authorities on how to:

- Develop a suicide prevention action plan.
- Monitor data, trends and hot spots.
- Engage with local media.
- Work with transport to map hotspots.
- Work on local priorities to improve mental health.

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<sup>9</sup> Page 50, Suicide Prevention Strategy for England, DH (2012)

<sup>10</sup> *Prompts for local leaders on suicide prevention*, DH (2012)

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/216930/Prompts-for-local-leaders-on-suicide-prevention.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216930/Prompts-for-local-leaders-on-suicide-prevention.pdf)

<sup>11</sup> *Suicide prevention: developing a local action plan*, Public Health England (Oct 2014)

<https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan>



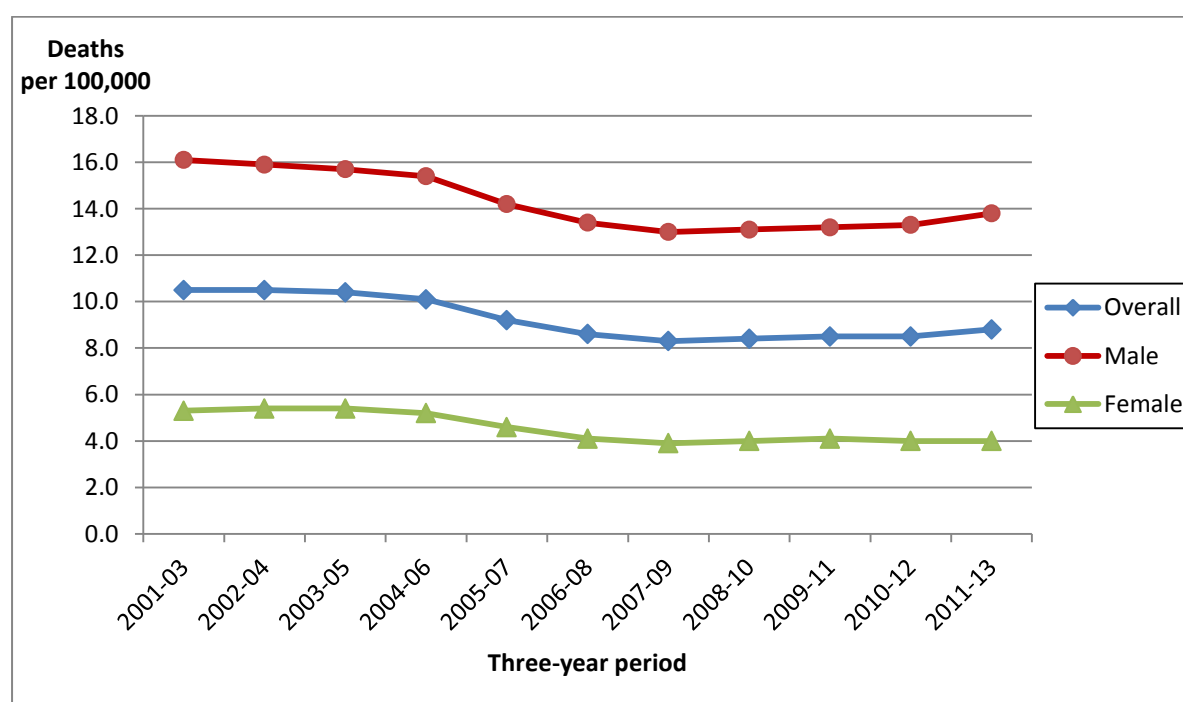
Some parts of the document specifically recommends work that has been carried out in certain local authority areas, such as for example by providing a link to the Leeds suicide audit for 2008-10 and endorsing it as an example of best practice. The publication of this guidance document therefore represents a significant step forward as it directs local authorities towards practical steps that they ought to take in a clearer way than the national strategy. However, as will be explored in Part Three, there is also more that could be done to support local authorities in this regard.

### **Suicide rate in England**

The suicide rate used by PHE is based on Office for National Statistics (ONS) figures which display the number of deaths by suicide per 100,000 of the population. These are calculated as an average annual rate across a three-year period because three-year averages are considered to be a more reliable indicator of trends than single-year figures.

As can be seen in the chart below, the suicide rate in England was in steady decline for most of the last decade until around 2008 since when there has been a small increase. Given the extensive evidence base linking difficult economic circumstances and higher unemployment to higher rates of suicide, some researchers attribute this rise in recent years to the economic downturn.

**FIGURE 2 – Suicide rate in England (three-year averages 2001-03 to 2011-13)**



Source: Public Health Outcomes Framework (indicator 4.10) <http://www.phoutcomes.info/>

**FIGURE 3 – Suicide rate in England (three-year averages 2001-03 to 2011-13)**

Three year period	Male suicide rate per 100,000	Female suicide rate per 100,000	Overall suicide rate per 100,000
2001-03	16.1	5.3	10.5
2002-04	15.9	5.4	10.5
2003-05	15.7	5.4	10.4
2004-06	15.4	5.2	10.1
2005-07	14.2	4.6	9.2
2006-08	13.4	4.1	8.6
2007-09	13.0	3.9	8.3
2008-10	13.1	4.0	8.4
2009-11	13.2	4.1	8.5
2010-12	13.3	4.0	8.5
2011-13	13.8	4.0	8.8

Source: Public Health Outcomes Framework (indicator 4.10) <http://www.phoutcomes.info/>

As part of the health commissioning reforms which took effect from April 2013, progress on a range of health issues is measured through the government's new system of Outcomes Frameworks. There are three main Outcomes Frameworks, (for the NHS<sup>12</sup>, Adult Social Care<sup>13</sup> and Public Health<sup>14</sup>) each of which has a set of indicators that act as a "dashboard" monitoring progress on key health outcomes and allowing comparisons between different regions and local authority areas. The main indicator on suicide is included as indicator 4.10 in the Public Health Outcomes Framework<sup>15</sup>, although the Department of Health has recently confirmed that a new suicide indicator will be added to the NHS Outcomes Framework for 2015/16. The new indicator (1.5 iii) will be 'suicide and mortality from injury of undetermined intent among people with recent contact from NHS services' which will be under the category of 'reducing premature death in people with mental illness'.<sup>16</sup>

In the Public Health Outcomes Framework, the suicide rate for each of the nine English regions and each of the 152 upper-tier local authority areas in England are compared to the national rate of 8.8 deaths per 100,000 and are coded red, amber or green to indicate whether their rate is worse, similar or better than the national average. This is therefore the main mechanism at national level for comparing and measuring progress in local areas across the country. However, it does not monitor what local authorities are actually doing to contribute towards this and so the APPG's survey aims to provide more information on this aspect of suicide prevention work in England.

<sup>12</sup> NHS Outcomes Framework 2014-2015, DH <https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015>

<sup>13</sup> Adult Social Care Outcomes Framework 2014-2015, DH <https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-2014-to-2015>

<sup>14</sup> Public Health Outcomes Framework 2013-2016, DH <https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency>

<sup>15</sup> Public Health Outcomes Framework, Domain 4: Healthcare and premature mortality. Indicator 4.10: Suicide rate <http://www.phoutcomes.info/>

<sup>16</sup> Page 9, NHS Outcomes Framework 2015-2016, DH (Dec 2014) <https://www.gov.uk/government/publications/nhs-outcomes-framework-2015-to-2016>

## **PART TWO – Main findings of the survey**

### **Question 1: Does your local authority area have an active suicide prevention plan?**

The first question that the survey asked was on whether there is an active suicide prevention plan in the local authority area. The previous report of the APPG, which carried out its survey in 2012, found that 73% of local authority areas had a suicide prevention plan while 27% did not.

As can be seen from the table below we have added a third category this time around as there are currently a significant proportion of local authorities that have a suicide prevention plan in development (24%). A major cause of this is that public health teams have been relocated to local authorities following the scrapping of Primary Care Trusts in 2013 and the consequent restructuring has inevitably led to some disruption. After taking this into account it appears that there are now 69% of local authorities that either have an active plan or a plan in development, representing a slight but not significant reduction in the proportion of local authority areas doing this work.

**FIGURE 4 – Survey responses on suicide prevention plans**

<b>Region (total number of authority areas)</b>	<b>Has active plan</b>	<b>Has plan in development</b>	<b>Has no plan</b>	<b>Did not reply</b>
North East (12)	9	1	2	0
North West (23)	15	3	5	0
Yorkshire & H (15)	3	7	5	0
East Midlands (9)	8	1	0	0
West Midlands (14)	8	0	5	1
East of England (11)	3	4	3	1
South East (19)	8	10	1	0
South West (16)	7	6	3	0
London (33)	7	5	21	0
<b>TOTAL (152)</b>	<b>68</b>	<b>37</b>	<b>45</b>	<b>2</b>
<b>%</b>	<b>44.7%</b>	<b>24.3%</b>	<b>29.6%</b>	<b>1.3%</b>
<b>Combined total (active plan/plan in development)</b>	<b>105 (69.1%)</b>			

From the responses received it was apparent that there remains a mixed picture across the country. Some responses outlined good examples of detailed and comprehensive suicide prevention plans supported by funding and partnership working and we also heard about the development of new suicide prevention plans in some other areas, but roughly **30% of local authority areas in England had no plan at all**. The absence of suicide prevention activity was most apparent in the Greater London region with as many as **21 of the 33 London Boroughs lacking a local plan**. The East Midlands was the only region where all local authorities either had an active plan or were developing one. In cases where local authorities have indicated that plans are in development, it is not clear for the majority of them when these will be financed and implemented.

## **Question 2: Does your local authority area has an active suicide prevention group?**

The second question asked in the survey was whether there was an active multi-agency group to oversee suicide prevention work in that local authority area. The previous report of the APPG, based on the 2012 survey, found that 51% of local authority areas had an active group.

As can be seen from the table below, just over 49% of local authority areas have an active multi-agency group according to the 2014 survey, although there are also a few local authorities that are currently in the process of establishing a new group following the recent NHS restructuring. If these are included in the total then the figure rises to 58%, which would represent a small but not significant rise since 2012 under the previous PCT-led system.

As with the prevention plans, some local authorities did indicate they were in the process of setting up groups but gave no further information on how long this might take. The APPG intends to seek an update on the situation with these local authorities in six months' time.

**FIGURE 5 – Survey responses on multi-agency suicide prevention groups**

<b>Region (total number of authority areas)</b>	<b>Has multi-agency group</b>	<b>In process of setting up multi-agency group</b>	<b>Has no multi-agency group</b>	<b>Did not reply</b>
North East (12)	9	1	2	0
North West (23)	12	1	9	1
Yorkshire & H (15)	11	0	4	0
East Midlands (9)	8	1	0	0
West Midlands (14)	4	0	9	1
East of England (11)	5	0	5	1
South East (19)	9	3	7	0
South West (16)	9	4	3	0
London (33)	8	3	22	0
<b>TOTAL (152)</b>	<b>75</b>	<b>13</b>	<b>61</b>	<b>3</b>
<b>%</b>	<b>49.3%</b>	<b>8.6%</b>	<b>40.1%</b>	<b>2.0%</b>
<b>Combined total (active group/setting up group)</b>	<b>88 (57.9%)</b>			

Again there is a mixed picture across the country as a whole, with London standing out as the region lacking multi-agency suicide prevention groups. **The overall proportion of local authority areas without a group is just over 40%**, thereby significantly exceeding the proportion of those without a formal suicide prevention plan.

### **Question 3: Is an annual suicide audit carried out in your local authority area?**

A further question that was asked in the survey was whether an annual suicide audit was carried out. This was not a question asked in the previous 2012 survey. A number of the responses indicated that suicide audit work was undertaken in their area but on a less frequent basis than every year or that a suicide audit had not been carried out for some time but that audit work would be carried out soon. We recognise that carrying out a suicide audit can be quite a labour intensive process and that resources may not always be available to do this on such a regular basis. Further categories have therefore been added to the table below to accommodate this.

**FIGURE 6 – Survey responses on suicide audits**

<b>Region (total number of authority areas)</b>	<b>Conduct audit annually</b>	<b>Conduct audits less frequently</b>	<b>Intend to conduct audits in near future</b>	<b>Do not conduct audits</b>	<b>Did not reply</b>
North East (12)	8	0	1	3	0
North West (23)	15	3	0	4	1
Yorkshire & H (15)	6	2	4	2	1
East Midlands (9)	6	0	0	3	0
West Midlands (14)	1	2	1	9	1
East of England (11)	4	1	3	2	1
South East (19)	10	1	1	5	2
South West (16)	10	3	3	0	0
London (33)	7	8	0	18	0
<b>TOTAL (152)</b>	<b>67</b>	<b>20</b>	<b>13</b>	<b>46</b>	<b>6</b>
<b>%</b>	<b>44.1%</b>	<b>13.2%</b>	<b>8.6%</b>	<b>30.3%</b>	<b>3.9%</b>
<b>Combined total (active or planned audit work)</b>	<b>100 (65.8%)</b>				

The survey results show that while only 44% of local authorities conduct a suicide audit on an annual basis, that figure rises to just over 65% when the scope is widened to include local authorities that conduct suicide audits less frequently or that are due to carry out a suicide audit soon. **At least 30% of local authority areas in England do no suicide audit work at all.**

### **Summary**

These headline findings of the survey provide a snapshot of the overall picture across the country with mixed results. The most positive aspect of the findings is that despite the view expressed by some of the witnesses to the previous inquiry in 2012 that many suicide prevention plans would not survive the transition of public health functions to local authorities, these concerns do not appear to have been borne out in most areas. That is not to say that there has been no disruption – we are aware of a few specific examples of areas that no longer have the active strategy/group that they previously had in place at the time of the last survey. **It is also important to note that in almost a quarter of local authority areas their suicide prevention plan was still in development at the time of the survey.** While the renewal of the new national strategy in 2012 may partly account for the need to develop new local plans, this survey was conducted more than 18 months after the national

strategy was published, suggesting that suicide prevention work in some areas had also been interrupted to some extent by the NHS restructuring. However, the overall proportion of local authority areas with suicide prevention plans/groups has not significantly reduced.

As with the 2012 survey, these findings highlight the significant gaps that remain in local suicide prevention work. **Around 30% of local authority areas do not have a local suicide prevention plan, around 40% do not have a multi-agency suicide prevention group and around 30% do not carry out suicide audit work.**

## **RECOMMENDATIONS**

It is clear from the APPG's survey that there remain significant gaps in local suicide prevention work across the country and that there are some areas when little or no work is being done to implement the government's national suicide prevention strategy.

All local authorities must have in place:

- a) Suicide audit work in order to understand local suicide risk.
- b) A suicide prevention plan in order to identify the initiatives required to address local suicide risk.
- c) A multi-agency suicide prevention group to involve all relevant statutory agencies and voluntary organisations in implementing the local plan.

Public Health England should use its 15 local centres across England to contact public health teams in local authority areas that do not have a suicide prevention plan to encourage the development of local suicide prevention plans and offer practical support.

The APPG maintains its view outlined in its previous report that the establishment of a local framework to prevent suicide should not be optional. While it seems that the government is currently unwilling to pursue this approach, there is more that Public Health England could do to stimulate local activity such as by providing support at a regional level for local public health teams. This is explored further in Part Three.

## **PART THREE – What more could be done to help at national level?**

In addition to the main questions about the work being carried out by each local authority, the APPG's survey also asked an open question about what more could be done at national level to support local suicide prevention strategies. This generated a significant number of detailed responses on common challenges faced by local authorities in delivering the priorities of the national suicide prevention strategy in their area.

### **Collection of local suicide data**

**More than 40 local authorities highlighted issues and offered suggestions on how the collection of data from coroners could be improved. Several of these local authorities suggested that additional national support and guidance on carrying out suicide audits would be beneficial.**

PHE publishes some data to support the suicide indicator in the Public Health Outcomes Framework which displays the male, female and overall suicide rate for each local authority area compared to the regional and national average rate. But more detailed information regarding suicides in a local authority area generally needs to be collected locally. The Suicide Prevention Strategy for England includes an Area for Action on supporting research, data collection and monitoring but does not provide any specific guidance on how local authorities should conduct suicide audit functions. Some guidance is available in a document entitled *Suicide Audit in Primary Care Trust localities: A Whole Systems Approach*<sup>17</sup>, which was published in 2006 by the former Care Services Improvement Partnership (CSIP) in partnership with the Peninsula Medical School. However, this document is now eight years old and was aimed at Primary Care Trusts which no longer exist.

A particularly common concern that was raised by several local authorities was the barriers that they experience in trying to access the data relating to their area, most notably information from coroners' records. One local authority noted in their response that *"there seems to be considerable variability in terms of processes in different coroner's office"*, an observation that certainly matches with much of the evidence that the APPG heard from various witnesses as part of its previous inquiry in 2012.

Several local authorities said that they would welcome support at a national level to improve access to the data held by coroners, a task that is most likely to be suited to the Chief Coroner. One local authority observed that because suicide audit is such a labour-intensive process it *"would be helpful if coroners' data collection and recording processes were digitalised"*.

One local authority told us that that they would welcome additional specialist analytical support from PHE and/or the public health observatories in auditing the suicide data in their borough. A different local authority instead favoured the development of an updated national suicide audit tool along with new protocols for information sharing between those carrying out the audit and those who hold the records. Another local authority suggested that there should be a national template specifying what data should be collected to enable clearer benchmarking between different local authority areas.

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<sup>17</sup> Church E, Ryan T. *Suicide audit in Primary Care Trust localities: a whole systems approach*, Care Services Improvement Partnership & Peninsula Medical School (2006)

The theme of being able to compare a wider range of data regionally or with neighbouring boroughs was explored further in some of the other responses that we received. One local authority called for *“standardised annual suicide audit across all local authorities which can be shared locally, regionally and nationally to allow for comparison and identification of at risk groups at all levels”* while another suggested that PHE could produce borough-level suicide profiles.

### **Pooling of data across more than one local authority area**

One local authority specifically suggested that it *“would be helpful if PHE could support the process of suicide audit on a wider geographical scale”* while another local authority expanded on the same point in more detail noting that *“the usefulness of audit is often questioned with reference to the findings of a limited evidence review which demonstrated that suicide audit, over one calendar year, in a locality, is insufficient to reliably identify high risk locations and population groups. It is our perspective that the value of local suicide audit needs to be considered more broadly than this”*.

Following on from that observation it should be noted that in 2012 there were 4,507 suicides in England and, given that there are 152 upper-tier local authorities, this represents an average of just under 30 suicides per local authority area per year. The identification of trends within such a small sample size in a single year is clearly difficult, although local authorities that collect and monitor data over a period of several years may be better able to do so. The pooling of data across a region or sub-region, particularly between neighbouring boroughs that have similar characteristics and demographics, may better enable a detailed understanding of suicide trends in certain population groups or in identifying suicide hotspots that attract people from a wide area.

### **Use of suicide data to support local action plans**

While the comprehensive collection of suicide data through an audit is generally considered to be the foundation for the development of a local suicide prevention strategy, it is of course vital to consider not just whether the data is collected but also how it is used. There is little point in collecting the data unless it is used to inform where and how resources and interventions should be targeted and to generate a local action plan.

The *Public Health* journal article referred to in Chapter One concluded that many PCTs were *“investing huge amounts of time and effort in conducting local audits by suicide and had worked hard to overcome procedural obstacles, but it is not clear that the findings were being translated effectively into action. With few exceptions PCTs were unable to demonstrate that the findings of local audits had exerted a direct influence on their suicide prevention plans.”*<sup>18</sup>

The use of suicide audit is a necessary part of local suicide prevention work and should be carried out more consistently across the country; however it must also be regarded by local authorities as just one part of a complete process that involves the translation of the data into specific targeted interventions involving a range of local organisations.

If the data is not used to help deliver tangible health and social benefits and reduce suicide risk among high risk demographic groups then it risks being just a costly data collection exercise largely

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<sup>18</sup> *Utility of local suicide data for informing local and national suicide prevention strategies*, Owens, C, Roberts, S & Taylor J, *Public Health* Volume 128, Issue 5, Pages 424-429 (May 2014)



for its own sake. Is it therefore essential that any future guidance issued by PHE on suicide audit, specifically addresses how best to maximise the use of data in the development of a local strategic approach to suicide prevention.

### **Sharing of evidence and information between local authorities**

#### **More than 30 local authorities referred to the potential benefits of sharing evidence and information about best practice between local authorities across the country.**

The previous APPG report in 2012 highlighted concerns that there was no systematic way for local statutory agencies to share their learning and experience of implementing suicide prevention plans and initiatives in their area. When analysing the evidence that the APPG collected, it was notable that there were many examples from across the country of innovative programmes, new ideas and good practice, many of which had been developed by local suicide prevention groups. However, it was also apparent that there was no real mechanism to ensure that this information is shared with other localities or fed back to the Department of Health in order to inform national guidance.

Many of the responses referring to this issue specifically called for evidence about what works well in other areas. Although clearly there are references in the national suicide prevention strategy and other supporting documents to specific initiatives that are going on across the country, the emphasis from local authorities appeared to relate to learning about the practical experience of putting these into practice. Essentially it was felt that it would be beneficial to know what had worked well, what difficulties had been experienced, what evidence there was that the work was reducing suicide risk and how this could then be replicated elsewhere. Examples of specific comments made about what local authorities said they would find useful included:

- “evidence based practical recommendations on suicide and self-harm prevention for public health teams”
- “details of interventions proven to be effective at a local level”
- “Providing case studies or examples of best practice from other boroughs”
- “Provide evidence on the short and long term economic benefits for investing in public mental health and suicide prevention.”
- “[we are] focusing on supporting children, young people and adults who are bereaved as a result of suicide and we would be interested to hear what other places are doing in this area.”

One local authority suggested that *“well-evidenced evaluations and project reviews are helpful in providing an evidence base on which to build local initiatives.”* This was echoed by another local authority which pointed out that they were aware of an initiative being carried out by voluntary sector organisation in a different local authority area but that while there was *“much good anecdotal and case study narrative”*, they were unable to *“find strong evidence from published evaluations of these type of campaigns”*.

One local authority specifically recommended that PHE could play a role in providing robust evidence of what works in suicide and self-harm prevention. The sharing of best practice would not necessarily have to take the form of national guidance. One local authority suggested that *“it would be useful if there was a national repository for evidence of effective interventions in suicide*

*prevention and for sharing best practice”* while another local authority proposed that it would be helpful to develop a national website specifically for the purposes of *“coordinating, collating and sharing best practice”*.

It has been noticeable from the responses received from local authorities that there is huge variability in the specific initiatives that are being undertaken in different areas. As local action plans should be tailored to meet local priorities using the suicide audit data then clearly some variability is to be expected. Nevertheless it is not always easy to understand the reasoning as to why, for example, suicide prevention training is prioritised in some areas, whereas funding for helplines or mental wellbeing promotion is prioritised in others. This suggests an inconsistent reasoning to the approach taken in different areas and so it could be helpful to attempt to reach a clearer national consensus on what the core activities that should usually be supported by a local suicide prevention action plan are.

It is important to point out that, as noted in Part One of this report, a new guidance document on developing a local suicide prevention action plan was published by Public Health England in October 2014. This is a significant step forward as the document summarises key actions that local authorities should be looking to take and provides links to useful resources and a best practice example of a suicide audit. The APPG welcomes this development and hopes that this resource can be built on through the additional actions recommended by this report.

## **RECOMMENDATIONS**

**Public Health England (PHE) and the National Suicide Prevention Strategy Advisory Group (NPSAG) should examine ways that local authorities can share information about suicide prevention initiatives that have worked well locally and could be replicated elsewhere. Ways that this could be achieved could include:**

- **The gathering and sharing of information between local authorities at regional level by Public Health England’s local centres. This could include evaluations of existing initiatives.**
- **National dissemination of this information via DH’s annual progress report on the national suicide prevention strategy or through updates to PHE’s new guidance on local suicide prevention action plans.**
- **Publication of relevant case study information online, either through the website of DH/PHE or via a website run by a relevant third party such as the National Suicide Prevention Alliance (NPSA).**

**Future updates to PHE’s guidance for local authorities on local suicide prevention action plans should also include information about how best to ensure that the local data collected through the suicide audit process can most effectively used to inform priorities for local interventions.**

**In the longer term, PHE and the Chief Coroner should consider whether it would be possible to ensure that a wider range of data on suicide could be routinely collected on a systematic basis and integrated electronically. If suicide data can be digitalised and made availability to public health teams and researchers, it could significantly reduce the resources currently required to collect this**

information manually in 152 separate areas, as well as improving the quality and reliability of the data.

Until a better system of suicide data collection is available, PHE should issue clear, updated guidance to local authorities on the collection of suicide data from local sources including coroner offices. This should include the provision of a new suicide audit tool/template.

PHE should consider whether new information sharing protocols could improve access to local suicide data. In particular, the Chief Coroner for England & Wales should issue guidelines to Senior Coroners on enabling free access to public health teams to all necessary records and data.

Public Health England should consider whether suicide audit work could be carried out on a regional basis and how local suicide data could be pooled over a wider area in order to better identify trends.

## **PART FOUR – DETAILED SURVEY RESULTS BY REGION**

This section of the report sets out the detailed findings of the survey carried out in 2014. As referred to in Part One there were a total of six questions put to each of the 152 upper-tier local authorities and the responses to four of these questions are displayed in the charts below for each region.

These are:

- Does the local authority have a suicide prevention plan? **(marked as ‘Q1’ in the charts)**
- Does the local authority have a multi-agency suicide prevention group? **(Q2)**
- Does the local authority carry out an annual suicide audit? **(Q3)**
- Does the local authority have a joint plan with a neighbouring local authority? (recorded where appropriate in the **additional notes column**)

The responses to the question asking what resources have been allocated to support local action plans have been included for each region in the commentary section beneath each chart. The final question regarding what more could be done at national level to support local implementation was addressed in Part Three.

The responses displayed in the charts are represented by a green tick if the plan/group/annual audit is fully active, an orange dot if it is in the process of being developed or a red cross if it is not in place at all. We recognise that there are inevitably some limitations in understanding exactly how effective each local authority is in reducing suicide risk in their area with yes or no answers on whether they are performing certain tasks. However, what we are aiming to provide is a snapshot picture of the extent to which each region has in place the basic three elements required for a framework that enables local implementation of the national strategy:

- The gathering of data about suicide locally. **(audit)**
- Using that data to establish the range of interventions needed to address suicide locally and how they will be carried out. **(action plan)**
- Overseeing the implementation of the action plan and engaging the key statutory agencies and voluntary organisations whose support is needed to make it happen. **(multi-agency group)**

We have also used the charts to illustrate the suicide rate in each local authority area and how it compares to the national average. This data is taken from PHE’s system of health indicators known as the Public Health Outcomes Framework which is used to measure progress on a wide range of public health issues. These are displayed under four categories known as “domains”, the fourth of which is “healthcare and premature mortality” under which indicator 4.10 is the suicide rate. This is measured by the number of deaths by suicide per year per 100,000 of the population using a three-year average and on this basis the national suicide rate for England is calculated as 8.8. The data is broken down into the nine English government regions and the 152 upper-tier local authority areas which are each compared against the benchmark of 8.8 using red, amber or green indicators to indicate whether the rate is significantly worse, similar or significantly better than the national average. Whether a local rate is judged to be “significantly” different from the national rate depends on the confidence intervals calculated for that area. The most recent data available is for the years 2011 to 2013 and can be viewed in full at: <http://www.phoutcomes.info/>

The variations in the regional data displayed in the table below indicate that suicide rates in some parts of the country, most notably the regions of the north, are significantly higher than areas in and around London.

Region	Suicide rate <sup>19</sup>	Population <sup>20</sup>
North East	10.6 ✕	2.60m
North West	10.1 ✕	7.05m
South West	10.1 ✕	5.29m
Yorkshire and the Humber	9.3 ✕	5.28m
South East	8.8 ●	8.63m
East Midlands	8.4 ●	4.53m
West Midlands	8.3 ●	5.60m
East of England	7.9 ✓	5.85m
London	7.2 ✓	8.17m

#### ADDITIONAL NOTES ON THE DATA:

**1** - The suicide rate figures represent the number of deaths per year per 100,000 of the population based on a 3-year average from 2011-2013. The categories used for the suicide rate are based on ONS-sourced data published by PHE as part of the Public Health Outcomes Framework. The confidence intervals used by PHE to determine whether a rate is higher/lower than the national average in a statistically significant way varies between local authorities due to differences in population sizes. This can result in some apparent anomalies in the charts. For example, in the North West region, Knowsley has a rate of 11.1 and is categorised as 'similar' to the national average while Cumbria has a rate of 10.9 and is categorised as 'higher' than the national average. This discrepancy is explained by differences in the confidence intervals between the two areas. Further information on the data can be found at [www.phoutcomes.info](http://www.phoutcomes.info)

**2** - It is important to point out that occasionally there may be circumstances where a local authority has arrangements that are not represented by a 'green tick' on the chart but could work well in practice. An example of this would be where a local authority has a suicide prevention action plan and although it is not overseen by a specific multi-agency suicide prevention group, it is supported by a more general Mental Health group. Any arrangements such as this are highlighted in the 'additional notes' column of the charts. The APPG has always taken the view that it is better to have a specific national suicide prevention strategy on the basis that if it is included as just one part of a more general national mental health strategy it is less likely to be afforded the status and prioritisation required to enable a comprehensive range of interventions to be delivered across the country. It obviously follows that at local level there would also ideally be action plans and multi-agency groups that are specifically focused on suicide prevention rather than wider mental health issues. However it is beyond the scope and resources of this inquiry to provide a detailed and authoritative account of how effectively particular arrangements in every specific local area are operating in practice.

<sup>19</sup> According to ONS-sourced data published by Public Health England as part of the Public Health Outcomes Framework.

<sup>20</sup> According to 2011 census data.

## **NORTH EAST REGION**

### **Region profile**

The North East Region comprises of three English counties: Northumberland, Tyne & Wear and County Durham and also includes the Tees Valley area. Across the North East region there are a total of 12 upper-tier local authorities - 7 of which are unitary authorities and 5 of which are metropolitan boroughs. There are also 12 CCGs in the region.

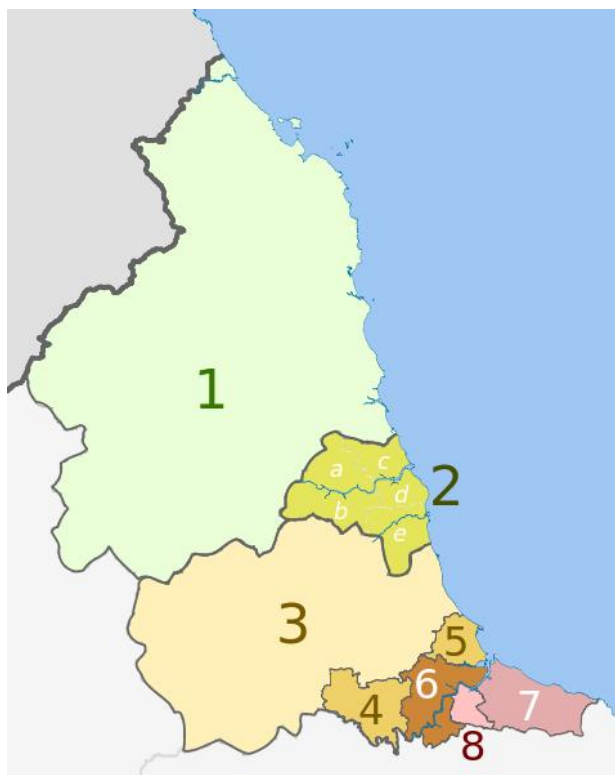
The suicide rate across the North East Region as a whole is 10.6 per 100,000 which is significantly higher than the national rate for England of 8.8 per 100,000. In terms of population it is the smallest of the nine regions with just under 2.6m people.

Northumberland county is covered by a single unitary authority, **Northumberland Council** (1 on the map).

Tyne and Wear is a metropolitan county (2) comprised of five metropolitan boroughs which are all independent unitary authorities. These are **Newcastle upon Tyne** (2a), **Gateshead** (2b), **North Tyneside** (2c), **South Tyneside** (2d) and **Sunderland** (2e).

County Durham is covered by a single unitary authority, **Durham County Council** (3).

The Tees Valley area is covered by 5 unitary authorities, **Darlington Borough Council** (4), **Hartlepool Borough Council** (5), **Stockton-on-Tees Borough Council** (6), **Redcar & Cleveland Council** (7) and **Middlesbrough Borough Council** (8).



## Survey results: local action plans, multi-agency groups and suicide audits

Local authority	Q1	Q2	Q3	Suicide rate	Additional notes
Northumberland (1)	✓	✓	✗	11.4 ✗	Action plan refreshed annually in June.
Newcastle-upon-Tyne (2a)	✗	✓	✗	10.2 ●	Discussions underway about developing an action plan.
Gateshead (2b)	✓	✗	②	6.5 ●	Plan (2010-15) is supported by Gateshead Mental Health and Wellbeing Partnership
North Tyneside (2c)	●	●	✗	11.4 ✗	A plan and group was being established following a local needs assessment.
South Tyneside (2d)	✓	✓	✓	8.1 ●	Strategy group had recently reconvened to develop an updated plan.
Sunderland (2e)	✓	✓	✓	10.2 ●	Previous plan ran to 2013 with an updated plan in development.
County Durham (3)	✓	✓	✓	13.4 ✗	Latest plan introduced in Nov 2013.
Darlington (4)	✗	✗	✓	10.0 ●	Since dissolution of PCTs, Darlington lost its previous joint strategy with Durham.
Hartlepool (5)	✓	✓	✓	11.4 ●	These four local authority areas coordinate their activity through the Tees Suicide Prevention Taskforce which meets quarterly. Their revised suicide prevention plan was published in late 2013 with a two year implementation plan to run from 2014 to 2016.
Stockton-on-Tees (6)	✓	✓	✓	8.7 ●	
Redcar & Cleveland (7)	✓	✓	✓	8.7 ●	
Middlesbrough (8)	✓	✓	✓	12.8 ✗	

### Key

**Q1** – Does the local authority have a suicide prevention plan?

- ✓ Yes
- Plan in development
- ✗ No

**Q2** – Does the local authority have a multi-agency suicide prevention group?

- ✓ Yes
- Group in process of being established
- ✗ No

(DNR = Did not reply to question)

**Q3** - Does the local authority carry out an annual suicide audit?

- ✓ Yes
- ① Audits are carried out but less frequently than every year
- ② Audits are not carried out but there are plans to do so in the near future
- ✗ No

**Suicide rate** (Data: Public Health England 2011-13)

- ✓ Rate lower than national average
- Rate similar to national average
- ✗ Rate higher than national average
- \* Not possible to calculate rate due to low population size

## Joint working and resources

Suicide prevention work in the North East is relatively well developed, reflecting the public health priority of the issue as the region currently has the highest suicide rate in England.

Of the 12 upper-tier local authorities in the North East region, 10 had either published a plan or had one in development. This includes 4 local authorities in the Teeside area which co-ordinate their activities through the Tees Suicide Prevention Taskforce. There has been a Tees suicide prevention plan since 2006 but the plan was revised in late 2013 to reflect the priority areas of the new national strategy and the local JSNAs. Each of the local authorities has a dedicated Public Health Lead to support the Taskforce and a two-year partnership implementation plan has been ratified for 2014-16.

The other eight local authorities mainly carry out their suicide prevention work independently. Five of these have an active plan and North Tyneside will follow shortly following the completion of a local needs assessment. The two local authorities that told us they did not have a suicide prevention plan were:

- **Newcastle City Council** which told us that there were no firm plans to develop a local strategy but that discussions were underway about potentially developing one, and
- **Darlington Borough Council** which told us that they had previously had a joint plan with County Durham but that this was lost following the dissolution of the PCTs. Darlington borders other local authority areas which are part of the Tees Suicide Prevention Taskforce. As Darlington has a relatively small population of just over 100,000 people, it may be beneficial to join a nearby sub-regional network such as this. Darlington's response indicates that this option is being considered.

The local authorities of the North East Region provided us with some quite detailed information on the resources that they allocated to support suicide prevention. As mentioned above, the four local authorities of the Tees Suicide Prevention Taskforce (**Hartlepool Borough Council, Stockton-on-Tees Borough Council, Redcar & Cleveland Borough Council** and **Middlesbrough Borough Council**) each have a dedicated Public Health Lead to support the Taskforce but up to £60,000 has also been secured to commission a Tees Mental Health Training Hub.

The other local authorities in the region gave us the following information about resources available:

- **Durham County Council** told us that *"financial resources allocated directly to suicide prevention programmes for 2014/15 is £345,000."* This is significantly more than the allocations referred to by the vast majority of other local authorities in England and perhaps the priority given to the issue reflects the fact that the suicide rate in County Durham is the second highest in the country according to Public Health England. The council also told us that *"County Durham Public Mental Health Strategy intertwines Suicide Prevention and Mental Health Improvement believing that improving mental wellbeing reduces suicide and self-harm rates. £370K is allocated to Mental Health Improvement programmes including mindfulness and social prescribing"*.



- **Newcastle City Council** identified £50,000 allocated to public health to support mental ill health prevention activities.
- **Gateshead Metropolitan Borough Council** told us that their budget for public mental health commissioned activity is £180,000 per annum. Initiatives have included *“suicide prevention training, mental health promotion, information sharing with coroners, etc.”*
- **North Tyneside Metropolitan Borough Council** provides £120,000 *“to support people with low to medium mental health problems, including depression into positive activities via GP/social care referral.”*
- **South Tyneside Metropolitan Borough Council** refers to staff time and the commissioning of suicide prevention training.
- **Northumberland County Council** reported that they commission Mental Health First Aid training and that they are currently looking at *“the possibility of commissioning a further suicide bereavement support group.”*
- Of the remaining local authorities, **Sunderland City Council** did not provide further information while **Darlington Borough Council**, told us that it has no *“specific resources for suicide prevention”*, but points out that their public health budget commissions a *“mental health improvement programme”*.

## NORTH WEST REGION

### Region profile

The North West Region comprises of five English counties: Cumbria, Lancashire, Merseyside, Greater Manchester and Cheshire. Across the North West region there are a total of 23 upper-tier local authorities - 6 of which are unitary authorities, 2 of which are county councils and 15 of which are metropolitan boroughs. There are also 33 CCGs in the region.

The suicide rate across the North West Region as a whole is 10.1 per 100,000 which is significantly higher than the national rate for England of 8.8 per 100,000. The region has a population of just over 7m which is the third highest in the country.

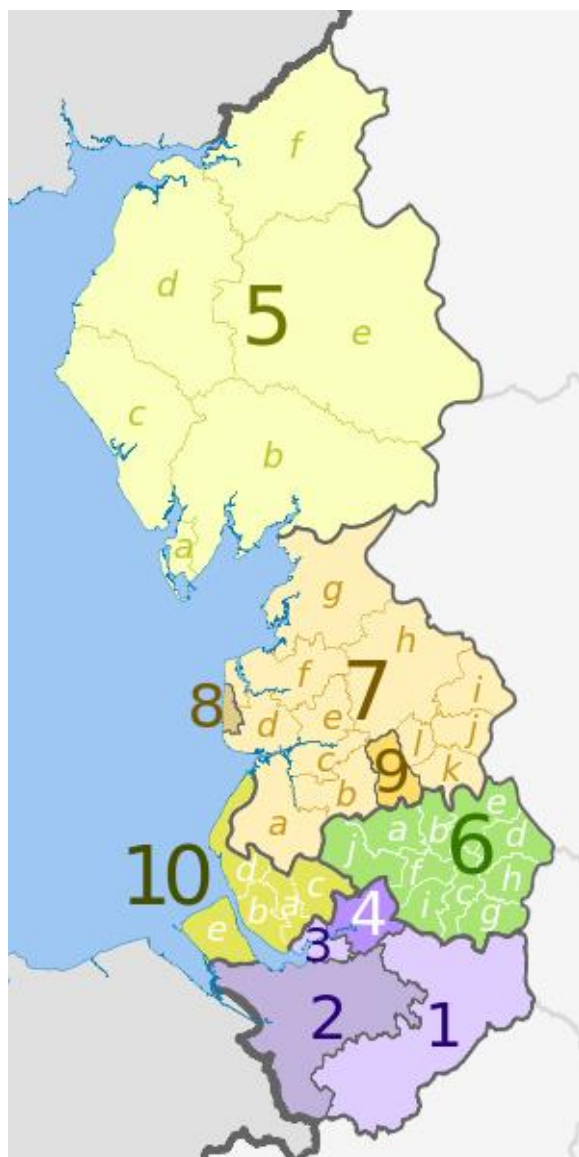
Cumbria is covered by **Cumbria County Council** (5 on the map) which oversees six district councils.

Lancashire is mainly covered by **Lancashire County Council** (7) which oversees twelve district councils, but there are also two separate unitary authorities, **Blackpool** (8) and **Blackburn with Darwen** (9).

Merseyside is a metropolitan county (10) comprised of five metropolitan boroughs which are all independent unitary authorities. These are **Knowsley** (10a), **Liverpool** (10b), **St Helens** (10c), **Sefton** (10d) and **Wirral** (10e).

Greater Manchester (6) is a metropolitan county comprised of ten metropolitan boroughs which are all independent unitary authorities. These are **Bolton** (6a), **Bury** (6b), **Manchester** (6c), **Oldham** (6d), **Rochdale** (6e), **Salford** (6f), **Stockport** (6g), **Tameside** (6h), **Trafford** (6i) and **Wigan** (6j).

The county of Cheshire is covered by four separate unitary authorities, **Warrington** (4), **Halton** (3), **Cheshire West and Chester** (2) and **Cheshire East** (1).



## Survey results: local action plans, multi-agency groups and suicide audits

Local authority	Q1	Q2	Q3	Suicide rate	Additional notes
Cheshire East (1)	✓	✗	✗	7.9 ●	A joint suicide prevention plan has been developed by the Cheshire and Merseyside Regional Suicide Prevention Network which covers these nine local authorities. Each local authority area is responsible for establishing a local working group and delivering the plan locally but the regional network assists in coordinating the activity.
Cheshire West & Chester (2)	✓	✗	①	8.9 ●	
Halton (3)	✓	✓	✓	9.6 ●	
Warrington (4)	✓	DNR	✗	9.2 ●	
Knowsley (10a)	✓	✗	✓	11.1 ●	
Liverpool (10b)	✓	✗	✓	9.5 ●	
St Helens (10c)	✓	●	✓	11.9 ✗	
Sefton (10d)	✓	✓	✓	9.7 ●	
Wirral (10e)	✓	✓	✓	8.0 ●	
Cumbria (5)	✓	✓	✓	10.9 ✗	Action plan for 2010-12 refreshed for 2013-15.
Bolton (6a)	✓	✓	✓	11.5 ✗	Strategic framework of evidence-based recommendations for 2013-16.
Bury (6b)	✗	✗	①	9.8 ●	A plan and possibly also a group will be developed during 2015/16.
Manchester (6c)	✓	✓	✗	11.8 ✗	Plan completed in 2013. Group chaired by Prof Kapur from Univ of Manchester.
Oldham (6d)	✗	✗	✓	10.0 ●	No population-wide strategy but there is one for users of mental health services.
Rochdale (6e)	✓	✓	✓	9.9 ●	Local plan due to run 2012-15.
Salford (6f)	●	✓	✓	9.2 ●	Review process being carried out for development of new strategy.
Stockport (6g)	●	✓	DNR	11.4 ✗	Draft vision statement written which will help development of new strategy.
Tameside (6h)	✗	✗	✗	10.2 ●	No plan but suicide will be included in mental health needs assessment
Trafford (6i)	✓	✓	✓	9.2 ●	Action plan in place – suicide also a priority of health and wellbeing strategy
Wigan (6j)	✗	✗	✓	11.3 ✗	No plan but there is an intention to develop one during 2014/15.
Lancashire (7)	●	✓	✓	10.2 ✗	Action plan being developed and partly implemented but not yet published.
Blackpool (8)	✗	✗	①	13.6 ✗	Suicide prevention integrated into current Mental Health Action Plan.
Blackburn with Darwen (9)	✓	✓	✓	12.0 ✗	Plan for 2011-14 being reviewed and new plan for 2014-17 being developed.

NOTE: Key to chart symbols is on page 27

## Joint working and resources

With a large population, a relatively high suicide rate and sizeable urban areas, the North West region is a particularly suitable area for joint suicide prevention work between local authorities, especially in the metropolitan counties. There is a high level of suicide prevention activity in the region as a whole, but it is particularly worrying to note that there was relatively little suicide prevention work being done in Blackpool despite that area having the highest suicide rate in the country.

There are two large sub-regional suicide prevention networks in the North West which cover 19 of the 23 local authority areas in the region. One of these is the **Cheshire and Merseyside Suicide Prevention Network** which covers all five metropolitan boroughs in Merseyside along with the four unitary authorities in the county of Chester. The Network has a Partnership Board which meets twice a year with representatives from a wide range of statutory authorities including Directors of Public Health, CCGs, Mental Health and Acute Trusts, Coroners, Network Rail, Police and Crime Commissioner and the Fire Service. In addition, there is an Operational Group which is also a multi-agency group and includes suicide prevention leads from each of the nine local authorities. The Operational Group has produced a draft 'Cheshire Merseyside Suicide Reduction Action Plan' based on the six Areas for Action of the new national strategy which will be published after approval by the Partnership Board. Other areas of collaborative sub-regional work are also ongoing including co-ordinated suicide audit arrangements and a systematic approach to suicide awareness training modules.

Other network activity in the last two years has included:

- Two sub-regional Summits (2012 / 2013)
- NW Summit (2013)
- Assisting in the establishment of 2 additional "Survivors of Bereavement by Suicide" self help groups in Wirral & St Helens
- Supporting the development of Rugby League's "State of Mind" initiative
- Installation of signage on Sherdley Bridge in St Helens and Runcorn Bridge, promoting CALM and Samaritans services in known or potential suicide hotspots
- Membership of the European Suicide Reduction Network – Euregenas
- CALM re-commissioned and target group widened.

The nine local authorities within this network also provide separate resources for initiatives within their local area.

- **Knowsley Metropolitan Borough Council** has invested £500,000 into "*a public mental health programme of work to improve mental health and wellbeing*". £10,891 is provided to the CALM charity per year for suicide prevention activity targeted at men.
- **Liverpool City Council** also provides funding for CALM, and for suicide prevention training and Time to Change measures among other initiatives.
- **St Helens** and **Sefton Metropolitan Borough Councils** also provide funding to CALM. St Helens also estimates that it funds £94,000 worth of suicide prevention training with initiatives similar to that of Liverpool.
- **Wirral Metropolitan Borough Council** has invested £23,000 into the regional CALM project and is also providing for a public health manager to lead Wirral suicide prevention work locally. **Halton Borough Council** also provide suicide prevention training via public health commissioning, as well as a local post-intervention service.

- **Cheshire East Council** and **Cheshire West and Chester Council** refer to “*staff resources and a financial contribution to the Cheshire and Merseyside Public Health Collaborative Network*” in their suicide prevention work.
- We received further information from **Warrington Borough Council** at a later date, indicating that they invest in a public mental health programme to improve population wellbeing, co-ordinated through a multi-agency Mental Health Promotion and Prevention group who monitor this work through an agreed action plan. Warrington also provide mental health awareness and suicide prevention training to professionals, especially to key target groups.

The other sub-regional group is the **Greater Manchester Suicide Prevention Network** which operates under the umbrella of the Greater Manchester Public Health Network (GMPHN). The GMPHN is a membership organisation of all ten of the Greater Manchester local authorities that “*works on behalf of the Greater Manchester Directors of Public Health to ensure that public health has a strong and credible voice with national, local and regional partners.*”<sup>21</sup>

We are not aware of there being a specific sub-regional action plan but the purpose of the Suicide Prevention Network, as described by the GMPHN website, is as “*a forum for policy development and a platform for sharing information*”. This is facilitated through initiatives such as two half-day conferences per year for members which feature keynote speakers and workshops. One local authority within the Network told us that this helped to identify opportunities for development and joint working. Another told us that some initiatives need to be carried out at sub-regional level – for example, the sub-regional Network was the appropriate forum to discuss suicide prevention measures with agencies responsible for highways and the rail network.

In terms of resources at local level:

- **Manchester City Council** has access to £700,000 for a wider public mental health and emotional resilience programme, although it was not possible to specify the exact amount from that which applies just to suicide prevention.
- **Rochdale Metropolitan Borough Council** commission and support delivery of initiatives including ASIST training, mental health promotion and anti-stigma campaigns, wellbeing programmes and a social marketing campaign aimed at men aged 35-49 to encourage earlier help-seeking.
- **Oldham Metropolitan Borough Council** commission “*a range of community and wellbeing related activities*”.
- **Stockport Metropolitan Borough Council** benefits from the staff time of a public health advisor who chairs a multi-agency group which has developed a draft vision statement. A budget of £30,000 is available to fund suicide prevention and wellbeing work.

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<sup>21</sup> From Greater Manchester Public Health website, <http://www.gmphnetwork.org.uk/>

- **Trafford Metropolitan Borough Council**, pointed to the availability of existing mental health service programmes such as *“IAPT, cyber-bullying awareness for children/young people and voluntary sector programmes for mental health awareness”*.
- **Bolton Metropolitan Borough Council** referred only to public health staff time provided while **Bury Metropolitan Borough Council** said they were yet to determine exactly what resources will be allocated to suicide prevention, in line with their development of a prevention plan and strategy by 2016.
- **Tameside Metropolitan Borough Council** said that suicide prevention was indirectly supported by a range of commissioned services including a young people substance misuse service, a home visiting and befriending services and a domestic abuse advisory service.
- **Salford City Council** could not provide any details as resources would be allocated after the development of the new action plan had been completed. Similarly, **Wigan Council** said that they were using the outcomes of the joint mental health and wellbeing strategy to inform resourcing requirements moving forward but they did not specify any further details.

Of the other four local authorities in the region that are not part of either of the two sub-regional networks two have published a suicide prevention plan (Cumbria County Council and Blackburn with Darwen Borough Council), one is currently developing a plan (Lancashire County Council) and one does not have a plan but has integrated suicide prevention into its Mental Health Action Plan (Blackpool Council). In terms of resources:

- **Blackburn with Darwen Borough Council** specifically identifies £5,000 per year for ASIST training and awareness campaigns.
- **Cumbria County Council** were the first to mention EU funding to support participation in the European suicide prevention initiative “Euregenas”. The council also allocates £25,000 for suicide prevention training.
- **Lancashire County Council** reported that there is an overall public mental health budget of £473,700, with suicide prevention work (which includes ASIST training) accounting for £25,000 of that.
- **Blackpool Council** told us that their public health budget funds a number of initiatives and services aimed at improving mental health and wellbeing and reducing the risk of suicide. These include *“arts and health activities, social prescribing coordination, counselling, a workplace wellness scheme and suicide prevention training (SafeTalk and ASIST).”*

## YORKSHIRE AND THE HUMBER REGION

### Region profile

The Yorkshire and the Humber Region comprises of four English counties: North Yorkshire, West Yorkshire, South Yorkshire and East Riding of Yorkshire. It also includes a small part of Lincolnshire although most of this county is in the East Midlands region. Across the Yorkshire & the Humber region there are a total of 15 upper-tier local authorities - 5 of which are unitary authorities, 1 of which is a county council and 9 of which are metropolitan boroughs. There are also 25 CCGs in the region.

The suicide rate across the Yorkshire and the Humber region as a whole is 9.3 per 100,000 which is significantly higher than the national rate for England of 8.8 per 100,000. The population of the region is 5.28m.

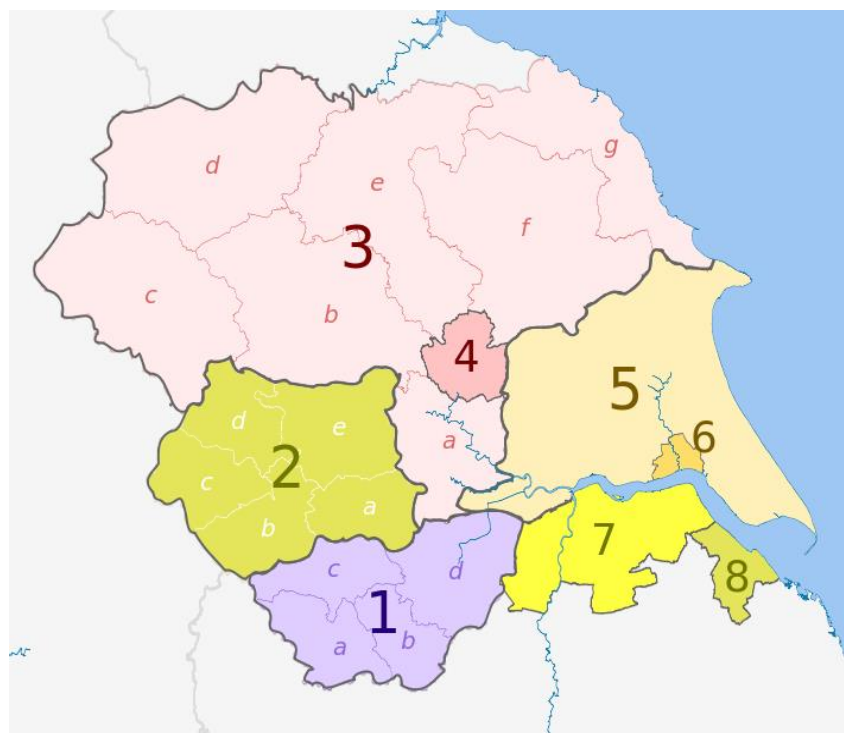
The bulk of North Yorkshire county is covered by **North Yorkshire County Council** (3 on the map) which oversees seven district councils, but there is also one separate unitary authority, **City of York** (4).

West Yorkshire is a metropolitan county (2) comprised of five metropolitan boroughs which are all independent unitary authorities. These are **Wakefield** (2a), **Kirklees** (2b), **Calderdale** (2c), **Bradford** (2d) and **Leeds** (2e).

South Yorkshire is a metropolitan county (1) comprised of four metropolitan boroughs which are all independent unitary authorities. These are **Sheffield** (1a), **Rotherham** (1b), **Barnsley** (1c) and **Doncaster** (1d).

East Riding of Yorkshire is covered by two separate unitary authorities, **East Riding of Yorkshire Council** (5) and **Kingston-upon-Hull City Council** (6).

The bulk of Lincolnshire is in the East Midlands region but part of the north of the county falls within the Yorkshire and the Humber region. This part of the county is covered by two separate unitary authorities which are **North Lincolnshire Council** (7) and **North East Lincolnshire Council** (8).



## Survey results: local action plans, multi-agency groups and suicide audits

Local authority	Q1	Q2	Q3	Suicide rate	Additional notes
Sheffield (1a)	✗	✗	①	8.5 ●	Intend to develop plan and establish group in near future.
Rotherham (1b)	✓	✓	✓	8.9 ●	Local plan established after publication of national strategy in 2012.
Barnsley (1c)	●	✓	DNR	10.2 ●	Previous plan developed by PCT is out of date – new plan being developed.
Doncaster (1d)	●	✓	②	8.6 ●	Short term actions have been identified while long-term plan is developed.
Wakefield (2a)	●	✗	①	8.1 ●	Draft plan based on national data. Local audit required to inform final version.
Kirklees (2b)	●	✓	✗	7.7 ●	Draft plan awaiting ratification.
Calderdale (2c)	✓	✓	②	10.3 ●	Action plan being reviewed in light of structural organisational changes.
Bradford (2d)	✗	✓	✓	10.8 ✗	Completing a local action plan is part of future planned work.
Leeds (2e)	●	✓	✓	9.8 ●	Local plan almost signed off by health and wellbeing board.
North Yorkshire (3)	✓	✓	②	9.7 ●	Group established in Feb 2014 – expect to develop new plan in future.
City of York (4)	✗	✗	②	10.1 ●	No specific local plan but are working closely with North Yorkshire on suicide.
East Riding of Yorkshire (5)	✓	✓	✓	7.7 ●	Local strategy with annual action plans. 2014/15 plan currently under review.
Hull (6)	✗	✗	✗	11.7 ✗	No further details provided.
North Lincolnshire (7)	●	✓	✓	11.2 ●	Draft plan awaiting formal sign off.
North East Lincolnshire (8)	●	✓	✓	8.1 ●	Local plan currently in development.

NOTE: Key to chart symbols is on page 27

## Joint working and resources

Of the 15 upper-tier local authorities in the Yorkshire and the Humber region, 10 had either published a plan or had one in development. However, at the time of the survey, only 3 of these had been published with 7 still in the drafting stage or awaiting sign off.

There is already some joint work in the region. We understand that there is some county-wide work going on in Yorkshire as North Yorkshire County Council established a new group earlier in the year and are working closely with City of York Council. At the time of the last survey in 2012 we were aware that East Riding of Yorkshire Council and Hull City Council had a joint strategy. However this time round, while East Riding of Yorkshire still have a local strategy, Hull City Council told us that they do not currently have an active suicide prevention plan/group and it appears that this work has not survived the NHS restructuring.

In terms of resources, the metropolitan authorities in South Yorkshire all mention staff time that is provided and that there are general public health budgets:

- **Sheffield City Council** did not mention any other resources beyond this and **Doncaster Metropolitan Borough Council** specifically said that no further funding for prevention apart from staff time is available.



- However, **Barnsley Metropolitan Borough Council** does reference an annual £50,000 public health grant allocated to Samaritans. **Rotherham Metropolitan Borough Council** also mention that they hosted a suicide prevention conference for frontline workers and managers in 2013 and have also produced a resource for frontline workers and the general public called 'CARE' which encourages them to act on Concerns, Ask about Suicide, Respond and Explain their actions to help a person at risk.

In West Yorkshire:

- **Wakefield City Council** also refers to staff time, pointing out that their suicide audit is funded by their public health budget.
- **Kirklees Council** make reference to "dedicated" staff time to plan initiatives and that much of the prevention work is delivered through integrated commissioning via a range of budgets (including Children & Young People budget or Better Care Fund).
- **Calderdale Metropolitan Borough Council** and **City of Bradford Metropolitan District Council** also referred to staff time with the former providing a senior commissioning manager for the purposes of suicide prevention and the latter a public health consultant for mental health, supported by other staff. Calderdale also has access to around £150,000 to address self-harm and emotional wellbeing amongst young people.
- **Leeds City Council** finances "various initiatives" including a "Postvention Project", which allocates £210,000 over three years, as well as providing for suicide prevention training and information sharing with the local coroner. They also finance bespoke Crisis cards widely targeted at and distributed to the local public.

In North Yorkshire:

- **North Yorkshire County Council** and **City of York Council** said that a business case was being developed for the joint funding of a suicide coordinator post and data clerk. North Yorkshire County also referred to other public health funding which helped to support prevention which focused on *"community resilience and providing lifestyle services, low level mental health support and brief interventions for alcohol misuse"*.

Elsewhere in the region:

- **North East Lincolnshire Council** said they have a "small" amount of funding available for mental health promotional work, and other initiatives that could be targeted towards suicide prevention such as training programmes or consultation events.
- **North Lincolnshire Council** reported a total budget for suicide prevention of £27,100 over the period 2013-15.
- **East Riding of Yorkshire Council** have funded a *"training programme, the production of resources, consultation events and the purchase and distribution of national resources"*.

## EAST MIDLANDS REGION

### Region profile

The East Midlands Region comprises of six English counties: Derbyshire, Nottinghamshire, Leicestershire, Northamptonshire, Rutland and Lincolnshire. While the majority of Lincolnshire is within the East Midlands Region, part of the north of the country falls within the Yorkshire and the Humber region. Across the East Midlands region there are a total of 9 upper-tier local authorities - 4 of which are unitary authorities and 5 of which are county councils. There are also 21 CCGs in the region.

The suicide rate across the East Midlands Region as a whole is 8.4 per 100,000 which is similar to the national rate for England of 8.8 per 100,000. The population of the region is 4.53m.

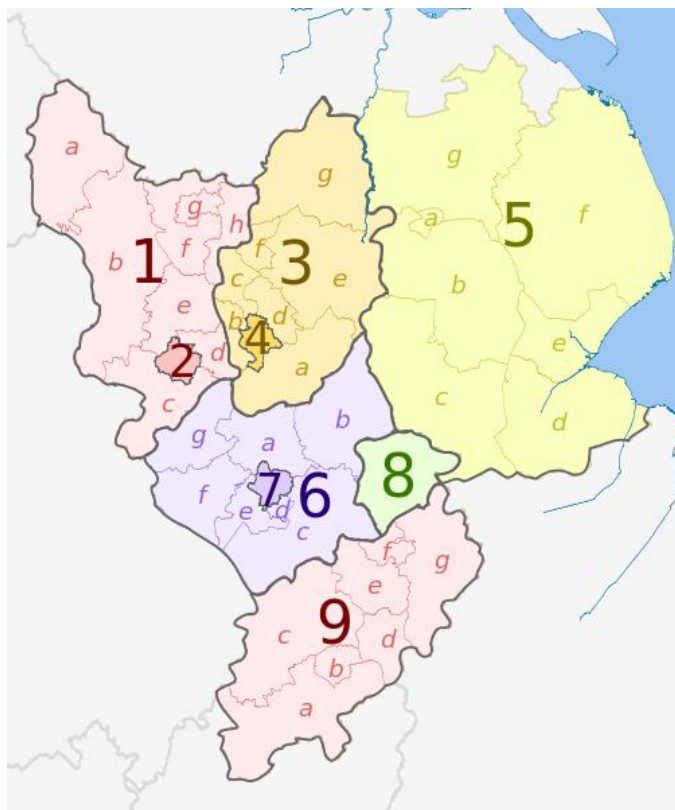
The bulk of Derbyshire county is covered by **Derbyshire County Council** (1 on the map) which oversees eight district councils, but there is also one separate unitary authority, **Derby City Council** (2).

The bulk of Nottinghamshire county is covered by **Nottinghamshire County Council** (3) which oversees seven district councils, but there is also one separate unitary authority, **Nottingham City Council** (4).

The bulk of Leicestershire county is covered by **Leicestershire County Council** (6) which oversees seven district councils, but there is also one separate unitary authority, **Leicester City Council** (7).

The county of Rutland comprises of just a single unitary authority, **Rutland County Council** (8).

Northamptonshire is covered by **Northamptonshire County Council** (9) which oversees seven district councils.



The bulk of Lincolnshire is covered by **Lincolnshire County Council** (5) which oversees seven district councils. There are also two separate unitary authorities in the north of the county but these fall within the Yorkshire and Humber region rather than the East Midlands region.

## Survey results: local action plans, multi-agency groups and suicide audits

Local authority	Q1	Q2	Q3	Suicide rate	Additional notes
Derbyshire County (1)	✓	✓	✗	6.6 ✓	Joint plan across two local authority areas covering whole of Derbyshire county. Plan updated on annual basis. There is also an annual stakeholder event.
Derby City (2)	✓	✓	✗	8.6 ●	
Nottinghamshire County (3)	✓	✓	✓	8.5 ●	Joint plan across two local authority areas covering whole of Nottinghamshire county. New draft plan for 2014-17 out for consultation.
Nottingham City (4)	✓	✓	✓	10.3 ●	
Lincolnshire County (5)	●	✓	✓	9.5 ●	Draft plan for 2014-17 due for publication shortly.
Leicestershire County (6)	✓	✓	✓	8.8 ●	Joint plan across three local authority areas covering whole of Leicestershire and Rutland counties. Current plan runs 2013-16.
Rutland (8)	✓	✓	✓	*	
Leicester City (7)	✓	✓	✓	9.1 ●	Local plan published 2011/12. Group last met in 2012 and is being re-established.
Northamptonshire (9)	✓	●	✗	8.2 ●	

NOTE: Key to chart symbols is on page 27

### Joint working and resources

Although the East Midlands has a suicide rate and population size that are both broadly similar to the national average, it is also unique among all the English regions in that it is the only one in which 100% of its local authorities have both suicide prevention plans and groups either in place or in development.

There are only nine upper-tier local authorities in the region and as there is a significant amount of joint working there are only five local strategies altogether. The counties of Derbyshire, Leicestershire and Nottinghamshire all have similar arrangements in which the unitary city authority has joined with the county council to establish a joint action plan and group. As a particularly small county with a population of just 37,600, Rutland has joined with the Leicestershire group.

Despite the 100% region wide coverage, many of the local authorities in the East Midlands **did not make a clear distinction between mental health and suicide prevention**, and **nor do they make it clear how much, if any, of the money allocated to “public health” or “mental health” budgets goes to suicide prevention strategies.**

In terms of resources:

- the **Derbyshire** group referred to the availability of staff time and the commissioning of various initiatives and services including the delivery of Suicide Awareness Training across the county, but did not specifically refer to the size of the budget for this.
- the **Nottinghamshire** group also said that there are “no allocated public health funds set aside to support suicide prevention initiatives”, but that they have a dedicated team leading the mental health agenda including to support suicide prevention initiatives. The team consists of four Public Health Managers and a Consultant in Public Health Medicine.

- the **Leicestershire/Rutland** group's reply stated that staffing support is provided from local public health departments and that funding for initiatives such as suicide prevention training provided on an ad hoc basis from the public health budget.
- The other two local authorities in the region have their own individual strategies. **Lincolnshire County Council** has the services of a "Senior Programme Officer" who leads the delivery of a prevention strategy, supported by a "Suicide Programme Officer". It has also paid for the delivery of Safe Talk and ASIST training. **Northamptonshire County Council** provides a mental health promotion budget but has no separate budget specifically for suicide prevention.

## WEST MIDLANDS REGION

### Region profile

The West Midlands Region comprises of six English counties: Shropshire, Staffordshire, Warwickshire, Worcestershire, Herefordshire and the West Midlands metropolitan county. Across the region there are a total of 14 upper-tier local authorities - 4 of which are unitary authorities, 3 of which are county councils and 7 of which are metropolitan boroughs. There are also 22 CCGs in the region.

The suicide rate across the West Midlands Region as a whole is 8.3 per 100,000 which is similar to the national rate for England of 8.8 per 100,000. The population of the region is 5.6m.

### Geography

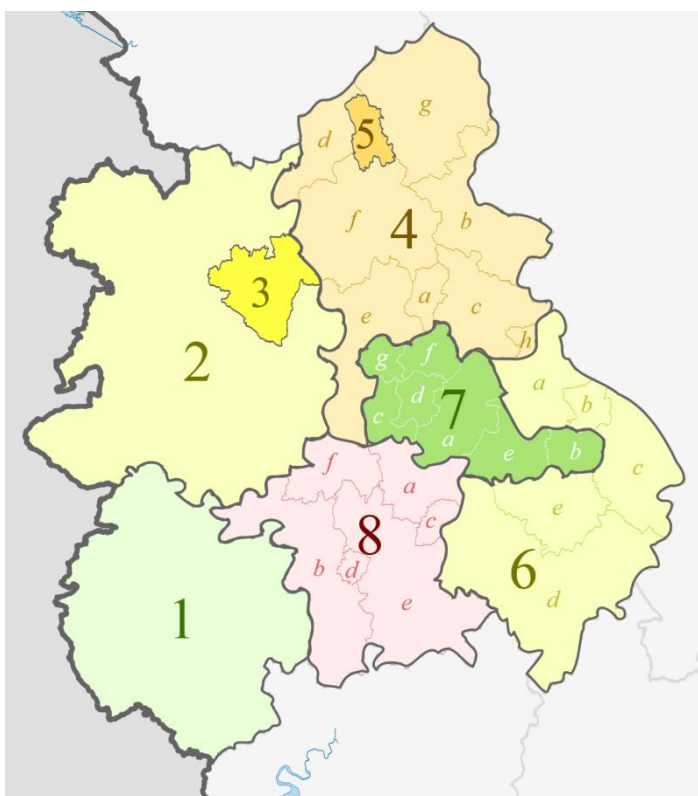
Herefordshire is covered by a single unitary authority, **Herefordshire County Council** (1 on the map).

Shropshire is covered by two unitary authorities, **Shropshire Council** (2) and **Telford & Wrekin Council** (3).

The bulk of Staffordshire is covered by **Staffordshire County Council** (4) which oversees eight district councils but there is also one separate unitary authority, **Stoke-on-Trent City Council** (5).

Worcestershire is covered by **Worcestershire County Council** (8) which oversees six district councils.

West Midlands is a metropolitan county comprising of seven metropolitan boroughs which are all independent unitary authorities. These are **Birmingham** (7a), **Coventry** (7b), **Dudley** (7c), **Sandwell** (7d), **Solihull** (7e), **Walsall** (7f) and **Wolverhampton** (7g).



Warwickshire is covered by **Warwickshire County Council** (6) which oversees five district councils.

## Survey results: local action plans, multi-agency groups and suicide audits

Local authority	Q1	Q2	Q3	Suicide rate	Additional notes
Herefordshire (1)	✗	✗	①	9.2 ●	Mental Health Steering Group has oversight of suicide audit work.
Shropshire (2)	✗	✗	✗	10.1 ●	New staff post to cover mental health. Future priorities will include suicide.
Telford & Wrekin (3)	DNR	DNR	DNR	10.2 ●	
Staffordshire (4)	✓	✗	✗	9.2 ●	Plan runs 2013-16. Implemented by mental health commissioning group.
Stoke-on-Trent (5)	✓	✓	②	12.6 ✗	Plan runs 2013-18 and is updated annually.
Warwickshire (6)	✓	✗	✗	9.3 ●	Plan runs 2012-15 but there has been no group since NHS restructure.
Coventry (7b)	✓	✗	✗	10.0 ●	Plan was developed in 2012 by NHS Coventry but no formal group.
Birmingham (7a)	✗	✗	✗	6.3 ✓	Suicide “not a key public health outcome” as local rate has declined in Birmingham.
Sandwell (7d)	✗	✓	✗	7.5 ●	Local group for suicide in children/young people – looking to expand to adults.
Dudley (7c)	✓	✓	✗	5.7 ✓	Two local strategies – one by public health, one by Mental Health Trust.
Solihull (7e)	✓	✗	①	4.5 ✓	Plan published although originally due to run 2010-13.
Walsall (7f)	✓	✗	✗	6.5 ✓	Has a “Mental Health Promotion and Suicide Prevention Strategy” for 2013-16.
Wolverhampton (7g)	✗	✗	✗	8.5 ●	Aim to develop plan/group as part of Mental Health Strategy refresh.
Worcestershire (8)	✓	✓	✓	9.1 ●	Mental Well-being and Suicide Prevention Plan runs 2014-17.

NOTE: Key to chart symbols is on page 27

## Joint working and resources

Like the East Midlands, the West Midlands also has a suicide rate and population size that are both broadly similar to the national average. Of the 14 upper-tier local authorities in the West Midlands Region we were only able to find 8 that had a local suicide prevention plan although 2 of the local authorities did not respond to the survey. As can be seen on the chart, the use of multi-agency groups and suicide audits are also quite limited in the West Midlands.

In terms of resources:

- **Stoke-On-Trent City Council** highlighted its dedicated budget from public health which is used to support training for front line staff across a range of agencies in mental health first aid/suicide awareness and to run a local suicide awareness campaign based on the approach used by Choose Life’s “Read Between the Lines” campaign. Staff time has been allocated from public health and from the CCG.
- **Warwickshire County Council** have an identified Public Health Consultant lead for mental health including suicide prevention and have also allocated £15,000 for suicide prevention training for GPs across the county in 2014/15.

- **Coventry City Council** said that they provide some funding to Samaritans to support the helpline and also support other well-being initiatives.
- **Birmingham City Council** provides approximately £10,000 per year on supporting the delivery of ASIST training.
- **Sandwell Metropolitan Borough Council** has a budget for mental health and wellbeing which covers suicide prevention. This includes the support of one of the public health programme managers and the commissioning of ASIST and self-harm awareness training for frontline staff.
- **Worcestershire County Council** and **Wolverhampton City Council** made reference only to staff time spent on suicide prevention initiatives.
- **Shropshire Council** said that they had a new member of staff to cover the mental health agenda and were working to map local service provision and to engage with partners and stakeholders. Suicide prevention is on their list of priorities but they did not indicate that any kind of formal plan or multi-agency group was yet in place.
- **Solihull Metropolitan Borough Council, Dudley Metropolitan Borough Council, Walsall Council, Staffordshire County Council** and **Herefordshire County Council** provided no specific information on any resources – staffing or financial – that are currently allocated for the purposes of suicide prevention.
- **Telford & Wrekin Council** did not respond to our survey.

## EAST OF ENGLAND REGION

### Region profile

The East of England Region comprises of six English counties: Hertfordshire, Bedfordshire, Cambridgeshire, Norfolk, Suffolk and Essex. Across the region there are a total of 11 upper-tier local authorities - 6 of which are unitary authorities and 5 of which are county councils. There are also 21 CCGs in the region.

The suicide rate across the East of England Region as a whole is 7.9 per 100,000 which is significantly lower than the national rate for England of 8.8 per 100,000. The population of the region is 5.85m.

Hertfordshire is covered by **Hertfordshire County Council** (4 on the map) which oversees ten district councils.

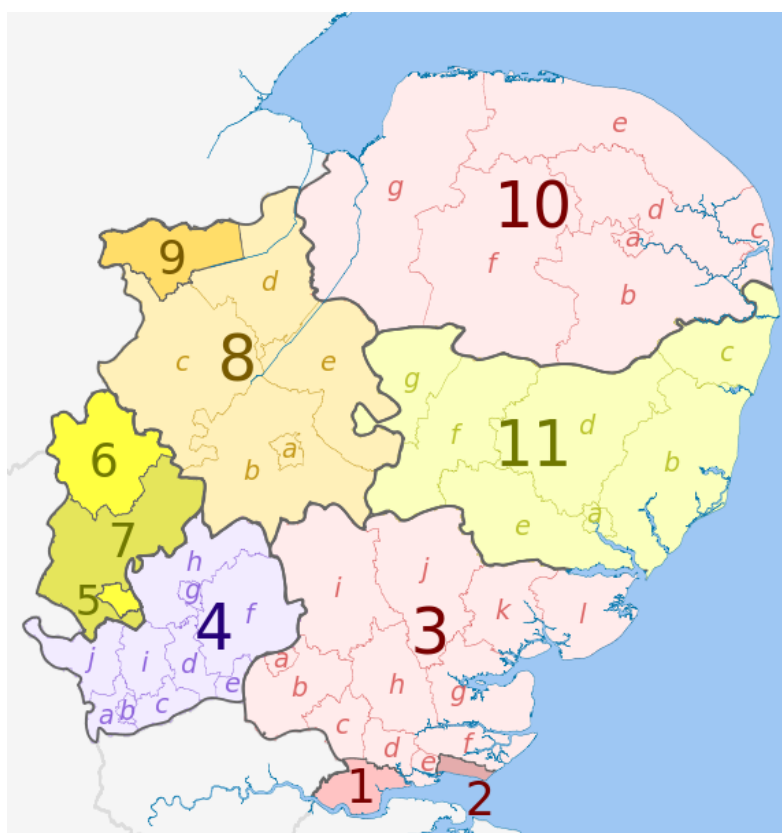
The county of Bedfordshire comprises of three separate unitary authorities, **Luton Borough Council** (5), **Bedford Council** (6) and **Central Bedfordshire Council** (7).

The bulk of Cambridgeshire is covered by **Cambridgeshire County Council** (8) which oversees five district councils but there is also one separate unitary authority,

**Peterborough City Council** (9). Norfolk is covered by **Norfolk County Council** (10) which oversees seven district councils.

Suffolk is covered by **Suffolk County Council** (11) which oversees seven district councils.

The bulk of Essex is covered by **Essex County Council** (3) which oversees twelve district councils, but there are also two separate unitary authorities, **Thurrock Council** (1) and **Southend-on-Sea Borough Council** (2).





## Survey results: local action plans, multi-agency groups and suicide audits

Local authority	Q1	Q2	Q3	Suicide rate	Additional notes
Thurrock (1)	✗	✗	✗	7.4 ●	No plans to establish plan/group in the immediate future.
Southend-on-Sea (2)	✗	✗	②	6.3 ●	Suicide audit being scoped and development of a plan will follow this.
Essex (3)	DNR	DNR	DNR	9.4 ●	
Hertfordshire (4)	✓	✗	①	5.7 ✓	No multi-agency group but public health is coordinating implementation.
Luton (5)	●	✓	✓	4.8 ✓	Plan is being developed by Suicide and Self-harm Reduction Group.
Bedford (6)	●	✓	✓	9.1 ●	Plan being developed following recent Suicide Prevention Stakeholder Event.
Central Bedfordshire (7)	✓	✓	✓	5.9 ✓	Plan completed in 2013, new plan being drawn up for 2014/15.
Cambridgeshire (8)	●	✓	②	7.8 ●	Joint strategy for Cambridgeshire and Peterborough drafted and put out for consultation.
Peterborough (9)	●	✓	②	10.4 ●	
Norfolk (10)	✓	✗	✗	8.9 ●	Plan for 2011-14 due to be reviewed. Group disbanded after closure of PCT.
Suffolk (11)	✗	✗	✓	9.0 ●	A 5-year mental health plan is being developed which will include suicide.

NOTE: Key to chart symbols is on page 27

## Joint working and resources

The East of England region has a significantly lower suicide rate than the national average with fewer deaths per 100,000 of the population than any other region except for London.

Of the 11 upper-tier local authorities in the East of England, seven had either published a plan or had one in development. One local authority (Essex County Council) did not respond to the survey.

The only joint strategy in the region is a draft Cambridgeshire-wide strategy including both Cambridgeshire County Council and Peterborough City Council that, at the time of the survey, had been put out for consultation.

In terms of resources:

- **Thurrock Council, Luton Borough Council and Southend-on-Sea Borough Council** did not allocate specific funds for suicide prevention, but said that any specific actions identified could be supported from the public health budget.
- **Suffolk County Council and Cambridgeshire County Council** both said that staff time was provided to support the suicide prevention group, as well as some funding to support suicide prevention training. **Peterborough City Council** reported that the Cambridgeshire and Peterborough CCG had recently secured a bid from Managed Clinical Network for £50,000 to support implementation of its key priorities which include the raising of awareness of suicide.

- **Norfolk County Council** referred only to staff time that was available to provide support.
- **Central Bedfordshire Council** reported that their suicide prevention group was recently awarded a grant from the Improving Mental Health Outcomes (IMHO) Pathfinder Programme to support initiatives for the next two years.
- **Hertfordshire County Council** said that they do not *have “fixed ring-fenced money available for suicide prevention”* but also said that *“each lead agency is expected to and has committed necessary resources for suicide prevention work.”*
- **Bedford Council** reported that their multi-agency suicide prevention group had been successful in receiving a grant of £50,000 from the East of England Strategic Clinical Network Pathfinder Programme.
- **Essex County Council** did not respond to our survey.

## **SOUTH EAST REGION**

### **Region profile**

The South East Region comprises of nine English counties: Oxfordshire, Buckinghamshire, Berkshire, Hampshire, the Isle of Wight, Surrey, Kent, West Sussex and East Sussex. Across the region there are a total of 19 upper-tier local authorities - 12 of which are unitary authorities and 7 of which are county councils. There are also 37 CCGs in the region.

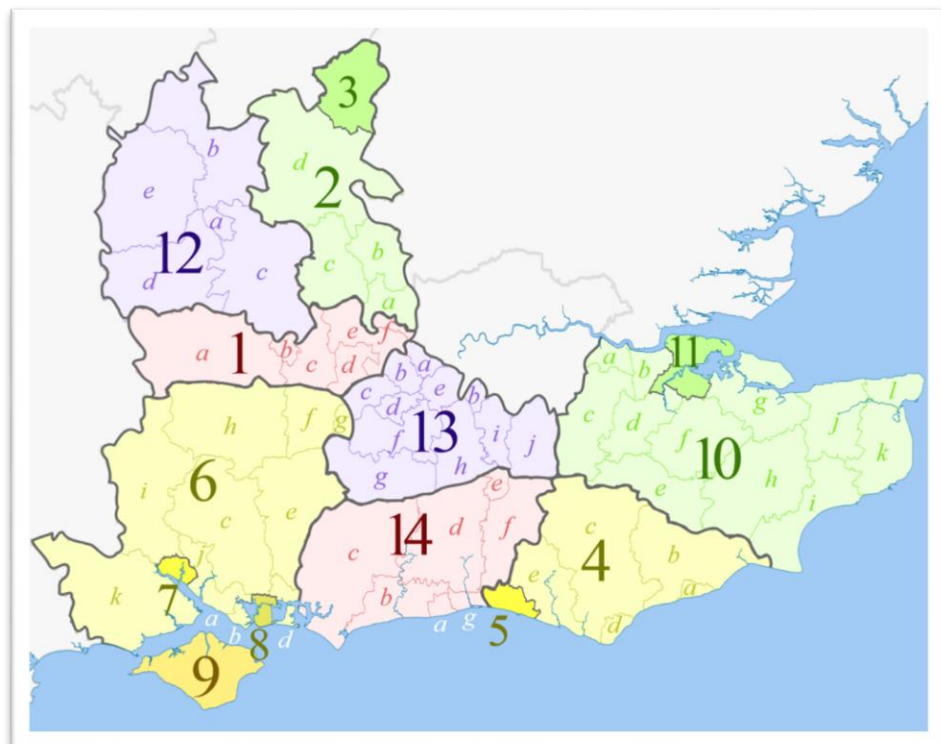
The suicide rate across the South East Region as a whole is 8.8 per 100,000 which is similar to the national rate for England of 8.8 per 100,000. The population of the region is 8.63m.

Oxfordshire is covered by **Oxfordshire County Council** (12 on the map) which oversees five district councils.

The bulk of Buckinghamshire is covered by **Buckinghamshire County Council** (2) which oversees four district councils but there is also one separate unitary authority in the county, **Milton Keynes Council** (3).

Berkshire comprises of six separate unitary authorities, **West Berkshire Council** (1a), **Reading Borough Council** (1b), **Wokingham Borough Council** (1c), **Bracknell Forest Council** (1d), the **Royal Borough of Windsor & Maidenhead** (1e) and **Slough Borough Council** (1f).

The bulk of Hampshire is covered by **Hampshire County Council** (6) which oversees eleven district councils but there are also two separate unitary authorities, **Southampton City Council** (7) and **Portsmouth City Council** (8).



The county of the Isle of Wight comprises of just a single unitary authority, **Isle of Wight Council** (9).

Surrey is covered by **Surrey County Council** (13) which oversees eleven district councils.

The bulk of Kent is covered by **Kent County Council** (10) which oversees twelve district councils but there is also one separate unitary authority in the county, **Medway Council** (11).

West Sussex is covered by **West Sussex County Council** (14) which oversees seven district councils.

The bulk of East Sussex is covered by **East Sussex County Council** (4) which oversees five district councils but there is also one separate unitary authority in the county, **Brighton & Hove City Council** (5).

### Survey results: local action plans, multi-agency groups and suicide audits

Local authority	Q1	Q2	Q3	Suicide rate	Additional notes
West Berkshire (1a)	●	✗	DNR	9.0 ●	A joint county-wide plan is in development to include all six unitary authorities in Berkshire.
Reading (1b)	●	✗	✓	8.3 ●	
Wokingham (1c)	●	✗	✗	*	
Bracknell Forest (1d)	●	✗	✓	8.7 ●	
Windsor & Maidenhead (1e)	●	✗	✓	7.0 ●	
Slough (1f)	●	✗	DNR	9.5 ●	
Buckinghamshire (2)	●	●	✗	8.8 ●	Inaugural workshop held to develop plan and establish group.
Milton Keynes (3)	✗	✗	✗	7.8 ●	Most recent strategy was 2007-10, most recent group disbanded in 2007.
East Sussex (4)	✓	✓	✓	11.0 ✗	Plan updated annually. Suicide also to be part of 2014/15 mental health strategy.
Brighton & Hove (5)	✓	✓	✓	12.9 ✗	Annual action plan with group that meets quarterly and has four working groups.
Hampshire (6)	●	●	②	8.0 ●	Strategy, group and audit all in development.
Southampton (7)	✓	✓	✓	12.1 ✗	Current strategy published in 2005, new strategy currently being written.
Portsmouth (8)	●	●	✓	11.6 ✗	Group suspended following NHS restructure but plan to recommence.
Isle of Wight (9)	✓	✓	✓	8.9 ●	Plan in place for 2014-19.
Kent (10)	✓	✓	✗	9.2 ●	Joint strategy and joint group for two local authorities covering whole of Kent county which runs 2010-15.
Medway (11)	✓	✓	✗	8.3 ●	
Oxfordshire (12)	✓	✓	✓	8.5 ●	Plan drafted with stakeholders in Dec 2013 and has now been approved.
Surrey (13)	✓	✓	①	8.2 ●	Plan for 2014/15 – 2015/16 agreed.
West Sussex (14)	●	✓	✓	8.3 ●	Group in place with 2014/15 plan in development.

NOTE: Key to chart symbols is on page 27

## **Joint working and resources**

The South East region has a suicide rate that is similar to the national average and it is the largest in England in terms of population. Suicide prevention work in the South East is relatively well developed as 18 of the 19 upper-tier local authorities in the region either have a suicide prevention plan published or in development. The only exception was Milton Keynes which disbanded its group in 2007 following the publication of its 2007-10 strategy which has not been renewed.

The main piece of joint working in the South East is in Berkshire where all six of the unitary authorities there have joined together to develop a county-wide plan. There is also a county-wide plan in Kent where Medway Council has joined with the larger authority Kent County Council. In terms of resources:

- **Brighton & Hove City Council** allocates a budget of £5,000 for initiatives led by the suicide prevention group. The wider mental health promotion budget for public health also includes £25,000 for training frontline staff in self-harm and suicide prevention, £3,000 for World Suicide Prevention Day and Suicide Safer City work, and a range of support services including those targeting men, the transgender community and people in deprived areas of the city.
- **Southampton City Council** provides both staff time and £7,000 from the public health budget to support ASIST and Safetalk suicide prevention training.
- **Isle of Wight Council** has funding of £72,875 in 2014/15 provided for public mental health initiatives that are indirectly related to suicide prevention. A further £30,000 is allocated for Mental Health First Aid courses.
- **Kent County Council** and **Medway County Council** have access to large public mental health budgets that they can draw from to support their joint suicide prevention strategy; £750,000 from Kent and £177,000 from Medway.
- **Oxfordshire County Council** and **Milton Keynes Council** also have access to a public mental health budget *“looking at preventing suicide through developing resilience and mental wellbeing”*.
- **Hampshire County Council** provides staff time and also said that resources to support suicide prevention initiatives *“have been identified within the public health budget”*.
- **West Sussex County Council** provides access to staff time and there is a public health budget of £163,000 allocated for initiatives pertaining emotional wellbeing, from which suicide prevention initiatives can be funded.
- **Windsor & Maidenhead Council, Bracknell Forest Borough Council, Reading Borough Council, Surrey County Council, Buckinghamshire County Council, Milton Keynes Council, East Sussex County Council** and **Portsmouth City Council** all referred to the provision of staff time but gave no further information on any other specific resources.
- No resources at all were specified by **Wokingham Borough Council**.

- **West Berkshire Council** and **Slough Borough Council** did not respond to our survey so we do not have information about specific resources that they have available. We are aware of their involvement in the joint Berkshire-wide suicide prevention plan from the responses from the other Berkshire authorities.

## **SOUTH WEST REGION**

### **Region profile**

The South West Region comprises of six English counties: Cornwall, Devon, Somerset, Dorset, Gloucestershire and Wiltshire. It also includes the City of Bristol which has previously been administered by Somerset and Gloucestershire at different times but currently has its own City Council. Across the region there are a total of 16 upper-tier local authorities - 12 of which are unitary authorities and 4 of which are county councils. There are also 12 CCGs in the region.

The suicide rate across the South West Region as a whole is 10.1 per 100,000 which is significantly higher than the national rate for England of 8.8 per 100,000. The population of the region is 5.29m.

Cornwall includes **Cornwall County Council** (16 on the map) and the **Council of the Isles of Scilly** (15) off the coast, both of which are unitary authorities.

The bulk of Devon is covered by **Devon County Council** (12) which oversees eight district councils but there are also two separate unitary authorities in the county, **Plymouth City Council** (14) and **Torbay Council** (13).

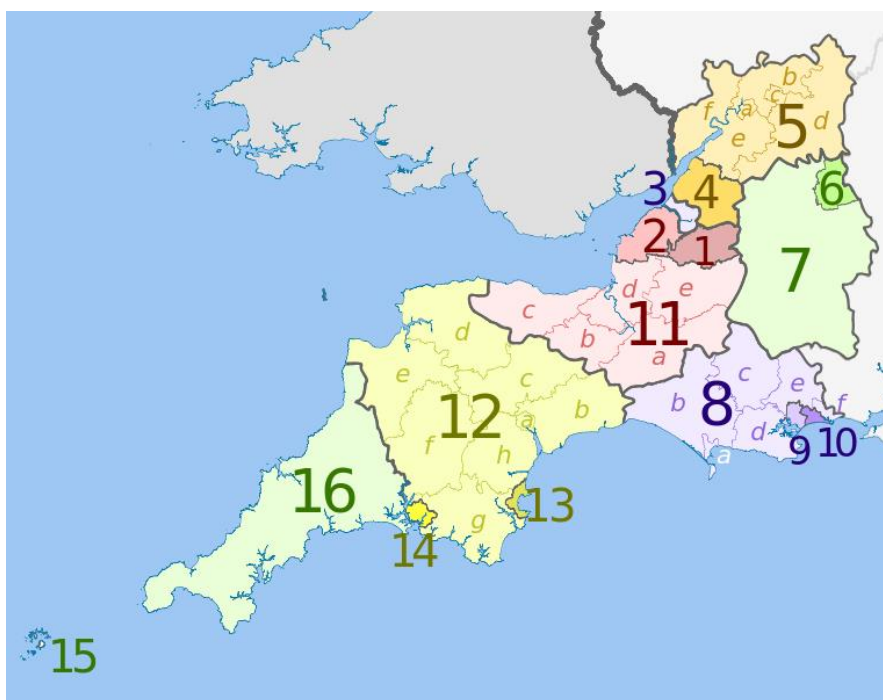
The bulk of Dorset is covered by **Dorset County Council** (8) which oversees six district councils but there are also two separate unitary authorities, the **Borough of Poole** (9) and **Bournemouth Borough Council** (10).

The bulk of Somerset is covered by **Somerset County Council** (11) which oversees five district councils but there are also two separate unitary authorities, **North Somerset Council** (2) and **Bath and North East Somerset Council** (1).

Bristol is represented by a single unitary authority, **Bristol City Council** (3).

Wiltshire comprises of two unitary authorities, **Wiltshire Council** (7) and **Swindon Borough Council** (6).

Gloucestershire comprises of one unitary authority, **South Gloucestershire Council** (4), and one county council, **Gloucestershire County Council** (5) which oversees six district councils.



## Survey results: local action plans, multi-agency groups and suicide audits

Local authority	Q1	Q2	Q3	Suicide rate	Additional notes
Bath & North East Somerset (1)	✓	✓	①	10.2 ●	Current strategy runs 2012-15. Group meets quarterly.
North Somerset (2)	●	●	✓	9.6 ●	Strategy being developed and there are plans to set up a group.
Bristol (3)	✓	✓	✓	10.0 ●	Plan runs 2013-16.
South Gloucestershire (4)	●	✓	✓	7.6 ●	2014/15 plan in development based on recently refreshed audit.
Gloucestershire County (5)	✓	✓	①	11.5 ✕	Strategy runs 2011-2015 and is supported by 2-year rolling action plan.
Swindon (6)	✓	✓	✓	9.3 ●	Audit and action plan updated annually.
Wiltshire (7)	●	●	①	8.0 ●	Plan to be drafted and group to be established soon.
Dorset (8)	✕	✕	②	10.2 ●	Joint response received from these three local authorities which work together on various issues but do not have a specific suicide prevention plan or group at present.
Poole (9)	✕	✕	②	8.3 ●	
Bournemouth (10)	✕	✕	②	9.6 ●	
Somerset (11)	✓	✓	✓	9.8 ●	Plan runs 2013-16. Group has been active for at least five years.
Devon (12)	●	●	✓	10.4 ✕	Group to be drawn from Public Mental Health Alliance members. Plan due soon.
Torbay (13)	●	●	✓	11.7 ●	Plan has gone to Mental Health Redesign Board meeting.
Plymouth (14)	●	✓	✓	11.3 ✕	Group working on development of new action plan.
Isles of Scilly (15)	✓	✓	✓	*	Joint strategy across these two local authority areas refreshed and approved in 2013.
Cornwall (16)	✓	✓	✓	11.7 ✕	

NOTE: Key to chart symbols is on page 27

## Joint working and resources

The South West Region is the only part of southern England that has a suicide rate significantly higher than the national average and perhaps as a consequence of this, the suicide prevention work in the region is relatively well developed. While none of the three local authorities in the county of Dorset currently have a specific suicide prevention plan or group at present, the other 13 local authorities throughout the rest of the region all either have a local plan published or in development.

The only joint strategy that we are aware of is between Cornwall County Council and the much smaller neighbouring local authority of the Isles of Scilly.

In terms of resources:

- **Bath and North East Somerset Council** identified two key public health staff who allocate part of their role to support suicide prevention work, as well as some funds, although we were told that it was hard to specify the exact proportion of financial resources set aside to support suicide prevention initiatives. There was a “dedicated sum” for suicide-specific



programmes alongside a wider range of locally funded programmes which aim to improve mental wellbeing or to provide support to people facing specific issues such as unemployment or debt.

- **Bristol City Council** also pointed to the availability of staff time to support the multi-agency group, and a budget aimed at commissioning well-being initiatives and support for high-risk groups.
- **South Gloucestershire Council** indicated that staff time was available from their Consultant in Public Health, their Outcome Manager and a Commissioning Officer to support prevention activities. There was also investment in ASIST and Mental Health First Aid Training, as well as *“Peer Mentoring for school children who may be experiencing emotional distress”*.
- In addition to staff time, **Wiltshire Council** allocated a budget of £15,000 in 2014/15 for the implementation of a self-harm register across three acute trusts and had set aside an additional £10,000 for supporting further initiatives through the development of the local suicide prevention plan.
- The joint response from **Dorset County Council, Bournemouth Borough Council** and the **Borough of Poole** referred mainly to staff time and also said that there was a small amount of funding used to provide training such as Mental Health First Aid.
- **Somerset County Council** identified £11,000 that it allocated to suicide prevention in the previous year, a significant amount of which was used to commission ASIST suicide prevention training.
- **Plymouth City Council** referred to staff time, financial support for ASIST and Mental Health First Aid training and sponsorship of the Plymouth Mental Health Network Annual Conference in 2014 which was themed *“Let’s Talk About Suicide and Self-harm”*.
- **Swindon Borough Council** identified a Public Mental Health budget for 2013/14 of £50,000 which supports initiatives including ASIST training and mental health first aid courses, the establishment of a self-harm register at the local hospital and the development of self-harm guidelines for schools.
- **Cornwall County Council** and **Isles of Scilly Council** referred to staff time commenting that suicide prevention is a responsibility of a Consultant in Public Health allocated for two days a week who is supported by a full-time mental health promotion manager. Public health funding has supported ASIST training and Kernow CCG has commissioned a suicide liaison service to support people bereaved by suicide.
- **Gloucestershire County Council** and **Devon County Council** referred to the provision of staff time but gave no further information on any other specific resources.
- **Torbay Council** could not identify specific resources that relate to suicide prevention, other than staff time which relates to part of the role of a public health principal.

- **North Somerset Council** has identified staff working on suicide prevention and has developed a public mental health strategy.

## **LONDON REGION**

The London Region comprises of 33 local authority areas of which 32 are London Boroughs and 1 is the City of London Corporation. All of these are single-tier local authorities. There are also 32 CCGs in the region, most of which match the boundaries of the local authorities. The Hackney and City CCG covers both the Hackney Borough area and the City of London Corporation area. The suicide rate across the London Region as a whole is 7.2 per 100,000 which is significantly lower than the national rate for England of 8.8 per 100,000. The population of the region is 8.17m.



- |                          |                           |                     |
|--------------------------|---------------------------|---------------------|
| 1 - City of London       | 15 - Richmond upon        | 28 - Waltham Forest |
| 2 - City of Westminster  | Thames                    | 29 - Haringey       |
| 3 - Kensington & Chelsea | 16 - Kingston upon Thames | 30 - Enfield        |
| 4 - Hammersmith & Fulham | 17 - Merton               | 31 - Barnet         |
| 5 - Wandsworth           | 18 - Sutton               | 32 - Harrow         |
| 6 - Lambeth              | 19 - Croydon              | 33 - Hillingdon     |
| 7 - Southwark            | 20 - Bromley              |                     |
| 8 - Tower Hamlets        | 21 - Lewisham             |                     |
| 9 - Hackney              | 22 - Greenwich            |                     |
| 10 - Islington           | 23 - Bexley               |                     |
| 11 - Camden              | 24 - Havering             |                     |
| 12 - Brent               | 25 - Barking & Dagenham   |                     |
| 13 - Ealing              | 26 - Redbridge            |                     |
| 14 - Hounslow            | 27 - Newham               |                     |

### Survey results: local action plans, multi-agency groups and suicide audits

Local authority	Q1	Q2	Q3	Suicide rate	Additional notes
City of London (1)	✗	✗	①	*	These two local authorities are jointly undertaking a suicide audit. Recommendations from this will lead to the development of an action plan.
Hackney (9)	✗	✗	①	8.0 ●	
City of Westminster (2)	✓	✓	✓	10.1 ●	These three local authorities have a Tri-borough strategy for 2013-18 and a group with membership from across the three local authority areas.
Kensington & Chelsea (3)	✓	✓	✓	7.5 ●	
Hammersmith & Fulham (4)	✓	✓	✓	9.7 ●	
Wandsworth (5)	●	✓	①	8.7 ●	Group is chaired by Public Mental Health lead and is developing new plan.
Lambeth (6)	✗	✗	✗	7.9 ●	No plan but suicide prevention is an objective of mental health commissioning.
Southwark (7)	✓	✗	✗	7.5 ●	Plan published in 2005, supported by public health consultant but no group.
Tower Hamlets (8)	✗	✗	✗	8.4 ●	There is a mental health strategy for 2014-19 but not suicide specific.
Islington (10)	●	●	✓	8.5 ●	Joint strategy between these two local authorities. Last plan ran 2007-12, new plan in development.
Camden (11)	●	●	✓	7.8 ●	
Brent (12)	✗	✗	✗	7.2 ●	No plan/group/audit. No further information provided.
Ealing (13)	✗	✗	✗	7.8 ●	Last action plan was drafted in 2011 but there is no current plan.
Hounslow (14)	✗	●	✗	5.9 ✓	No plan but looking to set up group soon.
Richmond upon Thames (15)	●	✗	①	6.4 ●	Suicide/self-harm strategy being drawn up expected to be published in 2015.
Kingston upon Thames (16)	✗	✗	①	7.0 ●	No plan but will "probably" develop one in future.
Merton (17)	✗	✗	✗	7.9 ●	No plan but adult mental health review will address suicide prevention.
Sutton (18)	✗	✗	✗	7.2 ●	No plan but suicide will form part of JSNA which may then inform a future plan.
Croydon (19)	✗	✗	✗	6.2 ✓	No plan/group but there is a multi-agency mental health partnership group.
Bromley (20)	✓	✗	✓	7.2 ●	Audit and plan published each year.
Lewisham (21)	✗	✗	✗	8.1 ●	No suicide plan/group but there is a Mental Health Executive Group.
Greenwich (22)	✗	✗	①	5.2 ✓	No plan/group but JSNA identifies mental health as a priority.
Bexley (23)	✗	✗	✗	8.8 ●	No plan/group/audit. No further information provided.
Havering (24)	✗	✗	✗	6.9 ●	No plan/group/audit. Council highlights local mental health/vol sector services.
Barking & Dagenham (25)	✗	✗	✗	6.7 ●	There is a mental health strategy being developed and a Mental Health Subgroup.
Redbridge (26)	✓	✓	✓	6.1 ✓	Plan runs 2013-15 and there is a multi-agency steering group.
Newham (27)	✗	✗	✗	5.5 ✓	No plan/group but a JSNA is being carried out which will include mental health.
Waltham Forest (28)	●	✓	①	6.5 ✓	Consultation recently completed on new plan which will run until 2016.
Haringey (29)	✗	✗	①	8.5 ●	Suicide prevention integrated into overall mental health and wellbeing policy.
Enfield (30)	✗	✗	✗	5.7 ✓	Objective of developing plan is included in Mental Health Strategy for 2014-19.

Barnet (31)	x	x	x	5.7 ✓	No plan but "local partners have been meeting with a view to developing one".
Harrow (32)	✓	✓	x	5.0 ✓	Local action plan in place. Last meeting of group was Oct 2012.
Hillingdon (33)	x	✓	x	7.8 ●	Currently undertaking needs assessment and development of plan will follow.

NOTE: Key to chart symbols is on page 27

### Joint working and resources

The London region has the lowest suicide rate of all the regions of England and it appears that this has led to suicide prevention falling down the list of priorities for public health in the capital. As many as 21 out of the 33 local authorities in London told us that they had no suicide prevention plan at all.

The only active joint strategy in the region was part of the "Tri-borough" arrangements that are in place in the three West London Boroughs of Hammersmith & Fulham, Kensington & Chelsea and Westminster City. Islington and Camden Boroughs have previously worked together but their last joint strategy expired in 2012. Hackney Borough have also been working with the much smaller City of London authority to jointly conduct a suicide audit and presumably would work together should they develop a formal strategy in future.

- The "Tri-borough" Public Health Service has a £60,000 budget from which suicide prevention work is commissioned across the three boroughs. Initiatives have included a resource pack for people bereaved by suicide, joint work with the CALM charity targeting young men, and partnership work with Samaritans, NCP Car Parks, TfL and London Underground to install posters at known suicide hotspots.
- **Islington Borough Council** and **Camden Borough Council** reported that there are "significant resources in the Deputy Director's team for mental health promotion and suicide prevention, and analytical resources". Programmes commissioned have including training such as mental health first aid and community development/outreach. A further initiative on suicide prevention pathway mapping was expected to be commissioning shortly.
- The **City of London Borough Council** and **Hackney Borough Council**, which work together on public health matters, indicated that suicide prevention is included within the budget for mental health and will include the development of a new integrated mental health network as well as a new drug and alcohol service.
- **Lambeth Borough Council** and **Southwark Borough Council**, which gave a joint response, said that suicide prevention work is subsumed within mental health commissioning and had included funding for STORM training.
- **Tower Hamlets Borough Council** told us that they provide resources to support their mental health strategy rather than specifically for suicide prevention but did not elaborate on what the funding is used for.

- **Ealing Borough Council** has appointed a new public health specialist whose role will include responsibility for suicide prevention. A public health grant of £60,000 has been allocated in 2014/15 to be spent on ASIST training for front line staff.
- **Hounslow Borough Council** has provided £30,000 for suicide prevention and mental health promotion activities for 2014/15 from the public health budget.
- **Kingston-upon-Thames Borough Council** said that their public health budget for mental well-being is approximately £100,000.
- **Sutton Borough Council** told us that funding was available for suicide prevention initiatives including the recruitment of a public health manager whose remit will include suicide prevention.
- **Barking & Dagenham Borough Council** have funding for various initiatives including £30,000 for the “Big White Wall” online tool for people with anxiety and depression, “Creative for Life” creative interventions for people with anxiety and depression and £60,000 for mental health first aid training.
- **Waltham Forest Borough Council** referred to the use of a Public Health Strategist who leads on suicide prevention work and the funding of a project with Samaritans from the public health grant. **Lewisham Borough Council** also referred to the provision of a programme of training for front line workers on mental health awareness and mental health first aid. **Greenwich Borough Council’s** public health team also provide mental health first aid training and ASIST training.
- **Wandsworth Borough Council** referred to staff time and a public mental health budget of £10,000, although they indicated that this would rise to £60,000 in time.
- **Redbridge Borough Council** said that resources have been identified to implement the suicide prevention strategy but did not elaborate further.
- **Enfield Borough Council, Hillingdon Borough Council, Bromley Borough Council, Bexley Borough Council** and **Merton Borough Council** referred only to the availability of staff time and wider mental health budgets.
- The remaining Borough Councils of **Haringey, Havering, Newham, Barnet, Harrow, Croydon, Brent** and **Richmond-upon-Thames** said that no funding is provided for specific suicide prevention initiatives although some did refer to the availability of wider mental health budgets.

## **Relationship between local suicide prevention plans and the local suicide rate**

At the time of the publication of the previous report of the APPG in 2012, a common question we were asked was whether we had found any correlation between areas that had not produced a suicide prevention action plan and areas that had particularly high suicide rates. The implication of this query was that areas that did not put in place effective suicide prevention initiatives were consequently likely to see a higher number of suicide deaths.

However, the difficulty in examining whether such a link exists is that there are wide range of different factors that impact on a local suicide rate, the most obvious of these being the relative level of deprivation in each area. It is important to recognise that a higher than average suicide rate in a particular local authority area is not necessarily a reflection of the quality of mental health services or suicide prevention initiatives being delivered in that locality. Rather it may be a consequence of wider issues such as higher levels of unemployment/deprivation or related to specific demographic factors.

The link between suicide and difficult economic circumstances is well established. Research shows that economic cycles give a clear indication of suicide trends, and recessions have been shown to be accompanied by an increase in suicide rates. Studies show that people who are unemployed are two to three times more likely to die by suicide than people in employment<sup>22</sup>, with unemployed men more at risk than unemployed women<sup>23</sup>. Increased bankruptcies, housing insecurities<sup>24</sup> and debt problems are all also associated with increased suicide risk<sup>25</sup>. A Samaritans research report published in 2012, *Men Suicide, and Society*<sup>26</sup>, emphasised that men of lower socio-economic position in their mid-years are particularly vulnerable to death by suicide<sup>27</sup>. It found that men in the lowest social class, living in the most deprived areas, are up to ten times more at risk of suicide than those in the highest social class, living in the most affluent areas. We must therefore expect to see higher suicide rates in local authority areas with high levels of deprivation irrespective of whether that local authority has a suicide prevention plan in place or not.

Local public health teams can typically be expected to prioritise the use of their finite resources based on public health issues that they can identify from local health data. It is reasonable to expect that local authorities with high suicide rates are more likely to have a local suicide prevention plan than those with lower rates because they have a more pressing need to respond to the problem. When compiling the results of our survey it was particularly striking that large parts of the London region had little or no suicide prevention planning but that it was also the region with the lowest suicide rate in the country.

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<sup>22</sup> Platt, S., *Suicide and Work*, in *Suicide in Specific Populations*. 2003, Psychiatry. Copyright 2003 The Medicine Publishing Company. P. 25-28.

<sup>23</sup> Platt, S. and K. Hawton, *Suicidal Behaviour and the Labour Market*, in *The International Handbook of Suicide and Attempted Suicide*, K. Hawton and K. van Heeringen, Editors. 2000, John Wiley & Sons, Ltd: Chichester, West Sussex. p. 309-384.

<sup>24</sup> Viren, M., *Suicide and business cycles: new empirical evidence*. Applied Economics Letters, 2005. **12**: p. 887-892.

<sup>25</sup> Stack, S. and I. Wasserman, *Economic strain and suicide risk: A qualitative analysis*. Suicide and Life-Threatening Behavior, 2007. **37**(1): p. 103-112.

<sup>26</sup> *Men, Suicide and Society: Why disadvantaged men in mid-life die by suicide*, Samaritans (2012) <http://www.samaritans.org/about-us/our-research/research-report-men-suicide-and-society>

<sup>27</sup> Haw, C, Hawton K, Gunnell, D, & Platt, S, 2014, "Economic recession and suicidal behaviour: Possible mechanisms and ameliorating factors". *The International Journal of Social Psychiatry*.

This was a noticeable pattern throughout the country. The following chart compares the suicide rate in each region to the proportion of local authorities in that region that have a suicide prevention plan (either active or in development). We found that just over 69% of local authorities across England had a plan and so each region is marked red or green according to whether their proportion of authorities with local plans were higher or lower than the national average. As can be seen from the chart, the regions with the higher suicide rates have responded to this as they typically have a higher proportion of local authorities with a suicide prevention plan.

Yorkshire and the Humber was the only region not to fit this pattern (although four of their five local authorities without a local action plan did tell us that they intended to develop one as part of their future work). This is particularly concerning as in our 2012 inquiry, the Humber in particular came across incredibly well, and it must be hoped that they are able to address this situation.

**FIGURE 7 – Suicide rate and proportion of local authorities with suicide prevention plans by region**

Region	Suicide rate	% of authorities with suicide prevention plan
NATIONAL	8.8	69.1%
North East	10.6 ✖	83.3% ✓
North West	10.1 ✖	78.3% ✓
South West	10.1 ✖	81.3% ✓
Yorkshire and the Humber	9.3 ✖	66.6% ✖
South East	8.8 ●	94.7% ✓
East Midlands	8.4 ●	100.0% ✓
West Midlands	8.3 ●	57.1% ✖
East of England	7.9 ✓	63.6% ✖
London	7.2 ✓	36.4% ✖

An alternative comparison is to look at the specific local authority areas with the highest suicide rates and examine how they have responded. The chart below comprises of the 20% of local authority areas in England with the highest suicide rates. In addition to their response to the survey on whether they have suicide prevention plans/group/audits, we have also added the level of deprivation and the unemployment rate in that area.

To identify the level of deprivation in these areas we looked at English Indices of Deprivation<sup>28</sup>. Published by the government, these are statistics on relative levels of deprivation in England. The most recent data available is from 2010 with the next update due in summer 2015. In this column each authority is colour coded red, amber or green according to whether they are in the top, middle

<sup>28</sup> English indices of deprivation 2010, (DCLG) <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2010>



or bottom third in the rank of relative deprivation.

The unemployment figures are taken from ONS official labour market statistics<sup>29</sup> and in this column, local authorities are colour coded red or green according to whether their unemployment rate is higher or lower than the national average.

**FIGURE 8 – 20% of local authority areas with the highest suicide rates in England**

Local authority (region)	Q1	Q2	Q3	Suicide rate (England: 8.8)	Deprivation rank	Unemployment rate (England: 6.8%)
Blackpool (NW)	✗	✗	①	13.6	10th/326	10.0%
County Durham (NE)	✓	✓	✓	13.4	70th/326	8.7%
Brighton & Hove (SE)	✓	✓	✓	12.9	67th/326	6.7%
Middlesbrough (NE)	✓	✓	✓	12.8	27th/326	13.2%
Stoke (WMid)	✓	✓	②	12.6	18th/326	9.1%
Southampton (SE)	✓	✓	✓	12.1	72th/326	7.4%
Blackburn (NW)	✓	✓	✓	12.0	28th/326	8.6%
St Helens (NW)	✓	●	✓	11.9	64th/326	9.9%
Manchester (NW)	✓	✓	✗	11.8	4th/326	10.1%
Cornwall (SW)	✓	✓	✓	11.7	82th/326	5.3%
Kingston upon Hull (Yorks)	✗	✗	✗	11.7	15th/326	12.6%
Torbay (SW)	●	●	✓	11.7	49th/326	7.5%
Portsmouth (SE)	●	●	✓	11.6	76th/326	7.2%
Gloucestershire (SW)	✓	✓	①	11.5	*219th/326	4.9%
Bolton (NW)	✓	✓	✓	11.5	48th/326	9.3%
North Tyneside (NE)	●	●	✗	11.4	124th/326	8.1%
Northumberland (NE)	✓	✓	✗	11.4	144th/326	7.0%
Stockport (NW)	●	✓	DNR	11.4	167th/326	5.8%
Hartlepool (NE)	✓	✓	✓	11.4	30th/326	12.5%
Plymouth (SW)	●	✓	✓	11.3	80th/326	7.7%
Wigan (NW)	✗	✗	✓	11.3	85th/326	8.6%
North Lincolnshire (Yorks)	●	✓	✓	11.2	129th/326	6.9%
Knowsley (NW)	✓	✗	✓	11.1	12th/326	9.7%
East Sussex (SE)	✓	✓	✓	11.0	*130th/326	4.9%
Cumbria (NW)	✓	✓	✓	10.9	*128th/326	5.7%

<sup>29</sup> Official Labour Market Statistics (ONS), Labour supply: Employment and unemployment (Jul 2013-Jun 2014) [www.nomisweb.co.uk](http://www.nomisweb.co.uk)

Bradford (Yorks)	✗	✓	✓	10.8	33rd/326	10.2%
Devon (SW)	●	●	①	10.4	*157th/326	5.5%
Peterborough (East)	●	✓	②	10.4	79th/326	7.4%
Calderdale (Yorks)	✓	✓	②	10.3	110th/326	7.7%
Nottingham City (EMid)	✓	✓	✓	10.3	17th/326	11.8%

(\*) Note on data: The English Indices of Deprivation rank of deprivation by local authority area uses district councils in areas where they exist. This means that the local authorities on this list area ranked out of 326 rather than 152. For the purposes of this chart, the nominal ranks of the four county councils on this list (denoted by the \* symbol) have been calculated by using an average of the ranks of the district councils within the county council boundaries. While this is not an ideal method, it does give a general indication of the relative level of deprivation in these areas.

Unsurprisingly most of these local authority areas had higher than average levels of deprivation. The first thirteen local authorities on the list ranked within the top 30% of the most deprived areas according to the government's Indices of Deprivation measure. 70% of the local authorities on the list as a whole were ranked within the top 30% of the most deprived area (21 out of 30). Over three-quarters of the local authorities on the list had an above average rate of unemployment (23 out of 30).

As with the regional pattern, we also find that specific local areas with high suicide rates are more likely to provide a public health response to this. As can be seen in the table below, the proportion of local authorities with suicide prevention plans, multi-agency groups and carrying out suicide audits were higher than the national average in these areas.

**FIGURE 9 – Prevalence of suicide prevention work – areas with high suicide rates compared to national average**

Proportion of local authorities with...	20% of areas with highest suicide rates	National average
A suicide prevention plan	86.7%	69.1%
A multi-agency group	86.7%	57.9%
A suicide audit	83.3%	65.8%

Nevertheless, despite this apparent pattern it is important to note that while some regions might have a lower than average suicide rate this is not a valid reason for a local authority not to pro-actively develop initiatives to prevent suicide in its area. While the London region has a suicide rate of 7.2 deaths per 100,000 compared to the national average of 8.8 per 100,000, this still represents a total of 1,678 deaths in the three year period from 2011 to 2013 many of which may have been preventable.

## **RECOMMENDATIONS**

**Public Health England and the NSPSAG should give consideration to whether support could be provided to set up additional sub-regional suicide prevention groups across a number of local authorities similar to the existing ones in Greater Manchester and the Cheshire/Merseyside area.**

**Public Health England should urgently investigate the worrying low level of suicide prevention activity in the Greater London area and work with local authorities to establish new local plans and multi-agency groups.**

## **PART FIVE – Engagement with the Police**

In the case of the last report, the focus was on local authorities, which was where the Call for Evidence was initially directed. However further information from other agencies, particularly the police, emerged during the course of the gathering of evidence. Although this report has also focused primarily on local authorities, consideration has also been given to the role of the police.

*“Police intervention when somebody is in need of mental health care is an indication of failure of statutory services.”<sup>30</sup>*

Police officers are one of the most regular points of contact for people in mental health crisis and also for families who have been bereaved through a suicide; increasingly it has become the case that police officers are fulfilling roles that were traditionally dealt with by professionals within health or social care services. The Inquiry initially extended invitations to give evidence to Directors of Public Health and other related professionals, but subsequently also made contact with representatives in the police.

The Inquiry subsequently heard submissions from suicide lead representatives from within the British Transport Police and the Metropolitan Police, detailing their day-to-day work with those undergoing mental health crisis and their experience of the success or otherwise of suicide prevention plans. The British Transport Police in particular have a high rate of contact with individuals in distress.

For every sexual offence dealt with on the railways, there are 15 mental health incidents, four of which relate to suicide. For every offence of robbery, there are 39 mental health incidents, 10 of which will relate to suicide. For every non-sexual assault, there are two mental health incidents.<sup>31</sup>

In 2013, there were more phone calls placed to the British Transport Police relating to mental health incidents than there were reports of robbery and assault combined. Overall, the British Transport Police prevents 1.7 people per day from taking their own life on the railway system.<sup>32</sup>

Despite their high rate of contact with those undergoing potential mental health crisis and those attempting to take their own life, both the British Transport Police and the Metropolitan Police gave examples of where police officers felt unprepared to give such individuals the appropriate aftercare.

This can lead to difficult situations where an officer has been in contact with somebody intending to take their own life, escorted them either home or for medical examination, and then if the individual subsequently takes their own life - even if that takes place weeks after they have been in contact - the officer is placed under formal investigation by the Independent Police Complaints Commission.

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<sup>30</sup> HC Home Affairs Select Committee, 1 July 2014

(<http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/home-affairs-committee/policing-and-mental-health/oral/11179.html>)

<sup>31</sup> British Transport Police, Written Submission to HC Home Affairs Select Committee, 13 May 2014

(<http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/home-affairs-committee/policing-and-mental-health/written/9179.pdf>)

<sup>32</sup> British Transport Police, Written Submission to HC Home Affairs Select Committee, 13 May 2014

(<http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/home-affairs-committee/policing-and-mental-health/written/9179.pdf>)

*“If the person dies after we have been in contact with them, we are subject to an investigation by the Independent Police Complaints Commission; we were not at the point of leaving them responsible for that individual but we are finding ourselves investigated if they later go on to take their own life...there is no equivalent investigation for health professionals. (British Transport Police representative in Evidence Session)”*

For its part, the Independent Police Complaints Commission has stated that it believes police are “too often” asked to deal with “acutely mentally ill people who may be a danger to themselves” due to failures of provision. Whilst the IPCC also maintains that, on the whole, officers have the appropriate training to respond to people in such a position, our evidence suggests that officers do not feel they are fully equipped to deal with individuals who may be at risk of taking their own life, or whom the exact responsibility with such individuals lies with.<sup>33</sup>

As well as corroborating the evidence from the British Transport Police, the Metropolitan Police also had an individual perspective on the varying degrees of success of different prevention plans. The Metropolitan Police have recently introduced a community model operating in 10 boroughs which they are waiting for full results on; the joined-up plan is designed to include representatives from the local community in its planning and operation.

*“Whenever we (the Metropolitan Police) conduct analysis of areas (where high levels of suicide may be occurring), it is often dynamic and for tactical reasons. (Metropolitan Police representative in Evidence Session)”*

A recent study which focused on suicide in Darlington and County Durham over a three-year period identified a total of 205 individual cases of suicide, 41 of whom had a documented contact with the police at least three months prior to taking their own life, while an additional seven cases had impending court appearances.<sup>34</sup> In a quarter of suicide cases, the person in question had been in direct contact with the criminal justice system within the previous three months.

The evidence received from police representatives by the Group reflected the concerns that were heard from health professionals, from previous adjournment and Westminster Hall debates, and also from the previous inquiry.<sup>35</sup>

The current situation was acknowledged as disappointing by the former Policing Minister during the most recent Westminster Hall debate on the subject of police procedures in dealing with mental health, when he was asked to respond to the point that police are taking on increased responsibilities.

*“It is obvious that the police have, and will continue to have, a key role in dealing with mental health issues as they arise. They need to be adequately trained to identify vulnerabilities and behaviours that require further intervention, but they are not and cannot replace health professionals. Both*

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<sup>33</sup> Independent Police Complaints Commission, Written Submission to HC Home Affairs Select Committee 13 May 2014 (<http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/home-affairs-committee/policing-and-mental-health/written/9015.html>)

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

<sup>35</sup> Hansard, HC Deb, 28 November 2013, c140WH (<http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm131128/halltext/131128h0001.htm#13112857000222>)

*types of professionals should be left to do the job that they are best at doing and trained to do, because that, in the end, will be the best response for mental health patients themselves.”<sup>36</sup>*

88 of the 150 responses provided by local authorities specifically mentioned that their suicide prevention strategy involved a multi-agency approach, and all of these included contact with representatives from the police. The majority of those 81 authorities which have local boards or task groups relating to suicide also included a police representative.

The Evidence Sessions found that where the police were involved in prevention groups and engaged locally, the relationships between health professionals and the police became very constructive and a more successful, joined-up suicide prevention strategy occurred.

In one Evidence Session, mention was made of the perception by police officers that local authorities had highlighted the alleged overuse of Section 136 powers, and in some cases had expressed a wish for them to be used less where possible;

*“We are told that we are overusing the powers of a Section 136 Order, but we do not have any other alternative. If protection of life is the key responsibility, then a Section 136 will be used if it is felt that the person’s life is at risk (British Transport Police representative in Evidence Session).”*

A common problem that has emerged is the uncertainty over who exactly is responsible for an individual in distress. Police representatives highlighted cases where individuals had been discharged from Accident and Emergency, deemed to have no obvious case of mental ill health, before subsequently going on to take their own life. This testimony was supported by the evidence given to the House of Commons Home Affairs Select Committee’s recent Evidence Session on policing and mental health.

*“...a case where a woman was found on the railway, intending to take her own life. After being taken to accident and emergency, she was not deemed to have a mental disorder that required any immediate treatment, and so was just released from hospital that evening, after which she subsequently returned to the railway and successfully took her own life (British Transport Police representative in Evidence Session).”*

Accident and Emergency assessments currently consider a large number of factors when considering whether a person whom the police believe is at risk of taking their own life should be admitted for further treatment.

The assessment process is divided into three core considerations: evidence of a mental disorder that requires treatment, evidence suggesting that the patient is at a risk of suicide or self-harm, and the application of the Least Restriction Principle – that those taking any actions without a patient’s consent must attempt to keep to a minimum the restrictions they impose on the patient’s liberty.<sup>37</sup>

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<sup>36</sup> Hansard, HC Deb, 28 November 2013, c140WH

(<http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm131128/halltext/131128h0001.htm#13112857000222>)

<sup>37</sup> British Transport Police, Written Submission to HC Home Affairs Select Committee, 13 May 2014

(<http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/home-affairs-committee/policing-and-mental-health/written/9179.pdf>)

The evidence from both the Metropolitan Police and British Transport Police suggested that a majority of officers believe not enough consideration is given to the second of those considerations, and that evaluating the risk of suicide or self-harm is given less immediate priority than assessing whether or not the individual concerned has a mental disorder that requires treatment.

The Inquiry's Call for Evidence found that there have been cases of areas trying pro-actively to increase their involvement with the police. Individual South Yorkshire local authorities developed a resource called CARE (Concern, Ask, Respond and Explain) that focuses on suicide, and was produced in partnership with South Yorkshire Police – they are also currently in discussions with South Yorkshire Police about extending the scheme across the entire region.<sup>38</sup>

Of those 88 authorities that mentioned working directly with the police in their suicide prevention strategy, a large number concluded that data and information sharing between the police, health professionals and coroners' officers needed to be developed and improved if a true multi-agency prevention strategy is to exist.

British Transport Police have also sought to demonstrate how a joined-up approach to suicide prevention is the most effective means of delivering an effective prevention plan. In 2012 British Transport Police sought out partners within the railway industry and the health service to coordinate their approach.<sup>39</sup>

The points that were consistently raised by all of those who gave evidence related mostly to the sharing of information and the importance of both joined-up strategies and localism in improving suicide prevention plans.

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<sup>38</sup> [http://www.rotherham.gov.uk/info/200068/mental\\_health/803/get\\_advice\\_on\\_suicide\\_prevention](http://www.rotherham.gov.uk/info/200068/mental_health/803/get_advice_on_suicide_prevention)

<sup>39</sup> British Transport Police, Written Submission to HC Home Affairs Select Committee, 13 May 2014

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