One suicide//One too many

A Suicide Prevention Strategy for Coventry

2016 - 2019

1. Our Vision

Death by suicide *is* preventable. Each life lost is a tragedy. One suicide will always be one too many.

Coventry City Council and its partners will oversee the establishment of robust networks and clearly defined processes to reduce suicides in Coventry. Citizens will be in a stronger position to realise options for long term wellbeing and improved quality of life. Suicidal behaviours will be minimised through the availability of timely and effective support that is accessible to people in personal crisis. We propose a focused approach towards **zero suicides** in our city, an approach which has been shown to effective in significantly reducing suicides.

2. Introduction

Across the UK it has been a clear priority in recent years to end the disparity between physical and mental health with 'no health without mental health' becoming the mantra of reform for our health system[1]. A vital part of this agenda is recognising suicide as a major public health problem. The majority of those who die by suicide are not in contact with mental health services when they make the decision to end their life and so our strategy must reach beyond specialist services and take account of the broad range of societal and individual factors that lead to a person dying as a result of suicide. There is much more to be done across our whole community to prevent these unnecessary deaths.

This strategy was developed by Coventry Public Health to translate national guidance into local action. We talked to our local stakeholders in September 2015 (Appendix 2) then took the priorities they gave us and integrated them with our research into the national and international experience of suicide prevention. We worked closely with our colleagues in Warwickshire so that the plan we put forward provides a joint strategic vision. Our objectives have been mapped to the same seven priority areas identified by the *Warwickshire Suicide Prevention Strategy 2016-20* and our actions will be shared wherever possible.

This strategy is one example of how we plan to work collaboratively with Warwickshire in the future. The NHS Five Year Forward vision has tasked the health and care system to work across a Coventry and Warwickshire footprint to produce a Sustainability and Transformation plan (STP)[2]. The STP necessitates our two areas work in unison to provide the best possible services for our local populations. Many of our services already work across the footprint and we hope that the closer relationship between Coventry and Warwickshire at the strategic and commissioner level will yield positive results.

3. Our Aims

This strategy has three key aims to help us achieve our **Zero Suicides** vision:

1. Raise the level of understanding and awareness across Coventry of suicidal ideation, behaviours, acts and the impact of suicidal acts across our communities.
2. To highlight key areas of service development and demonstrate ways forward to assist services in supporting Coventry to be 'Suicide Safer'.
3. To set out a clear action plan to mobilise all sectors to reduce suicidal behaviour across the city.

[1] Department of Health, *No Health without Mental Health: a cross-government mental health outcomes strategy for all ages*, February 2011.

[2] Further information available from: https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/ [Accessed 30/09/2016]. At the time of writing, specifics of the STP for Coventry and Warwickshire had not been published.

We have worked closely with our colleagues in Warwickshire in developing this strategy to provide a joint strategic focus for our services. With this in mind we will achieve our aims by focusing our efforts in line with the same seven priority areas developed in the *Warwickshire Suicide Prevention Strategy 2016-20*:

1. Reducing the risk of suicide in key high risk groups.
2. Tailoring approaches to improve mental health in specific groups.
3. Reducing access to the means of suicide.
4. Reducing the impact of suicide.
5. Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour.
6. Improving data and evidence.
7. Working together.

This strategy will outline the scale of the problem and why we believe suicide prevention is a vital component in improving wellbeing in our city. The deliberate similarities with Warwickshire allow us to put forward an action plan (see Appendix 1) that is coherent across the region whilst taking account of the particular challenges faced within Coventry's population.

4. Facts and Figures: The Bigger Picture

4.1 The United Kingdom

It is important to know the scale of an issue before we try to tackle it. Suicide has consistently been the leading cause of death for adults under the age of 50.[3] The Office of National Statistics (ONS) composes annual reports on death by suicide that demonstrate why suicide prevention needs to be a priority on a national and local level. The figures from the latest report are summarised below.[4]

In 2014, a total of 6,122 suicides of people aged 10 and over were registered in the UK, 120 fewer than in 2013. Historically, a generally downward trend in suicide rates was observed between 1981 and 2007, with a decrease from 14.7 to 10.0 deaths per 100,000 population (see Figure 1). Sadly, coinciding with the global economic downturn, suicide rates began to increase in 2008 – peaking at 11.1 deaths per 100,000 in 2013, before dropping slightly in 2014 to 10.8 deaths per 100,000.

Of the total number of suicides registered in 2014 in the UK, 76% were male and 24% were female. Although suicide rates fell significantly for both sexes between 1981 and 2007, the fall was more pronounced among women. Consequently, the proportion of male to female suicides has increased since 1981 when 63% were male and 37% were female.

The male suicide rate increased significantly between 2007 and 2013. It peaked at 17.8 deaths per 100,000 population in 2013, before falling to 16.8 deaths per 100,000 in 2014. In the same year as male suicides fell, 2013-14 saw UK female suicide increase by 8.3%. However, since 2007, the female suicide rate has remained relatively constant and throughout the whole time period covered by the data, female rates of suicide have been consistently lower than in males, currently standing at 5.2 deaths per 100,000 in 2014.[5]

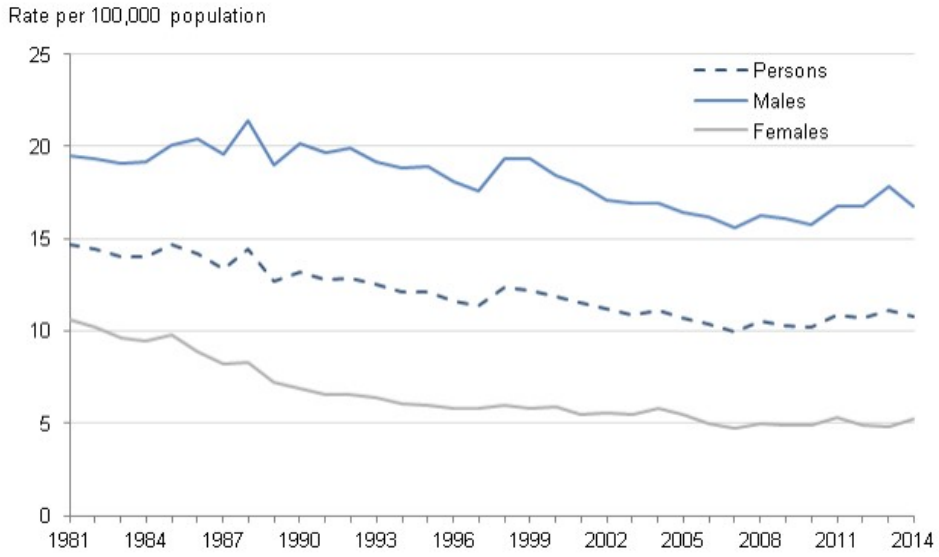
[3] ONS Digital, *What are the top causes of death by age and gender?*, February 2015. Available from: http://visual.ons.gov.uk/what-are-thetop-causes-of-death-by-age-and-gender/ [Accessed 22/09/2016]

[4] Statistics and figures taken from Office of National Statistics, *Suicide in the United Kingdom: 2014 registrations*. Available from: http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2014registrations [Accessed 20/09/2016]

[5] Suicide data is based on coroners' records – the inquest causes a delay between the death occurring and the date the death is registered; 'Difficult to code' coroners' verdicts can skew data e.g. an area with a high proportion of narrative verdicts may falsely appear to have a lower suicide rate because of difficulties in coding those verdicts as suicide.

Figure 1: Age-standardised suicide rates by sex, deaths registered between 1981 and 2014

UK



Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency

4.2 England

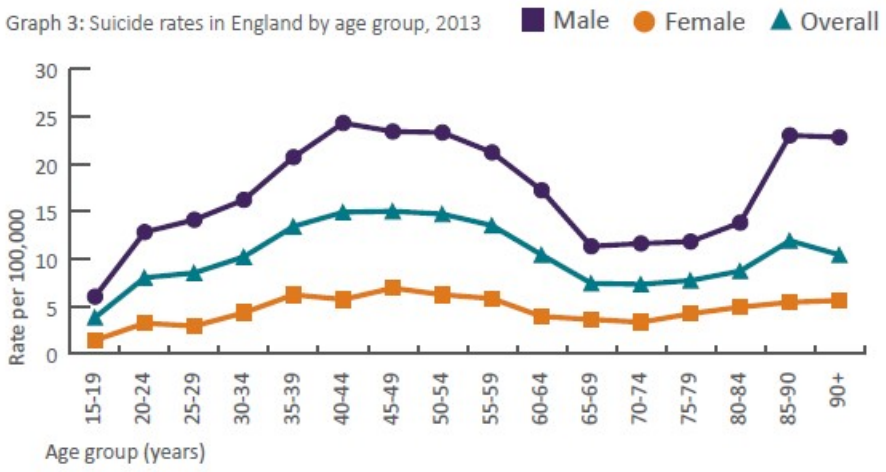
There were 4,882 suicides among people aged 10 and over registered in England in 2014, 155 more than 2013 (a 3% increase). This increase appears to have been driven by an increase in the number of female suicides, with 14% more suicides in females in England in 2014 than in 2013. In contrast, male suicide rates have remained stable.

The increase in the suicide rate for all persons in England in 2014 contrasts with the rest of the UK as suicide rates fell in Wales, Scotland and Northern Ireland in the same period. Overall, the age-standardised suicide rate increased slightly, from 10.1 deaths per 100,000 population in 2013 to 10.3 in 2014, equal to the previous highest suicide rate in recent times recorded in 2004.

Research by the Samaritans provides greater detail on the age of those who die by suicide. Their 2016 report uncovers a peak in rates for people aged 45-54 and again at age 80-85 years[6]. As can be seen from the figure below, whilst this true for both sexes, it is a trend much more pronounced for men:

[6] Elizabeth Scowcroft (Samaritans), *Suicide Statistics Report 2016,* May 2016. Available from: http://www.samaritans.org/about-us/ourresearch/facts-and-figures-about-suicide [Accessed 21/09/2016]

Figure 2: Suicide rates in England by age group[7]



Source: Samaritans (Elizabeth Scowcroft), Suicide Statistics Report 2015

This demonstrates that middle age is a high risk time for suicide in both men and women, but that coupled with a greater number of men dying by suicide overall leads us to the conclusion that men in mid-life are the group at highest risk.

5. Facts and Figures: The Local Picture

The national figures produced by the ONS look at suicides in 3 year aggregates. This is broken down into locality specific data. From this we can see that Coventry had 83 deaths by suicide in the 2012-14 period, which equates to an age-standardised rate of 10.1 per 100,000 population. This continues a downward trend from high of 103 deaths in 2009-11.[8] More recent figures that suggests this downward trend may be continuing with 18 deaths receiving a verdict of suicide following coroner's inquest in 2015 – although this number should be viewed with caution as it is likely to be an under-estimate given that a proportion of suicides do not receive this verdict at inquest.[8]

The table below shows the number of people who died by suicide in Coventry each year between 2005 and 2014; 300 lives were lost prematurely during this time period.

Number of deaths by suicide in Coventry over a 10 year period[8]

Year	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
No. of deaths	36	26	22	30	41	27	35	27	28	28

Source: Office of National Statistics, Suicide Registrations by Local Authority (February 2016)

Public Health England publishes data that allows us to compare Coventry with both national and regional rates. The table below (Figure 3) shows that, overall, Coventry does not have statistically significant differences in

[7] Figure taken from Elizabeth Scowcroft (Samaritans), *Suicide Statistics Report 2015,* March 2015. Although not the most recent report, there was no change in the age distribution apparent in the updated 2016 report. [8] ONS, *Table 2: Suicide Registrations by Local Authority*, February 2016. Available from: http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority [Accessed 23/09/2016] N.B. 2014 is the most recent data available from the ONS.

[8] Gunnell D et al, *A Multicentre Programme of clinical and public health research in support of the National Suicide Prevention Strategy for England; Chapter 3 The influence of changes in coroners' practices on the validity of national suicide rates in England,* October 2013, Programme Grants for Applied Research Vol1(1).

suicide rates to the West Midlands or England. We appear to follow the national trend which puts those in middle age, and particularly men in this stage of life, at the greatest risk of death by suicide.[10]

Figure 3: Public Health England Suicide Profile for Coventry [9]

Compared with benchmark Lower Similar Higher

Benchmark Value
Lowest 25th Percentile 75th Percentile Highest

Indicator	Period	Coventry		Region	England	England		
		Count	Value	Value	Value	Lowest	Range	Highest
Suicide age-standardised rate: per 100,000 (3 year average) (Persons)	2012 - 14	83	10.1	10.2	10.0	5.1		17.6
Suicide age-standardised rate: per 100,000 (3 year average) (Male)	2012 - 14	68	16.8	16.5	15.8	8.1		28.3
Suicide age-standardised rate: per 100,000 (3 year average) (Female)	2012 - 14	15	*	4.2	4.5	-	*Insufficient number of values for a spine chart*	-
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Persons)	2012 - 14	79	31.5	33.0	31.9	10.7		62.6
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Male)	2012 - 14	64	51.5	53.4	50.2	16.4		101.6
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Female)	2012 - 14	15	10.9	12.6	13.7	0.0		26.2
Suicide crude rate 15-34 years: per 100,000 (5 year average) (Male)	2010 - 14	24	8.9	12.3	12.3	4.1		33.5
Suicide crude rate 15-34 years: per 100,000 (5 year average) (Female)	2010 - 14	-	3.0*	3.0	3.4	2.9		4.7
Suicide crude rate 35-64 years: per 100,000 (5 year average) (Male)	2010 - 14	71	25.5	20.5	20.5	7.9		33.8
Suicide crude rate 35-64 years: per 100,000 (5 year average) (Female)	2010 - 14	-	5.7*	5.7	5.9	4.9		7.1
Suicide crude rate 65+ years: per 100,000 (5 year average) (Male)	2010 - 14	18	17.1	13.1	12.4	2.1		24.5
Suicide crude rate 65+ years: per 100,000 (5 year average) (Female)	2010 - 14	-	4.2*	4.2	4.3	3.5		5.2

Source: Public Health England, Suicide Prevention Profile

The latest publication from the National Confidential Inquiry has stratified their data across the Coventry and Warwickshire STP footprint – worryingly, this has shown the footprint's suicide rate to be in the upper quintile of English footprints.[10] This gives a different picture to the PHE data, suggesting that our population is more prone to suicide and should serve to emphasise the need to take co-ordinated action across the region.

Reducing suicide requires understanding the underlying causes that pre-dispose to suicidal action. Taking into account the wider determinants that place people at higher risk of suicide, we know that Coventry has high levels of deprivation and that this effects the number of people in our population at higher risk of suicide. Using the Public Health England fingertips data tool referenced above, compared to national figures Coventry has higher rates of homelessness, long term unemployment, children currently in care and consequently high numbers of care leavers in the city. Rates of hospital admissions related to alcohol and self-harm are higher than those for other areas in the West Midlands and nationally. These are areas we can work to understand and improve on, to make a real difference to the risk of suicide within the Coventry population.

The Coventry Mental Well-being and Mental Health Assets and Needs Assessment, completed in 2015, recognises that increasing health inequalities have a detrimental effect on mental health and well-being. There is evidence that suicide risk in men has a linear relationship with socio-economic position, with those who have stable employment, higher educational attainment and higher economic achievement at lowest risk.[11] It is interesting to note that this gradient does not clearly occur in all countries, and that the correlation is not as

[9] Public Health England, Public Health England Suicide Profile for Coventry [Accessed 21/09/2016]

[10] University of Manchester, The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Making Mental Health Care Safer: Annual Report and 20 year Review: England, Northern Ireland, Scotland and Wales, October 2016. The data used to calculate these rates is not age standardised and includes deaths by those aged 10-14 which are excluded from ONS figures. Furthermore the two differ in that this report uses date of death rather than the date death is registered, as such they include estimated figures in 2013/14 to account for those inquests which have yet to be included.

[11] Lorant V et al, Socio-economic inequalities in suicide: a European comparative study, British Journal of Psychiatry (June 2005) 187 (1) 4954.

strong for female suicides. Understanding the role of these factors is vital; suicide prevention needs to be an integral part of the wider public mental health and wellbeing agenda to reduce suicidal behaviour across all groups.

The good news is that Coventry has some positives to build on - the Public Health data suggests that mental wellbeing in the city is higher than the national average, with fewer people reporting high anxiety or low happiness scores.[12] We want Coventry to build on this and become a city that promotes mental wellbeing and emotional resilience for all.

6. What factors do we need to consider?

6.1 Gender and Suicide

As we have seen above, men are more likely to die by suicide - three quarters of deaths by suicide in England are men, with those in middle age at particular risk. This is typically a hard to reach group and it is vital that our strategy involves services that men are both able and willing to access.

However, it would be wrong to say that suicide is a male problem; whilst less likely to die by suicide, more women than men attempt to take their own lives each year. This gender paradox was demonstrated in the 2007 household survey of adult psychiatric morbidity which highlighted: [13]

"Women are more likely to experience suicidal thoughts - 19% of women had considered taking their own life. For men the figure was 14%. And women aren't simply more likely to think about suicide – they are also more likely to act on the idea. The survey found that 7% of women and 4% of men had attempted suicide at some point in their lives."

This incidence of suicidal ideation highlights the imperative that we take a holistic, person-centred approach to suicide prevention. Whilst identifying and protecting vulnerable groups is important, if our focus is only on these groups we will miss opportunities to save many others at risk of death by suicide.

6.2 Other Risk Factors

Many people who take their own life are known, or have been known, to mental health services, and as such the quality of their care is a vital aspect of any strategy to reduce suicide. The relationship between self-harm and suicide is complicated and far beyond the scope of this strategy to investigate in full, but it is know that people who self-harm have a significantly increased risk of suicide, particularly in the 12 months following initial presentation.[14][15] It is crucial to recognise that the right support at the right time for those who present with mental health problems or self-harm could make all the difference to that individual. However, it cannot be forgotten that figures suggest that only 28% of people were in contact with mental health services in the year leading up to their death.[16]

A number of other factors increase the likelihood of someone taking their own life. As well as younger men and those with a history of mental health problems or self-harm, the 2012 National Suicide Prevention Strategy identifies those in contact with the criminal justice system and specific occupational groups such as doctors, nurses, vets, farmers and agricultural workers as being at higher risk. We know that people who have adverse childhood experiences, or who have themselves been bereaved by suicide are also at increased risk.

Certain groups have specific mental health needs that in turn require specific service responses. The 2012 national strategy suggests nine groups that represent particular points of concern:

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[12] Public Health England, Fingertips Data tool 'Related Risk Factors' based on Annual Population Survey published by the ONS, Available from: http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/1/gid/1938132831/pat/6/par/E12000005/ati/102/are/E08000026/iid/22303/age/164/sex/4 [Accessed 21/09/2016]

[13] Adult psychiatric morbidity in England: Results of a household survey, (2007), The NHS Information Centre For Health and Social Care.

[14] Cooper J, Kapur N, Webb R et al. (2005) Suicide after deliberate self-harm: a 4-year cohort study. *American Journal of Psychiatry* 162:

[15] –303

[16] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, Annual Report 2015: England, Northern Ireland, Scotland and Wales, July 2015, University of Manchester.

1. Children and young people – especially those currently in the care system, recent care leavers and those in contact with the criminal justice system.

2. Survivors of domestic and sexual abuse
3. Veterans
4. People with long term physical health conditions
5. People with untreated depression
6. People who misuse drugs and alcohol
7. Lesbian, Gay, Bisexual and Transgender (LGBT) people
8. Black, Asian and other minority ethnic groups and Asylum Seekers
9. Those who are especially vulnerable due to socioeconomic conditions.

Some of these groups featured in the Warwickshire suicide audit, for example the coroner highlighted in one case that provision of high quality mental health care for military veterans needed to be addressed. We know from Coventry's demographics that a higher than average proportion of our population fits into one or more of these vulnerable groups. A particular challenge will be addressing suicide in our migrant and refugee communities, where we will need to address different cultural understandings of suicidal behaviour and mental ill health. This means it is vital that our strategy reaches beyond health services and has a truly multi-sector approach. We must address the barriers faced by these groups that prevent them from seeking and accessing help.

6.3 The Wider Determinants of Health

Suicide is about crisis, a sense of hopelessness and often a lack of purpose. When wider socioeconomic factors bring about negative circumstances, these added pressures, often outside of the control of the individual, can increase the likelihood of suicidal ideation and behaviours. We have seen above that these wider determinants have a significant impact on the likelihood of someone taking their own life. We must fully consider the wider negative socioeconomic determinants and how they can be addressed when developing and implementing our plan for suicide prevention.

6.4 Missed Opportunities

Effective suicide prevention across the public sector is crucial to saving lives. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2014) highlighted that increased regularity in attendance at GP practices was evident for many people who took their own lives [17]. As the inquiry stated:

> *"Suicide risk increased with increasing number of GP consultations, particularly in the 2 to 3 months prior to suicide. In those who attended more than 24 times, risk was increased 12-fold."*

Every contact can be seen as an opportunity to change the outcome for a person considering suicide. This ethos stretches across primary and secondary care services and wider still in respect of culture, attitude, responses and practice regarding suicide prevention. There is good evidence that investing in GP suicide prevention training makes real differences to reduce the incidence of suicide.

As previously discussed, suicidal behaviour is influenced by a vast number of factors and people can come into contact with a wide variety of agencies. Although there was a correlation between suicide and frequent attenders to GP services, the same inquiry evidenced that 37% of the people who had died by suicide had not seen their GP at all in the previous year. The burden cannot solely be placed on health services to recognise warning signs of suicidal ideation and signpost people to help.

Prison suicides are at the rate of 0.7 per 1,000 and there is a considerable rise in apparent suicides within two days of release from police custody. Furthermore, in 2014 there were 84 self-inflicted deaths in prisons in

[17] Suicide in primary care in England: 2002-2011. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester 2014.

England and Wales compared to 75 in 2013. Suicide is not just an issue for health services, it must be addressed across the board if we are to see real differences to people's lives.

6.5 Far-reaching Consequences

Suicide is a major social and public health issue. The impact of suicide is devastating and far reaching, affecting not just the individual and those that knew them, but the community as a whole. It carries a financial burden for the local economy and contributes to worsening inequalities. Work done in support of the Scottish suicide prevention strategy looked at the overall cost of suicide – when taking into account direct, indirect and intangible costs arising from the premature loss of life and the impact it has on those who survive them, each life lost carries a potential cost of £1.29-1.67million.[18] Based on the average number of deaths from suicide in Coventry this equates to an annual loss of at least £38.7million.

For family and friends, losing a loved one to suicide can be devastating; they are up to three times more at risk of taking their own lives and can experience severe effects on their health, quality of life, ability to function well at work and in their personal lives. This strategy considers the effect of suicide on people of all demographics in recognition of the fact that one suicide has a much wider impact on their family and community.

7. Our Approach

A half day stakeholder event to drive forward plans for a Coventry City Council Suicide Prevention Strategy was undertaken in September 2015. This event highlighted key areas where it was felt there was an opportunity for change and positive development in respect of suicide prevention. This is outlined in Appendix 2 and reflected within our approach outlined below. Our strategy brings together these local priorities with the national and Warwickshire strategies to put forward an action plan reflecting our **Zero Suicides** vision.

7.1 National Strategies

In 2012 the government published *Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives*[19]. The strategy identifies six key areas for action:

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.

Following on from this guidance, an All-Party Parliamentary Group (APPG) was tasked with monitoring local authority responses. Their latest report in 2014 recommended that there are three elements vital to successful implementation of the national strategy[20]:

a. Undertaking a 'suicide audit' to understand local risk factors for suicide.
b. Developing a suicide prevention action plan.
c. Establishing a multi-agency suicide prevention group to implement the plan throughout the local community.

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[18] Knapp M, McDaid D, Parsonage M. *Mental Health Promotion and mental illness prevention: the economic case; 2.11 Population-level Suicide Awareness Training and Intervention*, January 2011, Department of Health. This work was and update to 2009 prices from the previous economic work completed in Platt S, McLean J, McCollam A et al, *Evaluation of the First Phase of Choose Life: the National Strategy and Action Plan to Prevent Suicide in Scotland*, 2006. Edinburgh: Scottish Executive.

[19] Department of Health, *Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives,* September 2012. Available from: https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england [Accessed 16/09/2016]

[20] All-Party Parliamentary Group (APPG) on Suicide and Self-Harm prevention, *Inquiry into Local Suicide Prevention Plans in England,* January 2015.

The advice of these two national documents, as well as the experiences of other local authorities and international developments in suicide prevention have been taken into account in the development of our Coventry strategy.

7.2 Coventry Stakeholder Event

Our stakeholder event in September 2015 looked at current gaps in provision of services for suicide prevention, the features of an 'excellent' community based suicide prevention programme and asked stakeholders to identify key priority areas. (Appendix 2). From this it was clear that our suicide prevention strategy needed to be rooted in our community with a focus on education and training. It also emphasised the importance of having all agencies working with a co-ordinated approach.

In the course of developing this strategy, as well as considering national guidance, research was conducted into strategies in place elsewhere, both in and outside of the UK, to reduce suicides. Of particular interest was the work carried out by LivingWorks to adapt the Canadian 'suicide-safer communities' model into a framework for action that can be applied internationally[21]. Their work reflected the priorities highlighted by our stakeholder group and provided a focus on which actions provide the greatest impact.

Some significant aspects of the LivingWorks model have been incorporated into our strategy. Firstly, their model relies on gatekeepers - peers or professionals trained in recognising and responding to potential suicidal behaviour. This focus on training and suicide awareness is clear priority for our Coventry stakeholders and our colleagues in Warwickshire, who have commissioned suicide awareness training for all GPs in their area.

Secondly, their model emphasises the importance of sustainable, whole community approaches and multiagency steering groups. This is an area where we will collaborate with Warwickshire to ensure congruity across the Coventry and Warwickshire region. We are acutely aware that improving mental wellbeing generally across the whole population is key protective feature against suicide and we plan to follow Warwickshire's lead in working to achieve this. We also recognise that working collaboratively with multiple partners and local communities will help embed our strategy to promote long lasting positive change.

The other aspects of the 'suicide-safer communities' model (e.g. services for those bereaved by suicide, improved data collection and evaluation, accessible mental health support and intervention services) are explicit in the national strategies and thus are reflected in our seven 'Warwickshire and Coventry Priorities'.

7.3 Warwickshire and Coventry Suicide Prevention Strategy Priorities

'Joined up provision' was a clear priority from our stakeholder event and many of our providers will work across both Coventry and Warwickshire. This is particularly key in the current climate with joint action occurring through the NHS-led Sustainability and Transformation plan (STP). We have worked closely with our colleagues in Warwickshire to ensure that this strategy mirrors the *Warwickshire Suicide Prevention Strategy 2016-20*.

Seven key priority areas were developed by Warwickshire Public Health with reference to the national strategies. These key priorities will provide the framework for our action plan. Below is an explanation of the seven key areas and what actions they entail within both the Coventry and Warwickshire areas:

1) Reducing the risk of suicide in key high risk groups

This includes efforts to reduce the stigma around suicidal thinking and seeking help, encouraging help seeking and ensuring services are responsive and offer appropriate support. The key high risk groups are identified as middle-aged men, those with known mental health issues especially those under Crisis Resolution/Home treatment plans, those with physical health problems (in particular chronic pain). Further to these key groups, there is an awareness of increased need for support to people in contact

[21] LivingWorks, Suicide-safer Communities, Available from: https://www.livingworks.net/community/suicide-safer-communities/ [Accessed 16/09/2016]

with the criminal justice system, certain occupational groups (doctors, vets, farmers, agricultural workers) and the LGBT community.

Both areas will commission suicide awareness training for groups best placed to provide support e.g. local GPs. Work with local GP practices will also aim to publicise the link between poor physical health and suicide. Providers often work across both Coventry and Warwickshire and we will work with them to improve care for those with mental health problems, particularly focusing on crisis care.

In recognition of the data around gender and suicide, we will both ensure services are accessible for men and provide appropriate support. This must also encompass addressing the stigma of suicide and help seeking in those not previously known to services. *It Takes Balls to Talk* has already begun tackling this issue with their successful campaign targeting men at sporting events in Coventry and Warwickshire; this strategy will support the continued promotion of their campaign message.

2) Tailor approaches to improve mental health in specific groups

Young people who self-harm were identified at being at particular risk of suicide and thus efforts will be made to provide services to improve emotional resilience and wellbeing services aimed at young people. In Coventry we have a wider strategic aim across our 0-19 services to provide early help to families and provide the conditions that will build emotional resilience in future generations of children born in the city. In the here and now, we are working to develop a separate strategy to address the mental health and wellbeing of our children and young people. We must also be aware of the needs of our student population and recognise the great resource we have in our universities to address issues in this group.

3) Reduce access to the means of suicide

Both areas aim to address overdose suicides by highlighting issues surrounding the prescription on opiate medication, particularly tramadol and codeine in view of the National Confidential Inquiry figures[22].We have a commitment from Network Rail to work with Coventry to support suicide prevention on railways. Furthermore, we know that suicidal behaviour correlates with substance misuse; tackling the harmful use of alcohol in our city is one approach we can take to reduce impulsive suicidal acts.

4) Reducing the impact of suicide

In recognition of the wider impact of suicide, both areas have identified a need to improve their bereavement services. In order to do this, both areas will work with local people affected by suicide and charitable organisations with experience in this area to develop more effective, timely and practical support. At present, support in Coventry is available through drop-in groups run by SOBS (Survivors of Bereavement by Suicide) and *Facing the Future*, run in partnership between the Samaritans and Cruse Bereavement Care, which provides a more structured form of group support. We will use our connections to improve access to these services where appropriate, and work with them to develop new ideas of how support can be provided. We recognise that people who have lost a loved one to suicide are themselves at high risk of suicidal behaviour and support must be made available to them. There is a commitment from both local authorities to utilise nationally produced material in their provider services, such as the 'Help is at Hand' booklet produced by Public Health England (PHE) and the National Suicide Prevention Alliance (NSPA).

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

Both areas have existing communications networks that can be used to disseminate national media guidelines to support the work the Samaritans are doing nationwide to address this. We also support

[22] The report suggests that, in 40% of mental health patient suicides by opiate overdose, the medication had been prescribed for the patient; where the fatal overdose was of codeine or tramadol (or a both in combination) 73% had been prescribed. Although this latter category represents only 16 deaths nationally, it provides a clear focus for preventative action through increased prescription awareness. Report can be found at: University of Manchester, The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Making Mental Health Care Safer: Annual Report and 20 year Review: England, Northern Ireland, Scotland and Wales, October 2016.

the work of local charitable organisations in publicising campaigns which align with our aims of reducing suicide across the region.

6) Improving data and evidence

Having completed a local suicide audit, Warwickshire have a number of areas they plan to look into more deeply. Namely, variations in suicide rates across the region and qualitative work around young people and self-harm. We plan to undertake a similar piece of work in Coventry. Both areas also plan to keep up-to-date with PHE national publications and guidance.

7) Working together

Working together encompasses professional partnerships both within each local authority and further afield. There are plans to establish a multi-agency suicide prevention group with the potential to span both Coventry and Warwickshire. Membership would potentially include input from: the three CCGs in the area, Coventry and Warwickshire Partnership Trust (CWPT), Warwickshire County Council People Group mental health commissioners, Coventry Public Health, Network Rail, Warwickshire and Coventry Police, Coventry and Warwickshire Coroner's office, National Suicide Prevention Alliance (NSPA), Samaritans and other voluntary sector colleagues such as the Farming Community network, service users and suicide survivors from Warwickshire Well-Being Hubs, co-production services and families affected by suicide. This list is not exhaustive and we would encourage all interested partners to have a voice.

Warwickshire's Suicide strategy highlights the importance of sharing information and best practice with the rest of the West Midlands and we are in agreement that Coventry and Warwickshire will work together wherever possible.

Working Together also includes the need to foster closer working relationships with families, particularly those affected by suicide, and to improve communication between families and services around potentially suicidal individuals.

This strategy for Coventry will utilise these same seven priority areas and share actions where appropriate. An initial action plan based around these priorities is available in Appendix 1. Although the ultimate aim is to establish a suicide prevention group spanning Coventry and Warwickshire, it is recognised that achieving this level of collaboration takes time to establish. Therefore, in the first instance it is proposed to set up a Task and Finish Group of interested local partners in Coventry to convene in early 2017 so that action against suicide is not delayed. This group will include representatives from local mental health commissioners, providers and voluntary sector agencies. Through this group, it is envisaged that there will be close collaboration with wider local authority departments, universities and business leaders to broaden our reach beyond those already known to health services.

7.4 Our Potential Partners

In '*Preventing Suicide: A global imperative*' the World Health Organization call for a systematic response to suicide and making prevention a multi-sector priority involving not only health care but education, employment, social welfare, the judiciary and others.[23] The factors leading to someone taking their own life are complex but they *are* amenable to change. This strategy works on the assumption that every suicide is preventable provided that prevention measures address this complexity.

No single organisation is able to directly influence all factors - services, communities, individuals and society as a whole work together to help prevent suicides. Below are examples of areas we need to engage in our work towards **Zero Suicides**:

[23] World Health Organization (WHO), Preventing Suicide: A Global Imperative, 2014. Available from: http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/ [Accessed 23/09/2016]

Arena for Action	Examples of groups to involve
Wider Community	Community and voluntary sector organisations, sports clubs, educational establishments, faith groups, retail organisations, housing trusts, prisons and probation services, workplaces, employment support
Health and Well Being Board	Local Authorities, Public Health, CCG, Police, Fire, Voluntary Sector etc.
Primary Care	GP Practices, Community Health Trusts, IAPT providers
Secondary Care	Mental Health Trusts, A&E Departments, CAMHs Teams, Hospitals, Ambulance Trusts

8. Accountability and Governance

From April 2013 the co-ordination of suicide reduction became a local authority responsibility, with guidance provided by Health & Wellbeing Boards, as set out in the government's 2012 national strategy for suicide reduction "Preventing suicide in England - A cross government outcomes strategy to save lives". The Task and Finish Group leading the work arising from this strategy will provide reports to Coventry Health and Wellbeing board so that progress can be monitored.

9. How will we know when we have achieved our vision?

We will have achieved our overarching vision when we can demonstrate through an action plan that suicides in Coventry have reduced. We will strive to realise zero suicides in Coventry – some may say it is an overly ambitious aim but it is one that will always teach us lessons about where we can improve.

The action plan will be a practical tool for implementation and is intended to be updated regularly to reflect changing needs and demands.

10. Acknowledgements

This document has been produced with significant supporting material from *Warwickshire Suicide Prevention Strategy 2016-20* produced by the Warwickshire Public Mental Health and Wellbeing Team, Warwickshire County Council. We must credit them for developing the seven priority areas on which our strategy relies.

Special thanks to Terry Rigby for his significant contribution in the development of this strategy and to Dr Charlotte Gath (Consultant in Public Health, Warwickshire County Council) for her support.

Appendix 1

DRAFT Action Plan

The following plan incorporates actions required to meet the nine pillars of a 'Suicide Safer Community' and aligns them to the priority areas produced by Warwickshire. It presents a clear, coherent approach to be applied across Coventry to reflect our vision of Zero Suicides. In the first instance, the Task and Finish Group will coordinate these actions and provide oversight between reports to Health and Wellbeing Board. It is expected that a more specific action plan will arise when this group convenes in early 2017.

Objective	Actions	Lead	Timescale	Target Group	Anticipated Outcome
Reducing the risk of suicide in key high risk groups	Support and commission accessible suicide intervention services e.g. improve crisis response, ensure services are responsive and offer appropriate support	CCG		Vulnerable groups, population at risk of mental ill health	Improved clinical intervention to reduce suicide rates
	Support and commission proactive suicide prevention activities e.g. training of community gatekeepers, suicide awareness training for frontline staff	CCG/Public Health		General population/community services involved in preventing suicide	Reduce the risk of suicide in the population; improve communication around the issue of suicide so that people feel safe to seek help and that help is clearly signposted
	Identify opportunities for establishing robust referral and support systems with the necessary training realised e.g. good links with substance misuse services, GP suicide prevention training.	CCG		Vulnerable groups, population at risk of mental ill health	Improve mental health services to allow early intervention to prevent suicide in those with mental health issues.
	Review and improve discharge	CCG/Acute and Mental Health Trusts		Vulnerable groups at higher risk of	Vulnerable people feel supported when they are

	planning processes for vulnerable people e.g. people with known mental health problems, people with chronic illnesses			suicide	stepped down from secondary/tertiary services.
	Build on the success of the It Takes Balls to Talk campaign by continuing to target the suicide awareness message at sporting events in the Coventry and Warwickshire area	It Takes Balls to Talk Steering Group	Ongoing	General population, particularly men	Reduce stigma surrounding suicide; increase help seeking behaviour with regards to mental and emotional health.
Tailoring approaches to improve mental health in specific groups	Within Public Health contracts ensure the promotion of mental health and wellness activities e.g. 0-19 services to increase emotional resilience in young people, reduce stigma around mental distress and suicide	Public Health		General population/ vulnerable groups	Improve overall public mental wellbeing to reduce the risk of suicide
	Ensure active engagement with the Coventry and Warwickshire Mental Health Care Crisis Concordat to drive forward the aim of reducing suicides	CCG	Ongoing	Those with a known mental health problem who could be at risk from suicide	Reduce rates of suicide amongst those known to mental health services
	Increase awareness of				

Reducing access to the means of suicide	overdose of prescribed opiates amongst GPs and hospital prescribers	CCG		Vulnerable groups	Reduce fatal suicide attempts
	Work with network rail	Samaritans	Ongoing	Vulnerable groups	Reduce fatal suicide attempts
	around reducing railway suicide with a particular focus on high risk locations.				
Reducing the impact of suicide	Support accessible suicide bereavement services e.g. improve communication between mental health/crisis services and families	Voluntary sector bereavement support providers		People affected by suicide	Reduce the impact of suicide
	Work in conjunction with existing services to develop support for those exposed to, bereaved by or affected by suicide and encourage the use of the 'Help is at Hand' booklet developed by PHE	Task and Finish Group		Individuals affected/ bereaved by suicide	Reduce the impact of suicide; Standardise approach to supporting those bereaved by suicide
Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour	Support local initiatives through existing communications networks to increase suicide awareness e.g. It Takes Balls to Talk campaign	Comms teams (Public Health/Local Authority/ CCG)	Ongoing	General Population/ Vulnerable populations	Increase in help seeking behaviour; reduce stigma around talking about suicidal feelings

	Participate in World Suicide Prevention Day; as well as publicising events, send an annual reminder to local press about the importance of adhering to Samaritans Media Guidance	Comms teams (Public Health/CCC), Voluntary sector agencies	10th Sept (annually)	General Population	Communicate with the general public that suicide prevention is a priority in Coventry; show support for those in the city affected by suicide
Improving Data and Evidence	Gather background information - incidence/prevalence of suicide in Coventry, awareness of current strategies in place	Public Health	October 2016	Local Authority, other members of the key partnership agencies	Provide knowledge base for interventions and baseline figures to measure improvement
	Undertake a 'Suicide Audit' of coroner's records	Public Health	End of 2016	Board overseeing Suicide Strategy	Identify any vulnerable groups or means of suicide that are a particular risk in Coventry
	Follow national publications, provide evidence for consultations where appropriate and discuss implementation of new recommendations as appropriate	Public Health	Ongoing	CCG/NHS Mental Health Trust, Board Overseeing Suicide Strategy	Coventry is in line with national strategies on suicide prevention

Working Together	Identify a multisector committee to oversee implementation of suicide prevention strategy and spearhead future initiatives.	Public Health	ASAP	Stakeholders, key partnership agencies	Clear governance structure and leadership to coordinate suicide reduction efforts
	Identify organisations linking in with the Task & Finish Group to support implementation and hold regular engagement events	Task and Finish Group	January 2017	Voluntary sector, national transport agencies, coroner's office etc.	Co-ordinated messages around suicide prevention across all sectors
	Further develop long term opportunities for effective suicide/suicidal behaviour reduction in the sectors of education, criminal justice, employment, housing, university, and public transport	Task and Finish Group		General population whose circumstances increase the likelihood of suicidal behaviour regardless of pre-existent mental illness	Reduce the chances of reaching the 'crisis point' which we know increases the risk of suicide
	Agree strategy and action plan priorities and monitor delivery of plan	Health and Well Being Board	December 2016	Vulnerable groups, population at risk of mental ill health	Planned actions are achievable within given timescales

Appendix 2

Suicide Prevention:

Overview of the stakeholder event to drive forward plans for a Coventry City Council Suicide Prevention Strategy // 22nd Sept 2015

Hosted by Voluntary Action Coventry

Developed and Facilitated by Forward for life

A Brief Background

In England, one person dies every two hours as a result of suicide. When someone takes their own life, the effect on their family and friends is devastating. Many others involved in providing support and care will feel the impact.

Figures released by the Office for National Statistics (ONS) in February 2015 showed that suicides in the UK had rose by four per cent in 2013,

In 2013, 6233 suicides were registered in the UK; a rate of 11.9 per 100,000 (19 per 100,000 for men and 5.1 per 100,000 for women).

The male suicide rate is the highest since 2001, and suicides among middle aged men aged 45-59 are at 25.1 per 100,000 which is the highest rate for this group since 1981.

Preventing suicide in England: A cross-government outcomes strategy to save lives (2012) stated

"THERE ARE DIRECT LINKS BETWEEN MENTAL ILL HEALTH AND SOCIAL FACTORS SUCH AS UNEMPLOYMENT AND DEBT. BOTH ARE RISK FACTORS FOR SUICIDE. PREVIOUS PERIODS OF HIGH UNEMPLOYMENT AND/OR SEVERE ECONOMIC PROBLEMS HAVE BEEN ACCOMPANIED BY INCREASED INCIDENCE OF MENTAL ILL HEALTH AND HIGHER SUICIDE RATES."

A recent British Medical Journal Study (published August 2012) showed clear evidence linking the recent increase in suicides in England with the financial crisis that began in 2008 for both men and women.

English regions with the largest rises in unemployment have had the largest increases in suicides, particularly among men. Recent figures for the West Midlands showed that suicide rates have increased by 24 per cent, with 2007 data recording 245 deaths by suicide/undetermined deaths and the 2010 data showing the number of recorded deaths being recorded as 450.

The draft Coventry Mental Well-being and Mental Health Assets and Needs Assessment recognises that increasing health inequalities are having a detrimental effect on the mental health and well-being of the most vulnerable communities and there is a need to develop intelligence and establish a clear framework for ensuring that suicide prevention is realised strategically as an integral part of the wider public mental health and wellbeing agenda.

ONS data 2011-13 highlights that although not statistically significant, suicide in Coventry was 10.0 deaths per 100,000 population, which was higher than both the regional and national estimates (8.3 and 8.8 deaths per 100,000 respectively).

It is recognised by Coventry City Council that to have a real impact on suicide rates across Coventry, there is a need for the development of a City Wide Suicide Prevention Strategy that brings together a range of sectors and service providers across Health and Social Care and beyond.

The Suicide Prevention Stakeholder Event on the 22nd September 2015 brought together a range of organisations from across the city with the following intended outcomes:

- Awareness of the issue of suicide
- The start of a community approach to suicide prevention
- The development of a multi-agency steering group to inform a Coventry wide strategy
  - Knowledge of services, gaps, needs.
- Access to potential future learning opportunities

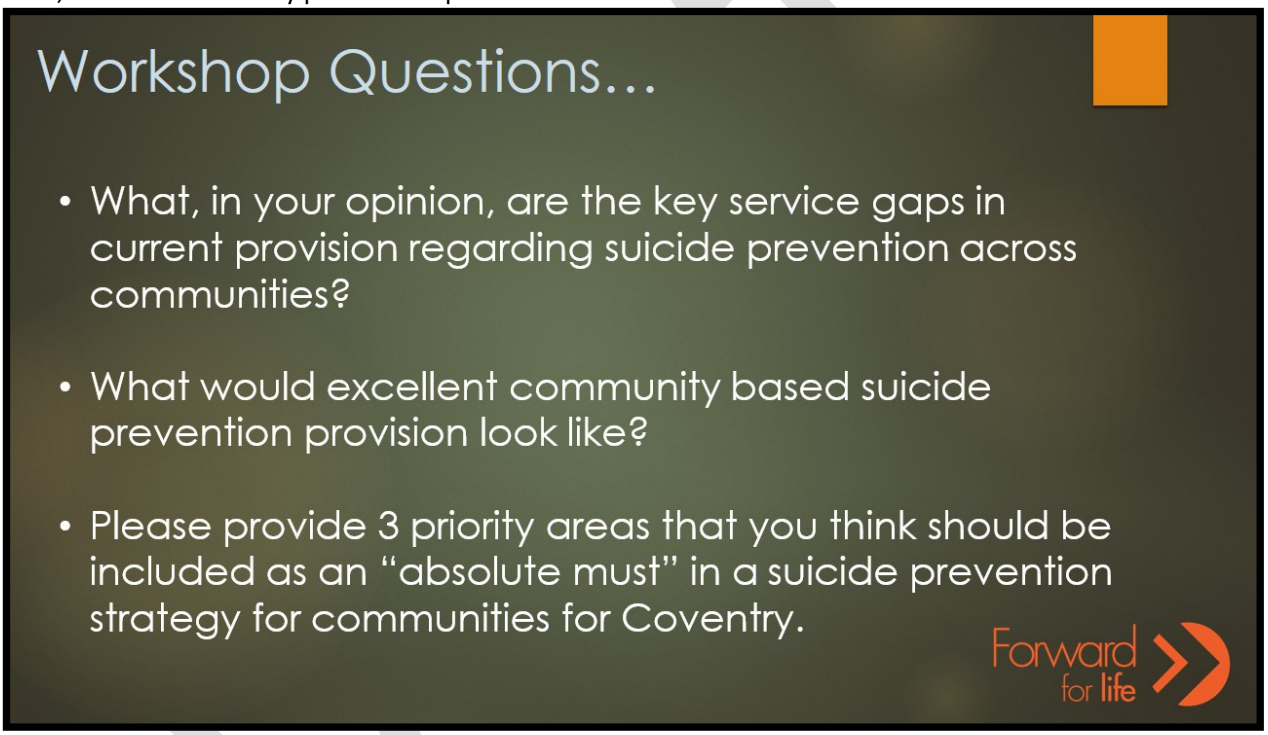
The Presentation

Based on the outcomes outlined above – An overview of suicide (internationally, nationally and locally), suicide prevention approaches and an opportunity to consider possible next steps was presented to delegates present.

The abridged version of this presentation can be found at the following link in PDF Format

Workshop Discussions:

Three key questions were asked of delegates, with an opportunity to discuss for a 30-minute period of time, before frank on key points. The questions were as follows:



Workshop Responses:

Question 1: What, in your opinion, are the key service gaps in current provision regarding suicide prevention across communities?

The responses have been grouped according to key areas of commonality[24]:

A) Time:

- Time –not enough of this is spent or available, trying to get to the root of problems/issues
- Waiting time for counselling/other services
- GP's – time/approach

B) Knowledge:

- Lack of in depth information only stats
- Stigma of suicide, how it is managed in agencies – recognition not stigma
- Lack of knowledge about organisations/lack of links between organisation

[24] Please note responses have been duplicated where it is felt they fit into more than one category.

- Links to other areas of wellbeing and support
- Need to have a clear action plan when someone presents suicidal thoughts. This takes the responsibility away from you as you know you have done everything you can to offer support.
- Lack of clarity around responsibility
- Gaps in information for public

C) Resources/Services

- 16-18 years' gap – No adults /Children
- Links to other areas of wellbeing and support
- Lack of prevention support prior to "crisis"
- Lack of knowledge about organisations/lack of links between organisation
- Lack of peer mentoring
- GP's – time/approach
- Out of hours' services / crisis team
- Mental health leads at GP surgeries
- Lack of services for isolated people
- Support for children /teenagers
- Advice for teachers
- Gaps in intervention in general

D) Financial:

- Funding

E) Training:

- Training/reflection upon ability to have difficult conversations or offer help
- Need to have a clear action plan when someone presents suicidal thoughts. This takes the responsibility away from you as you know you have done everything you can to offer support.
- GP's – time/approach
- Advice for teachers
- More training in general

F) Planning:

- Lack of clarity around responsibility
- Gaps in intervention in general

Question 2: What would excellent community based suicide prevention provision look like?

A range of ideas were supplied in respect to "Community Facing" suicide prevention provision. Many of these areas require little investment but would reap great rewards including the development of network opportunities and building on intelligence through improved information.

There appears to be a range of options to be considered further in respect of providing opportunities for upstream engagement in accessible, community based locations – For most of these areas proposed, there is a relatively strong evidence base regarding suicide prevention including GP Training, Buddy Services, Outreach work, Peer support and social media/technology development.

- *Develop inclusion in communities*
- *Things to do – places to go*
- *Build resilience*
- *Develop areas where people feel they can share information – have trust*

- *Training to identify and support (signs – symptoms and behaviour)*
- *A place/ someone to listen*
- *Multi agency working*
- *More outreach work e.g. Schools*
- *Improve drop in services – more accessible with shorter waiting times*
- *Services available to get people involved in activities which will support their wellbeing e.g. home visits to support people to take part*
- *More services for isolated people*
- *Buddy services*
- *Better information*
- *GP training/awareness*
- *Less onus on drugs*
- *Better communication between services (consistency)*
- *On-line support*
- *Peer support*
- *Directory of resources*
- *Appropriate training – for frontline staff*
- *Challenging ideas of suicide*
- *Early intervention*
- *Using different forms of media/tech to cascade messages*
- *Peer support/group support*

Question 3: Please provide 3 priority areas that you think should be included as an "absolute must" in a suicide prevention strategy for communities for Coventry.

The responses have been grouped according to key areas of commonality[25]:

Education and Awareness Raising

- *Educating young people – schools etc.*
- *Education for people with responsibility i.e. teacher / community leaders etc.*
- *Training*
- *Awareness Campaigns (inclusive, not "mental Healthy" responsible reporting – pressure on media)*

Young People

- *Support for children and young people Educating young people – schools etc.*
- *Education for people with responsibility i.e. teacher / community leaders etc.*

Community Facing

 Community based projects
Increased outreach work

Joined Up Provision

- *A clear formalised referral pathway to specialised services and support meeting the clients need*
- *Multi agency network which is accessible and communicates effectively*
- *Joined up (unified response from all services – coordinated approach)*
- *Clear strategy for information sharing – multi-agency working Better packages of care following first attempt*

Funding

- *Proper funding with infrastructure to support your clients*

Risk Minimisation

 Alcohol abuse

[25] Please note responses have been duplicated where it is felt they fit into more than one category.

Appendix 3

References and Supporting Material

Data Sources

Updated annually unless otherwise stated.

Office of National Statistics, *Suicide in the United Kingdom: 2014 registrations*. Available from: http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2014registrations [Accessed 20/09/2016]

Elizabeth Scowcroft (Samaritans), *Suicide Statistics Report 2016,* May 2016. Available from: http://www.samaritans.org/about-us/our-research/facts-and-figures-about-suicide [Accessed 21/09/2016]

Public Health England, Public Health England Suicide Profile for Coventry [Accessed 21/09/2016] PHE produces a Suicide Prevention Profile available on fingertips that gives suicide figures and statistics on suicide related risk factors and service contacts.

University of Manchester, The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, Annual Report 2015: England, Northern Ireland, Scotland and Wales, July 2015. (N.B. 2016 annual report has been published since the strategy was written)

NHS Digital. Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014. Available from: http://ht.ly/byUk304GRIB (N.B. repeated every 7 years, latest report was not available at the time of writing the 2016-19 strategy but has since been published)

Guidance Documents

Department of Health, *Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives,* September 2012. Available from: https://www.gov.uk/government/publications/suicide-prevention-strategyfor-england [Accessed 15/11/2016]

All-Party Parliamentary Group (APPG) on Suicide and Self-Harm Prevention. Provided updates in 2014 and 2015 with regards to progress against the 2012 strategy. At the time of writing a further inquiry is underway. Available from: http://www.parliament.uk/business/committees/committees-a-z/commons-select/healthcommittee/inquiries/parliament-2015/suicide-prevention-inquiry/ [Accessed 15/11/2016]

Public Health England, Suicide Prevention Resources. Available from: https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance [Accessed 15/11/2016] Multiple links to PHE guidance including Suicide Prevention: creating a local action plan and documents relating to specific problems e.g. LGBT suicide, suicide in public places).

World Health Organisation (WHO), Preventing Suicide: A Global Imperative. Available from: http://www.who.int/topics/suicide/en/ [Accessed 15/11/2016]

Other Resources

University of Manchester: Centre for Mental Health and Safety http://research.bmh.manchester.ac.uk/cmhs/ Useful resource for publications related to mental health and Suicide. Responsible for the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report.

The Samaritans, Research Report: Men, Suicide and Society, why disadvantaged men in mid-life die by suicide http://www.samaritans.org/about-us/our-research/research-report-men-suicide-and-society Research report containing 5 articles looking at the topic of male suicide.

Liverpool Public Health Observatory, Rapid Evidence Review Series: Suicide Prevention Training, October 2014. Available from:. https://www.liverpool.ac.uk/psychology-health-and-society/research/public-healthobservatory/publications/report-series/ Concludes a stronger evidence base needed, but potentially GP training indicated and upstream training in schools effective

Knapp M, McDaid D, Parsonage M (DoH, LSE Personal Social Services Resourse Unit), Mental Health Promotion and Mental Illness Prevention: the economic case, April 2011. Available from: Section 2.11 and 2.12 show evidence for cost effective methods of suicide prevention, again GP training seen to be worthwhile. http://www.pssru.ac.uk/blogs/blog/population-level-suicide-awareness-training-and-intervention/ Blog update to figures in 2014.

Feltz-Cornelis, CM et al, Best Practice Elements of Multilevel Suicide Prevention Strategies: a review of systematic reviews, Crisis (2011). Available from: http://econtent.hogrefe.com/doi/abs/10.1027/02275910/a000109 [Accessed 25/10/2016]. Netherlands review of evidence – GP and community gatekeeper training, reducing access to fatal means, targeting high

risks groups, sensitive journalistic approaches and public awareness campaigns provided there is access to support available are all potentially effective.

Public Health England/Health Education England, Mental Health Promotion and Prevention Training Programmes, September 2016. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/558676/Mental_health_promotion_and_prevention_training_programmes.pdf Compilation list of Mental Health and Suicide prevention programmes available across the country including approximate costings and links to evaluations.

Moulin L, Aiming for Zero Suicides: an evaluation of a whole system approach to suicide prevention in the East of England, October 2015 Available from: https://www.centreformentalhealth.org.uk/zero-suicides Evaluation of experience of a similar strategy in place in East of England – recommendation includes training for health and police services, importance of working with the coroner, and emphasised ongoing importance of evaluation and evidence building.

Important National Groups

The following groups produce evidence and guidance that have informed the development of this strategy.

The Samaritans http://www.samaritans.org/

National Suicide Prevention Alliance http://www.nspa.org.uk/

Survivors of Bereavement by Suicide (SOBS) http://uk-sobs.org.uk/

Support After Suicide Partnership (SASP) http://www.supportaftersuicide.org.uk/ Available from here is the 'Help is at Hand' the booklet created in conjunction with DoH, PHE, NSPA and TASC to support anyone bereaved by suicide.