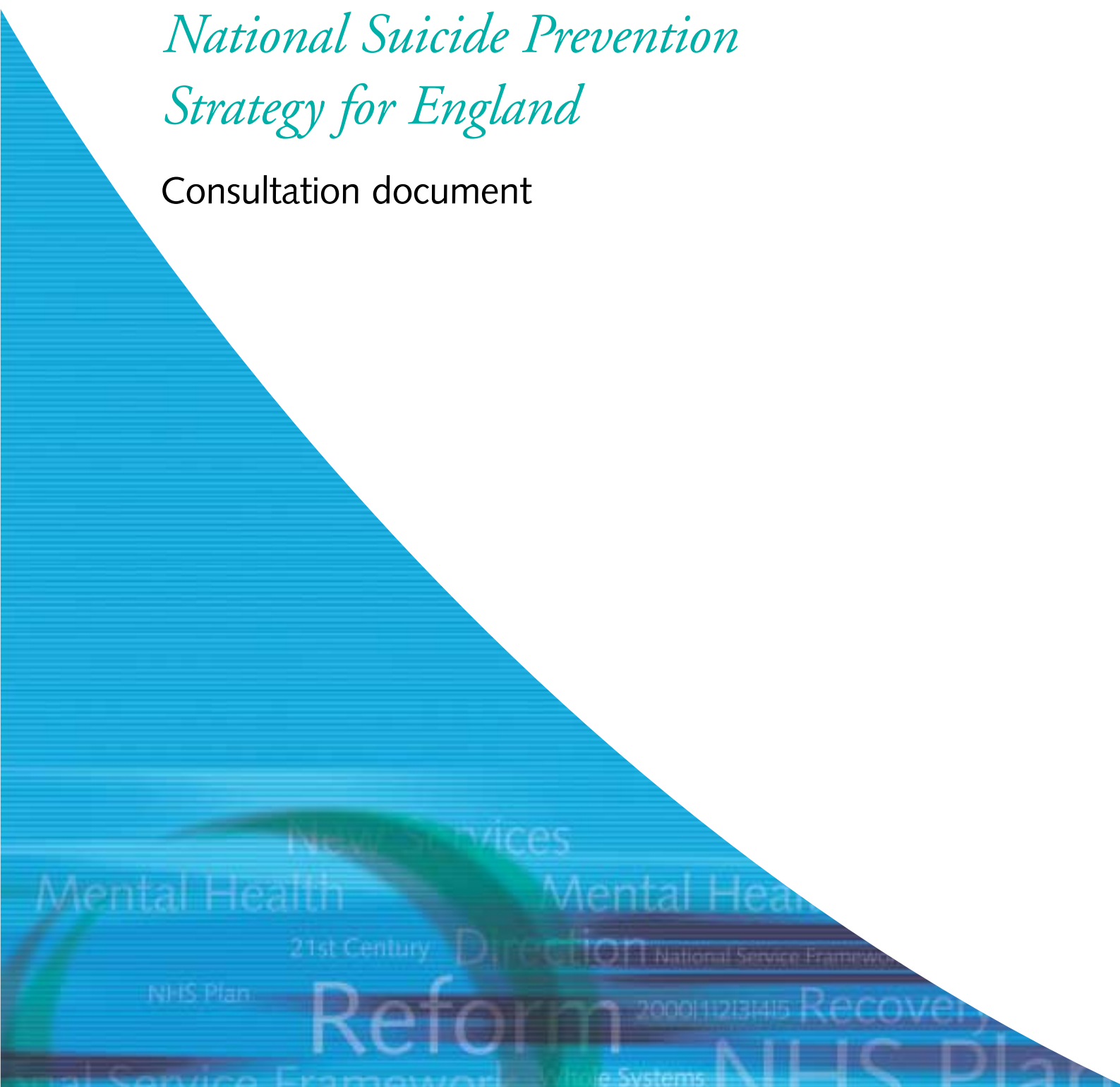


*National Suicide Prevention  
Strategy for England*

Consultation document



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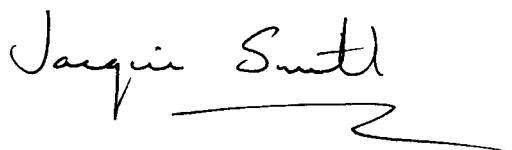
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# Foreword

Suicide is a devastating event. Its emotional and practical consequences are felt by family and friends and the many statutory and voluntary agencies involved in the provision of health and social care. Although the rate of suicide in England is not high in comparison with other countries in the European Union, the figures remain disturbing. On average, a person dies every two hours in England as a result of suicide. It is the commonest cause of death in men under 35. It is the main cause of premature death in people with mental illness.

The Government's White Paper *Saving Lives: Our Healthier Nation* sets out a challenging target to reduce the death rate from suicide and undetermined injury by at least a fifth by the year 2010. There is no single route to achieving this target. The factors associated with suicide are many and varied – they include social circumstances, biological vulnerability, mental ill-health, life events and access to means. A coherent, co-ordinated suicide prevention strategy therefore needs the collaboration of a wide range of organisations and individuals.

This consultation document sets out the components of a national suicide prevention strategy. It provides a framework for the prevention of suicide in England and has been informed by expert opinion and broad consultation. We intend it to be an evolving document which will develop in the light of progress made and emerging evidence. This is your opportunity to participate in the development of the strategy and we welcome your views on our proposals.

A handwritten signature in black ink that reads "Jacqui Smith". The signature is written in a cursive style and is followed by a long, horizontal, wavy line that extends to the right.

Jacqui Smith  
Minister of State for Health

# Strategy development personnel

## Advisory Group

Professor Louis Appleby ( <i>Chairman</i> )	National Director for Mental Health	Dr David Gunnell	University of Bristol
Simon Armson	The Samaritans	Professor Keith Hawton	Centre for Suicide Research, Oxford University
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## Reference Group

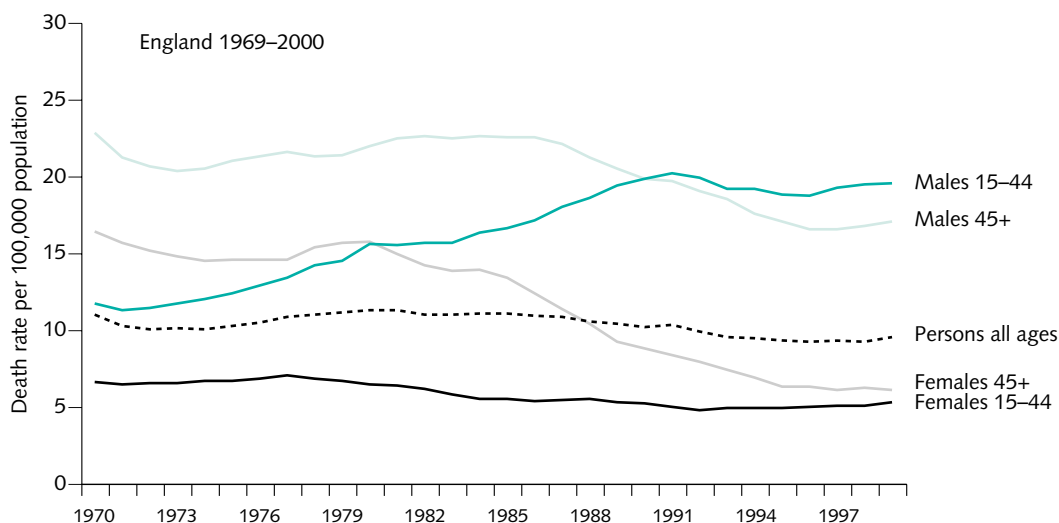
Eric Appleby	Alcohol Concern	Adrienne Katz	Young Voice
Dr Dinesh Bhugra	Institute of Psychiatry	Professor Michael Kerfoot	University of Manchester
Anna Brown	Papyrus	Trevor Lloyd	Men's Health Forum
Dr Tom Denning	Department of Health	Dr Nicola Madge	National Children's Bureau
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Dr Michael Farrell	Institute of Psychiatry	Professor Maggie Pearson	NHS North West Regional Office
Bob Garner	Department of Health	Pippa Sargent	CALM
Dr Alan Glanz	Department of Health	Dr Jenny Shaw	Guild Community Healthcare NHS Trust
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Gary Hogman	National Schizophrenia Fellowship	Professor Graham Thornicroft	Institute of Psychiatry
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Rosemary Jenkins	Department of Health	Maila Upanne	STAKES, Finland
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# Introduction

## Why do we need a national strategy for suicide prevention in England?

Suicide is a major public health issue. Around 5000 people take their own lives in England every year†. In the last 20 years or so, suicide rates have fallen in older men and women, but risen in young men (figure 1). The majority of suicides now occur in young adult males (figure 2). In men under 35, suicide is the most common cause of death.

**Figure 1: Standardised mortality rates\* from suicide and undetermined injury by age and sex**



Source: ONS Mortality Statistics (ICD E950-E959, E980-E989 less E988.8)

**Figure 2: Deaths from suicide and undetermined injury**

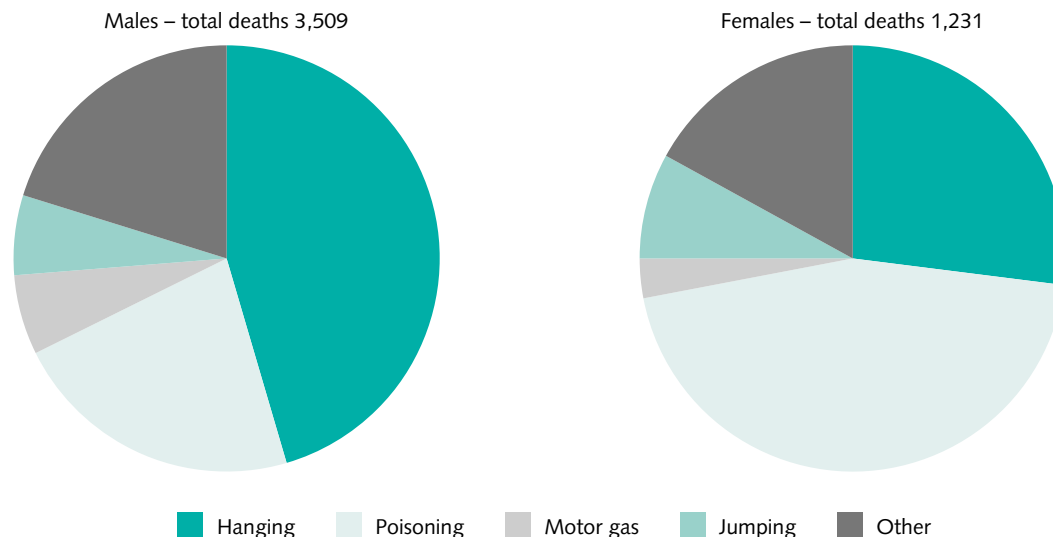


Source: ONS (ICD E950-E959, plus E980-E989, excluding E988.8 (inquest adjourned))

† This figure includes both suicide verdicts and undetermined deaths.

\* Each age group has been separated age standardised, i.e. adjusted for differences in the age structure of the population

Figure 3: Deaths from suicide and undetermined injury by method and gender



Source: Office For National Statistics (ONS)

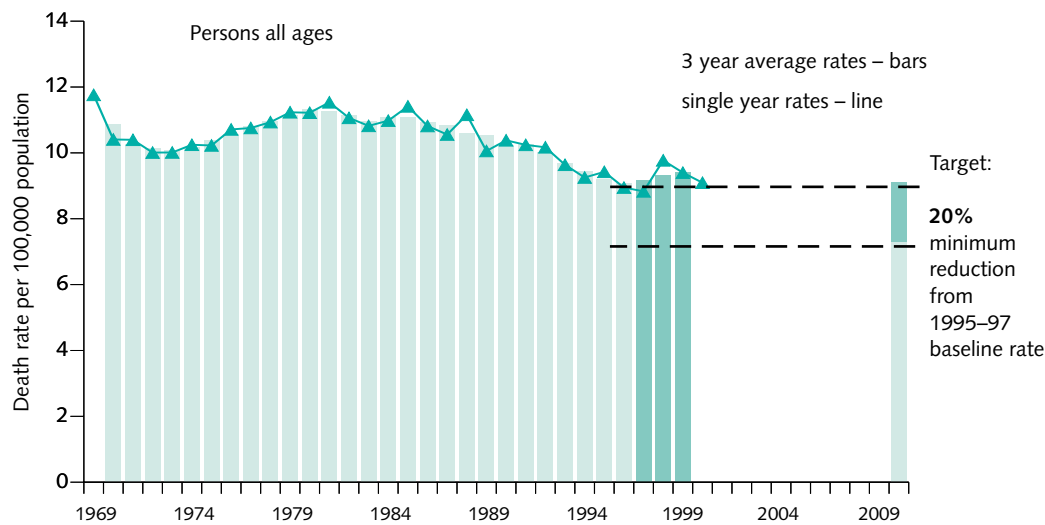
Each suicide represents both an individual tragedy and a loss to society. Suicide can be devastating for families and other ‘survivors’ – economically, psychologically and spiritually. For these reasons the Government has made suicide prevention a health priority.

Many of the risk factors for suicide are known from research – being male, living alone, unemployment, alcohol or drug misuse, mental illness. We also know that the main methods of suicide are hanging and self-poisoning with psychotropic or analgesic drugs (figure 3). These characteristics tell us who should be a target of prevention efforts and suggest ways in which prevention might be achieved.

They also show that there is no single approach to suicide prevention. We need a broad strategic approach – one that co-ordinates the contributions of public services and organisations, academic research, voluntary groups, the private sector and the concerned individual.

## What are the aims of the strategy?

The strategy aims to support the achievement of the target set in the White Paper *Saving Lives: Our Healthier Nation (OHN)*<sup>1</sup>, and reinforced in the National Service Framework for Mental Health<sup>2</sup>, to reduce the death rate from suicide and undetermined injury by at least a fifth by the year 2010 (figure 4). The strategy is not a one-off document. It is a co-ordinated set of activities that will take place over several years, and it will evolve as new priorities and new evidence on prevention emerge.

**Figure 4: Death rates from suicide and undetermined injury**England 1969-2000 and *Saving lives: Our Healthier Nation* target for the year 2010

Rates are calculated using the European Standard Population to take account of differences in age structure.

Three year average rates plotted on middle year, 1999 (ie 1998–2000) is the most recent available 3 year rate.

Source: ONS (ICD E950–E959, plus E980–E989, excluding E988.8 (inquest adjourned))

OHN targets measure suicide rates using three-year pooled rates. The three year pooled rate for 1997/98/99 and 1998/99/2000 (the latest available) are higher than the corresponding three year rate for 1996/97/98, so the three year pooled rate trend continues upward, although the latest three year rate is still well down compared to 10 years earlier.

Although the single year suicide rate increased in 1998, it fell in both 1999 and 2000, and is now lower again than the 1995 rate. However, following the rise in 1998, as the 1999 and 2000 single year rates are higher than the 1996 and 1997 rates, the most recent three year pooled rates are higher.

## What are the underlying principles?

The strategy is intended to provide a coherent approach to suicide prevention, based on four key principles. It aims to be:

- **Comprehensive**

The strategy recognises that suicide prevention is not the exclusive responsibility of any one sector of society, or of health services alone. This is particularly important in mental health services. People with mental illness are at high risk and mental health services have a vital part to play; however, around three quarters of people who commit suicide are not in contact with mental health services<sup>3</sup>.

- **Based on evidence**

The strategy is intended to be evidence-based. It draws on published research wherever possible. Where the evidence is weak, we propose to improve it.

- **Specific**

The strategy will be built around a number of actions. These are intended to be specific, practical and open to monitoring.

- **Subject to evaluation**

The strategy itself must be subject to continual evaluation and changed when necessary.

## What is this document intended to achieve?

This document sets out as concisely as possible a proposal for a suicide prevention strategy for England, formulated by an expert advisory group through consultation with mental health professionals, researchers, survivors of suicide, the voluntary sector and others with relevant experience. It sets out a programme of activity to reduce suicide based on six goals:

1. To reduce the availability and lethality of suicide methods.
2. To reduce risk among high risk groups.
3. To promote mental well-being in the wider population.
4. To improve the reporting of suicidal behaviour in the media.
5. To promote research on suicide prevention.
6. To improve the monitoring of progress towards the *Saving Lives: Our Healthier Nation* target for reducing suicide.

Under each goal, a series of more precise objectives is proposed. For each of these, we describe:

- key actions already taken
- new actions to be taken
- further consultation, often with other Government departments and other organisations
- information needed

Figures for suicide are given in relation to a number of objectives, based on the most recent available figures, rounded up or down, and a breakdown according to gender is also provided. As a guide to the potential benefits of each of these objectives, the impact of meeting the *OHN* target of a 20% reduction in suicide is set out for each group. These figures are not intended as individual targets: they show what each objective could contribute to the overall target. For simplicity, these figures are based on the most recent three-year average figures available.

The document is being published for consultation. Responses will be considered by a Strategy Group which we will establish.

## What would we like people to do?

Individuals, agencies and organisations are invited to consider this proposed strategy and to submit comments to the Department of Health at the following address by Friday 26 July 2002:

Professor Louis Appleby  
National Director for Mental Health  
C/o Department of Health  
Room 5W28  
Quarry House  
Quarry Hill  
Leeds  
LS2 7UE

Email: [nspicons@doh.gsi.gov.uk](mailto:nspicons@doh.gsi.gov.uk)

# Goals and objectives for action

## Goal 1: To reduce the availability and lethality of suicide methods

### Importance of goal

Reducing access to lethal methods of self-harm is known to be an effective way of preventing suicide<sup>4-7</sup>. One reason is that suicidal behaviour is sometimes impulsive<sup>8</sup>, so that if a lethal method is not immediately available a suicidal act can be delayed or prevented altogether. Although “method substitution” does occur, there will still be a significant number of people who do not go on to use another method and lives can therefore be saved.<sup>9, 10</sup>

Objectives have been set in order to reduce access to the main methods of suicide in this country (figure 3). Hanging, strangulation and asphyxiation are particularly associated with mental health wards<sup>3</sup> and prisons<sup>2</sup>, but these are also frequent methods of suicide in the community, especially among young men.

### Objective 1.1: Reduce the number of suicides as a result of hanging, strangulation and asphyxiation

**Current situation: 1900** deaths per year (latest 3 year average 1,880; 1573 male, 307 female)

**Impact of 20% reduction in suicides: 380** fewer deaths

#### Actions already taken

- 1.1.1 Health services have been asked to replace non-collapsible bed and shower curtain rails in mental health inpatient settings by March 2002, to meet the target set by the Department of Health to reduce to zero the number of suicides as a result of hanging from such ligature points.
- 1.1.2 The Prison Service’s strategy to reduce self-inflicted deaths includes changes to the physical environment such as the re-design of cell windows and furniture to reduce ligature points, care suites where prisoners can be supported and reduced access to materials commonly used as ligatures (see also Objectives 2.3 and 2.4).

#### Actions to be taken

- 1.1.3 Mental health services will be asked to ensure that regular environmental audits are carried out in all mental health in-patient settings to minimise risk of hanging and strangulation (see also Objective 2.1).

#### Information needed

- 1.1.4 On the ligatures and ligature points used in hanging and strangulation in the community. The Strategy Group will ask NHS R&D to carry out appropriate research in this area.

## Objective 1.2: Reduce the number of suicides as a result of self-poisoning

**Current situation: 1330 deaths per year** (latest 3 year average 1,326; 744 male, 582 female)

**Impact of 20% reduction in suicides: 265 fewer deaths**

### Actions already taken

- 1.2.1 From September 1998 the maximum pack size for over-the-counter sales of paracetamol and aspirin was reduced to 32 for pharmacies and 16 for other outlets. This appears to have led to an initial fall in overdose deaths using these substances<sup>7</sup>.

### Further consultation

- 1.2.2 With the Medicines Control Agency, the Committee on Safety of Medicines and the pharmaceutical industry on further steps that can be taken to reduce the availability of paracetamol, including paracetamol compounds, and aspirin.
- 1.2.3 With the Medicines Control Agency, the Committee on Safety of Medicines and other key stakeholders on practical steps that can be taken to promote safer prescribing of antidepressants.
- 1.2.4 With the Department of Health Pharmacy Division, the Communications Directorate and others on the feasibility and likely benefits of promoting the safe disposal of unwanted medicines by the public.

### Information needed

- 1.2.5 On the preventable factors in overdose deaths prior to and following hospital admission. The Strategy Group will ask NHS R&D to carry out appropriate research in this area. (*see also Objective 2.2*).

## Objective 1.3: Reduce the number of suicides as a result of motor vehicle exhaust gas

**Current situation: 350 deaths per year** (latest 3 year average 350; 319 male, 31 female)

**Impact of 20% reduction in suicides: 70 fewer deaths**

### Action already taken

- 1.3.1 The introduction of catalytic converters in motor vehicles for environmental reasons appears to have reduced the number of suicides by this method<sup>4</sup>.

### Further consultation

- 1.3.2 With car manufacturers and the Department for Transport, Local Government and the Regions, on the scope for further changes to car design – for example to alter the shape of exhaust pipes, to introduce carbon monoxide detectors, to improve catalytic converter efficiency.

## Objective 1.4: Reduce the number of suicides on the railways

**Current situation: 190 deaths per year** (latest 3 year average 187; 144 males, 38 females, 5 unknown)<sup>11</sup>

**Impact of 20% reduction in suicides: 38 fewer deaths**

### Action already taken

- 1.4.1 The Samaritans have advised a number of local authorities about measures that can be taken to improve safety at railway ‘hot spots’.
- 1.4.2 The Suicides and Open Verdicts on the Railways Network (SOVRN) Project is investigating railway suicides.

### Actions to be taken

- 1.4.3 All health and local authorities will be asked to identify railway ‘hot spots’ for suicide and to provide information on these to the Strategy Group.

### Further consultation

- 1.4.4 With railway companies, Railway Safety, London Underground and other key stakeholders, on the potential for developing safety measures on railways.
- 1.4.5 With the Home Office, on how coroners can in future report suicides on railways separately from those on roads to aid monitoring.

## Objective 1.5: Reduce the number of suicides as a result of jumping from high places

**Current situation: 140 deaths per year** (latest 3 year average 133; 97 male, 36 female)

**Impact of 20% reduction in suicides: 28 fewer deaths**

### Actions already taken

- 1.5.1 The Samaritans have posted contact numbers on a number of bridges and other high places.

### Actions to be taken

- 1.5.2 All health and local authorities will be asked to identify bridges and other high places that are ‘hot spots’ for suicide and to provide information to the Strategy Group on these.
- 1.5.3 The Strategy Group will provide preventive guidance on suicide from high places to health and local authorities.

## Questions for consultation

*Are these the best actions?*

*In what other ways can the availability and lethality of suicide methods be addressed?*

## Goal 2: To reduce risk in key high risk groups

### Importance of goal

Many risk factors for suicide have been described, and it is possible to identify groups that are at higher risk and to target them for specific action. In selecting high risk groups for inclusion in this strategy, we have applied clear criteria that are linked to the principles outlined earlier, namely: the need for specific action and the need to evaluate actions that are taken.

Criteria for selecting high risk groups:

- the group has a known statistically increased risk of suicide
- actual numbers of suicides in the group are known
- evidence exists on which to base preventive measures
- ways of monitoring the impact of preventive measures exist

There are several groups over whom concern has been expressed but who in our view do not meet these criteria. This is usually because there are no satisfactory current figures for suicide and/or there are no research data suggesting the main preventive measures that should be taken. In such groups, we are not proposing specific actions to prevent suicide. However, we are highlighting their needs in goal 3 (promotion of the mental well being), and taking steps to address these gaps in information.

### Objective 2.1: Reduce the number of suicides by people who are currently or have recently been in contact with mental health services ('recently' defined here as within one year of discharge)

**Current situation: 1200** deaths per year (latest 3 year average 1238; 826 males, 412 female)

**Impact of 20% reduction in suicides: 240** fewer deaths

#### Actions already taken

- 2.1.1 Standard 7 of the National Service Framework for Mental Health asks local mental health services to ensure that they have systems for suicide audit, and that local prison staff are supported in preventing suicides among prisoners and managing those who are vulnerable to self-harm.
- 2.1.2 The NHS Plan introduces a number of new clinical teams that are intended to improve mental health care to high risk groups, e.g. assertive outreach teams, early intervention teams, and to improve access to care at times of crisis.
- 2.1.3 The National Institute for Clinical Excellence funds the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, a national study of the antecedents of suicide by people under mental health care.
- 2.1.4 Mental health services have been asked to reduce to zero the number of suicides by mental health inpatients as a result of hanging from non-collapsible bed or shower curtain rails on wards (*see also Objective 1.1*).
- 2.1.5 Mental health services have been asked to provide follow-up within 7 days of discharge from psychiatric inpatient care for people at high risk (those with severe mental illness or recent non-fatal deliberate self-harm, or who were detained under the Mental Health Act because of suicide risk).

2.1.6 The Department of Health has developed an Acute In-patient Care Strategy due for publication in April 2002 which addresses issues such as the training of staff in suicide risk assessment and management.

#### **Actions to be taken**

2.1.7 Mental health services will be asked to adopt the checklist *Twelve Points to a Safer Service* (from the work of the National Confidential Inquiry<sup>3</sup>).

- staff training in the management of risk every 3 years
- all patients with severe mental illness and a history of self-harm or violence to receive the most intensive level of care under the Care Programme Approach
- individual care plans to specify action to be taken if patient is non-compliant or fails to attend
- prompt access to services for people in crisis and for their families
- assertive outreach teams to prevent loss of contact with vulnerable and high-risk patients
- atypical anti-psychotic medication to be available for all patients with severe mental illness who are non-compliant with 'typical' drugs because of side-effects
- strategy for dual diagnosis covering training on the management of substance misuse, joint working with substance misuse services, and staff with specific responsibility to develop the local service
- in-patient wards to remove or cover all likely ligature points
- follow-up within 7 days of discharge from hospital for everyone with severe mental illness or a history of self-harm in the previous 3 months
- patients with a history of self-harm in the last 3 months to receive supplies of medication covering no more than 2 weeks
- local arrangements for information-sharing with criminal justice agencies
- policy ensuring post-incident multi-disciplinary case review and information to be given to families of involved patients

2.1.8 A toolkit will be developed to assist mental health services in the implementation of NSF Standard 7.

#### **Objective 2.2: Reduce the number of suicides in the year following deliberate self-harm**

**Current situation:** 1180 deaths per year (latest 3 year estimate 1,176; 672 male, 504 female)<sup>12</sup>

**Impact of 20% reduction in suicides:** 236 fewer deaths

#### **Actions already taken**

2.2.1 The Royal College of Psychiatrists has made available *Guidelines on the Management of Deliberate Self-Harm*<sup>13</sup> and *Managing Deliberate Self-Harm in Young People*<sup>14</sup>.

2.2.2 The National Institute for Clinical Excellence has been asked to prepare a clinical guideline on the management of deliberate self-harm in accident and emergency departments and mental health services.

\* See also Objective 1.1 and 1.3

### **Actions to be taken**

- 2.2.3 A risk assessment training package will be made available to frontline clinical staff, with the support of the National Institute for Mental Health in England.

### **Objective 2.3: Reduce the number of suicides by young men (age 19–34)**

**Current situation: 1300** deaths per year (latest 3 year average 1294)

**Impact of 20% reduction in suicides: 260** fewer deaths

### **Actions already taken**

- 2.3.1 A CALM (Campaign Against Living Miserably) crisis helpline for young men has been established in a number of local authorities, supplementing the work of the Samaritans and NHS Direct. It aims to support young men who may become suicidal.

### **Actions to be taken**

- 2.3.2 A risk assessment training package will be made available to frontline clinical staff, with the support of the National Institute for Mental Health in England.

### **Further consultation**

- 2.3.3 With substance misuse services and the National Treatment Agency on steps that can be taken to improve the clinical management of alcohol and drug misuse among young men who carry out deliberate self-harm.
- 2.3.4 With primary care organisations, to promote the assessment of suicide risk in young men.
- 2.3.5 With colleges and universities, to promote the mental health of students.

### **Objective 2.4: Reduce the number of suicides by prisoners**

**Current situation: 85** deaths per year (latest 3 year average 85; 80 males, 5 females)

**Impact of 20% reduction in suicides: 17** fewer deaths

### **Actions already taken**

- 2.4.1 The Prison Service suicide prevention strategy includes the following key elements:
- a multi-disciplinary Safer Custody Group, encompassing suicide prevention policy and casework, links with other organisations, research and training, and operational support including outreach support visits to prisons
  - a Safer Local Prisons Programme, incorporating key elements of the new strategy in five local prisons
  - new suicide screening, care plan and staged risk management systems
  - implementation of intervention strategies for repeat deliberate self-harm in all prisons

- dedicated units in high-risk prisons where prisoners undergoing detoxification from drugs or alcohol have access to services
- improved health screening on reception into custody to assist in the identification of mental disorder, vulnerability to suicide and self-harm, and substance misuse
- strengthened investigations procedures and follow-up
- greater inter-agency liaison, including improved information-sharing with health services and other parts of the criminal justice system
- extended use of peer support for suicidal prisoners, including piloted peer “watchers” scheme
- reports and bulletins on suicide and self-harm statistics and trends, strategy developments and good practice
- standards on suicide and self-harm on safer prison environments
- regularly audited suicide and self-harm reduction standard
- Samaritan Trained Prisoner listeners accessible at all times for prisoners in distress
- design standards for safer prison environments

2.4.2 Community mental health teams are being developed by NHS mental health services in collaboration with prisons, to improve the mental health care of prisoners.

2.4.3 The Prison Service is funding a number of research studies on the antecedents of suicide and self-harm in prison.

#### **Further consultation**

2.4.4 With the Prison Service, to investigate ways of improving information flow into and across the criminal justice system concerning individuals known to be at risk of suicide.

2.4.5 With the Prison Service, on the dissemination of World Health Organisation Primary Care Guidelines for Prison, including guidance on suicide prevention.

### **Objective 2.5: Reduce the number of suicides by high risk occupational groups**

#### **Current situation:**

**Farmers:** 52 deaths per year

**Nurses:** 27 deaths per year

**Doctors:** 17 deaths per year

**Impact of 20% reduction in suicides:** 21 fewer deaths

#### **Action already taken**

2.5.1 Helplines are provided by the National Union of Farmers, the Rural Stress Information Network, ruralMinds, the British Medical Association and The Samaritans.

2.5.2 The Department of Health has supported the Rural Stress Action Plan co-ordinated by the Department for the Environment, Food and Rural Affairs by funding voluntary working with rural communities.

## **Further consultation**

- 2.5.3 With occupational leaders and organisations, on how more systematic support can be built into occupational health and supportive management practices, on dissemination of helpline numbers, and on reducing access to suicide methods.

## **Questions for Consultation**

*Are these the right high risk groups?*

*What other measures might be taken for these high risk groups?*

## **Goal 3: To promote mental well-being in the wider population**

### **Importance of goal**

Suicide rates reflect the mental health of the community as a whole. It could therefore be argued that any measure intended to improve mental well-being in the wider population has the potential to reduce suicide. Standard 1 of the National Service Framework for Mental Health<sup>2</sup> adopts this broad approach by stating that health and social services should:

- promote mental health for all, working with individuals and communities
- combat discrimination against individuals and groups with mental health problems, and promote their social inclusion

In this strategy we aim to stress the importance of general measures to improve mental health and to address aspects of people's life experiences that may damage their self-esteem and their social relationships – for example bullying in schools or in prisons, low educational achievement, racial discrimination, family conflict, isolation, violence and abuse.

However, to incorporate such general measures as part of the National Suicide Prevention Strategy would make it unwieldy. We want instead to highlight a number of groups within society for whom specific measures should be taken. These are not groups at high risk of suicide, as defined earlier. They are however groups about whom concerns were expressed during the consultations that led to this document. They are vulnerable groups whose needs suggest particular actions.

### **Objective 3.1: Promote the mental health of socially excluded groups by supporting implementation of NSF Standard 1 by local mental health services**

#### **Actions already taken**

- 3.1.1 Mental health services have been asked to develop a mental health promotion strategy by March 2002, based on an assessment of local need.
- 3.1.2 Mental health services have been asked to ensure that by March 2002 the written care plan for those on enhanced Care Programme Approach must show plans to secure suitable employment or other occupational activity, adequate housing and the appropriate entitlement to welfare benefits.
- 3.1.3 The Department of Health has issued *Making It Happen: a guide to delivering mental health promotion* to local mental health services.

### **Actions to be taken**

- 3.1.4 The Department of Health will disseminate a framework to help mental health services take action needed to promote employment of people with mental health problems.
- 3.1.5 The Prison Service will shortly be publishing a Health Promotion Strategy for prisons which will include actions on mental health promotion.
- 3.1.6 The Department of Health will disseminate a toolkit to support primary care staff in promoting mental health.
- 3.1.7 The Department of Health will disseminate guidelines on meeting the physical health needs of people with mental health problems.
- 3.1.8 The Department of Health will develop and implement a Programme for Promoting Mental Health and Social Inclusion within the National Institute for Mental Health in England.

### **Objective 3.2: Promote mental health among children and young people (aged 18 and under)**

#### **Actions already taken**

- 3.2.1 The Royal College of Psychiatrists has published *Managing Deliberate Self-Harm in Young People*<sup>14</sup> (see also Objective 2).
- 3.2.2 Work has been commissioned through the DfES to map current initiatives at a national level to promote mental health in schools; and identify further opportunities for promoting mental health in schools, such as the new National Curriculum focus on Citizenship and the National Healthy Schools Standard.
- 3.2.3 The Community Fund has supported a study of the frequency and characteristics of self-harm among school students
- 3.2.4 The Department of Health's *mind out for mental health* anti-stigma campaign has specifically targeted young people in universities and youth organisations and will be expanded to reach wider youth audiences in 2002/03.

#### **Further consultation**

- 3.2.5 With those responsible for developing the National Service Framework for Children, on steps to improve identification and clinical management of depression in children and young people.
- 3.2.6 With those responsible for developing the National Service Framework for Children, on the assessment and support for children and young people coming out of care.

### **Objective 3.3: Promote the mental health of those bereaved by suicide**

#### **Actions already taken**

- 3.3.1 Organisations such as PAPYRUS provide support to parents bereaved by suicide.

**Further consultation**

3.3.2 With the Home Office, on good practice by coroners in court procedures to improve the support to bereaved families.

**Information needed**

3.3.3 On appropriate support for people bereaved by suicide. The Strategy Group will ask NHS R&D to carry out appropriate research in this area..

**Objective 3.4: Promote mental health among older people**

**Actions already taken**

3.4.1 The National Service Framework for Older People seeks to promote good mental health in older people and to treat and support those with dementia and depression by:

- ensuring access to integrated mental health services
- effective diagnosis
- treatment and support for them and for their carers.

**Further consultation**

3.4.2 With leaders of services for older people, on improving the clinical management of depression in older people, particularly those who are suffering from physical illness.

**Objective 3.5: Promote mental health among black and ethnic minority groups including Asian women**

**Action already taken**

3.5.1 The Department of Health has commissioned a toolkit to support local services in promoting mental health for black and ethnic minorities.

**Action to be taken**

3.5.2 The Department of Health will publish a strategy for the mental health care of people from black and ethnic minority groups (consultation document expected September 2002).

**Further consultation**

3.5.3 With the Home Office, about the routine recording of ethnicity by coroners.

**Information needed**

3.5.4 On extent of risk and preventative measures for suicide among Asian women. The Strategy Group will ask NHS R&D to carry out appropriate research in this area.

### Objective 3.6: Promote mental health among women during and after pregnancy

3.6.1 Although the risk of suicide is reduced in childbearing women, suicide continues to account for a proportion of maternal deaths.

#### Action already taken

3.6.2 The Confidential Enquiries into Maternal Deaths in the United Kingdom<sup>15</sup> includes a series of key recommendations, including:

- Protocols for the management of women who are at risk of a relapse or recurrence of a serious mental illness following delivery should be in place in all Trusts providing maternity services;
- Women with a past history of serious psychiatric disorder post-partum or non-postpartum should be assessed by a psychiatrist in the antenatal period;
- Women who require psychiatric admission following childbirth should ideally be admitted to a specialist mother and baby unit together with the infant.

#### Further consultation

3.6.3 With the Confidential Enquiries into Maternal Deaths, the National Institute for Clinical Excellence and Department of Health policy colleagues on implementation of the key recommendations.

### Questions for Consultation

*Are these the right objectives and tasks to promote this goal?*

*What others might there be?*

## Goal 4: To improve reporting of suicidal behaviour in the media

### Importance of goal

Media of all kinds have a significant impact on our behaviour. There is evidence that reporting of suicide in the media can increase the rate of suicide, especially among people already at risk<sup>16, 17</sup>. By limiting some aspects of the reporting of suicide, and by portraying it in ways which may discourage imitation, the media can make an important contribution to suicide prevention.

### Objective 4.1: Promote the responsible representation of suicidal behaviour in the media

#### Actions already taken

4.1.1 Guidelines for the media on the reporting of suicides have been produced by The Samaritans. The key measures are:

- reduce sensationalism and remove positive messages about suicide
- avoid reference to suicide methods
- increase the prominence given to responsible reports on suicide prevention
- include facts about suicide

- influence the training of journalists to ensure that they report on mental illness and suicidal behaviour in an informed and sensitive manner
- establish a method of ensuring that such training is repeated as a rolling programme

4.1.2 The Department of Health's *mind out for mental health* anti-stigma campaign aims to influence the ways in which the media report mental health issues – for example, through providing workshops and training materials for student journalists.

#### **Actions to be taken**

4.1.3 A systematic review of the research literature on the influence of the media on suicidal behaviour will be disseminated to media organisations.

#### **Further consultation**

4.1.4 With media groups and representatives, on further actions that can be taken to promote the guidelines in 4.1.1.

#### **Questions for Consultation**

*Are these the right measures to improve the portrayal and reporting of suicidal behaviour in the media?*

*What other measures might help?*

## **Goal 5: To promote research on suicide and suicide prevention**

### **Importance of goal**

Research evidence on suicide prevention is a crucial foundation of this strategy. A large amount of evidence has been reported from epidemiological and clinical studies on risk factors associated with suicide. However, there have been no intervention studies in which suicide has been the main outcome. This is largely because of the huge sample of people (running to several million) that would have to be in such a study before reliable results could be produced.

We therefore need research to develop in two ways. We need detailed studies of high risk groups from which we can draw conclusions on prevention with reasonable certainty. We also need to conduct intervention studies with more common outcomes that can act as 'proxy' measures for suicide.

### **Objective 5.1: Improve research evidence on suicide prevention**

#### **Action already taken**

5.1.1 Reviews of current research evidence have been published<sup>18–20</sup>

#### **Action to be taken**

5.1.2 The NHS and other funders of mental health research will be asked to support research on suicide prevention, and in particular:

- intervention studies for suicide prevention and management of deliberate self-harm
- controlled studies of the antecedents of suicide in high risk groups, particularly those highlighted in this document
- support for people bereaved by suicide and for those with a suicidal/self-harming family member (*see Objective 3.3*)
- detailed studies of common suicide methods – hanging and self-poisoning (*see Objectives 1.1 and 1.2*)

## Objective 5.2: Disseminate existing evidence on suicide prevention

### Action to be taken

- 5.2.1 Current evidence, including recent major studies and systematic reviews, will be made available to local services through the National Institute for Mental Health in England.

### Questions for Consultation

*Are these the right measures to promote and co-ordinate research into suicide and suicide prevention?*

*What other measures might help?*

## Goal 6: To improve monitoring of progress towards the *Saving Lives: Our Healthier Nation* target to reduce suicide

### Importance of goal

A large amount of data about suicide is already collected by the Office for National Statistics and through programmes of research. However, additional information will be required to support the objectives in this strategy. It will also be necessary to monitor progress on each of the actions listed above. This will be carried out by the Strategy Group.

## Objective 6.1: Monitor suicide statistics relevant to the objectives in the strategy

### Actions to be taken

- 6.1.1 The Strategy Group will receive regular reports on national suicide rates – in the general population and in age, gender and social class sub-groups, by the methods highlighted under goal 1, and in the high risk groups listed under goal 2. This will allow us to monitor rates in young men, children and older people, and inequalities in suicide rates across social class.
- 6.1.2 The Strategy Group will establish a deliberate self-harm monitoring group and will receive regular reports on rates of deliberate self-harm in the general population and in the groups described under 6.1.1.

### Further consultation

- 6.1.3 With the Home Office and the Office for National Statistics, on the recording by coroners of ethnicity and employment status in deaths by suicide, using standardised definitions.

- 6.1.4 With the Home Office and the Office for National Statistics, on the separate recording by coroners of railway and road suicides.

## **Objective 6.2: Evaluate the national suicide prevention strategy**

### **Actions to be taken**

- 6.2.1 The Strategy Group will regularly assess progress on all objectives listed in the strategy.

### **Question for Consultation**

*What other measures could help in improving and expanding the monitoring of progress towards the OHN Target of reducing suicide?*

# Timetable for consultation

April 2002	Draft suicide prevention strategy published for public consultation
July 2002	Consultation ends
July/August 2002	Collation and consideration of responses to consultation; development of final strategy; development of implementation programme
September 2002	Publication of final agreed National Suicide Prevention Strategy for England

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