Dorset Council

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Public Health Dorset

Suicide Prevention Evidence Review 2024

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1. Introduction

The World Health Organisation (WHO) have made preventing suicide an urgent high-level priority [1]. Globally, over 700,000 die from suicide each year and it is estimated that there are around 20 suicide attempts for each of these. Over three-quarters of global suicides occur in low- and middle-income countries where conflict, disaster, violence and belonging to minority groups are of added importance [2]. Both the WHO and UN aim to reduce the global suicide mortality rate by a third by 2030 [3, 4]. Their LIVE LIFE guide recommended four key interventions for an international prevention approach [5]:

- Limit access to the means of suicide.
- Interact with the media for responsible reporting of suicide.
- Foster socio-emotional life skills in adolescents.
- Early identify, assess, manage, and follow up anyone who is affected by suicidal behaviours.

a) Literature review

An initial search was conducted in partnership with Morag Evans - Dorset County Hospital Library Manager. A keyword search was made of PsychInfo, Medline and Google Scholar including variations of suicide, prevention, policy, mental health and wellbeing, and self-harm. Grey literature reports were additionally found via the UK Government website, the Royal College of Psychiatrists (RCPSYCH) and through Google and secondary sourcing.

Suicide prevention policy and guidelines are informed by surveillance, data analysis, research analysis, and cross-systems thinking reflecting the multi-factorial complexity behind suicide. In clinical practice, work is required to influence the acceptance of evidence-based practices and a similar situation is found in the community [6].

Suicide statistics in England and Wales are reported on by the Office for National Statistics (ONS). These statistics are compliant with the Code of Practice for Statistics and are designated as National Statistics. Their definition includes all deaths from intentional self-harm for persons aged 10 years and over, and deaths caused by injury or poisoning where the intent was undetermined for those aged 15 years and over. It uses information provided by the coroner and based on the year of registration [7]. For certain areas or ages, the number of deaths may be too small to allow calculation of a rate. Local authorities' estimates are based on three years of registrations. The ONS does not calculate rates where there are fewer than 10 deaths and note the uncertainty when using fewer than 20. Some parameters such as ethnicity, sexual orientation or reasoning behind the suicide are not routinely recorded.

This type of research is used to inform predictive models and can help elucidate risk factors [8]. For example, key risk factors for suicide include male gender, poor social support, chronic painful illness, family history and availability of means [9]. It may also identify protective factors including: a well-developed social network, religiosity, responsibility for young children, extraversion or those with strong coping strategies. System dynamics modelling (SDM) is one method available to quantify the multiple, nonlinear, and interacting components within this complex system [10]. It aims to account for these dynamic factors to understand trajectories of suicidal behaviour. Local stakeholders can be brought together to inform a tailored model. However, it is important to note that suicide cannot be predicted at an individual level and patients should be engaged with at an individual level [11].

Each factor increases or decreases the risk by a small amount and suicide remains a rare – yet, tragic – occurrence. Evaluation of interventions is important to understand which recommended actions are effective. An Irish report on suicide prevention focused their resources on reviewing peer-reviewed systematic reviews to produce a "review of reviews" [12].

They found strong evidence for restricting means and psychotherapy, and moderate evidence for training gatekeepers (such as primary healthcare workers) to other services. "Means" included barriers to jumping hotspots and restricting analgesics. However, a similar method found that no one strategy stood out and combinations of evidence-based strategies would be required at the individual and population levels [13].

Managing rail suicide and vulnerable presentations - Network Rail

Network Rail recognised that many locations have had multiple suicide attempts. Up to half of these attempts do not involve a train. Nationally, rail suicide occurs every 34 hours on average. These are mostly men aged between 35 and 55 but the numbers of women are increasing. These traumatic events also have an impact on workforce wellbeing. Their plan was to:

- Utilise intelligence more by supporting targeted action plans and improving their response. This also limits passenger impact.
- Created targeted trespass and suicide management plans and increased use of increased surveillance and barriers.
- Incorporated tools for behavioural change by raising awareness and signposting support interventions for those in crisis.

2. National Policy Context

First published in 2012, "Preventing Suicide in England" is the integrated national strategy to reduce the suicide rate and to better support those bereaved or affected by suicide [14]. Local authorities were mandated to lead the suicide prevention work to acknowledge the importance of multi-agency working. In 2019, the Samaritans partnered with the University of Exeter to analyse local authority suicide prevention planning [15]. They recommended that local authorities lean into their local strengths and focus on areas of existing effective partnership working. The scope of the national strategy was extended by 2017's third progress report to include self-harm [16]. The most recent National Strategy was published in 2021 and focused on the impact of the pandemic on suicide prevention [17]. It reiterated the current key areas for action:

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

3. Priority groups

NHS England's 2016's "Five Year Forward View for Mental Health" recommended local authorities' plans to target high risk locations and groups [18]. The Department of Health and Social Care's "Suicide prevention strategy for England: 2023 to 2028" lists several groups who may benefit from tailored or targeted action, with the understanding that individual needs and

experiences should be catered to where possible and that local populations may identify other groups [19]. These groups may have higher, or rapidly rising, suicide rates compared with the general population or who may be of particular concern, such as children and young people:

- Children and young people.
- Middle-aged men – remain at the highest risk of suicide.
- People who have self-harmed – the biggest indicator of suicide risk.
- People in contact with mental health services – account for around a third of all suicides.
- People in contact with the justice system.
- Autistic people.
- Pregnant women and new mothers.

4. Other associated risk factors

The national 5-year cross-sector strategy advocates addressing risk factors as an inherent part of effective suicide prevention [19]. Several factors have been identified as priority areas:

- Physical illness.
- Financial difficulty and economic adversity.
- Harmful gambling.
- Substance misuse.
- Domestic abuse.
- Social isolation and loneliness.

Additionally, wider social determinants are linked with suicide, and it may be considered as an issue of social inequality [20]. Being male is associated with an increased risk of dying by this method [21].

Employment

Certain occupations are associated with an increased risk of suicide [22]. Males had higher risks in the lowest-skilled occupations, those who work in construction, building finishing trades *e.g.* plasterers and painters, and for those in culture, media, and sport roles. The highest risk for women were for those working in artistic, literary and media occupations, and female nurses. Male and female carers had a suicide risk of almost twice the national average.

Rewarding employment is associated with reduced suicide rates as well as fewer depression and anxiety symptoms [23]. Macroeconomic decline, such as a rising cost of living or recession, exacerbates these factors - plus alcohol abuse - through its effects on employment, income, insecurity, and loss of social networks [24]. Ecosystem hazards, such as lead – or other toxin - exposure, increase risk [25]. Suicide has been linked to low educational attainment through chronic stress and poor social capital [26].

A new crisis café to prevent suicide at a high-risk location

Hertfordshire County Council and Stevenage Borough Council responded to a reported increase in the number of suicide attempts, fatalities, and interventions at Stevenage train station by:

- Setting up a Task and Finish Group to explore what support could be offered to people in crisis at the station.
- Opened the NightLight crisis café close to the station which received 108 visits in its first month.

- Café team provide every visitor with face-to-face person-centred support.
- Team is able to provide de-escalation, discussion of coping strategies and making a crisis exit plan.

Additionally:

- The council made suicide prevention a part of Stevenage's regeneration project through partnership working *e.g.* considering safety as part of planning a new multi-storey car park.
- Cafe has been integrated into their local Healthy Hub.
- This includes the Men's Club: a free four-week course that includes weekly workshops and activities to help men improve their physical and mental health in a friendly, supportive environment.

Suicide Prevention in the Square Mile programme

Addresses the needs of a high-risk location in London: Workers in the stressful finance industry are withing an area of bridges and tower blocks.

- Instigated a bridge pilot: Samaritans signs were placed on the three bridges.
- Prevention training was given to the staff and public, and leaflets handed out to workers.
- Planning guidance was offered to buildings above four storeys and barriers suggested for bridges.
- A mental health street triage was made up of volunteer patrols. Provision was made for mental health nurses to accompany police officers.
- A Samaritans service delivery centre was installed in the area.

Baton of Hope project

A baton is being taken around the country to garner media interest for suicide awareness. The project developed a workplace charter of 6 principles to recognise employers' role in prevention and to foster an open environment to discuss suicide and its prevention.

5. Evidence-based recommendations

The National Institute for Health and Care Excellence (NICE) have issued guidelines on self-harm and preventing suicide in community and custodial settings: these comprise primarily evidence-based clinical guidelines for professionals [27, 28].

The national cross-sector strategy outlined their evidence-informed priorities for action over the next five years [29]:

- Improving data and evidence to ensure that effective, evidence-informed, and timely interventions continue to be developed and adapted.
- Tailored, targeted support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.
- Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.
- Promoting online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.
- Providing effective crisis support across sectors for those who reach crisis point.
- Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.
- Providing effective bereavement support to those affected by suicide.

- Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

6. Third sector organisations

The voluntary, community and social enterprise (VCSE) sector provide diverse and innovative mental health support for individuals, families, communities and populations and who often present with complex needs. This is often demonstrated by case studies or qualitative research but is difficult to quantify economically.

There are many and various 3rd sector organisations who engage with suicide prevention and mental health issues at all ages by offering advice and support, awareness campaigns, and training. To support the work of charities, alongside the NHS, in August 2023 the government placed £10m into reopening their Suicide Prevention Grant Fund [29]. Locally, the Dorset Community Mental Health Alliance (DCMHA) brings together 31 organisations from the voluntary, statutory, and business sectors of Dorset. They comprise two subgroups: the first covers suicide prevention training and organisational strategy, and the second group assists people who repeatedly present to emergency services because their lives are at risk - this is informed by Real-Time Surveillance data. The Alliance meets monthly to collaborate to deliver the best outcomes.

Directories

Many of these operate at a national level, which provides resources for greater exposure among the general population. The Hub of Hope (provided by Chasing the Stigma) is an example of a mental health database that aims to bring together all the mental health support and services; it is searchable at a local level.

Advice Lines

A number of large, recognisable, national mental health charities and organisations offer support and advice for those struggling to cope or who have thoughts about killing themselves; or people who may be worried about others or affected by suicide. Organisations such as Samaritans, Mind, Suicide Prevention UK, and SOS have dedicated helplines staffed by trained workers. 999 or A&E is still recommended for signs of immediate danger. The National Suicide Prevention Alliance (NSPA) fosters partnership working and shares good practice. Questionnaires have been shown to reduce suicidal and self-harming ideation in callers.

Training

Training and increasing awareness remain a focus for these groups. Grassroots Suicide Prevention and Zero Suicide Alliance (ZSA) offer training in suicide prevention, talking about suicide, mental health, and self-harm. They reach a variety of individuals, workplaces and institutes including schools, universities, and prisons. Suicide Prevention UK offers training to achieve Mental Health First Aid (MHFA) accreditation. MHFA showed that 75% employees do not believe that suicide prevention is part of their organisation's mental health and wellbeing strategy. Only 13% knew how to ask a colleague they were worried about if they have a plan to end their life. A third believed, incorrectly, that asking about suicide can put the idea into someone's head.

Campaigns

Campaigns have the same objectives as the training and the above organisations have engaged in: *Ask Now Save Lives* to learn how to talk about suicide; or Campaign Against Living Miserably (CALM) using celebrities and patrons to publicise their stand against suicide. ANDYSMANCLUB is a suicide prevention charity aimed at men, and which offers free, weekly, peer-to-peer supports groups nationally. They provide a safe space for men to talk and reduce the stigma of mental health. A systematic review by NICE found that suicide awareness campaigns have been shown to increase help-seeking behaviour.

Children and Young People

Most of the larger organisations above either don't discriminate by age or have tailored services aimed at children and young people. This group has specific concerns which require tailored support by staff experienced with working with this age group. The RCPCH noted that suicide is the leading cause of death for both males and females between the ages of 5 and 19 across England and Wales [30]. Anxiety and depression are becoming increasingly common and mental health disorders are linked to physical or developmental problems and associated with vulnerable groups [31]. Half of all mental health problems are established by the age of 14 [32]. Continuity of care is often lost when transitioning from child and adolescent to adult mental health service [33]. Those young adults who fall into this "transition gap" often access adult services later when existing problems may have worsened.

Several organisations are specifically aimed at children and young people or have concessions in place to facilitate access to their services. Papyrus Prevention of Young Suicide is aimed at young people below 35 years of age. They operate the HOPELINE247 helpline but have a digital platform to help maintain contact; for example, by storing and updating a suicide plan. YoungMinds aims to improve timely access to mental health services through a variety of methods and empower young voices to shape the services that affect them. They also help to train young people, and adults, who wish to be a source of support. Whilst the telephone remains the most common way of contacting these services, Samaritans is an example of the provision of multiple access methods: this additionally includes email, letter, online chat, face-to-face or via a self-help app. Shout 85258 provides a free 24/7 test service for anyone in crisis and could be a vital alternative for someone who initially does not feel ready to talk with someone.

Custodial settings

RECONNECT is a "care after custody" service aimed at tackling the crisis point of prison release, or immigration removal centre (IRC) [34]. It works with individuals who have significant health or social care vulnerabilities and who struggle to engage with community-based healthcare services [35]. They act as care navigation and support for a maximum of 12 weeks pre-release and 6 months post-release, thereby increasing access to, and uptake of, healthcare and support.

Lived experience

Voices are a collective of People with Living Experience of Suicide who use their shared knowledge to inform programmes on suicide prevention and bereavement. They can assist with developing strategies and informing policy from the design, implementation, and evaluation stages. They can be an important advocate for those people affected by suicide. In Scotland, a lived experience panel as part of an action plan brought about an increased understanding of suicide and a fresh perspective on the development of suicide prevention strategies, whilst raising the profile of their work.

7. Examples and recommendations for practice

a. Those known to mental health and other statutory services.

Mental health patients exhibit higher rates of self-harm and suicide accounting for its inclusion as one of the three priority areas of the Royal College of Psychiatrists' (RCPSYCH) Suicide Prevention Programme. Tackling this issue lies mainly in the clinical domain although patients may be managed in the community. By way of example, people with personality disorder (instability of mood and impaired social functioning) are associated with violent and self-harming behaviours. They are high service users which is also attributable to other comorbidities such as substance abuse, which was not addressed in two-thirds of patients [36]. Many physical health problems are associated with elevated suicide risk as well as providing the means to overdose *e.g.*, opioids or paracetamol. For psychiatric patients with physical co-morbidities, overdose rather than hanging was found to be the leading cause of suicide [37]. Further, opioid prescribing increased by a third between 1998-2018 even as the strength of the medication increased over the same period [38].

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) developed a Safer Services Toolkit comprising ten key elements for safer care for patients with demonstrated reduction of suicide rates. A US-based Safety Planning Intervention included follow-up telephone contact with suicidal patients which reduced the incidence of suicidal behaviour [39]. RCPSYCH gives five examples of good practice:

LOCATION	TITLE	ACTION
Cornwall and Isles of Scilly	Safety planning	GP delivered 90m session, Website with safety plan resources for community, Safety planning training
Coventry and Warwickshire	MindStance	Six-week course: Better understand addiction and impact on mental health, Increase coping skills
Mid and South Essex	Primary care training	Virtual training modules: Suicide Awareness and Response in Primary Care, Emotional resilience for professionals
North East and North Cumbria	Connecting people with training	Connecting with People training: Targeted modules to sectors, Encourage everyone to create a Safety Plan, Use social media for booking and local champions
Suffolk and North East Essex	Primary care training	4 Mental Health used Connecting with People for Webinar suicide awareness and response training.

London's mental health joint response car (MHJRC)

This project was initiated as EDs are busy and often cannot provide the calm environments people in mental health crises need. The London Ambulance Service (LAS) plays a crucial role in the mental health care crisis pathway as 999 and NHS 11 are often the first point of care.

- This project is for LAS crew who needs clinical input for mental health care for patients that require support but not ED care.
- The ambulance crew call 111 and press *5 to speak with clinical assessment service (CAS).
- A clinical assessment services (CAS) clinician – part of the NHS e-Referral Service - returns the call to provide senior clinical advice to enable conveyance to the right place of care or to leave with appropriate follow-up.
- The **pilot study** demonstrated that just 4% of patients seen by the MHJRC attended ED after a "see and treat" intervention. An estimated cost saving of 45% across London and a 45% reduction in ED conveyance. Further evaluation will be on the impact of the police services who convey 50% cases classified under S136 of the Mental Health Act.

b) Self-harm

There are an estimated 200,000 presentations to A&E departments in England following acts of non-fatal self-harm annually. This figure does not include non-presentations and dates from 2007 [40]. Self-harm is the strongest risk factor for subsequent suicide [41]. Around a half of individuals who die by suicide have a history of self-harm, and they often present to hospital shortly before suicide [42, 43].

Any causative link between self-harm and suicide is imperfectly understood. Certain methods of self-harm are associated with an increased risk of suicide. These include asphyxiation or hanging, drowning, use of firearms and carbon monoxide poisoning [44, 45, 46]. Repeating episodes of self-harm may convey a greater risk of suicide [47]. Suicidal behaviours, including self-harm, is associated with socioeconomic disadvantage, especially in men [48]. The suicide rate is at its highest in the year following discharge from hospital for self-harm and extremely elevated in the first month of that period [49]. By contrast, this study, that took place in three urban centres in England: Oxford, Manchester and Derby, also found that patients from the least socioeconomically deprived were more likely to die by suicide following presentation to hospitals for self-harm. The authors posited that an awareness of the characteristics that increase the risk of subsequent suicide can be included as part of an assessment following an episode of self-harm. Factors might include male gender, older age, self-harm method, and area of residence. Crucially, individual factors have poor predictive efficacy when evaluating suicide risk at the time of self-harm presentation [50]. and risk reduction strategies with safety planning [39].

Part of the University of Manchester, NCISH developed a services for self-harm toolkit following on from the NICE Quality Standard on Self-Harm (QS34). This allows care providers to assess and monitor self-harm through eight quality statements. A recovery service was developed in Staffordshire offering non-clinical support to those who self-harm.

TITLE	ACTIONS
The Manchester Self-Harm Project	Collects data on ED presentations for self-harm, Supports research, clinical guideline development, and the creation of local and national self-harm and suicide prevention initiatives and strategies

Staffordshire and Stoke-on-Trent Self-harm and Recovery Service and Year One Review	3-tier non-clinical intervention: Structured, professional 1:1 support (6 sessions), develop recovery plan, Self-refer to structured workshops, therapeutic activities, social groups, Out of hours support; telephone support calls (2 weeks)

Managing self-harm in North Tyneside schools

This project involved raising awareness of self-harm management within schools and amongst CYP. In summary, it:

- Was a multi-agency project led by Northumbria NHS CAMHS nurses and included teachers, charity workers, students, and health professionals.
- Developed and delivered training package for early identification and management of self-harm.
- Provided resources specifically for CYP.
- Developed a standardised guide for management across North Tyneside schools.
- Increased understanding of the services and agencies available to support the management of self-harm.
- Provided resources to support professionals to open up discussions with CYP who are self-harming.
- Built resilience among children through awareness raising sessions.
- School staff were given a base line survey and a post-training survey which demonstrated an increased awareness and confidence in managing self-harm for people associated within these North Tyneside schools. Their understanding of when and how to seek specialist support had also increased.

Older People and Self Harm:

A Greater Manchester Campaign looked to improve mental wellbeing and raise awareness of self-harm in older people.

Older people who self-harm are at 67 times greater risk of suicide than the general older population and three times greater than the relative risk of suicide among younger people who self-harm.

In summary, the project:

- Involved the Greater Manchester Older People's Network in developing and running the campaign.
- Included experienced cartoonist/ graphic minute taker to share and shape the conversation, such as where programme should be targeted.
- Involved meetings that were fluid and didn't always follow an agenda.
- Circulated posters to the target group along with social media posts with, for example, Age UK.
- Noted improved outcomes such as increased access to talking therapies: this age group tended to complete the course.

c) Middle-aged men

Middle-aged men have the highest suicide rate in the UK, accounting for a quarter of all suicide deaths [51]. This group has a rate three times higher than women, and one and a half time greater than men of other age groups. Middle-aged men are thought to not to be in contact with health or support services, or more likely to suffer economic adversity. The Manchester study reported on the complex long-term and short-term risks leading to suicide and is rarely due to a single cause. Additionally:

- Contrary to popular thought, almost all the men in their study had been **in contact with a front-line service or agency**. GPs have often seen people who have died by suicide within three months beforehand highlighting an opportunity for early intervention [52]. Significant portions of men in a Scottish study who had visited their GP were unemployed, lived alone, have self-harmed, work-related problems or a current major physical illness.
- Primary care, A&E, the justice system, and mental health services can play a joint role in identifying risk.
- Common antecedents of suicide include economic adversity, alcohol and drug misuse, and relationship stresses.
- **Physical ill-health** is an important risk factor. More than half of the men who died in the study had a physical health condition; of those who were prescribed medication, over a third were prescribed opiates.
- Around half of the men who died were known to have **self-harmed**.
- Many of the men appear to have been affected by **bereavement**. There is a need to ensure appropriate bereavement support.
- Information on **suicide methods** were searched for on the internet.

The RCPSYCH notes a lack of conclusive evidence for interventions in this area. Their good practice examples recognise innovation in this hard-to-reach group as a priority of their Suicide Prevention Programme.

LOCATION	TITLE	ACTION
Kent & Medway	Release the pressure campaign	24/7 support line awareness campaign: media, pubs, service stations, Use Mental Health Matters and Shout
Norfolk & Waveney	12th man	Creating a safe place for men to talk: Campaign and training, Mental Health First Aid, Engaged with barbers, pub staff, tattooists, Affiliated club events
Sussex Health and Care Partnership	Warning signs campaign	Address high rates and reduce help-seeking stigma, Online advertising campaign tested with target audience, Information and resource hub
Humber, Coast & Vale	#TalkSuicide campaign	Reduce stigma: F2F and virtual training workshops,

		Engage businesses in campaign
Cheshire and Merseyside	MoveMENt campaign	Address high rates and enable men to talk and support: Survey of 600+, Training to facilitate activities for men, Held virtual event, Created a Strava group

Providing men at risk of suicide with emotional support and advice with employment, housing, and financial difficulties

In summary, this project:

- Worked with the Hope service to provide psychosocial and practical support for men aged 30-64 over a three-month period.
- Involves an initial assessment session directed by the service user and which includes a risk assessment.
- Arranges regular planned phone calls between meetings for those with active suicidal feelings.
- Addresses major practical issues first *e.g.* imminent homelessness or financial difficulties.
- Men who had taken part reported in an **evaluation** that the programme allowed them to regain a **sense of control.**
- However, it was difficult to access special counselling for those men who had shared histories of abuse.

The It's OK Not to Be OK campaign

Based at The Square: a bar in Aberdeenshire, the owner has put safe spaces for customers to have conversations about mental health at the front of his design. Mr MacDonald employs mental health champions who are fully trained in listening and providing advice. Customers are encouraged to check in with friends and family who may not be out with them.

d) Prison populations

The Government report: "Safety in Custody Statistics" examined deaths in prison custody to December 2022. In the 12 months up to this point, 301 deaths in England and Wales of which 74 deaths were self-inflicted. The rate of self-harm incidents rose 5% in female establishments with a slight decrease in the number of individuals. People on probation comprise the largest prison population with 230,000 people under community supervision in December 2021. They are hard to reach, stigmatised and socially disadvantaged, and have increased rates of premature mortality. There were 409 self-inflicted deaths recorded by people on probation in 2020-21 rising 18% from 2019-20.

The Suicide prevention strategy: action plan makes several provisions for the prevention of suicide in prisons. Funding will continue for Samaritans Listener scheme and postvention service; continue the roll out of suicide and self-harm training and pursue the installation of ligature-resistant cells [53]. The "listeners" are trained prisoners who can give confidential emotional support to their peers. Prisoners are entitled to call the Samaritans helpline free of charge, as required. Samaritans staff may still visit the prison to offer face-to-face assistance with prisoners and staff. The Howard League for Penal Reform aims to prevent suicide by addressing wider determinants. Besides advocating for trained and experienced staff, they encourage prisons to structure their regime around a normal life, including access

to a shower and regular meals, productive occupation; and able to socialise, exercise and go outdoors.

RECONNECT helped Kevin stay out of prison and he now works there as a care navigator [34]. He has a background of domestic abuse and eventually turned to steroids and other drugs to cope. He disliked his altered appearance and his behaviour changed. His relationships suffered; he was unable to work due to an injury and eventually became homeless. Kevin suffered bouts of depression and was suicidal as his drug taking worsened eventually landing him in jail. RECONNECT peer support was able to offer him support as the pandemic hit and visits dried up. They helped him get CBT and talk through his past traumas. He was able to organise an apprenticeship and a job for when he left prison.

e) Children and Young People

Approximately 200 young people die by suicide each year. Young men are three times as likely as women to take their own life [54]. Risk factors accumulate over the life course, and these include poor mental health, self-harm, academic stresses (allied with seasonal trends), bullying, social isolation, family environment and bereavement, relationship problems, substance misuse, or neglect. Adverse childhood experiences, deprivation and poor physical health also contribute. The 15–24-year olds' rate rose in the UK in 2018 to 9.1 per 100,000 young people; it is highest in Northern Ireland. In Dorset, there were no deaths reported at this age range in 2020, but 10 reported in 2021 – all male. Increases have also risen in males ages 11-14 and in females of all ages. In England, nearly half of 17–19-year-olds with a mental disorder reported self-harm or attempted suicide. Referrals to Childline for suicide have increased year-on-year since 2009/10 - 3,518 were made in 2018/19. Research is also uncovering other, emerging, risk factors: anxiety disorders should be examined along with depression in suicide assessment, and this may be linked with sleep problems as a predictor [55, 56].

Family members of a young person who has died by suicide often use the expression of its occurrence as "out of the blue" to indicate its apparent suddenness. Examining a case series over three years from 2014 in those below 19 years of age, almost half were known to have self-harmed, three-fifths had spoken of suicidal ideas or communicated these online, and a similar proportion had been in contact with relevant service [57]. However, a substantial minority of young people who had died by suicide had given no direct indication or had self-harmed. This "minimal warning" group had lower rates of risk factors and were less likely to have been in contact with services [58]. By relying on inquest and other investigation data, families and other witnesses may have under-reported warning signs that suggest they could have intervened.

Within young people (<25), suicides can occur in **clusters**. They may happen in institutions or within linked episodes spread geographically and can be at risk of future clusters. Mechanisms include social transmission (person-to-person or via the media), perception that suicidal behaviour is widespread, susceptible young people socialising with others at risk, and social cohesion diffusing ideas and attitudes. Recognising these clusters leads to more effective intervention and can include bereavement support, provision of help for susceptible individuals, proactively engaging with the media (especially social media) and public health approaches [59].

Safety planning was first described for use in the military to accompany a thorough suicide risk assessment [60], coping strategies, utilising contacts as a means of distraction from

suicidal thoughts, contacting family members and friends, contacting mental health professionals and agencies, and reducing the potential for use of lethal means. Safety planning for CYP has been identified as a promising approach to reduce the risk of suicide [61]. Suicide planning has been recommended as a routine part of care packages for CYP with suicidal ideation, although more evidence is required from male populations [62]. Healthcare professionals require specific training before administering safety planning and parents/carers may require their own, similar, planning resource.

The government's suicide prevention strategy aimed most of its actions at the Department for Education [53]. They aim to expand the numbers of mental health support teams in schools, consider including suicide and self-harm prevention in the curriculum, fund anti-bullying organisations within schools, support universities to embed its Suicide-safer universities guidance, commission, and independent review of higher education student suicides, and add suicide prevention into their Promoting the health and wellbeing of looked-after children guidance.

They have produced guidance on promoting and supporting mental health and wellbeing in schools and colleges. Their whole school approach to mental health and wellbeing can ultimately improve learning. Beginning this approach involves understanding how the pre-existing statutory responsibilities relate to mental health and wellbeing. These include: the special educational needs and disabilities (SEND) code of practice, safeguarding and relationships, health and sex education (RSHE) curriculum. The approach involves identifying a senior mental health lead for training, and understanding the role of Mental Health Support Teams (MHSTs): a serviced aimed at meeting the mental health needs of 5 to 18 year olds. The training covers psychological first aid training. The school should be able to signpost suitable resources and be aware of local support.

Currently, it is unclear whether universities owe their students a duty of care - that includes mental health - and this question currently lies before the High Court following the suicide of a student with social anxiety due to give a presentation.

Hull City Council: You are not alone
This is a suicide awareness campaign developed by young people aged between 11 to 20 years old that involved creating a soundscape of positive messages to reach out to vulnerable people, alongside a local co-produced website providing information and advice. It included:

- Skills training that was commissioned by Papyrus to address appropriate language and information around suicide.
- Young people themselves identified positive messages to turn into poems and record in a studio using a sound engineer and creative writing tutor.
- They designed postcards detailing how to access local support and made a film for the Headstart YouTube channel.
- The project provided practical and media training (allowing the participants to promote the campaign themselves), support to understand budget and spending, and produced a book of poems and messages created during their time on the project.

- Advice from the course organisers to others considering a similar approach is to allow young people to lead and be flexible as it may evolve into something unexpected.

Havering Council: mental health training and support for schools
This project brought together partners to support a whole school approach to mental health and the utilisation of a locally developed online resource setting out information on mental health and suicide prevention training with support for schools and families.

- It established a CYP Emotional Wellbeing Group co-chaired by the public health team and local CAMHS commissioner.
- The partners included: school reps, CAMHS, LA Education services (psychiatrists, behaviour officers *etc*), Youth Offending Team, Youth Services, Police, and members of the voluntary sector.
- It provided an understanding of the available training and support and how to respond to emerging needs.
- A shared online resource was developed.

Improving student mental health through partnerships between universities and NHS services
Large numbers of students engage with both university and NHS services. However, communication between universities and the NHS has been variable and often based on individual people and their network of contacts. This project:

- Aimed to develop a standard operating procedure to ensure that students in crisis are supported in a joined-up and systematic way.
- Created U-COPE - (University – Community Outpatient Psychotherapy Education) service to deliver therapeutic interventions to students who self-harm over six sessions – part of the Liverpool Model
- The student liaison service also developed essential links between the university and NHS services.

f) Media

Reporting of suicide has become prominent in an increasingly sensationalist media. Media reports have been associated with increased number of suicides [63]. Media related imitation of suicides has been dubbed the Wether effect [64]. Studies measuring the effect of **celebrity suicide reporting** are more likely to find a copycat effect [65]. This effect is markedly increased - a 30% increase in deaths - when the suicide method that was used was reported. General reporting of suicide did not appear to be associated with suicide [66].

Various organisations around the world have developed tips for journalists to promote responsible reporting about suicide. For example, the WHO's information lists tips on what to do and what not to do and the appropriate use of language. Removing these stories from prominent positions and avoiding sensationalism is key, as is including information about where to seek help and educating the public with correct facts about suicide and its prevention. The level of caution is increased when reporting on celebrity suicides.

Research by the Molly Rose Foundation (MRF) and the Bright Initiative criticised the system failings of major social media giants in handling self-harm and suicidal content [67]. Harmful content on Instagram, Tik Tok and Pinterest are found in sizeable amounts and promoted

suicide through high-risk algorithms and well-known hashtags to exacerbate feelings of depression, hopelessness, and misery. A systematic review identified an association between the use of social media and suicide attempts in young people but the direction of causality remains difficult to ascertain. It can be harmful through specific mechanisms: cybervictimisation and cyberbullying is associated with suicide attempts, but also suicide ideation and self-harm. A landmark case concerned the death of 14-year-old Molly Russell. Her use of Pinterest and Instagram facilitated her finding content around depression. A senior coroner overturned an initial cause of death as suicide but stated that she died of an act of self-harm while suffering from depression and the negative effects of online content.

Media monitoring and training

This project was a collaboration with Samaritans' Media Advisory Service, Oxfordshire County Council and the NSPA. In brief, it:

- Funded the Samaritans media team to monitor local media reporting of suicides, support, and offer training to media outlets in Oxfordshire noting its impact on the bereaved and as a trigger.
- The project team needed to attend suicide inquests to understand the causes of death. Details of these were provided by Coroner's office.
- 16 BBC Oxford staff were trained according to the Samaritans' media guidelines
- The training was in an informal style allowing the participants to talk about their feelings around suicide and discuss reporting etiquette and further information.

Online Safety Act 2023

Media and public pressure prompted the Government to investigate and legislate against harmful online content.

- As an example, a BBC investigation uncovered a forum website linked to 50 cases of suicide.
- Sustained media pressure and letters from bereaved parents resulted in leading broadband providers blocking access to the forum through its filters.

The Government's Online Safety Bill has recently become law:

- It seeks to force technology firms to take more responsibility for the content on their platforms.
- Some critics have raised concerns over implications to an individual's privacy.
- This Bill provides OFCOM with extra regulatory powers.
- These platforms must now demonstrate that they are committed to removing illegal content including those sites that promote or facilitate suicide.

MRF and the Bright Initiative demand of the Act [67]:

- This was a bold and ambitious regulatory response to reflect the scale and risk posed by harmful content.
- Technology companies must assess and mitigate risk through a demanding risk-assessment framework emphasising the risk posed by interacting harmful content, high risk design, and algorithmic amplification.
- Ofcom should set priorities for companies to tackle including isolated exposure, active engagement with online hazards, and long-term cumulative risks.

- They must commit to active supervision and enforcement with regulatory regime.

g) Domestic Abuse

Intimate partner violence (IPV) is common in England, especially among women, and is strongly associated with self-harm and suicidality [68]. Lifetime prevalence is higher in those living in rented accommodation or deprived neighbourhoods. Work with the Agenda Alliance explored this further [69]. have made a suicide attempt in the past year compared to women who have not experienced IPV. Sexual IPV is ten times more common in women than men and is especially associated with self-harm and suicidality. Women who had been affected by IPV are more than twice as likely as unaffected women to have five or more other adversities such as financial crises, redundancy, bereavement, and serious physical illness. Hence, they request:

- **Enquire** into domestic abuse and provide support for survivors across public services.
- **Reduce the likelihood of economic abuse** by focusing on opportunities for women to leave abusive relationships.
- **Sufficient and long-term funding** for DA and sexual abuse charities and service providers.
- **Increase knowledge and understanding** of the links between gender, domestic abuse and suicide.

The recent pandemic prompted the Home Office to investigate domestic homicides and suspected victim suicides with work undertaken by the National Police Chiefs Council (NPCC), College of Policing and the national policing Vulnerability Knowledge and Practice Programme (VKPP). "Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021" Notably, a substantial increase in homicides was not recorded during Covid's first year, although it was used as a cover for abuse by some suspects. This report uses the word “victim” and parts.

For *intimate partner homicides*:

- Nearly all victims were female.
- Nearly all suspects were male, likely to have a previous police record for domestic violence and engage in coercive controlling behaviour.
- Heavy alcohol use was associated with both victims and suspects.
- Previous threats or attempts of suicide was a risk factor.
- A sizeable number of cases involved separation (or attempts to separate) and previous non-fatal strangulation.
- Victims were mostly in their 30s or 40s, with another notable group of over 65s.

For *suspected suicides in people with a known history of domestic abuse victimisation*, the characteristics are similar although:

- Victims were more likely to be casualties of high-risk domestic abuse with coercive control.
- Suspected victims were mostly under 45 years old.
- There were fewer BAME victims which may be due to under-identification.

The report led to many recommendations for the police whilst remembering that their, albeit vital, role are still just one section of identifying and safeguarding. The Domestic Abuse

Matters training programme improved officers' identification of coercive control and patterns of domestic abuse. They found that only 6% of suspects were known to the police service and better identification and referral processes are urgently required. Domestic abuse may be a contributing factor in (mainly female) unexplained deaths and that a criminal offence may have been committed.

Kent and Medway: Highlighting the relationship between domestic abuse and suicide using Real Time Suicide Surveillance (RTSS) data supplied by Kent Police
Research has demonstrated that approximately 30% of all suspected suicides in the area have been impacted by domestic abuse (either as a victim, perpetrator or as a young person affected by the abuse). The project:

- Continues to fund Kent Police to deliver the RTSS.
- Prompted the addition of extra data fields (including "type of abuse", "current or former relationship", "dependent children?")
- Secured funding for a county-wide roll out of the Trauma Impact workshops for victims of DA.

h) Bereaved by suicide support

Suicide bereavement - the period of grief, mourning and adjustment after a suicide death - is estimated to affect up to 9% of adolescents and 7% of adults. The WHO has suggested that relatives and close friends of people who die by suicide are a high-risk group for suicide due to the grief and self-questioning, shared environmental risk, and the burden of stigma associated with violent losses. Bereavement by suicide was found to be a specific risk factor in young adults aged 18-40 whether they are related to the deceased or not. A history of suicide in close contacts should form part of any suicide risk assessment.

Survivors of Bereavement by Suicide (SoBS) is the only UK organisation offering peer-led support to adults impacted by suicide loss. They recognise that every suicide has a lasting impact on families, friends, and communities. The bereaved experience a complex grief that may encompass guilt, shame, stigma, and unanswered questions. In contrast to normal bereavements, they may be subject to inquests, media coverage, trauma response or difficult family relationships. They may feel isolated and unable to share their true feelings worried about the impact. Their quality of life or financial situation may be severely impacted. SoBS:

- Patronises over 66 local, volunteer-led **support groups** across England, Scotland, and Wales
- Recruit **volunteers** to their helpline, email support and group facilitators; being bereaved by suicide for more than 2 years previously is a requirement for these roles.
- Train volunteers

Sing Their Name Choir
This NHS Greater Manchester Integrated Care project organised a weekly peer support group for those bereaved by suicide. The choir brings people together, offers support and assistance with preparing for public performances. Participants benefitted from a boost to their confidence and being able to hone a new skill.

i) LGBTQIA+

Whilst it is understood that systemic inequalities are related to suicide distribution, understanding LGBT+ [*sic*] suicide in the UK has been hampered as sexual orientation, trans- or gender identity are not collected when recording death [70]. However, previous studies demonstrate that LGBT+ people are more likely than heterosexual people to think about and attempt suicide [71, 72]. The LGBT community experiences increased levels of common mental health problems including depression and anxiety [73]. This group are also affected by substance abuse: 16% of LGBT people reported drinking every day over the past year; this proportion increased with age [74]. A Youth Chances project showed that when compared to heterosexual non-trans young people, LGBTQ people reported more suicidal thoughts (44%) and greater rates of self-harming (52%) [75]. Stonewall found that 13% of LGBT people aged 18-24 had tried to take their own life in the previous year [74].

LGBT+ people have been recognised by the government as requiring tailored suicide prevention [16]. Marzetti *et al* illustrate the limited nature of these guidelines [76]. Reductive reasoning has led to a two-pronged approach that fails to consider the complexity of suicidal distress and constrains further understanding in this group. One path views suicide as internal to LGBT+ individuals: this groups is seen as being inherently risky and suicide is therefore a pathological issue. A second approach externalised suicide risk located within queerphobia thus conceptualising prevention within the purview of anti-hate This narrative may be internalised by LGBT+ individuals and risks becoming causative as well as ignoring other possible contributors [77, 78].

Hence, this approach may leave mental health and preventative services feeling uninformed and under-resourced to provide tailored approaches to suicide at the level of the individual. Suicide prevention may be pushed onto stretched LGBT+ communities to provide peer-to-peer support [79].

LGBTQ+ Resources in Brighton & Hove

A number of LGBTQ+ helplines and resources in Brighton & Hove offer advice on mental health and suicide prevention. It is important that people within this group feel that they will be listened to without judgment and that their peers understand and can relate to their situation. As examples, MindOut is a mental health charity run by and for LGBTQ people. They offer support and training and can act as a gateway to mainstream services. Switchboard's Health and Inclusion project highlights the needs of LGBTQ communities and individuals. Through engaging with their community and health service commissioners, they have advocated for improved mental health support access, safe housing for those being experiencing queerphobia and domestic abuse recognising the protective effect of specific social spaces.

Evaluation of media-based school intervention (Canada) [80]

The Out in Schools Film-Based Intervention is a school-based initiative operated by a non-profit organisation and designed to combat queerphobia. It involves:

- A series of short films introduced and punctuated by guided discussion about key concepts.

- The films are generally teen-oriented and represent the diversity of the teens themselves.
- Facilitators identify as LGBTQ+ and trained in speaking and providing content between the ages of 5 to 18.
- Other funded work had filmmakers visit schools to encourage them to make a Public Service Announcement.

Girls who had attended one or more of these events showed significant changes whilst boys showed no relationship. Both lesbian and bisexual girls as well as heterosexual girls reported less suicide ideation as well as less discrimination or verbal harassment.

j) Neurodiversity

Neurodiversity refers to the concept that brain differences are natural variations: they simply work in a different way [81]. The term was coined by the neurodivergent movement to contrast with neurotypical: those whose brains are seen to be standard. Over 20% of the UK's adult population may not be seen as neurotypical and may have been diagnosed with neurological conditions such as autism spectrum condition (ASC), dyslexia and attention deficit hyperactivity disorder (ADHD), although the term has expanded to encompass anyone who does not have a neurological condition. Additionally, this group is still susceptible to other conditions and behaviours which may increase the risk of suicide, for example, depression and self-harm.

Autistica are UK-based autism research and campaigning charity. They show that people with autism make 1% of the UK population but account for 11% of suicides. The true proportion is likely to be significantly greater when accounting for undiagnosed possible autism (elevated autistic traits) [82]. For the five months either side of the start of the first lockdown, a quarter of young people who died by suicide were diagnosed with autism or ADHD. Children with autism are 28x more likely to think about or attempt suicide. Two-thirds of adults with autism have considered suicide and are far more likely to die by more aggressive methods [83]. People with autism experience more life stressors leading to reduced coping, low mood and suicidal thoughts [84].

This crisis formed the basis of a RCPSYCH workshop [85]. Removing barriers to accessing care was the major issue identified. Tackling this issue would involve including people with autism in service design. Policy makers must work with researchers and clinicians to better identify people with autistic traits and develop appropriate prevention strategies. Developing and promoting guidelines can help to raise the profile of this issue and highlight the importance of acquiring up to date caregiving skills, which requires appropriate training. People with autism who are feeling suicidal may not show signs that are typically expected: they have difficulties interacting and communicating with other people and may not want to discuss the issues. Taking time to listen properly and take seriously a person with autism bringing up this issue is paramount. Specific questions may be required, and time given to process; be flexible and allow time to process. Our community can help minimise these barriers, but we can help to better understand the experience of suicidality in autistic people and how existing awareness campaigns might need to be amended.

The other neurodiverse conditions should also not be forgotten and barriers to accessing care addressed using the same methodology as above. ADHD is associated with an increased

risk of suicidal behaviour and atypical presentation, especially in females [86]. The combined subtype of ADHD is associated with significant impulsivity and is associated with the highest vulnerability of attempts. Other linked factors include being female, lower educational attainment, substance abuse, history of depression and childhood maltreatment. Less evidence exists for dyslexia but a US study of 15-year-old students found that poor reading ability was associated with school dropout and were more likely to experience suicidal ideation or attempts [87].

Much of the work in this area is conducted by Dr Sarah Cassidy and her Mental Health in Autism research group based at the University of Nottingham. Her team has developed several assessment tools for this condition:

- **Suicidal Behaviours Questionnaire - Autism Spectrum Conditions (SBQ-ASC)** - developed with and for adults with autism, it has been validated for use in research to identify suicidal thoughts and behaviours [88].
- **Autistic Depression Assessment Tool - Adult (ADAT-A)** - initial evidence shows promise in capturing autistic specific depression symptoms in research.

Preventing suicide re-attempt by child with ASD [89]
Treating an 11-year-old girl sustaining injuries after jumping from a great height. She was diagnosed with ASD and adjustment disorder. Notable points:

- Psychosocial factors such as low self-esteem due to inability to build relationships and poor communication with parents contributed to risk.
- In this group, adjustment disorders not leading to depression may be associated with increased risk of suicide.
- Recognising the characteristics of ASD holds therapeutic significance for parents/guardians.

Management - prevention:

- Reduce risk factors and reinforce the protective function of families; make it easier for adolescents to seek help.
- Mitigated environmental factor - interpersonal relationships at school - by enrolling her into a special class in cooperation with the local community.
- Utilised psychiatric treatment method where the child, family, and therapist cooperate in the intervention and focusing on patient's personal history.

8. Conclusion and recommendations

Support and interventions should be prioritised for nationally identified high-risk groups and risk factors. Local data and audits approaches can identify these groups and risk factors within Dorset. Local level interventions must be evaluated at this level to add to the evidence base and understand its effectiveness.

High risk groups include:

- Children and young people.
- Middle-aged men – particularly, those risks in the lowest-skilled occupations, those who work in construction, building finishing trades *e.g.* plasterers and painters, and for those in culture, media, and sport roles.
- People who have self-harmed – the biggest indicator of suicide risk.
- People in contact with mental health services – account for around a third of all suicides.
- People in contact with the justice system.
- Autistic people.
- Pregnant women and new mothers.
- Carers.

Risk factors for suicide include:

- Male gender.
- Poor social support.
- Chronic painful illness.
- Family history.
- Low educational attainment through chronic stress.
- Poor social capital.
- Financial difficulty and economic adversity.
- Harmful gambling.
- Substance misuse.
- Domestic abuse.

Any intervention should also address **protective factors** which includes:

- A well-developed social network.
- Religiosity.
- Responsibility for young children.
- Extraversion or those with strong coping strategies.
- Rewarding occupations.

In accordance with the WHO international guidelines and the UK national strategy, **local suicide prevention approaches** should focus on the following areas:

- Improving the **quality of data and evidence** to ensure that effective, evidence-informed, and timely interventions continue to be developed and adapted.
- Tailored, targeted **support for priority groups** (specified below), including those at higher risk, to ensure there is bespoke action using interventions that are both effective and accessible to everyone.
- Fostering socio-emotional life skills in **adolescents**.
- Addressing common **risk factors** linked to suicide at a population level to provide early intervention and tailored support.
- Promoting **online safety** and **responsible media content** to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.
- Interact with and support the **media** in delivering sensitive approaches to suicide and suicidal behaviour.

- Early identification, assessment, management, and follow-up of anyone who is affected by suicidal behaviours and provide better information and support to those bereaved or affected by suicide.
- Reducing access to the **means and methods of suicide** where this is appropriate and necessary as an intervention to prevent suicides.
- Making suicide **everybody's business** so that we can maximise our collective impact and support to prevent suicides.

NICE have published a Quality Standard for Suicide Prevention and a guideline on preventing suicide in community and custodial settings that uses the former as the foundation for specific recommendations.

The Quality Standard is summarised in five statements:

1. **Multi-agency suicide prevention partnerships** have a strategic suicide prevention group and clear governance and accountability structures.
2. Multi-agency suicide prevention partnerships reduce access to **methods of suicide** based on local information.
3. Multi-agency suicide prevention partnerships have a **local media plan** that identifies how they will encourage journalists and editors to follow best practice when reporting on suicide and suicidal behaviour.
4. Adults presenting with suicidal thoughts or plans discuss whether they would like their family, carers, or friends to be involved in their care and are made aware of the limits of **confidentiality**.
5. People **bereaved or affected by a suspected** suicide are given information and offered tailored support.

The guideline is aimed at local commissioners and providers of healthcare and includes as recommendations:

- Suicide prevention partnerships – multi-agency partnership comprising a core group and a wider network of representatives.
- Suicide prevention strategies - should emphasise that suicide is preventable, and it is safe to talk about it.
- Suicide prevention action plans – should also include plan for after a suspected suicide, and adapted for agencies which may spot clusters.
- Gathering and analysing suicide-related information.
- Awareness raising by suicide prevention partnerships.
- Reducing access to methods of suicide – use local data to understand characteristics and emerging trends. Ensure local compliance with national guidance.
- Training by suicide prevention partnerships – training should be made available to certain groups *e.g.* those working with high-risk groups or those offering support among others.
- Supporting people who are bereaved or have been affected by a suspected suicide – may be identified through rapid intelligence gathering or coroners, and offered practical information expressed in a sensitive way. This group is at an increased risk of suicide and tailored support may reduce this risk. There are no routinely collected data sources for this measure, but data can be collected from information recorded locally by partnership organisations including coroners.

Proposed audits include:

- Identifying the proportion of people who have been asked if they need help, and the proportion of people accessing tailored support services.
- Preventing and responding to suicide clusters.
- Reducing the potential harmful effects of media reporting of a suspected suicide – promote best guidance on media reporting and develop a clear plan for liaison.

A clear understanding of **self-harm** need is required locally, including who are most at risk of suicide post self-harm admission. NICE also have a self-harm guideline, which offers recommendations in the following areas:

- Information and support.
- Consent and confidentiality.
- Safeguarding.
- Involving family members and carers.
- Psychosocial assessment and care by mental health professionals.
- Risk assessment tools and scales.
- Assessment and care by healthcare professionals and social care practitioners.
- Assessment and care by professionals from other sectors.
- Admission to and discharge from hospital.
- Initial aftercare after an episode of self-harm.
- Interventions for self-harm.
- Supporting people to be safe after self-harm - Safer prescribing and dispensing.
- Training.
- Supervision.

Recommended interventions aimed at a population level for **specific groups** are given below. Individuals should be engaged with at a personal level. This is because suicide cannot be predicted via a linear risk assessment at an individual level due to the complexity of suicide risk.

Training and VCSE

- Most programmes involve centring services allied to promotion and education using existing programmes *e.g.* ZSA or Samaritans.
- VCSEs can also assist in co-designing and developing potential interventions.
- Involve the VCSE sector and those with **lived experience** in scoping and developing wider bereavement support activities *e.g.* bereavement support.

Widening Access and Awareness

- Contacting support – use of multiple platforms and discuss and test with targeted group *e.g.* age or minority group.
- Implement responsible **media reporting guidelines** as highlighted in the good practice examples and based on the Samaritans toolkit.

Men

- Support and information can be provided at **target locations** *e.g.* barbers, pubs, and service stations.
- Programmes should address **stigma** and provide safe places to talk. Examples include Strava group or Men's Club.
- Intervention could provide advice for **wider factors** that affect mental health to increase a sense of control *e.g.* housing and money.
- Work with agencies and services that men come in to contact with (Primary care, A&E, the justice system, and mental health services) to ensure staff are supported and confident in having conversations with men and identifying suicide risk.

Mental health crises – for specific locations:

- Frequent venues or locations allied with the main local methods of mitigation need to be understood.
- **Multiagency task groups** should then codesign and own actions to restrict the local means identified (See NICE)

For example:

- A **Crisis café** close to a station with high rates of suicide is used as a means of providing face-to-face support.
- Patrol and signpost **jumping hotspots**.

Healthcare associated means:

- Restrict **analgesic** use and doses.
- Important to identify local staff groups that act as **gatekeepers**, particularly to high-risk groups.
- Explore local post-discharge pathways providing all patients all patients with comprehensive assessment and risk reduction strategies with safety planning.

Children and Young People

- Engage people who will be affected by programme. This is true generally.
- Universal **school-based** suicide prevention awareness programmes should be implemented.
- Suicide planning is recommended as a routine part of **care packages** for CYP with suicidal ideation, and staff should be trained appropriately to administer effectively.
- Implement local actions in line with the **National Suicide Prevention Strategy** with respect to CYP and universities, drawing on examples of good practice to test locally where need is identified.

Domestic Abuse

- The notable link between domestic violence and suicide risk should be acknowledged through safeguarding systems and processed such as Domestic Homicide Reviews, Adult Safeguarding Reviews and Child Death Panels.
- Suicide Prevention training should be targeted at those who work with and support people who have experienced domestic abuse.

People in contact with mental health services

Local level strategic planning, commissioning and service delivery should consider:

- The Royal College of Psychiatrists' (RCPSYCH) Suicide Prevention Programme
- Safer Services Toolkit
- Examples of good practice that may be adapted for local use.

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