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Policy paper

Suicide prevention in England: 5-year cross-sector strategy

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Applies to England

Contents

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Foreword: Maria Caulfield MP

When someone takes their own life, the impact on family and friends is devastating and widespread, with many people throughout the community feeling the aftershocks. In my role as minister and as an MP, I have all too often seen these impacts first hand.

This government is committed to reducing the number of lives lost to suicide, and this cross-government strategy sets out how we will achieve this reduction over the next 5 years.

I would like to thank partners across the suicide prevention sector, whose tireless support and campaigning has driven progress on suicide prevention and saved the lives of many. To support the crucial work of voluntary, community and social enterprise (VCSE) organisations, we have established a £10 million VCSE Suicide Prevention Grant Fund to run from this year to March 2025 to assist in the delivery of suicide prevention activity.

In developing this strategy, we have set out how we can build on the progress made over the last 11 years, while identifying and responding to new and emerging concerns. While there are countless benefits, the internet also raises issues of safety for children, young people and adults. And emerging evidence continues to show links between factors such as harmful gambling and domestic abuse with suicide.

Prevention and early intervention are a key element of this strategy, with a large focus on what more can be done by government, the NHS, wider local public services, businesses and community groups to help stop people getting to a point where they are contemplating ending their own life. However, I also know that sometimes it is too late for prevention, and timely and effective action must be taken to save a life. To support this, we have a large programme of work to ensure there is effective and appropriate crisis support available, supported by £150 million capital funding for urgent and emergency care, alongside many other actions to reduce access to methods of suicide and support those who are bereaved by suicide.

While this strategy sets out ways that we can prevent suicides for everyone over the next 5 years, we must ensure we also continue to look at what we can do for groups where we see higher suicide rates or have observed concerning trends.

I would like to end on a call to action for everyone. One of the key themes of this strategy is that suicide is everyone’s business and everyone has a role to play in suicide prevention. I believe this to be true now, more than ever.

We must support each other to ensure that no one feels like their only option is to take their own life. I urge you all to check on your friends and family, your colleagues, the people you manage and the people you speak to every day. Equip yourselves with the knowledge and skills to help people find the support they need, so that together we can continue driving this agenda forward and do all we can to prevent suicide.

Maria Caulfield MP, Minister for Mental Health and Women's Health

Foreword: Professor Sir Louis Appleby

I regularly hear from people who have lost someone through suicide. Their stories are complex, tragic and, although there may be common threads, unique. They often ask whether there was more they could reasonably have done – a poignant question, though there was rarely anything in my experience. For me, the question is broader: what more could we have done collectively – society, governments, the NHS, workplaces, charities, schools and universities, the media, all of us?

We have had a suicide prevention strategy in England for 21 years. During that time national suicide rates have been the lowest on record, the average rate around 20% lower than in the previous 2 decades. We have faced overwhelming threats to our mental health: a global recession that put suicide rates up and a pandemic that – against most expectations – did not.

This is progress but not enough. The national suicide rate has not fallen since 2018. There are still over 5,000 deaths by suicide in England each year. The male rate remains 3 times higher. Suicide and self-harm have increased in young people.

So the first purpose of a national strategy is to make it clear that suicide prevention matters. It is a way of updating our priorities, reflecting new evidence on who is at risk. The new strategy therefore highlights domestic violence, gambling, online safety and people on the margins of society because of poverty, ethnicity, disability or prejudice.

It also recognises the financial uncertainty people are facing and the potential long-term consequences of COVID-19.

And it reminds us that suicide prevention starts with society's values, with breaking down the shame that can deter men from seeking help, with offering young people opportunity and hope.

The strategy stresses the crucial role of frontline services. We need to ensure that mental health patients at risk of suicide are not denied support because of assumptions about mental capacity or impulsiveness. We need frontline agencies to work together to respond to people in crisis. We need to take adolescent distress seriously.

To back up these actions requires high-quality evidence - data and research but also the personal narratives of bereaved families and those who feel at risk. It is their experiences that have raised the public profile of suicide, that have shown us the urgent necessity of doing better on prevention. They deserve our thanks and support - their contribution has been literally vital.

Professor Sir Louis Appleby, national adviser on the suicide prevention strategy

Executive summary

Considerable progress has been made since the last Suicide prevention strategy for England (https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england) was published in 2012.

All areas of the country now have local suicide prevention plans and suicide bereavement services, supported by a £57 million investment through the NHS Long Term Plan (https://www.longtermplan.nhs.uk/). We have seen one of the lowest ever suicide rates (in 2017) and collective efforts to improve patient safety led to a 35% fall in suicides in mental health inpatient settings (https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/) in England between 2010 and 2020.

However, while overall the current suicide rate is not significantly higher than in 2012, the rate is not falling. There is therefore much more we must all do to save more lives.

This will require a national government effort, as well as continued action across the NHS, local government, the voluntary, community and social enterprise (VCSE) sectors, employers and individuals. The aim of this cross-government strategy is to bring everybody together around common priorities and set out actions that can be taken to:

- reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner
- improve support for people who have self-harmed
- improve support for people bereaved by suicide

Data, evidence and engagement with experts (including those with personal experience) has identified the following priority areas for action to achieve these aims. These are to:

- improve data and evidence to ensure that effective, evidence-informed and timely interventions continue to be adapted
- provide tailored, targeted support to priority groups, including those at higher risk. At a national level, this includes:
  - children and young people
  - middle-aged men
  - people who have self-harmed
  - people in contact with mental health services
  - people in contact with the justice system
  - autistic people
  - pregnant women and new mothers
- address common risk factors linked to suicide at a population level by providing early intervention and tailored support. These are:
  - physical illness
  - financial difficulty and economic adversity
  - gambling
  - alcohol and drug misuse
  - social isolation and loneliness
  - domestic abuse
- promote online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm
- provide effective crisis support across sectors for those who reach crisis point
- reduce access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides
- provide effective bereavement support to those affected by suicide
- make suicide everybody's business so that we can maximise our collective impact and support to prevent suicides

This strategy sets out over 100 actions led by government departments, the NHS, the voluntary sector and other national partners to make progress against these areas, particularly over the next 2 years.

We will continue to review and develop actions to make further progress throughout the timeframe of this strategy. A summary of actions has been published alongside this strategy (https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028). Key actions include the following:

1. The Department of Health and Social Care (DHSC) has established a £10 million Suicide Prevention Grant Fund (https://www.gov.uk/government/publications/suicide-prevention-grant-fund-2023-to-2025) to run from 2023 to March 2025 to support VCSE organisations to deliver suicide prevention activity. The fund launched in August 2023 and will support non-profit organisations to meet the increased demand seen in recent years through a range of diverse and innovative activity that can prevent suicides, both at a national and community level. It will especially support charities working with groups identified in this strategy.
2. NHS England (NHSE) is taking forward improvements to the mental health crisis support offer, supported by an investment of £150 million (https://www.gov.uk/government/news/mental-health-services-boosted-by-150-million-government-funding). This includes procuring specialised mental health ambulances and investing in a range of infrastructure schemes, including alternatives to A&E, crisis cafés, and new and refurbished mental health assessment and liaison spaces. It is also intended that, by the financial year 2024 to 2025, all parts of the country will have introduced crisis text lines. This will help to ensure that people are able to access timely support in a range of appropriate spaces.
3. The Department for Education (DfE) is engaging experts and those with personal experience to review relationships, sex and health education (RSHE) guidance (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education) to determine whether suicide and self-harm prevention will be included as an explicit part of the curriculum to support young people to spot signs and seek the right support. Revised guidance will be published in 2024.
4. The Ministry of Justice (MoJ) will continue to roll out suicide and self-harm prevention training among prison and probation staff to help staff across the justice system better identify and support people who might be experiencing suicidal thoughts or feelings. MoJ is planning to install new ligature-resistant cells to make cells safer, focusing on the highest-priority prisons.
5. NHSE has convened a safety-planning working group to identify opportunities to improve the quality and culture of risk management and safety planning within mental health services. This group intends to develop and publish guidance by March 2024, and scope and start delivery of training and quality improvement programmes by March 2025. This will help ensure that culture and practice across mental health services reflects an individualised, person-centred approach to safety-planning and risk management, and that access to appropriate support is not closed off as a result of assessments of risk.
6. DHSC will work with NHSE and professional bodies to improve suicide prevention signposting and support to people in contact with primary care services, including those receiving care for physical ill-health and groups such as middle-aged men. The Royal College of General Practitioners (RCGP) is in the process of revising their curriculum and will assess where guidance on safe

prescribing may be strengthened to reduce risks associated with the prescribing of certain medicines.

7. The Department for Work and Pensions (DWP) is procuring a call alert and transcription service across its telephony estate to support the quick identification of people who raise suicidal thoughts when using DWP call helplines and services. This will help staff identify these callers quickly and provide timely signposting. It will also identify opportunities to review and strengthen guidance and staff training to support customers that disclose that they are experiencing suicidal thoughts or feelings. Alongside this, DWP has committed to a mandatory 2-day mental health awareness training for all its frontline staff.
8. The government's Online Safety Bill (https://bills.parliament.uk/bills/3137) will – if passed, enacted and implemented – introduce legislation to tackle harmful online suicide and self-harm content, and better support bereaved parents and coroners in accessing data in the event of the death of a child.
9. Government will take a leading role in tackling methods of suicide, collaborating with partners across the world in policy, law enforcement and society more broadly to limit access, reduce awareness, and share research, evidence and lessons learned. This will include seeking to tackle at source the suppliers of harmful substances for the purposes of suicide.
10. Working with DWP, DHSC will look for opportunities to improve the government's role in supporting employers to improve the support they provide for the mental wellbeing of themselves and their employees. This will include working with the Health and Safety Executive to explore options for revising its first aid guidance, and other relevant guidance, to emphasise the importance of parity of managing risks to mental and physical health in the workplace.
11. British Transport Police is rolling out bereavement support training for officers who may be the first contact for families, friends and loved ones after someone has died, and the Support After Suicide Partnership will continue to offer support to local areas to embed suicide bereavement services, in line with their Core Standards (https://hub.supportaftersuicide.org.uk/resource/summary-of-core-standards/). This will support the roll-out of more consistent, high-quality bereavement support.
12. The Office for Health Improvement and Disparities (OHID) within DHSC is developing a new nationwide near real-time suspected suicide surveillance system that, once launched, will improve the early detection of and timely action to address changes in suicide rates or trends. This is due to launch in November 2023.
13. The National Police Chiefs' Council, OHID and local authorities will work together to explore opportunities for improving data collection and data sharing in all areas. This includes building on work to identify and record where an individual resides as well as the location in question. This should improve understanding, provide appropriate support and guidance for future lessons learned, and help direct support to try and intervene at locations of concern.

This, of course, is supported by the investment that continues to be made into mental health services and suicide prevention and by a large package of work to support people with their mental health and wellbeing, which is essential for suicide prevention.

We continue to roll out mental health support teams in schools and colleges, with 50% of schools expected to be covered by April 2025, and DfE has set a target for all universities to join the University Mental Health Charter Programme (https://universitymentalhealthcharter.org.uk/) by September 2024 so that they are taking a whole-university approach to mental health.

DfE is also supporting the higher education mental health implementation taskforce (https://www.gov.uk/government/groups/higher-education-mental-health-implementation-taskforce), which will consider how mental health and suicide prevention can be improved for a wide cohort of students across different higher education providers and set out recommendations by May 2024. The NHS Long-Term Workforce Plan (https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/) sets out steps we will take to boost the mental health workforce and NHSE continues to transform community mental health services.

In addition to the £10 million Suicide Prevention Grant Fund, the government is investing at least an additional £2.3 billion a year into mental health services by March 2024. Within that funding, £57 million is specifically for suicide prevention and suicide bereavement services, which has supported the development of local suicide prevention plans.

As detailed throughout this strategy, the government is also investing in action that will support those most at risk and address risk factors. For example:

- £532 million over 3 years to 2025 through the 10-year drugs strategy (https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives), which DHSC will use to increase capacity and improve the quality of drug and alcohol treatment services
- the Department for Culture, Media and Sport's £30 million Know Your Neighbourhood Fund (https://www.gov.uk/government/publications/29-million-know-your-neighbourhood-fund-confirmed), which aims to increase volunteering and reduce chronic loneliness in high-deprivation areas
- the Home Office's £7.5 million investment from 2022 to 2025 into domestic abuse interventions in healthcare settings (https://www.gov.uk/government/publications/tackling-domestic-abuse-plan), which will better equip healthcare professionals to respond to domestic abuse disclosures, enhance referral pathways and build on best practice

All of this, and many more actions, underpin our collective efforts to save lives. The government will continue to implement this strategy and develop actions to

prevent suicides over the coming years. However, this strategy is not the limit of suicide prevention. Suicide prevention is everyone's business and we call on everyone to consider this strategy, the groups identified and the risk factors set out to take action to ensure that lives are saved.

Introduction

Why we need a new suicide prevention strategy

Since the previous Suicide prevention strategy for England (https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england) was published in 2012, considerable progress has been made in implementing the priorities and actions that were set out.

Local authorities, NHS organisations and suicide prevention organisations have aligned their suicide prevention activities with the national strategy. New programmes of work have been established to tackle methods and improve the coverage of crisis and bereavement support, and collective efforts to improve patient safety have led to a 35% fall in suicides in mental health inpatient settings in England between 2010 and 2020 (https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/).

Within the last 10 years, we observed one of the lowest ever rates of registered suicides (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2021registrations) (a rate of 9.2 registered suicides per 100,000 people, in 2017). But we cannot ignore the fact that there is more we must do.

In 2018, there was an increase in the suicide rate following several years of steady decline. Although this was partly due to a change in the 'standard of proof' required for coroners to record a death as suicide, we know that other factors have played a part too. In 2022, 2 years on from the COVID-19 pandemic, provisional data suggested there were 5,275 deaths by suicide registered (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathscausedbysuicidebyquarterinengland), a rate of 10.6 per 100,000 people. And while, overall, the current suicide rate is not significantly higher than in 2012, the rate is not falling. We must do all we can to prevent more suicides, save many more lives and ultimately reduce suicide rates.

This cross-government strategy sets out priority areas for action to achieve this, with consideration of new opportunities we can take and challenges we must address to save lives. The way that organisations work together to deliver services locally has changed since the last strategy was published. New and better-quality evidence has emerged pointing to links between suicide and risk factors such as harmful gambling and domestic abuse. As a society, our use of the internet and online platforms has grown and developed, providing new opportunities but also new harms that must be addressed. We are recovering from a pandemic, with known impacts to mental health, and many have been impacted by the rising cost of living.

The following sections have been set out to ensure that actions are focused on prevention and early intervention while also ensuring there is the right support for people experiencing suicidal thoughts and feelings as well as for those bereaved by suicide.

Ambition and vision for the next 5 years

This strategy sets out the national ambitions for suicide prevention over the next 5 years and the steps we will collectively need to take to achieve them. This includes individuals, organisations across national and local government, the NHS, the private sector, the VCSE sectors, and academia.

To be successful, we should all consider and incorporate the following principles in the design and delivery of interventions, services, resources and activities to prevent suicides. These are:

- suicide is everybody's business. Everyone should feel they have the confidence and skills to play their part in preventing suicides – not just those who work in mental health and/or suicide prevention directly – and take action to prevent suicides within and outside of health settings
- mental health is as important as physical health. We must reduce stigma surrounding suicide and mental health, so people feel able to seek help – including through the routes that work best for them. This includes raising awareness that no suicide is inevitable
- nobody should be left out of suicide prevention efforts. This includes being responsive to the needs of marginalised communities, addressing inequalities in access to effective interventions to prevent suicides. It also requires listening to individuals and being responsive to their needs
- early intervention is vital. In addition to providing support to those experiencing crisis and/or suicidal thoughts or feelings, action needs to be taken to stop people reaching this point

- voices, perspectives and insights of people with personal experience should inform the planning, design and decisions at all levels of suicide prevention activity. This includes people with experience of feeling suicidal, those who have made previous suicide attempts, and people who are bereaved by suicide
- strong collaboration, with clarity of roles, is essential. Suicide prevention is the responsibility of multiple government departments, as well as wider public, private and VCSE sector organisations
- timely, high-quality evidence is fundamental. Practice and policy should be informed by high-quality data and research, and be responsive to trends and emerging evidence. This includes harnessing digital technology and data advancements to provide earlier interventions and wider access to support

Aims of this strategy

The overall ambitions set by this strategy are to:

- reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner
- continue to improve support for people who self-harm
- continue to improve support for people who have been bereaved by suicide

These are all important goals in their own right. Many actions supporting suicide prevention can also support self-harm prevention. Actions to improve self-harm and bereavement support may, as known risk factors, also contribute to suicide prevention.

Suicides are not inevitable and collectively we should, and will, aim to prevent every suicide we possibly can. Suicide rates can be influenced by factors outside of our control, such as global events or recessions. However, it is imperative that government departments and other organisations responsible for delivering suicide prevention activity are accountable for the delivery of these actions to ensure progress is made against the ambitions set.

Alongside this strategy, we have therefore published a summary of actions, setting out the basis for an implementation plan. This sets out the actions that will be taken, intended timelines for delivery and who the responsible delivery agency is.

Following publication, we will work with our National Suicide Prevention Strategy Advisory Group (NSPSAG) to develop the implementation plan and establish governance mechanisms to ensure accountability for delivery, with consideration to the role of NSPSAG and ministers across government departments.

We will continue to consider what further actions are needed to make progress over the next 5 years. This will help ensure that, collectively, we have as much impact as possible and save lives.

Priority areas for action

The actions and priorities in this strategy have been informed by evidence, data and engagement with people with expertise in suicide prevention. This includes people with personal experience, researchers, and those involved in the planning and delivery of services. NSPSAG has provided invaluable advice and expertise throughout.

The responses to our engagement exercises, such as the mental health call for evidence (https://www.gov.uk/government/calls-for-evidence/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence), roundtable discussions and many ongoing discussions with experts, have helped us understand the depth and breadth of challenges and opportunities to reflect in this strategy.

Over the next 5 years, priorities for action include:

1. Improving data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.
2. 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.
3. Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.
4. Promoting online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.
5. Providing effective crisis support across sectors for those who reach crisis point.
6. Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.
7. Providing effective bereavement support to those affected by suicide.
8. Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

We encourage everyone – including employers, local government, NHS and VCSE organisations – to review their plans and approaches to ensure alignment with this new strategy, including consideration of the latest data, evidence and

contextual factors. We will continue to promote cross-sector working and joint action, including at a local level through integrated care partnerships, integrated care boards (ICBs), local authorities and local suicide prevention organisations, with regional support offered by both NHSE and OHID.

Improving data and evidence

Timely and high-quality data, evidence and intelligence allows for better understanding of the drivers of suicide and self-harm, the development of more effective interventions, and more rapid responses to prevent suicides. It is an essential part of suicide prevention both to understand what has worked in preventing suicides and where to direct future efforts.

We have made progress in addressing evidence gaps at a national level. Studies by the Office for National Statistics (ONS), the National Confidential Inquiry into Suicide and Safety in Mental Health (https://sites.manchester.ac.uk/ncish/) (NCISH), the Multicentre Study of Self-Harm in England (https://www.psych.ox.ac.uk/research/csr/ahoj), the Adult Psychiatric Morbidity Survey (https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey) and others have improved our understanding of suicide and self-harm trends among people from ethnic minority backgrounds, people diagnosed with severe health conditions, people in certain occupations, students, people experiencing homelessness and middle-aged men.

Local intelligence, including local real-time suicide surveillance data, has helped improve our knowledge and understanding of suicide trends in recent years – for example, by providing more timely monitoring of suicide rates during the COVID-19 pandemic.

Equally, the views and experiences of people affected by suicide have been essential for understanding trends, and the potential impacts and suitability of actions and solutions. DHSC has funded the National Suicide Prevention Alliance (https://nspa.org.uk/) (NSPA), in part to ensure that insights from their Lived Experience Network can inform policy and help government departments understand key issues.

Future work must continue to address evidence gaps to inform more effective actions.

Ambition and vision for improving data and evidence over the next 5 years

National government, local government, researchers and the VCSE sectors continue to work together to address key gaps, and continually progress our understanding to inform priority topics and areas that require intervention.

There is more comprehensive research on, and better understanding of, national trends and suicide rates in particular groups, including:

- occupational groups
- autistic people
- people affected by domestic abuse
- people experiencing harmful gambling
- ethnic minority groups including people who are Gypsy, Roma or Travellers
- refugees and asylum seekers
- people who are LGBT

The underlying causes and factors associated with particular trends are better understood, and inform the development of interventions and resources to address those factors. There is better understanding of which interventions work well and for whom.

Data and intelligence on suicide and self-harm is collected and recorded more quickly, and leads to more timely action locally and nationally. Local real-time intelligence continues to expand in breadth and quality, and there are mechanisms to inform our understanding of trends nationally.

The views and experiences of people with personal experience are involved routinely in the development of policy and actions.

Data and evidence are readily available and easily accessible to anyone who wants to do more to prevent suicide including policy makers, practitioners and the public.

We will take action to make progress towards this vision and to continually build our understanding of what is needed to prevent suicides.

OHID within DHSC is developing a new nationwide near real-time suspected suicide surveillance system, scheduled to launch in November 2023. This work aims to improve the early detection of changes in suicide rates, identify key risks, and inform timely national and local suicide prevention action and policies. This will build on the ongoing efforts of the National Police Chiefs' Council to bring together local intelligence.

The National Police Chiefs' Council will also lead work to identify opportunities to improve the quality of intelligence and data that is used to improve our knowledge. This could include, for example, information about the link between suicide and factors such as ethnicity and domestic abuse.

The National Institute for Health and Care Research (NIHR) has identified suicide prevention and risk factors as a priority topic area for research. The NIHR has commissioned a number of suicide prevention research studies to date, and recently launched another funding opportunity for applications for NIHR-funded research studying which interventions, aimed at groups at high risk of suicide and suicide attempts, are effective (https://www.nihr.ac.uk/documents/2382-suicide-prevention-in-high-risk-groups/33795).

Multiple government departments and local organisations will work with coroners with the aim of sharing insights to address evidence gaps and inform practical actions. DHSC will continue discussions with coroners to encourage data sharing at local and national level to prevent further deaths. DHSC intends to use findings from ONS analysis of themes from recently published Prevention of Future Deaths Reports (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/mentalhealth/articles/preventionoffuturedeathreportsforsuicidesubmittedtocoronersinenglandandwales/january2021tooctober2022) to inform national policy and actions, working with other government departments and agencies.

Government departments, including DHSC and ONS, will conduct and commission research and data linkage projects, including:

- projects to better understand:
  - incidences of suicide following a bereavement
  - links between the cost of living and suicide
  - trends in suicide rates in different occupational groups
  - suicide rates in veterans
- supporting the Department for Environment, Food and Rural Affairs (Defra) to look at agricultural workers so we can understand the unique challenges in that occupational group and respond appropriately throughout the strategy

Government departments will consider insights from the Adult Psychiatric Morbidity Survey, including insights relating to groups such as carers, and those with experience of the justice system, gambling and domestic abuse.

Collectively, these actions will inform further priority work and actions across government and arms-length bodies as this strategy is implemented.

Providing tailored and targeted support to priority groups

This strategy is population-wide, and the actions set out within are designed to support as many groups and individuals as possible. Many of the actions taken to address risk factors for suicide (as set out in later sections), may particularly benefit specific groups.

However, there are some groups that could particularly benefit from more bespoke support. Some groups have higher suicide rates than the general population.

For some groups, such as people in contact with mental health services, data suggests relatively high numbers of suicides. Others may not have high rates but are of particular concern, such as children and young people, for whom rates have increased in recent years despite being low overall. Urgent attention is needed to address and reverse these trends.

It is therefore crucial that organisations and individuals tailor and target resources and services to support these groups.

Priority groups

We have not set out an exhaustive list of groups that could benefit from bespoke support. It is imperative that individual needs and experiences are considered in the design and delivery of suicide and self-harm prevention activity.

However, based on evidence and data (including numbers, rates and trends), stakeholder engagement and expert views, we have identified the following groups for consideration for tailored or targeted action at a national level:

- children and young people
- middle-aged men
- people who have self-harmed
- people in contact with mental health services
- people in contact with the justice system
- autistic people
- pregnant women and new mothers

Vision and ambition for providing tailored support

Our vision and ambition is:

- there is consistent access to high-quality services and resources to prevent suicides, no matter where the person lives or which population groups they are part of
- the individual needs of people in these groups are routinely considered in national and local interventions to prevent suicides. There is support for these groups when they interact with public sector agencies and government departments, and staff from agencies likely to come into contact with priority groups have access to suicide prevention training and resources
- the needs of these groups at key transition points between public services are considered. This includes the transition from children and adolescent to adult mental health services, and the transition between justice and community settings
- engagement with people with personal experience from these groups is a central part of the development of national and local services and policies
- there is more support available for informal caregivers, parents and carers

To support all priority groups, including those at higher risk:

- DHSC has established a £10 million Suicide Prevention Grant Fund (https://www.gov.uk/government/publications/suicide-prevention-grant-fund-2023-to-2025) to run from 2023 to March 2025 to support VCSE organisations to deliver suicide prevention activity. The fund launched in August and will support a wide range of charities and activities, including those that work closely with these groups
- by the end of 2024, OHID will refresh local suicide prevention plan guidance to support the development of local plans in line with national priorities, including guidance on providing bespoke support to demographic groups and communities of concern
- NHS Long Term Plan funding to support suicide prevention activity, including to support specific groups, continues to run until March 2024

Children and young people

While the suicide rate in under-20s is relatively low compared with older age groups, rates across all age groups under 25 have been increasing (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2021registrations) over the last decade in

England. This increase is particularly apparent among females under 25. This increase in rates is now levelling off – however, we must focus action to reverse this trend.

Self-harm rates have also been rising in children and young people (https://pubmed.ncbi.nlm.nih.gov/31175059/).

Mental health support

Timely mental health support is crucial to suicide prevention, and NHSE continues to increase investment and explore ways to improve standards and support young people's mental health as set out below.

NHSE continues to invest in mental health services through the NHS Long Term Plan and aims to improve access to NHS-funded mental health support for people up to the age of 25 by March 2024. This is expected to benefit at least an additional 345,000 children and young people.

NHSE is also in the process of measuring waiting times in urgent and emergency care and the community mental health sector, including for children and young people, in line with the clinically led review of NHS access and waiting time standards.

Services and support offered by the VCSE and social care sectors and informal caregiving, including by parents and carers, also play an important role in suicide prevention. A collaborative approach between public, private, charity and informal support must be fostered to best support the needs of children and young people, and their parents and families.

People looking after a child or young person's mental health, including parents and carers, will continue to be able to access online support resources through Every Mind Matters (https://www.nhs.uk/every-mind-matters/supporting-others/childrens-mental-health/).

Support in schools, colleges and universities

Providing the right support and environment in schools and colleges is an integral part of suicide prevention. This includes ensuring pupils and learners benefit from a safe, calm and supportive learning environment with early targeted support for those who need it, as part of a whole-school or college approach to promoting health and wellbeing (https://www.gov.uk/guidance/mental-health-and-wellbeing-support-in-schools-and-colleges).

While ONS statistics suggest that higher education students in England have lower suicide rates (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/

articles/estimatingsuicideamonghighereducationstudentsenglandandwalesexperimentalstatistics/2017to2020) compared with the general population of similar ages, given the range of unique challenges and stresses associated with the transition into higher education, tailored support for university students is essential for preventing suicides.

DfE has set a target for all universities to sign up to the University Mental Health Charter Programme (https://universitymentalhealthcharter.org.uk/join-the-charter/) by September 2024. The charter brings together universities to share effective practice and create cultural change around mental health, and includes guidance on staff mental health training, supporting staff to recognise and respond appropriately to poor mental health.

To build on progress to improve mental health support and suicide prevention activity within schools, colleges and universities, DfE is:

- working with NHSE and DHSC to continue to roll out mental health support teams in schools and colleges. In spring 2023, 35% of pupils and further education learners in England were covered by a team, with 44% expected to be covered by April 2024 and at least 50% by spring 2025
- reviewing RSHE guidance to consider the inclusion of suicide and self-harm prevention as an explicit part of the curriculum. Engagement with experts and those with personal experience of suicide and self-harm has already commenced. Revised guidance will be published in 2024
- offering all state schools and colleges funding to train a senior mental health lead by 2025, enabling settings to take a whole-school or college approach to mental health and wellbeing
- funding anti-bullying organisations to support schools to tackle bullying, which may support suicide prevention given links to bullying (https://sites.manchester.ac.uk/ncish/reports/suicide-by-children-and-young-people/)
- working with Universities UK to support universities to embed its suicide-safer universities guidance (https://www.universitiesuk.ac.uk/what-we-do/policy-and-research/publications/features/suicide-safer-universities), which covers both prevention of suicide and compassionate responses to suicide in universities. This guidance has been developed in partnership with the charity PAPYRUS
- commissioning an independent organisation to carry out a national review of higher education student suicides. This will support rigorous local reviews and identify recommendations to prevent future deaths
- supporting the higher education mental health implementation taskforce (https://www.gov.uk/government/groups/higher-education-mental-health-implementation-taskforce), which is being chaired by Professor Edward Peck and includes bereaved parents, students, mental health experts, charities and sector representatives. The taskforce will set out a plan to improve mental health support and suicide prevention in higher education by May 2024

In addition to effective mental health support and support in educational settings, further bespoke support may be needed to respond to particular circumstances and experiences of some children and young people.

One study of deaths by suicide in those under the age of 20 (https://www.cambridge.org/core/journals/bjpsych-open/article/children-and-young-people-who-die-by-suicide-childhoodrelated-antecedents-gender-differences-and-service-contact/ACA727371498065C7B8ABB80054E13BE) found that 25% had been bereaved (including by suicide), 15% had a mental illness and 30% had a physical health condition, 6% percent reported being LGBT or uncertain, and 8% had experience of the care system. People with experience of the care system have been found to be 4 to 5 times more likely to attempt suicide in adulthood than their peers.

All of these factors may require particular consideration and support. Government departments, mental health services, the social care system and educational settings must continue to work together to better identify and implement actions that both advance understanding and provide targeted support for these groups.

DfE and DHSC will strengthen the joint guidance Promoting the health and wellbeing of looked-after children (https://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children--2). This includes extending it to cover care leavers up to age 25, seeking to incorporate key learning from recently published research into the emotional wellbeing needs of care leavers (https://whatworks-csc.org.uk/research-report/an-exploratory-study-of-the-emotional-wellbeing-needs-and-experiences-of-care-leavers-in-england-2/) and considering how best to address the risk of suicide.

There is also increasing evidence of the association between exposure to harmful content on the internet, and suicide and self-harm in children and young people (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6263311/). Actions to address this concerning trend are outlined in the ‘Online safety, media and technology’ section below.

Improving evidence to better understand the experience of children and young people

To strengthen our understanding through data and evidence of the experiences of children and young people in relation to suicide:

- DHSC is commissioning research via NIHR to advance our understanding of why rates of suicide have been increasing in certain age groups. We expect this research to conclude in 2025
- NHSE and DHSC will continue to work together to ensure data and evidence from child death overview panels and the National Child Mortality Database

(https://www.ncmd.info/guidance/) are harnessed to support learning and future interventions

Middle-aged men

Men are 3 times more likely to die by suicide than women (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2021registrations), with middle-aged men having the highest rates of suicide of any other group (based on age and sex) since 2010.

There are several factors that have been particularly strongly linked to suicide in this group. Socioeconomic disadvantage is strongly associated with suicide among this demographic and middle-aged men did not have the highest rates of suicide of any group until after the 2008 recession, suggesting a link between recession and suicides. National evidence on suicide in middle-aged men (https://sites.manchester.ac.uk/ncish/reports/suicide-by-middle-aged-men/) shows that factors such as living in the most deprived areas and experiencing unemployment or financial difficulties (including debt and housing difficulties) have also been particularly linked to suicide in this group.

A history of alcohol or drug misuse, contact with the justice system, family or relationship problems, and social isolation and loneliness are also factors that are common in men who died by suicide (https://sites.manchester.ac.uk/ncish/reports/suicide-by-middle-aged-men/).

Addressing risk factors with strong links to male suicide

Addressing many of the risk factors included throughout this strategy will be essential for preventing suicide in men. For example:

- embedding initiatives to support financial difficulty. This includes:
  - work to improve support and signposting for debt support in NHS services
  - work by DWP to strengthen support for people who disclose that they are experiencing thoughts of suicide or self-harm, including for those experiencing financial difficulty, unemployment and other risk factors for suicide
  - activity to address financial difficulty at a national level, such as the government's £37 billion package of cost-of-living support (https://www.gov.uk/government/publications/cost-of-living-support) to help households and businesses

- improving treatment and support for alcohol and drug misuse through the 10-year drugs strategy (https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives). This includes £532 million over 3 years (from 2022 to 2023 through to 2024 to 2025) for DHSC to increase capacity and improve the quality of drug and alcohol treatment services

Making the most of every interaction

It is also essential that we enhance support and signposting at key interactions points.

A study published in 2021 of men aged 40 to 54 who died by suicide in the UK (https://sites.manchester.ac.uk/ncish/reports/suicide-by-middle-aged-men/) found that two thirds had been in contact with frontline agencies or services in the 3 months before their death. Most had been in contact with primary care services (43%), and contact had also been made with mental health services and the justice system, among others.

Each of these interaction points provides additional opportunity to prevent suicides and encourage middle-aged men at risk of suicide to seek the right support. Therefore:

- there needs to be appropriate support and signposting for suicide prevention from services men commonly interact with, especially primary care, as well as government agencies, and wider physical and mental health services. This can also include places where people may seek support for risk factors that have been linked to male suicide, including debt, and alcohol and drug misuse
- initiatives led by the MoJ to reduce suicide among those in contact with the justice system – such as safer cells, suicide and self-harm prevention training to staff, and support on release for people with complex needs – are particularly relevant to men, who make up over 90% of the prison population (https://commonslibrary.parliament.uk/research-briefings/sn04334/)
- DHSC will work with the Government Debt Management Function (https://www.gov.uk/guidance/government-debt-management-function-gdmf) on the links between debt and suicide, using the function's Vulnerability Toolkits (https://www.gov.uk/government/publications/public-sector-toolkits) to explore how the support and training offer for suicide prevention can be strengthened in frontline services
- the charities Homeless Link, Pathway, Groundswell and Enabling Assessment Service London – funded by the VCSE Health and Wellbeing Alliance, which is jointly managed and funded by DHSC, NHSE and the UK Health Security Agency (UKHSA) – have in March 2023 developed and published a set of resources to support organisations to manage the risk and impact of suicide for people experiencing homelessness (https://homeless.org.uk/knowledge-hub/suicide-prevention-and-postvention/)

Further information on support that will be provided across public sector services is set out in subsequent sections of this strategy.

Bespoke services to support middle-aged men

We also need bespoke services to prevent suicide by addressing the specific needs of middle-aged men. The voluntary sector is essential to this.

Samaritans has developed an Engaging men earlier (https://www.samaritans.org/about-samaritans/research-policy/middle-aged-men-suicide/engaging-men-earlier/) handbook that provides a set of principles that wellbeing initiatives for men should be based on, and VCSE organisations are leading the way in ensuring that men – especially middle-aged men – have access to different types of services to address a range of needs and preferences in places where they are most likely to engage.

Examples of these are set out in the case study box below.

Services available

Examples of different types of services available are as follows:

- Men's Sheds (https://menssheds.org.uk/) have been established throughout England, bringing men together to reduce isolation and loneliness
- The Lions Barber Collective (https://www.thelionsbarbercollective.com/) is encouraging barbershops to create spaces where men can open up and be signposted to support
- Mates in Mind (https://www.matesinmind.org/) is developing positive workplace mental wellbeing, including in industries with large male populations such as construction
- Mental Health Innovations worked with international brands to improve access to mental health resources for men
- James' Place (https://www.jamesplace.org.uk/) is offering free clinical interventions to men who are in suicidal crisis in London and the north, with more centres expected to open in the coming years
- charities such as Harmless and the Tomorrow Project have carried out case study work to understand the services that men in suicide crisis would like to engage with (PDF, 203KB) (https://harmless.org.uk/wp-content/uploads/2022/06/A-consultation-aimed-at-understanding-the-needs-of-males-in-suicide-crisis-A-Case-Study-Part-1.pdf), and to raise awareness and increase referrals of men into mental health services (PDF, 133KB) (https://harmless.org.uk/wp-content/uploads/2022/06/A-Case-Study-on-Community-Interventions-Collaborative-Efforts-to-Target-Men-for-Suicide-Prevention.pdf)

- Shout collaborated with the Premier League (https://giveusashout.org/latest/shouts-new-partnership-premier-league/) to support the mental wellbeing of players, fans and those in communities
- State of Mind (https://stateofmindsport.org/) is using sport to promote positive mental health among players and communities, with the ultimate aim to prevent suicides

Sport can play an important role in reaching audiences in local communities and across the country, including people in groups at risk of suicide and self-harm. We encourage sports organisations to continue to focus on this issue, working with charity partners and building on previous successful awareness campaigns. In addition:

- OHID will, through local guidance, continue to encourage local government, NHS and voluntary sector organisations to work together to ensure that there are initiatives that reach men in places that suit them, encourage the reduction of stigma and support their needs
- DHSC will work with organisations that represent, work with or are popular among largely male populations to explore further options to support men, and share innovative and good practice
- DHSC will encourage employers, including in largely male industries, to have adequate and appropriate support in place for employees – including, for example, people trained in mental health first aid, mental health support and suicide prevention awareness

People who have self-harmed

Self-harm does not necessarily mean someone is experiencing suicidal thoughts or feelings. However, as well as being an important issue to address in its own right, we know that self-harm is associated with a significant risk of subsequent suicide. It is therefore important that we focus efforts on prevention and the provision of consistent high-quality care for self-harm (including aftercare and support within community settings).

There are an estimated 200,000 hospital presentations for self-harm per year (https://www.psych.ox.ac.uk/research/csr/ahoj) in England. The occurrence of self-harm in the community is likely to be much higher. Evidence also suggests that the suicide rate is highest in the year following hospital discharge (https://www.phc.ox.ac.uk/publications/1047918) for self-harm, particularly in the first month.

Progress to date

There has been good progress to improve support for people who have self-harmed, including:

- good-quality psychosocial assessments have been shown to increase engagement with support services and reduce the risk of repeated self-harm
- in 2022, NHSE introduced a financial incentive (https://www.england.nhs.uk/publication/combined-ccg-icb-and-pss-commissioning-for-quality-and-innovation-cquin-guidance/) to ensure that, by 2023, 80% of patients referred to psychiatric liaison teams in hospital emergency departments received a comprehensive psychosocial assessment[footnote 1] in line with National Institute for Clinical Excellence (NICE) guidelines (https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#psychosocial-assessment-and-care-by-mental-health-professionals). Reporting currently indicates strong compliance with this target
- NICE guidance on the assessment, management and prevention of recurrence of self-harm (https://www.nice.org.uk/guidance/ng225) has been updated for the use of health and social care professionals and providers, educational staff, VCSE organisations, the criminal justice system, and people using services. This guidance outlines the importance of carrying out a psychosocial assessment at the earliest opportunity following an episode of self-harm, and provides recommendations for mental health professionals in carrying out psychosocial assessments
- underpinning all this work is the importance of good-quality data and evidence, which has further developed in recent years. For example, the work of the Multicentre Study of Self-Harm (https://www.psych.ox.ac.uk/research/csr/ahoj) has been vital in informing the development of policy across government and clinical practice across hospital settings, the NHS and voluntary sectors

To build on this work:

- DHSC will continue to fund the Multicentre Study of Self-Harm to improve our understanding of emerging issues, data and trends, so that we can continue to act on the determinants and factors associated with self-harm risk
- NHSE will publish data outlining whether the 80% target for psychosocial assessments was achieved and is exploring plans to support psychiatric liaison teams in continuing to provide psychosocial assessments in line with NICE guidance at these levels
- NCISH is working alongside experts from the Manchester Self-Harm Project (https://sites.manchester.ac.uk/mash-project/) and the Patient Safety Translational

Research Centre (https://www.psrc-gm.nihr.ac.uk/), with support from NHSE, to support integrated care systems (ICSs) across England to improve community-based services and care for people who self-harm. These models are aimed at providing improved care for adults and older adults who self-harm in the community

Everyone can be exposed to harmful self-harm content online, including content purposefully generated by others to cause harm. This risk applies to adults just as it does to children and young people. There is increasing evidence of links between internet usage and self-harm, with one study finding that, among self-harm hospital presentations, the prevalence of suicide and self-harm related internet use was 8.4% among adults and 26% among children and adolescents (https://research-information.bris.ac.uk/en/publications/suicide-and-self-harm-related-internet-use-a-cross-sectional-stud).

To tackle this, the government:

- introduced the Online Safety Bill (https://bills.parliament.uk/bills/3137) to Parliament in 2022. The bill includes a range of measures to tackle self-harm content, including a new offence of encouraging or assisting serious self-harm by means of verbal or electronic communications, publications or correspondence
- has committed to expanding this offence to cover encouragement or assistance given in ways that are outside the scope of the Online Safety Bill, such as the provision of physical assistance, when Parliamentary time allows

People in contact with mental health services

When individuals are in contact with mental health services, it is crucial that they are offered safe, compassionate and patient-centred care each and every time.

People known to be in contact with mental health services represent around 27% of all deaths by suicide in England (https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/) – on average around 1,300 people each year. This includes anyone in contact with mental health community services, people in inpatient settings, and anyone that has been in contact with these services within 12 months.

Evidence suggests that history of self-harm, alcohol and drug misuse, co-morbidity (more than one mental health diagnosis), and living alone may be particular risk factors (https://documents.manchester.ac.uk/display.aspx?DocID=66829) for suicide for people in contact with mental health services. The actions included across this strategy focus on addressing these risk factors.

Between 2010 and 2020, there was a 35% fall in the number of suicides in inpatient settings (https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/) in England when taking into account the number of admissions. This fall is likely due to safer physical environments (including the removal of ligature points), staff vigilance, and wider improvements in mental health inpatient settings.

We must continue to build on this progress. To support this:

- mental health trusts and providers of NHS-funded mental healthcare should identify and implement actions to further prevent suicides in these settings. This includes reviewing and implementing evidence-informed recommendations such as those outlined in the NCISH annual reports (https://sites.manchester.ac.uk/ncish/reports/) and 10 ways to improve safety (https://sites.manchester.ac.uk/ncish/) recommendations (which include safer wards such as removing ligature points, personalised risk management and early follow-up on discharge)

Of all people that had been in contact with mental health services who died by suicide in England, nearly half (48%) had been in contact with mental health services (https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/) within 7 days before their death. A large proportion (82%) of patients that died by suicide in England were assessed to be at 'low' or 'no risk' of suicide (https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/) in short-term risk assessments before their death.

In 2022, NICE published updated guidelines (https://www.nice.org.uk/guidance/ng225) that reiterate the importance of risk-assessment tools and scales not being used to predict future suicide or repetition of self-harm, or to determine who should and should not be offered treatment or discharged. NHSE has asked that all services review the use of risk assessment tools and scales, and develop highly personalised assessment and management of needs, risks and contexts. This is often referred to as safety planning.

NHSE will:

- take steps to ensure that patients receive good-quality (in line with NICE guidelines) follow-up support within 72 hours of being discharged from inpatient mental health settings. This includes developing effective integrated pathways
- convene a safety planning working group that brings together experts and people with personal experience to identify opportunities to improve the quality and culture of inpatient services, including risk management of suicide and self-harm across different settings. Guidance on safety planning will be developed and published by March 2024, and training and quality improvement programmes will be scoped, with the aim to begin delivery by March 2025

We must also continue to explore opportunities to better support those with specific diagnoses of conditions associated with higher rates of suicide by working with policy, clinical and personal experience experts to provide bespoke suicide prevention activity where needed.

DHSC, with NHSE, intend to explore opportunities to improve the quality of care for patients with these diagnoses and ensure compliance with NICE guidelines. This includes patients diagnosed with:

- affective disorders, including depression and bipolar, who accounted for 42% of all patient suicides (https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/) in England between 2010 and 2020
- personality disorders, who accounted for 11% of all patient suicides (https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/) in England between 2010 and 2020 (and this figure is increasing)
- schizophrenia and other delusional disorders, who accounted for 16% of all patient suicides (https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/) in England between 2010 and 2020
- eating disorders, where one-quarter to one-third of people diagnosed with anorexia nervosa and bulimia nervosa have attempted suicide. NHSE continues to work with systems and healthcare professionals to support the adoption of guidance from the Royal College of Psychiatrists on medical emergencies in eating disorders (https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2022-college-reports/cr233)

People in contact with the justice system

People in contact with the justice system have higher rates of suicide and self-harm behaviour than the general population. Action to prevent suicide and self-harm is needed across the justice system – in police custody, in prison services for those on remand or serving a sentence, in probation services and for all people on release.

For police custody settings, the College of Policing has developed a national course for custody sergeants and detention officers to help reduce the risk of death, including by suicide, and other adverse incidents in custody.

Work continues to prevent suicide and self-harm across the prison system, including for people on remand and people serving a sentence.

MoJ continues to work in partnership with Samaritans to facilitate the Listener Scheme (https://www.samaritans.org/how-we-can-help/prisons/listener-scheme/), through

which, in 2021 to 2022, 1,200 people in prison were trained to provide emotional support to their peers, including people on remand.

MoJ has revised the Assessment, Care in Custody and Teamwork case management approach – a care-planning process for prisoners at risk of suicide or self-harm. This revised approach embeds a stronger emphasis on person-centred care planning, and on identifying and addressing an individual's risks and protective factors.

To build on these important actions throughout the timeframe of this strategy, MoJ:

- has committed £625,000 funding per year until March 2025 to Samaritans to maintain delivery of the Listener Scheme and postvention service
- will continue to roll out suicide and self-harm prevention training among prison staff, encouraging a joined-up approach to prison safety
- is planning to install new ligature-resistant cells, focusing on the highest-priority prisons

To support collaborative government policy making, the Home Office, MoJ and DHSC will continue to consider advice from the Independent Advisory Panel on Deaths in Custody (https://www.iapondeathsincustody.org/), and maintain links between this group and NSPSAG, so that recommendations and good practice to prevent suicide remain a core part of policy considerations.

NHSE, DHSC, MoJ, HM Prison and Probation Service, and UKHSA are, through the National Partnership Agreement on Health and Social Care in England (https://www.gov.uk/guidance/healthcare-for-offenders), committed to continuing to improve support for people with mental health problems in the justice system. The agreement sets out shared priorities to deliver safe, decent and effective care that improves health outcomes for people in prison, as well as those under the supervision of probation services.

Given the increased risk of suicide at key transition points and the higher rates of suicide in people on probation compared with the general population:

- NHSE will continue to provide its RECONNECT and Enhanced RECONNECT (https://www.england.nhs.uk/commissioning/health-just/reconnect/) services. RECONNECT seeks to improve care continuity for prison leavers with health needs by working with them before they leave prison and supporting transition to community-based services. Enhanced RECONNECT is a pilot service, available for individuals identified as high risk of harm to the public and who have complex health needs, that supports this group to get treatment from mental health, substance misuse and other services for up to a year

- HM Prison and Probation Service is planning to develop new suicide prevention training to be rolled out among probation practitioners and staff in approved premises (premises managed by the probation service in which a person might be required to stay following release from prison)

Autistic people

Evidence suggests autistic people, including autistic children and young people (https://sites.manchester.ac.uk/ncish/reports/annual-report-2022/), may be at a higher risk of dying by suicide (https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/premature-mortality-in-autism-spectrum-disorder/4C9260DB64DFC29AF945D32D1C15E8F2) compared with those who are not autistic. It is essential that health, mental health, and local authority services and education providers consider the needs of autistic people in suicide prevention activity. While many actions in this strategy will support autistic people, we need to tackle the specific preventable risk factors and tailor support to their needs.

Undiagnosed or late-diagnosed autism (https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/autism-and-autistic-traits-in-those-who-died-by-suicide-in-england/04367C4DD9D8B4B3375A0D25C4764A54) may be a preventable risk factor for suicide and, therefore, earlier identification and timely access to autism assessment services is vital.

NHSE and DHSC have set out steps to improve access to autism assessment services in England. This includes:

- encouraging ICBs to deliver improved outcomes in all-age autism assessment pathways in line with the NHSE national framework (https://www.england.nhs.uk/long-read/a-national-framework-to-deliver-improved-outcomes-in-all-age-autism-assessment-pathways-guidance-for-integrated-care-boards/)
- operational guidance for autism assessment services (https://www.england.nhs.uk/long-read/operational-guidance-to-deliver-improved-outcomes-in-all-age-autism-assessment-pathways-guidance-for-integrated-care-boards/)
- steps set out in the National strategy for autistic children, young people and adults: 2021 to 2026 (https://www.gov.uk/government/publications/national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026)

Specific factors that further increase the risk of suicide among autistic people include traumatic, painful life experiences (https://link.springer.com/article/10.1007/s10803-020-04393-8), barriers to accessing support (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6625034/), pressure to 'camouflage' or 'mask' autism (https://link.springer.com/article/10.1007/s10803-019-

04323-3) (for example, concealing particular traits that are common in autistic people) and feelings of not belonging (https://link.springer.com/article/10.1007/s10803-020-04393-8). Autistic people report difficulties in accessing mental health support (https://www.sciencedirect.com/science/article/abs/pii/S0272735822000162?via%3Dihub) because they have an autism diagnosis, are awaiting autism assessment or because of a lack of reasonable adjustments to services.

DHSC and NHSE have already set out steps to improve access to appropriate and effective mental and physical health support for autistic people. This includes ongoing work to strengthen the availability and accessibility of community mental health support.

We are determined to reduce the number of people with a learning disability and autistic people in mental health hospitals.

In the NHS Long Term Plan, there is a commitment to increase the availability of community support for autistic people in order to reduce reliance on mental health inpatient care.

The Building the Right Support Action Plan (https://www.gov.uk/government/publications/building-the-right-support-for-people-with-a-learning-disability-and-autistic-people) brings together actions across government and public services to improve community support and reduce over-reliance on mental health hospitals. This includes the requirement for all ICBs to have an executive lead for learning disability and autism, investing £121 million in 2023 to 2024 (including for children and young people's keyworkers) to improve community support as part of the NHS Long Term Plan.

These steps will help us continue to reduce our reliance on mental health inpatient care for autistic people, which we recognise should only be used when absolutely necessary for clinical reasons.

We have also acknowledged the need for health and care staff to have the right knowledge and skills to provide safe and compassionate care for autistic people. From 1 July 2022, the Health and Care Act 2022 (https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted) required providers of Care Quality Commission-registered services to ensure their staff receive specific training on learning disability and autism, appropriate to their role. We are rolling out the Oliver McGowan mandatory training (https://www.hee.nhs.uk/our-work/learning-disability/current-projects/oliver-mcgowan-mandatory-training-learning-disability-autism) to support this. Part one of this training, an e-learning package, is now live.

To develop more effective direct suicide prevention activity, there needs to be a focus on improving the national evidence base of suicide prevention and autism. DHSC and NHSE will therefore continue to identify opportunities to strengthen the

evidence base to inform policy and practice. It is important that research decisions reflect the perspectives of people with personal experiences, building on the learning presented by the International Society for Autism Research on Autism community priorities for suicide prevention (https://www.researchgate.net/publication/351334079_Autism_community_priorities_for_suicide_prevention).

Initial steps that DHSC and NHSE will take include:

- working with NCISH to develop a clearer national picture of suicides in autistic adults, children and young people (as well as children and young people with attention deficit hyperactivity disorder (ADHD) to inform recommendations for policy and practice
- drawing learning from the Learning from lives and deaths – people with a learning disability and autistic people (https://www.england.nhs.uk/learning-disabilities/improving-health/learning-from-lives-and-deaths/) (LeDeR) programme to identify areas for improvement to prevent suicides
- considering the results of the NIHR-funded study testing the effectiveness of adapted suicide safety plans to reduce self-harm, suicidal thoughts and behaviours among autistic people (https://fundingawards.nihr.ac.uk/award/NIHR129196), once it is completed

DfE will also continue to consider opportunities for providing support for autistic children within the education system and consider any tailored support that might be needed for different groups, including autistic children.

As part of the RSHE review, DfE will consider whether more specific guidance is needed to support those teaching RSHE to pupils with special educational needs and disabilities, including autism.

Pregnant women and new mothers

In the UK, suicide is the leading cause of direct deaths 6 weeks to a year after the end of pregnancy (https://www.npeu.ox.ac.uk/mbrrace-uk/reports). In 2020, women were 3 times more likely to die by suicide during or up to 6 weeks after the end of pregnancy compared with 2017 to 2019. Impacts on affected families are devastating and often have lasting effects, particularly on children from a very early stage in their development.

Overall, the level of risk of suicide after pregnancy is not higher than at other times in a woman's life. However, the high risk compared with other causes of maternal death (most of which are rare) and the potential long-term consequences on

children's development mean we must take action to prevent suicides in this group. The increasing numbers of teenage maternal suicides, in particular care leavers, in recent years is a significant concern and particular targeted support is needed for this age group.

Complex risk factors

Perinatal mental illness affects up to 27% of new and expectant mothers (https://www.england.nhs.uk/mental-health/perinatal/) and is linked to suicide.

Progress has been – and will continue to be – made on several NHS Long Term Plan commitments to improve maternal mental health services, for example:

- since 2019, there has been a specialist community perinatal mental health services in every ICS area of England
- as of February 2023, there were 35 maternal mental health services (https://www.england.nhs.uk/mental-health/perinatal/maternal-mental-health-services/) (which combine maternity, reproductive health and psychological therapy for women experiencing mental health difficulties related to their maternity experience), with services in each ICS area due to be operational by 2024
- the government is investing around £100 million for perinatal mental health and parent-infant relationship support as part of the Family Hubs and Start for Life programme (https://www.gov.uk/government/collections/family-hubs-and-start-for-life-programme) in 75 local authorities in England. This investment includes enhanced support for parents experiencing mild to moderate mental health difficulties in the perinatal period. This focus on early intervention will help mothers access timely mental health support as soon as difficulties arise, acting as a protective factor

More recently, in comparison with previous years, very few women who died by suicide had formal mental health diagnoses. Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries across the UK (MBRRACE-UK) (https://www.npeu.ox.ac.uk/mbrrace-uk/reports) highlights that complex problems remain extremely common in women who die by suicide and there are several overlapping risk factors that services need to consider. Understanding and identifying risk factors and their complexities allows care to be tailored to individual needs.

Clinicians should complete screening of women's mental health during pregnancy and the first year after pregnancy as part of ongoing care, and should actively seek to identify risk factors, including current and past mental ill health, domestic abuse, substance misuse, baby loss, teenage parenthood and experience of the care system. These are all factors that may require additional support and access to resources from a range of services.

To further understand possible relationships between these factors and suicide and self-harm, the VCSE Health and Wellbeing Alliance (https://www.england.nhs.uk/hwalliance/), managed by DHSC, NHSE and UKHSA, is sponsoring a project led by the Tommy's and Sands Maternity Consortium (https://www.sands.org.uk/maternity-consortium), which will engage people who have had suicidal thoughts or self-harmed and present with certain risk factors during the perinatal period.

Furthermore, women may struggle to engage with services for a variety of different reasons, including fears of losing their child or children. Providing early intervention to support women with complex needs with tailored care and well co-ordinated services may contribute to better outcomes. This is key at the point where a child is removed or taken into care as well.

Assessment and support at every contact point

There are multiple opportunities to identify and act on these risk factors across the NHS, social services and VCSE organisations, and across different time points, including throughout antenatal, neonatal and postnatal care, as well as within specialist services.

This includes:

- first appointments with midwives and ongoing antenatal care
- referrals to GPs and/or specialist mental health services
- engagement with health visitors
- engagement of a specialist teenage pregnancy or drug and alcohol specialist midwife

The 3 year delivery plan for maternity and neonatal services (https://www.england.nhs.uk/publication/three-year-delivery-plan-for-maternity-and-neonatal-services/) also made a commitment to offer all women a personalised care and support plan, taking into account physical health, mental health and social complexities, with a risk assessment updated at every contact.

Healthcare professionals involved in the care of women in the perinatal period play a vital role in supporting the mental wellbeing of expectant and new mothers.

Midwives have a crucial role to play to identify women who are at risk of, or are suffering from, perinatal mental illness, and ensure these women and their families get the care they need at the earliest opportunity. This includes signposting or referring women for additional care, if this is required, and

supporting women to access this care (by working in partnership with relevant services).

Health visitors will offer an initial contact post-28 weeks of pregnancy and then following the birth. These contacts provide an opportunity to assess women and families regarding perinatal ill-heath and risk. NHSE is also working closely with RCGP to develop new guidance for GPs who deliver 6-to-8-week postnatal consultations. This includes a chapter specifically on support for perinatal mental health, and what the most appropriate crisis and/or emergency support might be, where required.

By 2024, bereavement services will be operational 7 days a week in every area in England to support women and families who experience pregnancy loss or neonatal death.

In addition to the roll-out of further services, the Minister for Mental Health and Women's Health, Maria Caulfield MP, established the Maternity Disparities Taskforce (https://www.gov.uk/government/news/new-taskforce-to-level-up-maternity-care-and-tackle-disparities) in 2022 to co-ordinate focus and deliver evidence-based interventions to address maternal disparities. The taskforce is currently focused on pre-conception care, which includes mental health and wellbeing.

And, while a range of support is available, and significant progress is being made to improve the assessment, early recognition and quality of, and access to, the right help and services, there is more that is needed.

To build on this work, furthering our understanding of perinatal suicide and how to prevent it will be an important next step. We will continue to learn from key studies and evidence such as reports by MBRRACE-UK (https://www.npeu.ox.ac.uk/mbrrace-uk/reports) and consider how to embed recommendations in practice to prevent perinatal suicides. This will include considering how to strengthen the co-ordinated cross-sectoral approach, the improvement of communication between parts of the system and how we can better identify those at risk.

Addressing risk factors

Addressing risk factors linked to suicide is a central part of effective suicide prevention. This provides an opportunity for effective early intervention, as well as providing appropriate, tailored support for those experiencing suicidal thoughts or feelings.

Many risk factors are common across different individuals, groups and communities. Therefore, actions to address these risk factors are likely to prevent suicides at a population level with potential benefits for some groups.

Links have been evidenced between suicide and social determinants of health such as housing, poverty, employment and education. We encourage everybody working in suicide prevention to consider the impact of wider determinants in their efforts to prevent suicides.

And, while there is ongoing work across government to address these factors, there are some specific factors (many of which are linked to these wider determinants) that have been identified as priority areas to address within this strategy. Through data, evidence and engagement, we have assessed these to be:

- physical illness
- financial difficulty and economic adversity
- harmful gambling
- substance misuse
- domestic abuse
- social isolation and loneliness

Vision and ambition for addressing risk factors

Early intervention is prioritised, with different sectors and government departments addressing risk factors with a strong link to population-level suicide and self-harm rates.

There is strong collaboration within ICSs, building on existing successes that bring a wide range of partners together to address risk factors and wider determinants linked to suicide prevention, such as housing and financial difficulty.

All local suicide prevention plans include tangible actions to address risk factors at a local level.

People who work in relevant public services are supported to identify and support people who might be at risk of suicide or self-harm.

Physical illness

Evidence suggests that a diagnosis of a severe physical health condition may be linked to higher suicide rates (https://pubmed.ncbi.nlm.nih.gov/36545003/). Evidence from NCISH suggests that over half of men aged 40 to 54 who died by suicide had a physical health condition (https://sites.manchester.ac.uk/ncish/reports/suicide-by-middle-aged-men/#:~:text=Physical%20health%20conditions).

And, while 2 of 3 people who die by suicide have not been in contact with mental health services within the previous year, evidence suggests that many (49 to 92%) make contact with primary healthcare services in this time (https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/contacts-with-primary-and-secondary-healthcare-prior-to-suicide-casecontrol-wholepopulationbased-study-using-personlevel-linked-routine-data-in-wales-uk-20002017/8AB097902BA78C0061211B348805CCA0). Over 40% of middle-aged men have been in contact with primary care services (https://sites.manchester.ac.uk/ncish/reports/suicide-by-middle-aged-men/#:~:text=Physical%20health%20conditions) for either physical or mental health needs within 3 months before taking their own life. It is essential that we support those seeking help for physical illness to meet both their physical and mental health needs.

DHSC will take steps to address the link between physical illness and suicide by:

- publishing a major conditions strategy outlining what we will do to ensure health services are more preventative and person-centred. This will put forward a strong and coherent policy agenda that sets out a shift to integrated whole-person care, building on measures that we have already taken forward through the NHS Long Term Plan. This will ensure that mental ill health is considered alongside physical health conditions, meaning the interactions between them are reflected in any resulting commitments, such as how to do more to implement physical health support across mental health pathways
- working with NHSE and professional bodies to improve suicide prevention signposting and support to people in contact with primary care services, including those receiving care for physical ill-health. It is important that those working in primary care recognise the risk of suicide associated with physical ill-health, and have the knowledge and skills to effectively intervene and signpost to support where this may be needed. This is especially true for groups such as middle-aged men

Financial difficulty and economic adversity

Financial difficulty and adversity can result in suicidal thoughts or action. Evidence shows an increased risk of suicide for people with debt, and economic recession has been consistently linked to suicide (https://onlinelibrary.wiley.com/doi/abs/10.1002/9781118903223.ch16). More recently, evidence from charities such as Money and Mental Health has suggested that rises in the cost of living have been linked to some people feeling unable to cope (https://www.moneyandmentalhealth.org/suicide-prevention-cost-of-living-crisis/), with some feeling suicidal.

Support programmes for people facing difficulties over jobs and benefits can mitigate the impact of economic adversity and financial difficulty on suicide rates. Action to support people facing financial difficulty, such as through the Coronavirus Job Retention Scheme (https://commonslibrary.parliament.uk/research-briefings/cbp-9152/) implemented during the COVID-19 pandemic, is therefore an essential part of preventing suicides.

There has been important activity to address financial difficulty in recent years, including:

- the government's £37 billion package of cost-of-living support (https://www.gov.uk/government/publications/autumn-statement-2022-cost-of-living-support-factsheet/cost-of-living-support-factsheet) to help households and businesses
- a guide from the Money and Pensions Service (MaPS) and the National Academy for Social Prescribing setting out how primary care network leaders can employ social prescribing link workers who are able to provide money guidance (PDF, 1.73MB) (https://socialprescribingacademy.org.uk/media/uefliimk/maps-nasp-pcn-guide.pdf)
- work within voluntary sector organisations such as Samaritans and Shout has helped banks and energy companies provide resources to staff to help them to identify and support people who might be experiencing suicidal thoughts or feelings, or who may be vulnerable to this in the future

Economic factors such as financial difficulty, debt, unemployment and poor housing may also be linked to the regional variation in suicide rates across England. The suicide rate is highest in the north-east (14.1 suicides per 100,000 people) (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2021registrations#:~:text=The%20North%20East%2C%20North%20West,lower%20than%20any%20English%20region.) and this is over double the rate in London, which has the lowest suicide rates in the country (6.6 suicides per 100,000 people).

We must continue to address financial difficulty and economic adversity to prevent suicides as a priority, especially in the context of the recent rises in the cost of

living. Ongoing commitments include:

- DHSC will work with the Government Debt Management Function on the links between suicide and debt, using the function's Vulnerability Toolkits (https://www.gov.uk/government/publications/public-sector-toolkits/debt-management-vulnerability-toolkit-for-service-and-policy-managers-v2-html) to explore how the support and training offer for suicide prevention can be strengthened in frontline services
- DWP will identify opportunities to review and strengthen its guidance for staff to support customers that disclose that they are experiencing suicidal thoughts or feelings, with training to support staff to do this and with consideration to the role of financial difficulty
- DWP will procure a call alert and transcription service across its telephony estate to support the quick identification of callers who raise suicidal thoughts. This will help staff identify these callers quickly and provide timely signposting. Alongside this, DWP has committed to a mandatory 2-day mental health awareness training for all of its frontline staff
- NHSE and MaPS will continue work to improve access and signposting to debt support to ensure people aren't struggling alone and know what options are available to them

Gambling

There is increasing evidence of the relationship between harmful gambling and suicide, including in younger people (https://www.gov.uk/government/publications/gambling-related-harms-evidence-review). Although reasons for suicide can be complex, we do know that gambling can be a dominant factor without which the suicide may not have occurred. Action therefore needs to be taken to address the harms of gambling, including suicide, and reach people at risk.

The government and NHSE have already taken steps to address the health harms associated with gambling. Through the NHS Long Term Plan, the NHS is expanding treatment provision and it continues to deliver on its commitment to open 15 specialist gambling treatment clinics, which will now open by September 2023 – 6 months ahead of schedule.

NHSE has also enhanced its Help for problems with gambling (https://www.nhs.uk/live-well/addiction-support/gambling-addiction/) webpage to include improved signposting to sources of advice and support.

The white paper High stakes: gambling reform for the digital age (https://www.gov.uk/government/publications/high-stakes-gambling-reform-for-the-digital-age), published by the Department of Culture, Media and Sport (DCMS) in April 2023, sets out steps the government is taking to have the right controls and safeguards in place on gambling products to minimise the risk of harm. This includes a commitment to consult on potential changes to make products 'safer by design' to reduce harm, and more prescriptive rules on when online operators must check customers' financial circumstances for signs their losses are harmful.

These are important milestones for protecting people from gambling-related harms, including suicide. Building on these milestones:

- DCMS, DHSC and the Gambling Commission are working together to strengthen informational messaging, including on risks associated with gambling, and will continue to work to further strengthen evidence on how to reduce gambling-related harms. In 2023, DCMS will consult on the design and scope of a statutory levy paid by gambling operators and collected by the Gambling Commission to fund research, education and treatment of gambling harms, which will lead to further opportunities to take action
- NICE is developing clinical guidelines to support the identification, assessment and management of harmful gambling. Publication is expected in spring 2024
- DHSC will continue to work with the NHS and others to explore opportunities to improve current treatment provision for gambling-related harms, including gambling-related suicidality. This includes a review of the existing treatment system in England, with recommendations to support improvements expected in 2023
- the Local Government Association is updating guidance for local authorities on gambling-related harms, and will encourage public health teams to consider the potential links between their work on suicide prevention and harmful gambling
- the Royal College of Psychiatrists will develop a continuous professional development resource to improve professionals' understanding of harmful gambling. This will include suicide risk as a result of gambling. The college will launch the resource in 2024

Alcohol and drug misuse

Consistent links have been evidenced between alcohol and drug use and suicide. Acute intoxication, as well as dependence on alcohol and/or drugs, has been consistently associated with a substantial increase in the risk of suicide (https://www.cambridge.org/core/journals/bjpsych-open/article/alcohol-use-and-its-association-with-suicide-attempt-suicidal-thoughts-and-nonsuicidal-selfharm-in-two-

successive-nationally-representative-english-household-samples/A0BDB904D24BBEDFE4320FA16569D671) and self-harm.

Addressing alcohol and drug use may be especially important for supporting particular groups. In a study of middle-aged men that died by suicide in 2017, 49% had experienced alcohol misuse, drug misuse or both (https://sites.manchester.ac.uk/ncish/reports/suicide-by-middle-aged-men/), particularly where individuals were unemployed, bereaved or had a history of self-harm or violence. Among people in contact with mental health services in England who died by suicide between 2010 and 2020, there were high proportions of both alcohol misuse (45%) and drug misuse (35%) (https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/).

It is essential that we tackle the link between suicide and alcohol or drug use, and especially alcohol and drug misuse and dependency. Reducing excessive alcohol consumption at a population level and instances of acute intoxication is an important part of this, as is ensuring that people misusing or dependent on drugs and alcohol are able to access the right support.

This includes support both for substance misuse but also for any mental health or self-harm concerns, with a ‘no-wrong-door’ policy that makes every contact with services count. Services should consider the needs of particular groups and engagement with people with personal experience should inform the development of appropriate treatment practices.

Taking action to address these links can effectively prevent suicides. Mental health trusts that implemented a policy on co-occurring drug and alcohol use observed a 25% fall in patient suicides (https://sites.manchester.ac.uk/ncish/reports/suicide-by-middle-aged-men/). Guidelines make clear that mental health providers are accountable for leading care for those with severe mental illness and co-existing alcohol or drug use, and that people with co-occurring conditions should face no wrong door. However, many people entering substance treatment services are not receiving treatment for their mental health needs, and many patients that died by suicide are not in contact with specialist drug and alcohol treatment services.

We are committed to further improving support for drug and alcohol treatment recovery, and the government is already making progress towards this.

In December 2021, the government published a 10-year drugs strategy (https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives), which sets out a long-term vision for change in this area. This includes the government’s plans for improving the quality of drug and alcohol treatment services, and getting 54,000 more people into substance misuse treatment by 2024 to 2025. A total of £532 million is being made available to local authorities, who commission substance misuse treatment and recovery services.

Local authorities have set out plans for their systems, choosing from a set of evidence-based interventions to meet the needs of their local areas.

DHSC has also published guidance for local authorities to support them in commissioning effective alcohol and drug treatment and recovery services in their area (https://www.gov.uk/government/publications/commissioning-quality-standard-alcohol-and-drug-services). This commissioning quality standard encourages a partnership approach to commissioning that includes the local NHS and other health providers in the planning and delivery of these services.

The government has also made progress to address population-level harmful alcohol consumption. From 1 August 2023, reforms to alcohol duty (https://www.gov.uk/government/publications/reform-of-the-alcohol-duty-system) structures came into force. For the first time, the new alcohol duty system will be based on the principle of taxing alcohol according to its strength. This will help to target problem drinking by taxing products associated with alcohol-related harm at a higher rate of duty, and incentivising the production and consumption of lower-strength products.

In addition to these actions, over the next 5 years:

- the government – including multiple government departments – will continue to implement the actions set out in the 10-year drugs strategy. This includes increasing the capacity, and improving the quality of drug and alcohol treatment services, including upskilling the workforce across England
- as part of this, OHID is exploring ways to improve access to substance misuse treatment, including how to improve referrals from health services and the criminal justice system
- DHSC and NHSE will also consider suicide prevention in their joint action plan for mental health and substance misuse services. This plan will identify actions to improve mental health treatment for people with mental health conditions who also misuse alcohol and drugs. This will include improving access to mental health services for people using drugs and alcohol as people are currently too often excluded from, and/or fall between the thresholds of, services. It will also promote better links between mental health services and substance misuse treatment services to ensure people receive joined-up care
- DHSC will include guidance for clinicians and support staff working in alcohol treatment services on identifying and managing immediate risk of suicide or self-harm in the upcoming UK clinical guidelines for alcohol treatment. DHSC will consult on these guidelines in 2023, with final publication to follow by 2024
- HM Treasury and HM Revenue and Customs, with support from DHSC, will evaluate the impact of alcohol duty reforms, including on population-level rates of alcohol consumption and levels of alcohol harm

Social isolation and loneliness

Social isolation (having few people to interact with regularly) and loneliness (not having the quality or quantity of social relationships we want, regardless of social contacts) have been closely linked to suicidal ideation and behaviour (https://pubmed.ncbi.nlm.nih.gov/32664029/).

This includes for particular groups – one study suggested that social isolation was experienced by 15% of under-20 year olds and 11% of 20 to 24 year olds who died by suicide (https://sites.manchester.ac.uk/ncish/reports/suicide-by-children-and-young-people/), and qualitative research undertaken by the Samaritans (https://www.samaritans.org/about-samaritans/research-policy/young-people-suicide/) found loneliness played a significant role in young people's suicidal thoughts or feelings. A further national study suggested that, of men aged 40 to 54 who died by suicide, 11% reported recent social isolation (https://documents.manchester.ac.uk/display.aspx?DocID=55305).

We know that loneliness is one of the primary reasons that individuals access crisis services, and that actions to reduce social isolation and loneliness are therefore likely to be key to suicide prevention.

We are committed to building a more connected society where everyone is able to build meaningful relationships. Across government, we are taking action to support people who feel lonely, as outlined in the Tackling Loneliness fourth annual report (https://www.gov.uk/government/publications/loneliness-annual-report-the-fourth-year).

This includes:

- DCMS's £30 million Know Your Neighbourhood Fund (https://www.gov.uk/government/publications/29-million-know-your-neighbourhood-fund-confirmed), which aims to increase volunteering and reduce chronic loneliness in high-deprivation areas, including projects to prevent suicide. Through delivery and evaluation of the fund, local authorities and community organisations will have access to evidence on what works
- the Department for Transport's publication of the £5 million Tackling loneliness with transport fund (https://www.gov.uk/government/news/funding-for-transport-projects-to-help-tackle-loneliness) in autumn 2023, which will provide insight into how transport policies can reduce the number of people feeling lonely
- NHSE's Workforce, Training and Education directorate strengthening existing social isolation and loneliness digital learning resources to include links to existing learning resources on suicide prevention
- DHSC, DCMS and NHSE exploring further ways to signpost people to social prescribing and other loneliness support. This includes plans to launch an online social prescribing platform for commissioners and practitioners, and an

NHS toolkit to support primary care networks in expanding their social prescribing to children and young people

- DHSC encouraging suicide and mental health helplines to signpost to interventions that tackle loneliness and prioritise community-based schemes that tackle loneliness within national signposting tools, including the NHS App (https://www.nhs.uk/nhs-app/)
- the Social Prescribing Information Standard (https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dapb4066-social-prescribing) enabling link workers and primary care practitioners to capture information about needs and support offered to individuals. Data can be used by local NHS planners and commissioners to support groups known to be at higher risk of loneliness

Domestic abuse

Since the 2012 strategy, more evidence on a link between domestic abuse and suicide (https://www.vkpp.org.uk/vkpp-work/domestic-homicide-project/) has emerged. Research on intimate partner violence, suicidality and self-harm (https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(22)00151-1/fulltext) showed that past-year suicide attempts were 2 to 3 times more common in victims of intimate partner violence than non-victims. It highlighted deaths in male and female victims, children and young people in households impacted by domestic abuse, and among perpetrators. Research by the Kent and Medway Suicide Prevention Programme and Kent Police (https://nspa.org.uk/resource/link-domestic-abuse-and-suicide/) found around 30% of all suspected suicides in that area between 2019 and 2021 were impacted by domestic abuse.

Tackling domestic abuse and identifying victims, including children who witness abuse, is key to preventing related suicides. In March 2022, the Home Office published its Tackling Domestic Abuse Plan (https://www.gov.uk/government/publications/tackling-domestic-abuse-plan), with the aim to drive down the prevalence of domestic abuse and domestic homicide, and provide victims and survivors with the support they need. The plan sets out how government will invest over £230 million to tackle the issue. This includes funding to support victims and children experiencing domestic abuse, support for whole families, and to improve data and knowledge.

To improve data around domestic abuse and suicide:

- the Home Office will continue to collate data on victim suicides at a national level. Although we recognise this data is likely to underestimate the number of

victim suicides following domestic abuse, this will improve our ability to start to understand and compare trends over time

- the Home Office is also supporting the development of methods to comparably measure the effectiveness of different interventions that support children experiencing domestic abuse. These measures will consider key outcomes for children and young people who have experienced domestic abuse, such as the impact on relationships and wellbeing. This will improve our understanding of what works to support and improve outcomes for children who experience domestic abuse
- intelligence and recommendations from domestic homicide reviews (DHRs) where there has been a suicide will improve our understanding of any trends and links. To ensure we make best use of this information and learn lessons from these reviews, the Home Office will continue to implement actions in the Tackling Domestic Abuse Plan including reforms to the DHR process, working with the National Police Chiefs' Council to identify best practice in referring suicides that followed domestic abuse for a DHR

Improving support throughout the healthcare system will also provide important opportunities to prevent suicides where there is a link to domestic abuse, therefore:

- NHSE has set up a dedicated Domestic Abuse and Sexual Violence Programme (https://www.england.nhs.uk/long-read/sexual-safety-of-nhs-staff-and-patients), which aims to transform the NHS's response to domestic abuse and sexual violence. The programme is considering how to improve training for staff and better embed routine enquiry around domestic abuse, including links to suicide. The programme is also leading work to improve support for staff who are experiencing domestic abuse and sexual violence
- NHS ICBs have a duty to set out in their joint forward plans how they meet the needs of domestic abuse victims. NHSE guidance on developing joint forward plans (https://www.england.nhs.uk/publication/joint-forward-plan/) recommends that this includes appropriate training, identification and referral pathways to meet the needs of victims of domestic abuse
- from 2022 to 2025, the Home Office is investing up to £7.5 million into domestic abuse interventions in healthcare settings to better equip healthcare professionals to respond to domestic abuse disclosures, enhance referral pathways and build on best practice

For children and young people, the Domestic Abuse Act 2021 (https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted) acknowledges the devastating impact domestic abuse can have and recognises children who see, hear or experience the effects of domestic abuse and who are related to either the perpetrator or victim as victims of domestic abuse in their own right. As part of the investment covered in the Tackling Domestic Abuse Plan, the Home Office has

increased funding for the Children Affected by Domestic Abuse Fund (https://www.gov.uk/government/news/new-funding-to-support-child-victims-of-abuse) and has allocated up to £10.3 million across 3 years (2022 to 2025) to 8 organisations across England and Wales that provide specialist support within the community to children who have been impacted by domestic abuse.

Online safety, media and technology

Recent decades have propelled us forward in advances of the internet, technology and the availability of media sources. This has been invaluable in raising awareness and improving access to support for suicide and self-harm – however, the online world also poses new harms that national government, online platforms and media companies must work together to address.

There has been emerging evidence of the link between the online environment and suicide across different age groups. Internet use for suicide-related purposes has been linked to children and young people who have presented to hospital for self-harm or a suicide attempt and middle-aged men who have died by suicide.

Five-year ambitions for online safety, technology and media

We will transform online safety over the next 5 years. Our ambitions are that:

- social media and online platforms are much safer places for children and adults. People are less likely to be exposed to harmful suicide and self-harm content, and it is clear who is responsible and accountable for keeping people safe from this content online
- the public is educated and equipped with knowledge and skills for healthy and safe usage of online platforms
- high-quality signposting and support are prevalent across a range of platforms. These are more easily accessible for people who might need support for suicidal ideation and self-harm
- the benefits of technology are explored more comprehensively and applied where they can support the implementation of effective suicide prevention activity. This includes testing of digital therapeutics, and further developing our knowledge of the potential benefits and risks of artificial intelligence (AI) in relation to suicide prevention

- the media consistently portrays suicide and self-harm content responsibly, and continues to have access to and follow high-quality guidelines and resources to do this

Tackling online harms

Since 2012, we have taken robust action to improve online safety and reduce online harms related to suicide and self-harm. In 2022, the government published the new Online Safety Bill (https://bills.parliament.uk/bills/3137) as part of our mission to make the UK the safest place in the world to be online. The bill is currently making its way through Parliament.

The legislation will require all in-scope companies to tackle illegal content, such as suicide and self-harm content, that reaches the criminal threshold.

The bill, if passed, will also introduce requirements on providers in relation to content that falls below the criminal threshold. The largest services will have to offer adults optional tools to limit their exposure to legal content that encourages, promotes or provides instructions for suicide or self-harm.

For services that are likely to be accessed by children, the bill also includes requirements that should be put in place to prevent children of all ages from encountering content that encourages, promotes or provides instructions for suicide or self-harm.

Over the course of this strategy:

- the government will seek to enact and then implement the Online Safety Bill (subject to the will of Parliament)
- DHSC will continue to work closely with Samaritans on the delivery of their Online excellence programme (https://www.samaritans.org/about-samaritans/research-policy/internet-suicide/samaritans-online-excellence-programme/) with social media and search engine platforms, learning from research and providing input where appropriate
- government departments, including the Department for Science, Innovation and Technology and DHSC, will continue to work with social media and search engine platforms. We expect that platforms take the right actions to tackle harmful content and provide supportive environments, and share good practice across the sector

Harnessing the benefits of online platforms and technology

Technological advances have also brought benefits, and we should continue to harness these in supporting individuals to access information, speak openly about their thoughts or experiences, and identify options for peer and general support.

Recent initiatives

There have been many initiatives developed over recent years, led by the voluntary and private sectors. This has included, for example:

- the introduction of the Google OneBox (https://www.google.com/support/enterprise/static/gsa/docs/admin/current/gsa_doc_set/oneboxguide/oneboxguide.html), a pop-up alert providing contact details for Shout and the Samaritans
- the development of Samaritans' guidance and resources on safe internet usage (https://www.samaritans.org/about-samaritans/research-policy/internet-suicide/online-safety-resources/) for platforms, users, parents and carers and NHS professionals
- the development of the Hub of Hope (https://hubofhope.co.uk/) by Chasing the Stigma – a mental health database bringing together local, national, peer, community, charity, private and NHS mental health support and services in one place for the first time
- mental health information, including signposting to suicide prevention partners, is now more accessible via the NHS App (https://www.nhs.uk/nhs-app/)
- apps have also been developed in recent years to support specific groups, such as veterans, including the Samaritans Veterans app (https://www.samaritans.org/how-we-can-help/military/samaritans-veterans-app/) funded by the Office for Veterans' Affairs within the Cabinet Office

We encourage the voluntary sector and online platforms to continue to ensure that appropriate online signposting and resources reach the right people. This includes anyone that may be affected by suicide or self-harm and people that support them (such as parents and carers, and frontline professionals).

NHSE supports several programmes to increase innovation across the NHS, academia and industry. These programmes aim to speed up access to digital health technologies that are proven to be safe and effective for patients. Mental health is being prioritised within work by NICE, NHSE and DHSC to assess the value of digital technologies.

Over the course of this strategy, DHSC and NHSE will continue to explore opportunities to use digital and technology to support mental health and suicide prevention, and intend to:

- test digital therapeutics that can reduce suicidal ideation and behaviours in the short and long term
- engage with the technology and AI sector to identify opportunities to apply digital innovation safely and effectively to suicide prevention activity, in line with national clinical guidelines

Machine learning and AI may also offer many valuable opportunities to enhance mental health and suicide prevention services. Shout has demonstrated where this could be particularly helpful for services using text elements, by using an AI role play simulator to support volunteer training.

However, there are limitations of AI and machine learning, particularly in relation to suicide prevention. The use of AI in predictive tools or in real-time conversations with individuals would currently not be appropriate, for example. More research and greater understanding of the capabilities and impacts of AI and machine learning for suicide prevention is therefore required over the next few years.

Responsible portrayal of suicide in the media

The availability and accessibility of media, including online media, provides opportunities for raising awareness, reducing stigma, and improving the reach of helpful signposting and support for many who need it. However, suicide can be a complex issue to cover, and it is important that we keep pace with the changes in media reporting to ensure safe, accurate and responsible reporting, while ensuring space is made for bereaved families who may wish to tell their stories.

Samaritans continues to lead on work with the media industry to do this. This includes providing a comprehensive media advice service including education, training and guidelines, monitoring of press reporting, and engagement with editors and regulators in relation to any emerging concerns identified. We expect everyone in the media industry and anyone publishing public articles relating to suicide to follow guidelines such as those published by Samaritans (https://www.samaritans.org/about-samaritans/media-guidelines/).

As media continues to evolve, we are committed to ensuring that new ways of consuming media, such as video on demand, are also dealing with the portrayal of suicide responsibly. To do this:

- DHSC will continue to review resources, including guidelines, to ensure that they reflect current and emerging issues
- DHSC will continue to collaborate with Samaritans to support the media to understand and act on evolving issues in suicide prevention
- DHSC intends to demonstrate strong leadership nationally on responsible reporting. We will highlight where there may be an impact of other countries' practices on UK audiences and seek to collaborate on, and share good practice in, tackling online harms

Providing effective and appropriate crisis support

It is essential that timely and effective crisis support is available to those who need it.

Research by NCISH suggests that, of all deaths by suicide by people in contact with mental health services in England between 2010 and 2020, 15% were under the care of crisis resolution and home treatment teams (https://documents.manchester.ac.uk/display.aspx?DocID=65805) (CRHTTs). This is equivalent to 180 suicides per year on average. NHS 24/7 mental health crisis lines currently receive around 200,000 calls each month. And many more people are in contact with crisis services provided by other organisations, including those from the voluntary sector.

We have made progress in improving mental health crisis access and support through sustained investment through the NHS Long Term Plan.

Long-standing restrictions on older adult access to crisis services have been removed –everyone across England now has access to 24/7 mental health crisis services (including via open-access crisis lines). All local areas have seen investment in 24/7 intensive home treatment services.

NHSE is taking forward a range of wider improvements to the crisis support offer. This includes procuring specialised mental health ambulances and investing in a range of infrastructure schemes including alternatives to A&E. This aims to enable people to access support in more appropriate spaces and is supported by £150 million of capital investment.

We also introduced a Suicide Prevention Grant Fund (https://www.gov.uk/government/publications/suicide-prevention-grant-fund-2023-to-2025)

in 2021 to support the VCSE sectors to deliver different activities. Of the 111 fund recipients, 65% reported implementing crisis line activity.

But there is still further to go, and there is an increasingly high demand for crisis support and services.

Ambitions for providing appropriate and effective crisis support

Our ambitions are:

- anyone experiencing suicidal crisis is signposted to, and easily able to access timely and effective support and information. Care provided is person-centred and considers the mental health, physical health, and social needs of those in suicidal crisis
- people are able to access crisis support in the most appropriate environment for them, when they need it, whether that is through statutory health, VCSE or social care services. People can access support in the way that feels most suitable for them, whether that be on the phone (for example, through ringing an NHS 24/7 crisis line or a charity helpline), over text or accessing support face to face. Options are available to suit everyone's needs and preferences
- information-sharing processes are implemented and strengthened. This includes sharing information about suicide risk with families and carers, in accordance with the DHSC suicide prevention consensus statement (https://www.gov.uk/government/publications/consensus-statement-for-information-sharing-and-suicide-prevention), supported by Zero Suicide Alliance's SHARE resource (https://www.zerosuicidealliance.com/open-about-suicide-sharing-information-can-save-lives) for health and social care staff
- pathways between services and sectors are stronger, and uphold a person-centred, joined-up approach to crisis prevention and response, including through timely follow-up and aftercare processes

Actions to provide effective crisis support

NHSE will continue to progress actions to improve crisis support as outlined in the NHS Long-Term Plan, including those in the community. These include:

- expanding all-age mental health crisis services across NHS trusts, in partnership with wider partners such as the VCSE sectors, to support current demand for services. There has been significant expansion of open-access, community-based crisis teams for adults and older adults. Children and young people's crisis services are expanding with the aim of reaching 100% coverage by 2023 to 2024
- 24/7 mental health crisis lines are already available in all areas of the country. By the end of 2023 to 2024, anyone seeking urgent mental health support in England will be able to access these crisis lines via ringing NHS 111 and selecting the mental health option.
- as signalled in the Delivery plan for recovering urgent and emergency care services (https://www.england.nhs.uk/publication/delivery-plan-for-recovering-urgent-and-emergency-care-services/), it is intended that, by 2024 to 2025, all parts of the country will have introduced crisis text lines to enable easier access to crisis care for those with specific needs, such as people who are neurodiverse and other marginalised groups

In cases that people do need to be referred to emergency departments, there should be appropriate support and processes in place for responding to a suicidal crisis, including following appropriate risk management, discharge and aftercare processes.

It is well understood that many people will still require mental health service support in emergencies. NHSE is therefore:

- leading the procurement of specialised mental health ambulances for phased roll-out by 2024 to 2025, via the £150 million capital investment that has been made available for urgent and emergency care mental health pathways. This investment is also funding a range of capital infrastructure schemes, including improved and new crisis cafés, crisis houses, mental health crisis hubs, mental health assessment and liaison spaces, improvements in emergency departments, and health-based places of safety. These schemes will help anyone experiencing mental health or suicidal crisis. For example:
  - crisis cafés can, in some cases, act as an appropriate short-term alternative to A&E for people seeking support, advice or signposting to other services from qualified mental health practitioners and support staff
  - new and refurbished mental health assessment and liaison spaces will provide more safe environments outside of A&E for people experiencing crisis to be assessed and to discuss support options. Improvements to emergency departments will help improve the therapeutic environment for people experiencing crisis who do arrive at A&E, including adoption of anti-ligature measures
  - investment in health-based places of safety will provide further appropriate facilities for people detained by the police where there is perceived to be a

risk of an individual harming themselves

- supporting ICBs to work with VCSE crisis partners to operate these alternative crisis spaces. Since 2019, local areas have seen ongoing investment in alternative models of crisis through £179 million of funding until 2024
- embedding mental health professionals in all emergency operations centres (such as ambulance control rooms) – helping ensure that mental health expertise is available where required
- continuing to support general hospitals, which all now have mental health liaison services, with an aim of 70% meeting the 'core 24' standard for adults and older adults by 2023 to 2024. All should seek to meet this standard where not yet achieved

The government is committed to ensuring that those experiencing a mental health crisis receive timely care from an appropriately trained professional who can provide them with the right support.

Therefore:

- DHSC will work with NHSE to increase the uptake of crisis services joining the Crisis Resolution and Home Treatment Teams Quality Network (https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/qncrhtt). This supports trusts in monitoring the quality of care provided by CRHTTs and assessing whether local crisis services operate in line with best practice
- the Home Office, DHSC, National Police Chiefs' Council, College of Policing, Association of Police and Crime Commissioners, and NHSE have published a National Partnership Agreement (https://www.gov.uk/government/publications/national-partnership-agreement-right-care-right-person) that sets out a collective agreement to work to end the inappropriate and avoidable involvement of police in responding to people with mental health needs, where there is no risk to life or of serious harm. This will support the roll-out of the Right Care Right Person approach, which was developed by Humberside Police
- the government has significantly reduced the use of police stations as a place of safety, as they are not appropriate places for people in crisis and contribute to people feeling criminalised. Since 2018, they can only be used in very limited circumstances (where there is imminent risk of serious injury or death, no other place is available and the use of the police station has been authorised by an inspector)

Tackling means and methods of suicide

> This section contains potentially distressing content around methods and means of suicide. Please take care if you do choose to read.

We must work together to reduce access to the means and methods of suicide, and limit the awareness of these methods.

Our plans to improve early intervention and tackle the drivers of self-harm and suicidality are vital, but only part of the overall picture, because we know there will still be individuals who may be contemplating and planning suicide. For people at this point, one of the most impactful practical interventions is to reduce access and limit awareness of the means and methods of suicide, providing more time to intervene with effective longer-term actions and preventative support.

Ambitions for tackling means and methods of suicide

Cross-government and cross-sector partnership working continues. There is work to monitor common and emerging methods of suicide and high-risk locations, and ensure that appropriate action is taken in a timely manner as new intelligence becomes available.

First responders and people working on the frontline feel equipped to respond appropriately to deaths by potential suicide, no matter the method used, and have the skills necessary to adapt to the situation they find themselves in.

There are continued efforts to ensure that there is responsible reporting of the methods used in suspected or confirmed suicide cases in the media. Information about methods of suicide is as restricted as possible in the public eye.

Robust reporting systems and mechanisms are in place to enable partners working in high-risk locations to share data and best practice with colleagues to ensure that effective interventions can be replicated across the country.

Tackling common methods of suicide

The most common method of suicide in England and Wales continues to be hanging, strangulation and suffocation (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2021registrations) (accounting for 58% of all

suicides registered in 2021), with poisoning the next most common method (20%). The proportion of suicides caused by hanging is increasing over time.

Successful intervention is possible. The introduction of legislation to reduce the accessibility of paracetamol and co-proxamol led to decreases in suicides by these methods, and there have been significant steps taken to improve the physical safety of specific settings, such as removing ligature points from the wards of inpatient mental health facilities over recent years. This has contributed to a 35% fall in the number of inpatient suicides in England between 2010 and 2020 (https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/).

However, more must be done to reduce access to these common methods of suicide. We will identify opportunities to do so over the life course of this strategy:

- the Medicines and Healthcare products Regulatory Agency (MHRA) will monitor compliance with guidance on the sales of analgesics such as paracetamol, including promotions that exceed the recommended maximum. MHRA will continue to review whether legislation and guidance on the sales of analgesics is safe and proportionate
- DHSC will explore with the MHRA as to whether regulatory change is required on the quantities of sales of tablets, linked to the above
- MoJ is planning to install a number of ligature-resistant cells, focusing on the highest-priority prisons
- mental health trusts should continue to review and implement evidence-informed recommendations such as those outlined in the NCISH annual reports (https://sites.manchester.ac.uk/ncish/reports/), including the continued removal of ligature points from wards
- medical professionals, and especially practitioners within primary care, should follow NICE safe prescribing guidelines, especially in the case of prescribing antidepressants and analgesics within primary care for both adults and children and young people
- RCGP is in the process of revising its curriculum and will assess where guidance on safe prescribing may be strengthened as part of this process. Safe prescribing is already a key component of the core Being a GP curriculum (https://www.rcgp.org.uk/mrcgp-exams/gp-curriculum/being-general-practitioner) and is assessed during a trainee's workplace-based assessment

High-frequency locations

High-frequency locations are public sites that are frequently used as a location for suicide. In England, jumping from a height accounts for 3% to 5% of suicides

(http://eprints.lse.ac.uk/32311/) and jumping or moving in front of a moving object accounts for around 4% of suicides (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesintheunitedkingdomreferencetables), Around a third of all suicides take place outside the home (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2781717/).

The effectiveness of interventions for reducing access to certain high-frequency locations (https://www.gov.uk/government/publications/suicide-prevention-suicides-in-public-places) has been well evidenced. For example, the construction of safety barriers has been shown to successfully reduce suicides on particular bridges. However, these interventions should always go hand in hand with additional measures, including help from others, increasing opportunities for help-seeking, and addressing awareness and reputation of specific locations as a 'suicide site'.

We would encourage those with a role in the planning system to consider the risks of suicide associated with buildings and public spaces and to consult the practice resource Preventing suicides in public places (https://www.gov.uk/government/publications/suicide-prevention-suicides-in-public-places) when creating local design policies.

In recent years, there have been many actions to prevent suicides in high-frequency locations.

The British Transport Police Harm Reduction Team (HaRT) is working in partnership with Network Rail, mental health trusts and other key partners to provide support to individuals that present on railways multiple times. The pilot project has found that, following this support, people were significantly less likely to be present in the railway environment.

To support local areas to tackle suicides in high frequency locations and public spaces, Public Health England (now OHID) developed resources such as Preventing suicides in public places: a practice resource (linked previously), which provides local areas with a step-by-step guide to identifying locations and taking action.

Samaritans has delivered suicide intervention training to over 27,000 members of the rail industry workforce. This is in addition to the Small Talk Saves Lives (https://www.samaritans.org/support-us/campaign/small-talk-saves-lives/) campaign which, in partnership with Network Rail and Samaritans, supports rail passengers to identify when someone is at risk of suicide and how to approach them. Highways England (PDF, 3.89MB) (https://nationalhighways.co.uk/media/pxojiscm/n170235-suicide-prevention-strategy-2022.pdf), the Royal National Lifeboat Institution (RNLI) and City of London all have strategies and actions to prevent suicides in high-frequency locations.

But there is still more we can do to prevent suicides in high-frequency locations. Therefore:

- OHID will update the guidance for local suicide prevention partnerships on suicide clusters and contagion to support effective local responses where there may be more suicides than expected in a particular area, or a suspected link between suicides
- the National Police Chiefs' Council, OHID and local authorities will continue to work together to explore opportunities for improving data collection and data sharing in all areas. This includes building on work to identify and record where an individual resides as well as the location in question. This should improve understanding, provide appropriate support and guidance for future lessons learned, and help in directing support to try and intervene at locations of concern
- collaborative work has been started between the National Police Chiefs' Council and the Highways Agency to better understand deaths that occur on and/or near roads and associated infrastructure
- Network Rail will continue to geotarget locations on social media following a suicide to signpost support services and try to prevent further occurrences at the same location. It will also continue to minimise risks in the infrastructure and design of rail stations, including in the refurbishment and development of new stations
- the UK National Water Safety Forum, including the RNLI, is partnering with public health teams and suicide prevention organisations to better understand and contribute to the prevention of water-based suicides. They are also delivering a Water Incident Database (https://www.nationalwatersafety.org.uk/waid) to better understand water-related deaths, including suspected suicides
- new major developments should consider the risks of suicide in public locations. OHID will continue to support those with a role in the planning process to consider suicide prevention outside of the home through good design and assessments
- OHID will publish an evidence review to assist with the scoping of mental health, including suicide, within impact assessments for new infrastructure projects
- National Highways will develop guidance for current and future projects to reduce suicide risk on its roads and structures
- DHSC will work with the Department for Levelling Up, Housing and Communities (DLUHC) and the Building Safety Regulator to explore where we can go further in improving and implementing suicide protection measures in new buildings
- DHSC New Hospital Programme (https://www.gov.uk/government/news/five-major-hospitals-to-be-rebuilt-as-part-of-over-20-billion-new-hospital-infrastructure-investment)

will work with NHSE on incorporating suicide prevention advice and measures in the standardised approach to delivering the new hospitals

Tackling emerging methods

While we continue to take steps to address common methods of suicide and high-frequency locations, we must remain vigilant to emerging methods and respond quickly and effectively.

We define emerging methods as dangerous or potentially dangerous methods of suicide that have been either previously rarely or never recorded in England, where their use for suicide has only recently been identified, or where their use appears to be occurring more frequently.

DHSC leads a cross-government and cross-sector group that has been established specifically to rapidly identify, and proactively tackle, emerging methods of suicide. This involves close working across government and with academics, the voluntary sector, police, local government, coroners, local suicide prevention leads, ONS and the NHS to ensure we are taking rapid and targeted action to address these methods.

Through this group's close working, there are currently over 30 live actions and interventions that collectively are:

- reducing public access to methods, both nationally and internationally, including by reducing the sale and importation of methods where appropriate
- reducing references to, and limiting awareness of, emerging methods, including by tackling online content and working with the media to ensure responsible reporting. This includes exploring further opportunities to address online harms including harmful content shared in pro-suicide websites and forums
- monitoring data and trends to inform rapid and targeted responses, improving the data we collect, and how that information is best shared to inform responses

While these actions have contributed to a decrease in the number of deaths by what would be classed as an 'emerging method', this work is an enduring priority – and there is always more that can be done. DHSC will continue to lead the cross-sector group to tackle emerging methods of suicide, including by developing new actions to respond to emerging trends.

In addition to this:

- DHSC will embed a new national process that both captures intelligence and subsequently issues alerts to relevant parts of the health, care, education and justice systems, as well as the VCSE sectors, on any emerging methods or risks to be aware of
- refreshed guidance will be developed for first responders when encountering a death by suspected suicide through an emerging method. This will include police, public health leads and NHS staff
- ONS will provide quarterly reports to the cross-sector group on provisional registered suicides by emerging methods
- NHSE will encourage all NHS trusts to be signed up to Toxbase (https://www.toxbase.org/), which provides clinical guidance and information relating to emerging methods, including treatment. Guidance will be regularly refreshed with input from clinical leads
- government will take a leading role in tackling methods of suicide, collaborating with partners across the world in policy, law enforcement and society more broadly to limit access, reduce awareness, and share research, evidence and lessons learned. This will include seeking to tackle at source the suppliers of harmful substances for the purposes of suicide
- DHSC will continue to support the Samaritans in its work with media to encourage responsible reporting and television programming, helping to maintain low levels of awareness of novel methods

Providing timely and effective bereavement support

Evidence suggests family, friends and acquaintances who are bereaved by suicide may have a risk of dying by suicide that is up to a 3 times higher than the general population. Compassionate, effective and timely support for people bereaved by suicide is essential.

Local authorities, police, national government, coroners, the NHS, schools and universities, and VCSE organisations all have an essential role in providing effective and timely bereavement support.

Ambition and vision for improving bereavement support over the next 5 years

Our ambition and vision is:

- there is widespread recognition that improving bereavement support is an important goal in its own right, and bereavement is a risk factor for suicide among family, friends and acquaintances
- all individuals bereaved by suicide are offered timely, compassionate and tailored support, wherever they live
- across workplace, education and health settings, there is recognition of the impact of a suicide bereavement on families, carers, loved ones and the wider community, and actions are taken forward to provide access to support
- understanding of the impacts of suicide bereavement on groups (including children and young people, people who are LGBT, and ethnic minority groups) is strengthened through research and personal experience insight

There are many resources, including resources available online to support people bereaved by suicide. Help is at Hand (https://supportaftersuicide.org.uk/resource/help-is-at-hand/), developed in partnership with the Support after Suicide Partnership (SASP) (https://supportaftersuicide.org.uk/) and the National Suicide Prevention Alliance, is a resource that provides emotional and practical support for people bereaved by suicide or other unexplained death, and people in contact with those bereaved through suicide. The guide is designed to be given out by bereavement support organisations and those who are likely to be first on the scene after a suspected suicide, including police and ambulance staff.

To further promote resources to support people who are bereaved by suicide, OHID will update the Better Health – Every Mind Matters bereavement and other traumatic events (https://www.nhs.uk/every-mind-matters/lifes-challenges/bereavement-and-traumatic-events/) webpage to include signposting to Help is at Hand or other resources specific to suicide bereavement.

In addition to improving awareness and access to resources, people bereaved by suicide should receive effective support and services following a suicide, regardless of where they live. Therefore:

- NHSE will continue to support all local areas, which will have in place a standardised bereavement support offer from investment of £57 million for wider suicide prevention activity through the NHS Long-Term Plan by 2023 to 2024
- SASP will continue to offer support to local areas to embed suicide bereavement services in line with their Core Standards (https://hub.supportaftersuicide.org.uk/resource/summary-of-core-standards/)
- the British Transport Police has started rolling out bereavement support training for officers who may be the first contact for families, friends and loved ones

after someone has died. The National Police Chief's Council recommends that all forces develop and roll out similar training

- local areas are expected to ensure they have made use of their local near real-time suicide surveillance systems in connecting families, friends, carers and loved ones to bereavement support
- as we outline in the following section, there is a crucial role to be played within the workplace to support suicide prevention. This should include employer consideration of where bereavement and postvention support offers could be implemented or strengthened. To move towards achieving this ambition:
  - DHSC will work with experts to update relevant guidance and improve employer support
  - NHSE and DHSC will explore the quality of the existing bereavement support offers for healthcare professionals following a suicide, and explore opportunities to strengthen these – for example, through guidance changes
  - NHSE will continue to assist NHS trusts to develop and implement a process to manage the impact of an employee suicide on colleagues, supported by the postvention toolkit (https://www.nhsconfed.org/publications/nhs-employee-suicide-postvention-toolkit-impact-support) developed by Samaritans, in partnership with the NHS Confederation
  - the Royal College of Psychiatrists will work with relevant organisations to consider opportunities to embed recommendations from their prevention and postvention support framework (including Supporting mental health staff following the death of a patient by suicide (https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2022-college-reports/cr234)

Bereavement services and support should consider the needs of different groups and communities to ensure a wide range of people receive the support they need, therefore:

- DfE and DHSC will work closely with Universities UK to embed guidance for universities, with practical, compassionate actions after a suspected death by suicide
- DHSC has been working with NIHR to commission research into the barriers that prevent minority ethnic groups from accessing bereavement support services. The initial findings are expected in 2024
- DHSC will develop resources in collaboration with key stakeholders that all first responders can access. This will aim to provide advice and support to bystanders who may have witnessed a suicide or an attempted suicide
- DHSC will continue to work with VCSE sector stakeholders to better understand the personal experiences of people bereaved by suicide and explore opportunities to improve access and support. This includes engaging with new evidence and supporting implementation of resources, such as those developed

and commissioned by SASP, including an Understanding Gypsy, Roma, and Traveller Communities: Support Guide (https://hub.supportaftersuicide.org.uk/resource/understanding-gypsy-roma-and-traveller-communities-a-support-guide/) developed in collaboration with community organisations, and an LGBTQ+ Bereavement by Suicide Research Study (https://supportaftersuicide.org.uk/lgbtq-bereavement-by-suicide-research-study/)

Making suicide prevention everyone's business

Suicide prevention is everyone's business. Every person, organisation and service up and down the country has a role to play. In recent years, good progress has been made to tackle the stigma surrounding suicide and mental health. However, there is more we can all do to ensure we are all equipped with the skills necessary to potentially save lives.

Five-year ambitions for making suicide prevention everyone's business

Our ambitions are:

- every individual across the country has access to training and support that gives them the confidence and skills to save lives. Training is routinely promoted, with significant numbers of people trained in suicide prevention
- there is no wrong door – when people experiencing suicidal thoughts or feelings reach out, they receive timely support, no matter what service the individual initially accesses. Systems and services are connected around individual's needs
- employers (especially those in high-risk occupations) have appropriate mental health and wellbeing support in place for their staff – learning from and building on the work the NHS and others are undertaking. This includes members of staff being trained in suicide prevention awareness, particularly those interacting with people who may be more vulnerable
- there is a national conversation so that everyone - from individuals through to organisations and services – feel responsible for ensuring that they are consistently using language that supports people while reducing shame and stigma. This supports everyone to feel able to seek support whenever they need it

Improving skills and knowledge

Crucial to these ambitions is ensuring everyone has the skills, knowledge and confidence to provide necessary support and intervention. The availability and promotion of easy-to-access guidance and training for everyone is a vital first step.

A range of suicide prevention awareness training courses are already available for both individuals and organisations, including from charities such as Samaritans (https://www.samaritans.org/how-we-can-help/workplace/workplace-staff-training/), and PAPYRUS (https://www.papyrus-uk.org/what-we-offer/). This includes free, online courses such as those provided by the Zero Suicide Alliance (https://www.zerosuicidealliance.com/training).

It is also vital that, collectively, we do all we can to reduce stigma. Stigma can be a barrier to people seeking support when they are feeling suicidal or looking for bereavement support. Everyone has a role in creating safe spaces for people to speak up and seek support. Using language that reduces shame and stigma, and encourages people to seek support is an important step everyone can take.

There have been great examples of campaigns, resources and action that support delivering this. Many have been led by people with personal experience of suicide and bereavement, whose bravery and perseverance in making positive change for the good of society, following such a personal tragedy, is incredibly admirable.

As an example of this, If U Care Share (https://www.ifucareshare.co.uk/) is committed to raising awareness of the importance of suicide prevention and postvention, and offering professional support to individuals. As part of this, it has developed resources in collaboration with people with personal experience to dispel the myths surrounding suicide and facilitate open conversations.

Organisations such as the National Suicide Prevention Alliance bring together individuals and organisations from a range of sectors, including people with personal experience. They provide resources and support to help ensure suicide prevention becomes everyone’s business.

The role of employers

Employers have an essential role to play in supporting practices and conversations that help prevent suicides. There are multiple ways this can be done – for example, through employment assistance programmes, line manager training or peer support networks.

While this is imperative for workers engaging with more vulnerable members of the public, every employee should feel supported and every employer should ensure that support is known and available.

We strongly encourage all employers to have adequate and appropriate support in place for employees, such as people trained in mental health first aid, mental health support and suicide prevention awareness. Employers should also encourage employees to take the time to look after their mental health, focusing on prevention as well as providing support.

Data suggests that suicide rates vary across occupation groups, with some at higher risk. For example, ONS data suggested that, between 2011 and 2015, there were higher rates of suicides amongst female nurses (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/suicidebyoccupation/england2011to2015). It is imperative that, where professions and occupations have higher rates of suicide, employers and professional bodies take targeted action to reduce rates as far as possible.

ONS will publish analysis in 2023 to provide updated information about suicide rates across different occupations, which will inform further evidence-based action.

Recognising the stresses that continue to impact frontline health and care staff, NHSE published a suicide prevention toolkit (https://www.england.nhs.uk/publication/working-together-to-prevent-suicide-in-the-nhs-workforce-a-national-suicide-prevention-toolkit-for-england) outlining how to raise awareness of suicide, identify risks and respond to warning signs.

NHSE has also commissioned the University of Manchester to establish a prospective data collection about suicide by NHS staff, with the aim of preventing future deaths.

People working in professions that bring them into contact with people who may be experiencing suicidal thoughts or feelings should be supported in identifying and helping those who need it. This includes those working in education, prison and probation services, and the NHS. This strategy contains actions targeted at these cohorts, including training, new guidance and support, and risk management.

Beyond publication of this strategy, we will continue to work with partners, including the NSPSAG, on the support offer for people who frequently come into contact with those who may be experiencing suicidal thoughts.

In addition to that set out above, further actions that will be taken include:

- DHSC will collate and promote training and guidance that helps guide constructive conversations, and empowers people to check-in on those around them. Training and guidance will be available to support people working in environments where effective suicide prevention can be provided. This includes national government, local government and VCSE sector services
- ONS will use occupation information provided on death certificates to improve understanding of the suicide rates in different occupations. This will help identify where actions should be prioritised to support different occupations
- working with DWP, DHSC will explore the government's role in supporting employers to improve the support they provide for the mental wellbeing of themselves and their employees. This will include updating and highlighting best practice guidance to support employers in supporting their employees
- working with the Health and Safety Executive to explore options for revising their first aid guidance, and other relevant guidance, to emphasise the importance of parity of managing risks to mental and physical health in the workplace
- Network Rail will continue to work with Samaritans to deliver suicide intervention training for railway staff, helping them identify people who may be vulnerable, giving staff the tools and confidence to start a conversation and, ultimately, move vulnerable people to a place of safety. Over 27,000 members of the rail industry workforce have received this training
- DHSC will launch a mental health impact assessment tool to inform broader policy making across central and local government. Initially this will be aimed at policy makers across national government to ensure that, when policy is being designed, the possible impacts on mental health and suicide are considered, particularly for more vulnerable groups
- DHSC will work with DLUHC to understand local authority-level analysis and mapping of suicides, and associated risk factors to ensure the actions taken following publication tackle geographical disparities, building on work of the Levelling Up (https://www.gov.uk/government/publications/levelling-up-the-united-kingdom) agenda including the Levelling Up Partnerships
- DHSC, working with charities and local authorities, will create a short resource outlining appropriate language to use when talking about suicide. This resource will be disseminated widely to support both online and in-person conversations

Call to action

Finally, and in conclusion, this strategy has throughout identified action across many organisations, in national and local government, the health service, and the VCSE sectors, to address risk in specific groups and people with risk factors in common, and to bring action to where potential harm exists – online and in high-

frequency locations, for example – and we have published a summary of actions alongside the strategy, setting out clearly where action will happen, by who and when. The summary of actions will set out the basis for the development of an implementation plan.

However, this strategy and summary of actions are not the limits of suicide prevention – suicide prevention is everyone's business. We call on everyone to consider this strategy, the groups identified and the risk factors set out to truly consider and bring forward action to ensure that the preventable is prevented, and that families and communities do not suffer the devastating impact that suicide brings.

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1. A comprehensive assessment involves working with individuals to identify personal factors that might explain an act of self-harm to facilitate a collaborative therapeutic relationship, and form a personalised management and aftercare plan.

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