NHS
Solihull
Clinical Commissioning Group

Solihull
METROPOLITAN
BOROUGH COUNCIL

SOLIHULL SUICIDE PREVENTION STRATEGY

2017-2021

Contents

OUR AMBITION: 'ZERO SUICIDE'

This strategy describes the approach and actions that will be taken over the next five years to reduce the number of suicides in Solihull and to improve the care of families of those who have died by suicide. Our longer-term ambition is to achieve 'zero suicides' in Solihull as we believe suicide is largely preventable.

This is a whole community strategy for Solihull – actions everyone and every organisation in the wider community can take to reduce the number of suicides. The strategy covers suicide prevention across all age groups, support and care for people at high risk of suicide, and reducing access to the means of suicide. It recommends improvements to care of families of those who have died by suicide as well as improvements to the way we learn, and ensure action is taken, when someone takes their own life. Finally, it describes the arrangements for monitoring implementation and evaluating the impact of the strategy.

This is a strategy for Solihull. We recognise that implementation will require working with other areas, in particular, with organisations in Birmingham and Warwickshire, and we are committed to this collaboration.

This strategy has been developed by Solihull Metropolitan Borough Council (MBC) and Solihull Clinical Commissioning Group (CCG), working with key local organisations. A panel (Appendix 1) spent a day reviewing available evidence, hearing from interested local stakeholders and national experts and developing the strategic priorities. Appendix 2 lists the different types of evidence considered during the development of the strategy. The West Midlands Combined Authority Mental Health Commission is due to report in December 2016 and its recommendations will be incorporated into this strategy before it is finalised.

The time and effort put into preparing this strategy by a wide range of individuals and organisations is gratefully acknowledged. The strategy development process was facilitated by the West Midlands Quality Review Service (WMQRS).

NATIONAL POSITION

In 2014, 4882 deaths from suicide were registered in England and for every person who dies at least 10 people are affected[1]. Men are over three times more likely than women to die by suicide. Suicide is now the biggest killer of men under age 50 and of young people aged 20 to 34. Some groups of the population are particularly vulnerable to suicide[2]:

a. **Young and middle-aged men**

   Men aged 55 to 74 are the group with the highest rate of suicide. Factors associated with suicide in men include depression, especially if untreated or undiagnosed, alcohol or drug misuse, family and relationship problems, social isolation and low self-esteem

b. **People in the care of mental health services, including inpatients**

   Although the percentage is reducing, approximately 28% of people who die by suicide were in contact with mental health services at the time. People with severe mental illness are at high risk of suicide. Particularly vulnerable are in-patients, people recently discharged from hospital and those who disengage from or refuse treatment.

c. **People with a history of self-harm**

   By the age of 16, between seven and 14% of young people will have self-harmed at least once in their life. Around one in a 100 people who self-harm die by suicide within a year, with those who repeatedly self-harm and those who use violent or dangerous methods at the highest risk. At least half of people who take their own life have a history of self-harm and one in four have been treated in hospital for self-harm in the preceding year.

[1] '*Local suicide prevention planning*', Public Health England, 2016.
[2] '*Preventing suicide in England: Two years on*', HM Government, 2015

d. **People in contact with the criminal justice system**

People at all stages within the criminal justice system are at high risk of suicide, including those on remand and recently discharged from custody. The first week of imprisonment is the time of greatest risk.

Risk of dying by suicide is multi-factorial and people with several risk factors are at significantly increased risk.

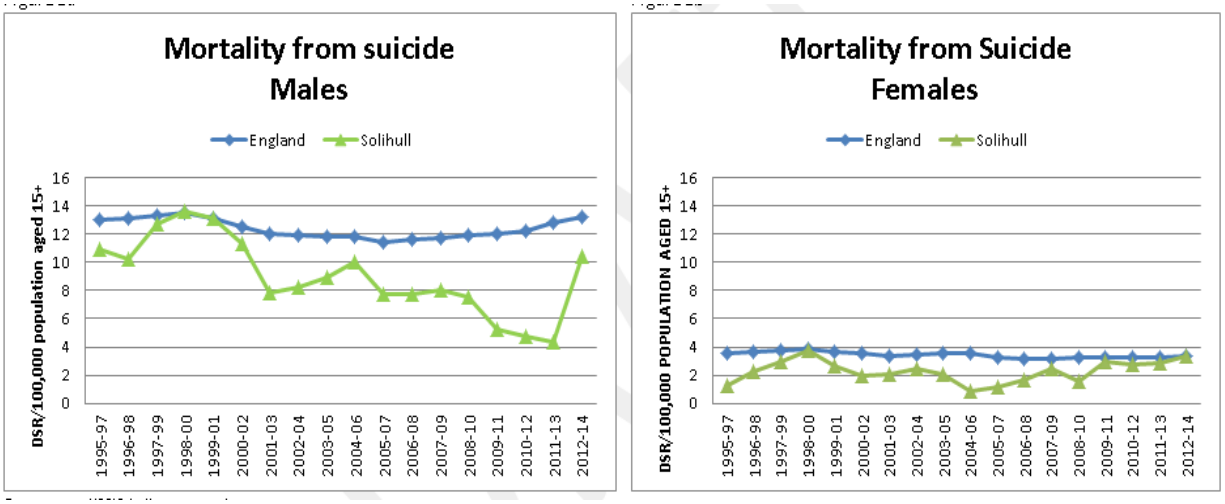
The national priorities for action were considered as part of the strategy development process and those of particular relevance to Solihull were selected as the Solihull priorities. The national priorities[3] are:

1. Reduce the risk of suicide in key high-risk groups (in particular: young and middle-aged men, people in the care of mental health services, including inpatients, people with a history of self-harm, people in contact with the criminal justice system, specific occupational groups such as doctors, nurses, veterinary workers, farmers and agricultural workers)
2. Tailor approaches to improve mental health in specific groups (e.g. community-based work, suicide prevention training, pregnant women and those who have given birth in the last year and children and young people)
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring.

SUICIDE IN SOLIHULL

Historically, the rate of suicide among Solihull residents is similar to that of its CIPFA4 'nearest neighbours'. The rate is, however, increasing, especially among females (Figure 1). An apparent increase in rates in 2014 is due to a backlog of coroner's cases where verdicts were delivered in this year which related to deaths in earlier years. As in the rest of the UK, men are over three times more likely than women to die by suicide. Hanging is the most common method for both genders but men are more likely to die by suicide in a public space or away from home. There are no specific 'hot spot' locations in Solihull.

Figure 1 Mortality from Suicide: Solihull Residents



[3] '*Preventing suicide in England: A cross-government outcomes strategy to save lives.'* HM Government, 2012
[4] The Chartered Institute of Public Finance and Accountancy

Suicide is a major cause of lost years of life. In Solihull, between 2012 and 2014, approximately 1000 years of life were lost due to suicide. In terms of high risk groups, Solihull has particularly high rates of:

- Looked After Children,
- people who are homeless,
- people who live alone,
- people who are in contact with mental health services and
- people whose day to day activities are limited by their health or disability.

Data on the number of suicides hide the immediate emotional heartache and the life-long impact on the families and loved ones of those who have taken their own life. Solihull has two local groups who work with these families, the Meriden Family Feedback and Survivors of Bereavement by Suicide (SOBS) which has a monthly meeting in Solihull.

The number of deaths classified as suicide does not give the full picture of those who take their own life. Many deaths recorded as 'open' or 'narrative' verdicts, and those due to alcohol and drugs, would be classified as suicide if a 'balance of probabilities' approach was used rather than the current "beyond reasonable doubt". Therefore, although 13 and 12 deaths of Solihull residents in 2014 and 2015 respectively were classified as due to suicide, it is likely that the actual number of people who died by suicide could be double this number. The economic impact of suicide is estimated as £1.67m for each person who dies by suicide[5].

PRIORITIES FOR ACTION

We have identified four priorities for action in Solihull. These are the areas which we think will have the greatest impact on reducing the number of suicides and improving the care of families of those who have taken their own life.

Four Priorities for Action:

1. **Safer Suicide Community**
2. **Better Support and Care for Those at the Highest Risk of Dying by Suicide**
3. **Working Together to Prevent Suicide**
4. **Learning from Those who have Died by Suicide**

These actions are additional to those already being taken by Birmingham and Solihull Mental Health NHS Foundation Trust as part of implementation of the Trust's Suicide Prevention Strategy[6]. This strategy identifies five 'primary drivers' to deliver improvements across the Trust:

1. **Leadership:** ensuring that suicide prevention is everyone's business
2. **Capability and capacity**: to deliver best practice consistently across the Trust
3. **Training:** ensuring that all clinical staff have received suicide prevention training and receive regular communication and updates on best practice
4. **Service user experience**: ensuring that the service user and carer experience is at the heart of all that we do in respect to suicide prevention and that we work to maximise opportunities for promoting self-help

[5] *'Local suicide prevention planning: A practice resource',* Public Health England, 2016
[6] https://www.google.co.uk/webhp?sourceid=chrome-instant&ion=1&espv=2&ie=UTF-8#q=Birmingham+and+Solihull+mental+health+nhs+foundation+trust+suicide+prevention+strategy

5. **Ensuring sensitivity in communications with respect to suicide prevention:** acting as a role model in our use of language and our attempts to communicate with service users, carers, colleagues and the wider community and ensuring that dialogue occurs as and where appropriate.

Actions being taken in the first year of implementation of the Birmingham and Solihull Mental Health NHS Foundation Trust strategy are:

- Implementation of a programme of training for clinical staff to improve competence and confidence around suicide risks and better understand suicide prevention strategies
- Examining the principles and merits of 'Safe from Suicide' teams and consider what a local model may look like in the context of wider evidence and the New Dawn service delivery model
- Changes to the Trust observation policy to reflect latest guidance
- A review of ways to improve the safety of the ward environment using new technologies
- Demonstrated improvements in the use of personalised safety plans
- A clear structure for working with other agencies to support this strategy and contribute to the wider local suicide prevention agenda across Birmingham and Solihull.

1. SAFER SUICIDE COMMUNITY

Becoming a 'Safer Suicide Community' will:

a. Empower everyone in Solihull to talk about suicide and to play their part in suicide prevention

b. Reduce the stigma associated with talking about someone who has died by suicide or who has attempted to do so

c. Raise awareness of the community support available and offer opportunities to become more involved by undertaking training or by volunteering

Why is this important?

The evidence submitted to the Strategy Development Panel indicated that many people are uncertain about talking about suicide. Evidence from other areas7 is that programmes of raising public awareness, reducing stigma and providing training for a wide range of groups and individuals are effective in reducing the number of people who die by suicide. The number of calls to Solihull Samaritans is increasing and their capacity needs to increase accordingly. Increasing the number of volunteers for this and other voluntary organisations will increase the community response to people who are considering taking their own life. The media can play an important role in suicide prevention, including publicising the help available locally. Good coverage can raise awareness and help people to 'talk about suicide'. Poor coverage, especially coverage of individual deaths which report on the method involved, can lead to 'copycat' deaths.8 We also need to respond to the opportunities and difficulties created by increased use of social media.

Objective 1a: "Let's Talk about Suicide" Design and implement a public awareness campaign "Let's talk about suicide" involving local schools, colleges, employers, community groups and media. This campaign will reduce the stigma associated with dying by suicide and will publicise the help and support available locally, recognising that men are at particularly high risk.	
Initial Actions:	
1.a.1	Identify good practice in suicide prevention public awareness campaigns
1.a.2	Identify local 'champions' to lead the campaign
1.a.3	Involve key local organisations in planning the campaign
1.a.4	Work with local media to: • Ensure national guidance on reporting people who died by suicide is understood and followed • Ensure support for public awareness campaign
1.a.5	Develop a costed proposal for a Solihull public awareness campaign
Objective 1b: Get involved: suicide prevention training Design and implement local suicide prevention training for a wide range of individuals and organisations.	
Initial Actions:	
1.b.1	Identify good practice in suicide prevention training
1.b.2	Involve key local organisations in planning the training
1.b.3	Develop a specification for local training
1.b.4	Develop a costed proposal for provision of local suicide prevention training

[7] For example, '*Aiming for 'zero suicides': An evaluation of a whole system approach to suicide prevention in the East of England*', Centre for Mental Health, 2015.
[8] '*Editors' Code of Practice*', Independent Press Standards Organisation: https://www.ipso.co.uk/editors-code-of-practice/

Objective 1c: Get involved: volunteering	
Initial Actions:	
1.c.1	As part of public awareness campaign (objective 1), publicise opportunities for volunteering, in particular: • Solihull Samaritans • Other local groups of relevance to suicide prevention

2. Better Support and Care for Those at the Highest Risk of Dying by Suicide

Providing better support and care for those at the highest risk of dying by suicide will:

a. Identify groups at particularly high risk of taking their own life

b. Map the existing service 'offer' for these groups and identify any gaps

c. Produce and communicate local 'here to help' summaries for each high risk group, identifying support and care available for them, including in a crisis, and how to access this help

d. Ensure that, wherever possible, those at high risk of dying by suicide have a risk assessment, care plan and crisis plan

Why is this important?

A common theme through the evidence submitted to the Strategy Development Panel was that organisations concerned about an individual did not have a good understanding of the service 'offer' and support and care available locally. The criteria for accessing services were sometimes such that a high risk individual was not eligible and available alternatives were not well understood. Accessing appropriate support and care was particularly difficult for those aged 16 to 18 and for those with multiple problems, for example, mental health and alcohol-related problems. Primary care services were therefore often left 'holding' a significant element of risk.

It was generally agreed that the services available were appropriate and that significant work had taken place to ensure a good mental health service 'offer' for children and young people and for adults. Birmingham and Solihull Mental Health NHS Foundation Trust was the main provider of mental health services for both young people (SOLAR) and adults, which helped coordination between services. Integrated drug and alcohol services were also available (SIAS) and aimed to ensure clients did not 'fall between' substance misuse and mental health services.

The support available to families of those who have died by suicide, who are also a high risk group, was not well understood and it is likely that some families are not made aware of the support that is available, for example through the Meriden family programme or SOBS.

Objective 2a: Identify groups at particularly high risk of taking their own life	
Initial Actions:	
2.a.1	Review available data on suicide and self-harm to identify groups at particularly high risk in Solihull, including but not limited to: • Young females engaged in self-harming behaviour • Looked After Children, young people on the edge of care and those who have recently left care • Older men, especially following loss of family or employment • Those involved with, or leaving, the criminal justice system (most of whom are men) • Those with alcohol and drug-related problems (most of whom are men) • Families of those who have died by suicide • High risk occupational groups • People who are homeless • People with multiple risk factors

2.a.2	Agree groups at highest risk of dying by suicide and 'here to help' summaries to be developed
Objective 2b: Map existing service 'offer' for highest risk groups	
Initial Actions:	
2.b.1	Identify current service 'offer' and care available for highest risk groups
2.b.2	Compare current services and care available with evidence-based best practice
2.b.3	Identify problems with current services and care available for these groups
2.b.4	Identify any 'gaps' in the services or care commissioned
2.b.5	Produce commissioning proposals for addressing any 'gaps' identified
Objective 2c: Produce and communicate 'here to help' summaries for each high risk group	
Initial Actions:	
2.c.1	Produce simple, easily understandable summaries of local support and care available for each high risk group, including in a crisis, how to access this help and guidance on when concerns should be escalated. Further consideration will be given to whether summaries are produced for those at risk and for professionals, or whether these could be combined.
2.c.2	Ensure 'here to help' summaries are implemented and easily available in all relevant local organisations including schools, colleges, GPs, pharmacies, Emergency Departments, Coroner's Office, Samaritans and other relevant local voluntary organisations, libraries, mental health services, other acute hospital services
2.c.3	Implement mechanisms for regularly updating and re-issuing 'here to help' summaries
Objective 2d: Care planning for high risk groups	
Initial Actions:	
2.d.1	Ensure that all providers of 'here to help' services for people at high risk of dying by suicide have: • An organisational suicide prevention plan • Quality assured mechanisms to ensure all clients have a risk assessment, care plan and crisis plan

3. WORKING TOGETHER TO PREVENT SUICIDE: "ERR ON THE SIDE OF LIFE"

Working together to prevent suicide will:

a. Ensure all education, criminal justice, health and social care professionals understand national guidance on sharing information about people who are thinking of taking their own life

b. Ensure a more timely service response when people are thinking of taking their own life

c. Ensure professionals are supported by their organisations when they share information about people at high risk of taking their own life

Why is this important?

Preserving confidentiality of information and respecting the wishes of individuals and families about whether information should be shared is of great importance to education, criminal justice, health and social care professionals. The Strategy Development Panel heard several examples, however, of situations where support and care could be improved if information had been shared. For example, schools are not routinely informed by health services when a young person has tried to take their own life. A young person can therefore return to school without any additional support being made available and with school staff unsure of whom they should contact if

they have concerns. National guidance is available[9] but did not appear to be well understood. As a result, service responses are delayed or uncoordinated.

Objective 3b: Ensure implementation of local 'information sharing and suicide prevention' summary

Objective 3a: Produce summary of 'Information sharing and suicide prevention'	
Initial Actions:	
1	Produce a short, easily understandable summary of 'Information sharing and suicide prevention: Consensus statement'
2	Obtain endorsement for summary from local education, criminal justice, housing, health and social care and relevant voluntary organisations
Objective 3b: Ensure implementation of local 'information sharing and suicide prevention' summary	
Initial Actions:	
1	Distribute 'information sharing and suicide prevention' summary throughout relevant local organisations (including education, criminal justice, housing, health and social care and relevant voluntary organisations)
2	Ensure information sharing is: • Included in all suicide prevention training (objective 1) • Reviewed as part of all learning exercises (objective 4)

4. LEARNING FROM THOSE WHO HAVE DIED BY SUICIDE

Learning from those who have died by suicide will:

a. Give a better understanding of the characteristics of Solihull people who die by suicide and baseline data against which progress can be assessed

b. Implement a 'real time' surveillance system

c. Implement better system-wide arrangements for learning lessons when someone dies by suicide

Why is this important?

Good data on suicide are available (see above) but there are still some gaps. For example, data from Emergency Departments are not yet routinely used as part of suicide prevention surveillance. Available information is not always shared so that all relevant organisations are aware of trends and patterns.

The Coroner classifies deaths as suicide only when it is shown, beyond reasonable doubt that the individual intended to take their own life, that this was deliberate, that the act undertaken led to their death and that other factors were not involved. As a result, many deaths which, on the balance of probabilities, were due to someone taking their own life are recorded as 'open', 'narrative' or deaths due to 'alcohol and drugs'. The number of suicides would approximately double if the 'balance of probabilities' classification was used.

The Strategy Development Panel also heard about a range of investigations which take place when someone takes their own life. If the individual was involved with a health or social care service, this organisation undertakes a Serious Incident investigation process, including a Root Cause Analysis. Solihull CCG has also implemented a DES scheme for GP notification followed by a meeting of GP and mental health services to review the case and identify lessons which can be learnt and shared. NHS England requires reports on all Serious Incidents, including deaths of people in contact with mental health services, but the reporting framework assumes that incidents involve a single

[9] 'Information sharing and suicide prevention: Consensus statement', Department of Health, 2014.

provider organisation. The Coroner also investigates deaths where the cause of death is unknown, the cause of death is unnatural, or the deceased was in detention, for example police custody, at the time of their death.

When appropriate, Coroners issue 'Reports to Prevent Future Deaths' to which organisations have to respond within 56 days. These reports are easily available on the Chief Coroner's Office website but the learning does not appear to be brought together or reviewed locally to ensure lessons are learnt and action taken.

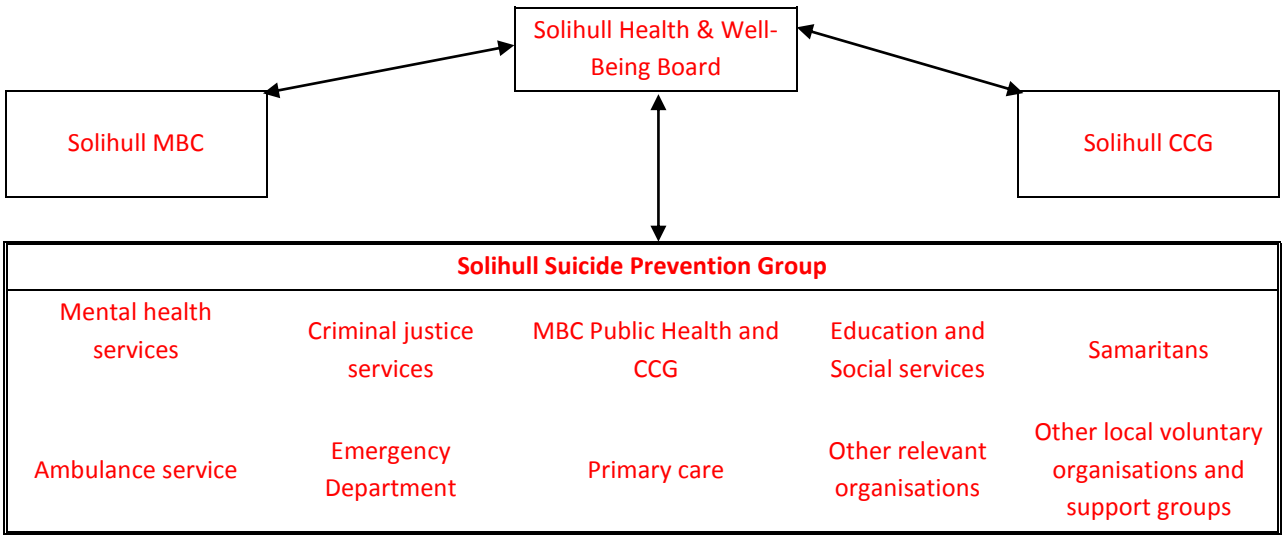
Network Rail will work with areas where three or more suicidal incidents (suicides or injurious attempts) have occurred at any local station within 12 months. Network Rail will provide access to a Learning Tool which contains discussions about suicidal incidents and events on the railway. The Learning Tool has been designed so that everyone can play their part in the industry's suicide prevention programme. The tool is accessible through video content that can form part of a briefing, training or personal awareness package.

Objective 4a: Data Analysis and 'Real Time' Surveillance System	
Initial Actions:	
4.a.1	Produce a suicide 'baseline data' report, identifying any gaps in the information available.
4.a.2	Obtain data to complete 'baseline' picture of suicides in Solihull
4.a.3	Establish a 'real time' surveillance system, including sharing of information with all relevant local organisations
Objective 4b: Design and implement arrangements for shared learning when someone dies by suicide	
Initial Actions:	
4.b.1	Identify statutorily required investigation processes
4.b.2	Design and implement arrangements for system-wide investigation and learning when someone dies by suicide
4.b.3	Improve support for families going through the investigation process[10].
4.b.4	Ensure Coroners' investigation reports of relevance to suicide are analysed and learning is brought to Solihull-based organisations
4.b.5	Discuss with NHS England whether Serious Incident reporting systems could be adapted to encourage system-wide investigation and learning

[10] Suggestions are given in the Meriden Family Programme submission to the Strategy Development Panel.

IMPLEMENTATION

This strategy requires action from a wide range of organisations, working in collaboration. Robust governance of the implementation process is essential if momentum is to be maintained which will be achieved through a Solihull Suicide Prevention Group, accountable to the Solihull Health and Well-Being Board. Dedicated time to support and drive implementation will also be required.



Objective 5: Implementation

Initial Actions:	
5.1	Identify Senior Responsible Officer for strategy implementation. This is the first action and should take place as soon as possible (ideally by the end of January 2017). This will require agreement between Solihull MBC Public Health Department and Solihull CCG.
5.2	Identify resources to support and drive implementation of the strategy
5.3	Establish a multi-agency Solihull Suicide Prevention Group, accountable to the Solihull Health and Well-Being Board with terms of reference to ensure implementation of the Solihull Suicide Prevention Strategy. As a minimum the group should include Solihull MBC Public Health Department, Solihull CCG, mental health services, criminal justice services, Samaritans, Emergency Department, ambulance, education and social service representatives.
5.4	Develop an action plan for implementation of the Strategy with identified lead responsibilities, timescales, measurable outcomes and expected progress in reducing suicides in Solihull
5.5	Establish arrangements for reporting progress on implementation of the Solihull Suicide Prevention Strategy to key stakeholder organisations and to the Solihull Health and Well-Being Board
5.6	Establish links with Birmingham, Warwickshire and West Midlands suicide prevention work to ensure shared learning and to avoid duplication of effort
5.7	Ensure the Solihull suicide prevention strategy is kept under review and responds to changes in trends and risk factors

APPENDIX 1 STRATEGY DEVELOPMENT PANEL

Name	Title	Organisation
Christine Badger	Quality Support Officer	NHS Solihull Clinical Commissioning Group
Dr Angela Brady	Clinical Lead, Mental Health POD	NHS Solihull Clinical Commissioning Group
Greg Burgess	Deputy Chief Executive Officer	Papyrus
Karen Fellows on behalf of: Paul Sanderson	Public Health Officer Health and Well-Being Programme Lead	Public Health England West Midlands Public Health England West Midlands
Julie Hackett	Commissioning Manager	Solihull Metropolitan Borough Council
Hilary Harrison	Director	Solihull Samaritans
Debbie King	Associate Chief Nurse	NHS Solihull Clinical Commissioning Group
Julia Phillips	Joint Strategic Commissioner – Mental Health	Public Health and Commissioning, Solihull Metropolitan Borough Council
Allan Reid	Specialty Registrar	Public Health, Solihull Metropolitan Borough Council
Sara Rooney	Senior Public Health Specialist	Public Health, Solihull Metropolitan Borough Council
Elaine Thompson	Associate Chief Nurse	NHS Birmingham CrossCity Clinical Commissioning Group
Kerry Webb	Nurse Consultant and Suicide Prevention Lead	Birmingham and Solihull Mental Health NHS Foundation Trust
Salena Williams	Senior Nurse, Liaison Psychiatry	Bristol Royal Infirmary (representing South West Zero Suicide Collaborative)
Unable to attend Strategy Development Day but participant in all other parts of the Panel's work:		
Natalie Willetts	Clinical Services Manager	Birmingham and Solihull Mental Health NHS Foundation Trust
Facilitator:		
Jane Eminson	Director	West Midlands Quality Review Service

APPENDIX 2 EVIDENCE CONSIDERED

PEOPLE WHO GAVE VERBAL EVIDENCE TO THE STRATEGY DEVELOPMENT PANEL

In addition to the members of the Strategy Development Panel, the following people gave verbal evidence to the Panel:

Name	Title	Organisation
Louise Hunt	Senior Coroner	Birmingham and Solihull Coroner Service
Tracy Organ	Lead Investigator	Birmingham and Solihull Coroner Service
Dr Anand Chitnis	GP and Chair	NHS Solihull Clinical Commissioning Group
Jenny McGuirk	Principal	John Henry Newman College, Chelmsley Wood
Dr Sanjay Mistry	Consultant in Emergency Medicine	Heart of England NHS Foundation Trust
Richard Godwin	Route Crime Manager LNW Route	Network Rail
Julie Booth	Associate Head Nurse for Integrated Quality	NHS Solihull Clinical Commissioning Group
Jenny Mathews		Survivors Of Bereavement by Suicide

WRITTEN SUBMISSIONS TO THE STRATEGY DEVELOPMENT PANEL

Written submissions received from:	Title of submission
Meriden Family Programme	Feedback from the Meriden Family Programme re: Contact with Families Following Suicide / Homicide
Solihull Public Health Department	Preventing Suicide in Solihull: Analysis of Public Health England suicide prevention profiling tool.
Solihull Public Health Department	Suicide and Suicide and undermined injury: Analysis of NHS Digital and Primary Care Mortality Database
Dr Faraz Mughal, GP, Solihull	-
Superintendent Sean Russell , West Midlands Police Mental Health Lead and Director of Implementation for West Midlands Mental Health Commission	-
Richard Godwin, Route Crime Manager LNW Route, Network Rail	Summary of Suicide Prevention
Paul Foster, West Midlands Police	West Midlands Police Crisis and Hostage Negotiators
Salena Williams, South West Zero Suicide Collaborative	South West Zero Suicide Collaborative Presentation to Solihull

The following organisations were contacted as part of the strategy development process but were not able to be involved at that time. It will be important that these organisations are involved in taking forward the development and implementation of this strategy:

- HM Prison, Hewell
- Coventry and Solihull Community Rehabilitation Company
- West Midlands Ambulance Service
- Solihull Mind
- Solihull Youth Offending Team

PUBLICATIONS

Date	Title	Publisher / Source
2016	Suicide prevention: interim report	House of Commons Health Committee
2016	Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England	Care Quality Commission
2016	Suicides in the UK: 2015 registrations	Office for National Statistics
2016	Guidance for creating a Suicide Prevention Plan: A collaborative approach to managing suicide risk on the railway	Rail Industry Suicide Stakeholder Group
2016	West Midlands Route Analysis	Network Rail
2016	Written evidence to Health Select Committee's Suicide Prevention Inquiry: Submission from Samaritans (SPR0072)	Samaritans
2016	Suicide….. Aspiring to Zero in the West Midlands	Presentation by Paul Sanderson, Public Health England
2016	Local suicide prevention planning: A practice resource	Public Health England
2015	Preventing suicide in England: Two years on. Second annual report on the cross-government outcomes strategy to save lives	HM Government
2015	Aiming for 'zero suicides': An evaluation of a whole system approach to suicide prevention in the East of England	Centre for Mental Health
2015	Help is at Hand: Support after someone may have died from suicide	Public Health England
2015	Suicide Prevention Strategy	Birmingham and Solihull Mental Health NHS Foundation Trust
2014	Information sharing and suicide prevention: Consensus statement	Department of Health
2012	Preventing suicide in England: A cross-government outcomes strategy to save lives	HM Government
Undated	Have you lost someone close to you to suicide?	Advice leaflet produced by Facing the Future, Samaritans and Cruse Bereavement Care
Undated	Gloucestershire Suicide Prevention Strategy: July 2015 – June 2020	