Journal of Psychiatry
ISSN: 2378-5756

Balogun, J Psychiatry 2018, 21:2
DOI: 10.4172/2378-5756.1000441

Review Article Open Access

Suicide Prevention in England: An Evaluation of Fifteen Years of Action

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Abstract

In his book 'History of Suicide: Voluntary death in Western culture', George Minois examines how a culture's attitudes about suicide reflect wider beliefs and values. Similarly, we too must examine our attitudes to suicide today in light of its prevalence and public health importance in contemporary Britain. Suicide is a major public health issue included as a public health indicator within England's Public Health Outcomes Framework to 'reflect the importance of sustained efforts to keep the suicide rate at or below current levels'.

The first government policy paper on suicide prevention in England titled 'National Suicide prevention Strategy for England' appeared in 2002. This landmark policy was presented by the then Labour government as an on-going, coordinated set of activities which would evolve over several years and would support the target set out in 'Saving Lives: Our healthier Nation' to reduce suicide by at least 20% by 2010. The government described the strategy as comprehensive and evidence based and planned to deliver it as a core program of the National Institute for Mental health in England. Ten years later, the strategy was re-launched by the coalition government and branded 'Preventing Suicide in England: A cross-government outcome strategy to save lives'. Billed as a new strategy it focused on reducing suicide rates and supporting bereaved families. It identified six key areas for action including new suicide prevention research funding; measures to restrict access to harmful suicide promoting media outlets by young people; reducing opportunities for suicide (making prisons and mental health settings safer); better support for high risk groups; improving existing services for children and young people and providing better information and support to bereaved families. That policy is the focus of this paper.

Keywords: Suicide; Prevention; Strategy; Government policy; Social determinants

Introduction

In his book 'History of Suicide: Voluntary death in Western culture', George Minois examines how a culture's attitudes about suicide reflect wider beliefs and values. He explains how Hamlet's famous question 'to be or not to be?' has shaped our changing attitudes to suicide [1-3]. Similarly, we too must examine our attitudes to suicide today in light of its prevalence and public health importance in contemporary Britain. In essence, what we do about suicide reflects on who we are as a society. Suicide is a major public health issue included as a public health indicator within England's Public Health Outcomes Framework to 'reflect the importance of sustained efforts to keep the suicide rate at or below current levels' [2]. Media coverage of suicide events has moulded our understanding of the subject and periodically invaded public consciousness but not always in helpful or meaningful ways.

The first government policy paper on suicide prevention in England titled 'National Suicide prevention Strategy for England' appeared in 2002. This landmark policy was presented by the then Labour government as an on-going, coordinated set of activities which would evolve over several years and would support the target set out in 'Saving Lives: Our healthier Nation' to reduce suicide by at least 20% by 2010. The government described the strategy as comprehensive and evidence based and planned to deliver it as a core program of the National Institute for Mental health in England. Ten years later, the strategy was re-launched by the coalition government and branded 'Preventing Suicide in England: A cross-government outcome strategy to save lives'. Billed as a new strategy it focused on reducing suicide rates and supporting bereaved families. It identified six key areas for action including new suicide prevention research funding; measures to restrict access to harmful suicide promoting media outlets by young people; reducing opportunities for suicide (making prisons and mental health settings safer); better support for high risk groups; improving existing services for children and young people and providing better information and support to bereaved families [1]. That policy is the focus of this paper.

Epidemiology

'Someone takes their own life every two hours in England' quoted Norman Lamb, the government's care services minister at the launch of the strategy on World Suicide Prevention Day 2012. Worldwide, the WHO estimates that over 800,000 people die by suicide annually with the highest national rate in the small South American state of Guyana (44.2 per 100,000 or 342 suicides in 2012) [4]. Our most recent age-standardized data (2015) puts the prevalence of suicide in the UK at 10.9 per 100,000 [5]. This corresponds to 6,188 suicides in 2015. The rate in England was 10.1 per 100,000 population and was the lowest of the constituent countries of the UK; the highest being in Northern Ireland at 19.3 per 100,000 population. In England the highest rates (11.9 per 100,000) were recorded in Yorkshire and the Humber with the lowest rates (9.3 per 100,000) in the East of England.

The 2015 rates in England represent a reduction from 10.3 per 100,000 in the preceding year. Suicide rates had been falling steadily in England since 2002 until 2012 when rates rose for two consecutive years [6].

Of the total number of suicides registered in the UK in 2015, 75% were male. The male suicide rate decreased from 16.8 per 100,000 in 2014 to 16.6 per 100,000 in 2015 [6]. However, the female rate increased

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Received: December 21, 2017; **Accepted:** January 24, 2018; **Published:** February 04, 2018

Citation: Balogun F (2018) Suicide Prevention in England: An Evaluation of Fifteen Years of Action. J Psychiatry 21: 441. doi:10.4172/2378-5756.1000441

from 5.2 to 5.4 per 100,000; the highest it has been in ten years. Across all age groups the rate for males was around 3 times higher than females [5].

Among women, the highest rates were seen in the 45-59 broad age bands and although the rate in the 10-29 age bands remained the lowest, it increased in 2015 to 1981 levels [6]. Among men, the rate was also highest in the 45-49 age bands however, the rate in men under 30 has been steadily increasing over recent years; and suicide remains the leading cause of death in young people in the UK aged 20-34 years [6]. It is also the second leading cause of death among males aged 5-19 years [6]. In 2014, there were 1556 young suicides (under the age of 35) and 99 children aged between 10 and 14 had taken their own lives since 2004. Between January 2014 and April 2015, there were 145 suicides and probable suicides by children and young people in England. The gender pattern reflects the adult data with 70% of male deaths [6].

The most common suicide method among males and females was hanging (58% and 43% respectively) [6]. This was followed by poisoning (with a higher percentage of females (35%) choosing this method compared to males (18%) [6]. Suicide is the fatal outcome of a complex interaction of the effects of various psychosocial and psychiatric risk factors.

28% of youth suicides (under age of 20) in England between 2014-2015 had themselves been bereaved; 36% had a physical condition (the most common being acne and asthma) and 29% of those in education were facing exams or exam results at the time of their death [7]. Bullying, social isolation and the use of suicide-related internet sites were antecedents in a quarter of deaths respectively. In the majority of cases (58%) there was a history of previous self-harm and sadly over 4 in 10 were not known to any service or agency [7]. Mental illness, substance misuse and familial domestic violence were also common themes in this age group [7]. Other suicide correlates include deprivation and related social factors; loss events (including material, person, and health) made worse during times of recession and economic uncertainty; and the weakening impact austere periods have on the effectiveness of mental health and other services to support those at higher risk of suicide [7]. This double negative economic effect is of particular relevance in England since the financial crisis of the last decade.

Depression is a known risk factor for suicide (which rarely occurs in the absence of depression) [8]. The economic impact of suicide on the British economy is huge with an estimated £1.67 million per suicide death; and an annual figure approximating £10.3 billion. Furthermore, there are projections that by 2020 suicide will account for 2.4% of the global burden of disease up from 1.8% in 1998 [9].

Overview

This policy initiative was always going to be a heavy lift given the sheer size of stakeholder organizations and individuals required to work in concert to realize its goals. As the adage goes, 'too many cooks spoil the broth'. How was this strategy going to address this most obvious of challenges? How would it deal with blurred lines of responsibility, overlapping areas and collective ownership with the associated risk of no effective leadership? How would the various state departments prioritize these goals?

In mentioning 'some' of the key players cooperating to realize the strategy's main aim of reducing England's suicide rate by a fifth, the government names over 20 groups, organizations or agencies. Many of these 'operatives' are charged with leadership roles at either central or local level and as mentioned above, there is bound to be considerable overlap of reach. The government admits that the success of this strategy depends on how well its related policy 'No health without Mental Health' is implemented. It argues that the outcomes of that policy have a direct impact on reducing suicide rates, and relies on the role of Public Health England and the 'Ministerial working group on preventing and tackling homelessness' to deliver improved outcomes for public health and wellbeing.

Other active bodies with suggested suicide reduction activities include local authorities (central to the local approach taken by this strategy); the NHS; GPs and health visitors; Health and Well-being boards (comprised of local councillors, Clinical Commissioning Groups (CCG), Local Safeguarding Children's Boards (LSCB), the Police, and directors of public health); Regional and sub-regional multi-agency suicide prevention groups; NHS Commissioning.

Board (NHS CB); the National Offender Management Service (NOMS); the Youth Justice Board (YJB); Coroners and NICE. Central leadership and support rests with the Cabinet sub-committee on Public health which has oversight for the implementation of 'No health without Mental health'; the Cabinet Committee on Social Justice (which works across government departments to ensure effective action on the social aspects and impact of mental health problems); and the longest acronym of them all, the National Suicide Prevention Strategy Advisory Group (NSPSAG) a large conglomerate of academics, voluntary agencies, professionals and those directly affected by suicide.

The strategy (which is essentially a synthesis, streamlining and re-focusing of multiple activities already in play) has two overall aims with action points organized under half a dozen objectives (essentially unchanged from the 2002 policy it supersedes). These action points address a range of target groups and risk factors associated with suicidal behaviour in England. The overall aims of Government as stated in this policy are to reduce the suicide rate in England and to provide robust support to families affected by suicide. The plan is to achieve this by reducing the risk of suicide in key high risk groups (such as those under 35, particularly men); promoting mental well-being in the wider population; reducing the availability and lethality of suicide methods; improving the reporting of suicidal behaviour by the media; promoting research on suicide and suicide prevention and improving monitoring of progress made towards the target of reducing suicides set out in 'Saving Lives: Our Healthier Nation'.

Evaluation

The 2012 strategy placed huge responsibility to translate plan to outcome on local authorities and local health services. The policy would work or warp based largely on local activities. However, three years post launch, a third of local authorities in England had no active suicide prevention strategy. In London, the figure was just under two-thirds [10]. Good intentions are not enough and this strategy failed in the translation of intent to actual improvements. Four years on and though more local authorities now have plans in place, there is no effective mechanism to enforce and monitor the quality of these plans [11]. There was no clear leadership written into the policy document and no provision for inspecting the progress made through the many activities and action areas outlined in the strategy. An independent agency with statutory powers akin to the CQC for health and social services or Ofsted for education and child care services should have been created with the sole purpose of policing the strategy. Leadership and scrutiny of the policy was always going to be key to the delivery of successful outcomes given the vastness of its reach; so the omission of a powerful regulator was a serious omission indeed.

Public Health England which was charged with the responsibility of supporting local authorities by providing high quality guidance had taken four years to publish any guidelines on suicide prevention [12,13].

In 2016, a scathing criticism of the strategy was delivered by the Chair of the Matthew Elvidge Trust and the Support after Suicide Partnership-' To me, it is extraordinary and very distressing that four years after the strategy was published we do not know how many local authorities have implemented anything we cannot allow more lives to be lost because we do not have effective governance and implementation. It is such a waste of time and a waste of money'. In its 2016 report, the Commons Health Select Committee judged that the strategy was besought with inadequate leadership, poor accountability and insufficient action. Calls were also made to make Local Authority suicide prevention plans mandatory which in the policy document had been left voluntary or at best ambiguous. For Ruth Sutherland (National Suicide Prevention Alliance co-chair and Samaritans CEO), the strategy needs to prioritize suicide prevention across sectors and to guarantee proper funding for the same. Young Minds (the leading voluntary sector organization for young people's mental health) argue that financial cuts to both public and voluntary sector services have limited the effective implementation of mental health strategy which was central to suicide prevention.

In addition, they make the important point that poor attitudes to mental health problems remain among health care workers as evidenced by the reported poor treatment received by adolescents seeking help for self-harm [14]. This problem is however not limited only to adolescents [15]. This is an important barrier to help seeking because the suicide risk in those who self -harm is increased by between 50-100 folds above the general population [16,17].

Other implementation failures were highlighted in the area of GP training to improve detection of depression in primary care. The policy suggested that GPs failed to recognize depression in patients presenting with non-mental health problems; some of which did go on to commit suicide in the succeeding weeks [18]. However, proposed additional training to improve GP skills in this area didn't materialize in any significant sense [19]. In changing professional practice as is required here, the government made a good point with another key professional group (journalists) with the suggestion that the training of journalists should be consistent with the aims of this policy. To achieve this, responsible reporting of suicide behaviour and related events would need to be included in the curriculum of professional trainees. It is surprising that this approach was not suggested for trainee GPs in addition to regular mandatory CPD training for already qualified ones. Embedded training arrangements such as described above are already in play in the complex multi-system of safeguarding children in the UK for multidisciplinary professionals, and it seemingly works quite well. Of course, in the latter, robust oversight and monitoring of procedures, arrangements and professional competences is well established; and any effort to introduce this into GP training and practice must be accompanied by similar strength of accountability and leadership; backed up wherever possible by statute. In principle, the case for further GP training is welcomed by the RCGP which has asked for funding to increase GP training from three to four years to enable more trainee experience in mental ill health [20].

Other professional training needs identified include improving communication with and involvement of carers and relatives in suicide risk management and recovery plans of patients. Sharing of suicide risk with families by doctors can often conflict with the clinician's duty of confidentiality thereby posing difficult ethical dilemmas. Clear guidelines are required to help clinicians effectively navigate these issues and to disclose suicide related information in a bid to save lives. The consensus statement issued by the Royal Medical Colleges sets out this principle quite clearly but not much has changed on the front-line of patient care [19].

Other undeveloped plans in health sector action areas are evident in post-discharge care, the practice of crisis teams and anti-depressant prescribing. In his testimony to the Commons Health Select Committee Professor Appleby explained that the current practice of reviewing patients within 7 days of discharge from in-patient mental health care wasn't snuggly consistent with recent evidence. He pointed out that the risk of suicide post discharge was highest in the first 72 hours of leaving hospital and advocated for a change in follow-up practice from 'within 7 days (current 7 day follow-up)' to 'within 3 days'. This has huge capacity implications for crises teams, a service with variable nationwide provision and where they do exist; they are already overstretched and under resourced. The government should standardize this service nationally according to local need and increase funding to meet this new demand. Furthermore, little or no actions have been taken to make crisis teams real effective alternatives to inpatient admission. In formulating the suicide prevention strategy, the government recognized the importance of psychiatry liaison teams; but four years one and there has been no traction on ensuring that all hospitals have liaison psychiatry departments.

Reducing access to lethal suicide methods is also highlighted in the policy. However, the vast majority of people who kill themselves in England do so by hanging and there isn't much government can do to restrict access to ligatures, which are essentially ubiquitous. Furthermore, the idea that unscrupulous or irresponsible prescribing of antidepressants is a significant contributor to suicide in the England is at odds with the evidence [21].

There are already public health measures in place limiting how much analgesics can be sold to the public in a single transaction. It is not fool proof and determined individuals would simple shop around to stockpile tablets.

Nonetheless, it is effective in buying time for the so called impulsive individual. The evidence associated with antidepressant prescribing is more convincing. Rather than over prescribing being associated with increased suicide rates as the government argues; it is under-prescribing that is associated with increased rates. Historically, appropriate widespread uptake of anti-depressants has been shown to correlate with a reduction in population suicide rates [21,22]. The clear message is that untreated depression is a significant risk factor for suicide, not the overprescribing of prozac.

At the core of 'localism' are Health and Well Being Boards with their responsibility of forging partnerships with local organizations in determining local health needs and setting priorities. As a principle, localism is opposed to making suicide prevention plans mandatory arguing that significant traction has been made in this area operating on a voluntary basis in spite of severe financial cuts. Making local suicide plans mandatory will restrict the very principle of localism, i.e., the ability to set local agendas without statutory compulsion [23]. It is common knowledge that budgets are being severely cut across all public sector areas and indeed local government authorities are struggling to do their best with little money. Nonetheless, scrutiny and regulation of the quality of local plans must occur if adherence to a minimum quality standard is to be achieved nationally. The cultural fault lines

between local and central government must be repaired in this area in order to deliver an effective national strategy. We have no way of knowing what each local plan includes or indeed how effective they are without regulation. For instance how many of the 150 plans include an effective suicide bereavement service? And for those that do, is the service proactive and adequately responsive?

Not everyone bereaved by suicide in England is offered support (in stark contrast to victims of crime) [24]. In many local areas, the bereaved have to seek out help and support whereas bringing support to them should be the standard [24]. The recommendation is for a joined up service with the police in a package that includes information about coroner issues, the investigation process of a serious untoward incident (SUI) and counselling within 24 hours of bereavement if possible and no later than a week. The impact of suicide on bereaved families is immense and thought to last for generations. There is a 65% increase in the risk of suicide among those bereaved by suicide [25] and it is advocated that these grieving relatives should be classified as a population at risk in their own right. Good practice in bereavement support is cited in the work of 'Help at Hand', 'Support after Suicide Partnership' and the 'National Suicide Prevention Alliance'; however, these efforts don't stretch nearly as far enough to be nationally effective. More certainly needs to be done by government in funding research into the impact of suicide on bereaved families including the prevalence of suicide among those bereaved.

As mentioned above, bereaved families have long campaigned for health professionals (particularly doctors) to share suicide risk information with their patient's families as part of suicide risk management and support. Their strong argument is that this is a barrier to suicide prevention [25]. This of course implies a breach of confidentiality which doctors take seriously indeed and which also have serious legal implications. In spite of a consensus statement from the academy of Royal Medical Colleges, bereaved families point out those three years on, medical practice has changed little in line with the statement. The fear of litigation has been put forward as a possible stumbling block in the way of corresponding practice change and because doctors are likely to seek advice on these mattes from the legal departments of their employing trust or their defence union, involving these bodies in the conversation may now become necessary [25].

Public health depends on accurate data and it is widely held that suicide rates are under reported in England. ONS and PHE provide accurate timely public health data which inform national health policy. However, the unique problems around the ambiguity of the current 'narrative verdict' and the 'beyond reasonable doubt threshold' required by Coroners to conclude death by suicide; suggest that more people die from suicide each year than the official figures show. Stakeholders (except the government) unanimously agree that the law should be changed to allow for a verdict threshold based on the 'balance of probabilities'. They argue that this would bring official suicide prevalence rates closer to real life burden figures and identify possible clusters, in order to prevent further suicides.

Furthermore, they point out that by using the current 'beyond reasonable doubt' threshold at inquest, Coroners are applying criminal standards of proof when determining a suicide conclusion thereby further perpetuating stigma for an already highly stigmatized event. The government however, has not signalled any intention to change current coroner practice in this regard and has rejected this recommendation. The Chief Coroner believes this is a matter ultimately for parliament [26].

It seems reasonable that reducing stigma around mental illness and suicide would be an important facet of the suicide prevention policy framework and the government points out its commitment to strengthen existing anti-stigma campaigns to improve health seeking behaviour in mental health. Mention is made of the 'Time to Change' campaign as a means of improving mental health literacy but the Samaritans which reports 5.4 million annual contacts to its service, argues that 'Time to Change' doesn't seem to have been successful at mobilizing the public to support vulnerable and at risk individuals. They advocate for a more robust approach to releasing the capacity of the general public to support suicide prevention efforts the same way the 'Dementia Care', 'anti-obesity' and 'stop smoking' campaigns did [5]. In the same vein but focused on building resilience in children, the government is urged to consider long term policy changes in education that embed mental health literacy and stigma reduction as mandatory elements of the national curriculum. Young men are classified in this strategy as a hard-to-reach population. However, the government should be reminded that this same group was also the target of a successful testicular cancer campaign which raised awareness, screening, self-examination and increased health seeking behaviour. Lessons can be learned from this campaign and applied to improving the effectiveness of mental ill-health anti-stigma campaigns focused on young men [27].

Reporting of suicide and mental health issues by the media is recognized by government as an action area in the prevention strategy. The required change is one of responsible reporting of suicides in ways that do not increase the risk of the same to the public more so within the on-line space which is particularly difficult to monitor and for which no enforceable practice codes apply. Taking an impressive lead in this area, the Samaritans monitor around 6,000 newspaper articles to identify poor practice and it advocates a naming and shaming approach to help strengthen regulation and pushes for further training of journalists [28]. The language used in media reporting, detail of method used, coverage of celebrity and opinion leaders and new and emerging suicide methods are deemed to be the risky aspects of irresponsible media reporting which require stricter practice codes and monitoring. The task is obviously an enormous one and internet based material which at times includes live streaming of suicides in process may be difficult to regulate if the source is outside the UK. The government draws attention to legislation in place that prevents inciting suicide on the internet but critics point out that the legislation has never been used; made ineffective by the heavy burden of proof required to obtain a conviction.

Conclusion

Suicide is an example of a rare event with enormous and complex psychosocial and financial implications.

Preventing it is everyone's business as suicide risk factors lie within the remit of several sectors and government departments. The government has inched towards providing an effective prevention strategy aimed at reducing the suicide rate in England. Intentions and aspirations set out in two policy documents separated by ten years have been largely welcomed by stakeholders but the general consensus is that the policy is 'light on the how' and requires leadership, clear accountability lines and a detailed implementation plan. These are its very weak points. The third sector has suggested the appointment of a National Implementation Board with strong project management capacity that cuts across government departments to ensure that local plans are fit for purpose. However, this is rejected by stakeholders with a strong belief in localism who see a top down approach as ineffective. Local suicide plans are at the centre of the prevention plan and ways

of monitoring the existence and quality of these plans must be found if the strategy is to be effective. Finally, mental ill health and suicide are associated with socio-economic status and economic downturns [29,30]. Compounding austerity policies of the present government are set to undermine the lofty ambitions set out in this strategy, unless government safeguards the most vulnerable and economically disadvantaged in our society.

References

1. World Health Organization (2016) Global Health Observatory Data Repository: Suicide Rates data by country. WHO, Geneva.
2. Adjacic GV, Weiss MG, Ring M, Hepp U, Bopp M, et al. (2008) Methods of suicide: international suicide patterns derived from the WHO mortality database. Bulletin of the World Health Organization 86: 657-736.
3. Withers J (2016) Suicides in the UK: 2015 registrations. Office for National Statistics, UK. pp: 1-23.
4. https://data.oecd.org/healthstat/suicide-rates.htm
5. http://www.parliament.uk/healthcom
6. http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/
7. Minois G (1999) History of suicide: Voluntary death in western culture (2nd edn.). John Hopkins University Press, Baltimore.
8. https://www.gov.uk/government/publications/public-health-outcomes-framework-2016-to-2019
9. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf
10. https://www.samaritans.org/about-us/our-research/facts-and-figures-about-suicide
11. Knapp M, McDaid D, Parsonage M (2011) Mental health promotion and prevention: The economic case. Department of Health, London. pp: 1-48.
12. Cheng ATA (1995) Mental illness and suicide. Arch Gen Psychiatry 52: 594– 603.
13. Isacsson G, Bergman U, Rich CL (1994) Antidepressants, depression, and suicide: an analysis of the San Diego Study. J Affect Disord 32: 277–286.
14. Isacsson G, Rich CL, Jureidini J, Raven M (2010) The increased use of antidepressants has contributed to the worldwide reduction in suicide rates? Br J Psychiatry 196: 429-433.
15. No Authors Listed (2015) Local suicide prevention planning: A practical resource. Public Health England.
16. No Authors Listed (2015) Inquiry into local suicide prevention plans in England. All Party Parliamentary Group on Suicide and Self-Harm Prevention.
17. https://publications.parliament.uk/pa/cm201617/cmselect/cmhealth/300/300.pdf
18. Palmer L, Blackwell H, Strevens P (2007) Service Users' Experience of Emergency Services Following Self-Harm. A National Survey of 509 patients. RCPsych CCQI.
19. Hawton K, Saunders K, O'Connor R (2012) Self-harm and suicide in adolescents. Lancet 379: 2373–2382.
20. Owens D, Horrocks J, House A (2002) Fatal and non-fatal repetition of self-harm: systematic review. Br J Psychiatry 181: 193–199.
21. Saab MM, Landers M, Hegarty J (2016) Promoting testicular cancer awareness and screening: A systematic review of interventions. Cancer Nurs 39: 473-487.
22. Barr B, Taylor-Robinson D, Scott-Samuel A, McKee M, Stuckler D (2012) Suicides associated with the 2008-10 economic recession in England: time trend analysis. BMJ 345: e5142.
23. Bertolote JM, Fleischmann A (2002) Suicide and psychiatric diagnosis: a worldwide perspective. World Psychiatry 3: 181-185.
24. https://www.belfasthealthycities.com/sites/default/files/Jessica%20Allen%20Compressed.pdf
25. Royal College of General Practitioners (2016) Suicide prevention.
26. https://www.samaritans.org/media-centre/media-guidelines-reporting-suicide
27. The Matthew Elvidge Trust (2016) Suicide prevention.
28. Chief Coroner (2016) Suicide prevention.
29. https://www.local.gov.uk/suicide-prevention-guide-local-authorities
30. https://www.samaritans.org/about-us/our-organisation/national-suicide-prevention-alliance-nspa