How far can we go?

THE JORDAN LEGACY CIC – REGISTERED NO. 12784768
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Advisory warning: content included in this report relates to suicide

This report refers to suicide. Although the content included in this report looks positively at a desired future state, where suicides are rare events, you may find continual references to people experiencing mental ill-health, self-harm and suicidal thoughts and actions triggering.

If reading this report causes you distress, you may find it helpful to speak with someone. The following resources may be helpful:

Samaritans:
Helpline: 116 123 (24 hours)
Email: jo@samaritans.org (24 hours)

Papyrus UK Suicide Prevention – (Prevention of Young Suicide):
Hopeline247: 0800 068 4141
Text: 07860 039967
Email: pat@papyrus-uk.org

The Jordan Legacy provides signposting to a comprehensive list of mental health and suicide prevention support services on this page of our website:
https://thejordanlegacy.com/help-resources/

The Jordan Legacy is a not-for-profit 'business with purpose'. A registered (Registered No. 12784768) Community Interest Company (CIC). All income received goes towards our mission of seeking ways of better supporting those who are feeling a sense of entrapment and hopelessness and, specifically, to reduce the number of lives being lost to suicide.

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Foreword - Steve Phillip

On December 4th 2019, I received a call that no parent ever wants to hear. My 34-year-old son, Jordan, had taken his own life. The following weeks of physical and psychological trauma I experienced eventually subsided enough to allow me to start reading countless books, watch videos and documentaries, listen to other people's stories of experiencing a suicide or in some cases multiple deaths by suicide, so I could begin to make some sense of why I never saw Jordan's suicide coming until it hit me like a freight train.

A pivotal moment in my new life came when, just 3 weeks following Jordan's death, I published an article on LinkedIn about our experience and the devastating ripple effect Jordan's suicide was having on his loved ones and all those who knew him. That article reached many thousands of people globally. Suddenly, I had become a voice for suicide.

In the summer of 2020, I founded The Jordan Legacy, a Community Interest Company (CIC) to explore, with others, practical solutions to preventing suicide. I was and still consider myself to be a novice when it comes to understanding mental health and suicide, I'm certainly not an expert. I've been fortunate though to have surrounded myself with a network of incredible people, many of whom have also had suicide touch their lives.

Very early on in my new journey, I was introduced to someone who has since become a good friend and my right-hand person at The Jordan Legacy. Paul Vittles is a research fellow, change consultant, coach and counsellor. Importantly, he has more than 10 years' experience working in the field of suicide awareness and prevention.

The report you are about to read has been co-authored by both Paul and I but importantly it has been created through conversations with the many other people we have met since The Jordan Legacy was founded.
This report is not a backward looking, statistical report about deaths by suicide in the UK. Instead, it positions a future vision, shared by those we have spoken with, who told us what should be happening if we are to live in a Zero Suicide Society.

We hope you find value in this report and decide to participate in the next steps featured at the end of the document.

Thank you.

Steve Phillip - Founder and Director of The Jordan Legacy

Foreword - Paul Vittles

Suicide prevention has been a personal and professional passion for me for the past 10 years.

There have been many highs. Each initiative I've been involved in - from helping to develop national suicide prevention strategies to supporting individuals struggling with thoughts of suicide - has had its moments of excitement, energy, hope; a sense of purpose, pride and achievement; and a driving belief that I was making a difference.

A recurring low through that 10 years has been looking at the suicide statistics and not seeing the numbers coming down.

At the end of 2022, Steve Phillip and I reflected on what we'd achieved through The Jordan Legacy. Many highs. Loads of favourable feedback for our posts and articles, website resources, talks, events, workshops, panel discussions, research, and support for Mental Health First Aiders. We're applauded for our campaigning and advocacy to government. We're appreciated for our collaborative partnerships.

The Hope for Life Conference in December 2021 was hailed as a fantastic event for bringing together a mutually supportive community, providing hope and inspiration. Following that event, Steve, Mike McCarthy and myself got together (also with Ian McClure) to discuss how to make a bigger difference, and the Baton of Hope initiative was born.

We do what we can but are always conscious those national suicide numbers are not coming down. Do we say 'not our responsibility' or walk more directly towards the elephant in the room?

Steve and I decided to launch our action research project in January 2023 and eat that elephant, bite-by-bite. We've been asking those in our networks what practical actions will reduce the suicide numbers and how far we can go. Our interviews and conversations highlight the actions needed along with barriers preventing us reducing the numbers.

This first report tries to foster hope and raise ambition through mapping out what a Zero Suicide Society looks like, and giving us confidence we can achieve it.

I hope you find it energising. I look forward to working with you towards a Zero Suicide Society.

Together we can transform!

Paul Vittles – Partner at The Jordan Legacy CIC

01 - Contributors to this report

This report has been created following in-depth interviews conducted by Paul Vittles and Steve Phillip between January 1st - June 30th 2023. Those interviewed, in the main, have experience of suicide, including those bereaved by suicide or who have made an attempt to end their own life. NHS mental health and suicide services workers were also interviewed, as well as those leading or working with third sector organisations (charities, CICs, etc). The report also includes the views of some people who have not previously had any experience of suicide but have valuable perspectives, eg on transformational change.

Other useful insights, also included in this report have come from: our previous online panel discussion events, authors we have been fortunate to receive books from, conferences and workshops we have attended, LinkedIn and other online discussion thread conversations.

We would like to thank everyone who has helped shape this report, especially those who have taken part in the first phase of action research interviews and whose names can be found in Appendix 1.

“I believe we can make a significant reduction in the annual number of suicides, if we get better at doing the things we know work and if we’re also prepared to do some things radically different.”

CEO - National Suicide Prevention Charity

02 - Moving Towards a Zero Suicide Society

2.1 - Report Context, Purpose and Approach

This report is the first in a series from The Jordan Legacy summarising what is emerging from our action research project, as well as our wider, ongoing action learning initiatives, focusing on how we can reduce the number of suicides in the UK and how far we can go.

Key actions deemed to be required to reduce the number of suicides have been written up in this first report in the form of a desired state map of what a 'Zero Suicide Society' looks like – for reasons explained below.

By 'desired state map' we don't mean a utopian or idealistic vision (although some might see some features as idealistic), we mean a practically achievable desired future which we have chosen to call a 'Zero Suicide Society' – a term we also explain below.

The core purpose of The Jordan Legacy is to help reduce the number of suicides in the UK and help us move towards a Zero Suicide Society, which we defined at the beginning of 2023 when launching our new strategy and website as:

"a society that is willing and able to do all it can to prevent all preventable suicides".

We chose our words carefully – as always!

We knew that the term 'Zero Suicide' (which is actually a philosophy and framework for reducing suicides not just a numerical target) can get pushback and upset people, including those who have done all they can to support a loved one, patient, or person in distress without being able to 'save' their lives.

As we have expressed it, the goal “to prevent all preventable suicides” accepts that not all deaths by suicide will be preventable and is sensitive to all the reasons we have heard for being uncomfortable with the term "Zero Suicide’. However, we believe that using the term ‘Zero Suicide Society’, defining it and describing its key characteristics, is likely to be helpful in achieving our shared goal of reducing the number of suicides.

We deliberately refer to a “society” response as everyone needs to play a part in reducing the number of suicides and it requires societal changes in knowledge, attitudes and behaviour not just action by government or other institutions like the NHS.

Our brief summary definition of a Zero Suicide Society refers to a society that is both “willing and able to do all it can”. In other words, the ‘will’ and the ‘way’; commitment to reducing the number of suicides and the ability to do so.

At the centre of our new strategy, The Jordan Legacy launched our action research project in January 2023 focused around the two key questions of ‘How can we reduce the number of suicides in the UK (from the 6000+ per year level)?’ and ‘How far can we go?’.

We have been continuously discussing these questions more informally in all the conversations, events, panel discussions, facilitated peer support groups, etc over the previous two years, but the action research project is a more formal focused examination.

This ongoing project includes semi-structured interviews with people who have lived experience of suicide, leaders within suicide prevention charities, suicide prevention leads, and a range of people working in the field of suicide prevention or who want to contribute their evidence-based or experience-informed views about reducing the numbers of suicides.

We want to keep hearing diverse perspectives, to respect research and data informed views, respect lived experience informed views, learn more about established approaches we might need to continue with or expand, and listen to new ideas where ‘doing something different’ might be a way forward. After all, every established, evidence-based, well-evaluated approach has to begin somewhere as a new idea!

2.2 How Far Can We Go? Ambition, Targets and Change Dynamics

Each interview begins with some discussion around "How far can we go?" and we often return to this question at the end too, partly because it needs consideration of the actions we can take to be able to then comment on how far we can go, and how fast.

These discussions reveal some crucial issues around level of ambition, the role of numerical targets, and the change dynamics operating within suicide prevention.

A common initial response is "we **must** reduce the numbers" but we deliberately shift the focus to "how far **can** we go?". Saying "we **must** act" is primarily an (emotional) expression of our dissatisfaction with the current level of more than 6,000 deaths per year in the UK, regarding this level as unacceptably high. However, asking "how far **can** we go?" is a much more difficult question to answer, often resulting in a reflective pause or responses like "that's a hard question", and leading to a range of considered answers.

We also hear responses such as "we must aim for zero deaths" or "even one death is one too many" and almost everyone says "we must have high ambition" (even the Department of Health and Social Care used the term 'high ambition' in one of our meetings with them) but, again, bringing the focus to what we can achieve changes the perspective. The focus shifts to our beliefs around what we can practically achieve, over what timeframe, with which actions, with which factors within or outside our control.

This has been a feature of the suicide prevention landscape for many years. We have seen signs of ambition, or at least the language of high ambition being used, but targets have been set at what many if not most people regard as low levels. Most suicide prevention strategies and plans have set a target of '10% reduction in the next 5 years' and, sadly, even these low targets have often not been met.

When asked to set formal targets, people and organisations focus on what they think they can realistically achieve given the resources they have and what they think is within their control. They tend to set their

sights low. Virtually no-one believes they are in a position to directly influence the numbers at national level to any significant degree so there is an inherent conservatism and resistance. No-one wants to put their hand up and be held accountable for national targets. This even leads to suggestions that no targets should be set which, for many, feels like 'giving up' and certainly not displaying ambition.

We have had a very small number of those interviewed saying they fear we may not be able to reduce the numbers of suicides over the next few years because of factors like recession and cost-of-living increases that are regarded as 'outside our control' and that could even increase the number of suicides. However, we have also heard from others who believe we can – and should! – address these economic factors with appropriate measures.

Almost all those interviewed as part of our action research project respond by saying that we can reduce the numbers of suicides with answers ranging from "we can significantly reduce the numbers" to "we can considerably reduce the numbers" to "we can reduce the numbers to the lowest level ever recorded" (which, from the current level, could be c 20% reduction) to "most suicides are preventable so we should be able to reduce the numbers by half" to "we can get the numbers on a downward trend" (which could mean relatively small % decreases in the short-to-medium-term but on a long-term path that could be a high % decrease from the current level) to "we can move towards zero deaths".

This is one of the key reasons why we have chosen to write up this initial report in the form of a desired state map of what a Zero Suicide Society looks like.

At a national level, discussions around precisely how much we can reduce the number of suicides and the role of targets can be unproductive and even unhealthy exchanges that do not help us move closer to where we all want to be. They discourage ambition and limit achievement.

Rather than argue about what precise % reduction we can achieve within, say, the next 5 or 10 years, we think it might be better here to map out the key characteristics of a Zero Suicide Society and then try to have a more positive, constructive discussion about how we – collectively and individually – can work towards that mutually desired state.

And there are other key reasons for taking this approach. In particular, we need a collaborative and collective effort where everyone plays their part in helping to reduce the numbers of suicides (and suicide attempts and

suicidal crises) and do not compete with each other.

Many of us are aware of the plethora of charities, social enterprises, community organisations, and other stakeholders involved in suicide prevention with enormous potential for collaboration but which can often end up competing, including competing for resources and attention in a 'crowded market'.

Then there is the inherently competitive nature of an environment at national level and often at other levels where discussions, plans and strategies focus on deciding on priorities, including 'priority groups'. Prioritising one group over another group can simply mean some reductions in suicides among the prioritised groups (although not always) and increases among other groups, while the overall number of suicides does not change. It is simply 'pushing air round in the balloon'.

A key characteristic of a Zero Suicide Society, and a key factor in getting the suicide numbers down, is avoiding this 'priority trap' and having complementary, collaborative, co-ordinated approaches where everyone is a priority for someone!

In our desired state map of a Zero Suicide Society, we will not advocate for priorities (certainly not 'priority groups') within suicide prevention, just map all the actions and features, and comment further on the 'priority trap' as a barrier to change, along with the potential to avoid such traps and barriers.

03 - What a Zero Suicide Society Looks Like

As stated earlier, our topline definition of a Zero Suicide Society is "a society that is willing and able to do all it can to prevent all preventable suicides".

'Society' means everyone – all individuals, families, communities, organisations, networks, institutions, etc. It includes government but recognises that suicide prevention extends way beyond government. Effective suicide prevention needs a 'whole-of-society' approach because suicide can affect anyone, everyone can help reduce the number of suicides, and we need everyone contributing to move to zero preventable deaths.

Below, we set out the key characteristics of a Zero Suicide Society – effectively all the key actions needed (along with a few shifts in our mindsets) to considerably reduce the number of suicides, get the numbers on a downward trend with perhaps some 'step change' shifts along the way (e.g. via legislative change or technological transformation), and move towards zero deaths by suicide, at least in terms of preventing all preventable suicides.

Please note that these 'key characteristics' are not being presented in any order of preference or priority – they are all important and all of these 'pieces of the puzzle' need to be in place to enable us to move towards a Zero Suicide Society. They are often linked in various ways, and they build on each other.

Some people and organisations will have a natural focus on one factor, e.g. education, government, health services or workplaces, and many individuals will have views on where is the best place to focus at any one time. But success in achieving our Zero Suicide Society is dependent on ensuring there is progress in each area with co-ordinated strategies and activities that move us forward towards our shared vision.

The following sections of this report – summarising those key characteristics of a Zero Suicide Society – effectively provide a 'future desired state map', a map of what our society would look like if everything those who contributed to this report told us needs to happen was happening.

3.1 Continuous learning, continuous action, collective impact

Across society, government and all institutions, there is a continuous action learning loop drawing from what is known to work in reducing suicides and what might also help.

All communities, businesses and institutions effectively develop and deliver 'Zero Suicide Plans' tailored to their communities, businesses and institutions; with co-ordinated action and monitoring through local area suicide prevention partnerships and a national suicide prevention office (more on each of these below).

This is the infrastructure of suicide prevention through which specific actions take place to ensure continuous reduction in the number of suicides and then keeping the numbers at the lowest level possible. There is also a culture that welcomes new ideas and innovation in suicide prevention so action learning is a symbiotic combination of what is known to work in preventing suicides and what else might help reduce the numbers further.

3.2 Society at large is educated about suicide and suicide prevention

Across the population, there is a wide and deep awareness, knowledge and understanding about suicide and suicide prevention, achieved through high profile campaigns and public education initiatives; promotion and high take up of appropriate training; education through schools, colleges, and universities; education and training via employers, industry bodies, and professional associations; and open, informed conversations within families, communities and networks of all kinds.

Suicide and suicide prevention are openly and widely discussed with sensitivity and without stigma. The population at large understands that anyone can be affected by suicide and that most suicides can be prevented with appropriate steps taken.

This understanding and open approach to conversations around suicide drives suicide prevention activity – from the home to workplaces to within parliament.

Breaking down barriers in everyday life for the population as a whole opens up opportunities for suicide prevention plans and actions where they are needed to reduce the numbers. It becomes a mutually reinforcing cycle.

It is widely understood that suicidal crises can arise due to a range of, or combination of, factors including long-term and ongoing challenges with mental illness (sometimes alongside long-standing challenges with physical illness) and as a response to a situation or set of circumstances (e.g. financial distress, loss of job, relationship breakdown) experienced by people with no previous history of mental illness.

From this understanding, people and organisations seek to support those known to be at risk or in danger, to look for the signs of others who may be at risk or in danger, and to ask appropriate questions to check in on family, friends, colleagues, neighbours, etc for prevention and early intervention.

Organisations and organised communities are also well-informed and actively play their part in suicide prevention (more on this below) but with a population at large that is well educated and active in having conversations, signposting, referring, and directly supporting where appropriate.

This 'suicide-educated' population is the bedrock for all other suicide prevention initiatives.

Regular national and local high profile campaigns and public education initiatives help maintain high levels of awareness about suicide, and continuously educate around appropriate actions, appropriate language and challenging stigma.

When The Jordan Legacy (Steve and Paul) was involved with Mike McCarthy in designing and developing the concept of the Baton of Hope as a very high profile awareness-raising and public education initiative, we crafted these words for the website:

"We have a vision of a society where suicide and suicide prevention are openly and widely discussed, where we inspire hope through action, where people are suitably supported, and where everyone plays their part in realising this vision".

See Baton of Hope website for more details:
https://batonofhopeuk.org/vision-mission/

Suicide and suicide prevention being "openly and widely discussed" would certainly be an indicator of a Zero Suicide Society being in place, even more so if those discussions are with sensitive curiosity and free from stigma.

3.3 Socio-economic-political structures and cultures support suicide prevention

In addition to a high level of education about suicide and suicide prevention, our Zero Suicide Society is developing a set of cultures and structures that underpin suicide prevention. These are all ongoing challenges, but progress is being made.

We are living in a more inclusive society, where diverse cultures and differences are being embraced. Reports of racism, ethnic and minority exclusion, bullying and abuse are at some of the lowest levels since records began. We are living in a kinder, more compassionate society. People report feeling better connected and less isolated and lonely.

People are moving to be more accepting and less judgemental. More people are saying they are being listened to and having their voices heard and respected, and this has helped increase their sense of belonging in society.

There are periodic national and local campaigns to highlight the problems of loneliness and social isolation, support services available, and ways in which we can all help to combat loneliness. Community support is available in the form of befriending services, e.g. for older people, peer support groups, helplines, online forums, local centres for people experiencing social isolation.

There is a constructive, collaborative approach between national government and local councils, working more in partnership with schools, communities and local businesses. This has led to a significant fall in people reporting instances of loneliness and isolation. Loneliness has ceased to become one of the leading factors in causing symptoms of anxiety and depression in the UK.

There are national and local 'digital inclusion' initiatives to ensure that no-one is disadvantaged by not having access to online services and support. Suitable devices are provided to those who need them and can't afford them via 'recycling' schemes, donations and some public funding. Free or subsidised internet access is also available. Training (induction refreshers, ongoing support) is available along with peer support in the community and helplines.,

After huge success in the provision of food banks for those who could not afford to eat, we have moved on to a society that expects social and economic policies which mean no-one needs to rely on food banks, although charities still provide 'safety net' support.

In our Zero Suicide Society, it is recognised how important it is for everyone to have a roof over their head and housing security. Policies and initiatives have included greater provision of affordable housing, appropriate rent controls and tenant protection, support for those struggling to meet mortgage payments, plus targeted support for those who find themselves in housing crisis, e.g. due to relationship breakdown.

Historically, relationship issues have been a key contributory factor for suicides, notably relationship breakdown and domestic abuse. In a Zero Suicide Society, there are not only policies and services to support those facing these challenges but specific 'suicide safe interventions'. Rather than trying to measure degree of suicide risk, every person affected by relationship breakdown or domestic abuse is offered suitable counselling support, a suicide screening, and a tailored safety plan.

There is a suicide-sensitive criminal justice system. All staff working in prisons, courts, custody suites, etc. are trained in suicide prevention and suicide-safe practices.

All national advertising for physical or online gambling has been removed from TV, social media and physical centres, such as arenas, sports grounds etc. Counselling and support services are widely available for those with gambling addiction, with the emphasis on encouraging help-seeking and early intervention.

Various forms of addiction have been recognised as contributory factors for suicide. In addition to suitably tailored support for the relevant addictions, specific suicide prevention support is available.

There is now also a clearer understanding about the difference between poor mental health (normal emotional pain and hardship – grief, heartbreak, stress etc.) and mental illness (a psychiatric disorder), which is helping to reduce the immediate pathologising and labelling of anyone experiencing poor mental health.

There has been a shift away from a focus on GDP growth as the primary measure of success. The Government has a ‘wellbeing budget’ and measures of success in a ‘wellbeing index’ that cover a wider range of economic, social and environmental indicators including mental health and reducing the number of suicides.

[N.B.: the above are just some examples of the kinds of socio-economic-political cultures and structures that would exist, and shifts that would be taking place, it’s not a comprehensive list. With further input, we will continue building this list, with the emphasis on practical shifts we can achieve not outlining what might appear to be utopian dreams]

3.4 Protective measures around employment and income

Historically, suicide rates have been higher among those on lower incomes or living in areas where levels of income and wealth are lower. Suicide rates have also been higher in areas with higher unemployment rates or where unemployment rates are rising fastest.

It has been recognised that mental ill-health and suicidal crises can be caused or exacerbated by financial distress, including living on low incomes or experiencing loss of income, and losing a job so there have been major reforms to income and benefits systems and appropriate support is available for those losing jobs and experiencing financial distress.

In our Zero Suicide Society, a Universal Basic Income has been introduced, ensuring a guaranteed minimum income for individuals and households. The benefits system takes into account the transition needed when people's circumstances change, including losing a job or having to move out of the family home after relationship breakdown.

Those who lose their jobs are supported with counselling for their mental health as well as being offered access to a financial counsellor. Debt counselling is widely available at no charge.

All Department of Work and Pensions (DWP) staff and all those from public services working with people who have lost their job or experiencing long-term unemployment are trained in suicide first aid and in developing safety plans.

3.5 Local area suicide prevention partnerships

At the heart of suicide prevention are well-resourced local area partnerships working collaboratively with local government, NHS, police, other public services and agencies, local charities and social enterprises, community organisations, business and business associations, people with lived experience of suicide, schools, colleges and universities, researchers, trainers and training organisations, and anyone who wants to be involved in suicide prevention.

Using real time suicide surveillance data, local audits, research, and input from all partners to ensure ongoing analysis, informed plans, rapid response, appropriate advocacy, further collaborative partnership working, etc with a relentless focus on the tailored local measures (informed by national data and research but primarily driven by local data and local learning) that reduce the number of suicides in the area (and suicide attempts and suicidal crises as the focus shifts more over time from interventions to prevention).

The Local Area Suicide Prevention Partnerships liaise with the National Suicide Prevention Office (NSPO) to share data and knowledge of 'what is working' (a two-way flow for mutual benefit) and guide national approaches where this is helpful but the Local Partnerships focus on key drivers of suicides and suicide attempts in their area and tailored local actions required, which may or may not be in line with national perspectives.

In our Zero Suicide Society, there is a combination of top-down leadership and ground-up leadership. This includes national government actions where appropriate but most of the action planning and the actions themselves are at a local area level because this is where the practical knowledge resides and where impact is likely to be most of the time.

Also, the historic problems with national targets for suicide reduction being set and not met, because few people or organisations feel they could make a difference at this level, has led to a focus on local plans and micro actions which collectively add up to a macro change.

3.6 National Suicide Prevention Office (NSPO)

In our Zero Suicide Society, there is a central government office taking a whole-of-government approach to suicide prevention and overseeing a whole-of-society approach.

Not having suicide prevention governed through any one department emphasises that it is multi-faceted and needs to be a co-ordinated, collaborative effort across all departments, agencies and areas of government activity – and then suitably connected beyond government.

The NSPO has responsibility for monitoring suicide data and suicide prevention activity, across government and across the country, monitoring suicide deaths, suspected suicides, and suicide attempts.

It works with relevant agencies and data sources such as the Office for National Statistics (ONS), coroners and the Local Area Suicide Prevention Partnerships (see above) to collate and publish all relevant suicide data. This includes real time surveillance of suspected suicides, post-inquest suicide data, audits and investigations, research and evaluation – with a focus on 'what works' in reducing the number of suicides, continuous progress in implementation of 'what works', and supporting innovations that might reduce suicide numbers further.

The NSPO co-ordinates national suicide prevention strategies and action plans. It ensures that every government department and agency has a suitable suicide prevention plan covering its external and internal responsibilities (for the external stakeholders it serves and the staff it employs), helps inform those plans, and monitors implementation of those plans.

There is also a statutory requirement for all new legislation, regulation or policy and all major policy reviews to be subject to a 'suicide prevention assessment' to highlight what can be done to assist suicide prevention and minimise the risk of harm. These assessments are carried out by the NSPO, involving relevant specialists and lived experience advisers.

The NSPO also works in partnership with all regulatory authorities to ensure there is appropriate suicide prevention planning, monitoring and action across all regulated sectors, along with monitoring statutory requirements for all organisations (e.g. suicide prevention training).

3.7 Suicide Prevention Act

In our Zero Suicide Society, The Suicide Prevention Act provides a robust legal and regulatory framework for appropriate and effective suicide prevention. It established the National Suicide Prevention Office (see above). It mandated the Local Area Suicide Prevention Partnerships (also above), including dedicated funding to meet the minimum requirements. It ensures monitoring of good practice based on continuous action learning to reduce the number of suicides and provide clear accountability for necessary actions.

The Suicide Prevention Act places a legal duty of care on all public institutions, and regulated industries and professions – to ensure all possible measures are taken to prevent suicides, including demonstrated action learning from suicide deaths/attempts/crises experienced by those they employ or provide services to, and to ensure appropriate and effective interventions where anyone within their jurisdiction is in suicide danger.

The Suicide Prevention Act brought together previously existing legal and regulatory requirements, such as health and safety at work, to ensure that all organisations (private, public, and third sector) take account of the perspective of suicide prevention, eg emphasising that all workplaces must be mentally healthy and psychologically safe for all employees.

Government and Parliament are Suicide-Educated and Support Zero Suicide Initiatives.

All MPs, their advisers and staff, all peers and all civil servants receive basic training in suicide awareness and suicide prevention to support their own safety, the safety of those they work with, and the safety of those whose lives they influence through their laws, policies, attitudes, behaviours, public communications, etc.

They all also receive briefings (induction briefings, updates and refreshers) on the Suicide Prevention Act, the work of the National Suicide Prevention Office and the Local Area Suicide Prevention Partnerships, progress on moving towards zero preventable deaths, current live action plans for reducing the number of suicides, current barriers to progress that are proving to be particular challenges, and emerging ideas for more effective suicide prevention.

Each government department also has a team dedicated to suicide prevention with members who receive more detailed and more frequent training and briefings on suicide prevention, and who regularly meet in cross-department forums to ensure continuous action learning and movement towards zero preventable deaths.

There is also a programme of briefings open to all MPs and senior civil servants on 'what works' in suicide prevention, where progress is not being made, lessons from 'prevention of future deaths' reviews, training available, helplines and other support available for those who are struggling, support available for those who have experienced bereavement, etc.

3.8 Everyone is a priority for someone

Historically, much suicide prevention planning and activity has centred around 'priority groups' or 'priority areas'. Research tended to be dominated by analysis of suicide data and the identification of groups within the population or areas within the country that have a higher-than-average incidence of suicide and then encouraging government and other statutory agencies to focus on these particular groups or areas.

One of the keys which has helped us move much closer towards a Zero Suicide Society has been a shift in mindset and activity to trying to prevent all suicides and making sure everyone is a priority for someone. We all understand that some organisations exist to focus on particular groups or particular areas of the country and they inevitably – and rightly – focus on suicide prevention within their group or area of focus. Apart from these organisations though, the emphasis now is on suicide prevention for all those at risk or in danger.

Rather than there being national strategies which focus on 'priority groups' or 'priority areas', there are now national frameworks for co-ordinating plans and activity to ensure that everyone is a priority for someone.

3.9 Stakeholder involvement, including people with lived experience

A key characteristic of a Zero Suicide Society, and the health of that Society in terms of its capacity to reduce the number of suicides and keep them low, is the wide and deep practice of involving all key stakeholders in the design and delivery of suicide prevention systems and new initiatives, including those with lived experience of suicide.

It is recognised that no-one is an 'expert' in all aspects of suicide and suicide prevention. Appropriate and effective solutions emerge from listening to, involving and learning from families, friends, communities, colleagues, neighbours, researchers, professionals, policymakers, etc.

Local Area Suicide Prevention Partnerships welcome all those with lived experience to be involved in all their planning and activity, as well as continuously seeking involvement from people with diverse experiences.

Local service providers, employers, employer associations, health authorities, councils, schools, etc all seek to learn from people with lived experience and a full range of stakeholder groups and organisations.

At national/national government level, there are regular efforts to listen to a diverse range of stakeholders and people with lived experience, as well as representatives from more organised 'lived experience networks'.

3.10 Community-centred support services

Communities include physical geographical communities – which is the primary unit of community referred to below – but also online communities, communities of interest, peer-to-peer support communities, etc.

Communities and local areas are the key drivers of suicide prevention plans and activities – for tailored local actions and services, so lots of 'micro zero suicide plans' and micro activities keep down the national suicide numbers – but with national government having a key monitoring and co-ordinating role and taking national action where appropriate.

One such plan is a network of professional and third sector services, embedded within communities and accessible to all. These services present a low threshold to access. Mental health professionals and clinicians work within the community to help understand and support people's mental health issues and recommend appropriate services and support.

These network cooperatives are able to recommend (socially prescribe) a range of services, including; holistic wellbeing, talking groups, physical safe spaces, social activity groups, outdoor pursuits, mental health and wellbeing third sector support and other social support services, all accessed and coordinated via a regional database.

Support services are tailored to suit specific geographic areas (and, where relevant, communities of interest). Support services and activities are provided for individuals, families and those caring for individuals experiencing, mental health challenges or suicidal thoughts.

The cooperatives' culture and attitude toward mental health recognises the right for individuals to be 'mentally different', as opposed to 'mentally ill' and focuses on people's right to participate in all aspects of their community. Restraint is considered only as a last resort and mental health services staff have confidence that in cases of low-level anxiety and mild depression, service users can manage their own risk.

Individuals and families are provided with access to training and guidance in how to manage their mental difference or poor mental health and how to support someone else.

Diagnosis and treatment via NHS services is only considered when all non-clinical interventions have been explored. NHS mental health services are no longer seen as the primary point of contact for someone experiencing poor mental health.

People have options and choices however unwell they are. Life stories and aspirations are embraced as the main tools for recovery and local groups as well as online communities (safe spaces) provide environments to support this approach (more on this below).

This approach to mental difference has eased the pressure and demand on CAHMS and adult mental health services, enabling mental health and crisis teams to provide a whole person assessment and treatment to those who are considered to be mentally ill and/or suicidal.

This non-clinical, community approach represents a relational response to mental health. However, 'mentally unwell' you are, you are not immediately labelled by a medical diagnosis. By contrast, those providing support to those who are mentally different recognise people's right to be different and embrace this difference rather than immediately pathologising the observed 'symptoms'.

3.11 Safe, supportive spaces and places

In our Zero Suicide Society, the term 'safe space' relates to physical and online spaces within a community setting. For physical safe spaces, a community is usually an area within a city, town or village. Online safe spaces provide support for those located in any part of the UK.

Physical safe spaces include those places which provide a range of support services, often clinically modelled, as well as more informal settings, such as listening cafés.

Similar types of safe spaces can also be found within NHS hospitals, workplaces and educational settings, such as schools, colleges and universities.

A safe space is somewhere where people can attend and feel safe and supported and accepted in a non-judgemental environment, surrounded by unconditional kindness.

One important criterion, to enable someone to be able to access a safe space, is that they do not have to have a diagnosed mental illness. If an individual is experiencing any sense of isolation, feelings of isolation, entrapment and hopelessness, they can be referred or self-refer to a local safe space centre.

Unlike clinical mental health and crisis centres, in most instances, individuals can self-refer and in many cases drop-in without a prior appointment.

Community safe spaces are accessible 24 hours a day, 7 days a week. Organisational safe spaces are available usually within the working hours that organisation operates within.

Safe spaces are non-clinical environments but follow clinically approved modelling. Each safe space is rigorously assessed and evaluated to ensure that a clear duty of care pathway exists and is followed.

Safe spaces are not for everyone. For example, someone who is experiencing severe mental health issues, such as psychosis, will be best supported in a clinical setting. Someone who is homeless will require an alternative source of support. However, all safe spaces have access to a

local directory of support services so that everyone can be signposted and referred to the type of support that is right for them.

Although a non-clinical environment, many safe spaces provide access to on-site, clinically proven support services. Such services are rigorously and frequently evaluated and assessed by a nationally recognised independent body. A high number of safe space centres are demonstrating significant reductions in levels of anxiety, depression, suicidal thoughts and acts of self-harm. One key 'success' measure has been evidence of lower numbers of re-attendances to NHS mental health services following an individual attending an agreed course of visits at a safe space centre.

Many of those attending safe space centres talk about the importance of the physical environment helping them to feel safe and welcomed from the moment they arrive.

Some safe spaces provide residential facilities, particularly for those who are feeling suicidal.

Most safe spaces provide a telephone help and befriending support service, staffed by trained volunteers.

In our Zero Suicide Society, approved community safe spaces work in close partnership with their local NHS trust and are recognised as being the 'experts' in providing early intervention and postvention support and care for individuals who are feeling suicidal.

Safe space centres provide continuous support, from someone initially presenting with a mental health issue, right through to their rehabilitation back into society. NHS mental health and crisis teams are called upon only when there is a critical risk to life identified by the approved safe space centre.

Internal focus groups also play an important role in many safe space centres around the UK. By engaging with those who attend safe spaces, asking for their ideas and what they would like to have happen, this helps inform centre teams so that a process of continuous improvement exists in those safe spaces.

A network of safe spaces is part of each town's, city's, region's 'Local Suicide Prevention Community'. Safe space representatives meet regularly and collaborate with local councils, sports clubs, schools and other education centres, parents, workplaces and mental health and suicide

prevention, third sector organisations to discuss local and regional strategies to help prevent suicides. This networking approach also helps to raise awareness about safe spaces and the specific types of services available in each region.

The most successful safe space networks are those which have a number of centres, spread around the community, each specialising in and catering for different mental health issues. For example, some safe spaces provide support specifically for men who are experiencing psycho-social issues such as financial crises, relationship breakdowns, loneliness, while other safe spaces provide support to those most at risk of self-harm or suicide.

In many cases, by operating as a network, safe spaces are able to refer an individual, who may have been previously experiencing high risk behaviours, to another safe space that specialises in low-risk, rehabilitation support, to help that individual continue with their recovery.

Approved safe spaces take a person-centred approach to suicide prevention and crisis support. This helps individuals to feel more comfortable when taking their first tentative steps toward engaging with a safe space centre. This is particularly helpful for men who are often more wary and reluctant to approach such a service.

Community safe spaces provide a range of wellbeing services, from holistic and mindfulness workshops to an on-site professional therapist and pharmacist, who is trained in safer-prescribing of medications. All those employed by or who volunteer to work within a safe space are trained in the philosophy and values of that centre and the national code of practice all safe space centres must agree to sign up to.

Safe space interventions can be one-visit sessions, or a number of visits spread over the course of several weeks, depending on the specific needs of each individual. Importantly, the number of safe space visits is not capped, although a solution-focused approach is taken with every service user to enable them to manage their own mental health and engage and thrive within their community and workplace.

Approved community safe spaces are considered a vital aspect of the government's national and local mental health and suicide prevention strategy, which operates independently but alongside the national mental health strategy. Sufficient funding is made available to ensure the sustainability of approved safe space centres.

Informal safe places

In our Zero Suicide Society, informal, listening café-style safe spaces can be found on most high streets and other areas where communities exist. These face-to-face spaces provide an environment where customers are encouraged to chat with other customers rather than sitting alone in isolation in a regular café. Hosted by volunteers, these locations are having a significant impact on reducing loneliness and/or social isolation.

Online safe places

These are made available for geographic communities to complement in-person communications but are developed primarily for communities of interest that cross geographical boundaries. There is appropriate design and facilitation to ensure safety and effectiveness.

In much the same way that physical café style spaces operate, online spaces also help to reduce feelings of loneliness and/or isolation for those aged 18+. People come together simply to chat to others. Many of these online safe spaces also provide a telephone befriending service for anyone over 18 who could benefit from a regular chat on the phone.

3.12 Appropriate mental health support - available and accessible

In our Zero Suicide Society, there is a whole person approach to health and wellbeing, with appropriate support for mental health and physical health as each person needs, driven by their needs not by institutional NHS structures.

An ecosystem of support services is in place, where anyone experiencing 'mental health problems', including those who may be in 'crisis', are assessed to identify and understand what the root causes are which have led them to that point. This then feeds in to action learning processes, including the NHS Zero Suicide framework and the work of the Local Area Suicide Prevention Partnership as well as internal improvement mechanisms for individual services.

There is an emphasis on community, social and non-clinical support unless it is clear that clinical care or treatment is required. The NHS is supported by a network of community support organisations, including suicide prevention charities, crisis centres, wellbeing practitioners, counsellors, therapists, safe spaces and other services. All these services work in partnership and meet regularly to review and assess how far the numbers of suicides have reduced in their region.

There is a range of services and support available for those who are struggling with their mental health or having suicidal thoughts. These include websites, apps and other online information or support, telephone helplines, social support and peer support, and clinical services.
There is a primary emphasis on prevention or early intervention but with appropriate crisis support services and restrictions on access to the means of suicide.

Efforts are made to take pressure off clinical services to ensure that those who really need them can have ready access along with appropriate and effective care and treatment.

Based on the Samaritans 'No wrong door' approach, someone in crisis (or someone supporting an individual in crisis) is able to choose from any of the previously mentioned community support services, which are easily accessible via a directory of providers for each healthcare trust. These

services operate as a collaborative community, funded by the local NHS trust.

By having NHS services working in partnership with other emergency services and crisis support services, carrying out urgent assessments and ensuring appropriate follow up support or treatment and care, the instances of people having suicidal thoughts or acting on those thoughts has fallen significantly.

This NHS/Community partnership, which takes a less clinical approach to mental health and wellbeing has significantly reduced the frequency with which 'mental health' issues are being pathologised. By supporting life skills which help an individual manage their own recovery better, there is also less pressure being exerted on NHS mental health crisis teams.

For those instances where someone experiences a severe mental crisis or is suicidal, all NHS staff, including GPs, receive mandatory suicide prevention training. Training includes how to be more suicide aware, how to have a direct and appropriate conversation with someone who may be suicidal, the creation of suicide safety plans- in conjunction with the individual and their family – and how to support those bereaved by suicide.

NHS crisis teams and mental health services are also trained in how to be more proactive when making decisions whether to intervene when identifying someone who might be a potential suicide risk. Recognising that, often, someone who is suicidal may be 'unable' to or simply won't reach out for help, NHS leaders empower responsibility to mental health and crisis team managers to act, where risk is identified, rather than relying on the individual in crisis to reach out for help.

The introduction of NHS/Community partnerships to support those leaving psychiatric care and making the transition back into the community has led to a significant reduction in re-attendances to NHS mental health and crisis centres.

Safer prescribing training for GPs and other relevant NHS practitioners has contributed to reducing instances of anxiety, depression and suicide – more on the role of medication in a Zero Suicide Society in this report.

Various forms of addiction have been recognised as contributory factors for suicide. In addition to suitably tailored support for the relevant addictions, specific suicide prevention support is available. Charities and community services supporting people with addictions are all trained in

suicide prevention and safety planning.

NHS staff and other mental health professionals now receive training to better understand what were previously considered as exclusion behaviours (behaviours not deemed to be relevant or related to suicidal behaviour), such as eating disorders, alcohol abuse, self-harm etc. Training focuses on what is causing these behaviours so that appropriate support and treatment can be provided.

The introduction of NHS/Community partnerships to support those leaving psychiatric care and making the transition back into the community has led to a significant reduction in re-attendances to NHS mental health and crisis centres.

In our Zero Suicide Society, pharmacies also play an important role. Pharmacists are trained to identify those at risk, provide support for suicidal individuals and make referrals to appropriate primary and secondary care services. Suicide prevention and mental health first aid training is also incorporated into pharmacy degrees.

All healthcare organisations implement the Zero Suicide framework for continuous action learning and focus on moving towards zero preventable deaths.

A national direct suicide prevention support resources/helpline is in place, which employs a dedicated and trained team, which is staffed 24/7). This facility operates outside of the current 111 services.

All these changes mean that NHS Mental Health Services are able to urgently respond to a life-threatening crisis due to a combination of having better community support and non-clinical services reducing demand on those services, adequate funding, and improved NHS Mental Health Services.

The strides being made in education and support for young people, as outlined in Section 3:15 of this report, has seen a significant reduction in the number of young people being referred to NHS mental health services. A much greater emphasis being placed on prevention of mental illness and suicide prevention, rather than intervention, has helped to reduce the constant need for NHS mental health services' intervention and postvention care.

3.13 Support for trauma and loss experiences

In a Zero Suicide Society, there is a widespread understanding of the impact trauma and loss experiences have, the wide range of different types of trauma and loss experiences people have, and how to support those experiencing trauma and loss.

Historically, many of those taking their own lives have experienced trauma in childhood and/or adult life, they have often experienced more than one traumatic episode, and even seeking help and opening up about their experience has been traumatic.

It has also been the case historically that those bereaved by suicide have a higher risk of suicide themselves, and those making suicide attempts were more likely to make further attempts.

In a Zero Suicide Society, all people known to have experienced trauma are offered appropriate counselling and support. Counselling is widely available, easily accessible, affordable, encouraged, and there is no stigma – it is an expectation within society and across all service providers that counselling will be made available and at least tried by the person who has experienced the trauma or loss experience. It may not 'work' for them and it is their choice but the 'default' position is that counselling should be part of a package of support.

Given the significantly elevated risk of someone bereaved by suicide, also dying by the same means, significant focus has been placed on addressing this concern and to ensure that protective, postvention factors are in place for anyone bereaved by suicide.

One key feature of our Zero Suicide Society is the introduction of a Family Liaison Contact. A FLC is immediately offered to the family or next of kin of anyone who has died by a suspected suicide (i.e. not yet confirmed by the coroner). The role of the FLC is to provide:

- signposting to local, free one-to-one and group counselling and bereavement support services
- an explanation and practical guidance in the form of next steps, such as; how your GP can help, funeral arrangements, dealing with the deceased's personal affairs, the coroner's inquest process, access to financial support (if required)
- guidance for those supporting the family or loved one of someone who has died by suicide (what to say, what to try and avoid saying)
- support information to the employer of the deceased to enable them to explain and manage the impact on their colleagues following a death by suicide.

Another important feature of our Zero Suicide Society, welcomed by those who have been bereaved by suicide, is a change to the process of coronial inquests. Coroners are now required to fully consider the deceased's mental health history in cases where previously a verdict of accidental death might have been recorded due to substance or alcohol misuse for example. This is particularly relevant to Article 2 inquests, where an inquest will now look at the wider circumstances surrounding a person's death.

3.14 Support for people with disabilities and chronic illness

Historically, suicide rates have been high for those with disabilities and chronic illnesses. Not all disabled people or all people with chronic illnesses of course but some in certain circumstances, so support for these people in these circumstances is seen as vital for keeping suicide numbers down.

In our Zero Suicide Society, there is support from family, friends, neighbours, charities, community organisations, peer support groups, etc with an understanding of key issues such as loneliness, lack of mobility and independence, discrimination and stigma, the impact of ongoing pain- and pain-relieving drugs.

Training among statutory agencies and health professionals also includes awareness and understanding of the particular risks for people who live with disabilities or chronic illness so they can help to support optimal mental health, help prevent suicidal crises, and support those who do experience suicidal crises.

All those working with people with chronic illness are trained in suicide awareness, suicide prevention and safety planning.

3.15 Schools and all education centres embracing suicide prevention

(The term 'education centre' refers to any school, college, university)

In our Zero Suicide Society, education centres believe it is a key part of their role to consider the physical, emotional and mental wellbeing of their students. Any changes to the schools' curriculum, policies and practices always consider (and in most cases are determined by) 'How will this decision impact the wellbeing of our students?'.

Adequate budgets and resources are available to ensure that all teaching staff, lecturers, heads of faculties/departments, receive training to enable them to support any student who discloses that they are feeling suicidal or displays evidence of self-harm or risk of suicide.

Each school has a wellbeing team which supports pupils and teachers. This includes staff who are trained in mental health and suicide prevention and liaise with colleagues within the school and appropriate external professionals. The wellbeing team oversees generic wellbeing programmes and targeted support, including safety plans for any children or staff identified as at risk or in danger, liaising with parents and relevant professionals.

Each education centre has a documented student wellbeing and suicide prevention policy, which is part of every education centre's statutory duty of care. The policy includes access for teachers and students to a safety plan, to help provide a range of strategies to help them cope with thoughts of self-harm and suicide. Most education centres are reporting that students who present in crisis are cared for immediately when staff have been informed, in line with the centre's policy and that a student's nominated contact is informed the same day.

Suicide prevention policies include the provision of a 'psychologically safe environment' and also safe, supportive spaces where appropriate. Risk assessments include checking on suicide safe design and restricting access to the means of suicide.

Mental health and suicide prevention policies are regularly updated to ensure that the latest knowledge, understanding and training solutions are

being implemented across all education centres. Student wellbeing and suicide prevention policies, including safety plans, are created and reviewed in collaboration with students, their parents/guardians and local NHS mental health/crisis teams.

All schools have wellbeing programmes that recognise that mental health and wellbeing is crucial for the health and development of children, their relationships within and beyond school, their performance in any intellectual, creative or physical activities that are part of the school curriculum, ensuring an optimal school experience, and their preparation for their lives and work beyond school.

These wellbeing programmes begin at primary school including using all forms of expression to help children communicate their feelings, understand different emotions in themselves and others, learn how to cope with thoughts and feelings that might be challenging, and learn how to communicate with others for emotional good health.

Children are taught about specific topics that might affect their mental health and wellbeing, such as experiencing loss, falling out with a friend, bullying, etc and basic suicide awareness is introduced at the primary level covering the fact that some people have thoughts about not wanting to live and the importance of talking about this (with a parent or teacher).

At secondary schools, the wellbeing programmes step up to cover more aspects of emotional and psychological health and safety, and there are formal suicide awareness and suicide prevention modules, including as part of the school curriculum.

These raise awareness and understanding of suicidal thoughts and behaviours, the various factors that lead people to have suicidal thoughts or crises, how to cope with suicidal thoughts, the importance of talking about suicide, how to spot signs and symptoms, sources of support, and how to help others who are struggling.

Suicide and self-harm are openly talked about within all education centres. In fact, the introduction of safe spaces and a concerted effort to avoid stigmatising any aspect of emotional or mental ill-health has encouraged students to feel they can more openly raise concerns they have about their own emotional and mental health concerns.

Mental health and wellbeing are at the centre of teacher training and ongoing professional development for teachers, including their own

wellbeing, the wellbeing of the children they are responsible for, the wellbeing of their colleagues, and the wellbeing of the school and the community it serves. It is generally recognised that this is crucial for individual and collective performance and optimal mental health is a goal in itself.

Teachers report how the training they receive has increased confidence levels when it comes to discussing suicide with students. This includes when discussing historical, fictional literature, such as Shakespeare's Romeo and Juliet, for example – teachers feel they are able to discuss such topics with students in a way that is not harmful or triggering for them and helps them understand the complex array of situations which can lead someone to consider suicide as an option and that these circumstances are often temporary.

Student inclusivity is another primary objective of every education centre. All staff are trained in how to be empathic when teaching students from more culturally diverse environments, as well as those from different faith and cultural backgrounds. A better understanding – as a result of training - of mental health, allows staff members to provide appropriate time and support to those students with diagnoses or suspected traits of autism, ADHD, OCD and other forms of neurodiversity.

Teachers report feeling more knowledgeable and better equipped to help students develop a sense of belonging, and national schools' statistics show a marked decrease in the numbers of children who previously said they felt isolated and excluded when attending school.

lAnonymous online surveys are an invaluable tool in gaining insights into the student experience. Surveys have a clear focus (anti-bullying, wellbeing, equality etc) and compare responses from key demographics. It is this diverse cohort input which helps to inform the education centres wellbeing and suicide prevention strategy and policy.

In our Zero Suicide Society, education centres are adequately resourced and time is allocated to devote to students with any form of physical or mental difference. Children in primary and secondary schools are taught to understand about and celebrate the importance of difference and this has led to significantly reduced levels of bullying and exclusion in schools.

Increasing the recruitment of teaching staff from different ethnic and cultural backgrounds has also helped students from similar backgrounds to feel more included and less isolated in school.

Importantly, students from primary, through to secondary school are taught how to build self-regulation skills, specifically; emotional self-regulation and how to cope in a range of potentially challenging societal and career situations, including transition from primary, to secondary school and then to college or university and then career transition.

Specific to higher education centres (colleges, universities)

All teachers, lecturers, tutors and other staff in all colleges and universities are required to undertake mental health and suicide prevention training with regular updates.

Each institution has wellbeing programmes and policies and wellbeing teams providing appropriate and effective support to students and staff. Their wellbeing programmes, policies and support available are clearly documented for the benefit of those applying as well as those attending. Regulatory bodies also make available audit and inspection data to check on access to support and effectiveness of support.

There is a good understanding of all the generic factors that impact on the mental health of students and staff, along with the key factors in a college or university setting, e.g. living away from home for the first time, pressure of exams, etc.

Students and staff are encouraged to disclose to the wellbeing team if they are experiencing any form of mental ill-health or suicidal thoughts.

3.16 Workplaces embracing suicide prevention

Industry/sector/professional organisations taking responsibility

All organisations, associations or peak bodies that represent a particular industry, sector or profession take responsibility for reducing the number of suicides among those working in their industry/sector/profession, working in partnership with others who have a shared interest in that industry/sector/profession and in suicide prevention more broadly.

There are regulatory requirements to monitor suicide deaths, investigate each death, produce reports on lessons learned with relevant partners (bereaved families, close colleagues, coroners, local area suicide prevention partnerships, NSPO, etc) and produce reports on steps to avoid future deaths.

Zero Suicide Plan templates and toolkits are provided to employers or members, learning from what works in preventing suicides.

Some sectors that had historically high suicide rates, such as construction, and those with higher exposure to suicide, e.g. the rail industry, have become highly sophisticated in their understanding of suicide and suicide prevention. They run training courses and conferences for other sectors to learn from their experience and knowledge.

Training, Personal Development and Organisation Development

As has been illustrated elsewhere in this report, a key characteristic of a Zero Suicide Society is the wide implementation of training and development in suicide awareness and suicide prevention.

Suicide awareness and suicide prevention training is a core part of all professional training – from health professionals and emergency services workers to accountants, architects, engineers and lawyers. It is acknowledged that suicide crisis can be experienced by anyone in any profession, that it is essential training to help save lives, and that the skills learned are transferable so well worth investing in for the benefit of individuals (and their colleagues and clients) and the organisation.

workplace training and development programmes (provided by and for employers and also by industry associations), all public services and all community support organisations.

Generic mental health and suicide prevention training courses and programmes are adapted or built upon with industry/sector specific content, modules, or follow-up sessions.

Mentally Healthy and Psychologically Safe Workplaces

In line with both legal and regulatory requirements and the growing recognition that it is 'good for business', creating and maintaining a psychologically safe workplace is now embedded into most organisation's culture, from training and development, support infrastructure, governance, compliance, data and monitoring, as well as within the physical workplace environment.

Risks to psychological and physical wellbeing (environment – including home - internal social interactions, emotional wellbeing, cognitive stimulation and engagement) are frequently assessed for all employees, with the aim of minimising the risks of overwhelm and excessive stress. This approach has helped to reduce assessed levels of anxiety and depression within workforces around the UK. Instances of suicidal thoughts have also seen a significant reduction.

One of the key drivers for this positive change has been a recognition that employee wellbeing and suicide prevention should not sit just with HR departments. Much improved results are being experienced when employee wellbeing also becomes a wider responsibility across an organisation and at all levels of the organisation.

All company directors agree to provide a general duty of care, not only for those they employ directly but also for the families who rely on that employee's income. A general duty of care covers all aspects of wellbeing, including physical health and safety, providing a psychologically safe workplace and a clearly communicated suicide prevention policy with evidence of appropriate and effective monitoring and implementation.

A minimum of two company directors must be trauma informed and have undertaken a certification in mental health, suicide prevention and employee wellbeing and attend annual refreshers courses.

Physical and mental health policies are designed to provide much more

effective support and counselling for employees who may be struggling with a range of mental health issues and life challenges.

Another important development has been recognition of how employees can take care of and responsibility for their own mental wellbeing. Regular group workshops, newsletters, signage, and one-to-one progress reviews are provided, alongside other awareness, advice and guidance resources, which focus on self-care and personal development.

Workplaces are expected to create and maintain an up-to-date directory of external mental health and wellbeing services in addition to existing Employee Assistance Programme (EAP) and Mental Health First Aid (MHFA) support. This has been particularly helpful for those employees who do not feel comfortable sharing concerns about their wellbeing – mental health in particular.

Suicide prevention, intervention and postvention support is now embedded in most workplace cultures throughout the UK. Although not a mandatory requirement, most companies agree to sign-up to and implement and maintain the Suicide Prevention Workplace Charter. The Charter expects companies to include suicide awareness and prevention as an integral part of their employee wellbeing strategy, policies and procedures.

The inclusion of employee wellbeing and suicide prevention as part of the internationally recognised ISO Standards has allowed organisations to further demonstrate their commitment to creating and sustaining a psychologically safe workplace. It helps to ensure minimum standards of safety and support along with a continuous development culture and structure to build on the minimum requirements. This has been a significant step forward in encouraging companies globally, who wish to maintain ISO status, to make employee wellbeing and suicide prevention an integral part of organisational processes and culture.

Companies are able to sign up to a TripAdvisor style ranking process, where employees anonymously rate their employer, publicly, in relation to how employee wellbeing is embedded into the company's culture and practices. Suicide awareness and prevention forms an integral part of this ranking. Given the public nature of this approach, most companies are keen to be seen as a 'Psychologically Safe Organisation' in the same way that corporate social responsibility (CSR) influences their brand's reputation in relation to local and national environmental, social impact and general governance.

In summary, a range of expected behaviours from companies has helpe to ensure that employee wellbeing and suicide prevention are factored in alongside all other operational objectives, processes and procedures. Results are encouraging, with significant falls in workplace stress, anxiety and other mental health issues, as well as greatly reduced instances of reported self-harm and suicide.

3.17 Designing out suicide

In our Zero Suicide Society, it is recognised that there are many opportunities to 'design in' mentally healthy and suicide safer environments and processes and 'design out' suicide, and these opportunities are being grasped.

It is acknowledged that suicide is a practical act involving a process of thinking, planning and acting which leads to suicide attempts by a chosen means and, therefore, design changes or interventions within that process can reduce the number of suicide attempts and suicide deaths. Design thinking and process reengineering approaches are being employed to help reduce the number of suicide deaths.

In particular, those who are involved in designing the built environment and publicly accessible spaces are making a major contribution to reducing the number of suicides. Architects, designers, engineers, building control officers have contributed to enhanced building regulations and good practice design with mental health and psychological safety now core considerations, and 'suicide safer' initiatives being commonplace.

There are constant efforts to restrict access to the means of suicide. Designers and representatives from many sectors, charities, local area partnerships, etc regularly meet to discuss ways of restricting access, both via greater spread of established approaches, and by finding additional ways to restrict access, including using the latest technology.

3.18 Using technology for good

In our Zero Suicide Society, there is a positive view of technology and the helpful role it can play in suicide prevention combined with a desire to counter the harmful impacts of those who do not use technology for good. It is not the technology that is harmful (although Artificial Intelligence is blurring the boundaries) but the way technology is used or abused.

Digital communications technology is used in suicide prevention and early intervention as a key means of keeping suicide rates low. Public-private partnerships at national and local level involving relevant national and local government agencies, technology and data analysis organisations, and other key partners such as the financial sector help to identify both those at risk or in danger to input into suicide prevention plans and activities and to get suitable messages of support to individuals at risk or in danger.

Those who are overtly seeking information about suicide are directed to appropriate support services, with anyone showing signs of searching for harmful content being sent further support or intervention tools.
Those who are posting publicly on social media with content that suggests they may be at risk or in danger are also sent suitable messages of support.

Such identifications, interventions, messages of support and sources of support have all been reviewed for ethical good practice and continue to be monitored for appropriateness and efficacy. As they are potentially life-saving interventions, the bar for ethics approval is set at 'why not do this?' and this is also the guiding principle used in evaluations and reviews.

These 'digital life-saving' measures are designed to try and identify those at risk or in danger who are 'not known to the (mental health) system' which, historically, have been the majority of suicides in some areas. People with no prior history of mental illness, who have not appeared to show any outward signs of distress, who have not even seen a GP, can find themselves in a suicidal crisis due to a range of factors such as loss of job, relationship breakdown.

Approved digital apps and AI technology is being applied through social prescribing by GP surgeries, pharmacies and NHS mental health services.

Where there are people with a history of mental illness or suicidal crisis, ‘tracking for life’ tools are made available so those discharged from hospital and those with episodic mental illness can agree to be tracked with nominated contacts alerted, e.g. if they do not go home after discharge or are known to be heading towards a location known to be a ‘suicide hotspot’.

04 - Suicide Prevention as a window into society's problems

In our Zero Suicide Society, it is understood that suicide is a problem that society needed to solve because of the human pain and financial cost. However, at the level of an individual experiencing a suicide crisis, it also recognised that suicide is effectively seen as a solution to their problem (or problems more likely).

In official national statistics, suicide has historically been listed as a 'cause of death' but it is actually a means of death. There are a range of factors that cause people to be in a suicide crisis including a wide range of socio-economic factors (some mentioned in this report) as well as mental illness. And this diverse range of socio-economic factors also contribute to poor mental health and mental illness, as well as people with mental illness being more likely to experience problems such as financial distress, unemployment, addiction, etc.

So in our Zero Suicide Society, plans, policies, systems and practices designed to reduce the number of suicides (and suicide attempts and crises) are actually a route to tackling these underlying problems facing society.

And the desire and capacity of society to tackle these underlying problems are being increased when seen through the lens of suicide prevention. Actions are being taken to save lives.

05 - Next Steps

The Jordan Legacy's action research project and action learning initiatives will continue because moving towards a Zero Suicide Society is an ongoing journey of learning, action, learning, action, learning, action.

We want to continue to listen to and learn from all perspectives. We want to continue to collaborate. We want to continue to facilitate learning and action, and the important conversations around what we can do and what we are doing to reduce the numbers of suicides.

This initial report is not designed to be comprehensive in its coverage, just a summary of conversations to date and input into our next round of conversations. We welcome input from anyone who wants to help us continue mapping out what a Zero Suicide Society would look like and 'be part of the solution' in helping us move towards this Zero Suicide Society.

So, after reading this first report with our first draft of what a Zero Suicide Society looks like, please let us know what you think.

What would a Zero Suicide Society look like for you?

What do you think we should add to our desired state map?

We intend to publish further reports, updating and developing the desired state map and setting out how we are doing in moving towards that desired state.

Please contact us and let us know if you can assist with updated and/or additional reports, especially where you could assist in writing a chapter or dedicated report on a particular focused topic.

The intention is to annually update the 'desired state map' of what a Zero Suicide Society looks like and to produce focused reports on how we are doing in moving towards that Zero Suicide Society, i.e. how we are doing in education, health, community support, workplaces, etc.

Appendix – List of contributors

We would like to say a special thank you to all those listed below who have helped shape this report. Many were willing to be personally interviewed or participated in one of The Jordan Legacy's panel discussion events, workshops or conference events. Others have shared their thoughts and knowledge in other ways, such as sending us copies of books they have authored.

Thank you to:

- Alice Hendy – Ripple Suicide Prevention
- Andrew Dunn – Property Investment Management – Lived experience
- Andrew Mullaney – author
- Andy Airey, Mike Palmer, Tim Owen- The 3 Dads Walking
- Angela Samata – TEDx speaker, Speakers Collective Founding Member
- Becky Inkster – Digital Mental Health Neuroscientist
- Chukumeka Maxwell – Action to Prevent Suicide CIC
- Clare Schmidt – Just 'B' – bereavement support charity
- Conor Warren – Spark UK mental health charity
- Darren Gargan - Tees, Esk and Wear Valleys NHS Foundation Trust
- Darren Stokes – Metropolitan Police
- Dean Russell - MP for Watford
- Debbie Rogers – Sean's Place
- Deryn Basnett/Jess Gallier – The Martin Gallier Project
- Douglas Cave – Lived experience
- Ellen O'Donoghue – James' Place
- Emily Pearson – Our Minds Work
- Emma Barrand – QES
- Evelina Dzimanaviciute – Elite Mind Academy
- Ged Flynn – Papyrus UK Suicide Prevention Charity
- Harry Bliss – Champion Health UK
- Helen Garlick – Author of 'No Place to Lie'
- Jacqui Morrisey - Samaritans
- Jan Hawkins - The Foundation for the Developing Person
- Jason Rich – The Listening Cafe
- Jenny Thrasher – All That We Are
- Jess Parker – West Yorkshire Suicide Prevention Partnership

- Jo Kent – Suicide Prevention Lead
- Jodie Hill – Thrive Law
- Joy Hibbins – Suicide Crisis UK
- Lee Fryatt – The LEARN Network
- Leslie Kulperger – Myles Ahead

More contributors:

- Matt Pinkett – Author of 'Boys Do Cry: Improving Boy's Mental Health and Wellbeing in Schools'.
- Matthew Steans – Hope Upstream Charitable Trust
- Lisa Edwards – University academic and trustee of Grassroots Suicide Prevention
- Mike McCarthy – Co-founder of the Baton of Hope UK
- Natalie Howarth – Maytree Respite Centre
- Paul Chambers – Co-founder of The Creative Mental Health Charity – PoetsIn
- Sangeeta Mahajan – NHS Consultant Anaesthetist
- Sarah Meek – Mates in Mind Charity
- Simon Blake – MHFA England

We have listed, above, all those who have had a more formal involvement in this project or who have engaged with The Jordan Legacy and shared their knowledge and experience with us through less formal means, such as being a guest on our live panel discussion events or in other settings. We would also like to thank everyone else who has inspired us to create this report, without which it would lack vital information and critical thinking when it came to positioning a desired future state map and a vision for what a Zero Suicide Society would look like.

We would also like to thank Kate Martin, a friend of The Jordan Legacy CIC, for helping produce this finished report.

Would you consider supporting this action-based research project?

The Jordan Legacy is a not-for-profit business with purpose. We are a registered (No. 12784768) Community Interest Company (CIC). All income received goes toward our mission of seeking ways of better supporting those who are feeling a sense of entrapment and hopelessness and, specifically, to reduce the number of lives being lost to suicide.

We would greatly appreciate any financial donation to support this specific project. You can donate via our website's Home page or through our specific JustGiving page.

Thank you.

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