Title:	Impact Assessment (IA)
Preventing suicide: a cross-government strategy to save lives	**IA No:** 7037
Lead department or agency: Department of Health	**Date:** 11/07/2011
Other departments or agencies:	**Stage:** Consultation
	Source of intervention: Domestic
	Type of measure: Other

Summary: Intervention and Options

What is the problem under consideration? Why is government intervention necessary?

In England, 4,400 people took their own lives in 2009. Suicide has devastating impacts on society and economic costs are also high, estimated at £1.7m for each life lost. Many suicides can be prevented, however most suicides are among people not in touch with mental health services. GPs, other frontline workers, as well as families, friends and colleagues have an important role in ensuring people who need support are able to access it. Government can support efficient and effective action by bringing together knowledge about groups at higher risk of suicide, evidence around effective interventions and highlighting resources available. This will support local decision-making, while recognising the autonomy of local organisations to decide what works in their area.

What are the policy objectives and the intended effects?

The strategy aims to reduce the suicide rate in the general population in England and improve support for those bereaved or affected by suicide by: reducing the risk of suicide in key high risk groups; tailoring approaches for groups in need of specific actions; reducing access to the means of suicide; providing better information and support to those bereaved or affected by suicide; supporting the media in delivering sensible and sensitive approaches to suicide and suicidal behaviour; and supporting research, data collection and monitoring.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Option 1: Do nothing

Option 2: Develop a cross-government suicide prevention strategy that provides evidence on the factors that contribute to suicide prevention, including cost effective interventions: provision of high quality, accessible mental health services; population-level suicide awareness training and intervention; building on existing measures to ensure the safety to people in the care of mental health services or in custody (e.g. safer cells); bridge safety measures for suicide prevention; signposting effective sources of support for family and friends bereaved by suicide; responsible media reporting of suicide/suicidal behaviour; Internet service providers working to remove harmful and illegal website content on suicide; improved data collection.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** 2/2013	
What is the basis for this review? PIR. **If applicable, set sunset clause date:** Month/Year	
Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?	Yes

SELECT SIGNATORY Sign-off For consultation stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister: [signature] Date: 16/7/11

URN 10/1268 Ver. 2.0 12/10

Summary: Analysis and Evidence

Policy Option 1

Description:

Implement the strategy set out in Preventing Suicide

Price Base Year 2010	PV Base Year 2009	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	**High:** Optional	**Best Estimate: 6,821**

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional	1	Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	133		3	**164**

Description and scale of key monetised costs by 'main affected groups'

Costs refer to training of GPs and provision of CBT for people identified by GPs as likely to belong in the risk group plus putting up barriers at suicide hot spots (assumed one at each LA). The cost for a ten-year period is estimated at £68m, with an opportunity cost of around £164m.

Other key non-monetised costs by 'main affected groups'

Costs of identifying people in risk of committing suicide.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate			698	**6984**

Description and scale of key monetised benefits by 'main affected groups'

Savings from emergency treatment avoided and police/coroner costs at around £2m for a ten-year period, at an opportunity cost of around £4m. There are large savings from reduction in fatalities (valuation of life) - around £7bn.

Other key non-monetised benefits by 'main affected groups'

Benefits do not include improvements in the quality of life of members of the family.

Key assumptions/sensitivities/risks **Discount rate (%)** 3.5%

Training is provided to all GPs. For the final IA we would need to model how many GPs (and other professionals may need training) and what is the likely take up. There are no costs associated with identification of people. Again, we would want to include this cost to the model. Workforce productivity gains have assumed to be already included in the intangible costs and therefore although presented have been excluded when calculating net benefits.

Setting up barriers is based on Clifton Bridge. We have assumed one hot spot per LA. We would revise this following consultation responses.

Direct impact on business (Equivalent Annual) £m:						In scope of OIOO?	Measure qualifies as
Costs:	0	**Benefits:**	0	**Net:**	0	No	NA

Enforcement, Implementation and Wider Impacts

What is the geographic coverage of the policy/option?			England		
From what date will the policy be implemented?			01/02/2012		
Which organisation(s) will enforce the policy?			N/A		
What is the annual change in enforcement cost (£m)?			N/A		
Does enforcement comply with Hampton principles?			Yes		
Does implementation go beyond minimum EU requirements?			No		
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** N/A	**Non-traded:**	
Does the proposal have an impact on competition?			No		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			**Costs:** N/A	**Benefits:**	
Distribution of annual cost (%) by organisation size (excl. Transition) (Constant Price)	**Micro**	**< 20**	**Small**	**Medium**	**Large**
Are any of these organisations exempt?	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No

Specific Impact Tests: Checklist

Set out in the table below where information on any SITs undertaken as part of the analysis of the policy options can be found in the evidence base. For guidance on how to complete each test, double-click on the link for the guidance provided by the relevant department.

Please note this checklist is not intended to list each and every statutory consideration that departments should take into account when deciding which policy option to follow. It is the responsibility of departments to make sure that their duties are complied with.

Does your policy option/proposal have an impact on…?	**Impact**	**Page ref within IA**
Statutory equality duties[1] Statutory Equality Duties Impact Test guidance	Yes	15
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	15
Human rights Human Rights Impact Test guidance	Yes	16
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	Yes	16
Sustainable development Sustainable Development Impact Test guidance	No	

[1] Public bodies including Whitehall departments are required to consider the impact of their policies and measures on race, disability and gender. It is intended to extend this consideration requirement under the Equality Act 2010 to cover age, sexual orientation, religion or belief and gender reassignment from April 2011 (to Great Britain only). The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Evidence Base (for summary sheets) – Notes

Use this space to set out the relevant references, evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Please fill in **References** section.

References

Include the links to relevant legislation and publications, such as public impact assessments of earlier stages (e.g. Consultation, Final, Enactment) and those of the matching IN or OUTs measures.

No.	Legislation or publication
1	*No health without mental health: A cross-government mental health outcomes strategy for people of all ages, HM Government*
2	*Healthy lives, healthy people: Our strategy for public health in England*
3	
4	

+ Add another row

Evidence Base

Ensure that the information in this section provides clear evidence of the information provided in the summary pages of this form (recommended maximum of 30 pages). Complete the **Annual profile of monetised costs and benefits** (transition and recurring) below over the life of the preferred policy (use the spreadsheet attached if the period is longer than 10 years).

The spreadsheet also contains an emission changes table that you will need to fill in if your measure has an impact on greenhouse gas emissions.

Annual profile of monetised costs and benefits* - (£m) constant prices

	Y_0	Y_1	Y_2	Y_3	Y_4	Y_5	Y_6	Y_7	Y_8	Y_9
Total Transition costs	133	0	0	0	0	0	0	0	0	0
Total Annual recurring cost	3	3	3	3	3	3	3	3	3	3
Total annual costs	136	3	3	3	3	3	3	3	3	3
Total Transition benefits	0	0	0	0	0	0	0	0	0	0
Total Annual recurring benefits	0	780	748	748	748	748	641	641	641	641
Total annual benefits	0	780	748	748	748	748	641	641	641	641
Business transition costs	0	0	0	0	0	0	0	0	0	0
Business annual recurring costs	0	0	0	0	0	0	0	0	0	0
Business annual costs	0	0	0	0	0	0	0	0	0	0
Business transition benefits	0	0	0	0	0	0	0	0	0	0
Business annual recurring benefits	0	0	0	0	0	0	0	0	0	0
Business total annual benefits	0	0	0	0	0	0	0	0	0	0

* For non-monetised benefits please see summary pages and main evidence base section

Microsoft Office
Excel Worksheet

Evidence Base (for summary sheets)

A. What is the problem under consideration? Summary of analytical narrative

1. Suicide is a major public health issue, with devastating impacts on the family and friends of those affected, as well as wider society. In England, 4,400 people took their own life in 2009. It is estimated that the average cost per completed suicide for those of working age only in England is £1.67m (at 2009 prices). This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as lost output (both waged and unwaged), police time and funerals.

2. The factors contributing to somebody taking their own life are complex, and for many people it is the combination of factors which is important rather than one single factor. Factors include: gender, age, mental illness and physically disabling or painful illnesses including chronic pain, alcohol and drug misuse. Stressful life events such as a loss of a job, imprisonment, debt, living alone, bereavement, family breakdown and conflict including divorce and family mental health problems can all play a part. Stigma, prejudice, harassment and bullying call all contribute in increasing an individual's vulnerability to suicide.

3. Suicides are not inevitable and many can be prevented. Over recent years, progress has been made in reducing the already relatively low suicide rate to record low levels (2007 being the lowest rate on record). However, 2008 and 2009 both saw small rises in the suicide rate among the general population.

4. Previous periods of high unemployment or severe economic problems have had an adverse effect on the mental health of the population and have been associated with higher rates of suicide. Suicide risk is complex and for many people it is a combination of factors that determine risk, rather than a single factor. It is important that, while remaining vigilant, we do not over-emphasise the risk or suggest that an increase in suicides is inevitable.

5. In writing this strategy, the lack of information about suicide risks in many groups has become apparent. However, a number of groups are known to be at higher risk of suicide:

    - people in the care of mental health services, including inpatients
    - people with a history of self-harm
    - people in contact with the criminal justice system
    - adult men under 50
    - specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

6. As well as targeting high risk groups, the other way to prevent suicide is to take a whole population approach to improve the mental health of the population. In order for the whole population approach to reach all groups who may need it, it needs to include tailored measures for groups with particular vulnerabilities or issues of access to services. These are groups of people who may have higher rates of mental health problems including self-harm. Many individuals may fall into more than one of these groups. The groups identified are:

    - children and young people;
    - survivors of abuse or violence in childhood, including sexual abuse, looked after children and care leavers;
    - veterans;
    - people with untreated depression;

- people who are especially vulnerable due to social and economic circumstances, including periods of economic uncertainty, rising unemployment and increased debt and homeless people;
- people who misuse drugs or alcohol;
- Lesbian, gay and bisexual people;
- Black, Asian and minority ethnic groups and asylum seekers;
- Other groups with protected characteristics under the Equality Act 2010

ii. Summarise and put into context the analytical narrative

7. In February 2011 the Coalition Government published *No health without mental health: a cross-government mental health outcomes strategy for people of all ages*. The strategy is key in supporting reductions in suicide amongst the general population as well as those under the care of mental health services. Objective one of the strategy is:

   More people will have good mental health
   More people of all ages and backgrounds will have better wellbeing and good mental health. Fewer people will develop mental health problems – by starting well, developing well, working well, living well and ageing well.

   To achieve this, we need to:

   - improve the mental wellbeing of individuals, families and the population in general;
   - ensure that fewer people of all ages and backgrounds develop mental health problems; and
   - continue to work to reduce the national suicide rate.

8. The mental health outcomes strategy, *No health without mental health*, includes new measures to develop individual resilience from birth through the life course, and build population resilience and social connectedness within communities. These too are powerful suicide prevention measures.

9. Suicide prevention is most effective when it is combined as part of wider work addressing the social and other determinants of poor health, wellbeing or illness. Public Health England, the new national public health service, will focus on improved outcomes for people's health and wellbeing locally and reducing the health inequalities experienced by individuals and specific groups within society. The Public Health Outcomes Framework will support improvements in the public health of the population, and reducing the suicide rate is a proposed outcome in the framework.

10. The new suicide prevention strategy builds on, but supersedes, the national strategy for suicide prevention set out in the 2002, taking account of the changing trends in suicide rates, highlighting new and emerging interventions and reflecting new evidence from research.

11. The draft suicide prevention strategy has the overall objectives of:

    - a reduction in the suicide rate in the general population in England and
    - better support for those bereaved by suicide.

12. We have identified six key areas for action to support delivery of these objectives:

    - reduce the risk of suicide in key high risk groups
    - tailor approaches for groups in need of specific actions
    - reduce access to the means of suicide

- provide better information and support to those bereaved or affected by a suicide
- support the media in delivering sensible and sensitive approaches to suicide and suicidal behaviour
- support research, data collection and monitoring.

13. Much of the planning and work to prevent suicides will be carried out locally. The strategy outlines a number of evidence based local approaches. However, it will be for local partnerships, and particularly local health and wellbeing boards to decide the best way to achieve the overall aim of reducing the suicide rate.

14. The strategy does not mandate the means of achieving any particular objective, so the interventions and good practice examples are to support local implementation and are not compulsory. Many of them are already being implemented locally but local commissioners and providers will be able to accept, or leave, these suggestions based on their assessment of the needs of their local area.

15. This Impact Assessment excludes commitments and announcements that have already been made (e.g. the broader objectives and interventions set out in the mental health outcomes strategy, the outcomes and interventions set out in the NHS, Public Health and Social Care outcomes frameworks, as well as interventions carried forward from the 2002 suicide prevention strategy). It also excludes examples that are already in place but merit a mention in the strategy. Therefore the focus of this work is on those interventions that the suicide prevention strategy is presenting for the first time.

16. The cost benefit analysis presented in the following sections is based on work undertaken by the London School of Economics (LSE) on behalf of the Department of Health[1]. The analysis is presented at a national level and demonstrates that these interventions are not only highly cost-beneficial, but also expected to be cost saving to the public sector and can deliver important cost savings to the NHS.

17. The draft strategy has been developed with the support of leading experts in the field of suicide prevention, including the National Suicide Prevention Strategy Advisory Group chaired by Professor Louis Appleby. It takes account of the changing trends in suicide rates, highlights new and emerging interventions and reflects new evidence from research. Given the current financial climate, the draft strategy has been designed to keep financial consequences to a minimum by continuing or re-focusing current actions, and by drawing together existing strands of policy and activity.

B. What are the policy objectives and the intended effects?

Objective 1: a reduction in the suicide rate in the general population in England

- A number of groups are known to be at higher risk of suicide. The provision of high quality, accessible, mental health services is fundamental to reducing the suicide risk in people of all ages with mental health problems. Training for frontline staff working with, or coming into regular contact with, high risk groups, will be important to help them recognise, assess and manage risk, and fully understand their roles and responsibilities.
- As well as targeting high risk groups, the other way to prevent suicide is to take a whole population approach to improve the mental health of the population. In order for the whole population approach to reach all groups who may need it, it needs to include tailored measures for groups with particular vulnerabilities or issues of access to services. Again,

[1] Martin Knapp, David McDaid and Michael Parsonage (editors) *Mental Health Promotion and Prevention: the Economic Case*. PSSRU, London School of Economics and Political Science. www2.lse.ac.uk/LSEHealthAndSocialCare/PSSRU/pdf/MHPP%20The%20Economic%20Case.pdf

training for staff in frontline agencies can help to identify and support vulnerable people who may be at risk.

- One of the most effective ways to prevent suicide is to reduce access to the means of suicide. In addition to building on existing measures to reduce suicides by people in the care of mental health services or in custody, effective approaches to reduce suicides at high risk locations will be key.
- Media reporting and portrayals of suicide can lead to copycat behaviour, especially among young people and those already at risk. There is growing concern about misuse of the internet to promote suicide and suicide methods. The Press Complaints Commission has taken a lead in highlighting appropriate approaches in the media, supported by a number of other organisations and agencies. Work continues with internet service providers to remove harmful and illegal website content on suicide, and to promote links to trusted suicide prevention and support services.
- Research is essential to suicide prevention. Research studies highlight trends, identify risk groups and key factors in suicide risk and develop the evidence base on what works in suicide prevention. Much of the data to support research are already collected, but they are not all easily accessible to researchers. The Coalition Government will work with the devolved administrations in the UK to share evidence from research studies and effective interventions, and identify gaps in current knowledge. The Department of Health will work with other government departments to consider ways to improve reporting, recording and access to data.

Objective 2: better support for those bereaved by suicide

- Family and friends bereaved by suicide are at increased risk of mental health and emotional problems and at potentially higher risk of suicide themselves. Effective and timely emotional and practical support is essential to help the grieving process, prevent further or long-term emotional distress and support recovery. Building on existing arrangements to signpost effective sources of support will be important to achieve this. The reporting of suicide and suicidal behaviour in the media will also have an impact on those bereaved by suicide.

18. The beneficiaries of the strategy will include people with mental health problems, people in contact with the criminal justice system, specific occupational groups and other groups within society for whom additional measures are needed (including people with untreated depression, or who are especially vulnerable due to social and economic circumstances). The strategy will also benefit families, friends and colleagues of those who take their own lives, and the wider population. It will also be of interest to schools, employers, the NHS, public health, local authorities and the criminal justice system.

Consultation question 16: What approaches would you suggest to measure progress against the objective provide better support for those bereaved or affected by suicide?

C. What policy options have been considered?

Option 1: Do nothing

19. In England, 4,400 people took their own lives in 2009. While the suicide rate in England is comparatively low, it is still a major cause of death. Suicide has devastating impacts on the family and friends of those affected, as well as wider society. The economic costs are also high, estimated at £1.67m for each death for those of working age.

20. Many suicides can be prevented, and much of the work to prevent suicides will be carried out locally. The existing suicide prevention strategy for England published in 2002 has been associated with significant reductions in suicide rates with the lowest number ever recorded

in 2007. However, in 2008 and 2009 numbers increased slightly, resulting in a slight increase in the 2007-9 3-year average suicide rate. We know from experience that suicide rates can be volatile as new risks emerge.

21. Without any Government intervention, some local suicide prevention work will of course continue. However, it may not be clear where suicide prevention activity fits within the new model for public sector delivery, at a time of significant change.

22. There are some groups that are known to be at high risk of suicide, including people in the care of mental health services, people with a history of self-harm, people in contact with the criminal justice system, adult men under 50 and specific occupational groups. There are also new challenges such as the internet and new methods emerging, which it would be inefficient and potentially impossible for individual local agencies to identify and address.

23. No additional investment required but the high costs associated with suicide will continue, and potentially rise if the recent slight increases continue.

Option 2: Develop a cross-government suicide prevention strategy

24. The draft strategy identifies six areas for action to deliver the objectives of reducing the suicide rate in the general population in England and providing better support for people bereaved by suicide. These are based on the priorities identified by the National Suicide Prevention Strategy Advisory Group using the evidence from research and national data, and reflect early discussions with stakeholders representing groups that may need special attention.

25. In writing this strategy, the lack of information about suicide risks in many groups has become apparent, particularly for groups with protected characteristics under the Equality Act 2010. We have presented the best evidence we are currently aware of in the draft strategy, under areas for action one and two. The strategy also includes a specific area for action six, to support research, data collection and monitoring.

26. The document sets out the evidence on the factors that contribute to suicide prevention, including cost effective interventions. However, it is important to stress that, the main thrust of the draft strategy is to pull together the messages from national statistics, research and practice to support local implementation of effective suicide prevention. It does not mandate local action, and the specific interventions are not compulsory. Many of them are already being put into practice in some areas. Commissioners and providers will be able to accept, or leave, these suggestions based on their assessment of the needs of their local area.

27. This Impact Assessment covers some of the interventions set out in the strategy. It is not a comprehensive list and excludes commitments and announcements that have already been made (e.g. the broader objectives and interventions set out in the mental health outcomes strategy, the outcomes and interventions set out in the NHS, Public Health and Social Care outcomes frameworks, as well as interventions carried forward from the 2002 suicide prevention strategy) or that are the lead responsibility for other government departments (ie not DH). The interventions presented in this Impact Assessment are the following:

- Population-level suicide awareness training and intervention
- Bridge safety measures for suicide prevention.

D. Option 2 Impacts, Costs and Benefits

Introduction

28. In March 2010, the Department of Health commissioned Professor Martin Knapp and colleagues from the LSE and the Institute of Psychiatry to undertake economic modelling to support the development of the mental health outcomes strategy. This work included a study of two interventions relevant to suicide prevention, presented in the draft strategy.

29. The interventions are presented below, with a brief summary of the underlying problem and proposed intervention, as well as a description of the modelling undertaken by LSE and the modelling assumptions. No changes have been made to the LSE modelling methodology or assumptions. For this version of the IA we have not made any changes to the LSE methodology. For the final version of the IA we plan to engage with LSE analysts and evidence from the consultation process to improve our knowledge on the likely costs and benefits of these interventions.

30. Further, DH has sought to estimate the likely costs and benefits of rolling out the interventions nationally. This process involved, where appropriate, scaling up the results of the LSE work to a national level and aggregating the costs and benefits of annual cohorts across different years. Future costs and benefits have been discounted in line with DH Impact Assessment Technical Guidance and HM Treasury Green Book Guidance, and cost and savings inputs have been uplifted to 2010/11 prices using an appropriate price index.

31. Future costs and savings have been discounted by 3.5% per year (QALYs by 1.5%) in accordance with DH IA Technical Guidance. Similarly, we present the opportunity cost of the best practice examples by multiplying costs and savings by 2.4, again in accordance with DH IA Technical Guidance. Figures have been rounded to the nearest million.

Population-level suicide awareness training and intervention

Problem

32. It is estimated that the average cost per completed suicide for those of working age only in England is £1.67m (at 2009 prices). This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as lost output (both waged and unwaged), police time and funerals.

33. There are also costs to the public purse from recurrent non-fatal suicide events; these are more difficult to estimate, and will vary by means of suicide attempt. One recent English study indicates that only 14% of costs are associated with A&E attendance and medical or surgical care; more than 70% of costs are incurred through follow up psychiatric inpatient and outpatient care. This is in part because a proportion of individuals who survive suicide attempts are likely to make further attempts, in some cases fatal. There are nevertheless economic benefits from delaying completed suicide as the number of lost years of productive activity will be reduced; overall it is estimated that costs are averted of £66,797 per year per person of working age where suicide is delayed.

Proposed intervention

34. Around 81% of working age adults in England come into contact with a GP at least once a year,[i] and there is evidence that suicide prevention education for GPs can have an impact as a population-level intervention to prevent suicide. This has the potential to be cost-effective if it leads to adequate subsequent treatment.[ii] With greater identification of those at risk, individuals can receive cognitive behavioural therapy (CBT), followed by ongoing pharmaceutical and psychological support to help manage underlying depressive disorders. Evidence from the US suggests that CBT can help reduce the risk of future suicidal events by up to 50%.[iii]

35. The cost of this type of intervention has several components. A course of ten sessions of CBT in the first year is around £400 per person. Further ongoing pharmaceutical and psychological therapy is estimated to cost £1,182 a year (2009 prices). The cost of suicide prevention training for GPs, based on the Applied Suicide Intervention Skills Training (ASIST) course, is £200, which would mean a total cost of around £8m if delivered to all GPs in England.

36. For this consultation impact assessment, we are looking at training GPs based on the work completed by the LSE. However, it has been suggested that appropriate suicide prevention training may also be beneficial if targeted at other groups, such as staff working in schools and colleges, emergency departments, other emergency services, primary care, care environments and the criminal and youth justice systems. We would welcome comments and evidence on this point from consultation responses.

Consultation question 17: Do you have any comments and evidence on the costs and benefits of targeting suicide prevention training at groups other than General Practitioners?

Modelling assumptions

37. The model looks at the economic case over 10 years for investing in GP suicide prevention education aimed at reducing suicide among the cohort of working age adults. It is assumed that, without any action, 20% of individuals experiencing suicidal thoughts are at risk of completing suicide within a one year period. The risk of serious non-fatal events in the year following a non-fatal suicide attempt falls from 41.6% to 24.1% as a result of the intervention. The model does not assume any decrease in the risk of suicide in the 10 years after the first self-harm event other than that initially achieved, and that individuals identified as being at risk will continue to receive a combination of therapies to help maintain reduced risk. Based on an earlier study, GPs who go on the suicide prevention training course will have a 20% greater chance of identifying those at risk of suicidal behaviour in the year following training. The model indicates that 603, 706, or 699 suicides would be avoided over the 1-,5- and 10-year time horizons, respectively.

38. The analysis of costs/savings includes expenditure on health care, police/coroner activities, funerals, productivity and intangible costs. The additional treatment and support costs for individuals who do not complete suicide are to some extent offset by a reduction in the costs to the health care system of completed suicides and serious self-harm events, but the intervention has significant net costs to the health care system of up to £19m over 10 years. However, if the reductions in productivity losses are also included then the intervention is cost-saving by a very large margin (Table 1), and remains so even if the estimated impact on productivity is reduced to just 5% of the baseline case. Overall, net savings of £1.27bn arise over 10 years if intangible costs are also included. All results are sensitive to assumptions about the future risk of suicide.

39. From a cost-effectiveness perspective, for the health system the cost per life saved would be £15,726, £20,438 and £29,235 over 1, 5 and 10 years respectively. Using conservative assumptions about the gain in life and quality of life, this yields a highly effective cost of the NHS per QALY saved of £1,573, £2,044 and £2,924 respectively.

Costs and benefits results

40. The results show that:

- The intervention, using the assumptions from LSE analysts, appears to cost around £21m, with an opportunity cost of around £49m, for a ten-year period. There are some moderate public sector savings and large benefits in terms of workforce productivity and

intangible benefits (mainly valuations of life). Figures have been rounded to the nearest million.

Table 1: Net costs/pay-offs for suicide prevention following suicide awareness training including opportunity costs (2009 prices)

	After 1 year	After 5 years	After 10 years
	(£m)	(£m)	(£m)
Costs			
Suicide awareness training	8	8	8
Suicide prevention measures	2	7	13
Total cost	10	15	21
Opportunity cost	24	37	49
Emergency Treatment	0	1	1
Police/coroner costs	0	1	1
Total public sector savings	1	1	2
Opportunity cost of savings	2	3	4
Funerals	1	1	1
Workforce productivity	186	340	417
Intangible benefits	390	713	874
Total Net Benefit	369	681	829

41. Figures in table 2 have been uprated using HMT GDP deflators from calendar year 2009 to calendar year 2010. Intangible benefits mainly refer to valuations of life which include calculations of productivity. To avoid double counting we assume workforce productivity gains are already included in the intangible benefits figure.

Table 2: Net costs/pay-offs for suicide prevention following suicide awareness training including opportunity costs (2010 prices)

	After 1 year	After 5 years	After 10 years
	(£m)	(£m)	(£m)
Costs			
Suicide awareness training	8	8	8
Suicide prevention measures	2	7	13
Total cost	10	16	21
Opportunity cost	24	38	51
Emergency Treatment	0	1	1
Police/coroner costs	0	1	1
Total public sector savings	1	1	2
Opportunity cost of savings	2	3	4
Funerals	1	1	1
Productivity losses	192	350	429
Intangible costs	402	734	899
Total Net Benefit	379	700	853

Further analysis required:

42. As mentioned earlier, we need to discuss with LSE analysts how to improve the model for the final IA. The model assumes that training will be offered and taken up by all GPs. This does not seem realistic. Furthermore, the model does not assume that there will be any identification costs. Again, we may need to adjust the model to take account of this.

Bridge safety measures for suicide prevention

Problem

43. Jumping from a height accounts for around 3% of completed suicides. Given high fatality rates of over 50%, the lifetime costs of completed and attempted suicides by jumping account for more than £176m per year.

Proposed intervention

44. Bridges provide obvious jumping sites, and the construction of safety barriers has been shown successfully to reduce suicides on particular bridges. It appears that these averted suicides are not simply displaced to other, unsecured jumping sites, but whether suicide occurs by another method is difficult to analyse.

45. The Clifton Suspension Bridge in Bristol is one such suicide hot-spot. Following the installation of a safety barrier in 1998, at a cost of £300,000 (in 2009 prices), the number of suicides reduced from an average of 8.2 per annum in the five years before the barrier, to 4 per annum in the five years after it was installed.

46. The analysis in this consultation impact assessment assumes that there are 10 similar jumping sites within England, where similar costs and benefits would arise from the

proposed intervention. In practice, most local authorities will have at least one public site which is frequently used as a location for suicide and provides either means (e.g. a particular bridge from which individuals frequently jump to their death) or opportunity (e.g. the seclusion that most suicides require) for suicide. The costs and benefits for similar interventions at such sites will vary greatly. We would welcome consultation responses providing evidence on this point.

Consultation question 18: Are you able to offer any evidence on the number of public sites in England frequently used as locations for suicide?

Modelling assumptions

47. Using the Clifton Suspension Bridge as a case study, the model estimates the savings (both tangible and intangible) to society of installing a safety barrier. It assumes that the barrier prevents around half of suicide attempts, but also considers the impact if these individuals instead attempt suicide using other methods. The model includes the probability of subsequent attempted and fatal suicides.

48. The cost savings are calculated first for a 1-year cohort of those attempting suicide from the bridge in a single year, and follows this group over a 10-year period. It then looks at aggregated savings from ten consecutive cohorts, assuming that the pattern of suicides would have recurred every year. The savings do not include the costs of bereavement support, or the impact on children losing a parent. It is assumed that barrier construction costs are incurred in the first year.

Costs and benefits results

49. The results show that:

- investment in a barrier to prevent suicide jumping from a particular bridge can generate substantial financial benefits, even if suicides are diverted to other, less lethal, suicide methods.
- such savings would potentially also apply to other suicide hot-spots, including alternative jumping sites, and other high fatality suicide methods.

Table 3: Pay-offs following installation of the Clifton Suspension Bridge safety barrier (2009 prices)

	After 1 year (£m)	After 5 years (£m)	After 10 years (£m)
1-year cohort			
- No displacement	-3.0	-2.7	-2.6
- Displacement to other methods	-2.5	-2.2	-2.1
10 consecutive cohorts			
- No displacement	-3.0	-22.4	-44.0
- Displacement to other methods	-2.5	-20.0	-40.0

50. For the purpose of this analysis, we have assumed that the cost of the barrier will be similar to the Clifton Bridge barrier (£300k) and we have assumed one barrier per LA. We have also assumed that it is more than likely to have displacement to other methods and calculated the cost and benefits for ten consecutive cohorts at 2010 prices. Again, figures have been rounded to the nearest million.

Table 4: Cost and benefits following installation of barriers across 152 LAs including opportunity cost (2010 prices)

	After 1 year	After 5 years	After 10 years
	(£m)	(£m)	(£m)
Cost			
Setting up barrier	47	47	47
Opportunity cost	113	113	113
Benefits	380	3,040	6,080
Net benefit	267	2,927	5,967

51. The above table shows that there are large benefits. We have assumed that all benefits are intangible (valuations of life). There will be some savings to health and police/coroner costs but they are quite small.

Further analysis required:

52. We need to discuss with LSE analysts how applicable this analysis is to other suicide hot spots. Following the consultation exercise, we can focus on how many hot spots there are in the country.

v. Impacts upon Equality and Human Rights:

53. We have not prepared a separate analysis of the impact on equalities, as recognition of the implications for people with the nine protected characteristics under the Equality Act 2010 is an integral part of the draft suicide prevention strategy.

Health Impact Assessment

54. The primary purpose of the suicide prevention strategy is to save lives, and is therefore likely to contribute to significant positive impacts on health and wellbeing of the population.

Are the potential positive and/or negative health and well-being impacts likely to affect specific sub groups disproportionately compared with the whole population?

55. We know that suicide disproportionately affects some groups in society, and the draft strategy presents information in some detail. It is clear that the risk factors, and resilience factors, for suicide do not exist consistently across individuals or groups in society. Complexity arises from the combination effect of multiple risk and resilience factors, and attempting to understand what this means for specific population sub groups.

56. The draft strategy highlights the need to develop individual resilience from birth through the life course, and build population resilience and social connectedness within communities. It makes the links to wider work addressing the social and other determinants of poor health, wellbeing or illness.

57. The draft strategy also addresses a broad range of risk factors for suicide, including mental health problems, self-harm, debt and unemployment, social deprivation, social isolation and exclusion, family breakdown, alcohol and drug misuse, and the impact that the current economic situation may have on some individuals and families. It goes on to consider how

specific population sub groups may be affected due to their known greater exposure to combinations of risk factors.

58. By combining a population-level approach with a targeted approach to specific groups, the strategy seeks to maximise its positive health and well-being impact.

Are the potential positive and/or negative health and well-being effects likely to cause changes in contacts with health and/or care services, quality of life, disability or death rates?

59. As already discussed, successfully averting a suicide attempt will lead to additional treatment and support costs for individuals who do not complete suicide. These are to some extent offset by a reduction in the costs to the health care system of completed suicides and serious self-harm events.

60. However, when reductions in productivity losses and intangible costs are also included then the intervention is cost-saving by a very large margin. This is reflected in improved quality of life for the individuals affected, their families, friends and wider community. It will also be reflected in lower death rates from suicide.

Are there likely to be public or community concerns about potential health impacts of this policy change?

61. Initial discussions with representatives of those bereaved by suicide, as well as representatives of groups with protected characteristics under the Equality Act 2010, have helped to shape the draft strategy. This engagement work will continue during the consultation on the draft strategy and as the strategy is finalised and implemented. The draft strategy attempts to reflect issues which have been raised to date.

Human Rights Impact Assessment

62. The European Court of Human Rights has considered the issue of suicide, specifically in the context of questions relating to assisted suicide. Most recently, in the Haas judgment, the Court held that the right of an individual to decide how and when to end his life, provided that said individual was in a position to make up his own mind in that respect and to take the appropriate action, was one aspect of the right to respect for private life under Article 8 of the Convention.

63. The Court also recalls that the Convention must be read as a whole, therefore it is necessary to take into account Article 2 of the Convention, which protects the right to life. The Court notes that the vast majority of member States place more weight on the protection of an individual's life than on the right to end one's life, but there is no consensus, so that States have a broad margin of appreciation in that respect. In any case, respect for the right to life compels the national authorities to prevent a person from putting an end to their life if such a decision is not taken freely and with full knowledge of the facts.

64. The draft suicide prevention strategy therefore has an important role to play in ensuring that the Government and public authorities appropriately protect Convention rights.

Rural Impact Assessment

65. This strategy is unlikely to have an adverse impact on rural areas or people. Local authorities and commissioners of health services are expected to consider the diverse needs of their own population, including that of rural areas. We recognise that farmers and

agricultural workers are at particularly high suicide risk, and the draft strategy targets these occupational groups under area for action one.

E. SUMMARY AND WEIGHING OF OPTIONS

148. The previous section presents the details of the analytical work undertaken by LSE analysts. This section brings together the analysis and shows the overall costs, cost savings and benefits of these interventions if they were implemented at a national level. However, these examples are indicative and local areas will decide if they want to implement them or not, or implement alternatives.

149. Figures have been discounted to 2009 and using HMT GDP deflator we present results at a 2010 level. The time period over which we present costs, cost savings and benefits is 10 years. Finally, costs and cost savings are presented as opportunity costs (multiplied by 2.4) according to DH Impact Assessment Technical Guidance.

Table 5: Summary table of cost and benefits (including savings) associated with the interventions presented in the IA

(£m, 2010 prices)	Costs			Savings		Benefits		
	Total Transition	**Average Annual** (exc. Transition)	**Total Cost**	**Average Annual** (exc. Transition)	**Total Savings**	**Average Annual** (exc. Transition)	**Total Benefits**	**Net Benefits**
Suicide training and CBT	20	3.1	51	0.4	4	90	900	853
Setting up barriers	113	0	113	0	0	608	6080	5967
Total	133	3	164	0	4	698	6980	6821

Annexes

Annex 1 should be used to set out the Post Implementation Review Plan as detailed below. Further annexes may be added where the Specific Impact Tests yield information relevant to an overall understanding of policy options.

Annex 1: Post Implementation Review (PIR) Plan

A PIR should be undertaken, usually three to five years after implementation of the policy, but exceptionally a longer period may be more appropriate. If the policy is subject to a sunset clause, the review should be carried out sufficiently early that any renewal or amendment to legislation can be enacted before the expiry date. A PIR should examine the extent to which the implemented regulations have achieved their objectives, assess their costs and benefits and identify whether they are having any unintended consequences. Please set out the PIR Plan as detailed below. If there is no plan to do a PIR please provide reasons below.

Basis of the review: The draft strategy includes a commitment to publish an annual update on progress.
Review objective: The annual update will assess progress on the objectives and areas for action outlined in the draft strategy.
Review approach and rationale: The annual update will summarise developments, identify relevant research studies and their findings, and report detailed statistical information on suicides by gender, age, method and location. The draft strategy proposes to establish a National Suicide Strategy Implementation Advisory Group, including researchers, third sector representatives, representatives from relevant professional bodies and government departments, as well as people with direct experience of bereavement by suicide. This group will meet regularly to assess progress on implementation of the strategy, and will contribute to the annual update.
Baseline: The three-year rolling average rate of deaths from intentional self-harm and injury of undetermined intent in England, 2007-2009 is 8.1 per 100,000 population.
Success criteria: Ongoing monitoring of suicide rates and trends to identify any emerging patterns. Monitoring of lessons from research to ensure any findings which could have a positive impact on suicide rates and the support available to families are disseminated.
Monitoring information arrangements: Objective 6 of the draft strategy details the existing sources of data on suicides, and the proposals to expand and improve the systematic collection of data.
Reasons for not planning a review:

[i] Bermingham S, Cohen A, Hague J, Parsonage M (2011) The cost of somatisation among the working-age population in England for the year 2008/09. *Mental Health in Family Medicine* forthcoming.

[ii] Appleby L, Morriss R, Gask L et al (2000) An educational intervention for front-line health professionals in the assessment and management of suicidal patients (The STORM Project). *Psychological Medicine* 30:805-12.

[iii] Brown GK, Ten Have T, Henriques GR et al (2005) Cognitive therapy for the prevention of suicide attempts: a randomized controlled trial. *Journal of the American Medical Association*294:563-70.