SOUTHAMPTON SUICIDE PREVENTION PLAN

2020 - 2023

OWNER: SOUTHAMPTON SUICIDE PREVENTION PARTNERSHIP
BOARD RESPONSIBILITY: SOUTHAMPTON HEALTH AND WELLBEIGN BOARD
COMPILED BY: PUBLIC HEALTH SOUTHAMPTON

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Death by suicide is preventable and every one suicide is one too many. It is a deeply personal tragedy, which has a long-standing effect on families, friends and communities. Nationally, there is a call to reduce deaths by suicide. The Five Year Forward View for Mental Health sets out the ambition to reduce the number of suicides in England by 10 per cent by 2020, and the NHS Long-term Plan (2019) reaffirms the commitment to make suicide prevention a priority over the next decade.

AIM

This plan **aims to reduce the number of suicides in Southampton, and ensure provision of support to those bereaved by suicide, focusing on but not limited to groups at high risk of taking their own life.**

PRIOIRTY AREAS

In line with the 2012 (updated in 2017) cross-government strategy on Suicide Prevention, we will focus on the 6 key areas for action to reduce suicide, plus an additional priority in relation to leadership:

1. Achieve city wide leadership for suicide prevention
2. Reduce the risk of suicide in key high-risk groups
3. Tailor approaches to improve mental health in specific groups
4. Reduce access to the means of suicide
5. Provide better information and support to those bereaved or affected by suicide
6. Support the media in delivering sensitive approaches to suicide and suicidal behaviours.
7. Support research, data collection and monitoring.

CONTEXT

This Plan is being introduced during an international COVID-19 pandemic. As it is widely acknowledged that the pandemic will have a major impact on people's mental health and wellbeing, the direction that this Suicide Prevention Plan provides is critical to ensuring a coordinated response that will support our residents, families and communities both during the pandemic and in the recovery period.

Within the published literature there are suggestions that suicide rates will rise, although this is also acknowledged that this is not inevitable. Suicide is likely to become a more pressing concern as the pandemic spreads and has longer-term effects on the general population, the economy, and vulnerable groups. Preventing suicide therefore needs urgent consideration. The response must capitalise on, but extend beyond, general mental health policies and practices[1].

The likely adverse effects of the pandemic on people with mental illness, and on population mental health in general, might be exacerbated by fear, self-isolation, and physical distancing. Those with psychiatric disorders might experience worsening symptoms and others might develop new mental health problems, especially depression, anxiety, and post-traumatic stress (all associated with increased suicide risk). These mental health problems will be experienced by the general population and those

[1] Gunnell D. et al. 2020. *Suicide risk and prevention during the COVID-19 pandemic*. The Lancet. See: https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30171-1/fulltext

with high levels of exposure to illness caused by COVID-19, such as frontline health-care workers and those who develop the illness.[2] Longer term impacts in terms of trauma, grief and distress may exacerbate the burden of mental ill-health in the community long after recovery.

The Plan has therefore been refreshed to ensure that it is COVID-19 sensitive, and addresses the risk factors that are likely to be heightened by the pandemic, and which could exacerbate poor mental health and subsequent suicidality.

NATIONAL PICTURE

Death by suicide refers to a deliberate act that intentionally ends one's life. Suicide is often the end point of a complex history of risk factors and distressing events. Suicide affects people across the life-course, and whilst the highest proportion of deaths are in middle aged men, nationally, suicide is a leading cause of death for young people aged 15–24 years.

According to data from the Office for National Statistics (ONS)[3] in 2018 there were 6,507 deaths by suicide registered[4] in the UK, an age-standardised rate of 11.2 deaths per 100,000 population. The 2018 rate is significantly higher than the rate in 2017 and represents the first increase since 2013. This is accounted for by the increase in the male suicide rate; for females the UK rate of 5 deaths per 100,000 is consistent with rates over the past 10 years. Despite having a low number of deaths overall, rates among the under 25s have generally increased in recent years, particularly 10 to 24-year-old females where the rate has increased significantly since 2012 to its highest level with 3.3 deaths per 100,000 females in 2018. However, when looking at all age suicide rates over the last two decades, there does continue to be a general decrease over time from a rate of 10.3 deaths per 100,000 population in 2001-03 to 9.6 in 2016-18.

Three-quarters of registered deaths by suicide in 2018 were among men (4,903 death), which has been the case since the mid-1990s. Males aged 45 to 49 years have the highest age-specific suicide rate (27.1 deaths per 100,000 males); for females, the age group with the highest rate is also 45 to 49 years, at 9.2 deaths per 100,000.

As seen in previous years, in 2018 the most common method of suicide in the UK was hanging, accounting for 59% of all suicides among males and 45% of all suicides among females.

There is a relationship between suicide and deprivation, with suicide rates being statistically significantly higher in the most deprived areas of England.

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[2] Gunnell D. et al. 2020. *Suicide risk and prevention during the COVID-19 pandemic*. The Lancet. See: https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30171-1/fulltext

[3] ONS. 2019. Suicides in the UK – 2018 registrations. See: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations

[4] In England, Wales and Northern Ireland, when someone dies unexpectedly, a coroner investigates the circumstances to establish the cause of death. The investigation, referred to as an "inquest", is a process that can take months or, in some cases, years. The length of time it takes to hold an inquest creates a gap between the date of death and the date of death registration. For deaths caused by suicide, this generally means that around half of the deaths registered in a given year will have occurred in the previous year or earlier.

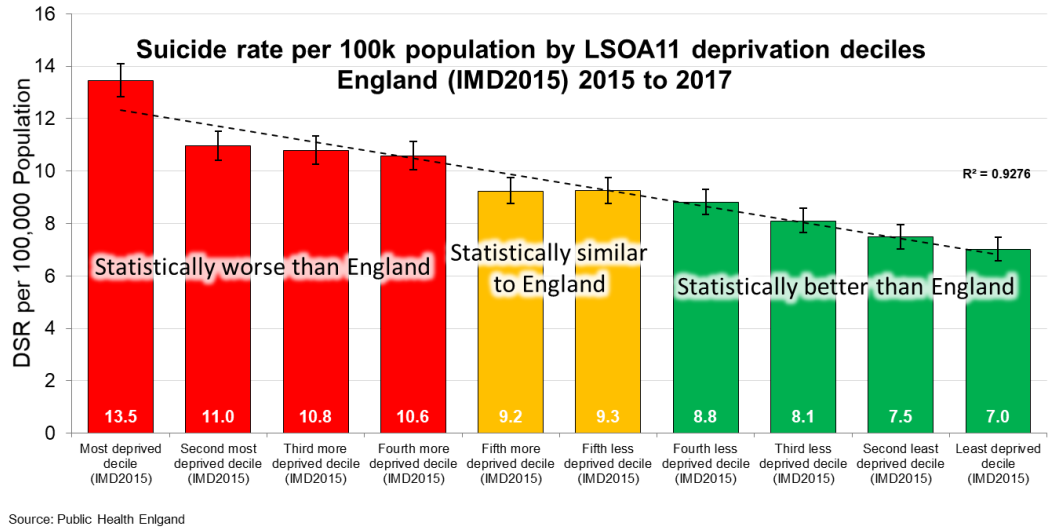

Figure 1. Differences in suicide rate by deprivation deciles in England.

LOCAL PICTURE

In Southampton, the suicide rate has fallen in recent years from 15 deaths per 100,000 in 2012-14 to 12.7 in 2016-18. However, Southampton continues to have a significantly higher rate of suicides than the national (9.6 deaths per 100,000) and South East (9.2 deaths per 100,000) average. Southampton's suicide rate is also the third highest when compared to 15 similar Local Authorities (using the CIPFA nearest neighbour definition)[5]. Translated into numbers of registered deaths by suicide, we know that around 26 residents in Southampton take their own life by suicide each year (based upon 2016-18 data). This number is subject to small year on year variability, and in the period 2001 to 2018 was highest in 2012-14 when there was an average of 29 registered deaths by suicide per year.

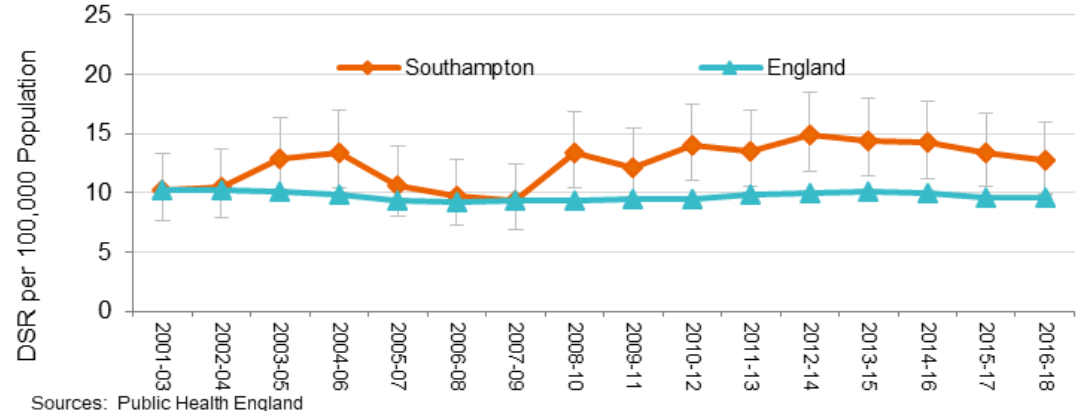

Figure 2. Southampton and England suicide rates per 100,000 from 2001-2003 to 2016-2018

[5] Public Health England suicide prevention profile: https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

The figure below shows suicide rates for Southampton, compared to the other Sustainability and Transformation Plan (STP) areas (Hampshire, Portsmouth and the Isle of Wight).

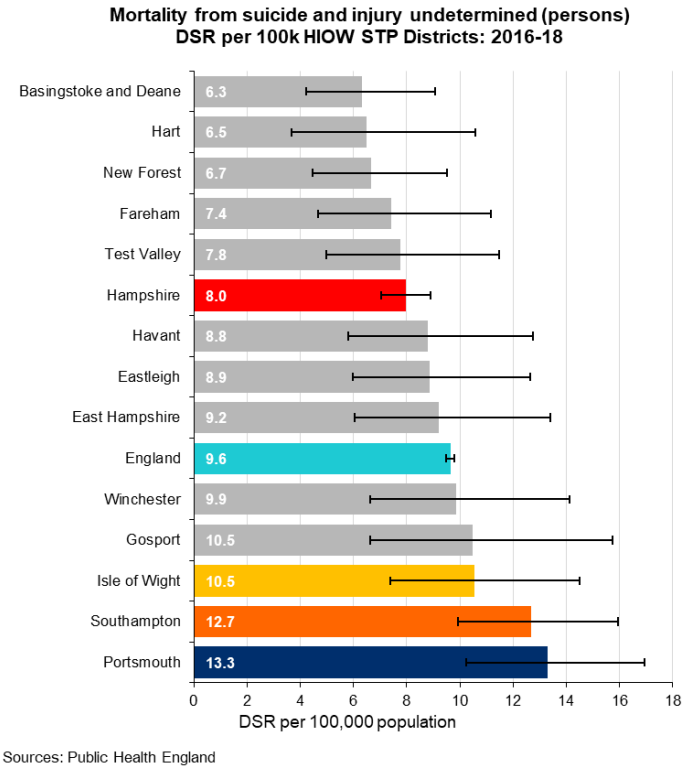

Figure 3. Suicide rate for the South East region.

SCC Public Health works with the coroner's office to undertake suicide audits to gather intelligence on deaths by suicide. For the two year period 2017-2018, 38 deaths by suicide in Southampton were audited. Of the 38 deaths by suicide:

- 71% (27) were male, and 28% (11) female.
- The highest proportion of deaths took place in men aged 51-60 years.
- 90% were White British (for 5% ethnicity is unknown).
- 52% were known to mental health services (48% were not), and 31% had been in contact with their GP in the 4 weeks prior to taking their life.
- 47% were known to have previously attempted to take their life by suicide, and 23% were known to have a history of self-harm.
- Hanging was the most frequent method of suicide (55%), with most people taking their own life at home. The next most frequent methods are overdose/poisoning (16%), injuries (10%), suffocation (5%), falling from a height (3%) and by being hit by a train/life taken on the tracks (2%).
- 42% of those that died were employed, 29% unemployed, 13% retired, and 13% had a long-term disability which meant they could not work.
- Mental health problems (65%), relationship problems such as separation (52%), physical health problems (52%), job problems (28%), history of contact with the criminal justice system (28%), financial issues (26%), adverse childhood experiences (26%), and being a victim of abuse (21%) were the most common recorded "life event" risk factors.

In relation to risk factors for suicide, according to the Public Health Outcomes Framework (2019), Southampton has a higher than the national average prevalence of recorded depression in those aged 18 years and over, and higher prevalence of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers for all ages. Southampton also has a higher than national average levels of unemployment, and a higher than average percentage of people living alone. In relation to children and young people, Southampton has higher than national average levels of looked after children, care leavers, and children in the youth justice system.

Unfortunately, many of these known risk factors could be exacerbated by the current COVID-19 pandemic. The diagram below, developed by Hertfordshire County Council in April 2020 demonstrates the mental health impacts of COVID-19 across the life-course, and which will have implications for suicidality.

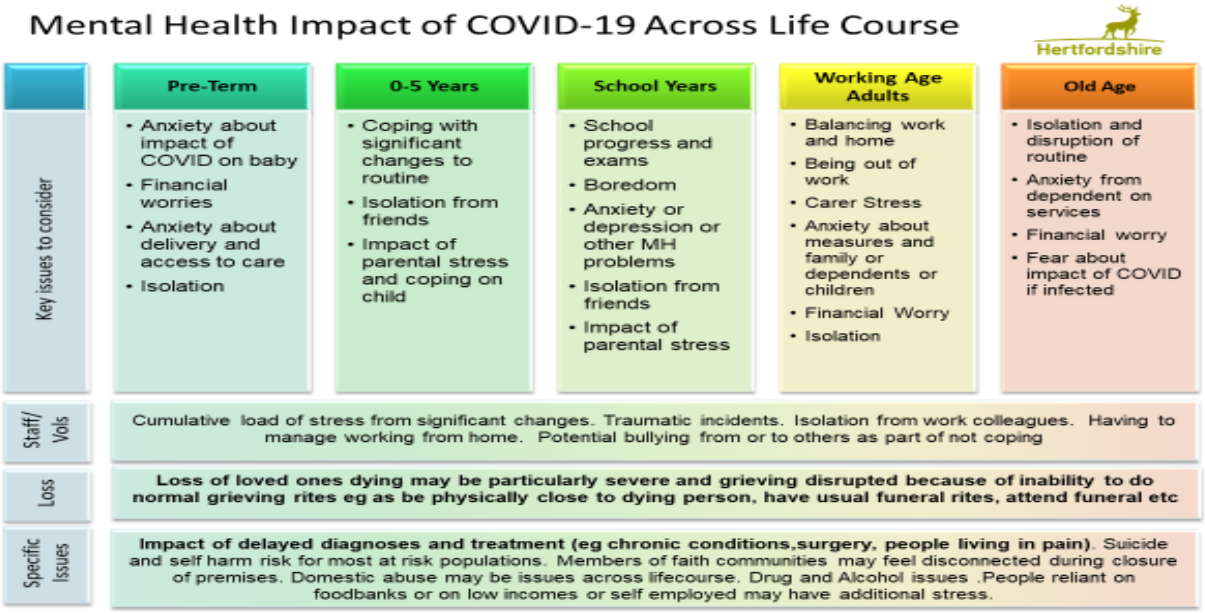

Figure 3. MH impacts of COVID-19, which could be interpreted as risk factors for poor mental health. Source: Hertfordshire County Council, April 2020.

SELF-HARM

Self-harm is a concern in its own right, as well as being a risk factor for completed suicide. Not everyone that self-harms will have suicidal thoughts, whilst not everyone that dies by suicide will have self-harmed. However, we know that previous self-harm is an important predictor for suicide.

As already noted, of those deaths by suicide in Southampton during 2017 and 2018 that were audited, 47% were known to have previously attempted to take their life by suicide, and 23% were known to have a history of self-harm.[6] In line with national guidance, self-harm has been identified for inclusion in this Plan as a priority for further action.

[6] The local audit of Coroner's records will under-estimate the individuals that have self-harmed as it is well documented that many people who self-harm do not seek help from health or other services and so self-harm episodes are not recoded.

National and local Southampton data suggest levels of self-harm are increasing, although only the 'tip of the iceberg' presents to healthcare services. Young people and adolescents (especially females) have disproportionately high rates of self-harm, both nationally and in Southampton. Self-harm in adults of all ages, taken together, also represents a significant health (and healthcare) burden. Local hospital admissions for self-harm in 10-24 year olds are significantly higher in Southampton than the national average.[7]

National risk factors for self-harm include the following:

- Women - rates are two to three times higher in women than men;
- Young people - 10-13% of 15-16-year-olds have self-harmed in their lifetime;
- Mental health disorders including depression and anxiety;
- People who have or are recovering from drug and alcohol problems;
- People who are lesbian, gay, bisexual or gender reassigned;
- Socially deprived people living in urban areas;
- Women of black and South-Asian ethnicity;
- Groups including veterans, prisoners, those with learning disabilities, and those in care settings;
- Individual elements including personality traits, family experiences (being single, divorced or living alone), exposure to trauma (including bullying, abuse or adverse childhood experiences), life events, cultural beliefs, social isolation and income.

OUR APPROACH

Partnership: As a large percentage of suicidal individuals are not in contact with health or social care services, action is required beyond the health and social care system. Partnership is required with community groups, local business and the voluntary and community sector to help identify and support people at risk of suicide and those bereaved by suicide. Key messages learned from practice and research are that suicide is preventable, that it is everyone's business, and that collaborative working is key to successful suicide prevention. This Plan has been developed by a wide range of partners to ensure that is a collaborative effort, and that action to prevent suicide is a shared responsibility across Southampton.

Prevention and early intervention: The Plan supports taking early action to prevent individuals from reaching the point of personal crisis where they feel suicidal. This requires action much earlier and across a range of settings from general practice, to schools, the workplace and community groups.

Life-course: This Plan takes a "life course" approach as advocated by the Marmot Review (2010), and aligned with the national mental health and suicide prevention strategy.

Evidence based: This Plan is informed by the evidence base. It uses national and local evidence to both identify areas of focus and specific need, and to inform the actions that will be taken to address need. This includes national guidance, published literature, and national and local intelligence, including from the local suicide audit of coroner records and real-time surveillance data from Hampshire Constabulary. The Plan has also been informed by stakeholder engagement with partners across the system, including Southampton residents with lived experience of mental health.

[7] See https://fingertips.phe.org.uk.

Agile use of intelligence and resources: As new or additional intelligence on the mental health implications of the current pandemic becomes available, the Plan may need to flex to adapt to a changing situation, with resources potentially needing to be reprioritised to focus on areas of greatest need.

HOW WE WILL MEASURE SUCCESS

Ultimately, we want to see a reduction in Southampton's suicide rate. This will be particularly challenging in the current context of a pandemic, and in the years beyond due to the economic fall-out, which is expected to be far-reaching and be felt for many years. However, aiming to reduce deaths by suicide is the right thing to do, and we should be doing all we can as a system to prevent each and every death.

Due to the low numbers of suicides it is difficult to show a *statistically* significant improvement in suicide rates across a local area and additional (proxy) measures will be used to assess the Plan's success. This includes for example, hospital admissions for self-harm and stigma in the population. See **Appendix A** for a breakdown of monitoring measures that will be used.

DELIVERY AND GOVERNANCE

Southampton Suicide Prevention Partnership (SPP) has responsibility for delivering on and monitoring progress towards the Suicide Prevention Plan. The Suicide Prevention Partnership will report to the Health and Wellbeing Board, which has overall responsibility for suicide prevention.

The Suicide Prevention will review status against actions on a six basis, for which all partners will be expected to submit a short status report.

ACTION PLAN

AREA 1: ACHIEVE CITY-WIDE LEADERSHIP FOR SUICIDE PREVENTION

This plan has been developed by a wide range or partners to ensure this is a collaborative effort and that action to prevent suicide is a shared responsibility between stakeholders in Southampton. The Suicide Prevention Partnership (SPP) in Southampton has been in place for a number of years and will continue to work together to achieve shared outcomes.

Ref	Target Group	Action	Lead Partner	Anticipated Outcome	Timescale
1.1	All groups	Continue with regular meetings by the strategic multi-agency group; Southampton Suicide Prevention Partnership (SPP), reporting to Southampton Health and Wellbeing Board.	SCC Public Health	Clear leadership and governance structure to enable decision-making and coordinate suicide prevention efforts.	Ongoing
1.2	All groups	Members of the SPP advocate suicide and self-harm prevention in their organisations/service areas, disseminate key messages, and take action where they are a "lead partner" in this Plan.	All partners	Co-ordinated advocacy and ownership of suicide prevention across all sectors.	Ongoing
1.3	All groups	SPP maintains and develops strong links with national, South East and Hampshire-wide mental health networks, including: - STP Suicide Prevention programme, including links with the National Collaborating Centre for Mental Health (NCCMH) and the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) - LRF Mental Health Recovery Group (formed from the STP MH Board) - CYP Transformation Board and sub-groups - H&IW CYP Mental Health Steering Group - PHE South East Mental Health Network	All appropriate partners, including SCC PH, STP SP Programme Manager, CCG, Southern Health, CAMHS	Alignment of suicide prevention outcomes, strategic support from other networks, and learning from other areas.	Ongoing Aligned with the COVID-19 response Good representation on all of the networks

1.4	People with lived experience	Refresh the membership of the SPP to ensure that key stakeholders are represented, including people with lived experience.	SCC Public Health Solent Mind	Improved representation of stakeholders on SPP, co-production, and engagement in delivery of actions.	2020-21
1.5	People with lived experience	Establish links with networks representing residents with lived experience to maximise coproduction opportunities.	SCC Public Health ICU Solent Mind	Coproduction with those with lived experience	2020-21

AREA 2: REDUCE THE RISK OF SUICIDE IN KEY HIGH-RISK GROUPS

The following groups are at higher risk of suicide in Southampton. These groups are in line with at risk groups identified by national guidance such as the national strategy report Preventing Suicide in England: Two Years On (2018).

- Men, particularly middle-aged men.
- People experiencing mental health problems, particularly depression and personality disorders – both in the care of mental health services and those not currently receiving treatment. For those in treatment, high risk periods include the first 3 months post-discharge from acute mental health services.
- People experiencing:
    - Relationship difficulties, particularly separation for men (most commonly occurring life event identified by the Southampton Suicide Audit)
    - Unemployment and financial difficulties
    - Physical health problems, particularly disability and chronic pain
    - Housing difficulties and/or social isolation
    - Bereavement, especially bereavement by suicide
- People with history of attempts of suicide or self-harm
- People formerly convicted of a crime
- People with a history of substance misuse (especially co-occurring substance misuse and mental health needs)
- People who have experienced abuse (either as victims or witnesses)

All of the above risk factors could be exacerbated by the COVID-19 pandemic and economic fall-out in years to come. Additional risk factors include those stated in Figure 3.

Ref	Target Group	Action	Lead Partner	Anticipated Outcome	Timescale
2.1	All groups	Provide immediate suicide prevention guidance to key settings within the context of COVID-19, to support them in providing effective advice and support to CYP, adults and families who may be distressed or in crisis. The guidance should include advice on known risk factors, risk factors that the pandemic may exacerbate, free online training for front line staff, details on support available	SCC Public Health	Suicide prevention knowledge better embedded in key settings to for immediate use	2020-21

		locally/nationally, and clarity on what to do in a crisis.			
2.2	All target groups	Map the different services, organisations and support groups (e.g. Citizens Advice, Foodbanks, Gyms, Libraries, Men's Sheds, Relate, Street Pastors, Housing services as well as health services) that each of the at risk groups are likely to have frequent contact with – their "touch points" in order to identify gaps, unmet needs, and opportunities i.e. to target suicide prevention interventions.	Public Health to utilise a Southampton Suicide Prevention Partnership meeting to complete mapping	Identification of opportunities to utilise community organisations and support groups as assets in the prevention of suicide.	2020
2.3	All target groups	Develop and secure an improved training offer to ensure the provision of mental health, self-harm and suicide prevention training to frontline staff and "touch points" (see above) to enable them to better identify those in need of help, provide support, and signpost/refer. Examples would be working with Related and similar organisations that work with recently separated men, and organisations that provide advice on debt and financial difficulties. The above will require mapping what is currently being delivered across the city, and exploring opportunities to collaborate locally and regionally where appropriate.	SCC Public Health to coordinate All partners to support	Improved competence and confidence in suicide prevention in front-line staff and key "touch points" in the community.	Developed and secured in 2020-21
2.4	Men, and especially those that are recently separated, socially isolated,	Deliver public awareness mental health campaigns (including suicide prevention and self-harm messaging) that target at risk groups, reduce stigma, and encourage people to seek support. These should amplify national campaigns as appropriate.	Southampton Anti-Stigma Partnership	Reduce stigma surrounding suicide, and increase help-seeking behaviour with regards to mental and emotional health.	At least one campaign each year Ongoing messaging as part of MH and wellbeing

	have a disability/ pain and/or financial difficulties				communications, and including during the COVID-19 period
2.5	All groups and especially, men, CYP, LGBT and BME groups	Deliver Time to Change events that raise public awareness of mental health, tackle stigma, and encourage people to talk about mental health. Events include Mela, Pride, and sports related events, though should also be delivered via online events and communication channels in the absence of mass gatherings.	Southampton and Portsmouth Time to Change Hub (Solent Mind) Southampton Anti-Stigma Partnership	Reduce stigma surrounding suicide, and increase help-seeking behaviour with regards to mental and emotional health.	At least two events each year for 2020-21 and 2021-22
2.6	All groups	Promote the distribution of Life Cards* to local organisations, services and support groups, including those that are frequent "touch points" for our target and vulnerable groups. *Developed by Southern Health, credit card sized, and with vital information on the back aimed to signpost people to key tools and organisations that can offer support and advice to anyone that needs it.	Southern Health	Improved signposting to service	2020-21 (and ongoing)
2.7	All groups	Promote community resilience in relation to mental health and suicide prevention through the establishment of a H&IW Innovation Fund to fund community projects that will deliver interventions that promote suicide prevention	STP Suicide Prevention Programme SCC ICU and Public Health	Improved community resilience	2020-21 and 2021-22
2.8	All, though targeting of men, and especially recently separated, socially	Gain the commitment of key employers to promote mental health and wellbeing within their organisations through a combination of: - Mental health (including suicide prevention) training; - Signing up to the Time to Change Employer Pledge;	All SPP partners Southampton and Portsmouth Time to Change Hub (Solent Mind)	Improved awareness and identification of mental health need, support, and referral amongst targeted high-risk employers and employee groups.	Ongoing and by end of 2023

	isolated, have a disability/ chronic pain and/or have financial difficulties	- And/or other workplace health policy and procedures that promote good mental health and wellbeing in the workplace and better identify and respond to those in need of support – aligned with the STP Suicide Prevention Programme. Occupations: Low skilled male labourers (three times more likely to take their own lives than the national average); nursing staff and primary teachers also high.	STP Suicide Prevention Programme Align with the work of LRF and STP groups i.e. workforce and Business/economy sub-groups of the LRF MH Recovery Group		
2.9	As above	Engage with Trade Unions and industry/business representatives to develop workplace suicide prevention tools and initiatives in targeted industries.	STP Suicide prevention programme Align with the work of LRF and STP groups i.e. workforce and Business/economy sub-groups of the LRF MH Recovery Group	Improved awareness and identification of mental health need, support, and referral amongst targeted high-risk employers and employee groups.	2020-21 and 2021-22
2.10	Target groups: As above	Strengthen the debt/financial need pathway through the following actions: - Work with LA stakeholders to ensure that Local Authority debt recovery is sensitive the MH and wellbeing needs of residents. - Improve the skills and confidence of those providing debt and financial advice in identifying MH and wellbeing needs and providing proactive support in accessing MH resources and services. - Work with health partners (i.e. Southern Health and primary care) to strengthen the pathway to debt and financial advice.	STP Suicide Prevention Programme SCC PH Align with the work of LRF and STP groups i.e. workforce sub-group of the LRF MH Recovery Group	Improved pathways and access to both debt and financial advice and services, and MH resources and services.	2020-21

		- Embed financial literacy, access to financial advice and support, and active sign-posting to support organisations amongst targeted high-risk employers, and other key organisations.			
2.11	Social isolation	Promote social prescribing as a means of improving mental health and wellbeing, including as a way of reducing social isolation. Ensure existing VCSO's/projects that support life events and address risk factors (e.g. financial advice, relationship advice) are involved.	Southampton CCG	Improved early intervention and access to protective factors.	Ongoing
2.12	All target groups	Improve identification of, and care planning with, patients with low mental health and wellbeing amongst the primary care workforce, with a focus on suicide prevention and self-harm training and making good quality resources easily available.	STP Suicide Prevention Programme Align with the work of LRF and STP groups i.e. primary care education sub-group of the LRF MH Recovery Group	Improved identification of suicide risk and care planning for vulnerable patients in primary care.	2022
2.13	People with a history of self-harm People that could self-harm - primary prevention and early intervention	Better understand the data and pathways in relation to self-harm and identify areas for quality and service improvement, with a focus on identifying and delivering interventions that promote prevention and early intervention in the school and/or family settings (i.e. access to peer support for family/carers), and interventions within the first month post ED admission for self-harm.	STP Suicide Prevention Programme Align with the work of CYP ICS Transformation Board	Improvements in the self-harm pathway and subsequent contribution to reducing self-harm rates	2022
2.14	People in contact with services.	Mental health trusts have robust suicide prevention plans in place, which include:	Solent NHS Trust Southern Health	Improved clinical intervention to reduce suicide rates.	2020-21 and ongoing

	High risk periods; first 3 months post-discharge from MH services and first month after ED	• The undertaking of psychosocial assessments for all people who present at emergency departments for self-harm. • Robust discharge planning processes for vulnerable patients (heeding the House of Common's Health Committee's recommendation that people being discharged from inpatient care should receive follow up support within 3 days of discharge, rather than the current standard of 7 days). • Compliance with NICE guidance.			
2.15	Children and young people	Promote positive mental health and wellbeing in the schools through the work of Mental Health Support Teams*, partnership with the Anna Freud programme, and the work of the CYP Social and Emotional Mental Health Partnership. This should include a focus on key protective factors such as training CYP and parents/carers on safe use of social media (protective in reducing online bullying). *Have a remit to provide evidence-based physiological interventions for those with mild to moderate level MH needs, and promote a whole school approach to MH and wellbeing.	CYP Social and Emotional Mental Health Partnership (chaired by the ICU)	Improved social and emotional health in CYP	Ongoing 2020-2023
2.16	Families	Inform the proposals for locality based teams so that support families in Southampton to raise awareness of suicide prevention support and build community and family resilience.	SCC Public Health ICU	Suicide prevention embedded within Locality Team proposals	2020-21
2.17	Physical health problems, particularly disability	Embed mental health and wellbeing within key physical health pathways and vice versa, including through: - The chronic pain pathway	Southampton CCG UHS Steps 2 Wellbeing	Improved integration of both mental and physical health needs	During both 2020-21 and 2021-22

	and chronic pain	- Through the Persistent Physical Symptoms pilot at UHS - Promotion of physical health through the Steps 2 Wellbeing service. - The roll out of physical health checks for those with severe mental illness (SMI).			
2.18	Housing difficulties	Explore how the mental health needs of those using night shelters could be better met to address unmet need.	Southern Health Society of St James Southampton ICU	Recommendations for meeting the MH needs of those using night shelters	2022-23
2.19	Co-occurring substance misuse and MH	Assess co-occurring conditions policy and services against NICE standards, identify priority areas for action, and develop strategies to manage co-occurring conditions effectively, including integrated care pathways.	Drug and Alcohol Partnership Group Suicide Prevention Programme Supported by all relevant partners	Improved outcomes for those with drug and/or alcohol and mental health needs	By end of 2023
2.20	People in contact with the criminal justice system	Roll out of suicide prevention training within Hampshire Constabulary, and exploration of plans and procedure in relation to the pre and post release period (i.e. “through the gate” services/pathways).	Hampshire Constabulary	Improved awareness and identification of mental health need, support, and referral to MH and wellbeing resources and services.	Training – 2020-21 Pre-and post-release period – 2022-23

AREA 3: TAILOR APPROACHES TO SUPPORT IMPROVEMENTS IN MENTAL HEALTH IN SPECIFIC GROUPS

As identified by national guidance, the following groups may need tailored approaches to support improvements in resilience and contribute to improved mental health and wellbeing:

- Looked after children and/or care leavers;
- Military veterans;
- People who are lesbian, gay, bisexual or gender reassigned;
- Black and Minority Ethnic groups and asylum seekers (men of Eastern European backgrounds were found especially at risk by the Suicide Audit);
- Those with complex (and often multiple) needs;

Ref	Target Group	Action	Lead Partner	Anticipated Outcome	Timescale
3.1	Adults Those with complex needs i.e. MH, substance misuse, rough sleeping	Ensure SPP representation at the Vulnerable Adults Group of Better Care Southampton; to ensure suicide prevention is aligned with other work and embedded as appropriate.	SCC Public Health SSJ	Improved partnership working in relation to vulnerable adults and subsequent work on co-occurring conditions.	2020 and ongoing
3.2	All age groups Target groups: LGBT, BME, Veterans (ex), young offenders, bereavement support services.	Identify individuals/groups/organisations that can help engage with those identified as requiring tailored support (i.e. LGBT, BME groups, those with learning disabilities) and ensure they are aware of the pathways, services and resources in place so that they can best support individuals.	CYP Social and Emotional Mental Health Partnership sub-group (work on pathways, services and resources underway and will be promoted through Wessex Healthier Together)	Improved awareness of pathways, services and resources by professionals and in turn residents. Community groups/organisations identified and included in implementing the Suicide Prevention Action Plan.	2020-21

	Vulnerable CYP	Using the suicide audit, real time surveillance and other available data, complete a "deep dive" on the characteristics (including risk and protective factors) of CYP up to and including 25 year olds that have taken their own life by suicide; to inform the work of the H&IW CYP Mental Health Steering Group, including the following: - Work with Coroner's on the information that they are able to capture and record, including in relation to adverse childhood experiences (ACE's). - Work with the Child Death Overview Panel (CDOP) on joined up learning in relation to deaths of CYP by suicide. - Co-design changes to the Joint Agency Rapid (JAR) information gathering process.	SCC Public Health	Improved knowledge about the characteristics of CYP to inform H&IW CYP Mental Health Steering Group decision-making on unmet needs and interventions; which will seek to improve MH in vulnerable groups, including improvements to the JAR, and CDOP process, and recording of risks by Coroners.	2020-21

AREA 4: REDUCE ACCESS TO THE MEANS OF SUICIDE

This refers to reducing or restricting access to lethal means individuals use to attempt suicide is an important part of a comprehensive approach to suicide prevention.

Ref	Target Group	Action	Lead partner	Anticipated outcome	Timescale
4.1	Adults Those experiencing chronic pain	Promote safe prescribing of painkillers and antidepressants, including through promoting NICE guidelines on the appropriate use of drug treatments for depression, and sharing findings from the suicide audit in relation to deaths by overdose of prescription drugs.	SCC Public Health Southampton CCG	Safer prescribing and reduced fatal suicide attempts	Ongoing Larger push in 2021-22
4.3	All age groups	Include suicide risk in building design considerations for: - SCC major refurbishments and upgrading of social housing stock - SCC corporate assets - Acute MH Trust settings - Custody settings	SCC Housing Southern Health Hampshire Police	Suicide risk embedded in SCC housing stock (where major refurbishments and upgrading), and within MH Trust Suicide Prevention Plans, and Police plans	By 2023
4.4	All age groups	Work with planning and developers to include suicide risk in new building design considerations, especially in relation to multi-storey car parks, bridges and high rise buildings that may offer suicide opportunities.	SCC Planning and other partners as required	Suicide risk embedded in building design of major new infrastructure	2020-21
4.5	All age groups	Review suicide prevention measures at high-frequency locations (for attempted and completed suicides) and make recommendations.	SCC Public Health, Planning and Infrastructure and Transport Hampshire Police, and emergency services	Suicide prevention measures in place at specific high-risk locations	2021-22

4.6	All age groups	Continued commitment to mental health and suicide prevention training for front line staff, and continued assessment of locations for suicide risk and implementation of subsequent actions.	Network Rail	Suicide prevention measures in place in relation to the rail infrastructure and network rail staff (i.e. suicide prevention training).	Ongoing

AREA 5: PROVIDE BETTER INFORMATION AND SUPPORT TO THOSE BEREAVED OR AFFECTED BY SUICIDE

The provision of timely information and support to those bereaved or affected by suicide such as families, friends, colleagues and peers, is important in supporting people through the different stages of bereavement and in preventing future mental ill health. We know that death of a family member or friend by suicide is a risk factor for suicide in the bereaved.

Ref	Target Group	Action	Lead partner	Anticipated outcome	Timescale
The following actions are embedded in the STP Suicide Prevention Programme and so will be led by the STP work-stream on bereavement support and postvention, though the SPP will play an active role in informing the programme and supporting the delivery of solutions in the Southampton system. The work will align with the bereavement sub-group of the LRF MH Recovery Group and the work of the CYP Transformation Board.					
5.1	Families bereaved by suicide or a death of undetermined intent	Strengthen effective referral to bereavement support/services by emergency services that attend the death and those in contact with the families soon after bereavement from suicide occurs (i.e. Coroner's Office), so that referrals are appropriate and timely.	SCC Public Health Hampshire Police NHS South Central Ambulance Service (SCAS) Coroner's Office Bereavement services	Strengthened pathways and referral to bereavement support services. Standardise approach to supporting those bereaved by suicide	2021-22
5.2	Families bereaved by suicide or a death of undetermined intent	Promote the distribution of the "Help is at Hand"* booklet or zcard by local organisations, services and support groups, including the first responders, Coroners, Funeral Directors and education settings. *A national bereavement support resource developed by those with lived experience of bereavement in partnership with Public Health England.	SCC Public Health Hampshire Police Coroner's Office NHS Solent Southern Health Southampton General Southampton CCG (including primary care) British Transport Police Network Rail Voluntary sector partners	Information about bereavement support services more accessible	2020-21
5.3	Families bereaved by suicide or a	Develop and implement a Real-Time Suicide Surveillance System to 1. Enable a timely response by partners to ensure	SCC Public Health Hampshire Police Southern Health	Implementation of real-time suicide surveillance	First phase: 2020-21, and second phase 2021-22

	death of undetermined intent	family/carers/friends are appropriately supported after a death by suicide (i.e. within 48 hours), 2. Enable system learning by partners to inform future prevention work and 3. Enable early identification of any 'clustering' to inform prevention work.	NHS Solent Education settings		
5.4	Families bereaved by suicide or a death of undetermined intent	Review the current bereavement support offer to families in Southampton, determine how best needs can be met, and work with services to strengthen the provision of suicide-specific bereavement support.	SCC Public Health Bereavement support services	Strengthened suicide specific bereavement support	By end of 2021-22
5.5	Families bereaved by suicide or a death of undetermined intent	Build awareness raising on suicide-specific bereavement into core mental health and suicide prevention training for front line staff.	Southampton CCG (primary care)	More informed and competent workforce	2023
Out of scope of the STP programme					
5.6	Families bereaved by suicide or a death of undetermined intent	Develop a prevention and postvention protocol with Southampton schools and colleges; to ensure they can provide a supportive and robust response in the event of a suicide.	SCC Public Health SCC Education Education settings	More informed and robust response to deaths by suicide by education settings – reducing the risk of further suicidality.	2020-21
5.7	All groups Families affected by a suicide attempt	Ensure those affected by an attempted suicide are signposted to resources, tools and organisations where they can seek further support.	Southern Health Solent NHS Trust UHS	Strengthen support, reduce risk of future attempts Learn from attempted suicides	Ongoing

AREA 6: SUPPORT THE MEDIA IN DELIVERING SENSITIVE APPROACHES TO SUICIDE AND SUICIDAL BEHAVIOURS

There is a proven link between certain types of media reporting of suicide and increases in suicide rates. This objective aims to promote the responsible reporting and portrayal of suicide and suicidal behaviour in the media and reduce the risk of additional suicides

Ref	Target Group	Action	Lead partner	Anticipated outcome	Timescale
6.1	All age groups	Promote the responsible reporting and portrayal of suicide and suicidal behaviour in the media, including by encouraging use of the Samaritans guidance on responsible reporting, and challenging the publication of harmful or inappropriate material with reference to the updated laws on promoting suicide.	Anti-stigma partnership SCC comms	Reduce stigma around suicide	Ongoing (recirculate guidance when new reporters and when timely to do so i.e. when a death by suicide in a public place)
6.2	All age groups	Work with local media to encourage inclusion of positive stories (i.e. hope and recovery) and signposting of national helplines and local services for people that are affected by local campaigns and coverage of deaths by suicide or undetermined intent.	All partners, including SCC comms, CCG comms, Samaritans, Solent Mind	Establish a direct approach/contact with local media Increase in help-seeking behaviour	Ongoing

AREA 7: SUPPORT RESEARCH, DATA COLLECTION AND MONITORING

It is important to build on the existing research evidence and other relevant sources of data on suicide and suicide prevention.

Ref	Target Group	Action	Lead partner	Anticipated outcome	Timescale
7.1	All age groups	In relation to the Suicide Audit: - Ensure suicide data is recorded consistency across the STP so that it can be better analysed at the STP footprint. - Explore what further risk and protective factors can be included in relation to CYP and families, in discussion with the H&IW CYP MH Steering Group. - Continue to include findings of all serious incident reviews.	SCC Public Health, Coroner's Office	Audit to inform Suicide Prevention Plan refresh.	2021-22
7.2	All age groups	Circulate the key findings of the suicide audit to Partners to encourage learning from suicides locally.	Public Health CCG SPP	Learning from suicide audit inform practice.	2020-21 and ongoing
7.6	Children and young people	Include a section in the Year 7 Survey (with schools) or Youth Forum Survey, which will collect information on the status and views of children and young people in relation to mental health, social and emotional wellbeing – to support identification of need and preventative activities.	Public Health SCC	Identification of need and preventative activities.	2021-22
7.7	All age groups	Establish links with regional and leading universities on suicide and self-harm prevention to strengthen research links and academic input to the Partnership.	SCC Public Health, Academic partners	Strengthen academic and research links.	Ongoing
7.8	All age groups	Conduct "deep dives" where there is an opportunity to inform strategic and commissioning decision-making (could be in relation to self-harm, attempted suicides and/or completed suicides).	SCC Public Health, Academic partners Samaritans	Learning on suicidal thoughts and risk factors can help inform suicide prevention	Ongoing

APPENDIX A: MONITORING MEASURES AND OUTCOMES

No	Quantitative indicators
1	Suspected deaths by suicide as reported by first responders through real time surveillance data
2	Confirmed deaths by suicide as reported by Coroner's and captured through the Suicide Audit (biannual)
3	Recorded deaths by suicide as reported by ONS (annually)
4	3 year suicide rate as captured by the Public Health Outcomes Framework (PHOF)
5	Crude suicide rate by age group (10-34 years, 35-64 years, 65 years plus) as captured by PHOF (5 year average)
6	Years of life lost due to suicide, age standardised rate 15-74 years (3 year average, and for all persons, males and females) as captured by PHOF
7	Hospital admissions as a result of self harm by age group (10-14 years, 15-19 years, 20-24 years) as captured by PHOF
8	*Will explore how improve intelligence in relation to attempted suicides*
No	**Cross sectional and qualitative intelligence**
1	SCC PH snap shot survey of residents repeated periodically to monitor MH stigma in the community setting
2	People's Panel/Residents survey (MH and wellbeing questions embedded in the COVID-19 surveys)
3	No Limits survey
4	MRC University of Southampton study to understand the impacts of COVID-19 restrictions on young people, engaging young people in Southampton and surrounding areas about their experiences and concerns under lock down measures, to identify and develop solutions that support their wellbeing, mental and physical health. SCC PH informing.
5	Feedback through SMILE (network of Southampton residents with lived mental health experienced)

APPENDIX B: SOUTHAMPTON SUICIDE PREVENTION PARTNERSHIP MEMBERSHIP

Public Health, SCC
GP clinical lead for Southampton CCG
Mental health commissioner, ICU
Community engagement officer, ICU
Southern Health
Steps 2 Well-being
Southampton Solent University
University of Southampton
Solent Mind
Samaritans
British Transport Police
Hampshire Police
Society of Saint James
Survivors of Bereavement by Suicide (SOBS)

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