Preventing Suicides in Southwark

Our Strategy and Action Plan, 2017-2022

Southwark's Suicide Prevention Steering Group

13 March 2018

GATEWAY INFORMATION

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EXECUTIVE SUMMARY

Every suicide is a tragic event and has devastating impacts on families, friends and communities. In Southwark we know that many suicides are preventable. Therefore all partners within Southwark's suicide prevention network are committed to reducing suicide, attempted suicide and self-harm in Southwark from currently among the highest to among the lowest rates in London.

Areas for action

In order to achieve this vision, we have identified seven priority areas for action that have been built around the recommendations outlined in the National Suicide Prevention Strategy and tailored to local needs:

1. Reduce the risk of suicide in high risk groups
2. Tailoring approaches to improve mental health across all communities
3. Prevention of suicide in high risk locations and reducing access to the means of suicide
4. Providing better information and support to those bereaved or affected by suicide
5. Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Reducing rates of self-harm as a key indicator of suicide risk
7. Supporting research, data collection, monitoring and information sharing

A partnership approach

No single organisation has the ability to deliver effective suicide prevention in isolation. It is the combined knowledge, expertise and resources of organisations across the public, private and voluntary sectors that are essential to achieving Southwark's vision. We intend to establish a network for suicide prevention across Southwark consisting of the following partners:

FOREWORD

Every suicide is a tragic event with devastating impacts on family, friends and communities. Many of us in Southwark will have been directly or indirectly impacted by suicide. All of us are committed to ensuring that we do all we can to prevent self-harm, attempted suicide and suicide: this document sets out our vision and intent.

Like many parts of the country, Southwark has seen an increasing trend in the number of suicides over the last decade. Southwark is one of just a few London boroughs to report higher suicide rates than the national average. Just over four out of five suicides occurring locally are among men. The rate of suicide is highest among those in middle age, mirroring the national picture. Self-harm and attempted suicide are both significant risk factors for suicide. It is our intent to reduce suicide, attempted suicide and self-harm in Southwark to among the lowest rates in London.

Our new Suicide Prevention Strategy builds upon the accomplishments and lessons learnt since we published our previous strategy in 2005. With emerging evidence on what works to prevent suicide and self-harm, our new strategy incorporates new national guidance from Public Health England and the Independent Mental Health Taskforce. Indeed, our seven priority areas for action have been built around the recommendations outlined in the National Suicide Prevention Strategy and tailored to Southwark's unique needs as well as our unique opportunities and capability.

A key approach to our suicide prevention work in Southwark has been to involve, engage and empower our partners. We have worked with experts from a wide range of backgrounds and created new and more robust partnerships to learn from each other. This work started with the creation of Southwark's multi-stakeholder Suicide Prevention Steering Group in 2017 that has co-produced this strategy. The Steering Group will continue and will oversee our strategy's implementation and report back in due course.

We know that the drivers for someone to take their own life are extremely complex. Therefore the vision, objectives and actions outlined in this strategy will not be achieved if partners work in isolation. It is essential that key stakeholders work together effectively and alongside local communities. In doing so, we are committed to taking a more holistic approach to preventing suicides, understanding and addressing individual, community and the wider social determinants of suicides, and how these act across the life course. A concrete example of this approach is situating our suicide prevention actions within the wider context of improving mental health and wellbeing. We are pleased to have worked closely with the community and our partners to ensure there is full alignment with the new Southwark Council and NHS Southwark Clinical Commissioning Group's Joint Mental Health and Wellbeing Strategy. This will ensure all partners are working together towards improving mental health and promoting higher levels of wellbeing across the borough: ultimately reducing self-harm, attempted suicide and suicide in Southwark.

Cllr Richard Livingstone
Lead Member

Professor Kevin Fenton
Director, Health and Wellbeing

CONTENTS

1. INTRODUCTION

With approximately 13 people taking their life every day in England (1), suicide and self-harm are a major public health and social concern. The national suicide rate has been increasing year on year since 2006-8 (2) and is now the leading cause of death among men below the age of 50. (1)

Between 2014 and 2015, the number of suicides in London increased by 33 percent from 552 to 735 incidents; the highest number recorded by the Office of National Statistics since 2002. (2) Although London's suicide rate is the lowest in England, it varies significantly across the capital. Specific groups of people in London are at a higher risk of suicide. These include young people who have been in care or have suffered abuse, people living in the most deprived areas and individuals from the LGBTQ+ community. (3)

Southwark is one of five London boroughs to report a higher suicide rate than the national average over the period 2013-15 and there has been a general upward trend in the number of suicides since 2007-8. In this strategy we also consider self-harm as there is a very strong association between those who self-harm and go on to attempt suicide or take their own life.

The effect of suicide is devastating: for family and friends, not only are their relationships and ability to work impacted, but they become up to three times more likely to take their own lives. Alongside the emotional burden, financially it is estimated that each suicide among working adults marks a loss to the economy of approximately £1.67 million. (4) Suicide is seen as a proxy of underlying rates of mental ill-health. However, not all suicides occur among those with mental illness. Other factors such as bereavement, social isolation and abuse significantly contribute towards the risk of an individual taking their own life. (5)

In Southwark we know that many suicides are preventable. Therefore we are committed to alleviate the burden of mental illness and promote positive mental health: only this way can we reduce the incidence of self-harm and suicide across the borough. We will only achieve this by delivering this Suicide Prevention Strategy and Action Plan in the context of our wider Joint Mental Health and Wellbeing Strategy. It is essential that key stakeholders including the council, National Health Service (NHS) partners, the voluntary and community sector, Her Majesty's Coroner, and emergency services share this commitment and work together to achieve all our objectives.

2. DEFINITIONS

Suicidal act: Refers to all suicides and suicidal attempts

Suicide: In the UK, suicide is defined as deaths given an underlying cause of intentional self-harm or injury/ poisoning of undetermined intent

Attempted suicide: Act of self-poisoning or self-injury with suicidal intent, that is not fatal

Suicidal ideation: Recurring thoughts or preoccupation with suicide

Self-harm: Self-harm is defined as an intentional act of self-poisoning or self-injury, self-harm does not include attempted suicide

3. OUR VISION

Every suicide is a tragic event and has devastating impacts on families, friends and communities. In Southwark we know that many suicides are preventable…

Therefore all partners within Southwark's suicide prevention network are committed to reducing suicide, attempted suicide and self-harm in Southwark from currently among the highest to among the lowest rates in London.

We also know that the reasons why an individual may choose to take their own life are extremely complex and that the risk factors for suicide are many. Therefore, we acknowledge that avoiding all preventable suicides in Southwark will be extremely challenging and it may take a number of years to achieve our ambition. This strategy and action plan represents the first steps towards this challenge.
A national ambition to reduce the suicide rate by 10 per cent by 2020/21 has been set by the Independent Mental Health Taskforce in the Five Year Forward View for Mental Health. (6) In Southwark we have set a target to meet and exceed this.

We have set a local target: to reduce the number of suicides across Southwark by at least 10% over the five years of this strategy as well as reduce the incidence of self-harm and attempted suicide.

In order to realise our vision, Southwark's Public Health Directorate have developed this strategy and action plan in partnership with partners across the council, Southwark NHS Clinical Commissioning Group, providers and the voluntary and community sector, to better understand our local population and their needs. We have identified the key priority areas that we need to focus over the next five years and developed an action plan which outlines how this vision will be achieved.

4. SIX MYTHS ABOUT SUICIDE

There are a number of common misconceptions around suicide and suicidal ideation. It is important that the facts around suicide are widely understood to allow the appropriate support to be provided when someone is in need.

1. **MYTH:** People who talk about suicide do not intend to do it.

   FACT: People who talk about suicide may be reaching out for help or support. A significant number of people contemplating suicide are experiencing anxiety, depression and hopelessness and may feel that there is no other option.

2. **MYTH:** Most suicides happen suddenly without warning.

   FACT: The majority of suicides have been preceded by warning signs, whether verbal or behavioural. Of course there are some suicides that occur without warning. But it is important to understand what the warning signs are and how to look out for them.

3. **MYTH:** Someone who is suicidal is determined to die.

   FACT: On the contrary, suicidal people are often ambivalent about living or dying. Someone may act impulsively by drinking pesticides, for instance, and die a few days later, even though they would have liked to live on. Access to emotional support at the right time can prevent suicide.

4. **MYTH:** Once someone is suicidal, he or she will always remain suicidal.

   FACT: Heightened suicide risk is often short-term and situation-specific. While suicidal thoughts may return, they are not permanent and an individual with previously suicidal thoughts and attempts can go on to live a long life.

5. **MYTH:** Only people with mental disorders are suicidal.

   FACT: Suicidal behaviour indicates deep unhappiness but not necessarily mental disorder. Many people living with mental disorders are not affected by suicidal behaviour, and not all people who take their own lives have a mental disorder.

6. **MYTH:** Talking about suicide is a bad idea and can be interpreted as encouragement.

   FACT: Given the widespread stigma around suicide, most people who are contemplating suicide do not know who to speak to. Rather than encouraging suicidal behaviour, talking openly can give an individual other options or the time to rethink his/her decision, thereby preventing suicide.

Source: World Health Organization, Preventing suicide: A global imperative. (17)

5. POLICY CONTEXT

5.1. National Policy Context

England's overarching mental health strategy 'No health without mental health' references suicide throughout as a key indicator of mental ill-health and states that suicide prevention can only be achieved by improving mental health across the whole population. (7)

In September 2012, HM Government published a strategy for the prevention of suicide in England, focusing on six key action areas. (8) In January 2017, the scope was extended to include self-harm: (4)

1. Reducing the risk of suicide in high risk groups
2. Tailoring approaches to improve mental health in specific groups
3. Reducing access to means of suicide
4. Providing better information and support to those bereaved or affected by suicide
5. Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Supporting research, data collection and monitoring
7. Reducing rates of self-harm as a key indicator of suicide risk

In the Five Year Forward View for Mental Health the Independent Mental Health Taskforce set a national ambition to reduce the suicide rate in England by 10 per cent by 2020/21. (6) Recommendations were made for local government to contribute to the above ambition by putting in place a multi-agency suicide prevention plan by 2017. The plan should set out targeted actions in line with the National Strategy and demonstrate how evidence based interventions that target high-risk locations and high-risk groups can be implemented, drawing on localised, real-time data.

In partnership with the National Suicide Prevention Alliance, Public Health England published a guidance and support manual for local suicide prevention planning in October 2016.[1] The guidance focuses on three main recommendations that were first highlighted by the All-Party Parliamentary Group on Suicide and Self-harm Prevention as essential to successful local implementation of the national strategy:

1. Establish a multi-agency suicide prevention group involving all key statutory agencies and voluntary organisations
2. Complete a suicide audit
3. Develop a suicide prevention strategy and/or action plan that is based on the national strategy and local data

5.2. Regional Policy Context

The NHS and local councils have come together in 44 areas across England to develop Sustainability and Transformation Partnerships (STPs) that aim to integrate and improve health and care in their areas. Southwark is part of the South East London STP. South East London aims to deliver the full implementation plan of the Mental Health Five Year Forward View, including the commitment to reduce suicide rates by 10% against the 2017/18 baseline. (9)

Thrive London is a new initiative towards the improvement of mental health and wellbeing across the capital and is supported by the Mayor of London and the London Health Board. Launched in December 2016, Thrive London aims to bring together multiple city agencies and providers as well as voluntary, business and community partners to enable every Londoner to live happier healthier lives. Suicide prevention has been announced as one of six specific areas of focus for the initiative. (10)

5.3. Local Policy Context

Southwark Council and NHS Southwark Clinical Commissioning Group recently launched a new Joint Mental Health and Wellbeing Strategy for 2018-2022 that explicitly references this Suicide Prevention Strategy and Action Plan as a companion document. The Joint Mental Health and Wellbeing Strategy aims to improve the mental health and wellbeing of our whole population, narrowing the gap in life expectancy, and ensuring parity of esteem with physical health. (11)

In 2005, Southwark Primary Care Trust completed a suicide audit and developed a strategy and action plan for suicide prevention. (12) This was the last time a suicide audit was carried out and a strategy and action plan developed. The audit used data from Public Health Mortality Files (PHMFs), GP records, coroner inquest files, mental health service records and Emergency Department records. Analysis of the above data produced a number of key findings and trends including; high risk age groups and ethnicities, common methods of suicide, previous contact with services and common risk factors.

Our strategy and action plan builds on these existing national, regional and local strategies and aims to provide a holistic approach to improving suicide prevention and reducing its impact on our communities.

6. UNDERSTANDING SUICIDE PATTERNS AND TRENDS

Suicide has been defined by the Office for National Statistics (ONS) as a death with an underlying cause of intentional self-harm or an injury or poisoning of undetermined intent. (5) In England and Wales all suspected suicides are subject to a coroner inquest, which seeks to ascertain the cause of death. The death cannot be registered until the inquest is completed, which can take months and sometimes years. The median registration delay for suicides in London in 2015 was 192 days. (13) A coroner records a verdict of suicide when they have decided that there is evidence, beyond reasonable doubt, that the injury was self-inflicted and the deceased intended to take their own life. Open verdicts are given to cases where there is insufficient evidence to conclude that the death was a suicide or an accident. Given the time lag between the occurrence of a suicide and its registration as a death, figures present deaths registered within a particular year, rather than deaths which occurred in that year. (14)

It is commonly acknowledged that official statistics under-report the actual number, and therefore rate, of suicide in most countries including the UK. Misclassification of deaths is a key reason for this problem. In England and Wales the common use of narrative verdicts by coroners eliminates the issue of trying to restrict a verdict to one single cause (or code). Therefore the death may often be coded as ‘accidental’ rather than ‘suicide’ or ‘undetermined intent’ by the ONS.

6.1. The National Picture

Every day in England approximately 13 people will take their own life. (1) As such, suicide is, and will increasingly be, a significant social and public health problem. In 2007, England recorded its lowest ever suicide rate, however since then the national suicide rate has been rising (Figure 1). There were 4,410 deaths due to suicide and undetermined injury in England in 2015, equivalent to a rate of 10.1 per 100,000 people (of all ages). (13) Suicide rates vary significantly across England (Figure 2); rates are highest in the north and south west of the country and London’s suicide rate is among the lowest nationally. (2) In England and on average, men are at least three times more at risk of taking their own life than women.

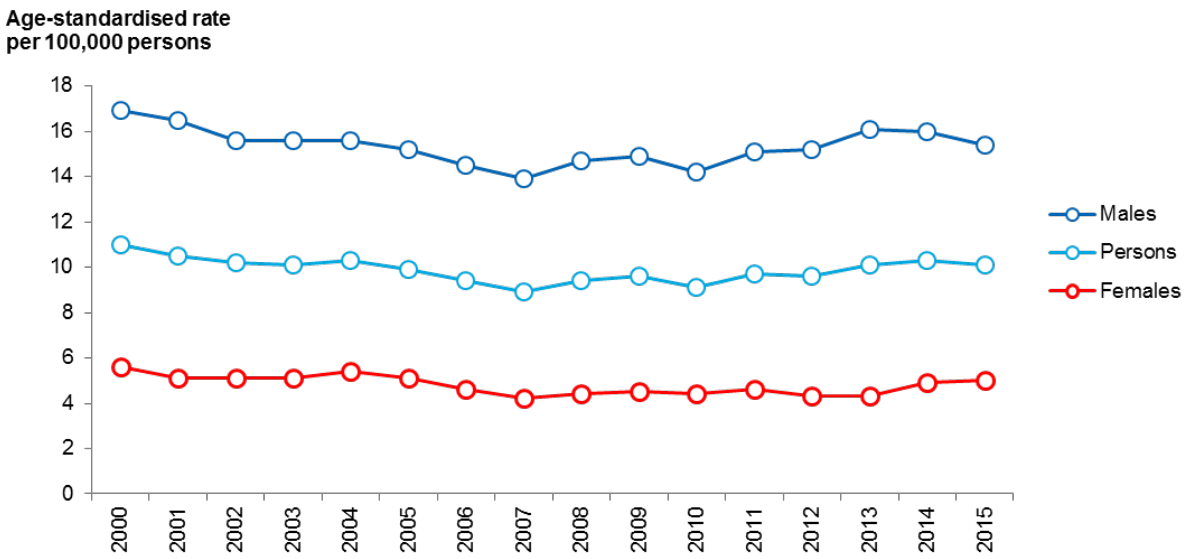

Figure 1: Directly age-standardised mortality rates from suicide and undetermined injury in England

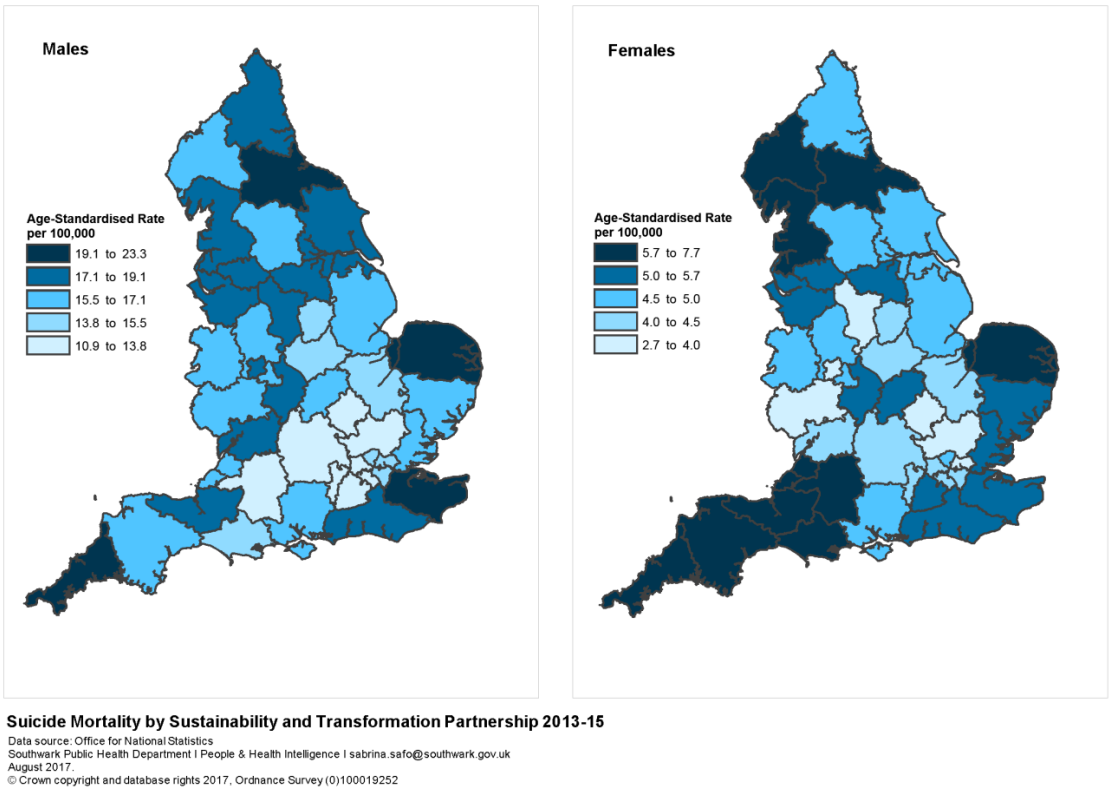

Figure 2: Directly age-standardised mortality rates from suicide and undetermined injury by Sustainability and Transformation Partnership 2013-15 (2)

National data show that the suicide rate increases with age among both males and females. The highest suicide rates in men are among those aged 45-49, with the female rate peaking slightly later between the ages of 50 and 54 (Figure 3). (13)

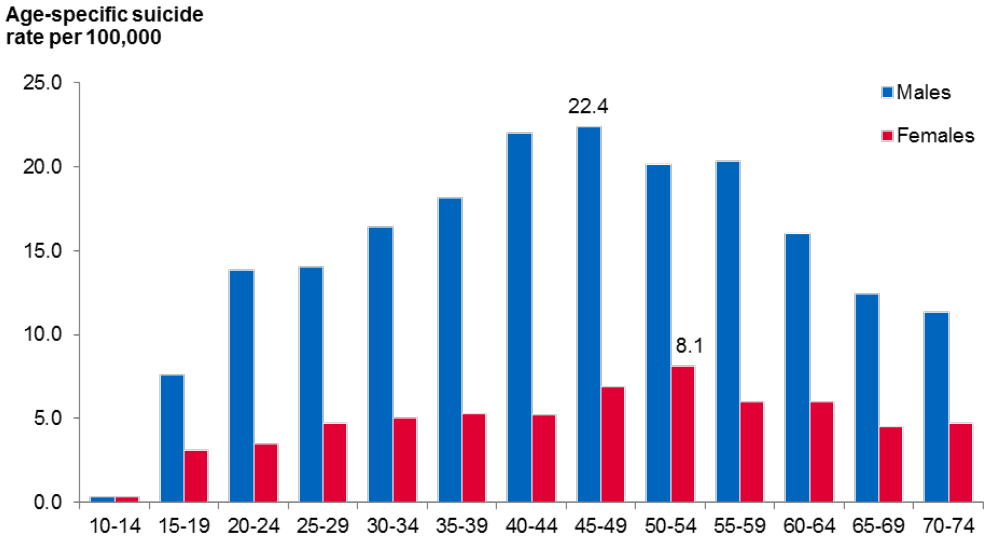

Figure 3: Age specific suicide rates in England, 2015

Hanging was the most common method of suicide in the UK in 2015 amongst both males and females (Figure 4). (13) The proportion of suicides from hanging has increased in recent years. This increase has been seen in particular among females and may be related to restrictions on the availability of other methods, for example, drugs used in overdose and to a misconception that hanging is a quick and painless way to die. Poisoning as a method of suicide is significantly more common among females that males. (13) (15)

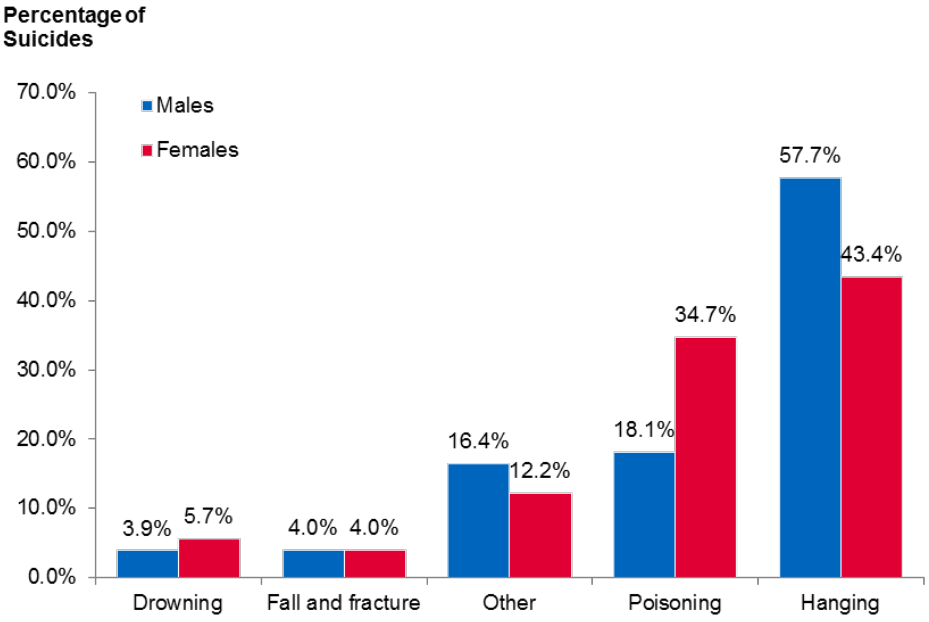

Figure 4: Suicides in the UK by method and sex, 2015

6.2. The Local Picture

In 2013-15 the suicide rate in Southwark was 11.0 per 100,000 persons and was slightly above the regional and national level (Figure 5). (16) A three year reported period is used because of the relatively small numbers involved. In that three year period (2013-15) there were 78 cases of suicide within the borough. Despite a recent increase, local suicide rates are relatively stable, with an average of 26 deaths per year in Southwark. While local figures fluctuate each year due to the small number of cases, there has been a general increasing trend in the number of suicides in Southwark since 2007-9, reflecting the national picture.

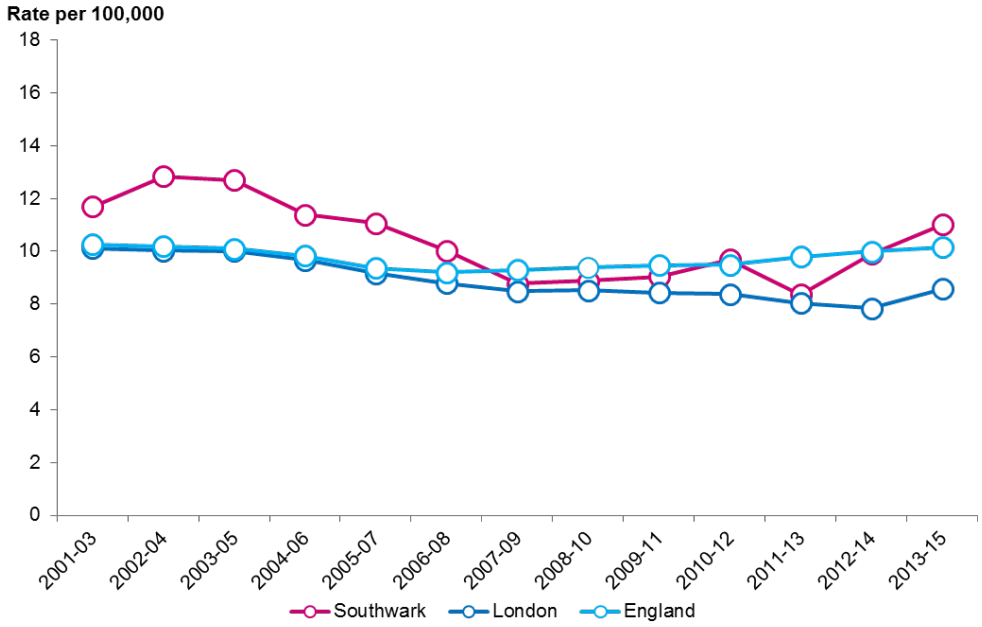

Figure 5: Directly age-standardised mortality rates from suicide and undetermined injury in Southwark, London and England

Southwark is one of five London boroughs to report higher suicide rates than the national average in 2013/15 and has the fourth highest suicide rate of the London boroughs (Figure 6). Looking at the suicide rates within neighbouring boroughs, Lambeth is ranked sixth, while Lewisham is ranked much lower at 24th. In spite of this, Southwark's suicide rate is not significantly different to the London or England averages, or to either rates for Lambeth or Lewisham. (16)

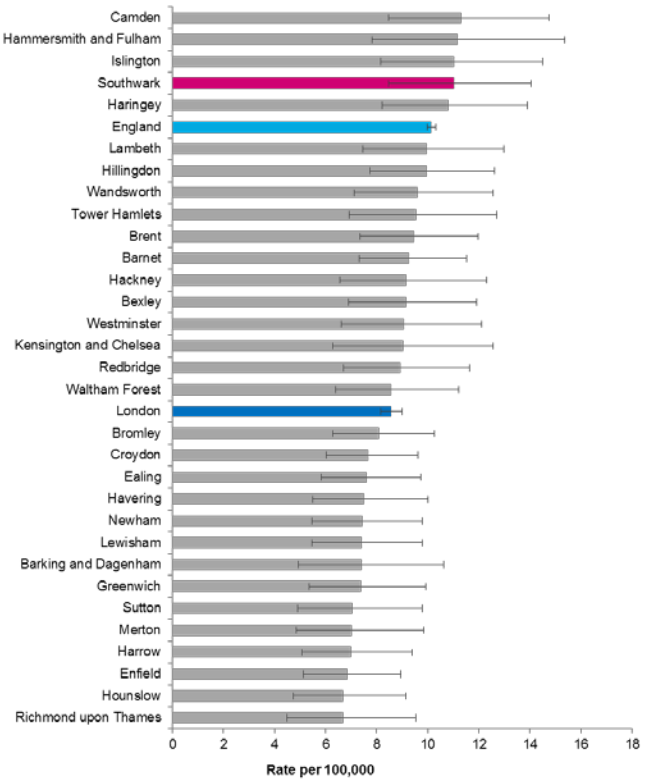

Figure 6: Directly age-standardised mortality rates from suicide and undetermined injury across London, 2013-15

The overwhelming majority of suicides in Southwark occur among men, mirroring the national picture. In 2013-15, just over four out of five local suicides were among men. This pattern has remained relatively stable over time. In Southwark, the rate of suicide is highest among those in middle age, mirroring the national pattern. Deaths among those aged between 40 and 59 in Southwark account for approximately half of all suicides in the borough (Figure 7). (16)

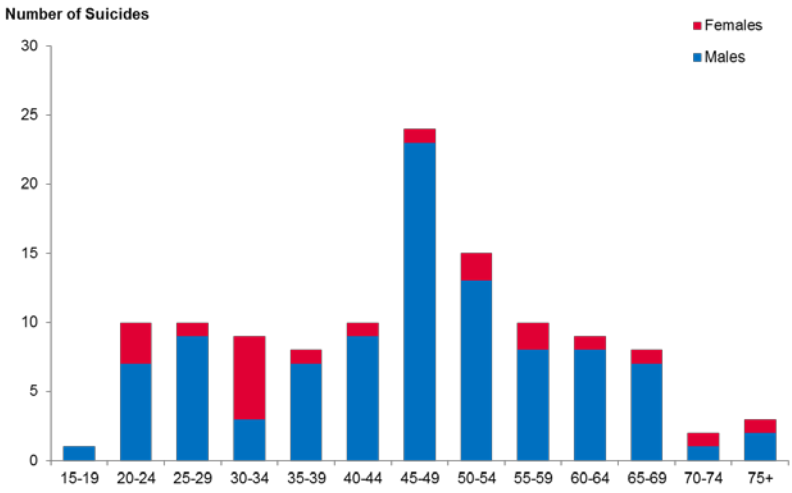

Figure 7: Number of suicides in Southwark by age, 2013-15

Hanging is the most common method of suicide in Southwark, accounting for half of all cases. Poisoning is the second most common method of suicide in the borough, accounting for around one in seven cases (Figure 8). (16)

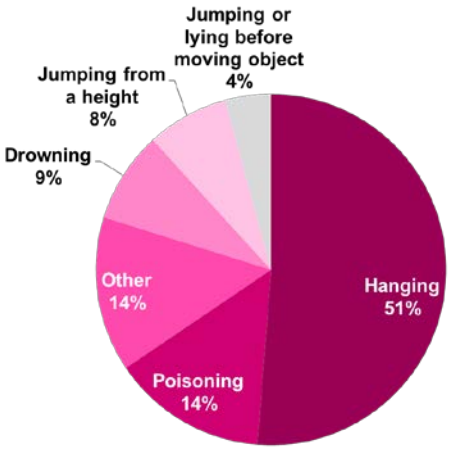

Figure 8: Suicides in Southwark by method, 2011-15

7. WHY DO PEOPLE TAKE THEIR OWN LIVES?

7.1. Key risk factors for suicide

People who take their own life often do so for a wide range of reasons. As such, risk factors for suicide are many (Figure 9). Often, no single cause explains a suicidal act and usually several risk factors cumulatively increase an individual's risk of taking their own life. At the same time, the presence of risk factors does not necessarily lead to suicidal behaviour. (17) For example, it is estimated that 90% of people who attempt suicide have one or more mental health conditions, most commonly depression. (18) However, not all those with depression will attempt suicide.

The national suicide prevention strategy has identified a number of population groups that require a tailored approach to their mental health so to reduce their suicide risk. A number of these specific risk groups are particularly relevant to Southwark including; people who are especially vulnerable due to social and economic circumstances; Black, Asian and minority ethnic groups and migrants; lesbian, gay, bisexual and transgender people; and people who misuse drugs or alcohol.

- Southwark is the 40th most deprived out of 326 England local authorities and ninth most deprived out of 33 London local authorities. Almost 40% of Southwark residents live in areas which are considered among the most deprived nationally. (19)
- Southwark has an ethnically diverse population and the number of residents who identify as Black, Asian and from other minority ethnic groups is predicted to increase substantially over the next ten years. (19)
- According to sexual identity estimates developed by the Office of National Statistics in 2017, of the 98 Local Authorities surveyed, Southwark has the second largest proportion of individuals who identify as part of the LGBTQ+ community. The survey revealed that 6.7% of Southwark's population identify as gay, lesbian, bisexual or 'other'. (20)
- Southwark's admission rates for alcohol-related conditions are significantly higher than the London average and Southwark ranked sixth among the 32 London boroughs for hospital admission episodes in 2014/15. (21)

To further develop our understanding of the population groups most at risk of taking their own life in Southwark, we intend to analyse data from the local Coroner Court and possibly complete a suicide audit.

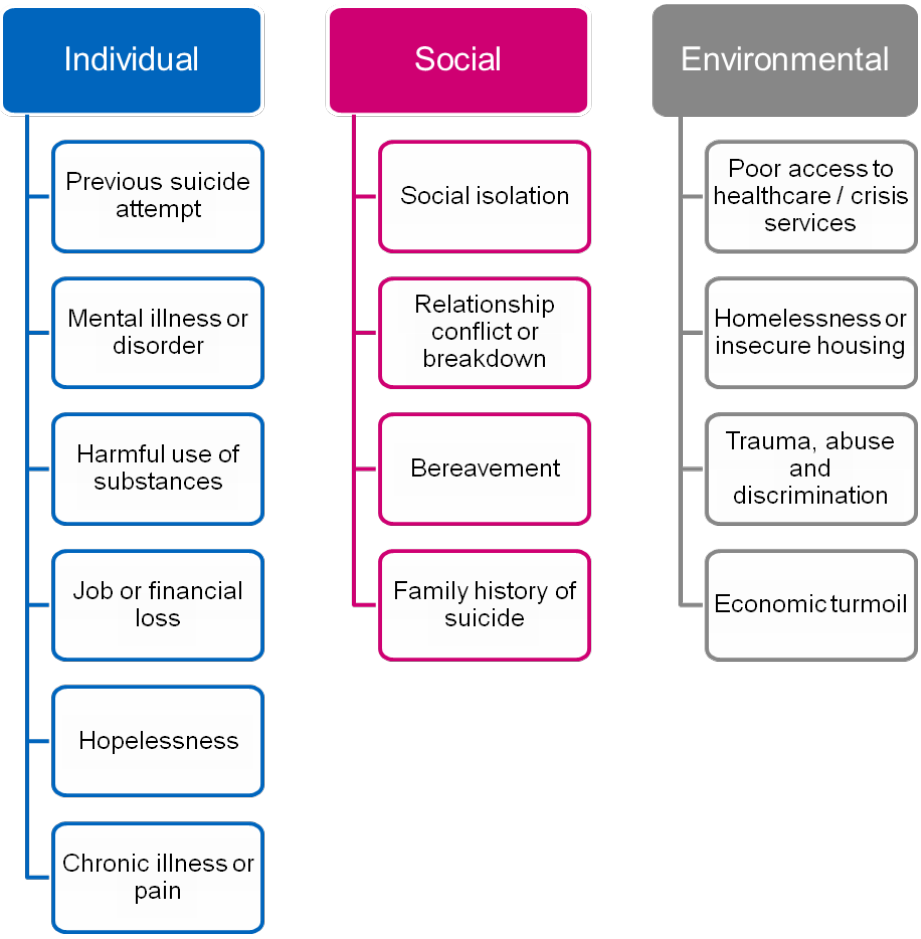

Figure 9: Key suicide risk factors, adapted from World Health Organisation, Preventing Suicide: A global imperative (17)

7.2. Protective Factors

While it is important to focus on reducing risk factors associated with suicide, there are a number of protective factors that develop resilience to its risk. While those with mental ill health are at a higher risk of suicide, it is estimated that 50%-70% of those who die by suicide are not in contact with mental health services. Therefore, suicide needs to be understood as a culmination of a series of factors, many of which are social. Individual resilience helps people cope with life's stressors and the development of such resilience should begin in pregnancy and span the life course. (22)

In order to develop the protective determinants of suicide, we need to focus on improving population health and wellbeing. In doing so we can enable our residents to better contribute to their community, develop meaningful social networks and relationships, and reach their full potential. Social connectedness, positive personal relationships and feelings of belonging are known to be strong protective factors, along with healthy lifestyle choices, good physical health, employment and positive educational experiences. Southwark's Joint Mental Health and Wellbeing Strategy 2017-20 outlines the council's commitment to improve mental health and wellbeing outcomes of all residents.

Within Southwark there exist a number of core assets which form the foundation of a strong Suicide Prevention Strategy and Action Plan. Southwark has a strong and vibrant voluntary and community sector, the role of which is vital for delivering preventative solutions for people at risk of suicide, providing an essential link between statutory and primary services and developing community cohesion. Southwark Council partners including housing, education, and Children and Adult's Social Care are working closely and collaboratively with each other and the CCG to ensure a cross-cutting approach to suicide prevention. Southwark's children and adolescent mental health services (CAMHS) have channelled additional resources into early intervention and preventative work and the council continues to support the development and expansion of talking therapies, including online options, and ensure that these services are accessible to all Southwark citizens.

Figure 10: Protective factors for positive mental health and wellbeing

8. AREAS FOR ACTION

Southwark's priority areas for action have been built around the recommendations outlined in the National Suicide Prevention Strategy and tailored to local needs. (4) The following section describes these priority areas in more detail. Each of the priorities are underpinned by a detailed action plan (see section 12) that outline how we intend to achieve our vision; to reduce the number of suicides across Southwark by at least 10% over the five years as well as reduce the instances of self-harm and attempted suicide.

8.1. Reducing the risk of suicide in high risk groups

A number of population groups have been identified to be at a statistically significant higher risk of suicide compared to the general population.

- Young and middle aged men

  Suicide was the biggest killer in men aged under 50. (1) *Men in Southwark are at least three times more likely to take their own life than women, mirroring the national picture. Middle aged men; those aged between 40 and 59 are at a particularly high risk.* (14) *Factors commonly associated with suicide among men include; economic issues such as debt, social isolation, drug and alcohol misuse, family and relationship problems, and depression, particularly if it remains untreated.* (1)

- People with a history of self-harm

  Self-harm and attempted suicide have been identified as the greatest determinant of future suicide risk (4)*. It is thought that up to 1 in 14 adults in London report self-harming at some point in their lives. This equates to approximately 17,000 adults in Southwark. Young people are at greatest risk of self-harm, in particular young women. They are more than twice as likely to report having self-harmed as their male counterparts, with one in five females aged 16 to 24 reporting having self-harmed at some point in their life.* (23)

- People in the care of mental health services

  Evidence shows that around a third of all suicides were among those who had contact with mental health services in the past 12 months. (1) *In 2005, Southwark Primary Care Trust conducted an audit of all suicide cases in 2002/3 and found one in five suicides were in contact with mental health services at the time of death. Additionally, national evidence shows that post-discharge is a time of increased risk, with the greatest risk in the first week.* (12)

- People in contact with the criminal justice system

  Suicide risk is highest at times of transition - when people move into, within and out of the criminal justice system. It is important to be mindful of the impact of custody and trial on an individual's mental health, in particular for young people and those with pre-existing mental health issues.

- Those who are unemployed or working in specific occupational groups including doctors, nurses and veterinary workers

  Risk of suicide and self-harm is higher among those who are unemployed. However, evidence indicates that certain occupational groups including doctors, nurses, veterinary and agricultural workers are at a higher risk of suicide. (4) *According to evidence gathered by the Office of National Statistics, a common explanation is ease of access to the means of suicide e.g. health professionals can easily access lethal drugs and farmers are more likely to possess a firearm. High risk of suicide among health professionals could also be due to their relevant knowledge of suicidal methods and their effectiveness.* (24)

What works?

- **For men:** Deliver information and support through trusted sources e.g. through peers and undertake outreach work in community rather than formal health settings.
- **For people in the care of mental health services:** Ensuring access to specialist community teams, providing 24 hour crisis care and developing local policies on dual diagnosis patients.
- **For people in contact with the criminal justice system:** Provide suicide awareness training for those who work in prisons, probation services and the courts and focus interventions on transition times.
- **For specific occupational groups:** Encourage employers to promote mental health in the workplace and reduce stigma to increase help seeking behaviour. Work with local occupational health services to strengthen the support available to employees and regularly signpost staff to national and local support services.

Source: Local suicide prevention planning, Public Health England (1)

8.2. Tailoring approaches to improve mental health across all communities

In its Five Year Forward View for Mental Health the independent Mental Health Taskforce highlighted the importance of improving the mental health of the population as a whole. (6) Therefore, as well as targeting high-risk groups, efforts to improve population mental health should be targeted towards groups of people with particular vulnerabilities or problems with access to services. People within such population groups are more likely to suffer from mental health problems. It is likely that individuals will fall into more than one group. (4)

- Children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the Youth Justice System (YJS);
- Survivors of abuse or violence, including sexual abuse;
- Veterans;
- People living with long-term physical health conditions;
- People with untreated depression;
- People who are especially vulnerable due to social and economic circumstances;
- People who misuse drugs or alcohol;
- Lesbian, gay, bisexual and transgender people; and
- Black, Asian and minority ethnic groups and migrants.

The 2002/3 suicide audit conducted by Southwark PCT evaluated the risk of suicide in some of the high risk groups outlined above. (12) Findings from the audit revealed:

- Half of all suicides in Southwark struggled with some sort of substance abuse (including alcohol), as noted in GP files or mentioned at the Coroner's inquest
- Almost 70% of suicides in Southwark (2002/3) had a psychiatric illness; over half of these were mood disorders, largely depression.
- Just under a third of all suicides in Southwark in 2002/3 suffered from a long-term condition
- Four in five suicides were among people that were unemployed
- The largest category (36%) were those unemployed and in receipt of sickness benefit, 20% of cases were unemployed and just under 4% were students

What works?

- Education of primary care doctors targeting depression recognition and treatment
- Community based awareness campaigns to reduce stigma and discrimination and increase help seeking behaviour
- Provide suicide prevention training to specific groups of people who have the greatest opportunity to identify people at risk of suicide e.g. GPs, mental health staff, faith leaders, teachers, community members
- Provide financial and debt counselling support to vulnerable individuals
- Develop school based awareness programmes targeted at specific times in the curriculum e.g. exams and transitions

Source: Local suicide prevention planning, Public Health England (1)

8.3. Prevention of suicide in high risk locations and reducing access to means of suicide

Evidence suggests that people sometimes attempt suicide on impulse, and if the means are not easily available or they survive an attempt at suicide, the impulse can pass. Therefore, reducing access to means of suicide can be an effective way to prevent individuals from taking their own lives. (4)

The suicide methods most amenable to intervention are; hanging in psychiatric inpatient and criminal justice settings, self-poisoning, those at high risk locations and those on rail and underground networks. (13)

What works?

- Use local data gathered from suicide audits to identify high risk locations and consider implementing physical barriers, delivering suicide prevention training to staff (if appropriate) and fit Samaritans material such as signs and posters to increase help seeking behaviour

Source: Local suicide prevention planning, Public Health England (1)

8.4. Providing better information and support to those bereaved or affected by suicide

Family and friends bereaved by a suicide have an increased risk of mental health problems and may be at a higher risk of suicide themselves. In their guidance for local prevention planning, Public Health England recommends all local authorities establish a postvention component to their suicide prevention strategy. The term postvention describes activities developed by, with, or for people who have been bereaved by suicide, to support their recovery and to prevent adverse outcomes, including suicide and suicidal ideation. (1)

What works?

- Distribute the *Help is at Hand* booklet to first responders, Coroner's offices, local funeral directors, bereavement support agencies and other voluntary organisations
- Ensure individual approaches for anyone identified as being at risk of contagion, including rapid referral for community mental health support where needed

Source: Local suicide prevention planning, Public Health England (1)

8.5. Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour

Research shows that inappropriate reporting of suicide may lead to imitative or 'copycat' behaviour among vulnerable groups, particularly young people. The Samaritans have published guidance on responsible media reporting (25) and it is critical that all local media agencies are made aware of the following principles:

- To not provide details about the method of suicide used or state that a particular method is quick or easy
- To not sensationalise and / or romanticise suicide
- To avoid prominent or repetitive reporting; e.g. high frequency areas
- To avoid reporting an individual's life circumstances e.g. a debt problem, as this may risk vulnerable individuals identifying with the person who took their life

What works?

- Ensure local media are aware of Samaritans' guidance on responsible media reporting
- Encourage local media to provide information about sources of support and contact details of helplines when reporting mental health and suicides

Source: Local suicide prevention planning, Public Health England (1)

8.6. Reducing rates of self-harm and attempted suicide as a key indicator of suicide risk

In its third progress report of the cross-government strategy to save lives, Department of Health identified self-harm and attempted suicide, as the greatest determinant of future suicide risk. (4) We have defined self-harm as separate to attempted suicide. Self-harm is an intentional act of self-poisoning or self-injury without suicidal intent. Attempted suicide is an act of self-poisoning or self-injury with suicidal intent.

Self-harm is an expression of personal distress and there are varied reasons for a person to harm themselves irrespective of the purpose of the act. Individuals who start to self-harm when young might adopt the behaviour as a long-term strategy for coping; there is a risk that the behaviour will spread to others; and also that greater engagement with the behaviour may lead in time to a higher suicide rate.

It is thought that up to 1 in 14 adults in London report self-harming at some point in their lives. This equates to approximately 17,000 adults in Southwark. Young people are at greatest risk of self-harm, in particular young women. They are more than twice as likely to report having self-harmed as their male counterparts, with one in five young women (those aged 16 to 24) reporting having self-harmed at some point in their life. (23)

Findings from the 2002/3 suicide audit conducted by Southwark Primary Care Trust showed that self-harm was recorded as a risk factor in almost a third of all local suicides. It was also revealed that over half of all suicides in Southwark had tried to take their life at least once before. Most commonly this information was mentioned at the Coroner's inquest and not in the GP files, indicating that GPs are often unaware of previous attempts. (12)

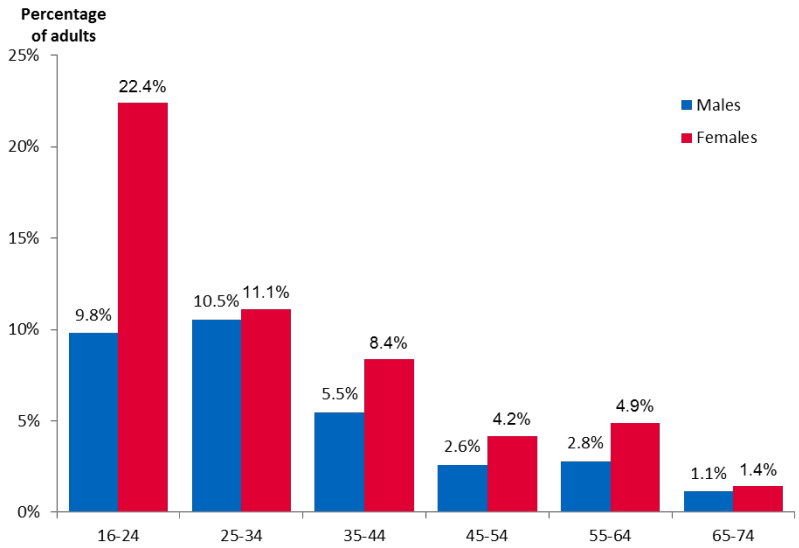

Figure 11: Self-harm and attempted suicide by age group and sex in England, 2014

What works?

- Ensure the implementation of the NICE standards and pathways CG16 and CG133 for managing patients who self-harm

Source: Local suicide prevention planning, Public Health England (1)

8.7. Supporting research, data collection, monitoring and information sharing

In order to best target and allocate resources efficiently, a comprehensive local understanding of the risk factors and high risk groups is required. Given that more than a decade has elapsed since the last strategy and action plan, more up to date information and intelligence is needed.

What works?

- National guidance for local suicide prevention planning encourages working with the Coroner Court to agree a data disclosure protocol and, if possible, carry out a suicide audit.

Source: Local suicide prevention planning, Public Health England (1)

9. BUILDING A PARTNERSHIP APPROACH

Most suicides are the result of a wide and complex range reasons and often, no single cause explains a suicidal act. Usually several factors cumulatively increase an individual's risk of taking their own life. As such, no single organisation has the ability to influence all factors and deliver effective suicide prevention in isolation. It is the combined knowledge, expertise and resources of organisations across the public, private and voluntary sectors that are essential to achieving Southwark's vision of lower rates of suicide and self-harm.

Southwark has established a multi-stakeholder Suicide Prevention Steering Group which meets on a six-monthly basis. The group represents a shared commitment across the council, Southwark NHS Clinical Commissioning Group, the voluntary and community sector and local service providers to prevent suicides locally. Southwark's Suicide Prevention Steering Group has committed to developing this preventative strategy as well as oversee the implementation of the proposed action plan (see section 10). In doing so we hope to establish a network for suicide prevention across Southwark consisting of the following partners;

Figure 12: Southwark's Suicide Prevention Network

10. WHAT WE PLAN TO DO

This strategy represents Southwark's commitment towards achieving a reduction in the local suicide rate. However, we need to do more in order to demonstrate how this strategy will be implemented. Southwark's multi-stakeholder Suicide Prevention Steering Group will work together to develop and implement a local Suicide Prevention Action Plan, reflecting the national and local policy context and our local priorities.

The action plan corresponding to the first two years of the strategy is included within this document. At the 18-month point of the strategy, the Steering Group will look to revise the action plan and seek approval from the Health and Wellbeing Board.

Objective	Actions	Owner	Deadline
1. Reduce the risk of suicide in high risk groups	**Improve help-seeking behaviour among men**		
	1.1. Explore opportunities to establish a peer support / communication network and use peer communicators to provide support and information around mental health and suicide to men in high risk population / occupation groups *(MH&W 7.1 & 13.4)*	**CCG**, VCS, Public Health	January 2019
	1.2. Explore opportunities for the development of an outreach programme that delivers information and advice to targeted community and occupational groups (outside formal health settings)	**CCG**, VCS, Public Health (including workplace), Leisure and Communications	January 2019
	1.3. Deliver training to front line primary care staff to improve recognition of risk factors and assessment *(MH&W 2)*	**CCG**, GP federations	June 2018
	1.4. Develop pathways that enable referral into wellbeing and other support services *(MH&W 4)*	**CCG**, GP federations, VCS	June 2019
	1.5. Improve signposting to practical support for those affected by environmental risk factors such as sudden loss of job, housing or financial turmoil *(MH&W 6.3 & 28.3)*	**Primary care**, Local job centres and benefit advisors, Housing, Primary care, VCS	December 2018
	People in contact with the criminal justice system		
	1.6. Improve the availability and timeliness of health records and data sharing between MH services, primary care and the police	**CCG,** SLAM, Metropolitan Police,	October 2019

	Improve understanding of information governance and awareness of what data can be shared between stakeholders *(MH&W 37.1)*	GPs	
	1.7. Map Southwark's bail houses / hostels, engage local hostels and provide links and information on local support services e.g. the Wellbeing Hub	**Public Health**, VCS, Samaritans	April 2018
	1.8. Provide a training workshop to staff at local bail hostels to increase awareness of suicide and how to identify those who are at risk	**Samaritans**	December 2018
	Specific occupational groups		
	1.9. Lobby for suicide prevention to be included in the Healthy Workplace Charter; currently the charter covers mental health awareness, tackling stigma, and preventing work-related stress but does not mention suicide prevention *(MH&W 11.3)*	**Public Health**	December 2018
2. Tailoring approaches to improve mental health across all communities	2.1. Improve engagement with local schools and explore opportunities to develop a programme of work around emotional health and wellbeing among young people, recognising that self-harm is prevalent	**Public Health**, Education	April 2018
	2.2. Leverage the Big White Wall online community to deliver messages around suicide to targeted population groups via social media e.g. the June campaign focused on male mental health *(MH&W 5)*	**CCG**, Public Health	June 2018

	2.3. Deliver training to front line primary care staff to improve recognition of risk factors and assessment *(MH&W 2)* 2.4. Offer suicide awareness and prevention training for clinicians with specific focus on: complex patients with concurrent physical and mental health needs; patients with substance misuse; urgent referral and seamless transitions of care *(MH&W 2)* 2.5. Work with and support Thrive LDN around the various opportunities for local, sub-regional and regional benefits and learning to Southwark *(MH&W 12.3)* Further actions are to be identified following analysis of data from the Coroner Court and possible completion of a suicide audit.	**CCG**, GP federations **CCG**, GP federations, Public Health **Public Health and Thrive LDN** **Public Health**	June 2018 December 2019 December 2018 April 2018
3. Prevention of suicide in high risk locations and reducing access to the means of suicide	3.1. Expand GP learning to include safe prescribing to reduce the number of poisoning cases 3.2. Identify and assess risk area stations and consider implementing physical barriers (fitment is not always possible due to design restrictions, platform designs and size and other factors such as available budget but they can be considered as part of a layered approach to mitigations) 3.3. Establish a programme of regular training courses for Network Rail and Train Operator Staff; Samaritans Managing Suicidal	**CCG**, GP federations **Network Rail**, Train Operating Companies **Network Rail**, Train Operating Companies	June 2018 Ongoing Ongoing

	Contacts (MSC) and promoting the use of the Learning Tool	Samaritans	
	3.4. Increase signposting to help and support services for individuals who have suicidal ideation e.g. Samaritans material such as signs and posters can be fitted at identified stations	**Network Rail**, Train Operating Companies, Samaritans	Ongoing
4. Providing better information and support to those bereaved or affected by suicide	4.1. Ensure all first responders and those in contact with bereaved families have supplies of, and distribute, the Help is at Hand z-card. Relevant local stakeholders would be the police, the Coroner's office, local funeral directors and voluntary services	**Public** Health, Police, LAS, Coroner Office, Emergency Departments	December 2018
	4.2. Provide Help is at Hand in community settings such as libraries, primary care and through bereavement support organisations	**Public Health,** Primary Care	December 2018
	4.3. Engage members of the local community who have been bereaved to sit on the Suicide Prevention Steering Group to inform local planning and commissioning	**Public Health**	December 2017
	4.4. Improve signposting for patients and families/carers affected by suicide to additional support	**Public Health**, VCS, GP federations, CCG	December 2018
	4.5. Conduct a needs assessment focusing on the support for individuals in Southwark who have been bereaved or affected by suicide with special consideration for vulnerable population groups. For example; carers, individuals from BAME backgrounds, refugees, individuals with a learning disability	**Public Health**, VCS	March 2019
5. Supporting the media in	5.1. Ensure local media are aware of , the guidance published by the Samaritans on responsible media reporting of suicide	**Samaritans,** communications	April 2018

delivering sensitive approaches to suicide and suicidal behaviour	5.2. Provide local media with access to a single point of contact either within the council or the Samaritans to discuss a story before it is run 5.3. Encourage local media to provide information about sources of support and contact details of help lines when reporting a mental health / suicide story	**Samaritans** **Samaritans**, VCS	December 2017 April 2018
6. Reducing rates of self-harm as a key indicator of suicide risk	6.1. Complete a rapid health needs assessment on self-harm, as part of Southwark's JSNA process, and use learning to develop key recommendations 6.2. Work with local Emergency Departments to conduct a case note review of potential cases of self-harm and attempted suicide 6.3. Explore other sources of intelligence relating to self-harm focusing specifically on young people in Southwark 6.4. Implement active follow up with appropriate safeguards post-treatment. Learning and process details from the successful BTP model should be shared to inform this 6.5. Develop an appropriate out of hours pathway for individuals in distress / at crisis point, alternative to A&E *(MH&W 20)*	**Public Health** **Public Health** **Public Health** **SLAM and GPs**, BTP **CCG**, Public Health, SLAM, Acute Care	June 2017 December 2018 December 2019 June 2019 December 2019
7. Supporting research, data collection, monitoring and	7.1. Work with HM Coroner to agree a data disclosure agreement with the coroner court in order to develop a more detailed understanding of local suicide patterns and trends *(MH&W 37.2)*	**Public Health**	April 2018

information sharing	7.2. Explore opportunities to work with the HM Coroner to conduct a suicide audit, adopting an appropriate sampling method *(MH&W 37.2)*	**Public Health**	December 2019
	7.3. Explore opportunities for more real time data reporting of suicide, attempted suicide and self-harm:	**CCG**, Public Health, SLAM	December 2017
	▪ Serious untoward incidents reports to the CCG from NHS trusts	**BTP**, Network Rail, Public Health	October 2017
	▪ The Rail Industry in conjunction with BTP will provide information on numbers of incidents at stations	**Network Rail,** Train Operating Companies, BTP, Samaritans	October 2017
	▪ Network Rail will inform Local Authorities where three or more suicides/attempts have taken place in a rolling 12 month period on its infrastructure. It will then seek to work with them to make the community in and around the area less vulnerable to suicide		
	▪ Explore opportunities to use local Metropolitan Police Service data to enable better real-time reporting of suspected suicide, suicide attempts and self-harm	**Public Health**, MPS	June 2018
	7.4. Explore data sharing and learning opportunities between stakeholders e.g.:	**Public Health** (facilitating), All	December 2018
	▪ BTP to share details of their process for dealing with and mitigating the impact of suicide on the rail network as an example of best local practice		

	▪ BTP to share learning from 'clusters' review of suicide cases in the local area 7.5. Promote serious incident reviews by primary care teams and if possible, involve other professionals as indicated	**CCG**, GPs	June 2018

(MH&W #): Cross reference to the relevant shared action in Southwark's Joint Mental Health and Wellbeing Strategy.

11. MONITORING AND EVALUATION

With this strategy Southwark has set a target to reduce the number of suicides across Southwark by at least 10% over the next five years as well as reduce the instances of self-harm and attempted suicide.

Due to the registration delay in reporting suicides (see section 6) and the relatively low number of local cases annually, suicides are reported over a three-year period. Therefore, we recognise that we will not be able to measure the number of suicides in Southwark five years from now, in 2022, until 2025. Therefore, in order to determine success we will look to assess the trajectory in suicide rate at the end of the strategy period, using data for 2018-20.

In order to realise this vision we need to monitor progress against the actions that partners have committed to undertaking. The following framework will be used to monitor and evaluate the success of Southwark's Suicide Prevention Strategy and Action Plan:

Monitoring metric	Information source	Time Period
Near real-time reporting of suspected suicide, attempted suicide and self-harm from SLAM	Serious incidents reports to CCG	▪ Baseline Q3 2017/18 ▪ Quarterly
Near real-time reporting of suspected suicide fatalities and injuries as well as 'interventions' on the local rail network	BTP, Network Rail and Train Operating companies	▪ Six-monthly
Near real-time reporting of suspected suicide, attempted suicide and self-harm from the MPS analytical team	MPS data shared through the MPS analytical team	▪ TBC
Evaluation Metric	**Information source**	**Time period**
Local rates of: ▪ Suicide ▪ Attempted suicide ▪ Self-harm With a particular focus on rates among high risk and vulnerable groups	▪ NHS Digital, Primary Care Mortality Database ▪ Hospital Episode Statistics ▪ Data from the local Coroner Court	▪ Baseline year 2016/7 ▪ Final year 2021/22

12. GOVERNANCE AND OVERSIGHT

Local partners committed to reducing the rates of suicide and self-harm across the borough have come together as a Suicide Prevention Steering Group. The group was formed in February 2017 and meets every six months. Southwark's Suicide Prevention Steering Group comprises the following partners; Public Health and Southwark Council partners, NHS Southwark Clinical Commissioning Group, South London and Maudsley NHS Foundation Trust, the Metropolitan Police, Network Rail, British Transport Police, London Ambulance Service, general practice, voluntary and community sector partners. The group has committed to oversee the development and implementation of this strategy and action plan, monitor progress and ensure the delivery of agreed actions. The Suicide Prevention Steering Group is accountable to Southwark's Health and Wellbeing Board.

The action plan will be reviewed and revised ahead at the two-year point.

13. COMMUNCATION AND DISSEMINATION

In order to monitor progress against this action plan, an annual review will be carried out by Public Health and partners and brought forward for discussion through the Suicide Prevention Steering Group. It is intended that wherever possible, the review for this strategy would be considered alongside the equivalent review for the Joint Mental Health and Wellbeing Strategy.

14. CONCLUSION

This strategy and action plan has set out our vision and commitments for preventing suicide and reducing the incidence of attempted suicide and self-harm in Southwark. We will achieve this vision by working in partnership, as a suicide prevention network, to oversee the implementation of the commitments outlined in this document.

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