Draft Surrey Suicide Prevention Strategy 2024- 2027

Engagement document: Updated 13 August 2024

Suicide Language

Don't say	What to say	Why
Committed suicide	Died by suicide Death by suicide Suspected suicide	Using the word 'commit' implies suicide is a sin or crime, it has not been a crime in England since 1961. Using the word Commit reinforces the stigma that suicide is a selfish act and personal choice. Using neutral phrasing like 'died by suicide' helps remove shame or blame.
Failed suicide	Attempted suicide Suicide attempt	Saying 'failed' or 'unsuccessful' is inappropriate because it implies that the opposite would be a positive outcome.
Successful suicide	Died by suicide Death by suicide Suspected suicide	Saying 'successful' or 'completed' is inappropriate because it frames a very tragic outcome as an achievement or something positive
Cry for help	Emotional distress Need help and support	Suicide attempts must be taken seriously. Describing an attempt as a 'cry for help' dismisses the intense emotional distress that someone may be experiencing.

Source: Language-guide-for-talking-about-suicide.pdf (shiningalightonsuicide.org.uk)

Support

If you or someone you know is experiencing poor mental health or is in a mental health crisis, there is help and support available.

Call 999 immediately if you or someone you know is in a life-threatening situation.

Call 111 if you urgently need medical help or advice but it is not a life-threatening situation.

Surrey Mental health crisis helpline - 24 hours 7 days a week support for people in Surrey experiencing a mental health crisis. Call 0800 915 4644. If you have speech or hearing difficulties, you can contact the helpline by: SMS: 07717 989024 or Relay UK (United Kingdom) Dial 18001 0800 915 4644 from your text phone or smart app.

Safe Havens- provide out of hours care if you or someone you care for are experiencing a crisis. They are staffed by mental health practitioners and two trained Safe Haven workers and provide a safe alternative to Emergency Departments. Safe Havens are open evenings, weekends and bank holidays and are in Redhill, Aldershot, Epsom, Guildford, and Woking. You can drop in and do not need to make an appointment.

Shout UK - Free crisis text line. A safe space with trained crisis volunteers. Text line does not appear on phone bills. Text 85258, 24-hour text line.

Papyrus- Hopeline247- HOPELINE247 is a 24 hour support line that children and young people under 35, and adults supporting children and young people can call for support, including advice to create a Papyrus safety plan. Papyrus safety plans can be created confidentially online with a secure login, so that children and young people can revisit the plans as needed. Call 0800 068 41 41 or visit www.papyrus-uk.org.

Samaritans - A free 24-hour helpline here to listen to you. The phone line will not appear on phone bills. Call 116 123, or email jo@samaritans.org.

Stay Alive app - Information, safety plans and a life box where you can store photos important to you. The app can be used yourself if you are having thoughts of suicide or if you are concerned about someone else who may be considering suicide. There are links to Surrey crisis services.

Surrey Suicide Bereavement Service

The death of a loved one through suicide is one of the most difficult situations to face. The Surrey Suicide Bereavement Service is a service from the Lucy Rayner Foundation, which provides 1:1 practical support & advice for families bereaved by suicide. Call: 01737 886551 Email: info@ssbs.org.uk.

Suicide Bereavement support- The Surrey Support After Suicide Service (SSASS) provides a range of support to people in Surrey who are bereaved by suicide.

They provide support for people 18+ in Surrey who are bereaved by suicide This includes family, friends, and people exposed to suicide - for example witnesses.

The service is free to access. SSASS leaflets can be downloaded here:

- Leaflet for people bereaved by suicide e.g. family and friends
- Leaflet for people exposed to suicide e.g. witnesses, health and social care professionals

Suicide prevention in England: 5-year cross-sector strategy

The Suicide prevention strategy for England: 2023 to 2028 was published in September 2023 and sets out the government's ambitions over the next 5 years is to:

- Reduce suicide rates
- Improve support for people who have self-harmed
- Improve support for people bereaved by suicide

It includes steps and actions from across *government and a wide range of* organisations to achieve these ambitions with the ultimate aim to reduce the suicide rate over the next 5 years – with initial reductions in half this time.

The strategy focuses on prevention and early intervention with a large focus on what more can be done by government, the NHS, wider local public services, businesses and community groups[i].

The England five-year cross sector suicide prevention strategy was published in September 2023 *Suicide prevention in England: 5-year cross-sector strategy - GOV.UK (www.gov.uk)*

The strategy sets out some key aims. These are to:

- Reduce England's suicide rate within 2.5 years with launch of new National Suicide Prevention Strategy
- Aid specific groups at risk of suicide, including children and young people, middle-aged men, Autistic people, pregnant women, and new mothers
- Introduce more than 100 measures, including a national alert system to combat emerging methods of suicide and refreshed guidance for first responders
- Local interpretation: Embed suicide prevention into other parts of the system, include building early resilience

Over the next 5 years the key priorities for action include:

1. Improving data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.
2. Tailored, targeted support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.
3. Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.
4. Promoting online safety and responsible media content to reduce harms, improve support and signposting.
5. Providing effective crisis support across sectors for those who reach crisis point.
6. Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.
7. Providing effective bereavement support to those affected by suicide.
8. Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides

Priority Groups

The strategy was informed by the mental health call for evidence launched in 2022 and was developed to identify priority groups and suicide risk factors.

This is not an exhaustive list of groups that could benefit from bespoke support. It is imperative that individual needs and experiences are considered in the design and delivery of suicide and self-harm prevention activity.

However, based on evidence and data (including numbers, rates and trends), stakeholder engagement and expert views, the strategy identified the following groups for consideration for tailored or targeted action:

- Children and young people
- Men of all ages
- Middle-aged men
- Autistic people
- Pregnant women and new mothers
- Refugees and asylum seekers
- People who have self-harmed
- People in contact with mental health services
- People in contact with the justice system
- People affected by domestic abuse
- People experiencing harmful gambling
- Ethnic minority groups including people from the Gypsy, Roma or Travellers (GRT) community
- People who are from the LGBTQ+ community
- People with Long Term health Conditions (LTCs)

However, for men, subsets have been identified in the national strategy.

- Men of all age - In England the suicide rate for men remains 3 times higher than women.
- Middle aged men - 40s and 50s. Key risk factors for this group include debt, financial difficulties, alcohol and drug misuse, untreated depression and poor access to services.
- Older men - Key risk factors include bereavement, isolation and physical illness.

Risk Factors

Addressing the risk factors is important for suicide prevention. This provides an opportunity for effective early intervention, as well as providing appropriate, tailored support for those experiencing suicidal thoughts or feelings.

Many risk factors are common across the different individuals, groups and communities. Therefore, actions to address these risk factors are likely to prevent suicides at a population level with potential benefits for some groups.

Links have been evidenced between suicide and social determinants of health such as housing, poverty, employment and education. There are four population - based risks that have been identified:

- Economy
- Alcohol
- Social isolation and loneliness
- Mental Illness

Other risks that have also been identified in different individuals, groups and communities include:

- Physical illness- older adults
- Harmful gambling- in men
- Substance misuse- in men
- Domestic abuse- in men and women
- Maternal mental health

Vision and ambition for providing tailored support

The vision and ambition is:

- There is consistent access to high-quality services and resources to prevent suicides, no matter where the person lives or which population groups, they are part of.
- The individual needs of people in these groups are routinely considered in national and local interventions to prevent suicides. There is support for these groups when they interact with public sector agencies and government departments, and staff from agencies likely to come into contact with priority groups have access to suicide prevention training and resources
- The needs of these groups at key transition points between public services are considered. This includes the transition from children and adolescent to adult mental health services, and the transition between justice and community settings
- Engagement with people with personal experience from these groups is a central part of the development of national and local services and policies
- There is more support available for parents, carers and informal caregivers'

Surrey v National priority areas

National priority area	What Surrey currently does	What do we need to do in Surrey
Improving data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.	There is a real time surveillance (RTS) database in Surrey. The local mental health trust is able to add intelligence to this. However, it is not possible to get GPs or voluntary sector to add intelligence to this. The RTS has enabled Surrey to identify actions. As a result targeted prevention has been delivered to key high risk groups. Additionally projects have been set up and services with specific KPIs have been commissioned to target these groups.	Surrey needs to continue to share learnings with national colleagues on emerging themes. Additionally, it is important that in this strategy the Board identified who else needed the intelligence to inform their work and develop a process to share this with a mechanism to share impact and changes made as a result of having this data.
Tailored, targeted support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.	In Surrey, the high-risk groups are determined by the data and intelligence gathered from the real time surveillance database and the suicide audit. National intelligence is also used to identify high risk groups.	**Intelligence** • Gather evidence-based approaches to emerging risk groups. **Response work:** • Deliver targeted response actions to respond to social contagion risks **Prevention work:** • Deliver targeted campaigns talking priority groups.

		Service improvement/development: • Share the learning with commissioners and provider so that they can identify service gaps and provisions for priority and high-risk groups.
Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.	Common risk factors are shared with commissioners, strategic leads, and service providers. Campaigns and targeted messages address common risk factors linked to suicide are delivered across Surrey.	Continue to gather evidence and intelligence to understand common risk factors and develop evidence based early intervention and tailored support.
Promoting online safety and responsible media content to reduce harms, improve support and signposting, and with particular attention to the messages around self-harm and suicidal thinking	Online safety is included in the Healthy School approach.	There is a need for more education and awareness of online harm and keeping safe online. The R;pple tool[ii] has not been embedded across Surrey and this is a key action.
Providing effective crisis support across sectors for those who reach crisis point.	There is a crisis offer across Surrey that targets children and young people and adults. There is a mental health crisis phone line.	As Surrey is adopting the Right Care Right Person Approach there is a need to ensure that there is no gap in support for people who reach crisis point. The Right Care, Right Person is an approach designed to ensure that people of all ages, who have health and/or social care needs, are responded to by the right person, with the right skills, training, and experience to best meet their needs.

		At the centre of the RCRP approach is a threshold to assist police in making decisions about when it is appropriate for them to respond to incidents, including those which relate to people with mental health needs. A National Partnership Agreement has been established to support the national implementation of Right Care Right Person.
Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.	Through the Surrey suspected suicide real time surveillance work, there is a process to monitor means and methods of suicide. A response and learning process is instigated systematically when there are means and methods of suicides that are either emerging or other concern. Local and national level suicide prevention leads are consulted when there is a concern about a method or a location. Local guidance has also been developed and shared with the appropriate partners.	It is important that Surrey continues to monitor means and methods of suicide. Some suicide mitigation requires the funding for physical structures, therefore it is important that areas with high risk work with Public Health to identify mitigation methods. There is often a cost involved in responding to physical locations.
Providing effective bereavement support to those affected by suicide.	There is a suicide bereavement support service in Surrey for adults. The service offers support to families bereaved by Suicide and those impacted through the suicide ripple effect[iii]. However, it is only currently funded until February 2025.	There is no sustainable funding for suicide bereavement support, additionally it is not a core service. There is a gap in the provision of suicide bereavement support for children and young people.

	There is a general bereavement service available to children and young people who have been impacted by any type of bereavement.	
Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides	We have developed the Alison Todd suicide prevention protocol. The aim of the protocol is to embed suicide prevention in work streams, strategies, and policies across Surrey.	Suicide Prevention in Surrey cannot be delivered on its own. It is important that Suicide Prevention is embedded in work streams, strategies, and policies across Surrey. The Alison Todd Protocol will be reviewed to ensure that sign up process is clearer.

Working together to prevent suicide in Surrey 2024- 2027

In this strategy we emphasise that suicide prevention needs to be embedded across Surrey. Therefore, a key aspiration for Surrey is to embed suicide prevention across Surrey so that: “Suicide Prevention is Everybody Business”

In Surrey suicide prevention has its own strategy, board and working groups. When there have been gaps and needs identified, workstreams have been set up to respond.

In this strategy we aim to reset how suicide prevention is developed and embedded across Surrey. The Surrey health system, social care providers, educational setting and local communities are encouraged to review the action areas in the strategy and take accountability for the areas that they lead on.

Therefore in this strategy round it is important that suicide prevention is embedded in:

- Local planning departments decision making process[iv]
- Transport planning and services[v]
- Organisation, policies
- Economic workstreams
- Strategies and working streams across the health, social care and education system
- Across all frontline health and community services
- Across the education system starting from primary school to university.
- Across all communities.

There is a need to ensure that suicide prevention is embedded across Surrey and all area leads commit to signing up to the Alison Todd Suicide Prevention Protocol.

Embedding of suicide prevention: Suicide Prevention is everyone's business

Surrey has identified five action areas that cover the eight priorities in the national strategy.

These five action areas ensure that suicide prevention in Surrey is addressed through:

- Understanding the data
- Prevention
- Early intervention
- Timely support
- Responding to real time surveillance data
- Having learning process
- Making changes where needed

Action Area A. Lived Experience

Ensuring that people with lived experience of suicide or attempted suicide are empowered to share their experiences and views is important. The voice of lived experience will be embedded across all the strategy.

The strategy recognises that across the Surrey, we must give people with lived experience a safe space to share their experience as this is key to suicide prevention.

Across Surrey there are networks where people with lived experience can share their experiences and views. However, each of the networks is specific to the area, organisation or project. It would be beneficial to have one overarching place where lived experiences and views are collected. This would enable the Surrey Suicide Prevention Partnership Board and the key suicide prevention workstreams to really understand what people with lived experience are experiencing.

In order to do this, the below actions are recommended:

Action	Details
A1	Continue to work with VCSE sector stakeholders to better understand the personal experiences of people bereaved by suicide and explore opportunities to improve access and support.
A2	Ensure that Lived Experience Networks are supported to inform local policy, service improvement, commissioning and the development of new services and initiatives.
A3	Ensure that bereaved families have a safe mechanism to share their experiences
A4	Ensure that there is engagement with the below groups: ○ Children and young people ○ Men of all ages ○ A subset target - middle-aged men ○ People who have self-harmed ○ People in contact with mental health services ○ People in contact with the justice system ○ Autistic people ○ Pregnant women and new mothers
A5	Develop a local “suicide lived experience process” that includes gathering learning from existing groups and explores learning opportunities where there is an underrepresentation from key high-risk groups.
A6	In all projects and services ensure that there is a feedback loop so that those who shared insights are updated on how this was used.

Action Area B. Data, Learning and Intelligence.

There are a number of existing processes in Surrey where data, learning and intelligence are routinely gathered. These processes are used to inform suspected suicide response work, learning processes and prevention plans.

Surrey real time surveillance led learning process- Surrey Police and Public Health

In July 2020, Surrey Police set up the Surrey suspected suicide real time surveillance database. The database records cases of suspected suicide. This enables Surrey Public Health Team to understand emerging risks, high risk locations, trends and the demographics of people who had sadly died of suspected suicide. This intelligence is used to inform immediate response work and the ongoing learning work.

Clinical process- NHS Patient Safety Incident Response Framework [vi]

The Patient Safety Incident Response Framework, known as PSIRF will replace the current Serious Incident Framework (2015).

The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the NHS patient safety strategy.

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement

Surrey Safeguarding Practice Reviews- Children and young people

The overall purpose of a Child Safeguarding Practice Review (CSPR) is for agencies and individuals to learn lessons, to improve the way in which they work, both individually and collectively and to explore how practice can be improved more generally through changes to the system as a whole in order to safeguard and promote the welfare of children. Reviews seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose, including through employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings

Multi-Agency Audit Focus: Children and young people who have survived a suicide attempt

This audit looked at Children and Young People aged 11–19 who survived a suicide attempt within the last 6 months (April-Oct 2023). The audit period lasted for a period of 4 weeks during which leads from each agency completed and return audit tools. The audit tool included 9 questions for agencies to respond to.
At the Multi Agency Meeting there is representation from Health agencies, Childrens Services, Police and Education (School Relationships). Each child/ young person's experience is considered using the following points:

- How well have we been working together and planning together to support this young person and their family?
- How well has the young person's voice been captured?
- Is there evidence of "Think Family" principles in our work?
- Have we identified any gaps in service provision during periods of transition (where appropriate)?
- Is there any evidence that we have had any impact in the life of this young person?

Surrey Safeguarding Adult Reviews

Surrey Safeguarding Adult Reviews-(SAR) is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place.

The Care Act 2014 states that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when:

- an adult in its area dies as a result of abuse or neglect, whether known or suspected, or
- the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect, and
- there is concern that partner agencies could have worked together more effectively to protect the adult from harm.

This is a statutory responsibility. The purpose of a SAR is not to apportion blame. It is to promote effective learning and improvement to prevent future deaths or serious harm occurring again.

The objectives include establishing:

- Lessons that can be learnt from how professionals and their agencies work together.
- How effective the safeguarding procedures are.
- Learning and good practice
- How to improve local inter-agency practice
- Service improvement or development needs for one or more services or agencies.

Lessons learnt are shared to maximize the opportunity to better safeguard adults with care and support needs, who are or may be at risk of abuse or neglect. The Care Act 2014 requires that lessons learnt are published in the Annual Report following the conclusion of the review.

Domestic Abuse Related Death Reviews (Formerly known as Domestic homicide reviews)

Domestic Abuse Related Death Reviews were established on a statutory basis under Section 9 of the **Domestic Violence, Crime and Victims Act (2004).**

Domestic Abuse Related Death Reviews are carried out by Community Safety Partnerships to ensure that lessons are learnt when a person has been killed as a result of domestic abuse. The duty also applies in cases of suicide where domestic abuse may have been a cause. The purpose is to:

- Establish what lessons can be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply those lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic abuse and domestic homicides, and improve service responses for all domestic abuse victims and their children through improved intra- and inter-agency working

Suicide Audit- Surrey Public Health Team

The Surrey suicide audit involves a review of coroners' records where there is a conclusion of suicide. Surrey Public Health Team has a lead role in collecting and analysing suicide audit data to inform the development of the suicide prevention strategy and to feed into the local health and wellbeing plans.

Formal suicide audit reports are every three years in Surrey. However starting in March 2024 the coroners' records where there is a conclusion of suicide will be audited monthly.

National learning

Surrey leads regularly link with regional and national networks to understanding learning, data, and intelligence to identify emerging trends and risks. Additionally, Surrey seeks support and learning from other areas that have also experienced similar themes.

Gaps

Currently there is no work in Surrey to collate the future deaths notifications that are issued by the Coroner and work collaboratively around the learning. As a result, there is no system approach to learning and responding from these.

Additionally, across Surrey County Council there are many different incident learning and review processes that work in isolation. There is a need to join up these learning and review processes to ensure that there is a collaborative way to understand the issues and opportunities for further development.

What do we need to do?

Action	Details
B1	Continue to ensure that the learning from these is embedded in the prevention plans.
B2	Learning to be shared with the appropriate service directors and leads.
B3	Understand the prevention of future deaths notifications that are issued by the Coroner and develop a local shared learning process with the appropriate leads.
B4	Expand the real-time surveillance work to triangulate the data with key services.
B5	Surrey County Council to review the learning and review processes and identify how they can be joined up to maximise capacity and benefits

Action Area C: Tailored support high risk groups and circumstances

There are some groups that have been identified as having higher suicide rates than the general population. This has been seen locally and nationally.

The recommended action is split into priority groups and circumstance to reflect that there are already existing workstreams and services that target these priority groups and circumstance. Therefore, it is important that the area leads for these priority groups and circumstances consider the below recommended actions in their work plans.

C1. Loneliness and isolation

Loneliness and isolation can affect anyone at any point in their lives. Nationally, loneliness and isolation have been seen as a risk factor to suicide. The lack of support and social connectedness have left people isolated.

This section is sparse as there is currently a *loneliness and isolation need assessment* underway in Surrey that will embed recommendations and actions that will reduce the risk of mental health and suicide.

Key population-based action

Promote connectedness and building social capital together by decreasing isolation, encouraging adaptive coping behaviours, increasing belongingness and to help build resilience in the face of adversity.

Engage with wider community initiatives to demonstrate the contribution to this agenda.

C2. Children and Young People

The Children and Young People's Emotional Wellbeing and Mental Health Strategy 2022-2027[vii] is underpinned by engagement from children, young people, their families, and the professionals who support them.

The strategy brings together partners from across Surrey including health, education, social care, the third sector and Mindworks Surrey, to assess our strengths and what we need to improve, to support children and young people's emotional wellbeing and mental health.

The strategy includes an action plan that details how we will address this over the next 5 years. This strategy will serve as both the NHS England's Local Transformation Plan and the Joint Strategic Needs Assessment (JSNA) for children and young people's mental health.

Area	Actions
Data and intelligence	• Understand attempted suicide data in Surrey and carry out responses, as necessary. • Understand self-harm data in Surrey and carry out responses, as necessary. • Ensure we have the evidence and intelligence to inform children and young people suicide prevention across the spectrum. • Identify the key concerns of young people ages 16 - 25 and develop local plans to respond to this. • Understand local waiting times in urgent and emergency care, the community mental health sector for children and young people in line with the NHSE clinically led review of NHS access and waiting time standards.
Prevention and Early Intervention	• All professionals working with children and young people receive mental health and suicide prevention awareness training • Educate and equip CYP with knowledge and skills for healthy and safe usage of the internet and social media. • Ensure that the Think Family approach is embedded across Surrey • Embed Healthy Schools approach across all Surrey Schools • Roll out a suicide prevention toolkit across all educational establishments (e.g. schools, colleges and universities).

	• Ensure that self-harm prevention and intervention is embedded across the existing children and young people workstreams • Enhance support and guidance to educational establishments regarding screening for suicide risk and the services which schools and other settings can refer to (i.e. services as appropriate and Mindworks). • Explore Mental Health Support Teams' role for independent sector, home schooling, alternative provision. • Support the universities in Surrey to sign up to the University Mental Health Charter Programme by September 2024
MH support	• Ensure that young people and their families are at the heart of the work and co-production is embedded across the mental health pathway. • Ensure that there is timely mental health support for CYP. • Ensure that parents and carers of CYP have support. • Risk assessment and Safety planning- holistic approach • Transition
Crisis	• Ensure that there is crisis support in Surrey
Postvention	• Develop postvention support for children and young people in line with national recommendations and guidance.

C3. Men

In England the male rate remains 3 times higher than the female rate.

The National Confidential Inquiry into Suicide and Safety in Mental Health, Social and clinical characteristics of mental health patients dying by suicide in the UK report shows the main social features of patients dying by suicide in the UK. The report highlights that 6% of patients identified as male patients.

In Surrey between 2017 and 2021 a quarter of deaths by suicide were in females and three quarters were in males. The most common age group was 45–59-year-olds. Key risk factors identified in this group included social isolation, relationship breakdown, bereavement, job loss, financial issues, gambling, alcohol use and substance use. Additionally, it is recognised that men are less likely to access to help and support.

In Surrey there is a men's mental health work stream that include:

- Targeted men's emotional and mental health awareness campaign in Surrey.
- Peer support groups
- Further developing peer support groups
- Raising awareness of men's mental health

Area	Action
Prevention and Early Intervention	• Review and improve signposting of debt support across Surrey. • Map the support groups available to men in Surrey and where there are gaps further develop the provision. • Ensure there is a workstream on gambling prevention and support for people impacted by gambling. • Ensure that there is targeted drug and alcohol support treatment available. • Deliver targeted men's emotional and mental health awareness campaign in Surrey. • Through the Surrey workplace heath program encourage employers, including in male industries, to have adequate and appropriate support in place for employees – including, for example, people trained in mental health first aid, mental health support and suicide prevention awareness.
MH support	• Carry out engagement with men to understand what mental health support they access and what the barriers are to accessing support. Share the learning with commissioners and service provider.
Crisis	• Carry out engagement with men to understand what mental crisis support they access and what the barriers are to accessing crisis support; share the learning with commissioners and service provider.

C4. Maternal and Perinatal Mental Health

Overall, the level of risk of suicide after pregnancy is not higher than at other times in a woman's life. However, the high risk compared with other causes of maternal death (most of which are rare) and the potential long-term consequences on children's development means we must take action to prevent suicides in this group. The increasing numbers of teenage maternal suicides, in particular care leavers, in recent years is a significant concern and particular targeted support is needed for this age group.

Nationally, it is recommended that clinicians should complete screening of women's mental health during pregnancy and the first year after pregnancy as part of ongoing care, and should actively seek to identify risk factors, including current and past mental ill health, domestic abuse, substance misuse, baby loss, teenage parenthood and experience of the care system. These are all factors that may require additional support and access to resources from a range of services.

In Surrey we have identified risk points in maternal and perinatal mental health for the expectant mother and their partner. These include:

- Difficult pregnancy
- Miscarriage
- Traumatic births
- Postnatal depression

In Surrey there is a specialist perinatal mental health service for women and birthing people who are planning a pregnancy, are pregnant or have a baby. Women with a baby can be referred to the service before their baby is 12 months old. They provide a service to women with serious or complex mental health needs.

Area	Action: maternal and perinatal mental health
Prevention Early Intervention	• Review the messaging, awareness, and education around maternal and perinatal mental health for for the expectant mother and their partner. • Surrey Public Health to routinely share the suicide learning with maternal health workstream leads, commissioners and maternal health service providers.
MH support	• Ensure that there is timely support for expectant mothers and mothers. • Ensure that there is also timely support for expectant fathers and fathers.
Crisis	• Ensure that there is crisis support available for women and birthing people who are planning a pregnancy, are pregnant or have a baby

C5. Gender dysphoria

Gender dysphoria occurs when there is a conflict between the gender a person was assigned at birth and the gender in which they identify. People with Gender dysphoria can experience discrimination, bullying and isolation. Therefore the below are higher in people with gender dysphoria:

- Depression
- Anxiety
- Negative self-image
- An increased risk of substance abuse,
- Self-harming behaviours
- Suicide attempts

Nationally there have been suicides in people who have Gender dysphoria. Locally in Surrey it has been identified as an area for action.

Area	Action
Prevention Early Intervention	• Map the support available to people with Gender dysphoria. • Work with local partners to raise awareness of Gender dysphoria and mental health ensuring it is embedded in clinical settings, education, health, and social care. Work with VCSEs on promoting positive emotional mental well-being messages.
MH support and MH Crisis Support.	• Map the mental health support available in Surrey.

C6. Long Term Conditions (LTCs)

Chronic or long-term conditions are generally defined as any condition or health problem lasting longer than 3 months. Generally, having a chronic condition is associated with poorer mental health, with this becoming even more pronounced in people who are living with more than one condition (multimorbidity or co-morbidity). People with chronic conditions, like diabetes, cardiovascular disease or respiratory disease are also more likely to have co-morbid mental illness, like anxiety or depression.

In Surrey, the most common long-term conditions are diabetes, hypertension and cardiovascular disease (CVD) and 13.5% of Surrey residents have a long-term health problem or disability. It is estimated that depression rates are likely to be 2-3 times higher in people with a chronic physical condition, and this rate will increase even further for people living with more than one chronic condition.

A comprehensive study from 2017 looked at over 2000 suicides and compared them with matched controls. They found 17 conditions associated with higher risk of suicide, nine of which remained significant after controlling for mental health problems and substance use. These were back pain, brain injury, cancer, heart failure, COPD, diabetes, epilepsy, HIV/AIDS, heart disease, hypertension, migraine, Parkinson's disease, psychogenic pain, renal disorders, sleep disorders and stroke. Three conditions which carried a twofold increase in suicide risk – traumatic brain injury, sleep-related disorders and multimorbidity (presence of two or more chronic conditions) – were higher in those who had died by suicide compared to controls. This means that having multiple physical conditions increased the risk of suicide significantly[1].

A systematic review found that somatic symptom and related disorders are associated with increased risk for suicidal ideation and suicide attempts. This was independent of co-occurring mental disorders. Additionally, risk factors for suicide attempts in people with somatic symptoms and related disorders included scores on measures of anger, alexithymia, alcohol use, past hospitalisations, dissociation, and emotional abuse.

A review on the suicide risk associated with chronic pain found that suicide risk is significantly higher in people living with chronic pain, but this risk is attributed to the psychosocial rather than the physical aspect of pain. This is consistent with previous literature which found that not just having a diagnosis of a chronic condition, but rather the functional limitation is associated with increased risk of suicide[2]. This review is based on a narrative review and meta-analysis[viii] which found robust evidence confirming the link between chronic pain and suicidal ideation, attempts and death by suicide.

A restful sleep is critical to positive health outcomes. Insomnia refers to difficulty getting to sleep, difficulty maintaining sleep, early wakening or non-restful sleep. It involves impaired daytime functioning and symptoms such as poor concentration, fatigue and mood disturbance. Chronic insomnia (insomnia symptoms occurring at least 3 nights per week for over three months) is commonly co-occurring with other physical and mental conditions, including anxiety or depression, COPD, heart failure, neurodegenerative diseases, MSK conditions and chronic pain, as well as substance

[1] Major Physical Health Conditions and Risk of Suicide - ScienceDirect

[2] Racine, M., 2018. Chronic pain and suicide risk: A comprehensive review. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*, *87*, pp.269-280.

use. Bidirectional effects often exist between insomnia and co-morbid conditions. Research estimates that around a third of adults in Western countries experience sleep problems, and 6-10% meet the criteria for insomnia disorder. This is more common in females compared to males, and more common in older adults. Around half of all people with insomnia have a co-morbid psychiatric disorder.

People with long-term conditions and co-morbid mental health problems disproportionately live in deprived areas and have access to fewer resources. The interaction between multiple conditions and deprivation makes a significant contribution to generating and maintaining inequalities.

Children and young people with long-term health conditions are also at an increased risk of poor mental health.

Area	Action
Data and intelligence	• Understand data around multimorbidity and specifically the co-occurrence of mental health and physical long-term conditions in Surrey. • Understand physical health for people with Severe Mental Illness (SMI) • Explore sleep quality and insomnia at population level in Surrey and need for support. • Understand need and existing mental and emotional wellbeing for people living with key LTCs including chronic pain, tinnitus, cancer, diabetes. • Use suicide audit to inform priorities of LTCs workstreams • Understand the emotional mental impact of long term health conditions on children and young people in Surrey.
Prevention Early Intervention	• Improve physical health and reduce health inequalities for people with SMI (work led by the SMI Health Inequalities Board, and co-designed by people with lived experience who have membership on the board as well as inform individual workstreams) • Inform programme to review and roll out information and resources for residents and clinicians about key long-term conditions which have increased risk of suicide (e.g. chronic pain, tinnitus, sleep problems, cancer) • Inform programme (led by PH) to improve access to mental and emotional wellbeing services and resources for people with LTCs including chronic pain, tinnitus, diabetes, cancer, and sleep problems • Inform programme focusing on primary, secondary and tertiary prevention in improving sleep quality and sleep hygiene in Surrey • Support the implementation of training programme for clinicians and healthcare staff focusing on Making Every Contact Count and mental health, and rolling this out in primary care as a priority

MH support and MH Crisis Support.	Ensure that support and resources are available to residents across the pathway from diagnosis to long-term management of LTCs.

C7. Relationships

Through the Surrey Realtime Surveillance work 2021- 2024 and in all the Surrey Suicide Audits from 2008- 2021 breakdown in relationships has emerged a key risk factor to poor mental health and suicides.

Meaningful and positive relations are an important mental health protective factor. The Mental Health Foundation highlights that[ix]:

"Relationships are one of the most important aspects of our lives. People who are more socially connected to family, friends, or their community are happier, physically healthier, and live longer, with fewer mental health problems than people who are less well connected.

It's not just the number of friends you have, and it's not whether or not you're in a committed relationship, but it's the quality of your close relationships that matters. Living in conflict or within a toxic relationship is more damaging than being alone."

Mental Health Foundation Website, March 2024

C8. Older adults

Area	Action
Prevention Early Intervention	• Work with VCSES to ensure that they understand the evidence base on metal health, suicide, and relationships. • Deliver the- Surrey Against Domestic Abuse Strategy • Consider a campaign on raising awareness of positive relationships
MH support and MH Crisis Support.	• Ensure that there is timely support for people who have experienced domestic abuse. • Suicide prevention is embedded in the domestic abuse services. • Domestic abuse awareness is embedded in all mental health services.

One in every five residents in Surrey is aged 65.This group has also grown by 15 per cent between 2012 and 2022.

In 2022 there were 231,993 residents aged 65 and over in Surrey. This represents 19.1% of Surreys population[x].

The Royal College of Psychiatrists[xi] identified four factors which are specific to the risk of suicide in older adults:

- Mental and neurocognitive disorders
- Social exclusion, loneliness, and bereavement
- Functional disability and physical conditions

- Alcohol and substance misuse

Area	Action
Prevention Early Intervention	• Develop targeted emotional mental wellbeing messages for older adults. • Understand the alcohol and substance misuse of older adults in Surrey. • Work with VCSEs that support older adults to embed suicide prevention. • Ensure that older adults are included in the loneliness and isolation work. • Ensure that older adults are embedded in the long-term health conditions workstreams.

C9. Armed Forces and Veterans

The Armed forces suicide prevention strategy and action plan was published in 2023.

The action plan identifies eight focus areas. These are:

1. understand high risk groups within the armed forces.
2. educate armed forces about Suicide.
3. enable individual resilience and personal support needs.
4. enable safe military environments.
5. enable organizational management of those at risk.
6. enable access to support for those at risk.
7. develop accessible postvention support.
8. improve organizational learning.

Area	Action
Joint working	Work with local armed forced and veterans' boards and working groups to develop a joint suicide prevention working group to review and support the delivery of the eight focus areas.

C10. People engaged with Criminal Justice system.

People engaged with the criminal justice system are at a high risk of suicide compared to the general population[xii]. Surrey has five prisons.

Area	Action
Prevention and early intervention	All professionals in Statutory agencies understand the increased risk of suicide in this cohort the various risk factors including substance misuse issues, mental health and childhood trauma etc.
Joint working	Work with Criminal Justice Board and key working groups to develop a joint suicide prevention action plan.

.

Mental Health Conditions

C11. Prevention of suicide among identified high risk groups, particularly those with known mental ill health.

The National Confidential Inquiry into Suicide and Safety in Mental Health, Social and clinical characteristics of mental health patients dying by suicide in the UK report[xiii] shows the main social features of patients dying by suicide in the UK. The report highlights that 66% of patients identified as male patients. There were high rates of social adversity and isolation. 53% of patients had a comorbid diagnosis. 64% of patients had a history of self-harm. 47% of patients had a history of alcohol use and 27% had drug use.

Having a mental health condition is a risk factor for suicide. Therefore, it is important that Surrey Public Health Team reviews the suicide data and intelligence of the different mental health conditions (e.g., Anxiety, depression, bipolar, personality disorder, schizoaffective disorders) so that targeted prevention work and early intervention can be delivered.

Self-harm

In Surrey over one third of individuals who died by suicide had a previous history of self-harm. In most cases, people who self-harm- do not present for medical attention[xiv]. Evidence shows that self-harm is higher in females than males.

Medication prescribing

People are often prescribed medication to manage suicidal thoughts. Whilst treatment is important this needs to be combined with regular follow ups as research show that suicide rate increases in the first 28 days after starting and stopping antidepressant treatment.

In Surrey, evidence-based criteria should be developed to identify people who need to be followed up when they have been prescribed medication. The follow up is recommended for day 3, day 7, and then in line with the needs of that person.

A safety plan should be developed with people prescribed medications for mental health.

It is also recommended that people prescribed medications for mental health have regular follow ups by a clinician or a pharmacist.

Recommended questions for medication follow up:

- Have you collected medication?
- Have you started medication?
- When are you taking it?
- How are you feeling?
- Check the safety plan

Crisis care

The **Mental Health Crisis Care Concordat** is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

The Mental Health Concordat focuses on four main areas:

1. **Access to support before crisis point** – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
2. **Urgent and emergency access to crisis care** – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
3. **Quality of treatment and care when in crisis** – making sure that people are treated with dignity and respect, in a therapeutic environment.
4. **Recovery and staying well** – preventing future crises by making sure people are referred to appropriate services.

In Surrey there is already a number of mental health crisis services that can be accessed by people having thoughts of suicide.

Safe Havens

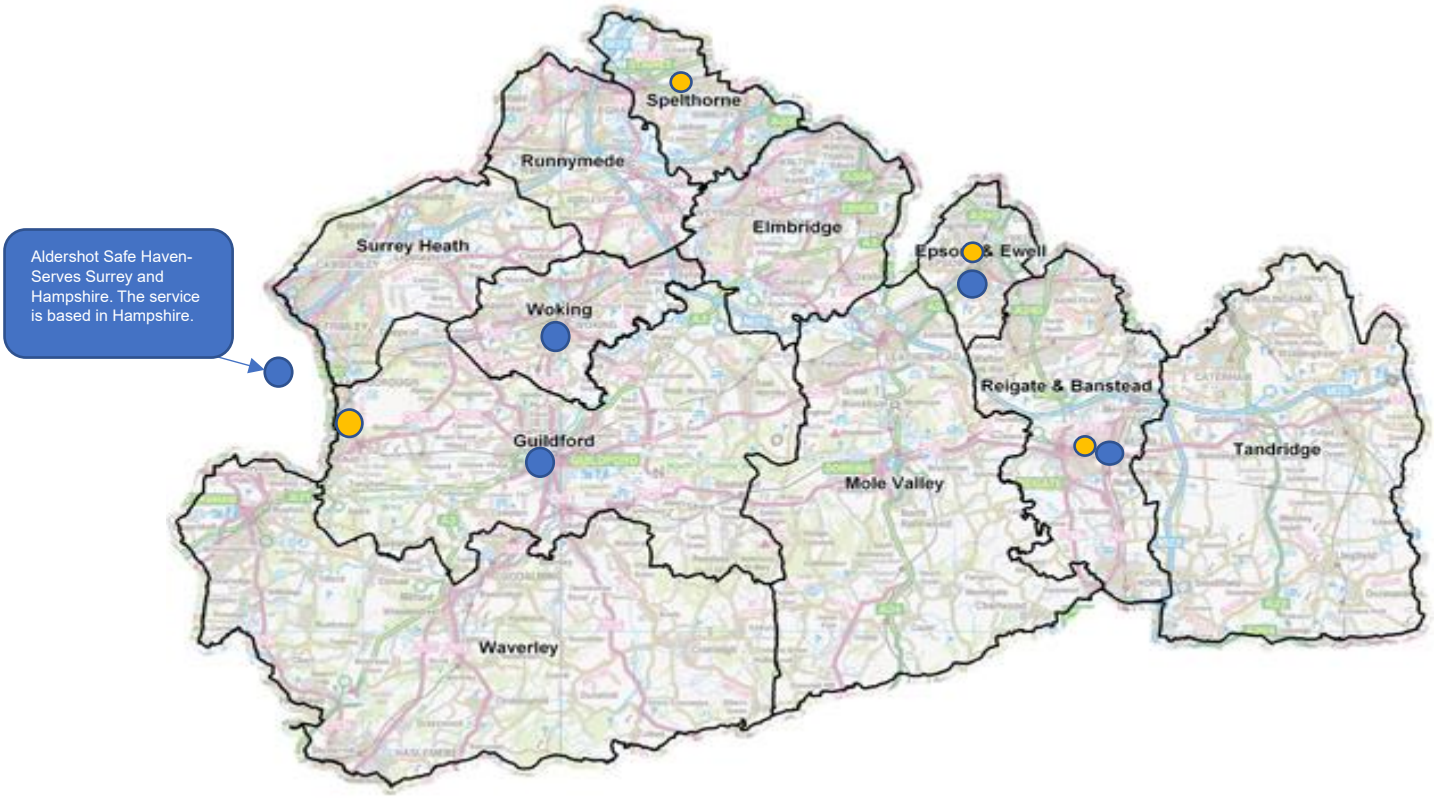
There are four Safe Havens in Surrey. They provide out of hours help and support to people and their carers who are experiencing a mental health crisis or emotional distress. They are designed to provide adults with a safe alternative To Emergency Departments When In Crisis.

The Safe Havens are open evenings, weekends and bank holidays.

The Safe Havens are provided in partnership between Surrey and Borders Partnership NHS Foundation Trust (SABP) and third sector mental health specialists. Peer support from people with lived experience of mental health issues is also increasingly available.

Figure 1 *Map of the Safe Havens that serve Surrey population.*

Key: Adult Safe Havens in Surrey ● Children and young people Safe Havens ●



The current Safe Haven provision in Surrey covers Guildford, Woking, Epsom and Ewell and Reigate and Banstead. Whilst all of the Safe Havens are near public transport, consistent feedback from people with lived experience and professionals is that they are not easy to access from people living in Tandridge, Spelthorne and Waverley. This is due to the public transport networks and the cost of transport to get there and back.

Improving safety in mental health care

Figure 2. *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 10 components of safety in mental health care (NCISH, 2022)*

SABP already audit themselves against foundations standards that covers these 10 components.

It is recommended that there is a workstream with private providers to ensure that they are regularly audited against these ten components.

Preventing suicide (Surrey and Borders Partnership NHS Foundation Trust)

Surrey and Borders Partnership NHS Foundation Trust (SABP) is the leading provider of health and social care services for people of all ages with mental ill-health and learning disabilities in Surrey and North East Hampshire.

They deliver care across 140 services, all of which are registered with the Care Quality Commission. Individual treatment and support, which help people work towards recovery, is at the heart of everything that they do.

Their services are provided in community settings, hospitals and residential homes with an emphasis on providing local treatment and support close to people's homes wherever possible.

Preventing suicide is a key objective for SABP. The trust will focus on the below key areas:

A. Education and training

- They will establish an annual coordinated training plan for mental health awareness and suicide prevention targeted to high-risk groups.
- Encourage all health organisations to utilise the Safer Services NCISH toolkit to self-assess their services against the evidence based, ten key elements of safer care for patients.
- Commit to system wide support for suicide prevention and patient safety through strong leadership, workforce training, systematic identification and assessment of suicide risk, implementation of evidence-based treatments, continuity of care, and continuous quality improvement.

B. Clinical developments

- Develop links with neuro-disability networks to ensure effective signposting to mental health support is in place.
- Explore a workstream around patients with chronic pain.
- Work with inpatient services to audit, consult and mitigate ligature points as part as an overall reduction of means programme.
- Ensure inpatient wards adhere to 10 key elements to improve safety criteria in line with the NCISH recommendations. They will also audit mental health care against these 10 components.
- Development of an older persons' services suicide prevention working group
- Development of children and young people's suicide prevention working group.

C. Organisational change

- Fundamental membership and engagement with Surrey Wide Working group.
- 6 weekly SABP Suicide Prevention Steering Group meetings.
- Sign up to the QES real time suicide surveillance database.
- In line with data agreements, share data and intelligence to inform prevention, intervention and response work.

Other key actions for Surrey and Borders Partnership NHS Foundation Trust

- Develop a harm minimisation policy/ safer methods to self-harm policy.
- Continue to develop the brief contact intervention Samaritans project, rolling out the project to all GPIMHS and MHICS.
- Continue to roll out CAMS training to all community staff
- As part of working with hard-to-reach groups, SABP will develop a meaningful offer for the travelling community.
- Develop a 'Carers webinar' for people who a carers for those experiencing suicidality.
- Develop a mutual aid policy for staff working in the Trust and surrounding Mental Health Trusts
- Develop a dedicated resource page for staff who are experiencing mental health difficulties
- Offer staff who have been bereaved professionally by suicide support sessions via Rethink suicide bereavement service.

Key action areas:

Area	Action
Awareness	Continue to raise awareness of the crisis care available in Explore a workstream around patients with chronic pain. Raising awareness in both primary care and secondary care.
Medication prescribing	An evidence-based criteria should be developed to identify people who need to be followed up when they have been prescribed medication. The follow up is recommended for day 3, day 7 and then in line with the needs of that person.
Access to Crisis support	Review the provision of Safe Havens, identifying how people can be supported to access these and consider how Safe Havens can be more accessible to people who need to travel to access them.
Audit	Carry out an audit against the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: 10 components of safety in mental health care

C12. Neurodiversity

National prevalence of autism is approximately 1% of the population. So, our best approximation of Surrey's autistic population is 12,000 people, made up of:

- 2,500 children aged 0-16
- 1,000 young people aged 17-25
- 8,500 people aged 25 and over (www.surreyi.gov.uk)

The estimated number of autistic people over 18 is 9,400, and the number open to Surrey Adult Social Care is 1,834. This means 20% of the adult autistic population receive a service from Adult Social Care.

Research suggests that 70% of autistic people have a mental health condition, and that 40% have two or more. Autistic people are up to ***four times*** more likely to have anxiety disorder, and twice as likely to have depression. Research has shown that autistic people are more vulnerable to negative life experiences, which may also impact mental health. Compared to the general population, autistic people report having a lower quality of life. Research indicates that suicide is a major cause of early mortality in autistic people.

In Surrey, we need to identify autistic people's needs ***earlier*** and improve their physical and mental health. This will help better understanding of the inequalities autistic people face, such as the causes for the gap in life expectancy, so we can take the right actions to improve people's health outcomes.

Surrey Aspiration

- Autistic children young people and adults have good mental health and wellbeing, and access to universal or specialist Mental Health services as required.
- Deliver a dynamic programme of autism training to upskill the workforce.
- Reasonable adjustments in universal Mental Health services
- Review mental health pathways
- In-patient accessibility
- Support when autistic people struggle with their mental health

Surrey- All Age Autism Strategy 2021-2026[xv]

The top 10 community priorities

Suicide and Autism, a National Crisis[xvi] (Sue Willgoss) Advisor for Suicide Prevention with Lived Experience, Norfolk and Suffolk NHS Foundation Trust Founder Lived Experience Influencer for National Suicide Prevention Alliance identified 10 top community priorities for suicide prevention.

1. Identify barriers that autistic people encounter when seeking help, which may increase their risk for suicide.
2. Identify the risk and protective factors for suicide in autism across the lifespan.
3. Examine the extent to which autistic people are not believed when reporting the severity of their distress.
4. Examine the development of suicidality that is not associated with other mental health symptoms across the lifespan.
5. Identify the best ways of assessing suicidal thoughts and behaviours in autistic people in clinical practice and research.
6. Identify how interventions could be adapted for autistic people and individual presentations.
7. Understand the experience of suicidality in autistic people and determine if it is different from that of the general population.
8. Examine how autistic people seek help when they are in crisis.
9. Examine how well existing models for understanding suicide apply to autistic people
10. Study the impact of poor sleep on suicide risk in autistic people.

Through the Surrey suicide prevention learning work the below key learnings have been identified:

- There have been cases of people who have died of suspected suicide where families thought they may have had autism, but they had not being diagnosed.
- There have been cases of people with diagnosed autism who have died of suspected suicide
- There have been family members of autistic people who have died of suspected suicide
- Autistic adults mental health and suicide crisis presentations are different from non-autistic adults
- We need to better understand what autistic adults need to support them to keep emotionally and mentally well, what mental health and crisis support they need and what the gaps and issues are in Surrey. This information can then be used to develop and further improve the work in Surrey.

In order to develop the suicide prevention work targeting autistic people and their families and carers, the below two projects are recommended in Surrey:

Project	Area
Project 1	• Co-develop mental health awareness resources and develop emotional mental wellbeing plans for Autistic adults. • Work with key groups and embed these across Surrey.
Project 2	• Surrey to carry out local review using the top 10 community priorities in the *Suicide and Autism, a National Crisis*[xvii] report. • Surrey to use the learning to codesign a population based Surrey autism and suicide prevention plan that ensures a holistic approach that include Autistic people, their families and communities.

C13. Alcohol and substance use

The risk of poor mental health, self-harm and suicide is greater for people who misuse alcohol than those who don't misuse as alcohol[xviii].

The 2021 Surrey suicide audit identified that 57% of people who died by suicide acknowledged either alcohol or substance use before death. This largely covers individuals who had a combination of long-established alcohol use and/ or drug misuse. However, only 3% of the individuals who died by suicide were in contact with specialist substance misuse service prior to death, 1% in the previous 3 months, 3% in the last 12 months and 3% over 24 months.

Area	Action
Prevention and early intervention	The Audit C tool[xix] is rolled out in: • Mental health. • Emergency Departments • Mental health crisis support services- SafeHaven and Emergency Departments. • Domestic Abuse services
Joint working	Work with alcohol and substance use boards to ensure that suicide prevention is embedded.

Action Area D. Suicide Safer Community

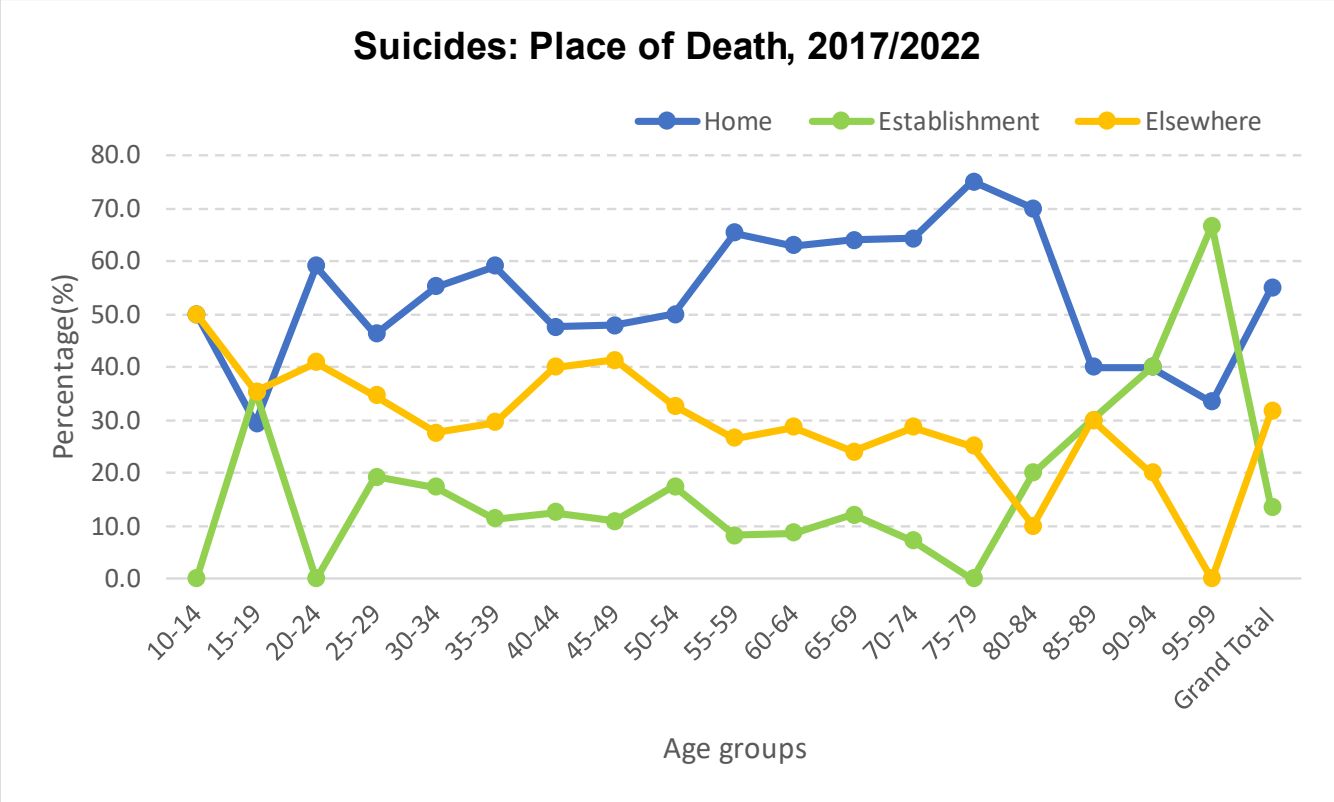
The National Suicide Prevention Strategy Third Progress Report (Department of Health, 2017) highlights that in order to reduce access to means of suicide we should:

- Identify high risk locations.
- Put safeguards in place to prevent suicides.
- Be aware of emerging suicide methods.
- Work with local media around sensible reporting of suicide.

On average 65% of deaths occurred in the deceased's own home, with 35% in a public place or someone else's home.

50% of deaths in young people ages 10-14 years old were in a public location.

Figure 3 *Suicide in Surrey by place of death 2017-2022*



It is important that high risk locations are identified quickly through the suicide response work and response plans are developed in partnership with key agencies.

It is also important to reduce the access to means that have been identified in Surrey cases and nationally. This should include working with NHS England, Trading Standards, Local Retailers, clinical staff and key frontline staff to identify and reduce key means that may increase the risk of suicide.

Action Areas:

Project	Area
D1	Use the real-time suicide surveillance data to inform suicide response work.
D2	Develop a local suicide high risk location working group.
D3	Continue to raise awareness of responsible reporting of suicide in the media.

Action Area E: Bereavement

Death by suicide can affect a broad range of people. The impact of the death can be affected by the relationship of the individual to the deceased, whether the person witnessed/ found the deceased, and the emotional struggles and resilience skills of the individual.

The people affected can be considered in four groups:[1]

Group 1: Suicide bereaved long-term: Family, partners, close friends.

Group 2: Suicide bereaved short-term: Friends, peers, close work colleagues, longstanding health/ social care workers, teachers.

Group 3: Suicide affected: First responders (family, friends, members of the public, police, paramedics), those directly involved such as train drivers, neighbours and local residents, teachers, classmates, co-workers, health/ social care staff.

Group 4: Suicide exposed: Local groups, communities, passers-by, social groups, faith groups, acquaintances, wider peer groups including those via social media contacts (e.g. Facebook friends)

A key action in the NHS Long term plan is to roll out suicide bereavement support services across all *Integrated care systems* (ICSs) by 2023/24 (NHS, 2019).

National recommendations suicide bereavement (McDonnell S, November 2020):

1. The implementation of national minimum standards in postvention services
2. A national online resource for those bereaved or affected by suicide
3. Campaign to raise awareness of the impact of suicide bereavement

4. Suicide bereavement training for front line staff. Evidence-based suicide bereavement training should be mandatory for those who provide postvention services.
5. Support for people with risk taking behaviours
6. Workplace suicide bereavement support
7. Further research on the impact of suicide.

There is a commissioned suicide bereavement support service in Surrey. The service is contracted to support anyone who has been bereaved or impacted by a suspected or completed suicide.

Action Areas:

Project	Area
E1	Ensure that there is sustainable suicide bereavement support across Surrey and that Surrey continues to fund suicide bereavement support in Surrey.
E2	Provide a suicide bereavement support service for children and young people- taking learning on service provision from other areas.
E3	Raise awareness of suicide bereavement.
E4	Train frontline professionals and community members in suicide bereavement awareness.
E5	Ensure that contracted suicide bereavement services are regularly reviewed against national strategies.

Governance processes

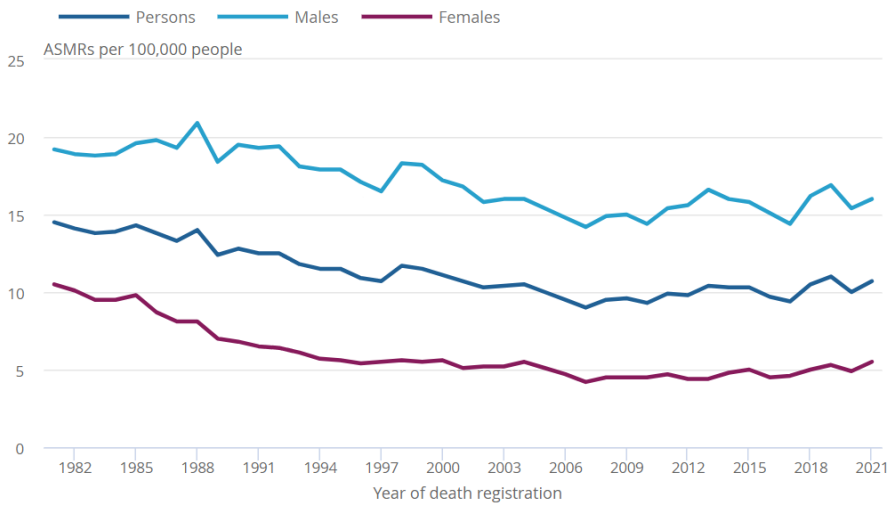
Intentionally blank- will be reviewed after engagement.

Appendix 1: Data profile for Surrey

Understanding suicide in Surrey

Figure a: Age-standardised suicide rates by sex, England and Wales, registered between 1981 and 2021

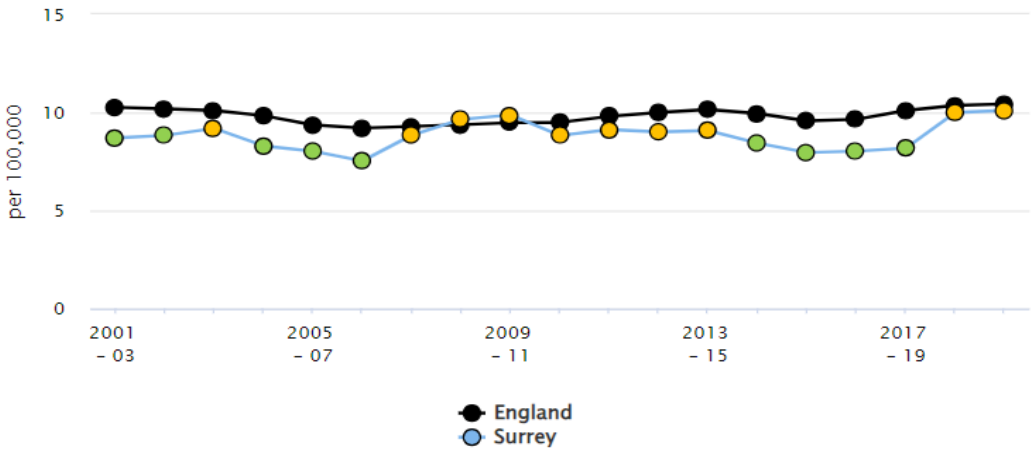
Source: ONS data



Suicide rates in England and Wales have decreased over last 40 years.

The level of evidence needed by coroners to conclude whether a death was caused by suicide as changed from the criminal standard of "beyond all reasonable doubt", to the civil standard of "on the balance of probabilities" on 26 July 2018. This maybe a reason for suicide increases in 2019/20.

Figure b: suicide rates trend data Surrey compared to England- 2001 to 2022



Source: PHE Fingertips

Key points

- The current suicide rate in Surrey is 10.1 per 100,000 of population. This is similar to England (10.1 per 100,000 population)
- There were approximately 92 deaths by suicide in Surrey each year.

- In 2007/8 the number of suicides within Surrey increased by approximately 20%. A key risk factor was the impact of the recession.

The key high-risk groups identified with Surrey are:

  - Men aged 45 to 65.
  - Older adults- people aged 65+
  - Children and young people
  - Neurodiversity- suspected and diagnosed.
  - People who have been bereaved by suicide.
  - People with long term health condition

Suicide audits learning

Every three years Surrey Public Health Team carry out a suicide audit. This audit reviews the case files of people who have a conclusion of suicide and looks at key themes, learning opportunities and emerging risks.

The key finding from the 2017-2021 Surrey suicide audit report:

- Approximately three quarters of those who took their own life were male (76%) and a quarter were female (24%).
- The majority of individuals (71%) who died by suicide were categorised as 'white', 7% were categorised as other (Asian, Black, African, Caribbean and other Asian) and 5% categorised as European.
- The mean age at death was 53 for males and 41 for females (48.2 overall), with the highest number of deaths, one third, in the 45-59 years age bracket.
- 36% of people who died lived alone, and 36% were not in a long-term relationship of any sort. Approximately a quarter (27%) of Surrey residents live alone according to the 2011 census.
- Individuals who died by suicide had many complex needs. One in five were recorded to have a disability, one in three had a history of violence and abuse (either as perpetrators or victims, or both), and one in three had a previous history of self-harm.
- By far the most common mental health condition that individuals had who died by suicide was depression. Over half had either a clinical diagnosis of depression or had documented in their clinical notes that periods of depression had occurred over their lifetime. One third had an anxiety condition.
- 57% acknowledged either alcohol or substance use before death. This largely covers individuals who had a combination of long-established alcohol use and/ or drug misuse. However, only 3% of the individuals who died by suicide were in contact with specialist substance misuse service prior to death, 1% in the previous 3 months, 3% in the last 12 months and 3% over 24 months.
- The strongest risk factor for suicide is a previous suicide attempt, and 37% of individuals who died by suicide had a previous suicide attempt.
- 51% of the individuals for whom information about mental health was available were in contact with mental health services.

- Over the 4-year period, this has been quite consistent with an average of 51% of individuals who died by suicide having contact with mental health services and 45% having with no contact with mental health services.
- A quarter of individuals who died by suicide were in contact with a mental health service at the time of their death.
- 4% visited their GP in the preceding 24 hours to death and 1 in 5 individuals had a GP visit up to 2 weeks before death. The highest proportion of individuals, equating to just over a quarter (28%), visited over 3 months prior to death. The reasons for the visit varied between a mental health issue, a physical issue, both issues or just a routine appointment. There was no obvious pattern.

References

[i] Suicide prevention in England: 5-year cross-sector strategy - GOV.UK (www.gov.uk)
[ii] Home - R;pple (ripplesuicideprevention.com)
[iii] The ripple effect, silence and powerlessness: hidden barriers to discussing suicide in Australian Aboriginal communities Todd R. Heard etal.
[iv] Suicide Prevention in public places
[v] Suicide prevention on the railway - Network Rail
[vi] NHS England » Patient Safety Incident Response Framework
[vii] Emotional wellbeing and mental health strategy (datapress.cloud)
[viii] Chronic pain and suicide risk: A comprehensive review - ScienceDirect
[ix] Relationships and community: statistics | Mental Health Foundation
[x] Population Estimates | Surrey-i (surreyi.gov.uk)
[xi] college-report-cr229-self-harm-and-suicide.pdf (rcpsych.ac.uk)
[xii] Suicide in the Criminal Justice System - Health Research Authority (hra.nhs.uk)
[xiii] NCISH | The University of Manchester
[xiv] college-report-cr229-self-harm-and-suicide.pdf (rcpsych.ac.uk)
[xv] All age autism strategy 2021 to 2026 (surreycc.gov.uk)
[xvi] Suicide and Autism, a National Crisis. (rcpsych.ac.uk)
[xvii] Suicide and Autism, a National Crisis. (rcpsych.ac.uk)
[xviii] Alcohol use and its association with suicide attempt, suicidal thoughts and non-suicidal self-harm in two successive, nationally representative English household samples | BJPsych Open | Cambridge Core
[xix] Alcohol use disorders identification test for consumption (AUDIT C) (publishing.service.gov.uk)