Suicide Prevention Strategic Plan

2026-2031

Partnerships

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INTRODUCTION

Suicide can have a devastating impact on families, friends, neighbours, colleagues and whole communities. The national suicide rate has not fallen since 2018, and there are still over 5,000 deaths by suicide in England each year.

A death by suicide is a tragic and traumatic event. Its most fundamental impact is the loss of the opportunity for that person to experience all that life holds. It is also a devastating bereavement for family and friends, and the pain and grief can be immense and long lasting. The impact also extends into the wider community, workplaces and to all services involved. In addition, people who are bereaved by suicide are at increased risk of suicide and mental health problems themselves. The impacts of suicide are felt most deeply on a human level. However, the economic cost of each death by suicide in England for those of working age is estimated to be £1.67 million. This covers the direct costs of care, indirect costs relating to loss of productivity and earnings and the intangible costs associated with pain, grief and suffering.

Every life lost to suicide is a tragedy. Preventing deaths by suicide needs action from national and local Government, from the NHS and other health & care services, from Voluntary, Community and Social Enterprise sector (VCSE), from education and businesses, communities, and individuals.

Suicide can be preventable. But it is essential that the preventative approach addresses the complexity of the issue. No one organisation is responsible for suicide prevention and there are no simple measures to prevent suicide. Suicide prevention is broad and includes measures to improve emotional wellbeing, support for people with mental health issues (from early intervention through to crisis care) and support for people who are bereaved by suicide.

We all have a role to play in challenging stigma, improving understanding about mental health and wellbeing, and developing the knowledge, skills and confidence to have mental wellbeing conversations. Suicide prevention is everybody’s business. A whole systems approach is required between national and local organisations, communities and individuals so that partners are working in collaboration towards the same priorities.

THE NATIONAL CONTEXT

The Suicide prevention in England 5-year cross-sector strategy sets out the national direction and ambition for suicide prevention from 2023 to 2028. The strategy has three key aims, and eight priority areas for action.

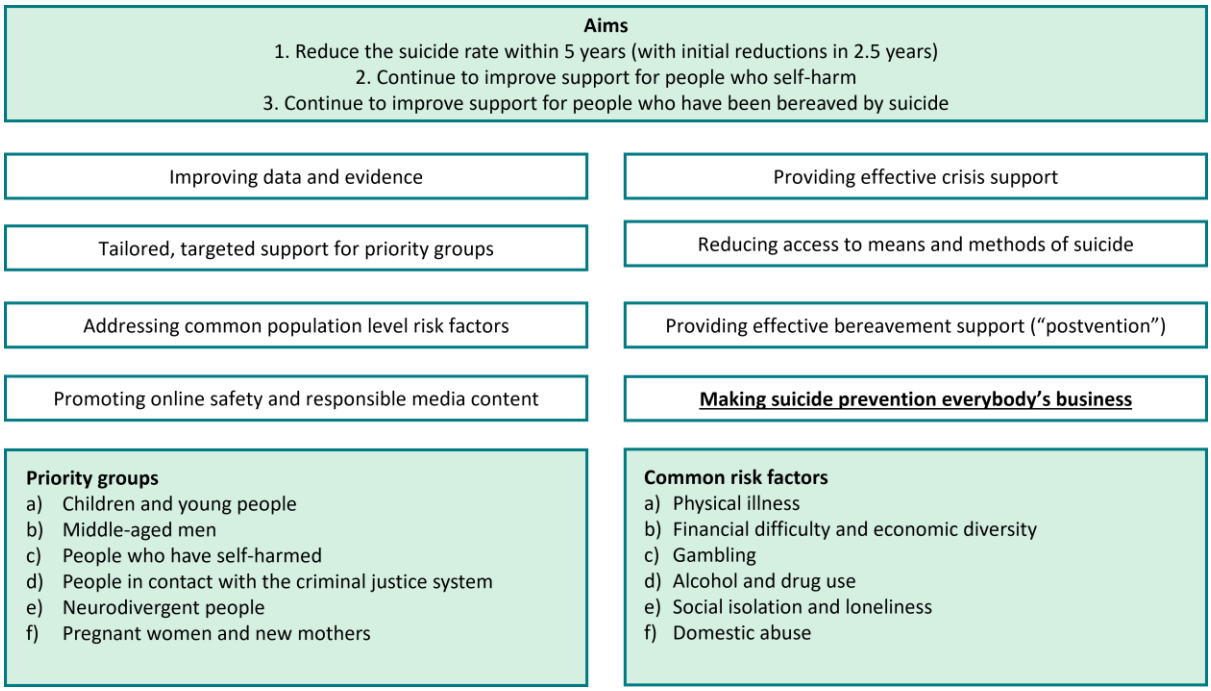

Figure 1 National Suicide Prevention Strategy 2023-2028 aims and priority areas.

Alongside the strategy, an action plan was produced which summarises over 100 actions, and details which government department or organisation will deliver each action, and by when. Both the national strategy and its' supporting action plan have been used to benchmark the local position against those national priority areas and actions, to inform the development of this suicide prevention action plan.

This strategic plan has been organised so that it aligns with the national strategy's aims and priority areas. Each section of the plan reflects these themes, allowing local partners to see how their work contributes to the wider national direction, while responding to local needs and priorities.

THE LOCAL CONTEXT

Multi-agency suicide prevention groups help coordinate action to reduce suicides in local areas. In England, responsibility for local suicide prevention strategies and action plans usually sit with local government through Health and Wellbeing Boards.

Previously the multi-agency suicide prevention groups in Devon, Plymouth and Torbay have aligned around a strategic vision but maintained their own strategic plan. The common vision is:

"Our vision in Devon is for all suicides to be considered preventable and that suicide prevention is everyone's business. The ambition for suicide prevention is to deliver a consistent downward trajectory in the suicide rate for all areas of Devon, Plymouth and Torbay so that they are in line with or below the England average."

While this plan seeks to provide a consistent strategic framework, it recognises that there are existing differences between Devon, Plymouth and Torbay in terms of population size, demography and risk profile, as well as variation in the availability of mental health services and VCSE support. Some areas face additional challenges such as smaller populations that make auditing and evaluation more difficult, or higher concentrations of groups at increased suicide risk. Where such variation exists, the plan aims to make these differences visible, promote equity of access and outcomes, and support partners to adapt or strengthen local provision so that people receive timely, appropriate support wherever they live.

The NHS Devon: Health and Care Strategy sets out the future model of the local care system. Mental health is a clear priority in that plan with the aim of moving towards a more prevention, person-centred, community and neighbourhood approach. This Suicide Prevention Strategic Plan aligns with that approach.

ABOUT THIS STRATEGIC PLAN

The plan has been co-developed by system partners structured around the aims and priority areas of the national suicide prevention strategy. It brings together the three existing local

suicide prevention action plans for Devon, Plymouth and Torbay into one co-ordinated Integrated Care System (ICS) wide plan. It provides a shared framework for suicide prevention across our region, based on the eight priorities of the Suicide prevention strategy for England: 2023 to 2028, ensuring that activity is connected, evidence informed and aligned to national priorities, while retaining the flexibility to respond to local need.

The plan is intended for all partners involved in suicide prevention, including local authorities, NHS organisations, voluntary, community and social enterprise (VCSE) organisations, education providers, emergency services, criminal justice partners, employers and community leaders, as well as for commissioners and system leaders who oversee and resource suicide prevention activity. It is also a reference point for anyone developing, delivering or commissioning services and interventions that may reduce suicide risk.

Governance for this strategic plan is provided through the existing suicide prevention partnerships in Devon, Plymouth and Torbay and accountable to their respective Health and Wellbeing Boards. Oversight, prioritisation of the objectives and development of specific actions to meet the objectives will be held by the Devon ICS Suicide Prevention Oversight Group (SPOG), which provides senior strategic leadership and ensures effective cross-communication and alignment between suicide prevention partnerships and the wider ICS. This governance framework enables consistent priorities across the system while allowing local adaptation based on existing contexts and assets, supports timely sharing of learning and intelligence, and ensures that progress, challenges and successes are fed back to all areas.

This is a suicide prevention strategic plan, not a mental health strategy. There are significant overlaps between work to improve mental health and suicide prevention. The priority areas of the national strategy and therefore this suicide prevention strategy also highlight this crossover, with people who have self-harmed, people in contact with mental health services being a priority group and providing effective crisis support as a priority area. This strategic plan considers these priority areas with a suicide prevention lens and does not cover the whole scope of mental health services, which can be considered as a core service delivery area for the system.

The plan shows:

- **System-level objectives** where a coordinated approach is needed to deliver consistent impact across Devon, Plymouth and Torbay.
- **Shared ownership** identifying leads and partners, and promoting collaboration across NHS, local authorities, VCSE organisations and other system stakeholders.

Objectives within this plan span the full spectrum of suicide prevention work. It builds on existing core delivery while addressing identified gaps, variation and inequity across the system.

OVERARCHING PRINCIPLES

The following principles underpin the development and delivery of this suicide prevention strategic plan. They reflect how we will work together as a system and the values that should guide all activity across Devon, Plymouth and Torbay:

Localised delivery within a system-wide framework	Actions agreed at Integrated Care System (ICS) level should be implemented in ways that respond to the specific needs, assets and contexts of local areas. Where appropriate, actions will be adapted to reflect the priorities and delivery models of locality partnerships while remaining aligned to the overall system plan.
Collaborative system working and strong partnerships	Suicide prevention is everybody's business. Success depends on effective collaboration between local authorities, NHS organisations, voluntary and community sector partners, education, employers, emergency services, criminal justice partners and community leaders. System partners will share learning, resources and expertise to maximise impact.
Meaningful involvement of people with lived experience	People with personal experience of suicide, bereavement and mental health crisis bring essential insight to prevention work. The system will review how they will be engaged and supported in a safe, respectful and impactful way, shaping priorities, informing service design and contributing to evaluation and continuous improvement.
Equity and inclusion	All activity will take account of the unequal distribution of suicide risk, ensuring that prevention approaches are inclusive and responsive to the needs of groups who experience higher risk, due to factors such as deprivation, discrimination, trauma, neurodiversity or other vulnerabilities and to differences in local service provision and capacity.
Evidence-informed and continuously improving practice	Decisions will be based on the best available data, research and real-time intelligence. The system will monitor outcomes, evaluate interventions and adapt approaches in response to emerging evidence and feedback from those affected.

CORE SERVICE DELIVERY

Alongside the new objectives and priorities set out in this plan, there is already a significant programme of suicide prevention activity in place across Devon, Plymouth and Torbay. This

core service delivery forms the foundation on which further work will build. It is delivered collaboratively by local authorities, NHS organisations, the Integrated Care Board (ICB), mental health providers, voluntary and community sector partners, the police, coroner's service and other system stakeholders.

Current system-wide core-delivery includes:

Priority area	Description of core service delivery
1. Improving data and evidence	• Routine use of the Devon Real Time Surveillance System (RTSS) system and national data (Office for Health Improvement and Disparities profiles, ONS data) to monitor trends and novel methods, support early response and inform planning. • Contribution to local suicide audits (Plymouth and Torbay) and sharing of key learning widely. • Coordinated campaigns and communications to raise awareness, reduce stigma, and promote help-seeking. • Insights from audits, reviews (including avoidable deaths reviews, domestic abuse related death reviews and safeguarding processes) and pilots are shared to inform ongoing improvements.
2. Tailored targeted support to priority groups	• Prioritisation of activity to support these priority groups • Existing community and health services providing support to these groups
3. Addressing risk factors	• Prioritisation of activity to support people with these risk factors • Existing community and health services providing support to people with these risk factors
4. Promoting online safety and responsible media content	• Signposting to existing resources
5. Providing effective Crisis support	• A 24/7 local crisis response offer through NHS providers (NHS 111 option 2), supported by clear signposting tools for professionals and the public. • Signposting to appropriate other crisis services such as Shout, Papyrus, and Samaritans.
6. Reducing access to means and methods of suicide	• Work with local authorities, police, and transport partners to address access to high frequency locations, implement safe design principles and share alerts about emerging methods or risks.

7. Providing effective bereavement support to those affected by suicide	• Specialist bereavement services (e.g. Pete's Dragons) are commissioned across the ICS, linked to the RTSS to enable timely support, including support to settings. Police and other partners continue to improve referral processes and promote awareness of available services.
8. Making suicide everyone's business	• Local authority-based suicide prevention partnerships • Training and workforce development: A wide range of suicide prevention, mental health and trauma-informed training is offered across sectors, including universal awareness training (e.g. Making Every Contact Count).

ONE DEVON SUICIDE PREVENTION STRATEGIC PLAN 2026-2031

The strategic objectives described below are framed using the priorities of the Suicide prevention strategy for England: 2023 to 2028, which is sets the overall strategic direction for this plan. Progress of this shared system plan will be overseen and driven by the One Devon Suicide Prevention Oversight Group (SPOG). The objectives under each priority are provided with a rationale and context for that objective, together with the key partners who will support the work to achieve the objective. This includes partners who are members of SPOG (Public Health, NHS Devon, Mental Health providers, Devon and Cornwall Police) as well as partners from the mental health system and beyond.

1. IMPROVING DATA AND EVIDENCE

Timely and high-quality data, evidence and intelligence allow for a better understanding of the drivers of suicide and self-harm, the development of more effective interventions and more rapid responses to prevent suicide. It is an essential part of suicide prevention both to understand what has worked in preventing suicides and where to direct future efforts.

	Objective	Rationale and context	Key partners
1.1	**Create a One Devon Suicide Prevention Dashboard.**	Bringing together data from a range of sources to provide a temporal and spatial view of suicide across the county including risk factors. This includes data from Real Time Surveillance System (RTSS), ONS, Concerns for Welfare and Trust data. This will enable suicide prevention activity to be better targeted to the level of need. Consider how to link to National Real Time Surveillance System.	Public Health, Police, Pete's Dragons, NHS Devon, Highways, BTP
1.2	**Improve local data and use national data on potential or emerging risk factors and priority groups.**	Such as people with chronic pain, people from diverse communities (particularly in the context of the current social and political landscape due to increasing polarisation, discriminatory narratives, and structural inequities), experiencing harmful gambling, people who are homeless and rough sleeping, are neurodiverse, LGBTQIA+, people who are care experienced, farming and fishing communities and the armed forces community.	Public Health, Police, Pete's Dragons, NHS Devon, provider of support services to people in these groups

		Improving understanding of the robust data for certain groups enables more effective prioritisation of resources to where the need is.	
1.3	**Application and sharing of data, evidence and learning from local and national reviews and frameworks related to suicide such as child death reviews, PSIRF, avoidable death reviews, suicide audits to inform support prioritisation and build on this strategic plan.**	There are multiple local and national system reviews that have implications for suicide prevention work. Being able to review these for key learning and trends to share with the wider system is crucial to ensure that these reviews are leading to positive system change and quality improvement.	System-wide. All partners involved in these reviews and services where learning can be applied

2. TAILORED TARGETED SUPPORT TO PRIORITY GROUPS

Suicide prevention is population-wide, and the objectives set out within this plan are designed to support as many groups and individuals as possible. However, there are some groups that could particularly benefit from bespoke support. For some groups, such as people in contact with mental health services, data suggests relatively high numbers of suicide. Others may not have high rates but are of particular concern, such as children and young people, for whom rates have increased in recent years despite being low overall. It is therefore crucial that organisations and individuals tailor and target resources and services to support these groups.

	Objective	Rationale and context	Key partners
2.1	**Raise awareness, challenge stigma, promote training and signposting of resource and support to the priority groups and workforces that support these groups.**	These groups have been identified through national data, evidence and engagement as priority groups for suicide prevention activity.	System-wide

2a. Children and young people

While the suicide rate in under-20s is relatively low compared with older age groups, rates across all age groups under 25 have been increasing over the last decade in England. This increase is particularly apparent among females under 25. This trend in rates is now levelling off – however, we must focus action to reverse this trend.

	Objective	Rationale and context	Key partners
2a.1	**Support young people, parents/carers and non-mental health professionals who work with young people to have a greater awareness of self-harm and suicide prevention**	Improving knowledge of self-harm and suicide reduces stigma and improves help-seeking. Through the general and targeted provision of effective resources and training young people, parents/carers and professionals can have greater confidence to recognise risk factors, the signs of distress, have confidence about having a conversation with somebody, make a safety plan and signpost/refer appropriately.	Public Health, CAMHS services, CYP systems

		Children with additional risk factors, including those not in education employment or training (NEET) and those who have Adverse Childhood Experiences (ACEs) are at a higher risk of suicide – specific prioritisation needs to be given here to ensure awareness of risk factors and to support suicide prevention efforts. Target organisations such as CYP drug and alcohol services, Children's Social Care, children not in mainstream education.	
2a.2	**Support all secondary schools, colleges and FE institutions to have a suicide prevention policy**	This should inform staff of the risks and ways to support young people. The policy should contain up to do ate signposting to support individuals or groups where necessary. It should also include examples of how to communicate information to staff, young people, parents/carers. Policies should have senior leadership ownership and be updated annually.	Educational settings Public Health
2a.3	**Support universities to implement national plans regarding student mental health, wellbeing and suicide prevention.**	Support universities to Suicide-safer universities guidance, which covers both prevention of suicide and compassionate responses to suicide in universities. Guidance developed in partnership with PAPYRUS-UK.	Universities, Public Health
2a.4	**Support young people to be aware of ways to support their own mental health.**	Supporting young people to understand and manage their mental health is a key preventative measure that reduces long-term risk of suicide and improves overall wellbeing. Providing accessible information, tools, and resources empowers young people to build resilience, seek help early, and develop healthy coping strategies. Promotion of resources such as 5 ways to wellbeing. Consider participatory work with young people to develop own resources.	Public Health, CYP systems

2b. Middle-aged men

Men are three times more likely to die by suicide than women, with middle-aged men having the highest rates of suicide of any other group (based on age and sex) since 2010.

There are several factors that have been particularly strongly linked to suicide in this group. Socioeconomic disadvantage is strongly associated with suicide among this demographic, and middle-aged men did not have the highest rates of suicide of any group until after the 2008 recession, suggesting a link between recession and suicides. National evidence on suicide in middle-aged men shows that factors such as living in the most deprived areas and experiencing unemployment or financial difficulties (including debt and housing difficulties) have also been particularly linked to suicide in this group.

A history of alcohol or drug use, contact with the justice system, family or relationship problems, harmful gambling and social isolation and loneliness are also factors that are common in men who died by suicide.

	Objective	Rationale and context	Key partners
2b.1	**Support employers of largely male industries to have adequate and appropriate support in place for employees, including through targeted awareness raising and training.**	Men from more deprived areas have one of the highest suicide rates. Ensuring that suicide awareness and training is targeted to where men are working, particularly in manual and routine workforces, where the suicide rate is higher.	Public Health, training providers, DMHA
2b.2	**Support system-wide Men's Mental Health work across the region, prioritising men in mid-life particularly in deprived areas.**	Raise awareness, challenge stigma, promote training and signposting of resource and support - targeting areas where men may be. Consider engaging with sports clubs, barbers, pubs to normalise conversations about mental health in male-dominated settings. Support development of evidence base including proactive outreach to men who may not traditionally seek help.	Public Health, DMHA, Active Devon

2c. People who have self-harmed

Self-harm does not necessarily mean someone is experiencing suicidal thoughts or feelings. However, as well as being an important issue to address in its own right, we know that self-harm is associated with a significant risk of subsequent suicide. It is therefore important that we focus efforts on prevention and the provision of consistent high-quality care for self-harm (including aftercare and support within community settings).

There are an estimated 200,000 hospital presentations for self-harm per year in England. The occurrence of self-harm in the community is likely to be much higher. Evidence also suggests that the suicide rate is highest in the year following hospital discharge for self-harm, particularly in the first month.

	Objective	Rationale and context	Key partners
2c.1	**Review current service provision for people who self-harm to ensure compliance with NICE standards and pathways.**	NHS quality incentive for at least 80% of eligible patients who have self-harmed and referred to psychiatric liaison teams in emergency departments receive a comprehensive psychosocial assessment. For CYP (< 25s) to achieve NICE-compliant self-harm services each Emergency Department should as a minimum, undertake comprehensive psychosocial assessments for any child or young person presenting with self-harm, conducted by multidisciplinary teams (e.g. medical, CAMHS and social care teams) including child protection and safeguarding considerations. For < 25s who are frequent service users should have multi-professional assessments with the appropriate agencies (social care, education, mental health services and paediatrics).Self-harm Prevention in Children and Young People - South West Population Health Tools - Futures	NHS Devon, MH providers, children's social care, acute hospitals, CYP community services (LWSW and CFHD)
2c.2	**Develop an understanding of local need, system and support for people who self-harm.**	Utilise the self-harm needs assessment, to identify and escalate gaps and further opportunities for improving self-harm care.	Public Health, NHS Devon, MH providers, DMHA
2c.3	**Raise population level awareness of self-harm, tackle stigma, promote training and safety planning.**	Through the provision of resources, such as written, videos and training offers.	Public Health, NHS Devon, MH providers, DMHA

2d. People in contact with mental health services

When individuals are in contact with mental health services, it is crucial that they are offered safe, compassionate and patient-centred care each and every time.

People known to be in contact with mental health services represent around 27% of all deaths by suicide in England – on average around 1,300 people each year. This includes anyone in contact with mental health community services, people in inpatient settings, and anyone that has been in contact with these services within 12 months.

Evidence suggests that history of self-harm, alcohol and drug use, co-morbidity (more than one mental health diagnosis), and living alone may be particular risk factors for suicide for people in contact with mental health services.

Between 2010 and 2020 there was a 25% fall in the number of suicides in inpatient settings in England when taking into account the number of admissions. This fall is likely due to safer physical environments (including the removal of ligature points), staff vigilance, and wider improvements in mental health inpatient settings.

	Objective	Rationale and context	Key partners
2d.1	**Support system wide identification and response to gaps in mental health services.**	The local mental health system has previous identified gaps such as those between talking therapies and secondary mental health services for adults, and school-based Mental Health Support Team and young people's specialist mental health services. Properly characterising these gaps will support the development of appropriate responses.	NHS Devon, MH providers, DMHA, Public Health
2d.2	**Mental health service providers to identify and implement actions to further prevent suicides, including reviewing and implementing evidence-informed recommendations such as those outlined in the NCISH annual reports.**	Implementing evidence-informed recommendations, such as those outlined in NCISH annual reports, ensures best practice, strengthens clinical governance, and supports continuous learning. Example: the NCISH toolkit – 10 ways to improve patient safety.	NHS Devon, MH providers
2d.3	**Take steps to ensure that patients receive good quality (in line with NICE guidance) follow-up support within 72 hours of being discharged from inpatient mental health settings.**	The period immediately following discharge from inpatient mental health care is a high-risk time for suicide. Ensuring timely, high-quality follow-up within 72 hours, in line with NICE guidance, provides continuity of care, supports recovery, and reduces risk of harm. This includes developing effective integrated pathways.	NHS Devon, MH providers

2d.4	**Ensure that mental health providers across the range of services provide support in line with Staying Safe from Suicide guidance and more broadly the Personalised Care Framework.**	This new NHS guidance promotes a shift towards more a holistic, person-centred approach rather than relying on risk prediction which is unreliable.	NHS Devon, MH providers
2d.5	**Using PSIRF framework and mortality reviews to support the development of a culture of system learning and improvement.**	PSIRF (Patient Safety Incident Response Framework) supports the development and maintenance of an effective patient safety incident response system and includes four aims of compassionate engagement, proportionate responses, system based approaches to learning, and supportive oversight, with an overall emphasis on learning and improvement.	MH providers, NHS Devon
2d.6	**Align to established clinical effectiveness oversight processes to ensure compliance with NICE guidance for specific conditions that are associated with higher rates of suicide.**	This includes affective disorders (depression and bipolar), personality disorders, schizophrenia and other delusional disorders and eating disorders. Consider how waiting times, disengagements, transitions and other factors impact on suicide	MH providers, NHS Devon

2e. People in contact with the justice system

People in contact with the justice system have higher rates of suicide and self-harm behaviour than the general population. Action to prevent suicide and self-harm is needed across the justice system – in police custody, in prison services for those on remand or serving a sentence, in probation services and for all people on release.

	Objective	Rationale and context	Key partners
2e.1	**Explore support at specific points in criminal justice pathways, particularly for sensitive offenses.**	RTSS data indicates that there may be a higher rate of suicide in people who are arrested for sensitive offences.	Police, Public Health
2e.2	**Review and support optimisation mental health pathways for people leaving prison**	Utilisation of mental health continuity of care recommendations from the CMO report: The health of people in prison, on probation and in the secure NHS estate in England - GOV.UK	Prisons, mental health services, drug and alcohol services

2f. People with neurodiversity including autism and ADHD

Evidence suggests that people who are neurodiverse (particularly ADHD and autism), including children and young people, may be at a higher risk of dying by suicide compared to those who are not. It is essential that health, mental health, and local authority services and education providers consider the needs of people who are neurodiverse in suicide prevention activity.

	Objective	Rationale and context	Key partners
2f.1	**Support universal mental wellbeing and suicide prevention initiatives to be neurodivergent inclusive.**	Embedding neurodivergent inclusion within universal initiatives ensures equity, improves accessibility, and strengthens the effectiveness of prevention efforts across the whole population.	Public Health, DMHA
2f.2	**Raise awareness of learning opportunities such as the Learning from Lives and Deaths (LeDeR) programme and other review processes.**	Learning from Lives and Deaths (LeDeR) and similar review processes provide critical insights into avoidable factors contributing to premature mortality among people with learning disabilities and autism. Raising awareness of these learning opportunities supports continuous improvement, strengthens safeguarding, and ensures that lessons inform practice across all partners.	Public Health, MH providers, NHS Devon, DMHA
2f.3	**Support system wide work to improve earlier identification and timely access to autism and ADHD assessment services.**	Timely identification and access to autism and ADHD assessment services are essential to reducing unmet need, preventing escalation of mental health issues, and improving life outcomes. Delays in diagnosis can lead to increased distress, social exclusion, and higher risk of crisis.	MH providers, NHS Devon
2f.4	**Support for young autistic adolescents transitioning into adulthood**	This should include support for accepting their diagnosis, exploring their identity, building their independence and navigating social interactions	MH Providers DHMA, NHS Devon, social care, CYP community MH providers

2g. Pregnant women and new mothers/parents

In the UK, suicide is the leading cause of direct death 6 weeks to a year after the end of pregnancy. In 2020, women were three times more likely to die by suicide during or up to six weeks after the end of pregnancy compared with 2017 to 2019. Impacts on affected families are devastating and often have lasting effects, particularly on children from a very early stage in their development.

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 to other cause of maternal death (most of which are rare) and the potential long-term consequence on children's development mean we must take action to prevent suicides in this group. The increasing numbers of teenage maternal suicide, in particular care leavers, in recent years is a significant concern and particular targeted support is needed for this age group.

	Objective	Rationale and context	Key partners
2g.1	**Provide greater person-centred support for women and parents who have children's social care involvement including child removal**	These women often experience multiple disadvantage including mental health issues, domestic abuse, and substance use, and are at risk of harm from themselves and others. Greater person-centred coordinated support should be provided including through the use of Section 42 enquiries and Multi-Agency Risk Management (MARM) processes.	NHS Devon, Children's social care, midwifery, health visitors, adult safeguarding and social care, Mental health services

3. ADDRESSING RISK FACTORS

Addressing risk factors linked to suicide is a central part of effective 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 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. Therefore, the impacts of the core determinants of health need to be considered in suicide prevention work.

There are some specific factors (many of which are linked to the core determinants of health) that, through data, evidence and engagement, have been identified as priority areas to address in the national strategy.

	Objective	Rationale and context	Key partners
3.1	**Raise awareness, challenge stigma, promote training and signposting of resource and support people with these risk factors and workforces that support them.**	These risk factors have been identified through national data, evidence and engagement as priority areas for suicide prevention activity.	Whole system

3a. Physical illness

Evidence suggests that a diagnosis of a severe physical health condition may be linked to higher suicide rates. Evidence from NCISH suggests that over half of men aged 40 to 54 who died by suicide had a physical health condition.

And, while 2 or 3 people who die by suicide have not been in contact with mental health services in the previous year, evidence suggests that many (49 to 92%) make contact with primary healthcare services in this time. Over 40% of middle-aged men have been in contact with primary care services for either physical or mental health needs within 3 months before taking their own life. It is essential that we support those seeking help for physical illness to meet both their physical and mental health needs.

Objective	Rationale and context	Key partners

3a.1	**Support the General Practice workforce with suicide prevention through exploration of training offers and resource provision.**	Evaluation results of the primary care suicide prevention training pilot indicate that training was well received by primary care and improved capacity and capability to have conversations around suicide in a compassionate way. There was high demand for the course. This outcome should be used to advocate for a regular training offer to people working in primary care.	NHS Devon, Primary Care. Public Health
3a.2	**Raising awareness of suicide risk to workforces supporting people with chronic conditions, especially life-altering conditions and chronic pain.**	Chronic conditions, life-altering conditions, chronic pain, degenerative, terminal, conditions that affect mobility can all increase isolation and affect mental health including leading to suicidal ideation.	Primary care. Secondary care. NHS Devon, Public health

3b. Financial difficulty, economic adversity and unemployment

Financial difficulty and adversity can result in suicidal thoughts or action. Evidence shows an increased risk of suicide for people with debt, and economic recession has been consistently linked to suicide. More recently, evidence from charities has suggested that rises in the cost of living have been linked to some people feeling unable to cope, with some feeling suicidal.

Objective		Rationale and context	Key partners
3b.1	**Explore how suicide prevention system can support, align to and influence employment programmes such as Connect to Work.**	Connect to Work provides support to help individuals with whatever challenges they face that prevent them from engaging with work, including mental health.	Public Health, DWP, Citizen's advice
3b.2	**Explore opportunities to influence local economic strategies to ensure that there is sufficient focus on local residents living with or at risk of financial difficulty.**	Influencing local growth agenda to be inclusive of local residents living in more deprived communities.	
3b.3	**Embed suicide prevention awareness in housing, employment and debt advice services.**	Embedding suicide prevention awareness within these services enables early identification and signposting for individuals in distress. This approach strengthens frontline capacity, promotes holistic support, and ensures that key partners contribute to reducing risk factors.	Public Health, housing, employment and financial services

3c. Harmful gambling

There is increasing evidence of the relationship between harmful gambling and suicide, including in younger people. Although reasons for suicide can be complex, we do know that gambling can be a dominant factor without which the suicide may not have occurred. Action therefore needs to be taken to address the harms of gambling, including suicide, and reach people at risk.

	Objective	Rationale and context	Key partners
3c.1	**Support relevant partners to improve identification of harmful gambling through routine inquiry and promote and raise awareness of gambling support available.**	Supporting partners to include routine inquiry and raise awareness of available support ensures earlier identification and intervention. Signposting to free training available.	Public Health, gambling support organisations

3d. Drug and alcohol use

Consistent links have been evidenced between alcohol and drug use and suicide. Acute intoxication, as well as dependence on alcohol and/or drugs, has been associated with a substantial increase in the risk of suicide and self-harm.

Addressing alcohol and drug use may be especially important for supporting particular groups. In a study of middle-aged men that died by suicide in 2017, 49% had experienced harmful alcohol and/or drug use, particularly where individuals were unemployed, bereaved or had a history of self-harm or violence. Among people in mental health services in England who died by suicide between 2010 and 2020, there were high proportions of both harmful alcohol (45%) and drug (35%) use.

	Objective	Rationale and context	Key partners
3d.1	**Take an avoidable death approach to deaths including by suicide where drugs and alcohol, homelessness and domestic abuse were factors to share intelligence, raise awareness of suicide risk and learning and drive system improvements.**	Deaths involving suicide, drugs, alcohol, homelessness and domestic abuse often share common risk factors and system gaps. This may also include co-existing mental health issues and contact with the criminal justice system (section 2e). Taking an avoidable death approach enables intelligence sharing, learning and coordinated action across agencies. This strengthens awareness of suicide risk, drives improvements in safeguarding and service pathways, and supports a whole-system prevention response.	Public Health, substance use providers, DASVVAWG, housing system, Police
3d.2	**Ensure those with severe mental illness and co-existing alcohol or drug use are receiving treatment for their mental health needs.**	People with severe mental illness and co-existing substance use face significantly higher suicide risk and poorer health outcomes. Ensuring access to appropriate mental health treatment alongside drug and alcohol support promotes integrated care and helps to addresses complex needs. This approach aligns with national guidance on dual diagnosis and supports equity in service provision.	Substance use providers, MH providers, Public Health

3e. Social isolation and loneliness

Social isolation (having few people to interact with regularly) and loneliness (not having the quality or quantity of social interactions we want, regardless of social contacts) have been closely linked to suicidal ideation and behaviour.

This includes for particular groups – one study suggested that social isolation was experienced by 15% of under 20-year-olds and 11% of 20-24 year-olds who died by suicide, and qualitative research undertaken by Samaritans found loneliness played a significant role in young people's suicidal thoughts or feelings. A further national study suggested that, of men aged 40 to 54 who died by suicide, 11% reported recent social isolation.

We know that loneliness is one of the primary reasons that individuals access crisis services, and that actions to reduce social isolation and loneliness are therefore likely to be key to suicide prevention.

	Objective	Rationale and context	Key partners
3e.1	**Promote suicide prevention training for staff who may be in contact with people who are socially isolated.**	Including but not limited to, befriending services, community builders, community hubs, wellbeing hubs.	Public Health, DMHA, social care
3e.2	**Explore further ways to signpost people to social prescribing and other loneliness support.**	Strengthening signposting to social prescribing and community-based support will help individuals build connections, access practical help, and improve wellbeing.	Public Health, Primary Care, DMHA
3e.3	**Increase awareness of the impact of bereavement on suicide risk and organisations that can support people.**	Bereavement is a known risk factor for suicide. Raising awareness of this impact and promoting organisations that provide specialist support ensures timely intervention and reduces isolation.	Public Health, DMHA, Pete's Dragons
3e.4	**Increase awareness of the impact of relationship breakdown on suicide risk and organisations that can support people.**	Relationship breakdown can result in acute crises that increases the risk of suicide. This is often linked to emotional distress, social isolation, access to family (e.g. children) and housing challenges.	Public Health, DMHA

3f. Domestic abuse

Since the 2012 strategy, more evidence on a link between domestic abuse and suicide has emerged. Research on intimate partners violence, suicidality and self-harm showed that past-year suicide attempts were 2 to 3 times more common in victims of intimate partner violence than non-victims. It highlighted deaths in male and female victims, children and young people in households impacted by domestic abuse and among perpetrators. Research by the Kent and Medway Suicide Prevention Programme and Kent Police found around 30% of all suspected suicides in that area between 2019 and 2021 were impacted by domestic abuse.

Tackling domestic abuse and identifying victims, including children who witness abuse, is key to preventing related suicides.

Objective		Rationale and context	Key partners
3f.1	**Suicide prevention and VAWG/DASV colleague should work together with partners across multiple disadvantage to ensure that there is a tiered, pragmatic workforce development model for recognising and responding to suicide risk in situations of domestic abuse.**	This should include: Raising awareness of the link between domestic abuse and suicide through the suicide timeline helps professionals understand the mechanisms involved and identify opportunities for early intervention. Particular effort should be targeted to the multiple disadvantage system and situations where children are removed. Ensuring appropriate agencies, such as domestic abuse services have appropriate suicide prevention policies so there is a structured approach to identifying and managing risk. The challenge of implementing safety plans when under coercive control needs to be considered in the response. Understanding and responding to the suicide and homicide-suicide risk of perpetrators of harm, including the use of safety plans.	DASVVAWG system, substance use system, Public Health
3f.2	**Explicitly embed suicide prevention within MARAC, MATAC and Safeguarding processes**	Suicide risk must become a routine and explicit part of MARAC discussion. This includes updating MARAC Operating Protocols and referral forms requiring direct questions to be asked about suicide ideation for both victims and perpetrators. MATACs should also adopt a similar approach. These processes should also be clear on the next steps required if suicide risk is identified.	DASVVAWG system, NHS Devon MARAC/MATAP, Police,
3f.3	**Build suicide prevention awareness in DASH training offers.**	Domestic Abuse, Stalking and Harassment (DASH) assessments often identify individuals at high risk of harm, including suicide. Building suicide	DASVVAWG system, Public Health

		prevention awareness into DASH training equips practitioners to recognise warning signs and respond appropriately. However, not all agencies use DASH, and so wider workforce development is required to ensure all frontline practitioners can identify and respond appropriately to suicide risk.	

4. PROMOTING ONLINE SAFETY AND RESPONSIBLE MEDIA CONTENT

Recent decades have propelled us forward in advances of the internet, technology and the availability of media resources. This has been invaluable in raising awareness and improving access to support for suicide and self-harm. However, the online world also poses new harms that need to be addressed.

There has been emerging evidence of the link between the online environment and suicide across different age groups. Internet use for suicide-related purposes has been linked to children and young people who have presented to hospital for self-harm or a suicide attempt and middle-aged men who have died by suicide.

	Objective	Rationale and context	Key partners
4.1	**Work with local media to build a positive relationship to continuously improve responsible reporting and relevant signposting within articles and promote positive mental health reporting.**	Building strong relationships with local media supports responsible reporting in line with national guidelines and ensures inclusion of signposting to support services. Promoting positive and accurate reporting helps reduce stigma, encourages help-seeking, and supports community resilience.	Public Health, local media
4.2	**Raise awareness and promote good practice guidance and resources around online safety and reducing online harms.**	Raising awareness and promoting good practice guidance supports safer online environments and empowers professionals, parents and communities to reduce risk.	Public Health
4.3	**Review effectiveness of moderation skills training for social media group administrators and consider ongoing opportunities.**	Social media groups can influence community attitudes and provide support, but poor moderation may allow harmful content that increases suicide risk. Cornwall, Plymouth and Somerset Public Health Teams have collaborated to provide training sessions for social media forum moderators to support them to manage content on their pages.	Public Health

5. PROVIDING EFFECTIVE CRISIS SUPPORT

Research by NCISH suggests that, of all deaths by suicide by people in contact with mental health services in England between 2010 and 2020, 15% were under the care of crisis resolution and home treatment teams (CRHTs). This is equivalent to 180 suicides per year on average. NHS 24/7 mental health crisis lines currently receive around 200,000 calls each month. And many more people are in contact with crisis services provided by other organisations, including those from the voluntary sector.

It is therefore essential that timely and effective crisis support is available to those who need it.

	Objective	Rationale and context	Key partners
5.1	**Improve system awareness of mental health crisis support provision, including options available and what the service can and cannot provide.**	Improving system awareness of available local and national options, including service capabilities and limitations ensures individuals in crisis receive the most effective support. This may include face to face, digital and telephone offers as different people have different preferences.	NHS Devon, MH providers, DMHA, Public Health
5.2	**Explore how to seek assurances on NHS crisis responses, identify areas of missed opportunities and unmet need and escalate appropriately.**	Exploring mechanisms to identify missed opportunities and unmet need enables system-wide learning and improvement. Escalating concerns appropriately strengthens supports continuous quality improvement across crisis pathways.	NHS Devon, MH providers
5.3	**Joint working with ICBs to explore VCSE alternatives to crisis support such as crisis cafes, sanctuaries and safe havens.**	Community-based alternatives such as crisis cafés, sanctuaries and safe havens provide accessible, non-clinical support for individuals in distress and can reduce pressure on statutory crisis services. Supporting ICBs to explore VCSE-led models promotes innovation, improves choice, and strengthens local capacity for early intervention.	NHS Devon, DMHA, Public Health
5.4	**Build capacity and resilience in communities by providing appropriate intervention training, such as Mental Health First Aid or ASIST.**	Building capacity within communities through training such as Mental Health First Aid or ASIST equips individuals to recognise signs of distress and respond effectively. This approach promotes early intervention, strengthens local resilience, and reduces reliance on statutory services.	Public Health, training providers

6. REDUCING ACCESS TO MEANS AND METHODS OF SUICIDE

We must work together to reduce access to the means and methods of suicide and limit the awareness of these methods.

Our plans to improve early intervention and tackle the drivers of self-harm and suicidality are vital, but only part of the overall picture, because we know there will still be individuals who may be contemplating and planning suicide. For people at this point, one of the most impactful practical interventions is to reduce access and limit awareness of the means and methods of suicide, providing more time to intervene with effective longer-term actions and preventative support.

	Objective	Rationale and context	Key partners
6.1	**Develop a suicide cluster response plan for Devon**	Suicide clusters can have a profound impact on communities and increase contagion risk. Developing a Devon-wide cluster response plan ensures a coordinated, timely approach to prevention and postvention, enabling rapid mobilisation of support and intelligence sharing.	Public Health
6.2	**Working with partners such as highways, bridges, railways and the coast guard to identify and implement appropriate suicide prevention measures.**	Locations such as highways, bridges, railways and coastal areas are associated with higher suicide risk. Working collaboratively with partners to identify and implement prevention measures—such as physical barriers, signage and surveillance—reduces access to means and supports early intervention.	Public Health, Highways, National Rail, Coast Guard
6.3	**Review and strengthen the role of Public Health in assessing planning applications to support 'designing out' risk factors for suicide**	The built environment can influence suicide risk through access to means and lack of protective design features. Reviewing the role of public health in planning applications supports a proactive approach to 'designing out' risk, ensuring developments incorporate safety measures and promote wellbeing. This strengthens upstream prevention and embeds suicide awareness into local planning processes.	Public Health, Planning teams
6.4	**Explore measures to improve medication safety particularly in situations where suicide risk may be higher.**	People who are bereaved and people who have a terminal or life-altering diagnosis may be at increased risk of suicidal ideation. They may also have access to strong (e.g. opioid, benzodiazepines, gabapentin etc.) medication through leftover prescriptions or because they are prescribed for their condition.	

7. PROVIDING EFFECTIVE BEREAVEMENT SUPPORT TO THOSE AFFECTED BY SUICIDE

Evidence suggests family, friends and acquaintances who are bereaved by suicide may have a risk of dying by suicide that is up to three times higher than the general population. Compassionate, effective and timely support for people bereaved by suicide is essential.

	Objective	Rationale and context	Key partners
7.1	**Adopt a 'Public Task' legal basis for referrals from the Police to suicide bereavement support services, rather than relying on individual consent.**	Using a 'Public Task' legal basis for referrals from the Police to suicide bereavement support ensures timely and appropriate information sharing without relying on individual consent, which can be challenging during periods of acute distress.	Police, Pete's Dragons, NHS Devon
7.2	**Develop a consistent approach across Devon to support education settings affected by a suicide.**	Suicide within an education setting can have a profound and lasting impact on students, staff and the wider community. Developing a consistent approach across Devon ensures timely, coordinated postvention support, reduces the risk of contagion, and promotes emotional wellbeing.	Public Health, CYP system
7.3	**Work with organisations to ensure appropriate plans are in place to enable an effective response that supports the wellbeing of staff members (and clients) following a suicide in a client or staff member.**	Suicide within an organisation can have profound emotional and operational impacts on staff and clients, increasing risk of trauma and further harm. Ensuring organisations have clear postvention plans promotes timely, compassionate support, reduces stigma, and helps maintain workforce wellbeing.	Public Health

8. MAKING SUICIDE EVERYONE'S BUSINESS

Suicide prevention is everyone's business. Every person, organisation and service play a role. In recent years, good progress has been made to tackle the stigma around suicide and mental health. However, there is more we can all do to ensure we are all equipped with the skills necessary to potentially save lives.

	Objective	Rationale and context	Key partners
8.1	**Develop a shared online space for Devon-wide suicide prevention.**	A shared online space will enable consistent communication, resource sharing, and coordination across Devon partners. This improves accessibility to guidance, training, and data, reducing duplication and ensuring alignment with regional priorities. It supports collaborative working and strengthens the collective impact of suicide prevention efforts.	SPOG
8.2	**Improve system ability to access funding for suicide prevention activity.**	Securing funding is critical to deliver and scale effective suicide prevention interventions. Improving system capability to identify, apply for, and manage funding opportunities will support innovation and continuous improvement of suicide prevention efforts. To achieve this, we need a clear understanding of need and a cohesive and shared strategy with clear system-wide direction.	SPOG
8.3	**Raise awareness, challenge stigma, promote training and signposting of resource and support to the whole population with a particular focus on the priority groups and risk factors identified in the strategy.**	Promoting training, signposting, and accessible resources across the population, while prioritising high-risk groups identified in the strategy (including people who support people in these groups in a formal or informal capacity), will build protective factors, improve community resilience, and ensure equitable access to support.	SPOG
8.4	**Increase the general awareness of safety plans and their use.**	Safety plans are an evidence-based tool that help individuals manage suicidal thoughts and reduce risk during crisis. Increasing awareness of their purpose and use among professionals, communities, and those at risk will promote early intervention and empower individuals to access support.	SPOG
8.5	**Share progress, learning and key updates from the One Devon Suicide**	Transparent reporting and shared learning are essential to maintain accountability, drive improvement, and strengthen collaboration across the system. Disseminating progress and key updates—such as through an annual	SPOG

	Prevention group widely, e.g. through an annual report.	report—ensures partners remain informed, promotes best practice, and supports continuous development of suicide prevention activity across One Devon.	
8.6	**Review as a system how people with lived experience of suicide bereavement and mental health crisis will be engaged and supported in a safe, respectful and impactful way to help shape priorities and inform service design.**	Engaging people with lived experience of suicide bereavement and mental health crisis is critical to ensuring services are relevant, compassionate, and effective. A system-wide review will help establish safe and respectful mechanisms for involvement, reduce risk of harm, and ensure contributions are impactful. The system should also highlight where this is being done currently and share good practice.	SPOG
8.7	**Support the whole system to embed trauma informed approaches, ensuring service are able to recognise and respond to the impact of Adverse Childhood Experiences (ACEs) and other forms of trauma.**	Embedding trauma-informed approaches across the system acknowledges the impact of Adverse Childhood Experiences (ACEs) and other traumatic events on mental health and suicide risk. This ensures services respond with empathy, reduce re-traumatisation, and promote recovery.	SPOG