Interim evaluation of the Sandwell Suicide Prevention Strategy and Action Plan 2022-2025

July 2024

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Executive summary

Suicide remains a critical public health issue, ranking among the leading causes of death worldwide and significantly affecting individuals, families, and communities. Despite various efforts, suicide rates have remained relatively stable over the past two decades (Image 1Image 2), necessitating continuous, evidence-based, and multi-agency prevention strategies.

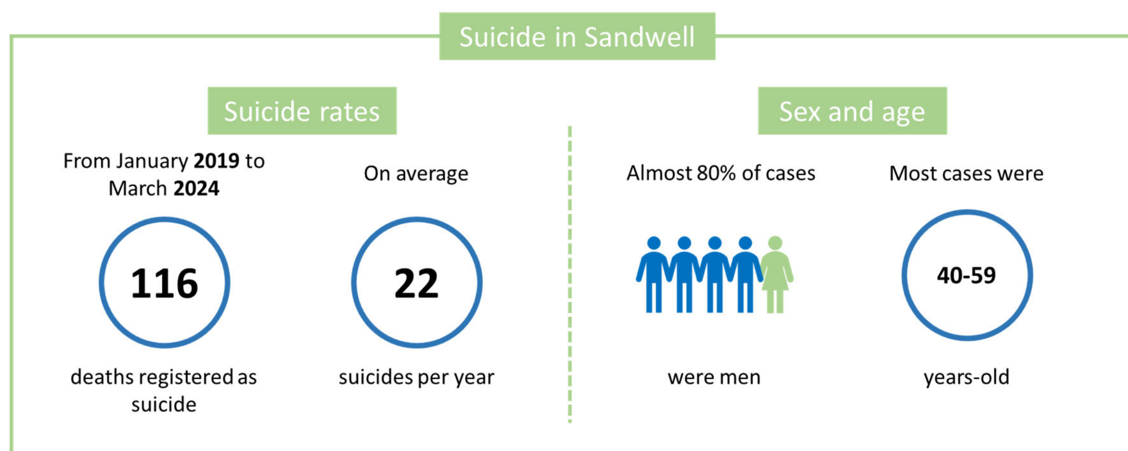


Image 1: Summary figures for suicide in Sandwell (2019-2024)

This report provides an interim evaluation of the Sandwell Suicide Prevention Strategy and Action Plan 2022-2025. It aims to assess the progress of the current strategy, identify barriers and facilitators to its implementation, and make recommendations for improving its impact and setting long-term goals beyond 2025. The evaluation relies primarily on an analysis of processes conducted, gathering data from a consultation with the Sandwell Suicide Prevention Partnership, examination of the strategy's action log and a summary of national and locally available data on suicide and related measurable outcomes.

Key findings

Continued Relevance: Suicide remains a significant issue in Sandwell, with middle-aged men being the most at-risk group. Social isolation and financial struggles are critical factors influencing mental health and suicide risk.

Achievements: The strategy has made notable progress, particularly in raising awareness and providing suicide prevention training in workplace settings, and successful community-led projects, such as the Tipton pilot project.

Challenges:

- Data Limitations: There is a lack of timely, reliable data on suicide and its risk factors, which hampers rapid intervention and understanding of local trends.
- Healthcare and Community Support Disconnect: Limited integration between healthcare services and community support systems restricts comprehensive support for individuals at risk.

- Partnership Functioning: The Sandwell Suicide Prevention Partnership is functioning more as a network than a collaborative group, with insufficient ownership and accountability among partners and limited senior engagement.

Recommendations

1. **Restructure the Partnership:** Establish operational and overview groups within the partnership, assign specific tasks to individuals, and enhance senior representation to ensure effective collaboration and strategic progress.

2. **Refresh the Action Plan:** Streamline the action plan to focus on key objectives, ensuring alignment with strategic goals and phased implementation to maintain clarity and momentum.

3. **Strengthen primary care links:** Build relationships with primary care representatives to integrate healthcare and community support more effectively, leveraging senior partnership members' influence.

4. **Improve data quality:** Pursue a near real-time suspected suicide surveillance system to provide a deeper understanding of suicide in Sandwell and enable rapid response. Consider suicide case reviews to learn from each case and improve future prevention efforts.

5. **Advocate for men's mental health:** Prioritise middle-aged men in suicide prevention initiatives and ensure their needs are addressed within the broader mental health agenda.

6. **Cultural appropriateness:** Investigate and enhance culturally appropriate engagement and support mechanisms to address the diverse needs of Sandwell's population.

7. **Future strategy development:** Co-produce future versions of the strategy with experts by experience and partners, incorporating feedback and addressing identified gaps such as domestic abuse, safety plans, support pathways, and the needs of older adults and young people.

Conclusion

While significant strides have been made in suicide prevention in Sandwell, more work is needed to achieve the strategy's objectives fully. However, it is clear that those currently involved in the implementation of this strategy have displayed exemplary enthusiasm and commitment to the cause of suicide prevention. By addressing the identified challenges and implementing the proposed recommendations, Sandwell can strengthen its suicide prevention efforts, ultimately saving lives and improving the mental health and well-being of its residents.

Section 1: Introduction

Suicide can occur at any point in the lifespan and is among the leading causes of death worldwide [1]. The impact of suicide is profound and far-reaching:

> "When someone takes their own life, the impact on families, friends and the local community is devastating. As well as the immense pain and grief caused to loved ones, there are often wide-reaching and long lasting effects on all involved."
>
> *Sandwell Suicide Prevention Strategy and Action Plan 2022 – 2025*

The interplay of genetic, psychological cultural and social factors has been implicated the occurrence of suicide and its complex multi-faceted nature render suicide challenging to research and prevent [1]. A 2016 systematic review [2] on the impact of suicide prevention strategies, while highlighting the many gaps in robust evidence in this area, recognises the effectiveness of several interventions and advocates for careful assessment of individual- and population-level suicide prevention combination strategies.

Despite increased efforts to prevent deaths by suicide, average suicide rates[1] have remained fairly constant over the past two decades both nationally and in Sandwell [3]. Thus, suicide prevention remains a public health priority requiring an evidence-informed, concerted and multi-agency approach.

Given the considerable impact of suicide at the individual, local and societal level, its prevention remains a public health priority. Since the publication of the Sandwell Suicide Prevention Strategy in 2022, the corresponding national strategy has been updated. Furthermore, substantial socio-political shifts such as the cost-of-living crisis, international conflict, and changes in migration patterns have placed increased pressure on public mental health and several of the known suicide risk factors. In view of these changes, an update on the progress of current suicide prevention efforts in Sandwell is warranted.

This report presents the findings of an interim evaluation of the Sandwell's suicide prevention strategy and action plan for 2022 to 2025. In order to assess the impact of this strategy has had so far, the following objectives were set for this evaluation:

- To assess the progress of the current suicide prevention strategy by examining the extent and success of its implementation and its impact it has had on measurable outcomes.
- To explore barriers and facilitators to the implementation of the suicide prevention strategy.
- To identify priorities for the period up to 2025 to maximise the impact of the suicide prevention strategy and increase the likelihood of achieving its goals.
- To make recommendations for long-term strategic goals beyond 2025

While this evaluation has sought to provide a comprehensive and balanced view on the progress of the current Sandwell Suicide Prevention Strategy, it is important to bear in mind that it by no means

[1] When considering the Office of National Statistics' (ONS) definition of suicide, which is "deaths with an underlying cause of intentional self-harm (ages 10 years and over) and deaths with an underlying cause of event of underdetermined intent (ages 15 and over)"

captures the totality of suicide prevention efforts carried out in Sandwell. Furthermore, as an interim evaluation, it recognises the strategy is not expected to have achieved all its objectives by this point.

Finally, a note must be made on the approach of this evaluation, given the scarcity of reliable and timely measurable outcomes for suicide prevention. As a case in point: the most recent data on cases of suicide available through the Office of Health Improvement & Disparities (OHID) pertain to 2020-2022, and, therefore, do not even cover the period since the implementation of the strategy being evaluated. It would also be unrealistic to presume suicide prevention actions to produce immediate results, since much of their focus is aimed at shifting cultural and societal norms and perceptions. In view of these caveats, this evaluation focuses primarily on processes and the insights and feedback of those involved in suicide prevention in Sandwell.

Section 2: Policy context

2.1 National drivers

Following on from the initial suicide prevention strategy for England created in 2012, the Department of Health and Social Care published an updated strategy in 2023. During this period, several relevant publications were generated, including:

- Care Act (2014) charges local authorities with the statutory duty of promoting mental and emotional wellbeing.
- Local Suicide Prevention planning (2016) which provides guidance on how to implement the national SPS locally.
- Support after a suicide: A guide to providing local services (2017) where guidance is given on how to deliver postvention support locally.
- The NHS Long Term Plan (2019) which sets reduction of suicides as an NHS priority for the coming decade.
- Multiple progress reports of the Suicide Prevention Strategy for England (most recent published in 2021)
- The yearly National Confidential Inquiry into Suicide and Safety in Mental Health (most recent published in 2023)

The Suicide prevention in England: 5-year cross-sector strategy (2023) outlines several key actions including:

- The establishment of a £10 million suicide prevention grant fund to support voluntary, community and social enterprises to deliver suicide prevention activities from 2023 to March 2025
- A £150 million investment in NHS England improvements to the mental health crisis support offer.
- A review of relationships, sex and health education (RHSE) guidance being led by the Department of Education.
- The development of a new nationwide near real-time surveillance system for suspected suicide by the Office for Health Improvement and Disparities

2.2 Local drivers

In light of considerable changes brought about by the COVID pandemic, a local needs assessment was produced in 2021 which sought to provide an updated characterisation of the situation with regards to suicide prevention in Sandwell. This report informed the Sandwell Suicide Prevention and Strategy and Action Plan 2022-2025 which developed by the Sandwell Suicide Prevention Partnership. The strategy sought to enhance efforts to raise awareness about suicide, ensuring that all Sandwell residents receive timely and appropriate support. It highlights the how early intervention during times of despair can save many lives and significantly improve others. It also recognises the need for a societal and cultural shift toward open, respectful conversations,

understanding individual experiences and needs, and collaborative efforts to address the issues that can lead to suicide.

The Sandwell Suicide Prevention Strategy recognises the inextricable link between actions aimed at preventing suicide, and those that seek to improve mental health and well-being of the community. To that effect, it is worth considering how the strategy has been rolled out and implemented within the context of the development of the Sandwell Better Mental Health Strategy, which is soon to be launched.

The Sandwell Suicide Prevention Strategy follows six key strategic objectives (

Image 2).

Image 2: Sandwell Suicide Prevention Strategy objectives.

Objective 1

- To work in partnership to fulfil the 'Zero Suicides' Ambition.

Objective 2

- To ensure the highest quality of care and support guaranteed by professionals.

Objective 3

- To encourage a better awareness of suicide within local organisations and our communities.

Objective 4

- To reduce the chances of suicide in high-risk populations.

Objective 5

- To create an open culture where we listen to those with lived experience.

Objective 6

- To reduce access to the means of suicide.

Section 3: Evaluation approach and methodology

As previously mentioned in the introduction, measuring the impact of a strategy designed to prevent a specific outcome can be challenging. While data is routinely collected on suicides, often little is known about its precursors and risk factors. Furthermore, it is not always possible to establish set timelines by which to expect to see the impacts of a suicide prevention strategy or intervention. Thus, this evaluation, while analysing what outcomes are available, has focused primarily on an investigation of processes.

A mixed-methods approach has been employed, drawing on data from a variety of sources.

3.1 Routinely collected quantitative data

With the assistance of the Research Sandwell team based within Public Health, a variety of data sources were searched and their results analysed:

- The OHID Suicide Prevention Profiles were used to obtain historic data on suicide and related service contacts. These provide a picture of national, regional and local trends. Profiles were searched in June 2024 and the most contemporary data set at the time (for some indicators) was 2022 to 2023.
- Hospital Episode Statistics (HES) were searched for data on Sandwell residents admitted to hospital with intentional self-harm by age, sex, and ethnicity. The codes used were X60 and X84.
- Coroner's Summary Report, compiled by Research Sandwell with data shared from the conclusions of the Black Country Coroner's Office. This report was created in June 2024 and provides an overview of suicides occurred in Sandwell between 2019 and 2024. This is the most contemporary and local source of data at present.

3.2 Sandwell suicide prevention partnership consultation

In order to obtain their insights and feedback, a consultation was conducted with the Sandwell Suicide Prevention Partnership. This comprised of a survey and interviews.

3.2.1 Survey

A survey was created to gain a better understanding of the Sandwell Suicide Prevention Partnership's views on the current suicide prevention strategy, the partnership itself, its strengths, limitations, and opportunities for improvement. It comprised of a collection of multiple choice, rating and free text responses.

The survey was published online on 22nd April 2024 and invitations to complete it were sent out to the partnership's mailing list, along with several reminders in the subsequent weeks. The survey was also promoted during partnership meetings.

As people were expected to answer in their professional capacity, the survey was not anonymous. Respondents were also given an option to volunteer for an interview.

Following conclusion of the survey, descriptive statistics were used to analyse quantitative data and thematic analysis (described in further detail below) for free text responses.

3.2.2 Interviews

Members of the Sandwell Suicide Prevention Partnership were invited to participate in one-to-one interviews by email, through the survey and during partnership meetings.

Interviews were followed a semi-structured format using a topic guide that had previously been piloted. They were held online or in person (according to participants preference) and recorded for the purposes of analysis. They took the format of an informal conversation and participants were encouraged to share their own experiences and opinions, as well as bring up topics which had not been broached through use of the topic guide.

Thematic analysis as described by Braun and Clarke [4] was used to analyse the automatically generated interview transcripts. All text was coded, and themes were identified where they were felt to be salient enough to the participant and pertinent to the topic of the interview. They were also assessed for consistency across interviews.

As with all qualitative research, it important to highlight and consider the impact of the setting in which information was elicited (participants were aware this was an evaluation of the partnership and strategy) as well as the influence of the interviewer both in data collection and analysis. These influences were mitigated by frequent feedback sessions with members of the public health mental health team and reflexive practice throughout the consultation process.

3.3 Analysis of the action plan log

The action plan log which accompanies the Sandwell Suicide Prevention Strategy is the main repository where suicide prevention activities, interventions and updates provided by the Sandwell Suicide Prevention Partnership are recorded. In view of this, it was felt to be a useful source of up-to-date information on a variety of suicide prevention related activities carried out by multiple partners in Sandwell.

Actions detailed in the action plan log are matched to the 10 recommendations outlined in the Sandwell Suicide Prevention Strategy. They vary considerably with regards to their scope, efforts needed to complete them, as well as potential impact. Therefore, it was felt that a numerical analysis of rates or proportions of completeness would be unlikely to provide a reliable measure of progress of the strategy. Instead, examples of completed actions have been considered and a reflection on the overall accomplishments of the action plan log has been conducted.

Section 4: Findings of the evaluation

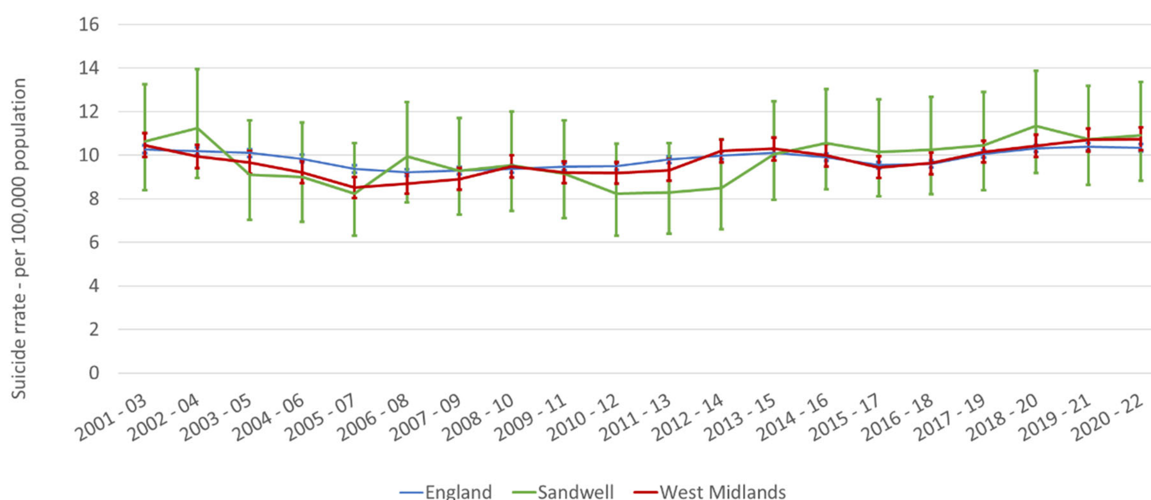
4.1 Local and national context

The following provides an overview of figures and trends of suicide and related incidents in Sandwell and how these compare with England. They are presented here primarily to provide a picture of the context in which the Sandwell Suicide Prevention Strategy is operating, rather than a means of assessing its impact.

4.1.1 General overview of Sandwell's suicide rates

As shown in Graph 1, rates of suicide in Sandwell have fluctuated over the past 20 years, rather than showing a clear upward or downward trend. The suicide rate in people aged 10 and over in Sandwell for 2020-2022 was 10.9 per 100,000 population.

Graph 1: Suicide rate per 100,000 (persons >10 years old) in Sandwell, West Midlands and England (2001/2003-2020/2022)

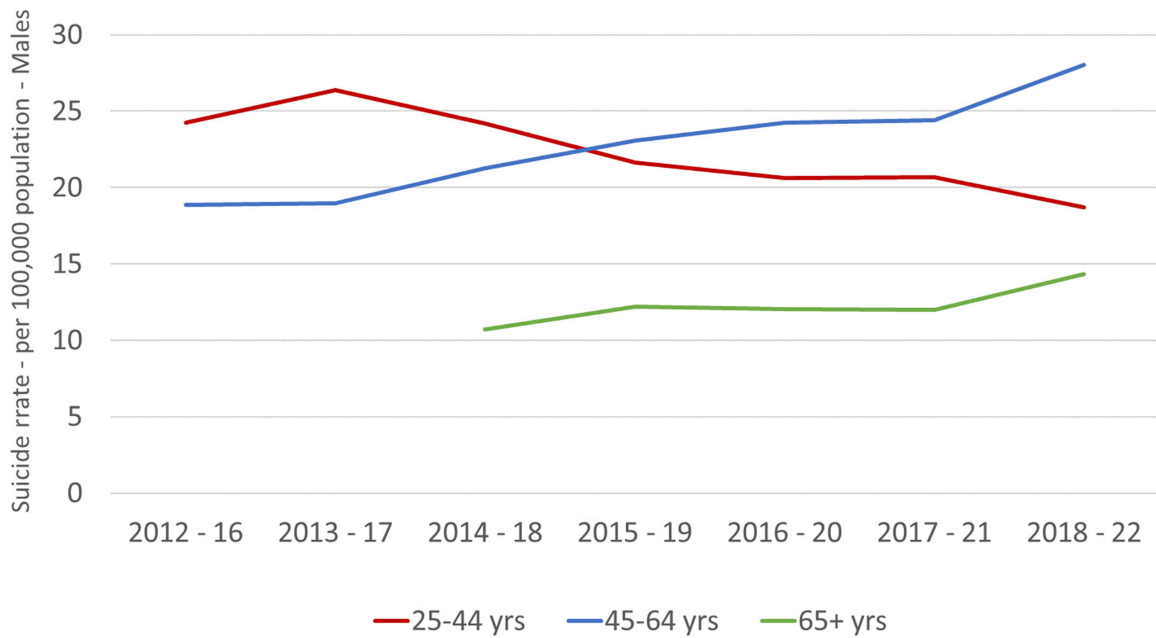


Source: Office for Health Improvement and Disparities (Fingertips) - Suicide Prevention Profiles

Suicide rates in Sandwell do not differ significantly from those observed regionally and nationally, as demonstrated by the England and West Midlands rates being contained within Sandwell's confidence interval brackets. However, given the relatively small numbers of incidents and wide confidence intervals, comparisons and figures need to be interpreted with caution. It is, however, possible to conclude that suicide rates have remained relatively unchanged in the last two decades and continue to be a concern in Sandwell, as well as the West Midlands and in England.

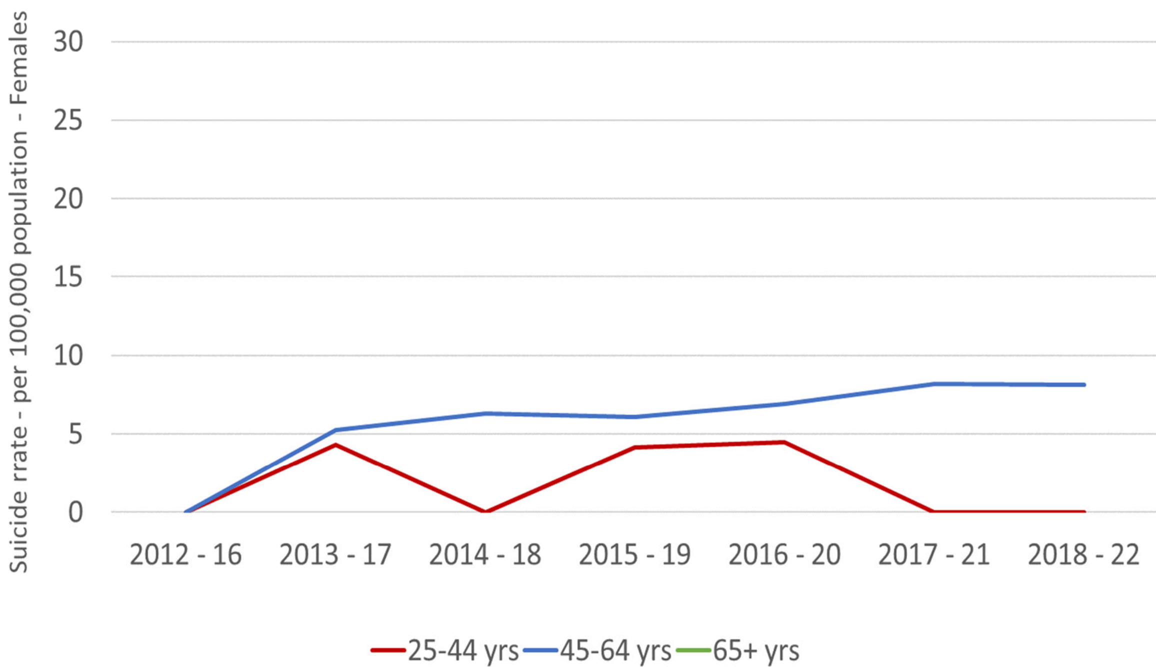
Graph 2 and Graph 3 allow us to compare rates of suicide between males and females by age group. In line with national figures, in all age groups, Sandwell's rate of suicide is considerably higher in males than in females. Although relatively small numbers do not allow for a detailed analysis, we can verify that these trends have not changed considerably in the last decade.

Graph 2: Suicide rate per 100,000 in males by age group in Sandwell (20122016-2018/2022)



Source: Office for Health Improvement and Disparities (Fingertips) - Suicide Prevention Profiles

Graph 3: Suicide rate per 100,000 in females by age group in Sandwell (20122016-2018/2022)

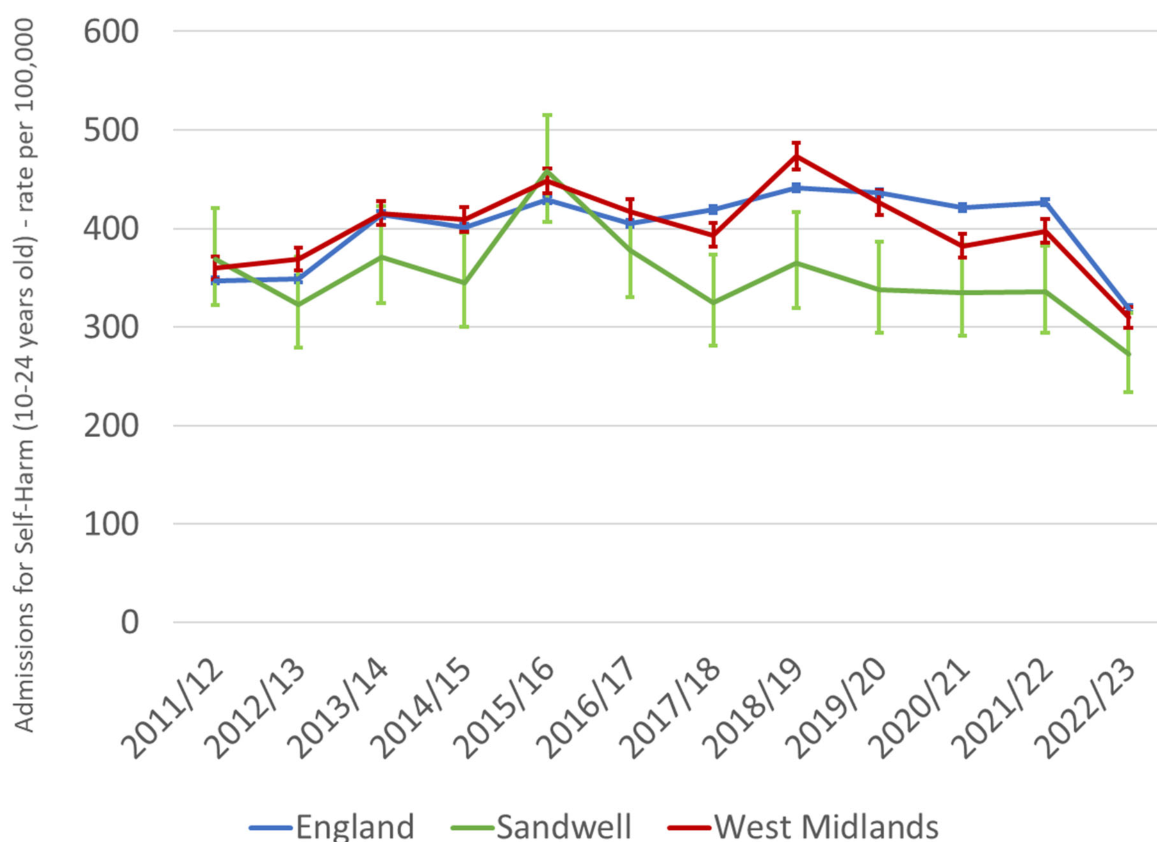


Source: Office for Health Improvement and Disparities (Fingertips) - Suicide Prevention Profiles

4.1.2 Hospital admissions for self-harm

The rate of hospital admission as a result of self-harm, which is often used as a proxy-measure for suicide, was 272.1 per 100,000 in Sandwell in 2022/2023. Graph 4 shows this rate has been decreasing in Sandwell over the last 5 years. Although the gap between the Sandwell and national rate has been narrowing, compared to England, the rate of hospital admissions as a result of suicide has remained significantly lower in Sandwell for the last 5 years.

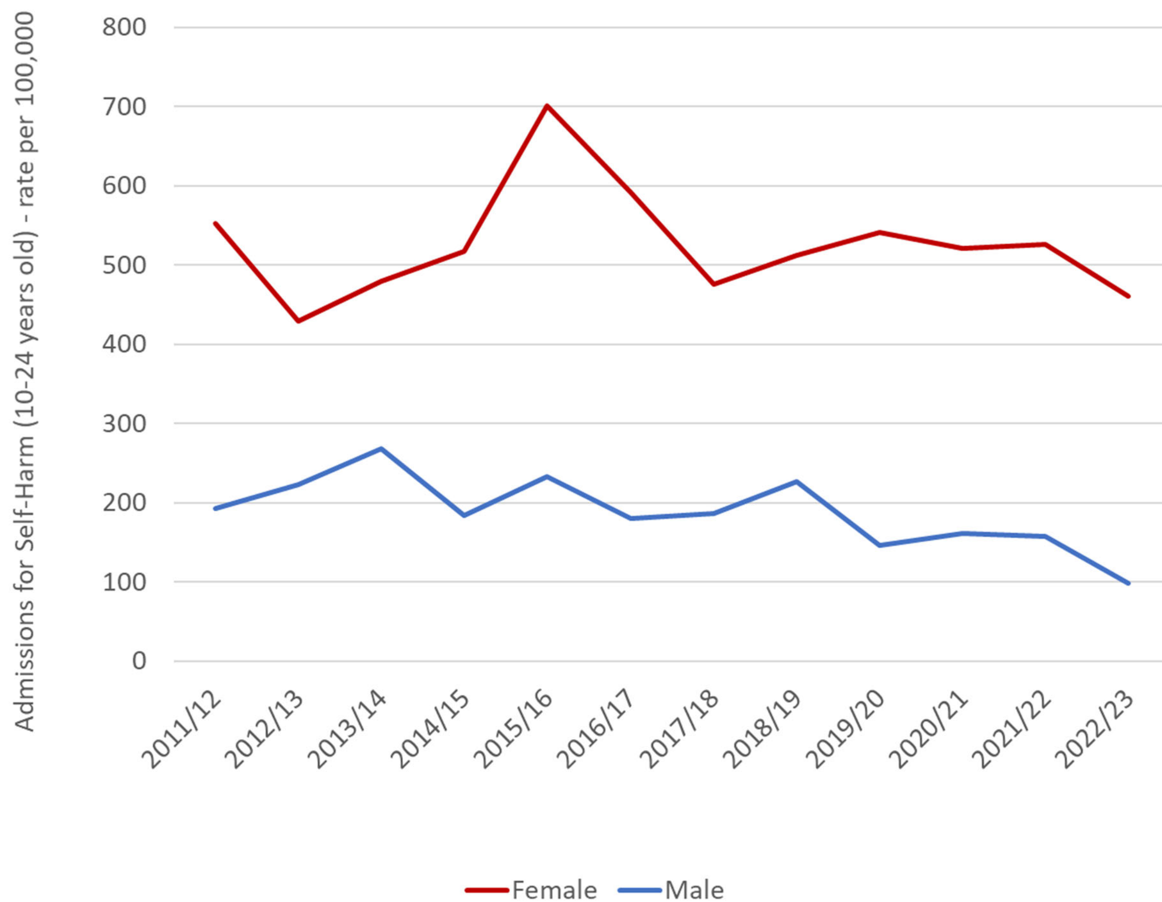
Graph 4: Hospital admissions as a result of self-harm (10-24 years) rate per 100,000, in Sandwell (2011/2012-2022/2023)



Source: Office for Health Improvement and Disparities (Fingertips) - Suicide Prevention Profiles

When comparing hospital admissions as a result of self-harm in Sandwell by sex, rates have remained considerably higher in females compared to males (Graph 5). Over the last 5 years, these rates have almost halved for males, while remaining somewhat constant for females. While the reasons for this are not entirely clear, it is worth bearing in mind that suicide rates have not accompanied this trend and hospital admissions for self-harm only capture a fraction of all self-harm instances. One possible explanation is a difference in how mental health issues are expressed between the sexes, with the literature showing that men being less likely to engage with mental health services [5] and more likely to use lethal means to take their own life [6]

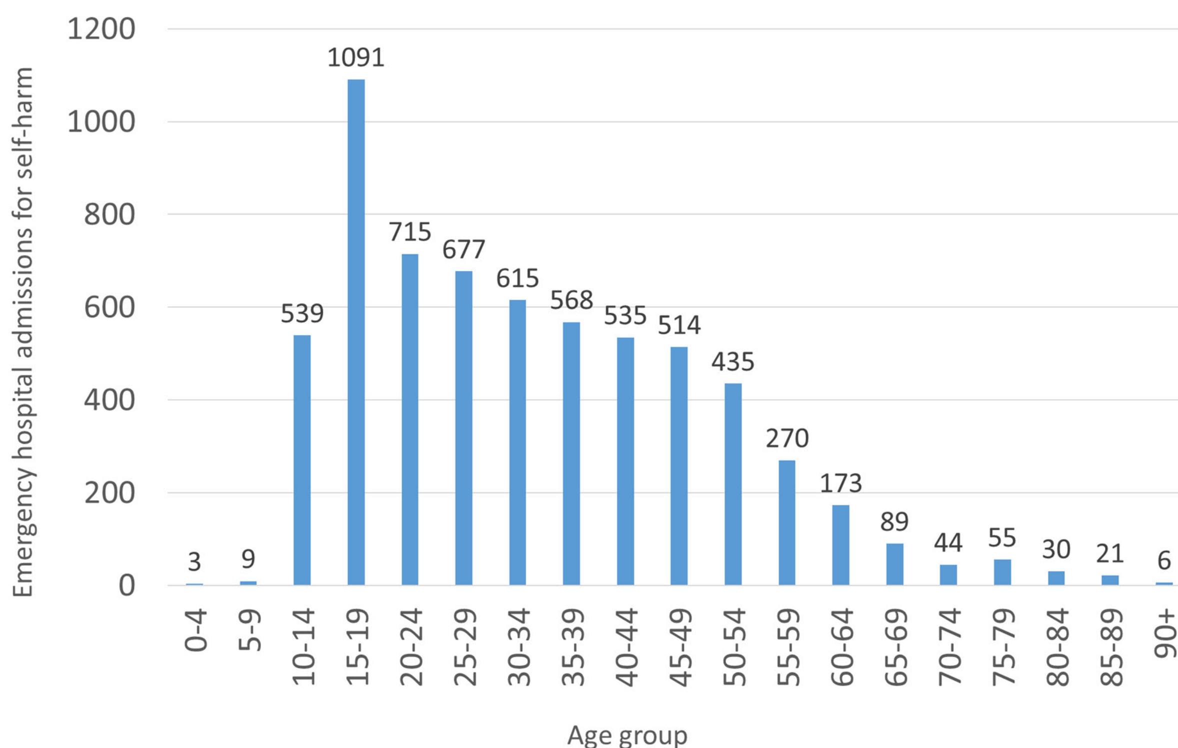
Graph 5: Hospital admissions as a result of self-harm (10-24 years by sex) rate per 100,000, in Sandwell (2011/2012-2022/2023)



Source: Office for Health Improvement and Disparities (Fingertips) - Suicide Prevention Profiles

When comparing admissions for self-harm by age group (Graph 6), a sharp increase can be seen starting at in the 10-15 and peaking in the 15-19 range. This is followed by a steady decline from ranges 20-24 to 50-54, and a more pronounce decrease after this. This may be an indication of when mental health issues tend to first manifest or, alternatively, different ways in which they are expressed along the course of people's life. Either way, these figures alert to the importance of starting suicide prevention (and wider mental health improvement) work early on, targeting children and young people.

Graph 6: Emergency hospital admissions for self-harm by age group, in Sandwell (2013/2014 - 2022/2023)



Source: Hospital Episode Statistics (HES) - NHS Digital

An in-depth comparison of hospital admissions for self-harm by ethnicity was not possible, given very small numbers for most groups. However, it is worth noting that, in Sandwell, for the 2022/2023 period, this rate was highest for people of "Any other White background" (372.6 per 100,000 for "Any other White background" compared to 175.9 per 100,000 for White).

4.1.3 Coroner summary report (2019-2024)

Data was extracted from the Black Country Coroner's system for deaths recorded as suicide between 1st January 2019 and 31st March 2024. During this period, there were 116 deaths recorded as suicide in Sandwell, with a breakdown of cases per year in Table 1. It is important to note that the dates given are for the coroner's verdict, rather than the date of death. Furthermore, this data does not capture at least 13 cases of death by suicide of Sandwell residents, where the death occurred outside of the Black Country.

Table 1: Number of deaths recorded as suicide in Sandwell (2019-2024)

Time period	Number of deaths registered as suicide
2019	27
2020	25
2021	19
2022	24
2023	16
January – March 2024	5

The following is a summary of the key trends and learning points derived from the data. Detailed breakdowns are not given due to small numbers and the potential to compromise anonymity.

- Males accounted for the vast majority, with the number of cases registered in men being almost 4 times higher than in women.
- The age range with the largest proportion of cases was 40-59.
- The vast majority of cases took place in people's homes, with only a minority occurring in railway stations.

Key themes identified from the analysis of these reports are highlighted below. However, it is important to avoid a simplistic view of the circumstances surrounding suicide, but rather consider the multitude and complexity of factors, as well as their interplay.

- Almost half of the reports indicated the person was known to mental health services, and in over a third people had had previous suicide attempts or self-harm.
- Almost half were unemployed or retired.
- Alcohol or substance misuse were mentioned in over a third of reports.
- Other circumstances frequently mentioned were relationship breakdown or family issues, financial issues, and recent bereavement.

While this data only provides a general overview and must be interpreted with caution, it points toward certain areas which may be of particular importance for the suicide prevention agenda, namely, social isolation and financial difficulties which are common to several of the themes identified above.

Further analysis of this data may provide valuable insight, particularly regarding trends in some of the key themes over different years, namely, contact with mental health services.

4.2 Comparison with national strategy

The national suicide prevention strategy, published in 2023, outlines the following 8 priorities for action over the next 5 years:

- Improving data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.
- 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.
- Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.
- Promoting online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.
- Providing effective crisis support across sectors for those who reach crisis point.
- Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.
- Providing effective bereavement support to those affected by suicide.

- Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

Despite the Sandwell Suicide Prevention Strategy having been developed prior the current version of the national strategy, it is considerably well aligned with it. Naturally, there are differences in scope of both strategies, as well as the sphere of influence each one is expected to have. Certain objectives, such as promotion of online safety and provision of effective crisis support can be argued to be within the remit of a national strategy, rather than a local one.

In both strategies, an emphasis is placed on the importance of a coordinated approach to suicide prevention, where services and organisations work in partnership to maximise their impact. Sandwell's strategy goes further in explicitly mentioning the importance of learning from those with lived experience (although the national strategy was informed, among others, by people with personal experience). Both strategies also highlight the importance of ensuring appropriate reporting of suicide in the media, though the national strategy goes further in seeking to harness the influence of the media to signpost and promote helpful messages around suicide and self-harm.

While both strategies emphasise the need to identify high risk group and tailor interventions toward them, the national strategy also recognises the importance of common risk factors linked to suicide at a population level. On the other hand, the Sandwell strategy focuses on the preceding step of improving intelligence around suicide to better understand local risk factors.

4.3 Consultation with Suicide Prevention Partnership

4.3.1 Survey results

A total of 13 people replied to the survey (33.3% response rate from mailing list), the majority (61.5%) of which had at least one role within Sandwell Metropolitan Borough Council. Within people's job roles there was representation from public health, NHS healthcare trusts, children and adult social care and domestic abuse teams.

Suicide prevention

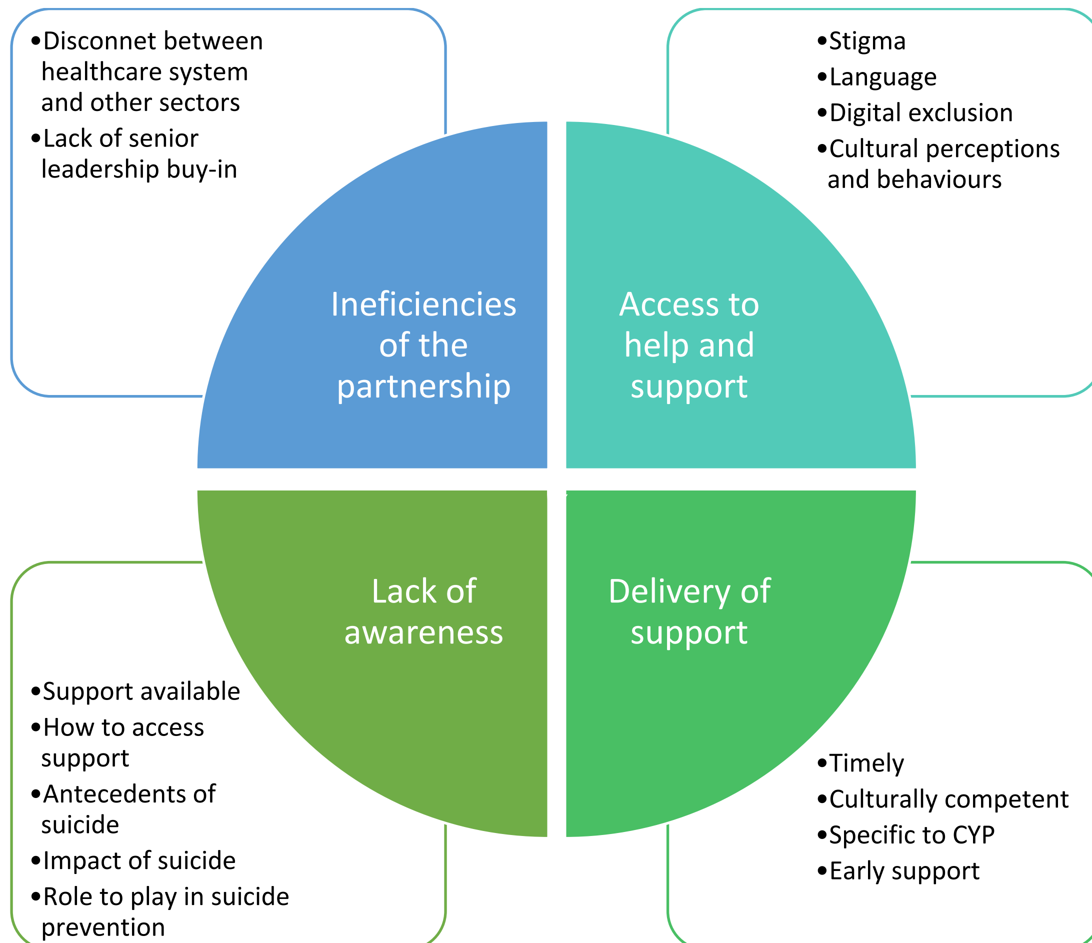
All respondents replied that suicide prevention was either very important (84.6%, n=13) or important (15.4%, n=13) to them personally. The majority (84.7%, n=13) of respondents stated that suicide prevention was one of the main priorities in their job role, and most (61.2%, n=13) would like it to be a greater priority than it currently is.

While most respondents felt either very confident (38.5%, n=13) or fairly confident (53.8%, n=13) in their knowledge and skills around suicide prevention, all respondents knew where to find information on this topic, should they need to.

Challenges and progress

When asked about the main barriers to suicide prevention in Sandwell, a variety of answers were given. Image 3 depicts the main themes from these responses.

Image 3: Main barriers to suicide prevention in Sandwell



When asked about examples of progress in suicide prevention in Sandwell:

- Training was highlighted by the majority of respondents (84.6%, n=13). This included making suicide prevention training freely available to the workforce, as well as training programmes for GPs, the public and the development of joint suicide prevention/domestic abuse training.
- Partnership work was also frequently mentioned (53.8%, n=13). This included collaboration between council and non-council members, including coroners and the West Midlands police.
- Examples of specific projects and areas of collaboration were given, namely the Tipton pilot community project (30.7%, n=13) as well as work with Network Rail to make train stations safer and more welcoming (23.1%, n=13)

Suicide prevention strategy

The majority of respondents were either very familiar (33.3%, n=13) or familiar (58.3%, n=13) with the suicide prevention strategy and, similarly, most were either very confident (69.2%, n=13) or fairly confident (23.1%, n=13) that they knew where to find it, should they need to.

While all respondents agreed that the Suicide Prevention Strategy was fit for purpose, when asked if it was on track to meet is objectives, only half (53.8%, n=13) responded with some level of agreement.

Analysis by recommendation

For each recommendation of the Sandwell Suicide Prevention Strategy, participants were asked to rate their level of agreement with regards to its relevance, achievability, and whether it was on track to be met by 2025 (see Image 4)

For ease of reference, recommendations are outlined in Table 2.

Table 2: Recommendations from the Sandwell Suicide Prevention Strategy

Recommendation	Details
1	Raise awareness of suicide prevention and bereavement support through training for all frontline staff
2	Pilot town-based, community-led forums
3	Support community organisations with funding applications
4	Work with Community Development Workers to identify gaps in accessibility
5	Encourage referrals from GP's to targeted services and establish an explicit pathway
6	Expand awareness and access of bereavement support to all First Responder and bereavement-related partners so that an offer of support can be made immediately
7	Identify and prioritise high-risk populations through working groups
8	Improve data collation and intelligence gathering
9	Engage with media organisations to work co-operatively on the reporting of suicides
10	Commission further assessments on a larger scale that considers further populations

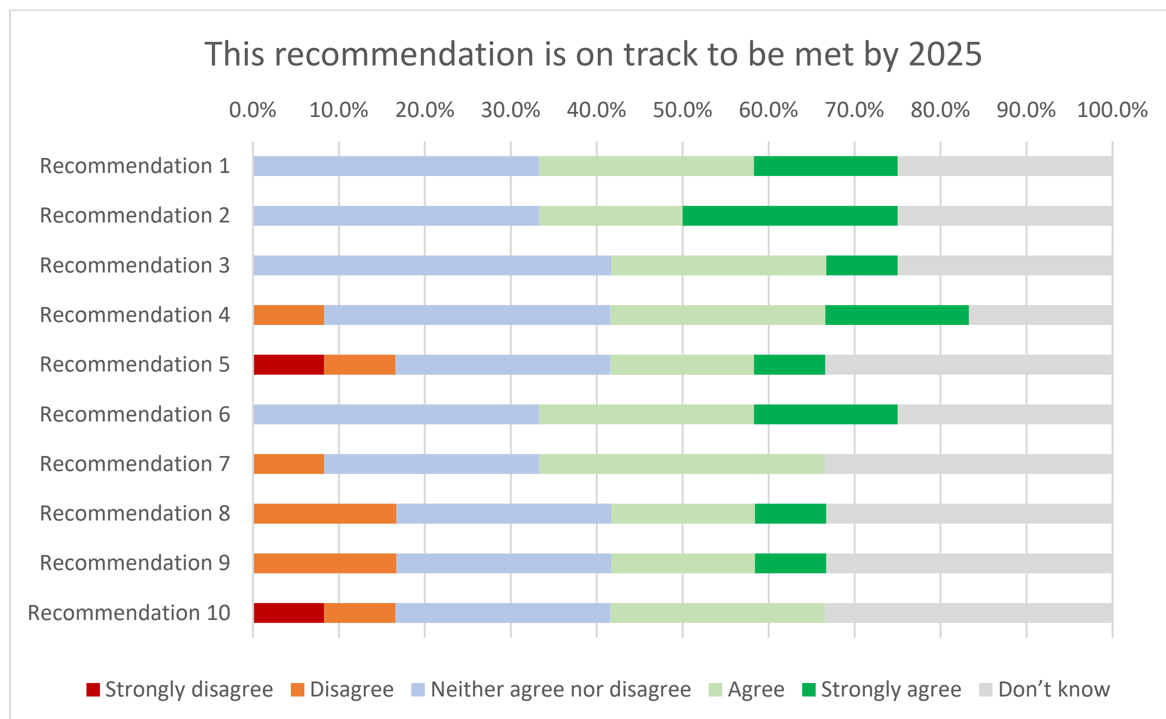
Image 4: Level of agreement with relevance and achievability of each recommendation

[a] n=13 [b] n=12

As can be seen in Image 4, the vast majority of respondents considered all recommendations to be relevant. Most recommendations were felt to be achievable. However, lower levels of agreement were seen for recommendation 5, 9 and 10.

Graph 7 shows, for each recommendation, participants' level of agreement with the statement "This recommendation is on track to be met by 2025".

Graph 7: Level of agreement with the statement "This recommendation is on track to be met by 2025".



Compared to questions about relevance and achievability, there is a higher proportion of respondents answering "Don't know" and also "Neither agree nor disagree". This may point toward respondents having less oversight of the general progress of the strategy. Interestingly, despite most recommendations having been described as achievable in the previous section, there appear to be higher levels of uncertainty when answering whether they can be achieved within the timeframe set by the strategy.

There was an overall positive outlook on recommendations 1, 2, 3, 4 and 6 being met by 2025. Recommendations 5 and 10 were those thought least likely to be achieved within this timeframe.

The Sandwell Suicide Prevention Strategy was described by several respondents as having an aspirational quality that aided in motivating and directing efforts to reduce the risks and impact of suicide in Sandwell. The main strengths most often mentioned by respondents were:

- How the strategy recognises the need for and encourages a partnership approach to suicide prevention (38.5%, n=13)

- The fact that the strategy highlights the importance and raises the profile of suicide prevention (30.8%, n=13) in a variety of settings, including in mental health discussions and strategies.
- Aspects of how it had been developed (30.8%, n=13), including the fact it aligned with the national suicide prevention strategy, it was evidence-based and had been co-produced with partners and people with lived experience.

When asked about the main limitations of the Sandwell Suicide Prevention Strategy, the most frequently mentioned responses related to:

- Limitations in ensuring continuous partnership engagement and ownership (38.5%, n=12). Some of the reasons for this mentioned were the fact that there were no named leads for different areas of the strategy and no clear mechanism by which to ensure accountability of members.
- Issues relating to the deliverability of the strategy were frequently mentioned (38.5%, n=12). This included a general sense that the strategies' objectives could not be achieved within the proposed timeline, either because there was not capacity to do so, or because they were not focused enough to ensure achievement was measurable. Some mentioned the action plan which accompanies the strategy being overly complicated thus leading to decreased partner engagement.

When asked how the Sandwell Suicide Prevention Strategy could be improved, most frequently mentioned actions related to:

- How the Sandwell Suicide Prevention Partnership operates (40%, n=10). This included striving to increase commitment and ownership by having designating people to deliver actions, co-producing future strategies with relevant partners and reviewing the partnership membership, particularly where engagement of additional partners could progress areas of difficulty.
- The action plan (40%, n=10). Suggestions included streamlining it, making it easier to read and ensure it had more details on how objectives could be delivered.
- Engaging the community and raising its awareness of suicide prevention (40%, n=10).

Suicide Prevention Partnership

12 of the 13 respondents were members of the Suicide Prevention Partnership. 54.5% (n=11) always attended meetings (or someone attended on their behalf) and 36.4% (n=11) attended them sometimes.

The majority of respondents (81.8%, n=11) would like meetings to be held every 2 months and most respondents (75%, n=12) preferred hybrid option compared to remote (25%, n=12).

When asked about the topics that should be discussed in the partnership meetings, there were two main themes:

- Some saw the purpose of the meetings to be primarily about sharing of information and updates (44%, n=9). This included updates on what services and support was available, how it could be accessed, learning from recent incidents and any local or national developments on suicide prevention related issues.
- Others expressed the need for meetings to be more focused on the strategic aspects of suicide prevention (56%, n=9). These should be used to provide oversight of the impact of the strategy and monitor progress against the action plan with partners providing updates on how objectives were being met.

25% (n=12) of respondents rated their contributions to the partnership as very important and 41.7% (n=12) as important. No one felt their contributions were unimportant.

When asked the main reasons that prevented respondents from contributing more to the partnership, the answer most frequently given (50%, n=10) was lack of capacity to attend, primarily due to competing work demands on time. Some respondents mentioned it was not the main focus of their work (20%, n=10).

From responses given on changes could be made to the partnership to enable members to contribute more to suicide prevention, the main theme identified revolved around adapting the format and purpose of meetings. This included holding separate operational and governance meetings (with different frequencies), having named leads or task and finish groups to focus on the delivery of specific actions/objectives, and having mechanisms to ensure partner accountability. Suggestions made also included holding occasional wider stakeholder forums to enable wider input and networking.

When asked about the strengths of the partnership, two clear themes could be identified: partnership (56%, n=9) and passion (33%, n=9). Respondents expressed that, through collaborative working across different sectors, the group had been able to have a bigger impact with regards to preventing suicide in Sandwell. They also recognised the importance of personal motivation of each member, as described by the following answer:

"[There] is a real passion and commitment to suicide prevention. This you don't get everywhere and it is hugely important to the success of the group…"

When asked about limitations of the partnership, answers given echoed themes previously discussed. Issues with attendance of meetings (43%, n=7) and limited buy-in and ownership from partners (43%, n=7) were raised as the main limitations. As detailed in the response below, some respondents felt that this led to overreliance on public health to progress the suicide prevention strategy.

"Turnover within partner organisations can make it difficult to maintain membership and momentum. As such much of the progressing of actions falls to PH when this needs to be more collectively owned."

Most respondents (73%, n=11) replied that additional members should be represented in the partnership. Several examples for services/groups that should be represented in the partnership (Image 5). Often it was mentioned that representatives should ideally be suicide prevention leads in their service, or should have some level of seniority.

Image 5: Examples of additional partners who should be considered for membership of the Sandwell Suicide Prevention ***Partnership***

- **Adult and CYP safeguarding**
- **Adult social care**
- **Ambulance services**
- **Citizen's advice**
- **Customer services** (those intercating directly with vulnerable people)
- **Fire services**
- **First responders**
- **Health professionals** (namely GPs and community mental health, preferably SP leads)
- **Housing**
- **Local member champion**
- **Local Samaritans branch**
- **Neighbourhood**
- **Survivors**
- **Various children's services** (education, health, etc)
- **West Midlands Police**
- **Workplace representative** (of local buisinesses)

4.3.2 Analysis of interviews

A total of 9 members of the Sandwell Suicide Prevention Partnership took part in interviews. Participants had varying degrees of involvement with suicide prevention at different levels (e.g., managerial role, face-to-face contact with patients/clients). Among the sample there was a strong representation of people within the public health team, as well as representatives from NHS healthcare trusts, children and adult social care and domestic abuse teams.

The following is a description of the main themes identified in interview discussions. They are presented here following a similar structure to the one used for the survey.

Suicide prevention in Sandwell

Drivers of suicide in Sandwell

Participants stated having varying degrees of awareness on the subject of suicide in Sandwell. Most expressed that, although numbers of deaths by suicide were not high, any number of suicides is too many and the impacts on the community are profound and damaging.

Several drivers of suicide were mentioned, namely:

- Social isolation and loneliness which were felt to be particularly problematic since the COVID pandemic and impacted certain groups disproportionately (e.g., older adults with mobility restrictions, certain cultural groups which may feel isolated from others).
- Bereavement, particularly in cases of older adults, loss of a child, or loss of a loved one to suicide.
- Varying degrees of trauma, depression, substance and alcohol misuse.
- Financial concerns, debt and the cost-of-living crisis were frequently mentioned as drivers which lead people to a state of despair.

When describing findings from a research project, one participant gave a chilling description of the impact of domestic abuse and subsequent consequences on mothers:

“[We talked with mothers] at a point where their children were potentially at risk of being removed from their care or on child protection plans. And the impact of being a victim of living in entrenched domestic abuse, being blamed for not being a protective carer because of that abuse, at risk of having your children removed (…) [having] all sense of who they are, stripped away from them to the point where the best option they consider for themselves and probably for everybody else, is to remove the problem…which they see as themselves.” (P1)

When asked about what aspects of life in Sandwell had a particular impact on suicide, several participants expressed some uncertainty. Although there was a general sense that Sandwell experiences higher levels of adversity, it was not always clear if this translated into higher rates of suicide.

“With Sandwell being such a diverse and such a poor borough, there's bound to be more incidents of people that are in debt or in unstable families or unstable relationships or having issues with drugs and alcohol. [Those] are all antecedents to suicide. But without having the evidence to back that up, it's difficult to say that that's definitely happening in Sandwell. (P4)

Some contextual factors were mentioned, such as the diversity of cultural backgrounds and the fact that the borough is spread out across 6 separate towns.

“We've got a diverse population and it's a known social factor that, actually, your race, lends itself to people experiencing discrimination, oppression and hardship (…) [And another thing] unique to Sandwell is the six towns (…) and if we're asking people to make journeys from say Tipton across to say, Smethwick, how likely is that? And where is that going to put somebody who's already feeling hopeless and feeling uncomfortable about their life, having to make a trek across there. (P6)

Support provision

When asked to comment on Sandwell's current provision of support for people struggling with mental health challenges, in particular, suicidal ideation, most participants felt there was a clear divide between clinical support and community/peer support.

There was a general sense that there is plenty happening in the community with regards supporting people with their mental health, emotional wellbeing, and even, in some cases, people in crisis.

"I think there'll always be gaps in terms of actual mental health services, but I do think that in the community there's a lot going on that supports their suicide prevention agenda. It's just perhaps not badged and labelled in that way. It's more just community activities and well-being." (P4)

Participants mentioned that there was an increasing demand for face-to-face support, particularly since the COVID pandemic. Some participants felt there was a gap in bereavement support which particularly affected older adults and those who had lost a loved one to suicide. One participant also mentioned that more was needed to support parents' whose children are struggling with their mental health.

With regards to health service support, clinical pathways were described by some as one of the greatest weaknesses of the current support offer. It was felt that the health service was not well connected within itself and had very few links with the support available in the community. Links with primary care were often thought to be problematic. Some participants expressed frustration at the fact that, where patients had to wait a long time before being assessed or supported by a service, more was not done to signpost them to alternative community support they could receive in the meantime.

"People don't know where to go apart from their GPs, and I think quite honestly, GPS aren't equipped and they struggle. [We have the] biggest waiting lists and the biggest gaps within our health system, so we can do as much as we want to [to support] community mental health, but it's our clinical pathways. It's our waiting times. People become desperate. You're desperate and you phone up the crisis line. They put you through to clinical support and you've got to wait four months. So who's gonna live in crisis for four months?" (P9)

Some participants also expressed concerns that support made available was not always culturally appropriate for some of the communities in Sandwell, particularly those where mental health was often seen as taboo.

"A lot of the population, because it is not in their background, in their culture to talk about [mental health]. So that's one of the main issues within Sandwell" (P5)

Barriers to engaging in suicide prevention

Several examples were given of barriers to engaging in suicide prevention for both the public and professionals. Those most often mentioned were the stigma associated to mental health, language barriers, cultural perceptions and the lack of awareness of what support is available.

The topic of mental health, and suicide in particular, was not seen as one that most people (both public and professionals) feel comfortable or confident in talking about. Several participants had encountered reluctance to broach the topic for fear that mentioning it to someone would make them more likely to think about taking their life.

"[Regarding] mental health as a whole, culturally, we've come along loads in the last 10 to 20 years. Actually speaking about mental health and well-being compared to what we did 10-20 years ago. But by and large it's still not spoken about and [people] feel like you can't be open about it. About yourself or asking other people about it - it's not appropriate, and it's the same thing [with suicide]. It's just a more severe end of the spectrum, so it's bound to be even more difficult." (P3)

Where there were cultural perceptions which sought to hide or silence mental health issues, this is particularly challenging.

"As soon as you, in some communities, you mention the words mental health or suicide prevention: 'We don't talk about that, OK?' And it's trying to kind of encourage people, in a positive way to say that 'You know what? It's OK, we can talk about suicide prevention' (P7)

Some participants also felt that the public and health professionals were not aware of the support that was available, particularly for mental health and wellbeing issues that could be seen minor or as antecedents to suicide. This in turn meant that those needing it, were not always accessing support at an early stage, and only later when they had reached a point of crisis.

"I think people are probably quite good at understanding where they need to go at times of crisis. They might go to A&E or they might call 999 or something like that. (…) I don't think there's perhaps an association between well-being activities and sort of preventing suicide and preventing crises. I think there's definitely more education that we can do (…) teaching and educating our members of the public and staff and anybody that works, and lives, and studies in Sandwell (…) that actually in their everyday they're preventing a mental health crisis by just engaging with society, engaging with people and that's having that sense of connection and belonging." (P4)

Suicide prevention strategy and action plan

Access to reliable data

Several participants mentioned that lack of access to reliable data was one of the main hindrances in progressing the suicide prevention agenda in Sandwell. Several factors impact the quality of the data, as well as its usefulness.

On one hand, small numbers of cases mean it is not always possible to make inferences.

"I think suicide's really difficult because, luckily, there's such small numbers. It is really difficult on such a small area of Sandwell to get a realistic look of what's going on. What we do know is that Sandwell has got loads of mental health difficulties, more so than England in general, so you would suspect that suicide is also worse in general. But. I think because the data's so small, I'm not sure it's reliable enough on its own, on such a small footprint." (P3)

There are plans to establish a system for near real time suspected suicide surveillance (nRTSSS) across the Black Country. However, this is still in development.. Consequently, the partnership relies on data with limited detail, or data which are no longer up to date. This leads to uncertainty of the partnership's understanding of the current situation in Sandwell with regards to suicide and limits targeted support and interventions

"I think we have probably have far more suicides than we actually are aware of. And I think we have lots and lots of people who are struggling. (P9)

"At the moment we're getting out the coroner reports from the deaths of suicide, so that will literally just tell us the cause of death. It won't tell us how that death has taken place. It won't tell us the back story of that individual and what's been going on in their lives. Maybe we need to do a little bit more about collating that information about that person. How we do that, I don't know." (P4)

One participant mentioned their involvement in domestic homicide reviews in which there was evidence to indicate the death had been caused by suicide. This activity brought together various agencies and sought to gain a better understanding of the events that led to the death and any learning that can be gained from missed or potential opportunities to intervene. These reviews (which are discussed again later in this analysis) are not currently conducted routinely for cases of suicide but were mentioned as something that could be considered to gain a better understanding of how and why suicides take place.

Raising awareness and the profile of suicide prevention

As already mentioned, participants have encountered several barriers when trying to encourage people to discuss and receive training for suicide prevention. Raising awareness of the importance of this and the resources available was seen by several participants as one of the main purposes of the suicide prevention strategy. Some participants felt that awareness had increased, but there was still much work to be done.

“I think there's been certainly in my time in Sandwell - which is now coming up well beyond ten years - I’ve seen an improvement in [people’s awareness of the importance of discussing suicide prevention]. It's spoken about much wider than before.” (P8)

Raising awareness was primarily seen as enabling people to feel more comfortable and willing to talk about suicide and how to seek support for it.

“[It’s about trying to] get that message out there and try and make as many people as possible comfortable about having a conversation around suicide. We don't expect people to feel like they've got all the answers but at least being able to have that conversation. [So] if it is put to they aren't going to be a rabbit in headlights” (P8)

Some participants commented that, for this awareness to permeate the different areas of Sandwell, it required those in senior leadership positions to display it and champion it. Similarly, those in the suicide prevention partnership should lead by example.

“For that awareness to be really community based and to become normal language, for it to be comfortable normal language, I think you really need senior leaders to get behind this. And for them to also feel comfortable having those conversations.” (P1)

“[As a partnership] we have to be role models in [raising awareness of suicide prevention]. [We need to] talk openly about it and that will sort of replicate [in others].” (P2)

Some participants also mentioned the need to raise the profile of suicide prevention. It was felt that, for some organisations and services, it was not enough of a priority to warrant investment of time and resources.

“I'm not sure how important the organisations who are receiving [suicide prevention training] think it is. It’s not always prioritised, so I think it's perhaps taken up more by people who are personally more interested in it rather than it being seen as an important thing for everybody to do. I think there's still something to be done about raising the importance of general awareness for people around that to get them into training in the first place. (P3)

One participant commented that one way of alerting others to the importance of suicide prevention was to use what data is available to us.

“If I go into a meeting and they're all sitting there, blasé about [suicide prevention] and then you start mentioning the data, you know that works out to about nearly two people a month in Sandwell are

dying by suicide. Suddenly people [pay attention]. And so, I think the data is good. I think we need to be a bit more robust with that and start sharing it more." (P9)

Training

Several participants commented that increasing the accessibility and uptake of suicide prevention training had been one of the greatest successes of the implementation of the suicide prevention strategy.

"The training offer is going from strength to strength and actually this year we'll do more targeted work for different departments and different organisations to make sure that they have a skilled workforce as well." (P4)

While recognising the positive impact of the progress in disseminating this training, some participants expressed reservations as to whether it was reaching the right people. While the strategy focuses on delivering training to frontline staff, some participants felt there should be an increased focus on senior leaders and cabinet members.

"I'd be interested to see how many senior leaders or cabinet members went on [the suicide prevention] training and if they went on that training, what are they doing with that? And I think that's the questions that should be being asked. Because I think what you'll get is a lot of frontline practitioners and middle manager" (P2)

Some participants reported difficulties in disseminating suicide prevention training among primary care professionals and felt that this was a considerable gap. One participant expressed a desire to incorporate mental health and suicide prevention training into partner mandatory training, as a means of reaching more people.

One participant expressed some frustration at how this goal was described in the strategy, feeling that it was not realistically achievable.

"With the training [actions] 'Train all frontline staff' - we're not going to do that. We're not going to get every frontline staff member trained in suicide prevention. It's just impossible. So actually we're not on track to achieve that and we'll be nowhere near achieving all frontline staff. So it then makes it very disheartening because we're not going to achieve it." (P4)

Listening to those with lived experiences.

Listening to experts by experience was recognised by all participants as an important objective of the strategy. Some participants mentioned how the suicide prevention strategy had been developed following the completion of a needs assessment which included consultation with this group. It was felt that this type of input provides invaluable information that is easily overlooked when focusing on other forms of data.

"[With data] there's always a risk that people just become numbers. Whereas actually having a more, you know, humanised view of that person and what their life was like would be great, because then it would enable us to be able to think actually, you know, debt is a big problem in Sandwell or, you know, actually domestic abuse is a big - we'd be able to actually look at things in a bit more depth and actually target things in a bit more" (P4)

When commenting on the usefulness of homicide reviews (previously mentioned), one participant explained how these were an opportunity to give a voice to the relatives of the victim, enabling their story to be heard.

"The reviews are useful for the families who want to engage. Feedback is (…) that it is enabling a voice of the victim to come through. But also for the family, it's helping them to come to terms and to give that voice. Because the voice of the victim is coming through the families" (P1)

Aspirations, scope, and gaps

Overall, comments regarding the structure, quality and scope of the suicide prevention strategy were very positive. Most participants felt it was comprehensive and covered the majority of relevant topics. With regards to its aspirational nature (e.g., setting the objective of zero suicides by 2030), there was a range of opinions among participants. While some felt this stirred people on and conveyed the seriousness and passion of those working in this area, others felt that it made objectives seem unachievable and lead to partners feeling demoralised. Some participants highlighted how it is important to include achievable targets, in order to keep people motivated.

"Strategies need to have small wins. To keep people motivated to keep moving forward!" (P1)

When commenting on areas which participants felt had been missed out from the strategy, or needed expanding on, a few examples were mentioned:

- Domestic abuse does not feature in the strategy.

- More detail should be given on how the support pathway should be structured, informing both professionals and the public where and how to seek help.
- A greater focus should be given to older adults and children and young people.
- Safety plans should be mentioned and promoted.

Some participants commented that, while the strategy was broad and comprehensive, it did, in some instances, lack focus and detail. This meant what some objectives aimed to achieve was not always clear and could be open to interpretation.

“The danger is it lacking. focus and where priorities are going to be made. Because it's so broad, everything can't be done at the same time” (P3)

Furthermore, some participants commented on the strategy needing to be made more accessible to those with limited health literacy as well as expressing some reservation as to whether it took into account the cultural and language subtleties of Sandwell’s diverse population.

“A big thing for us is around the health literacy and the type of language that we use. [Does the strategy] take into account cultural nuances and ethnicities and languages?” (P6)

Action plan

When asked about the suicide prevention strategy’s action plan, a considerable proportion of participants were either not aware of it or had had very little contact with it. For those who had used it, as well as those to whom it was presented during the interview, there was a general consensus that it was overly complicated, too long, and overwhelming. Several made comments on how it contained duplication and ambiguity. Several suggestions were made on how it could be improved:

- Streamlining it by merging some objectives and some actions.
- Make it more targeted by prioritising, stratifying, and creating stages.
- Separate sections of it to be working in task and finish groups.
- Reducing the amount of information on it to the actions and how they are achieved.
- Use a visual and easier to use format (as opposed to a spreadsheet).

Some participants expressed how any subsequent action plans should be co-produced with partners, thus ensuring their buy-in as well as allowing those who will be using it in future to shape something that fits their needs.

Suicide prevention partnership

Partnership and collaborative work

All participants recognised the importance of the partnership and collaborative work in the prevention of suicide in Sandwell. This type of work was described as being key in tackling a task which is not easy to achieve. The passion partnership members and their creativity in searching for solutions were highlighted as strengths.

Several examples were given of how collaborative work, enabled by the partnership had achieved meaningful results. The “adopt a station” projects were often mentioned as a case where there had been true collaborative work with different partners bringing their expertise together to work toward a common goal. However, there was some disagreement with regards to how well the partnership was functioning.

Those who felt the partnership was working well often showed appreciation for the opportunities it gave to network, learn, and keep updated with what is going on with regards to suicide prevention in Sandwell and further afield. These participants frequently saw linking up with other teams as an essential part of their work and the partnership provided an avenue for this. It was also seen as an enabler for wider discussions around suicide prevention and mental health.

“So it's great to have those partnerships and I think that is the only way that you can make gains and move forward” (P7)

Some participants expressed a sense that the partnership was only in the beginning stages. The progress achieved so far was considerable and the partnership was well set up to continue developing.

“We've been able to work more collaboratively. We're having wider conversations. And I think that will improve. I think that [the partnership] will become stronger and stronger.” (P1)

Where there was apprehension regarding the partnership’s functioning, this often revolved around partners not prioritising the partnership, its actions and meetings, and not taking ownership of different aspects of the strategy. Some participants felt there was a lack of accountability and an overreliance on council members (namely, public health) which meant the partnership functioned more like a network than a collaborative partnership. Some felt that this lack of buy-in from all partners may be due to them not realising the input that they have to offer and how suicide prevention relates to wider areas of work.

“It is very much the Council leading on it and the wider partnership aren't perhaps as equally involved as was initially envisaged at the outset. So, the Council's doing the leading and is progressing it, but the it feels more like a Council plan, rather than a local area partnership plan.” (P3)

What we need to do more of, I think as a as a partnership, is actually some more of that messaging around things like cost of living crisis or being in poverty or being in debt is actually a driver to someone who might actually end up taking their own life in suicide. And a lot of those wider determinants can be antecedents to suicide. And I think the more messaging we can get out about that out to our partners, hopefully they'll be more buy in and more responsibility from everybody.” (P4)

Membership and senior representation

The question of additional partners who should be considered for membership in the partnership has already been explored in the analysis of the survey results. However, certain groups were mentioned with particular emphasis during the interviews. Links with primary care were felt to be missing. Similarly, some mentioned an under-representation of the voluntary and community sector.

The [voluntary and community sector] has got a national presence, but it's [also] got a presence in Sandwell. They are services who engage the community as a whole, they will engage with many members of the community and citizens that probably the local authority will never ever come across. We've got to be supporting and working with them to make sure that they are comfortable having the conversations around suicide prevention (P8)

Other partners frequently mentioned were schools, the police, experts by experience and representatives of cultural and faith communities.

A lack of senior representation and accountability within the partnership was also identified by several participants as a major limitation to its functioning. Attendance in partnership meetings was often delegated and those present were not always able to make the decisions that needed to be made. Furthermore, it was felt that, unless leadership members are involved, awareness of the importance of suicide prevention and a willingness to engage with it will not be replicated in the remainder of the organisation. Some participants mentioned that this senior leadership representation should start within the public health team so as to be mirrored in the remaining partners.

“It doesn't really function in terms of an operational type partnership. It tends to be more of a place to update on suicide prevention rather than operate and have responsibility for the action plan. We've got a lot of enthusiasm and we've got people who attend [meetings] because they're learning something and they're networking and they bring something to the group as well as they take

something away with them, and I think that's really quite good and healthy. But we need we need teeth!" (P9)

Suggestions for improvement

Several suggestions were given on how to enhance the functioning and impact of the partnership (some of which have already been described in the previous sections).

Some participants felt there should be a better integration of the suicide prevention partnership with other strategic groups in Sandwell (namely, the Better Mental Health strategy and partnership) and in the Black Country (i.e. better links between suicide prevention partnership across the region).

Suggestions on how to adapt the functioning of the partnership to ensure a better spread of responsibilities and ownership across partners were also mentioned. These included rotating chairs, taking turns to set the agenda, and using task and finish groups to focus on different aspects of the strategy. Several participants mentioned the need to have regular update and sharing of progress meetings, as well as an oversight meeting with a smaller group of partners who could make decisions.

It was also suggested that with future strategies, there should be more comprehensive co-production with partners in order to ensure their participation and buy-in from the offset.

"Although we did consultation and the [suicide prevention strategy] was done on the back of a needs assessment which talked to people who were bereaved by suicide or were survivors of attempted suicide - it didn't really have good partnership buying from the off" (P4)

4.4 Analysis of action plan log

Objective 1. To work in partnership to fulfil the 'Zero Suicides' Ambition.

In order to ensure a cohesive and efficient approach to suicide prevention, it is important to work in partnership with all those involved in this workstream, both locally and regionally. Sharing of information, learning and resources will allow for a more comprehensive approach to suicide prevention and a greater impact of its strategy.

Working with the community and voluntary organisations

The council's Better Mental Health workstream has been played an important role in establishing partnerships with community and voluntary organisations in Sandwell to promote better mental health in communities. This has included supporting these organisations in applying for bids and granting funding to deliver a variety of suicide prevention and mental health projects (e.g. Team Talk, Ideal for all, KPG Sanctuary, Papyrus training, among others). Partnerships established with these organisations have also been used to harness local knowledge to map support already available within communities and stimulate innovative solutions to some of the main issues identified by residents.

> *"A community signposting resource is being designed for professionals which will act as a tool when working with residents. The resource covers areas such as local community facilities, social groups, financial advice and help, employment and education support. A mapping exercise has been undertaken to identify local support and services available to residents, which is now being collated into a central resource which will be launched in the near future. We aim to host community events and attend team meetings with key stakeholders in Tipton to promote this resource and ensure it is utilised. The document contains information on long-term services and support residents can access, to minimise the risk of information becoming quickly outdated. We plan to review and update the document periodically and enable stakeholders to provide feedback on how future versions can be designed to best support the community. The aim with this project is to promote the existing support and services residents can access and equip professionals with the information they need to best support residents."*
>
> *Irandeep Mann*
> *Public Health Development Officer - Tipton*

Partnerships for information gathering and sharing

Access reliable, local, up-to-date data on suicides and related issues (e.g. suspected suicides, attempted suicides, suicidal ideation, etc) in Sandwell is limited. The Sandwell Suicide Prevention Partnership currently relies on nationally produced figures as well as periodic updates from regional coroner reports for updates on trends in suicides. While both provide valuable information, this often comes with at least a 6-month delay. Links established through the partnership are often used as a means for *ad hoc* sharing of information on recent suicide-related events as well as suicide prevention updates.

It is expected that the implementation of nRTSSS in Sandwell will provide those working in suicide prevention with a more accurate picture of the current local situation as well as provide opportunities for prompt, reactive interventions where necessary.

Working with the media

There has been limited engagement with media organisations to support them in responsible reporting of suicide-related events. Although the Samaritan's have produced media toolkits on how to report suicides, these have not been promoted locally nor has training been developed for or offered to local media organisations.

Partnership with the Black Country

There are currently considerable interactions and sharing of information and resources between different areas of the Black Country. This allows for a more comprehensive and coordinated approach to suicide prevention, as well as the opportunity to learn from each other.

Strategic alignment

There is considerable overlap between the mental health and suicide prevention agendas. While the recently developed Better Mental Health strategy for Sandwell considers suicide prevention, it is not extensively addressed. Both strategies (Better Mental Health and Suicide Prevention), although ultimately aligned, appear to largely exist independently from each other.

Black Country suicide prevention leads and community development workers are currently developing a regional strategy and action plan.

Objective 2. To ensure the highest quality of care and support guaranteed by professionals.

Suicide prevention and bereavement support is available in a variety of different forms in Sandwell. While some aspects of this support is focused solely on suicide prevention, others are embedded within the wider mental health support offer. As with many other preventative services, it can be challenging to ascertain the quality and impact of suicide prevention support.

Links with primary care

Engaging primary care networks and staff in the suicide prevention agenda has been challenging. Well established links with health professionals and managers in this setting with a particular interest in suicide prevention are lacking. However, some progress has been seen in certain areas:

- Suicide prevention training was made available to primary care staff in the Black Country during 2023. 6 training events were held with a total of 64 Sandwell staff (including general practitioners, nursing staff and other associated healthcare professionals) having completed training. However, this programme is no longer in operation.
- A public health specialist with a focus on social prescribing has been recruited for Sandwell. This is likely to provide opportunities for involvement of social prescribers in suicide prevention in future.
- The public health team has been engaging primary care in other workstreams (e.g. MECC approach in health checks). It is possible that links established through this work may open opportunities for collaborative work on suicide prevention.
- Work has been done to increase awareness and accessibility of children and young people's (CYP) mental health services. This includes the dissemination of a CYP service directory among organisations and parents/carers and promotion of national self-help information.

Links with first responders

Suicide prevention training has been made available to first responders, as well as plans for providing them with Z-cards. However, it is unclear to what extent this training has been taken up by this group and there is a need to identify avenues for it to be shared more widely with them.

Signposting

A protocol has been developed to enable frontline staff to support residents experiencing suicidal ideation and/or refer or signpost them to appropriate services. This is currently being used in some Sandwell libraries and there are plans to promote its wider use.

"In light of the cost-of-living crisis, we have been working with Citizens Advice to set up and deliver Cost of Living, Financial Capability & Budgeting Training Workshops for professionals, staff, or volunteers to attend. The workshop follows a train the trainer delivery style and provides an overview of trusted websites, practical budgeting training and signposting. The session also looks at recent changes and new resources that can be shared. The workshops have been made available for professionals working in Tipton to access, primarily aimed at frontline staff that are working with residents and families and aims to equip professionals with key information, tools and resources. We have held one training workshop so far, which was well attended and we are now scheduling two further workshops in Tipton, ensuring one workshop is held per town ward."

Irandeep Mann
Public Health Development Officer - Tipton

There is also ongoing work to maintain an up-to-date directory of all mental health and suicide prevention community provision available. This is hoped to assist in signposting and referring into adequate support.

Objective 3. To encourage a better awareness of suicide within local organisations and our communities.

Raising awareness of issues surrounding suicide as well as the support available is one of the cornerstones of suicide prevention. Training in suicide prevention in certain groups has been shown to be an effective measure in reducing the number of suicides [7].

Training in suicide prevention

Considerable advances have been made in making high-quality suicide prevention training available through the council and easily accessible to all Sandwell residents. This training offer has been widely disseminated in a variety of contexts, namely, among the council workforce. This training has also been made part of the CYP workforce competency framework.

The following excerpts from the Delegated decision report on Papyrus Suicide Prevention Training Grant highlight the achievements of this training programme since it first started being delivered to staff working with children, young people and adults in Sandwell in April 2023.

The following are answers participants gave when asked about their use of the knowledge and skills they had gained 6 months after participating in the training.

"Returning from a holiday [I] came across a young man on bridge over M54, think it was a cry for help, it gave me courage to call for assistance, and to stay close by till the youth had support."

"I have sign posted to suicide hotlines and spoken to someone about their feeling regarding mental health and suicide."

"Thankfully I have not had to use any of the knowledge gained from the training, in my role at work (I work in a primary school) but I have been able to share it with other staff in the Pastoral Team."

"Working with a profoundly deaf sign language user with no speech [I have] developed a visual step by step safety plan for times of crisis."

Despite being recognised as an area of importance, there has been limited progress in incorporating suicide prevention training in council mandatory training, namely, for councillors and elected members.

Working with communities to raise awareness

It is hoped that through the work of mental health community champions and the Faith Sector & Inclusion Health Development Officer there will be further opportunities to promote the suicide prevention and bereavement support among a variety of businesses, services and groups across Sandwell.

There is also ongoing work to map current training available through the voluntary and community sectors as well as plans for a training directory to be made available online through the Healthy Sandwell website.

"[The Charlemont project] is based in a secluded area of West Bromwich, which borders Walsall and Great Barr, so has been quite neglected for a number of years. It has and will take a lot more time to make a significant impact in the area but we are trying!!

So far, we have developed a tasking group to see what was already available in the local area. It was noted Charlemont is not an area with a lot of resources and projects, so it was identified that more community engagement work was needed. I have worked closely with a colleague in the community partnerships team to work on the community engagement and development aspects in this area and we have set up regular sessions operating from Charlemont Community Centre including: Women's wellbeing mornings, Cuppa with a coppa, and Health and wellbeing mornings.

Through these sessions we have spoken to residents about their main concerns and identified organisations to come along that target these. For example, a number of residents highlighted concern with domestic violence and safety, so we have engaged with Black Country Women's Aid and the neighbourhood police teams to attend these sessions.

We also ran a walking Football and Rugby taster session with the aim to encourage men to come down to the centre to engage with Tough Enough to Care to encourage interest in a support group we had planned with them to begin in July. [We have also] promoted the papyrus training offer in the area ensuring those business and community groups that do operate in the area are aware of the offer.

Erinn Beech
Public Health Development Officer – West Bromwich

Making resources available

There is ongoing work to raise the profile of suicide prevention and increase the accessibility and visibility of suicide prevention training and support in Sandwell. This includes the creation of a communications and engagement post within the public health team to focus on a mental health and suicide prevention. Marketing and promotional is being created and will be made available online in a variety of languages. The planned refresh of the Healthy Sandwell website will bring together many of these resources, making them easily accessible from a single place.

Objective 4. To reduce the chances of suicide in high-risk populations.

In order to ensure effective use of resources in suicide prevention work, it is essential to have a good understanding of which population groups are at highest risk, as well as the needs and challenges they face. Once this has been achieved, it is possible to target interventions so as to maximise their impact. Below is a summary of some of the work developed in Sandwell to address this objective of the Suicide Prevention Strategy.

Gaining a better understanding of high-risk populations

Efforts to better understand the population interacting with health services for mental health related issues has seen limited progress. Despite hospital presentations for intentional self-harm in Sandwell having been identified as an important area requiring further exploration, little is known about who this population group is and their needs and risk factors. Similarly, reasons and sources of referrals into child and adult mental health services in Sandwell have not been analysed in detail. However, ongoing work exploring reasons for recent changes in trends of CAHMS referrals is likely to shed some light on this topic.

Despite having been recognised as a useful tool to better understand and prevent suicide at a local level, nRTSSS has not yet been established in the Black Country. This considerably limits the timeliness and quality of data available to those working to prevent suicide in Sandwell.

Work is currently underway to embed monitoring of outcomes of outcomes of funded mental health and suicide prevention projects, namely through use of WEMWBS and case studies. This will allow a better understanding of the impact of these projects, as well as the needs and challenges faced by high-risk groups.

Focusing on high-risk groups

There are several mental health community projects currently underway which focus on high-risk groups (e.g. older adults), protected characteristics groups (e.g. deaf/hearing impairment, blind/sight impairment and disability/long-term condition), as well as communities who are less likely to access traditional services or may face barriers in doing so. Furthermore, links have been established with a variety of specialist programmes and strategic groups focusing on some vulnerable groups, namely, children and young people, older adults, people who experience domestic abuse, and a variety of faith groups. There is still scope for further suicide prevention work to be targeted toward other high-risk groups such as rough sleepers, migrants, those in the criminal justice system, those who misuse drugs and alcohol, people who are unemployed and those who are LGBTQ+.

Links between Sandwell's Domestic Abuse and Suicide Prevention partnerships have been strengthened over the course of recent years. This is evidence by representation of both workstreams in each of the partnerships, as well as ongoing collaborative work to develop training that specifically addresses suicide prevention in the context of domestic abuse victims.

Other groups thought to be at higher risk of suicide are those affected by suicide of a close relative, friend, or colleague, as well as first responders to cases of suicide. Black Country postvention provision is available. However, it is unclear what is the level of uptake by Sandwell residents. Local postvention support is also offered by the Kaleidoscope+ group. There is scope to provide practical,

timely support targeted at these groups. Lack of nRTSSS also makes it harder to ascertain the extent to which this support is being offered to those who need it.

Work focused on children and young people

An anti-bullying project is currently delivering training to teachers, wider school staff, and pupils across Sandwell. Further work is also being established with Sandwell Adult and Family Learning Service to offer training and guidance sessions for parents and carers.

Despite an aspiration to do so, there has not yet been much progress in working jointly with schools to ensure they are aware risk factors for suicide in children and young people, as well as ensuring appropriate measures are in place to assess the risk of suicide in this population and prevent or minimise the impact of potential risk factors such as bullying and exclusion form school.

Objective 5. To create an open culture where we listen to those with lived experience.

As evidenced in the Sandwell Suicide Prevention Partnership consultation, the topic of suicide and suicide prevention is often felt to be too difficult or sensitive to be discussed in a variety of settings. It is, therefore, important to strive to create spaces where suicide can be talked about sensitively and respectfully, drawing on the experience of those who have been affected by it and learning from their needs and challenges.

Community-led forums and projects

Sandwell Suicide Prevention Partnership has been working closely with the Black Country Suicide Prevention Steering Group and Community Development Workers to facilitate community-led suicide prevention forums. Working with Public Health Development Officers and Communities Team Officers within towns offers opportunities to develop community forums and community-led projects. There are currently two ongoing town projects are seeking to engage with communities in identifying their concerns in this area and find solutions to address them (see quotes from Irandeep and Erinn).

Appropriate communication

Efforts have been made to ensure the imagery and language used to communicate about suicide prevention is relatable and reflects the unique experiences of marginalised communities and groups. Input is being sought from the council's Faith Sector & Inclusion Health Officer and, as stated previously, a communications officer has been recruited to deliver a mental health and suicide prevention communication marketing plan. Much of this work will come into effect once the Better Mental Health strategy has been launched, with a range of resources and leaflets having been produced.

Objective 6. To reduce access to the means of suicide.

Most measures put in place to limit the access to means of suicide have been implemented at a national and international level with the role of local authorities and local services in this area being modest. However, several steps can be taken to minimise access to means of suicide, as discussed below.

"We are working with the rail industry to look at ways Dudley Port and Tipton Train station can be adopted to improve the look of both stations. We aim to bring together a wide range of community stakeholders to get involved with the two local railway stations and enhance local community assets. We have identified a range of stakeholders we would look to work with, including the local youth service provision, schools and community and voluntary sector organisations. Working with the rail industry, we are looking to access funding opportunities to enable local stakeholders to get involved in contributing to the improvement of local community assets. Examples of work that could come out of train station adoption programmes includes creating artwork and positive welcoming messages and opportunities to promote Tipton's culture and local history. This project will help positively contribute to the health and wellbeing of our local communities by providing a range of opportunities for local people to be involved in the various projects within this proposal and by creating a welcoming local community asset. By introducing welcoming messages and designs, we aim to create a positive space that has a lasting impact and acts as a landmark or a way that people can relate to and create a sense of belonging in Tipton. Sandwell is a borough of Sanctuary and has a very diverse communities we will work within local communities to create artwork that is inclusive and welcoming for our residents and passengers visiting/using the stations. This project will contribute to achieving Sandwell's Suicide Prevention Strategy and deliver the Suicide Prevention Strategy for England 2023-2028 which identifies actions to reduce the means and methods of suicide and to "continue to minimise risks in the infrastructure and design of rail stations, including in the refurbishment and development of new stations". Both Tipton and Dudley Port stations are identified as high frequency locations and we will continue to work in partnership with Network Rail, Samaritans, First Responders and our Tipton Suicide Prevention Community Group to raise awareness of suicide prevention within these localities. Adoption of these two stations will include wider community support to promote better mental health as well as improving the aesthetics of the stations for our residents, passengers and those travelling through Sandwell."

Irandeep Mann
Public Health Development Officer - Tipton

Railway stations and highways

Work is currently underway with National Highways to improve the safety and reduce the risk of self-harm and suicide around a Sandwell bridge which had previously been identified as a location of concern (the exact location of the bridge will not be disclosed in this report). An assessment of the site has been conducted and recommendations for mitigating factors made.

Working in partnership with Network Rail, Sandwell has secured funding to "adopt" Tipton and Dudley Port Stations. These stations have been identified as high-frequency locations and this community-led project aims to raise awareness of suicide prevention in the locality by developing these areas as community assets.

Section 5: Discussion and recommendations

This evaluation set out to assess the progress of the Sandwell Suicide Prevention Strategy and Action Plan 2022-2025, examining the success and impact of its implementation and exploring the experience and insight of those involved in carrying it out. It used a variety of data sources but focused on appraising processes and relied primarily on a consultation with the Sandwell Suicide Prevention Partnership.

The issue of suicide needs to be interpreted within the wider context in which it is occurring, with social isolation (including due to bereavement) and financial struggles playing an important role in people's mental health, emotional wellbeing, and risk of suicide. The suicide prevention agenda is, therefore, inextricably linked to any efforts to improve and safeguard the populations mental health. The following conceptualisation model (Image 6) was developed throughout the process of this evaluation and is intended to serve as a framework to guide the not only the identification of areas of risk for suicide, but also moments in which implementation of suicide prevention actions can be considered. It highlights the importance of considering the societal context as well as the impact of suicide on the community.

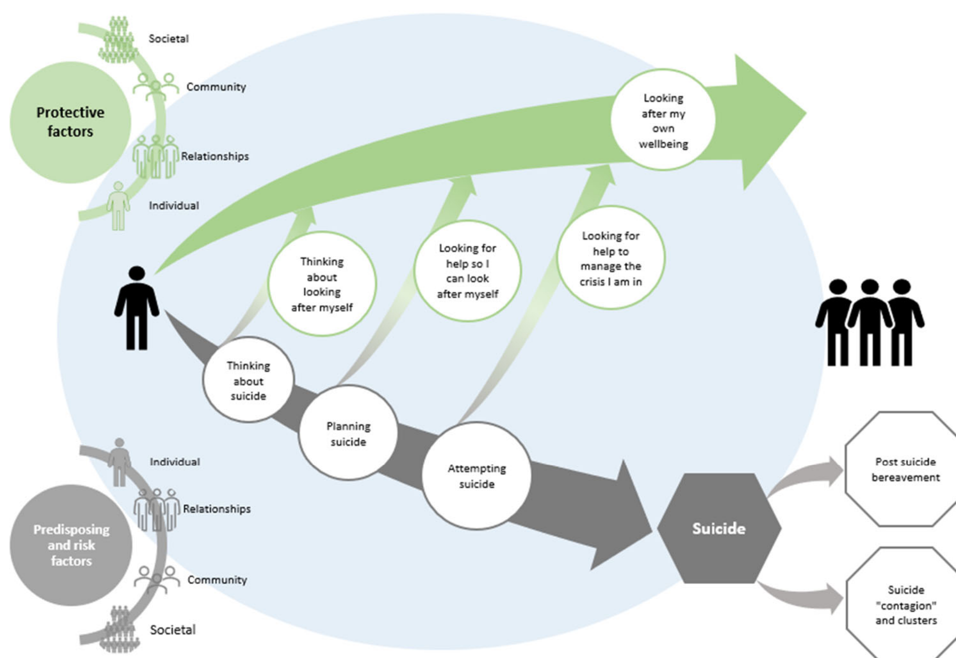


Image 6: Conceptualisation model for suicide prevention

Overall, findings from this report point toward suicide still being an important issue in Sandwell which requires strategic and concerted efforts to address. While it is unclear if Sandwell's suicide rates vary significantly comparatively to England, these rates have not seen substantial improvements in the last decades. Despite cases of death by suicide affecting all ages, males in the 40-60 age range are undoubtedly the most at-risk group. An analysis of local cases of suicide may also have identified "any other White background" as a potential group at higher risk of suicide in

Sandwell. However, small numbers and limited information on these cases do not allow for definitive conclusions to be drawn.

While there have been considerable efforts, both nationally and locally, to minimise access to means of suicide, particularly in public places such as railway stations and highways, the vast majority of cases of suicide occur in people's homes. Coupled with the limited scope of a local suicide prevention partnership in bringing about changes at a policy level, this should cause reflection on the level of priority that this is given in a local suicide prevention strategy.

Much has changed in recent years with regards to society's perspective and acceptance of mental health issues. While suicide is talked about more openly than before, there are still considerable barriers in making it everyone's business. This may be due to a fear or reluctance to engage in conversations about suicide or, alternatively, a failure to see it as a priority. Either way, raising the profile and awareness of suicide prevention, both in professional circles and the wider public, should remain as a priority.

This report highlights the many achievements in suicide prevention in Sandwell since the strategy was launched. There is a sense that suicide prevention is gaining traction and the partnership has a strong foundation on which to build. Some of the strategy's recommendations have seen particular success, namely, the dissemination of suicide prevention training in a variety of workplace settings, as well as community-led projects, such as the Tipton pilot project. Much of the Sandwell Suicide Prevention Partnership's achievements have drawn from its members' passion, enthusiasm, and personal commitment to suicide prevention.

However, on balance, the strategy is unlikely to accomplish all its objectives within the stipulated timeframe. In certain instances, this may be due to targets set being difficult to achieve or even measure (e.g., ensuring all frontline staff have received suicide prevention training). Other areas have seen limited progress, such as gaining an in-depth understanding of local high-risk groups and working collaboratively with the local media. While there have been advancements towards establishing nRTSSS in Sandwell, the fact it is not yet in place has limited progress in other areas of the suicide prevention agenda.

Certain areas were identified as particularly problematic in the advancement of suicide prevention efforts in Sandwell:

- **Lack of access to timely, reliable data on suicide and its risk-factors.**
  Uncertainty of the accuracy of current estimates further limits and undermines our understanding of the issue of suicide in Sandwell. The time lag in obtaining data also means that rapid targeted interventions are not possible.
- **A disconnect between healthcare services and other support available in Sandwell.**
  While there appears to be a comprehensive local community support offer, it is not often used as an asset to complement support provided to people seeking help within the healthcare system. Limited links between representatives of primary care and other Sandwell Suicide Prevention Partnership partners make it harder to fully understand the reasons for this. Furthermore, there appears to be uncertainty around the clinical pathway for suicide prevention/support.
- **The functioning of the Sandwell Suicide Prevention Partnership.**
  While the partnership was praised for its achievements, it does not appear to be functioning as initially intended. A lack of ownership and accountability mechanisms for partners has led to an overreliance on the Sandwell Council's Public Health team. The partnership is currently

functioning primarily as a network, rather than a collaborative group. Limited senior engagement in the partnership was also identified as a potential cause of limited senior engagement with the suicide prevention agenda outside of the partnership. Finally, the strategy's action plan, while comprehensive, was not felt to be supporting the partnership in providing appropriate guidance and overview.

Limitations

Several limitations have been identified and described throughout the report. These can be grouped in the following areas:

- Challenges in accessing and interpreting measurable outcomes.
    - There are few measurable indicators of whether a suicide prevention programme is having an impact. While cases of death by suicide can be measured, this metric does not allow us to analyse the changes in preceding stages. Furthermore, issues in how suicides are identified and reported lead to some uncertainty of the accuracy of this measure.
    - Relatively small numbers of suicides in Sandwell make analysis of trends and comparisons with national rates challenging.
    - Most recent data available on suicide cases is approaching being 2 years old and is no longer an accurate representation of the borough.
    - Using self-harm metrics as a proxy for risk of suicide can be problematic, as can be seen by the fact that the most at-risk group of self-harm does not correspond to the most at-risk group of suicide (young females and middle-aged males, respectively). While some instances of self-harm are indeed attempted suicides, this is not always the case.
- Consultation's sample size and representativeness
    - This evaluation relied primarily on the insights and experience of members of the Sandwell Suicide Prevention Partnership. It may present a one-sided view on this issue as it does not take into account the opinions of those involved in suicide prevention who are not part of the partnership.
    - Participation rates in both the survey and interviews were low. This may further reinforce some of the findings of the consultation, namely, engagement of wider partnership members.
    - Despite several attempts to establish contact and involve them in this evaluation, representatives of primary care and experts by experience have not been consulted.

Recommendations

1. **Restructure of the Sandwell Suicide Prevention Partnership**
   To ensure the partnership works as a collaborative group and maintains accurate oversight of suicide prevention efforts in Sandwell, its terms of reference should be refreshed to include the following actions:
    - Create two groups within the partnership:

    - An operational group with a greater emphasis on establishing links between partners and sharing learning and updates. This group could then feed into the overview group.
    - An overview group which focuses on keeping sight of the strategy as a whole and ensuring it is progressing appropriately. This group should be responsible for updating and maintaining an action log and, ideally, have close links with the Better Mental Health strategic group to ensure suicide prevention is firmly embedded within the mental health agenda.
  - Assign aspects of the strategy to named individuals and creating task and finish groups.
  - Ensure senior representation within the partnership, ideally beginning with the public health team. This is essential to ensure the partnership has adequate influence and can instigate senior representation form other partners.

2. **Refresh of the action plan**
   The action plan should be aligned with the strategy objectives and streamlined in order to have a maximum of 6 to 8 actions per objective. A phased approach could be considered whereby portions of the strategy are allocated to different periods of the strategy timeline. Any refresh of the action plan needs to be co-produced with the partnership in order to ensure members' understanding and ownership of the strategy.

3. **Links with local primary care representatives**
   Identification of and fostering of relationships with individuals within primary care with a personal interest in mental health should be a focus of the partnership. This is a crucial step to ensure a more seamless suicide prevention support offer between healthcare services and community and voluntary organisations. Senior representation within the partnership may further aid in achieving this goal.

4. **Improvement of quality of data available**
   As previously mentioned, securing nRTSSS is a crucial step in ensuring the partnership has an accurate understanding of the issue of suicide locally as well as enabling them to identify high-risk groups, identify high-risk areas, and coordinate rapid postvention responses. Suicide case reviews should also be considered not only as a means of gaining a more in depth understanding of the circumstances surrounding cases of death by suicide, but also as a means of ensure there are lessons learnt from these cases and both the case and their relatives are given a voice.

5. **Advocate for men's mental health**
   Middle-aged men are disproportionately represented in cases of death by suicide and should, therefore, be considered as a primary target for suicide prevention efforts. The Suicide Prevention Partnership has a role for ensuring this group is adequately considered in the wider mental health agenda.

6. **Assess cultural appropriateness of current suicide prevention offer**

Concerns regarding culturally appropriate engagement with and suicide prevention support for certain groups were raised during the consultation. Given the cultural diversity within Sandwell, this area warrants further investigation and could shed light on currently unknown and unmet needs.

7. **Co-production and scope of future versions of the suicide prevention strategy**
   As the Sandwell Suicide Prevention Strategy approaches its final year, considerations need to be made for its future versions. An emphasis should be made for this to be coproduced not only with experts by experience, but also with partners. This will aid in ensuring their ownership from the offset. Certain areas were identified as gaps in the current strategy and should be included or considered in future versions:
   - Domestic abuse
   - Promotion of safety plans
   - Structure of support pathways
   - Greater focus on older adults, children and young people.

   The partnership should also consider making a plain language version of the strategy available to the public.

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Appendices

Appendix 1 – Survey

Suicide Prevention Partnership questionnaire.

Thank you for taking part in this questionnaire – your time and insights are very much appreciated. Responses will be used to inform an interim evaluation of Sandwell's Suicide Prevention Strategy.

Although the survey is not anonymous, reporting of its results will ensure that individual responders cannot be identified. You will be provided with an opportunity to offer more in-depth information through a one-to-one interview.

The questionnaire is expected to take approximately 15 minutes. Please provide your honest opinion and answer all questions to the best of your knowledge.

Section 1. Responder details

1. Please provide the following details:
    a. Name:
    b. Professional group/organisation you represent:
    c. Organizational email:

Section 2. Suicide prevention

1. How important is suicide prevention to you personally?
    - Very important
    - Important
    - Moderately important
    - Of little importance
    - Unimportant
    - Don't know

2. To what extent do you agree with the following statement: "Suicide prevention is one of the main priorities in my current job role"?
    - Strongly agree
    - Agree
    - Undecided
    - Disagree
    - Strongly disagree
    - Don't know

3. To what extent do you agree with the following statement: “I would like suicide prevention to be a greater priority in my current job role”?
    - Strongly agree
    - Agree
    - Undecided
    - Disagree
    - Strongly disagree
    - Don’t know

4. How confident are you in your knowledge and skills around suicide prevention?
    - Very confident
    - Fairly confident
    - Somewhat confident
    - Slightly confident
    - Not confident at all
    - Don’t know

5. How confident are you that you would know where to find information on suicide prevention, should you need to?
    - Very confident
    - Fairly confident
    - Somewhat confident
    - Slightly confident
    - Not confident at all
    - Don’t know

6. In your opinion, what are the main barriers to suicide prevention in Sandwell?
   [Open text]

7. What would you describe as the greatest examples of progress in suicide prevention in Sandwell?
   [Open text]

Section 3. Sandwell Suicide Prevention Strategy

1. How familiar are you with the Sandwell Suicide Prevention Strategy?
    - Very familiar
    - Familiar
    - Somewhat familiar
    - Unfamiliar
    - Very unfamiliar
    - Don’t know

2. How confident are you that you would know where to find the Sandwell Suicide Prevention Strategy, should you need to?
    - Very confident
    - Fairly confident
    - Somewhat confident
    - Slightly confident
    - Not confident at all
    - Don't know

3. To what extent do you agree with the following statement: "The Sandwell Suicide Prevention Strategy is fit for purpose"?
    - Strongly agree
    - Agree
    - Undecided
    - Disagree
    - Strongly disagree
    - Don't know

4. For each of the Sandwell Suicide Prevention Strategy recommendations, please select your level of agreement for each statement:

Statement	Strongly disagree	Disagree	Undecided	Agree	Strongly agree
Recommendation 1: Raise awareness of suicide prevention and bereavement support through training for all frontline staff					
This recommendation is appropriate					
This recommendation is achievable					
This recommendation is on track to be met by 2025					
Recommendation 2: Pilot town-based, community-led forums					
This recommendation is appropriate					
This recommendation is achievable					
This recommendation is on track to be met by 2025					
Recommendation 3: Support community organisations with funding applications					
This recommendation is appropriate					
This recommendation is achievable					
This recommendation is on track to be met by 2025					
Recommendation 4: Work with Community Development Workers to identify gaps in accessibility					
This recommendation is appropriate					
This recommendation is achievable					
This recommendation is on track to be met by 2025					
Recommendation 5: Encourage referrals from GP's to targeted services and establish an explicit pathway					
This recommendation is appropriate					
This recommendation is achievable					

This recommendation is on track to be met by 2025					
Recommendation 6: Expand awareness and access of bereavement support to all First Responder and bereavement-related partners so that an offer of support can be made immediately					
This recommendation is appropriate					
This recommendation is achievable					
This recommendation is on track to be met by 2025					
Recommendation 7: Identify and prioritise high-risk populations through working groups					
This recommendation is appropriate					
This recommendation is achievable					
This recommendation is on track to be met by 2025					
Recommendation 8: Improve data collation and intelligence gathering					
This recommendation is appropriate					
This recommendation is achievable					
This recommendation is on track to be met by 2025					
Recommendation 9: Engage with media organisations to work co-operatively on the reporting of suicides					
This recommendation is appropriate					
This recommendation is achievable					
This recommendation is on track to be met by 2025					
Recommendation 10: Commission further assessments on a larger scale that considers further populations					
This recommendation is appropriate					
This recommendation is achievable					
This recommendation is on track to be met by 2025					

5. To what extent do you agree with the following statement: “The Sandwell Suicide Prevention Strategy is on track to meet its objectives”?
    - Strongly agree
    - Agree
    - Undecided
    - Disagree
    - Strongly disagree
    - Don’t know

6. What would you say are the main strengths of the Sandwell Suicide Prevention Strategy? [Open text]

7. What would you say are the main limitations of the Sandwell Suicide Prevention Strategy? [Open text]

8. In your opinion, how could the Sandwell Suicide Prevention Strategy be improved?

[Open text]

Section 4. Sandwell’s Suicide Prevention Partnership

8. Are you a member of Sandwell’s Suicide Prevention Partnership?
    - Yes
    - No
    - Don’t know

    [If answered “no” or “unsure”, skip to end

9. Suicide Prevention Partnership are currently held every 2 months. How regularly do you attend these?
    - As often as possible
    - Often
    - Sometimes
    - Rarely
    - Never
    - Don’t know

10. With regards to the Suicide Prevention Partnership meetings, please give your opinion on the following:
    - How often should they be held? [Open text]
    - What would be the preferred format?
        - Remote
        - Face-to-face
        - Hybrid
        - Don’t know
    - What topics should be discussed? [Open text]

11. How would you rate your contributions to the Suicide Prevention Partnership?
    - Very important
    - Important
    - Neutral
    - Unimportant
    - Very unimportant

12. What are the main reasons that prevent you from contributing more to the Suicide Prevention Partnership?
    [Open text]

13. Are there any changes that could be made to the Suicide Prevention Partnership that would enable you to contribute more to suicide prevention in Sandwell?
    [Open text]

14. What would you say are the main strengths of Sandwell's Suicide Prevention Partnership?
[Open text]

15. What would you say are the main limitations of Sandwell's Suicide Prevention Partnership?
[Open text]

16. Do you think any additional members should be represented in Sandwell's Suicide Prevention Partnership?
    - Yes
    - No
    - Don't know

    14.1 If yes, who?
    [Open text]

17. In your opinion, how could Sandwell's Suicide Prevention Partnership be improved?
[Open text]

Section 5. Further information

1. As part of the interim evaluation of the Sandwell Suicide Prevention Strategy, we plan to conduct interviews with members of the Suicide Prevention Partnership. These will be conducted either online or face-to-face and are expected to take approximately 45 minutes. Interviews will be conducted as an informal, semi-structured conversation where you will be asked about your views on suicide prevention in Sandwell, with a particular focus on the current Suicide Prevention Strategy. Your opinions and experience will provide valuable insight and contribute towards a better understanding of how to improve suicide prevention in Sandwell.
Would you be willing to take part in a one-to-one interview?
    - Yes
    - No

If you have replied yes, we will be getting in touch to arrange a date and time for an interview.

Appendix 2- Interview topic guide

Sandwell Suicide Prevention Partnership - Interview topic guide

The aim of the interview is to gain a better understanding of the views and experiences of members of the Sandwell Suicide Prevention Partnership with regards to the suicide prevention strategy and the partnership itself. Interviewees will also be asked about their opinions on how these could be improved.

Data collected from these interviews will be used to inform the interim evaluation of the Suicide Prevention Strategy for Sandwell.

Section 1. Interviewee details

1. What is your job title and role within your organisation/group?

Section2. Suicide prevention

2. What is your role in working toward suicide prevention (and bereavement support) in Sandwell?

   Prompts:

   a. How long have you been working in this area?
   b. Could you give examples of what this might look like on a regular day/week/month?

3. What do you think of current services and support focusing on suicide prevention in Sandwell?

   Prompts:
   a. Which do you know?
   b. Would you say they adequately meet the needs of the population?
   c. Are there any gaps in service/support provision?
   d. What do you believe your service does well with regards to suicide prevention?

4. What do you think is happening to suicide rates in Sandwell and why?

   Prompts

   a. Over the last years, the rate of suicides in Sandwell have been higher than in rates for England. Why do you think this might be?
   b. What aspects of Sandwell make suicide prevention particularly challenging?
   c. How have events from recent years (cost of living crisis, international conflict, Covid) have brought about changes in this area?

Section 3. Sandwell suicide prevention strategy

5. How familiar are you with the Sandwell suicide prevention strategy?

   Prompts:
   a. How well do you know it?
   b. Where would you go to find information about it?

6. What is your opinion on the SP strategy?

   Prompts:
   a. To what extent do you think it is fit for purpose?
   b. Is it broad enough? Too broad?
   c. What areas may have been missed out?
   d. How likely is it to meet its objectives?
   e. How well does it align with the national SP strategy?

7. What would you say are the strengths of the strategy?

   Prompts:
   a. Well researched, locally appropriate, comprehensive, carries authority

8. What would you say are its limitations?

   Prompts:

   a. Not well researched, locally appropriate, comprehensive, carries authority

9. Could you provide your opinion on the action plan of the Suicide Prevention Strategy?
   a. How well acquainted with the action plan tracker are you?
   b. How well does it fulfil its purpose?
   c. How could it be improved?
   d. What do you think would be the best way of keeping it updated?

10. How could the strategy be improved?

Section 4. Suicide prevention partnership

11. What do you see as being the role of a suicide prevention partnership?
    a. What should its focus be?
    b. Who should be part of it?

12. Could you describe your experience of being part of the Sandwell suicide prevention partnership?

  a. How active are you?
  b. How long have you been a member?
  c. Are you able to contribute as much as you would like to?
  d. What impression do you have of its functioning?

13. What would you say are its strengths?
    a. Leadership, buy-in from partners, reach, capacity to bring change, etc.
    b. Could you give examples of ways in which you believe it has achieved meaningful results?

14. What would you say are its limitations?
    a. Lack of leadership, buy-in from partners, reach, capacity to bring change, etc.
    b. Could you give examples of ways in which you feel it is not functioning as it should?

15. In your opinion, what changes would need to happen in order to make the partnership more effective?
    a. Who would need to be responsible for making these changes happen?
    b. How would you go about bringing those changes?
    c. Are you aware of previous attempts to make these changes?

16. Do you have any additional comments/insights?