Sandwell
Metropolitan Borough Council

SANDWELL BETTER MENTAL HEALTH
Better mental health for all

Sandwell Suicide Prevention Needs Assessment

July 2026

Acknowledgements

Thanks go to the multi-agency Sandwell Suicide Prevention Partnership who have willingly provided their support, guidance and expertise to support the work of the Sandwell Suicide Prevention Strategy 2022-2025 and informed this needs assessment.

Thank you to the individuals who took part in the stakeholder event in December 2025, sharing their insights and expertise to inform the development of this strategy.

Finally, a special thanks go to those individuals who have kindly shared their lived experience allowing our continued learning to deliver our actions and inform our future commitments to reduce the rates of suicide and support those affected by suicide in Sandwell.

This poem underpins our Men's Mental Campaign – 'You ok, mate?' delivered as part of our current Sandwell Suicide Prevention Strategy 2022-2025 to offer opportunities to connect more, talk about suicide and offer hope. A video from the campaign can be watched here.

'You mean more than you know'

If you're reading this
And feeling low
Always remember
You matter way more than you know

Tell your friends you love them
Let them know you care
Make it easy to talk
And let them know that you're there

Man up, don't be a wuss
Words of days gone by
Embrace the chaos of life
Know that real men DO cry

Behind every hard hat,
Every uniform, every high-vis, every suit
There's a man with a story
Strong yet mute

Progress isn't always noisy or fast
One step at a time
Tough times don't last

Restart reset refocus
Give yourself a break
But never underestimate the difference you make

Lads, don't struggle alone
Send that text
Make that call
Just pick up the phone

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Definitions, Abbreviations and Language

BCHFT: Black Country Healthcare NHS Foundation Trust

Child and Adolescent Mental Health Services (CAMHS): NHS-funded services that assess and treat children and young people who are struggling with poor mental health.

Child Death Reviews (CDR) are a mandatory, multi-agency process for reviewing the death of every child under the age of 18. Conducted by professionals to understand causes and improve child safety, they aim to prevent future deaths and support bereaved families through a formal, structured review.

Cluster: A cluster is a group of deaths, suicide-related activity or self-harm that are linked in some way by time, death, method, location, geography or demography.

Cluster Response Group: A cluster response group is a group of professionals with a clear practical role in a suicide cluster response which is active during a confirmed cluster in a local community.

Co-Occurring Substance Use and Mental Health: when people experience substance addiction and mental health conditions at the same time (also known as dual diagnosis).

Domestic Abuse Related Death Reviews (DARDR) (formally known as Domestic Abuse Homicide Reviews) are a mandatory, multi-agency review when a person aged 16 or over dies due to abuse, violence or neglect by a relative, intimate partner or member of the same household. Facilitated by Community Safety Partnerships a DARDR establishes what lessons can be learnt and make recommendations in response to those lessons.

Intersectionality means that a person can face more than one type of disadvantage or discrimination at the same time, and these can combine to make things harder for them.

LGBTQ+ is an abbreviation for lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual and more. The terms are used to describe a persons' sexual orientation and gender identity.

Lived Experience in mental health and suicide refers to the personal, firsthand understanding gained by individuals who have navigated mental health challenges, suicidal thoughts, attempts, or bereavement. It offers "expert knowledge" that informs better care, improved support and policy.

Near to Real Time Suicide Surveillance System (nRTSSS) is a national system operated by the Office for Health Improvement and Disparities (OHID) which collects quarterly data of suspected suicides from police forces. The primary purpose of the nRTSSS is to provide suicide prevention planners with an early indication of changes

in trends of suicide to inform and enable a more timely and targeted response. However, the suspected suicide rates data is only available at a national level.

NHS Talking Therapies (formerly known as Improving Access to Psychological Therapies, IAPT) is a mental health service for people aged 16 years and over experiencing common mental health problems such as low mood, depression, anxiety and stress.

NICE: The National Institute for Health and Care Excellence provide national guidance and advice for the NHS and wider health and care system.

Patient Suicide: a death by suicide of a person who had been in contact with mental health services in the 12 months before their death, but excluding the NHS Talking Therapies programme and other primary care-based mental health services.

Postvention Support refers to the support provided to individuals and communities after someone dies by suicide. It is a form of "prevention" that aims to support the bereaved—family, friends or colleagues—manage their loss, prevent further suicides, and mitigate the long-term impact of trauma.

RSHE: Relationship, Sex and Health Education. Delivered in both primary and secondary schools as part of the statutory curriculum.

Self-Harm: Causing intentional harm to ones' body – often a way of coping with or expressing overwhelming emotional distress.

SMI (Severe Mental Illness) refers to people who have received a diagnosis of schizophrenia, bipolar disorder or other psychosis. These psychological problems are often so serious they make it very hard for a person to carry out everyday tasks—like working, socialising, or taking care of themselves.

Statistically Significant means a result or difference in data is highly unlikely to have happened randomly. It is a way for data analysts to prove that a pattern or effect is real.

If a result is *not* statistically significant, it means that the result is likely to have occurred random as opposed to being a meaningful pattern or effect.

Suicide: Suicide is the act of intentionally taking one's own life. People can have thoughts about wanting to die (suicidal ideation), can have plans to die (suicide intent) or have attempted suicide (non-fatal).

Suicide Rate: the number of suicides per 100,000 population, adjusted to consider variations in populations (groups of people) such as age, gender, number of people receiving a service, etc.

Suicide Prevention refers to the collective efforts to reduce the risk of suicidal behaviour, manage crises and prevent deaths by suicide through education, crisis

intervention and increased access to care whilst also strengthening protective factors that promote resilience. Prevention efforts can occur at all levels: individual, immediate relationships, community or society as a whole.

Introduction

This needs assessment draws upon the successes of our Sandwell's Suicide Prevention Strategy 2022-2025 to inform a refreshed Strategy covering 2026 – 2031. The achievements delivered over the last 3 years has been testament to the commitment and determination of partners and communities to raise awareness of suicide prevention within Sandwell.

However, there is more to be done. The rates of suicide in Sandwell reflect the national picture remaining stable over the last two decades. However, while the current suicide rate is not significantly higher than 20 years ago, the rate is not falling. This needs assessment will highlight successes and identify needs, gaps and opportunities to strengthen system-wide suicide prevention activities.

This needs assessment has been developed by the Public Health Team in collaboration with the Sandwell Suicide Prevention Partnership, Sandwell Better Mental Health Partnership and other partner organisations. National, regional and local data, information and published research have also supported its development.

Why suicide prevention is important

When someone takes their own life, the impact on families, friends and the local community is devasting. As well as the immense pain and grief caused to loved ones, the effects of suicide are often felt in the wider community. For every death by suicide, it is estimated that 135 people are affected to the point where they would benefit from a supportive conversation with a mental health professional[1]. Each suicide is a tragedy and one that can have long-lasting effects on all involved.

Suicide is a complex issue for society and is a leading cause of premature death. Deaths by suicide rarely have a single cause. There is often a gradual and increasing build-up of vulnerability linked to a complex and interrelated set of factors including psychological, social, cultural, biological and environmental factors. There are some groups that are also disproportionality impacted by these contributing factors, and so there is a need to address these inequalities.

Suicide continues to be met with silence and stigma. Attitudes, understanding and media coverage are still barriers to providing care and support to individuals in crisis and to those who have lost a loved one to suicide. Acting early to help people during times of crisis and despair can save lives.

This starts in our communities, changing our society and culture so that we can have open and respectful conversations, better understand people's needs and work together to tackle the underlying factors that can lead someone to take their own life. Although no

single initiative or organisation can prevent suicides alone, there are many ways in which services, communities, individuals and society can work together to prevent suicides.

The actions that we take to prevent suicide will contribute to improving the mental health and wellbeing of our residents overall, and reducing health inequalities, building stronger more resilient communities.

Every death by suicide is a death that could be prevented. Our local suicide prevention work demonstrates our commitment to the zero-suicide ambition in Sandwell and to supporting the vision that every resident has the opportunity to lead a healthy and fulfilling life.

Our Key Principles

Local suicide prevention activity will align with the Joint Sandwell Health & Wellbeing Board principles:

- Keeping prevention at the heart of what we do
- Narrowing health inequalities in all that we do
- Strengthening partnership between public, private, and voluntary organisations
- Working in partnership with local people, empowering them and their communities
- Basing our work on evidence of what we know works or is likely to work locally
- Being clear strategically and translating that clarity into accountable action

The importance of language

It is important to reduce the stigma associated with suicide so that everyone feels confident talking about suicide in Sandwell. To do this, we should use appropriate, anti-stigmatising and compassionate language. The table below is a useful guide:

Don't say	Do say	Why
'Committed suicide' or 'Commit suicide'	'Died by suicide' or 'Took their own life' or 'Lost their life to suicide'	To avoid the association between suicide and 'crime' or 'sin' that may alienate people. It has not been a crime in England since 1961. Using neutral phrasing like 'died by suicide' helps remove shame or blame.
'Successful suicide attempt' or 'Completed suicide'	'Took their own life' or 'Died by suicide' or 'Ended their own life'	Talking about suicide in terms of success is not helpful. If a person survives, this language reinforces the feeling of failure. If a person dies by suicide, it cannot ever be a success or an achievement.

‘Failed suicide attempt’ or ‘Unsuccessful suicide attempt’	‘Attempted suicide’ or ‘Suicide attempt’ or ‘Survived a suicide attempt’ or ‘Non-fatal suicide attempt’	Saying 'failed' or 'unsuccessful' is inappropriate because it implies that the opposite would be a positive outcome.
‘You aren’t going to do something silly are you?’ or ‘Are you thinking of ending it all?’ or ‘You’re not going to top yourself, are you?’	‘Are you having thoughts of suicide?’ or ‘Are you feeling suicidal?’ or ‘Have you been thinking about killing yourself?’	You want to use a phrase that does not dismiss or make fun of how a person is feeling as this can make it harder for them to feel safe, understood or able to open up. It's important to be direct. Using the word suicide shows others that you are ok with them talking about suicidal feelings and that you are there to listen.
‘Suicide epidemic’	‘Concerning rates of suicide’	To avoid sensationalism and inaccuracy

Source: Adapted from Zero Suicide Alliance[2] and Shining a Light on Suicide[3]

Background

National Policy Drivers

The Department of Health and Social Care's National Strategy: Suicide prevention in England: 5-year cross-sector strategy 2023-2028[4] aims to:

- reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner
- improve support for people who have self-harmed
- improve support for people bereaved by suicide

It identifies the following priority areas for action to achieve these aims:

- improve data and evidence to ensure that effective, evidence-informed and timely interventions continue to be adapted
- provide tailored, targeted support to priority groups, including those at higher risk. Nationally, these have been identified as:
    - children and young people
    - middle-aged men
    - people who have self-harmed
    - people in contact with mental health services
    - people in contact with the justice system
    - autistic people
    - pregnant women and new mothers
- address common risk factors linked to suicide at a population level by providing early intervention and tailored support. These are:
    - physical illness
    - financial difficulty and economic adversity
    - gambling
    - alcohol and drug misuse
    - social isolation and loneliness
    - domestic abuse
- promote online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm
- provide effective crisis support across sectors for those who reach crisis point
- reduce access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides
- provide effective bereavement support to those affected by suicide

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

Other drivers for suicide and self-harm prevention can be found in Appendix 1. These include several other drivers and strategies relating to specific priority groups and topic areas.

Local Policy Drivers

Sandwell Better Mental Health Strategy 2024 - 2029

A local suicide prevention strategy will be intrinsically linked to the Sandwell Better Mental Health Strategy. Better mental health for all contributes to preventing suicide and our zero-suicide ambition. The Sandwell Better Mental Health Strategy will achieve this by working collaboratively across the Council, NHS and partner organisations, including the voluntary and community sector, to deliver the following strategic objectives:

- Supporting people to feel good and function well across the life course
- Recognising the community assets that help promote resilience and wellbeing in individuals, families, and communities
- Ensuring that people experiencing mental health problems receive the right care at the right time in the right place
- Reducing inequalities in mental health and wellbeing and access to care and support
- Improving people's experiences of mental health services and the care they receive
- Taking a person-centred approach to mental health promotion, mental illness prevention and recovery

Black Country Suicide Prevention Strategy 2026 - 2030

The Black Country Suicide Prevention Strategy 2026 – 2030 developed by Black Country Healthcare Foundation Trust in collaboration with partners and lived experience voice has identified three pillars for preventative action:

Pillar 1: Surveillance, Insight and Real-Time Intelligence

High impact actions:

1). Strengthen our surveillance processes by embedding a Near Real Time Suicide Surveillance System (nRTSSS)

2). Improve the quality and consistency of data collection across all partners, including protected characteristics and wider psychosocial risk factors.

3). Undertake an annual multi-agency audit and thematic review to identify high-risk groups, locations, methods and gaps in support. This will inform targeted intervention and annual priorities.

Pillar 2. Training, Awareness and Community Capacity

High impact actions:

4). Roll out NHSE Staying Safe from Suicide training for all health and care staff across the system. Break into internal & external partners.

5). Develop tailored resources for front-line services, including primary care, urgent care, ambulance, police, local authority teams, education, employers and voluntary sector partners. Resources should align to local health literacy levels and be adaptable for citizens with learning disabilities and from diverse backgrounds.

6). Embed a network of trained community champions who can deliver awareness and signposting sessions, with a particular focus on high-risk communities.

Pillar 3. Collaboration, Access and Person-Centred Support

7). Promote a no-wrong-door approach through integrated neighbourhood teams so that people at risk of suicide or self-harm can access the right support at the right time.

8). Strengthen postvention arrangements, including rapid support after suspected suicide and support for families, carers, staff and communities through the Suicide Bereavement Support Service.

9). Promote a consistent approach based on formulation and safety planning with supportive follow-up across services and places. Spilt into INTs and BCHFT actions.

10). Develop a shared approach to workforce support across multi-agency wellbeing offers including strengthening the offer for VCFSE providers and students.

These pillars and subsequent 10 high impact system actions will complement local strategies and activity in each of the four Black Country local authority areas to ensure a system-wide approach to suicide prevention.

Other local strategies and insight that will influence a refreshed suicide prevention strategy, and will continue to do so throughout its delivery, include:

- Sandwell Joint Health and Wellbeing Strategy (2026-2031)
- Sandwell Drug & Alcohol Strategy (2022-2032)
- Sandwell Domestic Abuse Strategy (2025-2028)
- Sandwell Council Plan (2024-2027)
- Sandwell End of Life Care Strategy (2021-2026)
- Sandwell Joint Autism Strategy (2023-2026)

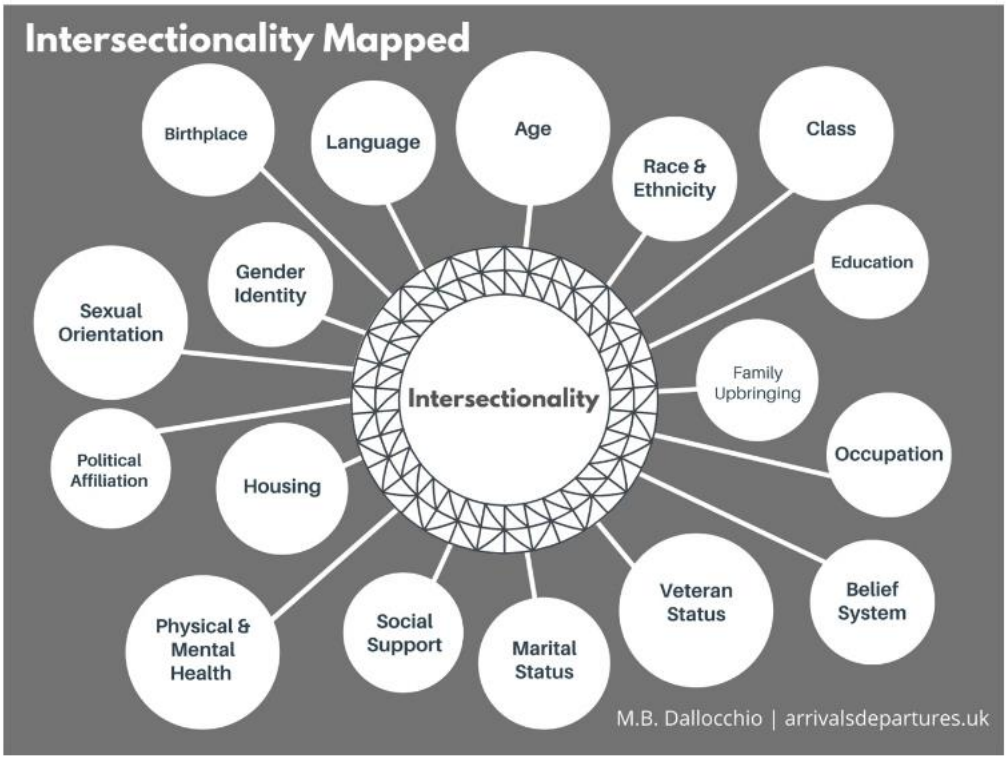
- Sandwell Homelessness Health Needs Assessment (2025)
- Sandwell Migrant Health Needs Assessment (2025)
- Emerging and evolving Birmingham, Black Country & Solihull ICB Neighbourhood Health plans.
- Black Country All-Age Autism Framework

Health Inequalities & Intersectionality

Suicide is a complex public health issue influenced by a wide range of social, economic and environmental factors. Evidence consistently shows that suicide risk is not evenly distributed across the population; instead, it is shaped by health inequalities such as deprivation, unemployment, housing instability, access to services and experiences of discrimination or social exclusion[4, 5]. People living in more deprived communities experience higher suicide rates than those in more affluent areas, demonstrating the strong relationship between socioeconomic circumstances and suicide risk[6]. Addressing suicide therefore requires action that goes beyond clinical treatment and recognises the wider determinants of health.

An intersectional perspective is also important in understanding suicide risk. Intersectionality recognises that individuals may experience multiple, overlapping forms of disadvantage or discrimination that can compound vulnerability as shown in Figure 2[7]. For example, a person's risk of suicide may be influenced simultaneously by factors such as gender, ethnicity, age, disability, sexuality and socioeconomic status. These intersecting identities and experiences can shape both exposure to risk factors and access to support[8, 4]. Taking an intersectional approach helps ensure that suicide prevention strategies are inclusive, culturally competent and responsive to the needs of diverse communities, particularly those who may face barriers to accessing services.

Figure 2: Intersectionality Mapped



A public health approach is widely recognised as the most effective framework for suicide prevention. This approach focuses on preventing suicide across the whole population while also targeting interventions for groups at higher risk[4, 9]. It involves:

- using data and evidence to understand patterns of risk
- addressing underlying determinants such as poverty, substance misuse, domestic abuse and social isolation
- strengthening protective factors including social connection, resilience and access to timely support.
- partnership working across sectors—including health services, local authorities, education, community, voluntary and faith sector—to create coordinated systems of prevention.

By addressing health inequalities, recognising intersecting vulnerabilities and applying a public health framework, this strategy can move beyond responding to crisis and focus on earlier intervention, reducing risk factors, strengthening protective factors and creating supportive environments that promote mental wellbeing for all. This approach is essential to achieving sustained reductions in suicide and ensuring that prevention efforts reach those who need them most.

Our Successes and Learning So Far

In our 2022-2025 Suicide Prevention Strategy, we set out our key objectives and recommendations for action in Sandwell. It is important to acknowledge the achievements delivered through this strategy and the journey we have taken so far to prevent suicide in Sandwell. The below highlights some of these key achievements:

Recommendation:

Raise awareness of suicide prevention and bereavement support through training for all frontline Council staff

Key Achievement: Workforce Training

Over the last two years, we have trained **868** members of staff/volunteers across Sandwell in suicide prevention training and **141** through the specific programme linking suicide prevention and domestic abuse.



Recommendation:

Improve data collection and intelligence gathering

Key Achievement: Partnership & Collaboration

There is real strength in the partnership and collaboration that has taken place as the result of the current strategy. The multi-agency relationships that have been developed over the last 3 years has improved information sharing. For example, established relationships with British Transport Police, Highways England and Network Rail have enabled us to respond to high frequency locations, bring in external funding and develop community-based interventions to support suicide prevention.

The partnership working has also enabled a sense of shared responsibility. For example, through learning from these Domestic Abuse Related Death Reviews we have jointly funded training linking domestic abuse and suicide prevention with the domestic abuse team.

Recommendation:

Pilot town-based, community led forums

Key Achievement: Tipton Projects

Using our local intelligence of high frequency locations, we have established a multi-agency stakeholder group in Tipton to initiate suicide prevention interventions.

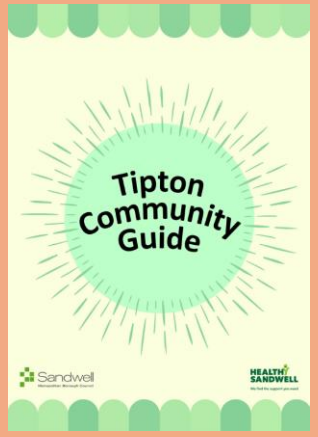




These included:

- The Adopt a Railway Stations projects at Tipton and Dudley Port railway stations. These projects saw local community groups and schools produce artwork to improve the overall station environment.

- The development of the Tipton Guide which is a signposting resource for staff, volunteers and residents to access support at the earliest opportunity to prevent suicidal crises.



Recommendation:

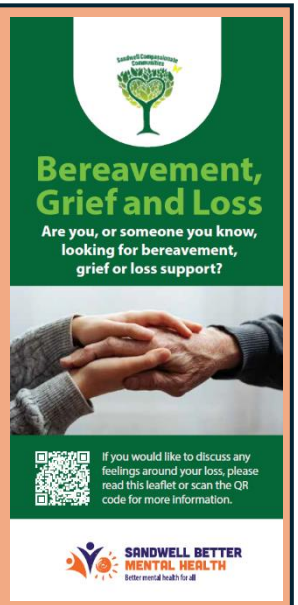
Expand awareness and access of bereavement support to all First Responders and bereavement-related partners so that an offer of support can be made immediately

Key Achievement: Bereavement Support Leaflet

We have developed a bereavement support leaflet showcasing the available support locally and nationally to ensure that people who have been bereaved can access support when needed.

This is available in the five mostly spoken languages in Sandwell: English, Bengali, Polish, Punjabi and Urdu. It is also available in large print. This is available electronically and in paper format. This has been shared widely with frontline workers to ensure it reaches those who have been bereaved.

We completed a Compassionate Communities Training Programme with Compassionate Communities UK for 35 representatives from statutory and community voluntary organisations. These partners now regularly contribute to the Sandwell Compassionate Communities Network and deliver the associated Action Plan.



Recommendation:

Identify and prioritise high-risk populations through working groups

Key Achievement: Domestic Abuse

Being data-led, we have strengthened collaboration between domestic abuse and suicide prevention in several ways:

- Using learning from Domestic Abuse-Related Death Reviews (previously called Domestic Homicide Reviews) to inform suicide prevention interventions.
- Public Health Suicide Prevention Lead contributing member of Domestic Abuse-Related Death Reviews when suicide prevention is mentioned.
- Suicide Prevention Strategy and Domestic Abuse Strategy interlinked.
- Jointly commissioned suicide prevention training for those who support domestic abuse victims.
- A multi-agency Domestic Abuse Forum established to focus on Suicide Prevention with 95 attendees.

Recommendation:

Identify and prioritise high-risk populations through working groups

Key Achievement: You Ok Mate?!

By being data-led, we identified a need to provide targeted suicide prevention and mental health interventions for men in Sandwell. We have facilitated two key projects:



Marketing Campaign:

Our men's mental health campaign ('You ok, mate') builds on behavioural science and real, local voices to deliver a bold ambition to change social norms around speaking up on men's mental health. Our innovative campaign centres on 45 black and white portraits of Sandwell men, with Sandwell voices giving powerful messages, rooted in lived experience. Vibrant partnership, including West Brom FC, has made our reach and Impact unprecedented: over 2 million views; 450,000 video views; and increased help-seeking. Data from NHS 111 shows a 29% increase in men calling the service across the first three months of the campaign, compared with the same period last year. This inspirational campaign continues, engagement is rising, and men in Sandwell are, increasingly asking each other, 'You ok, mate?'.

The campaign is proud to be the winner for 'Campaign of the Year' in the LGC Awards 2026.

Community Programme:

We have commissioned the You Ok Mate Community Programme which will provide:

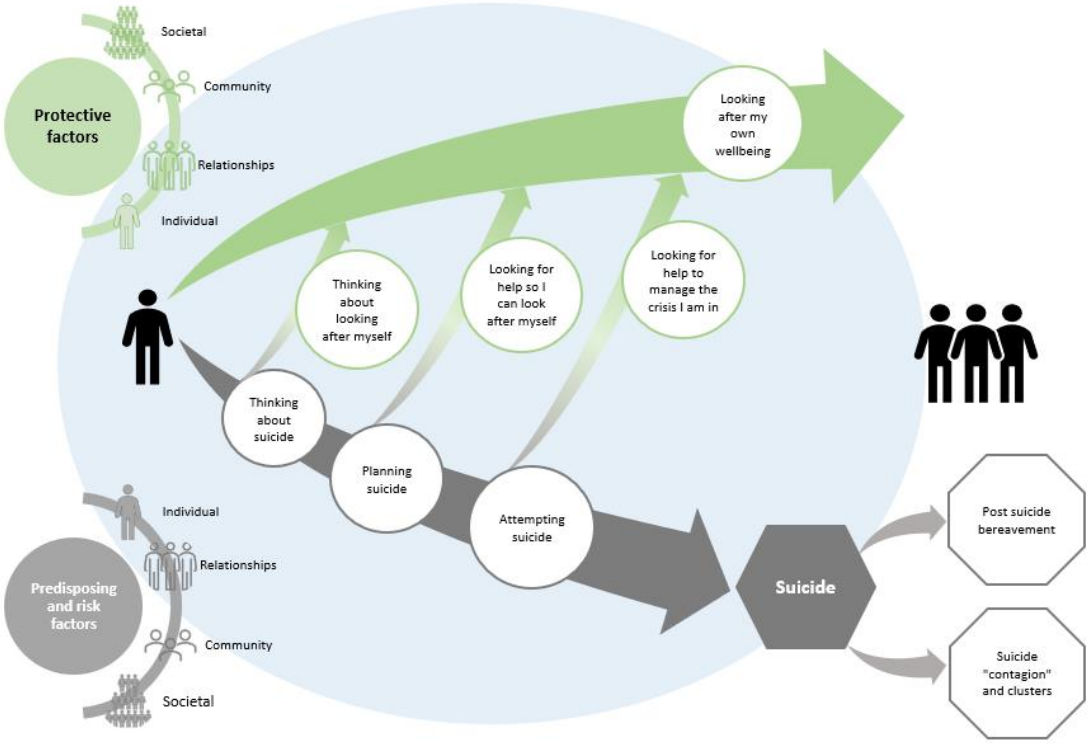
- **Awareness and Accessibility**- advice, information and resources, training, activities and sign posting, that help men improve mental wellbeing, seek support earlier and reducing crisis interventions.
- **Behaviours and Identity** – Provision of information/education sessions that tackle the cultural, religious and social perceptions of the role of men, tackling the stigma of mental health by changing the narrative and get men talking about mental wellbeing.
- **Community and Connecting -** community activities encompassing mental health & wellbeing in trusted locally based organisations, including physical activity, hobbies and the 5 ways to wellbeing. This offer will be inclusive and offer accessible provision to meet cultural, social and language appropriate, with varying activities and times using best practice models.

Interim Evaluation of the Strategy 2022-2025

To build on the good practice and achievements of the previous strategy, in 2024 we carried out an Interim Evaluation of the Sandwell Suicide Prevention Strategy and Action Plan 2022-2025. This evaluation set out to assess the progress of the Strategy and delivery of the Action Plan, examining the success and impact of its implementation. It identified that 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 model below was developed throughout the process of the evaluation to show 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. The refreshed strategy should focus upon a person-centred approach and journey of change as shown in the diagram below.

Figure 1: Model of Suicide Prevention



The recommendations of the evaluation should inform the development of the refreshed suicide prevention strategy:

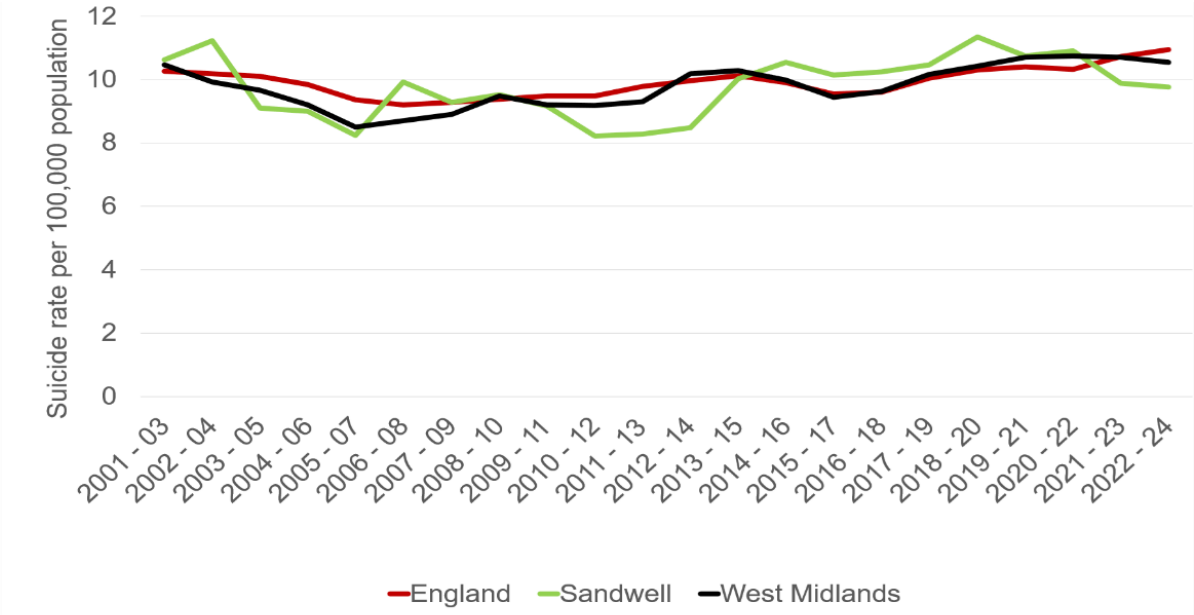
- **Restructure the Partnership:** Establish operational and overview groups within the partnership, assign specific tasks to individuals, and enhance senior representation to ensure effective collaboration and strategic progress.
- **Refresh the Action Plan:** Streamline the action plan to focus on key objectives, ensuring alignment with strategic goals and phased implementation to maintain clarity and momentum.
- **Strengthen primary care links:** Build relationships with primary care representatives to integrate healthcare and community support more effectively, leveraging senior partnership members' influence.
- **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.
- **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.
- **Cultural appropriateness:** Investigate and enhance culturally appropriate engagement and support mechanisms to address the diverse needs of Sandwell's population.
- **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.

National and local suicide data

Suicide Rates

The suicide rate in Sandwell has been relatively stable for the last two decades. During that time, the rate per 100,000 population has ranged between 8.2 and 11.4 as shown in Figure 2 below. These fluctuations were not statistically significant.

Figure 2: Suicide rate per 100,000 population 2001/2003–2022/2024



Source: Office for Health Improvement and Disparities

Figure 3 shows Sandwell's suicide rate for 22 years with confidence intervals (the red bars), and these overlap throughout the period. The suicide rate is an estimate of suicides per head of population, and the confidence intervals show the range within which the 'true' rate is likely to fall. They indicate the level of uncertainty around each annual estimate. Because the confidence intervals overlap, the true values for each year could fall within a similar range. This suggests that the year-to-year changes are likely due to normal random variation rather than a real increase or decrease in the underlying rate.

Sandwell's suicide rate has been broadly in line with both England and West Midlands rates. Differences between Sandwell and the national rates were also not statistically significant.

Figure 3: Suicide rate per 100,000 population with confidence intervals

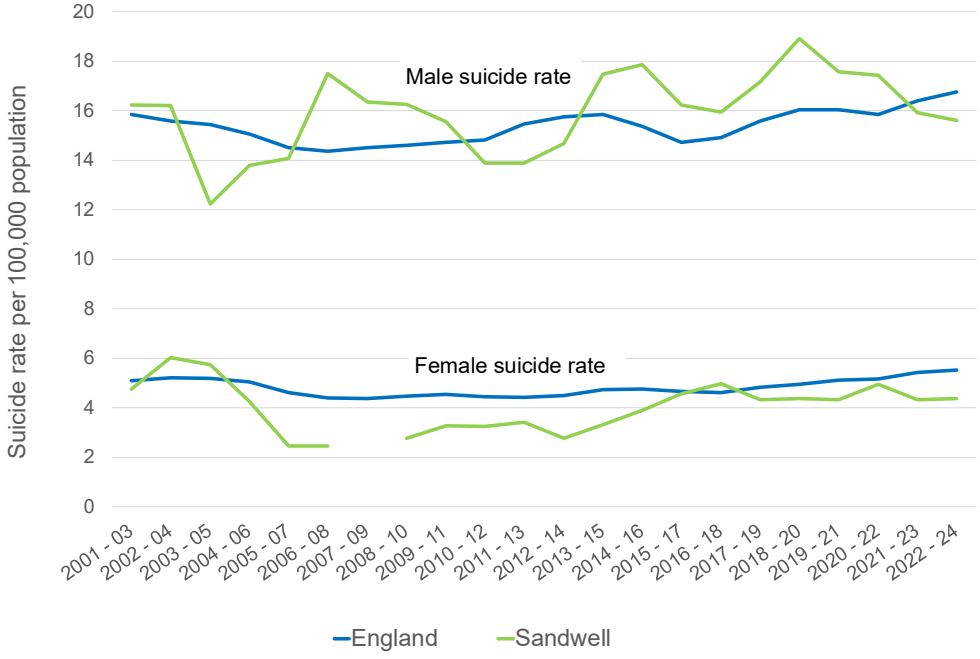


Source: Office for Health Improvement and Disparities

Suicide rates by sex

Male suicide rates were consistently and substantially higher than female rates in both Sandwell and England (Figure 4). Nearly four times as many males died by suicide as females. Sandwell's sex-specific suicide rates were broadly in line with England's trend, although there was more yearly variation in Sandwell due to relatively small numbers of suicides; small changes in the number of cases may lead to large changes in the rate.

Figure 4: Suicide rate by sex per 100,000 population 2001/03–2022/24



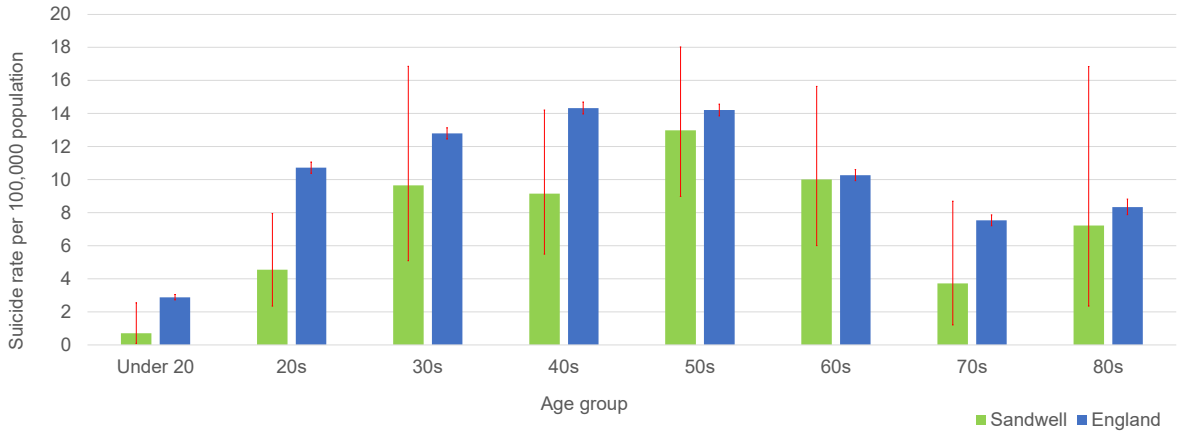
Source: Office for Health Improvement and Disparities

Suicide Rates by Age

In Sandwell, suicide rates for people under 20 and those in their 20s were significantly lower than the rates for England. This is illustrated by non-overlapping confidence intervals (the red bars on the figure below).

Across all other age groups, Sandwell showed lower suicide rates than England; however, the confidence intervals overlapped, meaning these differences were not statistically significant.

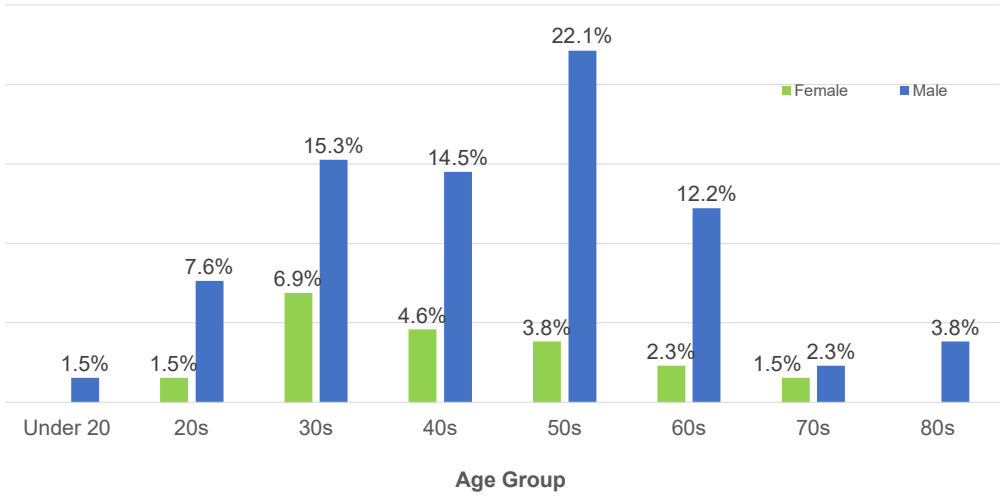
Figure 5: Suicide rate per 100,000 population by age group, 2019–2024. Sandwell and England comparisons with confidence intervals



Black Country Coroner's Data

Based on data extracted from the Black Country Coroner's system between January 2019 and December 2024, 131 Sandwell residents' deaths were certified as suicides. This amounts to an average of 22 deaths by suicide per year. Male deaths were 79% of the total and female deaths accounted for 21%. Figure 6 shows the age group with the highest number of deaths was men in their 50s, followed by men in their 30s and 40s, then men in their 60s. For females, the age group with the highest number of deaths was women in their 30s.

Figure 6: Suicides by sex and age group 2019–2024



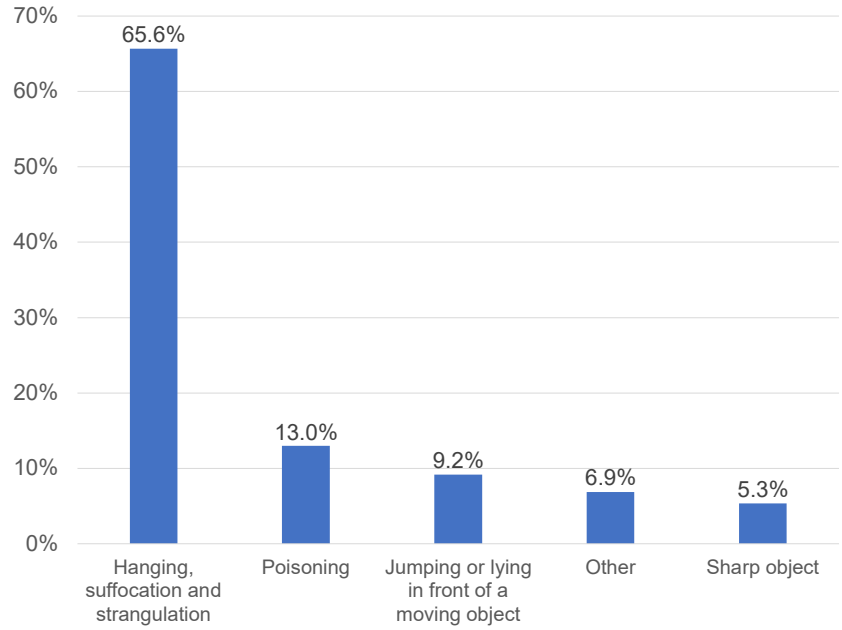
Source: Black Country Coroner's database

Methods of suicide

The most common method of suicide between 2019–2024 was 'Hanging, suffocation and strangulation' (65.6%) followed by 'Poisoning' (13%), 'Jumping or lying in front of a moving object' (9.2%), 'Other' (6.9%), and 'Sharp object' (5.3%) (Figure 7).

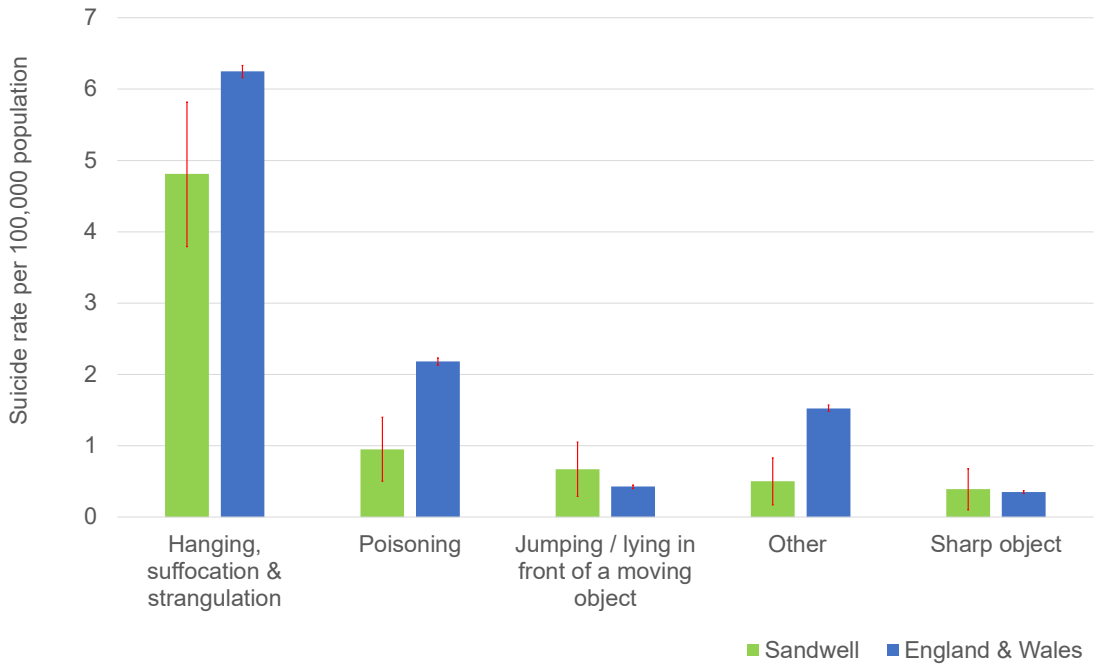
Note: The 'Other' category includes drowning, falling from height, fire or burning, and electrocution.

Figure 7: Suicide methods 2019–2024



Source: Black Country Coroner's database

Figure 8: Suicide rates per 100,000 population by method, 2019–2024. Sandwell and England comparisons with confidence intervals



Source: Black Country Coroner's database

Suicide rates for hanging, suffocation and strangulation were significantly higher in England than in Sandwell, as indicated by the non-overlapping confidence intervals (Figure 8). England also had significantly higher rates of suicide by poisoning. Rates of suicide from jumping or lying in front of a moving object were slightly higher in Sandwell than England, although this difference was not statistically significant. In the 'Other' category (including drowning, falls from height, fire or burning, and electrocution), England had significantly higher rates than Sandwell. Suicide rates involving sharp objects were low in both areas, with no significant differences.

Statistical significance is important because it helps to understand whether differences are meaningful or due to chance, but all suicide methods should still be taken into account when planning prevention.

Locations of suicide

Figure 9 shows that most deaths by suicide in Sandwell between 2019–2024 occurred at home or in private residences (72.5%), followed by 'Other' locations (14.5%), railway locations (7.6%) and parks and woodlands (5.3%). The 'Other' category includes canals, car parks, hotels, bridges, workplaces.

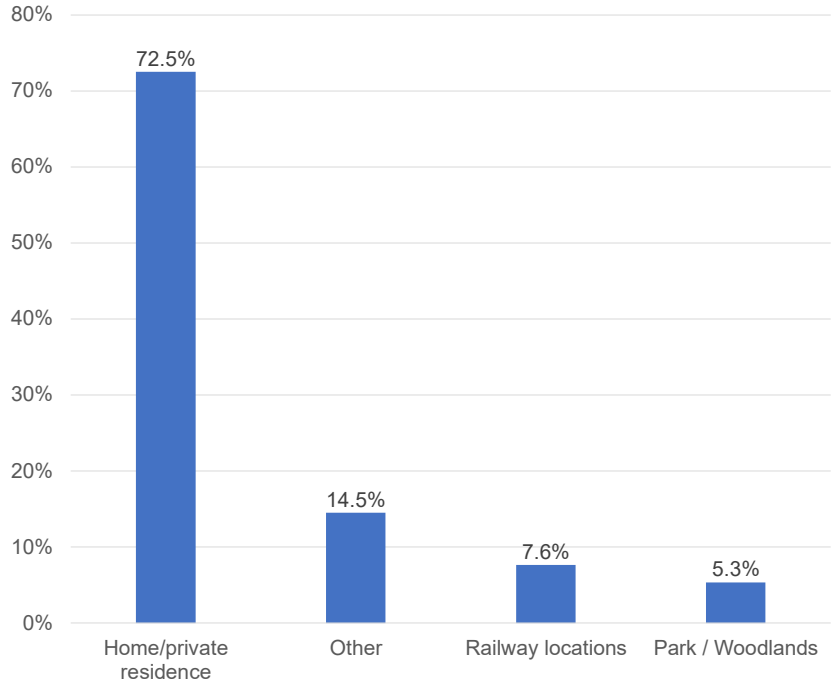
There is no directly comparable national data for the same period. However, near to real-time suspected suicide surveillance (nRTSSS) data for England from July 2024 to September 2025 shows that 65.7% of suicides occurred in a 'private residence', followed

by 8.2% in 'transport' locations, 6.6% in 'open or green space', and 'other' locations accounting for 19.4% (Source: Office for Health Improvement and Disparities, nRTSSS, accessed: 9 March 2026).

Note: Sandwell data covers confirmed suicides (coroner-certified) between 2019–2024. nRTSSS data covers suspected suicides for July 2024–September 2025. Therefore, comparisons are indicative rather than like-for-like.

These patterns align with evidence in The Department of Health and Social Care's 2023 Suicide prevention strategy which states that 'a third of all suicides take place outside the home', which implies that the majority of suicides occur in private residences.

Figure 9: Suicide locations 2019–2024



Source: Black Country Coroner's database

Circumstances and risk factors in Sandwell's suicide cases

Of the 131 cases of death by suicide in Sandwell between 2019–2024:

- 60 were known to mental health services
- 52 had previous suicide attempts or self-harm episodes
- 48 had substance or alcohol misuse issues
- 32 had relationship breakdown or family issues
- 32 were born outside the UK
- 27 had financial issues (e.g. debt or gambling)
- 22 had recent bereavements

- 16 were diagnosed with long-term physical illnesses
- 11 had been involved in the justice system
- Less than 10 cases had mentions of domestic abuse in coroner's case notes
- Less than 10 cases had mentions of the COVID-19 pandemic and lockdown in coroner's case notes

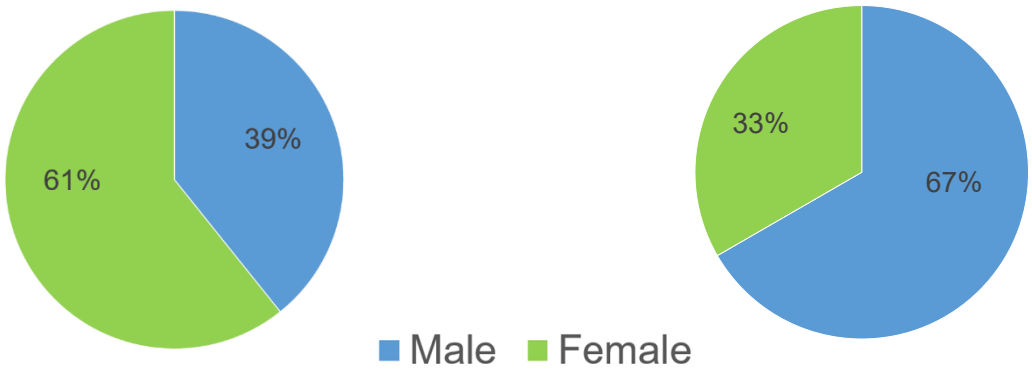
Most people who died by suicide had two or more of the above circumstances or risk factors linked to their death. Only 22 out of 131 cases did not have two or more co-occurring risk factors. The top five co-occurring risk factors were:

1. Known to mental health services and previous suicide attempt: 37 cases
2. History of alcohol or substance misuse and previous suicide attempt: 26 cases
3. Known to mental health services and history of alcohol or substance misuse: 24 cases
4. Known to mental health services and family or relationship issues: 19 cases
5. Family or relationship issues and previous suicide attempt: 17 cases

Self-harm

One of the main risk factors in death by suicide is a history of self-harm. Between 2014/15–2023/24 there were 5,635 emergency hospital admissions for self-harm by Sandwell residents. Female admissions (61%) were significantly higher than male admissions (39%) (Figure 10). However, of the 24 admissions which resulted in death, the proportions were higher for males (67%) than females (33%) (Figure 11).

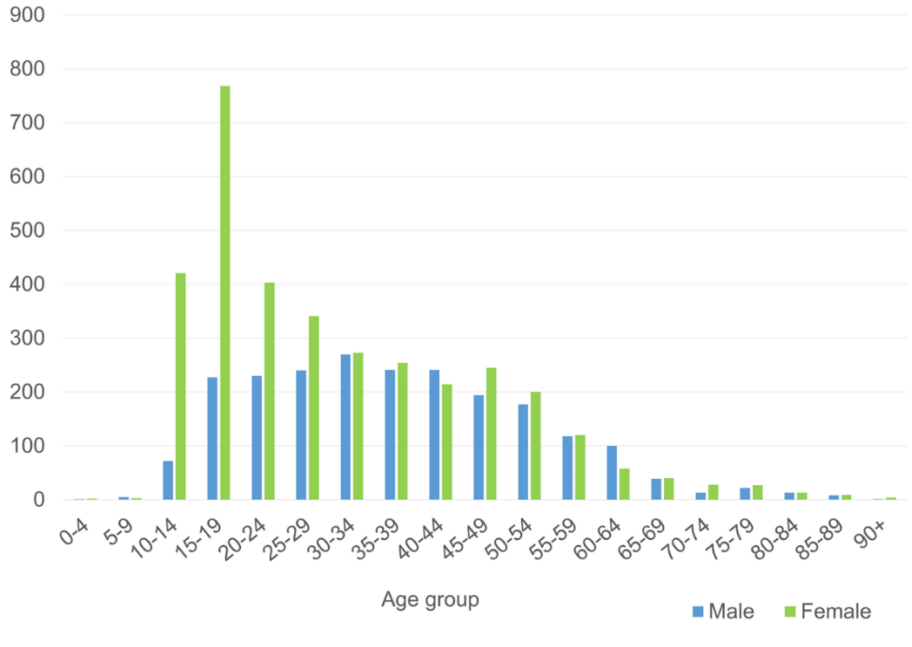
Figure 10: Hospital admissions for self-harm *Figure 11: Admissions resulting in death*



Source: NHS Digital Hospital Episode Statistics

As shown in Figure 12, the age group with the highest number of self-harm admissions was females aged 15-19 years old. Admissions were higher for females in all age groups except for males aged 40-44 years old and males aged 60-64 years old.

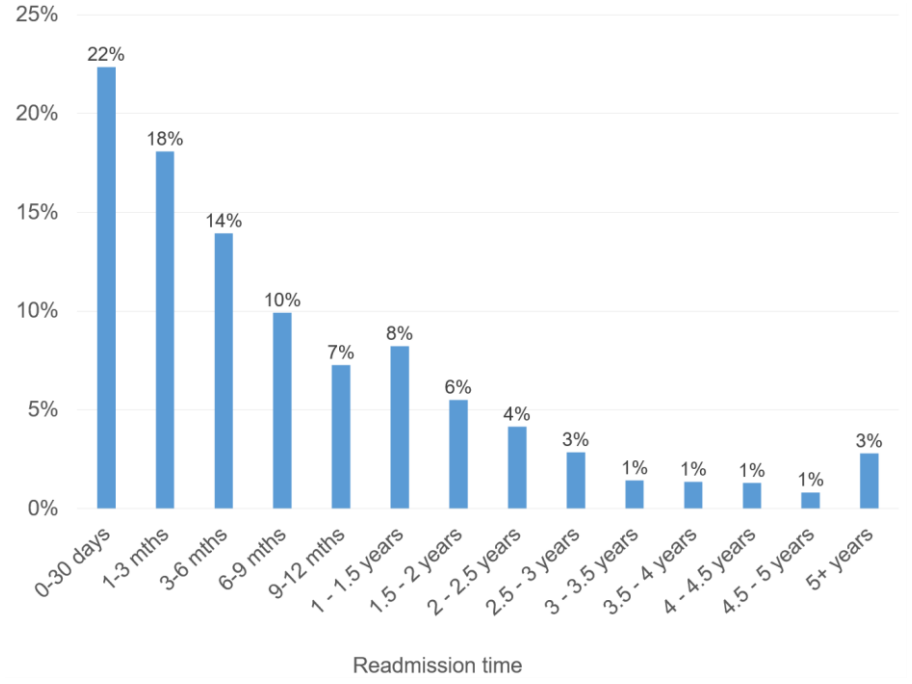
Figure 12: Self-harm hospital admissions by age group and sex



Source: NHS Digital Hospital Episode Statistics

46% of admissions for self-harm between 2014/15 - 2023/24 were readmissions. Most readmissions were within 30 days after the first admission (22%), 72% were within 12 months after the first admission (Figure 13).

Figure 13: Readmission times



Source: NHS Digital Hospital Episode Statistics

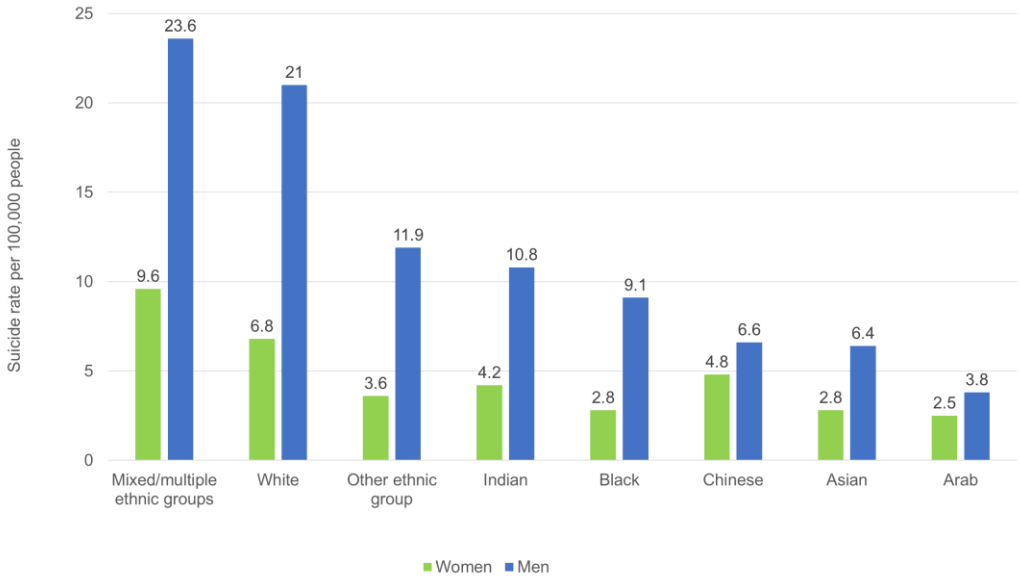
Inequalities: What does the data tell us?

We have drawn on national suicide data to inform this section. Locally, data of this level of detail is not always available and due to the small numbers involved, there is an increased risk of identifying individuals. Using national data helps to ensure that the analysis is both meaningful and proportionate, while ensuring confidentiality and sensitivity.

Ethnicity

Between 2011 and 2021, suicide rates were highest among people from Mixed/Multiple ethnic groups and White ethnic groups in England and Wales (Figure 14).

Figure 14: Suicide rate per 100,000 population by ethnic group in England and Wales, 2011–2021

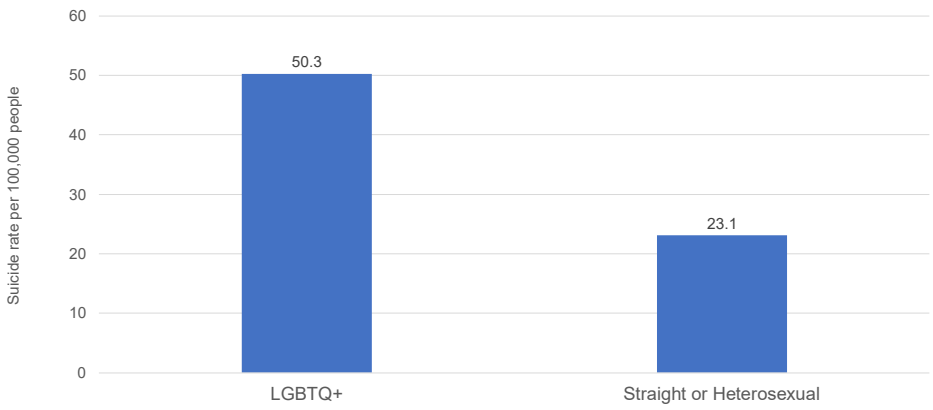


Source: Office for National Statistics (ONS)

Sexual orientation

Between March 2021 and December 2023, the suicide rate among people identifying as LGBTQ+ was 50.3 per 100,000 population, compared with 23.1 per 100,000 among those identifying as straight or heterosexual (Figure 15).

Figure 15: Suicide rate per 100,000 population by sexual orientation in England and Wales March 2021 to December 2023



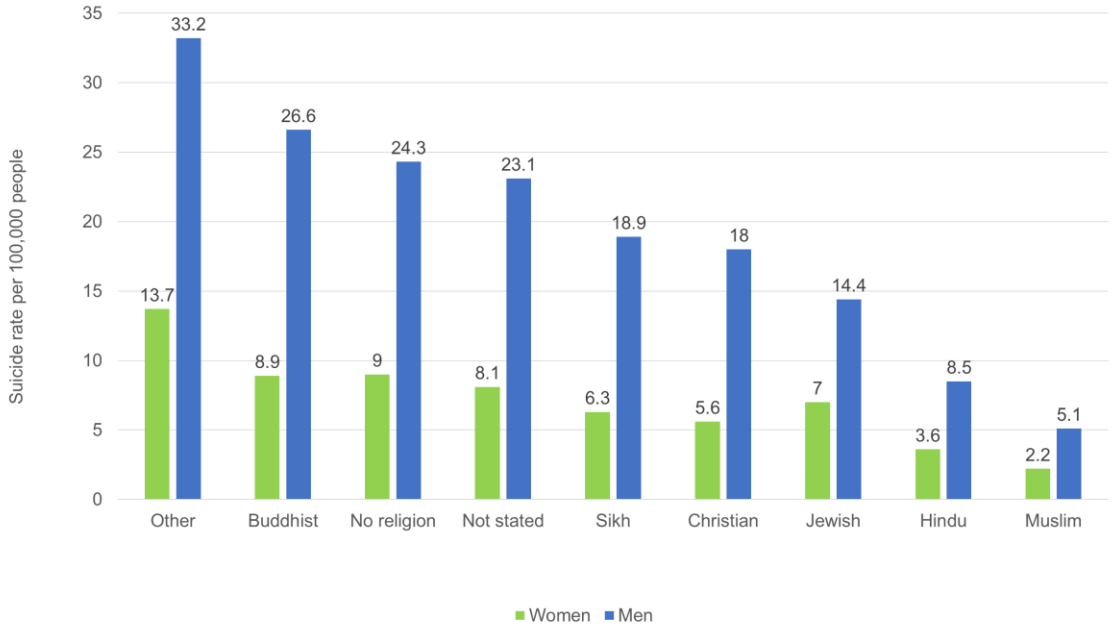
Source: Office for National Statistics (ONS)

Religious affiliation

Between 2011 and 2021, suicide rates were highest among people identifying with 'Other' religions, Buddhism, and no religion. Rates were lower among people identifying as Muslim, Hindu, Jewish, Christian, and Sikh compared with those reporting no religion.

The "Other" religious group included Pagan, Spiritualist, Mixed religion, Jain and Ravidassia.

Figure 16: Suicide rate per 100,000 population by religious affiliation in England and Wales 2011–2021

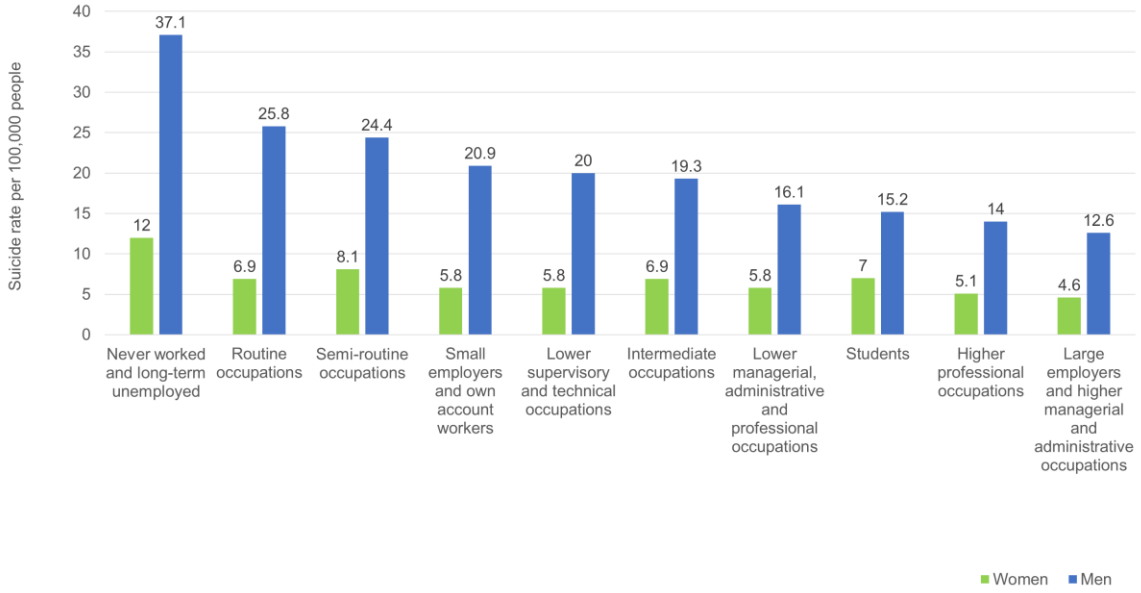


Source: Office for National Statistics (ONS)

Occupation

Between 2011 and 2021, suicide rates were highest among people who had never worked or were long-term unemployed (49.1 per 100,000), followed by those in routine occupations (32.7 per 100,000). Rates were lowest among individuals in higher managerial, administrative, and professional occupations (17.2 per 100,000).

Figure 16: Suicide rate per 100,000 population by occupation in England and Wales 2011–2021

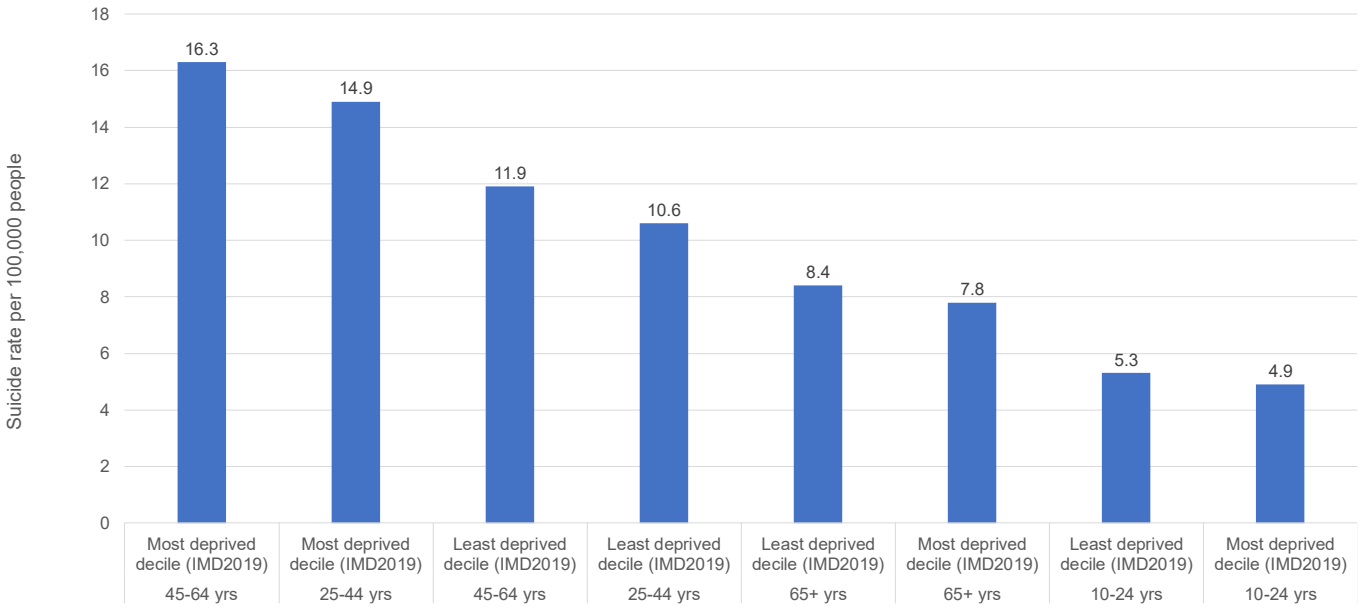


Source: Office for National Statistics (ONS)

Deprivation

Between 2020 and 2024, suicide rates were significantly higher in the most deprived areas, particularly among people aged 25–64. For younger people (10–24) and older adults (65+), differences were smaller, and in these groups the least deprived areas showed slightly higher rates (Figure 17).

Figure 17: Suicide rate per 100,000 population by age and deprivation in England 2020–2024

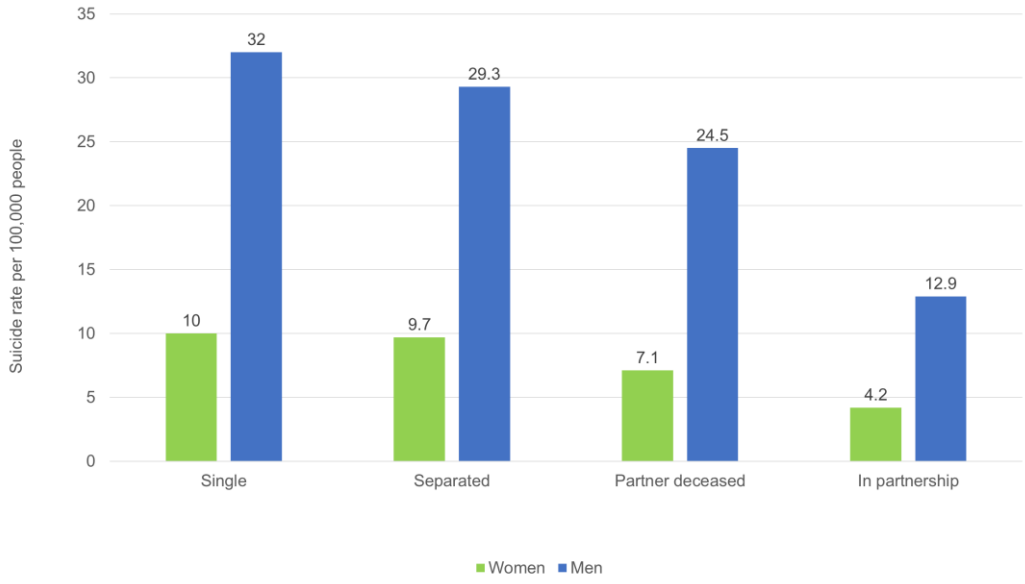


Source: Office for Health Improvement and Disparities (OHID)

Partnership status

Between 2011 – 2021, people in partnerships (married or in a registered same-sex civil partnership) had the lowest suicide rates (17.1 per 100,000 people), compared with people who are single (42 per 100,000 people), separate (39 per 100,000 people), or whose partner has died (31.6 per 100,000).

Figure 18: Suicide rate per 100,000 population by partnership status in England and Wales 2011–2021



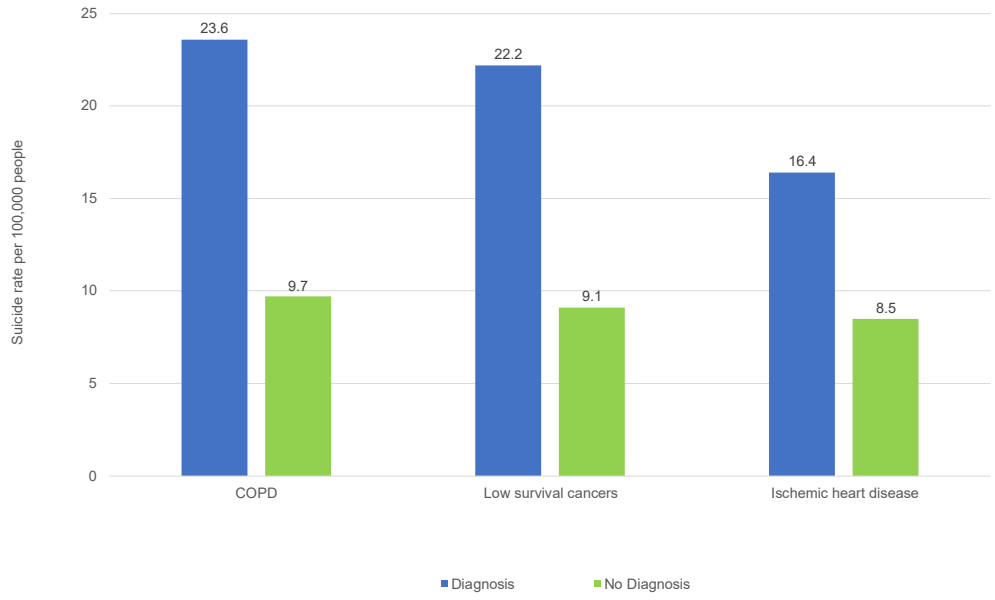
Source: Office for National Statistics (ONS)

Health conditions

Suicide rates are higher among people diagnosed with serious physical illnesses. One year after diagnosis, more people die by suicide compared to individuals of the same age, sex, ethnicity, religion and deprivation level who were not diagnosed with these conditions. ONS data (2022) showed that:

- People diagnosed with chronic obstructive pulmonary disease (COPD) had the highest suicide rate one year after diagnosis (23.6 per 100,000).
- People diagnosed with low-survival cancers (pancreatic, meningioma, lung, oesophagus, liver, mesothelioma) had a rate of 22.2 per 100,000.
- People diagnosed with chronic ischaemic heart conditions had a rate of 16.4 per 100,000.

Figure 19: Suicide rate per 100,000 population for people diagnosed with severe health conditions in England 2017–2020

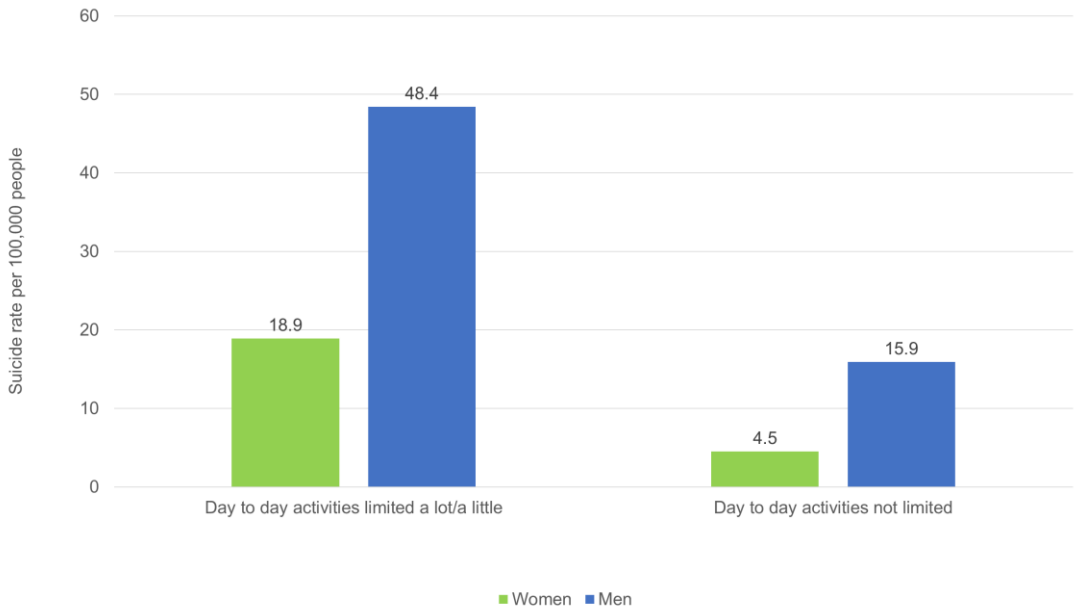


Source: Office for National Statistics (ONS)

Disability status

People whose day-to-day activities are limited by disability (including age-related limitations) experience higher suicide rates than non-disabled people. This pattern is seen in both sexes: 48.4 per 100,000 for men and 18.9 per 100,000 for women with disabilities, compared with 15.9 and 4.5 per 100,000 respectively among those without disabilities.

Figure 20: Suicide rate per 100,000 population by disability status in England and Wales 2011–2021



Source: Office for National Statistics (ONS)

Neurodivergence

A 2022 study published in The British Journal of Psychiatry examining suicides in England (2014–2017) found that autism and autistic traits were significant risk factors for suicidal behaviour[10]. It reported that 11% of people who died by suicide were autistic, despite autistic people making up only around 1% of the general population.

Alcohol and drug misuse

The National Confidential Inquiry into Suicide Safety in Mental Health Annual Report 2025 reported that among 18,670 patient suicides in the UK and Jersey between 2012 and 2022, 47% involved alcohol misuse and 38% involved drug misuse[11].

The National Drug Treatment Monitoring System shows that almost three-quarters (74%) of adults starting treatment between April 2024 and March 2025 said they had a mental health treatment need - 22% of these people reported they were not receiving any treatment to meet this need[12]. Locally, the proportion of people accessing drug and alcohol treatment services with a current unmet mental health need is 27%[13].

Furthermore, Dame Carol Black's independent review of drugs highlighted the *"persistent and widespread issues of people with co-occurring conditions often being excluded from service"*. Consequently, Dame Carol Black found that just under half (48%) of those in community treatment services with a mental health treatment need received treatment from their GP in primary care. However, the review concluded that it would be likely that the level of mental health treatment being offered within primary care would not be sufficient to meet the mental health needs of this population.[14]

Domestic abuse

Research by the Agenda Alliance found that women who have experienced intimate partner violence are three times more likely to die by suicide[15]. Between 2020 and 2024, domestic abuse was linked to 1,012 reported deaths, 35% of which were deaths by suicide[12].

Bereavement

The National Confidential Inquiry into Suicide Safety in Mental Health Annual Report 2025 reported that between 2012 and 2022 there were 1,312 patient suicides among people who had been recently bereaved (within <3 months). This accounted for 8% of all patient suicides, which meant an average of 119 deaths per year[9].

Financial hardship

A 2023 study published in The Lancet found that people experiencing financial stress were 74% more likely to die by suicide[16].

Unemployment

The same 2023 Lancet study found that people unemployed people were 87% more likely to die by suicide[11].

Housing status

A 2024 report by Samaritans highlighted that 'homelessness, housing insecurity and poor housing increase suicide risk'. In 2021, 13.4% of deaths among people recorded as homeless in England and Wales were registered as suicides.[17]

Children and young people

The number of suicides amongst children and young people are low; 5.4 per 100,000 people in England and 4.7 per 100,000 people in the West Midlands region (2022 – 2024). Nationally and regionally, rates have been rising over the last 10 years. The numbers of cases in Sandwell were too small to report in 2022-2024. In 2019-2023 the local rate was 3 per 100,000 people[18]. Despite numbers being low, suicide is the leading cause of death

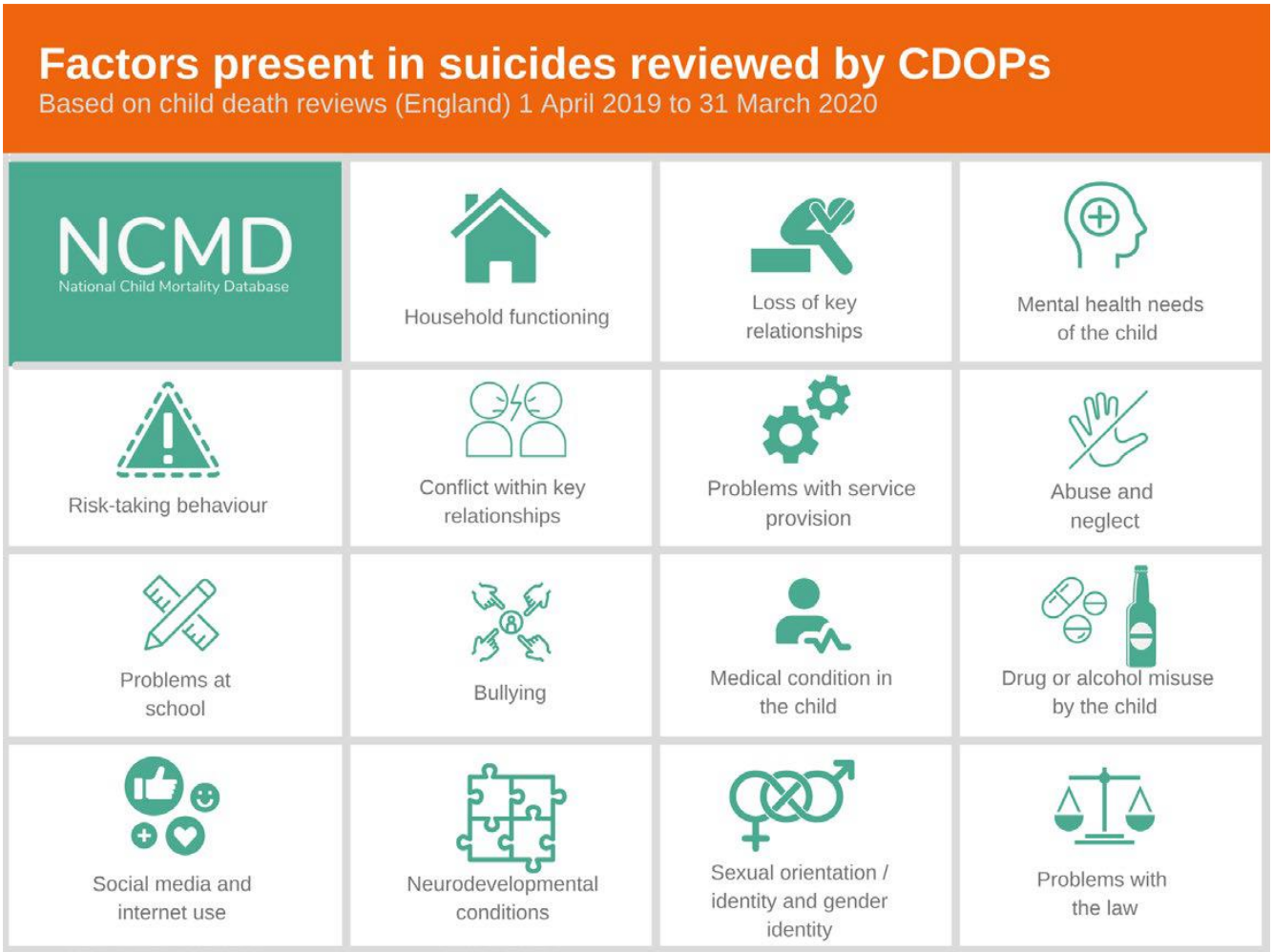
in children and young people aged 10 to 19[i]* and 20 to 34 years[19] and therefore preventative action needs to be taken.

A recent study conducted by the Office for National Statistics (ONS) using mortality data and information from the 2011 Census highlights key characteristics of children and young people aged 10 to 17 years who experience a higher risk of dying by suicide[20]:

- Suicide rates were higher for males than females (similar trend in adults).
- Suicide rates were 1.7 times higher in households where the household reference person (HRP)[ii] had a degree-level qualification.
- Children and young people from households where the HRP was Muslim or Christian had significantly lower suicide rates compared with children in households where the HRP had no religious affiliation.
- Suicide rates varied by ethnicity, with rates for children and young people of Mixed or Multiple ethnic groups significantly higher (around 1.5 times) than for White ethnic groups. Meanwhile, those of Asian or Asian British and Black or Black British ethnic groups had significantly lower suicide rates than White ethnic groups.
- The risk of suicide for males with special educational needs (SEN) support (without a SEN statement) was around 1.5 times higher than for males with no recorded SEN.
- Among children who had a SEN statement, differences in suicide rates between different kinds of need were assessed (social, emotional & mental health; communication & interaction; cognition & learning; sensory and/or physical needs). Those whose needs were related to social, emotional or mental health needs had the highest suicide rates.

To inform preventative action for suicides amongst children and young people, the National Child Mortality Database Programme (NCMD) conducted research which identified commonalities between deaths by suicide between April 2019 – March 2020[21]:

[i] In England and Wales, a conclusion of suicide cannot be returned for children under the age of 10 years.
[ii] The household reference person is the member of the household in whose name the accommodation is owned or rented, or is otherwise responsible for the accommodation - https://analysisfunction.civilservice.gov.uk/policy-store/household-reference-person/



The wide range of proceeding factors identified emphasises the need for multi-agency contribution to suicide prevention activity for children and young people.

Summary

- Suicide rates in Sandwell have been stable over the last 20 years and broadly in line with national rates
- For deaths by suicide, the majority were men aged in their 50s, 40s, and 30s
- Most suicides occurred at home or in private residences and by hanging
- Substance and alcohol misuse was a recurring issue
- Many individuals had a history of mental illness, previous suicide attempts and were known to mental health services
- Social isolation due to illness, bereavement, relationship breakdown, or the COVID-19 pandemic was common
- Risk factors commonly occurred together
- Hospital admissions for self-harm were mainly among young women aged 15–19 years

- There was a high likelihood of readmission after a first admission for self-harm
- Most self-harm readmissions occurred within 12 months of the first admission
- Inequalities are evident, with many groups disproportionately present in deaths by suicide.

Stakeholder Engagement

Stakeholder engagement is fundamental to the development of the refreshed suicide prevention strategy and our local suicide prevention work. We have listened to our residents and our partners in various ways over the last few years:

- Strategy Development Workshop engaging partners
- Better Mental Health Strategy Consultation with residents and partners
- Better Mental Health Strategy Partners Workshops
- Black Country Lived Experience Survey 2025
- Sandwell Health & Wellbeing Board Summit
- Men's Mental Health Co-production
- Expertise and information sharing within the Sandwell Suicide Prevention Partnership
- Tipton Suicide Prevention Projects engaging with residents and partners

Our Recommendations

Priority 1 – Evidence-based Practice

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

National Strategy, 2023[4]

Following the National Suicide prevention in England: 5-year cross-sector strategy 2023-2028 we believe that timely and accurate data and intelligence is critical to support our local suicide prevention activity.

Where We Are Now

Through the 2022-2025 Suicide Prevention Strategy we have developed data and intelligence pathways from the following sources:

- Black Country Coroners Service Data
- Black Country suicide and mental health data, including patient suicide.
- NHS 111 Option 2 Crisis Helpline Black Country Data
- Lived Experience
- Near to Real Time Suicide Surveillance System (nRTSSS)
- Mental Health Community Projects' data
- Black Country Coroner Death by Suicide Case Reviews
- Domestic Abuse Related Death Reviews (DARDR)
- Child Death Reviews (CDR)
- Research and Consultation

This enables us to identify trends and patterns, opportunities to embed prevention and allocate appropriate resources.

However, improvements are still required to strengthen data sharing and combine available data to have a more comprehensive view of suicide and suicide prevention activity. Efforts should also be made to address the inconsistency of data, particularly for some priority groups and known risk factors.

Where We Want to Be

- The voices, perspectives and insights of people with personal experience continue to inform local policy, service improvement, commissioning and the development of new suicide prevention services and initiatives in Sandwell.
- Sandwell has a Suicide Audit Group that regularly reviews data, both quantitative and qualitative, including lived experiences, to make recommendations and inform decision making within the Better Mental Health Partnership. The Audit Group acts as a Cluster Response Group, identifying and responding to suicide clusters as and when necessary.
- Sandwell contributes to the development of a Black Country Real Time Suspected Suicide Surveillance System (RTSSSS) allowing timely analysis of local suicide rates to identify patterns and risks. This real-time data also allows for more timely support for those bereaved and affected by suicide and sharing of lessons learned when someone dies by suicide.
- Sandwell effectively utilises near-to-real-time surveillance data to inform prevention activities.
- Sandwell develops and contributes to a Black Country Suicide Data Dashboard which includes data from NHS 111 Option 2 and referrals to local provision, such as Child and Adolescent Mental Health Services (CAMHS) and NHS Talking Therapies.
- Sandwell has a consistent Equality, Diversity and Inclusion Data Framework for all partners to systematically identify, understand need and support priority groups to reduce inequalities.
- Sandwell will have improved data sharing. Working with the new Neighbourhood Health Model we aim to link datasets, as shown in Figure 14 below, to identify and support priority groups and locations.

Figure 14: Linked Datasets Model



Priority 2 – Suicide Safer Communities

This priority should focus upon building communities where people are safe from suicide and where shared, coordinated action drives prevention efforts. Working with local and regional partners will strengthen the collective response to the factors that contribute to suicide, including but not limited to poverty, financial insecurity, poor health, long term conditions and unemployment. Supporting communities to enhance their connection to protective factors at the individual, relational, community and societal levels. By supporting communities in this way, we can create communities where people are connected, supported and able to thrive.

Where We Are Now

- **Support for priority groups:**
    - **Men (of all ages)**: We have engaged with men living and/or working in Sandwell through a highly successful marketing campaign "You ok, mate?" and through the commissioning of the Men's Mental Health and Wellbeing Community Programme which offers a range of social activities and educational sessions in each of the six towns. As 79% of suicides in Sandwell are men, this remains a challenge for us and continued efforts are needed.
    - **Children and young people:**
        - Mental Health Support Teams are now in every secondary school and in 51% of primary schools in Sandwell.
        - The Sandwell Well-being Charter Mark has been supporting schools to adopt a whole school approach to mental health and wellbeing for 10 years, with 72% of schools achieving their award.
        - Sandwell primary schools have access to the Healthy Mind, Happy Me curriculum.
        - Several local initiatives, including the SHAPE Anti-Bullying Roadshow, help to tackle bullying locally.
        - Sandwell's Senior Mental Health Leads were amongst the highest in the country to engage with the training offered by the Department for Education between October 2021 and December 2024 representing over 90% of Sandwell schools.
        - An All-Age Mental Health and Emotional Wellbeing Service Directory has been developed and updated for the last 3 years.
        - A dedicated mental health support service has been commissioned for children we care for and care experienced children in Sandwell.
        - The Sandwell ST*R Partnership Practice Model ensures families receive consistent help and support, as early as possible, no matter what professionals and which agencies are working with them. At the core of ST*R is understanding the root causes of problems, challenges, and behaviours. Trauma informed practice is a fundamental principle

within ST*R ensuring the need for physical, psychological and emotional safety for children and families. There is opportunity to build on this shared practice model and extending its reach across other system partners.
        - There is an occurring theme that children, young people and families do not know how or where to get support. This remains a priority for us.
    - **People in contact with mental health services:** BCHFT commissioned services including early intervention, community-based intervention, specialist intervention, crisis support and recovery support. Waiting lists for NHS mental health services remain long and are a concern for local people. A history of contact with mental health services is evident in many local suicides.
    - **People in contact with the justice system:**
        - Sandwell is represented at the Probation Service Regional Suicide Prevention Forum.
        - In addition to the mental health services above, BCHFT offer a Criminal Justice Mental Health Team for adults aged 18 years and over and have had contact with the criminal justice system in the last 3 months.
        - Cranstoun (local drug & alcohol treatment service) has an established pathway for prison leavers to access local treatment services which lessons the mental health impact upon release.
        - Harm Outside the Home, which includes young people in touch with the Youth Justice System or being drawn into criminality, is a priority for the Sandwell Children's Safeguarding Partnership. This pathway includes a comprehensive assessment and tailored plan of intervention and support, aimed at addressing underlying vulnerabilities and reducing both the harm experienced by the young person and the harm arising from their behaviours.
    - **Pregnant women and new mothers:** There is a well-established mental health support offer in Sandwell for pregnant women and new mothers including BCHFT Specialist Perinatal Mental Health Service, Family Hubs, Health Visiting and Midwifery Services. We know more work is needed to ensure that our services are culturally competent and accessible to racialised communities.
    - **LGBTQ+:** Grant-funding in Sandwell has provided an opportunity to establish community-based support groups to improve the mental health and wellbeing and the physical health of LGBTQ+ communities.
- **Risk factors:**
    - **Domestic Abuse:** In response to a rising number of domestic abuse related suicides, we are working closely with Sandwell Domestic Abuse Partnership and successfully delivered a bespoke Domestic Abuse Suicide Prevention

Training offer to strengthen awareness of suicide prevention among professionals and action recommendations from Domestic Abuse Related Death Reviews. This focus needs to remain to reduce these increasing incidences.

- **Self-harm:** Although many people who self-harm will not die by suicide, they are at a significantly increased risk of dying (either deliberately or inadvertently) than those who do not self-harm. BCHFT have established self-harm pathways and services. However, a multi-agency response is needed to reduce the rates of readmission as evidenced in our local data in line with NICE Guidelines (NG225)[22].
- **Drug and alcohol misuse:** There is an established process in Sandwell to review deaths for those known to or in local treatment services at the time of death which may include deaths by suicide. This allows us to identify learning and improve practice and understand risk factors and strengthen suicide-prevention practice within treatment services.
- Co-occurring substance misuse and mental health conditions is a key priority in Sandwell due to the level of unmet needs within this group.
- **Bereavement** Sandwell has an established Bereavement Task & Finish Group to work collectively on ensuring that support in Sandwell meets the needs of all communities. As part of this work, the Sandwell Bereavement Leaflet has been developed, which is available in English, Bengali, Polish, Punjabi, Urdu, in large-print format and online. The leaflet provides clear guidance on how to access timely, inclusive, and culturally sensitive bereavement support. It is included within the Bereavement Pack provided by Sandwell & West Birmingham Hospitals NHS Trust. Bereavement remains a significant priority locally.
- **Residents experiencing financial stress, deprivation and other wider determinants of health**: Established partnership working enables us to reduce inequality. For example, through our Hospital Discharge Pathway, we ensure that patients with mental health conditions are connected to welfare rights advice, tenancy support and other practical assistance when they leave hospital. This approach helps reduce the pressures that can intensify distress and supports people to maintain stability during vulnerable periods. We are embedding wellbeing screening into welfare rights and advice services to provide opportunity for early intervention and improved outcome monitoring. We are also exploring co-location and multi-disciplinary teams opportunities through local Neighbourhood Health Plans.
- **Loneliness and isolation**: Sandwell has a rich and vibrant community and voluntary sector and plenty of community assets including libraries, community centres, leisure centres and Welcoming Spaces, offering a variety of opportunities for residents to engage, connect and contribute to their local

community. Further work to enhance the structural enablers of connection and contribution such as employment/volunteering, transport, environment, inclusive services and communities, and digital skills is needed locally.

- **Reduce Access to the Means of suicide:**
    - Community-led initiatives play a vital role in suicide prevention activities in our towns. In Tipton, we have supported residents to establish the Tipton Mental Health and Suicide Prevention Group in response to local high frequency locations. We have provided suicide prevention training for its members to build confidence and capability within the community. The group has identified two suicide prevention projects aimed at reducing suicides locally - the Tipton Guide, designed to help residents in their town to access appropriate services and support earlier, reducing the likelihood of crises. The adoption of local railway stations as community assets, creating safer, more connected spaces through community involvement. These initiatives demonstrate the power of local leadership in creating safer, more supportive environments for everyone. This remains a key focus to engage communities and targeted priority groups in prevention activities.
    - We have robust partnerships with the transport industry and Samaritans to collaboratively identify priority locations and take action to reduce these risks such as improved signage and data sharing. Continued efforts to reduce these risks remain a local priority.
    - Prescribers follow appropriate guidelines on prescription medicines, e.g. paracetamol, through medicines management and trust policies. The Public Health School Nursing Service provides support and policy guidance for the management of medication in schools.
    - BCHFT have policies and procedures in place to reduce the risks in inpatient settings. This remains a local concern.
    - Working collaboratively with local police enforcement and trading standards, efforts are being made to tackle the illegal sale of prescription drugs in unlicensed premises in Sandwell. This remains a local concern.

Sandwell does not lack opportunity when it comes to suicide prevention activity – it lacks connection to it. A recurring theme arises when we speak with residents and the professionals that support them –they do not know how or where to get support.

Where We Want to Be

- Sandwell will have community-led interventions developed with, and delivered by, local communities across our six towns. To create suicide-safe communities and strengthen mental health resilience, we must embed mental wellbeing into everyday community life, build the capacity of residents to support themselves

and each other and strengthen multi-agency efforts to tackle inequalities for priority groups. These local interventions may include:

- **Community training** based on the Five Ways to Wellbeing and improving mental health literacy, equipping residents with increased knowledge and practical tools to maintain and improve their mental wellbeing.
- **Town-based community events and partnerships** designed to promote early help, encourage open conversations to reduce stigma and raise awareness of services that address inequality and the underlying factors that contribute to suicide.
- **Initiatives to improve social connectedness** across the life course and that are inclusive for all – ensuring that priority groups and those with protected characteristics have equal opportunity for social connection.
- **Maximising community assets including Welcoming Spaces, Family Hubs, libraries and community, voluntary and faith settings** ensuring a consistent knowledge base amongst staff/volunteers, meaningful signposting and warm referrals to accessible support for all ages. These assets also provide opportunity to bring essential services to communities linking in with Neighbourhood Health and other existing and emerging hub initiatives.
- **Community mental health and suicide prevention champions** offering peer mentors in community settings to support early identification and signposting and the promotion of safety planning.

This community-driven approach aims to build sustainable, locally owned solutions that strengthen resilience, reduce risk and ensure every resident has access to support when they need it.

- Sandwell will raise awareness of the support available through multi-agency communications campaigns and initiatives. This will include:
  - Awareness of support that can prevent mental health from deteriorating and promote good wellbeing and emotional resilience
  - Awareness of crisis support
  - Awareness of support that can reduce inequalities and the underlying factors that can contribute to suicide.

  This awareness raising should be available to all residents and professionals with targeted awareness raising for priority groups.

- Sandwell will ensure there is engagement with and targeted interventions for the following priority groups:
  - Men of all ages
  - Children and young people
  - People who have self-harmed

- People in contact with mental health services
- People in contact with the justice system
- Neurodivergent people
- Pregnant women and new mothers
- Older People
- LGBTQ+ people

- Sandwell will address common factors that contribute to suicide at a population level by providing early intervention and tailored support. We will do this by:
  - **Physical illness & Long-Term Conditions:** Sandwell will have a better understanding of multimorbidity and the co-occurrence of mental health and physical long-term conditions to inform prevention activity. Sandwell will improve the physical health and reduce the inequalities of people with SMI (Severe Mental Illness).
  - In Sandwell, people who are experiencing **financial difficulty and economic adversity** are identified early through local welfare, debt and advice services, housing teams and community organisations whose staff and volunteers are aware of the associated risks of poor mental health and suicide. Sandwell uses the resources available through The Crisis and Resilience Fund effectively to build financial resilience and improve long-term outcomes for households in Sandwell.
  - **Gambling:** Sandwell will have an updated needs assessment to establish the scale, distribution and inequalities associated with gambling-related harm in the borough. The needs assessment will make evidence-based recommendations to inform future commissioning and investment decisions across the life of this Strategy. In addition, a programme of workforce training to embed routine gambling harm screening and Very Brief Advice will be facilitated across key frontline services to identify gambling harm early and reduce escalation - in turn reducing associated risks, including suicide and suicidal ideation.
  - **Alcohol and drug misuse:** Sandwell will develop and implement a Co-Occurring Substance Use and Mental Health protocol establishing joint ownership and accountability to improve outcomes for individuals experiencing both substance use and mental health needs. It will incorporate training to improve suicide prevention competencies across commissioned services, the wider workforce and within the community.
  - **Social isolation and loneliness:** Sandwell will recognise isolation and loneliness as a structural inequality and will have a whole-system approach to address the issue. All system partners will have a shared commitment as part of strategic ambitions to reduce inequalities in the Borough.

- **Domestic abuse**: Our aim is to strengthen the alignment between suicide prevention and domestic abuse activity, ensuring that learning from DARDR informs how we improve safety and support for those at risk. We will deliver job-specific training to key initial responders, including GPs, Police, Welfare Rights Teams, social workers and other frontline professionals, so they feel confident in recognising risk and responding effectively. This approach will help ensure that every young person and adult experiencing domestic abuse is assessed for suicide risk and supported with their mental health needs.
- **Bereavement support** will be inclusive, culturally accessible, and responsive to the needs of all communities in Sandwell. Our ambition is to ensure that every resident can access appropriate support following a bereavement, including those affected by suicide (postvention). This includes strengthening awareness, improving access to information and embedding bereavement support across community settings.
- **Self-harm**: To address the significant readmission rates for self-harm, Sandwell will explore opportunities to strengthen the protective factors around people who self-harm such as effective safety planning, wraparound support from trusted professionals/organisations, identifying protective relationships, connection and belonging. This will involve people with lived experience and be aligned to NICE Guidance as necessary (NG225). We will raise awareness of self-harm and promote early identification through training to ensure that those who aren't seeking help get the support that they need.

- **Reducing access to means:** Our aim is to ensure that communities understand suicide risk, feel confident in how to intervene safely and know how to direct people to appropriate support. Working with partners, we will identify frequently used locations or potential public places that could provide means to suicide across our localities. We will ensure that individuals approaching these areas receive messages of hope, clear signposting and access to local support services. We will adopt a collaborative, multi-agency approach to reviewing and responding to frequently used locations through a Suicide Audit Group. This will include working with partners such as the British Transport Police, Network Rail, and the Samaritans to develop and implement a consistent community engagement protocol following a suspected suicide. This protocol will include coordinated communication, distribution of supportive resources and access to postvention support for affected communities. This approach aims to reduce risk and prevent contagion, strengthen community awareness and ensure that residents feel supported, informed and empowered to play an active role in suicide prevention. We want retail staff to feel comfortable questioning people buying lengths of rope or cord, knives or other potential means for self-harm.

Priority 3 – Suicide Prevention is Everyone's Business

"Suicide is everybody's business. Everyone should feel they have the confidence and skills to play their part in preventing suicides – not just those who work in mental health and/or suicide prevention directly – and take action to prevent suicides within and outside of health settings."

National Strategy, 2023[4]

In line with the National Strategy, we believe that suicide prevention is everyone's business and we will only achieve our local vision by embedding suicide prevention across policies and systems, within workplaces, schools and our communities, supported by responsible and sensitive media coverage.

Where We Are Now

- We have successfully delivered suicide prevention training to increase awareness and strengthen skills across our workplaces and within community settings, including the development of bespoke Domestic Abuse Suicide Prevention Training for domestic abuse professionals. Training to improve mental health literacy and suicide prevention in faith settings has been successfully rolled out with a wellbeing module developed for sustained use in the faith sector. Working in partnership with the Council's Learning & Skills Team, we have embedded the Zero Suicide Alliance free training in relevant mental health courses for managers.
- We have developed a range of resources and information on our Healthy Sandwell Mental Health webpages, further supported by the Sandwell All-Age Emotional Wellbeing and Mental Health Directory which provides comprehensive information on local and national mental health support, enabling residents to access appropriate and timely help.
- Media campaigns such as "You Ok, mate?" and "Five Ways to Wellbeing" support the reduction in stigma surrounding suicide and mental health.
- Development of the Multi-Agency Social Emotional Mental Health Competency Framework for Staff Working with Children and Young People in Sandwell.
- A full programme of activity delivered through the Council's Occupational Health Team, Wellbeing Ambassadors and Public Health to improve the workforce's mental health and wellbeing.

Where We Want to Be

In Sandwell, we want everyone who lives or works here to feel confident in looking after their mental health, recognising when someone may be struggling and knowing where to find support. We will continue to work with communities, schools, workplaces and local organisations to make this happen by embedding suicide prevention across communities and partners.

We will focus on workforce and community skills to improve understanding of mental health and wellbeing across all sectors by building skills and awareness through:

- **Community Mental Health and Suicide Prevention Training**: By embedding the 5 Ways to Wellbeing and suicide awareness/prevention training in workplaces, schools and community settings we aim to help people recognise when someone may be at risk, offer safe and confident support and guide them towards the right services.
- **Media & Communications** will be clear, accessible and culturally appropriate to encourage people to use local support services. We support local organisations, networks and influencers to follow the Samaritans' Media Guidelines for safe reporting of suicide and create media campaigns addressing stigma and priority groups and will use media channels to promote mental-health resilience, wellbeing messages, and awareness of local support.
- **Supporting Mental Health in the Workplace** to raise awareness of suicide prevention and the importance of staff wellbeing, helping workplaces to develop clear policies for responding to mental-health crises, supporting staff after a suicide, promoting staff wellbeing and early help. We are rolling out Safety Plans to help people manage distress and crises.
- **Strengthening Support in Schools** We will provide training to school staff to support the delivery of the RSHE curriculum and the new requirements for suicide prevention. We will evaluate the current whole school approach, The Wellbeing Charter Mark and explore alternative models to determine the way of working in Sandwell, ensuring child, young person and family voice shapes the overall outcome.
- **Connecting Services and Sharing Best Practice** with statutory services, the NHS, voluntary organisations and community groups to share learning, improve support pathways and raise awareness of local services to help ensure residents receive joined-up, timely support.
- **Improving Digital Resilience** to better understand how social media, AI and online platforms influence mental health and suicidal thoughts. We use behavioural science to design digital support that reaches people at the right moment.

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Appendix 1: National Policy Drivers

- Consensus statement for information sharing and suicide prevention, Department of Health and Social Care (2021)
- Health and Care Act, UK Parliament (2022)
- The National Confidential Inquiry into Suicide and Safety in Mental Health Annual Report. The University of Manchester (2026)
- The NHS Long Term Plan. NHS (2019)
- 10 Year Health Plan for England: Fit for the Future (2025)
- Staying Safe from Suicide: Best Practice Guidance. NHS England (2025)
- Self-harm: assessment, management and preventing recurrence. National Institute for Health and Care Excellence (2022)

In addition, the national strategy acknowledges several other drivers and strategies relating to specific priority groups and topic areas. These include:

- Domestic Abuse Act, UK Parliament (2021)
- Online Safety Act, UK Parliament (2023)
- Men's Health Strategy for England, Department of Health and Social Care (2025)
- The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Suicide by middle-aged men. The University of Manchester (2021)
- From harm to hope: A 10-year drugs plan to cut crime and save lives, Home Office, Department of Health and Social Care, Ministry of Justice, Department for Work and Pensions, Department for Education, and Department for Levelling Up, Housing and Communities (2021)
- Gambling-related harms: evidence review, Office for Health Improvement and Disparities and Public Health England (2019)
- High stakes: gambling reform for the digital age, Department for Culture, Media and Sport (2023)
- Loneliness annual report: the fourth year, Department for Culture, Media and Sport (2023)
- Loneliness, suicide and young people, Samaritans (2019)
- Suicide in Children and Young People, National Child Mortality Database (2021)
- National strategy for autistic children, young people and adults: 2021 to 2026, Department of Health and Social Care and Department for Education (2021)
- Relationships and sex education (RSE) and health education, Department for Education (2019)
- Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2021-23, MBRRACE-UK (2025)
- Tackling Domestic Abuse Plan, Home Office (2022)

- LGBTQ+ Bereavement by Suicide, Support After Suicide Partnership (2023)
- Understanding Gypsy, Roma and Traveller communities, Support After Suicide Partnership (2023)