Sandwell Suicide Prevention Partnership: Local Needs Assessment 2020 – 2021

Background

Current Situation

Sandwell has a preliminary strategy and action plan which relates to our Suicide Prevention priorities. These priorities have been developed alongside the Sandwell and West Birmingham CCG's Mental Health Strategy as well as the national guidance in the 2012 'Preventing Suicide in England' strategy by the Department of Health and Social Care.

Between 2017-19, Sandwell's average annual suicide rate was 10.8 per 100,000[1]. In line with national trends, the average rate in men is far higher than in women and the majority age range is between 35 and 64 years old[2]

The Suicide Prevention agenda within Sandwell is generally co-ordinated through the Sandwell Suicide Prevention Partnership (SSPP), which is attended by several key partners, including Samaritans, Kaleidoscope Plus and Papyrus who all provide an immediate suicide prevention service, and an NHS Mental Health Specialist. The partnership meets monthly to provide feedback on the strategy, share data insights and co-ordinate the local approach. The partnership is the primary group responsible for delivering the action plan.

The LNA uses the '6 Priorities' taken from the strategy (see Appendix 1). The principal priority is that by 2030, no-one will die of suicide in Sandwell.

The current six priorities of the Sandwell Suicide Prevention Strategy are:

1. To fulfil the 'Zero Suicides' Ambition.
2. To ensure the highest quality of care and support guaranteed by professionals.
3. To encourage a better awareness of suicide within local organisations and our communities.
4. To reduce the chances of suicide in high-risk populations.
5. To create an open culture where we listen to those with lived experience.
6. To reduce access to the means of suicide.

Purpose

The Suicide Prevention Strategy and Action Plan were drafted at the start of 2020. The picture in the borough and the ability to provide services has been forced to change by the Covid-19 Pandemic and so it is sensible to re-assess what the precise local situation is with regards to suicide prevention. This needs assessment uses both quantitative (i.e. statistical) and qualitative (i.e. interviews) data to analyse suicide prevention in Sandwell.

The outcome of this analysis will allow us to better understand what services are already available, how accessible these services are and whether they are functioning effectively or not. From the perspective of

[1] PHE Suicide Prevention Profiles, https://fingertips.phe.org.uk/suicide#page/0/gid/1938132828/pat/6/par/E12000005/ati/102/are/E08000028/cid/4/tbm/1/page-options/ovw-do-0 (Accessed: 09/02/2021)

[2] PHE Suicide Prevention Profiles, (Accessed: 14/04/2021)

those most affected, they will also provide an invaluable insight into the lived experience that will ultimately inform our action plan.

Once the needs assessment has been completed, the Partnership can develop an action plan based on both data and lived experience. The tasks of this action plan will be carefully linked to the specific needs identified as well as the services and support groups available in the borough. This action plan will help the partnership to deliver on the 6 Suicide Prevention Priorities that will underpin the new strategy.

Methods

This needs assessment has used a mixed methods approach. We have used data from three primary sources as our quantitative approach. This has allowed us to identify our key demographics and highlight trends.

Our three primary data sources were:

1. **The Public Health England Suicide Prevention Profiles**, which provides access to historic data regarding suicide and self-harm as well as associated risk factors. This will provide us with the national, regional and local picture. The most contemporary data set is from 2017 to 2019 as they are recorded in 3-year periods.
2. **Hospital Episode Statistics (HES)**, relating to intentional self-harm. This details Sandwell residents who have been admitted into hospital for intentional self-harm. The codes which we have used for this data are X60 through to X84. The data sets are broken down by 3 key identity characteristics. Firstly, number of admissions, within annual ranges, covering the period from 2015 to 2020. Secondly, age group which is broken down both by sex and approximate brackets of 14 years. Thirdly, ethnicity which is broken down into sex again and ethnic groups.
   The data from the HES will provide insight as to which groups of the population in particular are at a higher risk of being admitted to hospital for intentional self-harm, and therefore potentially at a higher risk of attempting and/or completing suicide.
3. **Annual Coroner's Summary Reports**, summary reports compiled by the Public Health Research and Intelligence Team with data shared from the conclusions of the Black Country Coroner's Office. They provide a snapshot of the suicides that have occurred in Sandwell over a 12-month period. This is the most contemporary and local source of data available to us.

We have used interviews as our qualitative approach. This has provided us with an understanding of the experiences and insights of those affected as well as those who work towards suicide prevention. The interviews were semi-structured and lasted no more than 1 hour. There are two different versions of the interview questions, one for organisations and one for individuals (Appendix 4 and 5).

Four interviews were conducted with key 3rd sector partners and community organisations who all contribute to Sandwell's suicide prevention agenda. These partners were:

- *Papyrus UK*; specific suicide prevention support for ages 0-35
- *Samaritans*; all-age crisis support and partner training.
- *Kaleidoscope Plus*; post-vention support for those bereaved by suicide.
- *Tough Enough to Care*; local men's mental health charity.

All those who consented to being interviewed were informed of the purposes of the Needs Assessment, generally, and the interviews, specifically. Interviews were conducted by Tanith Palmer, a consultant in Public Health with prior experience of qualitative research methods, and Alexander Quarrie-Jones, a graduate in Public Health. Interviews were recorded for transcription purposes and then deleted afterwards. All interviewees were informed that they reserved the option to ask for their answers to be amended or deleted up to 2 weeks after the date of the interview. All the interviewees signed consent forms and agreed to the terms and conditions of the interviews as well as the overall purpose of this needs assessment. These forms also provided contact numbers for mental health and wellbeing support organisations in case the individual wanted to stop the interview and seek support.

Findings

Epidemiology of suicide in Sandwell

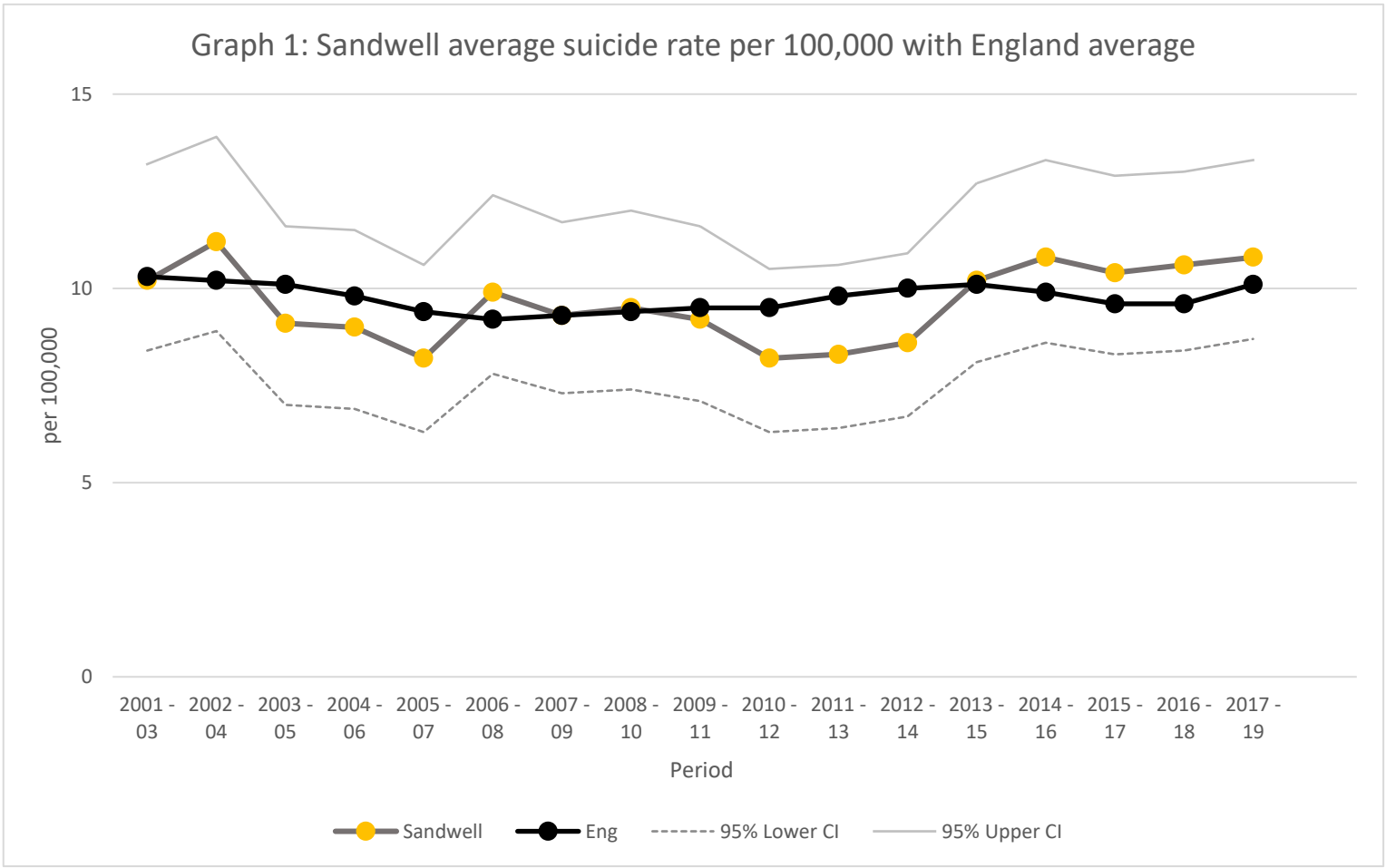
National, Regional and Local Data from 'Public Health England: Suicide Prevention Profile'

This is a publicly-accessible database that has been produced by Public Health England (PHE) to help develop understanding at the local level and support an intelligence-driven approach to suicide prevention[3]. For reference, it uses 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)*"[4].

General Overview of Sandwell's suicide rates

In Graph 1, we can see that Sandwell's average suicide rate has fluctuated for the past 20 years rather than demonstrating any clear upwards or downwards trend. For the most contemporary reporting period 2017-19, the average rate of suicide (persons) in Sandwell was 10.8 per 100,000. This is slightly higher than both the regional West Midlands average (10.2) and the national England average (10.1).

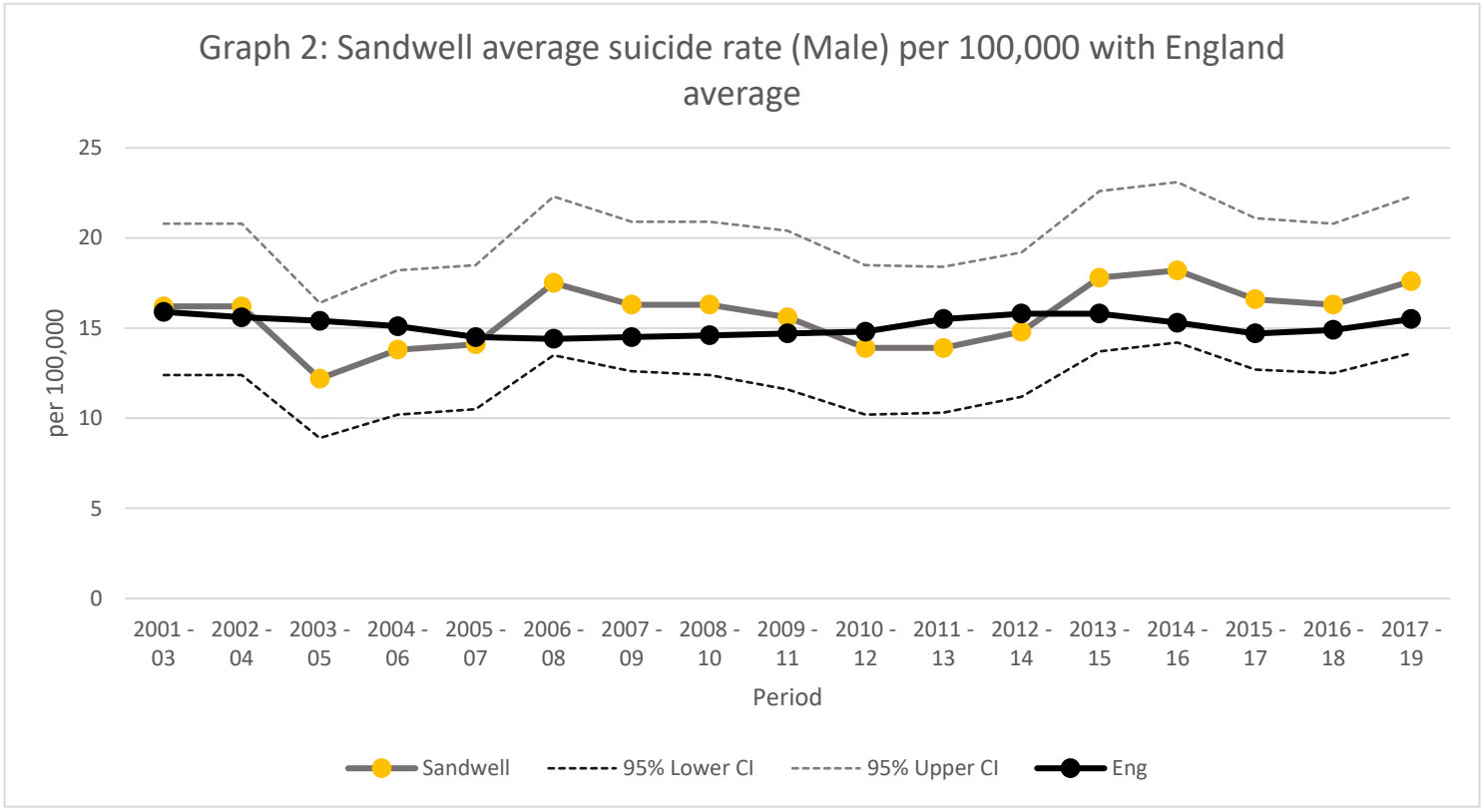
While these differences are not statistically significant, relatively small numbers at the local level means that we should interpret this with caution, as Sandwell's 'true' rates could fall anywhere between the upper and lower confidence intervals (dotted lines). Nevertheless, this demonstrates that suicide continues to be an issue of concern in Sandwell, the West Midlands region, and in England overall.



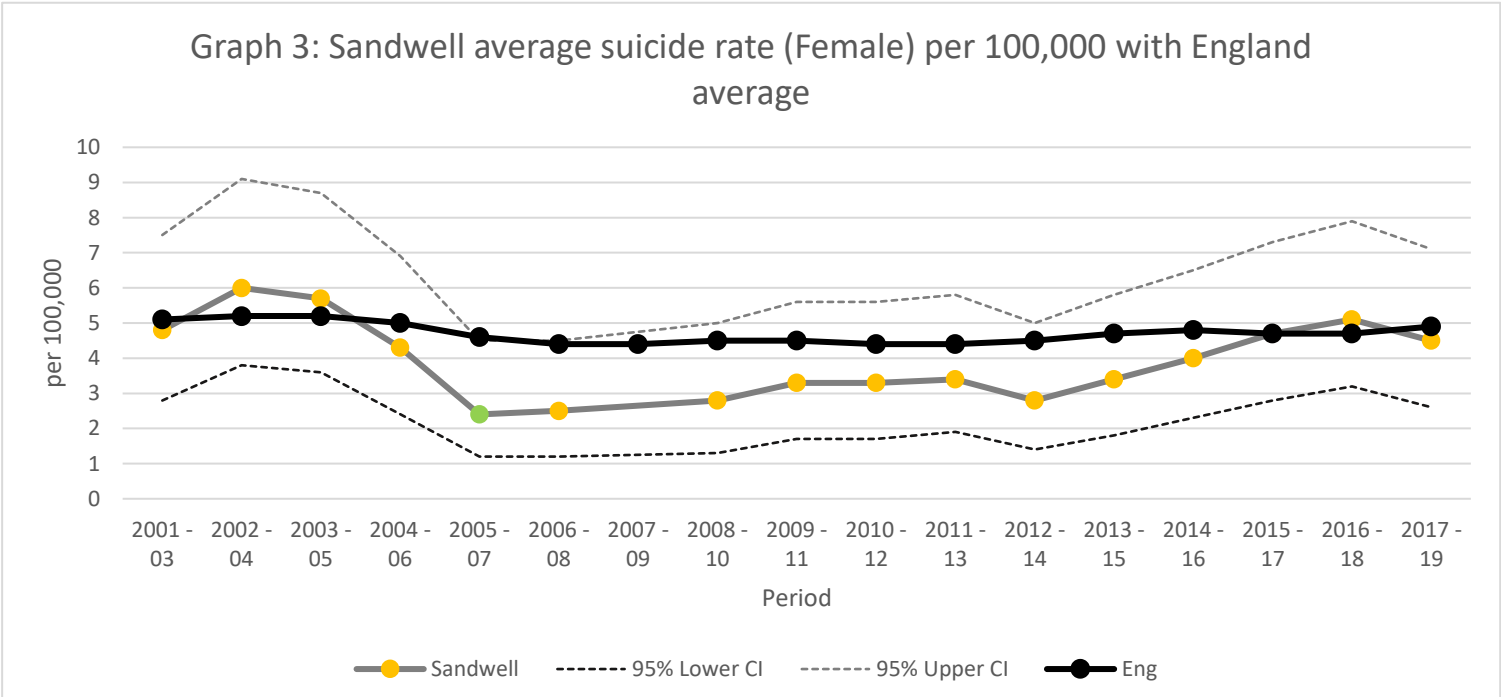
[3] https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide (Accessed: 18/02/2021)

[4] Office of National Statistics, https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/methodologies/suicideratesintheukqmi (Accessed: 23/02/2021)

In line with the overall national and regional picture, Sandwell's rate of suicide in males is far higher than in females. As we can see in Graph 2, for the 2017-19 period, the rate in males was 17.6 per 100,000. Again, the Sandwell rate has fluctuated more widely than the national rate, especially in the last 6 to 7 years. For the reporting period 2017-2019, 79.77% of persons completing suicide were recorded as male.



Graph 3 shows that Sandwell's suicide rate in females, for the period 2017-19, is slightly lower than the national rates. The Sandwell rate is 4.5 per 100,000 compared to 4.8 per 100,00 in the West Midlands and 4.9 per 100,000 in England. It should be noted though that the rate has only decreased compared to the national rate in the most recent reporting period and was otherwise on an upwards trajectory.



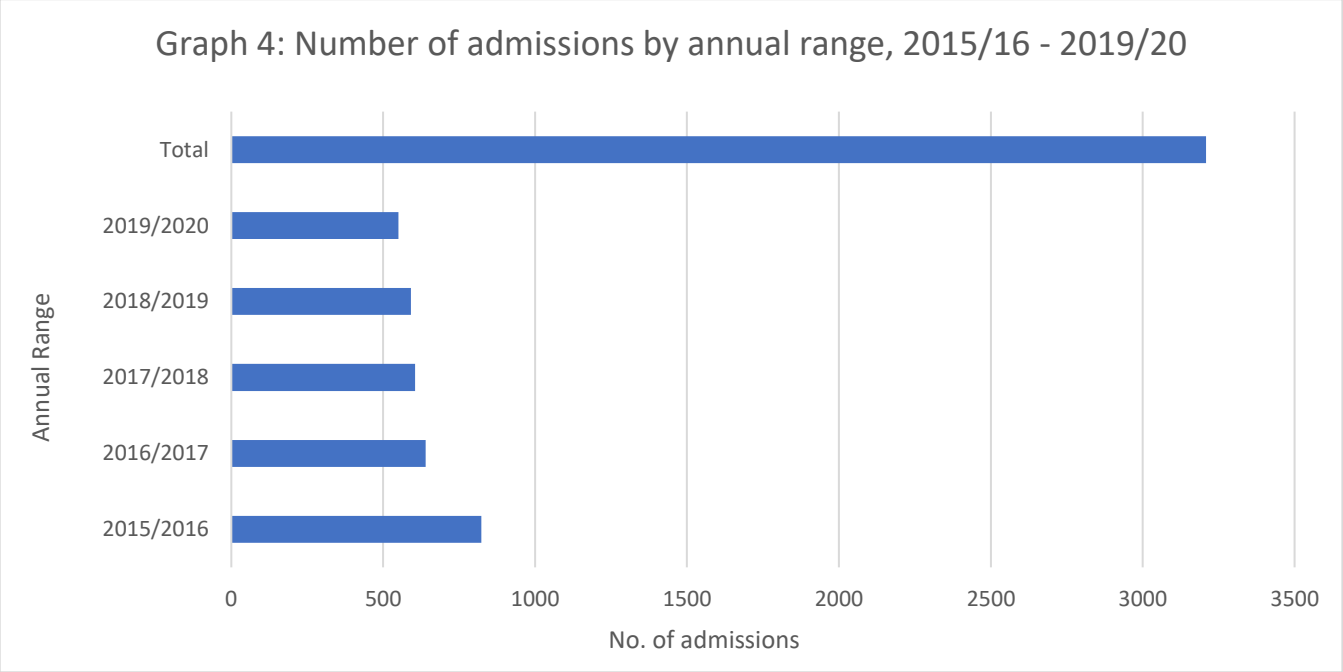
Hospital Episode Statistics (Sandwell & West Birmingham Hospitals NHS Trust)

Hospital Episode Statistics (HES) are recorded every time there is an admission of a patient to hospital. They are categorised through ICD 10 codes. We have used ICD 10 codes X64 through X80 as these relate to intentional self-harm.

Number of Admissions by Annual Range

Table 1: Number of Annual Admissions, 2015/16 – 2019/20		
Year	Number of admissions	% Proportion of Sandwell's population
2015/2016	823	0.26
2016/2017	640	0.20
2017/2018	605	0.19
2018/2019	591	0.18
2019/2020	550	0.17
Total	3209	*N/A*

The data in Table 1 gives us an overview of the admissions, categorised by the ICD10 codes above, in the past 5 years. As such, we can only comment about general trends. For example, we can see that the trend is generally decreasing over this most recent 5-year period, with admissions dropping by approximately 33% from 823 to 550. We can also see that the rate of admissions is dropping compared to the % proportion of Sandwell's population. This is best displayed in Graph 4 below.



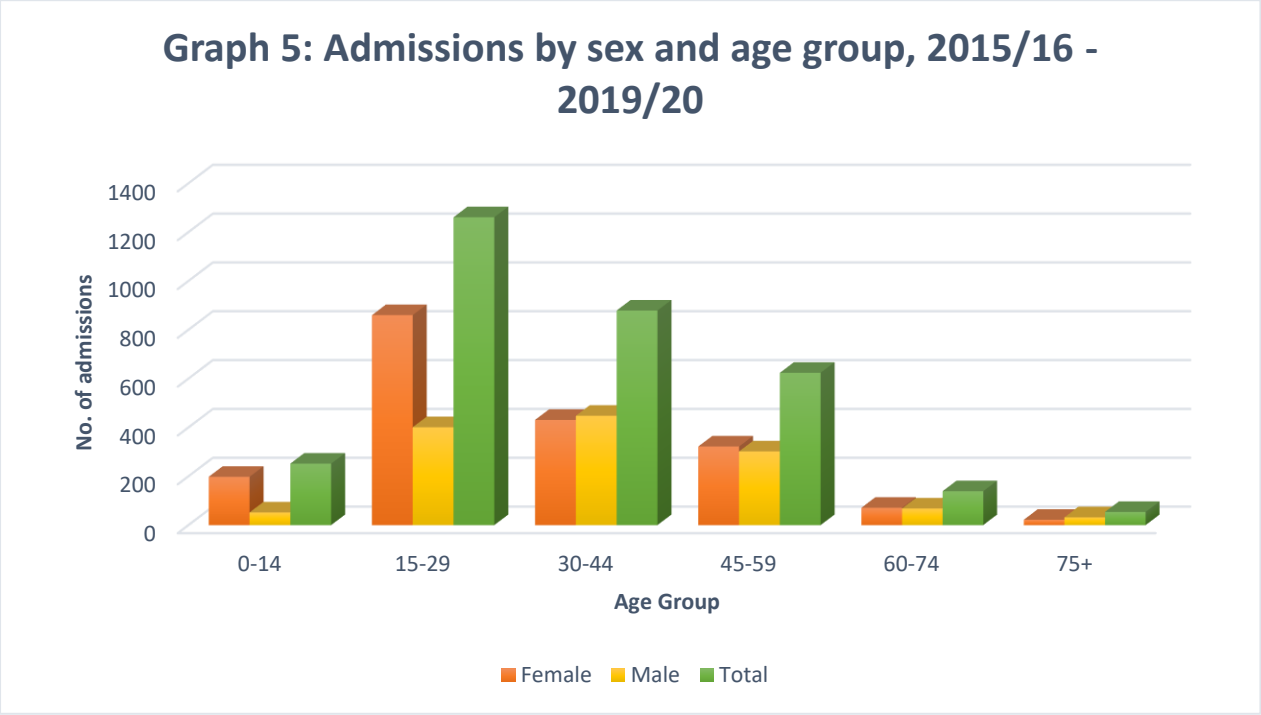
We cannot definitively explain why this is the case, although an increase in awareness and conversation around mental health in recent years may be partially attributable. It should be mentioned though that hospital admissions for intentional self-harm will only make up a fraction of actual instances of self-harm and/or attempted suicide as most will go unreported. Also, while we see a decrease in admissions here, there has been no equal decrease in the average suicide rate so completed suicides are not following this trend. Therefore, we are using these figures as a proxy for wider trends, but this may not accurately reflect the whole situation.

Age Groups

Table 2: Admissions by sex and age group, 2015/16 - 2019/20			
Age group	Female	Male	Total
0-14	198	52	252
15-29	860	401	1261
30-44	431	448	879
45-59	322	302	624
60-74	71	68	139
75+	22	32	54
Total			3209*

*Some values suppressed due to values <6.

Table 2 displays the admissions in the past 5 years broken down by sex and age group. In line with national statistics, the largest group being admitted for intentional self-harm is females aged between 15-29. Equally, there is a higher proportion of females than males being admitted for this reason.



Graph 5 illustrates a clear peak in the 15-29 range with a significant decease after the 45-59 range. This is generally mirrored by the trends for females only. It should be noted again that within the 15-29 range, females make up over 66% of the whole group. It should also be noted that while a smaller proportion compared to later age groups, females represent 79% of admissions in the 0-14 age group. This may suggest that mental health issues appear to either manifest at an earlier age than in males or are expressed more outwardly through intentional self-harm than seen in males.

Another trend to explore is within the 30-44 age group where the admissions for males is slighter higher than for females (448 to 431). This contributes to the trend that while the risk of intentional self-harm appears to decrease for females as they move from late adolescence/20's into their 30s, there is an increase for males. While the increased admission rate between 15-29 and 30-44 for males is approximately 10%, and this data does not confirm whether these were attempted suicides or not, it is representative of the overall increase in risk that appears to characterise this population group.

Ethnicity

Table 3: Admissions by ethnicity and sex, 2015/16 – 2019/20			
Ethnicity (general)	Female	Male	Total
White (British/Irish/Other)	1329	955	2284
Black or Black British	84	21	105
Asian or Asian British	198	119	317
Mixed	52	24	76
Other Ethnic Group	43	28	71
Not Stated/ Not Known	198	157	356*
Total	1904	1304	3209

*Some values suppressed due to values <6.

Table 3 displays a breakdown of sex and ethnicity, with the latter being grouped into general categories. When examining these figures, we should consider the demographic nature of Sandwell to understand the representation of different ethnicities in the admissions data relative to the wider ethnic populations. Using the data collected from the 2011 Census, we can summarise that 66.5% of Sandwell's population are White British while 33.5% of the population are from a Minority Ethnic Group[5]. It is acknowledged that population size will have likely changed since 2011 so these figures are for general reference. A further breakdown is displayed in Table 4 below:

Table 4: Sandwell population by ethnicity, 2011		
Ethnicity	No. of People	% of Population
White (British/Irish/Other)	205,008	66.5
Black or Black British	15,778	5.1
Asian or Asian British	52,779	17.1
Mixed	8,721	2.9
Other Ethnic Group	901	0.3

N.B. The 2021 Census will take place in March and will provide more contemporary data. Therefore, this document could be updated when the data is available to reflect the new trends.

Considering the data from Table 3, the percentage of White (British/Irish/Other) people of both sexes being admitted is approximately 71% while Black or Black British is 3%, Asian or Asian British is 10%, Mixed ethnicity is 2% and Other ethnic groups are 2%. Comparing this to the figures in Table 4, we can see that there is a higher representation of White (British/Irish/Other) people relative to population. On the other hand, there is a lower representation for most of the other major ethnicities in Sandwell. This is explored further in the discussion section.

In Table 3, we can also see that there have been more admissions for females than males, regardless of ethnicity, during the period 2015-20. Charts 1 and 2 below display how the proportions for each ethnicity broken down by sex. They show that there is a slighter higher proportion of non-White female representation in the overall figures for females compared to males. However, the trend of overrepresentation of White (British/Irish/Other) people in the figures continues in both sexes.

[5] Sandwell Trends, https://www.sandwelltrends.info/2011-census/2011-census-ethnicity-hub/ (Accessed: 09/02/2021)

Chart 1: Proportion of hospital admissions for intentional self-harm by sex and ethnicity (Male)

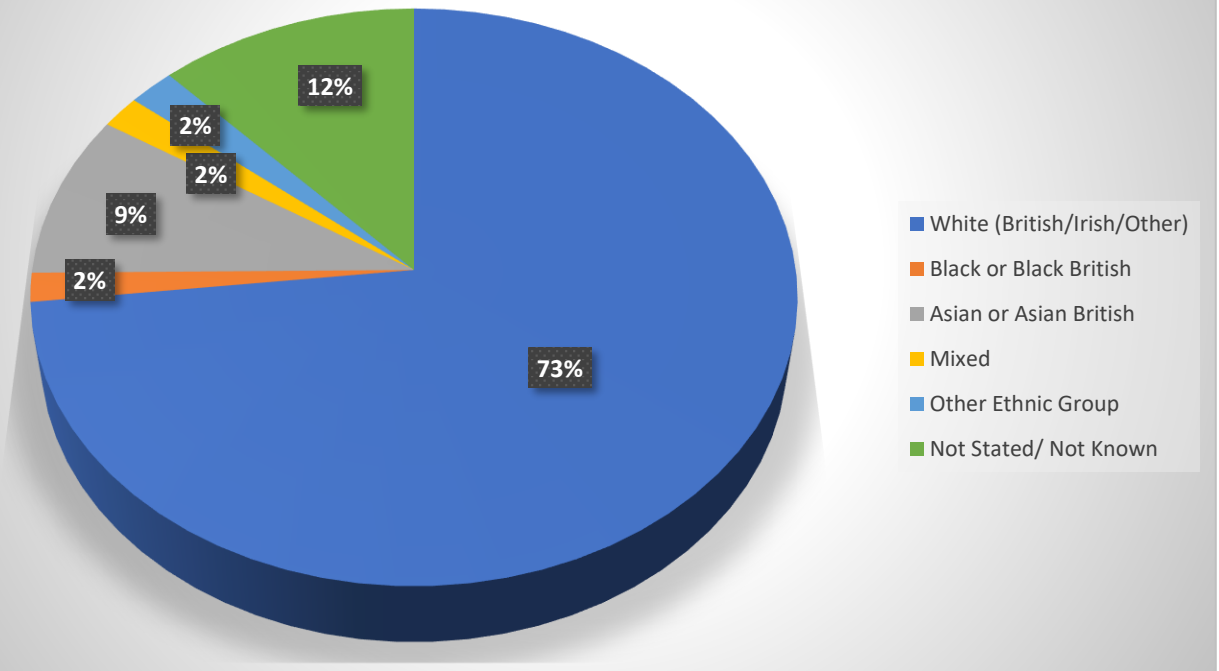


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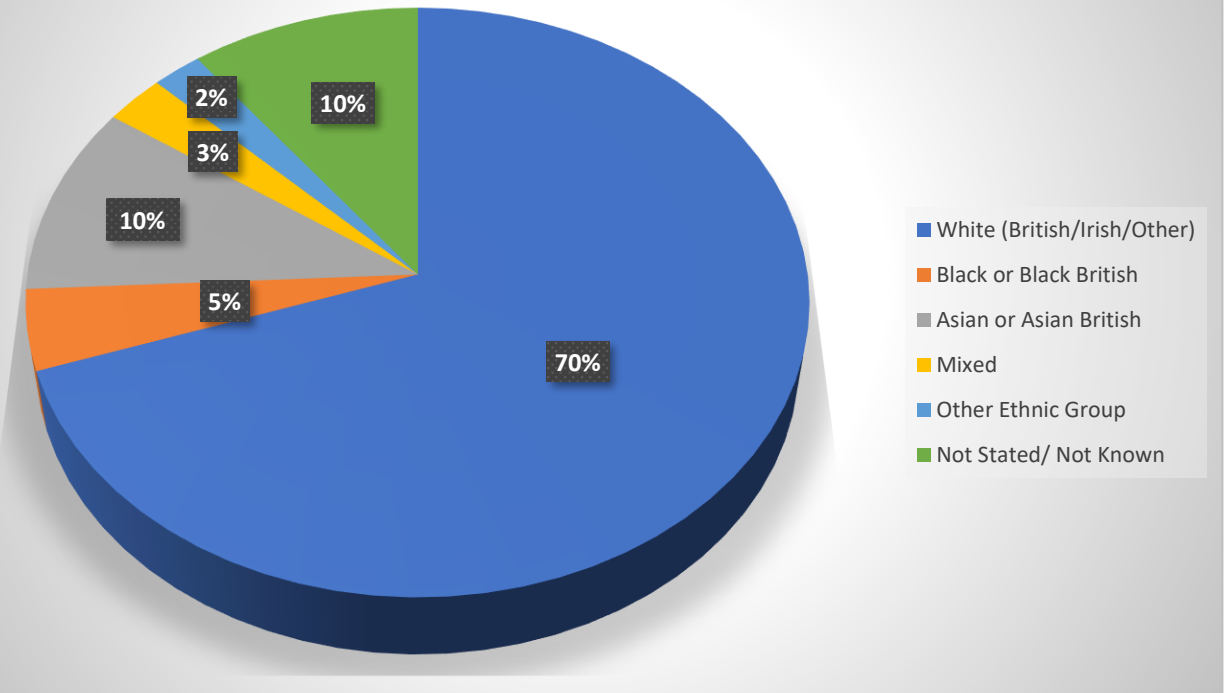
Chart 2: Proportion of hospital admissions for intentional self-harm by sex and ethnicity (Female)



Annual Coroner's Summary Reports (2019/2020)

Coroner's reports for the years 2019 and 2020 were examined to understand the characteristics of those who had recently died by suicide in Sandwell. There were 19 deaths recorded as suicide in January-September 2019 and 18 in the same period for 2020. The January to September reporting window is due to the data only being available for the Research and Intelligence Team in October.

In this section we summarise key trends and learning points derived from the data that will help to inform our recommendations for next steps. However, detailed statistical breakdowns are not given due to small numbers in some of the categories, which could compromise the anonymity of some individuals.

Local data appear to reflect national trends:

- Males accounted for the majority of completed suicides recorded across both periods. The number of recorded suicides was almost four times higher for males than for females.
- The majority of suicides were in those aged 40-69. It should be said that these figures do not reflect the anecdotal increase in reported suicides in children and young persons that have occurred over the 2020/2021 winter months.
- The majority of suicides took place at home or at a private location, with a minority taking place in public settings such as parks and railway stations.

Key Themes and Circumstances

Across the reports for both 2019 and 2020, there were a number of key themes that emerged. These themes can provide insights into factors that may contribute to risk of suicide and help us to identify where support may be needed. It should be noted however that the factors involved in suicide are complex, and that we cannot assume any single issue or combination of issues was the cause of suicide.

Key issues identified across the 2-year period were as follows:

- Relationship breakdown (including child custody issues) was cited in almost a quarter of reports. Approximately two-thirds of people who died by suicide in 2019 and 2020 were single, divorced/separated or widowed, and over one-fifth had recently experienced bereavement.
- Approximately 40% were unemployed or retired.
- Substance and/or alcohol use problems were noted in over one-third of recorded deaths by suicide over the 2-year period.
- Previous suicide attempts and/or admission to hospital for self-harm episodes were noted in over a third of reports. Almost half of people who died by suicide were known to mental health services.

Social isolation is potentially a common underlying factor, particularly among those experiencing relationship breakdown or bereavement, or those who are unemployed. These issues may also be linked to increased financial difficulty, particularly when they co-exist with other difficulties or risk factors. Although it is not possible to determine this from the data, these are areas that may warrant further exploration.

While the number of recorded suicides was similar across both periods, considerably fewer reports in 2020 mentioned contact with mental health services, self-harm admissions or substance and/or alcohol use problems compared with the previous year. This may reflect impacts of the pandemic on access to and interactions with health services.

Qualitative Analysis

Interviews with Partners and Community Organisations

From the interview responses, key themes have been identified and outlined here. These themes were; awareness of services, accessibility of services, the impact of deprivation, the impact of Covid-19, the impact of training and lack of funding. These themes have been explored below:

1. **Awareness of Services**; It was felt that there was a general lack of awareness around non-medical services relating to suicide prevention and bereavement by suicide. All interviewees highlighted this as a major issue in Sandwell. People with lived experience described a lack of follow up or further support following the initial contact with primary care services. This was supported by service providers who felt that partners and associates failed to promote their availability widely enough and that some healthcare professionals weren't aware of them. One interviewee also suggested that using grassroots organisations would help to encourage awareness and discussion of the wider issues around suicide that could lead to better knowledge of services.
2. **Accessibility of Services**; Interviewees felt that services can be difficult to access for residents due to language barriers or low confidence in their offer/s. Multiple interviewees said that with Sandwell's diverse population, there are those that do not speak and/or read English as a first language and therefore find it more difficult to engage with services. This is the case in both physical literature and digital material. One interviewee also noted that they were anecdotally aware of more issues then were being recorded because many residents did not want to formally 'access' the service.
3. **Impact of Deprivation**; There is a higher than average level of deprivation in Sandwell. Interviewees felt that this made risk factors for suicide more widespread and compounded. It was also noted by one interviewee that in areas with high levels of deprivation, more of the population rely on public medical services rather than being able to afford private therapy, for example. This puts extra pressure on these services when services offered by partners should be able to intervene.
4. **Impact of Covid-19**; all interviewees felt there had been an impact of the service they deliver from Covid-19. In particular, they noted that as time goes on, the average number of calls or contacts has only increased as mental health issues are either newly developed or exacerbated by isolation, anxiety or lack of support. Service providers felt that they had managed to adapt their services quickly so that they could still deliver services at the same level as before but in alternative formats.
5. **Impact of Training**; Training can vary from short, online sessions to day-long courses and certifications. Interviewees all spoke positively about the impact of training, mostly because it raises professional awareness of a very complex subject. However, interviewees expressed different ideas on whether training should be provided generally or to more specific groups. One interviewee felt that training did not have to relate just to suicide awareness/prevention and could be about how they could run a more effective organisation for that purpose.
6. **Lack of Funding**; increases in funding would allow services and organisations to expand their offer, for example, by employing more permanent staff or arranging sessions on a more frequent basis. Several interviewees said that there was scope to expand in their organisations but that they risked a loss of quality if they tried to stretch their current resources. This was in part because some of their funding comes from pots of money that they have to spend time and effort creating bids for.

Interviews with People with Lived Experience

The key themes identified through these interviews were; disappointment with clinical pathways, pro-activity from services, context of risk factors, reactions by communities and treatment by the media. These themes have been explored further below:

1. **Disappointment with Clinical Pathways**; Interviewees were dissatisfied with the routes offered by their GP's after seeking help for mental health issues. They described the common pathways as prescription of medication or referral for therapy, which they felt was over-subscribed with long-waiting lists. One interviewee said "*my GP just didn't have the focus on mental health. He recommended that I see a therapist but that couldn't happen for another 6 months, so I paid to go see someone eventually*". Another interviewee said that despite being quite distressed to visit the GP, they received little support and were "*fobbed off"* by being prescribed medication with little discussion of the actual issues. Another interviewee thought that going to the doctors first and ending up at a support group after all other options had been exhausted meant that the pathway was the wrong way around.
2. **Pro-activity from Services**; It was felt that the expectation that individuals who are/have been affected by suicide or suicidal ideation to "*make the call*" puts people off of accessing services because they might not be emotionally ready to move by themselves. One interviewee said that services need to reach out at the earliest point to families and friends affected by suicide. The interviewees stressed that there needed to be recognition by services that people will engage at very different points following their trauma. But if the offer is there then it's on the person's terms when they take it up. Similarly, one interviewee said that they thought it was only through luck that they managed to access a group therapy service after hospitalisation from an attempted suicide because no-one told them about it until they asked.
3. **Understanding Risk Factors**; There was a feeling that the wider context of common risk factors, especially in high-risk populations needs to be appreciated. For example, one interviewee when explaining why they thought suicide rates were much higher in men than in women remarked that for many men, their identity comes in part from their job. Therefore, if they become unemployed then they lose a key part of their identity which only heightens issues such as depression or anxiety. This theme was also touched on by another interviewee who said that the presence of structure in their life was one of the main factors in their recovery because they could appreciate succeeding in "*the positive small things*". For example, they said that when at their lowest even getting out of bed was physically difficult because it is like "*feeling the weight of a ten-tonne duvet*". Equally, one interviewee said it was the combination of a number of risks factors that caused them to attempt suicide. When identifying high-risk populations, we should consider first those who will already be affected by multiple factors.
4. **Reactions by communities**; interviewees who had lived experience of suicidal ideation said that despite the conversation on mental health, and more recently men's mental health, coming on leaps and bounds, there is still a stigma around emotional wellbeing. The biggest issue, they felt, was getting those who are most neglected to share. One interviewee noted that setting is very important and meeting men "*on their terms*" might help their ability to trust those with complex thoughts. Another interviewee who had suffered a bereavement by suicide said that the stigma against talking about it was even worse, especially in their community. They found there were lots of "*closed doors*" and very little professional help that realised how difficult it was to discuss the bereavement in recent terms. As a result, the interviewee felt very isolated and became affected from poor mental well-being.
5. **Treatment by the media**; Interviewees explained how reporting on suicides and treatment of bereaved families needed to be improved as some media outlets currently take a very unsympathetic approach. One interviewee said that that the media were very aggressive in their questioning and cared very little that their family had suffered a trauma so recently. The interviewee said that one reporter even "*got into my home on the day of the funeral to question my partner*". They also said that they reported inaccuracies and failed to respond to the family's complaints.

Discussion

Key Points from Findings

- The qualitative data and parts of the qualitative interviews confirm that the most at-risk group continues to be males aged between 40 to 60. Therefore, recommendations should in part focus on actions for this high-risk population.
- Within the 88% where ethnicity was known on the HES figures, only 15% of people identified as not White (British/Irish/Other). According to the 2011 Census, 33.5% of people in Sandwell identified as non-white. This suggests that fewer non-white people are attending hospital for self-harm/suicide attempts than we would expect. We can conclude at the least that there is over-representation in the HES by those who are recorded as White or from another, less common ethnic group in Sandwell while there is an under-representation of those who are Black/Black British, Asian/Asian British or Mixed ethnicity. A possible reason for this that those with a White ethnicity are more likely to suffer with poor mental health, however, there are not many factors to support that. Another reason could be that those from under-represented ethnicities are less likely to engage with services over mental health issues and as a result are not 'on the radar'.
- The prevalence of recorded suicides occurring at home through hanging can make discussions of measures more complex and this demonstrates the need to have digital tools available as much as physical ones. This data can also be used to ensure that we have partner organisations who can work to specifically prevent locations in certain places (e.g. railway stations/tracks).
- Those who had lived experience of serious mental health issues and/or had had a suicidal ideology acknowledged that self-referral is very difficult and complex. Therefore, there needs to be much greater encouragement to 'spot the signs' and openly discuss these issues regardless of group or settings.
- Those affected from a bereavement by suicide should be treated with support that is more appropriate and specific to their needs. There also cannot be a singular approach to all those affected; for example, within a family, the approach that is taken with parents might not necessarily be suited for siblings or wider family.
- There was broad agreement by both sets of interviewees that action and support at the grassroots community level is the most impactful. Moreover, for those with lived experience, one of the best features of support that they received was being able to talk to those who had experienced exactly the same as them.

Limitations

- Even though Sandwell's average suicide rate generally and in males appears higher than the England average, the relatively small figures for Sandwell mean that it is difficult to say whether it is actually any higher or lower statistically.
- Similarly, any changes in the average rate over time will reflect small changes (e.g. 1 or 2 more suicides a year will make the rate look even higher) so we should instead consider the trend over a period of years.
- While useful, it is important to distinguish that the HES data on intentional self-harm will not directly translate to other data we have on suicide. For example, according to the HES data, the most at-risk group is females aged 15-29. However, in our other data sources, this is a low-risk group. This is because intentional self-harm, while containing attempted suicide, does not always prove a suicidal intention. It does however, give us an insight into self-harm and highlights that these groups may need to be supported in different ways as the targeted suicide services are unlikely to provide the support they need.
- The most recent data from some sources is now approaching being 2 years old and therefore not still accurately representing the borough.
- It should be noted that the even the most up-to-date data will likely not fully reflect the effects of the Covid-19 pandemic yet, although significant effects are expected due to the detrimental impact on mental health.

- Fewer individuals came forward to participate in the interviews than was hoped for in the participants with lived experience. This could be because of the sensitive nature of the topic as well as the difficulty of only being able to use virtual means of communication. Despite this, common themes were found between the interviews that were undertaken.
- We were not able to engage with any individuals under the age of 18 so we are lacking in qualitative data from a child/young person's perspective.

Recommendations

1. **Raise awareness of suicide prevention and bereavement support through training for all frontline staff through online platform;** there is already a wide-ranging e-learning package around safeguarding available for council employees. We should consider using a similar approach for a training package that would cover these topics and link to wider themes on mental health and emotional wellbeing.
2. **Pilot town-based, community-led forums**; there are currently two different pilots based in Tipton with one in particular being wholly-community led with minimal steer from Public Health. This type of grassroots model is one that should be replicated if it works well enough because actions taken by and within the community are much more impactful.
3. **Support community organisations with funding applications**; Public Health and similar organisations with experience of the application process should aid community organisations with bid writing for funding so that they can access the means to grow.
4. **Work with Community Development Workers to identify gaps in accessibility**; one of the major issues highlighted was the lack of accessibility for suicide prevention services. Therefore, Public Health, the CDW's and partners should all actively work to remove the common barriers, whether these be in language or digital literacy or confidence.
5. **Encourage referrals from GP's to targeted services and establish an explicit pathway**; partners can work alongside GP's to ensure that they are aware of non-medical services as well as increase confidence that there is support available for anyone who has been affected by suicide. Part of this will require GP's to have a working knowledge of all up-to-date services so information and communication flow will be critical.
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**; similarly, to the point above, knowledge of bereavement services by professionals can help families and friends feel that help is available, at any time which they chose to take it.
7. **Identify and prioritise high-risk populations through working groups**; the data we've looked at has helped to identify high-risk populations which will require more intense efforts to fight the issues that affect them. There is currently a group undertaking work into suicides in children and young people that is making excellent progress. Further to this, we should actively engage with these populations because they will provide the best insight. Possible future working groups should be focused on populations such as middle-aged men who have recently been unemployed and/or faced a relationship breakdown. Ethnic minority communities, emerging groups directly and indirectly affected by the pandemic.
8. **Improve data collation and intelligence gathering**; there are multiple sources for statistical data that can be shared on a regular basis to identify developing trends. Equally, there should be encouragement for recorded and anecdotal evidence from the borough to be shared among partners so that we can continue to understand what is happening at every level. This also feeds into the requirement to link to the Police's real-time surveillance activities.
9. **Engage with media organisations to work co-operatively on the reporting of suicides**; we should ensure that media organisations have a responsibility to report accurately and compassionately on suicides. We should also establish awareness training sessions with media organisations and reporters so that they understand the impact of their messages on bereaved families and friends.
10. **Commission further assessments on a larger scale that considers further populations**; as noted, this exercise has identified some key issues but has demonstrated that there is scope to commit to further assessments that can explore more specific populations. For example, an investigation into the link between self-harm and suicide may provide further insight when analysis HES data.

Digital Sources

https://www.sandwelltrends.info/2011-census/2011-census-ethnicity-hub/

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/methodologies/suicideratesintheukqmi

https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

Appendices

Appendix 1: Sandwell's Suicide Prevention Six Priorities

Sandwell Suicide Prevention Partnershi

Appendix 2: Interview Questions for Partners/Community Organisations

Sandwell Suicide Prevention JSNA 202(

Appendix 3: Interview Questions for Individuals

Sandwell Suicide Prevention JSNA 202(

Appendix 4: Interview Guide and Consent Form

Sandwell Interview Information and Cons

Appendix 5: Needs Assessment PowerPoint Presentation

SSPP NA Presentation Apr 12 2