APPENDIX A



START A CONVERSATION

Leicester, Leicestershire and Rutland

# SUICIDE PREVENTION STRATEGY

## 2024-2029

Leicestershire County Council

Leicester City Council

Rutland County Council

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# Foreword

This is a draft strategy.

# Introduction

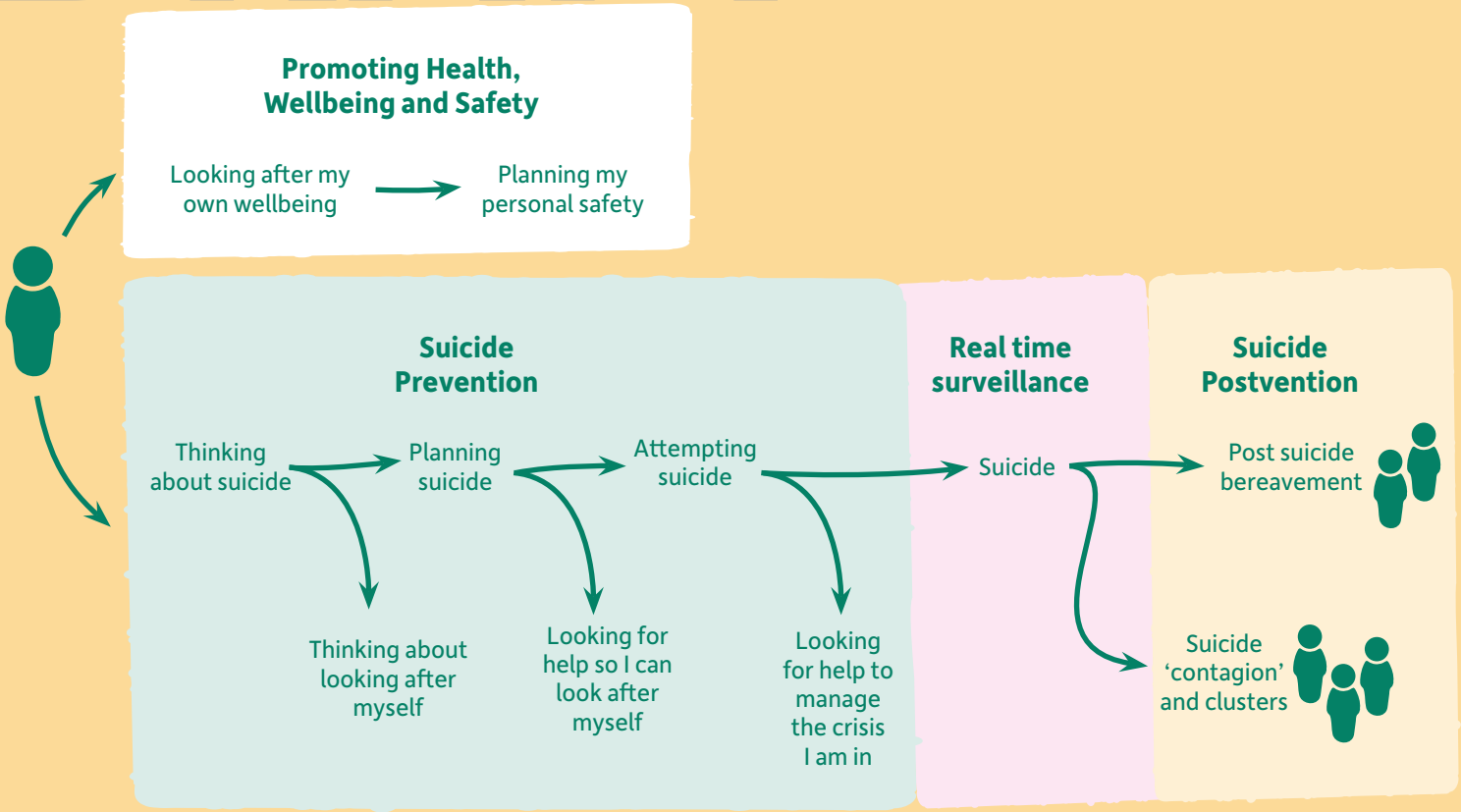
**Welcome to the refreshed Leicester, Leicestershire, and Rutland (LLR) Suicide Prevention Strategy 2024-2029. We have worked hard to refresh our strategy through extensive engagement, consultation, and collaboration. By listening to those with lived experience, stakeholders and partners, and using the best available data, we've created a strategy which aims to fit the needs of those who are experiencing suicidal thoughts, and those impacted by suicide, whilst also aiming to stop people from reaching a point where they feel suicide is their only option.**

This strategy covers LLR – a diverse area with a population of more than 1.1 million people. Every area is different, with its own community strengths and challenges. Understanding our data and populations is crucial so that we can respond to needs, which could be different across the three areas. However, we work in partnership to harness these strengths and tackle the challenges together.

We have aimed to align our LLR strategy with the National Suicide Prevention Strategy where possible, but ensure our principles and priorities are based on what is needed locally. While suicide is a hugely complex issue, it is one that we believe can be reduced through our joint efforts and collective action. Suicide is not inevitable.

Suicide prevention can mean many different things – covering various interventions, points in people's lives, stages of deteriorating mental health, and crisis points. There are opportunities to prevent poor mental health and opportunities to support those at key points in their life where risk is higher, such as unemployment and financial hardship.

The diagram below sums up the prevention pathway for suicide, clearly demonstrating the touch points where suicide could be prevented, and interventions put in place. Ultimately, we want to prevent suicide at the earliest possible opportunity and stop people going into crisis or having suicidal thoughts. Our strategy aims to capture prevention at all points along the continuum but noting that we are adopting a Public Health approach by understanding our data and populations, and aiming for early interventions where possible, with local services working together to address need.




NHSE Midlands Mental Health Team Suicide Prevention Forum 2024

# WHO ARE WE?

We are the LLR Suicide Audit and Prevention Group, a partnership of local authorities, NHS organisations, Leicestershire Police, lived experience and local voluntary and community sector organisations who work together on suicide prevention.

## Our previous strategy had 9 priorities

| | | |
|---|---|---|
| **Target support at key High-Risk Groups and at High-Risk Settings** | **Protect people with a history of self-harm** | **Preventing suicide in public places** |
| **Support Primary Care to Prevent Suicide** | **Engage with Private Sector to Enhance Their Efforts to Prevent Suicide** | **Support Provision of Enhanced Suicide Awareness Training** |
| **Better use of media to manage messages about suicide** | **Raise awareness with better data and better use of data** | **Provide a coordinated mental wellbeing approach to COVID-19** |

## What has been achieved since the previous strategy

Significant progress has been made across these priorities including the commissioning of the LLR Self-Harm service, expansion of the Suicide Bereavement Service and establishment of the LLR Lived Experience Network (for those who have experienced or live with suicidal thoughts, people who have attempted suicide, people living with or in relationships with those who have suicidal thoughts, and those bereaved by suicide). We have continued work on expanding our 'Start a Conversation' website and campaign, launching our new bespoke eLearning, supported by the lived experience network.

We have also worked together to improve our data and evidence, using this to drive service development. Since the previous strategy, we have also established Mental Health Friendly Places. A Mental Health Friendly Place is a public-facing organisation or community space (such as a shop or library) in Leicester, Leicestershire or Rutland that has received training, resources and support to confidently have conversations around low-level mental health and wellbeing. Greater understanding of our data has also led to important developments around high-risk locations, where community responses to local suicides are being utilised, linked to Mental Health Friendly Places, to support hyper local interventions.


However, with the launch of the strategy during the height of the COVID-19 pandemic, there were some elements that we were not able to fully address, which we are open and transparent about. We have used our learning from the previous strategy, to refresh and develop our next strategy iteration based on it being ambitious, but realistic.

Since the launch of the previous strategy, external factors beyond our control (such as the pandemic and cost of living crisis),have likely adversely affected people's mental health and financial stability, both of which are known risk factors for suicide.[1]

## KEY ACHIEVEMENTS

MY SELF REFERRAL

Development of the LLR self-harm service

THE TOMORROW PROJECT
WORKING TOWARDS A BRIGHTER FUTURE

Expansion of the tomorrow project, supporting those bereaved by suicide

Mental Health Friendly Places

Establishment of Mental Health Friendly Places

Lived Experience Network

Establishment of the Lived Experience Network

Production of adult and children's mental health COVID-19 resources

START A CONVERSATION

Start a Conversation eLearning, website revamp and various events and conferences

Established key working group on communications and media, high risk locations and data, which are driving our work in a targeted and evidence-based manner

Ongoing collaboration with Leicestershire Police on the Real Time Suspected Suicide Data

# How was this strategy developed?

This strategy has been informed by a wide range of data, both nationally and locally, as well as academic and expert literature, and importantly though engagement of those with lived experience. The mission, principles and priorities were driven by local Joint Strategic Needs Assessments (JSNA) and Health Needs Assessments on mental health, gambling harms, and substance use, as well as by local Health and Wellbeing Board Priorities, Child Death Overview Panel insight and recommendations on suicide, and the Leicester, Leicestershire and Rutland Integrated Care Board (ICB) 5-year plan. The strategy was also developed in line with the National Suicide Prevention Strategy.

A Health Needs Assessment was undertaken, examining our Real Time Suspected Suicide Surveillance Data (RTSSSD) from 2018-2023, as well as exploring our Office for National Statistics (ONS) data. Suicide data often doesn't show the full picture due to time lags, sensitivity and difficulties with reporting, so other sources, such as academic journals, were used to triangulate the findings, as well as explore **intersectionality** where appropriate. Literature was also systematically reviewed to determine the most recent and possible options for preventative activities and interventions.

**Intersectionality is a way of understanding how different parts of a person's identity, such as their gender or ethnicity, overlap and combine to shape their experiences in the world.**

Engagement with people who have lived experience, and with stakeholders working within suicide and mental health was very important to our strategy development. Focus groups and workshops were held to gather expert voice and were analysed to bring out common themes and areas, which have been translated into our Guiding Principles and Priorities.

The work has been overseen by the LLR Suicide Audit and Prevention Group (SAPG), but developed by a steering group comprising of local authorities, Leicestershire Police, LLR ICB, Leicestershire Partnership NHS Trust, various VCSE organisations and our Lived Experience Network. This strategy is a culmination of collaboration.

# National context, drivers and data

## National Suicide Prevention Strategy

Suicide prevention is an important public health priority nationally, as well as locally, with suicide rates presenting a significant challenge. In England, suicide rates are 10.3 per 100,000 population, which from 2020-2022 equated to 15,415 deaths.[2] The World Health Organisation estimate that for every suicide, there are in turn 20 non-fatal attempts, which equates to 16 million attempts annually (globally).[3] In response, the National Suicide Prevention Strategy 2023-2028[4] has set forth a comprehensive plan to reduce these rates.

The ambitions set out by the national strategy are:

**Reduce the suicide rate over the next 5 years** – with initial reductions observed within half this time or sooner

**Continue to improve support for people who self-harm**

**Continue to improve support for people who have been bereaved by suicide**

### The national strategy also sets out 8 priorities for action

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

Our strategy aligns closely with the National Suicide Prevention Strategy4, which underscores a multi-faceted approach to preventing suicide risk. This includes targeting support towards at-risk groups, promoting mental health education, and ensuring timely and effective interventions. Evidence from key academic literature supports these initiatives, highlighting the effectiveness of early intervention, community-based programs, and improved access to mental health services.

## Risk Factors and Higher Risk Groups

There is no single explanation of why people die by suicide – suicide is complex. However, there are common risk factors, and higher risk groups. The national strategy focuses on at risk groups including:

### Children and young people

- Although numbers are low, there is an increasing national trend which is concerning. In 2019 the World Health Organisation found suicide to be the fourth leading cause of death for young people, both sexes combined, aged 15-29 years.[5]
- Some studies have found that up to 54% of suicides in young people had a history of previous self-harm.[6]
- Antecedents to children and young people's suicides are varied including: academic pressures, bullying (including cyber bullying), bereavement, physical health conditions, family problems, social isolation and abuse or neglect.[6]

### Middle aged men

- Men are three times more likely to die by suicide than women.[4]
- Particularly linked to this group are factors around living in the most deprived areas, unemployment and/or financial hardship and difficulties.

### People with a history of self-harm

- Evidence shows that the risk of suicide among those who have self-harmed is much greater than that of the general population, with the risk elevated by between 30 to 100-fold in the year following an episode of self-harm.[7]

### People in contact with mental health services

- 26% of all people who died by suicide (2011-2021) had recent contact with mental health services (12 months prior to their death).[8]

### People in contact with the justice system

- People in contact with the justice system have higher rates of suicide and self-harm behaviour than the general population.[4]

### Autistic people

- It is estimated that around 1 in 7 people (more than 15% of people in the UK) are neurodivergent, meaning that the brain functions, learns and processes information differently. Evidence suggest that suicide could be one of the leading causes of early death in autistic people, with those diagnosed with autism and no other learning disability being over 9 times more likely to die by suicide.[9]
- We also need to be conscious of the estimated large numbers of people who are undiagnosed, and the impact this may have on their health and wellbeing, as well as acknowledgment of the lengthy waiting times people often experience before receiving a clinical assessment.
  This is also prevalent in other **neurodiversity** conditions, such as ADHD.

**What do we mean by neurodiversity?** People's brains all work in different ways. We all think, speak, feel, act and experience the world differently. Neurodiversity is a term that covers a range of conditions including autism, ADHD, dyslexia, dyspraxia, dyscalculia and Tourette's Syndrome. Neurodiversity encourages acceptance of these differences and conditions, recognising that everyone has unique strengths and challenges.

### Pregnant women and new mothers

- Suicide is the leading cause of direct maternal death in the first year following having a child.[10]

### Those who have been bereaved by suicide

- It is well documented that bereavement due to suicide is different to other forms of loss, including other forms of traumatic or sudden death. Research has shown that bereavement by suicide is associated with suicide risk and poorer mental health.[11,12]
- Evidence suggests family, friends and acquaintances who are bereaved by suicide may have a risk of dying by suicide that is up to 3 times higher than the general population.

### Other risk factors and high-risk groups include (but are not limited to):

- People who misuse alcohol and drugs
- People experiencing problem gambling
  - Data suggests between 4-11% of suicides in the UK are gambling related.[14]
- Access to means, such as firearms and pesticides, which can largely be driven by specific occupational groups e.g. veterinary works and those within the agricultural sector
- Armed forces personal and the veteran community
- Female nurses
- Financial instability and hardship, including unemployment
- Relationship breakdown
- Domestic abuse
- Trauma
  - Whether acute (such as accidents or violence) or chronic (such as ongoing abuse), significantly increases suicide risk. Individuals who have experienced trauma may struggle with emotional pain, hopelessness, and suicidal thoughts.[14]
  - Childhood abuse, sexual trauma, and combat-related trauma are all associated with increased suicide risk. [15, 16, 17]

The **National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)** 2024 annual report provided the follow findings related to people aged 10 and above who died by suicide between 2011 and 2021 within the UK[8]:

- 26% of all people who died by suicide had recent contact with mental health services (12 months prior to their death).
- Of those who died by suicide in contact with clinical care, 48% of them lived alone, 47% had alcohol misuse, 63% had a history of self-harm, and 54% had one or more mental health diagnoses

**Clinical prevention should focus on these common risk factors**

- Highest risk of suicide for those accessing acute mental health care settings was 1-2 weeks following discharge

**Prevention should focus on ward environment and careful transition to the community**

- The report picked out autistic people and patients with ADHD as an emerging group at risk, with 32 deaths per year in autistic people and 15 in those with ADHD
- There were 11 deaths per year for in-patients under 35, and 9 deaths per year in students aged 18-21 under mental health care, highlighting a clearer pathway to NHS services is needed for this cohort
- There were 354 deaths per year in public locations by patients who were generally younger and more acutely unwell

**Local suicide prevention plans should address high risk locations**

Leicestershire Partnership NHS Trust (LPT), in collaboration with the SAPG, have developed a trust wide plan to address the NCISH recommendations and the common themes associated between mental health services and suicide. Having an LPT Plan will support LLR residents who are in contact with local mental health services and ensure high quality of care. We are working closely to ensure this strategy and the LPT Plan are aligned and work together to address suicide, without duplicating efforts. Therefore, clinical mental health service (LPT delivered) and NCISH recommendations will remain within the LPT Plan.

By incorporating evidence-based strategies and drawing on the latest academic research, our local strategy aims to create a robust framework and action plan to ***prevent suicide and save lives***. This strategy not only supports individuals at risk but also builds a safer, more supportive community. Through collaboration with national initiatives and leveraging the insights from key literature, we are committed to making meaningful strides in suicide prevention.

# Local picture

KEY MESSAGES

**2 Suicide can be preventable**

## Our data monitoring

Locally we work closely as a system, relying on the hard work of Leicestershire Police, to understand our suicide data using RTSSSD. Data is extracted from the reports completed by the officers that attend the incidents recorded as a suspected suicide. The timely data that we receive from Leicestershire Police helps with identifying emerging patterns and trends, cluster analysis and the detection of vulnerable groups, allowing for real-time surveillance of suicide that enables systems to respond early and appropriate interventions to take place to reduce suicide rates across LLR. The RTSSSD also provides more granular data per suicide than nationally available data, allowing us to have a better understanding of suicides in LLR.

It is important to note that each record represents a death by suspected suicide and is reported by the date the incident occurred and not the date the death was registered. This means that the data is not conclusive as each case is still subject to a Coroner's inquest. The Local Authority level analysis carried out only applies to residents of those Local Authorities that have died by suspected suicide, whereas the LLR-wide analysis includes all cases of death by suicide attended by Leicestershire Police Officers and can therefore also include residents that live outside of LLR.

We also utilise ONS data, which uses confirmed cases of suicide, after a Coroner's inquest. There are differences between the data, as some cases recorded via RTSSSD may not be deemed as a suicide by the Coroner. There is also a time delay with confirmed suicides, with this being approximately 180 days across LLR (101 days Leicester City, 264 Rutland County and 175 Leicestershire County).[18]

RTSSSD is reported as absolute numbers and/or proportions, without calculation of rates, therefore data should be interpreted with caution, and with an appreciation and understanding of the local context and wider demography of LLR. Rutland data is often suppressed (not shown), due to low numbers.

KEY MESSAGES

**3 Suicide has a wide impact**

## Overall numbers

Between the years of 2020-2022, there were 268 confirmed cases of suicide across LLR.[2] This equates to rates of 9.2 and 9.5 per 100,000 for Leicestershire and Leicester respectively, with the number of suicides in Rutland being too small to calculate a rate. Figure 1 shows the trends of deaths by suicide over time. It can be seen that the local rates fluctuate over time, but at present are not significantly different to the England average but have shown an increase over the last few years.

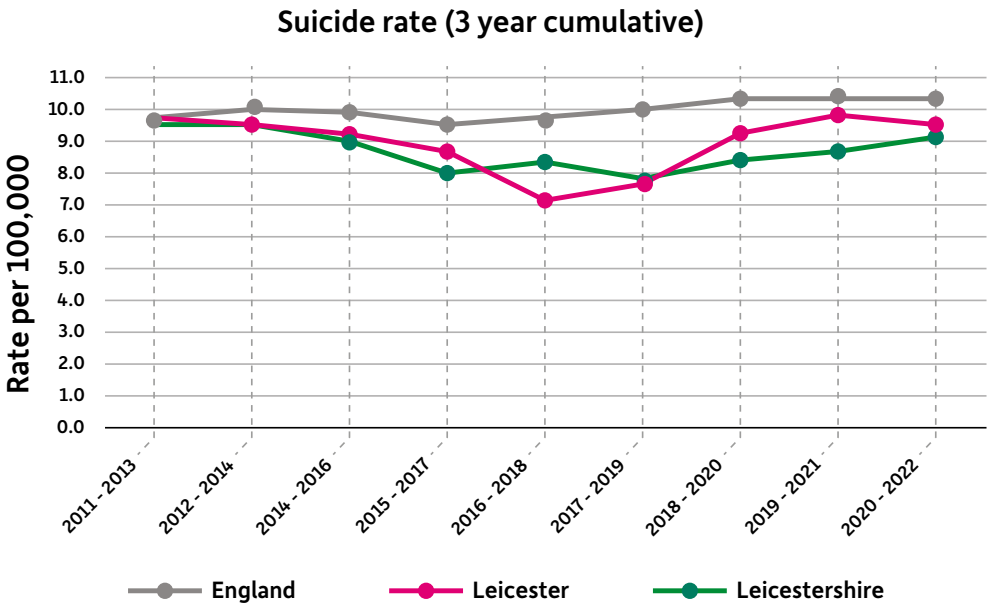



**Figure 1 – Suicide rates for Leicester and Leicestershire 2011-2022**

The numbers of suicides have also fluctuated over time, as demonstrated in figure 2, but have increased since 2020 (ONS). Although we cannot compare ONS data with RTSSSD, the RTSSSD also shows sequential increases. However, within 2023, a 7.8% decrease on the previous year was reported.

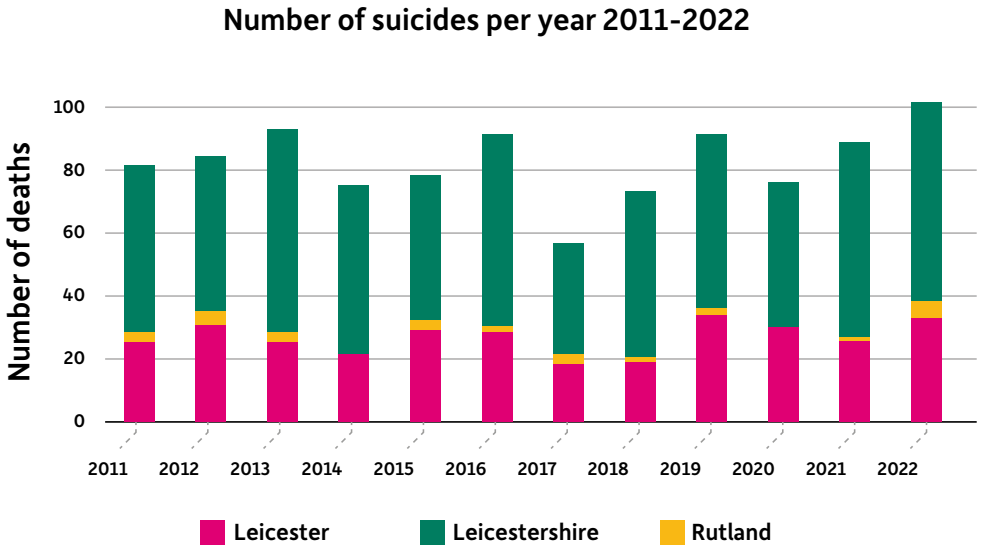



**Figure 2 – Numbers of suicides within LLR 2011-2022 Source: ONS**

## Age

The median (the middle number in an ordered list of numbers) age of suspected suicides varies across LLR (2018-2023), likely due to the varying age demographics per place. Within Leicester, the median ages for men and women are 42 and 38 years respectively, which is younger than the Leicestershire averages at 45 years for males and 49 years for females. Ages within Rutland are again higher at 52 years for males and 57 years for females. Ages also vary across gender, as demonstrated by the RTSSSD in figure 3, with females (46 years) generally being slightly older than males overall (44 years).

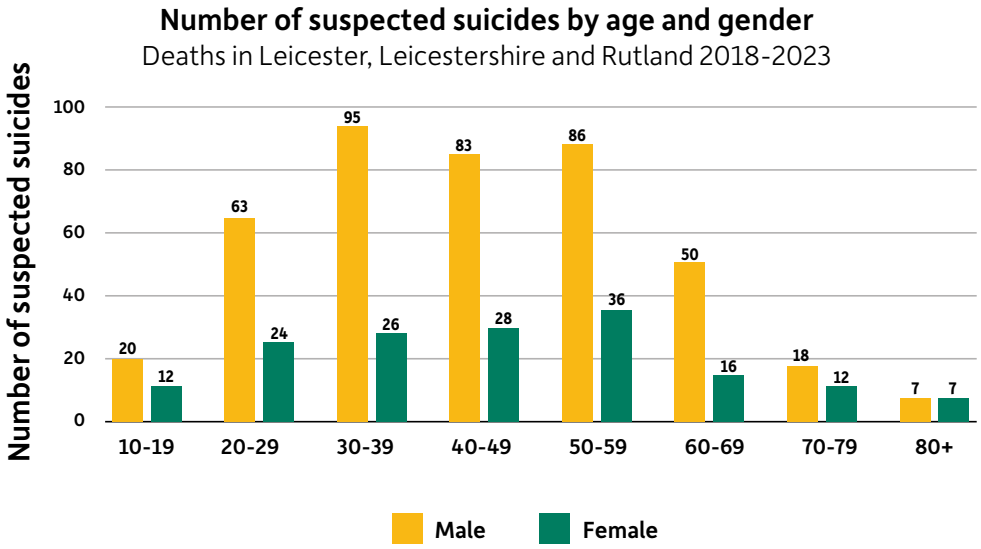



**Figure 3 - Numbers of suspected suicide across LLR 2018-2023 by age category and gender**

## Gender

Nationally, almost 75% of suicides are by men, and this is mirrored locally, with ONS data showing 74.6% of local suicides being in males (figure 4). This can also be broken down by area (figure 5).

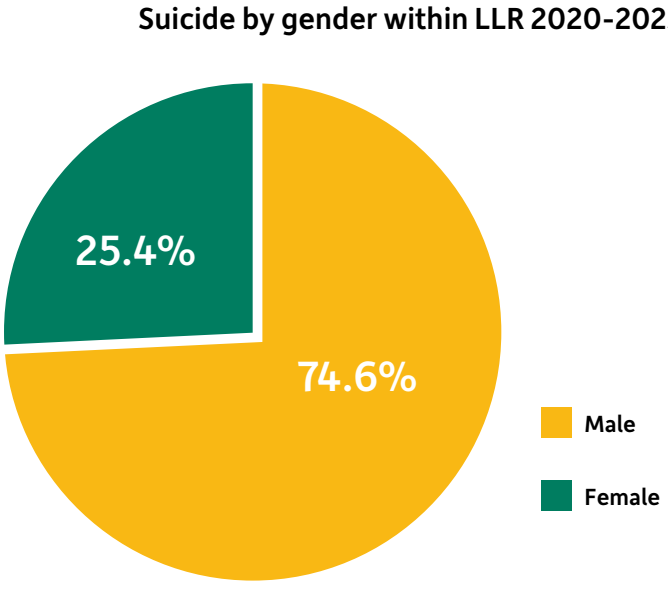



**Figure 4 - Suicide by gender split 2020-2022**

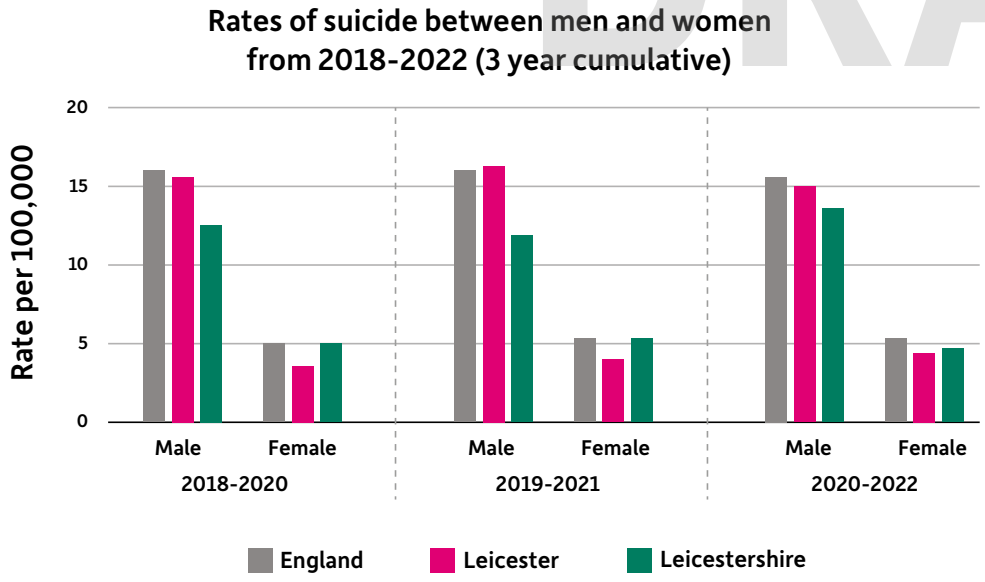



**Figure 5 - Suicide rates by gender 2018-2022**

## Self harm and previous attempts

Self-harm and previous suicide attempt categories within the RTSSSD were only recently separated, therefore data is only available for 2023. Analysis of 2023 data shows that 42% of suspected suicides had a history of self-harm, with a similar proportion (41.2%), having a history of attempting suicide. This demonstrates the significance of the risk factors of self-harm and previous attempts in future deaths.

The Leicestershire and Rutland Adult Mental Health JSNAs estimates 40,000 people to be self-harming and/or attempting suicide per annum[19], with Rutland estimated to be 2,000.[20] Recently, both Leicester and Leicestershire have become significantly worse than the England average for intentional self-harm.

## Other factors – key headlines

Other risk factors are also apparent within the RTSSSD and highlight the complexity of suicide, and the intersectionality that could be at play:

### Marital Status

- Between 2018 and 2023, 51.6% of Leicestershire deaths, 62.9% of Leicester City deaths and 50% of Rutland deaths occurred in single people. Married people accounted for 18.3% in Leicester City, 26.1% in Leicestershire. 2.2% of all suspected suicides in LLR occurred in those in civil partnerships. This could demonstrate the importance of relationships as a protective factor in suicide.

### Unemployment

- Employment is important, with 44.6% of suspected suicide deaths between 2018 and 2023 being in those categorised as unemployed. This is highest within Leicester City with 54.8% of deaths being in the unemployed.
- The majority of the unemployed that died by suspected suicide were unemployed for more than 3 years.

**KEY MESSAGES**

**5 Mental health is as important as physical health**

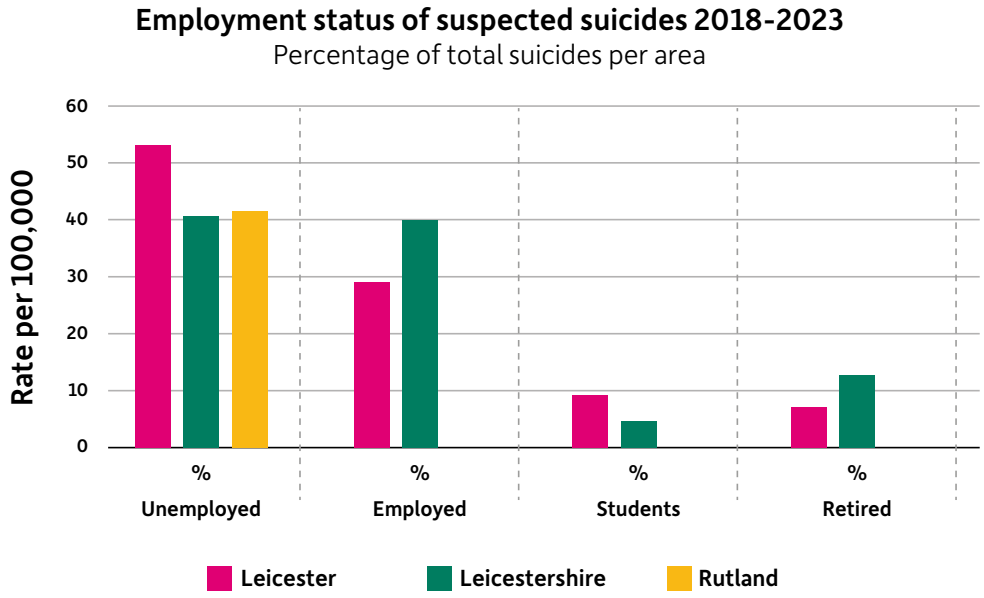



**Figure 6 - Suspected suicides by employment status, per area**

## Financial situation

- Based on 2023 RTSSSD data, 28.6% of suspected suicides were experiencing financial difficulty across LLR. The proportions were higher in Leicester City residents (29.7%) compared to Leicestershire residents (26.7%).

## Mental Health Services

- Our local RTSSSD shows higher values than national in those suicides who were in contact with mental health services prior to their death. Nationally 26% of all suicides were in contact with mental health services, however within Leicestershire this value is 43.3%, 46.2% in Leicester and 41.7% in Rutland.
- This could show the importance of local mental health services understanding and committing to their role around suicide prevention, which the new LPT strategy aims to do. However, the higher proportion could also be due to the success of local services reaching more people, therefore more exploration of this data needs to be undertaken for a more thorough understanding.

## Suicide Audit and Prevention Group

This is a **system**-wide strategy, which is overseen and delivered by the LLR Suicide Audit and Prevention Group (SAPG). The SAPG draws on expertise from the public, private and voluntary sectors. It works as a multi-agency group and as a wider network. The SAPG is responsible for suicide prevention activity development and implementation.

Core membership of the SAPG and associated sub-groups strives to include:

- Voluntary sector organisations with an interest in mental health, supporting people at risk of suicide and those bereaved by suicide
- Public Health, (Leicester City Council, Leicestershire and Rutland County Councils)
- Leicester, Leicestershire and Rutland Integrated Care Board
- Local Authority commissioners of mental health services (Adult Social Care)
- Safeguarding experts
- Secondary care
- Military and Veterans representatives
- Mental Health Providers (Leicestershire Partnership NHS Trust)
- Criminal Justice System, including Leicestershire Police and Probation
- Services and local prisons
- Emergency services (East Midlands Ambulance Service)
- Universities (University of Leicester, De Montfort University, Loughborough University)
- District councils
- Other local authority services such as education psychology and business intelligence
- British Transport Police

**System includes all the organisations (statutory, public and voluntary), settings and resources which are devoted to promoting, sustaining or restoring health, as well as preventing ill health. A system works together to address challenges and help improve the health of the population and the individual.**

**KEY MESSAGES**

**6 Early intervention is vital**

# Our Suicide Prevention Approach 2024-2029

## Mission

There is no acceptable number of suicides, and we believe that suicide does not have to be inevitable. That being said, we do need to be realistic about what can be achieved with the challenges that we face and the resources that we have. We also acknowledge circumstances out with our control which have severe and devasting effects, such as pandemics and austerity measures. We cannot put a number or target on suicide reduction due to this but strive on our mission to "**prevent suicide and save lives**".

## Key messages

From reading this strategy, there are several key messages we want people to remember and share where they can. We need to raise the profile of suicide prevention, and reduce the stigma attached to suicide, and more widely around mental health. We want people to talk about their mental health and not be afraid to reach out for help. Some of these are local key messages, whilst others reflect the messages within the national strategy:

### 1 Suicide is everybody's business

We challenge attitudes to suicide by improving knowledge of suicide risk behaviour and the signs of mental illness. We will work together to maximise our collective impact and support, to prevent suicides within LLR, intervening as early as possible. Everyone should feel confident and have the skills to help prevent suicide.

### 2 Suicide can be preventable

Suicides are not inevitable. We need to build individual and community resilience and support those at higher risk. Suicide rates can be influenced by external factors outside of our control; however, it is important to be accountable and deliver actions to mitigate circumstances where possible and reduce suicides.

### 3 Suicide has a wide impact

Over the last three years, on average 90 people died per year from suicide in Leicester, Leicestershire and Rutland. The reverberations from suicide are felt far and wide, impacting on individuals, families and communities, with an estimated 10 people intimately affected by every suicide. The impacts are also financial, including costs of care, loss of productivity and earnings and are felt by local businesses, individuals and communities.

### 4 Some people are at higher risk of suicide

Suicide risk is higher in particular groups – men are 3 times more likely to die by suicide than women. It is important to target and tailor resources at our local higher risk groups, and that individual needs and experiences are considered in the design and delivery of local services. Those bereaved by suicide are also at higher risk.

### 5 Mental health is as important as physical health

We must reduce stigma surrounding suicide and mental health, increasing the value put on positive mental health, so people feel able to seek help – through the routes that work best for them. This includes raising awareness that no suicide is inevitable.

### 6 Early intervention is vital

Although providing support to those in crisis or having suicidal thoughts is essential, we need to act as early as possible to stop people from reaching this point.

# Our Suicide Prevention Approach 2024-2029

## Plan on a page

### Guiding principles

Co-Production and Collaboration

Learn from past stories

Data driven

Normalising conversations

Settings-based approach

Trauma Informed Practice and Care

### Our mission from this strategy is to prevent suicide and save lives across Leicester, Leicestershire and Rutland

### Key Priorities

Children and Young People

High Risk Groups and Locations

Self-Harm

Bereavement

Leadership

### Key Messages

Suicide is everybody's business

Suicide can be preventable

Suicide has a wide impact

Some people are at higher risk of suicide

Mental health is as important as physical health

Early intervention is vital

# Guiding Principles

Our strategy was developed through research, insight and engagement. During the process key themes kept arising, which we felt as a partnership should guide our work. Rather than being priorities, these are principles which should underpin our work, and help us deliver on our priorities, and ultimately achieve our mission to prevent suicide and save lives. Although not mentioned explicitly, upskilling individuals and organisations is crucial in our delivery and will form key aspects within our actions to deliver the priorities.

### Co-Production and Collaboration

Meaningful and authentic lived experience involvement will underpin everything we do and will be viewed as an essential part of delivering effective services and interventions.

### Learn from past stories

We will seek to understand our local suicides and the intersectionality of factors, using this to inform our future work.

### Data driven

Our work will be driven by our understanding of local data, and the current and emerging evidence base to reduce suicides. We will target our work using data and evidence, ensuring we reach those that need help the most.

### Normalising conversations

We will strive to reduce stigma and taboo around suicide and mental health and encourage people to Start a Conversation. This will be instrumental to all of our work and our priority areas. We will work with local media on aspects of mental health and suicide, ensuring stories are portrayed sensitively and safely, in line with current guidance, and challenge inappropriate reporting and conversations where necessary.

### Settings-based approach

We will adopt a settings-based approach to integrate suicide prevention activity into local communities, organisations and sectors, emphasising education, awareness and training, with a strong focus on early intervention, and local leadership.

### Trauma Informed Practice and Care

We will work to adopt a Trauma Informed Approach in our interactions, delivery and commissioning: understanding past experiences and the needs of the people we serve, including being sensitive to any trauma they may have experienced. By offering support early and being thoughtful in how we provide care, we can help improve lives.

**Trauma Informed Practice (TIP) is an approach that recognises and responds to the impact of trauma on an individual. It involves recognising, understanding and responding to the effects of all types of trauma in a way that emphasises safety, trust and empowerment, whilst avoiding traumatisation.**

# Key Priorities

Our priorities reflect areas which are most important to our stakeholders and those with lived experience, whilst also being data driven. Our priorities are areas which we believe we can directly have an impact on. When devising this strategy, a conscious effort has been made to ensure it is ambitious but also realistic. Our priorities will be driven by our guiding principles.

A robust action plan will bring partners together to ensure our priorities are achieved. We will strengthen approaches through leadership, effective training, proper use of communications and media, and supporting others to take accountability and understand their role in relation to suicide prevention and the priorities below.

Our priorities are:

1

## Supporting the system to put in place measures to help reduce suicidal ideation and suicides in children and young people

Although numbers are small, the national increasing trend is a concern locally. Early interventions, and person-centred support for younger populations can lead to improved mental health and wellbeing, improved resilience and the ability to self-help, both now and into their adult lives. We want to build on the recommendations from the LLR Child Death Overview Panel, and work across the system to support partners to put measures in place to reduce suicidal ideation and behaviours. We want to understand the local system and ensure that suicide becomes everybody's businesses.

We want to normalise conversations around mental health from an early age and equip partners with tools and expertise around building resilience in our children and young people, as well as supporting other factors such as bullying, including cyber bullying, and educating young people on signs and symptoms of poor mental health and where to get help.


## Targeted support and resources at higher risk groups and locations, as identified by local and national data and evidence

Suicide, and the reasons behind are extremely complex, numerous and interlinked. However, by using national data, our RTSSSD and academic literature we can continue to understand the risk factors, higher risk groups and high-risk locations. We will identify and target high risk groups and risk factors, which may include, but are not limited to:

- Middle-aged men
- People in contact with mental health services
- People with substance use challenges
- Autistic people
- Unemployed
- Those in financial hardship
- People experiencing problem gambling
- Those with access to means, such as particular job sectors
- Veterans and those in the armed forces
- Impact of rurality, especially around loneliness and isolation
- Those within the agricultural and farming industries
- Care leavers

We will improve our data utilisation and understanding, taking into account intersectionality of factors that contribute to suicide. We will learn from past stories and put this learning into practice, targeting those higher risk groups, addressing risk factors and working with other organisations to expand our reach. Using a settings-based approach will be crucial to any intervention development and delivery. By working with different settings to strengthen community action, develop skills and knowledge (through training) and create supportive environments, we aim to have a larger impact.

By understanding where local suicides occur, we will continue our work on high-risk locations, aiming to put prevention plans in place. In the County, through our work on Health in All Policies we will work with planning colleagues on highway design, ensuring suicide is factored in through health impact assessments of planning policy and local design.


## Improve our local understanding of self-harm and support people with a history of self-harm

People with a history of self-harm are a key high-risk group, as demonstrated by national and local data. Locally we will work to understand our self-harm rates better, especially regarding data, whilst also working with local services and people with lived experience of self-harm.

Ultimately, we aim to improve the support on offer to people with a history of self-harm, across all age groups, ensuring their needs are met within a timely manner.

## Providing effective bereavement support to those affected by suicide

Every suicide can have a profound and traumatic effect on those close to the individual, as well as the wider community. This puts people experiencing suicide bereavement at risk themselves.

We will continue to develop and deliver the local suicide bereavement offer and ensure lived experience voice is captured and used. We will work on national guidance around how best to support those bereaved by suicide including providing effective and timely support and providing effective local responses to the aftermath of suicide.

## Leadership - Work with system partners and communities to support their role within suicide prevention.

We will work with key organisations, partners and the community to ensure suicide is considered a priority and everyone has an appreciation of their role within suicide prevention. Working as system leaders, we will act collectively to drive change across LLR.

It is crucial to work with our system partners and communities to understand their influences to supporting suicide prevention. We will guide them and provide access to resources and further support, such as training and communications and ensure they are engaged with our Start a Conversation campaign.

The whole is greater than the sum of its part, therefore working collaboratively is key for us achieving our aim of 'preventing suicides and saving lives'.

## How will we monitor and measure success?

A robust action plan will be developed and refreshed annually, to provide tangible and measurable actions. There will also be annual progress reports. Overall numbers of suicides will continue to be monitored and actions put in place to address new and emerging trends.

The action plan will be overseen by the SAPG and discussed as a standing agenda item. Progress against the strategy will also be reported to the relevant Health and Wellbeing Boards and place-based Mental Health meetings and collaboratives.

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Thank you to all partners involved in the creation of this strategy and who work together locally to prevent suicide and save lives.

Leicestershire County Council

Leicester City Council

Rutland County Council

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