Solihull
METROPOLITAN
BOROUGH COUNCIL

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Solihull Suicide Prevention Strategy

2026 - 2029

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1. Background

This strategy is being refreshed as the current strategy (2023-26) expires this year. Over the past 3 years a significant amount of work and progress has been made whilst some challenges remain.

This updated strategy has been informed by the local lessons learned from work conducted under the previous strategy, the national suicide prevention strategy and local engagement with key stakeholders such as colleagues from the Health and VCFSE sectors.

This strategy adopts an all-age approach and is a call to action for organisations, employers, communities and individuals who live, study and work in Solihull to continue to support one another and do all we can to prevent suicide and support those affected by it.

2. Suicide Overview

Suicide prevention is a critical public health priority that requires a coordinated, compassionate, and evidence-based approach. This strategy outlines a comprehensive framework to reduce suicide risk by strengthening protective factors, improving access to timely support, and addressing the social, psychological, and environmental influences on mental wellbeing. Through collaboration across communities, services, and sectors, the strategy aims to save lives and promote hope, resilience, and recovery.

2.1. Defining Suicide

For the purposes of this suicide prevention strategy, suicide is defined as the intentional act of causing one's own death. It is understood as a complex and multifaceted outcome influenced by a range of psychological, social, cultural, economic, and environmental factors, often occurring in the context of significant distress or reduced capacity to cope. This definition recognises that suicidal behaviour is preventable and that effective prevention requires addressing both individual risk factors and the broader conditions that contribute to vulnerability.

2.2. Language

Language plays a critical role in shaping understanding, reducing stigma, and supporting help-seeking around suicide. This strategy promotes the use of respectful, non-judgemental, and person-centred language, avoiding terms that sensationalise, blame, or imply criminality, such as "committed suicide." Instead, language such as "died by suicide" or "suicide attempt" is encouraged. Using clear, compassionate, and recovery-oriented language helps foster safe conversations, supports those with lived experience, and contributes to a culture of prevention, dignity, and hope.



2. Suicide Overview

2.3.1. Mental and Physical Health

Suicide is rarely the result of a single cause and is best understood as the outcome of a complex interaction of individual, social, economic, and environmental factors. Evidence from the UK consistently shows that people experiencing mental ill health, particularly those with a history of self-harm or previous suicide attempts, are at significantly increased risk. The NHS England Adult Psychiatric Morbidity Survey found that the proportion of adults aged 16-74 reporting a history of self-harm increased from 3.8% in 2007 to 10.3% in 2023/24. Among young people, research suggests that around one in five adolescents has self-harmed, with rates particularly high among teenage girls. Self-harm is also recognised as a significant risk factor for suicide, with approximately half of those who die by suicide having a history of self-harm[1]. Long-term physical health conditions, chronic pain, and disability can further compound vulnerability, especially when accompanied by social isolation or limited access to support[2].

2.3.2. Social and Economic Pressures

Wider social and economic pressures play a critical role in shaping suicide risk. Financial hardship, unemployment, debt, housing insecurity, as well as living in areas of deprivation are all associated with increased distress and higher suicide rates[3]. Experiences of trauma, including domestic abuse, sexual violence, and adverse childhood experiences, can have long-lasting effects on mental wellbeing and contribute to elevated risk across the life course[4]. Bereavement, particularly following a death by suicide, is also recognised as a significant risk factor, underlining the importance of timely and effective postvention support[5].

2.3.3. Specific Population Groups

Certain population groups experience disproportionate risk. Men, particularly those in middle age, account for most suicide deaths in the UK[6], while suicide remains a leading cause of death among younger people[7]. Evidence also highlights increased risk among LGBTQ+ individuals[8], people experiencing homelessness[9], those involved with the criminal justice system[10], and people working in high-stress or trauma-exposed occupations such as health and emergency services[11]. Social isolation and loneliness, which can affect people at all ages, further increase vulnerability[12].

2. Suicide Overview

2.3.4. Environmental and Situational Factors

Wider contextual factors can also influence suicide risk. Substance misuse, including alcohol and drugs, can increase impulsivity and exacerbate underlying mental health difficulties[13]. Relationship breakdown is also recognised as a significant risk factor for suicide, particularly among men. Evidence shows that separation, divorce, and the end of intimate relationships can increase feelings of loneliness, loss, hopelessness, emotional distress, and social isolation, all of which are associated with a higher risk of suicidal thoughts and behaviour[14]. Access to lethal means or high-risk locations increases the likelihood that suicidal behaviour results in death, reinforcing the importance of means-restriction and safety measures as part of a comprehensive preventative approach[15].



2.3.5.

Understanding these interconnected risk factors is essential to effective suicide prevention. This strategy recognises that reducing suicide requires action across the whole system, addressing individual needs, strengthening protective factors, tackling inequalities, and creating supportive environments that reduce risk and promote hope, connection, and recovery.

3. Our Journey So Far: 2023 - 2026

3.1 Priority 1 - Safer Suicide Communities

The 2023–2026 Suicide Prevention Strategy prioritised the development of site-specific action plans, strengthening collaboration with media and infrastructure partners, and enhancing data monitoring to guide timely interventions.

As part of our offer to children and young people, as well as providing additional support and resources, online safety was actively promoted through the Samaritans Online Excellence Programme. This was complemented by regular dissemination of guidance and best-practice updates across all stakeholders.

Locally, intelligence is now shared with transport and safety agencies, planning policies are reviewed, and national strategies are adapted to inform regional actions.

We successfully launched Solihull and Birmingham's Orange Button Scheme, which is a community-based suicide awareness and support initiative. The scheme is designed to make it easier for people experiencing suicidal thoughts, or those worried about someone, to find someone who can listen, talk openly about suicide, and point them toward appropriate help.

To date, more than 750 individuals have completed the training programme. Participants consistently report increased confidence in recognising the signs that someone may be considering suicide, how to engage in compassionate and supportive conversations with those experiencing distress, and where to signpost individuals to appropriate services and sources of support.

3. Our Journey So Far: 2023 - 2026

3.1 Priority 1 - Safer Suicide Communities (cont'd)

Quotes from people who have previously been on the training:

> **"It has helped me to ask pupils I work with directly if they are having thoughts of suicide. It helps them to speak to me more freely as they know I do not stigmatise those thoughts and feelings. I feel confident when they say they have been feeling like that, to support them but also to speak with parents about this."**



> **"My friend was very low. I felt I could speak to her and then signposted her to the help required. We made a signal on a text message if she needed support, I would know she needs help."**

3. Our Journey So Far: 2023 - 2026

Case Study

A recent example highlights the practical impact of the Orange Button training programme.

An individual who had recently completed the training was cycling across a bridge when they noticed a person in clear distress. Recognising the potential seriousness of the situation, they stopped to engage the individual in conversation. Through calm and supportive dialogue, they were able to build rapport and assess the level of risk.
Together, they agreed that attending hospital was the safest course of action.

The trained individual remained with the person, providing reassurance and support, until emergency services arrived. The incident was witnessed by several members of the public, who later confirmed that the responder had recently completed the Orange Button training, demonstrating the programme's direct and positive impact in a real-world situation.



3. Our Journey So Far: 2023 - 2026

3.2 Priority 2 - Better Support and Care for those at the Highest Risk of Dying by Suicide

This work focused on reducing suicide risk among key high-risk groups by strengthening safety, support and prevention across health, justice, occupational and community settings. Actions included improving patient safety and care transitions in mental health services, enhancing support for people at key transition points, as well as delivering targeted training for high-risk occupations. It also prioritised up to date guidance responses to self-harm in health services and provided improved postvention support for people bereaved or affected by suicide, including tailored support for schools and education settings. Tailored guidance and action pathways along with process maps were provided to Headteachers to support them managing the death of a student or staff member. This included establishing multi-agency task and finish groups immediately following an incident to coordinate support, and ensuring that all available resources were delivered in a timely, planned, and effective manner.



3.3 Priority 3 Working together to prevent suicide.

By tailoring suicide prevention and mental health support to specific groups, particularly children and young people, we strengthened prevention and postvention planning in educational settings, ensuring vulnerable young people, including those outside formal education, are reached. A comprehensive postvention package for schools has been implemented, alongside training, clear protocols, and stronger partnerships to support transitions and crisis responses. Wider actions ensure approaches reflect the needs of diverse populations through equality impact assessments, improved data sharing, and leadership on inclusion, while responsible media reporting is supported through Samaritans' advisory services. In primary care, NICE guidance on depression has been reviewed, with ongoing work to improve safe prescribing and links to chronic pain services.

3. Our Journey So Far: 2023 - 2026

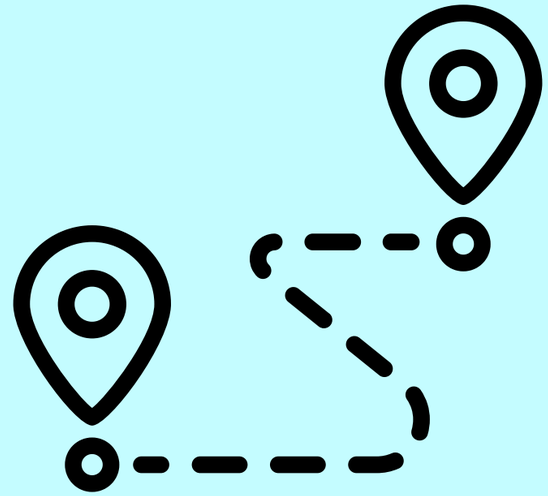
3.4 Priority 4 - Learning from those who have died by Suicide

This work focused on reducing access to the means of suicide by strengthening surveillance and data-led prevention. Plans are ongoing to implement a real-time suicide surveillance system, supported by a multi-agency group to identify and respond to emerging trends, as well as safer prescribing practices to reduce access to harmful medication. In parallel, a five-year coronial audit has been completed, with findings used to inform and refresh the local suicide prevention strategy. The audit highlighted the following:

- Men in mid-life remain the highest-risk group.
- Mental health issues are prevalent but not universal.
- A significant proportion had recent service contact, suggesting opportunities for intervention.
- Social adversity (childhood trauma, isolation, relationship breakdown) is strongly represented.
- Criminal justice contact appears repeatedly as a background or triggering factor.

Implications for prevention suggest efforts should focus on:

- Middle-aged men
- Individuals living alone.
- Those with deteriorating mental or physical health
- People experiencing relationship breakdown.
- Individuals in contact with criminal justice services
- Addressing social isolation and adverse childhood experiences
- Strengthening follow-up after primary and secondary care contact



4. National Suicide Data and Evidence

4.1. There were 6,190 suicides registered in England and Wales (11.4 suicide deaths registered per 100,000 people) in 2024; a similar rate to 2023, with 11.3 suicide deaths registered per 100,000 people.

4.2. For males, the suicide rate in England and Wales remained relatively unchanged in 2024 at 17.6 suicide deaths registered per 100,000 people, compared with 17.4 suicide deaths registered per 100,000 people in 2023; the suicide rate remained stable for females at 5.7 suicide deaths registered per 100,000 people in 2024 and in 2023.



4.3. The age-specific suicide rate was highest for males aged 50 to 54 years (27.5 suicide deaths registered per 100,000 people), and for females aged 45 to 49 years (7.9 suicide deaths registered per 100,000 people).

4.4. In 2024, the suicide rate in Wales (15.7 suicide deaths registered per 100,000 people) was higher than in England (11.1 suicide deaths registered per 100,000 people), this was an increase in Wales with the rate in 2023 being 14.0 suicide deaths registered per 100,000 people. (15)

5. **Suicide Data and Evidence in Solihull and the West Midlands**

5.1. Over the last 15 years, suicide rates in Solihull have shown an overall upward trend compared to the national average. Following a peak in the period 2017 – 19, rates are now in line with the national average. Suicide rates are measured using the Directly Standardised Rate (DSR), which adjusts for changes in population age structure, to enable meaningful comparison over time. This equates to an average rate from 2002-04 to 2011-13 of 6.13 per 100,000 population, compared with an average rate from 2012-14 to 2021-23 of 10.59. Factors that may have contributed to this trend are:

5.1.1 Despite having areas of high affluence,16% of Solihull's population live in the most deprived 20% of neighbourhoods in England. Research links social isolation and financial instability/poverty to higher suicide risks, which have been exacerbated by the cost-of-living crisis and post-COVID recovery.

5.1.2 Data indicates that white ethnicity is associated with a higher risk of suicide, and a higher proportion of the Solihull population is white compared to the national average.

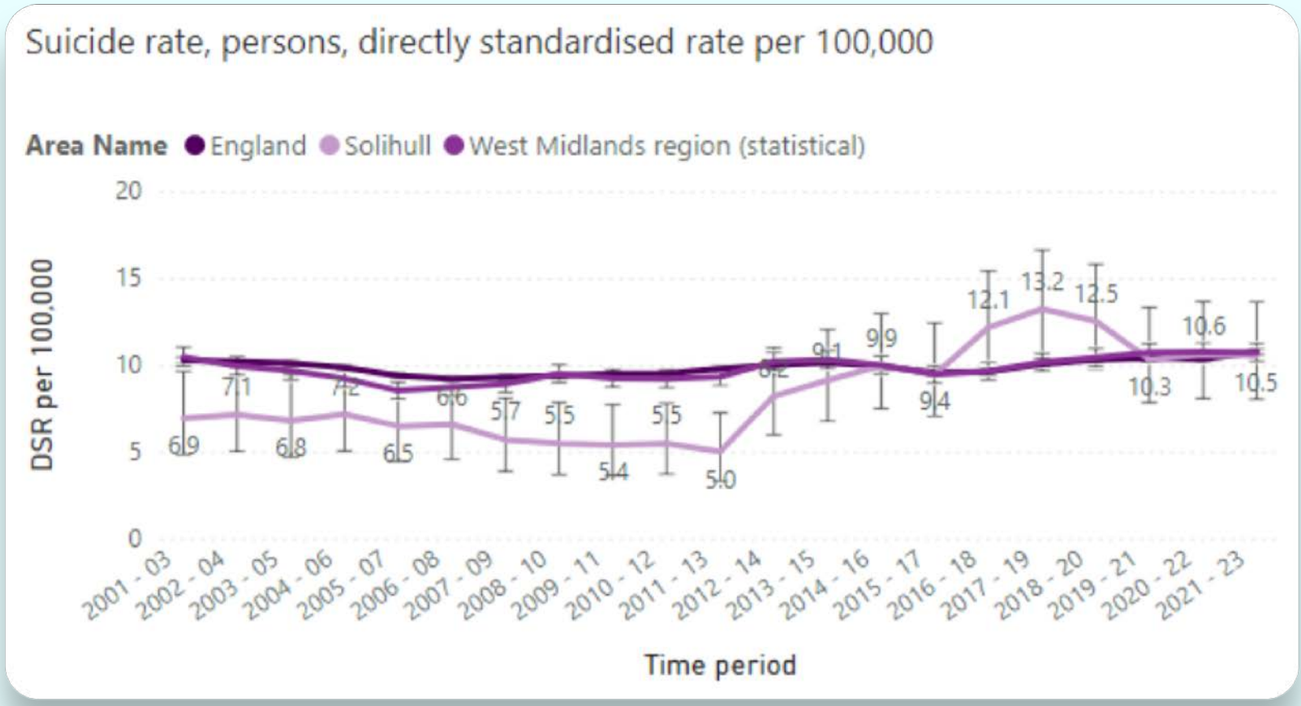
5.1.3 Following 2017/18, coroner guidelines changed to allow 'death through suicide' to be based on the "civil standard" (balance of probabilities) rather than "beyond reasonable doubt". This change has increased the number of deaths officially recorded as suicide across England, but it has had a more pronounced impact on local data in some areas, including those in the West Midlands.



5. Suicide Data and Evidence in Solihull and the West Midlands

5.1.4 Solihull has an aging population, which brings an increased risk of social isolation and, consequently, poorer mental health.

5.2 The following chart shows the suicide rate (per 100,000 population) in Solihull, West Midlands and England. Although rates were above the national average between 2016 and 2020, they have since declined and are now broadly in line with the national average. A directly standardised rate (DSR) is a statistical measure used to compare rates between populations that have different structures, most commonly different age distributions. Data Source: OHID Fingertips, updated September 2025



6. Gender Differences in Suicide Rates in Solihull

6.1. In Solihull, as across the rest of the UK, the suicide rate for males is significantly higher than for females, with men accounting for three-quarters of all suicide deaths. In Solihull specifically, men are over three times more likely to die by suicide than women. The reasons for this disparity are complex, stemming from a combination of social, cultural, and behavioural factors including:

6.1.2 "Stoic" Gender Norms and Help-Seeking Behaviour. Men often face societal pressure to "man up," remain stoic, and suppress emotions, leading to lower rates of seeking help for mental health issues.

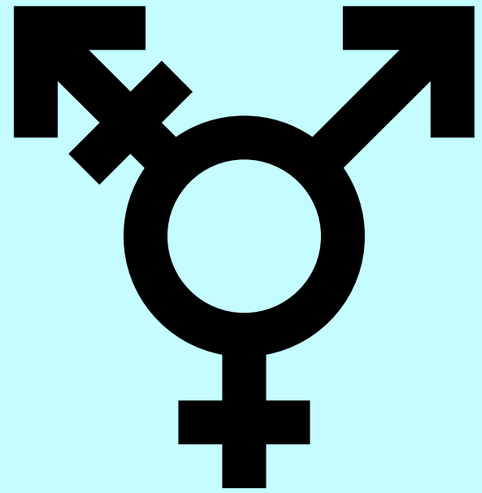
6.1.3 Method Lethality. While women are more likely to attempt suicide or self-harm, evidenced by higher hospital admissions for self-harm in Solihull, men tend to choose more violent or immediate methods of suicide.

6.1.4 Relationship Breakdown. Relationship breakdowns, including separation and divorce, have a more severe impact on men, significantly increasing their risk of suicide.

6.1.5 Social Isolation. Loneliness, particularly in middle-aged men, is a major risk factor, with many men having fewer, less supportive social networks than women.

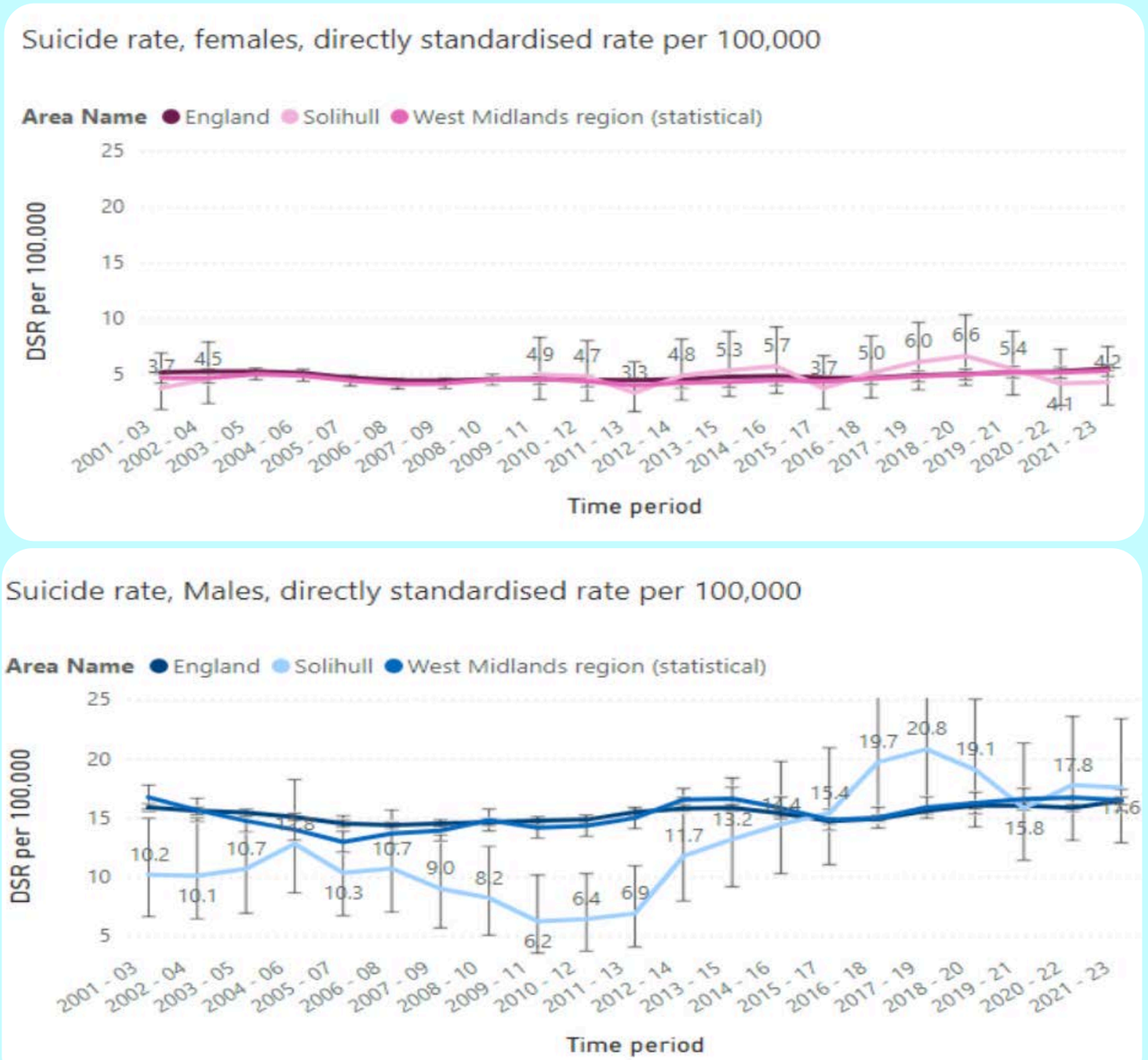
6.1.6 Substance Misuse. Men are more likely to use alcohol or drugs to "self-medicate" or manage distress, which can worsen depression and increase impulsive behaviour.

6.1.7 Socioeconomic Pressures. Financial instability, unemployment, or loss of employment are significant factors that disproportionately affect men, particularly when they identify as the primary provider.



6.1.8 The following charts shows the suicide rate in men and women (per 100,000 population) in Solihull, West Midlands and England. A directly standardised rate (DSR) is a statistical measure used to compare rates between populations that have different structures, most commonly different age distributions. Data Source: OHID Fingertips, updated September 2025

6. **Gender differences in Suicide Rates in Solihull**



7. Refresh of our Local Strategy

The Suicide prevention strategy for England: 2023 to 2028 identified eight priorities, these remain relevant and we have used them to inform our approach. They are:

7.1. Improve data and evidence
Strengthen the quality, timeliness, and use of data, research, and lived-experience insight to better understand suicide risk, trends, and what works in prevention.

7.2. Provide tailored, targeted support to priority groups.
Design and deliver suicide prevention approaches that meet the specific needs of groups at higher risk, addressing inequalities and barriers to access.

7.3. Address common risk factors at a population level.
Reduce exposure to shared social, economic, and environmental risk factors such as poverty, isolation, and substance misuse, through upstream, preventative action.

7.4. Promote online safety and responsible media content.
Encourage safe online environments, responsible reporting and portrayal of suicide to reduce harm, contagion, and distress, particularly among vulnerable groups.

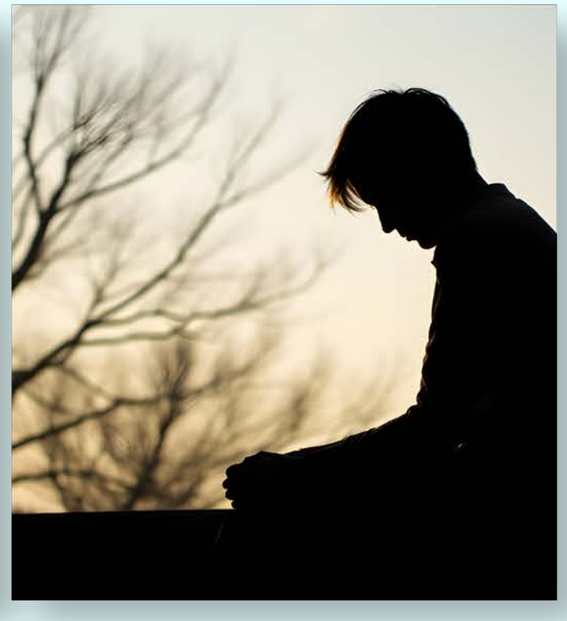
7.5. Provide effective crisis support.
Ensure timely, accessible, and compassionate crisis support is available to people experiencing suicidal distress, across health, social care, and community settings.

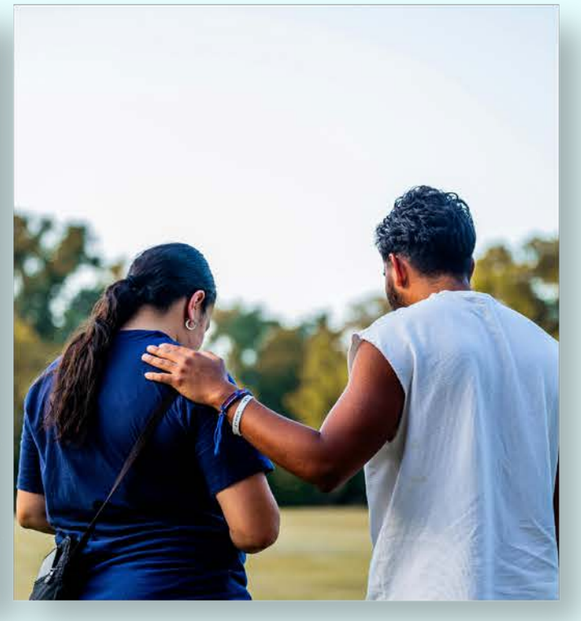
7. **Refresh of our Local Strategy**

7.6. Reduce access to means of suicide when appropriate.
Implement evidence-based measures to limit access to lethal means in high-risk situations, while respecting individual rights and clinical judgement.

7.7. Provide effective bereavement support.
Offer timely and appropriate support to people bereaved by suicide to reduce the risk of adverse mental health outcomes and further suicides

7.8. Make suicide prevention everybody's business.
Embed suicide prevention across government, services, workplaces, communities, and society, recognising the shared responsibility for preventing suicide.



8. **Local Context**

Solihull's Health & Wellbeing Board is responsible for the overarching governance of the Solihull Suicide Prevention Strategy.

Over the course of this strategy period there will be significant changes in the health and social care system. This includes the national restructure of the Integrated Care Boards (ICBs). For Solihull this will mean a larger footprint for a new Birmingham, Solihull and Black Country ICB and a refreshed approach to strategic commissioning. In addition, there are significant social care reforms aimed at increasing integration and reducing escalation of issues. Also, Neighbourhood Health will be implemented as part of the NHS 10 Year Plan, which aims to shift care closer to home, strengthen prevention, and improve how services are organised around people and communities.

Therefore, reporting of the delivery of the Suicide Prevention Strategy will be responsive to developments in local governance structures.

We also have local strategies and plans that involve action to address different risk and protective factors for suicide, suicidal behaviour, and self-harm, including:

8.1. The Birmingham and Solihull Mental Health and Learning Disabilities Provider Collaborative formally brings together the Birmingham and Solihull Mental Health NHS Foundation Trusty (BSMHFT), Birmingham Community Healthcare NHS Foundation Trust (BCHC) and Voluntary, Community, Faith and Social Enterprise organisations. The provider collaborative is hosted by Birmingham and Solihull Mental Health Foundation Trust and works in close partnership with Solihull Council and the ICB to shape mental health service provision across Birmingham and Solihull.

NHS
Birmingham and Solihull
Mental Health NHS Foundation Trust

8. **Local Context**

The provider Collaborative have developed the Five Year Strategy for Mental Health 2026-2031 - Supporting mental health and wellbeing at every stage of life.

This includes five transformation priorities: Children and young people; acute and urgent care; mental health services in the community; specialist placement pathways and learning disabilities and autism.



8.2. Sitting along-side the Birmingham and Solihull Five Year Strategy for Mental Health 2026-2031, the Solihull Mental Health Delivery Plan will strengthen system-wide commitment to improving the mental health and wellbeing of our citizens at place. This plan is being developed by a multi-agency Task and Finish Group.

9. **Findings from the Consultation**

A multi-agency consultation workshop was convened to inform the refresh of the local Suicide Prevention Strategy, bringing together a broad range of partners, stakeholders, and subject matter experts. The session formed a key milestone in ensuring the refreshed strategy reflects current evidence, lived experience insight, system learning, and emerging local priorities.

Attendees included representatives from health services, public health, local authority teams, voluntary and community sector organisations, education providers and lived experience representatives. The workshop provided a structured and collaborative environment to review progress against the existing strategy, assess evolving needs, and identify opportunities for strengthened partnership working.

The session focused on:

- Reviewing current trends and emerging risk factors
- Identifying gaps in provision and priority populations
- Exploring best practice guidance and national policy updates
- Generating consensus on refreshed strategic priorities and delivery principles

Facilitated discussions enabled participants to share insights from frontline delivery, highlight innovation, and identify barriers impacting prevention efforts. Emphasis was placed on early intervention, addressing health inequalities, strengthening community-based approaches, and improving postvention support.

Feedback gathered during the workshop has directly informed the updated Suicide Prevention Strategy, ensuring it is evidence-led, partnership-driven, and aligned with local population needs.

The workshop demonstrated strong collective commitment across the system to reducing suicide rates, improving mental wellbeing, and delivering coordinated, compassionate support to those at risk.

9. Findings from the Consultation

9.1. Summary of the key themes from Workshop

9.1.1 Enhanced Multi-Agency Working:
Suicide prevention benefits from improved, clear, joined up, and consistent system working.

9.1.2 Visibility, Access and Navigation of Support:
Support exists but can be fragmented, unclear, or inaccessible, especially at crisis points.

9.1.3 Priority Groups Need More Tailored, Targeted Support:
Inequalities and unmet needs persist, requiring tailored, culturally appropriate and accessible support models.

9.1.4 Workforce Capacity, Training and Empowerment:
A stronger, more confident, better-resourced workforce is key to prevention.

9.1.5 Stigma, Language and Cultural Barriers:
Further work could be undertaken to normalise conversations about suicide and reduce cultural and linguistic barriers.

9.1.6 Community-Based Prevention and Involvement:
Community engagement is essential, as well developing community capabilities and assets that provide additional protective factors for residents.

9.1.7 Data, Evidence and Learning Better:
Data and shared learning underpin effective action but could be improved.

9.1.8 Challenges and Systemic Limitations:
Structural constraints, such as resources hinder progress despite goodwill and collaborative spirit.

9.1.9 Governance Needs Modernising:
Governance should become more agile, inclusive and focused, with clearer communication.

10. **Priorities for 2026-29**

The proposed local priorities demonstrate strong strategic alignment with the national suicide prevention strategy for England (2023–2028), particularly in relation to targeted approaches, partnership working, and intelligence-led delivery. To evidence comprehensive alignment across all eight national priorities, further explicit development is recommended in relation to self-harm pathways, means restriction initiatives, and online safety measures. These findings have informed the priority areas below.

10.1 Priority One - Support trauma informed community development

Intent - To unlock the potential held within communities to build capacity and engage residents in collective trauma-informed change.

Impact - Place based community level change that facilitate conditions for healing, recovery, resilience and post-traumatic growth at individual and collective levels.

Implement -

- Establish meaningful relationships and build trust with key community members.
- Honor community expertise and centre voices of lived experience.
- Encourage and foster peer support.
- Use messaging opportunities for engagement and participation to increase community capacity for resilience-focused change.
- Foster mechanisms and settings for learning, such as community events, meetings, online platforms, and competency-based education, to raise consciousness and promote leadership within communities.



10. **Priorities for 2026-29**

10.2. Priority Two – Enhance targeted support for priority groups.

Intent - Support groups at higher risk of suicide to reduce preventable harm by addressing the specific factors that increase vulnerability.

Impact - Targeted approaches will improve access to timely, appropriate support, strengthen protective factors, and reduce inequalities in outcomes.

Implement -

- Identify local priority groups based on data, strategy and community engagement.
- Support community organisations to co-produce service delivery and improve credibility among at-risk populations.
- Integrate targeted messaging within the broader prevention infrastructure, such as helplines, campaigns and training frameworks.
- Influence future system developments that embed early intervention approaches that reduce barriers to help-seeking and respond to needs before crisis points are reached.







10. **Priorities for 2026-29**

10.3. Priority Three – Strengthen multi-agency working and collaboration

Intent - To develop partnership working in suicide prevention that ensures individuals at risk receive timely, coordinated, and holistic support across health, social care, education, community, and voluntary services.

Impact - Earlier identification of risk and more effective, joined-up responses, reducing the likelihood that individuals fall through gaps between services. This approach will strengthen prevention pathways, improve outcomes for individuals and families, and contribute to a reduction in suicide and self-harm.

Implement -

- Bring statutory services (health, police, local govt) alongside voluntary/community organisations and people with lived experience to map local suicide prevention challenges and plan improvements.
- Support joint training and capacity-building initiatives that promote shared learning and improve awareness, confidence, and consistency in responding to issues such as self-harm.
- Work with external stakeholders to embed suicide prevention as a core element of wider wellbeing and mental health initiatives, including areas such as means restriction and online safety.
- Develop strategic governance that includes senior representatives from health, local authorities, emergency services and voluntary sectors.

10. **Priorities for 2026-29**

10.4. Priority Four – Improve the use of data, evidence and learning

Intent - To strengthen understanding of local suicide risk, patterns and protective factors, and to ensure that prevention activity is informed by the best available intelligence. This includes using timely and high-quality data, research evidence and lived experience to guide decision-making, target interventions effectively, and continuously improve practice.

Impact - Improved use of data, evidence and learning will enable earlier identification of emerging risks and priority groups, more targeted and effective interventions, and better coordination across partners. Over time, this will lead to more responsive prevention strategies, reduced inequalities, improved outcomes for people at risk, and a more effective use of resources in preventing suicide.

Implement -

- A process to share surveillance data to inform targeted interventions, including cluster responses and high-risk groups.
- Improve the depth and coverage of intelligence on how suicide relates to factors such as ethnicity and domestic abuse, in partnership with the police and other agencies.
- Standardise data collection and reporting, aligning methods across regions to improve comparability and completeness.
- Establish shared local audits and collaborative intelligence, pooling local insights for broader coverage and nuanced understanding.

10. **Priorities for 2026-29**

10.5 Priority Five – Communication and Awareness Raising

Intent – To increase awareness and understanding of suicide prevention across communities, workplaces and services, reducing stigma and encouraging open conversations about mental health and suicide. This includes promoting key messages, improving access to information and support, and ensuring that people know how to seek help for themselves or others when they are concerned about suicide risk.

Impact – Improved communications and awareness will help to create a more informed and compassionate community where people feel confident talking about suicide and mental health. Over time, this will increase help-seeking behaviour, improve early identification of people at risk, strengthen community resilience, reduce stigma, and support a whole-system approach to suicide prevention.

Implement –

- Develop and deliver a coordinated communications plan to promote key suicide prevention messages, local support services and national awareness campaigns.
- Increase awareness of the warning signs and risk factors associated with suicide, including self-harm, social isolation, relationship breakdown, substance misuse and financial hardship.
- Work with partners, community groups, schools, workplaces and healthcare settings to share consistent, accessible and culturally appropriate information.
- Promote suicide prevention training and awareness initiatives, including campaigns that build confidence in having supportive conversations and signposting people to help.
- Use lived experience voices, where appropriate, to inform communications and reduce stigma surrounding suicide and mental health.
- Ensure that communications relating to suicide and self-harm follow national guidance on responsible and safe messaging.
- Utilise digital channels, social media and community networks to maximise reach and engagement with priority groups and communities.

10. **Priorities for 2026-29**

10.6 Priority Six – Workforce training and Capacity Building

Intent – To ensure that staff and volunteers across all sectors have the knowledge, skills and confidence to identify and respond appropriately to suicide risk. This includes building a competent and compassionate workforce, embedding suicide prevention into routine practice, and strengthening the capacity of services and communities to provide timely support and intervention.

Impact – A well-trained and confident workforce will be better equipped to recognise warning signs, engage in meaningful conversations, assess risk, and signpost or refer individuals to appropriate support. Over time, this will improve early intervention, strengthen multi-agency responses, reduce missed opportunities for prevention, and contribute to improved outcomes for individuals at risk of suicide.

Implement –

- Promote locally available suicide prevention training, targeting professionals, volunteers, and community organisations who may come into contact with people at risk.
- Build confidence among staff to identify warning signs, have supportive conversations, and respond appropriately to disclosures of suicidal thoughts or self-harm.
- Promote trauma-informed and culturally competent approaches to suicide prevention, ensuring staff understand the needs of diverse communities and priority groups.
- Develop mechanisms to monitor training uptake, coverage, impact, and workforce needs to inform continuous improvement and future workforce development.

10. **Priorities for 2026-29**

10.7 Priority Seven – Self harm

Intent – To reduce the incidence and impact of self-harm by improving prevention, early identification, access to support, and coordinated responses across the system. This includes recognising self-harm as a significant public health issue and an important indicator of future suicide risk, while ensuring that individuals who self-harm receive timely, compassionate, and effective support.

Impact – Improved prevention and support for self-harm will help reduce repeat episodes, improve mental wellbeing, and ensure that individuals receive help at the earliest opportunity. Over time, this will strengthen protective factors, reduce distress and crisis presentations, improve outcomes for vulnerable individuals, and contribute to a reduction in suicide risk across the population.

Implement –

- Develop a coordinated multi-agency approach to self-harm prevention, ensuring consistency across health, education, social care, voluntary sector and community settings.
- Improve awareness and understanding of self-harm among professionals, communities, parents, carers, and young people, helping to reduce stigma and encourage help-seeking.
- Strengthen pathways for early identification, assessment, intervention, and follow-up support for individuals who self-harm.
- Identify opportunities to enhance support for children and young people, recognising that self-harm is most common among younger age groups and can have long-term impacts on mental health and wellbeing.
- Promote trauma-informed and person-centred approaches that address the underlying causes of self-harm, including emotional distress, abuse, adversity, isolation, and mental ill health.
- Improve data collection, intelligence sharing, and learning relating to self-harm to better understand local trends, risk factors, and opportunities for intervention.
- Ensure that individuals presenting with self-harm receive compassionate care and appropriate aftercare, reducing the likelihood of repeat self-harm and future suicide risk.
- Use evidence, lived experience, and best practice guidance to inform service development, prevention initiatives, and continuous improvement.

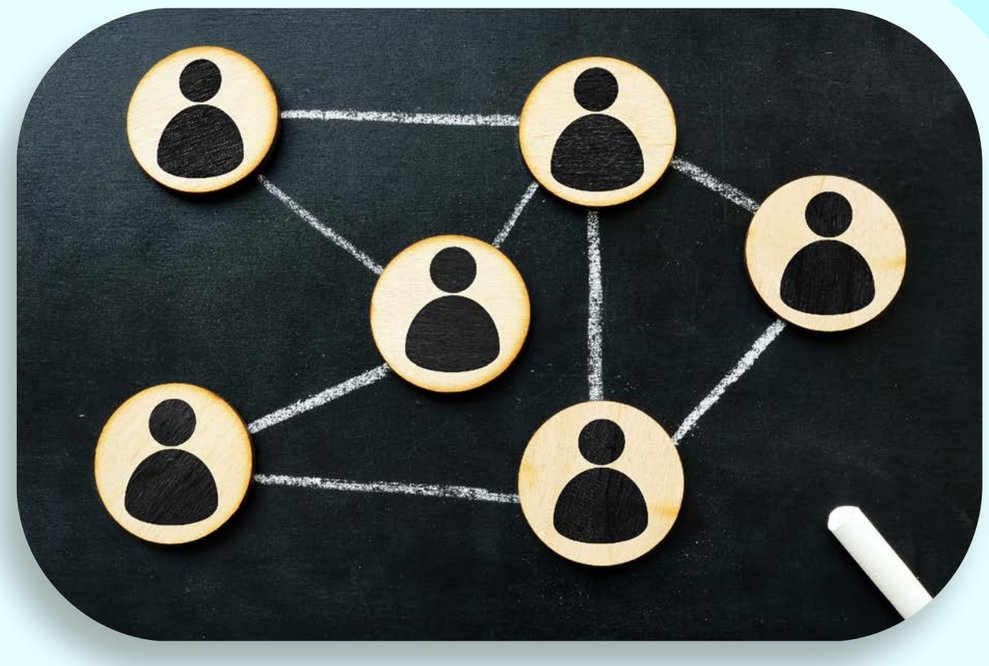
11. **Enablers**

11.1 Coordinated Action Planning and Delivery

To ensure the strategy translates into meaningful change, a coordinated delivery approach will align actions across local authority, health, voluntary, community, and partner organisations. A shared delivery plan will clearly set out priorities, actions, leads, timescales, and measures of success, reducing duplication and improving efficiency. Delivery will be aligned with existing local strategies and programmes, including mental health, wellbeing, housing, and inequalities agendas, to maximise impact and embed suicide prevention across the system. Mechanisms will be established to support joint planning, escalation of emerging risks, and rapid response to clusters or incidents, ensuring the system can act collectively and at pace when needed.

11.2 Effective Governance and Shared Accountability

Strong, transparent governance will underpin delivery of the strategy. Clear roles and responsibilities will be defined, with agreed reporting lines and decision-making processes. Shared accountability will be supported through regular performance reporting.



Governance arrangements will be reviewed in line with system developments (i.e. as governance for the Solihull Mental Health Delivery Plan, Solihull Public Mental Health Framework and Neighbourhood Health programme matures) and modernised to ensure they are agile, inclusive, and able to respond to emerging challenges, while maintaining oversight of quality, equity, and impact.

11.3 Learning, Evaluation and Continuous Improvement

The strategy will embed a culture of learning and continuous improvement across all suicide prevention activity. Routine monitoring, evaluation, and reflective practice will be built into delivery, using both quantitative data and qualitative insight from communities and people with lived experience.

11. **Enablers**

11.3 Learning, Evaluation and Continuous Improvement (cont'd)

Learning from surveillance data, audits, serious incidents, and postvention reviews will be systematically shared across partners to inform improvement and prevent recurrence. Evaluation findings will be used to refine interventions, re-prioritise resources where needed, and strengthen the evidence base for what works locally in reducing suicide risk.

11.4 Principles-Led Delivery

All activity delivered under this strategy will be guided by a clear set of shared principles, including trauma-informed practice, equity, compassion, cultural competence, and respect for lived experience. These principles will shape how interventions are designed, commissioned, delivered, and evaluated, ensuring consistency across sectors while allowing flexibility to meet local needs. Emphasis will be placed on using safe, non-judgemental language, reducing stigma, and promoting dignity and hope in all interactions. Principles-led delivery will help ensure that actions not only achieve outcomes but do so in ways that build trust and do not cause unintended harm.

11.5. Putting Residents and Citizens at the Centre

Residents, families, and communities will be at the heart of suicide prevention in Solihull. Lived experience will be actively involved in shaping priorities, co-producing interventions, and evaluating impact, ensuring that support is relevant, accessible, and responsive to real needs. Community assets, strengths, and protective factors will be recognised and supported, with a focus on empowering communities rather than relying solely on statutory services. Attention will be given to reaching groups who are often under-represented or face barriers to engagement, ensuring that prevention efforts are inclusive, equitable, and rooted in the voices of those most affected.

12. **Delivery Plan**

The delivery plan will be implemented through a multi-agency partnership approach, working collaboratively across organisations as part of the wider Birmingham and Solihull Mental Health Delivery Plan. This will ensure coordinated action, shared responsibility, and alignment with broader mental health priorities across the system.

12.1 To complement this strategy, a detailed Suicide Prevention Delivery Plan will be developed to translate strategic priorities into clear, coordinated, and measurable action for the period 2026–2029.
12.2 The delivery plan will set out specific actions, milestones, leads, and timescales aligned to the agreed strategic priorities, ensuring that ambition is matched with practical implementation. It will provide clarity on what will be delivered, by whom, and how progress will be monitored, while remaining flexible enough to respond to emerging risks, new evidence, and changes in local need.
12.3 The plan will be co-produced with partners across health, local government, education, voluntary and community sectors, and people with lived experience, reflecting the whole-system and community-centred approach set out in this strategy.
12.4 Existing local plans and programmes, including mental health, wellbeing, housing, and inequality strategies, will be aligned to reduce duplication and maximise impact.
12.5 Emphasis will be placed on targeted action for priority groups, strengthening multi-agency pathways, and embedding trauma-informed, culturally competent practice across services and communities.
12.6 Governance and overarching accountability for the delivery plan will sit with the Health and Wellbeing Board, with clear reporting mechanisms for oversight, performance management, and shared learning via local boards. This will be finalised as governance for the Solihull Mental Health Delivery Plan, Solihull Public Mental Health Framework and Neighbourhood Health programme matures.
12.7 Progress will be reviewed regularly using agreed indicators, including surveillance data, service intelligence, and feedback from communities and people with lived experience.
12.8 Ongoing evaluation and learning will ensure that the delivery plan remains dynamic, evidence-led, and focused on reducing inequalities, strengthening protective factors, and ultimately preventing suicide in Solihull.

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