# Richmond Suicide and Self-harm Prevention Strategy : 2026-2029

LONDON BOROUGH OF
RICHMOND UPON THAMES

## Our Commitment

We want Richmond upon Thames to be a place where everyone feels valued and supported.

We know that when people are overwhelmed, they may struggle in different ways, including self-harm or thoughts of suicide.

With a compassionate approach and the right care, harm can be prevented and recovery is possible.

This strategy sets out how we will work together to reduce stigma and make sure people can access support when they need it.

# Our Commitment to Preventing Self-harm and Suicide

## Working Together

Preventing suicide is everyone's business. This strategy is about partnership, between services, communities, families, voluntary organisations, and people with lived experience. By working together, we can build a borough where people feel connected, supported, and hopeful.

## Governance and Accountability

This Strategy is led by the Richmond and Wandsworth Suicide and Self-Harm Prevention Partnership, a multi-agency group chaired by Public Health and bringing together statutory services, emergency services, voluntary organisations and people with lived experience. The Partnership worked together to develop the strategy and oversees its delivery and progress.

Oversight and updates are provided through each borough's mental health partnerships, health and care partnerships, and annually to Health and Wellbeing Boards and Council Health Committees, ensuring shared responsibility, transparency and accountability.

# Our Objectives

## 1. Understanding what people need

We will use local information, learning from suicide audits, and lived experience to better understand who is most at risk and how services and communities can offer earlier and more effective support.

## 2. Tackling stigma and encouraging open conversations

We will work to reduce stigma around mental health and suicide by:

- helping people talk openly and safely about mental health
- offering inclusive, culturally appropriate training for people who support others

## 3. Making help easier to find

We will improve access to clear information and support, especially for:

- people who are worried about someone
- people who have been affected or bereaved by suicide

## 4. Supporting children and young people

We will strengthen mental health support in schools and colleges and make sure children and young people can access help early, easily, and safely.

## 5. Reaching people at higher risk

We will improve access to support for people more affected by suicide, including those experiencing multiple disadvantages, and improve how services work together, particularly mental health and drug and alcohol services.

## 6. Improving crisis support

We will ensure people in crisis receive compassionate, timely care, with better crisis planning, clearer pathways, and safer discharge from services.

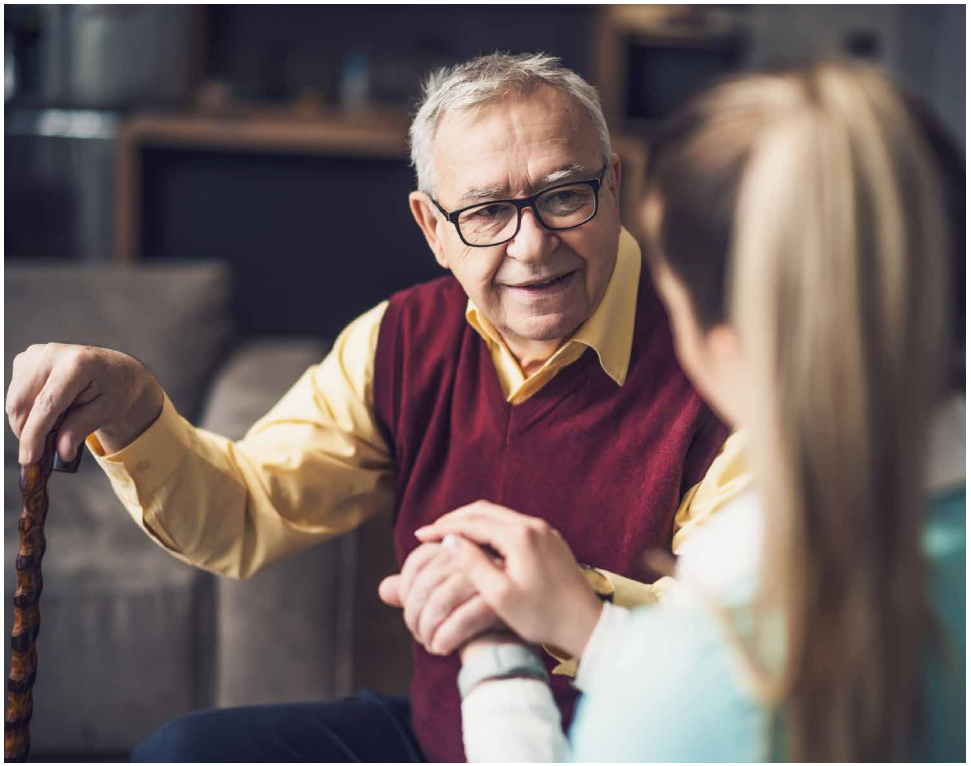
# National Trends and Implications for Local Prevention

The latest Adult Psychiatric Morbidity Survey highlights a concerning rise in suicidal thoughts, suicide attempts and self-harm across England over the past two decades. In 2023/24, 6.7% of adults reported suicidal thoughts in the previous year, up from 3.8% in 2000, while suicide attempts have also increased. Lifetime self-harm has risen more than fourfold, from 2.4% to 10.3%, reflecting increasing levels of emotional distress across the population.

The survey highlights clear inequalities in risk. Younger people, particularly young women, report the highest levels of self-harm, while those experiencing unemployment, financial hardship, deprivation, poor physical health or mental health conditions are significantly more likely to experience suicidal thoughts, suicide attempts and self-harm. These findings emphasise the strong influence of wider social and economic factors on suicide risk and emotional wellbeing.

Self-harm is most commonly reported as a way of coping with overwhelming emotions rather than an attempt to end life, with over 80% of people describing it as a response to feelings such as anxiety, tension, anger or depression. The survey also highlights significant gaps in help-seeking, with almost half of people who had attempted suicide not seeking support after their most recent attempt, particularly men and older adults.

These findings have important implications for local suicide and self-harm prevention. They show that effective prevention must go beyond crisis response to address wider drivers of distress, including social isolation, financial hardship, poor physical health and mental ill-health. The evidence supports a whole-system approach that combines population-wide prevention with targeted support for higher-risk groups, earlier identification of need, and timely access to support. This national picture provides an important foundation for understanding local needs and shaping the priorities set out in this strategy.



# Understanding Local Needs

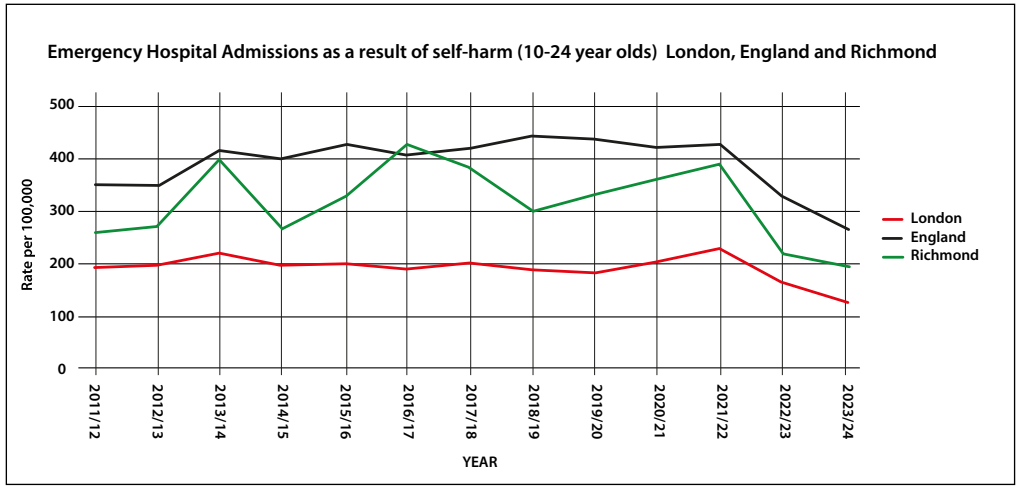
## Suicide

- **Richmond**: Suicide rates have varied over time, which is expected in a smaller population. Rates were lower in the late 2000s and early 2010s but have increased again in recent years.
- **Richmond compared with London**: Richmond was previously below the London average, but the gap has narrowed. In some recent years Richmond has been similar or higher than London, but not significantly.
- **England**: National suicide rates remain higher than both Richmond and London and show a gradual upward trend, reinforcing the need for continued prevention work locally and nationally.


Source: Suicide Prevention - Data | Fingertips | Department of Health and Social Care

## Self-harm among young people

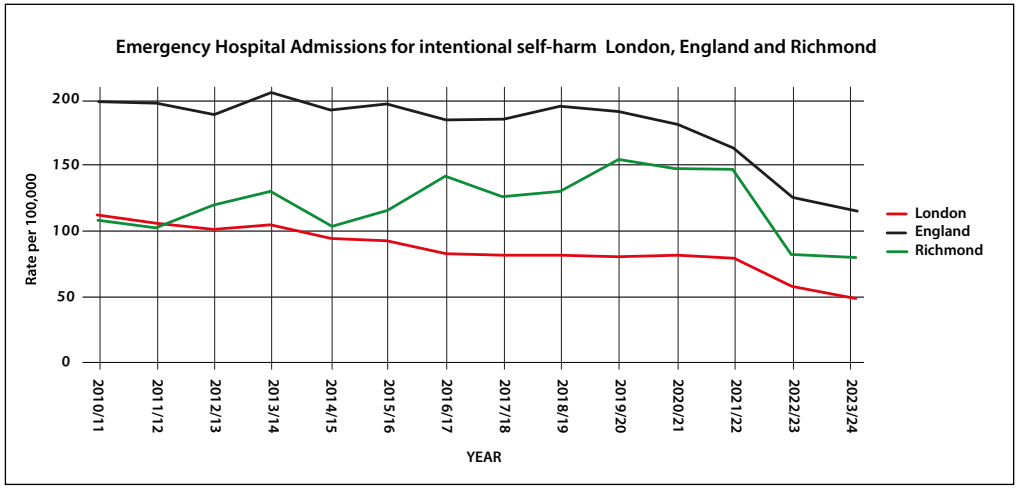
- **Richmond**: Self-harm admissions among young people have fluctuated over time, with particularly high rates during the mid-2010s and early 2020s. Encouragingly, rates have fallen significantly over the last two years.
- **Richmond compared with London**: Richmond has consistently recorded higher admission rates than London, although both have seen a marked decline since 2021/22. Despite the improvement, Richmond remains above the London average.
- **England**: Rates across England have generally been higher than both Richmond and London, but have also fallen sharply in recent years. Continued focus on prevention, early intervention and support for young people remains important.




Source: Fingertips | Department of Health and Social Care

## Self-harm hospital admissions

- **Richmond**: Hospital admissions for self-harm increased during the 2010s, remained high through the early 2020s, and have fallen sharply in the last two years.
- **Richmond compared with London**: Richmond has generally had higher self-harm admission rates than London since the early 2010s. Although rates have recently fallen in both areas, Richmond remains above the London average.
- **England**: Self-harm admission rates have been higher across England than in both Richmond and London for most of the period. Recent reductions reflect a wider national improvement, but continued prevention and early support remain important.




Source: Fingertips | Department of Health and Social Care

## Understanding Self-harm in Richmond

The data sets out two ways of understanding self-harm in the community, helping to explain why trends can look different over time.

**Different focus**: The 10–24 self-harm rate looks at children and young people, while intentional self-harm admissions cover all ages.

**What they show**: Both are based on hospital admissions, so they reflect more serious cases rather than all self-harm in the community. It is important to understand that most cases are not seen in hospitals. The 10-24 rate highlights distress in younger people; the all-age measure shows the wider population picture.

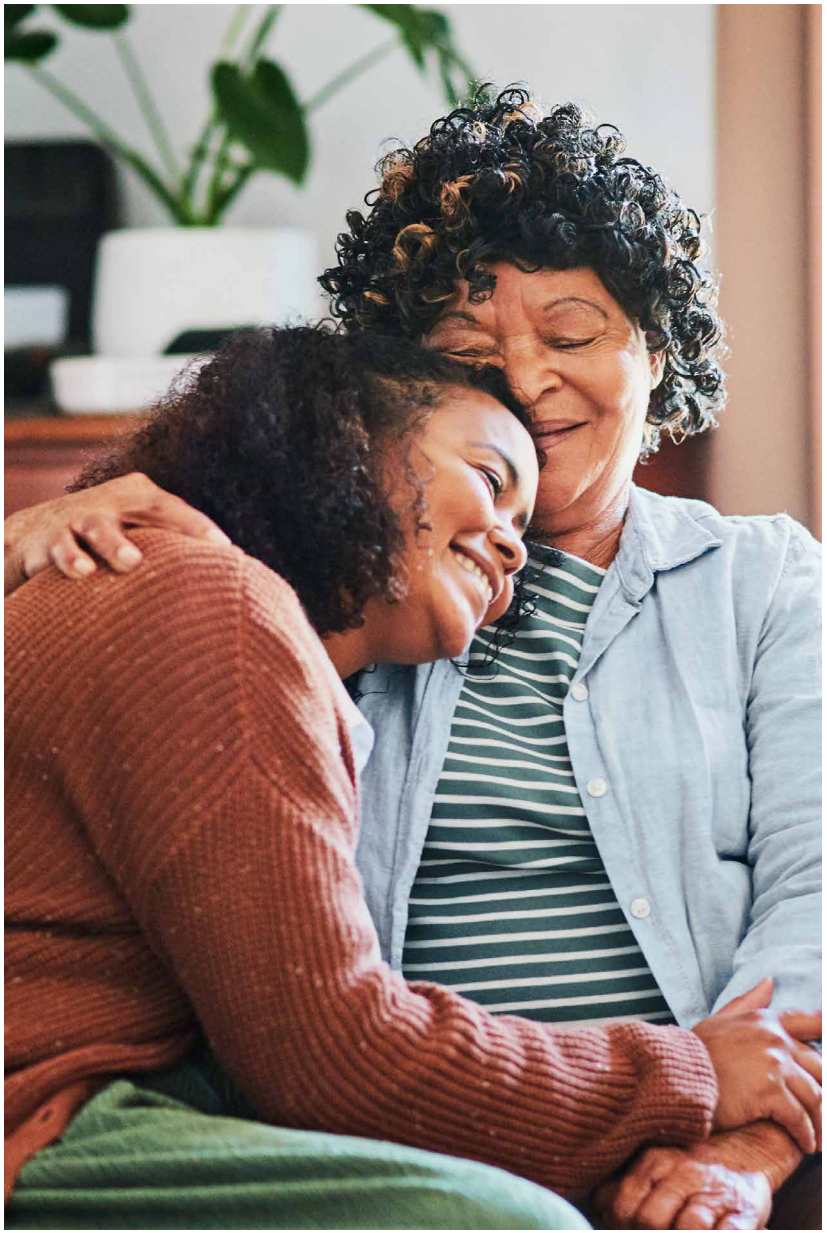
**Why they differ**: Trends may not match because they are influenced by different factors (e.g. school and relational pressures for young people vs financial, housing, and health issues in adults).

**What this means for Richmond**: The much higher rates seen in 10–24 year olds indicate that self-harm is a particular issue for younger residents. While recent reductions are encouraging across both measures, Richmond's rates remain above the London average, highlighting the continued need for early intervention, emotional wellbeing support and targeted prevention for children and young people alongside support for people of all ages.

# Guiding Principles

All activities undertaken as part of this strategy should be guided by the following principles:

| Our principle | What this means in practice |
|---|---|
| **Fairness and Equity** | We focus more support where it is needed most, so no one is left behind and inequalities are reduced, not reinforced. |
| **Easy to Access** | Support should be simple to find and use - local, inclusive, and accessible for people with disabilities, different needs, and different priorities. |
| **Early Help and Prevention** | We act early - giving people information, skills and support before problems escalate or reach crisis point. |
| **Working Together** | Services and organisations work as one system, so people don't have to repeat their story or fall through gaps. |
| **What Works** | We focus on approaches that are known to help, using evidence and learning to make the best use of resources. |
| **High Quality and Lived Experience Led** | Services are caring, safe and effective - shaped by the voices and experiences of people who use them. |
| **Built to Last** | Support is designed to be socially, economically and environmentally sustainable for the long term. |
| **Keeping People Safe** | People are protected and supported at every point, with safeguarding built into all services and responses. |
| **Dignity and Respect** | Everyone is treated kindly and respectfully, recognising that people seeking help may be going through very difficult times. |



# Reaching People at Higher Risk

Some people are at greater risk of suicide and self-harm and may face barriers to getting support. Risk is influenced by personal circumstances as well as wider social and economic factors. This strategy focuses on reaching those at higher risk through tailored, inclusive and compassionate support.

People may belong to more than one higher-risk group and experience multiple risk factors. Our approach therefore emphasises joined-up, person-centred care that responds to individual needs.

## Priority groups include:

**Middle-aged men** experience higher suicide rates and may be less likely to seek help early. Social isolation, relationship breakdown, employment or financial pressures, and substance use can increase risk.

**People who are LGBQT+** face higher risk due to increased exposure to stigma, discrimination, and exclusion, which can lead to chronic stress, isolation, and reduced access to supportive environments. These pressures can compound over time, increasing distress and vulnerability to self-harm and suicide.

**Autistic and neurodivergent people** may face higher risk due to increased experiences of social exclusion, misunderstanding, and stigma, alongside barriers to accessing appropriate and timely support. These challenges can contribute to heightened distress, masking, and burnout, increasing vulnerability to self-harm and suicide.

**Young people** may face higher risk due to a combination of developmental pressures, including identity formation, academic stress, social relationships, and exposure to online harms, which can increase distress and overwhelm. When combined with barriers to accessing timely support, this can reduce coping and increase vulnerability to self-harm and suicide.

While men remain at highest risk of death by suicide, there is growing recognition that the experiences of **women and girls** can be overlooked within suicide prevention. Rising rates of self-harm among young women, together with the impact of violence and abuse, anxiety, depression, eating disorders, and key life stages such as pregnancy, the perinatal period and menopause, highlight the need to better understand and respond to the often less visible needs of women and girls.

# Additional Risk Factors for Suicide and Self-Harm

Suicide and self-harm are rarely caused by just one thing. Experiences can build up over time, especially alongside distress, isolation, or difficulty accessing support, undermining key protections against self-harm and suicide. This section highlights factors that can increase risk, so services and communities can respond with care and understanding, particularly for those already facing greater vulnerability.

## Key risk factors that can undermine protective factors and increase vulnerability include:

**Mental health needs** (especially depression)- Persistent distress, hopelessness, and impaired coping, alongside reduced access to timely support.

**Domestic abuse and coercive control** - Emotional, psychological, financial, or physical abuse leading to fear, isolation, loss of control, and entrapment.

**Gambling-related harm** - Financial stress, debt, shame, and isolation reduce help-seeking and support.

**Financial hardship, debt, or unemployment** - Chronic stress, insecurity, and reduced hope, creating barriers to support and recovery.

**Housing insecurity or homelessness** - Compounding stress, trauma, and instability, alongside reduced access to care and support.

**Social isolation and loneliness** - Reduced connection, belonging, and support - key protective factors against harm.

**Trauma, abuse, and adverse childhood experiences** - Long-term impacts on stress, emotional wellbeing, and resilience.

**Relationship breakdown, bereavement, or significant loss** - Acute distress and disruption to support networks.

**Involvement with the criminal justice system** - Heightened stress, stigma, disrupted relationships, and barriers to consistent care.

**Alcohol and drug use** (including co-occurring conditions) - Increased risk where substance use interacts with mental distress, trauma, and social disadvantage.

## Focus on Carers

Carers may face an increased risk of suicidal thoughts due to the emotional strain, stress and isolation associated with their role. This risk can be particularly heightened for those caring for people with mental health conditions, drug or alcohol dependence or individuals who are actively suicidal, where ongoing worry, crisis management and feelings of responsibility can have a significant impact on the carer's own mental wellbeing.

# High Risk Groups and Risk Factors

## Population Groups with increased Risks

| Priority group | Key evidence | Strategic focus for prevention |
|---|---|---|
| **Men** (especially middle-aged and older) | Highest rates of suicide mortality; associated with social isolation, economic stress, alcohol use and barriers to help-seeking | Gender-informed approaches; outreach beyond clinical services; stigma-aware engagement |
| **Young people** (especially young women) | Rising suicidal ideation and self-harm linked to abuse, trauma, social pressure and coercive relationships | Integrate suicide prevention with safeguarding, Violence Against Women and Girls and youth-support strategies |
| **Neurodivergent people** (autism, ADHD; diagnosed and undiagnosed) | Autistic people have up to an 8-fold increased risk of suicide mortality; ADHD and co-occurring ADHD-Autism associated with elevated ideation and attempts across the life course | Neurodiversity-informed assessment; reasonable adjustments; inclusive communication; workforce training |
| **Women in mid-life / perimenopausal transition** | Systematic reviews show increased suicidal ideation during perimenopause/menopause, particularly with prior mental ill-health, trauma or low social support | Menopause-aware services; integration of primary care, mental health and women's health |
| **LGBTQ+ people** (lesbian, gay, bisexual, trans, non-binary and other sexual and gender minorities) | LGBTQ+ people experience significantly higher rates of suicidal ideation, self-harm and suicide attempts than heterosexual and cisgender populations. Trans and non-binary people are at particularly high risk. Elevated risk is strongly linked to minority stress, discrimination, social rejection, violence, homelessness and barriers to affirming care | Explicitly include LGBTQ+ populations in suicide-prevention planning; ensure inclusive, affirming services; address discrimination and hate crime; strengthen links with community-led LGBTQ+ organisations; improve staff competence and data collection on sexual orientation and gender identity |

# High Risk Groups and Risk Factors

## Key Personal Risk Factors

**Intersecting disadvantages create the highest suicide risk, calling for whole system, place-based prevention rather than single-issue responses.**

| Risk factor | Key evidence | Strategic focus for prevention |
|---|---|---|
| **Mental ill-health** (e.g. depression, PTSD, emotional dysregulation) | Strong links, often compounded by trauma, exclusion and inequality | Maintain access to timely mental-health support; avoid diagnosis-only or single-service models |
| **Trauma and adverse experiences** | Childhood abuse, coercive control and sexual violence strongly linked to suicidal behaviour | Trauma-informed, survivor-centred support |
| **Drug and alcohol use disorder** | Alcohol and drug misuse significantly increase suicide risk, particularly during periods of crisis or withdrawal | Early intervention and harm reduction multi-modal, chronic-care model |
| **Co-occurring substance use and mental ill health** | Combined substance use and mental health needs sharply increases risk and service disengagement | Integrated, trauma-informed, person-centred approach. "No Wrong Door" model |

## Social Factors that Increase Risk

| Structural factor | Key evidence | Strategic focus for prevention |
|---|---|---|
| **Poverty, debt, housing insecurity** | Financial strain and insecurity increase suicide risk, particularly where shame and isolation exist | Suicide prevention embedded in cost-of-living support, debt relief, housing and welfare-access work |
| **Barriers to services and exclusion** | Long waits, misdiagnosis, inaccessible systems and lack of reasonable adjustments increase risk | Redesign services for fair access and uptake |
| **Social isolation and loneliness** | Lack of social connection increases suicide risk, particularly for marginalised groups | Strengthen social connections through community-based support, peer networks and inclusive social spaces |

# High Risk Groups and Risk Factors

## Emerging and frequently overlooked risk factors

| Emerging factor | Key evidence | Strategic focus for prevention |
|---|---|---|
| **Victims and survivors of domestic abuse / Violence against women** | Around 25% of women who die by suicide while under mental-health care have documented exposure to domestic abuse; significant under-recording | Treat domestic abuse as a core suicide-prevention issue, not a parallel agenda |
| **Coercive control, financial and technology-facilitated abuse** | Non-physical abuse can be a primary driver of suicidality, particularly among women | Improve identification and response in primary care, mental health and community services |
| **Online and high-intensity gambling** | 24/7 access, rapid debt escalation and secrecy heighten suicide risk | Embed suicide prevention into gambling-harm strategies, debt advice and financial-wellbeing services |
| **Children and young people affected by child sexual exploitation (CSE)** | Child sexual exploitation and abuse are strongly linked to trauma and adverse childhood experiences; sexual abuse is associated with significantly increased risk of suicidal ideation and attempts (around 2-4 times higher), and high levels of self-harm and suicide attempts among survivors | Prioritise early identification and safeguarding; embed trauma-informed, whole-system responses across health, education and social care; ensure access to long-term specialist support and strengthen early intervention to mitigate lifelong risk |

# Staying Safe From Suicide

## Staying Safe from Suicide: A Shared Approach to Care and Support

When someone is experiencing psychological distress or crisis, the way we respond can be life-saving. The NHS England Staying Safe from Suicide guidance sets out a compassionate approach to supporting people at risk, moving away from risk-labelling and towards understanding, safety and hope. Across Richmond we strongly promote these principles wherever people seek support, across health and social care, voluntary services, education, housing, workplaces and communities, recognising that suicide prevention is a shared commitment, not the responsibility of any single service.

### See the Person, Not a Score

Staying safe starts with listening. Rather than relying on checklists or risk categories alone, this approach focuses on understanding what matters most to the person, what has led them to this point, and what they feel would help them stay safe. Feeling heard, respected and believed is often the first step towards recovery.

### Compassion at Every Contact

Every interaction matters. The guidance emphasises kindness, empathy and consistency, especially during moments of crisis. Simple acts of care, clear communication and follow-up can reduce fear and isolation, and reinforce that people are not alone.

### Hope, Strengths and Recovery

Staying safe is not just about preventing harm, it is about supporting hope. The guidance recognises people's strengths, resilience and capacity for recovery, even during crisis. Compassionate care helps people reconnect with what gives their life meaning and purpose.

### Safety Is Built Together

Support is most effective when it is planned with people, not for them. Staying safe means working alongside individuals to agree practical steps they can take during times of distress, who they trust for support, and what helps them feel safer. This shared approach builds trust, confidence and dignity.

### Support That Follows People, Not Systems

People's needs do not fit neatly into service boundaries. Staying safe means support that is flexible, joined-up and responsive, across mental health services, primary care, social care, voluntary organisations and workplaces. No one should fall through gaps or be left without help because they do not meet a threshold.

### Everyone Has a Role to Play

Suicide prevention is a shared responsibility. We encourage all organisations, employers and communities to adopt these principles, creating environments where people feel safe to talk about distress, seek help early, and receive support without judgement or stigma.

## A Call to Action

**We advocate for the principles of Staying Safe from Suicide to be embedded across Richmond, shaping local practice, partnerships and services. By listening first, acting with compassion and focusing on what matters most to each person, we promote support that builds safety, reduces harm and strengthens hope wherever people seek help - across health and care, community services, education and workplaces.**

# Our Priorities for Action

**Suicide and self-harm are preventable. This strategy sets out six priorities for action, informed by national evidence, local data and lived experience. Together, they aim to reduce risk, address the causes of distress, improve access to support, and ensure people get the right help at the right time.**

## 1 Understanding Need

*Using data, intelligence and lived experience to guide action.*

To prevent suicide and self-harm effectively, we need to understand what is happening in our communities and who may need support. We will use local data, information from services, and the experiences of people affected by suicide and self-harm to identify risks early, understand where support is needed most, and make sure our actions are making a difference.

**What we will do:**

- Monitor local suicide and self-harm trends to identify emerging issues.
- Use local evidence to identify people and communities who may be at greater risk.
- Involve people with lived experience in shaping services and future plans.

## 2. Tackling Stigma & Encouraging Open Conversations

*Helping people feel comfortable talking about mental health and asking for help.*

Many people find it difficult to talk about suicidal thoughts, self-harm or emotional distress. We will work with local communities, schools, workplaces and services to break down stigma, encourage open conversations and help people get support earlier.

**What we will do:**

- Run awareness campaigns to reduce stigma and promote help-seeking.
- Provide suicide prevention and Mental Health First Aid training.
- Promote Zero Suicide Alliance training across local services and communities.
- Support community organisations to recognise and respond to people in distress.

## 3. Making Help Easier to Find

*Ensuring people can access the right support at the right time.*

People experiencing distress often seek help in a range of settings, not just mental health services. We will improve awareness of local support, strengthen referral pathways and ensure a "no wrong door" approach across services.

**What we will do:**

- Improve visibility of local support, pathways and resources.
- Embed suicide prevention within housing, welfare, social care and community services.
- Promote early intervention and community-based support to reduce escalation to crisis.

## 4. Supporting Children and Young People

*Providing early support to improve emotional wellbeing and prevent self-harm.*

National evidence shows that self-harm is particularly common among young people, especially young women. We will strengthen prevention, early intervention and support across education, health and community settings.

**What we will do:**

- Promote emotional wellbeing and resilience in schools, colleges and universities.
- Strengthen awareness and use of local self-harm pathways and resources.
- Support earlier identification and response to emotional distress.

## 5. Reaching People at Higher Risk

*Targeting support where it is needed most.*

Suicide risk is influenced by social, economic and health inequalities. We will focus prevention efforts on groups known to experience higher levels of risk, including people facing financial hardship, unemployment, poor physical or mental health, social isolation and other forms of disadvantage.

**What we will do:**

- Strengthen support for men, LGBTQ+ communities and other vulnerable populations.
- Integrate suicide prevention into wider work on poverty, debt, housing and health inequalities.
- Promote community connections, peer support and activities that reduce isolation and build resilience.
- Develop a plan to prevent gambling harm.

## 6. Improving Crisis Support and Recovery

*Providing effective support before, during and after crisis.*

When people experience suicidal crisis or self-harm, timely and compassionate support can save lives. We will advocate for stronger crisis pathways, improved coordination between services and better support following a suicide attempt, self-harm episode or bereavement by suicide.

**What we will do:**

- Champion evidence-based suicide and self-harm prevention in primary care, secondary care and crisis settings, aligned with 'Staying Safe from Suicide' guidance.
- Support the implementation of improved crisis care pathways
- Postvention support for individuals, families, schools, workplaces and communities affected by suicide.

## Delivering the Strategy

This strategy is supported by a partnership action plan setting out the specific activities, responsibilities and timescales required to deliver our six priorities.

The Richmond and Wandsworth Suicide and Self-Harm Prevention Partnership will oversee delivery, review progress and identify emerging risks and opportunities throughout the life of the strategy.

Annual progress updates will be provided through local mental health partnerships, health and care partnerships, Health and Wellbeing Boards and Council Health Committees.

# Measuring Success/ Governance

## How We Will Measure Success

We will use a combination of local data, service intelligence, audit findings and lived experience to understand whether our actions are making a difference.

**We expect to see:**

✔ Fewer deaths by suicide over time (OHID data)
✔ Reduced rates of self-harm requiring hospital treatment (OHID Data)
✔ More people accessing support earlier (Talking Therapies)
✔ Improved awareness of local help and support (Survey)
✔ Increased suicide prevention knowledge and confidence across our workforce and communities
✔ Better support for people affected by self-harm, suicidal crisis and suicide bereavement
✔ Stronger partnership working across health, care, community and voluntary sector services
✔ Evidence that people with lived experience are shaping services and solutions

**Key Indicators**

- Suicide rates (ONS/OHID)
- Hospital admissions for self-harm
- Uptake of suicide prevention training and demonstrable improvements in knowledge, skills and attitudes
- Activity and learning from suicide reviews and audits
- Access to mental health, crisis and community support
- Feedback from people with lived experience
- Delivery of actions within the strategy implementation plan

## Closing Statement

**Suicide and self-harm are preventable. By working together across services, communities and local organisations, we can reduce harm, strengthen hope, and ensure that every person in Richmond can access support when they need it most.**

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