SSA EQUALITY IMPACT AND NEEDS ANALYSIS

Directorate	**Adult Social Care and Public Health**
Service Area	**Public Health**
Service/policy/function being assessed	**Self-Harm and Suicide Prevention Strategy 2026-2029**
Which borough (s) does the service/policy apply to	**Richmond**
Staff involved in developing this EINA	**Charlotte Perry**
Date approved by Directorate Equality Group (if applicable)	
Date approved by Policy and Review Manager All EINAs must be signed off by the Policy and Review Manager	**07/09/2026 Jamie Fisher**
Date submitted to Directors' Board	

1. Summary

Please summarise the key findings of the EINA.

The Self-Harm and Suicide Prevention Strategy 2026-2029 sets out a coordinated, whole-system approach to reducing suicide and self-harm in Richmond. The strategy aligns with the national Suicide Prevention Strategy for England and seeks to strengthen prevention, early intervention, crisis support and postvention activities through partnership working across health, local government, voluntary and community sector organisations, schools, employers and local communities. The strategy places a particular focus on groups known to be at increased risk of suicide and self-harm and aims to reduce inequalities in access to support and improve mental wellbeing across the borough.

The evidence reviewed highlights significant inequalities in suicide and self-harm risk. Men are substantially more likely to die by suicide, while young people are experiencing increasing levels of mental ill health, self-harm and suicidal thoughts. Higher risks are also identified among people with mental health conditions and disabilities, LGBTQ+ communities, residents experiencing deprivation, unemployment or debt and people affected by social isolation and discrimination. Although Richmond's suicide rates are generally lower than the England average, inequalities remain across several population groups.

The strategy is expected to have a positive impact by improving awareness, access to support and early intervention for groups at greater risk. It promotes accessible and inclusive services, strengthens partnership working with communities and voluntary sector organisations and supports more targeted approaches for populations experiencing barriers to support.

No significant negative impacts have been identified. However, there is a risk that some groups could be overlooked if interventions are not delivered equitably or if barriers such as stigma, discrimination, language, digital exclusion or accessibility are not addressed. These risks will be mitigated through initial consultation and ongoing working group meetings to ensure an appropriate feedback loop with residents and service users. There will also be targeted engagement, accessible communications, workforce

training, monitoring of outcomes across protected characteristics and delivery of actions through the accompanying implementation plan.

2. Evidence gathering and engagement

a. What evidence has been used for this assessment? For example, national data, local data via DataRich or DataWand

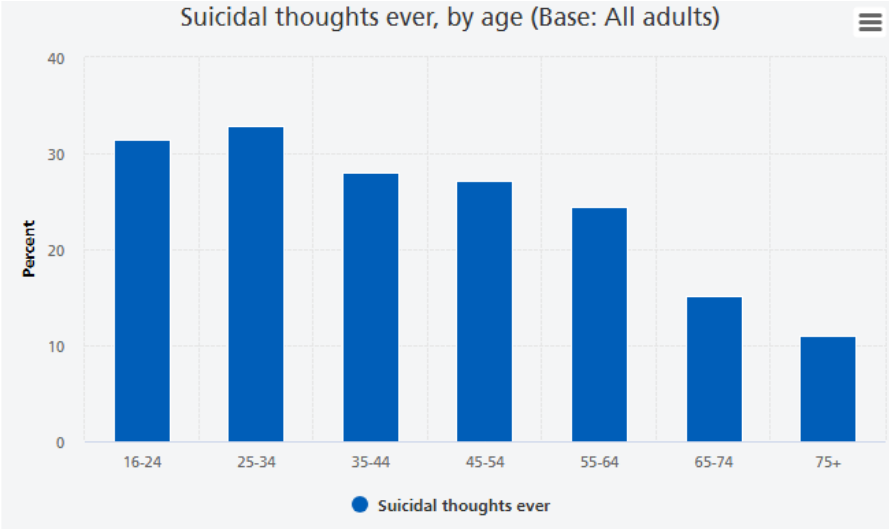
Evidence	Source
Richmond Mental Health Needs Assessment (2022)	Mental Health Needs Assessment - London Borough of Richmond upon Thames
ONS Census (2021)	Census - Office for National Statistics (ons.gov.uk)
NHS Talking Therapies Quarterly data dashboards	Microsoft Power BI
Suicide Prevention – Data | Fingertips | Department of Health and Social Care (2023/24)	Suicide Prevention | Fingertips | Department of Health and Social Care
Suicide prevention strategy for England: 2023 to 2028 - GOV.UK	Suicide prevention strategy for England: 2023 to 2028 - GOV.UK
NHS England » Staying safe from suicide	NHS England » Staying safe from suicide
NCISH | Self-harm in children and young people who die by suicide: UK-wide consecutive case series	NCISH | Self-harm in children and young people who die by suicide: UK-wide consecutive case series
Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE	Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE
Risk factors for suicide in adults: systematic review and meta-analysis of psychological autopsy studies | Evidence Based Mental Health	Risk factors for suicide in adults: systematic review and meta-analysis of psychological autopsy studies - PMC
A systematic review and meta-analysis of victimisation and mental health prevalence among LGBTQ+ young people with experiences of self-harm and suicide | PLOS One	A systematic review and meta-analysis of victimisation and mental health prevalence among LGBTQ+ young people with experiences of self-harm and suicide | PLOS One
Adult Psychiatric Morbidity Survey (2023/24)	https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey

b. Who have you engaged and consulted with as part of your assessment?

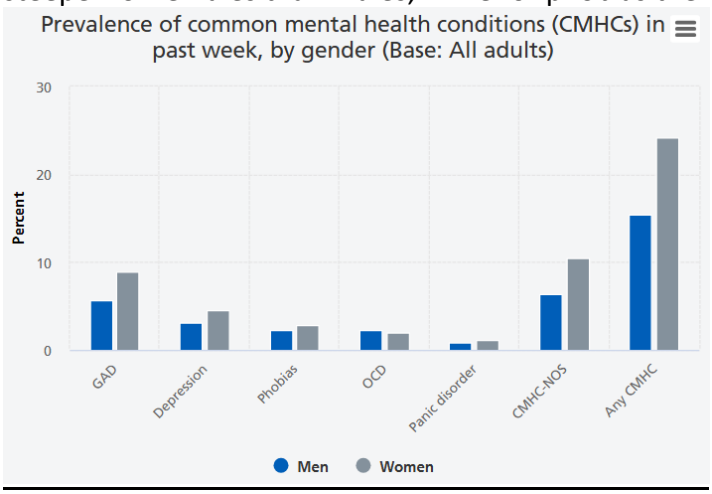
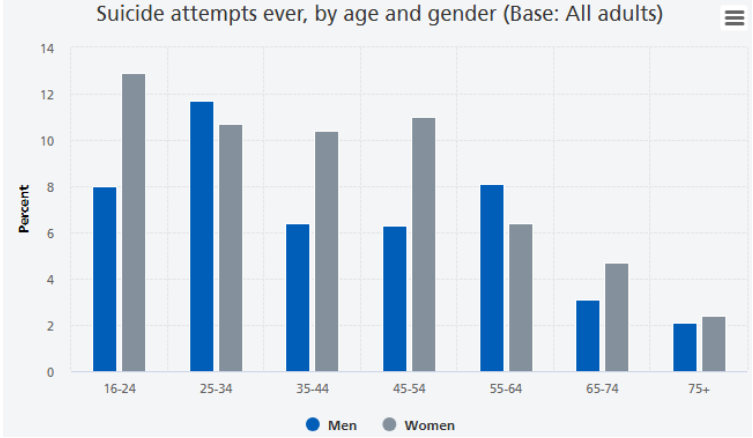
Individuals/Groups	Consultation/Engagement results	Date	What changed as a result of the consultation
Richmond and Wandsworth Suicide Prevention Working Group.	Feedback collected from members on both strategies and promotion of public consultation for further feedback.	07/08/2026	Qualitative experiences from community groups shared and included within consultation data.

3. Analysis of need

Protected group	Findings

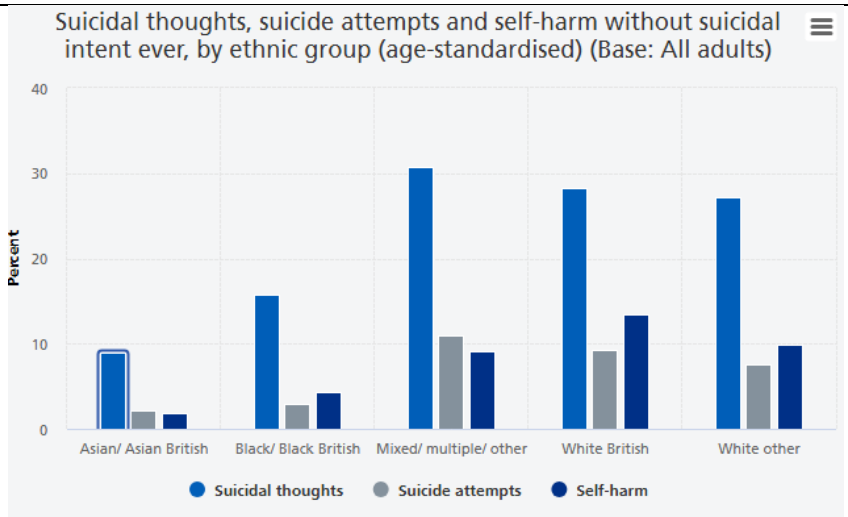
Age	The latest Adult Psychiatric Morbidity Survey (APMS) highlights a concerning rise in suicidal thoughts, suicide attempts and self-harm across England over the past two decades. **<u>Common Mental Health Conditions (CMHC) APMS 2024</u>** Young people's mental health has worsened significantly, with the COVID-19 pandemic having a sustained impact. The latest APMS findings show that one in four 16 to 24 year olds had a common mental health condition, the highest level recorded in the survey series. However, this increase began before the pandemic, with signs that mental health difficulties among young people are becoming more severe. Anxiety disorders, including generalised anxiety disorder, OCD and phobias, are particularly common in this age group. Depression was also notable among young women, although comparisons by sex should be treated cautiously because of the small sample size. These findings should be considered alongside wider evidence of increased self-harm among young people. **<u>Mental Health Treatment AMPS 2024</u>** Among those with CMHC symptoms, the proportion receiving treatment varied by age. Treatment use was highest in 16 to 24 (49.9%), 25 to 34 (53.5%), 45 to 54 (52.3%), and 55 to 64 (47.8%) year olds, and lowest in the older age groups (33.2% of those aged 65 to 74 and 21.9% of those aged 75 and over). Use of psychotropic medication among those with CMHC symptoms was highest in those aged 25 to 34 (43.4%), 45 to 54 (40.9%) and 55 to 64 (40.1%), and lowest in those aged 75 and over (19.1%). Receipt of psychological therapies among those with CMHC symptoms was highest among those aged 25 to 34 (23.1%), 35 to 44 (21.8%), and 45 to 54 (20.6%), and lowest in the oldest age groups: 5.1% of 65 to 74 year olds and 2.8% of those aged 75 and over. **<u>Suicide and self-harm AMPS 2024</u>** Prevalence of suicidal thoughts and suicide attempts has increased. The proportion of 16 to 74 year olds reporting suicidal thoughts in the past year has increased from 3.8% in 2000 to 6.7% in 2023/4.  **<u>Richmond data</u>**

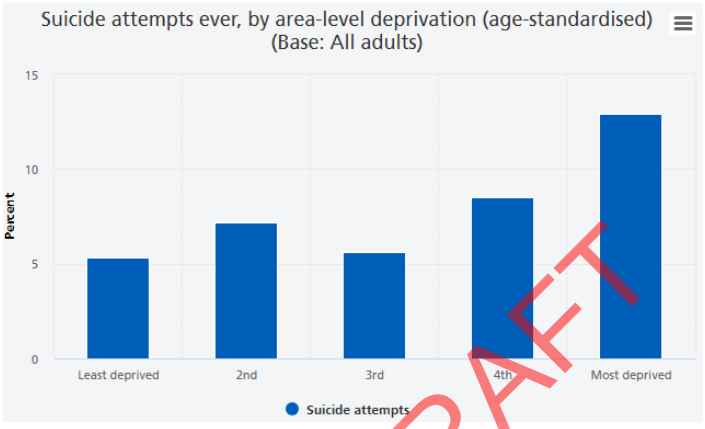
	Across age groups, Richmond records lower suicide rates than England in most age bands of the years 2020-24. For people aged 10-24 years, there were 5 deaths recorded, too small a value to calculate relative rate. Among those aged 25-44 years, the rate in Richmond was 10.2 per 100,000, less than the England rate of 12.7 per 100,000. For those aged 45-64 years, the rate was 9.8 per 100,000 compared with 13.8 per 100,000 nationally. The rate among people aged 65 years and over was 8.7 per 100,000, slightly above the England rate of 8.2 per 100,000. (Fingertips PHE)
Disability	Under the Equality Act 2010 mental health disorders can be categorised as a disability if they last longer than 12 months and they have an adverse effect on day-to-day living. People experiencing mental health disorders are at an increased risk of suicide compared to those not experiencing a mental health disorder. Physical health problems significantly increase the risk of poor mental health, and vice versa. Around 30% of all people with a long-term physical health condition also has a mental health problem, most commonly anxiety and mixed depression/ anxiety. People experiencing depression are at higher risk of suicide. (Barnett et. Al. 2012) Since 2010 over a million claimants of the main out-of-work disability benefit in the UK had their eligibility reassessed using a new tougher assessment, the Work Capability Assessment (WCA). Doctors and disability groups have raised concerns that this process has had a negative effect on the mental health of the claimants. An observational study in 2015 (by Barr et. Al. 2015) looked at population data over a specific period to explore whether there was an association between changes in the rates of mental health problems and rates of mental health problems. The researchers estimated for every 10,000 people reassessed they would expect to see: • An additional six suicides • An extra 2,700 reports of mental health problems • 7,020 extra antidepressant prescriptions The study can only demonstrate an association between the data and does not provide comprehensive evidence that the WCAs were the direct cause of the mental health outcomes examined. **<u>Neurodiversity</u>** Neurodivergent people, including autistic people and those with ADHD, experience significantly higher rates of suicidal ideation, self-harm and suicide than the general population. National evidence suggests autistic people may be up to eight times more likely to die by suicide, while ADHD and co-occurring ADHD/autism are associated with elevated suicidal thoughts and suicide attempts across the life course. Local intelligence indicates neurodiversity is present within a subset of suicide reviews in Richmond, although numbers are currently too small to publish. The strategy therefore recognises neurodivergent people as a priority group and will promote neurodiversity-informed approaches, reasonable adjustments, inclusive communication and workforce training to improve access to support.

Sex	**<u>Common Mental Health Condition (CMHC) APMS 2024</u>** Women (24.2%) were more likely than men (15.4%) to have a CMHC. Specific CMHCs that were more prevalent in women than men were Generalised Anxiety Disorder (8.9% compared with 5.7%) and depression (4.5% compared with 3.1%). The prevalence of phobias, OCD and panic disorder was similar among men and women. The rise in depression since 2007 was steeper for females than males, while for phobias the rise was steeper for males than females.  **<u>Mental Health Treatment AMPS 2024</u>** Among those with CMHC symptoms, the proportion of men (43.3%) and women (46.7%) receiving mental health treatment was similar. This was the case for both use of psychotropic medication (36.3% of men, 36.2% of women) and psychological therapy (17.5% of men, 17.3% of women). **<u>Suicide and self-harm AMPS 2024</u>** One in thirteen adults (7.8%) reported having made a suicide attempt at some point in their life, with the proportion of the wider population likely to respond in this way being between 7.0% and 8.7%. This equates to an estimated 3.6 million adults. Despite men being three times more likely than women to die by suicide (ONS 2024), women (8.6%) were more likely to report an attempt than men (6.9%).  **<u>Menopause</u>** Women experiencing perimenopause and menopause may be at increased risk of poor mental health, including anxiety, depression, emotional distress and suicidal thoughts. National evidence suggests that the hormonal changes associated with perimenopause can have a significant impact on mental wellbeing, particularly when combined with other risk factors

	such as previous mental illness, caring responsibilities, relationship difficulties, financial stress, bereavement or social isolation. Recent research has highlighted that suicidal thoughts may be more common during the perimenopausal transition than previously recognised, and that standard mental health assessments may not always identify women experiencing menopause-related psychological distress. National suicide data also show that suicide rates among women are highest in mid-life, particularly among women aged 45 to 54 years, which overlaps with the typical age range for perimenopause and menopause. Examining suicidality in relation to the menopause: A systematic review | PLOS Mental Health **Richmond data** The latest Fingertips data show a clear gender difference in suicide rates in Richmond, mirroring the national picture. Between 2022 and 2024, there were 51 suicides in Richmond, including 35 men and 16 women. The suicide rate for men was 13.7 per 100,000 population, compared with 5.9 per 100,000 for women, meaning suicide is over twice as common among men locally. The male suicide rate in Richmond (13.7 per 100,000) is considerably lower than the England average (16.8 per 100,000), while the female rate (5.9 per 100,000) is slightly above the national average (5.5 per 100,000). Despite the suicide count remaining relatively low, small increases in count can lead to a larger increase in the rate per 100,000.
Gender reassignment	The risk of suicide in trans adults is higher than the general population. The higher risk is related to experiences of discrimination, including stigma, transphobia and bullying. These negative experiences occur in many trans individuals' everyday lives, whether at home, work, or school. This stigma and discrimination, and the fear of it happening, can make individuals in this situation feel unable to reach out for help when they need it. One study in the UK found that 34.4% of trans adults had attempted suicide at least once and almost 14% of trans adults had attempted suicide more than twice (Whittle, et al 2007). Data suggests that children and young people who identify as lesbian, gay, bisexual, transgender, or questioning (LGBTQ) are significantly more likely to have a mental health disorder and history of self-harm and suicide. (NCMD, 2021) A quarter of LGBT aged under 20 had been bullied; most had previously self-harmed. (NCISH, 2017)
Marriage and civil partnership	People who are married tend to have the lowest suicide rates. People who are never married, divorced or widowed tend to have higher suicide rates. The relationship is often explained by factors such as social support, reduced isolation, and economic stability associated with partnership. In Richmond, Census 2021 data shows that: • 46.3% of residents aged 16 and over were married or in a civil partnership. • 37.0% had never married or registered a civil partnership. • 8.8% were divorced or had a civil partnership dissolved. • 6.4% were widowed or a surviving civil partner.

	• 1.5% were separated but still legally married or in a civil partnership.
Pregnancy and maternity	Post-natal depression is a depressive illness that affects between 10% and 15% of new mothers. New mothers experiencing post-natal depression have a higher risk of suicide than the general population. (Royal College of Psychiatrists, 2018) While the statistical risk of suicide is low for pregnant women and new mothers, mental health problems are more common in women during pregnancy, with 13% of mothers having depression and anxiety rising to 22% in mothers one year after the birth (Gavin et al. 2005).
Race/ethnicity	**<u>Common Mental Health Disorders (CMD) APMS 2024</u>** Using age-standardised figures, overall variation in CMHC prevalence by ethnic group was not statistically significant. However, the number of participants in some ethnic groups was small and the confidence intervals around estimates were wide. These figures for prevalence of adults having any CMHC for broad ethnic group bands were: • 17.1% for Asian/Asian British • 16.3% for Black/Black British • 23.7% for Mixed • 21.9% for White British • 18.5% for White Other **<u>Mental Health Treatment AMPS 2024</u>** White British (18.4%) adults and those from another White background (16.7%) were most likely to be receiving treatment. Adults in the Asian/Asian British (4.1%), Black/Black British (8.2%) and Mixed/multiple or other (9.5%) groups were less likely than their White British counterparts to be in receipt of mental health related treatment. 15.2% of White British adults were taking medication for a mental or emotional problem, compared with 3.1% of Asian/Asian British adults and 4.3% of Black/Black British adults. Receipt of psychological therapy was highest among adults from another White background (6.4%) and lowest among Asian/Asian British adults (1.3%). **<u>Suicide and self-harm AMPS 2024</u>** • Suicidal thoughts were more commonly reported among those in the Mixed/multiple/other ethnicity (30.8%) White British (28.2%) and White Other (27.2%) groups, and less so among those in the Black/Black British (15.8%) and Asian/Asian British (8.9%) groups. • Suicide attempts were more commonly reported in the Mixed/multiple/other (11.0%), White British (9.2%) and White Other (7.5%) groups, and less so in the Black/Black British (3.0%) and Asian/Asian British (2.1%) groups. • Self-harm was more common in the White British (13.5%) and White Other (9.9%) and Mixed/multiple/other (9.1%) groups and less so in the Black/Black British (4.3%) and Asian/Asian British (1.8%) groups.

	
Religion and belief, including non belief	People who reported belonging to any religious group generally had lower rates of suicide compared with those who reported having no religion, although rates were higher in Buddhists and people in the "Other religion" category. However, the ONS also notes that religion is not routinely recorded at death registration, so these findings come from linked Census and mortality data rather than routine suicide statistics. Suicides broken down by religion - Office for National Statistics Research findings are mixed. A large UK study of over one million people found that suicide risk was similar among Roman Catholics, Protestants and people with no religion, although some conservative Christian groups had lower risk. The authors concluded that religious affiliation alone may be a poor measure of the social and protective aspects of religion. Religion and the risk of suicide: longitudinal study of over 1million people | The British Journal of Psychiatry | Cambridge Core
Sexual orientation	A review of the research literature suggests that Lesbian, Gay, and Bi-sexual people are at higher risk of mental disorder, suicidal ideation, and deliberate self-harm. Evidence suggests people identifying as LGBT are at higher risk of experiencing poor mental health (Chakraborty. et al. 2011). Members of the LGBT community are more likely to experience a range of mental health problems such as depression, suicidal thoughts, self-harm and alcohol and substance misuse (Zietsch. et al 2012, Liu & Mustanski et al. 2012). The higher prevalence of mental ill health among members of the LGBT community can be attributed to a range of factors such as discrimination, isolation, and homophobia (LGBT Foundation 2015) This can lead to members of the LGBTQ community feeling dissatisfied with health services, with mental health services most often perceived to be discriminatory (Hudson-Sharp. N& Metcalf. H. 2016). Data suggests that children and young people who identify as lesbian, gay, bisexual, transgender, or questioning (LGBTQ) are significantly more likely to have a mental health disorder and history of self-harm and suicide. (NCMD, 2021)

	A quarter of LGBT people under 20 had been bullied; most had previously self-harmed. (NCISH, 2017) Young people who identified as lesbian, gay, bisexual or with another sexual identity were more likely to have a mental disorder (34.9%) than those who identified as heterosexual (13.2%) (MHCYP, 2017).
Socio-economic status (to be treated as a protected characteristic under Section 1 of the Equality Act 2010) Include the following groups: • **Deprivation (measured by the 2019 English Indices of Deprivation)** • **Low-income groups & employment** • **Carers** • **Care experienced people** • **Single parents** • **Health inequalities** • **Refugee status**	**<u>Area-level deprivation APMS 2024</u>** Likelihood of having a CMHC was associated with area-level deprivation. Prevalence of a CMHC was highest among those living in areas in the most deprived quintile (age-standardised 26.2%) and lowest among those living in areas in the least deprived quintile (16.0%). The pattern of association between having a CMHC and area-level deprivation was similar in men and women.  **<u>Problem debt APMS 2024</u>** In age-standardised analyses, being seriously behind on at least one debt repayment or having utilities cut off was associated with greater likelihood of having a CMHC, as well as each type of CMHC. Adults with problem debt were more than twice as likely to have a CMHC (39.0%) as those without problem debt (18.4%). • Adults with problem debt (21.2%) were three times more likely to report having attempted suicide (ever) than those not experiencing problem debt (6.6%). **<u>Employment status APMS 2024</u>** Those who were economically inactive (31.9%) or unemployed (29.8%) were twice as likely as those in employment to be in receipt of treatment for a mental or emotional problem (14.4%). One in four (27.5%) adults who were economically inactive and one in five (21.7%) of those who were unemployed were taking medication for a mental or emotional problem, compared with one in nine (11.0%) of those who were in employment. One in seven (14.4%) unemployed adults and one in ten (10.0%) of those who were economically inactive were receiving psychological therapy, compared with one in twenty (5.1%) among employed adults. • Unemployed (42.3%) and economically inactive (37.5%) adults were more likely to have experienced suicidal thoughts than adults in employment (26.3%).

- Unemployed (20.3%) and economically inactive (19.1%) adults were more likely to have attempted suicide than adults in employment (6.6%).
- Unemployed (23.2%) and economically inactive (19.4%) adults were more likely to have self-harmed than adults in employment (12.8%).

Carers

In Richmond, the Census 2021 data records 13,669 unpaid carers. Caring for someone with a mental health condition can have a significant impact on the carer's own mental health and wellbeing.

Mental health carers often experience stress, social isolation, emotional burden, anxiety and difficulty accessing support. Richmond carers centre provides specialist support for carers, including counselling, workshops and carers' assessments.

Care experienced people

In 2024, Richmond had the lowest rate of children looked after in England, at 25 per 10,000 children, compared with an England average of 70 per 10,000 children.

Although the rate is comparatively low, care-experienced children and young people can still face higher levels of emotional distress, placement disruption, trauma, social isolation and barriers to accessing timely mental health support.

Release home - Children looked after in England including adoptions - Explore education statistics - GOV.UK

Single parents

Local suicide data are not routinely available for single parents. However, national evidence suggests that single parents experience higher levels of mental ill health, social isolation and financial stress compared with coupled parents. These factors are recognised risk factors for self-harm and suicidal distress. The strategy therefore has potential to benefit single parents through improving access to mental health support, strengthening social connectedness and reducing inequalities in access to services.

Refugee status

Home Office data from March 2023 recorded 27 asylum seekers in Richmond in receipt of support from the authority, up from 23 in June 2021.

Home Office data from 2025 on regional and local authority immigration groups indicates that Richmond had 1,138 asylum seekers residing within the borough, representing 0.56% of the population. This was an increase from around 1,000 in March 2024, equivalent to a 13.8% increase in one year.

Richmond has been awarded Borough of Sanctuary accreditation, recognising their commitment to creating inclusive and supportive places for people seeking safety. Sanctuary seekers may be at increased risk of poor mental health due to trauma, displacement, uncertainty, language barriers, housing insecurity and difficulty navigating health and care services. Local health needs assessment work is planned to improve understanding of this population and address current data gaps.

Data gaps

Data gap(s)	How will this be addressed?
Details of each of the protected characteristics are often not known and therefore not routinely collected in rTSS suicide reporting.	Further data sharing with services that do collect this data more readily and support through the Suicide Prevention Working Group to improve data collection.

4. Impact

Protected group	Positive	Negative
Age	A positive impact is anticipated through our life course approach, with earlier prevention for children and young people, and targeted outreach to middle age and older men, there will be clearer pathways for support and accessible information for crisis care.	There is a risk that because the strategy has a strong focus on young people or middle-aged men the needs of other age groups such as older residents that still struggle with social isolation and mental illness could be neglected. This will be mitigated through age-band data monitoring, accessible non-digital information and regular review of service uptake and outcomes by age.
Disability	The strategy is anticipated to have a positive impact for disabled individuals. This accessible information should benefit people with mental ill-health, long-term physical conditions, learning disabilities, autism, and other neurodivergence. Through continued working with lived experience forums, there should be increased opportunities for people with disabilities to feedback on their mental health service experiences.	There is a risk that some disabled residents may face barriers if support relies too heavily on one format, such as in-person services, digital information or inaccessible communication and venues. This will be mitigated through accessible and non-digital information, reasonable adjustments and feedback from lived experience and disability-related engagement.
Sex	This EINA has identified men as being at higher risk of suicide, and women and girls at higher risk of self-harm. The strategy is anticipated to have a positive impact for women experiencing perimenopause and menopause. The strategy allows for targeted support for these specific demographics aiming to reduce both rates of suicide and self-harm.	There is a risk that focusing strongly on men's higher suicide risk could reduce attention to women's self-harm, perinatal mental health and menopause-related distress. This will be mitigated through inclusion of girls and women experiencing menopause as a high risk group and ensuring actions address the different risks experienced by men and women.
Gender reassignment	The strategy is anticipated to have a positive impact through explicit	**No negative impacts are anticipated.**

	inclusion of trans and non-binary people and links with LGBTQ+ organisations, which should reduce stigma and support earlier access to help.	
Marriage and civil partnership	The strategy is anticipated to have a positive impact. The focus on social connection, bereavement support, relationship breakdown and isolation aims to benefit people regardless of relationship status. Also, support for families, partners and people bereaved by suicide can strengthen protective networks.	**No negative impacts are anticipated.**
Pregnancy and maternity	The strategy is anticipated to have a positive impact through closer links between suicide prevention, primary care, perinatal mental health and crisis services should support earlier identification and compassionate care during pregnancy and after birth. Accessible information for parents can improve awareness of help.	**No negative impacts are anticipated.**
Race/ethnicity	The strategy is intended to have a positive impact. Partnership with local community organisations can strengthen trust and improve mental health outcomes from these groups, such as global majority groups accessing care earlier and reducing the proportion having first contact in crisis care.	There is a risk that stigma around suicide will act as a barrier to access support for this group. Some people may also struggle accessing services due to a language barrier if they do not have English as a first language. Culturally appropriate training and targeted engagement should reduce stigma and treatment inequalities. Promotion of support with embedded translation services should help to mitigate this risk. Some services still collect data using broad ethnicity bands so inequalities in specific ethnic groups may be missed. This will be kept under review as data collection and quality improves.
Religion and belief, including non belief	The strategy is intended to have a positive impact. Working with faith and non-faith community networks can promote safe conversations and increase awareness of support. Person-centered care should enable	**No negative impacts anticipated.**

	residents to draw on beliefs and community connections where these are helpful without impacting access to clinical support.	
Sexual orientation	The strategy is intended to have a positive impact through explicit inclusion of lesbian, gay, bisexual and other sexual minority residents and direct engagement with LGBTQ+ organisations which aims to improve trust and reduce stigma of self-harm and suicide in these groups.	**No negative impacts anticipated.**
Socio-economic status (to be treated as a protected characteristic under Section 1 of the Equality Act 2010) Include the following groups: • **Deprivation (measured by the 2019 English Indices of Deprivation)** • **Low-income groups & employment** • **Carers** • **Care experienced people** • **Single parents** • **Health inequalities** • **Refugee status**	Embedding suicide prevention across wider council services and teams including social care, housing, welfare, debt, employment and substance use should help support people across these groups aims to have a positive impact on socio-economic status. Community connections and a "no wrong door" approach aims to improve support for carers, care-experienced people, single parents and refugees.	There is a risk that residents experiencing poverty, debt, unemployment, insecure housing, caring responsibilities, or refugee/asylum-seeking status may face barriers to accessing support, including stigma, language barriers, digital exclusion or lack of awareness. This will be mitigated through targeted engagement, links with welfare, housing, employment, carers and refugee support services, accessible information and monitoring of uptake by higher-risk groups.

5. Actions to advance equality, diversity and inclusion

Action	Lead Officer	Deadline
Monitor Real Time Suicide Surveillance database to understand local trends including demographics of people dying by suicide and ensure targeted prevention based on intelligence.	Graeme Markwell	Ongoing
Coordinate annual World Suicide Prevention Day campaigns and community outreach activities.	Graeme Markwell	September 26
Include actions to target health inequalities and implement interventions for key vulnerable groups set out in the strategy, interventions include: MECC and Mental Health First Aid Training for frontline staff; suicide prevention training for neurodiverse populations; primary care fact sheets relating to suicide and women's health.	Graeme Markwell	March 27

Ensure lived experience representation on Suicide Prevention Group membership.	Graeme Markwell	December 26
Encourage a whole council approach to suicide prevention training by securing commitment to engage in MECC suicide prevention training across directorates. Targeting people experiencing cost of living pressures, debt and housing difficulties.	Graeme Markwell	December 26
Promote new crisis care pathways in collaboration with South West London and St. George' Mantal Health Trust	Graeme Markwell	Ongoing
Promote 'Portus' self-harm and suicide prevention pathway for children and young people.	Graeme Markwell	November 26
Establish the Hope Forum across further and higher education settings to promote evidence-based suicide prevention interventions for students.	Graeme Markwell	November 26
Increase uptake of the Staying Safe from Suicide guidance across primary and secondary mental health care.	Graeme Markwell	March 27
Support 'AllKind' to deliver evidence-based suicide prevention interventions focused on vulnerable and high-risk populations.	Graeme Markwell	March 27
Promote the South West London Suicide Bereavement Service through regular promotion of the services across primary and secondary care.	Graeme Markwell	March 27
Review and map No Wrong Door services across Richmond to improve access to support for people with co-occurring mental health and substance use needs	Graeme Markwell	March 27

6. Further Consultation (optional section – complete as appropriate)

Guidance

Consultation planned	**Date of consultation**
Formal consultation through Citizen Space, closing 15 October. Communications plan for this consultation includes methods for reaching higher risk groups such as sharing directly to LGBTQ+ groups, crisis cafés, jobcentres, BME MH forum and supported accommodation.	7 September