Kent and Medway Suicide and Self-Harm Prevention Strategy 2026-2030

Consultation Report November 2025

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Kent and Medway Suicide and Self-Harm Prevention Strategy 2026 - 2030

Consultation Report

Executive summary

How was the draft Strategy developed?

- The Strategy was developed by both Kent and Medway Suicide and Self-Harm Prevention Networks (for adults and children).
- The Networks are partnerships of over 250 organisations and individuals living with experience of suicidal thoughts, self-harm or bereavement by suicide.

How many people responded to the consultation?

- The consultation ran from 23 July to the 6 October 2025.
- 153 responses were received in total of which 149 responses were received through the online questionnaire.
- 2 questionnaire responses were received by email.
- 2 additional comments were received via email.

Who responded to the consultation?

- 80% of responses were from individual residents of Kent and Medway.
- 7% of responses were from voluntary sector organisations, 3% were from educational settings, and a further 3% were on behalf of a family member or friend.

What did respondents tell us?

- The majority of respondents supported the draft Strategy. 89% agreed with the vision, 88% agreed with the mission, and 91% agreed with the values.
- The majority of respondents (93%) also agreed with the priorities set out in the Strategy, which include making suicide everybody's business by maximising collective impact, and providing specialist suicide bereavement support.
- There was strong support for the identified high-risk groups within the Strategy, with 90% of respondents agreeing with the groups listed.
- Some respondents felt that other groups of individuals should be considered high risk, particularly the neurodivergent community as a whole (as opposed to only autistic people), the LGBTQIA+ community.
- Other respondents commented that focussing on a particular group(s) was inappropriate as anybody can be at risk of suicide. They emphasised the importance of a Strategy that works for all.

- For the purpose of the consultation report, we have highlighted the most prominent themes for each question in the analysis below.
- One of the key recurring themes advocated for suicide prevention training to equip as many people as possible with the skills required to identify when somebody may be at risk of suicide, and the actions to take accordingly.
- Another recurring theme was the need for the Strategy to be supported by available, accessible and robust mental health support services in addition to local community-based support, such as peer groups. The importance of multi-agency collaboration was frequently cited across the responses.
- It was suggested that these services should be supported by a range of visible and appropriate campaigns - particularly at high-risk locations - to enhance wider awareness and increase the likelihood of people taking up support when needed.
- Less frequent themes that occurred throughout the responses included the impact of intersectionality, the importance of involving those with lived experience, stigma, and the value of trauma-informed care.
- For children and young people (CYP) specifically, the role of schools and other education settings in suicide prevention was a consistent theme, as was the role played by friends, family and wider networks. Online harms and social media were highlighted as something as a particular risk to CYP.

What will change as a result of the consultation?

- The draft Strategy will be amended to take into account the feedback received. Details of what has been changed will be included in a 'You Said, We Did' document which will be made available on the Let's Talk Kent[1] webpage.
- An action plan will be developed which sets out the details of how the Suicide Prevention Programme will seek to fulfil its priorities.

[1] Let's Talk Kent website: https://letstalk.kent.gov.uk/kent-and-medway-suicide-and-self-harm-prevention-strategy-2026-2030

Kent and Medway Suicide and Self-Harm Prevention Strategy 2026 - 2030

Consultation Report

Contents

1. Introduction

This document provides a summary of the responses received through the public consultation on the draft Kent and Medway Suicide and Self-Harm Prevention Strategy 2026-2030.

The Kent and Medway Suicide and Self-harm Prevention Strategy 2026-30 is the continuation of the work undertaken as a result of the 2021-2025 Kent and Medway Suicide Prevention Strategy[2] and combines local data about who is dying by suicide in Kent and Medway with national research and policy direction.

Unlike the existing Strategy (2021-2025), the Suicide and Self-Harm Prevention Strategy for 2026-2030 encompasses both Adults, and Children and Young People (CYP) as opposed to creating a separate strategy for both. The new Strategy sets the same eight priorities for both groups, but across two separate action plans, in recognition of the need for a slightly different approach for each.

The draft Suicide Prevention Strategy 2026-30 was developed by the Kent and Medway Suicide Prevention Programme, which is hosted by KCC's Public Health department and funded by the Kent and Medway Integrated Care Board.

The draft Strategy was developed in conjunction with the Suicide Prevention Networks, which are well-established partnerships made up of over 250 agencies, including statutory and voluntary / community sector organisations as well as individuals living with experience of suicidal thoughts, self-harm or being bereaved by suicide. There is a network focused on supporting adults, and a network focused on supporting children and young people. These networks will oversee the action plans set out for each as a result of this Strategy.

The vision of the new Strategy is that Kent and Medway become a place where the number of people dying by suicide is reduced as much as possible. Our aim is for the Kent and Medway suicide rate to be below the national average by 2030 (if not sooner).

The mission of this Strategy is to make Kent and Medway a place where hope is always available to anyone, no matter what they are facing. Specifically, we would like to have achieved the following by 2030:

[2] The Kent and Medway Suicide Prevention Strategy 2021-2025: https://www.kent.gov.uk/about-the-council/strategies-and-policies/service-specific-policies/public-health-policies/suicide-prevention-strategy

- Children and young people in Kent and Medway to be resilient enough to cope with life's normal ups and downs, but knowledgeable and confident enough to reach out for more support when they need it.
- Adults in Kent and Medway to know how to look after their own emotional wellbeing but to feel comfortable and are able to seek more help when necessary.
- All agencies (statutory, voluntary, community) to work collectively to ensure support and help is available to those who need it.
- All agencies to share knowledge and support each other to learn what works in helping people get the support they need.

2. Consultation process

Pre-consultation engagement

In order to develop the draft Strategy for public consultation, the Kent and Medway Suicide Prevention Programme engaged with its wider networks on multiple occasions.

These included:

- A discussion at the Annual Kent & Medway Suicide & Self-Harm Prevention Conference in December 2023
- An in-person workshop in April 2024
- Opportunities for all to input during the Adult and CYP Suicide Prevention Network meetings in March and April 2025.

The draft Strategy was shared at network meetings in June and July 2025, prior to public consultation. The image below provides a small snapshot of some the partner organisations that sit within our networks:

The Kent & Medway Suicide Prevention Programme also oversees the Better Mental Health Network and has over 350 members. The Programme was made aware of the new draft Strategy at meetings throughout 2025.

Key updates across all three Networks are shared through the Better Mental Health monthly newsletter, which has over 900 subscribers.

In addition to engaging with Network members, the following internal actions took place:

- The consultation for the draft Strategy was featured in the Director of Public Health's verbal update at the Health Reform and Public Health Cabinet Committee on 1 July 2025.
- The draft Strategy and consultation was discussed at the Children & Young People's Departmental Management Team meeting on 14 May 2025.
- The draft Strategy, Data Pack and consultation updates were regularly shared with the Suicide Prevention Strategic Oversight Board (SPSOB), which includes colleagues from Medway Public Health, KMPT (now Kent and Medway Mental Health NHS Trust) and the Integrated Care Board.
- Engagement with the Cabinet Member for Social Care and Public Health prior to the consultation going live.

Public consultation

On the 23 July 2025, an 11-week consultation was launched and ran until the 6 October 2025. The consultation provided the opportunity for residents and other stakeholders to provide feedback on the draft Strategy. The key consultation documents included the draft Strategy and a supporting Data and Evidence Pack, which focused on key data and an analysis of the local real time suicide surveillance data from 2020-2024.

The consultation was hosted on Let's Talk Kent KCC's engagement website: https://letstalk.kent.gov.uk/kent-and-medway-suicide-and-self-harm-prevention-strategy-2026-2030 Feedback was captured via an online questionnaire which was available on the webpage. A Word version of the questionnaire was provided on the webpage for people who did not wish to complete the online version and hard copies were also available on request. Letters, emails were analysed and considered alongside the questionnaire responses.

All consultation material included details of how people could contact KCC to ask a question, request hard copies or alternative formats.

A consultation stage Equality Impact Assessment (EqIA) was carried out to assess the impact the Strategy could have on the protected characteristics. The EqIA was available as one of the consultation documents and the questionnaire invited respondents to comment on the assessment that had been carried out. An analysis of responses to this question can be found on page 75 of this report.

To raise awareness of the consultation and encourage participation, the following was undertaken:

- Emails sent to stakeholders asking them to promote the consultation through their networks.
- Invites sent to people registered with Let's Talk Kent who had expressed an interest in relevant the topics (11,532 users).
- Article in the Better Mental Health Suicide Prevention newsletter (circulated to approx. 900 stakeholders across the county) requesting participation and for recipients to share with their wider networks and service users.
- Promotional materials distributed at event locations during the visit of the Baton of Hope to Kent and Medway on 22 September 2025.
- Key commissioned service providers, including Amparo, Mid Kent Mind and CANWK were asked to raise awareness of the consultation among service users and support them to participate.

- Children and young people engagement through the CYP Network and wider partners.
- Shared with KMPT service users and their Lived Experience Panel.
- Shared across KCC staff comms channels and with all Staff Groups to help capture input from a wide range of groups (including ethnic diversity, disability and LGBTQ+ groups).
- Joint media releases and communications with Medway Council and the Integrated Care Board.
- Social media posts on KCC's Facebook, X (formerly Twitter), Instagram, Nextdoor and LinkedIn channels. Mid-way through the consultation period, four posts were boosted to gain wider reach and engagement.
- Posters displayed in KCC buildings, including libraries, Gateways and country parks.
- Promotional banner on the Kent.gov.uk homepage during the consultation.
- Articles in the KCC's residents' e-newsletter.
- Articles were sent for inclusion in the KELSI Schools e-bulletin.
- Presented at internal and external meetings, including the ReferKent Network meeting, the Suicide-Safer Strategic meeting hosted by Canterbury Christ Church University, and the Community Safety information sessions.
- Promoted to town and parish councils through the Kent Association of Local Councils (KALC).
- Shared by KCC's Adult Social Care team with the Learning Disability Partnership Board, the People's Panel, Your Voice network, and Carers Voice engagement group.
- Following a review of responses mid-way through the consultation, specific organisations were targeted in an efforts to increase the number of responses from underrepresented groups, such as middle-aged men and ethnic minorities.

A summary of interaction with the consultation website and documents can be found below:

- 3,276 visits to the consultation webpage by 2,887 visitors.
- 702 downloads of the draft Strategy and 225 of the Data and Evidence Pack.
- 66 downloads of the Word version of the consultation questionnaire.
- 30 downloads of the consultation stage Equality Impact Assessment.

Organic social media posts via KCC's corporate channels had a reach of 22,905 on Facebook. There were 53,127 impressions on Instagram, X (Twitter), LinkedIn, and Nextdoor. Reach refers to the number of people who saw a post at least once and impressions are the number of times the post is displayed on someone's screen. The posts generated 1,375 clicks through to the consultation webpage. (Not all social media platforms report the same statistics). Boosted Facebook posts had a reach of 50,223 and generated 847 clicks to the consultation webpage.

Figure 1. Examples of social media graphics

Points to note

- Respondents were given the choice of which questions they wanted to answer / provide comments. The number of respondents providing an answer for each question is provided throughout the report.
- The sum of individual percentages in any single choice question in this report may not sum to 100% due to rounding.
- Participation in consultations is self-selecting and this needs to be considered when interpreting responses.
- Response to this consultation does not wholly represent the individuals or practitioners the consultation sought feedback from and is reliant on awareness and propensity to take part based on the topic and interest.
- Respondents were asked to provide feedback in their own words throughout the questionnaire. Whilst this report includes thematic feedback received at these questions, specific feedback unique to particular organisations or

circumstances was also received. All feedback is being reviewed and considered.

- The presentation of thematic feedback in the main body of the report usually focuses on the 5 themes that were mentioned most frequently for each question, but in some questions this number will vary. This applies when there are more than 5 themes that have been raised by a similar number of respondents, or when there are fewer themes that have been mentioned more frequently than others.

3. Who responded to the consultation?

There were 149 questionnaire responses: 147 online and 2 via paper / email. An additional 2 emails / letters were received providing feedback. The content of these have been reviewed alongside open-ended feedback received within the consultation questionnaire.

This section details the profile of respondents who completed the consultation questionnaire. The first question asked respondents to select from a list the option that best described how they were responding to the consultation.

Are you responding as…? (Base – 148)	**Number of responses**	**Percentage**
A Kent or Medway resident	118	80%
On behalf of a family member or friend (please complete this questionnaire using their information)	4	3%
On behalf of a charity or Voluntary, Community or Social Enterprise (VCSE) organisation	10	7%
On behalf of a Parish / Town / Borough / District Council in an official capacity	2	1%
A Parish / Town / Borough / District / County Councillor	1	1%
On behalf of an educational establishment, such as a school or college	4	3%
On behalf of a business in Kent	3	2%
Something else	6	4%

Geographic profile

The following table shows how many people responded across each of the districts and boroughs in Kent and Medway.

Please tell us the first 5 characters of your postcode. (Base – 149)	**Number of responses**	**Percentage**
Ashford	13	9%
Canterbury	15	10%
Dartford	3	2%
Dover	10	7%
Folkestone & Hythe	8	5%
Gravesham	0	0%
Maidstone	11	7%
Medway	9	6%
Sevenoaks	8	5%
Swale	13	9%
Thanet	17	11%
Tonbridge & Malling	9	6%
Tunbridge Wells	5	3%
Did not provide postcode	28	19%

Demographics of respondents

The tables below show the demographic profile of individual respondents who completed the consultation questionnaire. Respondents were given the option to skip all or some of these questions and those responding on behalf of an organisation were advised not to answer them. The proportion who left these questions blank or indicated they did not want to disclose this information is not included in the statistics below.

What is your sex? (Base – 111)	**Number of responses**	**Percentage**
Female	87	76%
Male	24	21%
I prefer not to say	3	3%

Is the gender you identify with the same as your sex registered at birth? (Base – 112)	**Number of responses**	**Percentage**
Yes	110	98%
No	0	0%
I prefer not to say	2	2%

Which of these age groups applies to you? (Base – 114)	**Number of responses**	**Percentage**
18-25	4	4%
26-35	17	15%
35-45	19	17%
46-55	26	23%
56-65	26	23%
66-75	14	12%
76-85	7	6%
86 and over	1	1%
I prefer not to say	0	0%

Do you have a disability, health condition, physical or mental impairment that has a substantial and long-term negative effect on your ability to do normal daily activities? (Base – 114)	**Number of responses**	**Percentage**
Yes	50	44%
No	61	54%
I prefer not to say	3	3%

If you answered 'Yes' to Q21, please tell us if any of the following disabilities or health conditions apply to you. (Base – 50)	**Number of responses**	**Percentage**
Physical	22	44%
Sensory (hearing, sight or both)	1	2%
Longstanding illness or health condition, such as cancer, HIV/AIDS, heart disease, diabetes or epilepsy	14	28%
Mental health condition	30	60%
Learning disability	1	2%
Neurodivergent, such as ADHD, autism, dyslexia and dyspraxia	29	58%
I prefer not to say	2	4%
A different disability or health condition	2	4%

Please note, the total of the percentages above may exceed 100% on the basis that some respondents may experience multiple conditions.

What is your religion or belief? (Base – 112)	**Number of responses**	**Percentage**
No religion or belief	51	46%
Atheist	5	4%
Christian	37	33%
Buddhist	2	2%
Hindu	1	1%
Muslim	1	1%
A different religion or belief	9	8%
I prefer not to say	6	5%

Which of the following best describes your sexual orientation? (Base – 112)	**Number of responses**	**Percentage**
Heterosexual/Straight	94	84%
Bisexual	4	4%
Gay or Lesbian	6	5%
I prefer to define my own sexuality, please tell us:	4	4%
I prefer not to say	4	4%

Are you a Carer? (Base – 114)	**Number of responses**	**Percentage**
Yes	29	25%
No	81	71%
I prefer not to say	4	4%

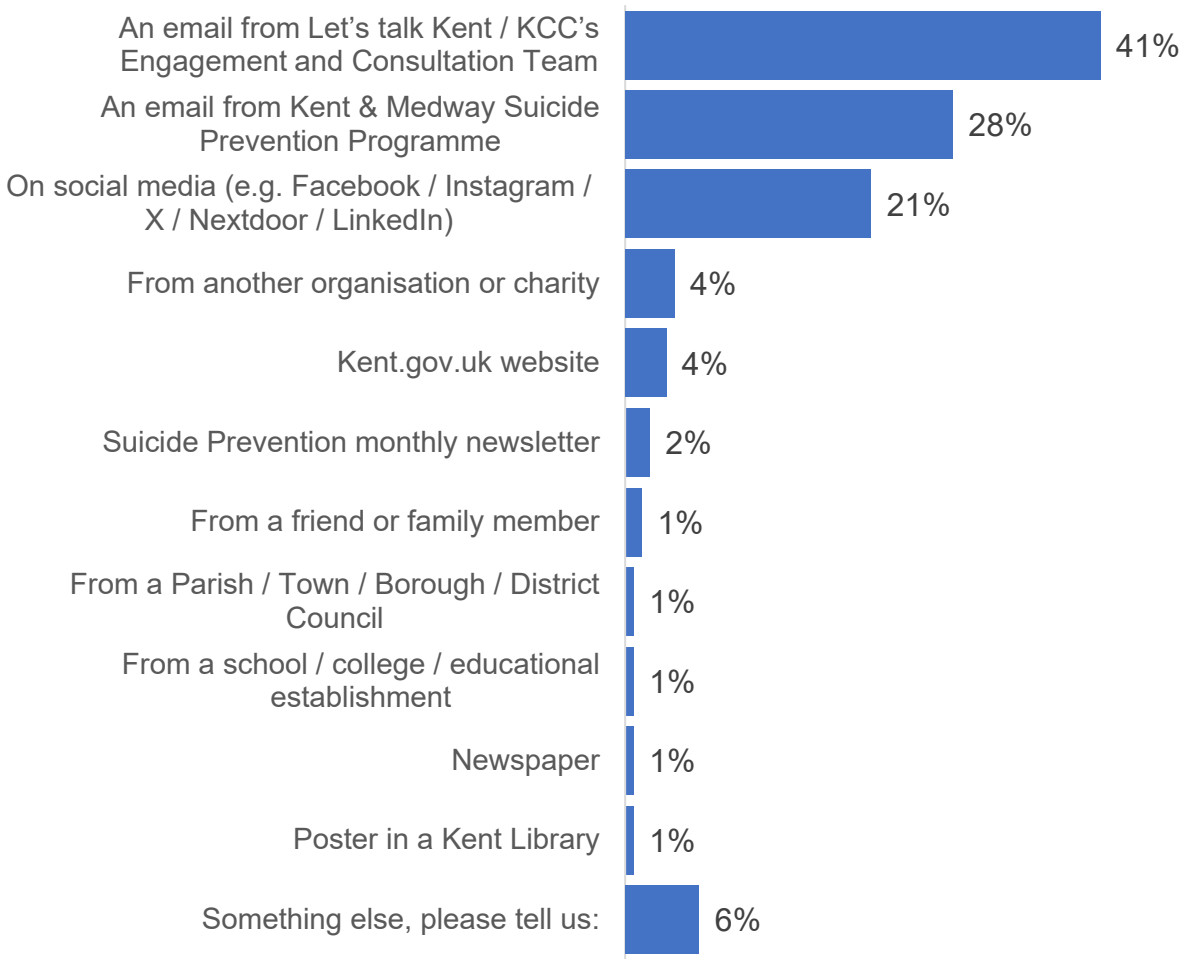
What is your ethnic group? (Base – 149)	**Number of responses**	**Percentage**
White	108	95%
Mixed or Multiple	2	2%
Asian or Asian British	2	2%
Black, Black British, Caribbean or African	2	2%

Which of the following best describes your working status? (Base – 114)	**Number of responses**	**Percentage**
Working full time	41	36%
Working part time	28	25%
Unemployed	4	4%
Retired	23	20%
Student	2	2%
I prefer not to say	3	3%
Something else, please tell us:	13	11%

Consultation awareness

The two most common means of finding out about the consultation were an e-mail from Let's Talk Kent / KCC's Engagement and Consultation Team (41%) and via e-mail from the Kent & Medway Suicide Prevention Programme (28%). 21% found out about the consultation through social media:

How did you find out about this consultation? Base: all providing a response 142



Supporting data table	Number of responses	Percentage
An email from Let's talk Kent / KCC's Engagement and Consultation Team	58	41%
An email from Kent & Medway Suicide Prevention Programme	40	28%
On social media (e.g. Facebook / Instagram / X / Nextdoor / LinkedIn)	30	21%
From another organisation or charity	6	4%
Kent.gov.uk website	5	4%
Suicide Prevention monthly newsletter	3	2%
From a friend or family member	2	1%
From a Parish / Town / Borough / District Council	1	1%
From a school / college / educational establishment	1	1%
Newspaper	1	1%
Poster in a Kent Library	1	1%
Something else, please tell us:	9	6%

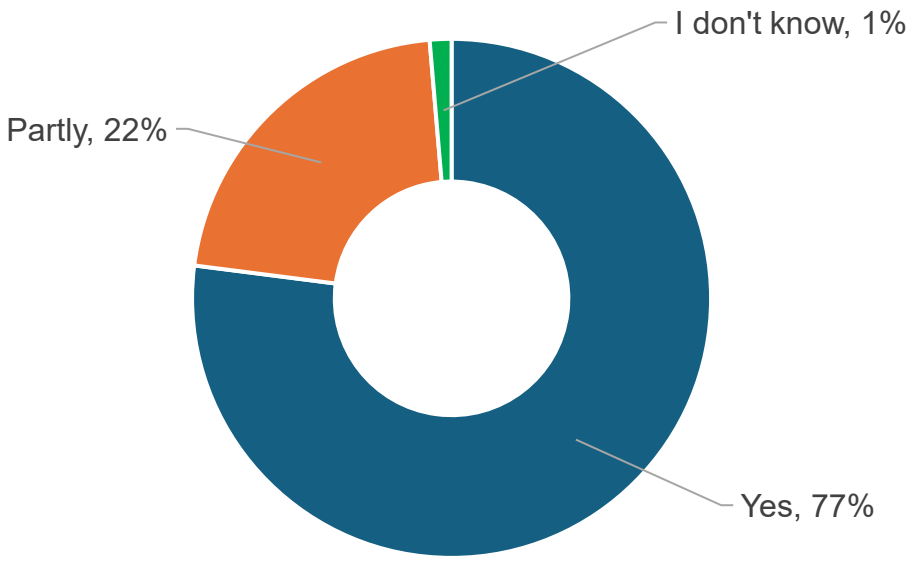
Please note, the total of the percentages above may exceed 100% on the basis that some respondents may have heard about the consultation through multiple channels

4. Feedback on the Strategy

Perceived ease of understanding of the Kent and Medway Suicide and Self-Harm Prevention Strategy

Over three quarters of respondents (77%) agreed that the Kent and Medway Suicide and Self-Harm Prevention Strategy is easy to understand. A further 21% indicated that it is partially easy to understand and 1% were not sure. No respondents stated that the draft Strategy is not easy to understand.

Chart 1. Is the draft Kent and Medway Suicide and Self-Harm Prevention Strategy 2026-2030 easy to understand? Base: 148



Supporting data table	Number of responses	Percentage
Yes	114	77%
Partly	32	21%
No	0	0%
I don’t know	2	1%

Respondent feedback on how the Strategy could be made easier to understand

Respondents were asked to detail how the Strategy could be made easier to understand. Respondent comments have been reviewed and grouped into themes.

In total, 18 different themes were raised, although several were not related to the ease of understanding the document. A number of respondents commented on the formatting of the document (11) and suggested increased use of spaces, bullets and visuals.

A further 10 stated that the Strategy required examples of specific interventions and actions needed to achieve the document aims, whilst 6 suggested that the Strategy needed to be more specific to particular demographics.

There were suggestions from 6 of respondents that an Easy Read version should have been available, and 5 suggested possible wording amendments.

The top 5 themes are included in the table below. A full analysis is provided in Appendix 2.

If you have any comments or suggestions on how to make the Strategy easier to understand, please tell us in the box below. Base:54

Themes	Number of respondents who raised this theme
Needs reformatting (e.g. space, bullets, visuals)	11
Needs specific examples of specific interventions / actions	10
Is too generalised / needs to be more demographic specific	6
Easy Read version required	6
Needs wording amends	5

Example quotes, in respondents own words, for the main themes can be found below:

Formatting of the draft Strategy

“The Strategy would benefit from more visual elements to improve accessibility.”

“Summary pages are particularly word-heavy and could be broken up with diagrams or infographics. Some sections felt generic and lacked specificity around domestic abuse and trauma-informed approaches.”

“The new information for the upcoming years is succinct and clear, but right at the end. The rest of the information is interesting but not necessarily needed ahead of the new idea's as that is what we are being asked to consult on. I understand why it’s been written that way but as an explanation of the new plan but it could be after the new plan as justification.”

“The formatting could be improved to make it easier to absorb the data at a glance.”

“Feels very repetitive, space writing out more to make it easier to differentiate sentences and sections.”

Need for specific examples of interventions and actions

“The reasoning and ideas are easy to understand and sufficiently detailed. However how the plan will be implemented is too vague, lacking detail about for example, timely and bespoke interventions for mental health support. What will this look like? What additional provisions will be made, will time frames will be introduced for those in need of services?”

“Feels like PR spin. Rhetoric is empty and irritating. It is not a Strategy, it is marketing. Simply Identify the issue, identify the goal, identify critical factors and then clearly demonstrate stress testing, factoring capacity, increased risks of developments known to perpetuate distress.”

“Provide specific details about what will actually be done - not broad statements that don't outline the exact strategies, resources, and support that will be available. For example, an increase in funding for mental health support, employing more therapists and counsellors, widening the range of therapies available - with specific numbers for finding and provision. Setting measurable and transparent goals.”

“Some is at the level of aspirations, impossible to evaluate.”

Need for the draft Strategy to be less generalised and more demographically specific

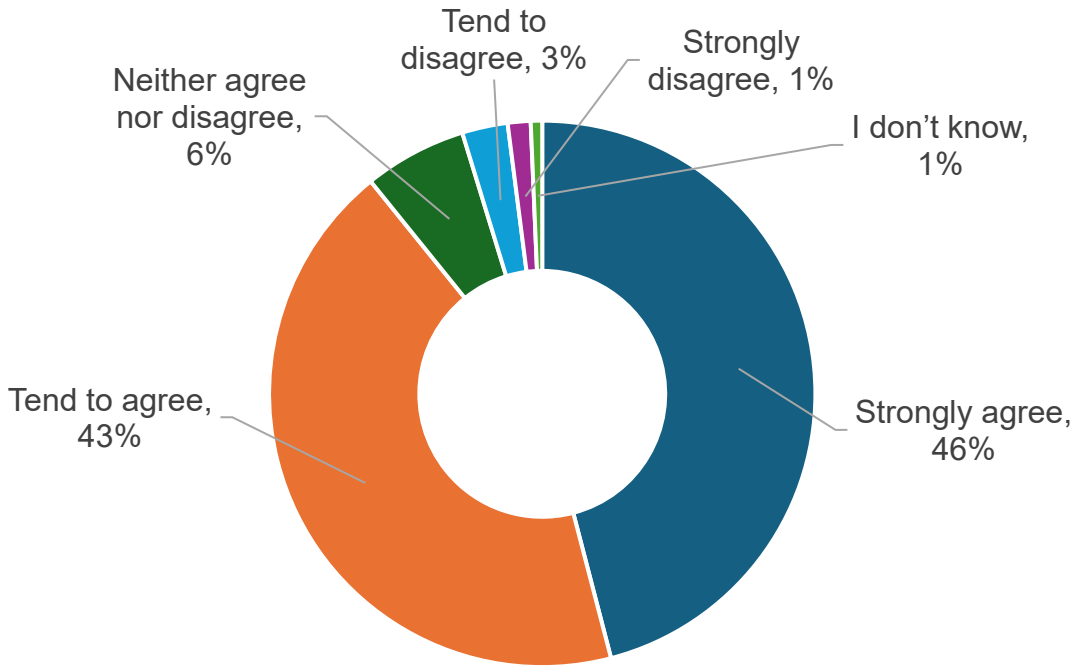
"Extremely generalised and most seems to be using the same stuff for the at risk groups rather than realising those things may not work for those groups and finding new things that might make a difference."

"Suggest you name the numerous voluntary organisations (eg Men's sheds, Allotment Societies, Sports Clubs), so that the professional organisations know where to focus training and assistance. Also needs stratification by age, lifestyle and gender of suicide rates. It's commonly thought that newly single older men are most at risk; is this true in Kent?"

Agreement with the proposed vision for the draft Strategy

In 89% of respondents agreed with the proposed vision of the Strategy, with,46% strongly agreeing and 43% tending to agree. 6% of respondents neither agreed or disagreed, 3% tended to disagree and 1% strongly disagreed.

Chart 2. How much do you agree or disagree with our proposed vision for the draft Strategy? Base:148



Supporting data table	Number of responses	Percentage
Strongly agree	68	46%
Tend to agree	64	43%
Neither agree nor disagree	9	6%
Tend to disagree	4	3%
Strongly disagree	2	1%
I don't know	1	1%

Respondent feedback on why they agree or disagreed with the proposed vision of the draft Strategy

Respondents were asked to provide more detail on why they agreed or disagreed with the proposed vision of the draft Strategy.

In total, 27 different themes were raised, covering a broad range of topics including the role of mental health support, neurodivergence and hope.

A number of respondents used this question as an opportunity to voice their approval and agreement of the vision (71).

35 respondents, including many who agreed with the vision of the Strategy, expressed scepticism around how effectively it could be put into practice.

14 respondents wanted to highlight the importance of good mental health support which should accompany this vision, and 8 advocated for the need to support children and young people. A further 7 stressed the importance of multi-agency collaboration to achieve the desired outcomes.

The top five themes are included in the table below. A full analysis is provided in Appendix 2.

Please tell us the reason for your answer in the box below: Base: 114

Themes	Number of respondents who raised this theme
Agreement with the vision	71
Scepticism over policy / needs focus on Strategy in practice	35
Importance of good mental health support	14
Support for young people	8
Multi-agency collaboration	7

Example quotes, in respondents own words, for the main themes can be found below:

Agreement with the vision

“I have lost many friends to suicide and very much view any death by suicide as one death too many and am pleased to see the desire to reduce deaths by suicide as much as possible”

“Seems like a balanced compromise as it doesn't rely on a huge injection of money which will never become available in the current state of the economy.”

“The aim is grounded, measurable, and time-bound—this makes it achievable. It’s a strategic and compassionate approach that focuses on progress, not perfection. “Below the national average” gives Kent and Medway a realistic benchmark. The decision not to say “zero suicides” reflects sensitivity, realism, and respect for the complexity of suicide.”

“We can't keep losing lives to suicide. People have to have hope in their lives, and your plans are great. Especially as you have linked up all the different groups and people. It is the saddest thing that people feel so overwhelmed, and I am glad to see that help is available for them.”

“Below the National Average is reasonable, as much as possible would be ideal. The only thing better would be more of a leaning toward 'as much as possible' for the specific aim, too, but there are limits on achievability and below the national average is an achievable and measurable goal.”

Scepticism of the vision – particularly in terms of how it will be put into practice

“The vision is great. You have identified high risk groups and wish to offer them better support. The plan to back it up with I have doubts about.”

“Pinning things to the "national average" is unfortunate and gives the impression that "some" suicides are not a problem as long as Kent is not notably an outlier in terms of cases. I don't for a moment think this is true, and I suspect this is just because it's a useful marker of progress but it gives the impression that the effort is a mainly bureaucratic one to improve the "optics" of the problem than an empathetic one to deal with the root causes. If the national average was 88% and Kent fell at 87% this would hardly be cause for celebration after all. At the same time, I do understand why it's presented the way it is.”

“I don't know how realistic it is without major transformation to the education system and relationship support. Also the lack of support services and ever changing research findings.”

“Focus entirely on suicide rate, not on self-harm and the poor state of mental health amongst the population in Kent and Medway.”

“Reduced as much as possible is meaningless. A clear Strategy sets out specific, measurable, and time-bound targets. The national average itself represents an unacceptable level of preventable deaths. Kent and Medway should aspire to be a leader in prevention, not just “less bad” than the rest of England.”

“I agree in principle, although coming at it from statistics depersonalises what is a very emotive issue. The indicator of success could be that the Kent and Medway suicide rate is below the national average by 2030, but I wonder if the start of the paragraph could be something like…

Our vision is that Kent and Medway becomes a place where people can access supportive services when they need to and that as far as possible, fewer die by suicide… Our specific aim is for the Kent and Medway suicide rate to be below the national average by 2030 (if not sooner).”

Need for good mental health support

“Most of it looks fine but we still need a proper NHS mental health service that offers continuous, joined-up care for as long as a person needs it.”

“It is important that as much support is put in place for vulnerable people no matter where they are from or what age group. Men often find it difficult to reach out so supporting them and letting them know its ok to feel vulnerable and reach for help is absolutely ok.... The crisis process needs to be made easier to access and people given more time before they are signed off.”

“I strongly agree with the Strategy topic but think it needs more detail , the mental health support from NHS is appalling in Kent and this needs a really strong focus to

help save people's lives . People are struggling and not knowing who to turn to . If you are on the waiting list for support from the NHS you are told if you go for counselling anywhere else the NHS will not help you . Yet you are put on a big waiting list with them. It's awful, school staff don't have a clue how to help either and pass mental health off as behaviour."

"I agree with all of the Strategic Objectives, and appreciate this is targeted towards those who are already suicidal, however I implore KCC to consider the bigger picture - if Mental Health Services and/or community support groups had more support (funding = recruiting more staff, providing more therapies, etc) we can prevent more people from getting to the suicidal point."

Support for young people

"You have included all relevant groups which can try to support vulnerable people and prevent suicide. However this assumes that (young) people will be correctly identified by e.g. their school or other education setting; or their employer, to name only 2. This requires a lot of support from these settings which I do not believe is in place at the moment. A lot of training will be required I believe."

"The priority around resilience for children needs rewording it is not fixed and not owned by an individual and sits with a context."

"Anything that helps to prevent youngsters from feeling that despondent that they feel they have no option but to self harm or commit suicide has to be a good thing"

"I think we have to take whatever initiatives we can to prevent the risk of suicide - especially in young people as today's world of social media bullying and harassment is seeing an increase in the number of young teens taking this route to end their suffering."

Need for multi-agency collaboration

"Seems KMPT are nowhere to be seen on this document which is very concerning considering it's the mental health trust. You need to be working closely with this trust to create better care for people with mental health."

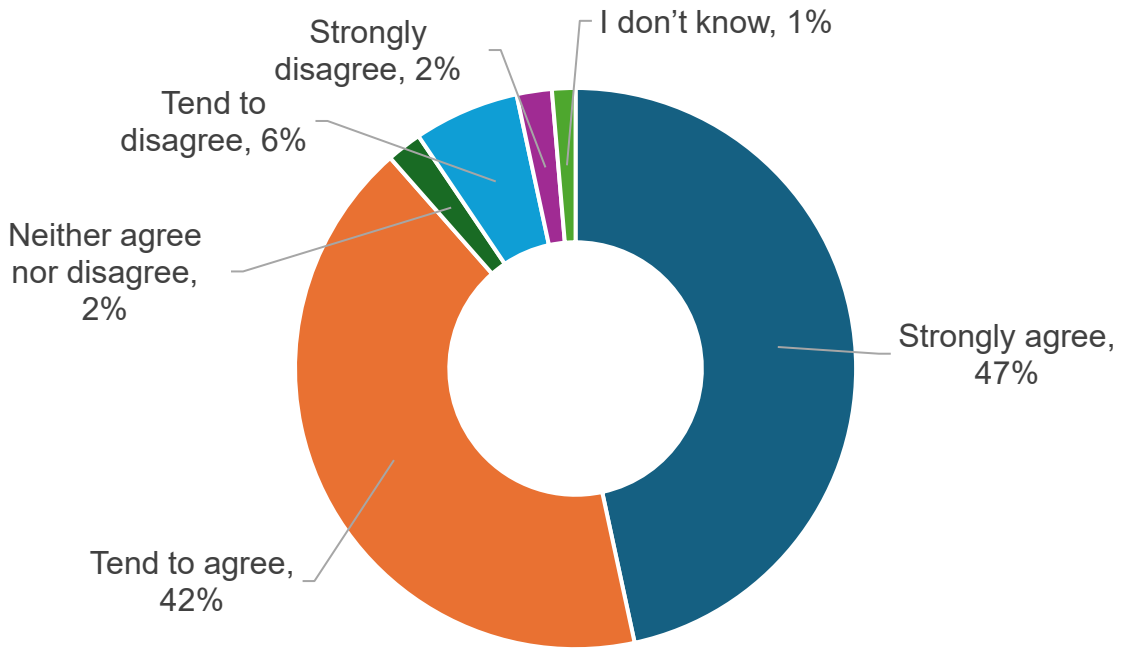
"Agencies don't work together, mental health provision extremely poor."

"Services working together. Professionals armed with evidence are crucial."

Agreement with the proposed mission

89% of respondents agreed with the proposed mission of the Strategy, either strongly (47%) or tended to agree (42%). 8% didn't agree with the mission, and 3% of respondents neither agreed or disagreed or weren't sure.

Chart 3. How much do you agree or disagree with our proposed mission for the draft Strategy? Base: 148



Supporting data table	Number of responses	Percentage
Strongly agree	69	47%
Tend to agree	62	42%
Neither agree nor disagree	3	2%
Tend to disagree	9	6%
Strongly disagree	3	2%
I don't know	2	1%

Respondent feedback on why they agreed or disagreed with the proposed mission of the draft Strategy

Respondents were asked to provide more detail on why they agreed or disagreed with the proposed mission of the draft Strategy.

In total, 29 different themes were raised, covering a broad range of areas including the importance of support for children and young people, service availability and standards, and resilience.

A number of respondents (37) used this question as an opportunity to voice their approval and agreement of the mission. 23 respondents used this question to express their thoughts on the availability and standards of mental health services.

21, including many who agreed with the mission of the Strategy, expressed scepticism around how effectively it could be put into practice.

Support for young people was referenced by 20 respondents, and multi-agency collaboration was again highlighted as an area of focus (16). 16 respondents had views – both positive and negative – of the use of the term, 'resilience'.

The top 6 themes are included in the table below. A full analysis is provided in Appendix 2.

Please tell us the reason for your answer in the box below. You can also let us know if you feel there is anything missing from the mission. Base: 108

Themes	Number of respondents who raised this theme
Agreement with mission	37
Service availability / standard	23
Scepticism of mission	21
Support for young people	20
Resilience	16
Multi-agency collaboration	16

Example quotes, in respondents own words, for the main themes can be found below:

Agreement with the mission

“I applaud the mission to restore in everyone the knowledge that life has its ups and downs. It is normal for levels of happiness and sadness to fluctuate. Children need to be reassured that is not abnormal to feel sad at times. They should not be labelled by others or label themselves as having mental health problems if things are not going well.”

“These strong aims don’t just clarify what needs to be achieved, they illuminate why it matters and how it fits into the bigger picture. This clarity fosters strategic coherence, boosts understanding, and empowers individuals to contribute with confidence and intent.”

“It has been developed collaboratively through ongoing engagement with relevant agencies.”

Service availability and standards

“Help needs to be available for those who need it, including lesser levels/early intervention options that enable people to get help before reaching crisis/suicidality. This is partially covered later on with mention of accessibility for all, but it should be noted that mental health teams refusing to take on autistic people is a very common problem, meaning autistic people may be denied the option of help when they do seek it.”

“Often onus is on the individual suffering to reach out for resources/self-refer which is very difficult at that point. Early intervention is key. Services in Kent are not interested unless a person have already planned their suicide.”

“Generally agree that opening up awareness and support across all agencies and populations is good as not everyone at risk will have the awareness, desire, or capability to access health services. However primarily mental health support (for those struggling) is a health and social care professional remit and the primary focus must be increased availability of professional services (specifically psychotherapy, and psychiatry access) at the point of needing it. Waiting weeks or months to be 'managed' by a basic Mental health practitioner is not adequate for those referred into MH services and more aligned to early intervention. We need more psychiatrists and advanced MH practitioners who can diagnose znx prescribe, and more specialised psychotherapists (trauma being a major cause of MH fragility) who can offer individualised therapy over for a satisfactory period.”

Scepticism of the mission – particularly in terms of how it will be put into practice

“The mission is a good one but I don't see how anything will be changed in practice and many professionals working in mental health for example don't want to help if someone is suicidal and other provisions to help certain at risk groups have been removed this year placing more people at risk.”

“I agree in principal I'm just not sure how this is achievable in the real world, having worked in mental health services and seeing the massive lack of collaboration between services (school, GP, MH services etc).”

“Again, not resolving the root cause of suicide. You will only fix the issue short term. More work with national rail is good but you cannot remove all methods of suicide, it would also be against human rights if you did.”

Support for children and young people

“Equipping youngsters to be masters of their own mental health should be encouraged.

“I applaud the mission to restore in everyone the knowledge that life has its ups and downs. It is normal for levels of happiness and sadness to fluctuate. Children need to be reassured that is not abnormal to feel sad at times. They should not be labelled by others or label themselves as having mental health problems if things are not going well.”

“There seems to be an implied “young people just need to toughen up” and their problems aren’t being taken seriously”

Use of the term ‘resilience’

“Putting emphasis on resilience for children and young people disregards the mental health crisis in this cohort and lack of support/access to CAMHS. Resilience is a problematic word and denies the social factors/lived experience of these individuals. Also adults looking after their own wellbeing places the onus on individuals and there is no support even when we do seek help.”

“I hate the use of the word 'resilient' as it is often tied to victim blaming, rather than accepting the huge pressures that someone is under. E.g. a young person who cannot attend school due to it causing actual sensory pain is often accused of being 'anxious' and not resilient in the face of challenges. It feeds into a sense of powerlessness and therefore more likely to lead someone to self-harm or suicidality.”

"I feel that working towards building resilience especially post covid & encouraging more children & adults to discuss their thoughts & feelings is a positive & necessary."

"The outlined points in the mission are all important. I think it is important to note that lasting resilience is built over time, with practice and with external support. People need to be taught how to maintain their wellbeing and not left to cope by themselves under the guise of building resilience, as this can affect both their self confidence in their skills and lengthen their distress."

Role of multi-agency collaboration

"There is no mention of adequately improving the communication link between Social care services and Community mental health services, the collaboration between these services is very broken."

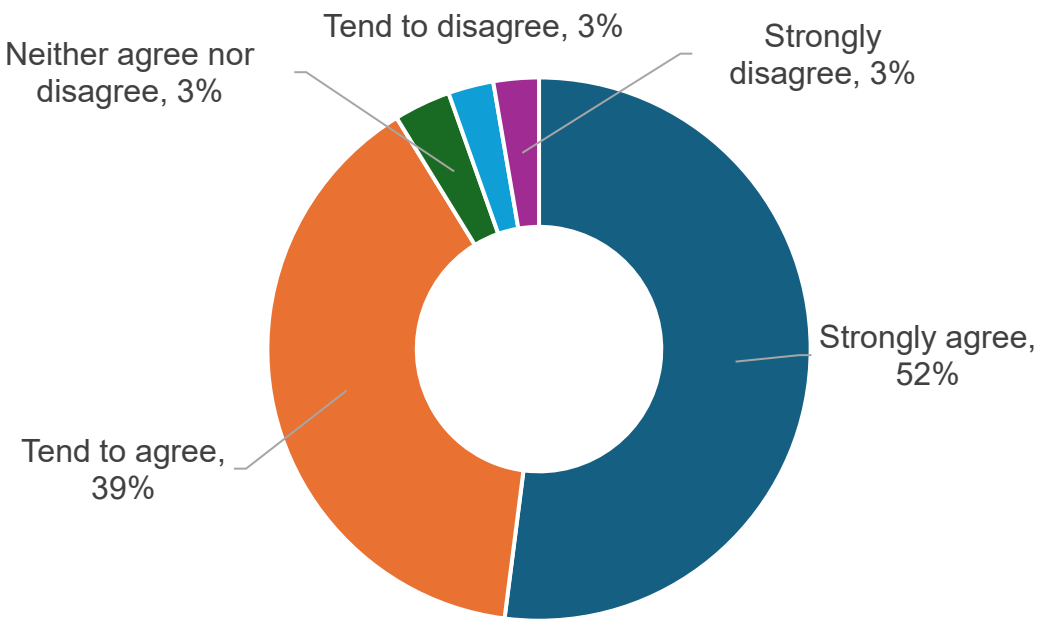
"I think working towards collaboration between all agencies, including charities, schools, police, workplaces and more, will be the key to this Strategy. This shared responsibility should be proactive and individuals need to be clear about the actions expected of them."

"Even when Social Services have significant concerns about the mental health care and treatment of a patient, they do not hold any power to press for care and treatment which has previously been proven to be effective. Support Services are ignored. Families are ignored. The idea of working together is a good one... in practice mental health services hold all the cards."

Agreement with the proposed values

91% of respondents agreed with the proposed values of the draft Strategy, 52% strongly so and 39% tending to. 3% of respondents neither agreed or disagreed, 3% tended to disagree and 3% strongly disagreed.

Chart 4: How much do you agree or disagree with our proposed values for the draft Strategy? Base: 148



Supporting data table	Number of responses	Percentage
Strongly agree	77	52%
Tend to agree	58	39%
Neither agree nor disagree	5	3%
Tend to disagree	4	3%
Strongly disagree	4	3%
I don't know	0	0%

Respondent feedback on why they agreed or disagreed with the proposed values of the draft Strategy

Respondents were asked to provide more detail on why they agreed or disagreed with the proposed values of the draft Strategy.

In total, 20 different themes were raised. These covered a broad range of topics, though there were clear parallels with those raised in previous questions, such as multi-agency collaboration and the availability and standards of services.

A number of respondents used this question as an opportunity to voice their approval and agreement of the values (49).

16 respondents, including some who agreed with the overall values of the Strategy, expressed scepticism. 16 spoke about the role of hope in a suicide and self-harm prevention strategy, and 15 raised the importance of multi-agency collaboration. Service availability and standards were once again raised as a key theme, this time by 13 respondents.

The top 5 themes are included in the table below. A full analysis is provided in Appendix 2.

Please tell us the reason for your answer in the box below: Base: 88

Themes	Number of respondents who raised this theme
Agreement with values	49
Scepticism of values	16
Hope	16
Agency collaboration	15
Service availability / standard	13

Example quotes, in respondents own words, for the main themes can be found below:

Agreement with the values

“I think these are great - avoiding the traditional values usually associated with MH gives the impression that there is some real "oomph" to this”

“The values are spot on - preventing harm is something any society that calls itself civilised should make a priority.”

“All vitally important, I love the use of the word 'determination' - When I think of the Suicide Prevention Team I also think of their passion and advocacy and would suggest these also feature in your values as it’s something the team embody strongly, and this is something I see being a big part of the Strategy's success”

“These values are important to make sure there is enough visibility at leadership level of this area of work.”

Scepticism of the values

“The. Values and direction is correct. But this should not rely on over using soundbites and generic terms as mental health information is very samey.”

“They sound nice but are quite vague. Anyone can claim these things, but what does e.g. determination actually translate into? Sensitivity is a good one to have in there though.”

“It’s probably best to omit the emotional stuff about hope and sensitivity etc - professionals should accept it”

Role of hope

“Hope and sensitivity is very important...”

“The inclusion of hope seems out of place among the other tenants”

“'Hope' as a concept needs definition. Hope of what, exactly?”

“Hope is empty without action. Hoping things improve simply won’t work. Tangible measurable and meaningful action groups and doing is what will make impact. Suicides are driven by a lack of acceptance, belonging and connection. This is Maslow basic human need above food and shelter. This is what will save lives. Not empty hope.”

Multi-agency collaboration

“These are perfectly acceptable motivations for the people who are working to prevent this. I do think that collaborative working is necessary, if only because the prevailing political winds have decided to strip back any funding and capacity for the NHS and local authorities to be leaders rather than "coordinators" in this. There are advantages to collaborative working, I wonder how much they are eclipsed by the difficulty of arranging so many disparate and separate groups - all well-intentioned. I realise this is beyond the remit of the Strategy to address.”

"Fine words but more targeted response needed, more collaboration with existing organisations within at risk groups like National Autistic Society. Self referral and wide advertising of what is accessible for individuals is definitely required."

"Collaboration is vital for suicide prevention and when concerns are raised to secondary services about someone experiencing suicide ideation, haven't always been positive experiences and a lot more work is needed to ensure that other professionals views (like from voluntary organisations) and judgements are taken seriously."

"Collaboration is really important and involving as many services, educational establishments and charities/community interest groups as possible will improve the likelihood of making meaningful and lasting changes."

Availability and standards of services

"I agree but you have not included any drug or alcohol charities or organisations in the collaboration to put the draft Strategy together, including the organisation which primary carers refer to in Medway. As always mental health problems are treated as a cause and not a reason. The mental health system needs to get away from this and not be allowed to use these problems as a reason not to treat. You also don't really explain HOW you are going to improve service providers and their staff (currently abysmal)."

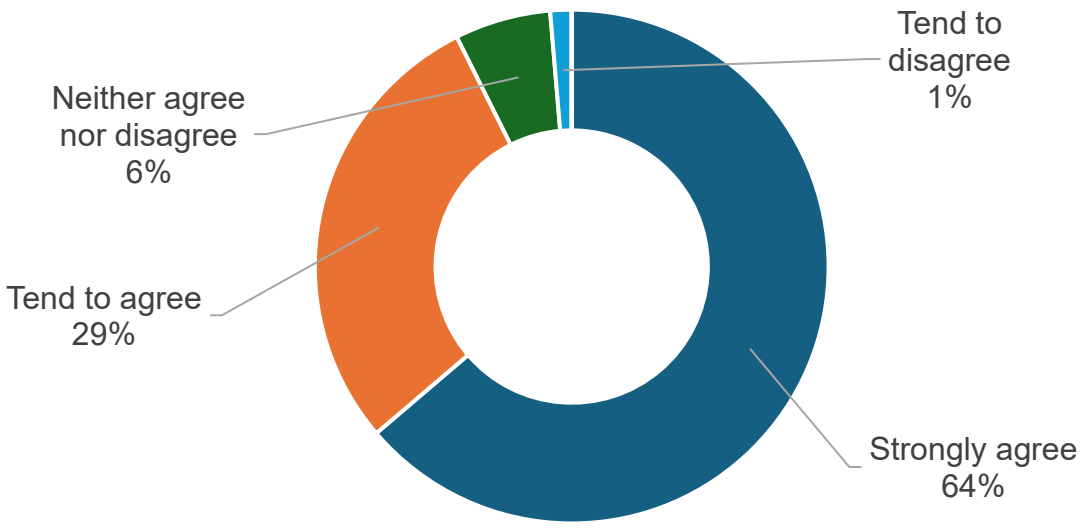
"Emphasis on hope can minimise risks. This Strategy should look beyond suicide to the state of mental health - eg numbers waiting for mental health treatment services and self-harm attendances at A&E"

"This is absolutely needed and urgent action needs to take place to minimise the negative impact the NHS and schools are having on young people who have suffered trauma and are struggling with their mental health . The provision is far from being adequate and sadly I feel there is a lot of work to be done in this area."

Agreement with priorities

93% respondents agreed with the proposed priorities of the draft Strategy, 64% strongly so and 29% tending to. 6% of respondents neither agreed or disagreed, 1% tended to disagree and 0% strongly disagreed.

Chart 5. How much do you agree or disagree that we should continue to follow the above priorities? Base: 149



Supporting data table	Number of responses	Percentage
Strongly agree	95	64%
Tend to agree	43	29%
Neither agree nor disagree	9	6%
Tend to disagree	2	1%
Strongly disagree	0	0%
I don't know	0	0%

Respondent feedback on why they agreed or disagreed with the proposed priorities of the draft Strategy

Respondents were asked to provide more detail on why they agreed or disagreed with the proposed priorities within the new Strategy.

In total, 29 different themes were raised. The range of topics was again broad, though the majority of these were referenced in fewer than 5% of all responses. Such examples of these include neurodivergence, gambling harms, and personality disorders.

A number of respondents used this question as an opportunity to voice their approval and agreement of the priorities (29).

24 were keen to again highlight the importance of service availability and standards and 11 expressed scepticism of the priorities.

10 spoke about the role of training in suicide prevention, and online safety / social media and support for those left behind both saw reference from 8 and 7respondents.

The top 6 themes are included in the table below. A full analysis is provided in Appendix 2.

Please tell us the reason for your answer in the box below. You can also let us know if you feel there are any priorities missing. Base: 89

Themes	Number of respondents who raised this theme
Agreement with priorities	29
Availability and standards of services	24
Scepticism of priorities	11
Training	10
Social media / online safety	8
Support for those left behind	7

Example quotes, in respondents own words, for the main themes can be found below:

Agreement with the priorities

“I fully support these priorities - I think it captures everything well”

"I agree with all 8 priorities, I think it would be beneficial to try and obtain information from people with lived experience these are the people who will really know where the gaps in support are and what they needed at the time of what is likely to be one of the most difficult times of their lives. We need to learn lessons now not when it's too late."

"These priorities reflect best practice and continued commitment to them is essential if we are to reduce suicide rates and support those affected with dignity and care."

"Agree with aligning to the national Strategy. Priorities are clear and provide a good structure around which to develop further work."

Availability and standards of services

"As previously stated, crisis support is too late and poorly staffed. Sharing information is one thing, but getting professionals to read up on a case before an appointment would stop the regular re-traumatising which goes on over most services, where individuals have to explain themselves over and over!"

"Suicide prevention is everybody's business but this should be to add to services not excuse inadequate or insufficient professional services. Wait lists of months and years for psychiatrist and psychology assessments are not acceptable. Access to ADHD medications needs drastically improving. Crisis interventions should be continued until routine services have confirmed they have picked up the case not just to slightly reduce the escalating situation (or the patient yo-yos in and out of crisis management with no regular support or improvement."

"Clear pathways, transparency and accountability when suicidal thoughts are reported. I don't feel this is very standardised and you could get a different response from different people within the same service. Everyone judges risk differently. It feels a bit unclear and vague."

"We would like to see sustainable and consistent recovery services, in addition to crisis and prevention support. Crisis and prevention are vital, but sustainable recovery pathways are equally important. The Strategy should also address how trends will be identified and communicated. It would be good to state a focus on frequently overlooked groups."

Scepticism of the priorities

"I mostly agree that the above priorities should be continued. They reflect a multi-layered approach to suicide prevention and show a clear commitment to data, crisis support, and bereavement care. However, it's important that these priorities are enacted effectively. For example, making suicide "everybody's business" must be supported with access, training, and recognition of community labour."

“Again I agree wholeheartedly, but I do wonder how you will achieve these aims in practice.”

“So where do you think this tailored support is coming from? There is a lack of funding into mental health support, so getting tailored support would be impossible without extra funding. People don't even get tailored support in secondary mental health services due to the lack of funding.

You need to sort out the crisis teams as they are dangerous to anyone who is suicidal.

Providing in-depth training in Autism and ADHD, especially ADHD as many MH professionals have no clue how to support someone with it as theres no ADHD-Specific training by law unlike Autism.

Not sure how you would reduce the means of suicide, as this would be impossible to do unless you stopped all trains, buying ropes, paracetamol/Medications, closed all bridges etc. I mean that statement doesn't really make sense.

Online safety and responsibility definitely needs more attention especially for children and young people. However, no matter how much awareness is out there, new harmful content reappears. TikTok is a very dangerous place, where individuals will create content which makes out mental health issues, psych wards, running from police, etc is fun and exciting. Its wrong and something needs to be done to stop these people who constantly waste services time and end up bed blocking so people who actually need urgent MH support are pushed to the back because there’s no beds or support.”

“Agree with the priorities but would like to see more substance around “how” this is going to be achieved”

Role of training

“As before your message must be made public. Helping vulnerable people will probably involve a lot of organisations, many of them which are run by volunteers. This will require training, investment i.e. funding, and collaboration between different organisations.”

“I have an acquaintance who recently lost her partner to suicide. I felt really unsure about how to offer support because the circumstances were so traumatic. I did what I could, but would have liked some advice on how I could have helped more usefully. I was aware her trauma was publicly known, yet her grief was private, and was anxious about choosing the right line with sensitivity.”

“Stop medics CAUSING mental health issues by lack of compassion and training. I thought their motto was DO NO HARM.”

"Important to widely publicise the support available. Important to raise awareness. As a former advisor at *(voluntary sector organisation)* I was not trained to either spot suicidal tendencies nor how to deal with them if I did spot them and yet I had several clients who I suspect were suicidal."

Social media and online safety

"I think social media has been a serious issue. Now with AI and algorithms picking up our conversations and even thoughts, it is imperative that something is done!"

"Social media platforms need to be held accountable for their content on suicide and self harm"

"…Sometimes younger people stumble across these messages and then it seeds the idea of suicide as a concept or a possibility before any stimulus for negative feelings enters their mind"

"…Online safety and responsibility definitely needs more attention especially for children and young people. However, no matter how much awareness is out there, new harmful content reappears. TikTok is a very dangerous place, where individuals will create content which makes out mental health issues, psych wards, running from police, etc is fun and exciting. Its wrong and something needs to be done to stop these people who constantly waste services time and end up bed blocking so people who actually need urgent MH support are pushed to the back because theres no beds or support."

Importance of supporting those left behind

"Support for people who are left when a family member has died is so important."

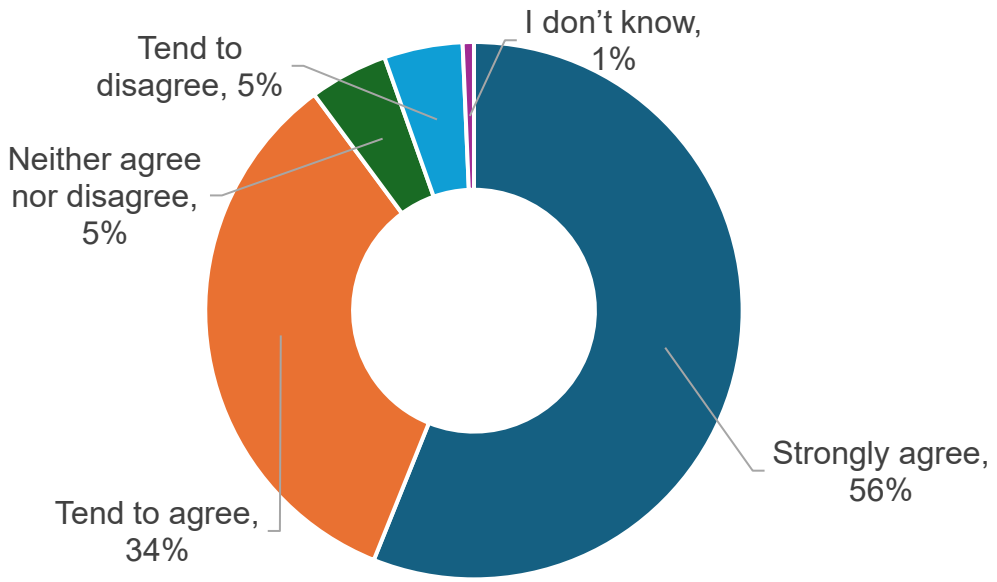
"I agree with all 8 priorities, I think it would be beneficial to try and obtain information from people with lived experience these are the people who will really know where the gaps in support are and what they needed at the time of what is likely to be one of the most difficult times of their lives. We need to learn lessons now not when it's too late."

"There needs to be support for families and this needs to have time measures in place - eg support will be within 24 hours / 2 weeks as timescales hold services to account and deliver support quickly for individuals"

Agreement with high-risk groups

90% of respondents agreed that the listed high-groups were the right ones to be prioritising, 56% strongly so and 34% tending to. 5% of respondents neither agreed or disagreed, 5% tended to disagree and 1% were not sure. No respondents strongly disagreed with the list.

Chart 6. How much do you agree or disagree that these are the right high-risk groups that we should be prioritising in the Kent and Medway Suicide and Self-Harm Prevention Strategy? Base: 148



Supporting data table	Number of responses	Percentage
Strongly agree	83	56%
Tend to agree	50	34%
Neither agree nor disagree	7	5%
Tend to disagree	7	5%
Strongly disagree	0	0%
I don't know	1	1%

Respondent feedback on why they agreed or disagreed with the high-risk groups cited as a priority in the draft Strategy

Respondents were asked to provide more detail on why they agreed or disagreed with the high-risk groups listed as a priority.

In total, 36 different themes were raised, with many of these being suggestions of other population groups which should be included in the proposed list.

A number of respondents used this question as an opportunity to voice their approval and agreement with the listed groups (30), compared to 11 who expressed scepticism.

Neurodivergence was referenced in 25 of the responses to this question and a notable proportion (12) were keen to highlight the LGBTQIA+ community as a suggested priority group.

The top 5 themes are included in the table below. A full analysis is provided in Appendix 2.

Please tell us the reason for your answer in the box below. You can also let us know if you feel there are any high-risk groups missing. Base: 109

Themes	Number of respondents who raised this theme
Agreement with groups	30
Neurodivergence	25
LGBTQIA+	12
Scepticism of selection	11
Children and young people	9

Example quotes, in respondents own words, for the main themes can be found below:

Agreement with the groups

“These groups are roughly in line with other evidence based research I have seen; as well as with what I have witnessed myself.”

“Important for common experiences of particular groups within society to be pooled and understood to support these vulnerable individuals”

"You have taken a data led approach. If other respondents feel there are any high-risk groups missing, I hope you will interrogate the data before adding them."

"I agree. It would be helpful to explore overlaps, eg autistic middle aged men known to secondary mental health services."

"There is good evidence to show that these groups are othered marginalised and excluded, alongside associated stigma and judgement. Acceptance, belonging and connection is the common most thematic missing for all of these groups."

Neurodivergence

"Individuals with ADHD (especially in Kent, as its the worse county in the UK for ADHD support, diagnosis and treatments)."

"Your focus should be on all neurodiverse individuals, not just those with Autism. However, getting a diagnosis for Autism or another neurodiverse condition is incredibly difficult so those who have self-diagnosed need support as well - if you only focus on those with a professional diagnosis then you will be ignoring hundreds of individuals who are probably at more risk because their lack of official diagnosis limits their access to support."

"I agree with prioritising these main groups but also people that may have autism but haven't been diagnosed when they were younger but clearly are struggling with a lot of the traits associated with it."

"I would strongly advocate for the Kent and Medway Strategy to reference 'neurodiverse' people rather than 'autistic' people. Further, "including those awaiting assessment". Whilst some of the data available to the SPN is not broken down enough to identify between e.g., autistic, or ADHD, or both in people who have died by suicide, we have seen in Kent practice reviews that ADHD can be specifically relevant in terms of impulsivity, for example. Given that the national priorities have already been adapted to meet local need, I think it is justified to be mindful of learning from Kent practice reviews and broaden the term. The reason I would suggest adding "including those awaiting assessment" is because we have also seen in reviews that where individuals are on a waiting list for neurodiversity assessment, sometimes their mental health needs are left unresponded to by virtue of the fact some symptoms may be ND related, rather than recognising a deterioration in mental health as something that needs an additional response."

LGBTQIA+ community

"LGBTQI+ people are a known risk group for suicide and I am really surprised that they are not included here. The Office of National Statistics calculates that LGB

people have a risk factor double that of heterosexual people for suicide. Studies suggest that the risk factor for transgender people may be as high as five times that of the general population."

"To NOT have LGBTQI+ in this list of groups of people is, quite incredible."

"As the data drives these results, then those groups are obviously the priority. I would also highlight LGBT+ people, particularly young Trans people as the literature suggests they are at a very high risk for suicide. See Shon Faye's 'The Transgender Issue' for great discussion of this."

"I agree with all the groups that you have included but i would add young men of early to mid twenties who are struggling with their sexual identity."

Scepticism of the groups

"This is definitely the case but care must be taken to not ostracise any group or individual. Suicide can be a split second negative thought and everyone is susceptible."

"I think there is always going to be people who don't fall into those categories who might slip through the net because they are the "unmet need".

"These are all higher risk groups but mental health does not discriminate and nor should we. It is good to focus targeted campaigns on these groups. However everyone regardless of age or gender or background should have equal timely access to bespoke mental health care when they request it. It must not be restricted to those deemed 'low risk' as if someone is requesting help, they have a need."

"I believe by using resources to address targeted groups, it is money wasted that could be available for anyone that requires support. This screams of hearing politicians that say they need to identify where an area needs improving rather than just getting on with it."

Children and young people

"Children should be made number 1 priority we need to shape their future one day they will be the ones running it the more we push them aside to deal with other categories the more they develop unhealthy mindsets and it will lead to larger issues in the future lets take children's mental illness and SEN children seriously."

"I would put children and young people at the top. Many people begin to have mental health problems in their early teens, so early intervention is crucial."

"Children and Young People feels too broad…"

"The overlaps between the different groups could be highlighted a bit more, especially for children and young people."

"Young people/secondary school age and neuro-divergent people should be a priority"

Suggestions for specific actions that could be taken to reduce the suicide risk for any of the high-risk priority groups

Respondents were asked if they had any suggestions for any specific actions that could be taken to reduce the suicide risk for any of the high-risk priority groups.100 respondents provided a response to this open-text question.

31 different themes were identified. The most prominent were around general access to support, making sure that services are visible and available to cater for peoples' needs. This was referenced in 28 responses.

Community cohesion, support groups and loneliness and isolation were themes that regularly came up with considerable overlap (20). Again, there was a considerable proportion of responses that made reference to the needs of the neurodivergent (16).

Other notable themes included the quality of available support (15), the needs of children and young people (12), and the role of schools and educational settings (12).

The top 6 themes are featured in the table below. A full analysis is provided in Appendix 2.

If you have any suggestions for any specific actions that could be taken to reduce the suicide risk for any of the high-risk priority groups, please tell us in the box below. Base: 100

Themes	Number of respondents who raised this theme
Availability / visibility / access to support	28
Community cohesion / support groups / loneliness and isolation	20
Neurodivergence	16
Quality of support	15
Children and young people	12
Schools / education	12

Example quotes, in respondents own words, for the main themes can be found below:

Availability, visibility or access to support

“I liked your introductory “poster” and would hope such information will be wildly available for all public areas where the vulnerable can see them with clear contact details given. I would also suggest areas such as churches, community halls, libraries, motorway service toilets, national trust at White Cliffs, Dartford bridge, etc.”

“Get out into community groups, have a presence, provide training and link up the signposting. People are always telling me "there is nothing out there" when there is - it's just not easy to link to it or obvious - make it widely known… Posters at railway stations, bus stations, community hubs, cafes, offices. Encourage conversations by providing information to key influencers. Also whilst secondary care is more and more difficult to access then there needs to be clear pathways to bridge the gap”

“Avoiding delays, wait lists, and having to see and disclose issues to multiple people. Direct appts with a psychiatrist or psychotherapist for MH referrals indicating this is needed and only initial assessments by general MH practitioners for lower level/more vague referrals so as not to waste time and risk reduction of engagement”

“There are helplines which are 24 hours such as Samaritans and shout which I think are helpful but know the demand for these is extremely high and can take hours to get support which again means that a difficult decision to reach out has been made but not got the timely support needed, could consideration be given to a local helpline? Especially outside of office hours. The safe havens are a great resource but know that people and organisations aren’t fully aware of these, they need to be publicised more effectively, as do many other supportive organisations in Kent and Medway, I think there is so much generalisation and a lack of specific actions in the Strategy overall.”

“Safe Havens and MH services are already overstretched. “Support efforts” is passive and meaningless. What additional crisis capacity will be funded? Where? When?”

Community cohesion, support groups and loneliness or isolation

“Loneliness and isolation among middle aged men is an invisible issue - it is hard to measure since they do not appear on many "radars" until it is too late… Perhaps some forms of interaction could be encouraged that could be engaged with remotely - Teams or Zoom clubs, meetings etc with options of in-person interaction, maybe arranged around certain themes. Even clubs to watch a football game with or to engage in gaming or Dungeons and Dragons etc.”

“More small casual groups in local areas so people can become passive friends with each other and become a natural support network”

"Making every contact count so that people feel confident to discuss their thoughts & feelings. Encouraging almost "whistleblowing" for friends, relatives & colleagues of those at risk."

"Creating spaces across the county for men to meet and build community. Self sufficient communities are so integral to combating the loneliness epidemic."

"Peer support groups, properly funded and led by lived experience will provide a sense of belonging and support, early support prevents escalation to more intense support and this is what is wanting. Whilst in the void many people escalate to higher need intervention when peer support would have prevented escalation and been a significantly cheaper option."

Neurodivergence

"Many autistic adults find making phone calls or having contact with a stranger extremely difficult if not impossible so the generalised mental health matters number or similar they are never likely to contact or the text things like SHOUT as they are often misunderstood at a very vulnerable time and end up feeling worse due to hope being taken away even more so a specialist service is needed for that risk group and none appears to exist now"

"Support services for autistic people. The new KCHFT keyworker service won't help people in crisis. There will be no help for autistic people and mental health services are not neuroinclusive."

"More ongoing support for autistic people following diagnosis. People are literally diagnosed and discharged with a leaflet."

"With regard to those with Autism they need consistency in the Teams they work with and the specialist KCC Autism team should be re-instated. Mental health workers need a greater understanding of Autism as they try to get them to attend group therapy. People in Kent with Autism should not have to travel out of the area to get access to mental health services who understand Autism."

Quality of support

"Improve Mental health services, properly funded and staffed. Let's see real action, rather talk"

"We need strong, robust and reliable crisis support - It's not good enough that people are being turned away from Safe Havens or can't get through on the phoneline. I know of people who have literally been crying out for help and have been turned away. This is so very sad and deeply concerning, it takes a lot for someone to reach out for help, so when they take that step they should be able to access it when they

need it, without the fear of being rejected when they are at such a low point in their lives."

"Avoiding delays, wait lists, and having to see and disclose issues to multiple people. Direct appts with a psychiatrist or psychotherapist for MH referrals indicating this is needed and only initial assessments by general MH practitioners for lower level/more vague referrals so as not to waste time and risk reduction of engagement."

"Better crisis support. GPs send people away to return for a later appointment. Crisis support stop checking if someone doesn't answer initial calls. Very difficult for people to get support from secondary care team, just a monthly call from primary care and phone numbers for self-referral. This is not good enough or sufficient to prevent suicides."

Children and young people

"For young people an app that sends supportive messages to them and where they can face time someone to talk to I think would make a huge difference."

"Children need safe spaces with trusted adults to be able to seek help and develop resilience. Short term interventions can be limited in impact."

"Ensure all staff looking after children and young people and vulnerable adults are educated to be able to support and refer people who are struggling with mental health and suicidal thoughts."

Schools and education

"I'm unsure how much power KCC has over school activities, but it may be worth considering bringing something into the PSHE syllabus - or have an outreach programme. I don't mean to talk about suicide with children - I mean to gently introduce them to the idea that something you might feel really bad, and you need to talk to someone about it. If possible get parents involved as well."

"The Strategy should also include "All secondary school pupils" from Yr 7 upwards, with definite attention to single sex schools (prevalent Self harm in Girls' only), private & Grammar schools"

"Effective support of PHSE leaders in co-design and delivery of suicide and self-harm in and across curriculum"

"More information and awareness sessions/workshops in schools and colleges."

Continuing to make suicide and self-harm prevention everybody's business

Respondents were asked how we could continue to make suicide and self-harm prevention everybody's business. This open-text question yielded a response from 113 out of 149 respondents (76%).

26 different themes were identified, with the main two being the importance of training (41), and the awareness and visibility of relevant campaigns (38).

The other top 5 themes in response to this question were; the roles of schools and education settings (15), the importance of community cohesion and local support groups (13), and the importance of conversation (10).

Examples of other themes, which did not fall into the top 5 for this question, included the role of the VCSE sector (7), the role of workplaces, friends and family in providing support (7) the importance of multi-agency collaboration (6), and the need to address stigma (4).

The top 5 themes are featured in the table below. A full analysis is provided in Appendix 2.

How can we continue to make suicide and self-harm prevention everybody's business? Base: 113

Themes	Number of respondents who raised this theme
Training	41
Awareness campaigns / communication	38
Schools / education	15
Community cohesion / support groups	13
Importance of conversation	10

Example quotes, in respondents own words, for the main themes can be found below:

Training

"As I answered earlier, having free or low cost training for interested individuals in suicide awareness and prevention would mean that more people in the community have the skills both to identify suicide risk and be confident about engaging in a conversation about this. Schools could adopt this training in an age and setting

appropriate manner for teenagers so that they know warning signs to look for in their friends and family."

"Make Suicide Prevention training a mandatory thing that everyone needs to do."

"Continue doing that training but remember not to just fob off the actual individual who is suicidal with a phone this helpline as that isn't possible for everyone and people aren't all the same"

"Conduct free community education sessions establish a DONT WALK BY Strategy where members of he public can help someone if they were to see someone in need of help."

"To make suicide and self-harm prevention everybody's business, we need to embed it across everyday settings. Normalising open conversations, training frontline staff, and promoting responsible media and online safety."

"Training on suicide prevention should be compulsory for business leaders, teachers, police officers and other people in positions of responsibility in Kent. Just offering the training isn't enough."

Awareness campaigns and other communications

"Create an awareness campaign (leaflets, for example) to explain the symptoms of suicidal thoughts. The majority of the people are not aware of the symptoms of suicidal thoughts."

"It's about publicity at its core I think. Each suicide is a tragedy but it's also a statistic. Everyone is used to euphemistic "person on the line" reports when commuting. There's never a story of that person, their name, who they were, the family they leave behind and so on. Suicides on railway property are literally the business of thousands of people and can provoke angry responses without much human empathy. I would favour a leaflet or display with some kind of memorial for those who died which is visible as people enter mainline stations. Just a moment's pause and reflection that this could be a family member or friend, and that having your journey disrupted is not the real story."

"The adverts need to be hard hitting but relatable. A man sitting quietly with his noose that he gets comfort from every night, knowing it is his only option for control. Someone playing with their special razor blade. When people are doing these things, and they do, they are already in crisis, they are the highest risk and yet they don't know that it is behaviour that others have had and got better from."

"Continue to provide messaging that help those dealing with thoughts of suicide and self-harm, including sign posting sources of support. Ensure everyone has

opportunities to access education that can help them reach out to others. Ensure messaging is well targeted and in places those who need it are most likely to find it."

"From my perspective the ad campaigns in public toilets and at petrol stations are particularly important, i have also heard students on construction industry courses discussing this."

Role of schools and education

"It starts with having an early years education Strategy building resilience in children from birth"

"Courses must be widely advertised and particular targets to school and college staff, youth leaders, those involved with vulnerable groups"

"Awareness, visiting schools, talking to pupils about how they access support."

Community cohesion and support groups

"Reach out to VCS groups who are well connected to their communities, particularly grassroots groups."

"It's important to recognise suicide prevention beyond formal training and settings. When people check in, share meals, or walk together, this can be a non-clinical lifeline for someone living with suicidal thoughts. Also, creative play like art and theatre offers ways for people to build community and experience joy beyond clinical settings. Recognising informal ways of preventing suicide and the importance of play for preventing suicide is very important."

"Use community hubs, like libraries, to offer support groups or places to access information - training individual staff at libraries so there is always at least one member of staff working who is able to react & respond appropriately to someone who may come in asking for support."

"Avoid the impression of top-down management of this issue. Run any training through local organisations that can be identified as coming from "my community" not some lofty County level. I need to feel that the issue is live and real on my street and that we, as a local community, are being empowered."

"Having your own resident group that rotates similar to jury service so people can offer insight from the local communities and how the Strategy is working."

Importance of conversation

"By bringing this topic into everyday life, normalising mental health as something that can affect anyone at any time, no stigma should be attached."

"Initiating cultures of speaking about feelings before they even get to the point of crisis."

"Give people the opportunity to talk about suicide in their workplace, at home, school etc. So many people suffer in silence, feel judged or ashamed."

"Promote bystander interventions. Promote open discussions about suicide and suicide prevention."

"By promoting, discussing the subject without fear but with care, love and support."

Reducing access to the means and methods of suicide in Kent and Medway

Respondents were asked how we could reduce access to the means and methods of suicide in Kent and Medway. This open-text question yielded a response from 96 out of 149 respondents (64%).

25 different themes were identified, with the main two being the need to focus on – and address - the risk at high risk locations (30) and the importance of visible, accessible and available support (22). The other top 4 themes included; some scepticism about how this priority could be achieved (17) and the role of awareness campaigns and other communications (17).

Examples of other themes, which did not fall into the top 4 for this question, included a suggestion to mitigate the risks of social media and other online platforms (10), increase the take-up of relevant training (10), and encourage greater multi-agency collaboration (11).

The top 4 themes are featured in the table below. A full analysis is provided in Appendix 2.

How can we reduce access to the means and methods of suicide in Kent and Medway? Please tell us the reason for your answer in the box below: Base:96

Themes	Number of respondents who raised this theme
Focusing on high risk locations	30
Availability / visibility / access to services	22
Scepticism of priority	17
Awareness campaigns / communication	17

Example quotes, in respondents own words, for the main themes can be found below:

Need to focus on high risk locations

"Put decent sized railings up at high-risk suicide spots (e.g. Car parks, tops of buildings, cliff edges & train tracks), to prevent people from taking the risk of ending their own lives and put a big sign on the railings to ask them if they've spoken to someone they trust about how they feel. Maybe put up a speaker at high-risk public places which plays a recorded message from different people's points of view (e.g. Children, parents, friends, partners), asking the person not to end their life and giving them reasons to stay. Above all, more should be put in place to break the stigma of asking for help with suicidal thoughts (be it going to the GP or talking to friends, loved ones or help services), in the first place, as people are ashamed to in this day & age due to unfair stigma around it being a weak thing to do."

"Unfortunately the most successful form of suicide is hanging which can be accessed anywhere. However, I definitely think it's a great idea to stop being able to get onto railway tracks, bridges - terrible for the driver and emergency services to deal with"

"I would think that having more police officers and other staff continually monitoring these locations would be a step in the right direction."

"I'd suggest a change to the wording: Ensure that environments are as safe as possible by restricting access to common means of suicide where evidence shows this saves lives - alongside support for underlying distress.

You can't police peoples every move so having support available in places that are a high suicide rate will be important."

"Look to see how motorway bridges can be made safer or at least put information regarding support near hotspots."

Availability, visibility or access to support

"To some extent its an impossible task as if the person is desperate enough they will find a way..... helping the individual before that point is the best solution"

" Increase availability / timely screening and early identification Implement routine mental health screenings in schools and paediatric care. Ensure pathways for follow-up and treatment when risk is detected are timely - offer youth accessible & friendly services that offer flexible, confidential, and low-cost/no-cost options"

"Clear places to go in crisis with well trained staff"

"Continue with the work you're doing; fund organisations like the Samaritans and MIND to do more sessions in the community where they can be visible."

Scepticism towards this priority

“I think if people want to do it they will find a way.”

“To some extent it’s an impossible task as if the person is desperate enough they will find a way..... helping the individual before that point is the best solution.”

“In my experience we already do a lot. As long as the Internet is available new ways will be found.”

“Oh for heaven’s sake, people have access the drugs, alcohol, toxic mixes of everything. This is a stupid question.”

“Unfortunately we'll always find a way - from medication, to buying ropes or helium from Amazon.”

Need for awareness campaigns and communications

“Check rail hotspots (on the advice of the rail authorities and transport police) and display notices for Samaritans”

“Very difficult challenge, I think public awareness of odd behaviour, noticing distress and being compassionate, signs in high profile areas to make people think about these issues. Make it a really Kent wide aim to get these rates down and that it can only ever be achieved if every person living in Kent becomes alert and compassionate.”

“Providing more awareness to services at hot spots where suicide is more commonly tried. For example the Samaritan stickers on bridges etc..”

“Increase public awareness so eyes and ears are everywhere. Ensure information about missing people is communicated to the public sector support families of missing people to access information about organisations who can help support in the search before it is too late.”

Best way of providing information and support to those bereaved by suicide

Respondents were asked what the best way was to provide information and support to those bereaved by suicide. This open-text question yielded responses from 100 out of 149 respondents (67%).

23 different themes were identified, and the proportions of the ones referred to most frequently were significantly smaller compared to the proportions of the ones referred to most frequently in previous questions. The theme which was raised the most was

the need for appropriate awareness campaigns to support visibility of existing support services (mentioned 21 times).

The importance of early intervention (13), the need for a range of flexible support methods (14) and the availability and general accessibility of specialist bereavement services (14) completed the top 4 themes for this question.

Examples of other themes, which did not fall into the top 4, included a recommendation to make sure those with lived experience were included within the design and delivery of relevant services (9) and the importance of making sure frontline professionals such as the Police, GPs and coroners have the knowledge of specialist suicide bereavement services required to identify the need for – and make – a referral (9).

The top four themes are featured in the table below. A full analysis is provided in Appendix 2.

What is the best way of providing information and support to those bereaved or affected by suicide? Base: 100

Themes	Number of respondents who raised this theme
Awareness campaigns / visibility	21
Importance of early intervention	13
Range / flexibility of support methods	14
Accessibility / availability of services	14

Example quotes, in respondents own words, for the main themes can be found below:

Need for awareness campaigns to help promote the visibility of services

“Those directly involved in “giving the news” (police?) to provide clear advice as to support. In various forms - leaflet, contact cards, website details. A follow up visit, phone call. In my limited experience many will not immediately seek any support so something has to be provided long term”

“In a short, concise email or on a dedicated website which is concise and easy to navigate, or in webinars where others can share their stories in a non-judgemental space and receive support from peers who are all in the same boat.”

“Sometimes I think just knowing the support is there if required - comms, marketing, social media campaigns”

"Advertising in public and private sectors, social media and support groups shops etc . Ensure GP's , police , schools, hospitals and funeral homes, coroners are advertising the support available to people who have had a bereavement by suicide . Ensure other districts are aware of the offer and able to signpost residents when the suicide happens outside the area."

Importance of early intervention

"Rapid access: Families should be proactively contacted within 72 hours of a suspected suicide by a trained bereavement worker (not left to hunt for services themselves). Long-term, stable funding: Support must be ring-fenced and guaranteed, not precarious annual contracts. Suicide bereavement is lifelong; support should not be short-term."

"This should be directly offered through police/health care as these are the services people will be in contact with following a suicide death of a loved one. Ensure it is offered immediately."

"Those directly involved in "giving the news" (police?) to provide clear advice as to support. In various forms - leaflet, contact cards, website details. A follow up visit, phone call. In my limited experience many will not immediately seek any support so something has to be provided long term"

Need for a range of flexible support methods

"However the bereaved want it, by being flexible to accommodate what works best for them, not expecting them (or the MH patient) to have to always fit in to what works best for the service"

"I would say by recognising that individuals need support in differing ways so rather than have a blanket approach listen to the needs and be flexible with the support and how it is delivered."

"Depends what they want. Offer of free contact with a bereavement counsellor would be good"

Need for generally accessible and available suicide bereavement support services

"You need to provide support so that those bereaved by suicide don't become the next lot of people who commit suicide ..... making sure there's no grey areas anymore so those people don't fall through the gaps on services (eg the person can be viewed as too complex for normal bereavement services but CMHT won't see people for bereavement and person requires more immediate help than a GP can give them)"

"You should reach in, not expect people to reach out. Support should be instant and warm. Access to trained grief counsellors who understand the complexities of suicide loss (different from general grief). Services should be free, trauma-informed, and not time-limited. Ideally includes options for one-to-one support, family sessions, and children's grief specialists…Services must be culturally competent, LGBTQIA+ inclusive, and attuned to different family dynamics."

"I feel leaflets could be available for those affected at the time of the suicide but it's probably too early to have a conversation and proactively giving out leaflets may feel insensitive. But could there be a follow up call 1-2 weeks later, then again 6 weeks later? Check in points could be good. Ensure services like Cruse Bereavement counselling is funded, or perhaps provided a payment for someone to seek private counselling."

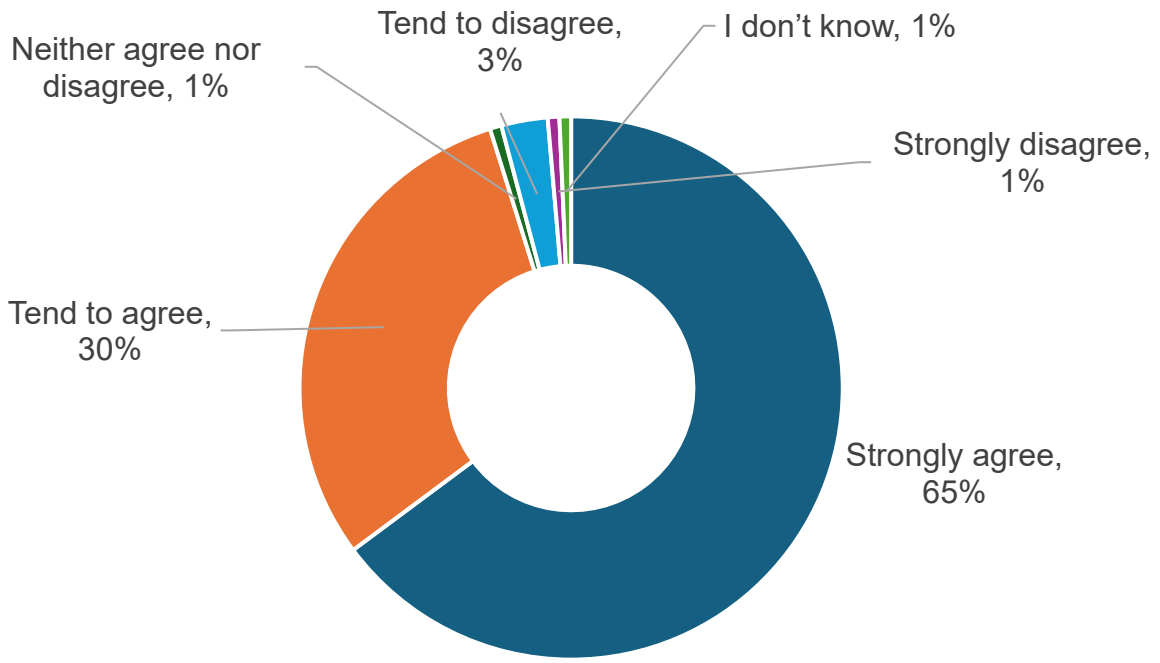
"I lost a friend and colleague to suicide prior to my own. Breakdown. I received no support from secondary care mental health services or IAPT. I was denied support to deal with my grief by 15 NHS and or voluntary services for various reasons including being too complex or no capacity within the service. Please provide a service for suicide bereavement that is accessible."

Children and Young People

Areas of focus that should be prioritised for children and young people

95% of respondents agreed with the areas of focus that should be prioritised for children and young people, (65% agreed strongly and 30% tended to agree). 1% of respondents neither agreed or disagreed, 4% disagreed (3% tended to disagree and 1% strongly disagreed) and 1% didn't know. 3% of all consultation respondents did not answer this question.

Chart 7. How much do you agree or disagree that these are the areas of focus that should be prioritised for children and young people in the Kent and Medway Suicide and Self-Harm Prevention Strategy? Base: 145



Supporting data table	Number of responses	Percentage
Strongly agree	94	65%
Tend to agree	44	30%
Neither agree nor disagree	1	1%
Tend to disagree	4	3%
Strongly disagree	1	1%
I don't know	1	1%

Respondent feedback on why they agreed or disagreed with identified areas of focus that should be prioritised for children and young people

Respondents were asked to provide more detail on why they agreed or disagreed with the identified areas of focus that should be prioritised.

In total, 33 different themes were raised, and once again there was a wide range of these.

The themes which featured the most were the role of schools and education settings, including universities (17), a general agreement with the priorities (16) and an urge for available and accessible support services (16). Each of these themes were expressed by 16-17% of all respondents who answered this question.

Other themes which saw considerable mention included concerns around the impacts of social media and online harms (9), and a need to better understand and tailor support to neurodivergent children and young people (9).

8 respondents stressed the need for smoother transitions between adolescent and adult mental health services, and several CYP specific risk factors were also referenced, including the impact of the care system (2) and 5 mentioned the unique challenges experienced by those not in education, employment or training (NEETs).

The top 5 themes are included in the table below. A full analysis is provided in Appendix 2.

Please tell us the reason for your answer. You can also let us know if you feel there are any areas of focus missing. Base: 99

Themes	Number of respondents who raised this theme
Schools / education (including universities)	17
Agreement with areas of focus	16
Accessibility / availability of services	16
Online / social media	9
Neurodivergence	9

Example quotes, in respondents own words, for the main themes can be found below:

Role of schools and education settings (including universities)

“The support in schools need to be taught in a way it is readily available for all students. The importance of telling someone if something is wrong or don’t feel right. All staff need adequate training in this just in case. Child does confide in them bout themselves or a peer or a family member.”

"Mental health support in schools, colleges and universities - this should be on the curriculum for PSHE - and all schools should have a wellbeing hub/wellbeing officer with training."

"Mental health support in education settings is vital but will need to be funded. It should be made a mainstream topic not one that has an air of embarrassment about it."

"You need to figure out just how much schools and universities themselves might be contributing to SEND suicide rates, such as with ever rising rates of homework. Some of the demands schools/universities try to make exceed those of an adult full-time job, which is wrong."

"I feel there is nothing about prevention, including education about how the mind works, what is depression and anxiety etc. Were schools linked in with? What is on the curriculum? Surely prevention and education at an early stage is key. Could there be a travelling assembly/show around schools in Kent/Medway to educate about these topics from an organisation that is passionate about the topic and has in depth knowledge?"

Agreement with the areas of focus

"This is clearly a high risk age group as the numbers are rising."

"The focus on the mental health of young people is understandable but many of the risk factors are mental health (eg autism, poverty, criminal justice). These other factors need focus too."

"Have to try to stop young people feeling that suicide is their only option."

"We should do all we can to inculcate a positive view of life and prospects."

General accessibility and availability of services

"Mental health support from medical/nursing is some counties has been very limited in the past. There must be a effective and fast referral to these people as waiting for help is not an option if you want to save lives."

"This is one of the most important steps in the process. Children should have access to mental health support the same way adults do, as they experience all the same emotions and sometimes struggles. The earlier children can be taught emotional regulation (when age appropriate), and about different cultures, families, brains, disabilities, the better the future will be."

"Mental health services in Kent are a joke. It is hard to get help and when it is offered it is limited A free counselling service for children would be extremely helpful but only

if provided by qualified counsellors. Free support for parents who are concerned about a child's mental health/behaviour could also make a difference. Opening the children's centres is helpful."

"It is notoriously difficult to access adequate or timely support from MH services or medication for this group, as primary care largely do not manage this group and MH referrals for this group are generally rejected, closed after minimal intervention, or left on long wait lists due to insufficient psychiatrist availability."

"Many children are denied support by CAMHS even following suicide attempts. Many vulnerable young people are NEET or EBSA so school and college support of no use to them."

"There are next to no effective and timely services. Those that exist are out dated. Cumbersome and the waits are huge. CAHMS is not fit for purpose with waits of up to two years for help and hugely excluding criteria. Escalation and harm ensues. Huge under investment year upon year given the rise in MH, understanding of SEND and neurodivergence."

Use and impact of social media and other online platforms

"Young people have things within their lives, phones, social media, pressure from peers which have not in previous generations been prevalent, and as such they need help to sort out disinformation from misinformation and seek genuine answers and truths rather than rely on technology to inform them."

"Concerns over cyber bullying. Never switching off from it and children looking at their phones too much."

"2025 has much different sources of bullying and harassment than in previous decades and this takes place in isolation now i/e behind closed doors in bedrooms rather than the school playground Young people have to not only have the tools and skills to be able to be robust enough to deal with this but also have a social environment where they can offload to their peers or support network."

"Areas missing - impact of social media on CYPs; and impact of family breakdown (system) on CYPs."

Neurodivergence

"Evidence may never help to understand. Young people are not as quickly diagnosed with SEND and are missed causing greater risk of self harm and suicide."

"Secondary MH services will actually refuse a referral if a patient has a primary diagnosis of Autism, learning disabilities or ADHD. No matter if they are struggling with their MH. This needs to change."

"The transition between child to adult mental health services can lead disabled and neurodivergent people without support, so it's really important that this group is prioritised. We also need to especially recognise young carers and those navigating the foster care system."

"I know people who have been turned away. I also know that the support provided has not taken into account the sensory needs of an autistic person. Neither was follow-up done or any other help offered. We should also identify individual patterns / flashpoints significant to the individual and provide more support around those times. We also need to make sure that the support offered is appropriate. Manualised CBT is not effective for autistic people, for example and runs the risk - especially in children - of adding yet another thing the think they have failed at."

Continuing to make suicide and self-harm prevention among children and young people everybody's business

Respondents were asked how can we continue to make suicide and self-harm prevention among children and young people everybody's business. This open-text question yielded 102 responses from 149 respondents (68%).

25 different themes were identified in the responses to this question. The theme raised the most was the need for appropriate training and education measures around suicide prevention (37). This was followed closely by mention of the roles that schools and other education settings can play (33), which included regular overlap with the training theme.

Raised awareness and relevant campaigns were mentioned in 21 responses, along with the role played by friends and family. The availability of – and general access to – relevant support services was highlighted in 11, along with themes around the use of social media and online harms (10).

Examples of other themes, which did not fall into the top 6 for this question, included the need for community support groups (8), the importance of early intervention (6), self-harm (6) and the need to ensure that all children and young people feel heard and believed (5).

The top 6 themes are featured in the table below. A full analysis is provided in Appendix 2.

How can we continue to make suicide and self-harm prevention among children and young people everybody's business? Base: 102

Themes	Number of respondents who raised this theme
Training / education	37
Schools / education settings	33
Raised awareness / campaigns	21
Role of friends / family	21
Availability / accessibility of services	11
Social media / online harms	10

Example quotes, in respondents own words, for the main themes can be found below:

Training and education

"Train as many teachers as possible in suicide prevention. Bring lessons into schools about talking! Make sure the MH campaigns make it to schools. Make sure schools have a suicide prevention policy."

"…having either internally or externally provided age and setting appropriate training in schools would seem to be a good way of increasing knowledge both among the target population and teachers. It could also be offered to parents through the school."

"Your current missing link is not delivering training and support direct to the young people themselves. Young people want to be empowered and this training not only enables them to support their peers but to directly improve their own resilience as well…"

"Make it mandatory in all people-facing roles to have some government provided training within the role."

"Encouraging conversations from all who have contact with children and young people, not specifically about self-harm or suicide but to forge relationships which could help to identify warning signs, also education and training and awareness including on social media as used extensively by young people on various platform"

"Embed suicide prevention into all youth-facing services. Include Youth Advisory Boards in Strategy development (e.g. feedback on page 12). Train professionals in

trauma-informed and DA-specific suicide risk. Ensure interventions are co-designed with young people."

"To make suicide and self-harm prevention among children and young people everybody's business, we must go beyond formal settings and ensure every adult who interacts with young people, including youth workers, sports coaches, community volunteers, and peer mentors has access to training and support."

Role of schools and other educational settings

"Education in schools and an officer they can turn to for their welfare needs. Like safeguarding."

"Be more proactive in schools and colleges by having a presence, demonstrating to everyone that feeling sad or upset is a normal process in life, not everyone is programmed to think like that."

"Start early with primary schools and continue to have open and honest conversations about feelings and emotions all the way through school."

"Make discussing everyone's wellbeing a common and regular topic in education and social settings. This could lead on to discussing self-harm - introduce an incident of self-harm to be discussed - e.g. what could have led up to this point? Why did they not ask for help? Why didn't anyone notice that they needed help? How could we prevent it happening to anyone else? This sort of discussion may not be successful in large groups. Small groups and single sex groups would probably be more successful."

"In use in the curriculum and have lived experiences talk to pupils. Many schools have archaic thinking as to not talk about suicide or they feel it will put ideas into pupils minds. This is utter rubbish and only perpetuates the stigma and inability to reach out for help or to talk about it. Children are also reluctant to tell adults but may confide in friends. Training needs to be levelled at peers ie what to do if they are worried about a friend. How can they flag this without going directly to a teacher or adult. How do they report this without seemingly betraying a confidence in their mind."

Need for raised awareness and specific campaigns

"Keep reporting and publishing key facts and figures, including what's going right, working well and improving as well as areas still needing improvement"

"Make role-play style adverts on social media, in cinemas & TV similar to the THINK Road Safety campaign that was on the radio, in cinemas and on TV a while ago."

"By increasing availability to more prevention and awareness of the many different services / supports already in place like youth groups, art, music , dance that increase community support and wellbeing rather than illness"

"Continue to provide messaging that help those dealing with thoughts of suicide and self-harm, including sign posting sources of support. Ensure everyone has opportunities to access education that can help them reach out to others. Ensure messaging is well targeted, in places young people who need it are most likely to find it, and uses language and imagery they can relate to."

"System leadership will be critical to ensure resources are in place to support this work, and to include this in occasional updates to joint Kent Chief Execs and Leaders to help raise the profile of this work. Build suicide prevention awareness around relevant activities within education settings – for instance ensuring posters/leaflets etc are displayed and talked about. Also that support services, such as Kooth and other YP mental health support, are known about and promoted"

Role friends and families can play

"Support for parents as to where to turn with direct contacts."

"Parents and peers need to know how to recognise the signs and need strategies to employ to support those they love."

"We need to expand responsibility beyond professionals and recognise suicide prevention as an everyday practice. That means recognising the role of peers, carers, and community members."

"Doesn't the buck stop with them and there family/friends rather than everyone's business. What if the individual doesn't want it to be everyone's business?"

"Run sessions for parents via schools"

Need for generally accessible and available support services

"Improve access to CAMS and mental health services - if someone is already self-harming or suicidal, prevention is too late, they need urgent help"

"Early diagnosis, banish waiting list, if people need help, should be provided immediately."

"More mental health professionals especially for younger age groups"

"More resources are needed for therapeutic interventions like DBT"

Use of social media and online harms

"…That means addressing all forms of bullying and social segregation - especially cyber bullying which adults often miss because of the new technology at play. Likewise, parents and teachers need to be aware of how predators groom youngsters online. This means identifying risky behaviours of youngsters - some of which openly invites predators into the online life. I've seen it first hand and it terrifies me how little adult understanding and safeguarding is in place. However bad you think it is - it is worse than that. If it does not give you nightmares, you have not seen the worst of it. Young people with suicidal thoughts are especially vulnerable and extremely hard to protect. Both the young people and the adults that care for them need a breadth of education and support about the risks that can precipitate suicidal inclination because at that stage most of the damage is done. There is a young person in my family in that exact situation and keeping their mental health stable and protecting them from online danger and "IRL" risky behaviours is a full time job for the entire extended family. The problem is real, deep, complex and poorly understood…"

"Being on top of social media and the challenges that go around ie holding your breath until you pass out. With knowledge of the 'in thing' awareness and discussing it and its dangers can dilute its appeal."

"Education about social media, particularly in group situations in school/colleges where things can be seen together as cause and effect."

"Reduce dependence on social media and peer pressure."

Reducing suicides in children and young people in Kent and Medway by controlling access to the means of suicide

Respondents were asked how we can reduce suicides in children and young people in Kent and Medway by controlling access to the means of suicide. This open text question yielded responses from 55 out of 149 respondents (37%).

22 different themes were identified in the responses to this question. The theme raised the most was around social media and online harms, which were mentioned 16 times.

10 respondents voiced scepticism around this priority and its achievability. 9 spoke about making physical adjustments, including at high-risk locations. The role of schools and other education settings were again identified as an important component (8) and the need for continued raised awareness and campaigns was also highlighted (7).

Examples of other themes, which did not fall into the top 5 for this question, included the role of parents and families (6), effective use of data and research (4) and youth / community groups (4).

The top 5 themes are featured in the table below. A full analysis is provided in Appendix 2.

How can we reduce suicides in children and young people in Kent and Medway by controlling access to the means of suicide? Base: 75

Themes	Number of respondents who raised this theme
Online / social media regulations	16
Scepticism of priority	10
Physical adjustments / high risk locations	9
Schools / education settings	8
Raised awareness / campaigns	7

Example quotes, in respondents own words, for the main themes can be found below:

Social media and online harms

“The internet can be an unsafe place and it is hard to police. Young people need to be protected regarding what sites they are visiting.”

“Social media and bullying online is a huge issue - monitoring platforms, calling out negative posts and rhetoric, encouraging parents to learn about apps, language changes, working on laws to stop parents posting their children online, will all be important steps.”

“Social media content is a way of accessing vulnerable youngsters so this requires far more rigorous control. There is talk of banning under 14s from using social media but it's probably not feasible as it already exists. Young people must be taught how to identify and question inappropriate content and seek advice. As before this will no doubt require training and funding.”

“Social media is a difficult area to tackle but people being aware of the law now around online crimes and the consequences is important educate up on this early.”

“There needs to be consequences for social media companies that allow their sites to publish suicide related materials - I think negligence in this area should be corporate manslaughter.”

Scepticism of this priority

"You cannot make everything in everyday life suicide proof, we need to program children to understand it is not a viable option in the first place."

"Not sure this is possible. Better to take away the ideation."

"Bluntly: this is a clear example of overreach. You cannot fence off every risk in a child's life. The real task is making sure help is available, accessible, and timely — so that children are not left so desperate that access to means becomes the last resort. No more fat consultation process, just Guaranteeing rapid access to care: no child or young person in crisis should be left waiting months for CAMHS or safe-haven services."

"Almost impossible to do that 100%. There are so many means that are available in everyday items. Trying to stop them wanting to do so by early intervention and help/therapy is the best way, plus monitoring their online activities if possible."

Need for physical adjustments, including at high risk locations

"The adults where they live and visit should ensure that harmful substances and sharp implements are secured and not accessible."

"Look at local area statistic as to where suicides are happening and get surveillance in these areas."

"At-risk areas should include clear, youth-friendly signs pointing to local support, and digital access to help via QR codes or text services."

Role of schools and education settings

"Work with schools and families to identify and restrict access to means of suicide."

"Ensure schools are not able to give up on children and young people up to 25 who have difficulties in school that they have a duty of care until adequate and sustainable support is available and have taken over the duty of care."

"Young people need safe spaces to talk long before they reach crisis, including access to peer-led groups in schools and communities."

Need for raised awareness and campaigns

"Young people can be drawn to the taboo so true empirical information should be readily available"

"Increasing parental awareness of signs of mental distress in their children, as well as monitoring use of medication, etc."

Best way of providing information and support to those children and young people bereaved or affected by suicide

Respondents were asked what the best way was to provide information and support to those children and young people bereaved or affected by suicide This open -text question yielded 85 out of 149 respondents (57%).

20 different themes were identified in the responses to this question. The theme observed most frequently was around the role of networks and communities, which was mentioned 21 times.

As has been consistent throughout the questions relating to children and young people, the important role of schools was also highlighted, and this was the second most frequent theme, mentioned in 16 responses.

13 respondents spoke about the need to ensure that there is a range of support methods available to children and young people. 10 referred to counselling and therapy specifically. A general need for available and accessible support was referenced by 10 of respondents.

The top 5 themes are featured in the table below. A full analysis is provided in Appendix 2.

What is the best way of providing information and support to those children and young people bereaved or affected by suicide? Base: 85

Themes	Number of respondents who raised this theme
Use of networks / community	21
Schools / education settings	16
Range of support methods	13
Therapy / counselling	10
Accessibility / availability of support	10

Example quotes, in respondents own words, for the main themes can be found below:

Roles of networks and communities

“This is where established communities, including schools, do best. It would be useful to look at house building here. New estates, and many older ones too, need facilities

such as community centres, shops, medical and other facilities which bring people together and create communities. Communities are the key to the sharing of information and mutual support."

"Create social groups so people can bond and learn together."

"Peer support - stories from those their own age that have experienced difficulty themselves and can share how they became strong enough to not give in."

"Support network with those who have experienced similar."

"Having groups that can proactively talk about issues, promoting projects and training for staff and parents and professionals (e.g. Stefan's Acts of Kindness)."

Role of schools and education settings

"Schools should have the capacity and sign posting ability here."

"Ensuring resources are available in education settings and other places where young people visit (e.g. family hubs, sports facilities, etc)."

"Schools, colleges and universities should have clear pathways to specialist bereavement services, and staff should be trained to respond with sensitivity. After initial support, young people should be offered the option of peer-led bereavement groups, where they can process their grief alongside others with shared experience in a safe, supported environment. Involving bereaved young people in shaping these services ensures they feel relevant, accessible, and genuinely helpful."

Need for a range of support methods

"Making sure there is a range of option both online face to face ,peer support those with lived experience."

"Supporting memorial/vigils etc can be helpful to families. Also ensuring there are a range of services on offer, in person online on the phone, individual and group etc"

"Offering consistent support for a period of time following the bereavement via a medium that they can choose and connect with (text, video chat, AI wellbeing app etc)"

"Through either online or face to face; dependent on requests 1 to 1 or group work, really depends on the child and context of the suicide. Also, in terms of children it may not be until they are older they are impacted by an historical suicide of a relative. (parent etc). needs to follow the need not the service."

"Everyone's needs are individual. Seek to establish those needs on a one-to-one basis and then provide the relevant information and support."

Need for therapy and counselling provisions

"Offer family counselling for bereavement. Explain the stages of loss the strong emotions to deal with such as anger , heartache, guilt 'duvet diving 'not being able to face the day."

"Don't think it will just go away. Provide support for those affected & make it easily accessible. Counselling online or a counsellor for each area of Kent to work with the school friends & relatives of school age. Allowing them the space to organise their thoughts & questions & often guilt. Just do so much more. educate their parents too."

"Professional help and therapy. Online support groups, such as The Compassionate Friends, who have advice for siblings affected by suicide, as well as support for the whole family."

Need for support which is generally accessible and available

"Be open, be available and most importantly be caring and not judging or opinionated"

"We could have information packs that are tailored to different age groups that are available in different formats (digital, physical, Braille, audio description, easy read). This could include practical guidance on grief, normalising feelings, how to ask for help, and contact information for support services."

"Timely support , relevant to them. The impact is huge and brings future issues around ACE's if not supported adequately. Increased services and timely, not 8 months down the line and to be fought for which was our experience and that of many."

"I felt supported but I still feel my remaining children were left to seek help themselves or see a school pastoral team member - they need specialist help to be brought into school to support them, not someone who has had half a day training"

"To make sure people are aware of all services and support available to them."

"Advertise! Ensure it is widely known that you offer this service and make sure it is easily and promptly accessible."

Feedback on any of the other priorities or actions for adults or children and young people in the Strategy

Respondents were asked if they would like to provide feedback on any of the other priorities or actions for adults or children and young people in the draft Strategy. This question yielded 30 responses out of 149 respondents (20%).

26 different themes were identified in the responses to this question, with the one observed most frequently being a general approval of the Strategy, which was voiced by 7 respondents.

The other top themes were neurodivergence (3), the importance of a wider mental health Strategy (3), and the importance of continued research to address risk factors 3().

The top four themes are featured in the table below. A full analysis is provided in Appendix 2.

If you would like to provide feedback on any of the other priorities or actions for adults or children and young people in the Strategy, please provide these below.
Base: 33

Themes	Number of respondents who raised this theme
Agreement / support of strategy	7
Wider mental health strategy	3
Neurodivergence	3
Importance of continued research / addressing risk factors	3

As the responses to this question were fewer in number, we have combined all 26 different themes for the purpose of supplying the example quotes below:

“Strategies are all well and good, totally pointless if mentally health provision not funded adequately.”

“There are so many deep seated root causes that the Strategy has not addressed. This is not a fault, these root causes are hidden and hard to find (until you find yourself in the middle of them). Every underlying and contributing factor that causes groups to be especially at risk must be addressed directly or you will forever be putting out fires that started a long time ago.”

"Stop doing a one size fits all approach such as mainly advertising one helpline and stop making it all about helplines as those do not suit everyone, not everyone is able to get to safe havens either and some people will already have loads of trauma associated with bad experiences of helplines and other services."

"Please add support for people with ADHD. We are always being left out of documents and missed. Kent has already taken NHS referrals away and the real possibly the chance for any kind of assessment or diagnosis for those waiting due to only providing right to choose as the only option left which Kent only has two approved companies for right to choose."

"Add more content about self-harm."

"What's missing throughout:

Accountability — who owns each action, and who is held responsible if targets aren't met?
Capacity stress-testing — what happens when demand spikes or funding is cut?
Structural action — poverty, debt, housing insecurity, domestic abuse, and gambling are drivers of despair, yet they're treated as footnotes."

"We welcome the overall direction of the Strategy and are particularly supportive of its emphasis on hope, collaboration, and tailored support. However, we believe more emphasis should be placed on investing in regular, local peer support groups as a core intervention across all priorities not just as an add-on. Peer groups offer consistent, trusted, non-clinical support that can prevent crisis, reduce isolation, and help people manage their mental health independently over time."

"Clarify what intersectionality looks like in practice for this Strategy. Include more detail on interventions for high-risk groups. Ensure Strategy is survivor-led and trauma-informed. Consider a programme for those with suicidal thoughts linked to domestic abuse."

Any other comments on the draft Strategy

61 out of 149 respondents (41%) provided additional comments on the Strategy.

30 different themes were identified, with the most frequent a call for greater mental health support (15) followed closely by a general approval of the Strategy (14).

A small number of respondents (5) used this question to voice some scepticism of the Strategy, and other themes that saw similar proportions included the importance of multi-agency collaboration (4), neurodivergence (4), accountability (4) and the impact of the wider socio-economic environment (4).

The top 7 themes are featured in the table below. A full analysis is provided in Appendix 2.

If you would like to make any other comments on the draft Kent and Medway Suicide and Self-Harm Prevention Strategy, please tell us in the box below:
Base: 62

Themes	Number of respondents who raised this theme
Improving mental health provision / increased funding	15
Agreement with Strategy	14
Scepticism of Strategy	5
Multi-agency collaboration	4
Neurodivergence	4
Accountability	4
Wider socio-economic environment	4

Example quotes, in respondents own words, for the main themes can be found below:

Need for greater mental health support

“Capacity and resource , funding for all system partners to participate in MDTs , Holistic health and social care assessments should be a priority.”

“Improve existing mental health provision. Invest in services that cannot cope under existing demands.”

“I think that you have it about right...the only thing that bothers me is that if A and E are busy in hospitals, still suicides are turned away as you did it you sort it...this has to change, these people are crying out for help.”

“Please help people with PTSD. So many of us are expected to continue on without support because there isn't any NHS trauma therapists within our immediate area & that just leads to us being retraumatised constantly, making our condition worse. I have had complex PTSD for around five years & despite being under secondary mental health services, I still haven't received trauma-focused support. I have done everything right, I have tried so hard to get help so that I can try to return to some level of normality & all I get is doors shut in my face, constantly being told that my trauma is

not something that a particular organisation or mental health professional can help with…..

I have spent years advocating for myself, trying to get support so that I can start working again & be a productive member of society but the help I need isn't available - I go through stages of coping well, but I always swing back to being suicidal & my fear is that this will all end with me taking my own life when my symptoms are especially bad because there is no other option at this point. Every nightmare or triggered memory makes my trauma worse, & eventually I won't be able to continue to cope with it on my own. And I know I'm not the only person with PTSD living like this. Please help us. Please focus on supporting people who have been traumatised, as well as all the other at-risk groups, instead of leaving us to cope alone. We deserve better."

"Have you linked it up with the NICE guidelines on Self Harm and Suicide where it talks about making sure that services who use screening questionnaires don't filter out people who have low scores and don't give them an intervention eg in an IAPT service using a PHQ-9 or CORE 10 questionnaire as evidence suggests that people who do go on to take their lives can score low when they present to a service and then they may only be given text support rather than in person."

Agreement with the Strategy

"The Strategy looks fantastic and has clearly been created with care and sensitivity. Thank you."

"This is needed, our business is happy to be involved."

"It is an excellent and well-thought-out piece of work."

"Really robust, strongly support it"

Scepticism of the Strategy

"If "hope" and intent could prevent suicide, Kent and Medway would already have the lowest rates in the country."

"This Strategy is a performative measure with no thought as to the people behind the numbers. It is just another empty strategic piece of nonsense doomed to fail. There is no joined up thinking and linking into stakeholders in real terms and is standalone all but in words. Unless a concerted combined effort is made more lives will be lost, most of which are entirely preventable."

Importance of multi-agency collaboration

“The issue of sharing personal information on people at risk between different departments will always be a stumbling block. It could be made clear in the Strategy on how you manage this.”

Neurodivergence

“Kent needs more specialist support for Autistic young men. Currently there is nothing for them. The Beacon in Thanet has no understanding of Autism. We have lost the specialist KCC Autism team. You never see the same GP or Psychiatrist for proper medication reviews or constancy of care.”

“We should make sure disabled and neurodivergent people feel fully included. Support should be flexible and respectful of the different ways people show stress and ask for help. Many people, like carers or people supporting friends, help in ways that aren’t always obvious. Their work matters and it should be recognised.”

Need for accountability

“Having a Strategy is fine - but it is ACTION that is required.”

“Just as already stated I would like to see more specific actions, I appreciate this is a huge area to try and tackle so think specific actions which can be piloted, monitored and evaluated and then potentially rolled out further rather than putting a great deal of effort into a blanket approach which is maybe not as effective.”

Wider environment

“In the context of Local Government Reorganisation, what thoughts are being given to how this Strategy/area of work may be managed going forward?”

“There does seem to be a culture of I want, I ought to have, someone else should give me. I am ENTITLED to ... I think this isn't doing any of us any good. Opportunities should be given more status in the minds of people. Those receiving benefits ought to give what they can in return and thereby achieve a sense of purpose. On Sark in the Channel Islands once the tourist work closes down the residents who can fix the roads DO, in return for payment which is what gets them through to the summer again. I have considered suicide and believed removing myself would make life better for those around me. I don't know enough about this! Sorry.”

5. Responses to the equality analysis

Respondents were asked to provide their views on the Equality Impact Assessment (EqIA) for the Strategy in their own words. Respondent comments have been reviewed and example quotes have been provided below.

43 respondents (29%) provided a comment to this question referencing a total of 17 themes. The most commonly observed theme was an approval of the EqIA (10 mentions). 9 voiced some scepticism of the EqIA, whilst 8referenced neurodivergence and 5 referenced the LGBTQIA+ community.

A table showing all of the themes is provided in Appendix 2.

Example comments from across all themes are included below, in the respondents own words:

“The equality analysis highlighted the need to add information and Strategy for both sexual orientation and gender identification so I am not sure why this does not seem to have been done.”

“Get rid of it as it creates division where there was none”

“These tools are useful but unless you can see and talk to someone face to face, people are going to slip through the cracks, so to speak. It’s going to be a long, slow process to do this effectively.”

“Its a good analysis, I think it could be more detailed in places but recognise there are gaps in the data”

“What does mental health need EQIA, mental illness doesn't choose patient based on gender or race or disability it affects us all”

“It's great that you've done an EqIA - which seems to point out the comments I've made earlier in the survey. Would be good to include more proactivity in the Strategy around supporting the LGBTIA+ community in terms of suicide prevention and support, on the back of this.”

“This should only be considered if it is relevant to the learning from each suicide case or statistics otherwise treat all cases on their detail and all persons as a life and nothing different. I don't think this is a subject matter where being "PC" is more important than reducing the number of persons dying from suicide, unless of course the statistics dictate a particular group are susceptible and a dedicated approach is necessary.”

"You have no impact on staff - this does not take into account colleagues within health and care who may be affected by the Strategy"

"Look at women - suicide rate for autistic women is 13% more than the average."

"Just to focus on all groups - mental health and suicide is a human response which excludes no one."

"Please ensure "neurodivergent" is used instead of "autistic" to be inclusive of undiagnosed individuals. Include "children in care" as a distinct group. Clarify how intersectionality will be addressed in practice."

"From our experience supporting people across Kent and Medway, we believe it's vital that the Strategy actively considers intersectionality recognising how overlapping factors (e.g. race, disability, neurodivergence, and economic hardship) can increase risk and impact access to support. We suggest ensuring that support services, especially peer-led groups, are physically and culturally accessible, and that they are co-designed with people from marginalised communities. It's also important to consider barriers faced by neurodivergent individuals, such as sensory needs or social anxiety, which may prevent them from engaging with standard services."

"Currently mental health services in Kent do NOT want to utilise reasonable adjustments for those with autism. Royal College of Psychiatrists Report CR228 shows the need for robust direct questioning, points out masking etc. There needs to be an acceptance that people can look okay even when they are not."

6. Next steps

All of the responses to this consultation have been considered by the Suicide Prevention Programme team, and where possible they will be used to help finalise the Strategy and the Equality Impact Assessment (EqIA).

This consultation report will be published on the Let's Talk Kent consultation webpage, alongside a "You Said, We Did" document detailing the key changes made to the Strategy because of the consultation and explaining any areas that haven't been included.

This report, along with the EqIA and the final draft Strategy is expected to be presented at the Adult Social Care and Public Health Cabinet Committee in early 2026.

The final draft Strategy and consultation report will also be shared at the Adult Suicide Prevention Network and the Children & Young Peoples' Suicide Prevention Network meetings in early 2026. In addition, we will also be delivering an update at the Annual Suicide and Self-Harm Prevention Conference on 27 November, where we will have around 250 attendees.

If approved, a link to the final Strategy will be published on the consultation webpage.

7. Appendix 1. Consultation questionnaire

Consultation Questionnaire

The Kent and Medway Suicide Prevention Programme is creating a new suicide and self-harm prevention Strategy for adults and children and young people. The current Strategy finishes at the end of 2025. We have reflected on what has worked well and where the priorities should be for the next five years. We would like to hear from anybody who is interested in having their say around suicide and self-harm prevention. We will use this feedback to help finalise the Strategy.

We have provided this feedback questionnaire for you to give your comments. The questionnaire is split into five parts:

You can respond to all or as many of the sections/questions as you like. If you would rather not provide feedback on a section or question, just move on to the next one.

This questionnaire can be completed online at kent.gov.uk/suicideprevention.

Alternatively, fill in this paper form and return to:

Email: suicideprevention@kent.gov.uk

Address: Suicide Prevention Team, Public Health, Room G17 Sessions House, County Road, Maidstone, Kent ME14 1XQ

Please ensure your response reaches us by midnight on 6 October 2025.

What information do you need before completing the questionnaire?

We recommend that you view the consultation material, including the draft Strategy online at kent.gov.uk/suicideprevention before responding to this questionnaire.

If you have any questions about the Strategy or need any help taking part in the consultation, please email suicideprevention@kent.gov.uk.

Kent and Medway Suicide and Self-Harm Prevention Strategy 2026 - 2030

Consultation Report

Please do not include any personal information that could identify you or anyone else in any of your answers.

Privacy: Kent County Council (KCC) collects and processes personal information in order to provide a range of public services. KCC respects the privacy of individuals and endeavours to ensure personal information is collected fairly, lawfully, and in compliance with the General Data Protection Regulation and Data Protection Act 2018. Read the full Privacy Notice at the end of this document.

Alternative formats: If you require any of the consultation material in an alternative format or language, please email: alternativeformats@kent.gov.uk or call: 03000 42 15 53 (text relay service number: 18001 03000 42 15 53). This number goes to an answering machine, which is monitored during office hours.

Help and advice: If you are struggling to cope and would like free advice from a trained counsellor, you can call the Release the Pressure helpline on 0800 107 0160.

Visit www.releasethepressure.uk for full details.

If you have been bereaved by suicide and would like to access free emotional and practical support from a specialist trained Liaison Worker, you can contact the Amparo service online (https://amparo.org.uk) or by calling 0330 088 9255.

A range of other information on the help and support available in Kent and Medway can be found on the Mental Wellbeing Hub (www.kmhealthandcare.uk/mental-wellbeing-information-hub).

Part 1 – About you

Q1. **Are you responding as…?** Please select the option from the list below that most closely represents how you will be responding to this consultation. Please select **one** option.

☐	A Kent or Medway resident
☐	A resident from somewhere else
☐	A representative of a local community group or residents' association
☐	On behalf of a family member or friend (please complete this questionnaire using their information)
☐	On behalf of a charity or Voluntary, Community or Social Enterprise (VCSE) organisation
☐	On behalf of a Parish / Town / Borough / District Council in an official capacity
☐	A Parish / Town / Borough / District / County Councillor
☐	On behalf of an educational establishment, such as a school or college
☐	On behalf of a business in Kent
☐	Something else, please tell us:

Q1a. If you are responding on behalf of an organisation or business, please tell us the name of your organisation in the box below:

Q2. Please tell us the first 5 characters of your postcode:

Please do not reveal your whole postcode. If you are responding on behalf of an organisation, please use your organisation's postcode. If you are responding on behalf of someone else, please use their postcode. We use this to help us to analyse our data. It will not be used to identify who you are.

Q3. How did you find out about this consultation? Please select **all** that apply.

- [ ] An email from Kent & Medway Suicide Prevention Programme
- [ ] An email from Let's talk Kent / KCC's Engagement and Consultation Team
- [ ] A Parish / Town / Borough / District / County Councillor
- [ ] From a Parish / Town / Borough / District Council
- [ ] From a friend or family member
- [ ] From a school / college / educational establishment
- [ ] From another organisation or charity
- [ ] Kent.gov.uk website
- [ ] Newspaper
- [ ] On social media (e.g. Facebook / Instagram / X / Nextdoor / LinkedIn)
- [ ] Poster in a Kent Library
- [ ] Postcard at an event
- [ ] Suicide Prevention monthly newsletter
- [ ] Something else, please tell us:

Part 2 – Feedback on the Strategy

Q4. Is the draft Kent and Medway Suicide and Self-Harm Prevention Strategy 2026-2030 easy to understand? Please select **one** option.

- ☐ Yes
- ☐ Partly
- ☐ No
- ☐ I don't know

Q4a. If you have any comments or suggestions on how to make the Strategy easier to understand, please tell us in the box below. If your suggestion relates to a specific section/page, please provide details.

Our **vision** is that Kent and Medway becomes a place where the number of people dying by suicide is reduced as much as possible and our specific aim is for the Kent and Medway suicide rate to be below the national average by 2030 (if not sooner).

Q5. How much do you agree or disagree with our proposed vision for the draft Strategy? Please select **one** option.

- ☐ Strongly agree
- ☐ Tend to agree
- ☐ Neither agree nor disagree
- ☐ Tend to disagree
- ☐ Strongly disagree
- ☐ I don't know

Q5a. Please tell us the reason for your answer to Q5 in the box below:

Our **mission** is to work towards making Kent and Medway a place where hope is always available to anyone, no matter what they are facing. By 2030 we would like:

- Children and young people in Kent and Medway to be resilient enough to cope with life's normal ups and downs, but knowledgeable enough and confident enough to reach out for more support when they need it.
- Adults in Kent and Medway to know how to look after their own emotional wellbeing but to feel comfortable and able to seek more help when necessary.
- All agencies (statutory, voluntary, community) to work collectively to ensure support and help is available to those who need it.
- All agencies to share knowledge and support each other to learn what works in helping people get the support they need.

Q6. How much do you agree or disagree with our proposed mission for the draft Strategy? Please select **one** option.

☐	Strongly agree
☐	Tend to agree
☐	Neither agree nor disagree
☐	Tend to disagree
☐	Strongly disagree
☐	I don't know

Q6a. Please tell us the reason for your answer to Q6 in the box below. You can also let us know if you feel there is anything missing from the mission.

Our **values** for suicide and self-harm prevention are:

1. **Collaboration.** The power of the Suicide Prevention Programme comes from the hundreds of network members who all work towards the Vision.
2. **Hope.** Hope is extraordinarily powerful, yet without it, everything is extremely difficult. We will embed hope into everything that we do**.**
3. **Determination.** Suicide prevention is not an easy task, particularly in a population of nearly two million. We will undertake every action with fierce determination.
4. **Sensitivity.** We will work sensitively with everyone impacted by suicide to ensure we don't add to their trauma.

Q7. How much do you agree or disagree with our proposed values for the draft Strategy? Please select **one** option.

- ☐ Strongly agree
- ☐ Tend to agree
- ☐ Neither agree nor disagree
- ☐ Tend to disagree
- ☐ Strongly disagree
- ☐ I don't know

Q7a. Please tell us the reason for your answer to Q7 in the box below:

To reduce suicide and self-harm as much as possible, we are proposing to adopt the **eight priorities** from the National Suicide Prevention Strategy[3] and adapting them for our local circumstances. The proposed priorities are:

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

Q8. How much do you agree or disagree that we should continue to follow the above priorities? Please select **one** option.

- ☐ Strongly agree
- ☐ Tend to agree
- ☐ Neither agree nor disagree
- ☐ Tend to disagree
- ☐ Strongly disagree
- ☐ I don't know

[3] Suicide Prevention Strategy 2023 to 2028 : https://www.gov.uk/government/publications/suicide-prevention-Strategy-for-england-2023-to-2028

Q8a. Please tell us the reason for your answer to Q8 in the box below. You can also let us know if you feel there are any priorities missing. If your response is about a specific priority, please make it clear in your answer.

Our Strategy is for everyone, and the actions set out are designed to support as many people as possible. However, there are some groups who have higher suicide rates than the general population. Others may not have high rates but are of particular concern, such as children and young people, because national rates have increased in recent years despite being low overall. It is therefore crucial that organisations and individuals tailor and target resources and services to support these groups. The national Strategy identifies the following high-risk groups as priorities for actions:

- Middle aged men.
- Children and young people.
- People with a history of self-harm.
- People known to secondary mental health services.
- People in contact with the justice system.
- Autistic people.
- People affected by social isolation and loneliness.
- People who are impacted by domestic abuse.
- Pregnant women and new mothers.
- People affected by physical illness.
- People affected by financial difficulty and economic adversity.
- People affected by gambling harms.
- People affected by drug and alcohol misuse.

Q9. How much do you agree or disagree that these are the right high-risk groups that we should be prioritising in the Kent and Medway Suicide and Self-Harm Prevention Strategy? Please select **one** option.

- ☐ Strongly agree
- ☐ Tend to agree
- ☐ Neither agree nor disagree
- ☐ Tend to disagree
- ☐ Strongly disagree
- ☐ I don't know

Q9a. Please tell us the reason for your answer to Q9. You can also let us know if you feel there are any high-risk groups missing. If your response is about a specific high-risk group(s), please make it clear in your answer.

Pages 11 and 12 of the Strategy give an overview of the **key actions** that will be undertaken for each of the priorities for adults and children and young people. The Strategy does not break these down into individual tasks for each high-risk priority group.

Q10. If you have any suggestions for any specific actions that could be taken to reduce the suicide risk for any of the high-risk priority groups, please tell us in the box below. If your response is about a specific high-risk priority group(s), please make that clear in your answer.

We would like to ask you some questions about some of the **priorities and actions** in the Strategy. There will be an opportunity later in the questionnaire to comment specifically on some of the priorities for children and young people (Q14 to Q17). If you would like to make any comments on the other priorities and actions you can do this in Q18.

Priority 1. Make Suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

- We will increase knowledge and awareness of suicide prevention techniques and tools by continuing to offer free to attend suicide prevention training for everyone.
- We will provide system leadership and quality improvement through our suicide prevention networks, annual conferences and relationships with individual services.

Q11. How can we continue to make suicide and self-harm prevention everybody's business? Please write in below:

Priority 6. Reduce access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.

- We will monitor our Real Time Suicide Surveillance and work with partners such as Kent Police, Network Rail and National Highways to identify, intervene and respond to high-risk locations or other means.

Q12. How can we reduce access to the means and methods of suicide in Kent and Medway? Please write in below:

Priority 8. Provide effective bereavement support to those affected by suicide.

- We will continue to commission a support service for people bereaved by suicide.

Q13. What is the best way of providing information and support to those bereaved or affected by suicide? Please write in below:

Key areas of focus for children and young people

The National Strategy has identified the following areas of focus as being crucial to suicide prevention in children and young people:

- Children and young people known to mental health services, including the 18 to 25 transition to adult mental health services for young people with Special Educational Needs and/or Disabilities (SEND).
- Mental health support in schools, colleges and universities.
- Improving evidence to better understand the experience of children and young people.

Q14. How much do you agree or disagree that these are the areas of focus that should be prioritised for children and young people in the Kent and Medway Suicide and Self-Harm Prevention Strategy? Please select **one** option.

☐	Strongly agree
☐	Tend to agree
☐	Neither agree nor disagree
☐	Tend to disagree
☐	Strongly disagree
☐	I don't know

Q14a. Please tell us the reason for your answer to Q14. You can also let us know if you feel there are any areas of focus missing. If your response is about a specific area(s) of focus, please make it clear in your answer.

We believe it is necessary to have a separate set of key actions in relation to children and young people because of the different risk factors that they face. These actions can be found on page 12 of the Strategy.

We would like to ask you some questions about some of the priorities and actions for children and young people in the Strategy. If you would like to make any comments on the other priorities and actions you can do this in Q15.

Priority 1. Make Suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

- We will increase knowledge and awareness of suicide prevention techniques and tools by continuing to offer suicide prevention training targeted at those who support children and young people.
- We will provide system leadership through our children and young people suicide prevention network and our informal system leaders group.

Q15. How can we continue to make suicide and self-harm prevention among children and young people everybody's business? Please write in below.

Priority 6. Reduce access to the means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.

- We will monitor our Real Time Suicide Surveillance and work with partners such as Kent Police, Network Rail and National Highways to identify, intervene and respond to high-risk locations or other means.

Q16. How can we reduce suicides in children and young people in Kent and Medway by controlling access to the means of suicide? Please write in below:

Priority 8. Provide effective bereavement support to those affected by suicide.

- We will ensure that our commissioned suicide bereavement service takes a whole family approach and continues to support children.
- We will ensure that support is available to schools, colleges and universities if they have a tragic suicide amongst their community.

Q17. What is the best way of providing information and support to those children and young people bereaved or affected by suicide? Please write in below:

Q18. If you would like to provide feedback on any of the other priorities or actions for adults or children and young people in the Strategy, please provide these below. If your response is about a specific priority or action, please make it clear in your answer.

Part 3 – Is there anything else you would like to tell us about the draft Strategy?

Q19. If you would like to make any other comments on the draft Kent and Medway Suicide and Self-Harm Prevention Strategy, please tell us in the box below:

Part 4 – Equality analysis

To help ensure that we are meeting our obligations under the Equality Act 2010 we have prepared an Equality Impact Assessment (EqIA) for the Strategy.

An EqIA is a tool to assess the potential impact any proposals or strategies could have on the protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. At KCC we also include carer's responsibilities.

The EqIA is available online at kent.gov.uk/suicideprevention or in paper copy on request.

Q20. We welcome your views on our equality analysis, including suggestions for anything else we should consider relating to equality and diversity. Please add your comments below. Please do not include any personal information that could identify you or anyone else in your answer.

Part 5 – More about you

We want to make sure that everyone is treated fairly and equally, and that no one gets left out. That's why we are asking you these equality monitoring questions. This information really helps us to understand how different people could be affected by our strategies and proposals, but if you would rather not answer any of these questions, you don't have to.

It is not necessary to answer these questions if you are responding on behalf of an organisation.

If you are responding **on behalf of someone else**, please answer using their details.

Q21. What is your sex? A question about gender identity will follow. Please select **one** option.

- ☐ Female
- ☐ Male
- ☐ I prefer not to say

Q22. Is the gender you identify with the same as your sex registered at birth? Please select **one** option.

- ☐ Yes
- ☐ No, please tell us your gender identity: ☐
- ☐ I prefer not to say

Q23. Which of these age groups applies to you? Please select **one** option.

☐ 0-17	☐ 18-25	☐ 26-35	☐ 36-45	☐ 46-55
☐ 56-65	☐ 66-75	☐ 76-85	☐ 86 and over	☐ I prefer not to say

Q24. Do you have a disability, health condition, physical or mental impairment that has a substantial and long-term negative effect on your ability to do normal daily activities? Please select **one** option.

- ☐ Yes
- ☐ No
- ☐ I prefer not to say

Q24a. If you answered 'Yes' to Q21, please tell us if any of the following disabilities or health conditions apply to you.
You may have more than one, so please select **all** that apply. If none of these applies to you, please select 'A different disability or health condition' and give brief details.

- ☐ Physical
- ☐ Sensory (hearing, sight or both)
- ☐ Longstanding illness or health condition, such as cancer, HIV/AIDS, heart disease, diabetes or epilepsy
- ☐ Mental health condition
- ☐ Learning disability
- ☐ Neurodivergent, such as ADHD, autism, dyslexia and dyspraxia
- ☐ I prefer not to say
- ☐ A different disability or health condition

If you have selected 'A different disability or health condition', please tell us:

Q25. What is your religion or belief? Please select **one** option.

- [ ] No religion or belief
- [ ] Atheist
- [ ] Christian
- [ ] Buddhist
- [ ] Hindu
- [ ] Jewish
- [ ] Muslim
- [ ] Sikh
- [ ] A different religion or belief, please tell us: _____
- [ ] I prefer not to say

Q26. Which of the following best describes your sexual orientation? Please select **one** option.

- [ ] Heterosexual/Straight
- [ ] Bisexual
- [ ] Gay or Lesbian
- [ ] I prefer to define my own sexuality, please tell us: _____
- [ ] I prefer not to say

A Carer is someone who gives unpaid care or help to anyone because they have a long-term physical or mental health condition or illness, or problem related to old age. Both children and adults can be Carers.

Q27. Are you a Carer? Please select **one** option.

- ☐ Yes
- ☐ No
- ☐ I prefer not to say

Q28. What is your ethnic group? Please select **one** option.

White

- ☐ English, Scottish, Welsh, Northern Irish or British
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ Roma
- ☐ Any other White background, please tell us: ☐

Mixed or Multiple

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other Mixed or Multiple background, please tell us: ☐

Please see over the page for more ethnic groups.

Asian or Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian background, please tell us: ☐

Black, Black British, Caribbean or African

- ☐ Caribbean
- ☐ African background, write in below
- ☐ Any other Black, Black British, or Caribbean background, please write in below:

☐

Another ethnic group

- ☐ Arab
- ☐ Roma
- ☐ Any other ethnic group, please tell us: ☐

Q29. Which of the following best describes your working status? Please select **one** option.

- ☐ Working full time
- ☐ Working part time
- ☐ Unemployed
- ☐ Retired
- ☐ Student
- ☐ I prefer not to say
- ☐ Something else, please tell us:

Thank you for taking the time to complete this questionnaire; your feedback is important to us. All feedback received will be reviewed and considered in the development of the Strategy.

We will report back on the feedback we receive, but details of individual responses will remain anonymous, and we will keep your personal details confidential.

Closing date for responses: 6 October 2025.

8. Appendix 2. Full list of themes for each question

Making the Strategy easier to understand

Q4a. If you have any comments or suggestions on how to make the Strategy easier to understand, please tell us in the box below.

Themes	Number of respondents who raised this theme
Needs reformatting (e.g. space, bullets, visuals)	11
Needs specific examples of specific interventions / actions	10
Approval of written format	7
Is too generalised / needs to be more demographic specific	6
Easy Read version required	6
Needs wording amends	5
Document is too long	3
Needs to raise awareness of available support	2
Needs alternative versions (e.g. Braille, BSL)	2
Needs to be more organisation specific	1
Needs more information about educating GPs	1
Too much emphasis on self-sufficiency	1
Institutional phrasing	1
Should include hyperlinks to resources	1
Not enough reference to self-harm	1
Needs more detail on how it was written / who with	1
Needs lived experience voice	1
Unable to download document	1
Schools	1

Vision, mission and values

Q5a. Please tell us the reason for your answer to Q5. (How much do you agree or disagree with our proposed vision for the draft Strategy?)

Themes	Number of respondents who raised this theme
Agreement with objectives	71
Scepticism over policy/ needs focus on strategy in practice	35
Importance of good mental health support	14
Support for young people	8
Agency collaboration	7
More support for community groups	4
ADHD / Autism	4
Crisis support	4
Support for those left behind	3
Need for training	3
Support for males	3
Hope	3
Costs of service	2
Inclusivity	2
Follow up	1
Readability of the Strategy	1
Support for women	1
Support for LGBTQIA+	1
Longer term support / therapy	1
Self-harm	1
Addiction	1
Access to resources	1
Medway	1
Needs less focus on numbers	1
Domestic abuse	1
Those known to justice system	1
Investigating deaths by misadventure	1

Q6a. Please tell us the reason for your answer to Q6. (How much do you agree or disagree with our proposed mission for the draft Strategy? You can also let us know if you feel there is anything missing from the mission.

Themes	Number of respondents who raised this theme
Agreement with mission	37
Service availability / standard	23
Scepticism of mission	21
Support for young people	20
Resilience	16
Collaboration between agencies	16
Autism / ADHD	7
Training	5
Stigma	4
Crisis support	4
Social media	4
Hope	4
Community cohesion	3
Support for males	3
Importance of listening	3
Language of mission	3
Costs	2
Trauma-informed care	2
Carers support	1
Need for research	1
Signage near hotspots	1
Support for women	1
Self-harm	1
Gambling	1
Support for older adults	1
Employer support	1
Needs information on support	1
Knowing how to support others	1
Visibility of services	1

Q7a. Please tell us the reason for your answer to Q7. (How much do you agree or disagree with our proposed values for the draft Strategy?)

Themes	Please tell us the reason for your answer
Agreement with values	49
Scepticism of values	16
Hope	16
Agency collaboration	15
Service availability / standard	13
Wording	6
Support for CYP	3
Accountability	3
Autism / ADHD	2
Use of data and research	2
Substance misuse	1
Support for those left behind	1
Community cohesion	1
Training and awareness	1
Support for older people	1
Justice	1
Accessibility	1
Stigma	1
Trauma-informed care	1
Involving family	1

Proposed priorities

Q8a. Please tell us the reason for your answer to Q8. (How much do you agree or disagree that we should continue to follow the above priorities? You can also let us know if you feel there are any priorities missing.)

Themes	Number of respondents who raised this theme
Agreement with priorities	29
Availability and of services / standards	24
Scepticism of priorities	11
Training	10
Social media / online safety	8
Support for those left behind	7
Costs	6
Use of data and research	6
Autism / ADHD	6
Suicide is everyone's business	5
Socio-economic / deprivation	4
Agency collaboration	4
Lived experience	4
Access to means	3
Self-harm	3
Support for CYP	3
Domestic abuse	3
Localised approaches	3
Prevention	3
Community cohesion	2
Accountability	2
Support for those who have experienced ideation / attempts	1
Personality disorders	1
Gambling harms	1
Needs more detail	1
Needs to focus on everybody, not just priority groups	1
Relationship breakdowns	1
Contact with justice system	1

High risk groups

Q9a. Please tell us the reason for your answer to Q9. (How much do you agree or disagree that these are the right high-risk groups that we should be prioritising in the Kent and Medway Suicide and Self-Harm Prevention Strategy? You can also let us know if you feel there are any high-risk groups missing.)

Themes	Number of respondents who raised this theme
Agreement with groups	30
Neurodivergence	25
LGBTQIA+	12
Scepticism of selection	11
CYP	9
People awaiting mental health treatment / support / not known to services	6
Loneliness / isolation	6
Asylum seekers	5
Women	4
Males (general)	4
Mental health conditions / personality disorders	4
Availability / visibility of services	4
Older males / females	3
Co-occurring conditions / substance misuse	3
People affected by financial adversity	3
Carers	3
Ethnic minorities	2
Veterans	2
Agency collaboration / signposting	2
Cuckooing	2
Gambling harms	2
People bereaved by suicide	2
Care leavers	2
Farmers	2
People in contact with justice system / family courts	2

Themes	Number of respondents who raised this theme
Trauma / ACEs	2
Students	1
Costs / funding	1
Homeless	1
Health conditions (physical)	1
UASC	1
Needs to be available to all	1
Domestic abuse	1
Relationship breakdown	1
Perinatal mental health	1

Key priorities and actions

Q10. If you have any suggestions for any specific actions that could be taken to reduce the suicide risk for any of the high-risk priority groups, please tell us.

Themes	Number of respondents who raised this theme
Availability / visibility / access to support	28
Community cohesion / support groups / loneliness and isolation	20
Neurodivergence	16
Quality of support	15
Schools / education	12
CYP	12
Training	11
Multi-agency collaboration	8
Co-occurring conditions / substance misuse	6
Support from friends / relatives	6
Data and research	5
Online / social media	5
Engagement with lived experience	5
Financial concerns / debt	4
Engagement with priority groups	3
Domestic abuse	3

Themes	Number of respondents who raised this theme
Primary care	2
Adequate support for self-harm	2
NHS	1
Support for those awaiting treatment	1
Carers	1
Benefits / universal credit	1
Physical adjustments (barriers etc)	1
Accessing confidential support	1
A sense of purpose	1
Workplace support	1
Support for peri / menopausal women	1
Housing	1
Accountability	1
Improved risk assessments	1

Q11. How can we continue to make suicide and self-harm prevention everybody's business?

Themes	Number of respondents who raised this theme
Training	41
Awareness campaigns / communication	38
Schools / education	15
Community cohesion / support groups	13
Importance of conversation	10
Availability / visibility / access to services	7
VCSE sector	7
Role of friends / family	7
Workplace / employer role	7
Multi-agency collaboration	6
System accountability	6
Scepticism of statement	5
High risk locations	4

Themes	Number of respondents who raised this theme
Quality of support	4
Lived experience	4
Stigma	4
Agreement with statement	3
Costs	2
Data and research	2
Leadership and accountability	2
Bystander interventions	2
Wider determinants / prevention	1
Self-harm	1
Sharing best practice	1
Online safety	1
Substance misuse	1

Q12. How can we reduce access to the means and methods of suicide in Kent and Medway?

Themes	Number of respondents who raised this theme
High risk locations	30
Availability / visibility / access to services	22
Scepticism of priority	17
Awareness campaigns / communication	17
Multi-agency collaboration	11
Training	10
Online / social media	10
Early intervention	6
Quality of support	6
Making it everyone's business	4
Use of data and research	4
Agreement with priority	3
Funding / costs	3

Themes	Number of respondents who raised this theme
Monitoring of high risk means	3
Importance of conversation	2
Schools / education	2
Lived experience involvement	2
Restricting medications	2
Stigma	1
Rural locations	1
Addressing socio-economic issues	1
Help for loved ones	1
Substance misuse	1
Importance of listening	1
Trauma-informed care	1

Q13. What is the best way of providing information and support to those bereaved or affected by suicide?

Themes	Number of respondents who raised this theme
Awareness campaigns / visibility	21
Range / flexibility of support methods	14
Accessibility / availability of services	14
Importance of early intervention	13
Involving lived experience	9
Frontline service role	9
Community cohesion / support groups	8
Role of family / friends	7
Multi-agency collaboration	7
Funding / VCSE sector	7
SOBS / peer led support	5
Scepticism of priority	3
3 month window	3
Role of schools	3

Themes	Number of respondents who raised this theme
Advice on how to share news	2
Online / social media	2
Amparo	2
System leadership / commitment to services	1
Service user identification	1
Physical goods	1
Counselling	1
System change	1
Support for those affected by attempted suicide	1

Areas of focus for children and young people

Q14. Please tell us the reason for your answer to Q14. (How much do you agree or disagree that these are the areas of focus that should be prioritised for children and young people in the Kent and Medway Suicide and Self-Harm Prevention Strategy? You can also let us know if you feel there are any areas of focus missing.)

Themes	Number of respondents who raised this theme
Schools / education	17
Agreement with focus	16
Accessibility / availability of services	16
Online / social media	9
Neurodivergence	9
Transition between CYP and adult services	8
Resilience	7
Raised awareness / training	6
Quality of services	6
Students / universities	5
NEETS / not in mainstream education	5
Impact of changes to wider living environment (e.g. political, technological)	4
Self-harm	4
Role of social environment	4

Themes	Number of respondents who raised this theme
Bullying	4
Scepticism of focus	3
Early intervention	3
CYP and parent insights	3
Understanding difference between standard emotions and suicide risk	3
LGBTQI+	2
Impact of services / stigma	2
Children in care	2
Workplace support	1
ACEs	1
Communication	1
Immigrants	1
Young carers	1
Youth groups	1
Educational pressures	1
Requires more detail	1
Trauma-informed care	1
Support for CYP bereaved by suicide	1
Role of CYP services	1

Q15. How can we continue to make suicide and self-harm prevention among children and young people everybody's business?

Themes	Number of respondents who raised this theme
Training / education	37
Schools / education settings	33
Raised awareness / campaigns	21
Role of friends / family	21
Availability / accessibility of services	11
Social media / online harms	10
Community support / groups	8

Themes	Number of respondents who raised this theme
Multi-agency collaboration	7
Early intervention	6
Self-harm	6
Scepticism of priority	5
Making CYP feel heard / believed	5
Stigma	3
System leadership	3
Lived experience	3
Sharing best practice	1
Addressing bullying	1
Empathy	1
Flexible approach	1
Substance misuse	1
Workplace	1
Quality of services	1
Trained advocates	1
Understanding wider factors	1
CYP-targeted resource e.g. books	1

Q16. How can we reduce suicides in children and young people in Kent and Medway by controlling access to the means of suicide?

Themes	Number of respondents who raised this theme
Online / social media regulations	16
Scepticism of priority	10
Physical adjustments / high risk locations	9
Schools	8
Raised awareness / campaigns	7
Parents / families	6
Training	5
Listening to CYP	5

Themes	Number of respondents who raised this theme
Youth clubs / community groups	4
Strengthening emotional development	4
Effective use of data and Research (including AI)	4
Access / visibility / availability of services	4
Multi-agency collaboration	4
Better quality support / services	2
Early intervention / identifying CYP who are at risk	2
Agreement with priority	1
Self-harm	1
Substance misuse	1
Educating the press / media	1
CYP suicide bereavement support	1
Role of friends	1

Q17. What is the best way of providing information and support to those children and young people bereaved or affected by suicide?

Themes	Number of respondents who raised this theme
Use of networks / community	21
Schools	16
Range of support methods	13
Therapy / counselling	10
Accessibility / availability of support	10
Involvement of those working with CYP	8
Use of lived experience	8
Visibility / awareness campaigns	8
Timeliness of support	6
Family Involvement	5
Agreement with priority	4
24/7 support	4
Social media	4
Books / films	3

Themes	Number of respondents who raised this theme
Funding	2
Memorials / vigils	1
Scepticism of priority	1
Training	1
Mentoring	1
Support for suicide attempts	1

Feedback on other priorities

Q18. If you would like to provide feedback on any of the other priorities or actions for adults or children and young people in the Strategy, please provide these below.

Themes	Number of respondents who raised this theme
Agreement / support of strategy	7
Importance of continued research / addressing risk factors	3
Wider mental health strategy	3
Neurodivergence	3
Importance of individualised approach	2
Accountability	2
Accessibility / visibility of support	2
Increased use of lived experience	2
Funding	1
Over-reliance on helplines	1
Isolation	1
Timespan of Strategy	1
Pressures on CYP	1
Self-harm	1
Education	1
Outdoor activities and therapies	1
Stress-testing	1
Structural action	1
Social media / online harms	1

Themes	Number of respondents who raised this theme
Needs more detail around intersectionality	1
Needs more details around interventions	1
Domestic abuse	1
Trauma-informed care	1
Increase peer support groups	1
Importance of early intervention	1
Role of schools	1

Anything else?

Q19. If you would like to make any other comments on the draft Kent and Medway Suicide and Self-Harm Prevention Strategy, please tell us:

Themes	Number of respondents who raised this theme
Improving mental health provision / increased funding	15
No / agreement with Strategy	14
Scepticism of Strategy	5
Multi-agency collaboration	4
Neurodivergence	4
Wider environment	4
Accountability	4
Continued research of risk factors	3
Importance of mental health support	2
Involvement of lived experience	2
Crisis teams / crisis support	2
Increased awareness / campaigns	2
RNLI / other organisations	1
Middle aged women / menopause	1
Timespan of Strategy	1
Role of family / friends	1
Asylum seekers / immigrants	1
PTSD	1
Self-harm	1

Themes	Number of respondents who raised this theme
Community / social groups	1
Where to find further info	1
Education / training	1
Use of green / blue spaces	1
Stigma	1
Intersectionality	1
Needs more detail around interventions	1
Trauma-informed care	1
Domestic abuse	1
Increase peer support groups	1

Equality analysis

Q20. We welcome your views on our equality analysis, including suggestions for anything else we should consider relating to equality and diversity.

Themes	Number of respondents who raised this theme
Agreement with EqIA	15
Scepticism of EqIA	9
Neurodivergence	8
LGBTQI+	5
Co-production with experts	3
Intersectionality	2
Hope	1
Housing	1
Employment	1
GP access	1
Women	1
Social media	1
Use of green and blue spaces	1
Resilience	1
Children in care	1
Ethnicity	1
Gender	1