London Borough of Havering

Havering all-age suicide prevention strategy 2025-2030

Working together to save lives

Document Control

Document details

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Equality & Health Impact Assessment record

<table>
<tr><td>1</td><td>Title of activity</td><td colspan="3">Havering Suicide Prevention Strategy 2025-2030</td></tr>
<tr><td>2</td><td>Type of activity</td><td colspan="3">A multiagency strategy to prevent suicide</td></tr>
<tr><td>3</td><td>Scope of activity</td><td colspan="3">- What is the scope and intended outcomes of the activity being assessed?
- Make sure you highlight any proposed changes.
- Please make sure that your description is understood by everyone, including members of the public

This document sets out the local strategic approach for reducing deaths by suicide in the Borough. .</td></tr>
<tr><td>4a</td><td>Are you changing, introducing a new, or removing a service, policy, strategy or function?</td><td>Yes</td><td rowspan="3">If the answer to <u>any</u> of these questions is ‘YES’, Please continue to question 5.</td><td rowspan="3">If the answer to <u>all</u> of the questions (4a, 4b & 4c) is ‘NO’, please go to question 6.</td></tr>
<tr><td>4b</td><td>Does this activity have the potential to impact (either positively or negatively) upon people (9 protected characteristics)?</td><td>Yes</td></tr>
<tr><td>4c</td><td>Does the activity have the potential to impact (either positively or negatively) upon any factors which determine people’s health and wellbeing?</td><td>Yes</td></tr>
<tr><td>5</td><td>If you answered YES:</td><td colspan="3">Please complete the EqHIA in Section 2 of this document. Please see Appendix 1 for Guidance.</td></tr>
<tr><td>6</td><td>If you answered NO: (Please provide a clear and robust explanation on why your activity does not require an EqHIA. This is essential in case the activity is challenged under the Equality Act 2010.)

Please keep this checklist for your audit trail.</td><td colspan="3"></td></tr>
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Date	Completed by	Review date

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Executive summary

A death by suicide is often the culmination of a complex interplay of risk factors and distressing life events, and results in a profound and long-lasting impact on families and friends. The effects extend beyond immediate circles, rippling through communities to affect neighbours, workplaces, schools and other social networks. Bereavement by suicide increases the risk of those affected taking their own lives.

Public health measures to reduce access to means of suicide and improve care for those who are at risk have contributed to a reduction in the national suicide rate since the 1980s. However, between 2015 and 2023, 194 lives were lost to suicide in Havering; averaging 19 deaths by suicide per year among residents[1].

From 2005 to 2021, the rate of suicide in Havering did not differ significantly from the London average. However, from 2020 to 2022, London recorded its lowest suicide rate at 6.9 per 100,000 people. This improvement in suicide rates was not seen in Havering, and consequently Havering now has a significantly higher rate of death by suicide (9.6 per 100,000) than London as a whole.

The risk of death by suicide is not evenly distributed across society. Those who are experiencing homelessness, debt, unemployment, or living in poverty are at heightened risk for poor mental health and suicide. Self-harm is the strongest predictor of death by suicide, with over half of those who die by suicide having a history of self-harm, often within the period leading up to their death[2]. In Havering, emergency hospital admissions for intentional self-harm are currently similar to the London average, yet there remains a need for targeted support and prevention strategies to reduce these admissions and support those who self-harm.

This suicide prevention strategy has been informed by national strategy and evidence, key population groups that are at higher risk, and additional local priorities. The complex nature of suicide means that prevention requires a coordinated, multi-agency approach spanning strategy, policy and frontline service delivery, in particular where local agencies come into contact with individuals who are more at risk. While most deaths by suicide occur within the home, one-third of deaths by suicide in Havering take place in public places. This highlights the need to mitigate the risks in these settings, both to prevent deaths and to manage the broader impact on the Havering community.

The strategy development has been led by the Council, in collaboration with the Lead Member for Adults and Wellbeing, the Public Health Service, and a wide range of Council and NHS frontline services. Over 20 stakeholder organisations contributed, alongside individuals who have experienced the pain of losing a loved one to suicide or have faced suicidal ideation themselves. Direct engagement and feedback was conducted with the Youth Council, Primary Care Networks (including GPs) and with head teachers and staff across Havering's education system.

[1] Suicide Prevention Strategy (havering.gov.uk)
[2] The National Confidential Inquiry into Suicide and Safety in Mental Health (2021), https://documents.manchester.ac.uk/display.aspx?DocID=55332

Every death by suicide is preventable, so we aim to improve the success of suicide prevention activities within Havering; leading to a reduction in the number of deaths by suicide over the next five years. This aim will be met through implementing objectives focused on:

- **identifying** those at increased risk and applying the most effective evidence-based interventions for our local population and setting
- **prevention** activities across the system including increasing knowledge and reducing stigma
- **support** at both individual and population levels, including those at risk of suicide and the bereaved

These objectives will be achieved through the delivery of a detailed action plan, the development of which was informed through consultation with the Suicide Prevention Stakeholder Group, detailed in Appendix 1. This detailed action plan will be monitored by a Suicide Prevention Strategy Steering Group, with representatives from the Council, NHS, safeguarding leads, mental health charities, and people with lived experience.

The strategy focuses on prevention, system coordination and addressing the wider determinants of health that influence the risk of a person dying by suicide. It outlines overarching goals and provides a framework for collaborative action across the wider system to reduce deaths by suicide in Havering, with the specific activities and timelines detailed in an accompanying action plan. Partner organisations are likely to have local policies, strategies and operational procedures relating to suicide prevention, and coordinated multi-disciplinary working, drawing on strengths and opportunities, will deliver the maximum benefit for the people of Havering.

Foreword

As co-signatories to this strategy we believe that every suicide is preventable, and each life lost to suicide is one too many. Far too many of us have experienced the pain and grief that suicide inevitably leaves behind, being personally affected or standing alongside others who have gone through the tragic loss of a partner, child, parent, friend or colleague.

We strongly support the approach that this draft strategy sets out: that **preventing suicide is everyone's business.** Every organisation working in, and for, Havering residents will play their part in keeping people safe from suicide. We want communities, employers, colleagues, friends and families to know how to talk to someone they care about to support prevention of suicide.

This strategy sets out how we can achieve this; organisations' strategies, polices and services will be suicide-informed, with a workforce that is trained to understand and respond to suicide risk and bereavement. We know that even small conversations can be key for prevention. We will work to increase knowledge and awareness amongst residents, volunteers and the wider workforce on how to recognise those at risk, ask the right questions, listen without judgement and signpost to help.

We want our Borough to be a place where suicide is not considered a solution to any problem; where people know where to go for help, and how to help one another. We believe that, together, we can make a difference to save lives and prevent families and communities from experiencing suicide loss.

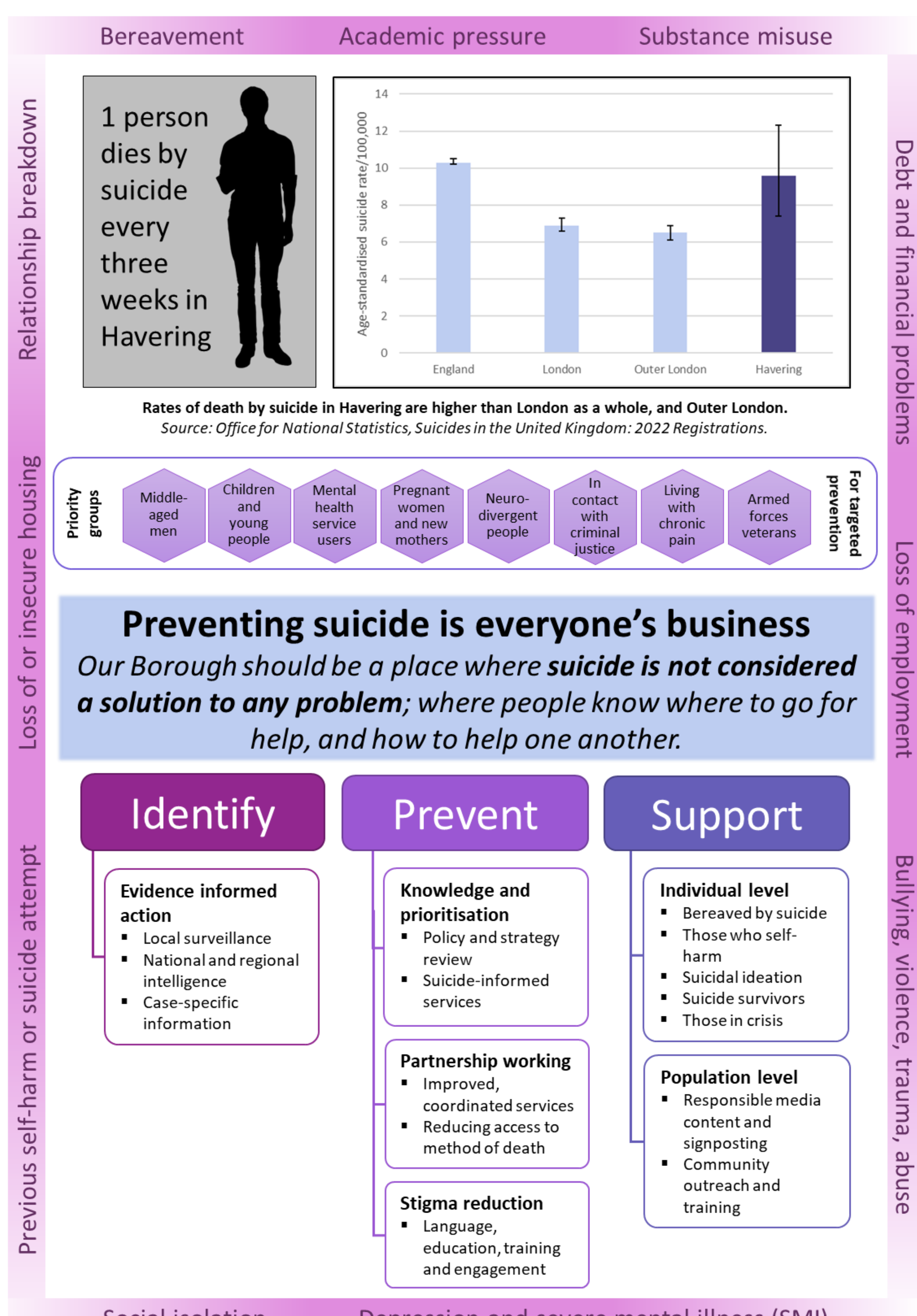
We take this opportunity to thank everyone who has contributed to the development of this suicide prevention strategy, especially those who have shared their experience of losing someone to suicide; providing a better understanding of how to prevent similar grief and pain.

Councillor Gillian Ford
Deputy Leader of the Council and Cabinet Member for Adults and Wellbeing

Dr Mark Ansell
Director of Public Health, London Borough of Havering

Dr Maurice Sanomi
Senior GP Partner and Havering Partnership Clinical and Care Lead for Mental Health (NEL ICB)

Strategy on a Page



Introduction

A death by suicide is often the culmination of a complex interplay of risk factors and distressing life events, and results in a profound and long-lasting impact on families and friends. The effects extend beyond immediate circles, rippling through communities to affect neighbours, workplaces, schools and other social networks. Bereavement by suicide, in particular, increases the risk of those affected taking their own lives.

This five-year, all-age *Havering Suicide Prevention Strategy 2025-2030* summarises what we will do to prevent such loss of life and so avoid the pain caused by losing someone to suicide.

The strategy development has been led by the Council, in collaboration with the Lead Member for Adults and Wellbeing, the Public Health Service, and a wide range of Council and NHS frontline services. Over 20 stakeholder organisations contributed, alongside individuals who have experienced the pain of losing a loved one to suicide or have faced suicidal ideation themselves. Direct engagement and feedback was conducted with the Youth Council, Primary Care Networks (including GPs) and with head teachers and staff across Havering's education system.

Work on this strategy commenced in 2023 by bringing together key information about suicide in the Borough: identifying risk factors and vulnerabilities, and gathering evidence from national and regional strategies and guidance. A comprehensive list is available in Appendix 1 but the main documents include:

- National strategy: *Suicide prevention in England: 5-year cross sector strategy*
- National Institute for Health and Care Excellence (NICE) Guidelines
- The NHS Long Term Plan
- Local Government Association Local Suicide Prevention Planning: a practice resource
- London-wide and NEL-wide arrangements and priorities for suicide prevention

> The Vision for Havering is that the Borough should be a place where **suicide is not considered to be a solution to any problem**; where people know where to go for help, and how to help one another. The Borough will be **home to communities that are happy, thriving and resilient**. People living in Havering will, with the **right support at the right time**, recover from crisis, psychological distress and mental disorder, by having **access to safe, integrated and compassionate services**.

This consolidation of key information led to the development of a Suicide Prevention Needs Assessment, which informed three multi-agency stakeholder workshops, held in July 2023, September 2023 and May 2024. Stakeholder engagement and the 2018-2023 Barking and Dagenham, Havering, and Redbridge Suicide Prevention Strategy also shaped the vision and contents of this strategy.

During the development of this strategy, partners in Havering continued implementing initiatives under the 2018-2023 strategy, including:

- Providing and promoting information and training on suicide prevention for frontline workforces, residents and others who work in the borough.
- Participating in North East London initiatives, such as support for people bereaved by suicide.

- Engaging in London-wide suicide prevention arrangements, including signing the data-sharing agreement for real-time suspected suicide notifications.
- Ensuring people in crisis are identified, taken to a place of safety and discharged with robust safety plans[1].

Timescales

This strategy covers the period Q1 (April) 2025 – Q4 (March) 2030.

Consultation

The Havering Suicide Prevention Strategy was developed through a consultation process aimed at capturing both broad community and stakeholder input, as well as detailed feedback from professional stakeholders of particular relevance to the contents of the strategy.

1. **Public Consultation Survey**
   The first phase of the consultation involved a public-facing survey hosted on Havering Council's *Citizen Space* platform from September 10th, 2024 to October 18th, 2024. An easy-read version of the strategy was available alongside the long-read version to aid accessibility and support the engagement of those with different learning needs and young people.

   The survey invited feedback from residents, Councillors, local businesses, public sector organisations, community groups and organisations, those who work in suicide prevention and individuals with lived experience.

   Links to the online survey were promoted through Living (Havering Newsletter) and Havering Council social media channels. The consultation was also promoted to the Havering Suicide Prevention Stakeholder Group, the Live Well Network, Liberty and Havering Crest Primary Care Networks, the PSHE (primary schools) network, the BAP (secondary schools) network, the Havering Integrated Care Coordination and Social Prescribing Network, the Practice Manager's Forum and the Community Mental Health Board.

2. **Stakeholder Focus Groups**
   To gather deeper insights, focus groups were conducted with key stakeholders, including Primary Care Networks (PCNs) and GPs, the Youth Council, and head teachers and staff from primary and secondary school networks.

Please see the Havering Suicide Prevention Strategy Public Consultation Report that summarises how consultation feedback and focus group findings shaped the final strategy and the associated action plan.

What we know about suicide

This strategy includes key insights from the Havering Suicide Needs Assessment.

National Context

From 2020-22, there were 16,449 suicides registered in England and Wales, equivalent to a rate of 10.5 deaths per 100,000 people[3]. "Suicide and injury or poisoning of undetermined intent" was the leading cause of death for both males and females aged 20 to 34 years in the UK between 2001-18[4].

Public health measures have reduced national suicide rate since the 1980s, though rates have remained stable over the last two decades. The 2016 NHS five-year forward view for mental health targeted to reduce suicides by 10%[5], but this target has not been met, with rates in 2020-22 (10.4/100,000) unchanged from 2013-15 (10.1/100,000)[3].

The Secretary of State for Health announced the ambition for zero suicides in mental health inpatient units, acknowledging the 42% reduction in inpatient deaths by suicide between 2009–2011 and 2018–2020[6]. This highlighted the importance of continuing efforts to reduce deaths by suicide within these settings, while emphasising the need to address deaths by suicide in other contexts, particularly in the home, the most common location of deaths by suicide in Havering, and in public places, which amount for approximately one-third of cases.

Havering Data

The current suicide rate for Havering is higher than the rate for London as a whole although not statistically significantly different to England (2020-22 data). On average, there have been 19 deaths by suicide per year in Havering since 2015[7]. In 2021-2022, the Havering suicide rate for males was 13.5 per 100,000; almost double the suicide rate for females (7.2 per 100,000).[7] There is wide variation in age-adjusted rate of suicide across the London Boroughs (Figure 1). Havering is one of five London Boroughs with a significantly higher rate than London as a whole, but a similar rate to England.[3,8]

[3] www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2022registrations
[4] Leading causes of death, UK - Office for National Statistics (ons.gov.uk)
[5] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[6] Hunt *et al.* (2024) Psychiatric in-patient care in England: as safe as it can be? An examination of in-patient suicide between 2009 and 2020. Cambridge University Press.
[7] NEL Suicide Prevention Data Dashboard
[8] The most recent age-adjusted rate of suicide in Havering is 9.6 per 100,000 population (95%CI: 7.4 – 12.3). This rate is not statistically significantly different from England, (10.3 per 100,000 [95%CI: 10.2 – 10.5]) but higher than London (6.9 per 100,000 [95%CI: 6.6 – 7.3]).

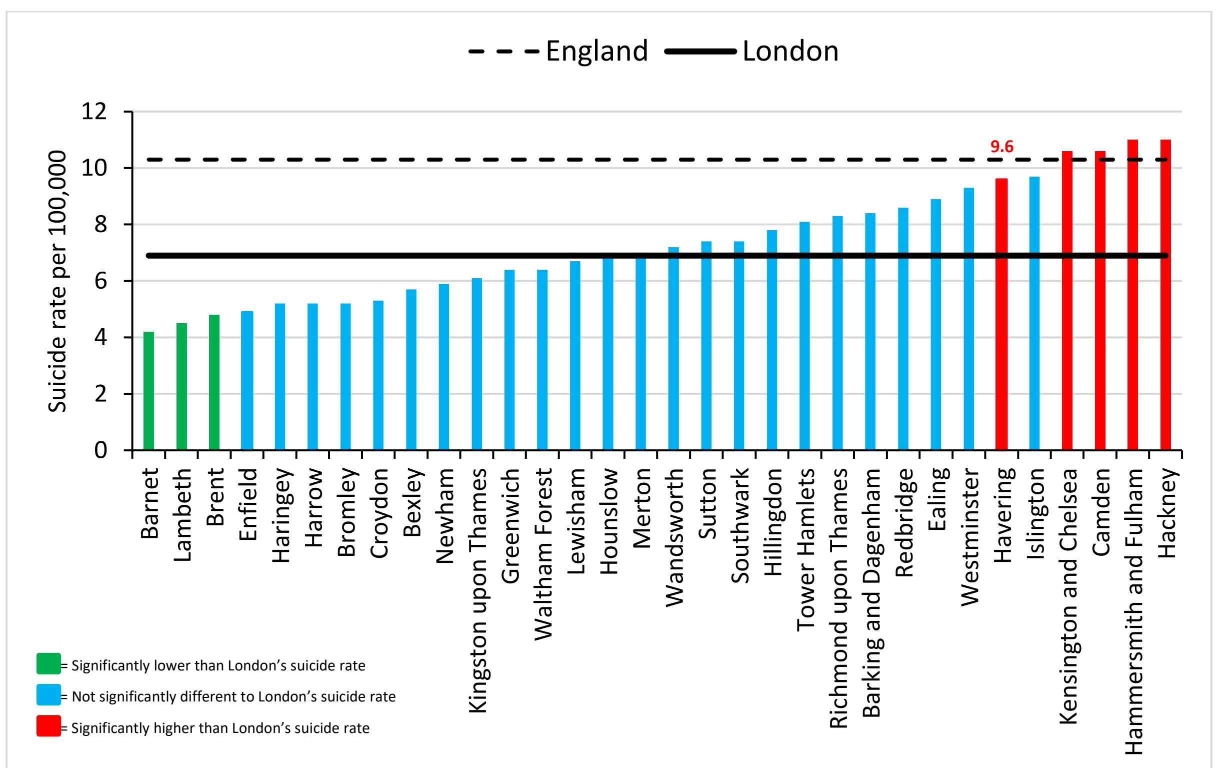


Figure 1 Three-year aggregate age-standardised suicide rates in London boroughs, London and England, 2020-2022*. Source: Office for National Statistics (2022). Suicides in the United Kingdom: 2022 Registrations.*

Risk factors for suicide

Suicide is rarely the result of a single cause. Instead, a complex mix of social, cultural, psychological and economic factors interact to increase an individual's level of risk (Figure 2). Factors are rarely experienced in isolation and often influence one another; for example, loss of employment may lead to debt and financial problems, increasing vulnerability to experiencing and acting upon suicidal thoughts.

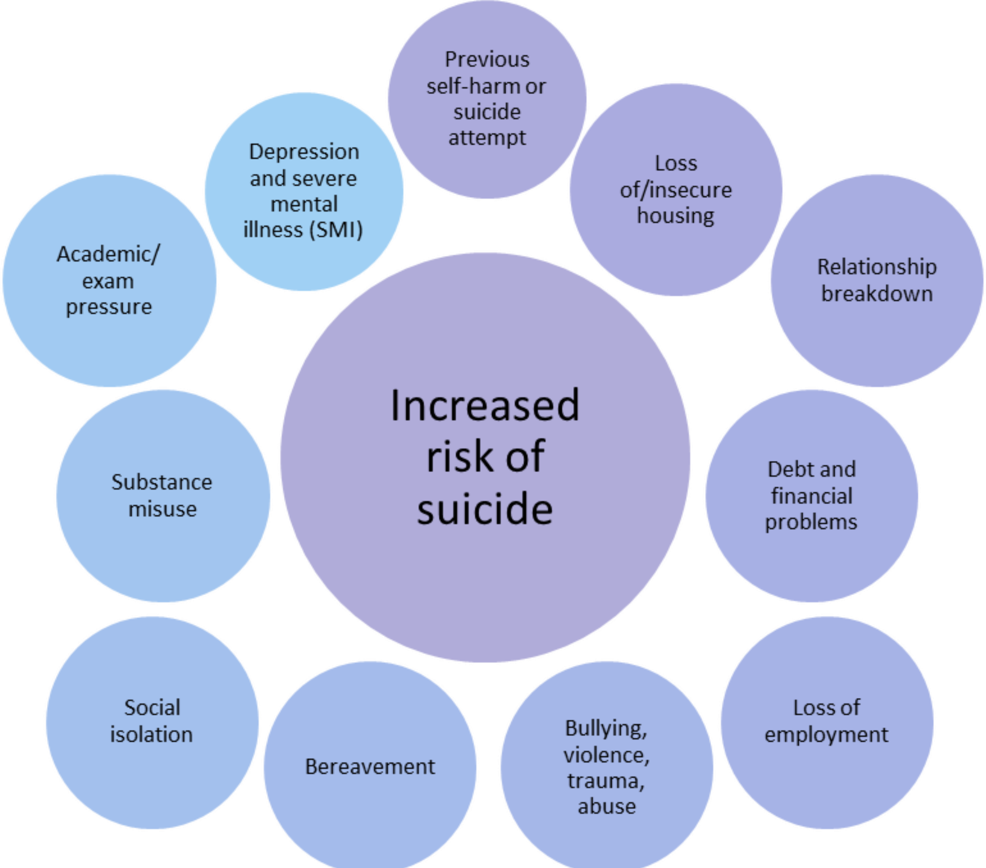


***Figure 2 Multiple factors that have been linked to an increased risk of suicide*[9].** *Examples of SMI include psychosis and paranoid schizophrenia. NB: Each of the factors can be experienced along with any of the others listed.*

Inequalities

As is the case with most health and wellbeing outcomes, the risk and frequency of suicide are unevenly distributed across the population. Socioeconomic deprivation, unemployment, housing insecurity and social isolation are factors that heighten suicide risk by increasing stress and reducing access to supportive resources. These also contribute to disparities in access to services and differences in risk factors within Havering's population. The accompanying Equality and Health Impact Assessment (EHIA) outlines these inequalities.

It is important to consider the impact of comorbidities, such as the co-occurrence of mental health disorder, chronic physical illnesses or substance misuse, can further increase suicide risk. When conditions overlap, they can compound challenges and create additional barriers to accessing timely and effective support. Other key insights from local, national and international data include:

- Age
  - Suicide affects all age groups, with middle-aged individuals (40-59 years) most at risk in Havering, reflecting national trends. [10].
  - Nationally, suicide rates among younger people, while lower overall, have seen an increase in recent years[10].

[9] https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028
[10] Office for National Statistics (ONS), 2022

  - Given these trends, both middle-aged people and children and young people are priority groups for suicide prevention efforts in Havering, aligning with the national suicide prevention strategy.
- Disability
  - Disabled women are over four times more likely to die by suicide compared to non-disabled women, while disabled men are three times more likely to die by suicide than non-disabled men[11].
  - Suicide is a leading cause of early death for autistic people without co-occurring learning disabilities; autistic people are seven times more likely to die by suicide than allistic (non-autistic) individuals[12].
  - Up to 66% of autistic adults have considered suicide[13]. Autistic people are around 7 times more likely than non-autistic people to die by suicide, and this gap is even larger for certain groups, such as autistic people without a co-occurring learning disability and autistic women[14].
  - Undiagnosed autistic people are at higher risk of suicide and suicidal behaviours than non-autistic people[14].
  - Adults with ADHD are five times more likely to die by suicide[15].
- Gender identity and sexual orientation
  - Men are three times more likely to die by suicide than women[16].
  - Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and those who are part of the LGBTQ+ community are at a higher risk of death by suicide compared to those who do not identify as LGBTQ+[17].
- Ethnicity
  - Although there is limited evidence of statistically significant differences in suicide rates between ethnic groups, racism and discrimination impact wellbeing and suicide risk[18].
- Religion or Faith
  - In the UK, people belonging to any religious group generally have lower suicide rates compared to those with no religion, with the lowest rates in the Muslim group[19].
  - The rates of suicide were highest in the Buddhist group and religions classified as "Other"[19].
  - For men and women, the rates of suicide were lower across the Muslim, Hindu, Jewish, Christian and Sikh groups compared with the group who reported no religion.
- Maternity
  - Maternal suicide remains the leading cause of pregnancy-related deaths in the year after childbirth in the UK[20].
  - Almost a quarter of all deaths of women during pregnancy or up to a year after the end of pregnancy were from mental health-related causes[20].

[11] Disabled people far more likely to die by suicide than non-disabled people | Disability Rights UK
[12] https://www.autistica.org.uk/our-research/research-projects/understanding-suicide-in-autism#:~:text=Autistic%20people%20are%20much%20more,alarming%2035%25%20have%20attempted%20suicide.
[13] High Suicide Rates among Neurodiverse Individuals: Why it matters and what can be done about it • Government Events
[14] London Region Learning Disabilities and Autism NSH Futures, Community of Practice.
[15] https://www.berkshirehealthcare.nhs.uk/media/109514702/suicide-in-adhd-adhd-bekrshire-healthcare.pdf
[16] Suicide rate in England & Wales by gender 2000-2022 | Statista
[17] Self-harm and suicidality among LGBTIQ people: a systematic review and meta-analysis. Marchi et al. (2022)
[18] https://www.samaritans.org/about-samaritans/research-policy/ethnicity-and-suicide/
[19] Jacob, L., Haro, J.M. and Koyanagi, A., 2019. The association of religiosity with suicidal ideation and suicide attempts in the United Kingdom. Acta psychiatrica scandinavica, 139(2), pp.164-173 and ONS sociodemographic inequalities in suicide
[20] Suicide remains the leading cause of direct maternal death in first postnatal year | Maternal Mental Health Alliance

- A recent confidential enquiry reported that improvements in care might have made a difference in outcome for 67% of women who died by suicide[21].
- Deprivation
    - People living in the least advantaged areas have a 10 times higher risk of suicide than those living in the most advantaged areas[22].
    - Living in poverty increases the risk of poor mental health and death by suicide.
- Stigma of mental ill-health
    - Members of groups and communities where stigma of mental ill-health and suicide is more prevalent are at an increased risk due to lower engagement with preventative and support[23].

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[21] MBRRACE-UK: Confidential Enquiry into Maternal Deaths in the UK and Ireland. "Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19"
[22] Inequality and suicide | Samaritans
[23] Mental illness stigma and suicidality: the role of public and individual stigma - PMC (nih.gov)

Priority Groups

Risk factors and resilience to the impact of risk factors are not distributed equally, meaning targeted suicide prevention actions are essential. Figure 3 highlights national and local priority groups identified for focused suicide prevention efforts.

National Priority Groups	Additional Local Priority Groups
• Middle-aged men • People who self-harm • Children and Young people (rising rates in recent years) • People in contact with mental health services • Autistic people and/or neurodivergent individuals • Pregnant women and new mothers • People in contact with criminal justice system	• People with economic risk factors* • People who misuse substances • People bereaved or impacted by suicide • Victims and perpetrators of domestic violence and abuse • People living with chronic pain and/or long term conditions • Veterans of the armed forces

Figure 3 National and local priority groups for targeted suicide prevention activity.
**Including those living in neighbourhoods of disadvantage, in debt, homeless or facing homelessness, unemployed, insecure or low quality housing*

Working Together

In the context of services often operating at full capacity, when an individual does not engage with care or services offered, they could be considered as "hard to reach" or even "beyond help", resulting in client disengagement leading to case closure and withdrawal of support. However, this strategy advocates for disengagement to be seen as a symptom of unmet needs or systemic barriers rather than a failure of the individual to engage with a service offer. Suicide prevention requires coordinated, multi-agency response that integrates strategy, policy and service delivery, especially as partner agencies have their own strategies, policies and pathways relating to suicide prevention. By improving coordination across partners, this strategy can work to ensure that no one is left behind.

The strategy outlines key objectives to improve knowledge, prioritisation and collaboration around suicide prevention at sub-regional, London-wide and national levels. This joined up working will deliver a well-coordinated and effective preventative response. From promoting training for healthcare professionals on the safe management of high-risk medications to encouraging housing officers to undertake suicide prevention training, partners can play their part in supporting prevention efforts for those at highest risk. Initiatives like these foster community resilience and empower individuals with the skills to recognise when someone is in need and connect them to appropriate support resources.

Stigma remains a barrier, discouraging individuals experiencing mental ill health, facing suicidal thoughts or experiencing bereavement due to suicide from seeking support. Creating safe, inclusive spaces where people feel encouraged to speak openly and access support is necessary. A key strategy priority is reducing stigma associated with suicide and bereavement by suicide. This will be achieved through education, training and engagement initiatives with the local, system-wide workforce and the broader Havering community,

addressing fear and fostering societal acceptance for both professionals and public to speak about and support suicide prevention.

Multi-agency case review panel

Upon notification of a death by suspected suicide, Public Health will lead the initial review and information gathering to determine whether a comprehensive review is required by partner agencies within the wider system (e.g. domestic homicide review). For cases not covered by other reviews, Public Health will lead the identification of lessons learned, patterns of risk factors and develop case-specific recommendations for actions to be shared across the wider system.

Aim

Every death by suicide is preventable, so this strategy aims to improve the success of suicide prevention activities within Havering; leading to a reduction in the number of deaths by suicide over the next five years[24]. This will be done through implementing objectives focused on identification, prevention and support (Figure 4).

Objectives

The strategy outlined objectives and key high-level actions to achieve its aims. A separate detailed action plan will enable the suicide prevention steering group to monitor implementation.

The local delivery plan will be flexible to accommodate emerging government initiatives, such as updates to the national curriculum, publication of the upcoming Major Conditions Strategy (expected in 2024) and implementation of the Department of Work and Pensions 'alert service to identify people who raise suicidal thoughts when using DWP helplines and services.

Why an All-Age Strategy?

An all-age strategy addresses the suicide risk factors that arise at different life stages. Whilst deaths by suicide amongst children are thankfully rare, the life course approach recognises that experiences throughout life, from childhood to old age, affect suicide risk. For example, children who have been suicide-bereaved, or experienced another adverse childhood experience (ACE) have an increased lifetime risk of death by suicide and need specific support.

Early childhood is a critical time when children develop foundational skills, such as emotional regulation, resilience and coping mechanisms that can protect them from mental health challenges later in life. Resilience factors include children feeling they belong in the community, have support networks, and trusted relationships with adults and peers. From teaching young children positive self-talk and self-esteem to fostering socio-emotional life skills in adolescents[25], suicide prevention starts in early childhood and flows into adulthood and later life, especially as young people face suicide risk factors like bullying including cyberbullying. When children and young people struggle to manage stress and emotions, it can lead to self-harm as a coping mechanism and increase their risk of suicide. Addressing self-harm in age-appropriate ways during adolescence can help young people understand

[24] Suicide rate data is aggregated for three year rolling periods. As such the impact from the suicide prevention strategy would not be seen until 2025-27 (Y1), 2026-28 (Y2) and 2027-29 (Y3) data is released.
[25] https://www.who.int/news-room/fact-sheets/detail/suicide

and manage their emotions safely, reducing the likelihood of harmful behaviours in the future.

In the Strategy's consultation, young people themselves highlighted the importance of these conversations. The young people also communicated that they encounter these topics on social media platforms, where content can often be misinformed or dangerous. Failing to address these issues with young people leaves them alone to navigate themselves, making it even more critical for adults to provide informed, supportive discussions that foster understanding and resilience.

Quote from Youth Council member: ***"Schools could treat students a bit more like adults, as how can a young people be expected to talk about grown-up issues in an environment where they're treated like a child?"***

Another member wanted ***"interactive sessions with students about self-harm and suicide to engage them in learning how to deal and support those struggling in these situations."***

Identify

Evidence informed action
- Local surveillance
- National and regional intelligence
- Case-specific information

Prevent

Knowledge and prioritisation
- Policy and strategy review
- Suicide-informed services

Partnership working
- Improved, coordinated services
- Reducing access to method of death

Stigma reduction
- Language, education, training and engagement

Support

Individual level
- Bereaved by suicide
- Those who self-harm
- Suicidal ideation
- Suicide survivors
- Those in crisis

Population level
- Responsible media content and signposting
- Community outreach and training

Figure 4 Overview of objectives

Identify

Objective 1: We will ensure local preventative actions are evidence-informed, effective, timely and responsive to local need. This will be achieved by:

- Conducting an annual review of local surveillance data through the Real Time Suspected Suicide Surveillance System (RTSSS) to identify trends/patterns in both risk factors and the method/location of death.
- Incorporating insights from national and regional data and intelligence, including Office of National Statistics reports and information shared by partners, such as British Transport Police.
- Improving our understanding of the local picture of self-harm and attempted suicide using the RTSSS, working with partners and local engagement.
- Identifying those bereaved by suicide through the RTSSS to improve pathways for people bereaved by suicide.
- Gathering qualitative information through multi-agency reviews performed upon notification of a suspected suicide led by Public Health or partner agencies, to generate actionable recommendations for both short- and long-term improvements.

> The **Real Time Suspected Suicide Surveillance System** (RTSSS) gives an early opportunity to understand local trends in suspected suicide before Coronial inquest has occurred, and supports timely intervention for people who have been bereaved or affected by suicide; providing links to effective postvention support.

Prevent

Objective 2: We will ensure knowledge and prioritisation of suicide prevention will be strengthened across the system. This will be achieved by:

- Reviewing relevant Council, NHS and partners' policies, strategies, and service provision from a suicide prevention perspective.
- Embedding and/or strengthening appropriate action for suicide prevention to take into account nationally identified priority groups, local priority groups, and known suicide risk factors.
- Educating healthcare professionals about high-risk medications, raising awareness among parents and carers about the safe custody of medications and improving monitoring of children and young people prescribed antidepressants. The support of effective medicine choice and management should take into account suicide risk.
- Ensuring named leads responsible for Council and NHS policies, strategies and service provision provide updates of improvements to the Suicide Prevention Steering Group.
- Encouraging the adoption of learning from multi-agency reviews to inform ongoing suicide prevention efforts for services and partners.
- Increasing uptake of suicide prevention training and mental health first aid among Council and NHS frontline workforces, and commissioned services' workforces.
- Promoting training to other local employers, as per the 2023 National Suicide Prevention Strategy.

Objective 3: We *will strengthen partnership working at sub-regional, London-wide and national levels. This will be achieved through:*

- Facilitating joined up working across organisations to improve service delivery to residents.

- Implementing evidence-based preventative measures, such as reducing access to means and method of suicide (e.g. modifying public places and effective medicines management of high-risk medications, such as antidepressants, hypnotics and anxiolytics and controlled drugs, in collaboration with patients, carers and medical colleagues as appropriate).
- Working with regional partners to address multi-borough and borough-specific suicide prevention priorities, coordinating strategies and policies across agencies.

Objective 4: We will work to reduce stigma surrounding suicide and bereavement by suicide. This will be achieved by:

- Collaborating with Council services, the NHS and voluntary and community sector partners to tackle stigma surrounding mental ill health and suicide, focusing on inequality.
- Providing information, education and training on suicide prevention for the local workforce, including those who are self-employed.
- Providing information and increasing awareness of suicide prevention efforts and resources among local communities and residents, including through public awareness campaigns and events.

Support

Objective 5: We will strengthen, coordinate and ensure equitable access to support key groups across the system, including:

- Individuals bereaved by suicide
- Individuals who engage in self-harm
- Staff of anchor institutions whose work exposes them to the effect of suicide (e.g. those responding to deaths by suicide or impacted by the loss of someone who died by suicide)
- Individuals who express suicidal ideation, including at A&E
- Individuals who are experiencing a mental health crisis
- Individuals who have survived attempted suicide
- Priority groups (both national and local) listed in Figure 3

Objective 6: We will ensure early intervention and tailored support for those with common risk factors at a population level. We will do this by:

- Collaborating to ensure responsible media content to reduce harm, improve support and signposting (both digital and physical), and promote helpful messages about suicide and self-harm.
- Making promotion of information more accessible to address both digital exclusion and cultural differences.
- Targeting training to organisations and community groups work with at-risk populations and priority groups.
- Supporting voluntary, community and social enterprise organisations in accessing government funding for these efforts.
- Collaborating with partners to identify and implement strategies to reduce waiting times, prevent premature discharges and provide targeted support for individuals awaiting services.

Governance

Suicide Prevention Steering Group

A steering group with representatives from the Council, the NHS, Safeguarding (adults and children), mental health charities, and people with lived experience will ensure progress against the action plan by:

- monitoring the action plan performance
- updating the action plan in response to learning from surveillance data and emerging national initiatives
- producing an annual report

The Suicide Prevention Steering Group will be responsible to the Havering Place Based Partnership and the Havering Health and Wellbeing Board, and accountable to the Council's Cabinet (Figure 5).

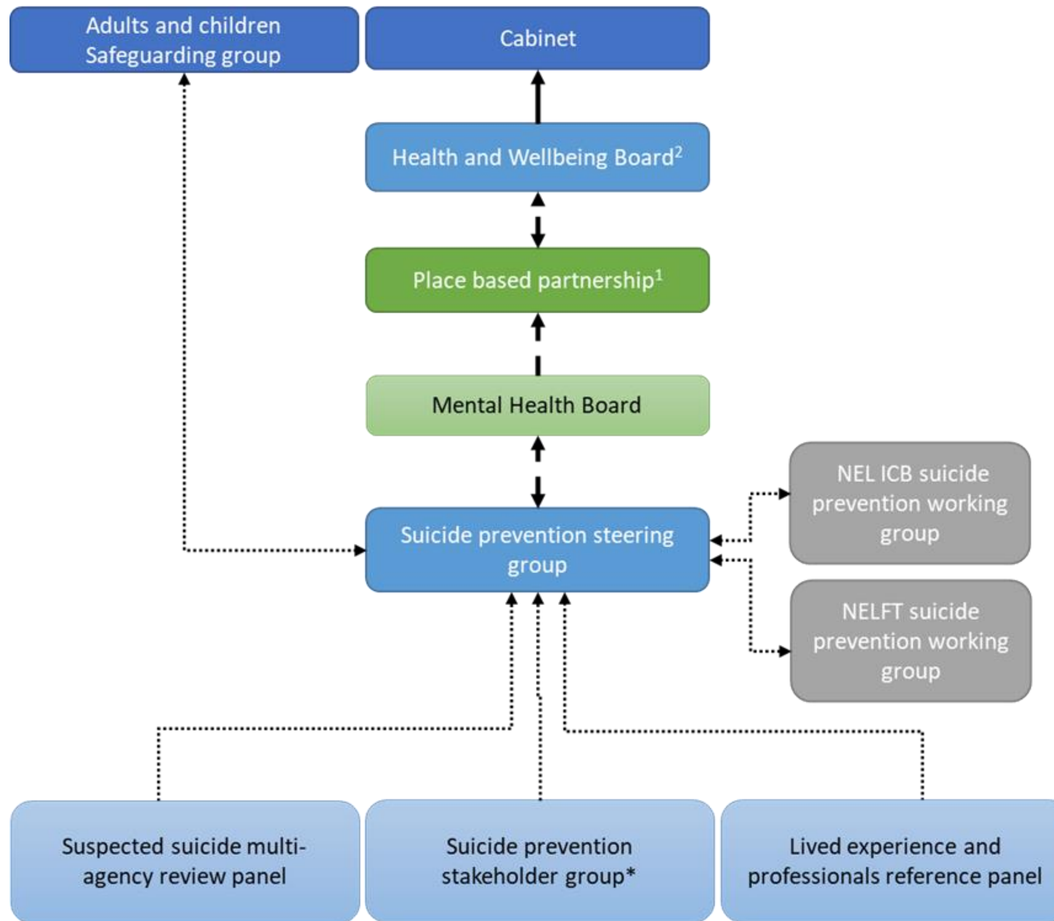

Figure 5 Proposed accountability structure for the Public Health led Suicide Prevention Steering Group. *Solid arrows indicate accountability, dashed arrows indicate responsibility and dotted arrows indicate sharing of information between groups.* [1]*Responsible for implementation.*[2]*Adoption of strategy. *Locally based stakeholders include those working in areas affecting the wider determinants of health that are known to be associated with increased risk of death by suicide. See Appendix 1*: High-level action plan, developed by organisations/representatives of the Havering Suicide Prevention Stakeholder Group.

High-Level Action	Actions

Identify those at increased risk and applying the most effective evidence-based interventions for our local population and setting	1.a Public Health will establish a systematic review panel and protocol, defining clear roles, responsibilities and meeting frequency.
	1.b Public Health and relevant partners will conduct comprehensive reviews of suspected suicides in Havering. From these, the panel will produce case-specific recommendations and lessons learned to develop a comprehensive understanding of the context and potential preventive measures.
	1.c Public Health will engage with MET Police colleagues and THRIVE London colleagues annually to review the suicide prevention panel and to improve data sharing.
	1.d Public Health will produce an Annual Suicide Prevention Report (ASPR), incorporating both epidemiology and gathered recommendations from suicide panel reviews, and findings from any relevant SARs and progress for the suicide prevention action plan.
	1.e Public Health will update and maintain mapping exercise to identify key strategies, policies, work areas and commissioned services to strengthen suicide prevention efforts.
	1.f All stakeholders will conduct thorough review of existing policies, strategies and service provision to ensure that suicide prevention is included.
	1.g Public Health will collaborate with relevant stakeholders to investigate and address gaps in referral pathways throughout services and organisations.
	1.h Children and Young People's Emotional Wellbeing and Mental Health Strategy will be developed, and to include young adults who are care experienced (up to age 25) in transition to adults services.
	1.i Safeguarding Team will conduct a retrospective exercise to consolidate findings and recommendations from past reviews of suicides. Then, Public Health will review the information extracted and consider how to disseminate findings.
Prevention activities across the system including increasing knowledge and reducing stigma	2.a From suicide review panel, immediate preventive measures will be implemented based on review findings, engaging with local authorities and stakeholders to enhance safety in high-risk and/or public areas.
	2.b Partners will promote Havering's Suicide Prevention Training Directory.
	2.c Public Health will work with PCN Leads to increase uptake of suicide prevention training among primary care staff.
	2.d Partners will promote suicide prevention training for community members that support people who have an increased risk of suicide or self-harm, or that provide support to people around distressing life events.
	2.e Public Health will investigate integrating suicide prevention into Community Engagement work (Health Champions).
	2.f Public Health will develop and improve approach to increase training uptake in Havering, including consulting with other Boroughs and NEL Training Hub.
	2.g As part of a Health in All Policies approach, Council services will integrate suicide prevention measures into the Council workforce by providing internal suicide prevention training and incorporating these measures into new or existing Council policies, for example, creating a staff guidance/protocol following a death of a service user by suicide.
	2.h Public Health will maintain up-to-date, brief resource that clearly directs individuals to self-harm and suicide prevention services, covering early intervention, prevention and postvention services.
	2.i Havering Communications and Public Health will develop a digital (QR code) and printable signposting guide for suicide risk factors, distributing it digitally to key partners and across the Borough, including libraries/community hubs, council services, places of worship, and incorporating the QR code on relevant Council materials.

	2.j Public Health will maintain and update suicide prevention council webpage.
	2.k Public Health will develop a communications and engagement plan to amplify national campaigns locally, coordinate activities for World Suicide Prevention Day and World Mental Health Day, and deliver an annual webinar on World Suicide Prevention Day. This plan will include involvement of people with lived experience.
Support at both individual and population levels, including those at risk of suicide and the bereaved	3.a Relevant services will recognise and put in place measures to support the specific needs of at risk and/or vulnerable groups in need of additional support.
	3.b Anchor organisations (e.g., the NHS, schools, police, fire service) will ensure that frontline staff receive sustained and evaluated support for dealing with the impact of suicide in their profession.
	3.c Public Health will form a reference group comprised of selected professionals and individuals with lived experience ("Expert by Experience") to provide feedback on various actions as part of the Havering Suicide Prevention Strategy such as reviewing an input into documents published by the suicide prevention public health team, leveraging existing connections with established groups, and amplifying the voice of those with lived experience.

for a complete list of stakeholder groups.

Informed by those with lived experience

We will ensure to continue incorporating the voices, perspectives and insights of people with lived experience, including people with experience of suicidal ideation, those who have made previous suicide attempts, and people who are bereaved by suicide. They will inform the planning, design and decisions at all levels of suicide prevention activity.

Glossary

Age-adjusted	Age adjustment enables meaningful comparisons to be made between two populations that vary in age structure.
Allistic	A person not affected by autism.
Consultation	A consultation for the public is a process by which members of the public are asked for input on public issues.
Domestic homicide review	A Domestic Homicide Review (DHR) is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves.
EqHIA	The Equality and Health Impact Assessment (EqHIA) is a legal requirement under the Equality Act 2010 and aims to improve the work of the council by making sure it does not discriminate in providing services and employment and that it does all it can to promote equality and good relations for the community and various socio-demographic groups that are typically underrepresented.
ICB	Integrated Care Board; an NHS organisation responsible for planning health services for their local population.
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and those who are part of the community
Major Conditions	Major conditions refer to the main causes of ill-health that contribute to disease in England, specifically: cancers, cardiovascular diseases (including stroke and diabetes), chronic respiratory diseases, dementia, mental ill health and musculoskeletal disorders.
Needs assessment	A needs assessment is a systematic approach to understanding the needs of a population. It can identify the unmet health and healthcare needs of a population, and what changes are required to meet those unmet needs.
NELFT	North East London Foundation Trust; NELFT provides an extensive range of integrated community and mental health services for people living in the London boroughs of Barking & Dagenham, Havering, Redbridge and Waltham Forest and community health services for people living in the south west Essex areas of Basildon, Brentwood and Thurrock.
Neurodiversity	Neurodiversity describes the idea that people experience and interact with the world around them in many different ways; there is no one “right” way of thinking, learning, and behaving, and differences are not viewed as deficits. The word neurodiversity refers to the diversity of all people, but it is often used in the context of autism spectrum disorder (ASD), as well as other neurological or developmental conditions such as ADHD.
Office of National Statistics (ONS) data	The ONS main responsibilities are collecting, analysing and disseminating statistics about the UK's economy, society and population. ONS produce a range of economic, social and population statistics that are published in over 600 releases a year.
Primary Care Network (PCN)	A primary care network is a structure which brings general practitioners together on an area basis, along with other clinicians.
QR code	A QR code is a machine-readable code consisting of an array of black and white squares, typically used for storing

	URLs or other information for reading by the camera on a smartphone.
Real-time suspected suicide surveillance system (RTSSS)	The RTSSS provides more up-to-date data on suicides locally compared to ONS data which has time lags of approx. 12-18 months to be published because of the time taken to complete an inquest; with the caveat that the suicide is only suspected and has not been confirmed as the cause of death by a coroner. RTSSS data Includes suspected suicides of any Havering resident including those where the suicide took place outside of the borough, it does not include suspected suicides by people who are not Havering residents even when the suicide occurs in the borough. The RTSSS provides the following data the individual's name, demographics, place of suicide, method, circumstances, warning signs, mental health issues however information on risk factors including finances, employment and family circumstances can often be less complete. The RTSSS was developed by Thrive LDN and utilises data on suspected suicides collected by the Metropolitan Police, the British Transport Police (BTP) and the City of London Police. Our level of surveillance will focus on the London Borough of Havering however; we work closely with the North-East London (NEL) suicide prevention working group who we expect to focus on surveillance across all seven NEL boroughs.
Severe Mental Illness (SMI)	Examples include psychosis and paranoid schizophrenia.
Sub-regional	Sub-regional refers to the subdivision of a region.
Suicidal ideation	Suicidal ideation, or suicidal thoughts, is the thought process of having ideas, or ruminations, with taking one’s own life.

Appendices

Appendix 1: High-level action plan, developed by organisations/representatives of the Havering Suicide Prevention Stakeholder Group.

High-Level Action	Actions
Identify those at increased risk and applying the most effective evidence-based interventions for our local population and setting	1.a Public Health will establish a systematic review panel and protocol, defining clear roles, responsibilities and meeting frequency.
	1.b Public Health and relevant partners will conduct comprehensive reviews of suspected suicides in Havering. From these, the panel will produce case-specific recommendations and lessons learned to develop a comprehensive understanding of the context and potential preventive measures.
	1.c Public Health will engage with MET Police colleagues and THRIVE London colleagues annually to review the suicide prevention panel and to improve data sharing.
	1.d Public Health will produce an Annual Suicide Prevention Report (ASPR), incorporating both epidemiology and gathered recommendations from suicide panel reviews, and findings from any relevant SARs and progress for the suicide prevention action plan.
	1.e Public Health will update and maintain mapping exercise to identify key strategies, policies, work areas and commissioned services to strengthen suicide prevention efforts.
	1.f All stakeholders will conduct thorough review of existing policies, strategies and service provision to ensure that suicide prevention is included.
	1.g Public Health will collaborate with relevant stakeholders to investigate and address gaps in referral pathways throughout services and organisations.
	1.h Children and Young People's Emotional Wellbeing and Mental Health Strategy will be developed, and to include young adults who are care experienced (up to age 25) in transition to adults services.
	1.i Safeguarding Team will conduct a retrospective exercise to consolidate findings and recommendations from past reviews of suicides. Then, Public Health will review the information extracted and consider how to disseminate findings.
Prevention activities across the system including increasing knowledge and reducing stigma	2.a From suicide review panel, immediate preventive measures will be implemented based on review findings, engaging with local authorities and stakeholders to enhance safety in high-risk and/or public areas.
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	2.c Public Health will work with PCN Leads to increase uptake of suicide prevention training among primary care staff.
	2.d Partners will promote suicide prevention training for community members that support people who have an increased risk of suicide or self-harm, or that provide support to people around distressing life events.
	2.e Public Health will investigate integrating suicide prevention into Community Engagement work (Health Champions).
	2.f Public Health will develop and improve approach to increase training uptake in Havering, including consulting with other Boroughs and NEL Training Hub.
	2.g As part of a Health in All Policies approach, Council services will integrate suicide prevention measures into the Council workforce by providing internal suicide prevention training and incorporating these measures into new or existing Council policies, for example, creating a staff guidance/protocol following a death of a service user by suicide.

	2.h Public Health will maintain up-to-date, brief resource that clearly directs individuals to self-harm and suicide prevention services, covering early intervention, prevention and postvention services.
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Support at both individual and population levels, including those at risk of suicide and the bereaved	3.a Relevant services will recognise and put in place measures to support the specific needs of at risk and/or vulnerable groups in need of additional support.
	3.b Anchor organisations (e.g., the NHS, schools, police, fire service) will ensure that frontline staff receive sustained and evaluated support for dealing with the impact of suicide in their profession.
	3.c Public Health will form a reference group comprised of selected professionals and individuals with lived experience ("Expert by Experience") to provide feedback on various actions as part of the Havering Suicide Prevention Strategy such as reviewing an input into documents published by the suicide prevention public health team, leveraging existing connections with established groups, and amplifying the voice of those with lived experience.

Appendix 1 Main sources of evidence used as key references for this strategy in gathering evidence for identifying risk factors and vulnerabilities.

Source documentation	Link
Havering All Age Autism Strategy	All age autism strategy Final 140722 002.pdf (havering.gov.uk)
Havering Substance Misuse Strategy	Havering Combating Substance Misuse Strategy
Havering Homelessness Strategy 2020-25	Havering Council Prevention of Homelessness and Rough Sleeping Strategy 2020 - 2025
Havering Community Safety Partnership Plan 2022-25	Appendix 1- HCSP Partnership Plan 2022- 25 V3.pdf (havering.gov.uk)
Gambling Policy 2020-23	App 1 Statement of Gambling Policy 2019-2022 Draft for Consultation.pdf (havering.gov.uk)
Supported Housing Strategy 2022-25	Supported Housing Strategy.pdf (havering.gov.uk)
Havering Housing Services Domestic Abuse Policy	Housing Domestic Abuse Policy (havering.gov.uk)
Adult social care support planning policy	Adult Social Care Support Planning Policy (havering.gov.uk)
Local suicide prevention planning: a practice resource	PHE_LA_Guidance_25_Nov.pdf (publishing.service.gov.uk)
National Suicide prevention in England: 5-year cross-sector strategy	Suicide prevention in England: 5-year cross-sector strategy - GOV.UK (www.gov.uk)
The NHS Long Term Plan	NHS Long Term Plan

The five year forward view for mental health	[The Five Year Forward View for Mental Health (england.nhs.uk)]
National Institute for Health and Care Excellence (NICE) Guidelines	[Overview | Suicide prevention | Quality standards | NICE]

NB: The above is not an exhaustive list and additional resources to cross cutting-issues and key documents the suicide prevention strategy were included in a Map of Suicide Priority Groups and Risk Factors as part of the suicide prevention needs assessment.

Appendix 3: Member organisations/representatives of the Havering Suicide Prevention Stakeholder Group, 2023-24.

LBH Public Health	BHRUT
LBH Elected member for Health and Wellbeing	Healthwatch
London Fire Brigade	Community Connectors
Mind	Local area coordinators
Samaritans	Health champions
Havering Carer's hub	Jobcentre plus / DWP
LBH Community Safety	LBH Housing
NELFT	LBH Adult Social Care
Metropolitan Police	LBH Children's Services
NHS NEL ICB	CAMHS
GP Representative	LBH Early Help
LBH Communications	LBH Education
People with lived experience / "Experts by Experience"	Safeguarding Adults Board
LBH CTax & Benefits, Exchequer & Transactional Services	LGBTQ+ forum / LGBTQ freelance trainer
Peabody	LBH Planning
Havering Integrated Team	Network Rail
Imago	ELFT
Community hubs	CGL
NEL Training Hub	LBH Workplace Health
PSHE Network	LBH Communities
Street pastors	LBH Social work
Town centres Manage	Havering Compact
Age UK	