Havering
LONDON BOROUGH

Suicide Prevention Needs Assessment

November 2024

Content warning: The content of this needs assessment may be emotionally challenging as it discusses suicidality and self-harm.

Support is available:

- Samaritans – a listening service which is open 24/7 for anyone who needs to talk.
- Campaign Against Living Miserably (CALM) - CALM's confidential helpline and live chat are open from 5pm to midnight every day.
- Shout – a free confidential 24/7 text service offering support if you're in crisis and need immediate help.

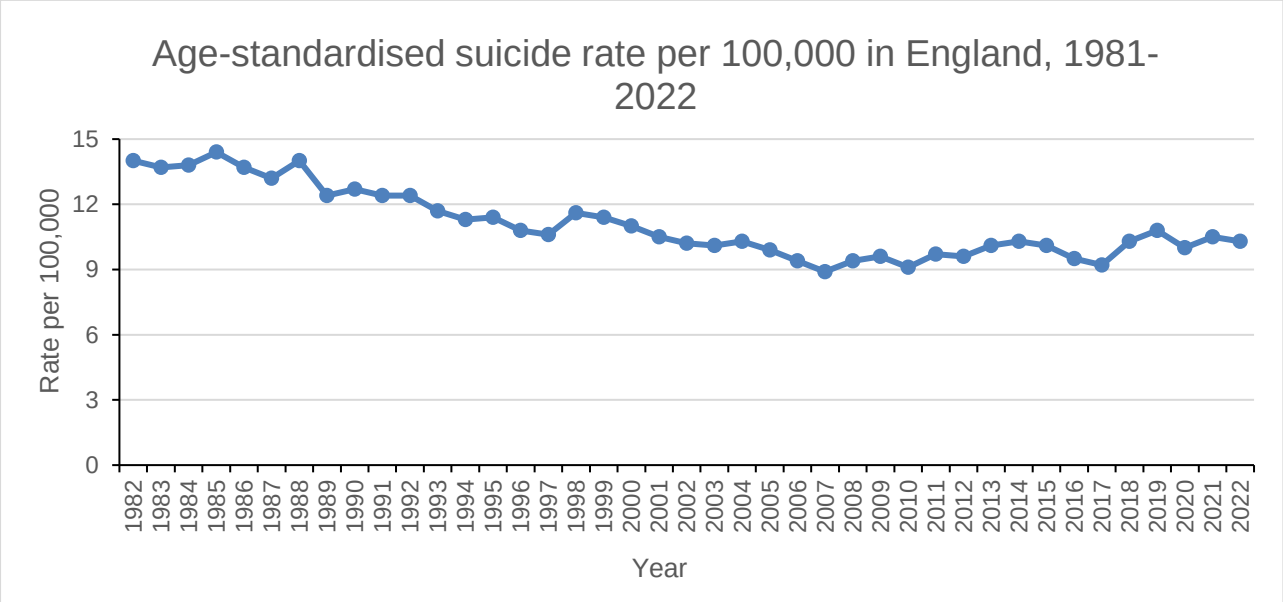
1. Introduction

1.1 Every suicide is preventable

Every suicide is a tragedy that leaves long-lasting effects on loved ones, colleagues, witnesses and frontline responders. For every suicide, individuals who are bereaved often experience suicidal thoughts or attempts themselves because of the loss[1]. The risk of suicide is unequally distributed throughout the population. Many different sociodemographic factors correspond risk of death by suicide, and inequalities unequally distributed throughout the population. Many different sociodemographic factors correspond to risk of death by suicide, and with people living in the most disadvantaged communities facing the highest risk of dying by suicide[2].

While death by suicide is a significant contributor to years of life lost amongst the population, suicides are not inevitable. Public health interventions aimed at limiting access to means and improving care for at-risk individuals have contributed to a decline in national suicide rates since the 1980s (See Figure 1)[3] and suicides are not inevitable. Suicidal incidents are complex and involve many factors, showing the need for a system-wide approach to prevention that involves services, communities, individuals and society as a whole.

Figure 1. Age-standardised suicide rate per 100,000 in England, 1981-2022.



Source: Office for National Statistics (ONS), 2022

[1] McDonnell, S., Flynn, S., Shaw, J., Smith, S., McGale, B., & Hunt, I. M. (2022). Suicide bereavement in the UK: Descriptive findings from a national survey. *Suicide & life-threatening behavior*, *52*(5), 887–897. https://doi.org/10.1111/sltb.12874

[2] Samaritans. *Inequality and suicide*. Retrieved from https://www.samaritans.org

[3] Office for Health Improvement and Disparities (OHID). *Fingertips data: Suicide rates per 100,000 in England compared to London & Havering*.

1.2 Policy Context

National Context

Since April 2019, all local authorities in England have implemented suicide prevention strategies aligned with the National Suicide Prevention Strategy (recently refreshed Suicide Prevention Strategy for England: 2023 to 2028)[4]. Supported by a £57 million investment in suicide prevention through the NHS Long Term Plan[5], these strategies ensure every local area has multi-agency suicide prevention plans in place. Moving forward, these plans must be tailored to tailored the specific demographics of the populations they serve, including considerations of ethnicity, age, gender identity and sexuality to meet local needs, and responsive to changes over time.

Havering Context

In 2018, a suicide prevention strategy was agreed upon between the London Boroughs of Barking and Dagenham, Havering, and Redbridge (BHR), along with the local NHS, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) and North-East London NHS Foundation Trust (NELFT). The BHR Suicide Prevention Strategy[6] was due to be refreshed in 2022, but then each borough developed separate strategies. Havering's refresh was delayed by the pandemic, leading to an extension of the 2018-2022 strategy to cover 2023 at the time of writing this document.

Havering Public Health coordinates the *Havering Suicide Prevention Stakeholder Group* with members including:

- Havering Council
- MET Police
- National Rail
- BHRUT
- VCS – Samaritans, Mind, Safe Connections
- NELFT
- ELFT
- PCN (Primary Care Network) leads, GPs and other medical professionals
- Individuals with lived experience

1.3 Purpose and Process

The Suicide Prevention Needs Assessment's informs the development of the Havering Suicide Prevention Strategy for 2025-2030. The Needs Assessment serves to identify at-risk populations, analyse suicide prevalence and provide recommendations for action. Key sources of information include the Office for National Statistics, the Office for Health Improvement and Disparities (OHID), the Northeast London Suicide Prevention Dashboard and the Primary Care Mortality Database (PCMD). Appendix A includes further details on interpreting suicide data and methodologies.

[4] Department of Health and Social Care. (2023). *Suicide prevention strategy for England 2023-28*.
[5] National Health Service. (2019). *The NHS Long Term Plan*.
[6] Barking and Dagenham, Havering, and Redbridge Councils. 2018, *Suicide prevention strategy*.

1.4 Who is at risk and why?

There is no single reason cause for why people take their own lives. A complex mix of social, cultural, psychological and economic factors interact to increase an individual's level of risk (Figure 1: Multiple factors that have been linked to an increase risk of suicide**. Examples of SMI include psychosis and paranoid schizophrenia. NB: Each of the factors can be experienced along with any of the others listed.**). Often, these risk factors intersect, and some have a direct causal link to others; for example, loss of employment leads to debt and financial problems.

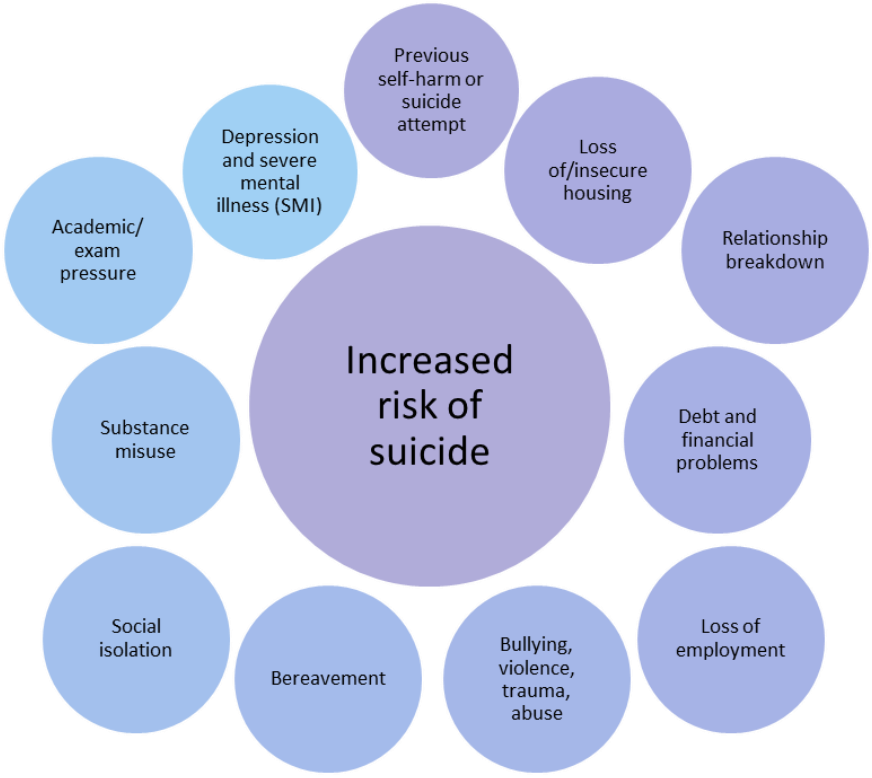


Figure 1: Multiple factors that have been linked to an increase risk of suicide[7]***. Examples of SMI include psychosis and paranoid schizophrenia. NB: Each of the factors can be experienced along with any of the others listed.***

1.5 The impact of suicide

For every death by suicide, on average 135 people are impacted, meaning that nearly 900,000 people a year are affected by suicide across the UK per year[8].	People bereaved by the sudden death of a friend or family members are 65% more likely to attempt suicide if the deceased died by suicide than if they died by natural causes[9].

[7] Centers for Disease Control and Prevention. *Risk and protective factors*. Retrieved November 29, 2024, from https://www.cdc.gov/suicide/risk-factors/index.htm

[8] Samaritans. *The economic cost of suicide in the UK*. Retrieved from https://www.samaritans.org

[9] University College London. (2016). 1 in 10 suicide attempt risk among friends and relatives of people who die by suicide. Retrieved from https://www.ucl.ac.uk/news/2016/jan/1-10-suicide-attempt-risk-among-friends-and-relatives-people-who-die-suicide

The death of a patient by suicide has an effect on the personal and professional life of health professionals, affecting recruitment, retention, quality of professional life and patient care[10]. 	One death by suicide cost at average £1.46 million to society. Employment productivity losses account for one third of all suicide costs in 2022 in England, reaching £2.48 billion[8]. 

1.6 Inequalities

Inequalities exist in the distribution of risk factors associated with suicide. The impact of suicide cannot be discussed without acknowledging that national and international trends reveal that inequalities exist in the distribution of risk factors associated with suicide, for example:

- **Age**
    - Suicide affects individuals across all age groups, with certain age-related risk factors warranting particular attention.
    - In Havering, the highest suicide rates between 2013 and 2023 were among middle-aged people, specifically those aged 40-49 years and 50-59 years. This trend aligns with national data for England and Wales.
    - While the overall number of suicides among younger populations is comparatively lower, recent years have seen a relative increase in suicide rates nationally[11].
    - Given these trends, both middle-aged people and children and young people have been identified as priority groups for suicide prevention efforts, 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[12]. Disabled men are three times more likely to die by suicide than non-disabled men[12].
    - 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 non-autistic individuals[13].

- **Gender identity and sexual orientation**
    - Men are on average twice as likely to die by suicide than women.
    - Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and those who are part of the community (LGBTQ+) are at a higher risk of death by suicide compared to those who do not identify as LGBTQ+[14].
- **Ethnicity**

[10] Royal College of Psychiatrists. *College report CR229: Self-harm and suicide*. Retrieved from https://www.rcpsych.ac.uk
[11] Office for National Statistics (ONS), 2022
[12] Disability Rights UK. Disabled people far more likely to die by suicide than non-disabled people. Retrieved from https://www.disabilityrightsuk.org
[13] Autistica. *Understanding suicide in autism*. Retrieved from https://www.autistica.org.uk/our-research/research-projects/understanding-suicide-in-autism
[14]Marchi, M., Arcolin, E., Fiore, G., Travascio, A., Uberti, D., Amaddeo, F., Converti, M., Fiorillo, A., Mirandola, M., Pinna, F., Ventriglio, A., Galeazzi, G. M., & Italian Working Group on LGBTIQ Mental Health (2022). Self-harm and suicidality among LGBTIQ people: a systematic review and meta-analysis. *International review of psychiatry (Abingdon, England)*, *34*(3-4), 240–256.

    - Although there is not enough data to give a full picture of suicide rates between ethnic groups, racism and discrimination can have significant impact on wellbeing and suicide risk[15].
- **Religion or Faith**
    - 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 (5.14 per 100,000 males and 2.15 per 100,000 females).[16]
    - The rates of suicide were highest in the Buddhist group (26.58 per 100,000 males and 31.05 per 100,000 females) and religions classified as "Other" (33.19 per 100,000 males and 28.95 to 38.06 females).
    - 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 is still the leading cause of direct (pregnancy-related) death in the year after pregnancy.
    - 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.
    - A recent confidential enquiry reported that improvements in care might have made a difference in outcome for 67% of women who died by suicide[17].
- **Deprivation**
    - People living in the least advantaged areas have a 10 times higher risk of suicide than those living in the most advantaged areas.
    - 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 as a result of lack of engagement with services that offer support to prevent death by suicide.

[15] Samaritans. *Ethnicity and suicide*. Retrieved from https://www.samaritans.org/about-samaritans/research-policy/ethnicity-and-suicide/
[16] 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
[17] MBRRACE-UK, Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020-22. Retrieved from https://www.npeu.ox.ac.uk/mbrrace-uk/reports/maternal-reports

2. Key Findings

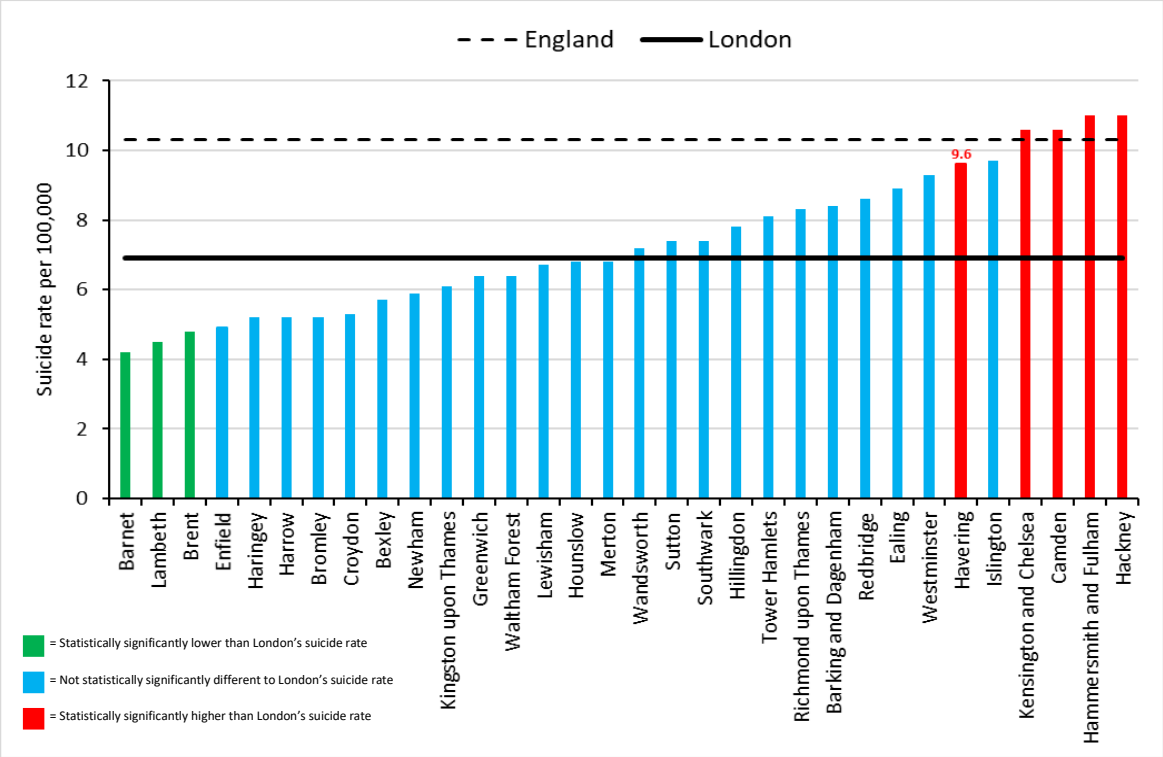
This section presents data on suicide prevalence, sociodemographics, methods and risk factors in Havering, contextualised with national data. While national data shows higher suicide risk among certain population groups, local data is insufficient to identify these differences due to small sample sizes. Consequently, local data for specific risk groups is presented where available. For more detail on high-risk groups, see Appendix B. Appendix C compares risk factors for suicide in Havering versus England.

2.1 Suicide Prevalence

Between 2015 and 2022, 139 lives were lost to suicide an additional 230 attempted suicides were registered among Havering residents[18]. Three-year rolling averages are used to detail the rate of suicide to ensure reliable rates can be produced and visibility of trends improved, and is especially useful when data can exhibit large changes in proportions owing to relatively small absolute numbers of occurrences each year. The average rate of suicide between 2020 and 2022 was 9.6 per 100,000 population [95%CI:7.4 – 12.3]. This is statistically significantly higher than the London rate of 6.9 deaths by suicide per 100,000 population [95%CI:6.6 – 7.3] and not different as the England rate of 10.3 per 100,000 [95%CI: 10.2 – 10.5][15]. Havering is now among one of the few boroughs with a notably higher age-adjusted suicide rate[4].

Figure 3. Three-year aggregate age-standardised suicide rates in London boroughs, London and England, 2020-2022.

[18] NEL Suicide Prevention Data Dashboard

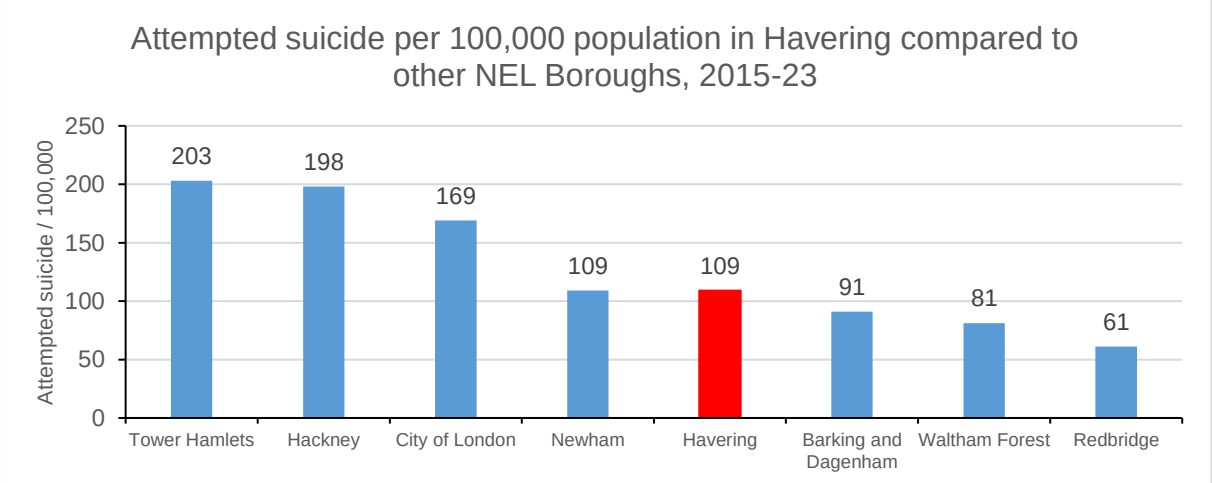


Source: Office for National Statistics (ONS), 2022. **Error! Bookmark not defined.**

2.2 Attempted Suicide

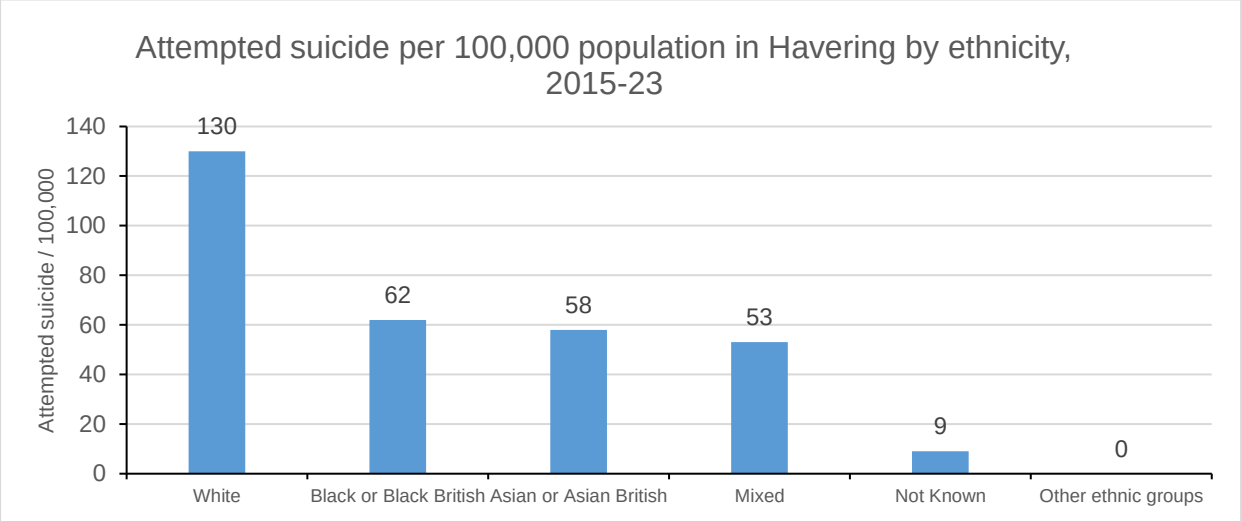
From 2015 to 2023, Havering reported an overall attempted suicide rate of 109 per 100,000, higher than neighbouring NEL boroughs (Barking & Dagenham, Redbridge and Waltham Forest). In Havering, the attempted suicide rate per 100,000 population between 2015 and 2023 was highest in the White population (130 per 100,000), the 13-19 age group (174 per 100,000) and 20-34 age group (217 per 100,000). Males accounted for 75% of attempted suicides and females accounted for 25% of attempted suicides from 2015 to 2023.

Figure 4. Attempted suicide per 100,000 population in Havering compared to other NEL Boroughs, 2015-23.



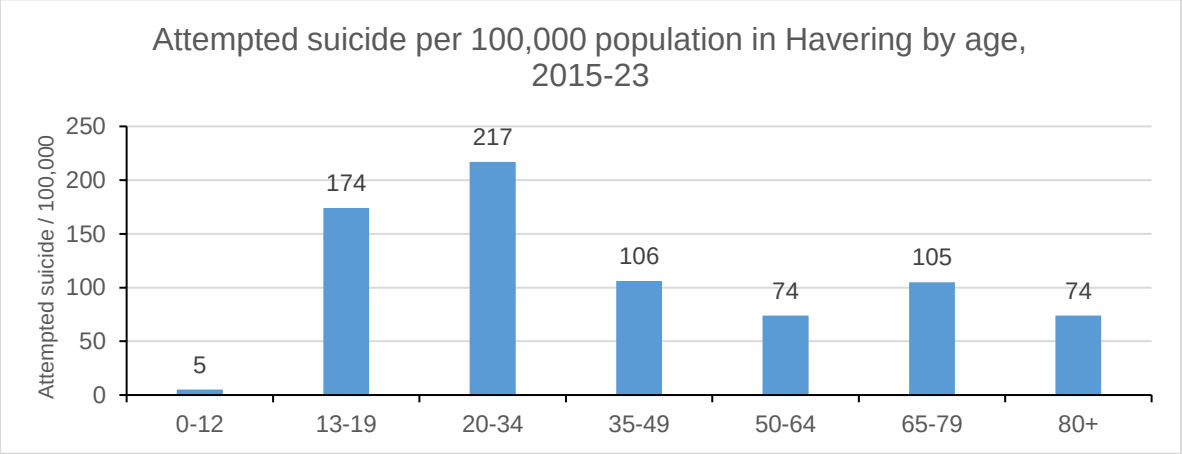
Source: Primary Care Discovery Data Service from the Suicide Prevention NEL Data Dashboard, 2015-23. N.B. This data may not always reflect the actual date of the event, as it might correspond to the date of the encounter with the GP. The primary care observation uses SNOMED code 82313006 – Suicide attempt (event).

Figure 5. Attempted suicide per 100,000 population in Havering by ethnicity, 2015-23.



Source: Primary Care Discovery Data Service from the Suicide Prevention NEL Data Dashboard, 2015-23. N.B. This data may not always reflect the actual date of the event, as it might correspond to the date of the encounter with the GP. The primary care observation uses SNOMED code 82313006 – Suicide attempt (event).

Figure 6. Attempted suicide per 100,000 population in Havering by age, 2015-23.



Source: Primary Care Discovery Data Service from the Suicide Prevention NEL Data Dashboard, 2015-23. N.B. This data may not always reflect the actual date of the event, as it might correspond to the date of the encounter with the GP. The primary care observation uses SNOMED code 82313006 – Suicide attempt (event).

2.3 Prevalence by demographic

Suicide rate by gender

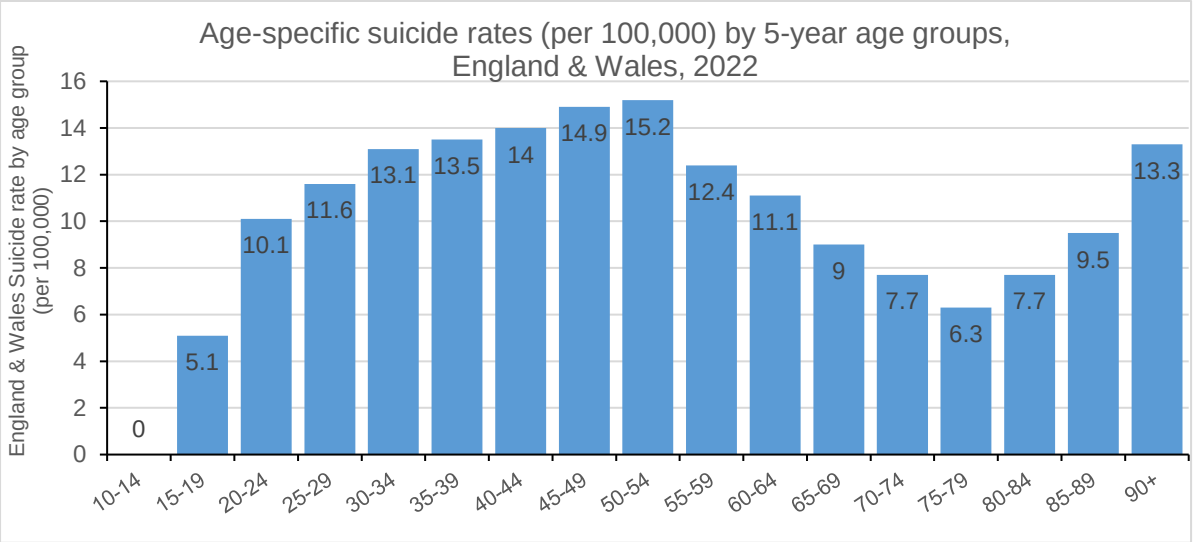
From 2015-16 to 2021-22, the average death by suicide by gender was 73.92% males and 26.08% females. This is similar to the England and Wales data, as three-quarters of suicides registered in England and Wales in 2022 were males (74.1%), equivalent to 16.4 deaths per 100,000[4].

Suicide rate by age

Between 2013 and 2023, Havering recorded the highest suicide rates seen among people aged 40-49 years and 50-59 years. This aligns with national data (England & Wales) where the highest suicide rates were among people aged 50 to 54 years in 2022, with those 45 to

49 as the second-highest age band[Error! Bookmark not defined.]. Males aged 45 to 64 have had the highest rate since 2010, with a rate of 20.4 per 100,000 in 2022[Error! Bookmark not defined.]. Suicide rates in Havering between 2013 and 2023 in younger age groups (18-29 years and 30-39 years) were lower than the national average[Error! Bookmark not defined.].

Figure 7. Age-specific suicide rates (per 100,000) by five-year age groups, England & Wales, 2022.



Source: Office for National Statistics (ONS), 2022[Error! Bookmark not defined.]

Suicide rates by occupation

A report by the ONS analysed suicide deaths in England from 2011 to 2015, focusing on differences across occupations[19]. Refer to Appendix D for the methodology and data description regarding suicide by occupation. Key findings included:

- Males employed in the lowest-skilled occupations faced a 44% higher risk of suicide compared to the male national average; the elevated risk among males in skilled trades was 35%.
- The risk of suicide among low-skilled male labourers, particularly those working in construction roles, was 3 times higher than the male national average.
- For males working in skilled trades, the highest risk was among building finishing trades; particularly, plasterers and painters and decorators had more than double the risk of suicide than the male national average, agricultural workers 1.7 times higher.
- The risk of suicide was elevated for those in culture, media and sport occupations for males (20% higher than the male average) and females (69% higher); risk was highest among those working in artistic, literary and media occupations.
- For females, the risk of suicide among health professionals was 24% higher than the female national average; this is largely explained by high suicide risk among female nurses.
- Male and female carers had a risk of suicide that was almost twice the national average.
- Females within the teaching and education profession had a lower risk of suicide but specifically for primary and nursery school teachers there was evidence of an elevated risk.
- Managers, directors and senior officials – the highest paid occupation group – had the lowest suicide risk.

[19] Office for National Statistics *Suicide by occupation, England*. Retrieved from https://www.ons.gov.uk

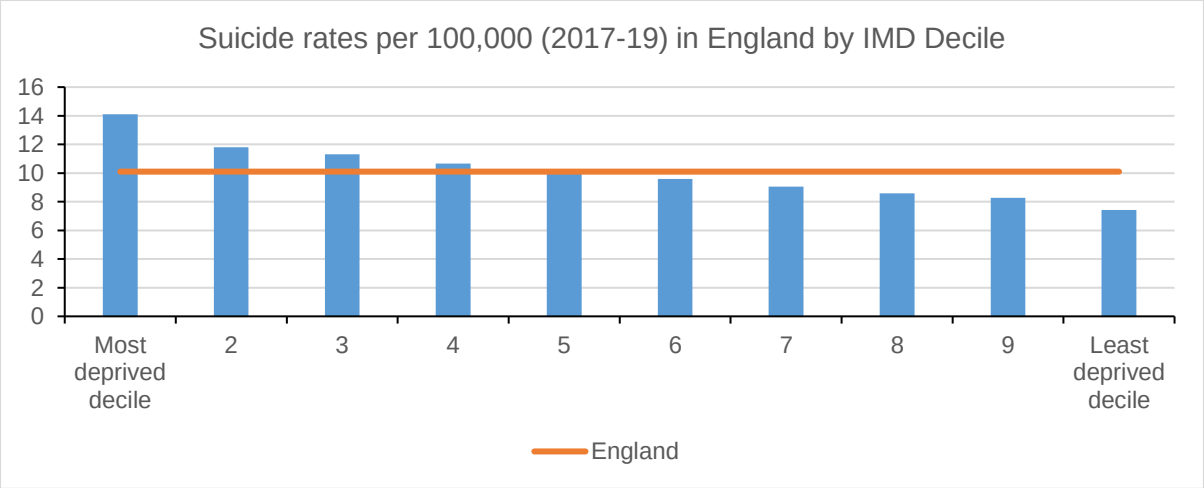
Suicide rates by ethnicity

A population level analysis compared the risk of dying by suicide across sociodemographic groups in adults in England and Wales[20]. It found that for ethnicity, rates of suicide were highest in the White and Mixed/Multiple ethnic groups for both men and women. Estimated rates of suicide were highest in the White (men: 21.03 per 100,000 people [95% CI: 20.56 to 21.51], women: 6.79 per 100,000 people [95% CI: 6.53 to 7.05]) and Mixed/Multiple ethnic groups (men: 23.56 per 100,000 people [95% CI: 21.32 to 26.04], women: 9.57 per 100,000 people [95% CI: 8.27 to 11.08])[20].

Suicide rates by deprivation

In Havering, the highest suicide rates were observed in the second most deprived quintile, while the lowest rates were in the least deprived quintile. This patterns contrasts with the national trend, which generally follows a social gradient for suicide rates: the more deprived the area, the higher the suicide rates. Across England, individuals living in the most deprived areas face a higher risk of suicide than those living in the least deprived areas. The suicide rate in the most deprived 10% of areas ('decile') in 2017-2019 was 14.1 per 100,000, nearly double the rate of 7.4 in the least deprived decile[21].

Figure 8. Suicide rates per 100,000 (2017-19) in England by IMD Decile (IMD 2019).



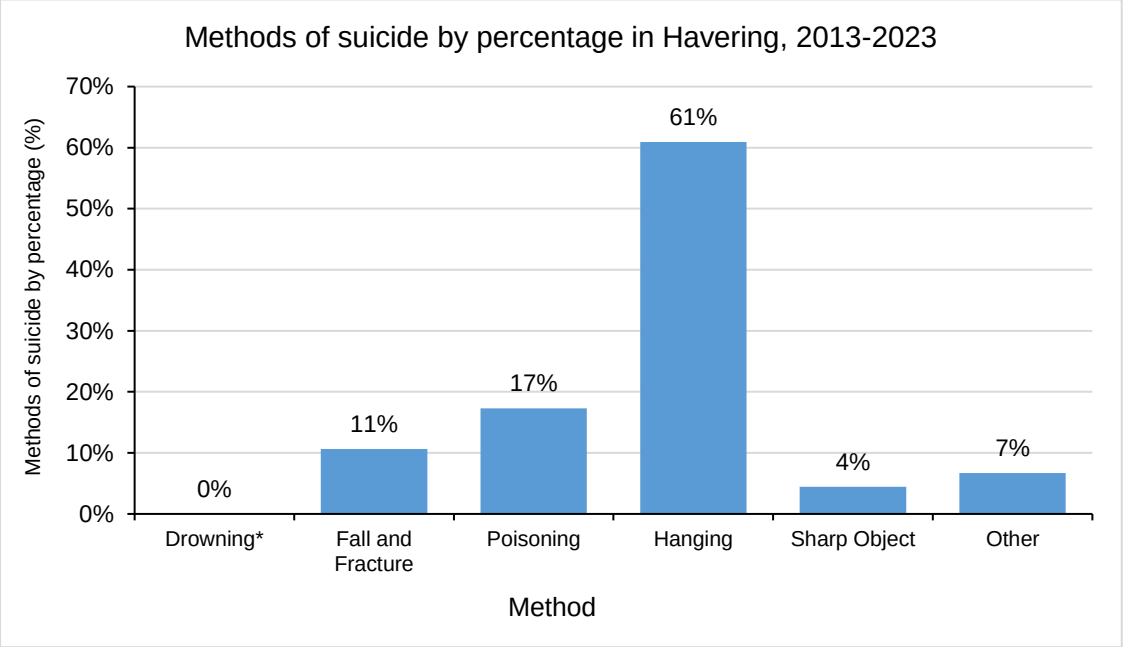
Source: OHID Fingertips Rates of suicide by deprivation decile in England, 2017-19.[22]

2.4 Prevalence of suicide by method

The most common method of suicide in Havering was hanging, accounting for 61% of all suicides from 2013 to 2023 (109 out of 180 registered deaths in this period, according to the PCMD). This is also the most common method of suicide in England and Wales for both males and females in 2022**Error! Bookmark not defined.**. The second most common method was poisoning, which accounted for 17% of all suicides (31 out of 180 deaths). This also mirrors England and Wales, as the second most common method continued to be poisoning and accounted for 19.9% of all suicides in 2022 (1,123 out of 5,642 deaths)**Error! Bookmark not defined.**. See Figure 10 below for more detailed method data.

[20] Office for National Statistics. *Sociodemographic inequalities in suicides in England and Wales*. Retrieved from https://www.ons.gov.uk
[21] Office for Health Improvement and Disparities (OHID). *Fingertips data: Rates of suicide by deprivation decile in England*.
[22] Office for Health Improvement and Disparities (OHID).*Rates of suicide by deprivation decile in England, 2017-19*.

Figure 10. Methods of suicide by percentage in Havering, 2013-2023.



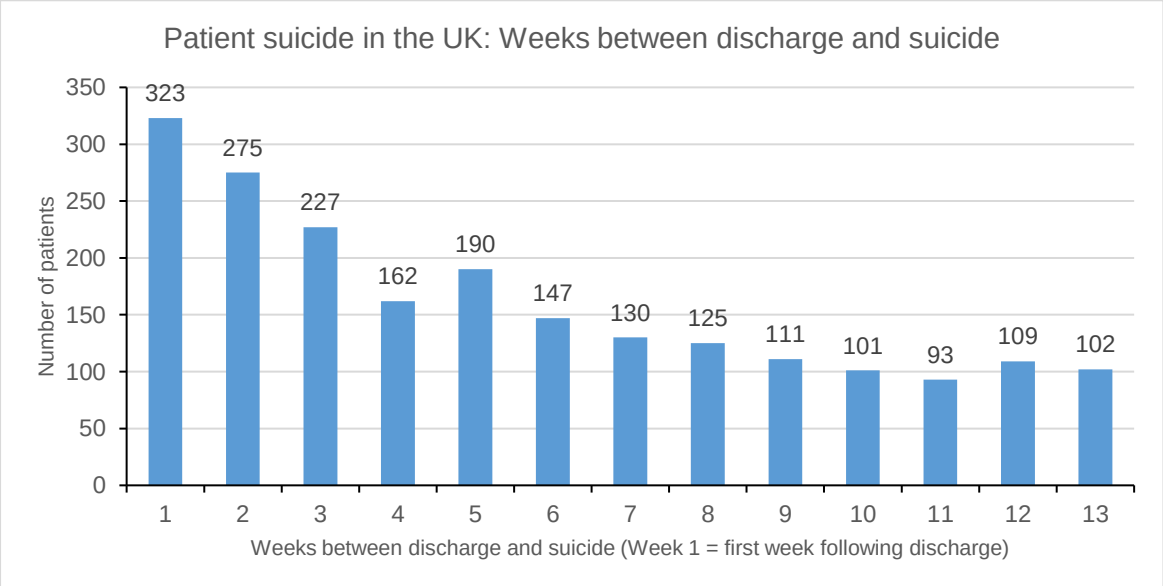
Source: PCMD. Produced by LBH PHI team. N.B. Data on suicides by drowning is suppressed due to the small number of cases (four or fewer) to prevent identification of individuals.

2.4 Prevalence by risk groups

Suicide among people in contact with mental health services

There were 18,403 suicide deaths by patients (i.e. people in contact with mental health services within 12 months of suicide) in the UK in 2010-2020, 27% of all general population suicides, an average of 1,673 deaths per year[23]. Post-discharge deaths by suicide were the most frequent in the first 1-2 weeks after leaving the hospital, see below.

Figure 11. Patient suicide in the UK: Weeks between discharge and suicide (Week 1 = first week following discharge, 2010-20.[10]



Source: National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), 2023 Annual Report.[20]

[23] Manchester University. *Understanding suicide in the UK*. Retrieved from https://www.manchester.ac.uk

Suicide among people who have self-harmed

Self-harm is defined as 'Any act of self-poisoning or self-injury carried out by an individual irrespective of motivation' and there is strong evidence that the risk of suicide among those who have self-harmed is much greater than that of the general population, as is the risk of premature death[24]. Almost half of the general population and over half of the young people who die by suicide have previously harmed themselves. The risk of suicide is elevated by between 30 and 100-fold in the year following an episode of self-harm, compared to the general population[24].

Between 2018 and 2023, Havering had an overall A&E self-harm rate of 834 per 100,000, lower than all other NEL boroughs except for city of London, which had a rate of 607 per 100,000[25]. In Havering, the highest self-harm rates per 100,000 population between 2015 and 2023 were highest in the Other Ethnic Groups population (1,467 per 100,000), the 13-19 age group (2,953 per 100,000) the 20-34 age group (1,424 per 100,000), and among females, who represented 60% of self-harm A&E attendances. The A&E self-harm percentage for Havering residents was 61% in females and 39% in males[25].

Suicide among people diagnosed with severe health conditions

A diagnosis or first treatment for certain severe health conditions is associated with an elevated suicide rate when compared with similar socio-demographic characteristics (age, sex, ethnicity, religion, deprivation and region of residence)[26]. For example, one year after being diagnosed with COPD, the suicide rate for patients was 23.6 deaths per 100,000 people. This is 2.4 times higher than the suicide rate for the matched controls at 9.7 deaths per 100,000 people[23]. Similarly, one year after diagnosis for chronic ischemic heart conditions, the suicide rate for patients was 16.4 deaths per 100,000 people, nearly double the rate for the matched controls, which was 8.6 deaths per 100,000[23].

Suicide among people diagnosed with Autism

Despite comprising only about 1% of the population, autistic individuals account for 11% of suicides, making it the second-leading cause of death within this community[27]. Autistic adults with no learning disability are nine times more likely to die by suicide than the general population. Autistic women are also at twice the risk of death from suicide[28]. The average life expectancy for autistic people is just 54 years old[29]. Autistic people are at higher risk of mental health challenges, as research indicates that 70% of autistic individuals have one mental health disorder (such as anxiety or depression), and 40% have at least two mental health problems**Error! Reference source not found.**.

Suicide among those in the LGBTQ+ community

Lesbian, gay and bisexual individuals are more than twice as likely than straight peers to experience suicidal thoughts or engage in self-harming behaviours[30]. Experiences of

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[24] Royal College of Psychiatrists. *College report CR229: Self-harm and suicide*. Retrieved from https://www.rcpsych.ac.uk
[25] North East London Suicide Prevention. (2018-2023). *Suicide prevention NEL data dashboard*.
[26] Office for National Statistics. *Suicides among people diagnosed with severe health conditions, England: 2017 to 2020*.
[27] Government Events. High suicide rates among neurodiverse individuals: Why it matters and what can be done about it.
[28] Cassidy S, Au-Yueng S, Robertson A, et al. Autism and autistic traits in those died by suicide in England. *The British Journal of Psychiatry.* 2022:221(5):683-691.
[29] T., Mittendorfer-Rutz, E., Boman, M., Larsson, H., Lichtenstein, P., & Bölte, S. (2016). Premature mortality in autism spectrum disorder. *The British journal of psychiatry : the journal of mental science*, *208*(3), 232–238.
[30] Kidd, G., Marston, L., Nazareth, I. *et al.* Suicidal thoughts, suicide attempt and non-suicidal self-harm amongst lesbian, gay and bisexual adults compared with heterosexual adults: analysis of data from two nationally representative English household surveys. *Soc Psychiatry Psychiatr Epidemiol* **59**, 273–283 (2024)

discrimination and bullying may play a role in increasing the risk of suicidality. Furthermore, a survey with lesbian, gay, bisexual and trans people across the England, Scotland and Wales[31] found that,

- One in eight LGBT young adults aged 18-24 (13%) reported surviving a suicide attempt in the past year.
- 46% of trans individuals and 31% of LGBT individuals who do not identify as trans have contemplated suicide in the last year.
- Almost half of LGBT young adults aged 18-24 (48%) reported self-harming in the past year. Additionally, 41% of non-binary individuals, 20% of LGBT women and 12% of LGBT men reported self-harming, compared to only 6% of adults in the general population.

Suicide among women in the perinatal period

There is an increase in suicide rates among women in the perinatal period in the UK and Ireland[32]. In 2020, 28 women died by suicide during pregnancy or within a year after pregnancy, a rate of 3.84 per 100,000 maternities[29]. The median age of these women was 30, with the majority (86%) being from white ethnic groups and 82% being UK or Irish citizens. Although pregnancy is usually considered a protective factor against death by suicide, there has been a statistically significant increase in the rate of suicide during pregnancy and up to six weeks postpartum in the UK, when comparing 2017-19 to 2020[329].

Suicide among those in contact with the criminal justice system

Individuals in prison in England and Wales are significantly more likely to die by suicide than those in the general population[33]. Over the last decade, the suicide rate in prisons in England and Wales has increased by over a third, making suicide the second leading cause of death in prisons.

This heightened risk continues post-release, with men being eight times more likely and women 36 times more likely to die by suicide within the first year after release compared to the general population. Additionally, people in prison are more likely to experience suicidal thoughts compared to the general population[33]**Error! Bookmark not defined.**.

2.6 Suicide prevention training uptake in Havering

The uptake of suicide prevention training courses in Havering was the lowest across the 7 NEL boroughs (Figure 13). According to the NEL Training Hub, the number of places taken up by Havering residents was 97 in April 2021/2022. This number more than doubled to 211 in April 2022/2023. This trend has continued into April 2023/2024, with 123 places already filled. As the current year progresses, more places are expected to fill, especially as the capacity of the NEL training hub grows. As a result, we anticipate that the uptake in 2023-24 will approach or surpass last year's figures.

[31] Stonewall. (2018). *LGBT in Britain - Health*.
[32] Confidential Enquiry into Maternal Deaths. *Unlocking the evidence: Understanding suicide in prisons*.
[33] Public Health England. *Local authority guidance on suicide prevention*. Retrieved from https://publishing.service.gov.uk

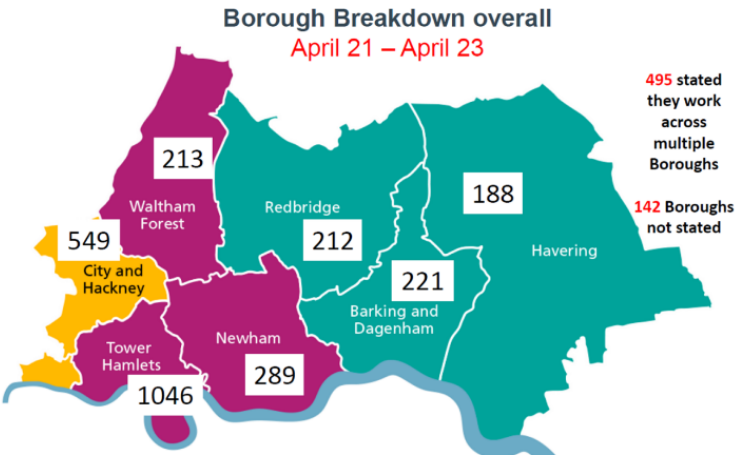

Figure 2: ***Uptake of NEL Training Hub suicide prevention training courses by NEL borough from April 2021-April 2023*** *Source: North East London Training Hub: Multi-Agency Mental Health & Suicide Prevention Training 2021-April 2023.*

3. NEL ICS Level

Northeast London (NEL) Integrated Care System (ICS) Level

Operating at the NEL level, the Suicide Prevention ICB working group collaborates with partners including:

- Public Health Suicide Prevention leads from the 7 NEL boroughs
- NELFT
- ELFT
- Network Rail
- Mind
- Safe Connections & Grief in Pieces
- Samaritans
- GP Care Group

The key priorities in the new Havering Suicide Prevention Strategy, aligned with the National Suicide Prevention Strategy, are outlined as follows:

1. Improving data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.
2. Tailored, targeted support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.
3. Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.

4. Promoting online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.
5. Providing effective crisis support across sectors for those who reach crisis point.
6. Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.
7. Providing effective bereavement support to those affected by suicide.
8. Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

The Suicide Prevention Stakeholder Group, launched in July 2023, provides input on the Havering Suicide Prevention Needs Assessment and the Suicide Prevention Strategy and Action Plan. Their efforts aim to raise awareness of suicide prevention, promote relevant services and training and enhance collaboration among partners to strengthen suicide prevention initiatives. See Table I below for member organisations.

Table I: Member organisations of the Havering Suicide Prevention Stakeholder Group, 2024

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

Further details on the actions and the responsibilities at different geographical footprints i.e. borough, ICS and London level are in the Havering Suicide Prevention Strategy and Action Plan.

4. Recommendations

4.1 Adopt and implement a local all-age suicide prevention strategy to ensure best use of local data, intelligence and partnership working

4.2 Promoting suicide prevention across Havering

The council should continue to collaborate with stakeholders, to address the intersecting factors that lead to suicide and provide comprehensive support for at-risk individuals. This includes the Public Health Suicide Prevention team to contribute to the development of the Adult Mental Health Needs Assessment. By continuing to work closely and develop an action plan with stakeholders (healthcare workers, community organisations, council services, etc.), the council can promote a coordinated approach to suicide prevention.

4.3 Review each death by suspected suicide amongst Havering residents

The "Local Suicide planning: a practical resource[34]" from Public Health England (PHE) in partnership with the National Suicide Prevention Alliance recommends a local suicide audit for local implementation of the national strategy. Therefore, Having Council should ensure that each death by suspected suicide is reviewed regarding possible lessons learned and areas of improvement to prevent future deaths by suicide. Such review processes provide detailed insights into individual cases, methods used and interactions with services, each year. This data can help identify cohorts of local people who are at risk of suicide as well as

[34] Public Health England. (2020). *Local suicide prevention planning: A practice resource*. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/939479/PHE_LA_Guidance_25_Nov.pdf

changes in the proportion of methods of death to indicate any particular preventative actions to be taken.

Completing a local suicide audit can help to identify inequalities by understanding the Havering-specific factors contributing to suicide within different demographic groups, such as socioeconomic status.

4.4 Continue to work with partners across the North East London Region and more widely (London and National)

Recognising a person's life experience is rarely contained in a single Local Authority geopolitical footprint, the need to work collaboratively with colleagues in suicide prevention efforts is crucial. In particular the response to potential clusters of deaths by suicide, when Havering residents die by suicide outside of the borough and when residents of other areas die by suicide within Havering (for example on our transport network). The need to be share an awareness and align, where appropriate, our response and processes should be continually considered along with shared learning that may help to improve the effectiveness of our work locally.

Contact Person

Public Health: publichealth@havering.gov.uk

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Appendices

Appendix A: Important considerations for interpreting suicide data, Office for National Statistics (ONS) Methodology

The Office for National Statistics (ONS) publishes national data on deaths registered as suicides during that year, not deaths occurring in each calendar year. Because of the time taken to complete an inquest, it can take months, sometimes years, for a suicide to be registered. ONS data describes the date a death was registered, as opposed to the date of death. Because of the length of time of coroners' inquests, only a proportion of deaths registered in a given year would have occurred in the same year.

For example, for England and Wales, 56% of suicides registered in 2017 also occurred in 2017; most remaining suicides (41%) occurred in 2016. In England and Wales, data on suicide concern all deaths that were assigned underlying cause of intentional self-harm (for those aged 10 years and above). Also included are those deaths cause by injury or poisoning of undetermined intent (for those aged 15 years and above), based on the assumption that the majority will be suicide.

ONS figures used for England, region and local authority describe postcode of residence (not place of death). The suicide rate is an age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (aggregated populations for the three years) in people aged 10+. ONS reported counts are totals for the three-year period (January 2020 to December 2022).

Data from the Primary care mortality (PCMD) database has been used to examine deaths recorded as suicides, with the data broken down by age group, method of suicide, and deprivation decile. Comparing suicide rates by age group between Havering and national data presents challenges due to differences in age band categorisation between the PCMD and ONS data.

Appendix B: Comprehensive Overview of High-Risk Groups for Suicide Risk Factors

Vulnerable and at risk groups	Take home message
Middle aged men[35]	• Men aged 40-54 have the highest suicide rates in the UK. • Key risk factors for middle-aged men include unemployment, living in deprived areas, substance misuse, mental health conditions, social isolation, and economic instability. • Men are less likely to seek or complete therapy compared to women.
People who self-harm[36]	• Self-harm greatly increases suicide risk, particularly in the year following an episode (30-100x higher risk than the general population). • Nearly half of those who die by suicide have a history of self-harm.
Children and Young People (CYP) [37]	• There are rising suicide rates in under-20s, especially among girls. • Risk factors for CYP include significant personal losses, bullying, and undiagnosed neurodevelopmental conditions (e.g., autism). • Over one-third of CYP who die by suicide were not in contact with mental health services.
People with Severe Mental Illness (SMI) [38] [39]	• 50% of suicide cases had a diagnosed mental health condition, with schizophrenia and bipolar disorder associated with significantly elevated risk. • The suicide rate is 25 times higher in mood disorders.

[35] Appleby, L., Kapur, N., Turnbull, P., Rodway, C., Graney, J. and Tham, S.G., 2021. Suicide in middle-aged men.
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Vulnerable and at risk groups	Take home message
Substance misuse including alcohol[40] [41]	• 22% of drug-related deaths receive a conclusion of suicide or undetermined intent at coroner's inquest, and this is likely an underestimate. • People who are dependent on alcohol are approximately 2.5 times more likely to die by suicide than the general population. • In England, 45% of all patients under the care of mental health services who die by suicide have a history of alcohol misuse.
LGBTQ+ [42] [43] [44]	• LGBT+ young people are twice as likely to contemplate suicide than non-LGBT+ young people, and Black LGBT+ young people are three times more likely. • 13% of people identifying as LGBTQ+ aged 18-24 have attempted to take their own life in the last year; almost half of trans people have thought about taking their own life in the last year. • 14% of people identifying as LGBTQ+ have avoided treatment for fear of discrimination because they're part of the LGBTQ+ community.
Women in the perinatal period[45] [17]	• Perinatal suicidality is considered one of the leading causes of maternal mortality in the first 12 months postpartum. • Perinatal suicide occurs mainly through more violent methods compared to suicide in non-pregnant women and at a higher rate among women with a previous or current mental illness.
Those not belonging to faith groups [46] [47]	• Religion generally lowers suicide risk, though stigma can deter help-seeking. • The highest rates of deaths by suicide are among Buddhist and "Other" religious groups.
Gypsy, Roma & Traveller (GRT) communities [48] [49]	• Travellers experience a 6.6 times higher suicide rate when compared with non-Travellers, accounting for approximately 11% of all Traveller deaths. • When disaggregated by gender and age, this rate was 7 times higher for men and most common in young Traveller men aged 15-25 and 5 times higher for Traveller women than in the general population. • GRT populations are rarely recognised in local or national suicide prevention plans.
Those bereaved or impacted by suicide [50]	• Around 38% of bereaved individuals reported suicidal thoughts, with 8% attempting suicide, often within a year of the loss. • The most common relationships to the deceased in those who reported a suicide attempt were parent (23%); friend (22%); spouse/partner (19%); sibling (13%); and child (11%).

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Vulnerable and at risk groups	Take home message
People who have attempted suicide [51] [52]	• A prior suicide attempt is the single most important risk factor for suicide in the general population. • Long-term studies of mortality among those with previous suicide attempts have found that between 2% and 13% have died by suicide after 20–37 years after the first suicide attempt.
Those subjected to DV [53] [54] and those in relationship breakdown [55]	• Among survivors of abuse, 24% reported suicidal ideation, particularly in cases of prolonged or multiple abuse forms. • Women experiencing intimate partner violence showed a strong dose-response relationship with suicidality. • One in five deaths by suicide is related to problems with current or former intimate partners, such as divorce, separation, romantic breakups, conflicts and intimate partner violence.
People with LTCs and/or recently diagnosed with a life changing illness (terminal) [56]	• Cancer patients, especially those with low-survival cancers, and individuals with COPD or heart conditions face elevated suicide risks, particularly within the first year-post diagnosis.
People with history of MH issues, in contact with MH services, after discharge from hospital [57]	• During 2006-2016, 28% of deaths by suicide in the UK were by mental health patients. • For patient suicides after hospital discharge, the highest risk was in the first two weeks after discharge and the highest number of deaths occurred on day 3 post-discharge.
People in contact with criminal justice system[58]	• Suicide is the second leading cause of death in prisons. • This risk remains high even after release from prison – in England and Wales, men have been shown to be 8 times and women 36 times more likely to die by suicide than others in the community, in the first year after their release from prison. • People in prison are also more likely to have suicidal thoughts.
Specific occupational groups, such as doctors, nurses, veterinary workers, agricultural workers, police.[59]	• Males in lowest skilled occupations, labourers, construction, skilled trades were at an elevated risk of suicide. • Job-related features such as low pay and low job security increase risk. • Between 1991 and 2000, occupational mortality in England and Wales indicated that doctors, dentists, nurses, vets and agricultural workers such as farmers were at increased risk of suicide.
Looked after children/children leaving care [60] [61]	• Transition periods, such as moving from one placement to another or leaving care, can increase trauma and suicide risk. • There is increased prevalence of suicidal ideation among looked after children.

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Vulnerable and at risk groups	Take home message
People with PTSD/trauma[62]	• PTSD is associated with increased suicide rates, with individuals diagnosed with PTSD twice as likely to die by suicide than those without PTSD.
People with Adverse Childhood Experiences (ACEs) [63]	• Childhood trauma increases the risk of suicide and self-harm in children and young people. • Emotional adversities, such as parental death or separation and living in care, had an association with risk of suicide. • The presence of multiple ACEs heightens this risk even further.
Refugees and asylum seekers [64]	• Research suggests that asylum seekers are five times more likely to have mental health needs than the general population, and more than 61% will experience severe mental distress. • Data shows that they are less likely to receive support than the general population; poor mental health, PTSD, mental health conditions, economic conditions including housing and income instability, lack of support will all contribute to increased suicide risk.
People leaving the armed forces [65]	• Suicide risk was two to four times higher in male and female veterans aged under 25 years than in the same age groups in the general population.
People who live on their own [66]	• For men, both living alone and living with non-partners were associated with death by suicide, independently of loneliness, which had a modest relationship with suicide. • For women, there was no evidence that living arrangements, loneliness or emotional support were associated with death by suicide.
Individuals who visit their GP more than 24 times a year [67]	• 37% of people who died by suicide had not seen their GP in the previous year. • Risk was increased by 67% in non-attenders. • Suicide risk also increased with increasing number of GP consultations, particularly in the 2 to 3 months prior to suicide. In those who attended more than 24 times, risk was increased 12-fold.
Unpaid carers [68]	• More than 45 studies have reported suicidal thoughts and behaviours in unpaid carers; the number of carers reporting suicidal ideation varies across studies, with some estimates as high as 71% and most likely to be an underestimate. • Among those who have contemplated suicide, research suggests that 1 in 6 carers are likely to attempt suicide in the future and 1 in 10 have already attempted suicide.
Disability, including autism and other neurodevelopmental conditions and learning disabilities [12] [69]	• Disabled women are over four times more likely to die by suicide compared to non-disabled women. Disabled men are three times more likely to die by suicide than non-disabled men. • Autistic adults with no additional learning disability are over 9 times more likely (relative to a general population) to die by suicide. • Multiple studies suggest that between 30% and 50% of autistic people have considered taking their own live.

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Vulnerable and at risk groups	Take home message
	• One study found that 14% of autistic children experience suicidal thoughts compared to 0.5% of non-autistic children.
Individuals who rough sleep[70]	• Attempted suicides is up to 5.3 times higher among individuals who rough sleep compared to the general population.
Individuals financial strain [71] [72]	• Accumulated financial strain, including a debt crisis mixed with unemployment, past homelessness or lower income, significantly predicts suicide attempts and suicidal ideation. • Individuals facing multiple financial stressors show up to 20 times higher likelihood of attempted suicide compared to those without such strain. • Men in lower social classes and deprived areas face up to 10 times higher suicide risk compared to affluent counterparts.

Appendix C: Risk factors associated with an increased risk for suicide, comparing Havering rates with England.

Risk Factor	Havering rate	England rate
Alcohol-related hospital admissions (narrow): directly age standardised rate per 100,000 persons (2022/23)	334 per 100,000	475 per 100,000
Hospital admissions due to substance misuse per 100,000 in 15-24 year olds (2020/21-22/23)	171.4 per 100,000	58.3 per 100,000
Self-harm hospital admissions per 100,000 by age group 10-14 (2022/23)	90.7 per 100,000	251.2 per 100,000
Self-harm hospital admissions per 100,000 by age group 15-19 (2022/23)	203.4 per 100,000	468.2 per 100,000
Self-harm hospital admissions per 100,000 by age group 20-24 (2022/23)	180.6 per 100,000	244.4 per 100,000
Emergency hospital admissions for intentional self-harm per 100,000 (all ages) (2022/23)	66.7 per 100,000	126.3 per 100,000
Deprivation Score (IMD 2019)	16.8 per 100,000	21.7 per 100,000

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Domestic abuse related incidents and crimes recorded by the police per 100,000 (age 16+) (2021/22)	35.5 per 100,000	30.7 per 100,000
Unemployment (Percentage of the working age population claiming out of work benefit) (2022/23)	5%	5%
Long term unemployment (+ 12 months) rate per 1,000 working age population (16+) (2021/22)	1.8 per 100,000	1.9 per 100,000
Households in temporary accommodation per 1,000 estimated total households (2022/23)	8.9 per 100,000	4.2 per 100,000
Children entering the youth justice system (10-17 yrs) (2020/21)	2.6 per 100,000	2.8 per 100,000
Percentage of looked after children whose emotional wellbeing is a cause for concern aged 5-16 years (2021/22)	32%	37%
Proportion of the population (aged 18+) with GP diagnosed depression	10.85 per 100,000	12.3 per 100,000
The prevalence (%) of Severe Mental Illness (SMI) including psychosis (all ages)	0.72 per 100,000	0.95 per 100,000

Source: Office for Health Improvement and Disparities. Public health profiles. 2024.

Appendix D: Methodology and Data Description for suicide by occupation

The figures described in this bulletin include deaths registered in England between 2011 and 2015. The analysis is based on suicides registered in England between 2011 to 2015 as this represents the approach used when this analysis was previously completed.[14] This approach reduces the likelihood that sudden changes in occupational populations impact the analysis.

Of the 18,998 suicides among individuals aged 20 to 64 during this period, occupation data was approximately available for 70% (13,232) of these cases.

Suicide was defined using the National Statistics definition of suicide which includes deaths given an underlying cause of intentional self-harm or injury or poisoning of undetermined intent (ICD-10 codes: X60 to X84, Y10 to Y34). The informant reports occupation at the time of death registration. This information is coded using the Standard Occupation Classification (SOC 2010). This classification system has 4 levels of granularity, ranging from higher-level groupings (for example, those working in skilled construction and building trades) to specific occupations (for example, bricklayers and masons). The analyses were restricted to those aged 20 to 64 years. This approach improves the likely comparability between the occupation recorded at census and that at the time of death registration.[73]

It is important to note that while suicide counts by occupation are available for England and Wales from 2011-20, disparities in absolute numbers may not accurately reflect differences in suicide risk. Higher counts within specific occupations may be attributed to larger workforces rather than indicating an inherently higher risk of suicide in those fields.

[73] Patterns of suicide by occupation in England and Wales: 2001–2005