Havering
LONDON BOROUGH

Equality & Health Impact Assessment (EHIA)

Document control

Title of activity:	*Havering Suicide Prevention Strategy 2025-2030*
Lead officer:	*Isabel Grant-Funck (Public Health Strategist), Public Health Service in the People Directorate*
Approved by:	*Samantha Westrop (Assistant Director of Public Health), Public Health Service in the People Directorate*
Version Number	**V0.1**
Date and Key Changes Made	*05/12/2024*
Scheduled date for next review:	*February 2030*

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.

Question	Answer
Did you seek advice from the Corporate Policy & Legal?	No
Did you seek advice from the Public Health team?	Yes
Does the EHIA contain any confidential or exempt information that would prevent you publishing it on the Council's website? See Publishing Checklist.	No

1. Equality Health Impact Assessment Checklist

About your activity

1	**Title of activity**	*Havering Suicide Prevention Strategy 2025-2030*
2	**Type of activity**	*A refreshed strategy*
3	**Scope of activity**	*Every suicide is a tragedy that affects families and communities, and has long-lasting effects on the people left behind: families, friends, colleagues, and healthcare workers. Importantly, bereavement as a result of suicide is itself a risk factor; people bereaved by the sudden death of a friend or family member are 65% more likely to try to take their own life if the deceased died by suicide than if they died by natural causes.* *Public health measures to reduce access to means and improve care for those who are at risk of suicide have contributed to a reduction in the national suicide rate since the 1980s. Suicide is preventable and it is our collective responsibility to do all that we can to reduce deaths through suicide. To be successful, this must be through a multi-agency approach bringing together the Council, primary care and secondary care services, voluntary and community sector organisations as well as communities and individuals. A strategy that is to succeed in reducing suicide deaths needs to combine a range of integrated interventions that build wider community resilience as well as targeting groups of people at increased risk of suicide. We need to ensure that suicide prevention and mental health are everyone's business.* *The BHR strategy was extended to 2023 with approval from the health and wellbeing board, but is now out of date. The strategy covered the 3 boroughs of Havering, Barking & Dagenham, and Redbridge, and was jointly led by the three Councils, NELFT and Clinical Commissioning Groups. The BHR strategy continues to guide current actions – with some actions now being led elsewhere in the system.* *We are now working on a localised strategy redesign to cover 2025-30* *The development of a local suicide prevention strategy is recommended by government and supports the national Suicide Prevention Strategy (2012) - Preventing suicide in England: A cross government outcomes strategy to save lives. As of April 2019, all local authorities in England have had suicide prevention plans in place.* *Aims & objectives* *The overall aim of this strategy is to reduce the rate of suicide, suicidal behaviour and self-harm through the following objectives:*

<table>
<tr><td></td><td></td><td colspan="4">1. We will ensure that our local preventative actions are evidence informed so that interventions are effective, timely and responsive to local need.
2. We will ensure that knowledge and prioritisation of suicide prevention will be strengthened across the system.
3. We will strengthen partnership working at sub-regional, London and national levels.
4. We will work to reduce stigma surrounding suicide and bereavement by suicide.
5. We will work across the sector with partners at sub-regional, London and national levels to strengthen, coordinate and ensure equity and accessibility of the support offered.
6. We will ensure local provision of early intervention and tailored support at a population level to those with common risk factors.</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 colspan="2" rowspan="2">If the answer to <u>either</u> of these questions is ‘YES’ Continue to question 5.</td><td rowspan="3">If the answer to <u>all</u> of the questions (4a, 4b & 4c) is ‘NO’ 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 from different backgrounds?</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><td>Use the <u>Screening tool</u> before you answer this question.</td><td>If you answer ‘YES’ Continue to question 5.</td></tr>
<tr><td>5</td><td>If you answered YES:</td><td colspan="4">Please complete the EHIA in Section 2 of this document. Please see Appendix 1 for Guidance.</td></tr>
<tr><td>6</td><td>If you answered NO:</td><td colspan="4">N/A</td></tr>
</table>

Completed by:	*Isabel Grant-Funck (Public Health Strategist) from the Public Health Service in the People Directorate* *Samantha Westrop (Assistant Director of Public Health) from the Public Health Service in the People Directorate*
Date:	*05/12/2024*

2. The EHIA – How will the strategy, policy, plan, procedure and/or service impact on people?

Background/context:

Between 2015 and 2023, 194 lives were lost to suicide in Havering. Every suicide is a tragedy that deeply affects families and communities, leaving long-lasting impacts on loved ones, colleagues, witnesses and healthcare workers. The aftermath of a suicide often leads to affected individuals experiencing suicidal thoughts or attempts themselves due to the emotional toll of the loss. The risk of suicide is closely linked to broader inequalities, with disadvantaged communities experiencing higher rates of suicide.

Recent data from 2022, shows that the recent reduction in London-wide suicide rate has lead to the rate in Havering rate now being significantly higher than London as a whole, and outer London (9.6 per 100,000 population).

Suicide is a significant contributor to years of life lost amongst our population and deaths by suicide 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 the national suicide rate since the 1980s. Suicidal incidents typically involve various contributing factors, underscoring the need for a comprehensive, system-wide approach to prevention involving services, communities, individuals and society as a whole.

Who will be affected by the activity?

While anyone can be at risk of suicide, certain groups are at higher risk and will be prioritised in the suicide prevention strategy. The likelihood of someone dying by suicide is influenced by broader inequalities, with significant differences in suicide rates based on individuals' social and economic circumstances. For example, people living in the most deprived areas of the country are ten times more at risk of suicide than those in the most affluent areas. Factors such as experiencing homelessness, being in debt, facing unemployment or living in poverty increase the risk of poor mental health and suicide, a concern that is especially relevant during the cost of living crisis we are currently experiencing.

Several factors further increase the risk of suicide. The strongest predictor of suicide risk is a history of self-harm or previous suicide attempts. Other high-risk groups include men, young and new mothers, people in contact with the criminal justice system, individuals in the LGBTQIA+ community, teens and young adults, people with depression and severe mental illness (e.g. psychosis, paranoid schizophrenia) and those who misuse substances. Addressing the needs of these vulnerable groups is crucial for suicide prevention.

Protected Characteristic - Age: Consider the full range of age groups

If there is an impact on under 18s, how have you / will you ensure their views are gained to inform decision making?

Please tick (✓) the relevant box:		**Overall impact:**
Positive	✓	The Havering Suicide Prevention Strategy takes into account the needs of different age groups, addressing age-related vulnerabilities associated with suicide, as well as the proportional years of life lost when a younger person dies by suicide. Actions from the strategy will have a positive impact on all age groups, with one of the focuses being on preventing suicide and self-harm in children and young people, who are a national priority group due to the years of lives lost. 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.
Neutral		
Negative		

		Public Health's engagement with stakeholders working with children and young people, such as Education, the PHSE network, the Havering Youth Council, The VCS (Papyrus, Mind, Samaritans), ensures that the strategy is informed by those directly working with CYP. Recognising the role of economic factors in suicide risk, particularly among middle-aged individuals, the Strategy's Action Plan includes targeted promotion of suicide prevention services and training opportunities targeting specific services and organisations (e.g. schools/colleges, council workforce including housing, food banks, citizen's advice bureau, financial support services in community hubs, social prescribers). The Strategy commits to review new guidance and evidence-based initiatives to adapt and improve.
Evidence: 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, where the highest suicide rates in 2022 were among people aged 50 to 54 years, followed by those aged 45 to 49 years. Furthermore, national data indicates a concerning trend among younger age groups. While the overall number of suicides among younger populations is comparatively lower, recent years have seen a relative increase in suicide rates. Notably, suicide and injury or poisoning of undetermined intent remained the leading cause of death in 2017. This accounted for an increased proportion of deaths in this age group compared with the previous year, with a notable rise among females, where it accounted for 13.3% of deaths at this age, compared with 9.6% in 2016. 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.		
Sources used: Office for National Statistics (ONS), 2022		

Protected Characteristic - Disability: Consider the full range of disabilities; including physical, mental, sensory, progressive conditions and learning difficulties. Also consider neurodivergent conditions e.g. dyslexia and autism.		
Please tick (✓) the relevant box:		**Overall impact:** **Overall impact:** The Havering Suicide Prevention Strategy will be published electronically to ensure that it is fully accessible to people who are partially sighted or blind. Accessibility standards to enable assisted technology will be considered and worked towards prior to publication of the final version of the strategy. An easy read version of the strategy will also be published. Furthermore, the Strategy includes considerations for suicide prevention concerning individuals living with disabilities and long-term conditions. Public health will raise awareness of suicide prevention to services that are working with different vulnerable groups, such as the Autism Hub in Liberty Mall (provided by Sycamore Trust) and the Havering Carer's Hub, which supports carers of autistic individuals. These services will then disseminate the information we share with those they support and work with. The distribution of suicide prevention training to the Havering workforce, especially those engaging with high-risk groups (including those with learning disabilities) will improve awareness of suicide and its associated risk factors.
Positive	✓	
Neutral		
Negative		

<table>
<tr><td></td><td></td><td>Public Health will also emphasise the need for services to be tailored to individuals who are deaf, disabled or neurodivergent, based on evidence from Autistica and NSPA. This ensures that those in need of support for suicide or its risk factors are more likely to access services.

Moreover, along with the Strategy, a mapping exercise has been conducted to identify opportunities for strengthening strategies, policies, work areas, and commissioned services to incorporate suicide prevention efforts. This includes the alignment with Havering’s All Age Autism Strategy and Learning Disability Strategy.

Continuous review of new guidance will inform the consideration of additional actions to mitigate the risk of suicide among those with disabilities and long-term conditions. Those with long-term conditions (LTCs) and those living with chronic pain are also a priority group, as chronic pain and LTCs are a risk factor for suicide. The suicide prevention team will work with organisations that interact those living with chronic pain and LTCs, like St Francis Hospice, to ensure that they have up-to-date, accurate information and bereavement support.</td></tr>
<tr><td colspan="3">Evidence:
Individuals living with disabilities and long-term health conditions, such as COPD, heart conditions and cancer face an elevated risk of suicide. Research indicates that following a diagnosis or initial treatment for these conditions, the likelihood of death by suicide is notably higher compared to matched controls with similar socio-demographic characteristics (age, sex, ethnicity, religion, deprivation and region of residence).

For instance, within one year of being diagnosed with COPD, the suicide rate for patients was 2.4 times higher than that of matched controls, with 23.6 deaths per 100,000 individuals compared to 9.7 deaths per 100,000 individuals, respectively. Similarly, following a diagnosis of chronic ischemic heart conditions, the suicide rate for patients was nearly double that of matched controls, with 16.4 deaths per 100,000 individuals compared to 8.5 deaths per 100,000 individuals, respectively. A wider confidence interval for the suicide rate in the low survival cancer patients is largely because of the lower number of suicides recorded for this condition.

Additionally, autistic adults without learning disabilities are nine times more likely to die by suicide than the general population. Despite comprising approximately 1% of the population, autistic individuals account for 11% of suicides. Alarmingly, suicide is the second leading cause of death for autistics individuals, with an average life expectancy of just 54 years. Autistic women, in particular, face twice the risk of death by suicide.

Furthermore, a recent report from the Mental Health Taskforce identified autistic people as being at a higher risk of mental health issues. Research indicates that 70% of autistic individuals have at least one mental health disorder, such as anxiety or depression, and 40% have at two or more mental health disorders.

Chronic pain is a risk factor for suicide, with rates of suicidal ideation ranging from 18 to 50 percent among patients with chronic pain. A US study found that 8.8 percent of suicide deaths involved chronic pain and over half of those individuals noted pain as a factor in their suicide notes.</td></tr>
</table>

Sources used:
Autistica. Suicide and Autism. Retrieved from: https://www.autistica.org.uk/what-is-autism/suicide-and-autismand autism | Autistica

Office for National Statistics, based on mortality records linked to the 2011 Census and Hospital Episode Statistics (HES) known as the Public Health Data Asset (PHDA).

The Independent Mental Health Taskforce to the NHS in England (2016). The five year forward view for mental health.

Hirvikoski, T. et al. (2015). Premature mortality in autism spectrum disorder. The British Journal of Psychiatry, 207

Mental Defeat and Suicidality in Chronic Pain: A Prospective Analysis, Themelis, Kristy et al. The Journal of Pain, Volume 24, Issue 11, 2079 - 2092

<table>
<tr><th colspan="3">Protected Characteristic – Sex / gender: Consider both men and women</th></tr>
<tr><td colspan="2">Please tick (✓) the relevant box:</td><td rowspan="4">Overall impact:
The Havering Suicide Prevention Strategy is inclusive and beneficial all genders, with a particular focus on men due to their higher suicide prevalence. The strategy aims to raise awareness of services tailored to men, such as Havering Talking Therapies, and informal support options offered by the Voluntary and Community Sector (VCS), which some men may prefer.

Suicide risk factors for men include economic challenges and relationship breakdowns. Consequently, promoting suicide prevention training, particularly to services and organisations in contact with financially struggling men, is essential. These include the council workforce (including housing services) food banks, Citizens Advice Bureau, financial support services in community hubs and social prescribers for socially isolated men. Additionally, services that promote social cohesion such as Mentell, will be promoted to men experiencing loneliness or social isolation.

BarberTalk Live, a service commissioned by Public Health, trained six barbers in suicide prevention and will continue its funding in 2025 and 2026. This training equips them to recognize suicide-warning sides, engage in supportive conversations and confidently direct men to appropriate resources. This training will be expanded to cover other occupations across the borough that have a high proportion of men working in them.

The strategy will also be inclusive of those of all genders, which will be highlighted later in the LGBTQIA+ section.</td></tr>
<tr><td>Positive</td><td>✓</td></tr>
<tr><td>Neutral</td><td></td></tr>
<tr><td>Negative</td><td></td></tr>
<tr><td colspan="3">Evidence:

There are differences in suicide prevalence depending on gender. From 2001 to 2022, the suicide rate per 100,000 in England amongst males is consistently three times that of females. In both London and Havering, suicide rates are also higher in males compared to females. In 2020-22, the suicide rate in Havering for males was 13.9 per 100,000 people and the suicide rate in females was 5.2 per 100,000.

Data shows that almost all (91%) middle-aged men had interacted with at least one frontline service, primarily primary care services (82%). Half had engaged with mental health services, and 30% with the justice system. This challenges the notion that men do not seek help. Public Health efforts should therefore encourage services to better recognize and respond to men's needs</td></tr>
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<table>
<tr><td>through initiatives like Making Every Contact Count (MECC) and widespread suicide prevention training for frontline workers, particularly those interacting with at-risk individuals. For the minority (9%) of men not in contact with any support, several local and national third-sector initiatives aim to reach this group.</td></tr>
<tr><td>Sources used:
Office for Health Improvement and Disparities (OHID) fingertips data, 2020-2022.

NCISH Annual report 2023: UK patient and general population data 2010-2020</td></tr>
</table>

<table>
<tr><td colspan="3">Protected Characteristic – Ethnicity / race / nationalities: Consider the impact on different minority ethnic groups and nationalities</td></tr>
<tr><td colspan="2">Please tick (✓) the relevant box:</td><td rowspan="4">Overall impact:
There are notable differences in suicide prevalence across different ethnicities in Havering. While the Havering Suicide Prevention Strategy benefits all ethnicities, it does not specifically target individuals based on ethnicity.

Racism has been linked to poor mental health, social isolation and loneliness. The BAME community are more likely to be impacted by poverty, which is an economic risk factor for suicide.

The Strategy addresses the intersectionality of overlapping risk factors. For instance, an individual of mixed ethnicity and a member of the LGBTQIA+ community faces compounded suicide risks. To support ethnic groups, the Strategy will align with the national strategy and adopt a cross-sector approach to tackle different risk factors for suicide, some of which are more likely to impact the BAME community.</td></tr>
<tr><td>Positive</td><td>✓</td></tr>
<tr><td>Neutral</td><td></td></tr>
<tr><td>Negative</td><td></td></tr>
<tr><td colspan="3">Evidence:
In 2021, the ONS published data on suicide rates among different ethnic groups in England and Wales for the first time looking at 2012 to 2019, although they did not take into account confidence intervals, so no statistically significant differences were found. 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 well-being and suicide risk.</td></tr>
<tr><td colspan="3">Sources used:
Office for National Statistics (ONS), 2022
Ethnicity and suicide | Samaritans</td></tr>
</table>

<table>
<tr><td colspan="3">Protected Characteristic – Religion / faith: Consider people from different religions or beliefs, including those with no religion or belief</td></tr>
<tr><td colspan="2">Please tick (✓) the relevant box:</td><td rowspan="4">Overall impact:

The evidence on how religion/faith influences suicide risk is mixed. Being part of a religious/faith group can provide a sense of belonging and community, which may protect against suicide. However, stigmatizing beliefs within these groups (e.g., that suicide is an unforgivable sin) could deter help-seeking, thus increase suicide risk. Stigma can inhibit emotional vulnerability, further hindering help-seeking.

Public Health will engage with religious/faith groups, such as street/rail pastors, Interfaith Forum and the VCS, to promote suicide prevention services and training opportunities. Raising awareness of different vulnerable groups and promoting evidence-based approaches to improving mental health in specific groups is crucial.</td></tr>
<tr><td>Positive</td><td></td></tr>
<tr><td>Neutral</td><td>✓</td></tr>
<tr><td>Negative</td><td></td></tr>
</table>

Evidence:
The evidence of religion/faith on suicide risk varies. 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). 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). The religions which were included in the "Other" religious group included Pagan, Spiritualist, Mixed religion, Jain and Ravidassia. 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.

Sources used:
ONS sociodemographic inequalities in suicide
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.

Protected Characteristic - Sexual orientation: Consider people who are heterosexual, lesbian, gay or bisexual

Please tick (✓) the relevant box:		**Overall impact:**
Positive	✓	The Havering Suicide Prevention Strategy is inclusive of all sexual orientations and genders, recognising differences in suicide prevalence among different groups. It focuses on promoting suicide prevention services and training, particularly targeting organisations in contact with LGBTQIA+ individuals, such as schools, colleges, council workforce and sexual health clinics. Public Health will raise awareness of different vulnerable groups and the services available for these groups and promote evidence-based approaches to improving mental health in specific groups as part of the Strategy. Distributing suicide prevention training widely, especially to those working with high-risk groups will promote awareness of suicide risk factors, build confidence to discuss suicide and help recognize warning signs to assist in a crisis. LGBTQIA+ training, provided by Outhouse and TMT, is also promoted. This training equips organisations with the knowledge and skills to use inclusive language, forms and data systems, improving understanding of LGBTQIA+ issues and barriers, and their link to mental health and suicide.
Neutral		
Negative		

Evidence:
Stonewall commissioned YouGov to conduct a survey involving over 5,000 lesbian, gay, bisexual and trans (LGBTQIA+) people across England, Scotland and Wales to gain insights into their lives in Britain.[17]
The survey revealed key findings related to mental health and suicide prevention within this cohort:

- Half of LGBTQIA+ respondents (52%) reported experiencing depression in the last year. This figure was even higher among trans people (67%) and non-binary individuals (70%).
- One in eight LGBTQIA+ young adults aged 18-24 (13%) reported surviving a suicide attempt in the past year.
- Almost half of trans individuals (46%) and 31% of LGBTQIA+ individuals who do not identify as trans have contemplated suicide in the last year.
- Almost half of LGBTQIA+ young adults aged 18-24 (48%) reported self-harming in the past year. Additionally, 41% of non-binary individuals, 20% of LGBTQIA+ women and 12% of LGBTQIA+ men reported self-harming, compared to only 6% of adults in the general population.

Sources used:
Stonewall YouGov survey
https://www.stonewall.org.uk/lgbt-britain-health

<table>
<tr><td colspan="3">Protected Characteristic - Gender reassignment: Consider people who are seeking, undergoing or have received gender reassignment surgery, as well as people whose gender identity is different from their gender at birth</td></tr>
<tr><td colspan="2">Please tick (✓) the relevant box:</td><td rowspan="4">Overall impact:

The Havering Suicide Prevention Strategy’s actions will benefit those seeking, undergoing or have receive gender reassignment surgery, as well as people whose gender identity is different from their gender at birth. As mentioned above, the Strategy will work closely with LGBTQIA+ organisations through distributing suicide prevention training to organisations and also promoting specific LGBTQIA+ training, which includes gender reassignment. The steering group will also include those will lived experience from the LGBTQIA+ community, so the action plan will be reviewed and amended by the steering group to inform inclusive actions.

The London Borough of Havering is developing a suspected suicide review panel, chaired by public health, which will support our surveillance function by analysing information from the London RTSSS, as part of the Havering Suicide Prevention Strategy. Any learning from this panel should be shared with the transitions panel in the event that suspected suicide was an individual who identified as transgender.</td></tr>
<tr><td>Positive</td><td>✓</td></tr>
<tr><td>Neutral</td><td></td></tr>
<tr><td>Negative</td><td></td></tr>
<tr><td colspan="3">Evidence:
People identify as non-binary or transgender are at an increased risk of suicide and self-harm. Almost half of trans people (46 per cent) have thought about taking their own life in the last year. This is compared to one in twenty adults in the general population who reported thoughts of taking their own life in the past year and fewer than one per cent said they attempted to take their own life in the last year (according to research for NHS Digital).Forty-one per cent of non-binary people said they harmed themselves in the last year compared to 20 per cent of LGBTQIA+ women and 12 per cent of LGBTQIA+ men. This is compared to around six per cent of adults in the general population who said they had self-harmed in the last year (according to research for NHS Digital).</td></tr>
<tr><td colspan="3">Sources used:
Stonewall YouGov survey
https://www.stonewall.org.uk/lgbt-britain-health</td></tr>
</table>

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<tr><td colspan="3">Protected Characteristic – Marriage / civil partnership: Consider people in a marriage or civil partnership</td></tr>
<tr><td colspan="2">Please tick (✓) the relevant box:</td><td rowspan="4">Overall impact:
The Strategy is inclusive of people of all relationship types. For those in stable marriages or civil partnerships are likely to experience a neutral impact from the suicide prevention strategy.

However, someone going through the end of a marriage and civil partnership, or during relationship breakdown and divorce, has higher risk of death by suicide. The Strategy outlines how divorced and separated individuals exhibit a higher suicide risk.</td></tr>
<tr><td>Positive</td><td></td></tr>
<tr><td>Neutral</td><td>✓</td></tr>
<tr><td>Negative</td><td></td></tr>
<tr><td colspan="3">Evidence: One study using data from the Marriage and Family Therapy Practice Research Network (MFT-PRN) examined suicidal risk and relationship satisfaction in couples undergoing therapy. Among 27 same-sex couples, a quarter exhibited suicidal risk at the first session. However, no direct association was found between suicidal risk and relationship satisfaction or changes over time.

Suicidal risk comes in with divorce, as multiple studies have identified a link between divorce and suicide risk, though the gender-related differences within this remain unclear. While some</td></tr>
</table>

research suggests an increased risk for men following relationship breakdown, further studies are needed to compare suicide risk and gender in this context.

Sources used:

Morgan, P. C., Love, H. A., Hunt, Q. A., & King, S. (2025). Dyadic Associations of Suicidal Risk Predicting Relationship Satisfaction in a Clinical Sample. *Journal of marital and family therapy*, *51*(1), e12757. https://doi.org/10.1111/jmft.12757

Evans, R., Scourfield, J., & Moore, G. (2016). Gender, Relationship Breakdown, and Suicide Risk: A Review of Research in Western Countries. *Journal of Family Issues*, *37*(16), 2239-2264. https://doi.org/10.1177/0192513X14562608

Protected Characteristic - Pregnancy, maternity and paternity: Consider those who are pregnant and those who are taking maternity or paternity leave

Please tick (✓) the relevant box:		**Overall impact:**
Positive	✓	The Havering Suicide Prevention Strategy aims to address the needs of pregnant and postpartum women by promoting suicide prevention services and training opportunities, particularly targeting services/organisations with women during the perinatal period (e.g. GPs, midwives, council workforce incl. housing, health visitors). Public Health will also raise awareness of different vulnerable groups and the services available for women in the perinatal period e.g. Mums Matter (perinatal support provided by Mind).
Neutral		
Negative		

Evidence:

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. Assessors felt that improvements in care might have made a difference in outcome for 67% of women who died by suicide.

Sources used:

MBRRACE-UK published their latest 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"

Socio-economic status: Consider those who are from low income or financially excluded backgrounds

Please tick (✓) the relevant box:		**Overall impact:**
Positive	✓	The Havering Suicide Prevention Strategy will promote targeting services/organisations in contact with people in financial difficulties (e.g. Council workforce incl. housing, food banks, citizen's advice bureau, DWP / Job Centres, community hubs financial support services and debt advice, housing associations). Public Health will raise awareness of different vulnerable groups and the services available for people in financial difficulties such as Harold Hill Community Hub and promote evidence-based approaches to improving mental health in specific groups e.g. alternative crisis support through housing team.
Neutral		
Negative		

Evidence:

Suicide is complex and is rarely caused by one thing. However, there is strong evidence of associations between financial difficulties, mental health and suicide. Struggling to make ends meet can lead to feelings of anxiety and shame. These feelings can themselves affect our motivation and ability to manage our money, and some people may experience a sense of entrapment or loss of control. All of these feelings are associated with suicide. Not everyone will experience these stressors equally, with those already in lower income households or with pre-existing mental health conditions likely to be among those worst impacted. More specifically, we know that men in the lowest social class, living in the most deprived areas, are up to ten times more at risk of suicide than those in the highest social class, living in the most affluent areas.

Economic risk factors that can increase someone's risk of suicide include living in areas of deprivation, being in debt, being homeless or facing homelessness, living in poor quality or insecure housing.

Sources used:
Samaritans report: Insights from experience: economic disadvantage, suicide and self-harm

Health & Wellbeing Impact:
Consider both short and long-term impacts of the activity on a person's physical and mental health, particularly for disadvantaged, vulnerable or at-risk groups. Can health and wellbeing be positively promoted through this activity?

Please tick (✓) all the relevant boxes that apply:		**Overall impact:**
Positive	✓	The Havering Suicide Prevention Strategy promotes health and wellbeing positively; it has short-term impacts: increased awareness, working with partners to increase crisis intervention, work with partners to increase access to services, reduce stigma and promote community resilience. Regarding long-term impacts, the strategy works for sustained mental health improvements and a reduction in suicide rates.
Neutral		
Negative		**Do you consider that a more in-depth HIA is required as a result of this brief assessment?** Yes ☐ No ✓

Evidence:
Public health measures aimed at limiting access to methods of suicide and enhancing care for individuals at risk have contributed to a reduction in the national suicide rate since the 1980s. Suicide is preventable and it is our collective responsibility to do all that we can to reduce deaths through suicide. This must be through a multi-agency approach bringing together the Council, primary care and secondary care services, voluntary and community sector organisations as well as communities and individuals. A strategy that is to succeed in reducing suicide deaths needs to combine a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide. We need to ensure that suicide prevention and mental health are everyone's business.

Distributing suicide prevention training to the Havering workforce as widely as possible particularly to those working with high-risk groups will raise awareness of suicide and self-harm, the risk factors, provide people with the confidence to have important conversations around suicide, and ensure that those working with people who may be at risk of suicide can recognise warning signs and assist in a crisis.

Reduce suicide rates in priority groups by raising awareness of evidence based approaches, services and training opportunities tailored to improving mental health in specific groups providing people with crisis support and other forms of support they need around broader risk factors for suicide e.g. economic risk factors, reducing stigma & encouraging help seeking behavior. Tailored support is available to priority groups in times of need e.g. Grief in Pieces (bereavement support service for those impacted or bereaved by suicide in NEL).

Suspected suicides reviewed by the panel should identify if anything could have been done to reduce access to the means of suicide e.g. ligatures, medications especially if the individual was a service user. The panel could also identify if communication between services in contact with the individual could have been improved. Suspected suicides that occur in public places will be reviewed by the panel to identify any lessons that can be learnt with the involvement of Planning and Network rail. Making Havering a safer place through borough design to reduce access to means of suicide e.g. tall places and railways.

Suicides in Havering should be reported sensitively without personal identifiable information or information regard location or method of suicide to prevent imitational suicidal behaviour or contagion. Media reports should also be used as an opportunity to promote suicide prevention services and training.
Sources used: Office for National Statistics (ONS), 2022

3. Health & Wellbeing Screening Tool

Will the activity / service / policy / procedure affect any of the following characteristics? Please tick/check the boxes below
The following are a range of considerations that might help you to complete the assessment.

Lifestyle YES ☐ NO ☒	**Personal circumstances YES ☒ NO ☐**	**Access to services/facilities/amenities YES ☒ NO ☐**
☐ Diet	☐ Structure and cohesion of family unit	☐ to Employment opportunities
☐ Exercise and physical activity	☐ Parenting	☐ to Workplaces
☐ Smoking	☒ Childhood development	☐ to Housing
☐ Exposure to passive smoking	☒ Life skills	☐ to Shops (to supply basic needs)
☐ Alcohol intake	☐ Personal safety	☐ to Community facilities
☐ Dependency on prescription drugs	☐ Employment status	☐ to Public transport
☐ Illicit drug and substance use	☐ Working conditions	☐ to Education
☐ Risky Sexual behaviour	☐ Level of income, including benefits	☒ to Training and skills development
☐ Other health-related behaviours, such as tooth-brushing, bathing, and wound care	☐ Level of disposable income	☒ to Healthcare
	☐ Housing tenure	☐ to Social services
	☐ Housing conditions	☐ to Childcare
	☐ Educational attainment	☐ to Respite care
	☐ Skills levels including literacy and numeracy	☐ to Leisure and recreation services and facilities
Social Factors YES ☒ NO ☐	**Economic Factors YES ☐ NO ☒**	**Environmental Factors YES ☒ NO ☐**
☒ Social contact	☐ Creation of wealth	☐ Air quality
☒ Social support	☐ Distribution of wealth	☐ Water quality
☐ Neighbourliness	☐ Retention of wealth in local area/economy	☐ Soil quality/Level of contamination/Odour
☒ Participation in the community	☐ Distribution of income	☐ Noise levels
☐ Membership of community groups	☐ Business activity	☐ Vibration
☐ Reputation of community/area	☐ Job creation	☐ Hazards
☐ Participation in public affairs	☐ Availability of employment opportunities	☐ Land use
☐ Level of crime and disorder	☐ Quality of employment opportunities	☐ Natural habitats
☐ Fear of crime and disorder	☐ Availability of education opportunities	☐ Biodiversity
☐ Level of antisocial behaviour	☐ Quality of education opportunities	☐ Landscape, including green and open spaces
☐ Fear of antisocial behaviour	☐ Availability of training and skills development opportunities	☒ Townscape, including civic areas and public realm
☒ Discrimination	☐ Quality of training and skills development opportunities	☐ Use/consumption of natural resources
☒ Fear of discrimination	☐ Technological development	☐ Energy use: CO_2/other greenhouse gas emissions
☐ Public safety measures	☐ Amount of traffic congestion	☐ Solid waste management
☐ Road safety measures		☐ Public transport infrastructure

4. Outcome of the Assessment

The EHIA assessment is intended to be used as an improvement tool to make sure the activity maximises the positive impacts and eliminates or minimises the negative impacts. The possible outcomes of the assessment are listed below and what the next steps to take are:

Please tick (✓) what the overall outcome of your assessment was:

Tick	Outcome		Next steps
✓	1. The initial screening exercise showed a strong indication that there will be no impacts on people and need to carry out an EHIA. 2. The EHIA identified **no significant concerns** OR the identified **negative concerns** have already been **addressed**	→	**Proceed with implementation** of your activity
	3. The EHIA identified some **negative impact** which still needs **to be addressed**	→	**COMPLETE SECTION 5:** **Complete action plan** with measures to mitigate the and finalise the EHIA
	4. The EHIA identified some **major concerns** and showed that it is **impossible to diminish negative impacts** from the activity to an acceptable or even lawful level	→	**Stop and remove** the activity or **revise** the activity **thoroughly.** **Complete an EHIA on the revised proposal.**

5. Action Plan

The real value of completing an EHIA comes from identifying the actions that can be taken to eliminate/minimise **negative** impacts and enhance/optimise positive impacts. In this section you should list the specific actions that set out how you will mitigate or reduce any **negative** equality and/or health & wellbeing impacts, identified in this assessment. Please ensure that your action plan is: more than just a list of proposals and good intentions; if required, will amend the scope and direction of the change; sets ambitious yet achievable outcomes and timescales; and is clear about resource implications.

Protected characteristic / health & wellbeing impact	Identified Negative or Positive impact	Recommended actions to mitigate Negative impact* or further promote Positive impact	Outcomes and monitoring**	Timescale	Lead officer
Age Disability Sex/Gender Ethnicity/Race Religion/faith Sexual orientation Gender reassignment Pregnancy Socioeconomic status	By 2030, we should expect to see an improvement in suicide prevention efforts relating to age, including for, but not limited to, middle-aged men and increased prevention efforts in schools for children and young people. By 2030, we should expect to see an improvement in suicide prevention efforts relating to disability, increased working with carers, working with different sexes, genders, religion groups, members of the LGBTQIA+	• Public Health will work with PCN Leads to increase uptake of suicide prevention training among primary care staff, making sure they know that middle-aged men are at highest risk and they understand inequalities that contribute to the distribution of suicide risk factors. • Public Health Team to ensure that anchor organisations (e.g., the NHS, schools, police, fire service) to ensure that frontline staff receive support for dealing with the impact of suicide in their profession. • Public Health Team to encourage partners to 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.	Outcomes include: a) embedding changes in the Havering system through an all systems approach b) introducing an approach which makes suicide prevention everyone's business, tapping into professions that have not been prioritized before Monitoring: • Suicide rates by age group • Suicide rates by disability	5 years, annual reviews and suicide panel annual report	Sam Westrop, Assistant Director of Public Health

	community, those who are pregnant or have recently had a child, and those from lower socioeconomic statuses.	• Children and Young People’s Emotional Wellbeing and Mental Health Strategy is planned and planned to include young adults who are care experienced (up to age 25) in transition to adults services. • Public Health to form a reference group comprising selected professionals and individuals with lived experience to provide feedback on documents produced and activities led by the suicide prevention public health team, leveraging existing connections with established groups. This group will aim to include members with disabilities, carers, those of different sex and genders, members of the LBGTQIA+ community, those who have experienced perinatal depression, those from all socioeconomic status to ensure diversity of insights and feedback.	• Suicide rates by ethnicity • Suicide rates by religion • Suicide rates by sexual orientation • Suicide rates in perinatal • Suicide rates by socioeconomic status		

6. Review

In this section you should identify how frequently the EHIA will be reviewed; the date for next review; and who will be reviewing it.

Review: The EHIA will be reviewed upon the refresh of the Suicide Prevention Strategy.

Scheduled date of review: February 2030

Lead Officer conducting the review: Suicide Prevention Lead, Public Health Team