HERTFORDSHIRE COUNTY COUNCIL

PUBLIC HEALTH AND PREVENTION CABINET PANEL
26 JUNE 2018 AT 10.00 AM

Agenda Item No.

5

SUICIDE PREVENTION IN HERTFORDSHIRE

Report of the Director of Public Health

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Executive Member: - Richard Roberts, Public Health and Prevention

1. Purpose of report

1.1 To set out data and information on the suicide rate in Hertfordshire, age groups affected and leading risk factors/reasons.

1.2 To highlight progress made on developing and delivering Hertfordshire's Suicide Prevention Plan.

2. Summary

2.1 Members requested a report on Hertfordshire's suicide rate at the Public Health, Prevention and Performance Cabinet Panel on 12 March 2018. This was linked to earlier discussions in the meeting around mental health.

2.2 Suicide rates for Hertfordshire have been lower than national and regional averages for the past decade. The latest data shows Hertfordshire to have one of the lowest rates in England. A total of 56 deaths by suicide were identified in Hertfordshire in 2015/16. 80% of these suicides were among men.

2.3 The age range of people who died by suicide was between 12 and 88 years. The average age for men who died by suicide was 47 years, compared to 44 years for women. The highest rate for males was among those aged 80+, followed by those aged 20-29 years. For females, the highest rate was among those aged 40-49.

2.4 For males, relationship breakdown (22%), family issues (18%), involvement in the criminal justice system (16%), financial issues (13%)

and health issues (13%) were the leading risk factors identified in the most recent suicide audit. For females, family issues (45%) was the main risk factor identified.

2.5 Hertfordshire was one of the first local authorities to publish a suicide prevention plan using updated guidance. Action around suicide prevention is an important element of a wider approach to improving public mental health across the county. The focus on suicide prevention will continue alongside other key actions for improving public mental health. These include supporting young people in schools, improving wellbeing in the workplace, and social support among older people.

3. Recommendation/s

3.1 Panel is asked to consider and comment on this report.

3.2 Panel is also asked to comment on the current approach to suicide prevention in Hertfordshire, and in particular whether the approach should change in the future.

4. Background

4.1 In the UK suicide is the leading cause of death for men under the age of 50 and for women aged 15-29. The human and financial cost of suicide is extremely high. Research suggests that each suicide can impact on up to 135 people, including family, friends, colleagues and those in emergency services[1]. Bereavement by suicide also tends to have a longer and deeper impact than other kinds of bereavement. Death by suicide costs the UK around £1.67 million through impact on public services and the emotional and physical cost to bereaved families[2].

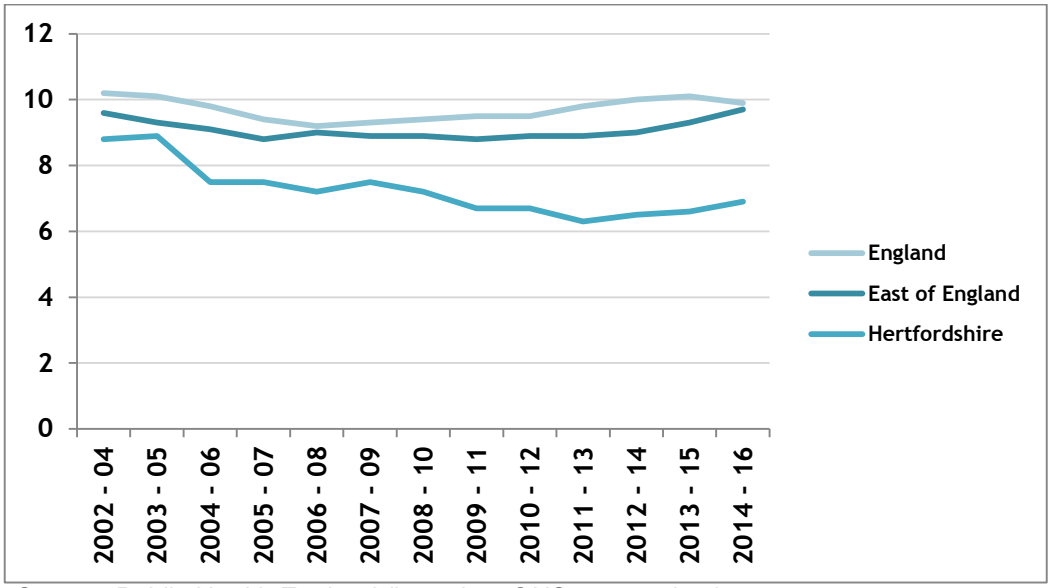
Local data on suicides in Hertfordshire, including the local suicide audit

4.2 Suicide rates in Hertfordshire have been lower than national and regional averages for the past 10 years (Figure 1). The latest three-year rolling average data for 2014-16 shows Hertfordshire to have one of the lowest rates in England. In line with national figures, there are considerably more deaths by suicide among men – more than triple the number among women over the period (Figure 2).

[1] Cerel J, Brown MM, Maple M, Singleton M, van de Venne J, Moore M, Flaherty C. How many people are exposed to suicide? Not six. Suicide and Life-Threatening Behavior. 2018 Mar 7.

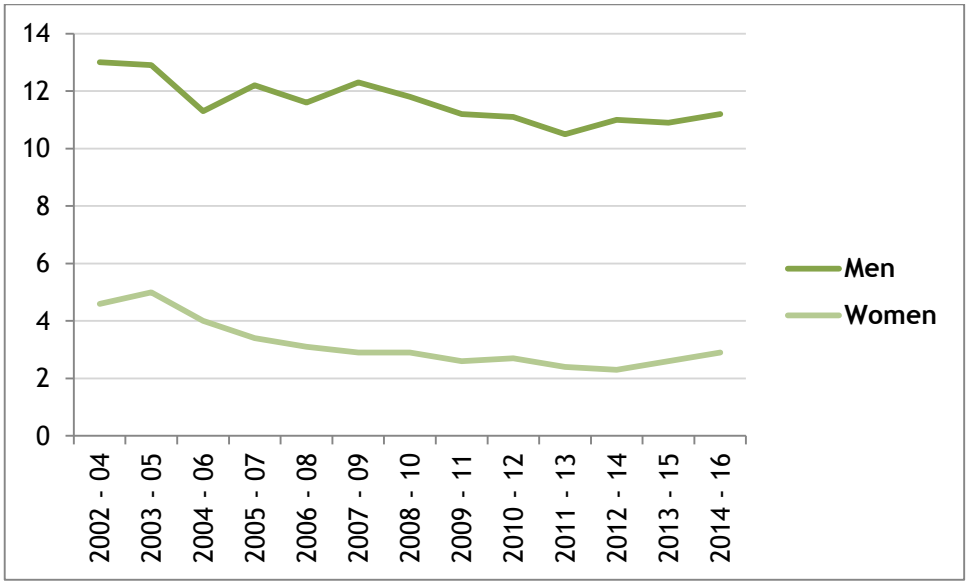
[2] Daid D et al. Population level suicide awareness training and intervention. In Knapp D, McDaid D, Parsonage M, editors. Mental health promotion and prevention: the economic case. London: Department of Health; 2011. p.26-28.

Figure 1 – Suicide in Hertfordshire, East of England and England: age-standardised rate per 100,000 population (3 year average)



Source: Public Health England (based on ONS source data)

Figure 2 – Suicide by males and females in Hertfordshire: age-standardised rate per 100,000 population (3 year average)



Source: Public Health England (based on ONS source data)

4.3 Suicide audits can provide important local data on the pattern and potential risk factors for suicides in Hertfordshire. Suicide audits are not a statutory requirement, but Hertfordshire's multi-agency suicide prevention partnership, made up of more than 20 organisations, supports these audits being carried out regularly. Suicide audits can provide important local data on the pattern and possible risk factors for

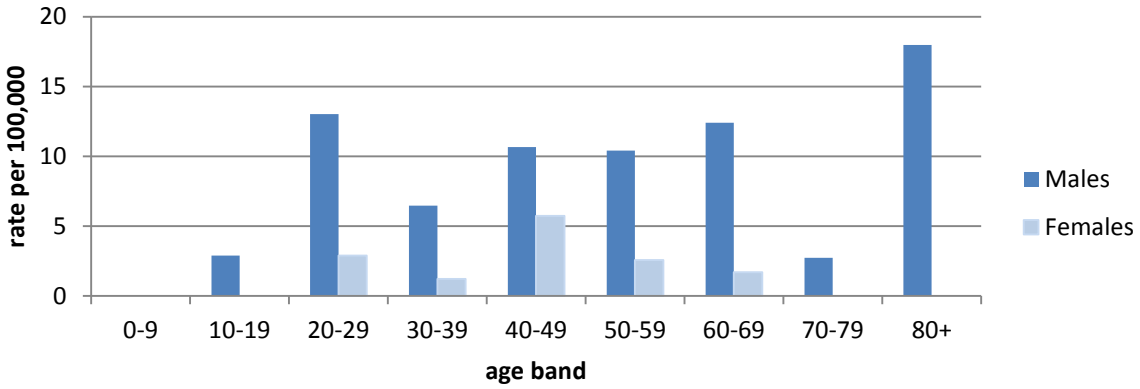
suicides in Hertfordshire. To date, these have been carried out every two years.

4.4 The most recent Hertfordshire Suicide Audit 2015/16 included individuals:

- who died in Hertfordshire where the coroner's verdict was either suicide or open verdict (i.e. the individual died at their own hand but the intention was unclear),
- and where their inquest took place between 1 April 2015 and 31 March 2016. Because the audit can only examine suicides where a verdict has been reached, this means some of the deaths recorded in the audit will have taken place before 2015.

4.5 A total of 56 deaths by suicide were identified by the audit in this period. The age range of people who died by suicide was between 12 and 88 years. The average age of men who died by suicide was 47 years, compared to 44 years for women. Figure 3 shows that the highest rate for females was among those aged 40-49, while for males it was among those aged 80+, followed by those aged 20-29 years.

Figure 3 Suicide rate in Hertfordshire in 2015/16, by age group & gender



Source: Hertfordshire Coroner's Service 2015/16

4.6 Some of the characteristics of those who were recorded to have died by suicide in Hertfordshire between April 2015 – March 2016 include:

- 80% were male (45 males, 11 females)
- 59% were not known to mental health services
- 67% were not in a relationship
- 82% had discussed their mental health with their GP in the month before death

- 50% were employed
- 23% were known to have had some previous involvement in the criminal justice system

4.7 For males, the leading risk factors identified by the audit were

- Relationship breakdown (one in five suicides ~ 22%),
- Family issues (18% - including family bereavement, previous abuse and estrangement from parents)
- Involvement in the criminal justice system (16%)
- Financial issues (13%).
- Health issues (13%)

4.8 For females, the leading risk factors identified by the audit were

- Family issues (45% - such as losing a carer role for an elderly parent, domestic violence, and estrangement from children)
- Financial issues (9%)
- Work/study stress (9%)

4.9 An updated suicide audit is currently being planned. It will draw on data beyond the coroner's service, including from mental health trusts, transport organisations and the police, to generate deeper insight into suicide in the county.

Hertfordshire's Suicide Prevention Programme

4.10 Hertfordshire was one of the first local authorities to publish a strategy using guidance from the updated Preventing Suicide in England national strategy. Hertfordshire's Suicide Prevention Strategy was developed in 2017. The vision is to make Hertfordshire a county where no one gets to a point where they feel suicide is their only option. In practice, this means an ambition for zero suicide. A comprehensive multi-agency approach is needed to achieve this.

4.11 Underpinning the strategy, Public Health have led on delivering a suicide prevention plan. The overarching action plan is included at the end of Hertfordshire's Suicide Prevention Strategy. Three events have taken place to help co-develop the county's action plan, with over 200 attendees from more than 40 organisations. People bereaved by suicide and their experiences continue to directly influence the direction of the plan. Task and finish groups have been set up and are detailed in the strategy.

4.12 Over 80 individuals from more than 20 organisations have been involved in delivering the plan. Delivery to date has included:

i. Training 700 professionals through the Spot the Signs of Suicide project, including around 200 GPs and practice staff.
   - training is aimed at those in contact with people likely to be at higher risk of suicide. Those trained can identify when someone is more at risk of suicide and can help them to access further support.

ii. Joint communications planning,
   - including supporting the Just Talk campaign for teenage boys. Just Talk is a preventative mental health campaign for secondary school aged boys, focusing on coping strategies and confidence to seek help if needed.

iii. A suicide-safer school kitemark, soon to be launched

iv. Improved suicide bereavement support
   - e.g. promoting the "Help is at Hand" bereavement support booklet by general practices, developing a local police leaflet on local support services.

v. Improved referral pathways for those at risk of suicide by the police, NHS 111 and HertsHelp, including promoting relevant services on existing systems.

4.13 Hertfordshire's suicide prevention plan depends on the results of other initiatives to address suicide across the county. For example,

- mental health is a key theme in Hertfordshire's Domestic abuse strategy 2016-2019
- there are initiatives to support residents in financial difficulties (such as Citizen's Advice Bureaux and Job Centre Plus)
- Spot the Signs materials focus on financial advice/support, and Spot the Signs have also linked directly to train staff in food banks, Job Centre Plus offices, and CAB.
- The County Council's Money Advice Service directly contributed to the Signposting & Referral task and finish group.

5 Equality Impact Assessment

5.1 When considering proposals placed before Members it is important that they are fully aware of, and have themselves rigorously considered the equalities implications of the decision that they are taking.

5.2 Rigorous consideration will ensure that proper appreciation of any potential impact of that decision on the County Council's statutory obligations under the Public Sector Equality Duty. As a minimum this

requires decision makers to read and carefully consider the content of any Equalities Impact Assessment (EqIA) produced by officers.

5.3 The Equality Act 2010 requires the Council when exercising its functions to have due regard to the need to (a) eliminate discrimination, harassment, victimisation and other conduct prohibited under the Act; (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it and (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it. The protected characteristics under the Equality Act 2010 are age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief, sex and sexual orientation.

5.4 An Equality Impact Assessment (EqIA) was undertaken for the Suicide Prevention Plan in 2017. This EqIA has been reviewed and is annexed at Appendix 1. A central principle of the strategy is to tailor approaches to various groups. This is likely to ensure positive equality impacts across protected groups

5.5 The EqIA action plan focuses on mitigating potential equality impacts for the following groups:

- **Men and boys** – reducing stigma and encouraging men to talk about mental health, and suicide
- **Those with learning disabilities** – reviewing accessibility to information
- **People with mental health difficulties that form a disability** – as above, and looking at transition through mental health services
- **Mothers, particularly during the perinatal period** – working with services that support pregnant and perinatal women to provide information and support on this issue
- **Those for whom English is not their first language** – improving suicide related data on race and ethnicity. This will inform whether language is a barrier to receiving communications and support around suicide prevention.

6. Financial Implications

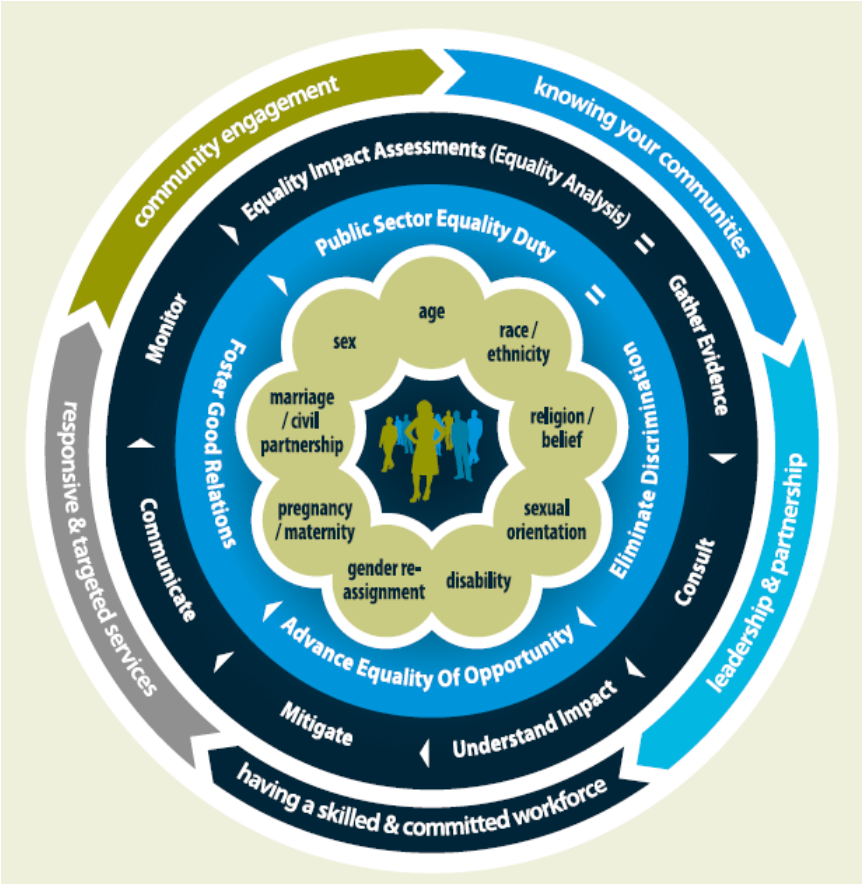
6.1 Hertfordshire's Suicide Prevention Plan has been developed within the existing resources of the partner organisations. Any proposals for funding to meet needs will be considered through the Programme's Governance Structure, with business cases where appropriate.

Appendix 1: Suicide Prevention Strategy Equality Impact Assessment

EqIAs make services better for everyone and support value for money by getting services right first time.

EqIAs enable us to consider all the information about a service, policy or strategy from an equalities perspective and then create an action plan to get the best outcomes for staff and service-users[1].They analyse how all our work as a council might impact differently on different groups protected from discrimination by the Equality Act 2010[2]. They help us make good decisions and evidence how we have reached them.[3]

An EqIA needs to be completed **as a project starts** to identify and consider possible differential impacts on people and their lives, inform project planning and, where appropriate, identify mitigating actions. It must be completed **before** any decisions are made or policy agreed so that the EqIA **informs that decision or policy**. It is also a live document; you should review and update it along with your project plan throughout.



Full guidance notes to help you are embedded in this form – see the End Notes or hover the mouse over the numbered notes.
If your project/proposal relates primarily to staff **– e.g. a restructure – there is a specific EqIA template for this here**

Please share your initial EqIA with the equalities team, equalities@hertfordshire.gov.uk and the final/updated version at the end of the project. Key EqIAs should be reviewed by the relevant Head of Service. Examples of EqIAs can be seen in the **EqIA Library**.

1. Who is completing the EqIA[4] and why is it being done?

Title of service / proposal / project / strategy / procurement you are assessing[5]	Suicide Prevention Strategy
Names of those involved in completing the EqIA	Caroline Bell Nathan Davies Maneka Kandola Charulata Joshi
Head of Service or Business Manager	Piers Simey
Team/Department	Health Improvement Team, Public Health
Lead officer contact details	Maneka.kandola@hertfordshire.gov.uk
Focus of EqIA – what are you assessing?[6] What are the aims of the service, proposal, project? What outcomes do you want to achieve? What are the reasons for the proposal or change? Do you need to reference/consider any related projects?	A Suicide Prevention Strategy for Hertfordshire has been developed through an analysis of local need, and listening to the views of service users, carers, stakeholders and partners. The Hertfordshire Strategy makes reference to the national Suicide Prevention Strategy. Hertfordshire has statistically significant lower rates of suicide than national and regional averages, but it is imperative that these are reduced further. In the most recent suicide audit for Hertfordshire, there were 56 deaths recorded as suicides at coroner's inquests in Hertfordshire between April 2015 and March 2016. The human cost of death by suicide is high and tends to have an especially heightened and widespread effect. Every death has a wider effect than solely on the person who dies. It affects family and friends, those who are involved in pre-death care (such as medical staff), and those involved in activity arising from the death (such as providing funeral services). Estimates vary between 6 – 60 people directly affected by each death. The multi-agency Hertfordshire suicide prevention strategy and action plan is a response to this need. The **vision** is to make Hertfordshire a county where no one ever gets to a point where they feel suicide is their only option. **Objectives** 1. Reduce the risk of suicide in key high risk groups 2. Tailor approaches to improve mental health in specific groups 3. Reduce access to the means of suicide 4. Provide better information and support to those bereaved or affected by suicide 5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour 6. Support research, data collection and monitoring

	The purpose of this EqIA is to ensure the suicide prevention strategy and aligned action plan meet the needs of the population of Hertfordshire and have taken account of high risk groups identified and the protected characteristic groups.
Stakeholders Who will be affected? Which protected characteristics ***(see end-notes 11-20)*** is it most relevant to? Consider the public, service users, partners, staff, Members, etc	Stakeholders • Hertfordshire residents • Service users with existing mental health conditions • Service users with suicidal ideation • Family, friends and carers who are bereaved or affected by suicide • Community/voluntary groups, particularly those involved in mental health improvement and suicide prevention work • Executive Member for Public Health and Prevention • County & District councillors • Local authority partners – district councils • Mental Health Services • NHS providers and commissioners • Public Health • Other Hertfordshire County Council departments, adult social care. • General Practices The strategy is applicable to everyone living in Hertfordshire, or resident elsewhere, but who may be attempting suicide in Hertfordshire.

2. List of data sources used for this

A range of useful local data on our communities can be found on Herts Insight and on the Equalities Hub

Title and brief description	Date	Gaps in data Consider any gaps you need to address and add any relevant actions to the action plan in Section 4.
Hertfordshire Suicide Audit 2015/16 An audit including all people who died in Hertfordshire where the coroner's verdict was either suicide or open verdict (i.e. died at their own hand but the intention was unclear), and where the inquest took place between 1st April 2015 and 31st March 2016. Hertfordshire Suicide Audit 2015/16	February 2017	
Hertfordshire Suicide Prevention Strategy Hertfordshire's Suicide Prevention Strategy	April 2017	
Public Consultation event on development of the Suicide Prevention Strategy A public consultation event was set up and ran in November 2017 to bring together partners, public and people affected by suicide in the county to look at the priorities for suicide prevention in Hertfordshire and to develop and review the key elements on the strategy document and the aligned actions and plan required	November 2017	
Hertfordshire Joint Strategic Needs Assessment Identifies the specific health and social care needs of our local population and points out areas of inequality. It helps public bodies decide what type of local services to commission. The JSNA contains a variety of needs assessments, each looking at a different issue. They are regularly updated to reflect the changing needs of the population. https://www.hertfordshire.gov.uk/microsites/jsna/hertfordshires-joint-strategic-needs-assessment.aspx		
ONS 2014 Population data http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsa		

ndmarriages/deaths/bulletins/suicidesintheunitedkingdom/2014registrations		
Department of Health. Preventing suicide in England: a cross government outcomes strategy to save lives. Department of Health 2012 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf	2012	
PHE Fingertips database 2012-2015 https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/0/gid/1938132828/pat/6/par/E12000006/ati/102/are/E10000015		
The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Making Mental Health Care Safer: Annual Report and 20-year Review. October 2016. University of Manchester http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/2016-report.pdf	October 2016	
Department of Health Statistical update on Suicide https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/405411/Statistical_update_on_suicide_acc.pdf	February 2015	
Suicide Prevention Network There is in place a countywide suicide prevention network which brings together all individuals, organisations and partners who have an interest in suicide prevention in Hertfordshire – this is supported via annual events and bi-annual newsletters.	March 2018	

3. Analysis and assessment: review of information, impact analysis and mitigating actions

Protected characteristic group	What do you know[7]? What do people tell you[8]? Summary of data and feedback about service users and the wider community/ public • **Who uses the service?** • **Who doesn't and why?** • **Feedback/complaints?** • **Any differences in outcomes? Why?**	What does this mean – what are the potential impacts of the proposal(s)[9]? - Consider positive and negative impacts - On service users / the public - *AND, where relevant,* ***staff**** **** if your proposals relate mainly to a staff restructure or reorganisation, you should use the template here***	What can you do[10]? What reasonable mitigations to reduce or avoid the impact can you propose? How will you communicate/engage or provide services differently to create a 'level playing field' – e.g. consultation materials in easy read or hold targeted engagement events ***If there is no current way of mitigating any negative impacts, clearly state that here and consider other actions you could take in the action plan in section 4.***
Age[11]	In Hertfordshire, nearly 31% of the population is under 25 and nearly 15% over 65. The over 65's are projected to increase by nearly 43% by 2030.	There has been a peak in numbers of male suicides in the 20-29 year age band, seen both in the 2012 suicide audit and the 15/2016 audit. The highest rate is seen in males aged 80+. The national suicide prevention strategy has identified young and middle aged men aged 35-49 as the groups at high risk from suicide as well as men aged over 75 as having higher rates of suicide. The age profile seen in the 2013 national data, which is most up to date data to include single year and sex, shows an increase in suicide rate in each 5 year age band in males up to the 40-44 age group, and then a decrease in the rate as age increases, till 65-69 where there is another rise in the rate for males aged 75+. For females, there is also an increase in the suicide rate till age 45-49, and then a decrease till 75+ when there is a small increase. In the Hertfordshire data, the highest rate is seen in females in the 40-49 year old age band. The small increase in the suicide rate in older females in the national data is not seen in the local data. The strategy will focus on prevention amongst key risk age groups - such as those aged 20-29 and 40-49 for men - and stratify these age groups by sex to target more effectively by targeting communications messages at them and looking their mental health pathways. The	The work of the task and finish group 'Men and boys' will have specific focuses on the age groups most vulnerable to dying by suicide.

Protected characteristic group	What do you know[7]? What do people tell you[8]? Summary of data and feedback about service users and the wider community/ public • **Who uses the service?** • **Who doesn't and why?** • **Feedback/complaints?** • **Any differences in outcomes? Why?**	What does this mean – what are the potential impacts of the proposal(s)[9]? - Consider positive and negative impacts - On service users / the public - *AND, where relevant,* ***staff**** **** if your proposals relate mainly to a staff restructure or reorganisation, you should use the template here***	What can you do[10]? What reasonable mitigations to reduce or avoid the impact can you propose? How will you communicate/engage or provide services differently to create a 'level playing field' – e.g. consultation materials in easy read or hold targeted engagement events ***If there is no current way of mitigating any negative impacts, clearly state that here and consider other actions you could take in the action plan in section 4.***
		net result is likely to be to a positive impact on inequalities in suicide rate amongst age groups.	
Disability[12]	In Hertfordshire, approximately 68,000 people have some degree of physical disability. 26,000 of people have a learning disability and nearly 11,600 people have dementia. In Hertfordshire, approximately 172,448 adults between the ages 18-64 have been known to experience some form of mental ill health (2015).	The 2015/16 Herts suicide audit showed: • 41% of people who died by suicide were known to mental health services at time of death • 65% of men and 77% of women discussed their mental health with their GP during their last visit prior to their death • 10 people, (all male) had no record of any discussion of their mental health with their GP However, there is no record in the suicide audit of whether mental illness was defined as a disability. There is also no local data on levels of physical disability linked to suicide. The national suicide prevention strategy indicates that physical illness is associated with an increased suicide risk. Many people who live with long-term conditions - including physical disability and chronic pain – will, at some time, experience periods of depression that may be undiagnosed and untreated. Those with mental health difficulties that form a disability are at far greater risk of suicide.	The task and finish group considering signposting and referral includes accessibility for those with physical and learning disabilities as part of their remit and consider implementing easy read documentation.

Protected characteristic group	What do you know[7]? What do people tell you[8]? Summary of data and feedback about service users and the wider community/ public • **Who uses the service?** • **Who doesn't and why?** • **Feedback/complaints?** • **Any differences in outcomes? Why?**	What does this mean – what are the potential impacts of the proposal(s)[9]? - Consider positive and negative impacts - On service users / the public - *AND, where relevant,* ***staff**** **** if your proposals relate mainly to a staff restructure or reorganisation, you should use the template here***	What can you do[10]? What reasonable mitigations to reduce or avoid the impact can you propose? How will you communicate/engage or provide services differently to create a 'level playing field' – e.g. consultation materials in easy read or hold targeted engagement events ***If there is no current way of mitigating any negative impacts, clearly state that here and consider other actions you could take in the action plan in section 4.***
		Improving mental health is a core part of the local suicide prevention plan and should have a positive impact on equality for this group. There is a potential negative impact in the work in improving signposting and referral if the needs of those with learning disabilities are not considered in the pathway improvement process.	
Gender reassignment[13]	20 per 100,000 people in the UK are estimated to be transgender. Applying this rate to Hertfordshire, we assume that there is around 183 transgender people in the county.	The national suicide strategy review found some indications that transgender people may have higher rates of mental health problems and higher rates of self-harm. Currently there are no standard national sources of transgender statistics, nor were these available for the suicide audit. Those in the process of, or who have completed, gender reassignment may have greater risk factors for suicide. Transgender people may not access services for fear of discrimination.	The task and finish group, 'Learn lessons and performance measures', will consider how to improve data quality on gender reassignment, particularly that collected by the coroner's office. Approaches to reducing suicide should focus on people as individuals.
Pregnancy and maternity[14]	Hertfordshire in 2012 had a live birth rate of (13.2) which was slightly higher than England at (13.0). The districts that had the highest proportion of MSOAs with the highest birth rates in 2012 were	There is no local data on the levels of those who die by suicide by pregnancy and maternity, although national data through the 2015 Mother and Babies: Reducing Risk Through Audits and Confidential Enquiries across the UK (MBRRACE-UK) report	The task and finish group focused on mapping mental health patient transition and the group focused on signposting and referral, will work with maternity services and other services engaged with pregnant women as part of their remits.

Protected characteristic group	What do you know[7]? What do people tell you[8]? Summary of data and feedback about service users and the wider community/ public • **Who uses the service?** • **Who doesn't and why?** • **Feedback/complaints?** • **Any differences in outcomes? Why?**	What does this mean – what are the potential impacts of the proposal(s)[9]? - Consider positive and negative impacts - On service users / the public - *AND, where relevant,* ***staff**** **** if your proposals relate mainly to a staff restructure or reorganisation, you should use the template here***	What can you do[10]? What reasonable mitigations to reduce or avoid the impact can you propose? How will you communicate/engage or provide services differently to create a 'level playing field' – e.g. consultation materials in easy read or hold targeted engagement events ***If there is no current way of mitigating any negative impacts, clearly state that here and consider other actions you could take in the action plan in section 4.***
	Dacorum, St. Albans, North Hertfordshire and East Hertfordshire.	highlighted that almost a quarter of women (23%) who died between six weeks and one year after pregnancy died from mental-health related causes, and one in seven women died by suicide. National data suggests suicide can be a risk for women throughout the perinatal period.	
Race[15]	Breakdown of Hertfordshire population shows: 81% - White British 5.5% - Asian/British Asian 6.5% - White non-British 2.7% - Black/Black British	The coroner's service in Hertfordshire does not routinely collect information on the individual's ethnicity or race, which in turn did not allow for its inclusion in the suicide audit. The national suicide prevention strategy review of the literature found a complex picture and that various ethnic groups experienced different presentations of mental health problems. Some black groups have admission rates around three times higher than average. The rates of mental health problems in particular migrant groups, and subsequent generations, are also sometimes higher. For example, migrant groups and their children are at two to eight times greater risk of psychosis. More recent arrivals, such as some asylum seekers and refugees, may also require mental health support following their experiences in their home countries. The most recent adult psychiatric morbidity	All task and finish groups involved in communicating with the public will consider language accessibility as part of their remit, including interpreter services and making documents available in other languages. The task and finish group, 'Learn lessons and performance measures', will seek to improve data quality on race and ethnicity, particularly that collected by the coroner's office, which will have a positive impact on improving equalities. Approaches to reducing suicide should focus on people as individuals.

Protected characteristic group	What do you know[7]? What do people tell you[8]? Summary of data and feedback about service users and the wider community/ public • **Who uses the service?** • **Who doesn't and why?** • **Feedback/complaints?** • **Any differences in outcomes? Why?**	What does this mean – what are the potential impacts of the proposal(s)[9]? - Consider positive and negative impacts - On service users / the public - *AND, where relevant,* ***staff**** **** if your proposals relate mainly to a staff restructure or reorganisation, you should use the template here***	What can you do[10]? What reasonable mitigations to reduce or avoid the impact can you propose? How will you communicate/engage or provide services differently to create a 'level playing field' – e.g. consultation materials in easy read or hold targeted engagement events ***If there is no current way of mitigating any negative impacts, clearly state that here and consider other actions you could take in the action plan in section 4.***
		survey found that although Black populations have the highest rates of PTSD, suicide attempt, psychotic disorder and any drug use/dependence, South Asian women have the highest rates for any common mental disorder and White populations have the highest rates of alcohol dependence (McManus et al, 2009) It is also likely that cultural practices may influence how mental health and suicidal ideation is seen, such as feelings of shame. The tailoring of approaches to mental health improvement should have a positive impact on this inequality. Those at risk who have English as a second language may find it more difficult to access support or services.	
Religion or belief[16]	The Census 2011 data show the breakdown of Hertfordshire's population classified as: 58% - Christian 2.7% - Muslim 2% - Jewish 2% - Hindu 0.49% – Buddhist 0.45%- Sikh Around 27% of Hertfordshire's	The coroner's service does not routinely collect information on the individual's ethnicity or race, which in turn did not allow for its inclusion in the suicide audit. The lack of data collected by the coroner's office on religion makes it difficult to judge whether particular groups are at particular risk of suicide. The task and finish group 'Learn lessons and	Services should consider religious practices and festivals when planning appointments and care plans. Approaches to reducing suicide should focus on people as individuals.

Protected characteristic group	What do you know[7]? What do people tell you[8]? Summary of data and feedback about service users and the wider community/ public • **Who uses the service?** • **Who doesn't and why?** • **Feedback/complaints?** • **Any differences in outcomes? Why?**	What does this mean – what are the potential impacts of the proposal(s)[9]? - Consider positive and negative impacts - On service users / the public - *AND, where relevant,* ***staff**** **** if your proposals relate mainly to a staff restructure or reorganisation, you should use the template here***	What can you do[10]? What reasonable mitigations to reduce or avoid the impact can you propose? How will you communicate/engage or provide services differently to create a 'level playing field' – e.g. consultation materials in easy read or hold targeted engagement events ***If there is no current way of mitigating any negative impacts, clearly state that here and consider other actions you could take in the action plan in section 4.***
	population said that they do not follow any religion or belief. And around 7% did not wish to declare. Urdu, Punjabi, Bengali-Sylheti and Arabic are mainly spoken by the Muslim population in Hertfordshire.	performance measures' will consider how to improve data quality on religion, particularly that collected by the coroner's office – which will facilitate a positive long-term impact on inequalities.	
Sex/Gender[17]	In Hertfordshire 51% of the population is female and 49% is male. This variance continues into older age.	Across the UK, the majority of suicides occur in adult males (78% in 2013). This is reflected in Hertfordshire; of the 56 cases in Hertfordshire where a suicide inquest was held between 1st April 2015 and 31 March 2016, 11 were female (20%) and 45 were male (80%) (Source: Suicide Audit 2015/16). The large majority of suicides in Hertfordshire and nationally involve males. Males are also generally less likely to seek help for mental health problems.	There will be a specific task and finish group set up that focuses on suicide prevention for men and boys which will address this inequality by reducing stigma among this age group including finding different language to use and not presuming that men don't want to talk. Work will be carried out in settings frequented by men. This will also link with current work and campaigns aimed at reducing mental health stigma in boys.
Sexual orientation[18]	There are no accurate figures available for this protected characteristic. Numbers of adults estimated to be gay, lesbian and bisexual is 12,997 in Hertfordshire	The coroner's service does not routinely collect information on the individual's sexual orientation, which in turn did not allow for its inclusion in the suicide audit. However, the national suicide strategy literature review found that lesbian, gay and bisexual people are at higher risk of mental disorder, suicidal ideation, substance misuse	All task and finish groups involved in work to meet the objective, "Tailor approaches to improve mental health in specific groups", should consider improving and individualising approaches to LGBT groups as part of their work. The lack of data collected by the coroner's office on sexual orientation makes it difficult to judge whether particular groups are at particular risk of suicide in

Protected characteristic group	What do you know[7]? What do people tell you[8]? Summary of data and feedback about service users and the wider community/ public • **Who uses the service?** • **Who doesn't and why?** • **Feedback/complaints?** • **Any differences in outcomes? Why?**	What does this mean – what are the potential impacts of the proposal(s)[9]? - Consider positive and negative impacts - On service users / the public - *AND, where relevant,* ***staff**** **** if your proposals relate mainly to a staff restructure or reorganisation, you should use the template here***	What can you do[10]? What reasonable mitigations to reduce or avoid the impact can you propose? How will you communicate/engage or provide services differently to create a 'level playing field' – e.g. consultation materials in easy read or hold targeted engagement events ***If there is no current way of mitigating any negative impacts, clearly state that here and consider other actions you could take in the action plan in section 4.***
		and deliberate self-harm. Across the UK, lesbian, gay and bisexual people are twice as likely as heterosexual people to self-harm. Gay and bisexual men have a particularly high prevalence of self-harm. One in ten gay and bisexual men aged 16 to 19 have attempted to take their own life in 2012. Compared to heterosexual people, LGBT people in England have higher rates of common mental disorder, depressive disorder, obsessive-compulsive disorder probable psychosis, drug dependence alcohol dependence, suicide attempts (and self-harm (Chakraborty et al, 2011). Evidence from Stonewall reflects that people in same sex relationships are more likely to experience a mental health problem as a result of stigma, hate crime or prejudice LGBT groups may be at greater risk of mental health problems and suicidal ideation yet not be picked up by mainstream services.	Hertfordshire. The task and finish group 'Learn lessons and performance measures' will consider how to improve data quality on sexual orientation, particularly that collected by the coroner's office.
Marriage and civil partnership[19]	Register office marriages, approved venue marriages and civil partnerships have stayed relatively similar since 2011/12. The number of civil partnerships shows a large	There were less people who died by suicide identified as married or co-habiting in Hertfordshire in 2015 than 2011 (31% compared to 37%).	N/A

Protected characteristic group	What do you know[7]? What do people tell you[8]? Summary of data and feedback about service users and the wider community/ public • **Who uses the service?** • **Who doesn't and why?** • **Feedback/complaints?** • **Any differences in outcomes? Why?**	What does this mean – what are the potential impacts of the proposal(s)[9]? - Consider positive and negative impacts - On service users / the public - *AND, where relevant,* ***staff**** **** if your proposals relate mainly to a staff restructure or reorganisation, you should use the template here***	What can you do[10]? What reasonable mitigations to reduce or avoid the impact can you propose? How will you communicate/engage or provide services differently to create a 'level playing field' – e.g. consultation materials in easy read or hold targeted engagement events ***If there is no current way of mitigating any negative impacts, clearly state that here and consider other actions you could take in the action plan in section 4.***
	increase from 2011/2012 – 2012/2013. The number of religious ceremonies in Hertfordshire is not currently recorded. Marriage between people of the same sex became legal in England and Wales in March 2014 – so numbers of gay marriages in Hertfordshire will develop over time.	No impact identified.	
Carers[20]	Nearly 15% of Hertfordshire residents are over 65. This is projected to increase by nearly 43% by 2030. One out of every five households in Hertfordshire contains only residents that are 65+. Of these, 59% contains one person living alone. Just under 10% of the Hertfordshire population provide unpaid care.	There is little local or national data available relating to suicide and carers. Nationally, In comparison with the general population, people with substantial caring responsibilities have higher levels of stress and depression and lower levels of subjective wellbeing (King's Fund), which could be a risk factor for suicide. National data suggests that carers have poorer mental health which is a known risk factor for suicide.	All task and finish groups involved in work to meet the objective, "Tailor approaches to improve mental health in specific groups", should consider approaches to carers as part of their work and link in with existing carer networks such as Carers in Hertfordshire.
Other relevant groups[21] Consider if there is a potential impact (positive or negative) on areas such as health and			

Protected characteristic group	**What do you know[7]? What do people tell you[8]?** Summary of data and feedback about service users and the wider community/ public • **Who uses the service?** • **Who doesn't and why?** • **Feedback/complaints?** • **Any differences in outcomes? Why?**	**What does this mean – what are the potential impacts of the proposal(s)[9]?** - Consider positive and negative impacts - On service users / the public - *AND, where relevant,* ***staff**** **** if your proposals relate mainly to a staff restructure or reorganisation, you should use the template here***	**What can you do[10]?** What reasonable mitigations to reduce or avoid the impact can you propose? How will you communicate/engage or provide services differently to create a 'level playing field' – e.g. consultation materials in easy read or hold targeted engagement events ***If there is no current way of mitigating any negative impacts, clearly state that here and consider other actions you could take in the action plan in section 4.***
wellbeing, crime and disorder, Armed Forces community.			

Opportunity to advance equality of opportunity and/or foster good relations[22]
A key objective of the suicide prevention strategy will be to tailor approaches to improve mental health in specific groups, including those with protected characteristics. It is expected this will improve equality of mental health outcomes and reduce suicide rates in protected groups.

Conclusion of your analysis and assessment -

OUTCOME AND NEXT STEPS	SUMMARY
i. No equality impacts identified - No major change required to proposal	
ii. Minimal equality impacts identified - Adverse impacts have been identified, but have been objectively justified (provided you do not unlawfully discriminate) - Ensure decision makers consider the cumulative effect of how a number of decisions impact on equality - No major change required to proposal	
iii. Potential equality impacts identified - Take 'mitigating action' to change the original policy/proposal, remove barriers or better advance equality - Set out clear actions in the action plan in section 4.	The following potential equality impacts have been identified: • Men and boys • Those with learning disabilities • People with mental health difficulties that form a disability • Mothers, particularly during the perinatal period • Those for whom English is not the first language Mitigating actions are included in the plan below
iv. Major equality impacts identified - The adverse effects are not justified, cannot be mitigated or show unlawful discrimination - You must stop and remove the policy **[you should consult with Legal Services]** - Ensure decision makers understand the equality impact	

4. Prioritised Action Plan[xxiii]

Impact identified and group(s) affected	**Action planned** Include actions relating to: • **mitigation measures** • **getting further research** • **getting further data/consultation**	**Expected outcome**	**Measure of success**	**Lead officer and timeframe**
NB: These actions must now be transferred to service or business plans and monitored/reviewed to ensure they achieve the outcomes identified.				
Men and boys	A task & finish group has been set up focusing on this population.	Reduction of stigma including finding a voice/language for this population. Not assuming men and boys do not wish to talk about suicide. Carrying out work in settings frequented by men.	Reduction of stigma around males talking about suicide. Links with current campaigns aimed at reducing mental health stigma in boys (such as Just Talk).	Jen Beer December 2018
Those with learning disabilities	The task & finish group has at signposting and referral has included accessibility for those with physical and mental (including learning) disabilities as part of its scope, including implementing easy read documentation. This is now to be monitored and work to be continued (if required) by the spot the signs group.	Increased access to support to be enabled for those in this population considering taking their own life	Improved awareness and availability of a range of materials/means of accessing support which can be access by this population	Nathan Davies June 2018

People with mental health difficulties that form a disability	As above, plus focus via the task & finish group looking at transition through mental health services	As above, plus improved handover from one mental health service to another	As above, plus an improved handover process	Dr Joanne Farrow December 2018
Mothers, particularly during the perinatal period	The task & finish groups looking at signposting and referral, and transition through mental health services, will work with services engaged with pregnant and perinatal women as part of their remits	Ensure access to support and materials tailored to this population	Tailored materials and support available	Nathan Davies June 2018 Dr Joanne Farrow December 2018
Those for whom English is not the first language	Task & finish group focused on learning lessons will seek to improve suicide-related data (particularly that collected by the coroner's office) on race and ethnicity. All task and finish groups involved in communication with the public will consider language accessibility as part of their remit.	Collection of suicide-related data pertinent to race and ethnicity (e.g. via suicide audit template).	Improved awareness and availability of suicide-related race and ethnicity data. Availability of documents in a wider range of languages according to local data on need. Ensuring availability of interpreter services.	Piers Simey (as Chair of Programme Board, for all task & finish groups) December 2019 Maneka Kandola (Learning Lessons) June 2019

This EqIA has been signed off by:

Lead Equality Impact Assessment officer: Charolata Joshi **Date: 6th June 2018**

Head of Service or Business Manager: Piers Simey **Date: 6th June 2018**

[1] The following principles explain what we must do to fulfil our duties under the Equality Act when considering the effect of existing and new policies/ practices/services on equality. They must all be met or the EqIA (and any decision based on it) may be open to challenge:

- **Knowledge:** everyone working for the council must be aware of our equality duties and apply them appropriately
- **Timeliness:** the duty applies at the time of considering proposals and **before** a final decision is taken
- **Real Consideration:** the duty must be an integral and rigorous part of your decision-making and influence the process.
- **Sufficient Information:** you must assess what information you have and what is needed to give proper consideration.
- **No delegation:** the council is responsible for ensuring that anyone who provides services on our behalf can comply with the duty, are required in contracts to comply with it, and do comply in practice. It is a duty that cannot be delegated.
- **Review:** the equality duty is a continuing duty – it continues after proposals are implemented/reviewed.
- **Proper Record Keeping:** we must keep records of the process and the impacts identified.

[2] **Our duties in the Equality Act 2010**

HCC has a legal duty under this Act to show that we have identified and considered the impact and potential impact of our activities on all people with 'protected characteristics' (see end notes 11-20 for details of the nine-protected characteristics). This applies to policies, services (including commissioned services), and our employees. **If you are creating an 'arms-length' company,** seek advice from the Equality Team or Legal.

We use this template to do this and evidence our consideration. **You must give 'due regard' (pay conscious attention) to the need to:**

- **Avoid, reduce or minimise negative impact**: if you identify unlawful discrimination, including victimisation and harassment, you must stop the action and take advice immediately.
- **Promote equality of opportunity**: by
  - Removing or minimising disadvantages suffered by equality groups
  - Taking steps to meet the needs of equality groups
  - Encouraging equality groups to participate in public life or any other activity where participation is disproportionately low
  - Consider if there is a need to treat disabled people differently, including more favourable treatment where necessary
- **Foster good relations between people who share a protected characteristic and those who don't**: e.g. by promoting understanding.

[3] EqIAs **should always be proportionate** to:

- The size of the service or scope of the policy/strategy
- The resources involved
- The size of the likely impact – e.g. the numbers of people affected and their vulnerability

The greater the potential adverse impact of the proposal(s) on a protected group (e.g. disabled people) and the more vulnerable the group is, the more thorough and demanding the process required by the Act will be. Unless they contain sensitive personal/employee data – EqIAs are public documents. They are published with Cabinet and Panel papers and public consultations and are available on request.

[4] **Who completes the EqIA:** The person who is making the decision or advising the decision-maker about a policy. It is better to do this as a team, with people involved who understand the implementation of the policy.
[5] **Title of EqIA:** This should clearly explain what service / policy / strategy / change you are assessing.

[6] **Focus of EqIA:** A member of the public should have a good understanding of the policy or service and any proposals after reading this section. Please use plain English and write any acronyms in full first time. Also explain if there is a particular focus to your equality analysis:

- What are the main aims or purpose of the policy, practice, service or function? How does it fit with other services?
- What outcomes do you want to achieve, why and for whom? e.g. what do you want to provide, what will change/improve?
- Which aspects are most important to equality and should be the focus of your attention?
- You should state all teams/organisations involved in implementing, carrying out or delivering the policy, practice or service
- What are the **reason(s) for** the proposal or change (financial, service, legal etc)? The Act requires us to make these clear.

[7] **Data & Information:** Your EqIA needs to be informed by data. You should consider the following:

- What data relevant to the impact on protected groups is available?
  (is there an existing EqIA?, local service data, national data, community data, similar proposal in another local authority).
- What further evidence is needed and how can you get it? (e.g. further research or engagement with the affected groups).
- What do you know from service/local data about needs, access and outcomes? Focus on each characteristic in turn.
- What might any local demographic changes or trends mean for the service or function? Also consider national data if appropriate
- Does data/monitoring show that any policies or practices create particular problems or difficulties for any group(s)?
- Is the service having a positive or negative effect on particular people or groups in the community?

[8] **What have people told you about the service, function, area?**

- Use service user feedback, complaints, audits, and/or the results of specific consultation/engagement

- Are there patterns or differences in what people from different groups tell you?
- Remember, you must engage/consult appropriately and in an inclusive way with those likely to be affected to fulfil the equality duty.
- You can read HCC's Consultation and Engagement toolkits for full advice on this
- For practical tips and advice on consulting with people from protected groups, see this 'How-to' guide

[9] **Impact:** Your EqIA must consider fully and properly **actual and potential impacts** against each protected characteristic:

- The equality duty does not stop changes, but means we must fully consider and address the anticipated impacts on people.
- Be accurate and transparent, but also realistic: don't exaggerate speculative risks and negative impacts.
- Be detailed and specific where you can so decision-makers have a concrete sense of potential effects.
- Questions to ask when assessing whether and how the proposals impact on service users, staff and the wider community:
    - Are one or more protected groups affected differently and/or disadvantaged? How, and to what extent?
    - Is there evidence of higher/lower uptake among different groups? Which, and to what extent?
    - Does the project relate to an area with known inequalities (where national evidence or previous research is available)?
    - If there are likely to be different impacts on different groups, is that consistent with the overall objective?
    - If there is negative differential impact, how can you minimise that while taking into account your overall aims?
    - Do the effects amount to unlawful discrimination? If so the plan **must** be modified.
    - Does it relate to an area where equality objectives have been set by HCC in our Equality Strategy?

[10] **Consider actions relating to the following:**

- That specifically address the impacts you've identified and show how they will remove, reduce or avoid any negative impacts
- Explain clearly what any mitigating measures are, and the extent to which you think they will reduce / remove the adverse effect
- Will you need to communicate or provide services in different ways for different groups in order to create a "level playing field"?
- State how you can maximise any positive impacts or advance equality of opportunity.
- If you do not have sufficient equality information, state how you can fill the gaps.

[11] **Age**: People of all ages, but consider in particular children and young people, older people and carers, looked after children and young people leaving care. Also consider working age people.

[12] **Disability**: When looking at disability, consideration should be given to people with different types of impairments: physical (including mobility), learning, aural or sensory (including hearing and vision impairment), visible and non-visible impairment. Consideration should also be given to: people

with HIV, people with mental health needs and people with drug and alcohol problems. People with conditions such as diabetes and cancer and some other health conditions also have protection under the Equality Act 2010.

[13] **Gender Reassignment:** In the Act a transgender person is someone who proposes to, starts or has completed a process to change his or her gender. A person does **not** need to be under medical supervision to be protected. Consider transgender people, transsexual people and transvestites.

[14] **Pregnancy and Maternity:** When looking at pregnancy and maternity, give consideration to pregnant women, breastfeeding mothers, part-time workers, women with caring responsibilities, women who are lone parents and parents on low incomes, women on maternity leave and Keeping in Touch days.

[15] **Race/Ethnicity:** Apart from the common ethnic groups, consideration should also be given to Gypsy, Roma and Irish Travellers communities, people of other nationalities outside Britain who reside here, refugees and asylum seekers and speakers of other languages.

[16] **Religion and Belief:** Religion includes any religion with a clear structure and belief system. As a minimum you should consider the most common religious groups (Christian, Muslim, Hindu, Jews, Sikh, Buddhist) and people with no religion or philosophical belief(s).

[17] **Sex/Gender:** Consider girls and women, boys and men, married people, civil partners, part-time workers, carers (both of children with disabilities and older cares), parents (mothers and fathers), in particular lone parents and parents on low incomes.

[18] **Sexual Orientation:** The Act protects bisexual, heterosexual, gay and lesbian people.

[19] **Marriage and Civil Partnership:** consider married people and civil partners – e.g. do same sex couple in a civil partnership have the same rights and benefits as married people?

[20] **Carers:** From April 2015, carers (people who provide unpaid care to a friend or relative) have been entitled to an assessment of their own needs in the same way as those they care for. Although not a 'protected characteristic' HCC Diversity Board has agreed that the impact of proposals on carers should also be considered.

[21] **Other relevant groups:** You should consider the impact on our service users in other related areas, such as health and wellbeing, crime and disorder (e.g. people experiencing domestic abuse), community relations and socio-economic status (e.g. homelessness or low incomes). If the proposal is likely to have an impact on service users in these areas, HCC Public Health and the County Community Safety Unit may be able to help. Also consider whether your policy or decision will impact current or former Armed Forces personnel living and working in Hertfordshire. The Council is committed to the Hertfordshire Community Covenant, a commitment from public and private organisations in the county to support the active and retired Armed Forces community.

[22] **Equality of opportunity and good relations:** summarise anything that will have a potential positive impact over and above the work of your project – e.g. engaging with the community may help raise awareness and community understanding of the needs of certain groups.

[xxiii] **Action Planning:** The Equality Duty is an ongoing duty: policies must be kept under review, continuing to give 'due regard' to the duty. If an assessment of a broad proposal leads to more specific proposals, then further equality assessment and consultation are needed.