APPENDIX B

Leicestershire County Council

Equality Impact Assessment Form

Before completing this form, please refer to the supporting guidance document

The purpose of this form is to aid the Council in meeting the requirements of the Public Sector Equality Duty contained in the Equality Act 2010. This requires the Council to have "due regard" of the impact of its actions on the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between persons who share a relevant protected characteristic and those who do not.

The assessment is used to identify and record any concerns and potential risks. The following actions can then be taken to address these issues.

- Remove risks: abandon the proposed policy or practice
- Mitigate risks – amend the proposed policy or practice so that risks are reduced
- Justify policy or practice in terms of other objectives

Once the EIA has been approved by the Senior Responsible Officer, please ensure that a copy is placed on the SharePoint folder: "Equalities Board, EIAs"

APPENDIX B

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1- Policy details	
Name of policy	Draft LLR Suicide Prevention Strategy 2024-2029
Department and service	Public Health
Who has been involved in completing the Equality Impact Assessment?	Lead Officer – Hollie Hutchinson
Contact numbers	0116 305 4204
Date of completion	03/09/2024

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2- Objectives and background of policy or practice change Use this section to describe the policy or practice change What is the purpose, expected outcomes and rationale? Include the background information and context	
What is the proposal? **What change and impact is intended by the proposal?**	**What is the proposal?** The proposal is for the County Council to adopt the refreshed LLR Suicide Prevention Strategy for the period of 2024-2029. The strategy sets the priorities across LLR for suicide prevention. The strategy has been developed in close partnership with the Leicester City Council, Rutland County Council, the Integrated Care Board, health providers such as Leicestershire Partnership NHS Trust and the voluntary and community sector, as well with those who have lived experience of suicide. The strategy was developed through a thorough understanding of local and national data and evidence, as well as through engagement with local stakeholders and those with lived experience. As a result, the priorities have been refreshed and are: 1. Supporting the system to put in place measures to help reduce suicidal ideation and suicides in **children and young people** 2. Targeted support and resources at **higher risk groups and locations**, as identified by local and national data and evidence 3. Improve our local understanding of **self-harm** and support people with a history of self-harm 4. Providing effective **bereavement** support to those affected by suicide

5. **<u>Leadership</u>** - Work with system partners and communities to support their role within suicide prevention.

The priorities will be delivered through adoption of the guiding principles, which crosscut the priorities:

1. **Co-Production and Collaboration**
    - Meaningful and authentic lived experience involvement will underpin everything we do and will be viewed as an essential part of delivering effective work at all levels.
2. **Learn from past stories**
    - We will understand our local suicides and the intersectionality of factors, using this to inform our future work.
3. **Data driven**
    - Our work will be driven by our understanding of local data, and the current and emerging evidence base to reduce suicides. We will target our work using data and evidence, ensuring we reach those that need help the most.
4. **Normalising conversations**
    - We will strive to reduce stigma and taboo around suicide and mental health and encourage people to Start a Conversation. This will be instrumental to all of our work and our priority areas. We will work with local media on aspects of mental health and suicide, ensuring stories are portrayed sensitively and safely, in line with current guidance, and challenge inappropriate reporting and conversations where necessary.

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	5. **Settings-based approach** • Adopt a settings-based approach to integrate suicide prevention activity into local communities, organisations and sectors, emphasising education, awareness and training, with a strong focus on early intervention 6. **Trauma Informed Practice** • We will work to adopt a Trauma Informed Approach in our interactions, delivery and commissioning: understanding past experiences and the needs of the people we serve, including being sensitive to any trauma they may have experienced. By offering support early and being thoughtful in how we provide care, we can help improve lives. A robust action plan will then be developed following adoption of the strategy providing actions against all priorities to ensure successful implementation. This will be reviewed and if applicable, refreshed annually. The refreshed strategy is in line with the National Suicide Prevention Strategy which was released in 2023. There is an expectation that all local strategies should support the national strategy. **What change and impact is intended by the proposal?** The overall mission of the strategy is to '**prevent suicides and saves lives'**. This is the intended impact. The strategy provides a framework and guidance around how the system can work together to address issues which will support suicide prevention. Other

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	intended impacts are to continue working to normalise conversations around mental health, allowing people to speak up and to not feel that suicide is their only option. We want everyone within LLR to accept that 'suicide is everybody's business' and that there is something that can be done by everyone.
What is the rationale for this proposal?	Local authorities are required by the Department of Health and Social Care to develop a Suicide Prevention Strategy to reduce the rate of suicide in the general population. The previous strategy (2020-2023) was due to be refreshed in 2023, however due to the imminent launch of the national suicide prevention strategy, development was put on hold to ensure any refreshed local strategy would be in accordance with the national strategy, of which there is an expectation. The Leicestershire Health and Wellbeing Board has a marker of success describing maintaining suicide rates lower than the national average and makes a commitment of 'Maintaining low rates of suicide and impact of suicide, supporting work of the LLR Suicide Strategy'. Suicide can be preventable and is not inevitable. The rationale for this strategy is to ensure work carries on across the system to address suicide prevention, especially within key high-risk groups and at specific touch points in the suicide prevention continuum. The strategy is essential to bring partners together to work on shared priorities and actions to prevent and reduce suicide.

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3- Evidence gathered on equality implications - Data and engagement

What evidence about potential equality impacts is already available?
This could come from research, service analysis, questionnaires, and engagement with protected characteristics groups

What equalities information or data has been gathered so far? What does it show?	**What equalities information or data has been gathered so far?** All data available on suicides in LLR was explored. LCC work in partnership with Leicestershire Police, who provide data via Real Time Suspected Suicide Surveillance. The Real Time Suspected Suicide Surveillance Data (RTSSSD) was explored for the time period 2018-2023. The RTSSSD is suspected suicides that have not been through the coronial process, so are not confirmed suicides. It provides a large database of suicides and allows some aspects of intersectionality to be explored. However, due to the unconfirmed nature, and the inability to calculate rates, the data does need careful interpretation. Some RTSSSD data is only available for 2023 as well, due to extra fields being added. Office for National Statistics data (ONS) suicide data is minimal and only covers rates over three years, numbers per year and gender breakdown. However, these are based on confirmed suicides. Both data sources were used. Joint Strategic Needs Assessment (JSNA) on Mental Health for the three local authority areas was used, as well as data provided via Child Death Overview Panel (CDOP) and reports such as JSNAs and HNAs covering substance use and gambling harms (not officially released yet). Academic literature has also been gathered and used. Engagement was carried out to understand thoughts on the current strategy priorities, the national strategy and what more could be done to address suicide prevention within LLR.

What does it show?

Age;

Nationally, middle aged men are more likely to die by suicide than any other group. Locally, from 2018-2023 males aged 30-59 saw the highest number of deaths.

The average age of suspected suicides varies across LLR, likely due to the varying age demographics per place. Within Leicester, the average ages for men and women are 42 and 38 years respectively, which is younger than the Leicestershire averages at 45 years for males and 49 years for females. Ages within Rutland are again higher at 52 years for males and 57 years for females.

Nationally, although numbers in children and young people are low, there is an increasing trend.

Disability;

There is limited local data available on disability and suicide. Disability and suicide is limited within the national strategy, except for the inclusion of autism which features strongly.

An emerging trend is in neurodiverse individuals, especially autism and ADHD. Within the RTSSSD a new category for neurodiversity was recently added in 2022 to capture this aspect. The numbers are small, therefore interpretation needs to be careful, but during 2023 5.9% (N=7) of suspected suicide deaths were in those with neurodiversity issues. Due to the emerging nature, they will be closely monitored. Nationally, evidence suggests that autistic people may be at higher risk of dying by suicide, compared to those that are not autistic. Undiagnosed or late-diagnosed autism may be

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a preventable risk factor for suicide and, therefore, earlier identification and timely access to autism assessment services is vital.

According to census data and academic literature however, people with disabilities are more likely to die by suicide and undertake suicidal behaviour than non-disabled people.

People in the care of mental health services, including inpatients are a group at high risk of suicide, and account for around one quarter of deaths by suicide each year nationally. The RTSSSD shows our local proportion to be higher, with over 40% of local suicides having been in contact with mental health services 12 months prior to their deaths (caution has to be used in interpreting this due to self-reporting). Leicestershire Partnership NHS Trust are in the process of developing their suicide prevention plan to address this.

Gender reassignment;

Locally, the numbers are too low to disclose. However nationally, the rates of suicides and suicide ideation, as well as poorer mental health are higher among transgender persons.

Marriage and civil partnership:

Research indicates that people who have never been married, people who are divorced, or people who are widowed are at an increased risk of suicide compared with those who are married.

Between 2018 and 2023, RTSSSD indicates that of the suspected suicides, 51.6% of Leicestershire deaths, 62.9% of Leicester City deaths and 50% of Rutland deaths occurred in single people. Married people accounted for 18.3% in Leicester City, 26.1% in Leicestershire. Rutland figures were supressed.

Pregnancy and maternity;

Local data has not been found for this cohort. However, in the UK, suicide is the leading cause of direct deaths 6 weeks to a year after the end of pregnancy. In 2020, women were 3 times more likely to die by suicide during or up to 6 weeks after the end of pregnancy compared with 2017 to 2019. However, the level of risk of suicide after pregnancy is not higher than at other times in a woman's life.

Race and Ethnicity;

There does not appear to be any data that suggests race is a characteristic which increases risk of death by suicide. Research shows that suicide is not so prevalent in minority ethnic groups. However, evidence suggests that suicidality may be expressed or developed in different ways in different cultural contexts and ethnic groups, along with different levels of associated stigma and taboo on suicide and mental health topics.

The RTSSSD shows that the largest proportion of deaths within residents of LLR are of white ethnicity and British nationality.

Religion or belief;

Research shows that religion can be a protective factor, with lower rates of suicide observed within those belonging to religious groups.

Percentages of those dying by suicide appear disproportionally higher in those without a religion, compared to those with. However, this is using the absolute numbers from the RTSSSD, rather than rates. RTSSSD captures this by asking next of kin, which opens this up to bias, as well as

	unknowing e.g. someone may describe themselves as 'Christian' on the census, however the next of kin may describe them as 'no religion' if they are not a practising Christian. Across LLR (using the RTSSSD), residents with no religion saw the largest proportion of deaths by suspected suicide, ranging from 50% in Rutland, 60.9% in Leicester City and 71.3% in Leicestershire. Sex Both nationally and locally, men are three times more likely to die by suicide than women, with middle-aged men having the highest rates of suicide of any other group. Within this group, there are several associated factors including socioeconomic disadvantage, living in deprived areas, experiencing unemployment or financial difficulties, relationship breakdowns, history of substance misuse, and social isolation and loneliness. Although suicide rates are lower in women, young women are more likely to self-harm than males. Self-harm is a key risk factor for suicide. Sexual Orientation The majority of LLR suicides occurred in heterosexual individuals (over 95% of suspected suicides). Literature demonstrates that LGBTQ+ experience higher rates of suicidal behaviour and ideation. Other There are other groups which have a higher risk of suicide (and have been considered within the strategy). They include:

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	- People with a history of self-harm - Those who have been bereaved by suicide - People who misuse alcohol and drugs - Suicide is also correlated with deprivation - Those facing financial hardship - Those experiencing loneliness and isolation - Those working in particular industries such as nursing, farming and agriculture Suicide is hugely complex, with numerous intersecting factors and risks. The reasons behind each death are different and hugely personal. We have worked hard to understand our data, but looking for linkages, correlations and intersectionality is a difficult process and one that through the strategy we will continue to strive to improve.
What engagement has been undertaken so far? **What does it show?**	**What engagement has been undertaken so far?** A significant period of engagement was undertaken during May 2024. Due to the sensitive nature of the topic and the necessary need to avoid suicide contagion, specific groups with lived experience and professional stakeholders were targeted to engage with. Three stakeholder focus groups were conducted. Two face-to-face, one in the City and one in the County, as well as an online session were held, which saw attendance from 32 individuals. These individuals covered various organisations including the three upper tier LA's, district councils, ICB,

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	LPT, provider services, educational establishments, Leicestershire Police and local VCSE organisations. Four focus groups were held with experts with experience (EwE) of suicide and mental health challenges, including a session specific for young people. In total 23 experts with experience were involved, including the LLR Suicide Lived Experience Network, which LCC coordinate. A member of the lived experience network also sits on the strategy steering group, helping to drive forward the strategy development. Attendees were asked questions around wider mental health and wellbeing such as what helps to support mental health, what are the barriers to accessing help and support and what are the currents needs within their communities. Questions were then asked around the current strategy and the national strategy and whether the priorities were still pertinent, and what individuals would like to see included in the refreshed strategy. The results were analysed and themed using a pragmatic thematic analysis approach. **What does it show?** The results from both the professional stakeholders and EwE were generally in agreement. Both felt that stigma and taboo around mental health were prevalent and stopped people seeking help, especially at an early stage. Discussions focussed on the need for education and awareness, and how suicide is everybody's businesses, so there needs to be a joined-up approach, including the private sector and workplaces to help address this. The need to support children and young people was evident, as was the importance of relationships and community cohesion.

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	Mental health services were discussed, with EwE discussing the difficulties they often faced accessing services, including bereavement support. The professionals were also pragmatic and felt that resources should be targeted where need was highest, rather than at all high-risk groups and circumstances. Throughout there were clear golden threads through the conversations: - The need to incorporate lived experience more and the need for co-production - The ability to learn from past stories and past suicides, and put that learning into practice - The need for services to be trauma informed, ensuring they promote recovery and healing, and prevent re-traumatisation - The need to normalise conversations around mental health and suicide and address the stigma attached Those who were engaged were supportive of the current governance and partnership working involved, as well as the Start the Conversation campaign. The use of data was understood and appreciated. They generally felt that the national strategy was good, however a local strategy needs to reflect local need and not simply be a replication of the national one. From the current priorities, the top three priorities that were still relevant were supporting primary care, targeting high risk groups and provision of enhanced suicide awareness training.

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4- Benefits, concerns and mitigating action

Please specify if any individuals or community groups who identify with any of the 'protected characteristics' may ***potentially*** be affected by the policy and describe any benefits and concerns including any barriers. Use this section to demonstrate how risks would be mitigated for each affected group. If a group will not be affected by the proposal please state so.

Group	What are the benefits of the proposal for those from the following groups?	What are the concerns identified and how will these affect those from the following groups?	How will the known concerns be mitigated?
Age	The strategy recognises that suicide cuts across all age groups, however it is more prevalent in some compared to others. Locally suicide rates are higher in middle aged men, and prevention at the earliest possible opportunity, such as during childhood and adolescence is imperative. By prioritising children and young people (priority 1) the strategy recognises the need for early intervention, whilst the priority of higher risk groups (priority 2) will use the best available data and evidence to	There are no specific risks or concerns. Targeted action for higher risk age groups is justified, however work will crosscut across all life course stages.	NA

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	target actions at high-risk groups, of which middle-aged men will be one. Other priorities and guiding principles within the strategy will ensure that all age groups will benefit, such as the normalising of conversations and adoption of trauma informed practice.		
Disability	The priority of targeted support and resources at higher risk groups (priority 2) will focus on those groups as identified by evidence and data as having a higher risk. Two of those groups include people in contact with mental health services and autistic people, due to the higher numbers and national increasing trends respectively. Disability may also intersect with other high-risk groups, as well as other priorities e.g. within children and young people (priority 1) and those who self-harm (priority 3).	There are no specific risks or concerns. Data monitoring will continue to occur, and actions put in place through priority 2 high risk groups. LPT's suicide prevention strategy is focussed on their mental health services and ensuring they reduce risk and put in place the recommendations from the National Confidential Inquiry into Suicide and Safety in Mental Health. The LPT strategy will	NA

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		complement the LLR Suicide Prevention Strategy ensuring high risk individuals are understood and activities put in place to reduce suicides.	
Race	Overall, the strategy aims to have benefits to all individuals across all races and ethnicities. The Suicide Prevention Strategy is overseen by the Suicide Audit and Prevention Group, where various organisations sit, including VCSE organisations with a focus on ethnic minority groups. Any activities arising from the strategy will cater for all races and ethnicities, in a culturally appropriate manner. Local understanding of race, ethnicity, mental health and suicide is more limited. The strategy seeks to be guided by data and evidence and as such needs to understand these groups more and how their needs vary.	There are no specific risks or concerns, there are however opportunities to learn more, understand local data better and ensure local voices from minority groups is captured. This strategy will not create inequalities in relation to this characteristic.	The strategy will continue to drive forwards with better understanding of our local data.

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Sex	Men are three times more likely to die by suicide than women. Men will feature as a key high-risk group under priority 2, as mentioned within 'Age' above. The guiding principles will allow specific groups of men to be targeted, intersectionality of factors understood and learning from past stories to be implemented, ensuring men can be understood and interventions put in place to support them. Self-harm rates are higher in young women, compared to their male counterparts. Self-harm is a key priority within the strategy (priority 3), as are children and young people (priority 1). Understanding local self-harm data is key and will allow specific groups to be targeted more effectively.	There are no specific risks or concerns. Priorities are targeted at groups where rates are significantly higher. Actions will be put in place to address these groups. Overall, the strategy aims to have benefits to all individuals who are at risk of suicide.	NA
Gender Reassignment	There is a need for further research in suicidality outcomes following gender-affirming treatment (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10027312/). Overall, this is nil for this group. There are no specific positive or negative implications. The strategy is designed to support everyone who is at risk of suicide, through both universal and targeted provision. Training is an aspect that will come from the strategy which will discuss higher risk groups.	There are however opportunities to learn more, understand local data better and ensure local voices are captured. This strategy will not create inequalities in relation to this characteristic.	NA

Marriage and Civil Partnership	The quality of social ties can influence suicide risk, and there is evidence of a lower risk of suicide amongst those who may be married or in a civil partnership (https://pophealthmetrics.biomedcentral.com/articles/10.1186/s12963-021-00263-2). The strategy is designed to benefit all who may be at risk of suicide. However, understanding the differential rates between those of different relationship status's allows targeted actions when it comes to intervention development to achieve the priorities, especially in relation to priority 2: high risk groups. Having a thorough understanding of the data is also important for priority 5: Leadership, where this can be shared across different organisations, and they can understand the risk factors and address these within their service areas.	There are no additional risks created by the strategy, there are however opportunities to learn more, understand local data better and ensure local voices are captured. This strategy will not create inequalities in relation to this characteristic.	
Sexual Orientation	The final strategy will be equally accessible and appropriate to all sexual orientations. Although the majority of suspected suicide numbers are within heterosexual individuals, rates are higher in other LGBTQ+ groups.	Overall, there are no specific positive or negative implications. The strategy is designed to	Training is an aspect that will come from the strategy which will discuss higher risk groups.

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	Through a commitment to understanding data better, a clearer picture will be made of those at higher risk and the intersectionality of factors.	support everyone who is at risk of suicide, through both universal and targeted provision.	
Pregnancy and Maternity	Pregnancy and maternity have been discussed within the national strategy as a key high-risk group, with national actions attached, which will have a positive effect locally. Our numbers for this cohort are low, we have not been made aware of any local suicides. However, data will be monitored and if issues arise, then through the delivery of priority 2: high risk groups, these will be addressed.	There are no additional risks created by the strategy, there are however opportunities to learn more, understand local data better and ensure local voices are captured. This strategy will not create inequalities in relation to this characteristic.	NA
Religion or Belief	Overall, the strategy aims to have benefits to all individuals across all faiths, and those with none. The Suicide Prevention Strategy is overseen by the Suicide Audit and Prevention Group, where various organisations sit, including VCSE organisations. Any activities arising from the strategy will cater for all faiths and those with none, in a culturally appropriate manner.	There are no specific risks or concerns, there are however opportunities to learn more, understand local data better and ensure local voices are captured. This strategy will not create inequalities in relation to this characteristic.	NA

	Local understanding of the role of faith is more limited. The strategy seeks to be guided by data and evidence and as such needs to understand these group more and how their needs vary.		
Armed Forces (including veterans)	Current members and veterans of the armed forces (over 24 years) are not at higher risk of suicide than the general population, however the rates of suicide are 2-4 times higher among young male and female veterans (aged 24 or under) than the civilian population. Suicide is multi factorial and there is increased risk for those experiencing struggles with depression or impacted by alcohol related harm, those who left involuntarily, due to disciplinary or medical discharge. (NCISH - 'Suicide after leaving the UK Armed Forces 1996-2018: a cohort study' 2022). The SAPG includes representation from the Armed Forces lead at LPT, alongside VCSE partners who work directly with the veteran's community. Veterans are listed under priority 2: high priority groups, and as such relevant actions will be put in place to address any occurrences.	There are no additional risks created by the strategy.	NA
People with lived care experience	Care leavers are at an increased risk of suicide, suicidal ideation and self-harm. Overall, the strategy aims to have benefits for all. Care leavers are listed as a high-risk group within priority 2, so targeted actions will be picked up during action plan development based on data and evidence. The strategy is designed to support everyone who is at risk of suicide, through both universal and targeted provision. Training is	There are no additional risks created by the strategy.	NA

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	an aspect that will come from the strategy which will discuss higher risk groups and aim to raise awareness.		
Other groups: e.g., rural isolation, deprivation, health inequality, carers, asylum seeker and refugee communities, looked after children, deprived or disadvantaged communities	The strategy is based on data, evidence and insight from those with lived experience. Various groups are listed within the strategy that are at higher risk including: - People with a history of self-harm - Those who have been bereaved by suicide - People who misuse alcohol and drugs - Those facing financial hardship - Those experiencing loneliness and isolation - Those working in particular industries such as nursing, farming and agriculture However, due to the wide range of risk factors, anyone could potentially be higher risk at some point within their life. Due to this the key messages and guiding principles of the strategy are important. The aim is for suicide to be everybody's business, and for everyone and every organisation to play their part. Reducing stigma and taboo is important to allow people to feel comfortable to talk about their mental health, their current situations and any suicidal thoughts that they may have, without fear of judgement or retribution. If when reading the strategy people can take home the key messages, then we will be on our way to achieve the mission of preventing suicide and saving lives.	No group will be adversely affected by the strategy.	NA

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5- Action Plan

Produce a framework to outline how identified risks/concerns identified in section 4 will be mitigated.

What action is planned?	Who is responsible for the action?	Timescale	Expected outcome
A better and more thorough understanding of the data is required for specific protected characteristic groups. Over the course of the strategy, we will continue to work with Leicestershire Police to understand our data better, capture lived experience voice more effectively and learn from past suicides. We can then use this data to provide services to meet the needs of the varying cohorts.	Suicide Audit and Prevention Group (Public Health LCC)	Ongoing development, however, within the first two years of the strategy a better understanding across all characteristics will be undertaken, as well as building in lived experience voice.	A better understanding of our local suicides, groups and intersectionality so that interventions can be more targeted at those with higher risk.

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6- Approval Process	
Departmental Equalities Group	The EIA was due to be considered at the Public Health Department Equalities Group on the 1st of October, however this meeting was postponed. Instead, the strategy and EIA were circulated for comment on the 24th of September. Comments were positive and officers felt the strategy was well thought out and had considered key risk factors and groups.
Corporate Policy Team	The Policy Team considered the EIA and provided the following comments: - Specific actions should be taken and a clear plan developed of mental health promotion and suicide prevention work which is targeted at those known to be at greatest risk. After discussions with the senior officer, this will be captured through an action planning process, where lived experience and user voice will feature. This is sufficient. - The EIA and strategy have considered the risks for each of the protected characteristics, and the actions will feature as part of the action planning process.
Sign off by the Senior Responsible Officer for the Project.	

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