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Preventing suicide in England: A cross-government outcomes strategy to save lives

Assessment of impact on equalities

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Preventing suicide in England: A cross-government outcomes strategy to save lives

Assessment of impact on equalities

Introduction

1. This document sets out the process we have gone through in considering equality impacts in developing the new suicide prevention strategy for England, and should be read alongside *Preventing suicide in England: A cross-government outcomes strategy for saving lives*
2. The Equality Act 2010 established a public sector duty to advance equality and reduce inequality for people with nine protected characteristics:
 - age, including specific ages and age groups;
 - disability (a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities);
 - race including colour, nationality and ethnic or national origins;
 - sex;
 - sexual orientation;
 - gender reassignment (transgender people);
 - pregnancy and maternity;
 - religion or belief, including a lack of religion or belief;
 - marriage and civil partnership status.
3. Carers of people with a protected characteristic also receive protection by virtue of their association with that person.
4. Much of the planning and work to prevent suicides will be carried out locally. The strategy outlines a number of evidence based local approaches, as well as national actions to support these local approaches, in each of the six areas for action identified in the strategy. In the case of local actions, it will be for local agencies, including working through health and wellbeing boards, to decide the best way to achieve the overall aim of reducing the suicide rate. Interventions and good practice examples are included to support local implementation and are not compulsory. Local commissioners will be able to accept, adapt or leave these suggestions based on their assessment of the needs and agreement of the priorities in their local area. This document therefore focuses on the national actions which will be taken to address the issues identified, and should be read alongside the full strategy document.

Consideration of equality impacts in the policy development process

5. Recognition of the implications for the people sharing protected characteristics has been an integral part of the process in developing the new strategy. Individuals sharing particular characteristics may be at heightened risk from some of the factors identified in area for action 1 of the strategy; key groups with a high risk of suicide. For example, lesbian, gay and bisexual people have a higher risk of mental health problems and self-harm. They are also considered under the second area for action; tailored approaches to improve mental health in specific groups.
6. As well as targeting high-risk groups, another effective way to prevent suicide is to improve the mental health of the population. In order for this whole-population approach to reach all groups who might need it, it needs to include tailored measures for groups with particular vulnerabilities or issues of access to services. They are groups of people who may have higher rates of mental health problems including self-harm. For many of these groups we do not have sufficient information about rates of suicide.
7. In writing this strategy the lack of information about suicide risk in many groups has become apparent. Under area for action 6, we consider how we can improve information and data collection. We recognise that there could be other high risk groups but that the data does not allow for them to be defined as there would be no way of monitoring progress in terms of suicide prevention amongst these groups. Where we have good reason to suspect a heightened suicide risk, and where there is good evidence to suggest that cost-effective action could be taken to limit that risk, we have included that in the strategy.
8. The individuals we identify as higher risk in the strategy are not discrete groups, and many individuals may share more than one high risk characteristic.

Sex

9. In 2008-2010, the age standardised suicide death rate for all persons is 7.9 per 100,000 population. Men are more than three times as likely as women to take their own life, with a death rate of 12.2 per 100,000 compared to 3.7 per 100,000 for women. Most suicides are among men aged under 50. The suicide rate for young men aged under 35 has fallen in recent years, and men aged 35-49 are now the group with the highest suicide rate.
10. The strategy addresses the high risk of suicide among men by identifying young and middle-aged men as a group at high risk of suicide in area for action 1 of the strategy. Although the strategy is focusing particularly on young and middle-aged men, this does not mean that older men should be overlooked. Rates of suicide in men aged over 75 are still above the rates for men all ages. Different risk factors, such as loneliness and physical illness, may be important in this age group. The needs of older men are highlighted in area for action 2, alongside other people potentially vulnerable due to untreated depression.
11. Women are at higher risk of self-harming than men. People who self-harm are at increased risk of suicide, although many people do not intend to take their own life when they self-harm. There is evidence of a strong association between domestic violence and self-

harm¹. The strategy includes people with a history of self-harm as a group at high risk of suicide in area for action 1 of the strategy. Survivors of abuse or violence, including sexual abuse, are included in area for action 2 of the strategy as a group in need of tailored approaches.

Age

12. The suicide rate is highest among males aged 40-44 and females aged 50-54. While suicide rates then fall for females, for males the rate rises sharply for the 75+ age group. Although the number of deaths are quite low in this group, the population is also low and so the rate is relatively high.

13. The strategy addresses the needs of men of different ages as outlined in the previous section.

14. The suicide rate among teenagers is below that in the general population. Self-harm is particularly common among young people. Studies have shown that by age 15-16, 7-14% of adolescents will have self-harmed once in their life. Also, half of lifetime mental health problems (excluding dementia) begin to emerge by age 14 and three-quarters by the mid-20s. Children and young people, including those who are vulnerable such as looked after children and care leavers, are included in area for action 2 of the strategy as a group in need of tailored approaches. In addition, area for action 5 describes how the Government will continue to work with the internet industry and content providers through the UK Council on Child Internet Safety to create a safer online environment for children and young people.

Disability

15. 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. They were included as a high risk group in the previous suicide prevention strategy published in 2002, and despite some reductions in suicide rates, they remain a group at high risk in the new suicide prevention strategy.

16. Physical illness is associated with an increased suicide risk. Epilepsy, in particular, is associated with an increased suicide risk. There is also evidence that receiving a diagnosis of cancer, coronary heart disease and airways diseases is associated with a jump in suicide risk. For cancer, the risk of suicide increases by more than ten times in the week after diagnosis.

17. Many people who live with long-term conditions – including physical illness, disability and chronic pain – will, at some time, experience periods of depression that may be undiagnosed and untreated. Depression is a risk factor for suicide. While depression explains some of the increased suicide risk in people with physical health conditions, it does not explain all of the increase. People living with long-term physical health conditions are included in area for action 2 of the strategy as a group in need of tailored approaches.

¹ Walby S. (2004) *The Cost of Domestic Violence*. Published by Women and Equality Unit www.lancs.ac.uk/fass/sociology/papers/walby-costdomesticviolence.pdf

18. Evidence suggests that rates of suicide and attempted suicide among people with severe learning disabilities are lower than in the general population. There is evidence to suggest that suicide risk factors and rates are higher in people with limited intellectual functioning (including mild or borderline learning disabilities).

Race

19. There is little evidence on suicide risks in Black, Asian and other minority ethnic groups, as information on ethnicity is currently not collected through the death registration and inquest processes. This is a major obstacle to getting reliable and accurate data on suicides and to improving the evidence base and monitoring trends².
20. The evidence on the incidence of mental health problems in Black, Asian and ethnic minority groups is complex. This covers many different groups with very different cultural backgrounds, socioeconomic status and experiences in wider society.
21. Research shows that some Black and minority ethnic groups have high rates of severe mental illness, which may put them at high risk of suicide. The rates of mental health problems in particular migrant groups, and subsequent generations, are also sometimes higher. More recent arrivals, such as some asylum seekers and refugees, may also require mental health support following their experiences in their home countries.
22. There is evidence to suggest that male Irish travellers are three times as likely to die by suicide as the general population³ and that Gypsies and Travellers have raised rates of depression and anxiety.
23. Black, Asian and minority ethnic groups and asylum seekers are included in area for action 2 of the strategy as groups in need of tailored approaches.
24. Through the consultation, a study has been highlighted which shows that suicide by burning remains a significant issue in the South Asian origin working-age population in England and Wales. The strategy includes action to reduce access to high-lethality means of suicide, which is one of the most effective ways to prevent suicide. However, not all suicide methods are amenable to intervention, including the most common method hanging/strangulation, except in the controlled environment of psychiatric inpatient and criminal justice settings. Similarly, given the free availability of petrol and matches, suicide by burning is not going to be amenable to an intervention which attempts to reduce access to the means. This means that any preventative efforts will need to be focused on reducing the suicidal impulse.

Sexual orientation

25. A review of the research literature suggests that lesbian, gay and bisexual people are at higher risk of mental disorder, suicidal ideation, substance misuse and deliberate self-

² (2006) *Suicide Prevention for BME Groups in England*

³ Walker MR (2008) *Suicide among the Irish Traveller Community 2000-2006*. Wicklow, Ireland: Wicklow County Council

harm⁴. One Danish study found the suicide risk among gay men in civil partnerships is eight times higher than in heterosexual couples and twice as high as the risk in men who have never married. However, the same study showed no statistically significant increase in suicide risk among women in civil partnerships⁵.

26. Notably, lesbian, gay and bisexual people are:

- twice as likely as heterosexual people to attempt suicide
- at 1.5 times higher risk of depression and anxiety disorders and 1.5 times higher risk of alcohol and other substance dependence.

27. Gay and bisexual men have a particularly high prevalence of suicide attempt. Stonewall recently published the *Gay and Bisexual Men's Health Survey*, carried out in 2011. They found that, in the last year, 3% of gay men, 5% of bisexual men, and 5% of black and minority ethnic gay and bisexual men had attempted to take their own life. In the same period, 0.4% of all men attempted to take their own life. The risk seemed to be particularly high for the youngest men, with one in ten gay and bisexual men aged 16 to 19 attempting to take their own life in the last year. The full report is available at: www.stonewall.org.uk/what_we_do/research_and_policy/health_and_healthcare/4922.asp

28. The PACE report *Where to Turn*, found that the majority of mental health service providers did not routinely record sexual orientation – only 31% of mainstream service providers compared with 89% for race and 58% for faith. The report is available at www.pacehealth.org.uk/Where%20To%20Turn%20-%20Final%20Full%20Report.pdf

29. Lesbian, gay and bisexual people are included in area for action 2 of the strategy as groups in need of tailored approaches.

Gender reassignment (transgender people)

30. There are some indications that transgender people may have higher rates of mental health problems and higher rates of self-harm. We need more information both about the rates of suicide in this group and also about what interventions may be helpful.

31. Transgender people are included in area for action 2 of the strategy as groups in need of tailored approaches.

Pregnancy and maternity

32. While the statistical risk of suicide is low for pregnant women and new mothers, mental health problems are more common in women during pregnancy⁶, with 13% of mothers having depression and anxiety rising to 22% in mothers one year after the birth. Research

⁴ King M, Semlyen J, See Tai S et al. (2008) *Mental Disorders, Suicide and Deliberate Self-Harm in Lesbian, Gay and Bisexual People*. London: National Mental Health development Unit.

⁵ Mathy RM, Cochran SD, Olsen J et al. (2009) The association between relationship markers of sexual orientation and suicide: Denmark, 1990– 2001. *Social Psychiatry Psychiatric Epidemiology* 46(2): 111–117.

⁶ Gavin NI, Gaynes BN, Lohr KN et al. (2005) Perinatal depression: a systematic review of prevalence and incidence. *Obstetrics and Gynaecology* 106: 1071–1083.

shows that teenage mothers have higher rates of poor mental health after birth than older mothers, and that these higher rates are evident for up to three years after birth⁷.

Religion or belief, including a lack of religion or belief

33. There is a wide range of evidence⁸ to suggest that religious participation may be a protective factor against suicidal behaviour.

Marriage and civil partnership status

34. It has long been recognised that people who are married have a lower risk of suicide⁹. One Danish study found the suicide risk among gay men in civil partnerships is eight times higher than in heterosexual couples and twice as high as the risk in men who have never married. However, the same study showed no statistically significant increase in suicide risk among women in civil partnerships¹⁰. It appears that the higher suicide risk among gay men in civil partnerships is likely to be associated with their sexual orientation rather than their civil partnership status.

Carers

35. While there is evidence of increased mental health problems among adult and young carers, we are not aware of any evidence of higher rates of suicide or attempted suicide among carers.

Other groups of concern

36. The strategy also identifies a number of other groups where action is needed either to reduce a high risk of suicide, or to ensure that they benefit from population-level approaches to improve mental health. This includes:

- People with a history of self-harm (area for action 1)
- People in contact with the criminal justice system (area for action 1)
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers (area for action 1)
- Survivors of abuse or violence, including sexual abuse (area for action 2)
- Veterans (area for action 2)
- People with untreated depression (area for action 2)
- People who are especially vulnerable due to social and economic circumstances (area for action 2)

⁷ Ermisch J (2003) Does a 'teen birth' have longer term impacts on the mother? Suggestive evidence from the British Household Panel Study ISER Working Papers No 2003-32, Institute for Social and Economic Research

⁸ Risk and Protective Factors for Suicide and Suicidal Behaviour: A Literature Review, Scottish Government Social Research 2008

⁹ ONS Health Statistics Quarterly 37. www.ons.gov.uk

¹⁰ Mathy RM, Cochran SD, Olsen J et al. (2009) The association between relationship markers of sexual orientation and suicide: Denmark, 1990– 2001. *Social Psychiatry Psychiatric Epidemiology* 46(2): 111–117.

- People who misuse drugs or alcohol (areas for action 2)

37. The strategy sets out the evidence of the suicide risk or potential vulnerability that people with these characteristics may face, together with information about potential interventions, links to helpful resources and information about relevant national actions.

Equality workshop held in March 2011

38. The draft strategy was informed by an equality workshop held on 10 March 2011.

39. We made the assessment of impact on equalities an integral part of the draft strategy. Some groups with protected characteristics are identified as having a known statistically increased risk of suicide (e.g. people with mental health problems, who are likely to be captured by the legal definition of disability within the Equality Act). For the other groups with protected characteristics (i.e. those which do not have a known statistically increased risk of suicide) we considered whether people in these groups may have particular vulnerabilities or issues of access to services which mean tailored measures are needed. These groups were discussed in areas for action 1 and 2 of the draft strategy.

Equality workshop held in September 2011

40. We held a further equality workshop on 29 September, during the public consultation on the draft strategy, to consider the actions to promote equality which we should be seeking to include in the new strategy

41. The intention is for the strategy to be evidence-based, as far as possible. While it is appropriate to seek to extend the available evidence, we also need to be clear about the actions that could usefully be taken now. Obviously we need to keep in mind the need for actions to be cost-effective and to enable care services to make the best use of limited resources. This means focusing on improving outcomes and preventing problems from getting worse, to avoid the need for more expensive interventions later on.

42. We asked stakeholders to work in small groups to identify potential actions, drawing on their knowledge of relevant evidence and research.

43. Information gathered at the workshop is included in Annex A.

44. A key theme at both the March and September workshops was concern about the lack of data available in relation to suicide amongst groups with protected characteristics.

45. Some of the participants in the September event have joined the Call to Action on suicide prevention facilitated by Samaritans in support of the strategy.

Changes to strategy as a result of equality analysis

46. The equality analysis has resulted in a number of changes in the final suicide prevention strategy.

47. Young and middle-aged men have been included in area for action 1 as a group at high risk of suicide. This replaces the focus in the draft strategy on adult men under 50, and reflects the heightened risk for men overall. The needs of older men are also highlighted in the final strategy.
48. Children and young people had an important place in the draft strategy, and we have built on this in the final strategy. As well as emphasising the role of schools, social care, the youth justice system and charities highlighting problems such as bullying, we are including measures to help parents keep their children safe online.
49. People with physical health conditions have been included in area of action 2 as a distinct group in need of tailored approaches. In the draft strategy they were covered as part of a group of people with untreated depression, but the respondents to the consultation raised concerns that this did not reflect all the issues.
50. Transgender people have been included in area for action 2 as a group in need of tailored approaches.

Action plan for improvement

51. A call for research has been issued by the Department of Health Policy Research Programme in support of the strategy. This call includes a focus on a number of groups where the equality analysis has shown gaps in the evidence. We hope that this will result in good quality research to improve our understanding of the patterns, associations and characteristics of self-harm and suicide in the following groups:
 - people from Black, Asian and minority ethnic groups and asylum seekers
 - lesbian, gay and bisexual people
 - transgender people
52. The call for research also invites proposals which look at how self-harm can be better managed and suicide reduced in children and young people, including looked after children and care leavers. It also invites proposals on how the health and social care system can provide better information and support to those bereaved or affected by a suicide.
53. We have set up a working group reporting to the National Suicide Prevention Strategy Advisory Group to consider how we can get the most out of the existing data sources on suicide. This will include considering options to address the current information gaps around ethnicity and sexual orientation.
54. *No health without mental health* is the cross-government mental health outcomes strategy. National work to implement this strategy includes cross-cutting work on equalities, to address particular vulnerabilities or issues. It is supported by the Ministerial Working Group on Equality in Mental Health.
55. The stigma associated with mental health problems, can act as a barrier to people seeking and accessing the help that they need, increasing isolation and suicide risk. The Government is supporting the national mental health anti-stigma and discrimination Time to Change programme, which includes work targetted at BME communities.

56. We plan to continue to involve stakeholders in the work to implement the suicide prevention strategy. There is a clear theme around isolation for some individuals in communities who share protected characteristics, and their immediate communities will be key in getting support to the individuals at risk of suicide. Capacity and the current financial position will limit what can be achieved, however we will seek to engage with organisations representing relevant communities over the next year to raise awareness around suicide, and encourage relevant national organisations to consider joining the Call to Action on suicide prevention facilitated by Samaritans.

Annex A: Equality workshop, 29 September 2011, output from discussion groups

These notes reflect the comments made on the day, by the individuals who participated.

General comments on strategy

- Gender is the big issue, especially rates for men. Concern that there are issues about treatment for men.
- Think about excluded groups, asylum seekers, sex workers, travellers, etc
- Try to capture local evidence outside national frameworks. Using local statistics effectively will be important.
- Monitoring and data collection is important, especially in relation to local implementation.
- Is the issue untreated or undiagnosed depression?
- Need for further evidence on risk groups. Given the current resource constrained environment standards relating to monitoring and reporting were considered to be high.
- Consider at suicide risk points in life as an alternative approach? High risk groups vs. 'at risk' points within the pathway of the individual – thematic areas and leads required.
- Specific outcomes framework – preferably high level reporting
- Local implementation – accountability?
- Chronic mental illness sufferers with a history of suicide attempts are an apparent omission from the current draft strategy.
- Many of the third sector services for persons in suicidal crisis do not lend themselves effectively to measurement; specifically in the way that monitoring and reporting frameworks which Government espouses would be preferable.

Evidence on which to base preventative measures

- For lesbian, gay and bisexual people the gap between first realisation and positive affirmation is a potentially vulnerable period. In terms of how services should approach the issue, there is a parallel to domestic violence guidance, i.e. approach is to green light the issue.
- Onus on individual to navigate the landscape of available services; this was perceived to be unsatisfactory, particularly in consideration of "*minority stress*" as identified by Mayer. K, H. Mayer has worked on this from the perspective of gay men. Appropriate response to minority stress is affirmation, ending isolation.

- For transgender people, there are different issues for people early on in their journey (very distressed/confused, not knowing where to turn for help) or end of journey. Highest risk is at beginning, before medial consultation.
- For BME communities, it was felt that including BME as a high risk group acted as too much of a 'catch-all'; further understanding of contributory groups within this field was required. In respect of BME groups, access to services was far more of a resonant concern, which, if addressed, would potentially have a greater impact.
- Children and young people, parent-infant therapy used in NW London. Patchy implementation, but effectiveness shown in research at Anna Freud Centre by Amanda Jones.
- Lack of therapeutic interventions relating to debt and spending.
- It was felt that evidence was incomplete as to the inclusion of survivors of abuse.

What actions, by whom, does this suggest are needed?

- The importance of getting our voices across following the NHS restructure change. Ensuring issues stay at top of agenda once structural reforms go through. Specific Ministerial Advisory Group on Equality requires formation and wide stakeholder input. Equality Delivery System – the development of a new framework to support equality in healthcare in the NHS (commissioned by David Nicholson?).
- How CAMHS and A&E respond is key.
- Listener schemes run by Samaritans in Prison Service. More detail in NOMS response to consultation.
- Stonewall campaign It Gets Better Today campaign. Podcast scheme for LGB community.
- Information to frontline staff re risk factors. Guidance should be produced which '*opens the way*' for disclosure (of suicidal feelings) and thereby the engagement of relevant services.
- Reducing isolation (real or perceived) for identified priority groups, and offering follow-on self-defined peer support (which was considered as being of real benefit for service users).
- Tailor responses to the individual and avoid specific responses based on "groups"
- Concern re. split between self-harm and suicide within the strategy. Groups, particularly women and young people, are at high-risk for self-harm, but not for suicide. Desire to see work on self-harm prevention.
- Monitor/research response rates/times for requests for support
- Information flows from coroners. It may be beneficial to hold up examples of good practice.

- Tailoring approaches to local communities, e.g. traveller groups are a small minority group overall, but may be quite a significant group in some local authority areas. Assessing needs through JSNAs, including an analysis of local demographics/contributory factors will be important to identify these locally significant groups.
- For the traveller community, there are high levels of illiteracy in the community, which means that using DVDs, audio and pictorial resources works very well. Children and young people, especially girls, leave school c13/14. If measures are targeted through school, this means that they will potentially be missed. Outreach approach works well, and have been successfully delivered in some areas by Friends Families and Travellers. This has included cultural awareness training for mental health services in the county. Support to families is really valued by the communities, and experience suggests that a little outreach sets the scene for a lifelong relationship.
- For men, something ambitious (equivalent to feminism?) is needed. PSHE may be key way to reach young men and to build positive mental health for men. Thinking skills training. Need to address deficits in problem-solving skills, support families with multiple problems. Welcome Government investing in parenting skills.
- Target high risk vulnerable families. But not necessarily label that way! If target vulnerable families, will likely pick up more BME parents. Cabinet Office running and evaluating parent partnership which targets women in antenatal classes.
- Suicide impact assessment of policies/strategies. Monitor consistency of values. Influencing media, politicians.
- Pressure point on GPs to pick up depression/issues
- Support for people in caring and health professions, who need somewhere to off-load.
- The importance of taking a multi-disciplinary approach to care/support

Organisations represented

St Andrews Healthcare
GIREs
South London and Maudsley
Mind Out
Stonewall
NOMS
Friends, Families and Travellers
British Psychological Society
TUC Disability Committee
DWP
PACE Health
Women's Health and Equality Consortium
Samaritans