Nottingham City Suicide Prevention Strategy 2015-2018

Produced by Nottingham City Public Health, in partnership with Nottinghamshire and Nottingham City Suicide Prevention Steering Group. December 2014.

THIS SUICIDE PREVENTION STRATEGY FOR NOTTINGHAM CITY FOR 2015-2018 IS AN UPDATE OF THE STRATEGY 2009-2012. THIS STRATEGY WAS DEVELOPED BY THE SUICIDE PREVENTION STEERING GROUP. CONTRIBUTORS INCLUDE:

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WELCOME TO THE NOTTINGHAM CITY SUICIDE PREVENTION STRATEGY 2015-2018

FOREWORD

The impact of suicide on family, friends and the community is huge and long lasting. We hope that anyone experiencing distress and contemplating suicide will be able to find support and hope. This strategy sets out our ambition in Nottingham to work together to prevent suicide and provide the support that is needed.

Many people who die by suicide have a history of self-harm, therefore, we want this strategy to deliver better outcomes to the people of Nottingham who have suicidal thoughts and a history of self-harm, and we want to improve our knowledge of this area to make sure people get the support and help they need early.

As a City we are working together to improve mental wellbeing overall and particularly to build mental resilience. This includes improving support for emotional wellbeing in schools and in the general population; work to reduce discrimination and stigma around mental health problems; the promotion of good early years services; and improved access to early interventions and recovery from mental health problems.

I would like to take this opportunity to thank all of the organisations that have contributed to the development of this strategy. We will continue to work together in a partnership approach to deliver improvements in preventing suicide and self-harm.

Councillor Alex Norris
Chair of the Nottingham City Health and Wellbeing Board

FOREWORD

Suicide is a major issue for society and a leading cause of years of life lost**.** Important factors are linked to suicide and self-harm such as mental ill-health, significant adverse life events and access to means.

Although the average rate of suicide in Nottingham City is not high in comparison with other areas, suicide is often preventable and it is most effective to address it across the life course. This means that we will focus on the needs of children and young people, adults and older people in Nottingham City, and particularly those who are most at risk of suicide and self-harm.

This strategy outlines the ways in which Nottingham City Public Health will work with our local health and social care commissioners and providers, police and the criminal justice system, emergency services, transport systems and the voluntary sector, alongside community partners towards a reduction in suicide and self- harm amongst our populations.

Dr Chris Kenny
Director of Public Health, Nottinghamshire County and Nottingham City Councils

Advice when reading this document:

If by reading and reviewing this strategy you become concerned about your own or someone else's suicidal and self-harm thoughts or behaviour we advise that you speak to a trained health care professional by either:

- ***Making an appointment with your GP***
- ***Telephoning the Samaritans on 08457 90 90 90***
- ***Cruse Bereavement Care on 0844 477 9400***

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1.0 EXECUTIVE SUMMARY:

In England, approximately one person dies every two hours as a result of suicide[1]. Suicide is a major issue for society and a serious but often preventable public health problem. Suicide can have lasting harmful impact- economically, psychologically and spiritually on individuals, families, and communities. While its causes are complex and no strategy can be expected to completely remove the tragedy of suicide, there is much that can be done to ensure that we reduce the likelihood of suicide and to ensure support is available for those at their most vulnerable.

Historically, Nottingham City has had a higher rate of suicide or injury of undetermined intention than England. However in recent years the rate has lowered to be in line with national rates. For the period 2010-12 the rate for Nottingham City was 7.6 per 100,000 population, which is below the England rate of 8.5 per 100,000 population.

Nationally, more men die of suicide than women, the ratio of male to female suicide deaths is 3:1. For Nottingham City the gender split in the suicide rate is in line with national suicide rates, with men accounting for around three quarters of suicides.

There is a socio-economic gradient in suicide risk. Those in the poorest socio-economic group are 10 times more at risk of suicide than those in the most affluent group living in the most affluent areas. Nottingham City has a similar pattern, although due to small numbers we need to be cautious in interpretation of our local data. In Nottingham City, for the period 2008-10 the highest rate of suicide occurred in the 35-64 age group, which is similar to the picture nationally. These differences are not statistically significant due to the small numbers.

Suicide prevention goes hand in hand with addressing self- harm. People who self-harm are at increased risk of suicide. UK studies have estimated that in the year after an act of deliberate self-harm the risk of suicide is 30–50 times higher than in the general population. Non-fatal self-harm leading to hospital attendance is the strongest risk factor for completed suicide[2]. Self-harm is one of the top five causes of acute medical admission and those who self-harm have a 1 in 6 chance of repeat attendance at A&E within the year[3].

Nationally, the rates of self-harm are highest in girls and women with the highest incidence being among 15-19 year olds. In men, the highest rates are in 20-29 year olds.

For the period 2010-13, the Nottingham City rate of hospital admissions caused by unintentional and deliberate injuries in children (aged 0 -14years) was 86.4 per 100,000 population. For the age range of 15-24, the rate was 94.7 per 100,000 population. Both rates are better than the national averages of 103.8 per 100,000 and 130.7 per 100,000 population, respectively.

This strategy outlines the ways in which Nottingham City Public Health and local partners aim to work towards a reduction in suicides and self- harm amongst the population of Nottingham City in line with the national suicide prevention strategy for

England (2012)[1] and the national mental health strategy – No health without mental health (2011)[4].

Overall aim of this strategy:

- ***To reduce the rate of suicide and self-harm in the Nottingham City population***

The following priorities have been identified as the local key areas for action in Nottingham City:

Priority 1: ***Identify early those groups at high risk of suicide and self-harm*** and support effective interventions

Priority 2: Review of ***timely suicide and self-harm data and be informed by national and local evidence based research and practice*** in order to better understand the local needs.

Priority 3: Access effective support for those ***bereaved or affected by suicide***

Priority 4: ***Engage with media personnel*** to agree on sensitive approaches to reporting suicide and suicidal behaviour

Priority 5: Improve the understanding and care for people at risk of suicide and self-harm through ***training of frontline staff*** to deal with those at risk of suicide and self-harm behaviour

This strategy is aligned and supports the delivery of a number of other Health and Wellbeing local strategies, including:

- Wellness in Mind, The Nottingham City– Mental Health and Wellbeing Strategy 2014-2017
- Nottingham City Children's and Young Peoples plan 2010-14

All of the above strategies place an emphasis on evidenced-based research and practice in prevention, early identification and intervention to ensure that people of all ages have the opportunity to enjoy good mental health and wellbeing.

Prevention of suicide calls for working across sectors at local and national level. There is need to tackle all the factors which may increase the risk of suicide and self-harm in the communities where they occur if our efforts are to be effective. Suicide prevention is most effective when it is addressed across the life course and when combined with wider prevention strategies that address improving the mental health and wellbeing of the population and the wider determinants that impact on health, such as: employment, low income and housing.

2.0: INTRODUCTION

"On average, one person dies every two hours in England as a result of suicide. When someone takes their own life, the effect on their family and friends is devastating. Many others involved in providing the support and care will feel the impact."[1]

Suicide is a major issue for society. The number of people who take their own lives in England has reduced in recent years. However, in 2010 there were over 4,200 reported deaths from suicide. The impact of every suicide can be devastating – economically, psychologically and spiritually – for all affected[1.] The cost of a completed suicide for someone of working age in the UK exceeds £1.6 million[5]. Suicidal thoughts at some point in a person's life are relatively common: in 2007 16.7% had thought about suicide, 5.6% reported attempting suicide and 4.9% had harmed themselves without suicidal intent[6].

Preventing suicide is acknowledged to be a complex challenge. This strategy is intended to outline the local approach to suicide prevention and it recognises the contributions that can be made across all sectors of society. This strategy draws on local experience and expertise and national research evidence and guidance.

In 2002, the government made suicide prevention a health priority and set a target to reduce the death rate from suicide and injury (and poisoning) of undetermined intent by 20% by the year 2010[7]. The new national strategy, launched in 2012[1] emphasises local action and supports this by bringing together knowledge about groups at higher risk of suicide, identifying evidence of effective interventions and highlighting available resources.

In 2009, Nottinghamshire County, Bassetlaw and Nottingham City Primary Care Trusts (PCT) produced a joint suicide prevention strategy for the period 2009-2012[8]. This placed emphasis on achieving the Our Healthier Nation target of reducing suicide by one fifth by 2010[9]. This 2015-2018 strategy provides an update on the continuous prevention work which has been carried out in Nottingham City since 2009 and reflects the new national and local priorities and guidance.

This strategy includes five priority areas for action to reduce the incidence of suicide. The Nottinghamshire and Nottingham City Suicide Prevention Steering Group, oversees the implementation of the associated action plan. This multi-agency steering group includes representation from Nottinghamshire County and Nottingham City Public Health, Clinical Commissioning Groups (CCGs), children and adults Mental Health Services (CAMHS), health and social care, HM Coroner's Service, police, fire and ambulance services, Network Rail and third sector organisations with a remit in suicide prevention and support. Progress against its objectives will be reported through the Mental Health and Wellbeing Steering Group to the Nottingham City Health and Well-being Board.

This strategy applies to all ages, from children to older people, with or without serious mental health problems.

The most recent published data and information used to inform this strategy is taken from the official statistical body, the Office of National Statistics (ONS) suicide data up to 2012[14]. This data has been analysed according to the calendar year in which the death was registered (as opposed to when it occurred) which follows the coroner's inquest verdict. Therefore, there will be a delay between the death occurring and being registered. Analysis is also based on the postcode of usual residence of the deceased (rather than where the death occurred).

Suicide rates have been standardised for age and sex, unless otherwise stated to allow comparisons over time and between localities which may differ in the size and age structure of the population.

In the UK, a coroner is able to give a conclusion of suicide for those as young as 10 years. However, rates per 100,000 are provided by the ONS only for ages 15 years and over when the suicide bulletin is released. This is due to the known subjectivity between coroners with regards to classifying children's deaths as suicide, and because the number in those under 15 tends to be low and their inclusion may not give a true picture of the rates.

3.0: CONTEXT

3.1 National drivers

This strategy responds to the national suicide prevention strategy, **Preventing suicide in England: A cross-government outcomes strategy to save lives, HM Government 2012**[1].

The national strategy is an all-age suicide prevention strategy which builds on the national Suicide Prevention Strategy (2002)[7]. The strategy supports actions by bringing together knowledge about groups at higher risk of suicide, applying evidence of effective interventions and highlighting resources available. The national suicide prevention key objectives and action areas aim to define what the strategy as a whole is intended to achieve. The objectives and actions are outlined in Box 1 overleaf:

Box 1: National suicide prevention strategy key objectives and areas for action

Key Objectives

- ***Reduce the suicide rate*** in the general population of England
- Offer better ***support for those bereaved*** or those affected by suicide

Six key areas for action

In order to support the Suicide Prevention strategic objectives, six key areas for action have been identified ***(Appendix A: Preventing suicide in England)*** and includes;

Action area 1- Reduce the risk of suicide in key high-risk groups.
Action area 2 - Tailor approaches to improve mental health in specific groups**.**
Action area 3 - Reduce access to the means of suicide.
Action area 4 - Provide better information and support to those bereaved or affected by suicide.
Action area 5 - Support the media in delivering sensitive approaches to suicide and suicidal behaviour.
Action area 6 - Support research, data collection and monitoring

The **Preventing Suicide in England – One year on (2014)**[10] report, published by the Department of Health sets out the developments since the launch of the national 'Prevention suicide in England (2012) strategy' and highlighted the areas where things need to be done in 2014. The messages in this report are designed to help local areas focus on the most effective things that they can do to reduce suicide.

The **Public Health Outcomes Framework: Improving outcomes and supporting transparency, 2012**[11] sets out the overarching vision for public health. This strategy set out the outcomes to be achieved. The indicator in relation to suicide prevention is to reduce the numbers of people living with preventable ill health and people dying prematurely.

No health without mental health: A cross-government outcomes strategy for people of all ages (2011)[4] is key in supporting reductions in suicide amongst the general population as well as those under the care of mental health services. The first agreed objective of *No health without mental health* aims to ensure that more people will have good mental health.

Healthy Lives, Healthy People: Our strategy for public health in England (2011)[9] gives a new, enhanced role to local government and local partnerships in delivering improved public health outcomes. This document outlines that the local responsibility for coordinating and implementing strategic direction for suicide prevention from April 2013, became an integral part of local authorities' new responsibilities for leading on local public health and health improvement. The prompts for local councillors on suicide prevention published alongside this strategy are designed as helpful pointers for how local work on suicide prevention can be taken forward**.**

National Institute for Health and Care Excellence (NICE) guidelines: Self-harm: short-term management, Self-harm: longer-term management and evidence

updates[12] - These are evidence-based clinical guidelines for professionals involved in the management of people who self-harm.

The Nation Confidential Inquiry into suicide and homicide by people with mental illness: Annual report for England, Northern Ireland, Scotland and Wales, University of Manchester 2014[13] report covers deaths by suicide for the period January 2001 to December 2012. Information on all general population suicides (i.e. deaths by intentional self-harm and deaths from undetermined intent) by individuals aged 10 and over is collected from the Office for National Statistics (ONS)[14]. Comparisons are made with those identified as patient suicides, i.e. the person had been in contact with mental health services in the 12 months prior to death. The report gives recommendations for mental health services to undertake in order to prevent suicide.

Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis[15] was published by the government in February 2014. The concordat outlines a vision for health, social care and emergency services work together to deliver a high quality response when people of all ages with mental health problems including suicidal behavior, urgently need help.

Annual Report of the Chief Medical Officer 2013 Public Mental Health Priorities: Investing in the Evidence[5] was published in September 2014. This report includes a focus on the epidemiology of public mental health and the quality of the evidence base, 'horizon scanning' of innovation in science and technology, the economic case for good mental health and chapters outlining the importance of both treating mental health as equal to physical health and of focussing on the needs and safety of people with mental illness. The chapters also include authors' suggestions for improvement.

The report, **Why children die: death in infants, children, and young people in the UK**[16] , which was published in May 2014 by the Royal College of Paediatrics and Child Health, National Children's Bureau and the British Association for Child and Adolescent Public Health recommends national analysis to be completed on young people's suicides and a concerted and sustained policy response "to the problem of violence and self-harm among Britain's young people is needed urgently to address the lack of progress in reducing deaths and injuries from these causes."

3.2 Local drivers

The priorities within this strategy capture local concerns and link with other local strategies listed in box 2 below:

Box 2: Nottingham City Health and Wellbeing Mental Health strategies

- Wellness in Mind The Nottingham City Mental Health and Wellbeing Strategy 2014-2017
- Nottingham City Children's and Young Peoples plan 2010-14

The above strategies place an emphasis on research and evidenced-based practice in prevention, early identification and intervention to ensure that people of all ages have the opportunity to enjoy good mental health and wellbeing.

All local strategies and plans linked to this strategy are detailed in Appendix B

4.0: OVERVIEW OF OUR AIMS AND PRIORTIES FOR THIS STRATEGY

Suicide prevention is not the sole responsibility of any one sector of society, or of health services alone. Therefore, prevention largely necessitates a general population approach rather than service-related initiatives. For example, restriction of access to means for suicide, population approaches to prevention of depression, improved detection and management of psychiatric disorders in primary care, and voluntary agency and internet-based support[5].

The greatest impact is likely to result from a combination of preventative strategies directed at potential suicide determinants, which include;

- The factors which increase the risk of suicidal behaviour in a population; for example, availability of means, knowledge and attitudes concerning the prevalence, nature and treatability of mental disorders, and media portrayal of suicidal behaviour

- Recognised high risk groups - e.g. people with recurrent depressive disorders, previous suicide attempts, people who misuse alcohol, the unemployed, people with certain co-morbid mental and personality disorders[17] and people recently discharged from psychiatric in-patient care

Since the 2002 National Suicide Prevention Strategy[7] the emphasis has shifted from focusing on achieving suicide prevention through a reduction in suicide target, to that of viewing this target as

'…. a guiding beacon that can lead to the problem of suicidal behaviour being taken more seriously and galvanise more active planning of national policy to improve mental health and mental health care.'[18]

This suicide prevention strategy aims to reduce the suicide and self-harm rate in Nottingham City. This strategy has been developed in line with the national Suicide Prevention Strategy for England (2012)[1] and builds on existing local work.

The overall strategic aim of this strategy is:

- ***To reduce the rate of suicide and self-harm in Nottingham City population***

In order to reduce the local suicide and self-harm rate the suicide prevention strategic priorities are outlined in Box 3 below.

As well as targeting high-risk groups, another way to reduce suicide and self-harm is to improve the mental health of the population as a whole. Therefore, this strategy takes a life course approach which recognises that mental health problems often start in childhood, and that opportunities to promote and protect good mental health arise form pre conception through to old age.

Box 3: Nottingham City suicide prevention priorities

Priority 1: ***Identify early those groups at high risk of suicide and self-harm*** and support effective interventions

Priority 2: Review of ***timely suicide and self-harm data and be informed by national and local evidence based research and practice*** in order to better understand the local needs

Priority 3: Access effective support for those ***bereaved or affected by suicide***

Priority 4: ***Engage with media personnel*** to agree on sensitive approaches to reporting suicide and suicidal behaviour

Priority 5: Improve the understanding and care for people at risk of suicide and self-harm through ***training of frontline staff*** to deal with those at risk of suicide and self-harm behaviour

5.0: SUICIDE AND SELF-HARM DEFINED

5.1 What is suicide?

Suicide is defined by the Oxford Dictionary of Law as *'the act of killing oneself intentionally.'*[19] For a Coroner to reach a conclusion of suicide this would need to be proved beyond reasonable doubt.

There are difficulties in determining the exact intent of a person who dies, therefore measuring or estimating the true level of suicide can be complex. However, for the purpose of this strategy the 'suicide rate', will include deaths recorded as follows;

'..as deaths given an underlying cause of intentional self-harm or injury/poisoning of undetermined intent[14] *'*

In England and Wales, it has been customary to assume that most injuries and poisonings of undetermined intent are cases where the harm was self-inflicted but there was insufficient evidence to prove that the deceased deliberately intended to kill themselves.

Throughout this strategy suicide cases will be those cases where the Coroner has given a conclusion of suicide or where the injury was of undetermined intent and an open verdict has been given.

However, it should be noted that over the past decade, coroners have increasingly returned narrative verdicts. These record the circumstances of a death rather than providing a 'short form' verdict such as suicide, accident, or natural causes. Prior to 2011, some narrative verdicts were coded as accidental deaths where intent was not specified, which may have led to an underestimation of suicide. However, in 2011 guidance was issued to coroners in England and Wales when returning narrative verdicts to provide clearer information on the intent of the deceased. This has led to improvements to the coding of narrative verdicts by the ONS coding team, and some cases which would previously be coded as accidental may now be coded as possible suicide. The impact of these changes, therefore, will potentially increase the number of estimated suicides in 2011, although the anticipated increase is likely to be small[144].

5.2 What is self-harm?

Self-harm is:

'.. self-poisoning or self-injury, irrespective of the apparent purpose of the act'.[144]

The self-harm focuses on those acts of self-harm that are an expression of personal distress and where the person directly intends to injure him/herself. It is important also to acknowledge that for some people, especially those who have been abused as children, acts of self-harm occur seemingly out of the person's control or even awareness, during 'trance-like', or dissociative, states. It therefore uses the term 'self-harm' rather than 'deliberate self-harm'[4].

6.0: WHY IS REDUCING THE RATE OF SUICIDE A PRIORITY?

6.1 National suicide rates and current trends

The report by the Department of Health (DH) Preventing Suicide in England - one year (2014)[10] outlines that;

- There were 4,524 suicides recorded in 2012, similar to the 2011 figure of 4,518. In the past decade, the national overall trend has been a decrease in the suicide rate but with a small rise in the last 4 years.

- Suicide continues to be more than three times as common in males (12.4 per 100,000 for males in 2010-12, compared to 3.7 for females)

- The numbers and rates of suicide and undetermined deaths vary between age groups, with rates among males highest for those aged 35-54 years and among females, highest for those aged 40-59 years

- Suicide is rare under the age of 15 years, and its incidence in 15-19 year olds is around a quarter of that seen in 40-54-year-olds

- Hanging, strangulation and suffocation accounts for the largest number of suicides in males, (60%). In females hanging and drug related poisoning are the joint most frequent methods, (38%)

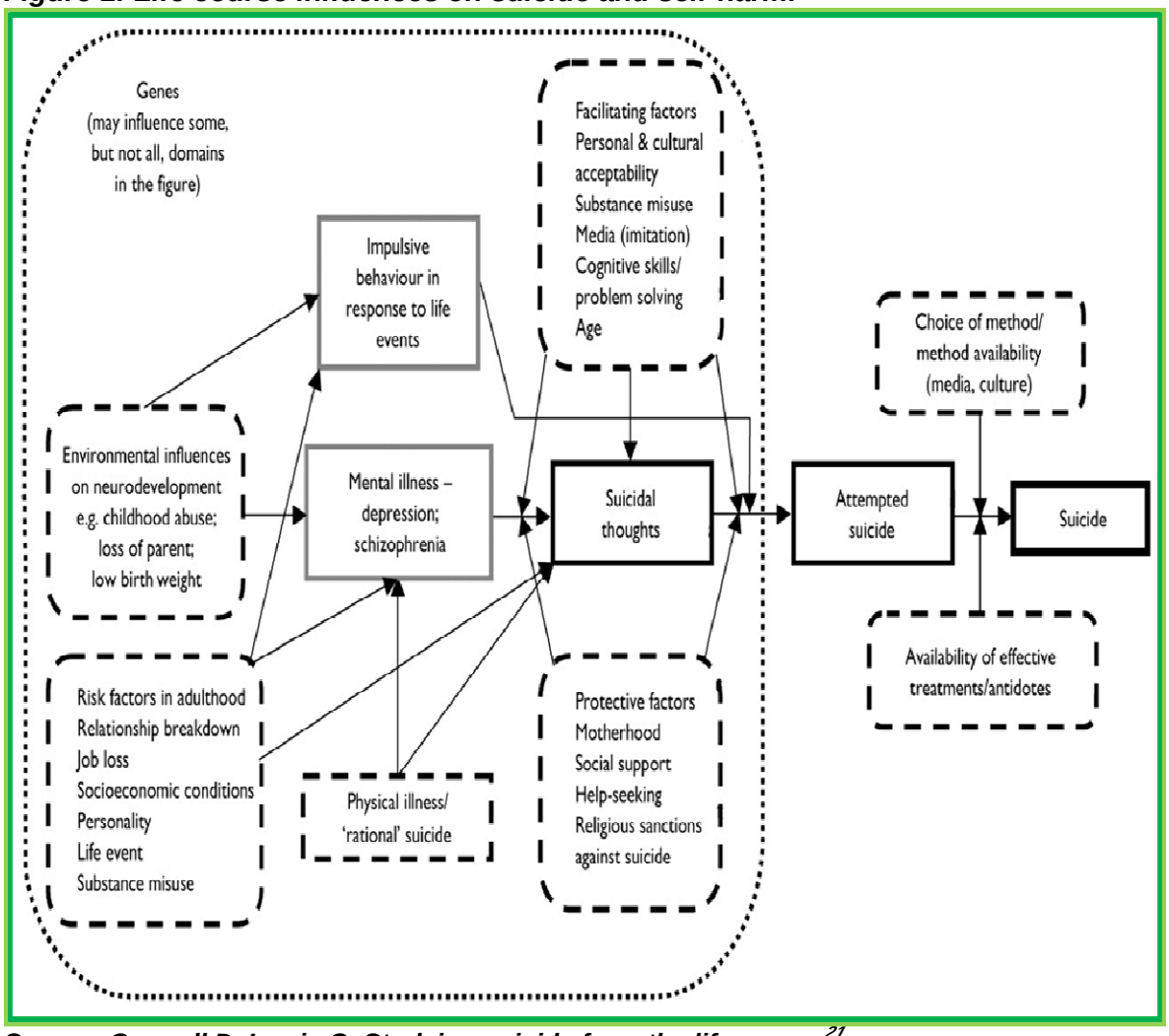
- There was a rapid rise in the number of deaths caused by helium poisoning, almost all of which, are likely suicide related. There were no recorded deaths in 2000 from helium. However since 2007 there has been a steady rise, with 51 deaths in England in 2012

- Suicide rates among older people in the UK are falling[20].

6.2 What are the suicide and self-harm risk factors?

There are a wide variety of factors that can contribute to suicide and self-harm[21,22,23] shown in **figure 1**, below. These include distal factors (e.g. genetic influences, family history and early trauma) and proximal factors (e.g. psychiatric disorder, physical illness, relationship breakdown and other life events). Changes in socio-economic environment are important, as is exposure to suicidal behaviour by others, including through the media. Availability of suicide methods can contribute to risk, and the danger of the method will partly determine whether an act is fatal or non-fatal.

Figure 1: Life course influences on suicide and self-harm.



Source: Gunnell D, Lewis G. Studying suicide from the life course[21]

Some groups of people are known to be at higher risk of suicide than the general population.

The groups at high risk of suicide[1] are;

- Men aged 35-54 years[24]
- People in the care of mental health services, including inpatients
- People with a history of self-harm, untreated depression, misuse of alcohol, those who are facing economic difficulties, are going through divorce or separation, or have long-term physical illnesses[1]
- People in contact with the criminal justice system (police, probation, the courts and prisons)
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers
- Young women from South Asian, Caribbean and African origin and older South Asian women[25,26]
- Children and Young People who have experienced abuse and/or neglect
- Lesbian, Gay, Bisexual or Transgender people
- Older people aged 65+ experiencing social isolation and loneliness[27].

Table 1 below shows the estimated increased risk for the high risk of suicide group to that of the general population. The highest risk of suicide group are patients up to 4 weeks following discharge from a psychiatric hospital with an estimated increased risk of x110-200**.**

Table 1: Increased risk for groups at higher risk compared to the general population

High risk group	Estimated increased risk
Males compared to females	x 2-3
Current or ex-psychiatric patients	x 10
4 weeks following discharge from inpatient psychiatric hospital	x 100-200
First year after self-harm[28,29]	x 60-100
Alcohol misuse and dependency	x 5-20
Drug misusers	x 10-20
Family history of suicide	x 3-4
Serious physical illness/disability	Not known/under review [30]
Prisoners	x 9-10
Offenders serving non-custodial sentences	x 8-13
Doctors	x 2
Farmers	x 2
Unemployed people	x 2-3
Divorced people	x 2-5
People on low incomes (social class IV/V)	x 4

Source: Adapted from information on Mental Health Specialist Library website at www.library.nhs.uk/mentalhealth

6.3 Factors associated with suicide and self-harm

Suicide and self-harm is often precipitated by recent adverse events across the life course. These include relationship breakdowns, conflicts, legal problems, financial

concerns, interpersonal losses, traumatic events. There is also research into the links between suicide and terminal and/or chronic illness.

The following points are also important in terms of suicide prevention[17]. These are shown in Box 4 below.

Box 4: Factors associated with increased risk of suicide

- In up to half of all suicides there have previously been ***failed attempts***[8]
- Only a quarter of people (nationally) who die by suicide are ***under psychiatric care*** in the year before their death (i.e. 75% are not)[10]
- 5-10% of all suicides happen in the ***four weeks after discharge from psychiatric*** hospital, making this a time of high risk[10]
- Following a suicide attempt or completion, adolescents are at an ***increased risk of copycat suicides***[31]. Reports indicates that youth suicide can increase two to four times more following exposure to another individual's suicide than among older age groups[32]
- ***Repeated exposure to bullying and cyber-bullying*** may precipitate or aggravate depression, anxiety, psychosomatic symptoms, eating difficulties and self-harm, and is associated with suicide[33]. Exposure to bullying is also associated with elevated rates of anxiety, depression and self-harm in adulthood[34,35]
- A number of ***occupational groups*** - doctors, farmers, vets, dentists and pharmacists - are at increased risk of suicide, although deaths in these groups make up only 1-2% of all suicides. One important factor influencing the increased risk in these occupations is their access to lethal means of suicide[1]
- The risk of suicide in men aged 24 years and younger who have ***left the Armed Forces*** is approximately two to three times higher than the risk for the same age groups in the general and serving population[36]
- ***Victims of sexual or domestic violence in adulthood*** is associated with the onset and persistence of depression, anxiety and eating disorders, substance misuse, psychotic disorders and suicide attempts[5]
- ***Several physical disorders*** such as diabetes, epilepsy and asthma are associated with increased risk of self-harm and suicide[37,38]
- The risk of suicide is four times more likely in ***gay and bisexual men***[39] and higher rates of suicidal thoughts and self-harm in ***lesbian and bisexual women*** compared to women in general[40]
- Suicide in ***older people*** is strongly associated with depression[41]
- A follow-up study of patients at a general hospital, reported a 0.7% risk of adults dying by suicide in the year following self-harm, a 1.7% risk within five years and 2.4% at ten years. The ***risk was far higher in men than in women***[42]
- ***More men die from suicide than women***, but suicidal thoughts and self-harm are more common in women[43].

Groups who have more frequent thoughts of suicide are:

- Women
- Those aged 16 to 24
- Those not in a stable relationship
- Those with low levels of social support
- Those who are unemployed[44].

6.4 Mental health services and suicide

The National Confidential Inquiry into Suicide and Homicide annual report (July 2013) shows a rise in overall patient suicide, probably reflecting the rise in suicide in the general population, which has been attributed to current economic difficulties. In-patient suicide continues to fall. There are twice as many suicides under crisis resolution/home treatment compared to in-patients. Opiates are the main substance in self-poisoning[13].

The number of people in contact with mental health services who died from suicide increased slightly from 1,261 in 2001 to an estimate 1,333 in 2011. Part of this increase in the patient suicide in 2011 may reflect the rising numbers of people under mental health care[13].

6.5 Offenders and suicide

People at all stages within the Criminal Justice System (CJS), including people on remand and recently discharged from custody, are at higher risk of suicide. The period of greatest risk is the first week of imprisonment[45].

Reasons for the increased risk include the fact that a high proportion of offenders are young men, who are already a high suicide risk group. However, the increase in suicide risk for women prisoners is greater than for men. An estimated 90% of all prisoners have a diagnosable mental health problem (including personality disorder) and/or substance misuse problem[1].

The patterns for both rates and numbers of self-inflicted deaths in custody closely mirror each other. Prison suicides are no longer falling after a major fall in 2004-08, with about 60 deaths each year, nationally, representing a rate of 0.7 per 1,000 individuals in custody. Suicides in women prisoners are now very rare[13].

There was a considerable rise in the number of apparent suicides within two days of release from police custody, with 59 such deaths in 2013, the highest number recorded over the last nine years. Almost two-thirds were known to have mental health concerns, a higher proportion than in 2011-12, and seven had previously been detained under the Mental Health Act[13].

6.6 What are the self-harm risk factors?

Self-harm occurs in all sections of the population but is more common among people who are disadvantaged in socio-economic terms and among those who are single or divorced, live alone, are single parents or have a severe lack of social support[46].

According to NICE[47], risk factors for self-harm include a number of other 'associations' such as: life events; alcohol and drug use; mental disorder; child abuse, domestic violence and being within the criminal justice system. Within this are special groups such as young people. There are others for whom the evidence is not so well collected such as gay men, lesbians and bi-sexual people[48].

6.7 Rates of self-harm

The Department of Health estimates that self-harm represents one of the top five reasons for admissions in Accident and Emergency services[3]. There are around 200,000 episodes of self-harm that present to hospital services each year[49]. However, many people who self-harm do not seek help from health or other services and so are not recorded.

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[50]. At least half of people who take their own life have a history of self-harm, and one in four have been treated in hospital for self-harm in the preceding year. Suicide risk is particularly increased in those repeating self-harm and in those who have used violent/dangerous methods to self-harm[51].

The rates of self-harm are highest in girls and women with the highest incidence being among 15-19 year olds. A recent child psychiatrists and paediatricians report highlights an alarming rise in self-harm presentations to paediatric departments, particularly among girls, which in some areas exceeds 50%[52]. In men, the highest rates are in 20-29 year olds[53]. However, in a recent study of over 4000 self-harming adults in hospital, 80% had overdosed and around 15% had cut themselves. In the community, it is likely that cutting is a more common way of self-harming than taking an overdose[12].

As the majority of young people who self-harm do not present to statutory services this figure is a possible underestimation of the level of self-harm incidences. Self-harm is often carried out in secret and so will often not come to medical attention.

The Multicentre Study of Self-harm in England studied 1,177 older adults aged 60 years and over who had presented to hospital with self-harm and found that within one-year of their self-harm presentation, 1.5% of older adults had subsequently died by suicide. Their risk of suicide was 67 times greater than older adults in the general population. Men aged 75 years and over had the highest suicide rate. Also examined were older adults who re-presented to hospital with another non-fatal self-harm episode: 12.8% repeated self-harm within one-year. Risk factors for non-fatal repetition included previous self-harm, previous psychiatric treatment and age 60–74 years[54]

6.8 What are the suicide and self-harm protective factors?

There are factors which research suggests protect some people against suicide[8].

These include:

- Stable and supportive family and social networks
- Being open about feelings and able to talk about concerns
- A sense of hope for the future

- Ability to problem-solve and set goals.

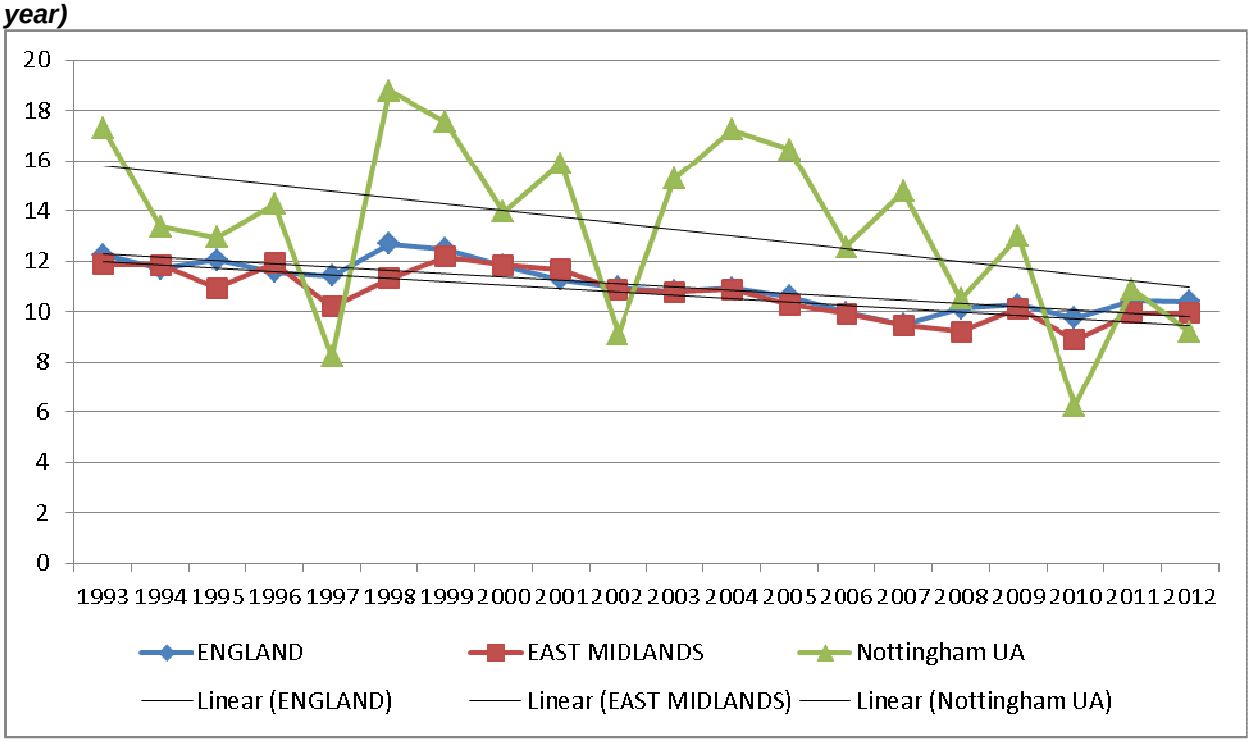
7.0: THE NOTTINGHAM CITY LOCAL PICTURE

This section summarises the local rates and trends in the incidence of suicide and undetermined intent death rate as well as particular risk factors in Nottingham City. Some comparisons against the national trends are given.

7.1 National and regional trends

Figure 2 below, illustrates that nationally, suicide and injury undetermined intent death rates are showing a downward trend. The latest (2012) data shows a reduction of 13.2% (to a rate of 10.4 per 100,000) from the 1993/4/5 baseline. The rate in the East Midlands dropped from a peak of 11.8 per 100,000 in 1999/00/01 to an average lowest rate, 9.6 per 100,000, in 2010/11/12. Nottingham City average mortality rate from suicide and injury undetermined death for the period 10/11/12 was slightly below the national average (Nottingham City: 7.6; England: 8.5 deaths per 100,000 populations).

Figure 2: Trends in mortality from suicide and injury undetermined intent death 15+yrs old in Nottingham City in comparison to England and East Midlands 1993-2012. (Rate per 100 000 by year)



Source: Compendium of Clinical and Health Indicators (2014)

Because annual rates for suicide can fluctuate widely from year to year, a three year rolling average is used to provide a more accurate representation of trends. **Table 2** shows these averages from 1993 to 2012.

Table 2: Directly standardised rate per 100,000 and numbers: mortality from suicide and injury undetermined intent death in Nottingham City

Authority area	3-year pooled	1993-1995	1996-1998	1999-2001	2002-2004	2005-2007	2008-2010	2010-2012 *(New definition[14])*
Nottingham City	Rate	11.3	10.7	12.3	11.2	11.9	7.8	8.8
	Number	102	89	103	95	92	67	62

Source: Compendium of Clinical and Health Indicators (2014)

7.2 Local trends

Table 3 shows a reduction in the rate of mortality from suicide and injury of undetermined intent for Nottingham City in the period 2010/11/12 compared to the 1995/6/7 baseline rated. However, as the numbers are small, statistical significance is not reached.

Table 3: Percentage changed in the Directly Age Standardised Mortality from Suicide and injury undetermined death rate and number – 1995/6/7 and 2010/11/12 for Nottingham City

Local Area and District	1995/6/7 (baseline)		12/11/2010* New Definition		Percentage difference in DSR (baseline to current year)
	DSR per 100,000	Number	DSR per 100,000	Number	
Nottingham City	9.21	77	8.76	62	*-4.89%*

Source: Compendium of Clinical and Health Indicators (2014)

Although numbers are relatively small, they are still high when compared to other avoidable causes of early deaths. For example, deaths by suicide and injury of undetermined intent for Nottinghamshire and Nottingham City for the period 2010-2012 account for over four times the number of deaths due to road traffic accidents.

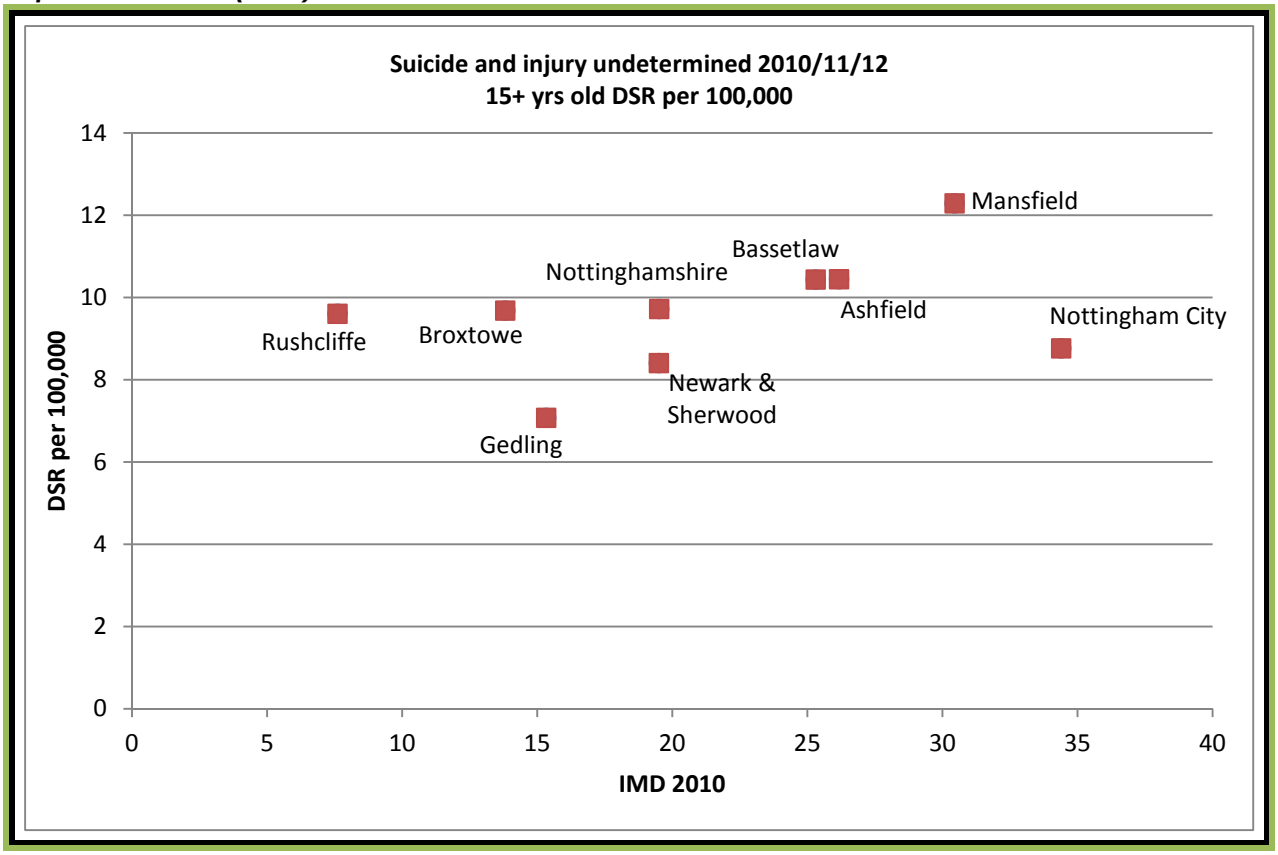
7.3 Suicide rate and deprivation

The Index of Multiple Deprivation score 2010 (IMD 2010) is a measure of multiple deprivation, at small area level. It is made up of seven domain indices, relating to income deprivation, employment deprivation, health deprivation and disability, education, skills and training deprivation, barriers to housing and services, living environment deprivation, and crime. The higher the IMD number indicates a higher level of deprivation for that area.

Research suggests that there is a strong relationship between suicide and socio-economic deprivation. **Figure 3** below shows the relationship between deprivation and suicide rate for Nottingham City and all Nottinghamshire Districts.

Over half of the population of Nottingham live in the 20% most deprived areas in the country and many risk factors for poor mental health are significantly higher in the city, such as unemployment, levels of violent crime and numbers of children in care.

Figure 3: District Suicide and injury undetermined mortality rate 2010/11/12 v Indices of Multiple Deprivation score (2010)



Source: Compendium of Clinical and Health Indicators (2014)

7.4 Suicide rate and age and gender

7.4.1 Children and young people

The true number of suicides amongst young people may be understated as it can be much more difficult to reach a conclusion of suicide beyond reasonable doubt.

Local analysis of data from the Child Death Overview Panel on cases of suicide among children 2009-12 has been carried out[53]. Due to the small numbers of cases, the specific findings will not be outlined. Broad findings include:

- Recognition of two main groups of young people taking their own lives are:

  (1) Those with recognised needs and service involvement from CAMHS/other services and

(2) A group of young people often invisible to services carrying out impulsive acts.

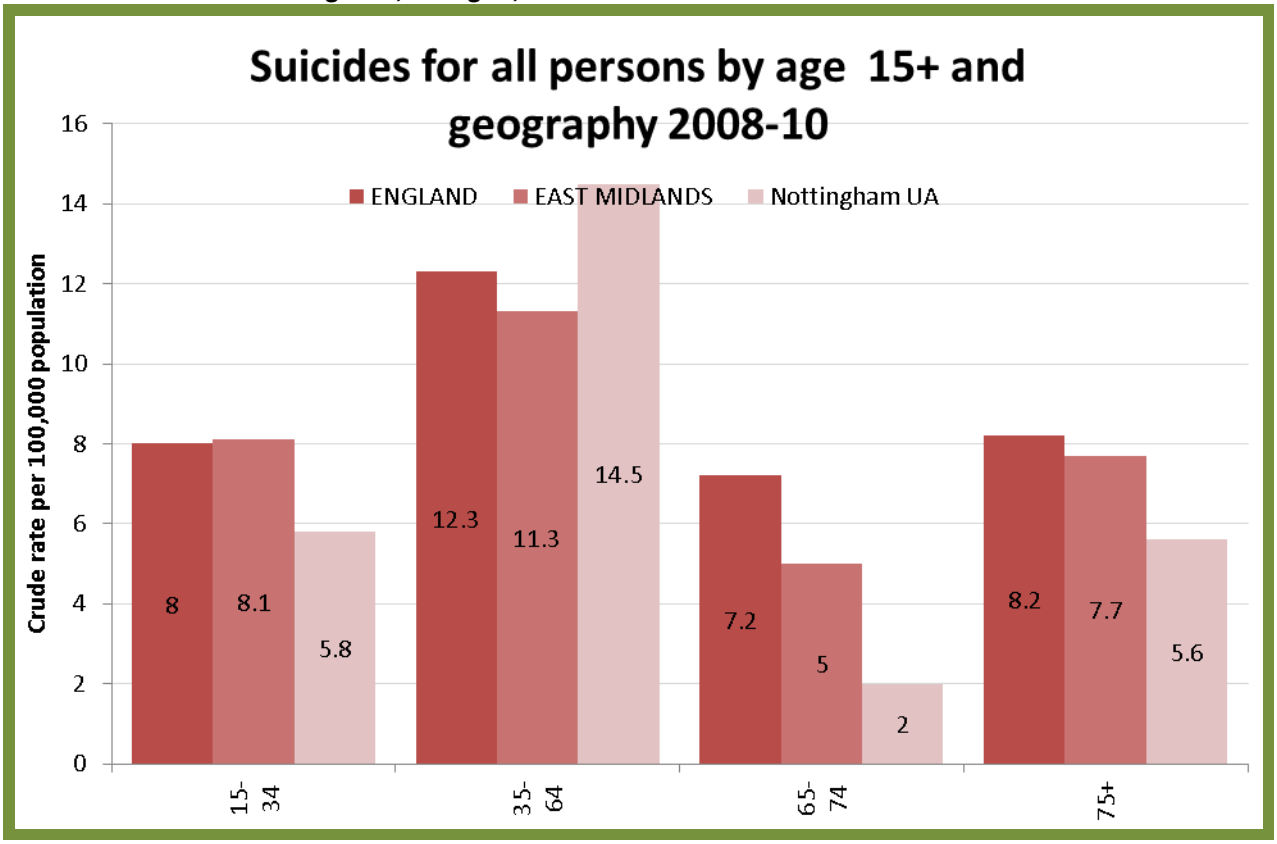
- The vast majority die by asphyxiation (from hanging/ligatures around neck). Overdoses were the cause of death in a minority.

- The presence of parental mental health disorders was highlighted in a large number of cases. Domestic violence was seen in a smaller group of cases.

7.4.2 Adults

Figure 4[*] below shows for the period 2008-10 when compared to the national suicide rate that Nottingham City had the highest rate of suicide in the 35-64 age group. Although none of these differences are statistically significant due to the small numbers.

Figure 4: Age of suicide and death by injury undetermined intent in Nottingham City, compared to the East Midlands and England, All ages, 2008-10



Source: Compendium of Clinical and Health Indicators (2012)

7.4.3 Gender

For the period, 1997 to 2012, the gender split in the proportion of suicide for Nottingham City was 26% female compared to 74% male. This is line with national suicide rates with men accounting for around three quarters of suicides.

[*] The 2010/12 suicide and injury undetermined death data by age groups is not available in line with new suicide definition[14]. Therefore, 2008/10 data is used.

Table 4 below shows the rate of change suicide mortality rate in the gender split from the 1995/6/7 baseline to 2010/11/12 shows a reduction in the number of male suicides and slight increase in the number of female suicides. However, as the numbers are small this highlights the difficulties of drawing significant conclusions and caution should be taken in interpreting this data.

Table 4: Gender number and percentage change in suicide and mortality – 1995/6/7 and 2010/11/12 for Nottinghamshire Districts

Local Area and District	1995/6/7 (baseline)	2010/11/12	% change (baseline to current year)	1995/6/7 (baseline)	2010/11/12	% change (baseline to current year)
	Number	Number		Number	Number	
	Male	Male		Female	Female	
Nottingham City	55	39	*-29.09%*	22	23	*4.55%*

Source: Compendium of Clinical and Health Indicators (2014)

7.5 Self-harm

For the period 2010-13, the Nottingham City rate of hospital admissions caused by unintentional and deliberate injuries in children (aged 0 -14years) was 86.4 per 100,000 population. For the age range of 15-24, the rate was 94.7 per 100,000 population. Both rates are better than the national averages of 103.8 per 100,000 and 130.7 per 100,000 population, respectively.

When older people self-harm the risk of further self-harm and suicides are substantially higher. All acts of self-harm in people older than 65 years of age should be regarded as evidence of suicidal intent until proven otherwise because the number of people in this age range who go on to complete suicide is much higher than in younger adults[Error! Bookmark not defined.].

7.6 Ethnicity

1. The 2011 census data indicates for Black and Minority Ethnic (BME) population breakdown showed Nottingham City rates as 65.4% white and 34.9% were from BME groups[55].

Local level ethnicity data with regard to cases of suicide is not currently available through existing information sources. However, national evidence highlights the increased risk to those from ethnic minority communities:

- Patterns of self-harm and suicide amongst people from minority ethnic groups continue to be different to those amongst white people. It has been reported that the highest rate of suicide in the BME groups in young black females age 16-34years[56].

- Suicide rates and classical indicators of suicide risk among inpatients committing suicide vary by ethnic group. Black African men have the highest rates of suicide compared to the White British group[57].

7.7 Suicide and mental health

The Nottingham City main mental health service provider is the Nottinghamshire Healthcare NHS Trust (NHCT). NHCT have a mechanism in place whereby all unexpected deaths for patients in contact with the service are reported on and examined to ascertain the circumstances and cause of the patient death. This scrutiny process aims to look at any lessons that could be learnt in order to prevent any unexpected deaths in the future.

It should be noted that only the Coroner can determine actual cause of death. Therefore the suicide and mental health data is categorised as unexpected deaths. This includes suspected suicide, and deaths from overdose of illicit substances and where NHCT are awaiting confirmation of cause of death but excludes homicides and deaths that were later confirmed by the coroner as physical/natural causes/unascertained**.**
Table 5 below shows the total annual numbers of NHCT unexpected deaths for the period 2010-2013.

Table 5: NHCT Nottinghamshire and Nottingham City (combined) unexpected deaths annual numbers for the periods 2010/11, 2011/12 and 2012/13.

Year	Number of Unexpected deaths
2010/11	39
2011/12	47
2012/13	37
Total	**123**

Sources: NHCT Serious Untoward Incident reporting data

7.8 Methods of Suicide

The Public Health Mortality Files contain a certain level of detail on each individual case of suicide such as age, place of death, cause of death etc. Using the International Classification of Diseases version 10 code (ICD-10) attached to each case, the methods used have been analysed. Results from analysis in this section are based on this data analysis for the period 2001-2011, combined for Nottinghamshire and Nottingham City by gender.

In keeping with national findings,[58] **Table 6** overleaf shows that the most common methods of suicide and injury undetermined are hanging for men and drug poisoning for women, 51.9% and 46.3% respectively. When analysing ICD-10 suicide only codes, hanging is the most common suicide method for men and women, 60.5% and 46.5%, respectively.

Table 6: Deaths from Suicide and Injury Underdetermined by Method and Gender - Nottinghamshire and Nottingham City combined (2001-2012)

Suicide and Injury Underdetermined (ICD-10 X60-X84, Y10-Y34 exc Y33.9)			Suicide Only (ICD-10 X60-X84)		
	Males	Females		Males	Females
Method	%	%	Method	%	%
Firearms	2.2	0.0	Firearms	2.9	0.0
Drowning	4.9	5.5	Drowning	2.4	2.6
Carbon Monoxide	6.2	1.1	Carbon Monoxide	7.5	1.9
Other	8.1	8.8	Other	6.7	5.2
Jumping/Falling /Lying	9.1	7.0	Jumping/Falling /Lying	8.7	7.1
Drug Poisoning	17.6	46.3	Drug Poisoning	11.4	36.8
Hanging	51.9	31.3	Hanging	60.5	46.5
Total	***100.0***	***100.0***	Total	***100.0***	***100.0***

Source: Compendium of Clinical and Health Indicators (2014)

7.9 Offenders

7.9.1 Her Majesty's Prison (HMP)

There is one closed male prison operating in Nottingham City, which is HMP Nottingham. **Table 7** below gives an outline of this prison's category and operational capacity.

Table 7: Nottingham City HMP Prison Classification

Classification	HMP Nottingham
Category of Prison	Local prison
Security status	Category B
Sex of prisoners	Male
Capacity of prisoners	Increased from 550 to 1060 in April 2010

Source: Ministry of Justice

The number of deaths from suicide within HMP Nottingham between 2005/06/06 (baseline) compared to 2008/09/10 and 2011/12/13 remains unchanged at <5 for each period. These suicide figures reflect those that are known and suspected as suicide, not necessarily as having a coroner's verdict as suicide.

However for the period 2011/12/13 the number of self-harm incidents has increased significantly by 56% compared to the 2005/06/07 baseline, although the capacity of the prison has also increased over this period. **(Table 8 overleaf)**

Table 8: Number of self-harm incidents in Nottingham Prison - pooled 3 year data for 2005/06/07 (baseline year) compared to 2008/09/10 and 2011/12/13.

Prison	2005/06/07 (Baseline)	2008/09/10	2011/12/13
	N=	N=	N=
HMP Nottingham	407	610	925

Source: NHS England

HMP Nottingham adhere to the Prison Service Order (PSO) 2700 Suicide and Self-Harm prevention first published in 2007 and revised in 2012[59]. The revised 2012 policy retained the Assessment, Care in custody and Teamwork (ACCT) procedures at its centre; ACCT is an individualised care planning approach for prisoners at risk of suicide or self-harm. The ACCT pathway improved cross agency information flows and integrated local Safer Custody Teams. Also reflected are long-standing areas of safer custody work such as peer supporters (Listeners and Insiders) and working with outside organisations such as the Samaritans.

The ACCT pathway aims to improve the quality of care by introducing individual/flexible care-planning, supported by improved staff training in case management and in assessing and understanding at-risk prisoners. The ACCT pathway alongside local prevention of suicide in the local prison initiatives such as the Listeners Scheme performed by prisoners for prisoners (trained by the Samaritans) who may be at risk from suicide or self-harm has had a significant impact in preventing suicides in prisons.

7.10 Where are the current gaps?

In order to set the strategic priorities and actions we needed to know what the local current situation was in relation to suicide and self-harm prevention. All key stakeholders of the Nottinghamshire and Nottingham City suicide prevention steering group were tasked with identifying current suicide prevention delivery. The delivery was then matched against the national suicide prevention strategy areas for action[1.] Gaps were identified by comparing the mapping results against national and local suicide and self-harm data. This enabled us to identify the five strategic priority areas and where we need to focus.

Box 5 overleaf outlines where the current gaps exist against the strategic priority areas.

Box 5: Summary of the result of mapping Nottingham City current service gaps

Risk of suicide in key high risk groups

- Access to self-harm and suicide awareness training for frontline professionals is required
- Access to suicide prevention and early identification is not delivered across all wards of Nottingham City
- There is a need to offer targeted screening in high risk professional groups such as: farmers, vets, nurse and doctors
- Targeted suicide prevention programmes for specific groups such as: BME and LGBT groups

Approaches to improve mental health in specific groups

- Better support for veterans suffering with depression and/or PTSD is required

Access to the means of suicide

- Improved monitoring of means of self-harm and suicide is required in order to put in place targeted strategies and interventions

Information and support those bereaved or affected by suicide

- Improved information and access to support for those bereaved or affected by someone else's suicide is required, particularly, in primary care, prisons and social care

Sensitive media

- An agreed and joined up approach is required by all Suicide Prevention steering group stakeholders in communicating self-harm and suicide to the local media
- A local suicide communication plan is required for dealing with media on self-harm and suicide

Research, data collection and monitoring

- Improved timeliness in self-harm and suicidal behaviour data is required in order that suicide prevention and self-harm strategic outcomes can be monitored
- Self-harm and suicide awareness, prevention and intervention programmes need to be delivered in line with national and local outcome based research and best evidence and to ensure effectiveness in reducing the rate of suicide and self-harm

8.0: OUR SUICIDE PREVENTION STRATEGIC PRIORITIES FOR NOTTINGHAM CITY

Priority 1: Identify early those groups at high risk of suicide and self-harm and support effective interventions.

To achieve this priority a multi-pronged approach is required that addresses suicide at three levels, such as:

- Whole population approach for suicide prevention

- Suicide prevention for specific groups who are more vulnerable. The identified specific groups are:

    - Men aged 35-54 years
    - Ex-armed forces men aged 24 years and younger
    - People in the care of mental health services, including inpatients
    - People with a history of self-harm, untreated depression, misuse alcohol, are facing economic difficulties, are going through divorce or separation, or have long-term physical illnesses[1]
    - Children and Young People who have experienced abuse and/or neglect
    - People in contact with the criminal justice system (police, probation, the courts and prisons)
    - Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers
    - Young women from South Asian, Caribbean and African origin and older South Asian women
    - Older people aged 65+ experiencing social isolation and loneliness and/or depression
    - Lesbian, Gay, Bisexual and Transgender people
    - People following repeated exposure to bullying and/or cyber-bullying
    - Victims of sexual or domestic violence in adulthood

- Reduce access to means of suicide

We can make a positive impact by:

i) Whole population approach

- Embed the promotion of good mental health to existing local services.
- Provide training on mental health, wellbeing and resilience to frontline staff including teachers, community groups, faith groups and service providers
- Develop and implement a local annual suicide prevention campaign programme for local campaigns that address mental health stigma and discrimination, bullying, and self-harm

ii) Suicide prevention for specific groups

Early identification and provision of evidence-based targeted interventions for:

- Children and young people - work with schools, social services and justice system to identify and refer those at risk to appropriate services
- People with untreated depression and those living with long term physical health conditions- work with GPs to increase identification and referral
- Black, Asian and minority ethnic groups and asylum seekers
- Lesbian, Gay, Bisexual and Transgender groups
- People who misuse drugs or alcohol- link with local substance misuse strategy to ensure joined up approach in addressing substance misuse needs
- People recently discharged from mental health inpatient care
- People recently sentenced to prison or released from prison
- Develop tailored interventions that support young and middle aged men, those who self-harm and vulnerable adults e.g. those who have been abused and/or looked after children who are discharged from care to independent living.

iii) Reduce access to means

- Reduce access to high-lethality means of suicide in hospitals, care institutions and criminal justice settings
- Regular assessments of mental health ward areas to identify and remove potential risks
- Identify high risk suicide sites in Nottingham City and limit access and make them safer for example put barriers or nets, provide emergency telephone numbers, e.g. Samaritans and British Transport Police
- Work with local authority and councils in the planning departments to include suicide risk in health and safety considerations when designing multi-storey car parks, bridges and high-rise buildings
- Reduce availability of certain medicines were appropriate
- Identify further high risk medicines by undertaking medicines review in line with national prescribing guidelines.

Priority 2: Review of ***timely suicide and self-harm data and be informed by national and local evidence based research and practice*** in order to better understand the local needs

To achieve this priority we need to improve timely data capture. This will enable suicide prevention and interventions strategies will target the most at risk groups. Also, applying evidence based research and practice that will inform the local commissioning of prevention and interventions will aim to ensure effectiveness in reducing the rate of suicide and self-harm.

We can make a positive impact by:

Undertaking regular reviews of national and local suicide and self-harm trends and conducting local regular suicide audits. Sources of data used to complete the annual audit in order to gain insights and identify areas to prioritise are:

- The Coroners' Office information on suicides and self-harm deaths.
- Public Health Mortality Files (main source)
- Compendium of Clinical and Health Indicators
- Nottinghamshire Healthcare Trust suicide audit
- Prisons (HMP): Nottingham
- Police, ambulance and fire service data
- Safeguarding of Children and Adult data
- Suicide and self-harm prevention and interventions evidence based research

By working with academic experts in the field, commissioners will aim to ensure that all locally delivered self-harm and suicide interventions are aligned to evidence based research and effective outcomes.

Priority 3: Access effective support for those ***bereaved or affected by suicide***

Suicide can also have a profound effect on the local community. We know from studies that, in addition to immediate family and friends, many others will be affected in some way[60,61]. They include neighbours, school friends and work colleagues, but also people whose work brings them into contact with suicide – emergency and rescue workers, healthcare professionals, teachers, the police, faith leaders and witnesses to the incident. It is important we:

- Collate local information on available support for those bereaved or affected by suicide
- Provide effective and timely support for families bereaved and other people affected by suicide e.g. friends and colleagues
- Have in place effective local responses procedure to deal with the aftermath of a suicide
- Provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide

We can make a positive impact by:

- Developing local responses to the aftermath of suicide
- Developing easily accessible information on mental health and wellbeing services
- Working with third sector organisations to provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide

Priority 4: ***Engage with media personnel*** to agree on sensitive approaches to reporting suicide and suicidal behaviour

The media have a significant influence on behaviour and attitudes. There is evidence to suggest that the reporting of suicide in the media can increase the rate of suicide, particularly amongst young people who may already be at risk[62,63]. It is apparent that the media have a role to play in suicide prevention, by limiting certain aspects of reporting, providing details of local support organisations and helplines and by portraying suicide in ways which may discourage imitation.

We can make a positive impact by:

- Developing a local suicide prevention communication plan that promotes responsible reporting of suicide in the media
- Ensuring details of local support organisations and helplines are included with any coverage of suicide deaths
- Promoting responsible reporting and portrayal of suicide and suicidal behaviour in the media
- Continuing to support the internet industry to remove content that encourage suicide and provide ready access to suicide prevention services.

Priority 5: Improve the understanding and care for people at risk of suicide and self-harm through ***training of frontline staff*** to deal with those at risk of suicide and self-harm behaviour.

Early identification of those at risk of suicide and self-harm is important in supporting people to access the right intervention.

We can make a positive impact by:

- Raising awareness of suicide and self-harm prevention identification and interventions through training of all health and social care professional, criminal justice and emergency frontline staff
- Training in self-harm for frontline and general hospital workers to address negative attitudes and knowledge gaps that have major negative effects on the experience of people who self-harm and can be a major impediment to their care
- Training of mental health staff in psychosocial assessment and in effective brief psychological interventions.

9.0: MONITORING OUTCOMES

The overall aim of this strategy is to reduce the rate of suicide and self-harm in the Nottingham City population. By improving the mental health and wellbeing of the populations of Nottingham City by effectively preventing mental health problems and ensuring appropriate access and delivery of mental health and social care services can support the reduction in the local rates of suicide and self-harm.

Measuring suicide and self-harm prevention outcomes is complex due to the level, types and complexity of mental health problems. Also, suicide and self-harm data has its limitations as mental health problems can go under diagnosed or under reported. Also, mortality data, such as suicide data lacks timeliness and does not capture the prevalence of mental illness, or the disability it causes.

Therefore, in order to monitor this strategy's progress and outcomes we will be looking at a number of key indicators. These indicators are found and incorporated into:

- The national outcome framework: the Public Health Outcomes Framework, which has a specific indicator to monitor a range of mental health outcomes,

- The Department of Health (DH), No Health without Mental Health dashboard (December,2013)[64] brings together a number of indicators for a wide range of sources to reflect progress against the national mental health strategy. There is specific indicator on reducing the number of suicide related deaths. Nationally, data and benchmarking against these indicators is in the process of being developed
- The Nottingham City Wellness in Mind – Mental Health Strategy for Nottingham 2014-2017

The priorities of this strategy are also linked with other local strategies and drivers, outlined in **Appendix B.**

10.0: TAKING THE NOTTINGHAM CITY SUICIDE PREVENTION STRATEGY FORWARD

10.1 Leadership

To realise the aims of the Nottingham City Suicide Prevention Strategy and in order to see real improvement in Nottingham City we need suicide prevention leaders and champions at all levels across the public and voluntary sectors.

Those of particular note are:

- Councillors and officers of Nottingham City Council have already committed to prioritising mental health by signing up to the ***Mental Health Challenge***[65]. The Mental Health Challenge is a new concept where local councils through a mental health leadership role help in the promotion of good mental health in their communities and to ensure people with mental health conditions have better, more fulfilling lives. Member champions for mental health can also help to raise awareness about mental health in Nottingham City.

- ***Senior leaders,*** including commissioners and mental health clinical leads, from NHS Nottingham City and Nottingham City Council Adult and Children's Social Care.

- ***Service providers*** including Nottinghamshire Healthcare NHS Trust, Nottingham University Hospitals, Nottingham Citycare Partnership, Nottingham City Council, Nottinghamshire Police and the voluntary sector.

There is a need to agree a clear way forward to ensure the strategy is implemented, including the development and delivery of detailed action plans for each of the five strategic priorities. Further strategic work will include ensuring that children's, adults and older people's suicide and self-harm prevention work is linked to this strategy with agreed suitable targets for assessing progress.

10.2: Governance

The strategy is owned by the Nottingham City Health and Wellbeing Board and steered by the Mental Health and Wellbeing Steering Group.

The Nottinghamshire and Nottingham City Suicide Prevention Strategy group comprising of key stakeholders will continue to deliver against this strategy key actions.

The overarching leadership for each of the five priorities will be developed and consist of the most appropriate suicide prevention leaders and champions.

10.3: Action plans

A detailed action plan is in development following the consultation on the strategy. Working groups will be set up to achieve each of the five priorities in this strategy.

10.4: Equality Impact Assessment

An equality impact assessment (EIA) is an assessment to ensure that policies do not discriminate and that where possible, equality is promoted. A full equality impact assessment of this strategy will be undertaken in accordance with the Nottingham City Council's Equality and Diversity Policies. Further equality impact assessment will be undertaken on the action plans resulting from this strategy.

Appendix A: Preventing suicide in England: A cross-government outcomes strategy to save lives 2012[1]

The strategy is not a one-off document but an on-going, co-ordinated set of evolving activities. It seeks to be comprehensive, specific, evidence-based, and subject to evaluation. For these reasons, when identifying high-risk groups as priorities for prevention, it selects only those for whom suicide rates can be monitored. The Strategy recognises however, that there are other groups for whom a tailored approach to their mental health is necessary if their risk of suicide is be reduced. These approaches are illustrated among the 6 Goals below.

Goal 1: Reduce the risk of suicide in key high-risk groups
The following high-risk groups are priorities for prevention:

• young and middle-aged men
• people in the care of mental health services, including inpatients
• people with a history of self-harm
• people in contact with the criminal justice system
• specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers

Goal 2: Tailor approaches to improve mental health in specific groups
Improving the mental health of the population as a whole is another way to reduce suicide. The measures set out in both *No health without mental health* and *Healthy Lives, Healthy People* will support a general reduction in suicides.

The strategy identifies the following groups for whom a tailored approach to their mental health is necessary if their suicide risk is to be reduced:

• Children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system
• Survivors of abuse or violence, including sexual abuse
• Veterans
• People living with long-term physical health conditions
• People with untreated depression
• People who are especially vulnerable due to social and economic circumstances
• People who misuse drugs or alcohol
• Lesbian, gay, bisexual and transgender people and Black, Asian and minority ethnic groups and asylum seekers

Goal 3: Reduce access to the means of suicide
One of the most effective ways to prevent suicide is to reduce access to high lethality means of suicide. Suicide methods most amenable to intervention are:

• Hanging and strangulation in psychiatric inpatient and criminal justice settings
• Self-poisoning
• Those in high-risk locations; and
• Those on the rail and underground network

Continued vigilance by mental health service providers will help to identify and remove

potential ligature points. Safer cells complement care for at-risk prisoners.

Safe prescribing can help to restrict access to some toxic drugs.

Local agencies can prevent loss of life when they work together to discourage suicides at high-risk locations. Local authority planning departments and developers can include suicide in health and safety considerations when designing structures.

Goal 4: Provide better information and support to those bereaved or those affected by suicide

Effective and timely emotional and practical support for families bereaved by suicide is essential to help the grieving process and support recovery. It is important that GPs are vigilant to the potential vulnerability of family members when someone takes their own life.

Post-suicide community-level interventions can help to prevent copycat and suicide clusters. This approach may be adapted for use in schools, workplaces and health and care settings.

It is important that people concerned that someone may be at risk of suicide can get information and support as soon as possible.

Goal 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour

The media have a significant influence on behaviour and attitudes. The government wants to support them by:

• promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media; and
• continuing to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention services

Local, regional and national newspapers and other media outlets can provide information about sources of support when reporting suicide. They can also follow the Press Complaints Commission Editors' Code of Practice and *Editors' Codebook* recommendations regarding reporting suicide.

The Government will continue to work with the internet industry through the UK Council for Child Internet Safety to create a safer online environment for children and young people. Recognising concern about misuse of the internet to promote suicide and suicide methods, they will be pressing to ensure that parents have the tools to ensure that children are not accessing harmful suicide-related content online.

Goal 6: Support research, data collection and monitoring

The Department of Health will continue to support high-quality research on suicide, suicide prevention and self-harm through the National Institute for Health Research and the Policy Research Programme.

Reliable, timely and accurate suicide statistics are essential to suicide prevention. The Department will consider how to get the most out of existing data sources and options to address the current information gaps around ethnicity and sexual orientation.

Reflecting the continuing focus on suicide prevention, the Public Health Outcomes Strategy includes the suicide rate as an indicator.

Appendix B: Local Policy Drivers

Key local documents

- Wellness in Mind, the Nottingham City– Mental Health and Wellbeing Strategy 2014-2017
- Nottingham City Suicide Prevention Strategy 2014-2017 (this document)
- Nottingham City Joint Strategic Needs Assessment (JSNA)
- Nottingham City Joint Health and Well-being Strategy 2013/14
- Nottingham City Children and Young People's Plan 2014-2016
- The Nottingham Plan 2020
- The Vulnerable Adults Plan for Nottingham City
- Working together for a healthier Nottingham, Nottingham City Clinical Commissioning Group Strategy 2013-2016
- The Nottingham City Joint Carers Strategy 2012 to 2020

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