Suicide Prevention

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Executive summary

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" (HM Government 2012).

Suicide is a major issue for society. Nationally, the overall trend in suicide and injury undetermined death rates has been decreasing since 1998 until 2008 and has been rising slightly since. From 2010 the number of reported suicides has gradually increased with highest number of reported suicides occurring in 2014 with approximately 4,707suicides (ONS 2015).

The impact of every suicide can be devastating – economically, psychologically and spiritually – for all affected (HM Government 2012). The cost of a completed suicide for someone of working age in the UK exceeds £1.6 million (CMO 2014). 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 (APMS 2007).

The latest three-year average data shows a national increase of 15.9% in the rate of suicide and injury undetermined deaths from the 2001-2003 baseline (to a rate of 8.9 per 100,000). The rate in the East Midlands dropped from a peak of 9.1 per 100,000 in 2001-2003 to an average lowest rate, 8.8 per 100,000 in 2011-2014(ONS 2015).

For Nottinghamshire there has been a slight increase in the average rate of death by suicide or injury of undetermined intention. For the period 2011 -13, the Nottinghamshire age-standardised rate of 8.5 per 100,000 population, increased to 9.2 per 100,000 population in 2012-14, which is

slightly above the England average of 8.9 per 100,000 population. However, as the numbers are small statistical significance is not reached.

In Nottinghamshire, for the period 2012-2014 the highest rate of suicide occurred in the 35-64 age group for both males and females, which is similar to the picture nationally. However, for the 65+ age male group, the suicide rate was higher when compared to the national suicide rate. Although none of these differences are statistically significant due to the small numbers.

Nationally more men die of suicide than women, the ratio of male to female suicide deaths is 3:1. For Nottinghamshire 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. Nottinghamshire has a similar pattern, although due to small numbers we need to be cautious in interpretation of our local data.

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 (Owens et al. 2002).

In England, self-harm is one of the most frequent reasons for emergency hospital admissions (Royal College of Psychiatrist 2006). It accounts for at least 150,000 presentations to general hospitals each year and those who self-harm have a 1 in 6 chance of repeat attendance at A&E within the year (Runeson et al. 2010). 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 following acts of self-harm is much higher than in younger adults (Gunnell et al. 2004) .

For the period 2013-2014, the Nottinghamshire emergency hospital admission for intentional self-harm rate was 207.9 per 100,000 population. Nottinghamshire is slightly higher when compared to the England rate of 203.2 per 100.000 population. However, this is not statistically significant.

There are a wide variety of factors that can contribute to suicide and self-harm (Gunnell & Lewis 2005). These include historical or familial risk factors (e.g. genetic influences, family history and early trauma) and recent risk 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.

Suicide prevention is acknowledged to be a complex challenge and 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 (HM Government 2012)

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 (Hawton and van Heeringen 2000) and people recently discharged from psychiatric in-patient care (HM Government 2012).

The suicide and self-harm prevention agenda is cross-cutting and relates most closely to the following JSNA chapters: Mental Health, (Emotional and Mental Health of Children and Young People (2014), Young adults and older people), Domestic and Sexual Violence, Carers, Employment, Asylum Seekers, Refugees and Migrant workers.

Unmet needs and service gaps

The following unmet needs and service gaps have been identified and are aligned to the Nottinghamshire and Nottingham City Suicide Prevention Steering Group Action Plan 2016-2018 and includes;

- Targeted health promotion initiatives towards men and older people
- Targeted suicide prevention programmes to specific groups such as: Black and Minority Ethnic (BME) and Lesbian, Gay, Bi-sexual and Transgender (LGBT) groups
- Training on self-harm and suicide awareness for frontline professionals in order to improve early identification and signposting those at risk of suicide and/or self harm
- Improved early identification and access to treatment of depression for older people and those experiencing long term physical conditions
- The provision of risk assessment and management as part of routine clinical assessment and care planning provided by front line staff working with high risk groups, particularly in primary care and A & E
- Better support for veterans suffering with depression and/or PTSD
- Monitoring of means of self-harm and suicide through REAL time surveillance in order to put in place targeted strategies and interventions
- 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. This includes support to families immediately following a suicide, support in dealing with the bereavement and follow up for the bereaved families
- An agreed and joined up approach by all Suicide Prevention steering group stakeholders in communicating self-harm and suicide to the local media
- A local suicide communication plan for dealing with media on self-harm and suicide
- Improved access to mental health crisis intervention services for all ages

Recommendations for consideration by commissioners

Recommendations		
Public Health Intelligence and data improvement		**Lead(s)**
1.	Nottinghamshire Public Health at the time of writing this JSNA chapter currently undertaking a Coroners Suicide Audit for all Suicide Verdicts for the period 2013-2014. This audit is due for publication in April 2016. The audit aims are to compare data with findings from previous local suicide audits and to identify local risk factors, groups at risk or localities of higher incidence that will inform the suicide prevention targeted actions	Nottinghamshire County Council Public Health
2.	Implement 'REAL' time surveillance in order that clusters and suicide hotspots are identified early	Nottinghamshire County Council Public Health
Prevention		
3.	Develop and implement a local annual suicide prevention campaign programme targeted towards at risk groups and address mental health stigma and discrimination, bullying, and self-harm	Kaleidoscope Plus Group
4.	Raise awareness of mental health problems through campaigns targeting schools and colleges in suicide awareness	Nottinghamshire Public Health Children and Young Peoples team
5.	Develop a local suicide prevention communication plan that promotes responsible reporting of suicide in the media	Nottinghamshire County Council Communications
Early identification and interventions		
6.	Improve early identification and access to interventions for those at risk of suicide by ensuring the locally commissioned suicide prevent training programme is including primary care, employers, job centres, Citizen's Advice Bureau, Emergency Services and Accident and Emergency Departments, teachers, community groups, faith groups in their training programme	Kaleidoscope Plus Group
7.	Primary care workforce trained in undertaking a suicide risk analysis so that patients contemplating suicide have access to early interventions	Kaleidoscope Plus Group
Service quality and accessibility		
8.	Data sharing agreements between coroners, primary care, acute hospital and mental health services to enable each suicide and open verdict to be identified investigated and lessons learnt.	Nottinghamshire and Nottingham City Suicide Prevention Steering Group
9.	Commission mental health crisis services	Nottinghamshire CCG Mental Health Commissioners
10.	Commission mental health early identification and targeted interventions services for specific groups at suicide and self-harm	Nottinghamshire CCG Mental Health Commissioners
11.	Reduce the means of suicide and self-harm through ensuring hospitals, mental health wards, care institutions and criminal justice settings are safe by identifying and removing any potential risks	Safety and Quality leads across all hospital, care and criminal justice settings
12.	Ensure pathways are in place that provide effective and timely support for families and other people bereaved or affected by someone's suicide	Harmless (self harm support)

Full JSNA report

What do we know?

1) Who is at risk and why?

There are a wide variety of factors that can contribute to suicide and self-harm (Gunnell & Lewis 2005). These include historical or familial risk factors (e.g. genetic influences, family history and early trauma) and recent risk 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.

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

The groups at high risk of suicide are;

- Men aged 35-59 years (Department of Health 2015)
- People in the care of mental health services, including inpatients (The University of Manchester 2015)
- People with a history of self-harm, untreated depression, misuse of alcohol, facing economic difficulties, going through divorce or separation or have long-term physical illnesses (CMO 2014)
- People in contact with the criminal justice system (police, probation, the courts and prisons (Shaw et al. 2004)
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers (HM Government 2012)
- Children and Young People who have experience abuse and/or neglect
  Lesbian, Gay, Bisexual or Transgender people (PHE 2015)
  Older people aged 65+ experiencing social isolation and loneliness (O'Connell et al. 2004)

Table 1 below shows the estimated increased risk for those groups at higher risk of suicide. The highest risk of suicide group are patients up to 4 weeks following discharge from a psychiatric hospital with an estimated increased risk of x100-200**.**

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

High risk group	Estimated increased risk
Doctors	x 2
Farmers	x 2
Males compared to females	x 2-3
Unemployed people	x 2-3
Divorced people	x 2-5
Family history of suicide	x 3-4
People on low incomes (social class IV/V)	x 4
Alcohol misuse and dependency	x 5-20
Offenders serving non-custodial sentences	x 8-13
Prisoners	x 9-10
Current or ex-psychiatric patients	x 10
Drug misusers	x 10-20
First year after self-harm (Hawton et al.2003) (Cooper, et al. 2005)	x 60-100
4 weeks following discharge from inpatient psychiatric hospital	x 100-200
Serious physical illness/disability	Not known/under review (Bazalgette et al. 2011)

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

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.

Factors associated with increased risk of suicide include:

- In up to half of all suicides there have previously been ***failed attempts*** (DH 2002)
- 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) (The University of Manchester 2015)
- 5-10% of all suicides happen in the ***four weeks after discharge from psychiatric*** hospital, making this a time of high risk (Bickley et al. 2013)
- Following a suicide attempt or completion, adolescents are at an ***increased risk of copycat suicides*** (King, K.A. 2006). Reports indicates that youth suicide can increase two to four times more following exposure to another individual's suicide than among older age groups (Gould, et al. 1990)
- ***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 (Copeland, W.E., et al 2013). Exposure to bullying is also associated with elevated rates of anxiety, depression and self-harm in adulthood (Meltzer, H., et., al. 2011), (Jordanova et al. 2007)
- 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 (HM Government 2012)
- 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 (Kapur N, et al 2009)
- ***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 (CMO 2014)
- ***Several physical disorders*** such as diabetes, epilepsy and asthma are associated with increased risk of self-harm and suicide (Foster et al. 1997) (Hawton, et al. 2003)
- The risk of suicide is four times more likely in ***gay and bisexual men*** (National Institute of Mental Health 2007) and higher rates of suicidal thoughts and self-harm in ***lesbian and bisexual women*** compared to women in general (Stonewall 2008)
- Suicide in ***older people*** is strongly associated with depression (Draper BM 2014)
- 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*** (Gunnell et al. 2004)
- ***More men die from suicide than women***, but suicidal thoughts and self-harm are more common in women (Royal College of Psychiatrist 2010)

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 (HM Government 2012)

2) Size of the issue locally

There are difficulties in determining the exact intent of a person who dies from suicide. Thus measuring or estimating the true level of suicide can be complex. However, for the purpose of this JSNA chapter the 'suicide rate' is defined using the same criteria as the Public health Outcomes Framework '*deaths given an underlying cause of intentional self-harm or injury/poisoning of undetermined intent*'.

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.

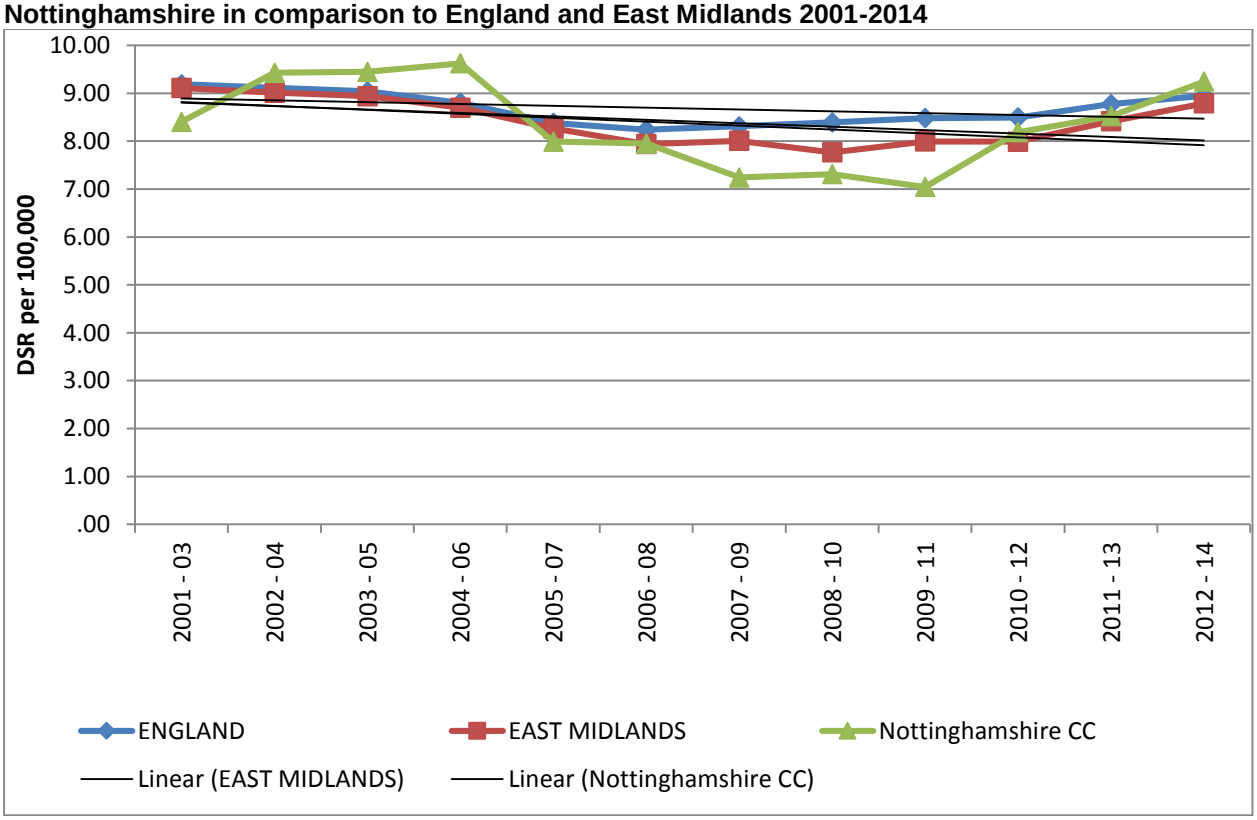
Local trends

Nationally, the overall trend in suicide and injury undetermined death rates has been decreasing since 1998 until 2008 and has been rising slightly since. From 2010 the number of reported suicides has gradually increased with highest number of reported suicides occurring in 2014 with approximately 4,707suicides (ONS 2015).

The latest three-year average data shows a national increase of 15.9% in the rate of suicide and injury undetermined deaths from the 2001-2003 baseline (to a rate of 8.9 per 100,000). The rate in the East Midlands dropped from a peak of 9.1 per 100,000 in 2001-2003 to an average lowest rate, 8.8 per 100,000 in 2011-2014 (ONS 2015).

For Nottinghamshire there has been a slight increase in the average rate of death by suicide or injury of undetermined intention. For the period 2011 -13, the Nottinghamshire age-standardised rate of 8.5 per 100,000 population, increased to 9.2 per 100,000 population in 2012-14, which is slightly above the England average of 8.9 per 100,000 population shown in figure 1.However, as the numbers are small statistical significance is not reached.

Figure 1: Trends in mortality from suicide and injury undetermined death 15+yrs old in Nottinghamshire in comparison to England and East Midlands 2001-2014



Source: Health and Social Care Information Centre (2015)

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 2001 to 2014. For Nottinghamshire the 2001-2003 baseline suicide rate was 8.4 per 100,000 population, with lowest rate of 7.0 per 100,000 population in 2009-2011 and the highest rate of 9.2 per 100,000 population in 2012-2014.

Table 2: Directly standardised rate per 100,000 and numbers: mortality from suicide and injury undetermined death in Nottinghamshire – 3 year pooled data – 2001 - 2014

Authority	3-year pooled	2001 - 2003	2002 - 2004	2003 - 2005	2004 - 2006	2005 - 2007	2006 - 2008	2007 - 2009	2008 - 2010	2009 - 2011	2010 - 2012	2011 - 2013	2012 -20 14
Nottinghamshire CC	Rate	8.40	9.43	9.45	9.62	7.99	7.95	7.24	7.31	7.04	8.19	8.52	9.24
	Number	184	206	209	218	184	183	166	169	164	191	200	219

Source: Source: Health and Social Care Information Centre (2015)

At the time of writing this JSNA chapter, suicide data at a Nottinghamshire District level is currently available up to 2013.

Table 3 and Figure 2 shows a slight decrease in the rate of mortality from suicide and injury undetermined for all Nottinghamshire Districts in the period 2011/12/13 compared to the 1995/96/97 baseline rate. However, as the numbers are small statistical significance is not reached.

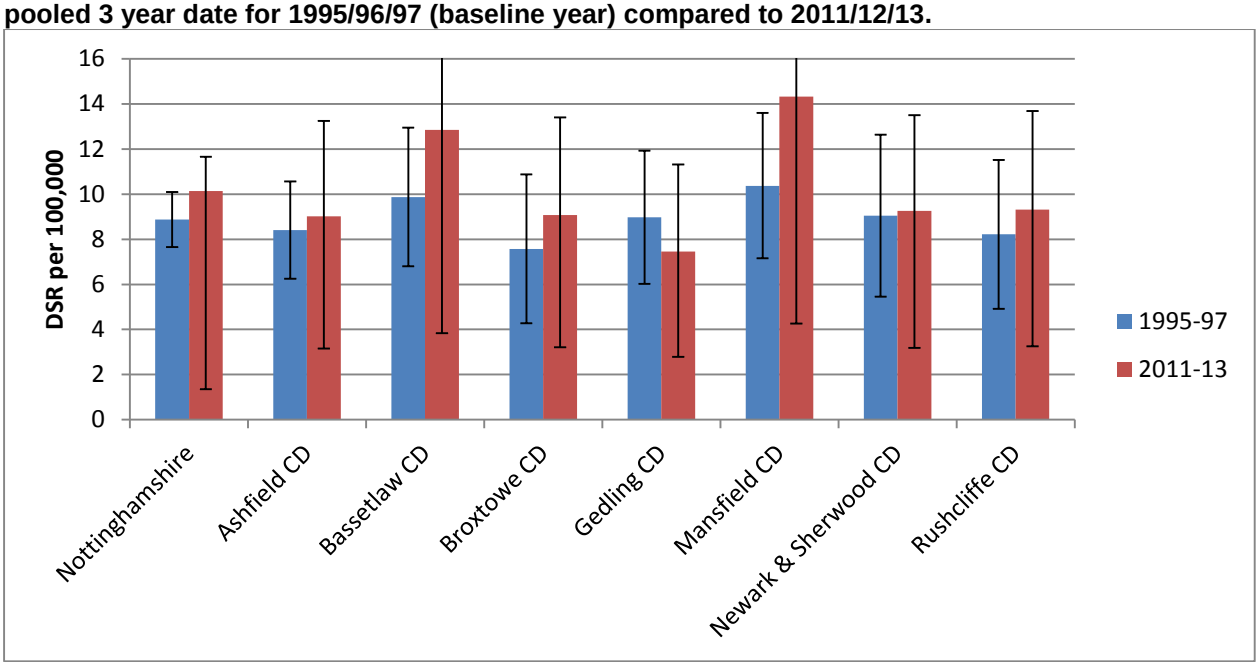
Table 3: Percentage changed in the Directly Age Standardised Mortality from Suicide and injury undetermined death rate and number

Local Area and District	1995/96/97 (baseline)		2011/12/13 (± New Definition)		Percentage difference in DSR (baseline to current year)
	DSR per 100,000	Number	DSR per 100,000	Number	
Nottinghamshire	8.87	212	10.14	200	*-5.66%*
Ashfield CD	8.41	30	9.02	26	*-13.33%*
Bassetlaw CD	9.87	35	12.85	37	*-0.08%*
Broxtowe CD	7.57	26	9.07	25	*-3.8%*
Gedling CD	8.97	32	7.46	22	*-31.25%*
Mansfield CD	10.37	33	14.32	37	*-12.12%*
Newark & Sherwood CD	9.04	30	9.26	27	*10.0%*
Rushcliffe CD	8.22	26	9.32	26	*0.0%*

Source: Source: Health and Social Care Information Centre (2014)

± In 2011, the introduction of a new version of the International Classification of Disease (ICD-10) software (version 2010) changed the coding rules for drug related deaths. In particular, some deaths from 'drug abuse' and 'acute intoxication' previously coded under 'mental and behaviour disorders' are now coded as 'self-poisoning of undetermined intent' and therefore included in suicide statistics.

Figure 2: Suicide mortality and injury undetermined death rates for districts within Nottinghamshire, pooled 3 year date for 1995/96/97 (baseline year) compared to 2011/12/13.



Source: Health and Social Care Information Centre (2014) NB: error bars indicate 95% confidence intervals

Gender and age

Table 4 shows the rate of change suicide mortality rate in the gender split from the 1995/6/7 baseline to 2011/12/13. Ashfield, Bassetlaw and Mansfield districts shows a slight increase for males. Broxtowe. Newark and Sherwood and Rushcliffe have seen a slight increase for females. Females show a more apparent decrease compared to males. However, as the numbers are small this highlights the difficulties of drawing significant conclusions and caution should be taken in interpreting this data.

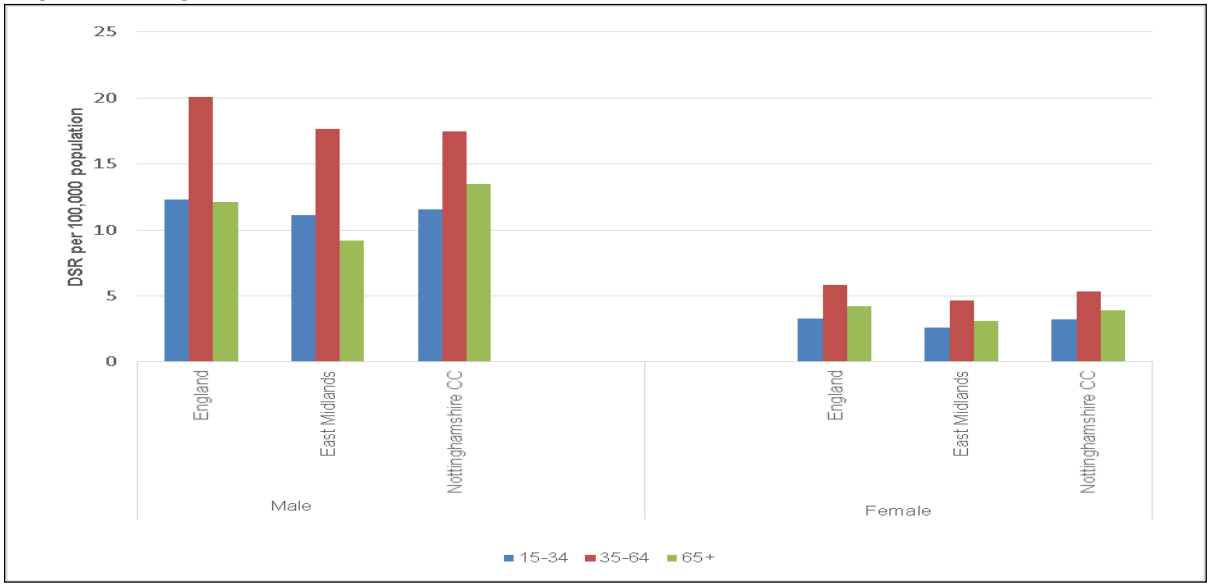
Table 4: Number and percentage change in suicide mortality (aged 15+) by Gender – 1995/96/97 and 2010/11/12 for Nottinghamshire Districts

Local Area and District	1995/96/97 (baseline)	2011/12/13	% change (baseline to current year)	1995/96/97 (baseline)	2011/12/13	% change (baseline to current year)
	Number	Number		Number	Number	
	Male	Male		Female	Female	
Nottinghamshire	152	153	*0.66%*	60	47	*-21.67%*
Ashfield CD	19	22	*15.79%*	11	<5	*-63.64%*
Bassetlaw CD	26	29	*11.54%*	9	8	*-11.11%*
Broxtowe CD	19	16	*-15.79%*	7	9	*28.57%*
Gedling CD	18	17	*-5.56%*	14	<5	*-64.29%*
Mansfield CD	22	27	*22.73%*	11	10	*-9.09%*
Newark & Sherwood CD	26	21	*-19.23%*	<5	6	*50.00%*
Rushcliffe CD	22	21	*-4.55%*	<5	<5	*25.00%*

Source: Source: Health and Social Care Information Centre (2014) *Numbers 1-5 suppressed to <5 to protect privacy

Figure 3 below shows for the period 2012-2014 Nottinghamshire had the highest rate of suicide in the 35-64 age group for both males and females. For the 65+ age male group the suicide rate was higher when compared to the national suicide rate. Although none of these differences are statistically significant due to the small numbers.

Figure 3: Suicides by age and gender in Nottinghamshire, compared to the East Midlands and England, All ages, 2012-14



Source: Source: Health and Social Care Information Centre (2015)

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 2001-2014, combined for Nottinghamshire and Nottingham City by gender.

In keeping with national findings (East Midlands PHO 2010) table 5, below shows that the most common methods of suicide and injury undetermined are hanging for both men women, 43.6% and 45.4%, respectively. When analysing ICD-10 suicide only codes, hanging is the most common suicide method for men and drug poisoning for women, 51.4% and 47.1%, respectively.

Table 5: Deaths from Suicide and Injury Undetermined by Method and Gender - Nottinghamshire and Nottingham City - combined (2001-2014)

Suicide and Injury Undetermined (ICD-10 X60-X84, Y10-Y34 exc Y33.9)			**Suicide Only (ICD-10 X60-X84)**		
Method	**Males**	**Females**	**Method**	**Males**	**Females**
	%	**%**		**%**	**%**
Firearms	*2.4*	*0.0*	**Firearms**	*2.1*	*0.0*
Drowning	*4.9*	*2.7*	**Drowning**	*5.1*	*5.5*
Carbon Monoxide	*7.6*	*6.8*	**Carbon Monoxide**	*6.4*	*1.2*
Other	*6.5*	*5.8*	**Other**	*6.7*	*8.9*
Jumping/Falling /Lying	*8.9*	*8.2*	**Jumping/Falling/Lying**	*8.2*	*7.4*
Drug Poisoning	*16.8*	*30.9*	**Drug Poisoning**	*17.8*	*47.1*
Hanging	*43.6*	*45.4*	**Hanging**	*51.4*	*29.9*
Total	***100.0***	***100.0***	**Total**	***100.0***	***100.0***

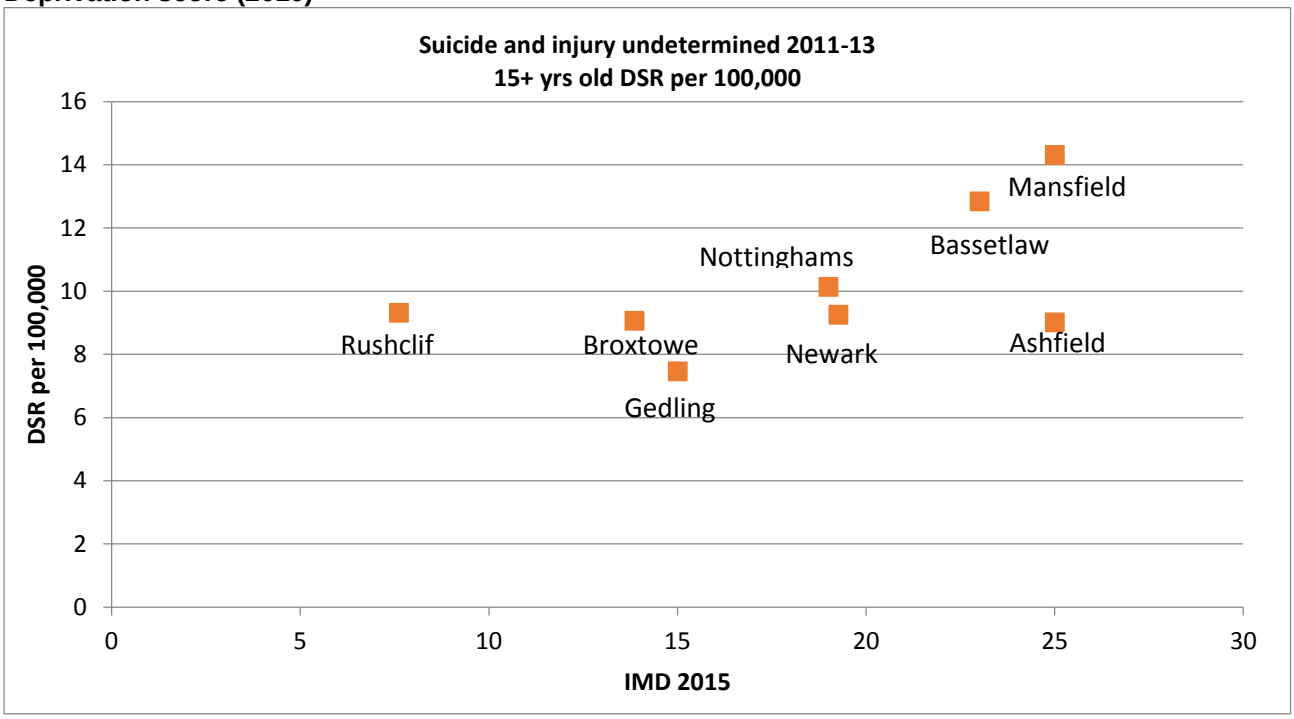
Source: Source: Health and Social Care Information Centre (2015)

Suicide rate and deprivation

The Index of Multiple Deprivation score 2015 (IMD 2015) 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 4 below shows the relationship between deprivation and suicide rate.

Figure 4: District Suicide and injury undetermined mortality rate 2001-2013 v Indices of Multiple Deprivation score (2010)



Source: Health and Social Care Information Centre (2014)

Ethnicity

The 2011 census data indicates for Nottinghamshire that the Black and Minority Ethnic (BME) population remains relatively small with 95.5% white and 4.5% from BME groups (ONS Census 2011).

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 occurs in young black females, aged 16-34 years (Ngwena, J 2014).
- Suicide rates and classical indicators of suicide risk among inpatient suicide deaths vary by ethnic group. Black African men have the highest rates of suicide compared to the White British group (Bhui KS, Dinos S, McKenzie K. 2012).

Offenders

The National Study of Self-Inflicted Death by Prisoners 2008-2010 (University of Manchester 2013) showed a downward trend in the number of self-inflicted deaths[±] in prisons in England and Wales. There were a total of 180 self-inflicted deaths amongst prisoners in 2008- 2010. The self-inflicted deaths in this period occurred across 70 prisons. One self-inflicted death occurred in the Prison Escort Custody Service (PECS). Twenty-nine (41%) prisons had 1 self-inflicted death, 37 (53%) prisons had between 2 and 5 self-inflicted deaths, and 4 (6%) prisons had between 6 and 8 self-inflicted deaths. More than half (102; 57%) of these self-inflicted deaths occurred in Category B Local prisons.

The majority of self-inflicted deaths were male, White British and predominantly aged between 20 and 39 years and not formally assessed as 'at risk' and were not on Assessment, Care in Custody and Teamwork (ACCT) at their time of death and . The study recommended that prevention should continue to highlight the importance of safer cells, and the identification and treatment of mental disorder. Hanging was the most common method used. (University of Manchester 2013).

Nottinghamshire Her Majesty's Prisons (HMP)

There are three closed male national prisons operating across Nottinghamshire, HMP Whatton, Lowdham and Ranby. Table 6 gives an outline of these prisons category and operational capacity.

Table 6: Nottinghamshire HMP Prison Classification

Classification	HMP Whatton	HMP Lowdham Grange	HMP Ranby
Category of Prison	Closed training prison	Closed training prison	Closed training prison
Security status	Category C	Category B	Category C
Sex of prisoners	Male	Male	Male
Daily capacity of prisoners	847	920	1060

Source: Ministry of Justice

For the period 20011-2013, NHS England data on self-inflicted deaths in Nottinghamshire prisons indicated that the incidence of self-inflicted death was lease than 5 for all prisons except for HMP Whatton where zero self-inflicted deaths were reported. These figures reflect those that are known and suspected as suicide, not necessarily as having a coroner's verdict as suicide.

Table 7 below shows 3-year pooled data for the number of self-harm incidents were data was provided across HMP Nottinghamshire prisons for the period 2005/06//07 to 2011/12/13. The data provided does not give the number of repeat self-harm incidents per prisoner. HMP Ranby shows a steady annual percentage prevalence increase in the rate of self-harm incidents. While HMP Lowdham shows a significant increase in 2008/09/10 compared to 2011/12/13. However, this data should be treated with caution due to missing data for 2008.

[±] A self-inflicted death refers to any death of a person who has apparently taken their own life irrespective of intent.

Table 7: Number of self-harm incidents in all Nottinghamshire Prisons - pooled 3 year data for 2005/06/07 (baseline year) compared to 2008/09/10 and 2011/12/13.

Prison	2005/06/07 (Baseline)	Estimated annual prevalence***	2008/09/10	Estimated annual prevalence***	2011/12/13	Estimated annual prevalence***
	N=	%	N=	%	N=	%
HMP Whatton	*	*	*	*	*	*
HMP Lowdham Grange	*	*	**132	*7.1*	1022	*36.9*
HMP Ranby	*	*	184	*5.7*	229	*7.1*
Total	**407**		**926**		**2,708**	

Source: NHS England

NB: * no data available ** Stats available for 2009/10 only * based on average daily prison population**

Suicide and mental health

The Nottinghamshire main mental health service provider is the Nottinghamshire Healthcare NHS Trust (NHCT). NHCT have a mechanism in place whereby all unexpected patient deaths in contact with the service are reported on and examined to ascertain the circumstances and cause of 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 or unascertained**.**

Table 8 below shows the total annual numbers unexpected deaths for both Nottingham City and Nottinghamshire NHCT Mental Health service provision, for the period 2010/11/12/13.

Table 8: NHCT combined Nottingham City and Nottinghamshire unexpected deaths annual numbers for the calendar years 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

Self-harm

In table 9 below shows the Nottinghamshire and all Nottinghamshire District rate for Emergency Hospital Admissions for Intentional Self-Harm as defined by external cause codes (ICD10 X60-X84).

For the period 2013-2014, the Nottinghamshire emergency hospital admission for intentional self-harm rate was 207.9 per 100,000 population. Nottinghamshire is slightly higher when compared to the England rate of 203.2 per 100.000 population. Rushcliffe District is significantly better than the England average (rate 141.9 per 100,000 population). While Ashfield and Bassetlaw Districts are significantly worse than the England average (rate 250.5 per 100,000 and 262.2 per 100,000, respectively).

Table 9: Number and Directly Age Standardised rate per 100,000 for Emergency Hospital Admissions for Intentional Self-Harm (ICD10 X60-X84) in Nottinghamshire Districts in comparison to England and East Midlands -2013-2014

Area	N=	Per 100,000 population
Ashfield	305	250.5
Bassetlaw	285	262.2
Browtowe	199	180.8
Gedling	227	198.9
Mansfield	218	205.3
Newark and Sherwood	242	215.9
Rushcliffe	156	141.9
Nottinghamshire	1,632	207.9
East Midlands region	9,781	209.2
England	111,997	203.2

Source – Hospital Episode Statistics (HES)

3) Performance and outcomes

The overall aim is to reduce the rate of suicide and self-harm in the Nottinghamshire population. By improving the mental health and wellbeing of the population of Nottinghamshire can effectively prevent mental health conditions. Also, by ensuring appropriate, timely 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 progress and outcomes in the prevention of suicide in Nottinghamshire there are 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 suicide indicator - 4.10 - Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population
- The Department of Health (DH 2013), No Health without Mental Health dashboard 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 Nottinghamshire No Health without Mental Health Framework for Action 2014-2017
- The Nottinghamshire Suicide Prevention Framework for Action 2015-2018
- Nottinghamshire and Nottingham City Suicide Prevention Steering Group Action Plan 2016-2018

Nottinghamshire Healthcare NHS Trust (local Mental Health Trust) conducts a monthly suicide prevention audit. This audit is part of the “Monthly Audit Tool” taking place across all Adult Inpatient Services. Each month all in patient areas undertake a self-audit on their records. Part of the audit considers a series of standards based on the National Audit for Suicide Prevention: Ward Audit.

In 2015 Nottinghamshire Health NHS Trust produced a 3 – year ‘Signup to Safety Plan’. The plan aims to ensure processes are in place so that the target of no incidents of suicide (or suspected suicide) among people with recent clinical contact and a 50% reduction in overall severity of self-harm incidents by 2018 is reached.

4) Current activity, service provision and assets

An overview of the available services provided in Nottinghamshire is below:

Public Mental Health

There are range of interventions and assets in Nottinghamshire that contribute to mental wellbeing, such as:

- Kaleidoscope Plus Group provide mental health and suicide prevention awareness and training
- Arts events
- Children's services, including parenting support
- Work to reduce domestic and sexual violence, and support its victims
- Work to reduce harm from drugs and alcohol
- Housing services
- Welfare advice and support
- Workplace wellbeing initiatives
- Campaigns and work to end loneliness and isolation
- Parks and recreation – including organised activities and walks
- Adult education services

A range of mental health services support suicide prevention and intervention by managing depression are in place in Nottinghamshire. These services are delivered in line with the NICE stepped-care model for managing depression in adults (figure 5)

Figure 5: The stepped-care model

Focus of the intervention	***Nature of the intervention***
STEP 4: Severe and complex[a] depression; risk to life; severe self-neglect	Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multi-professional and inpatient care
STEP 3: Persistent sub-threshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression	Medication, high-intensity psychological interventions, combined treatments, collaborative care[b] and referral for further assessment and interventions
STEP 2: Persistent sub-threshold depressive symptoms; mild to moderate depression	Low-intensity psychosocial interventions, psychological interventions, medication and referral for further assessment and interventions
STEP 1: All known and suspected presentations of depression	Assessment, support, psycho-education, active monitoring and referral for further assessment and interventions
[a] Complex depression includes depression that shows an inadequate response to multiple treatments, is complicated by psychotic symptoms, and/or is associated with significant psychiatric comorbidity or psychosocial factors **[b]** Only for depression where the person also has a chronic physical health problem and associated functional impairment (see 'Depression in adults with a chronic physical health problem: treatment and management' [NICE clinical guideline 91]).	

Nottinghamshire Healthcare Foundation Trust (NHCT) provides community, outpatient, day and inpatient services for all ages of the population for people with mental health problems. These can be summarised as follows:

- Adult Mental Health (AMH);
- Mental Health Services for Older People (MHSOP);
- Specialist Services (this includes: Child and Adolescent Mental Health Services (CAMHS) and Prescribed Services);
- Improving Access to Psychological Therapies (IAPT).

Accessing support in a mental health crisis is available

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.

HMP Whatton, Lowdham and Ranby Prisons

All Nottinghamshire Prisons adhere to the Prison Service Order (PSO) Suicide and Self-Harm prevention first published in 2007 and revised in 2012. The revised 2012 policy retained the Assessment, Care in Custody and Teamwork (ACCT) procedures at its centre. ACCT is an individualised care planning and cross agency approach for prisoners at risk of suicide or self-harm. ACCT also aims to improve staff training in case management and in assessing and understanding at-risk prisoners.

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 prevention suicides in prisons.

Cruse Bereavement Care

Cruse Bereavement Care provides support to people after the death of someone close (including death through suicide).

Since 2010, the service has "responded" to 17 bereavement cases related to suicide. They have noticed an increase during 2013-2014. In 2013, they supported 5 cases across Nottinghamshire and from January 2014 received 9 cases. Two cases were related to young people. On average the service is estimated to receive 1-2 case(s) per month. The organisation has received 24 child referrals since 2012; one of them was due to suicide of a close relative.

Samaritans

Samaritans is a charity that enables people who are experiencing feelings of distress or despair, including those who may be at risk of suicide, to receive confidential emotional support.

The charity also promotes a better understanding in society of suicide, suicidal behaviour and the value of expressing feelings which may otherwise lead to suicide or impaired emotional health.

Samaritans is part of the National Suicide Prevention Group formed to tackle the issue of railway suicide. This group comprises Samaritans, Network Rail, British Transport Police (BTP), Train Operating Company representatives and the wider railway industry, such as ATOC (Association of Train Operating Companies), RSSB (Rail Safety & Standards Board) and rail Unions. At local level, Samaritans branches work with station managers, station staff from both Train Operating Companies and Network Rail and the British Transport Police, in prevention and post-incident support work.
Samaritans works with Network Rail in providing two training courses for railway staff and gives them the skills and confidence to approach a person in distress at a railway location and provide them with emotional first aid before referring them for further support.
Samaritans also provides post-incident support through:

1. Delivery of the Trauma Support Training course
2. Development of a call-out facility and referral system to Samaritans branches where Samaritans volunteers can be called out to speak to a distressed person at a station
3. Presence of Samaritans volunteers at stations following an incident. These volunteers are able to provide emotional support to railway staff and members of the public who have witnessed a fatality. They can also distribute leaflets and contact cards containing information about Samaritans' services

4. Provision of guidance for Network Rail staff and the rail industry on responding to media enquiries following an incident.

Harmless

Harmless is a user led organisation that provides a range of services about self-harm including support, information, training and consultancy to people who self-harm, their friends and families and professionals. People can self-refer to the organisation and referrals are also received from professionals, the police, jobcentre, CAMHS, schools etc.
Harmless deliver monthly drop in sessions that offer support and information about self- harm and access to one to one therapy sessions.

The organisation is also running the "Tomorrow Project". The Tomorrow Project is a confidential suicide prevention service. The project offers three tiers of support:

1. Involvement in the local community and partnership working
2. Support, information, advice and signposting in relation to suicide and self harm
3. A clinical therapy service for anyone affected by suicidal thoughts, feelings or those who are bereaved by suicide. 12 weeks of therapy are offered with ongoing referrals on completion if needed.

The Coroners office

The Coroner's responsibility is to investigate all sudden and unexplained deaths, or violent and unnatural deaths or deaths that occur in custody. The coroner only considers deaths that occur within their jurisdiction (Nottinghamshire). They have got duty to ensure that relevant facts are fully, fairly and fearlessly investigated.

Following a referral the coroner has to answer four questions:

- Who was the deceased?
- When did they die?
- Where did they die?
- How did they come about their death?

A 'conclusion' (not verdict) of suicide is reached when there is no reasonable doubt that the person intended to take their life.

5) Evidence of what works

Strategies and reported evidence

Preventing suicide in England: a cross government outcomes strategy to save lives (2012)

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 as follows:

Preventing suicide in England 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 actions include;

- 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)** report, published by the HM Government sets out the developments since the launch of the national 'Prevention suicide in England (2012) strategy' and **Preventing suicide in England: Two years on (2015)** report. Both reports highlights the areas where things need to be done in 2014 and 2015. The messages in this report are designed to help local areas focus on the most effective things that they can do to reduce suicide.

No health without mental health: A cross-government outcomes strategy for people of all ages (2011) 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.

The **Annual Report from the Chief Medical Officer (CMO) 'Public Mental Health Priorities: Investing in the Evidence' (2014)** Chapter 15, 'Suicide and self-harm', provides an overview of the epidemiology of suicide and self-harm in England.

The **Public Health Outcomes Framework: Improving outcomes and supporting transparency, (2012)** 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.

Healthy Lives, Healthy People: Our strategy for public health in England (2011) 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.

Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis 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.

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 (2015) report covers deaths by suicide for the period January 2003 to December 2013. 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, 2011). Comparisons are made against 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.

'Aiming for Zero Suicides' – Centre for Mental Health report (2015)
Commissioned by the East of England Strategic Clinical Network, the Centre for Mental Health has published an evaluation report on a whole-system approach to suicide prevention being piloted in four local areas in the East of England. The 'zero suicide' pilot programme, which looks to take suicide prevention into local communities is based on an approach developed by Dr Ed Coffey in Detroit, Michigan.

Clinical evidence

National Institute for Health and Care Excellence (NICE) guidelines: **Depression in adults. The treatment and management of depression in adults (2009)** NICE clinical guideline 90

National Institute for Health and Care Excellence (NICE) guidelines: **Depression in adults with a chronic physical health problem: recognition and management. (2009)** NICE clinical guideline 91.

National Institute for Health and Care Excellence (NICE) guidelines: **Depression in children and young people: identification and management (2005)** NICE clinical guidelines 28.

National Institute for Health and Care Excellence (NICE) guidelines: Self-harm in over 8s: long-term management (2011). **NICE clinical guidelines 133**

Public Health England guidance

Guidance for developing a local suicide prevention action plan (2014) document gives advice to local authorities how to:

- develop a suicide prevention action plan
- monitor data, trends and hot spots
- engage with local media
- work with transport to map hot spots
- work on local priorities to improve mental health

Preventing suicide among lesbian, gay and bisexual young people: A toolkit for nurses (2015). This toolkit helps you develop your skills and knowledge and recognise the wider context of mental health in relation to LGB sexual orientation and identity. It provides a general outline for health professionals looking to increase their skills and knowledge around suicide prevention strategies with LGB young people.

The Identifying and responding to suicide clusters resource was published on 10th September 2015, World Suicide Prevention Day. This document supports local authorities in their reaction to unexpectedly high numbers of suicides occurring in a particular period of time, a particular place, or both. The resource highlights how imperative it is that plans for such events are in place before they occur to ensure an effective response.

Preventing Suicides in public places: A practice resource (2015) replaces the 'Guidance on action to be taken at suicide hotspots' published in 2006 by the National Institute for Mental Health in England (NIMHE). It has a broader focus, includes learning from those who have tried to take their own lives in public places, draws on recent research and expert opinion, and provides examples of innovative practice from England and around the world.

Research evidence

Interventions for self-harm in children and adolescents. Cochrane Review (2015).

Pharmacological interventions for self-harm in adults. Cochrane Review (2015).

Self-Harm in Young People. Clinical Review. Evidence-Based Mental Health. Townsend, E. (2014).

Effectiveness of Interventions to Prevent Suicide and Suicidal Behaviour: A Systematic Review. Scottish Government Social Research (2008)

Risk and Protective Factors for Suicide and Suicidal Behaviour: A Literature Review. Scottish Government Social Research (2008)

Suicide Prevention Strategies: A Systematic Review. JAMA (2005)

Population sub-groups

Youth suicide prevention - Evidence briefing. Health Development Agency (2005)

Risk-taking behaviour in men: Substance use and gender. Health Development Agency (2003)

Young men and suicide prevention: a scoping exercise for a review of the effectiveness of health promotion interventions of relevance to suicide prevention in young men. Evidence for Policy and Practice (EPPI) Centre (2002)

Older People and Suicide. Care Services Improvement Partnership and the Centre for Ageing and Mental Health, Staffordshire University (2006)

A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. King, M et al (2008)

Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination. The Equalities Review (2007)

Suicide in the homeless within 12 months of contact with mental health services - A national clinical survey in the UK. Social Psychiatry and Psychiatric Epidemiology (2006)

Reaching Out, the evaluation report of three mental health promotion initiatives aimed at reducing suicides in young men. National Institute for Mental health in England (2006)

Local level

1. No health without mental health, Nottinghamshire's Mental Health Framework for Action 2014-2017
2. Nottinghamshire Suicide Prevention Framework for Action 2015-2018
3. Nottinghamshire Health and Wellbeing Strategy 2014/16

4. Nottinghamshire Children and Young People Strategic Plan
5. The Mental Health and Emotional Well-being of Children and Young People in Nottinghamshire – Health Needs Assessment 2013
6. Nottinghamshire Children and Young People Mental Health and Emotional Wellbeing Strategy 2014-16
7. Nottinghamshire Workplace Health Strategy 2014-2017 (draft)

All of the above strategies and framework for actions place an emphasis on prevention, early identification and intervention to ensure that people of all ages have the opportunity to enjoy good mental health and wellbeing.

6) What is on the horizon?

Projected service use and outcomes in 3-5 years and 5-10 years

Forecasting suicides is complex, and it is difficult to incorporate significant influences such as economic conditions. Factors that increase risk of suicide have been discussed earlier. The Projecting Adult Needs and Services Information System (PANSI) forecasts risk such mental disorders, alcohol dependence and drug dependence. Though, little variation is seen over time and any changes are due to change to the population structure; no account is taken of varying factors affecting risk.

Mortalities of people aged 18-64 from suicide (per 100,000), by gender, Nottinghamshire projected to 2030				
	2015	2020	2025	2030
Males aged 18-34 predicted to commit suicide	7	7	7	7
Males aged 35-64 predicted to commit suicide	22	22	22	21
Females aged 18-34 predicted to commit suicide	2	2	2	2
Females aged 35-64 predicted to commit suicide	6	6	6	6
Total population aged 18-64 predicted to commit suicide	37	37	37	37

Source: www.pansi.org.uk

7) Local Views

Consultation that informed the development of the Nottinghamshire Suicide Prevention Framework for Action 2015-2018 was undertaken in November 2014. The consultation highlighted that in order to reduce the number of deaths from suicide that:

1. Risk factors such as: the distal factors (genetic, family history and early trauma), proximal factors psychiatric disorder, physical illness, relationship breakdown and other life events), socio-economic determinants(unemployment, job loss, financial concerns etc.) need to be addressed
2. Improvement is required in early suicide and self-harm detection mechanisms for those people at risk of suicide and self-harm through screening in primary care and pathways onto psychological intervention
3. Improved access to mental health crisis support is required
4. Better available information on where to access support for those bereaved or affected by a suicide
5. Improved access to suicide and self-harm awareness training for all frontline health, social and voluntary sector workers including schools and colleges.

At national level, there are numbers of studies of service users' views and experiences of contact with health services after self-harm. They emphasise that above all, people need an empathic non-judgemental approach to their self-harming behaviour, based on understanding the issues involved and the functions self-harm may fulfil for the individual listened to and supported.

What does this tell us?

8) Unmet needs and service gaps

The following unmet needs and service gaps have been identified and are aligned to the Nottinghamshire and Nottingham City Suicide Prevention Steering Group Action Plan 2016-2018 and includes;

- Targeted health promotion initiatives towards men and older people
- Targeted suicide prevention programmes to specific groups such as: BME and LGBT groups
- Training on self-harm and suicide awareness for frontline professionals in order to improve early identification and signposting those at risk of suicide and/or self harm
- Improved early identification and access to treatment of depression for older people and those experiencing long term physical conditions
- The provision of risk assessment and management as part of routine clinical assessment and care planning provided by front line staff working with high risk groups, particularly in primary care and A & E
- Better support for veterans suffering with depression and/or PTSD
- Monitoring of means of self-harm and suicide through REAL time surveillance in order to put in place targeted strategies and interventions
- 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. This includes support to families immediately following a suicide, support in dealing with the bereavement and follow up for the bereaved families
- An agreed and joined up approach by all Suicide Prevention steering group stakeholders in communicating self-harm and suicide to the local media
- A local suicide communication plan for dealing with media on self-harm and suicide
- Improved access to mental health crisis intervention services for all ages

9) Knowledge gaps

The knowledge gaps include:

- Improved timeliness in self-harm and suicidal behaviour data is required in order that suicide prevention and self-harm strategic outcomes can be monitored.
- Official suicide data is not timely enough to enable local services to respond adequately to emerging situations. Data on suicides that are not investigated are lacking, and therefore it is likely that some areas of prevention work may be being missed.
- Self-harm and suicide awareness, prevention and intervention programmes should be delivered on available best evidence
- Data are not currently available to allow for analysis of suicides by ethnicity, though national evidence suggests an increased risk to those from certain ethnic minority communities

What should we do next?

10) Recommendation for consideration by commissioners

Recommendations		
Public Health Intelligence and data improvement		**Lead(s)**
1.	Nottinghamshire Public Health at the time of writing this JSNA chapter currently undertaking a Coroners Suicide Audit for all Suicide Verdicts for the period 2013-2014. This audit is due for publication in April 2016. The audit aims are to compare data with findings from previous local suicide audits and to identify local risk factors, groups at risk or localities of higher incidence that will inform the suicide prevention targeted actions	Nottinghamshire County Council Public Health
2.	Implement 'REAL' time surveillance in order that clusters and suicide hotspots are identified early	Nottinghamshire County Council Public Health
Prevention		
3.	Develop and implement a local annual suicide prevention campaign programme targeted towards at risk groups and address mental health stigma and discrimination, bullying, and self-harm	Kaleidoscope Plus Group
4.	Raise awareness of mental health problems through campaigns targeting schools and colleges in suicide awareness	Nottinghamshire Public Health Children and Young Peoples team
5.	Develop a local suicide prevention communication plan that promotes responsible reporting of suicide in the media	Nottinghamshire County Council Communications
Early identification and interventions		
6.	Improve early identification and access to interventions for those at risk of suicide by ensuring the locally commissioned suicide prevent training programme is including primary care, employers, job centres, Citizen's Advice Bureau, Emergency Services and Accident and Emergency Departments, teachers, community groups, faith groups in their training programme	Kaleidoscope Plus Group
7.	Primary care workforce trained in undertaking a suicide risk analysis so that patients contemplating suicide have access to early interventions	Kaleidoscope Plus Group
Service quality and accessibility		
8.	Data sharing agreements between coroners, primary care, acute hospital and mental health services to enable each suicide and open verdict to be identified investigated and lessons learnt.	Nottinghamshire and Nottingham City Suicide Prevention Steering Group
9.	Commission mental health crisis services	Nottinghamshire CCG Mental Health Commissioners
10.	Commission mental health early identification and targeted interventions services for specific groups at suicide and self-harm	Nottinghamshire CCG Mental Health Commissioners
11.	Reduce the means of suicide and self-harm through ensuring hospitals, mental health wards, care institutions and criminal justice settings are safe by identifying and removing any potential risks	Safety and Quality leads across all

		hospital, care and criminal justice settings
12.	Ensure pathways are in place that provide effective and timely support for families and other people bereaved or affected by someone's suicide	Harmless (self harm support)

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