# NOTTINGHAM & NOTTINGHAMSHIRE JOINT STRATEGIC NEEDS ASSESSMENT

## SUICIDE PREVENTION

### DECEMBER 2023

| Topic information | |
|---|---|
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Nottinghamshire Health & Wellbeing Board

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## Executive summary

### Introduction

Suicide is preventable and Nottinghamshire County Council, Nottingham City Council and local partners work towards reducing suicide in the local population by proactively improving population mental health and wellbeing, and by responding to known risks for suicide in the population.[1]

The previous Joint Strategic Needs Assessment on Suicide Prevention was approved in February 2016. Seven years on, and post the coronavirus pandemic, research has shown increased psychological morbidity in UK populations.[2] In terms of suicide risk, systematic review research has shown that the way people seek help for suicidal behaviour has changed, with no overall rise in suicide deaths.[3]

A renewed understanding of local needs for those at risk of suicide is needed. Since 2019, Nottingham City and Nottinghamshire County have collected data on suspected suicide deaths (pre-Coroner's inquest) as part of a Real Time Suspected Suicide Surveillance (RTSSS) system. Insight from RTSSS provides an improved local assessment of suspected suicides, which along with nationally reported data, ensures actions to prevent suicides are based on local data and intelligence.

This executive summary contains findings in terms of unmet need, knowledge gaps, and recommendations. The full JSNA document provides the detail of who is at risk, what this tells us and what to do next.

This JSNA is owned by the Nottinghamshire and Nottingham City Suicide Prevention Strategic Steering Group. Development of the JSNA was driven by a dedicated task and finish group, consisting of stakeholders from within the owning group. This included representatives from Nottingham and Nottinghamshire Integrated Care Board mental health commissioners, Nottinghamshire County Council Public Health, Nottingham City Council Public Health, Nottinghamshire Healthcare Foundation Trust, Bassetlaw Place Based Partnership, and the voluntary sector (the Samaritans).

[1] Nottingham City and Nottinghamshire County Public Health. Nottingham City and Nottinghamshire Suicide Prevention Strategy 2019-2023. September 2019.
[2] Jia R, Ayling K, Chalder T, et al Mental health in the UK during the COVID-19 pandemic: cross-sectional analyses from a community cohort study BMJ Open 2020;10:e040620. doi: 10.1136/bmjopen-2020-040620
[3] John A, Eyles E, Webb RT et al. The impact of the COVID-19 pandemic on self-harm and suicidal behaviour: update of living systematic review [version 2; peer review: 1 approved, 2 approved with reservations]. F1000Research 2021, 9:1097 (https://doi.org/10.12688/f1000research.25522.2)

**Unmet need and gaps**

The following unmet needs were identified:

1. Current school-based mental health support does not specifically address suicide prevention. Evidence suggests vulnerability to suicide can be partly established early in life and that taking early intervention and school-based approaches can be preventative.[4]

2. There is a need for additional work to tailor support for men to reduce risk factors and antecedents for suicidality. These include economic adversity, alcohol and drug use, relationship stresses and lack of social connections.

3. There is a need to support health seeking behaviours in men. National data suggests that 9% of middle-aged men experiencing suicidality are not in contact with any support.[5]

4. Voluntary and community services report a need for increased skills and knowledge in how to help people experiencing self-harm and suicidality access a continuum of appropriate holistic support.

5. Ensure evidence-based approaches support social connectedness and emotional wellbeing to reduce self-harm and suicidality among LGBTQ+ young people in current school-based and community-based locations.

6. Further collaborative work is needed to improve access to support services for Gypsy Roma and Traveller communities.

7. Systems are needed to ensure professionals in community, healthcare, money help and other public-facing roles have up-to-date knowledge and can support access to financial advice and wellbeing and mental health support. This should include knowledge and pathways at a local level.

8. Follow-up support is commissioned after first attendance to emergency departments for suicide ideation, and not commissioned for later attendances. Effective follow-up care has the potential to help people who self-harm to access the right support and prevent suicide.

9. There is a need to identify effective interventions to address the mental health needs and prevent suicide for people with long term physical health conditions.

10. Greater links and shared learning between domestic abuse and suicide prevention teams is needed. National data and research highlight that women are disproportionately affected by domestic abuse suicide.[6]

11. There is a need to better support the needs of children and young people who are in crisis and present to the emergency department with self-harm or suicidal ideation. Looked after young people and those transitioning from CYP to adult services, were identified as groups of particular need.

[4] The developmental origins of suicide mortality: A systematic review of longitudinal studies, Vidal-Ribas, Pablo; et al, European Child & Adolescent Psychiatry, 2022.
[5] The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Suicide by middle-aged men. 2021. The University of Manchester.
[6] Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England Sally McManus et al.June 07, 2022 DOI:https://doi.org/10.1016/S2215-0366(22)00151-1

12. There is a need to address online safety and suicide-related internet use. In the absence of local data, we look to national data which indicates a general increase in suicide-related internet use since 2011.[6]

The following knowledge gaps were identified:

- Evidence is currently limited on the effectiveness of interventions to prevent suicide and self-harm in people using substances.
- Limited understanding of the links between gender, domestic abuse and suicide (particularly sexual violence).
- Effective and appropriate links between RTSSS and Mental Healthcare provider self-harm and suicide data to inform antecedent themes and prevention action.
- Prevalence and means of self-harm, including understanding of self-harm presentations to VSCE organisations and the scale of potentially unmet need.
- Understanding gambling harm local intelligence in relation to suicide risk factors to inform targeted interventions.
- Limited understanding of approaches to reducing suicidality in people in contact with probation and youth justice services.

**Recommendations for consideration**

The following recommendations have been identified and are aligned to components of the new Suicide Prevention Strategy for England (2023 to 2028):

| | Recommendations | Lead(s) |
|---|---|---|
| | **Improved Data and Evidence** | |
| **1** | Improve data and intelligence sharing between partners including through the local Real Time Suspected Suicide Surveillance (RTSSS) system in order to ensure the quality of the RTSSS data and learning reviews after a suicide death has occurred and to improve the understanding of local need and gaps. | Local authority Public Health teams/ Nottinghamshire Healthcare Trust/ partners in RTSSS working group |
| **2** | Establish protocols for appropriate sharing and analysis of data on self-harm and suicide attempts among key partners working with groups at increased risk of suicidality, including mental health, domestic abuse, drug and alcohol use services to inform preventative actions. | Local authority Public Health teams/ Nottinghamshire Healthcare Trust |
| | **Reducing access to means and high frequency locations** | |
| **3** | Continue to prioritise action on reducing access to means for suicide within public places using intelligence from Real Time Suspected Suicide Surveillance (RTSSS) and through the RTSSS Working Group. | Local authority Public Health teams and partners in RTSSS working group |
| | **Providing tailored and targeted support to target groups.** | |

| | | |
|---|---|---|
| **4** | Develop integrated suicide prevention approaches for children and young people (CYP) in school settings via the Whole School Approach and CYP Mental Health Transformation Programme | Local authority Public Health and Education teams/CYP Mental Health Transformation leads |
| **5** | Facilitate the development of services and support, co-produced with men, to address suicide risk factors and promote social connections in informal settings. | Local authority Public Health teams/VSCE sector |
| **6** | Develop targeted suicide prevention communications for men to support engagement in and access to support services. | Local authority Public Health teams/ Nottinghamshire Healthcare Trust |
| **7** | Work with partners (including VSCE and primary care) to better understand where people experiencing self-harm or suicide ideation come into contact with services and what further action is needed to identify and support them, particularly for those whose needs do not meet the threshold for secondary mental healthcare. | All commissioners in Local authority Public Health teams |
| **8** | Develop communication resources to support people experiencing self-harm to access the right support at the right time. | Local authority Public Health teams |
| **9** | Integrate evidence-based approaches to supporting social connectedness and emotional wellbeing for LGBTQ+ people into school and community-based approaches and services. | Local authority Public Health teams/CYP Mental Health Transformation leads |
| **10** | Partner with community champions and existing organisations to improve access to appropriate support services for people from Gypsy Roma and Traveller communities. | Local authority Public Health teams |
| | **Addressing risk factors** | |
| **11** | Use learning from local pilot projects and listening events to improve access for groups who are at increased risk of not accessing self-harm and suicide prevention support such as:<br>- Gypsy Roma Traveller groups<br>- LGBTQ+ groups<br>- Men<br>- Those who are financially vulnerable, unemployed or people with a gambling problem<br>- People with neurodevelopmental conditions<br>- Young people/adults at risk of self-harm/suicide<br>- People bereaved by suicide | Local authority Public Health teams/CYP Mental Health Transformation leads |
| **12** | Support the community and voluntary sector to support people from at-risk groups who are experiencing self-harm and suicidality such as: men, people with financial difficulty, LGBTQ+ communities, people experiencing loneliness, and people in contact with the criminal justice system. | Local authority Public Health teams/VSCE sector |

| | | |
|---|---|---|
| **13** | Work with services providing financial support/advice and wellbeing support to improve the pathways between psychosocial support and money help, promote workforce awareness of financial advice and wellbeing support, and strengthen links between financial support and mental health services. | Local authority Public Health teams |
| **14** | Identify contacts and foster links with commissioners and providers of chronic pain and cancer pathways to explore how to improve access to appropriate support services. | Local authority Public Health teams/ Nottinghamshire Healthcare trust |
| **15** | Develop links with probation, youth justice and community-based services for people in contact with criminal justice system to develop training and involvement with the Suicide Prevention Stakeholder Network and Suicide Prevention Strategic Steering Group. | Local authority Public Health teams |
| **16** | Review mechanisms for sharing learning from Domestic Homicide Reviews relating to suicide with the suicide prevention partnership and consider opportunities for links between Assurance Learning Implementation Groups (ALIG) and the Suicide Prevention Strategic Steering Group. | Local authority Public Health teams |
| | **Effective crisis support** | |
| **17** | Work with the Integrated Care Board to identify support following Emergency Department attendance for every incident of suicide ideation. | Integrated Care Board |
| **18** | Work with the Integrated Care Board's Children and Young People (CYP) team to identify opportunities to promote the mental health and wellbeing and appropriate crisis support for CYP and looked-after children and ensure pathways for support are aligned to facilitate easy access for CYP. | Integrated Care Board (CYP and looked-after children's team) |
| | **Online safety:** | |
| **19** | Develop an approach to promote online safety, informed by the national online excellence programme. | Local authority Public Health teams, Education and Children's social care teams. |

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## Full JSNA report

### Notable changes from previous JSNA

Real Time Surveillance for suspected suicide: (RTSSS) data collection (pre-Coroner's inquest) in Nottingham City and Nottinghamshire County has been in place since 2019, with data around sexual identity, deprivation and ethnicity consistently collected from 2022 onwards. Insight from this platform has allowed an improved local needs assessment of suspected suicide (pre-Coroner's inquest) of Nottingham City and Nottinghamshire County residents. RTSSS data is also used to highlight any potential clusters or patterns of suspected suicide deaths to inform timely strategies to help prevent suicide.

National Statistics definition of suicide: This includes all deaths from intentional self-harm for persons aged 10 years and over and deaths caused by injury or poisoning where the intent was undetermined for those aged 15 years and over.[7]

From January 2016 the National Statistics definition of suicide widened to include deaths from intentional self-harm in children aged 10 to 14 years. Deaths from an event of undetermined intent in 10- to- 14-year-olds are not included in suicide statistics. This is because for older teenagers and adults, it is assumed that the harm resulting in death is self-inflicted, however for younger children it is not clear whether this assumption is appropriate.

Research has been conducted and it was found that the inclusion of these deaths has not had a significant impact on the overall age-standardised rates.[1]

Change to the Standard of Proof for suicide in England and Wales: In England and Wales, all unnatural deaths are investigated by coroners to establish the cause and circumstances of the death. The investigation, known as an inquest, compiles evidence such as post-mortem, toxicology reports, and interviews with relatives and friends. Once all the available evidence has been collected, a coroner will then determine the cause of death, and manner of death and surrounding circumstances. [8]

On 26 July 2018, as a result of a case in the High Court, the standard of proof (the evidence threshold) used by coroners to determine whether a death was caused by suicide was changed from the criminal standard of "beyond all reasonable doubt" to the civil standard of "on the balance of probabilities". This legal change has not resulted in any significant change in the reported suicide rate in England and Wales; recently observed increases in suicide among males and females in England, and females in Wales, began before the standard of proof was lowered.

Since the change, the proportion of deaths in England and Wales with an underlying cause of intentional-self harm increased, whereas the proportion coded to undetermined intent

[7] Suicide rates in the UK Quality and Methodology Information 2019. Office for National Statistics. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/methodologies/suicideratesintheukqmi

[8] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/changeinthestandardofproofusedbycoronersandtheimpactonsuicidedeathregistrationsdatainenglandandwales/2020-12-08

decreased; this indicates a change in conclusions reached by coroners, but when taken as a whole does not impact suicide statistics as both of these are included in the suicide rate.

## What do we know?

### 1. Who is at risk and why?

Suicide is a major issue for society and a leading cause of years of life lost. Suicide can affect anyone and has a significant, lasting and often devastating impact on individuals, families, communities, and wider society.[9] [10]

Suicide is often the end point of a complex history of risk factors and distressing events. However, suicide is preventable by working towards improving population mental health and wellbeing, and by responding to known risks for suicide in the population.

#### 1.1. National context and general trends in suicide

Nationally, a total of 15,447 deaths from suicide were registered in the three-year period of 2019-21, equating to a rate of 10.4 per 100,000 people (Figure 1).[10] This is the highest rate recorded since records began in 2001-03. However, this is not statistically significant compared to the previous three-year period of 2018-20 (10.3 per 100,000). The overall trend in suicide rates has been on the rise since 2006-08, rising from 9.2 per 100,000 (2006-08) to 10.4 per 100,000 (2019-21).

Males continued to account for three-quarters of suicide deaths registered in 2021 (4,129 male deaths compared with 1,454 female deaths), as seen since the mid-1990s.[11] Among women, those aged 45 to 49 years had the highest age-specific suicide rate at 7.8 per 100,000 in 2021 (146 registered deaths). Among men, those aged 50 to 54 years had the highest age-specific suicide rate at 22.7 per 100,000 (456 deaths). In terms of age and suicide, small differences from year to year or between age groups are unlikely to be statistically significant.

#### 1.2. Risk factors for suicide

Many risk factors for suicide are well established. For example, most people who end their own life experience mental illness, with depression, psychosis, personality disorder, or substance dependence often implicated.[14] Among the most common risk factors identified is

[9] Zero Suicide Alliance. ZSA Training. 2021. Available from: https://www.zerosuicidealliance.com/training
[10] Suicide Prevention Profile. Office for Health Improvement & Disparities. Available from: https://fingertips.phe.org.uk/suicide
[11] Suicide registrations in England and Wales 2021: Statistical bulletin. Office for National Statistics (ONS). Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2021registrations

a history of self-harm and previous suicide attempts, present in approximately 40% of people who have died by suicide.[12]

The National Centre for Social Research (2019) identified and reviewed government-funded surveys to consolidate national self-harm and suicidal behaviour survey data in terms of common findings on trends, prevalence, subgroup variations, and risk and protective factors. Seven consistent themes emerged from analyses and included:

1. Mental illness and wellbeing
2. Physical health and health behaviours (multiple chronic health conditions)
3. Relationships (social isolation, relationship breakdown or violence and abuse)
4. Acute and chronic stressors (crisis and sustained adversity)
5. Economic adversity and insecurity (debt and housing insecurity)
6. Demographics and identity
7. Formal service contact

Mental illness was consistently the strongest risk factor for suicidal thoughts, suicide attempts and self-harm (without intent) to emerge across multiple analyses. Men in midlife and non-heterosexual population groups were also associated with higher rates of suicidal thoughts and attempts compared to the general population..

**The National Confidential Inquiry into Suicide and Safety in Mental Health**

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) provides findings relating to those who died by suicide between 2010 and 2020 across all UK countries. The dataset includes deaths in the general population and deaths of patients in contact with mental health services. This audit of suicides is useful in establishing key groups at risk, as well as changing trajectories seen through the context of current economic and societal factors. Key findings from the most recent annual report include:[13]

General population suicide trends: The rate of suicide decreased by 6% in the UK in 2020, the first year of the COVID-19 pandemic, compared to 2019. This followed a general increase in suicide rates in 2018-19 compared to 2017.

Patient suicide trends: This relates to people in contact with mental health services within 12 months of suicide. 27% of all general population suicides were among people who had been in contact with mental health services within 12 months prior to their death (18,403 deaths in 2010-2020). The overall increase in the rate of suicide in England over the reporting period was not reflected in the rate of suicide among patients under mental health care. There has been little change over time in this key group.

Clinical and social characteristics: The majority of mental health service patients who died had a history of self-harm (64%) and had more than one mental health diagnosis (53%). There were also high proportions of those with alcohol (48%) and drug (37%) use. Nearly

[12] McManus S et al. Suicide and self-harm in Britain: researching risk and resilience. NatCen Social Research, 2019 Available from: http://www.natcen.ac.uk//our-research/research/suicide-and-self-harm-in-britain-researching-risk-and-resilience/
[13] The National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report: UK patient and general population data, 2010-2020. 2023. University of Manchester. Available from: https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/

half (48%) of all patients lived alone. In 5% of cases overall, the patients were recent migrants, i.e. seeking permission to stay in the UK or resident in the UK for less than 5 years.

Clinical care: Between 2010-2020, 5,103 mental health patients died by suicide in mental health acute care settings (28% of the total deaths that occurred), including in-patients (6%), post-discharge care (14%) and crisis resolution/home treatment (13%), with an average of 464 deaths per year. The most common non-acute settings were community mental health services (14%), alcohol or drug services (13%), and older people's mental health services (8%).

Suicide-related internet use – Between 2011 and 2020, there were 73 deaths of mental health patients per year where there was evidence of suicide-related internet use, equating to 8% of all patient suicides. The number has generally been increasing since 2011 though figures for 2019-20 suggest a recent fall.

## 2. Size of the issue locally

This section looks at local suicide rates and how they vary over time compared to national and regional areas, along with District and City level data compared with statistically similar neighbours.

### 2.1. Local trends in suicide

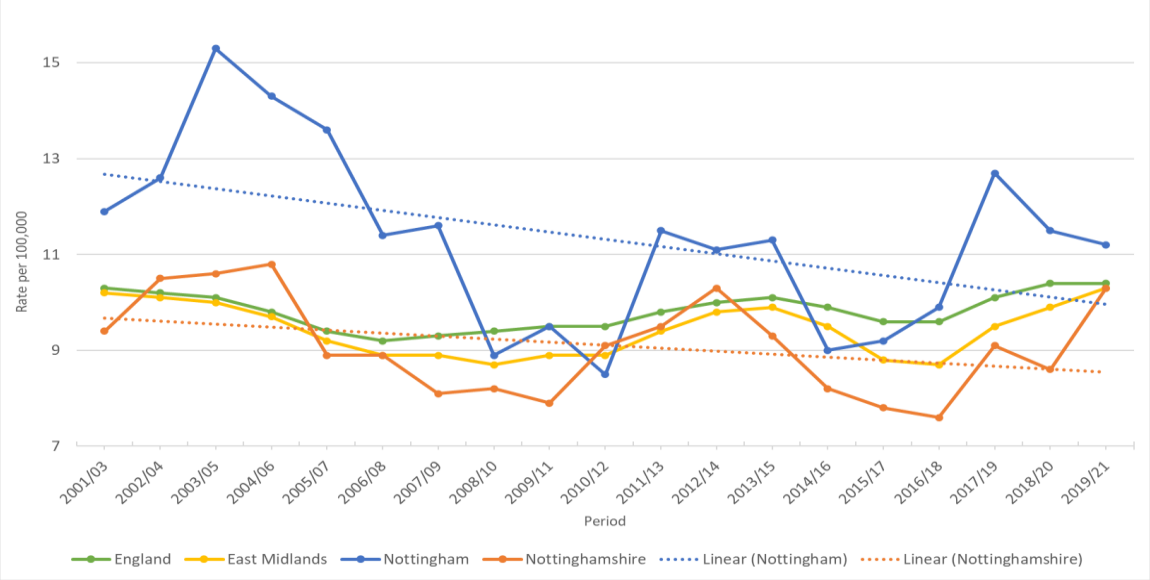
In the East-Midlands, the rate of suicide is 10.3 per 100,000 people (2019-21), which is statistically similar to the England average of 10.4. The overall trend for the region follows a similar pattern to the England average, but in more recent periods there has been a steady increase in the rate from 8.7 per 100,000 (2016-18) to 10.3 per 100,000 (2019-21) (Figure 1).[3]

In the latest three-year period (2019-21), Nottinghamshire's rate of 10.3 per 100,000 people is statistically similar to both the East-Midlands (10.3) and the England average (10.4). From 2012-14, the suicide rate in Nottinghamshire dropped from 10.3 to 7.6 per 100,000 in 2016-18 and has subsequently increased to 10.3 for the most recent period (2019-21). It is worth noting that the recent increase in rate from 8.6 in 2018-20 to 10.3 in 2019-21 is not significantly different.

In Nottingham, the most recent suicide rate is 11.2 per 100,000 people (2019-21), which is higher than both the East-Midlands (10.3) and England (10.4) rates, however is not a statistically significant difference. Recently in Nottingham, the rate of suicide has decreased from 12.7 per 100,000 people in 2017-19 to 11.2 per 100,000 in 2019-21.

Overall, between 2001 and 2021 the linear trend for rates of suicide in Nottinghamshire and Nottingham is following a downward trajectory.

***Figure 1: Age Standardised Mortality Rate from Suicide and Injury of Undetermined Intent per 100,000 people (10+yrs), 2001-2021***

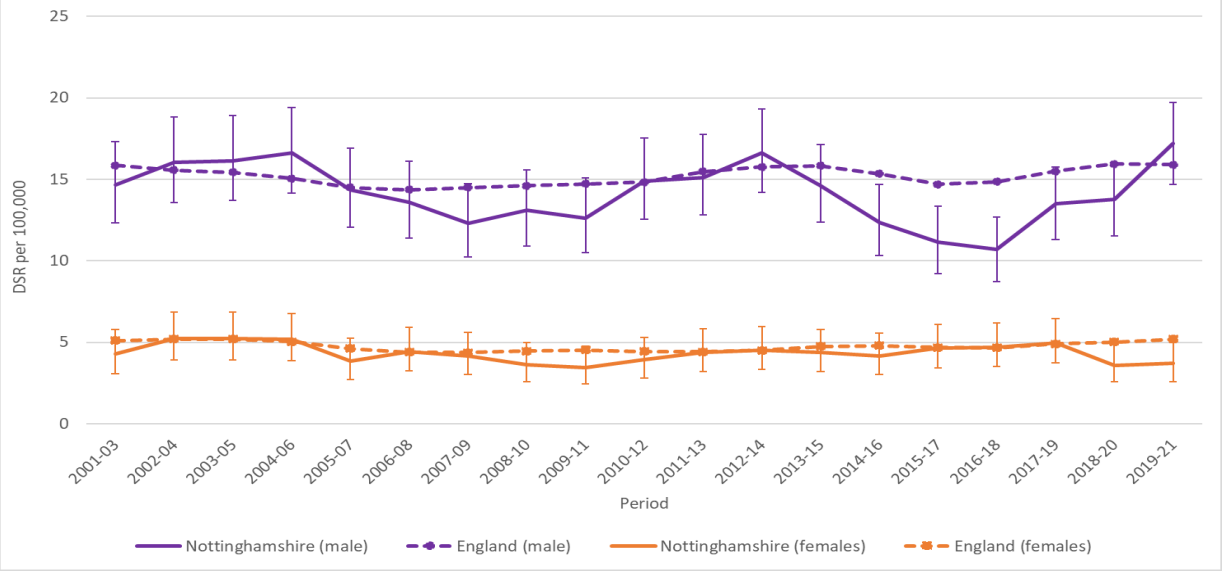



*Source: OHID*
**Y axis starts from 7*
*** Changes in coronial context from July 2018. This legal change has not resulted in any significant change in the reported suicide rate in England and Wales.*

Figure 2 shows that since 2001, suicide rates in Nottinghamshire have been significantly higher in males compared to females, mirroring national patterns. Rates in females have remained relatively stable and similar to the rates observed in England over the given time period. However, there was a notable decrease in rates among females in 2017-19 from 4.9 per 100,000 people to 3.6 in 2018-20. The rate has remained relatively constant in the recent period.

Rates among males exhibit annual variations, with a significant decrease observed from 16.6 per 100,000 people in 2012-14 to 10.7 per 100,000 people in 2016-18. However, since 2016-18 there has been a steady rise in suicide rates among males.

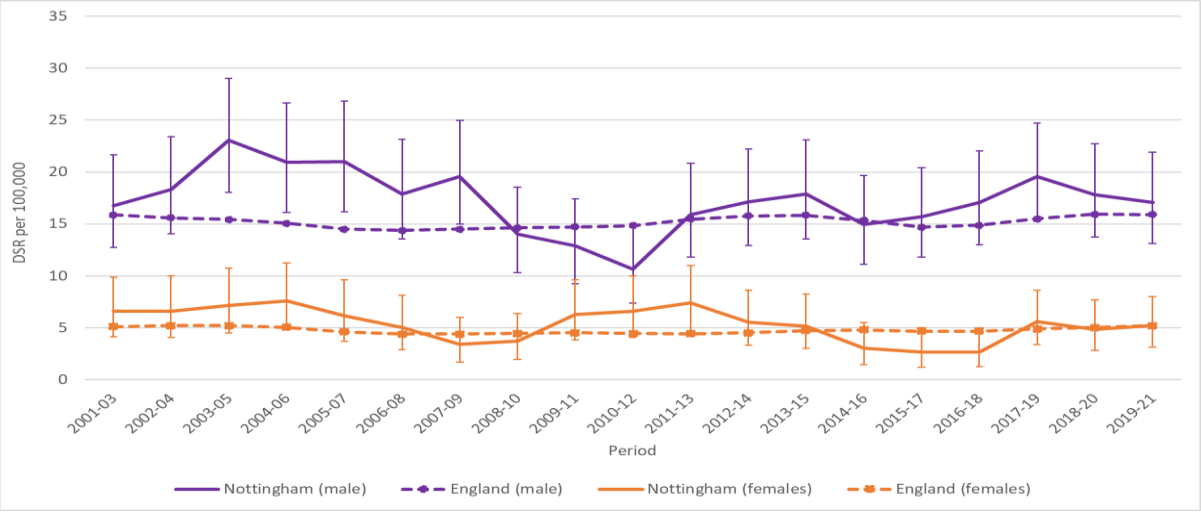
***Figure 2: Age Standardised Mortality Rate from Suicide and Injury of Undetermined Intent per 100,000 people (10+yrs) by gender, Nottinghamshire, 2001-2021***




*Source: OHID*
*Note: Directly standardised rate (DSR)*

Similar to Nottinghamshire, suicide rates for males in Nottingham City have been consistently higher compared to females since 2001, mirroring national patterns. Rates in females, though varying year on year have remained statistically similar to the England average and have plateaued in more recent years. Apart from the period between 2003 and 2007, rates in males have not been significantly different from the England average. In more recent periods, suicide rates in males in Nottingham has been decreasing as shown in Figure 3 below.

***Figure 3: Age Standardised Mortality Rate from Suicide and Injury of Undetermined Intent per 100,000 people (10+yrs) by gender, Nottingham, 2001-2021***



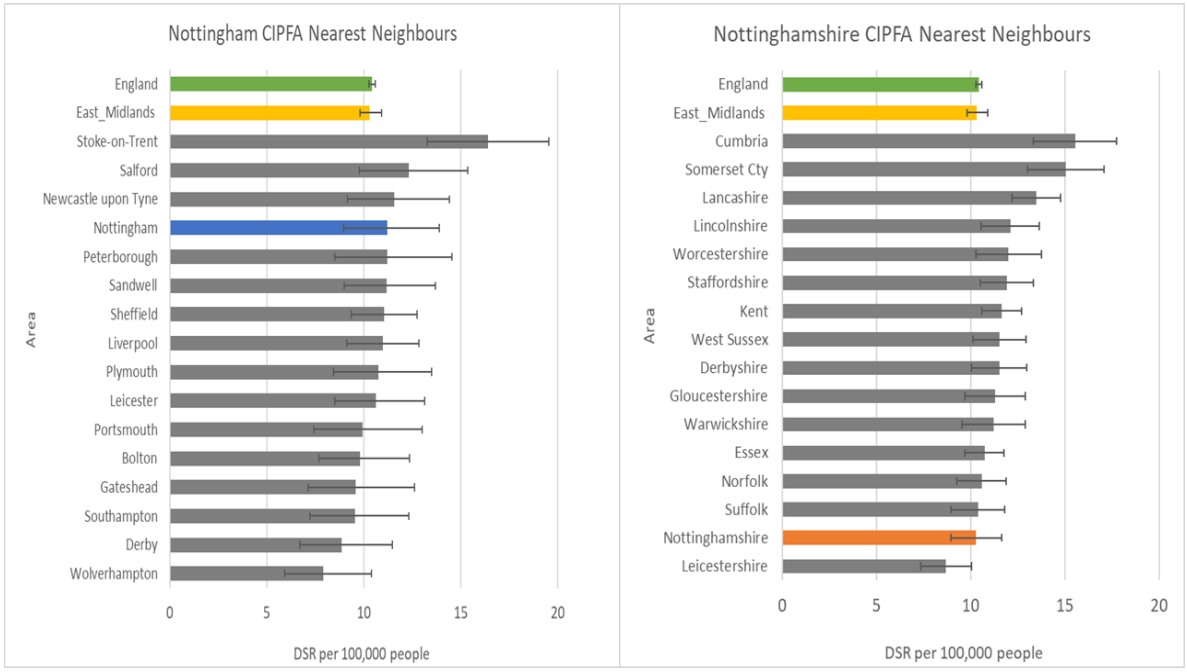

*Source: OHID*
*Note: Directly standardised rate (DSR)*

### 2.1.1 Comparison to CIPFA Neighbours

For the latest three-year period (2019-21), Nottinghamshire has the second lowest rate of suicide among its Chartered Institute of Public Finance and Accountancy (CIPFA) neighbours and is also statistically significantly similar to the National and East-Midlands rates. Among CIPFA neighbours, Cumbria has the highest suicide rate of 15.5 per 100,000 people and Leicestershire the lowest rate (8.7 per 100,000 people).

For the same three-year period, Nottingham has the fourth highest suicide rate compared to its CIPFA neighbours, but this is not significantly different to either its CIPFA neighbours, England or East-Midlands averages. Among CIPFA neighbours, Stoke-on-Trent has the highest suicide rate and Wolverhampton the lowest rate (16.4 and 7.9 per 100,000 people respectively).

***Figure 4: Age Standardised Suicide Rates (persons) per 100,000 people, Nottingham, Nottinghamshire and CIPFA Neighbours (2019-21)***

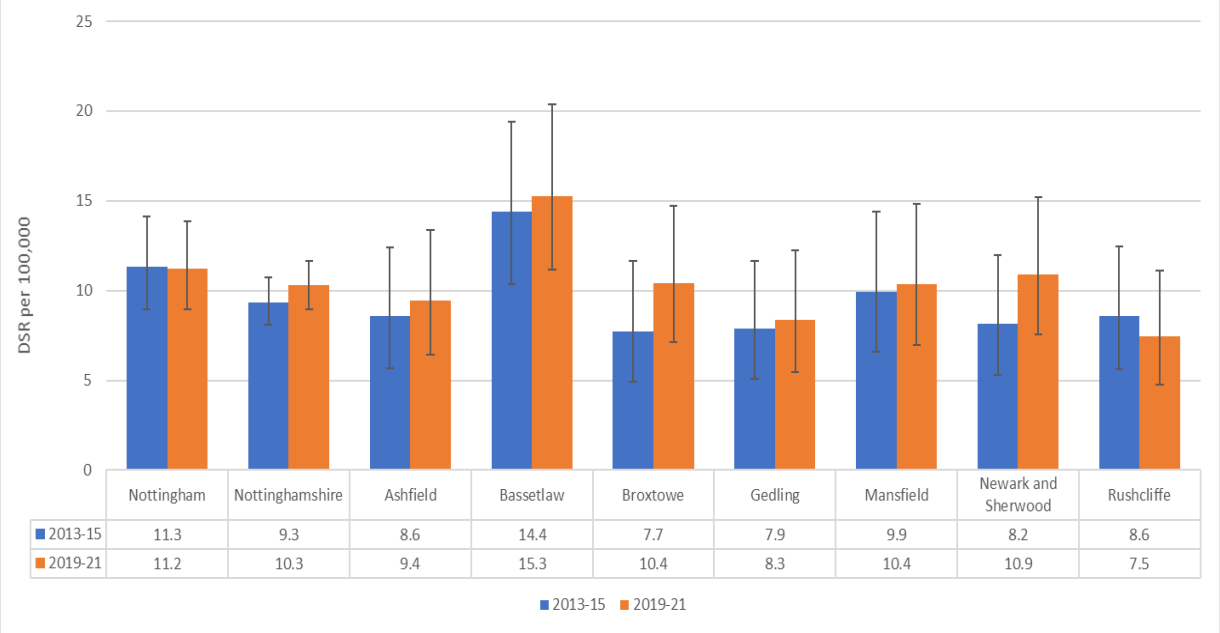



*Source: OHID*
*Note: Directly standardised rate (DSR)*

### 2.1.2 Suicide rates by area

Compared to the baseline year (2013-15), there has been no significant change in the suicide rates across the districts and Nottingham City as illustrated in Figure 5 below. Broxtowe and Newark & Sherwood had the highest rate change from the baseline year increasing from 7.7 to 10.4 and 8.2 to 10.9 per 100,000 people respectively (Table 1). Across the districts, Rushcliffe recorded a decrease in suicide rate from 8.6 (2013-15) to 7.5 per 100,000 people (2019-21). Due to absolute numbers being low, it is difficult to reliably detect patterns or changes over short periods of time.

***Figure 5: Age Standardised Mortality Rates from Suicide and Injury of Undetermined Intent, pooled 3-year data for 2013-15 (baseline year) compared to 2019-21***




*Source: OHID*
*Note: Directly standardised rate (DSR)*

***Table 1: Rate change in Mortality from Suicide and Injury of Undetermined Intent, 2013-15 (baseline year) versus 2019-21.***

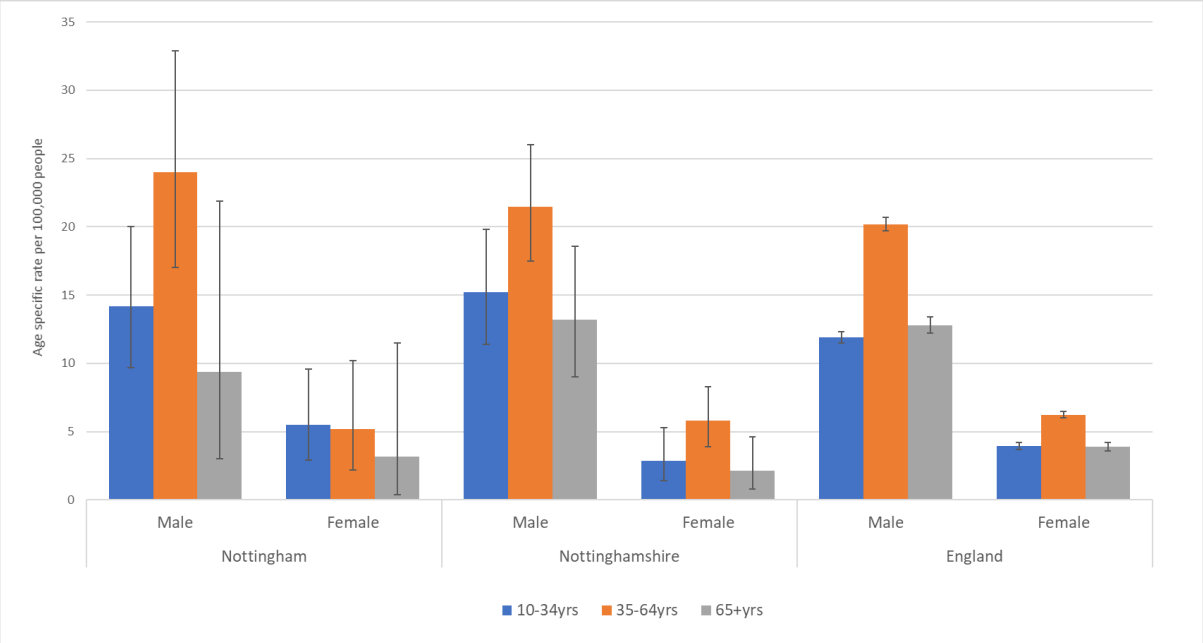
| Local Area & District | 2013-15 | | 2019-21 | | Difference | |
|---|---|---|---|---|---|---|
| | DSR per 100,000 | Number | DSR per 100,000 | Number | Rate Change | % Change |
| **Nottingham** | 11.3 | 85 | 11.2 | 94 | -0.1 | 11% |
| **Nottinghamshire** | 9.3 | 200 | 10.3 | 226 | 1 | 13% |
| Bassetlaw | 14.4 | 43 | 15.3 | 47 | 0.9 | 9% |
| Newark & Sherwood | 8.2 | 26 | 10.9 | 35 | 2.7 | 35% |
| Broxtowe | 7.7 | 23 | 10.4 | 32 | 2.7 | 39% |
| Mansfield | 9.9 | 28 | 10.4 | 30 | 0.5 | 7% |
| Ashfield | 8.6 | 28 | 9.4 | 32 | 0.8 | 14% |
| Gedling | 7.9 | 25 | 8.3 | 26 | 0.4 | 4% |
| Rushcliffe | 8.6 | 27 | 7.5 | 24 | -1.1 | -11% |

*Source: OHID*
*Note: Directly standardised rate (DSR)*
**The darker shades indicate higher rates.*

### 2.1.3 Age specific rates by gender

Figure 6 displays the age specific rates by gender in Nottingham, Nottinghamshire, and England. The data indicates significantly higher rates among males compared to females across all age groups except in the 10-35 and 65+ age groups in Nottingham. For both males and females, the rates are higher in age group 35-64; however, this is not statistically significant compared to other age groups in Nottingham and Nottinghamshire. Likewise, although rates are highest in males aged 35-64 in Nottingham, it is not significantly higher compared to rates in Nottinghamshire and England.

***Figure 6: Age Specific Suicide Rates by Gender, Nottingham City, Nottinghamshire and England (2019-21)***




*Source: NHS Digital/ONS*

### 2.2 Real Time Surveillance

This section looks at data from the Real Time Surveillance of Suspected Suicides (RTSSS) and includes general trends over time with further sub-group analysis by age, gender, ethnicity and deprivation.

The RTSSS data is comprised of data reported by Nottinghamshire Police and British Transport Police. Data is reported pre-Coroners' inquest and relates to deaths that are suspected to be suicide deaths rather than deaths that have been confirmed as a suicide by the coroner. The system supports the local response whilst there is a lag in official statistics on numbers of deaths by suicide.

There are a range of factors that may influence the numbers and patterns of reported suspected suicide deaths that the real-time surveillance system is informed of. Nationally reported data provides a more consistent measure.

Data reported by Nottinghamshire Police is collected from the next of kin at the time of death and is reliant on what next of kin are able and comfortable to share. Nottinghamshire Police made improvements to case finding methods in 2022 and some changes in rates may in part be attributed to this.

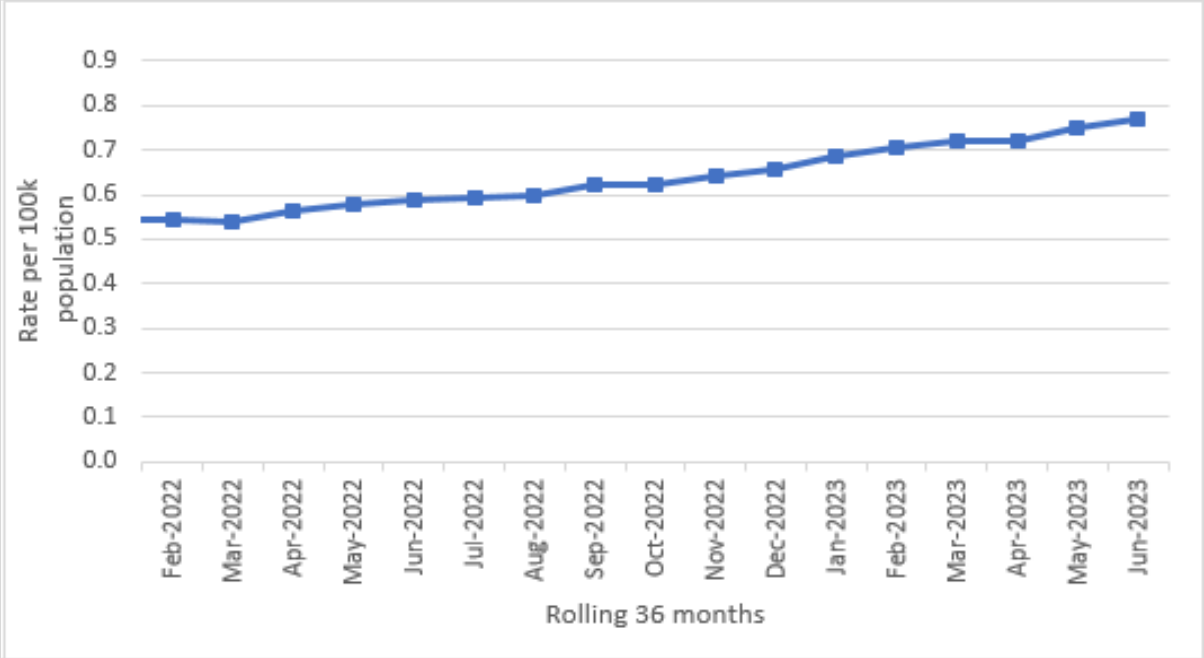
Data reported is based on the location of death rather than the location of residence. It is therefore likely that some deaths reported in the data were residents outside of Nottingham and Nottinghamshire. It is also likely that some Nottingham and Nottinghamshire residents will have died outside of the local area and will not be reflected within the data.

The time period used for RTSSS data is 1st February 2019 to 9th July 2023. This time period runs from when RTSSS data was first collected in Nottingham and Nottinghamshire, up to the most recent data submitted and available for analysis. Due to the small numbers of data at a local level, the longer time period was selected to ensure as large a dataset as possible. Even with the larger dataset this data is sensitive to changes in data collection and reporting and should be interpreted with caution.

#### 2.2.1 Suspected suicide rates

Local suspected suicide rates were calculated on a rolling 3-year average by month with the Nottingham and Nottinghamshire RTSSS data. Figure 7 shows that the monthly rolling 3-year average for suspected suicide rate from a rate of 0.53 per 100,000 population in February 2022 to 0.73 per 100,000 population in June 2023.

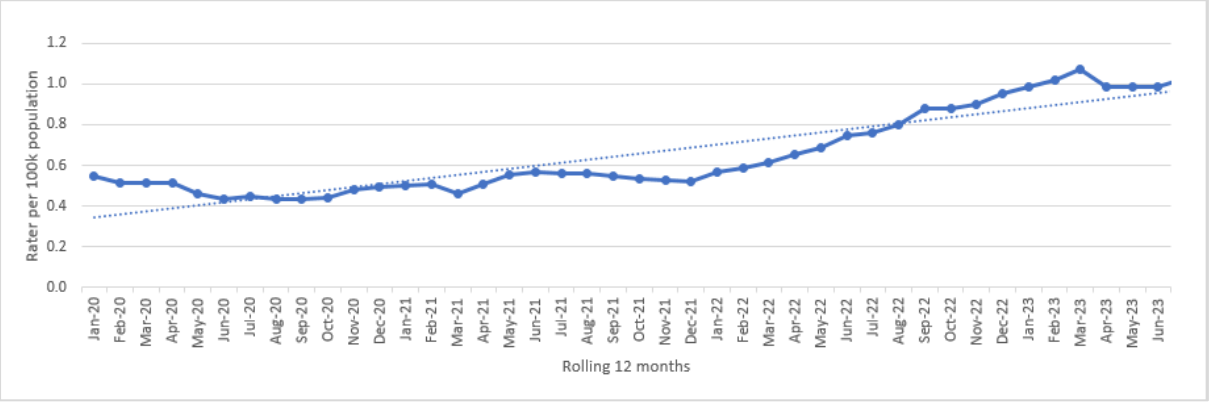
***Figure 7: Suspected suicide monthly rolling 3-year average per 100,000 population for Nottingham and Nottinghamshire from February 2022 to June 2023***




*Source: Real Time Suspected Suicide Surveillance data*

A 12-month rolling rate (Figure 8) calculated from February 2020 shows that the suspected suicide rate increases from early 2022. This is consistent with the time that the Police improved case finding methods for suicide reporting. It is not possible to deduce from this graph alone whether there was a true increase in suspected suicide in our population or whether the Police were capturing more cases due to changes made in reporting.

***Figure 8: Suspected suicide 12 month rolling average per 100,000 population for Nottingham and Nottinghamshire from January 2020 to June 2023***



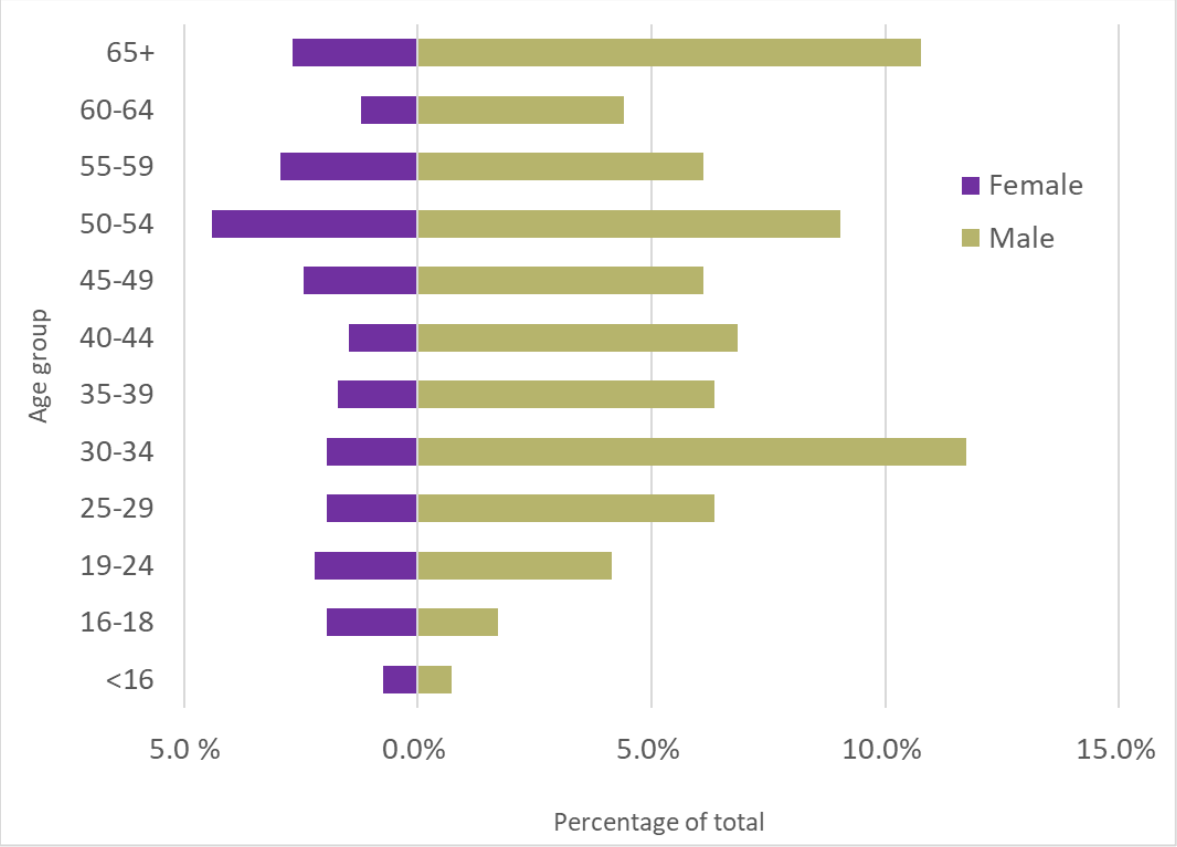

*Source: Real Time Suspected Suicide Surveillance data*

### 2.2.2 Age and Gender

RTSSS data for Nottingham City and Nottinghamshire County indicates that suspected suicide deaths of males are higher in age groups 30-34, 50-54 or 65+ years. Females

suicide deaths from RTSSS data are higher in the age group of 50-54 years (Figure 9). The proportion of male to female suspected suicides is approximately 2.9:1. The latest national data available is for 2021, which showed similar proportions of male to female suicide registrations (3:1), consistent with long term trends for male/female differences in suicides.[4]

***Figure 9: Proportion of suspected suicides for Nottingham and Nottinghamshire by age and gender from February 2019 to June 2023***




*Source: Real Time Suspected Suicide Surveillance data*

### 2.2.3 Ethnicity

National data on suicide rates and ethnicity is published by the Office for National Statistics (Table 2).[14] Estimated suicide rates for England and Wales are highest in Mixed/Multiple and White ethnic groups and lowest in Arab, Pakistani and other Asian/Asian British ethnic groups, for both men and women.

[14] Sociodemographic inequalities in suicides in England and Wales: 2011 to 2021: A population level analysis comparing the risk of dying by suicide across sociodemographic groups in adults in England and Wales. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/sociodemographicinequalitiesinsuicidesinenglandandwales/2011to2021

***Table 2: Rates of suicide per 100,000 people by ethnicity in England and Wales, 2011 to 2021***

| | Women | | | Men | | |
|---|---|---|---|---|---|---|
| **Group** | **Rate per 100,000 people** | **Lower 95% confidence limit** | **Upper 95% confidence limit** | **Rate per 100,000 people** | **Lower 95% confidence limit** | **Upper 95% confidence limit** |
| White | 6.79 | 6.53 | 7.05 | 21.03 | 20.56 | 21.51 |
| Arab | 2.54 | 1.32 | 4.88 | 3.75 | 2.33 | 6.03 |
| Caribbean, African, Black British and other Black | 2.8 | 2.35 | 3.34 | 9.1 | 8.15 | 10.15 |
| Chinese | 4.8 | 3.69 | 6.26 | 6.6 | 5.12 | 8.51 |
| Indian | 4.21 | 3.6 | 4.94 | 10.78 | 9.75 | 11.92 |
| Mixed/multiple ethnic groups | 9.57 | 8.27 | 11.08 | 23.56 | 21.32 | 26.04 |
| Other ethnic group | 3.59 | 2.42 | 5.32 | 11.87 | 9.55 | 14.75 |
| Pakistani and other Asian/Asian British | 2.75 | 2.33 | 3.24 | 6.43 | 5.75 | 7.19 |

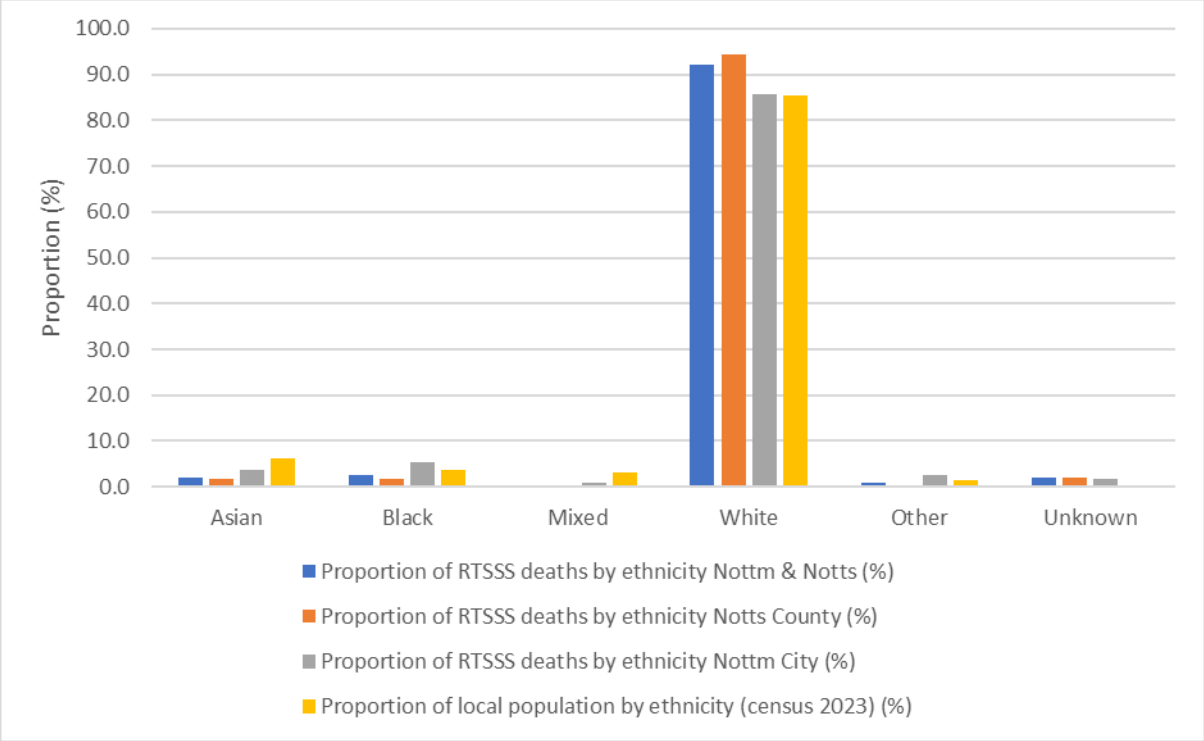
*Source: 2011 Census and death registration data from the Office for National Statistics*

When reviewing local data on suspected suicide deaths and ethnicity, it should be noted that the absolute numbers of suspected suicide deaths among non-White ethnic groups are low, and data should be interpreted with caution.

Within local RTSSS data (Figure 10), the highest percentage of suspected suicide deaths in Nottingham and Nottinghamshire are of people from White ethnic groups (92.1%) and this is broadly reflective of the ethnicity profile of Nottingham and Nottinghamshire combined. People from Black ethnic groups make up the second highest percentage of suspected suicide deaths in Nottingham and Nottinghamshire (2.62%), followed by people from Asian ethnic groups (2.14%). People from Mixed ethnic groups make up the lowest percentage of suspected suicide deaths (0.24%).

The population of Nottingham City is more ethnically diverse than the population of Nottinghamshire County and the population of Nottingham and Nottinghamshire combined. When looking at data for Nottingham City alone, it remains that the highest percentage of suspected suicide deaths are of people from White ethnic groups (85.6%).

***Figure 10: RTSSS stated ethnicity (01/02/19-09/07/23) as % of all deaths reported, compared by LA and with Census reported ethnicity (2023), Nottingham and Nottinghamshire***




*Source: Real Time Suspected Suicide Surveillance data*

### 2.2.4 Deprivation

Nationally, there is a clear link between deprivation and rates of suicide. In England the suicide rate in the most deprived 10% of areas ('decile') in 2017-2019 was 14.1 per 100,000, which is almost double the rate of 7.4 per 100,000 in the least deprived decile.[3]

The Index of Multiple Deprivation (IMD) is an overall measure of deprivation experienced by people living in an area and is calculated for 32,844 Lower layer Super Output Areas (LSOA) in England. Every such neighbourhood in England is ranked according to its level of deprivation.[17]

When ranking the most deprived local authorities based on IMD 2019, Nottingham ranks 10th nationally for the highest average levels of deprivation across an area, based on the population weighted ranks of all the neighbourhoods within it. Nottingham also ranks as the 15th local authority district with the highest proportion of neighbourhoods in the most deprived 10 per cent of neighbourhoods nationally on the IMD 2019.[15] Nottinghamshire County is ranked 101st out of 151 Upper Tier Local Authorities in England on IMD 2019.[16] At a local authority district level, Mansfield ranked 46th out of 317 Lower Tier Local Authorities

[15] The English Indices of Deprivation 2019. Ministry of Housing, Communities and Local Government. Available from: https://assets.publishing.service.gov.uk/media/5d8e26f6ed915d5570c6cc55/IoD2019_Statistical_Release.pdf

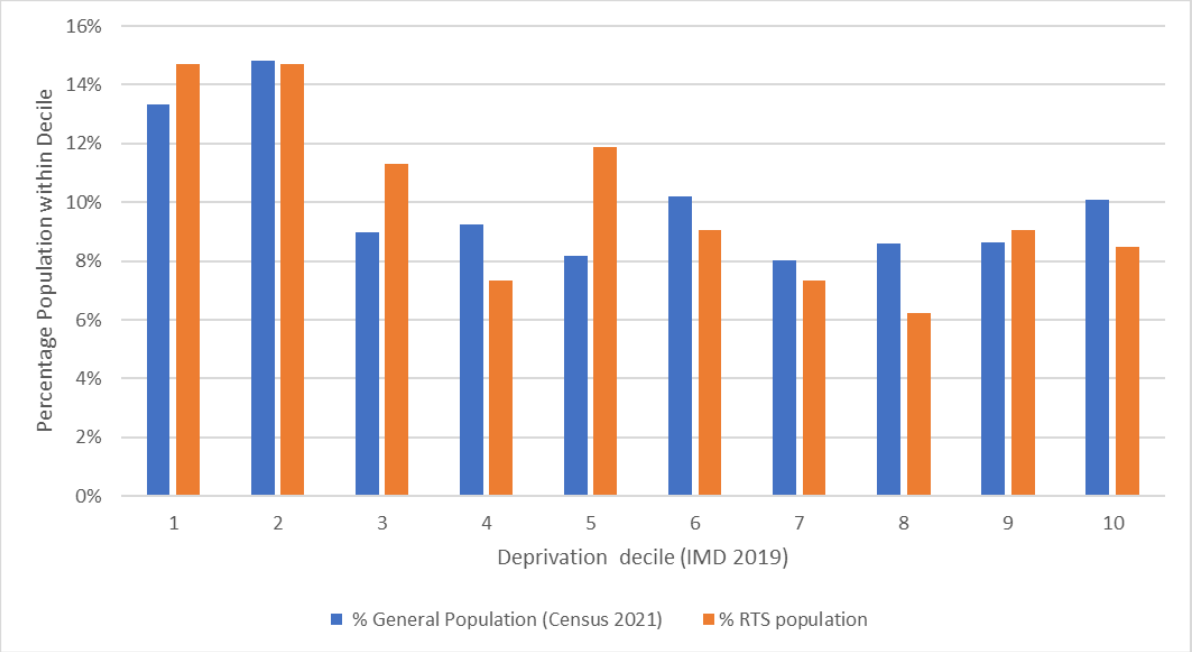
[16] Indices of Deprivation (2019). Nottinghamshire Insight. Available from: https://www.nottinghamshireinsight.org.uk/themes/deprivation-and-poverty/indices-of-deprivation-2019/

in England (using an average score measure) putting Mansfield in the top 20% of most deprived districts in the country. In contrast, Rushcliffe was within the top 3% of least deprived Local Authority Districts in the country.

Approximately 75% of suspected suicides reported in local RTSSS data take place at a private residence. Private residence postcodes were only collected as part of RTSSS from the year 2022 onwards. For those deaths taking place within a private residence, the deprivation decile can be calculated using the postcode of that residence, based upon an assumption that the individual died in their own residence. It is not possible to include those deaths occurring in a public place as the postcode for home residence is not collected.

Figure 11 displays proportions of suspected suicides by private residence deprivation decile against Nottingham and Nottinghamshire's population by deprivation decile, taken from Census 2021 data.

***Figure 11: Proportion of suspected suicides by private residence deprivation decile, compared to Nottingham and Nottinghamshire's population by deprivation decile, from 2022 onwards.***




*Source: Real Time Suspected Suicide Surveillance data*
*Note: The lower the decile the more deprived the area.*

Deciles 6-10 show proportionately fewer suicides than the population proportion living in matching deciles based on 2021 census data. Deciles 1-5 generally show higher proportions of suicide than the population proportion living in matching deciles based on 2021 census data. This indicates that locally we see a deprivation gradient, with suicides more likely to occur in more deprived areas, consistent with national trends.

## 2.3 Target groups

This section summarises the national and local data and research around specific targeted at-risk groups for suicide.

### 2.3.1 Mental health

Established data and research shows that a previous history of mental illness such as depression, psychosis or personality disorder can increase suicide risk.[12] [13]

Local data

Locally within RTSSS data, issues with mental health and wellbeing were the most common theme identified within the narrative reports and were mentioned in over half of all narrative reports analysed. This included undiagnosed poor mental health and wellbeing including 'low mood'.

Diagnosed mental health problems can span from common mental health disorders to severe mental illness. Whilst it is clear that there is heightened risk of suicidality with diagnosed mental health disorders, the differing levels of suicide risk between mental health conditions is less clear. A common mental health disorder is a generic term that includes depression and anxiety disorders. In 2017 the prevalence of common mental health disorders in people (aged 16 years or older) was approximately 21% in Nottingham City and 12-16% in the Nottinghamshire population.[17] Severe mental illness includes all patients with a diagnosis of schizophrenia, bipolar affective disorder, and other psychoses.[18]

The Population Health Management team at the Integrated Care Board (ICB) shared the following data at the level of the Nottingham and Nottinghamshire Integrated Care System around severe mental illness:

- 'As an ICS we have 8,880 people aged over 15 on the GP severe mental illness (SMI) register (0.8% prevalence).'
- '6,245 of these individuals have a recorded diagnosis of schizophrenia or other psychoses, and 2,635 have a recorded diagnosis of bipolar affective disorder (BPAD).'
- 'Prevalence of SMI is higher in Black and Mixed ethnic groups and in more deprived areas – the proportion of people with SMI living in the most deprived areas is more than double than in the least deprived areas.'
- 'Prevalence of GP recorded SMI is significantly higher in Nottingham City than the overall Nottingham & Nottinghamshire ICB rate.'

[17] Common Mental Health Disorders. Office for Health Improvement and Disparities. Available from: https://fingertips.phe.org.uk/profile/common-mental-disorders/data#page/1/ati/154/are/E38000132
[18] Severe Mental Illness Indicator definitions. Office for Health Improvement and Disparities. Available from https://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness/data#page/6/gid/1938132719/pat/159/par/K02000001/ati/15/are/E92000001/iid/90581/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

- 'More men have a diagnosis of schizophrenia and/or other psychoses than women (58% are male), but more women have a diagnosis of bipolar affective disorder (BPAD) than men (60% are female).'
- 'Prevalence of comorbidities and long-term conditions are also higher. 69% of people on the SMI Register have other long-term conditions.'

### 2.3.2 Mental Healthcare Service Users

Local mental healthcare usage data was not available during the joint strategic needs assessment and is noted as a knowledge gap. Going forward, establishing a data sharing agreement between partners would facilitate a better understanding of the needs of mental health service users.

Local data

Analysis of RTSSS data fields indicate 34% of suspected suicides in the last year of data collected (October 2022 - September 2023) were known to mental health services in the six months leading up to death, 52% were not known to mental health services and in 14% of cases the information was unknown. As RTSSS data is based police reporting rather than healthcare data, there is an element of uncertainty around these figures. Nationally people known to be in contact with mental health services over years 2010 to 2020 represent around 27% of all deaths by suicide in England.[19] NCISH also report that the overall increase in England in suicides over 2010 to 2020 was not reflected in the rate of suicide among patients under mental health care. There has been little change over time in this key group.

Where local views have been sought through engagement with Healthwatch, an independent consumer champion for both health and social care, local people have reported experiencing long waiting times when accessing mental health services:

- ‘Significant problems around a lack of Mental Health Services for those falling between Improving Access to Psychological Therapies (IAPT) and Crisis Care.’
- ‘Acknowledgment that there is a need for long waiting times for many Mental Health services to be reduced in order to prevent individuals' conditions deteriorating before they can access the support required.’

### 2.3.3 Self-Harm

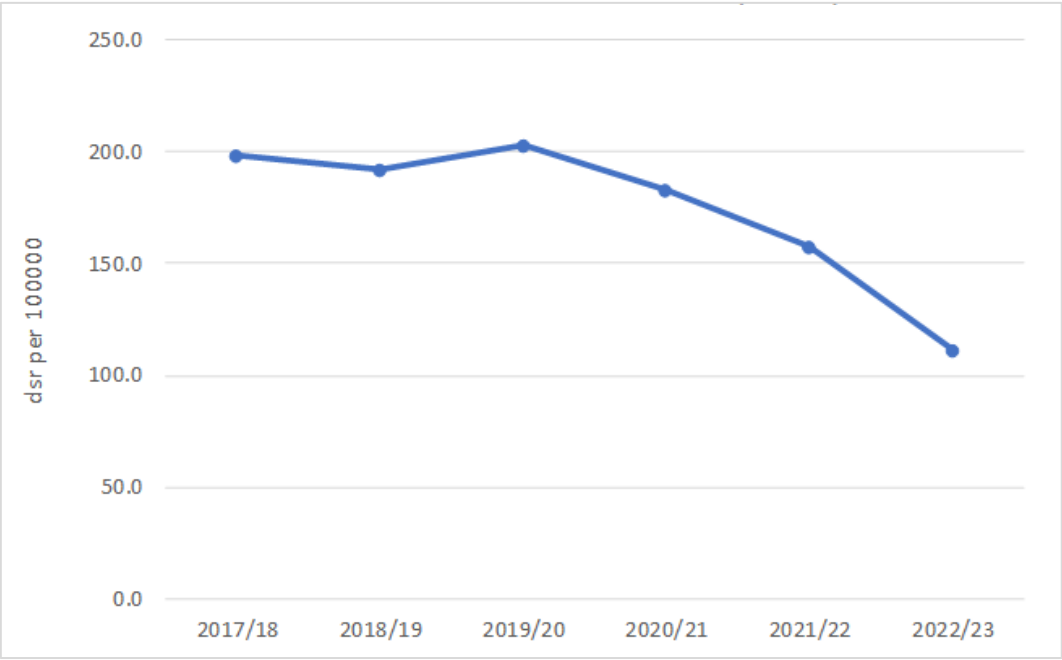
Self-harm as an antecedent for suicide has been increasingly recognised from data and research. Among the most common risk factors for suicide identified is a history of self-harm and previous suicide attempts, present in approximately 40% of people who have died by suicide. Self-harm requiring emergency hospital treatment has been found to be present in about 15% of those who take their own life.[8]

[19] The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Annual report 2022 Available from: https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/

Trends in emergency admissions for intentional self-harm

As part of the Mental Health Covid Impact Assessment for Nottinghamshire County Council, hospital admissions data for intentional self-harm was explored to assess any changes in trends over the COVID19 pandemic. Data included pre-pandemic years to post pandemic years (2017-2023) for Nottinghamshire County residents.

***Figure 12: Directly standardised rate of Emergency Hospital Admissions for Intentional Self-harm, for Nottinghamshire County residents, over time between years 2017 to 2023.***



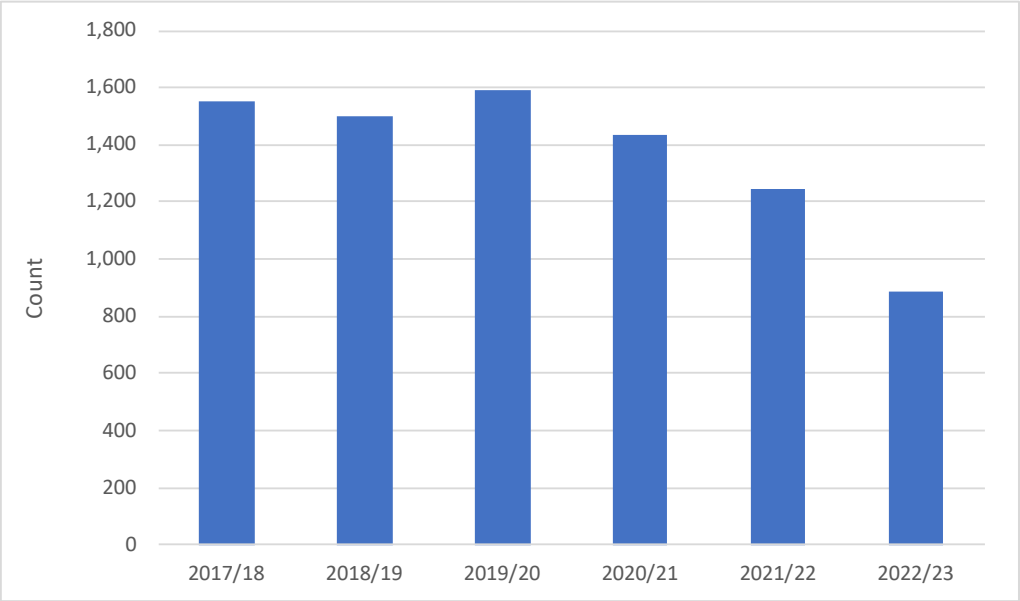

*Source: Hospital Episode Statistics (HES), NHS Digital*
*Note: Directly Standardised Rate (DSR)*

Figure 12 shows the direct standardised rate of Emergency Hospital Admissions for intentional self-harm remained stable in pre-pandemic years at around 198.8 to 202.8 per 100,000 people (2017-2020). There were then notable decreases year-on-year for the subsequent 3 years; with emergency admissions for intentional self-harm for the year 2022/23 being almost 50% of 2019/20 values, at 111.7 per 100,000 people. This decrease is consistent with the start of the COVID-19 pandemic and appears to have persisted well into recovery phases (2022/2023 data).

Figure 13 highlights counts of Emergency Hospital Admissions for Intentional Self-harm for Nottinghamshire County residents. This reiterates that admissions for intentional self-harm had a sustained fall from 1,590 in 2019/2020 to 888 in 2022/2023, constituting a drop of 40%. In terms of benchmarking, Nottingham City and Nottinghamshire County are in line

with England and regional averages on emergency admissions for intentional self-harm for the latest data available (2021/22).[20]

***Figure 13: Counts of Emergency Hospital Admissions for Intentional Self-harm, for Nottinghamshire County residents, over time between years 2017 to 2023.***




*Source: Hospital Episode Statistics (HES), NHS Digital*

Demographic Analyses

Further subgroup analysis by age, sex, district, ethnicity, deprivation, and provider trust indicated a general trend of reducing admission rates and count data over time. Patterns between categories within subgroup analysis also remained similar over time.

Local stakeholder input

On review of this data, the JSNA task and finish group noted that local voluntary and community sector organisations were reporting increases in people presenting with self-harm to their organisations for the time period this data covered. There were suggestions that there could be unmet demand in relation to people who intentionally self-harm accessing the right support. In addition, the Task and Finish group reported that follow-up support for intentional self-harm is currently provided at emergency departments after first attendance only, and not for later attendances, constituting a potential service gap.

[20] Suicide Prevention Profile. Office for Health Improvement & Disparities. Available from: https://fingertips.phe.org.uk/search/self%20harm#page/3/gid/1/ati/501/iid/21001/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

### 2.3.4 Men in mid-life

A 2021 report by National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) used national mortality data of men aged 40-54 who had died by suicide in 2017. [21] Key findings included:

- Suicide in men is complex and multi-layered: There is often a combination of longstanding and recent risks for suicide therefore attributing suicide deaths to single causes will make prevention less effective. Vital roles in suicide prevention exist particularly for primary care, A&E, the justice system, and mental health services.
- Service contact: Rates of contact with services among middle-aged men were higher than expected (91% had been in contact with at least one frontline service or agency). Middle-aged men who seek help for their mental health sometimes remain untreated – in particular, psychological therapies suited to their needs should be offered.
- Risk factors: Economic adversity, alcohol and drug misuse, and relationship stresses are common antecedents of suicide in men in mid-life. More than half of the middle-aged men who died had a physical health condition. Many of the men were affected by bereavement.
- Role of the Voluntary/Community Sector: 9% of middle-aged men experiencing suicidality appear to be out of contact with any support. There are several examples of local and national third sector initiatives aiming to reach this group.
- Online safety: Suicide methods were often obtained via the internet – online safety should be part of any prevention plan for men at risk of suicide.

### 2.3.5 Gambling

Summary of the key issues in relation to suicide and gambling

There is a growing evidence base linking gambling related harm and suicidality. The Office for Health Improvement and Disparities (OHID) estimates there are up to 496 gambling-related suicides every year in England which suggests that experience of a gambling problem can be a significant driver of suicidal behaviours and thoughts.[22]

Gambling is a legal activity that is participated in by half of the UK population.[23] Gambling can harm physical and mental health, relationships, finances, employment, and education. Gambling-related harms are the negative consequences of gambling on the health and wellbeing of individuals, families, communities, and society with suicide being the greatest harm. Individuals experiencing a gambling problem are a key risk group for experiencing suicidality. According to Public Health England, a person with a gambling problem is 19.3

[21] The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Suicide by middle-aged men. 2021. The University of Manchester. Available from: https://sites.manchester.ac.uk/ncish/reports/suicide-by-middle-aged-men/
[22] Office for Health Improvement and Disparities (2023). *The economic and social cost of harms associated with gambling in England.* The economic cost of gambling-related harm in England: evidence update 2023 (publishing.service.gov.uk)
[23] National Audit Office (2020). *Gambling regulation: problem gambling and protecting vulnerable people.* Gambling regulation: problem gambling and protecting vulnerable people - National Audit Office (NAO) report

times and 9.6 times more likely to die by suicide compared to the general population in younger (20-49 years) and older (50-64 years) age groups respectively.[24] A recent cross-sectional research study found a link between suicide attempts in 16-24 year olds and excessive gambling, even after adjustment for other factors.[25] The researchers conclude that young people and young adults experiencing gambling problems should be considered at risk for suicidality.

There are a range of factors which increase the likelihood of suicidality for people with a gambling problem. Research has highlighted gambling type, gambling severity, social relationships, quality of life and comorbidities as important factors which influence the risk of suicide. Women with gambling problems are at a higher risk of dying by suicide compared to their male counterparts, with identified factors such as social isolation, relationship breakdown, trauma and socio-economic stress having a greater impact on this group.[26]

The UK Government recently published the Gambling White Paper setting out a legislative framework to reduce gambling-related harms. The new National Suicide Prevention Strategy has highlighted that experiencing a gambling problem is a significant risk factor for suicidality which needs to be addressed through early intervention and tailored support.

Estimated prevalence rates of gambling

There is limited availability of local data sources to understand the prevalence of gambling in Nottingham and Nottinghamshire. The Gambling Commission national survey data (2020) was applied to Nottingham and Nottinghamshire population data to provide estimated gambling prevalence.

In Nottinghamshire (see table 3), almost 35% of people aged 16 or over have gambled in the last four weeks. Within this cohort, 6,300 individuals are at a moderate risk of a gambling problem where signs of gambling-related harms are demonstrated but the individual falls below the screening tool threshold for a gambling problem. 2,111 individuals are estimated as having a gambling problem (defined as having a PGSI score of 4 or above). The 35-44 age group has the highest prevalence of gambling problems, while prevalence of moderate risk gambling is highest for 16-24 year olds.

In Nottingham (see table 4), almost 40% of people aged 16 or over have gambled in the last four weeks. There are 3,447 individuals at moderate risk of a gambling problem, while 1,050 individuals are estimated to have a gambling problem. Similar to Nottinghamshire, the 35-44 age group has the highest prevalence of gambling problems in the city and the 16-24 age group is the highest for moderate risk gambling.

[24] Public Health England (2021). *Harms associated with Gambling.* Harms associated with gambling: an abbreviated systematic review (publishing.service.gov.uk)
[25] Wardle, H. (2021) *Suicidality and gambling among young adults in Great Britain: results from a cross-sectional online survey.* The Lancet. https://doi.org/10.1016/S2468-2667(20)30232-2
[26] Marionneau, V. and Nikkinen, J. (2022) *Gambling-related suicides and suicidality: A systematic review of qualitative evidence.* National Library of Medicine. https://doi.org/10.3389/fpsyt.2022.980303.

This data has important caveats to consider. The figures outlined are likely to be an underestimate because individuals can hide gambling behaviours and not disclose gambling problems due to factors such as guilt and shame. The figures are not a direct measure of local prevalence rate because the methodology involves applying national data to the local population which provides an estimate. The Gambling Commission data was incomplete for people aged 65 and over, which limits understanding of prevalence numbers for this cohort. Finally, the data is extracted from a survey which provides a snapshot of prevalence.

***Table 3: Estimated prevalence of gambling participation and gambling problems among people aged 16 and over in Nottinghamshire***

| Metric | | M | F | 16-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65+ | All 16+ |
|---|---|---|---|---|---|---|---|---|---|---|
| People surveyed | % | 47.8 | 52.2 | 10.1 | 14.4 | 16.2 | 18.9 | 16.9 | 23.6 | 100 |
| | n | 1,915 | 2,092 | 403 | 577 | 651 | 754 | 677 | 945 | 4,007 |
| Gambling in last 4 weeks | % | 44.5 | 39.6 | 31.2 | 39.0 | 45.8 | 48.4 | 46.5 | 39.1 | **34.9** |
| | n | 149,217 | 140,266 | 26,151 | 39,899 | 46,218 | 54,419 | 52,927 | 68,906 | 288,520 |
| Moderate risk of a gambling problem | % | 1.3 | 0.6 | 2.2 | 1.5 | 1.1 | 0.7 | 0.9 | 0.0 | **0.9** |
| | n | 4,359 | 2,125 | 1,844 | 1,535 | 1,110 | 787 | 1,024 | 0 | **6,300** |
| Gambling problem (PGSI ≥4)[27] | % | 0.6 | 0.03* | 0.5 | 0.2 | 0.8 | 0.2 | 0.4 | 0.0 | **0.3** |
| | n | 2,012 | 99* | 419 | 205 | 807 | 225 | 455 | 0 | **2,111** |

*Not officially reported in survey data. Calculated by subtracting number who are male from total age 16+

*Source: 2020 Gambling Commission national data applied to ONS 2021 Census Population Statistics.*

[27] The Problem Gambling Severity Index is a standardised, screening tool for a gambling problem.

***Table 4: Estimated prevalence of gambling participation and gambling problems among people aged 16 and over in Nottingham***

| Metric | | M | F | 16-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65+ | All 16+ |
|---|---|---|---|---|---|---|---|---|---|---|
| People surveyed | % | 47.8 | 52.2 | 10.1 | 14.4 | 16.2 | 18.9 | 16.9 | 23.6 | 100 |
| | n | 1,915 | 2,092 | 403 | 577 | 651 | 754 | 677 | 945 | 4,007 |
| Gambling in last 4 weeks | % | 44.5 | 39.6 | 31.2 | 39.0 | 45.8 | 48.4 | 46.5 | 39.1 | **39.9** |
| | n | 62,148 | 53,454 | 23,422 | 22,173 | 17,334 | 17,011 | 14,152 | 15,288 | 109,380 |
| Moderate risk of a gambling problem | % | 1.3 | 0.6 | 2.2 | 1.5 | 1.1 | 0.7 | 0.9 | 0.0 | **1.3** |
| | n | 1,816 | 800 | 1,652 | 862 | 418 | 253 | 261 | 0 | **3,447** |
| Gambling problem (PGSI ≥4) | % | 0.6 | 0.1[28] | 0.5 | 0.2 | 0.8 | 0.2 | 0.4 | 0.0 | **0.4** |
| | n | 838 | 212 | 402 | 139 | 311 | 76 | 122 | 0 | **1,050** |

Not officially reported in survey data. Calculated by subtracting number who are male from total age 16+

*Source: 2020 Gambling Commission national data applied to ONS mid-2020 population estimates.*

### 2.3.6 Financial wellbeing

Nationally reported data

According to the NCISH Annual report for 2023, there were 373 deaths per year between 2016 and 2020 in mental healthcare patients who had experienced recent economic adversity such as serious financial problems and loss of job, benefits or housing. The number increased over this five-year period.

The increases in the cost of living mean there is a potential for increased numbers of patients and the wider population experiencing economic adversity. The NCISH report recommends training for frontline staff on the risks associated with the loss of jobs, benefits and housing, among other issues, and information to signpost patients to sources of financial support and advice.[29]

Research

There is evidence further linking financial stress, unemployment, and suicide in a recent systematic review and meta-analysis which reported significantly elevated suicide risks following financial stress (23 studies) and unemployment (43 studies).[30] After controlling for physical and mental health, financial stress and unemployment remained weakly associated with suicide, suggesting financial wellbeing is more significant as a factor when combined with other risk factors.

[29] Annual report 2023: UK patient and general population data 2010-2020. March 2023 Available from https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/

[30] **Financial stress, unemployment, and suicide—A meta-analysis,** Roelfs, David J. and Shor, Eran, Crisis: The Journal of Crisis Intervention and Suicide Prevention, 2023.

Local data

Issues relating to work/employment and finances were mentioned in 15% of all narrative reports analysed within the RTSSS dataset. Mentions relating to work/employment encompass a range of experiences such as loss of job, recent retirement, being off work due to mental or physical ill-health, bullying, stress and issues relating to self-employment.

### 2.3.7 Those in contact with the criminal justice system

There are four closed male national prisons operating across Nottingham and Nottinghamshire:[31]

- Lowdham Grange is a privately run male prison in Lowdham, Nottingham.
- Nottingham Prison is a men's prison in the Sherwood area of Nottingham.
- Ranby is a men's prison in Retford, Nottinghamshire.
- Whatton is a prison in Nottingham for men convicted of a sex offence.

National data

The current national dataset reports up to 2019. Between 2008 and 2019, 677 deaths were reported as suicide in prison custody according to the Office for National Statistics (ONS) death registrations database. This equates to around 56 deaths a year.[32]

Of the 677 deaths in prison custody between 2008 to 2019, the large majority were male deaths, accounting for 97% (657 deaths) compared with 20 female deaths. The risk of suicide was 3.9 times higher between 2008 and 2019 in the male prison population, compared with the general male population.

Local data

It is important to note that the Real Time Surveillance for suspected suicides was set up from 2019. There are no overlapping reporting periods with national data. Suspected suicides reported in RTSSS data show that 2% of male suicides in Nottingham and Nottinghamshire occurred in prison. This equates to seven people dying by suicide. There was no pattern to suicides that highlighted a particular prison within Nottingham and Nottinghamshire.

### 2.3.8 Multimorbidity

Nationally reported data

According to the NCISH Annual report for 2022, the number of mental healthcare patients with a comorbid physical illness has been increasing since 2014, accounting for 25% of all patient suicides in 2009-2019 overall. The risk profile of these patients is not the same as for patients generally; they are older, common risk factors such as self-harm or alcohol/drug misuse are less often present, and a higher proportion are women.[33]

[31] Office for National Statistics (ONS), released 26 January 2023, ONS website, article, Drug-related deaths and suicide in prison custody in England and Wales: 2008 to 2019

[32] Office for National Statistics (ONS), released 26 January 2023, ONS website, article, Drug-related deaths and suicide in prison custody in England and Wales: 2008 to 2019

[33] The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Annual report 2022. Available from: https://sites.manchester.ac.uk/ncish/reports/annual-report-2022/

Research
Multimorbidity is classed as the presence of multiple chronic health conditions and confers additional risk of suicide.[34] [35]

In a large sample of UK adults, physical multimorbidity was associated with significantly higher odds for suicidal ideation and suicide attempts (more than six-fold for four health conditions). Researchers found cognitive problems and disability explained the largest proportion between multimorbidity and suicidal ideation. Pain and cognitive problems explained the largest proportion between multimorbidity and suicide attempts.

Local data
Within suspected suicides reported in RTSSS data, health conditions were mentioned in 15% of narrative reports analysed, covering a range of health conditions that are not specified in all cases. Where information or indication of the health condition is provided, the most common health condition mentioned related to a cancer diagnosis with experiencing physical pain being the second most commonly cited health condition within the narrative reports.

### 2.3.9 Children and Young people

National Data
A report drawing on data from the National Child Mortality Database (NCMD) identified common characteristics of children and young people who die by suicide as well as factors associated with these deaths. The 'Suicide in Children and Young People' report drew key findings from deaths that occurred or were reviewed by a child death overview panel between 1st April 2019 and 31st March 2020 and found that:[36]

- Child suicide is not limited to certain groups; rates of suicide were similar across all areas, and regions in England, including urban and rural environments, and across deprived and affluent neighbourhoods.
- 62% of children or young people reviewed had suffered a significant personal loss in their life prior to their death, this includes bereavement and "living losses" such as loss of friendships and routine due to moving home or school or other close relationship breakdown.
- Over one third of the children and young people reviewed had never been in contact with mental health services. This suggests that mental health needs or risks were not identified prior to the child or young person's death.
- 16% of children or young people reviewed had a confirmed diagnosis of a neurodevelopmental condition at the time of their death. For example, autism

[34] The association of physical multimorbidity with suicidal ideation and suicide attempts in England: A mediation analysis of influential factors, Smith, L., et al., The International journal of social psychiatry, 2023. 69(3): p. 523-531.
[35] Identification of Risk Factors for Suicide and Insights for Developing Suicide Prevention Technologies: A Systematic Review and Meta-Analysis, Jha, S., G. Chan, and R. Orji, Human Behavior & Emerging Technologies, 2023: p. 1-18.
[36] Suicide in Children and Young People. NCMD Programme. Available from: https://www.ncmd.info/publications/child-suicide-report/

spectrum disorder or attention deficit hyperactivity disorder. This appears higher than found in the general population.

- Almost a quarter of children and young people reviewed had experienced bullying either face to face or cyber bullying. The majority of reported bullying occurred in school, highlighting the need for clear anti-bullying policies in schools.

Local engagement

Local stakeholders have highlighted inappropriately met or unmet needs of young people who are in crisis, with some children and young people (CYP) experiencing long waits on physical health wards whilst appropriate provision was sought. Looked after young people and those transitioning from CYP to adult services, were identified as an area of particular need.

Research

Suicide prevention efforts generally target acute precipitants of suicide, though emerging evidence suggests that vulnerability to suicide is partly established early in life before acute precipitants can be identified. A systematic review of longitudinal studies published in 2022 found evidence consistently supported the link between sociodemographic, obstetric, parental and child developmental factors to higher risk of suicide death later in life.[37]

- Sociodemographic: young maternal age at birth, low parental education, and higher birth order
- Obstetric: low birth weight
- Parental: exposure to parental death by external causes
- Child developmental factors: exposure to emotional adversity

Researchers stated additional research into how early life factors interact with acute precipitants and increase vulnerability to suicide.

### 2.3.10 LGBTQ+ communities

Nationally reported data

According to the NCISH Annual report for 2023, there were 223 deaths by mental healthcare patients who identified as lesbian, gay, or bisexual and 37 patients within a trans group, an average of 49 deaths per year (between 2016 and 2020). In general LGBT patients were younger than other patients and a high proportion had experienced childhood abuse.[25]

Research

Within the last few years larger pieces of research, such as systematic reviews, have been published around the risk of suicidality and self-harm in the LGBTQ+ community.
In 2022, the International Review of Psychiatry journal published a systematic review and meta-analysis which quantified the risk of suicidality in LGBTQ+ people compared to their

[37] The developmental origins of suicide mortality: A systematic review of longitudinal studies, Vidal-Ribas, Pablo; et al. , European Child & Adolescent Psychiatry, 2022.

cisgender or heterosexual peers.[38] Researchers reported that the LGBTQ+ people had over four times the risk of attempting suicide over cisgender/heterosexual groups. The reported statistics were statistically significant however the overall quality of evidence included within the systematic review ranged from low to moderate.

Another systematic review aimed to elicit risk and protective factors for suicide attempts among sexual minority youth.[39] The identified risk factors associated with suicide attempts were:

- early coming out
- being unaccepted by family
- dissatisfaction with sexual minority friendships
- loneliness and bullying
- physical abuse and/or sexual abuse.

The identified protective factors for suicide attempts were:

- feeling safe at school
- teacher support
- anti-bullying policy
- other adult support.

Similar risk factors around victimisation, bullying (including cyber-bullying) and mental health difficulties, were highlighted in research looking at the risk profile of LGBTQ+ young people with self-harm, suicidal ideation or suicidal behaviour.[40] Considering this research, it seems clear that risk and protective factors for suicide attempts in the LGBTQ+ community stem directly from the environments in which youth grow up: family, school, and the internet.

Local data

Information around sexuality was only regularly collected in RTSSS data from 2022. Any inference from analysis is precluded due to high levels of 'unknown' status being reported.

### 2.3.11 Gypsy Roma and Traveller communities

In the 2021 census, 0.3% of population identified as 'Gypsy, Roma or Irish Traveller', however these figures are thought to be anunderrepresentation, with estimates of up to 300,000 Gypsy or Traveller people and up to 200,000 Roma people living in the UK.[41]

In the UK, these communities are recognised to have some of the poorest life outcomes with severe health inequalities. When considering mental health in these communities there are reported to be even larger disparities.[42] Suicide risk in the Gypsy, Roma or Traveller

[38] Self-harm and suicidality among LGBTIQ people: a systematic review and meta-analysis. Marchi, M et al. 2022. International Review of Psychiatry 34(3-4), pp. 240-256
[39] A systematic review of the factors associated with suicide attempts among sexual-minority youth. Wang, X. X et al. 2023. European Journal of Psychiatry 37(2), pp. 72-83
[40] A systematic review and meta-analysis of victimisation and mental health prevalence among LGBTQ+ young people with experiences of self-harm and suicide. Williams, A. Jess et al. 2021. PLoS ONE [Electronic Resource] 16(1), pp. e0245268
[41] https://www.ethnicity-facts-figures.service.gov.uk/summaries/gypsy-roma-irish-traveller
[42] Parry et al. Health status of Gypsies and Travellers in England. J Epidemiology Community Health. 2007 Mar;61(3):198-204. doi: 10.1136/jech.2006.045997.

communities has been reported to be 6.6 times higher than the general population's risk of suicide.

National data

At present mortality data published by the ONS does not include the ethnicity of the deceased, there are no official data on deaths by suicide among the Gypsy, Roma and Traveller individuals in England and Wales.[43]

Research

Nottinghamshire County council's public health team undertook a literature review in 2023 on suicide risk and the barriers to receiving suicide prevention support in the Gypsy, Roma and Traveller communities in the UK. The findings were:

- Lack of data: An understanding of risk, cause, and prevention of suicide in the Gypsy, Roma and Traveller community is greatly hampered by the absence of systemic data monitoring of these populations by health authorities.[44]
- Discrimination: A survey targeting the Gypsy, Roma and Traveller communities by the Traveller Movement charity highlighted high levels of direct discrimination related to ethnicity (91% reported by 214 community members).[23] Current suicide prevention and health services can also indirectly discriminate through digital exclusion and reliance on patient literacy.
- Barriers to healthcare access: Systematic review research and engagement with Gypsy, Roma and Traveller communities highlights digital exclusion and difficulty in registration with primary care, particularly when online registration is required and where proof of identity or proof of fixed address is essential.[45]
- Culture: In the Traveller Movement Policy Briefing, three patterns of suicide were identified as being closely linked to Travellers. These included bereavement suicides, where 40% of those who died by suicide had recently lost someone close to them to suicide. This also included 'violent suicide' following domestic feuding and thirdly, shamed suicide which occurred after disclosure of an alleged criminal act or awaiting a trial for a criminal act.[23]

### 2.3.12 Domestic abuse

Nationally reported data

The majority of people who died by suicide between 2009 and 2019 with a history of domestic violence were female, according to NCISH data.[29] This group was more often younger, single or divorced, living alone and unemployed than other women. Self-harm, previous alcohol or drug misuse and personality disorder diagnosis were more common in this group, potentially reflecting previous trauma or abuse.

[43] https://wp-main.travellermovement.org.uk/wp-content/uploads/2021/09/Mental-Health-and-Suicide-among-GRT-communities-in-England-Briefing-2019.pdf
[44] Millan, M. and Smith, D., 2019. A comparative sociology of Gypsy Traveller health in the UK. International journal of environmental research and public health, 16(3), p.379.
[45] Gypsy, Roma and Traveller access to and engagement with health services: a systematic review | European Journal of Public Health | Oxford Academic (oup.com)

Research
Intimate partner violence (IPV) is strongly associated with self-harm and suicidality.[46] Furthermore there is a disproportionate impact on women which is exacerbated by experiences of multiple unmet needs and poverty. Findings included:

- Over a quarter (27%) of women report experience of IPV in their lifetimes
- Women who have experienced IPV are three times more likely to have made a suicide attempt in the past year compared to women who have not experienced IPV
- Sexual IPV is ten times more common in women than men and is an IPV type particularly associated with self-harm and suicidality
- IPV often occurs in a context of poverty and multiple unmet needs, trapping women with fewer resources for escape.

Local data
A small number of RTSSS narrative reports mentioned domestic abuse. It is important to note that not all narrative reports where domestic abuse is mentioned have had police involvement or convictions related to domestic abuse and it appears that in some cases the information has been disclosed by the next of kin, family members or friends.
Domestic Homicide Reviews (DHRs) can also be instructed where a suicide is deemed to have resulted from ongoing domestic abuse. The percentage of DHRs in Nottinghamshire County that are identified as survivor suicides are 27% and perpetrator suicides are 13%. (These figures exclude Gedling district data which was unavailable).

### 2.3.13 Relationship breakdown

Local data
Within suspected suicides reported in RTSSS data, intimate partner relationships were the fourth most common theme identified within narrative reports and encompass a range of issues such as divorce, separation and arguments between partners.

Research
Stressful life events increase the risk of subsequently reported suicidal ideation and behaviours, based on systematic review and meta-analysis data.[47] Researchers reported after a stressful life event, there was a 37% significantly higher odds of reported suicidal ideation and behaviours combined, and a 45% significantly increased risk for suicidal ideation. The association is stronger in males, young adults, and studies with shorter term follow-up. These findings suggest that the experience of stressful life events should be incorporated into clinical suicide risk assessments and suicide interventions could include a component on developing resilience and adaptive coping to stressful life events.

### 2.3.14 Serving UK Armed Forces and Veterans

[46] Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England Sally McManus et al. Published:June 07, 2022 DOI:https://doi.org/10.1016/S2215-0366(22)00151-1
[47] Are stressful life events prospectively associated with increased suicidal ideation and behaviour? A systematic review and meta-analysis, Howarth, Emma J.; et al. , Journal of Affective Disorders, 04 01 ,2020. 266, pp. 731-742

National data
Annual summaries and trends of suicides in the UK regular armed forces were investigated from Ministry of Defence data covering 2002-2021.[48] In this period, 285 suicides occurred in the serving armed forces personnel. Suicides were male dominated (264 out of 285 suicide deaths). The report concluded suicide remains a rare event in the UK armed forces; confirmed suicides in 2021 representing less than one death per 1,000 armed forces personnel.

The UK regular armed forces have seen a declining trend in male suicide rates since the 1990s and were consistently lower than the UK general population over the last 35 years. However, in the last five years the number of army male suicides have been increasing and since 2017, the risk of suicide among army males was the same as the UK general population for the first time since the mid 1990's.

Research
A cohort study exploring suicide after leaving the UK Armed Forces (1996-2018) concluded that as a cohort, veterans are at no greater risk of suicide than the general population.[49] There are associated factors within this cohort that increases risk, such as age, where veterans under the age of 25 are at a two to four times greater risk than the same age group within the general population. Veterans over the age of 35 are at a lower risk than the same age group within the general population.

### 2.3.15 Alcohol and substance use

Nationally reported data
Alcohol and drugs are common antecedents of suicide. According to the 2019 NCISH annual report, in 2017 there were 866 suicides by mental healthcare patients who had a history of alcohol or drug misuse. This was 57% of all mental healthcare suicides and only a minority were in contact with specialist substance misuse services.[50]

Local data
Alcohol and drug use were the second most common theme identified within RTSSS narrative reports (34% of all narrative reports analysed), with alcohol use being more commonly cited than drug use.

Alcohol use included long-term use, alcohol use immediately prior to the time of death, and evidence of alcohol use at the location/time of death. Where drug use is mentioned within the narrative report this includes ongoing problems with drug use including Class A drug use, drug use that might be considered 'recreational' and evidence of drug use at the location/time of death.

[48] Suicides in the UK regular armed forces: Annual summary and trends over time (Ministry of Defence) https://assets.publishing.service.gov.uk/media/6241903be90e075f142546aa/20220331_UK_AF_Suicides.pdf
[49] Suicide after leaving the UK Armed Forces 1996–2018: A cohort study. Cathryn Rodway August 8, 2023 https://doi.org/10.1371/journal.pmed.1004273
[50] The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Annual report 2019. Available from: https://sites.manchester.ac.uk/ncish/reports/annual-report-2019-england-northern-ireland-scotland-and-wales/

## 3. Targets and performance

The Nottingham City and Nottinghamshire Suicide Prevention Strategy for 2019-2023 sets out the high-level priorities and objectives for delivery across the partnership. The areas of significant progress made by local authority public health teams and local partners against the strategy priorities have been summarised in table 5.

Nottingham City and Nottinghamshire Suicide Prevention Strategy 2019-2023
The overall aim of the strategy was to reduce the rate of suicide and self-harm in the Nottingham City and Nottinghamshire population, by proactively improving the population's mental health and wellbeing, and by responding to known risks for suicide in the population. The following priorities were identified as the local key areas for action:

- Priority 1: At-risk groups: Identify early those in groups at risk of suicide, and ensure they have access to evidence-based interventions.
- Priority 2: Use of data: Collect and review suicide and self-harm data in a timely manner, using it to inform local practice, particularly via real-time surveillance.
- Priority 3: Bereavement support: Ensure the availability of prompt bereavement support for those affected by suicide.
- Priority 4: Staff training: Provide effective training for frontline staff to recognise and respond to suicide risks, integrating current research into practice.
- Priority 5: Media: Foster close engagement with media personnel to ensure that suicide and suicidal behaviour are reported with sensible, sensitive approaches.

***Table 5: Summary of progress against the Nottingham City and Nottinghamshire Suicide Prevention Strategy 2019-2023***

| Priority | Areas of significant progress |
|---|---|
| **Identifying and addressing at-risk groups** | Findings of evidence reviews on at-risk groups regularly fed back to Nottingham and Nottinghamshire Suicide Prevention strategy group for wider stakeholder input and alignment of new priorities.<br><br>Development and implementation of Wave 4 pilots targeted towards men and older boys, parents/carers of CYP who self-harm, LGBTQ+ groups, Gypsy Roma Traveller communities, those experiencing relationship breakdown, and people with bereavement through suicide. |
| **Sensible use of local data** | Local RTSSS response process map and guide developed to support a consistent and systematic approach in identifying and responding to concerns in RTSSS data.<br><br>RTSSS Working Group has regular attendance of key partners ensuring a robust multi-agency approach, including, to respond to suspected suicide deaths in public places and implementation of local Suicide Cluster Response Plan Guidance. |

| | |
|---|---|
| **Bereavement support** | An evaluation was undertaken in 2020/21 which highlighted areas of good practice and provided evidence of interventions that can reduce the suicide risk of people bereaved by suicide. |
| **Staff training** | Development and circulation of a suicide prevention primary care and pharmacy resource pack.<br><br>Bespoke and tailored training is being developed for organisations who work with particular at-risk groups (including males, those experiencing relationship breakdown and bereavement services). |
| **Working with the media** | Development of a close working relationship with the Samaritans, who produce responsible media reporting guidance including sharing findings of an audit into how suicide was reported in local media. |

The NHS England Wave 4 funding for suicide prevention activity has contributed to the delivery of this strategy. An evaluation of the impact of the local Wave 4 programme activity is being commissioned and will be completed in early 2024.

## 4. Current activity, service provision and assets

### 4.1 Assets

#### 4.1.1 Partnership Working

Suicide Prevention Strategic Steering Group

The Suicide Prevention Strategic Steering Group (SPSSG) is responsible for the development and implementation of a suicide prevention strategy and action plan across Nottinghamshire and Nottingham City. Membership includes representatives from Public Health, Adult Social Care, Nottinghamshire ICB, Nottinghamshire Healthcare NHS Foundation Trust, Police, and local universities.

Real Time Suspected Suicide Surveillance (RTSSS)

As part of the Nottingham City and Nottinghamshire County suicide prevention strategic plan, Real Time Suspected Suicide Surveillance (RTSSS) was established in 2019. The RTSSS is collated with real time Police and British Transport Police intelligence and coroner reports. Public health teams from Nottinghamshire County and Nottingham City have oversight of the data and response. A multi-agency Nottingham and Nottinghamshire Real Time Surveillance Working Group (RTSSS Working Group) is in place with responsibility for the ongoing monitoring of RTSSS data processes, analysis of data and information to identify risks, patterns and trends, and to make recommendations for and implement timely action to respond to identified suicide risks. Membership includes representatives from public health Nottinghamshire Police, British Transport Police, Network Rail, Highways, the NHS LeDeR programme, Tomorrow Project local bereavement services, Integrated Care Board and Nottinghamshire Healthcare NHS Foundation Trust.

Since its inception, RTSSS has facilitated responsive postvention and cluster response, as well as providing insights to identify and target interventions for high-risk groups.

Stakeholder Network

The Network consists of approximately 250 members and brings together representatives from a broad range of organisations and groups who work with people across Nottingham and Nottinghamshire. The role of the network is to help shape local suicide prevention work, share good practice, and foster links with other professionals.

Wave 4 Suicide Prevention Funding

In 2020, the Nottingham and Nottinghamshire Suicide Prevention Strategic Strategy Group successfully secured NHS England Wave 4 Suicide Prevention Funding. Since 2021, local Wave 4 funding has supported the following activities:

- Commissioned pilot projects to support high-risk groups (including males, self-harm parents and carers group, children and young people, and people with history of self-harm).
- Development of a local recognisable suicide prevention brand and communications campaign.
- Commissioned suicide prevention, self-harm prevention and suicide bereavement training for front line professionals across the system.
- Small grants (up to £500) allocated to pilot projects to prevent suicide within identified at-risk groups. Due to low uptake, plans are now in place to increase the grant allocation and improve engagement.

Suicide Prevention Charter Task & Finish Group

The aim of the group is to plan, co-ordinate and support the development of a Nottingham and Nottinghamshire suicide prevention charter by people with lived experiences. This group will be responsible for delivering engagement activities with individuals with lived experiences, capturing the outputs from these activities, consulting with the Suicide Prevention Strategic Steering Group and informing the new suicide prevention strategy.

### 4.1.2 Resources to promote good mental health for all

National resources

**Better Health - Every Mind Matters:** This campaign aims to improve people's mental health, by directing them to free, practical tips and advice.

Better mental health for all [51]: This report focuses on what can be done individually and collectively to enhance the mental health of individuals, families, and communities by using a public health approach.

[51] Mental Health Foundation (2022) *Better Mental Health For All A public health approach to mental health improvement.* Available at: MHF-better-mental-health-for-all.pdf (mentalhealth.org.uk)

**Prevention Concordat for Better Mental Health**: The Concordat focus is on evidence-based planning to reducing health inequalities and address the social determinants of health.

Local resources

There are range of evidence-based interventions, assets and public health initiatives in Nottinghamshire and Nottingham that contribute to mental wellbeing, such as:

- Initiatives to reduce domestic abuse.
- Interventions to reduce drugs, alcohol, and gambling related harm.
- Interventions supporting people experiencing severe multiple disadvantage.
- Tackling Loneliness Collaborative: Campaigns and work to end loneliness and isolation.
- Workplace wellbeing initiatives: In 2023, a workplace mental wellbeing project for Nottingham City employers of all sizes and sectors was initiated to build on the success of the Time to Change social movement and campaign.
- Nottingham Better Mental Health Collaborative: In 2021, Nottingham City Local Authority along with system-wide partners, committed to the Prevention Concordat for Better Mental Health for All. Nottingham's Collaborative for Better Mental Health was subsequently established, with the aim to work in partnership to focus on what matters to people and improve mental health services and support and people's lives.

### 4.1.3 Mental Health Transformation

The NHS Long Term Plan (2019) outlined plans to improve and widen access to care for children and adults needing mental health support implemented through a series of transformation programmes delivered up to March 2024. Each transformation area has a multi-partner steering group from across the Integrated Care System (ICS). The transformation programmes are as follows:

- Specialist Community Perinatal Mental Health: Expansion of specialist community perinatal mental health teams, increasing access to evidence-based psychological therapies and extending the period of care from 12 to 24 months.
- Children and Young People's (CYP) Mental Health: Expansion and transformation of specialist community services, including expansion of Mental Health Support Teams in schools; Expansion of specialist community Eating Disorder Services and implementation of Avoidant Restrictive Food Intake Disorder (AFRID) pathway; 24/7 mental health crisis provision for CYP. Nottingham City and Nottinghamshire County partners have committed to using the Thrive Framework [52] model to support its CYP mental health transformation.
- Adult Severe Mental Illnesses (SMI) Community Care: Transform and enhance community services with the aim of developing enhanced primary care based

[52] Thrive (2019) Thrive Framework for system change. Available at: THRIVE-Framework-for-system-change-2019.pdf (implementingthrive.org)

integrated support to help manage fluctuating needs. This includes the transformation of Adult Eating Disorder Services.

- Adult Common Mental Illnesses (NHS Talking Therapies): Expand service availability to meet the local demand and national targets for people entering treatment; maintain waiting times and recovery rates.
- Mental Health Crisis Care and Liaison: Maintain coverage of 24/7 Adult Crisis Resolution and Home Treatment (CRHTs); commission a range of complementary and alternative crisis services (including VCSE/Local Authority provided services); develop a model with EMAS to improve the ambulance response to mental health; maintain 24/7 mental health liaison services within acute hospitals; eliminate all out of area placements (OAPs).
- Therapeutic Acute Mental Health Inpatient Care: Therapeutic approach to improve outcomes and experience from inpatient care and reduce length of stay. Eliminate all inappropriate adult acute out of area placements (OAPs).
- Suicide Reduction and Bereavement Support: Develop and implement multi-agency suicide prevention plans, to reduce suicides for people in contact with mental health services; deliver suicide bereavement support services.

#### 4.1.4 Suicide Prevention Training

National

**Samaritans**: The charity 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. They provide training to organisations on a range of suicide prevention approaches, in addition to engaging with the media and rail networks.

Zero Suicide Alliance provide suicide prevention training for the general population, as well as university students, veterans, taxi drivers and men in prison.

Local

**Primary Care:** Plans are currently progressing to develop and deliver a one-off training session on self-harm to primary care through their practice learning time.

**Nottinghamshire Healthcare NHS Foundation Trust** delivers suicide awareness and response training for its mental health staff.

**Harmless** is commissioned to provide mental health awareness, suicide prevention awareness, self-harm awareness and suicide bereavement training to frontline workers (including within the voluntary and community sector) across the system. The training is free to people living or working within Nottingham and Nottinghamshire (note: mental health awareness training is not currently commissioned for people living/working in Nottingham City).

### 4.2 Service Provision

#### 4.2.1 Nottinghamshire Healthcare NHS Foundation Trust (NHCFT)

Nottinghamshire Healthcare Foundation Trust (NHCFT) provides community, outpatient, day and inpatient services for all ages of the population for people with mental health problems. These services are delivered in line with the NICE stepped-care model for managing common mental health disorders. The stepped-care model is used to organise provision based on scale of severity and complexity of need, with recommendations for complex and severe mental health disorders focused on specialist mental health services. Access to support in a mental health crisis is available in both Nottingham and Nottinghamshire.

NHCFT services include:

- Acute Mental Health Inpatient Care
- Psychiatric Intensive Care Inpatient Facilities
- S136 Places of Safety
- Community Mental Health Services.
- Mental Health Crisis Services
- A&E Liaison Services
- Psychology And Psychotherapy
- Day Care services
- Recovery College

The Trust-wide suicide prevention strategy (Towards Zero Suicide Strategy 2020-2023) was written in consultation with key stakeholders and sets out our aims for reducing the incidence of suicide across the Trust whilst providing meaningful, effective, and compassionate care. In line with the strategy, NHCFT has developed suicide awareness and response training for its staff. NHCFT have a mechanism in place whereby all unexpected deaths for patients in contact with the service are reported 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 to prevent any unexpected deaths in the future. This work is in addition to the RTSSS led by public health leads for all local suspected suicides. The training offer, strategic development and suicide response is led by the Trust-wide Clinical Lead for Suicide Prevention.

#### 4.2.2 Crisis Resolution and Home Treatment (CRHT)

The CRHT provides a 24 hour, 7 days a week crisis resolution service, offering assessment to adults (18-65 years of age) with severe mental illness. The multidisciplinary team provide short-term home treatment and support to facilitate crisis recovery at home and reduce the need for hospital admission.

#### 4.2.3 Talking Therapies

NHS Nottingham and Nottinghamshire Talking Therapies is a free and confidential NHS treatment service designed to help with common mental health problems such as stress, anxiety, and depression. Therapeutic approaches include Cognitive behavioural therapy (CBT), Guided self-help, Counselling for depression, Eye Movement and Desensitisation

and Reprocessing (EMDR), Talking therapies for couples, Dynamic interpersonal therapy, as well as employment support.

#### 4.2.4 Primary Care

The Additional Roles Reimbursement Scheme (ARRS) was introduced in England in 2019 with the aim to expand general practice capacity and widen their offer. The scheme aligned with the NHS Long Term Plan and NHS Mental Health Implementation Plan 2019/20 – 2023/24 [53], which set out new and integrated modes of primary and community mental health care. As a result, Primary Care Networks (PCNs) had the option to select and fund Mental Health Practitioners to meet the needs of their local population. Mental health practitioners help to bridge the gap between adults whose needs cannot be met by local talking therapies, but who may not need ongoing care from secondary mental health services.

#### 4.2.5 Children and Young People Mental Health

Nottinghamshire Child and Adolescent Mental Health Services (CAMHS) are for people up to 18 years old and include the following services provided by Nottinghamshire Healthcare:

- Community CAMHS:
  - Looked After and Adoption Team
  - Crisis Resolution Home Treatment Team
  - Developmental Neuropsychiatry and Tourette's Clinic
  - Eating Disorder Team
  - Intellectual Disability Team
  - Paediatric Liaison Team
  - Head 2 Head is an assertive outreach team for young people who: present symptoms that could indicate early onset psychosis; are on an order within the criminal justice system and have co-morbid mental health or learning difficulties; are experiencing mental health difficulties and have co-morbid substance use needs (dual diagnosis); have harmful sexual behaviour as well as mental health difficulties and/or a learning disability.
- The Lookout Adolescent Unit
- Music therapy

A targeted CAMHS service in Nottingham City is provided by Nottingham City Council.

#### 4.2.6 CAMHS Crisis Resolution and Home Treatment

The CAMHS CRHT provides intensive home treatment for young people who have acute psychiatric/psychological problems or whose mental health is getting worse and who are at high risk of experiencing an acute psychiatric crisis. When young people are admitted to a psychiatric hospital, the CRHT can facilitate the transition to home.

#### 4.2.7 Mental Health Support Teams

[53] NHS (2019), *NHS Mental Health Implementation Plan 2019/20 – 2023/24. Available at:* NHS Long Term Plan » NHS Mental Health Implementation Plan 2019/20 – 2023/24

From 2019, local NHS commissioners initiated the roll out of Mental Health Support Teams (MHSTs) in over 100 schools across Nottingham and Nottinghamshire. The MHSTs aim to deliver evidence-based interventions for mild to moderate mental health issues, support the development of a whole school approach[54] to mental health and help children and young people access the right support by providing timely advice to educational staff.

#### 4.2.8 Be U Notts

Since April 2022 Be U Notts has delivered a free mental health and emotional wellbeing service to Children and Young People with low to mild emotional needs in Nottingham City and Nottinghamshire County.

#### 4.2.9 Student Mental Health Services

The two universities and three further education colleges in Nottingham and Nottinghamshire have differing models but all offer some form of mental health support or coaching, in addition to links with external provision. There is an opportunity within the Further Education and Higher Education network to map mental health provision to develop an understanding of met and unmet need for students.

#### 4.2.10 NottAlone

NottAlone is the first point of contact for children and young people, parents, carers and professionals seeking mental health information, including self-harm and suicidal thoughts.

#### 4.2.11 HMP Whatton, Lowdham Grange, Ranby and Nottingham Prisons

All Nottinghamshire Prisons adhere to the Prison Service Order Suicide and Self-Harm Prevention and the Assessment, Care in Custody and Teamwork (ACCT) procedures. 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.

#### 4.2.12 Harmless and The Tomorrow Project

Harmless is commissioned by the ICB to deliver The Tomorrow Project. The Tomorrow Project provides confidential support to people bereaved by suicide via self-referral. A referral mechanism has also been established with local police and regional railway operators to promote awareness of The Tomorrow Project where appropriate, and to facilitate self-referrals. Harmless also provides self-harm and suicide crisis support to the local population.

#### 4.2.13 Text SHOUT

Text SHOUT is a national service that has also been commissioned locally to provide 24 hours a day and seven-days a week confidential support from a trained volunteer via text.

[54] PHE (2015), *Promoting children and young people's mental health and wellbeing*. Available at: Promoting children and young people's mental health and wellbeing - GOV.UK (www.gov.uk)

The service is intended to help with: anxiety and stress, depression or sadness, suicidal thoughts, self-harm, panic attacks, loneliness or isolation, abuse and bullying.

#### 4.2.14 Crisis Line

Crisis Line is available to anyone in mental health crisis at anytime, anywhere across Nottingham and Nottinghamshire. It's open to people of all ages who need urgent mental health support. Local health workers operate the line and can provide access to mental health profession and signpost to other relevant services.

#### 4.2.15 Nottinghamshire Crisis Sanctuaries

The Crisis Sanctuaries provide support, information, and guidance to people over 18 years old experiencing mental health issues or in a mental health crisis. Crisis Intervention Workers can provide recovery-focused crisis support and community referral as appropriate. The Sanctuaries are delivered through a partnership of three VSCE organisations: Framework, Turning Point and Mind. People can attend in person by dropping into the one of the sanctuary sites at Chilwell, Mansfield, Worksop or Nottingham City. Phone and video call options are also available.

### 4.3 Activity

#### 4.3.1 Rail companies

In partnership with Network Rail, the Samaritans deliver a Managing Suicidal Contact course to rail staff on how to identify, approach and support a person potentially experiencing suicidality. Samaritans also provides Trauma Support Training to managers to assist staff recovery post-incident support and a 24hour post-incident call-out service at stations delivered by volunteers. Samaritans also works with the media and has developed a range of guidance, including reporting on suicides and self-harm, clusters and rail suicides.

## 5. Local Views

### 5.1 Healthwatch Nottingham and Nottinghamshire

Healthwatch is the independent consumer champion for both health and social care. The aim of local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality.[55]

At the beginning of the planning process for the Joint Strategic Needs Assessment (JSNA), Healthwatch Nottingham and Nottinghamshire were presented with the Nottinghamshire County JSNA: Project Initiation Document (PID) to consider ways in which relevant patient experience and evidence could be included. Healthwatch Nottingham and Nottinghamshire liaised with the Population Health Management team at the Integrated Care Board (ICB) to

[55] Healthwatch 2023. Available from: https://www.healthwatch.co.uk/our-history-and-functions

share local views of mental health service use (including barriers around access), as well as data at the level of Nottingham and Nottinghamshire ICS, used earlier in this report.

Healthwatch also shared that a service evaluation of the Specialist Mental Health services provided and commissioned by Nottinghamshire Healthcare NHS Foundation Report was being undertaken at the time of engagement. This was due to be published out of the timeframe for inclusion within the JSNA. The service evaluation will be shared once available and will feature into development of the local strategy for Nottingham and Nottinghamshire in 2024.

### 5.2 Suicide Prevention Stakeholder network

The Suicide Prevention Stakeholder network was set up by Nottinghamshire County Council Public health team and consists of over two hundred organisations that work within suicide prevention.

On the 17th of October 2023, the overall findings of the Joint Strategic Needs Assessment were shared in a presentation to virtual attendees at the Suicide Prevention Stakeholder network event, held on MS Teams by Nottinghamshire County Council Public health. The presentation was subsequently shared through email to the network for those who could not attend. Opportunities to feedback on findings were invited via email, or directly at the stakeholder network event.

## 6. Evidence of what works

### 6.1 National strategy and guidance context

#### 6.1.1 Suicide prevention

The Suicide prevention in England: 5-year cross-sector strategy is the national suicide prevention strategy published in September 2023. It highlights the role of national government, NHS, local government VSCE sector, employers and individuals in suicide prevention. The strategy has key objectives and action areas, outlined as follows:

Key objectives:

- Reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner.
- Improve support for people who have self-harmed.
- Improve support for people bereaved by suicide.

Eight key areas for actions:

- Improve data and evidence to ensure that effective, evidence-informed and timely interventions continue to be adapted.

- Provide tailored, targeted support to priority groups, including those at higher risk. At a national level, this includes:
    - Children and young people
    - Middle-aged men
    - People who have self-harmed
    - People in contact with mental health services
    - People in contact with the justice system
    - Autistic people
    - Pregnant women and new mothers
- Address common risk factors linked to suicide at a population level by providing early intervention and tailored support. These are:
    - Physical illness
    - Financial difficulty and economic adversity
    - Gambling
    - Alcohol and drug misuse
    - Social isolation and loneliness
    - Domestic abuse
- Promote online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.
- Provide effective crisis support across sectors for those who reach crisis point.
- Reduce access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.
- Provide effective bereavement support to those affected by suicide.
- Make suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

The NCISH Safer Services toolkit provides comprehensive evidence based guidance for self-harm and safety practices in mental health services and primary care. Ten key themes emerged from a UK study of clinicians' views on good practice in mental health services and secondary care services provide a best practice framework:

- Safer wards
- Early follow-up
- No out-of-area admissions
- 24-hour crisis teams
- Family involvement
- Guidance on depression
- Personalised risk management
- Outreach teams
- Low staff turnover
- Reducing alcohol and drug misuse

NCISH toolkit also provides recommendations for:

- Psychosocial assessment for self-harm
- Safer prescribing
- Diagnosis and treatment of mental health problems especially depression in primary care
- Additional measures for men with mental ill-health
- Children and young people

Aiming for Zero Suicides' – Centre for Mental Health report (2015) [56]: 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.

Suicide prevention: identifying and responding to suicide clusters (2015, updated 2019): This PHE toolkit, based on suicide cluster research describes steps to identify and respond to suicide clusters.

Suicide prevention: suicides in public places sets out PHE's guidance for Local Authorities for reducing suicide deaths in public places. It reports that reducing access to means is one of the most effective methods of preventing suicide and sets out four main steps:

- Identify locations and prioritise based on frequency.
- Plan and take action at priority locations.
- Apply the same thinking to similar locations.
- Evaluate and reflect.

PHE guidance also identifies four areas of action to eliminate suicides at frequently used locations:

- Restrict access to the site and the means of suicide.
- Increase opportunity and capacity for human intervention.
- Increase opportunities for help seeking by the suicidal individual.
- Change the public image of the site; dispel its reputation as a 'suicide site'.

Suicide-safer universities (2018): Developed by Universities UK, the document provides guidance to universities on developing a suicide prevention strategy covering the following areas:

- Steps to prevent student suicide.
- Intervening when students get into difficulties.
- Best practice for responding to student suicides.
- Case studies on approaches to suicide prevention through partnership working.
- Checklist highlighting steps university leaders can take to make their communities safe.

Online safety

[56] Centre for Mental Health (2015), *Aiming for Zero Suicides*. Available at: Aiming for 'zero suicides' – Centre for Mental Health

The Samaritans completed research into how social media users experience self-harm and suicide content, which has informed their online excellence programme.[57] The research report acknowledged that the internet can be valuable to some for accessing information and support, for others experiencing self-harm and suicidal feelings it can present a risk, by glorifying and promoting self-harm and suicide. Many of the key research recommendations are beyond the scope of local organisations and are informing the online safety bill. However, the following recommendations provide opportunities at local level:

When signposting individuals to appropriate support, platforms should include:

- Information about local services.
- Options for live chat and messaging services.
- The option for someone to contact you.
- Platforms should also consider ways to make signposting to support more visible to users across their site.

### 6.1.2 Mental Health

The strategic direction for mental health in England is described in the NHS Long Term Plan (LTP) published in 2019; the 10 year plan includes measures to improve access for mental health services for adults and children. The NHS Mental Health Implementation Plan (2019/20 – 2023/24) consolidated LTP ambitions and actions, building on the Five Year Forward View for Mental Health Plan. In addition to a commitment to advancing mental health equality, the Plan outlined a Suicide Reduction and Bereavement Support programme to:

- Deliver against multi-agency suicide prevention plans, working towards a national 10% reduction in suicides by 2020/21
- Work closely with mental health providers to ensure plans are in place for a 'zero suicide' ambition for mental health inpatients.
- Cover every local area in the country.
- Have suicide bereavement support services providing timely and appropriate support to families and staff.

The Implementation Plan identified that other mental health service improvements outlined in the LTP would further support their suicide reduction plan such as:

- 24/7 crisis care for all ages available via 111.
- integrated community models for severe mental illness which will include meeting needs for those who self-harm and with co-morbid substance use.

[57] Samaritans (2023), How social media users experience self-harm and suicide content.

- improving the therapeutic environment in inpatient settings

Prevention Concordat for Better Mental Health was published in 2017 and refreshed in 2022, in recognition of the long-standing inequalities highlighted by the COVID-19 pandemic. The concordat takes a prevention-focused approach to improving the public's mental health, addressing wider social determinants of health and tackling health inequalities.

### 6.1.3 Clinical guidelines and quality standards

The National Institute for Health and Care Excellence (NICE) issues clinical guidelines and quality standards drawn from the best available evidence. Key points are highlighted below.

Suicide Prevention (2019) NICE Quality Standard 189:

- Multi-agency suicide prevention partnerships have a strategic suicide prevention group and clear governance and accountability structures.
- Multi-agency suicide prevention partnerships reduce access to suicides based on local information.
- Multi-agency suicide prevention partnerships have a local media plan.
- Adults presenting with suicidal thoughts or plans discuss whether they would like their family, carers or friends to be involved in their care and are made aware of the limits of confidentiality.
- People bereaved or affected by a suspected suicide are given information and offered tailored support.

Preventing suicide in community and custodial settings (2018)[58], NICE Guideline 105: This guideline includes recommendations on partnerships, strategies and action plans, which largely reflect general overarching national suicide prevention approaches, with specific advice for some custodial settings.

Self-harm: assessment, management and preventing recurrence (2022), NICE Guidelines 225 [59]. The guideline includes those with a mental health problem, neurodevelopmental disorder or learning disability and applies to all sectors that work with people who have self-harmed including recommendations on:

- Information and support; consent and confidentiality
- Safeguarding
- Involving family members and carers
- Psychosocial assessment and care by mental health professionals
- Risk assessment tools and scales; assessment and care by healthcare professionals and social care practitioners; assessment and care by professionals from other sectors
- Admission to and discharge from hospital; initial aftercare after an episode of self-harm; interventions for self-harm

[58] National Institute for Health and Care Excellence (2018), *Preventing suicide in community and custodial settings*. Available at: Preventing suicide in community and custodial settings (nice.org.uk).
[59] National Institute for Health and Care Excellence (2022), *Self-harm: assessment, management and preventing recurrence*.

- Supporting people to be safe after self-harm; safer prescribing and dispensing; training and supervision

Depression in adults: treatment and management (2022), NICE Guidelines 222 [60]. This guideline provides recommendations for adults for: first-line treatment for less and more severe depression; relapse prevention, further-line treatment, treatment options for chronic depression, depression with personality disorder or psychotic depression and the "matched care model".

Depression in children and young people: identification and management (2019) [61], NICE guideline 134. This guidance provides recommendations on: psychological therapies for mild and moderate to severe depression; care for all children and young people with depression; the stepped-care model; detection, risk profiling and referral; recognition; transfer to adult services.

Depression in adults with a chronic physical health problem: recognition and management. (2009) [62] NICE clinical guideline 91. This outlines recommended care for all people with depression, as well as application of the stepped-care model.

### 6.1.4 Local level strategy

Key Nottinghamshire County and Nottingham City documents related to suicide prevention include:

ICS Mental Health (COVID-19) (July 2020)

Nottingham and Nottinghamshire Integrated Care System Mental Health and Social Care Strategy (2019-2024)

Nottingham Director of Public Health (Annual Report 2021) - Tackling Severe Multiple Disadvantage

Nottingham Joint Health and Wellbeing Strategy (2022 – 2025)

Nottingham Mental Health and Wellbeing Strategy (2019 – 2023)

Nottinghamshire Guide to Championing Suicide & Self-harm Prevention & Mental health (2022)

Nottinghamshire Joint Health Wellbeing Strategy 2022-2026

Nottinghamshire JSNA Chapters:

[60] National Institute for Health and Care Excellence (2022), *Depression in adults: treatment and management.*
[61] National Institute for Health and Care Excellence (2019*), Depression in children and young people: identification and management.*
[62] National Institute for Health and Care Excellence (2009), *Depression in adults with a chronic physical health problem: recognition and management.*

Domestic Abuse (2019)

Emotional and Mental Health of Children and Young People (2021)

Mental Health - Adults and Older People (2017)

Self-Harm (2019)

Nottinghamshire Mental Health Promotion Action Plan (2022-25)

### 6.1.5 Research evidence

Community based and clinical suicide prevention interventions.

A literature search of CINAHL, EMBASE, Epistemonikos, Medline, Public Health Database (ProQuest), PsycINFO, Social Policy & Practice and TripPro was completed to find the best available evidence relating to the question: What interventions are effective in preventing suicide? The following key search terms were used: suicide prevention, suicidal, suicide risk, prevent, intervention, program, community mental health, primary care, primary health care, general practice, GP, accident and emergency, emergency department, post hospital, post discharge, psychotherapy, psychological therapy, serious mental illness, mental illness, mental disorder, systematic review, United Kingdom. The search was conducted between the 12th and 16th June 2023.

The search included interventions conducted in the community; schools; primary care; clinical settings; and online. The results included UK and international publications of systematic review evidence, case studies and primary research.

Effective suicide prevention interventions

Although there is evidence that suicide prevention interventions can be effective in preventing suicidal behaviour, it is not always possible to determine which specific approaches are creating a difference.[63] Also, some approaches may work for some groups at-risk, but not others. Research and evaluation of suicide-related interventions provide useful insights. Combining this knowledge with an understanding of local determinants of suicidal behaviour, helps us understand the need and ways we can address it. [64]

Some population level and community-based interventions have a consistent evidence base and are listed below.

- Training primary care physicians in depression recognition
- Educating young people on depression and suicidal behaviour
- Active outreach to psychiatric patients after discharge or a suicidal crisis

[63] Effectiveness of suicide prevention interventions: A systematic review and meta-analysis, Hofstra, E., et al., General hospital psychiatry, 2020. 63: p. 127-140

[64] Effective Programs on Suicide Prevention: Combination of Review of Systematic Reviews with Expert Opinions, Fakhari, A., et al., International journal of preventive medicine, 2022. 13: p. 39.

- Interventions that reduce access to lethal means

Suicide Prevention and Awareness training

Suicide prevention and awareness training provides people with skills to identify early warning signs of suicidality, how to engage in conversation and signpost people to appropriate support and services. Due to the wide variation in training between providers, the effectiveness of this approach remains unclear.[65] Where effectiveness is apparent, it diminishes with time, eventually reaching pre-test levels.[66] Directly educating young people about depression and suicide, was found to be more effective than suicide prevention and awareness training for the same population. There is some evidence for exploring training for railway staff and rail commuters.[67]

Public Awareness

Suicide prevention media campaigns may improve awareness of suicide, but their effectiveness as a means of changing suicide related behaviour is less clear. One systematic review identified found that:

- Campaign exposure may improve knowledge and awareness of suicide.
- Campaign materials can improve attitudes to suicide, although there were some exceptions. In this context attitudes were described as precursors to behaviour change.
- Research on the impact of media campaigns on help-seeking behaviour was inconclusive.

Rigorous evaluation is recommended when embarking on a media campaign, with consideration given to the messaging and target audience; measuring knowledge, attitudes, behavioural intentions, and actual behaviours. [68] These evaluations should aim to explore the messaging contained within campaigns, to understand which do and do not work well. They should also consider the reach of the campaign, to ascertain if it is having the desired effect.

Means Restriction

Means restriction aims to reduce suicide by limiting public access to lethal methods [69]. Reducing access to poisons and medications (especially common and lethal methods) can reduce death by suicide and was not associated with an increase suicide by other means.[70]

[65] Gatekeeper training for suicidal behaviors: A systematic review, Yonemoto, N., et al., Journal of Affective Disorders, 2019. 246: p. 506-514.
[66] Evaluating the Longitudinal Efficacy of SafeTALK Suicide Prevention Gatekeeper Training in a General Community Sample, Holmes, G., et al., Suicide & life-threatening behavior, 2021. 51(5): p. 844-853.
[67] Intervening to prevent suicide at railway locations: findings from a qualitative study with front-line staff and rail commuters, Katsampa, D., et al., BJPsych open, 2022. 8(2): p. e62.
[68] Suicide Prevention Media Campaigns: A Systematic Literature Review, Pirkis, J., et al., Health communication, 2019. 34(4): p. 402-414.
[69] Public Health England (2015) *Preventing suicides in public places*. Available at: Preventing suicides in public places (publishing.service.gov.uk)
[70] Universal interventions for suicide prevention in high-income Organisation for Economic Co-operation and Development (OECD) member countries: a systematic review, Ishimo, M.-C., et al., Injury prevention: journal of the International Society for Child and Adolescent Injury Prevention, 2021. 27(2): p. 184-193.

Strategies to restricting access to poison and medication included “banning or withdrawing them from the market, reducing concentration, limiting the quantity sold, and allowing access for only a specific occupation or medical condition” [71].

The use of barriers such as fencing as a method of restricting access to sites used for suicide by jumping may be a cost-effective approach to suicide reduction.

There was limited research related to means restriction and suicide by road traffic[72].

Interventions to reduce rail deaths may be effective, but where multiple approaches were implemented simultaneously it was not clear which particular approaches made an impact. [73] [74] A small-scale study found that physical barriers and bystander interruptions, including frontline staff or commuters may prevent rail deaths.[75] [76] The study recommended clear help points, visibility of station staff and suicide prevention training for the public to facilitate bystander interventions.

Social and Peer Support

In this context social support interventions are described as providing social support, enhancing social connectedness or tackling feelings of loneliness. Social support can prevent suicide in people with a high suicide risk.[77]. A scoping review identified a range of peer-based interventions targeting suicide prevention, such as:

- One-to-one interventions delivered by lay people or professionals, via email, text, face-to-face or telephone.
- Face-to-face group interventions which met regularly and often engaged in an activity.
- Online groups providing opportunities for conversation.

However, research into the use of peer support for suicide prevention lacked methodological rigour and more rigorous evaluation methods are recommended to identify effective approaches.[78]

Suicide Surveillance

Real time suspected suicide surveillance (RTSSS) allows for rapid data-driven postvention responses. In particular, RTSSS is proven to support access to timely and effective services

[71] Association Between Means Restriction of Poison and Method-Specific Suicide Rates: A Systematic Review, Lim, J.S., et al., JAMA health forum, 2021. 2(10): p. e213042.
[72] Means restriction for the prevention of suicide on roads, Okolie, C., et al., The Cochrane database of systematic reviews, 2020. **9**: p. CD013738.
[73] Intervening to prevent suicide at railway locations: findings from a qualitative study with front-line staff and rail commuters, Katsampa, D., et al., BJPsych open, 2022. 8(2): p. e62.
[74] Intervening to prevent suicide at railway locations: findings from a qualitative study with front-line staff and rail commuters, Katsampa, D., et al., BJPsych open, 2022. 8(2): p. e62.
[75] Railway suicide in the Netherlands lower than expected: Are preventive measures effective?, van Houwelingen, C.A.J., et al., Crisis: The Journal of Crisis Intervention and Suicide Prevention, 2021.
[76] Intervening to prevent suicide at railway locations: findings from a qualitative study with front-line staff and rail commuters, Katsampa, D., et al., BJPsych open, 2022. 8(2): p. e62.
[77] Methods and efficacy of social support interventions in preventing suicide: a systematic review and meta-analysis, Hou, X., et al., Evidence-based mental health, 2022. 25(1): p. 29-35.
[78] Peer-based interventions targeting suicide prevention: A scoping review, Bowersox, N.W., et al., American journal of community psychology, 2021. 68(1-2): p. 232-248.

for those bereaved by suicide.[79] People bereaved by suicide are at an increased risk of suicide behaviour, consequently RTSSS approaches have the potential to prevent further deaths by suicide. Further research and evaluation are needed to understand the impact of other actions taken in response to RTSSS.

Riskassessment by health professionals

A high proportion of people are in contact with healthcare services in the year leading up to death by suicide. Consequently, interactions between patients and healthcare providers present an opportunity to identify and support those at risk. Risk assessment tools have regularly been used to predict self-harm and suicide behaviour, however there is now strong evidence that such tools are ineffective predictors [80]. Healthcare providers may instead benefit from specialist and soft-skills training to support conversations about mental health and the development of collaborative personalised safety plans with patients. [81] [82] [83]

Primary care

Primary care healthcare providers are often the first point of contact for people seeking help for suicidal ideation. There is evidence that the development of the following in primary care settings can prevent suicide [84] [85]:

- Training and educating healthcare providers to raise awareness of suicide.
- Screening for suicide risk and/or mood disturbance.
- Managing depression symptoms and mental disorders, through collaborative treatment form multidisciplinary teams.
- Managing suicide attempts and at-risk cases, for example through follow-up monitoring and Brief Contact Interventions (BCIs) [86] of people attempting suicide. BCI make use of phone calls, letters, postcards, or text messages to maintain scheduled long-term contact with a service user.

[79] Real-Time Suicide Surveillance: Comparison of International Surveillance Systems and Recommended Best Practice, Benson, R., et al., Archives of suicide research: official journal of the International Academy for Suicide Research, 2022: p. 1-27

[80] Suicide risk assessment in UK mental health services: a national mixed-methods study, Graney, J., et al., The Lancet Psychiatry, 2020. 7(12): p. 1046-1053.

[81] Effective suicide prevention strategies in primary healthcare settings: a systematic review, Azizi, H., et al., Middle East Current Psychiatry, 2022. 29(1): p. 101.

[82] The Effectiveness of the Safety Planning Intervention for Adults Experiencing Suicide-Related Distress: A Systematic Review, Ferguson, M., et al., Archives of suicide research: official journal of the International Academy for Suicide Research, 2022. 26(3): p. 1022-1045.

[83] Safety planning-type interventions for suicide prevention: Meta-analysis, Nuij, C., et al., The British Journal of Psychiatry, 2021. 219(2): p. 419-426.

[84] Effective suicide prevention strategies in primary healthcare settings: a systematic review, Azizi, H., et al., Middle East Current Psychiatry, 2022. 29(1): p. 101.

[85] Suicide interventions in primary care: A selective review of the evidence, Dueweke, A.R. and A.J. Bridges, Families, systems & health: the journal of collaborative family healthcare, 2018. 36(3): p. 289-302

[86] Milner A, Spittal MJ, Kapur N, Witt K, Pirkis J, Carter G (2016) Mechanisms of brief contact interventions in clinical populations: a systematic review. BMC Psychiatry 16:1–10

Again, it should be noted that risk assessments, are not reliable predictors of suicide behaviour, [87] A systematic review identified barriers to young adults (18-26 years of age) in raising and addressing suicide ideation. Unique to this group, was the finding that young people expected GP's to initiate conversations about suicide. [88]

Emergency Department (ED)

Recent research demonstrated a significant decrease in suicide behaviours through the use of continuous quality improvement methods to identify and implement improvements, such as the use of collaborative safety plans. [89]

In paediatric ED settings there is some evidence that family-based and motivational interviewing interventions may reduce suicidal ideation and risk in children and adolescents; however further research is needed [90].

Brief psychological interventions for people attending ED or following a suicide attempt may reduce suicide behaviours [91].

The use of combined safety-planning and telephone follow-up post hospital admission for a suicide attempt was recently piloted. This preliminary study shows promise, and the approach warrants further exploration [92] [93].

Caring Contacts makes use of periodic personalised texts to enquire about former patients' well-being without expectation of response. This approach may facilitate engagement with health services and have a protective effect [94].

Psychological therapies

Studies into the effectiveness of psychosocial and psychological interventions (such as cognitive-behavioural therapy, dialectical behaviour therapy and psychodynamic

[87] Suicide risk assessment in UK mental health services: a national mixed-methods study, Graney, J., et al., The Lancet Psychiatry, 2020. 7(12): p. 1046-1053.
[88] Raising Suicide in Medical Appointments-Barriers and Facilitators Experienced by Young Adults and GPs: A Mixed-Methods Systematic Review, Osborne, D., et al., Int J Environ Res Public Health, 2023. 20(1).
[89] Effect of an Emergency Department Process Improvement Package on Suicide Prevention: The ED-SAFE 2 Cluster Randomized Clinical Trial, Boudreaux, E.D., et al., JAMA Psychiatry, 2023.
[90] A rapid review of emergency department interventions for children and young people presenting with suicidal ideation, Virk, F., J. Waine, and C. Berry, BJPsych open, 2022. 8(2): p. e56.
[91] Effectiveness of brief psychological interventions for suicidal presentations: a systematic review, McCabe, R., et al., BMC psychiatry, 2018. 18(1): p. 120.
[92] Association of Suicide Prevention Interventions With Subsequent Suicide Attempts, Linkage to Follow-up Care, and Depression Symptoms for Acute Care Settings: A Systematic Review and Meta-analysis, Doupnik, S.K., et al., JAMA psychiatry, 2020. 77(10): p. 1021-1030.
[93] SAFETEL: a pilot randomised controlled trial to assess the feasibility and acceptability of a safety planning and telephone follow-up intervention to reduce suicidal behaviour, O'Connor, R.C., et al., Pilot and feasibility studies, 2022. 8(1): p. 156
[94] Caring contacts for suicide prevention: A systematic review and meta-analysis, Skopp, N.A., et al., Psychological services, 2023. 20(1): p. 74-83.

psychotherapies) on suicide and self-harm behaviours were contradictory and inconclusive. [95] [96]

Digital interventions

There is some support for the use of digital interventions in the reduction of suicide and self-harm, with the strongest evidence for iCBT (internet-based Cognitive Behavioural Therapy).[97] [98] Further research is needed to understand the implementation and impact of this intervention.

Population sub-groups

A literature search of CINAHL, EMBASE, Epistemonikos, Medline, Public Health Database (ProQuest), PsycINFO, Social Policy & Practice and TripPro was completed to find the best available evidence relating to the question: What interventions are effective in preventing suicide? The following key search terms were used: suicide prevention, suicidal, prevent, intervention, program, at risk, risk group, men, LGBTQ, gender diverse, substance use, financial, unemployed, systematic review, review, United Kingdom and UK. The search was conducted between the 9th and 14th June 2023.

The results included UK and international publications of systematic review evidence, case studies and primary research.

Older adults

Some evidence supports physical activity and the use of collaborative care for depression management and reduction of suicide ideation. Collaborative care is the use of multidisciplinary teams working jointly. [99]

Children and young people

Psycho-educational interventions delivered in clinical, community and educational settings may reduce suicidal ideation and behaviour in young people.[100] [101] It is recommended that interventions are coproduced and are acceptable to young people. These interventions show some signs of mid-to-long term effects, have the potential to reach a wide audience and may

[95] A systematic review and meta-analysis of psychosocial interventions aiming to reduce risks of suicide and self-harm in psychiatric inpatients, Yiu, H.W., S. Rowe, and L. Wood, Psychiatry research, 2021. 305: p. 114175

[96] The effectiveness of psychoanalytic/psychodynamic psychotherapy for reducing suicide attempts and self-harm: systematic review and meta-analysis, Briggs, S., et al., British Journal of Psychiatry, 2019. 214(6): p. 320-328.

[97] Effectiveness of internet-based cognitive behavioral therapy for suicide: a systematic review and meta-analysis of RCTs, Yu, T., et al., Psychology, Health & Medicine, 2022. 27(10): p. 2186-2203.

[98] Internet-Based Cognitive Behavioral Therapy to Reduce Suicidal Ideation: A Systematic Review and Meta-analysis, Buscher, R., et al., JAMA network open, 2020. 3(4): p. e203933.

[99] Prevention of suicidal behavior in older people: A systematic review of reviews, Laflamme, L., et al., PLoS ONE, 2022. 17(1): p. 1-14.

[100] A Systematic Review of School-Based Suicide Prevention Interventions for Adolescents, and Intervention and Contextual Factors in Prevention, Walsh, E.H., M.P. Herring, and J. McMahon, Prevention science : the official journal of the Society for Prevention Research, 2023. 24(2): p. 365-381.

[101] Research Review: The effect of school-based suicide prevention on suicidal ideation and suicide attempts and the role of intervention and contextual factors among adolescents: a meta-analysis and meta-regression, Walsh, E.H., J. McMahon, and M.P. Herring, Journal of child psychology and psychiatry, and allied disciplines, 2022. 63(8): p. 836-845.

help identify and address suicide risk factors.[102] [103][104] Lack of input from school staff and young people in the development of the programme is a limiting factor in the intervention's effectiveness.

The use of psychosocial approaches and Dialectical Behaviour Therapy for Adolescents (DBT-A) may reduce suicide risk. [105] [106]Further research and evaluation of suicide prevention programmes is needed in this area.

Men

Interventions have been developed to address some of the barriers to health seeking behaviour amongst men.[107] For example, campaigns to destigmatise mental illness, increase awareness and health seeking-behaviours, promoting talking to others and coping strategies have been implemented in various forms across the UK. However, studies and evaluation of these types of approaches have not been robust enough to draw conclusion on their effectiveness.[108] [109] Coproducing services with men, developing targeted communications promoting social connections and delivering interventions in informal settings did show some promise. [110]

Another potential intervention included offering psychosocial and practical support to men with financial difficulties and at risk of suicide. The intervention showed a reduction in depression and suicide ideation, in addition to increased financial self-efficacy. [111]

Misdiagnosed or unidentified depression are barriers to health-seeking in men. Training GPs to identify and support depression/suicidality in men is one opportunity to address this.[112]

LGBTQ+

[102] Effectiveness of school-based preventive programs in suicidal thoughts and behaviors: A meta-analysis, Gijzen, M.W.M., et al., Journal of Affective Disorders, 2022. 298(Part A): p. 408-420.
[103] The effects of educational interventions on suicide: A systematic review and meta-analysis, Pistone, I., et al., The International journal of social psychiatry, 2019. 65(5): p. 399-412.
[104] The effects of interventions preventing self-harm and suicide in children and adolescents: an overview of systematic reviews, Morken, I.S., et al., F1000Research, 2019. 8: p. 890.
[105] Suicide in young people: screening, risk assessment, and intervention, Hughes, J.L., et al., BMJ (Clinical research ed.), 2023. **381**: p. e070630
[106] Adapted Dialectical Behavior Therapy for Adolescents with a High Risk of Suicide in a Community Clinic: A Pragmatic Randomized Controlled Trial, Santamarina-Perez, P., et al., Suicide & life-threatening behavior, 2020. 50(3): p. 652-667.
[107] Barriers to help-seeking in suicidal men: A systematic literature review. Jones LJ, Iqbal Z, Airey ND, Brown SR, Burbidge F International Journal of Psychiatry. 2019 Dec 27;4(2):1-5.
[108] Kayikci S et al. Suicide Prevention Campaign in Barnet: Evaluation Report 2021-22. London Borough of Barnet, 2022
[109] A rapid review to determine the suicide risk of separated men and the effectiveness of targeted suicide prevention interventions, King, Kylie; Krysinska, Karolina and Nicholas, Angela, Advances in Mental Health, 2022. 20(3), pp. 184-199
[110] Men and suicide prevention: a scoping review, Struszczyk, S., P.M. Galdas, and P.A. Tiffin, Journal of mental health (Abingdon, England), 2019. 28(1): p. 80-88.
[111] Preventing male suicide through a psychosocial intervention that provides psychological support and tackles financial difficulties: a mixed method evaluation, Jackson, J., et al., BMC psychiatry, 2022. 22(1): p. 333.
[112] Men and suicide prevention: a scoping review, Struszczyk, S., P.M. Galdas, and P.A. Tiffin, Journal of mental health (Abingdon, England), 2019. 28(1): p. 80-88.

The evidence reviewed predominately identified research for children and young people. School based approaches promoting safe community, connectedness and acceptance may address suicide behaviour for LGBTQ+ young people[113] [114] The limited evidence in these areas warrants further exploration.

Substance Use

Evidence is currently limited on the effectiveness of interventions to prevent suicide and self-harm in people using substances [115]. Further research is needed in this field.

Finance and unemployment

Unemployment benefits, employment protection legislation, higher minimum wage and active labour market programmes may reduce suicide at the population level, however the evidence for financial-focused suicide prevention interventions is inconclusive.[116] A pilot programme using brief psychosocial interventions for people presenting with self-harm or acute distress to emergency departments due to financial difficulties, showed some early potential. [117]

In contact with the criminal justice system

The evidence search did not identify robust and strong evidence for approaches for reducing suicidality in people in contact with criminal justice system.[118] It is worth noting that the term "in contact with the criminal justice system" encompasses a broad spectrum of experiences and interactions.

## 7. What is on the horizon?

### 7.1 Resourcing for the Suicide prevention strategy for England: 2023 to 2028

The new national Suicide Prevention strategy and action plan (see section 6.1.2) sets out over 100 actions across sectors, agencies, and the general public, in promoting suicide prevention as everybody's business. The government has made resource commitments that are expected over the coming months, including:

- Establishing a new nationwide near real-time suspected suicide surveillance system will improve the early detection of and timely action to address changes in suicide rates or trends (expected to launch November 2023)

[113] Systematic Review of Interventions to Reduce Suicide Risk in Transgender and Gender Diverse Youth, Christensen, J.A., et al., Child psychiatry and human development, 2023.
[114] The roles of school in supporting LGBTQ+ youth: A systematic review and ecological framework for understanding risk for suicide-related thoughts and behaviors, Marraccini, M.E., et al., Journal of school psychology, 2022. 91: p. 27-49.
[115] Psychosocial Interventions for Reducing Suicidal Behaviour and Alcohol Consumption in Patients With Alcohol Problems: A Systematic Review of Randomized Controlled Trials, Hurzeler, T., et al., Alcohol & Alcoholism, 2021. 56(1): p. 17-27.
[116] The Role of Unemployment, Financial Hardship, and Economic Recession on Suicidal Behaviors and Interventions to Mitigate Their Impact: A Review, Mathieu, S., et al., Frontiers in public health, 2022. 10: p. 907052.
[117] The help for people with money, employment or housing problems (HOPE) intervention: pilot randomised trial with mixed methods feasibility research, Barnes, M.C., et al., Pilot and feasibility studies, 2018. 4: p. 172
[118] Interventions to reduce suicidal thoughts and behaviours among people in contact with the criminal justice system: A global systematic review, Carter, A., et al., eClinicalMedicine, 2022. 44: p. 101266.

- A £10 million Suicide Prevention Grant Fund is to support Voluntary Community Sector organisations to deliver suicide prevention activity.
- NHSE is taking forward improvements to the mental health crisis support offer, supported by an investment of £150 million. This includes procuring specialised mental health ambulances and investing in a range of infrastructure schemes, including alternatives to A&E, crisis cafés, and new and refurbished mental health assessment and liaison spaces.
- Funding the government's proposed Online Safety Bill which will introduce legislation to tackle harmful online suicide and self-harm content.

### 7.2 Suicide and self-harm service

The Integrated Care Board is commissioning a new integrated, all age suicide and self-harm service across Nottingham and Nottinghamshire aiming to provide timely, evidence-based support for people experiencing suicidal ideation, self-harm or have been bereaved by suicide.

Learning from the wave 4 programme and wider stakeholder engagement has been incorporated into the new service model including a greater emphasis on community engagement and development, understanding the role and support for parent/carers and improving communications and awareness of the service. The new service will commence in April 2024.

### 7.3 Wave 4 programme delivery

The Wave 4 suicide prevention programme concludes in October 2024. For the final year of the programme work will focus on:

- Completion of a series of engagement and training pilots being delivered on behalf of the programme by Harmless focussing on organisations and groups who work with and support men, LGBTQ+ communities, Gypsy Roma Traveller communities and those working in suicide bereavement and relationship breakdown.
- Development and delivery of a listening project focussing on higher risk groups of men, people with neurodevelopmental conditions, young people and young adults at risk of self-harm, people experiencing financial vulnerability (including from gambling harm) and suicide bereavement. Findings from the listening event will inform future commissioning decisions, provide qualitative evidence to identify gaps in suicide prevention work and inform the Nottingham and Nottinghamshire Suicide Prevention strategy.
- Development of targeted communication campaigns and a small community grants programme focussing on the higher risk groups and antecedents to suicide listed above.
- Continuation of training delivered via the Wave 4 Framework Agreement to continue to upskill and increase confidence across a range of groups and organisations who support those who may experience suicidality.
- Evaluation of the Wave 4 suicide prevention programme in its totality.

The work outlined above aims to identify learning and the needs of these at-risk groups and areas of concern to be shared across the system. This will influence key partners. wider stakeholders and will be incorporated into future suicide prevention activity by the Suicide Prevention Stakeholder Steering Group.

### 7.4 NHS 111

From April 2024, 111 option 2 will go live and will be the promoted as the first contact number for anyone in a mental health crisis. Calls will be diverted to a local Crisis hub for support, advice, triage and linked into CAMHS and AMH Crisis teams for further support. This will be a 24/7 offer.

### 7.5 Expected activity and provision for Children and Young People

Crisis Support and Complex Needs: A group will be established to review crisis support in children and young people on a complex needs pathway. The group will consist of partners including representatives from acute, health and social care. It will review feedback, embed services within pathways, and focusing on aligning crisis support following presentation at an emergency department.

Self-Harm Working Group: This group will review and streamline self-harm provision pathways.

Mental Health Champions will be embedded in local hospitals to:

- ensure that mental health has the same focus within acute settings as physical health.
- provide oversight of young people with complex needs attending acute settings
- support appropriate discharge.
- work with system partners to improve pathways.

### 7.6 Other relevant national strategy and guidance

Updated guidance on suicide cluster responses

In the Suicide Prevention Strategy for England: 2023-2028, OHID committed to updating guidance for local suicide prevention partnerships on suicide clusters and contagion. This will support effective local responses where there may be more suicides than expected in a particular area, or a suspected link between suicides. The publication is expected by 2024.

Guidance for Local Authorities on suicide prevention action plans

In the Suicide Prevention Strategy for England: 2023-2028, OHID committed to refreshing local suicide prevention plan guidance by the end of 2024. The updated guidance will support the development of local plans in line with national priorities, including guidance on providing bespoke support to demographic group and communities of concern.

Major Conditions Strategy

In 2023 the government committed to major conditions strategy which will include mental ill health, along with five other physical health groups of conditions. At the time of writing, it is understood that the major conditions strategy will replace the 'No Health Without Mental health' a cross government health outcomes strategy for all ages. The Department for Health and Social Care (DHSC) published an interim case for change and strategic framework [119] in August 2023, with the full strategy expected in 2024.

**What does this tell us?**

## 8. Unmet needs and service gaps

Unmet needs were identified by reflecting on the information presented by this JSNA on local population trends and at-risk groups, local service provision and assets, and by considering the evidence base of what works in suicide prevention. The following unmet needs were identified:

1. Current school-based mental health support does not specifically address suicide prevention. Evidence suggests vulnerability to suicide can be partly established early in life and that taking early intervention and school-based approaches can be preventative.[120] The Whole School Approach and Children and Young People (CYP) Mental Health Transformation Programme provides an opportunity to integrate suicide prevention within existing emotional wellbeing approaches.

2. There is a need for additional work to tailor support for men to reduce risk factors and antecedents for suicidality. These include economic adversity, alcohol and drug use, relationship stresses and lack of social connections. Current provision exists to support men addressing crisis, self-harm and suicide prevention but could go further to address additional risk factors and antecedents for suicidality.

3. There is a need to support health seeking behaviours in men. National data suggests that 9% of middle-aged men experiencing suicidality are not in contact with any support.[121] Currently there is not a year-round targeted communications strategy to support men to engage with appropriate services and support.

[119] Department of Health and Social Care (2023), *Major conditions strategy: case for change and our strategic framework*. Available at: Major conditions strategy: case for change and our strategic framework - GOV.UK (www.gov.uk)
[120] The developmental origins of suicide mortality: A systematic review of longitudinal studies, Vidal-Ribas, Pablo; et al. , European Child & Adolescent Psychiatry, 2022.
[121] The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Suicide by middle-aged men. 2021. The University of Manchester.

4. Voluntary and community services report a need for increased skills and knowledge in how to help people experiencing self-harm and suicidality access a continuum of appropriate holistic support. Voluntary and community sector providers have reported an increase of self-harm presentations to their services, during the same period that hospital admissions for intentional self-harm have decreased.

5. Ensure evidence-based approaches support social connectedness and emotional wellbeing to reduce self-harm and suicidality among LGBTQ+ young people in current school-based and community-based locations. A Wave 4 funded pilot project has been established to explore engagement and crisis support for LGBTQ+ people. CAMHS has engaged with local LGBT+ groups to identify and implement ways to support LGBTQ+ young people. There is currently an opportunity address the risk factors of suicidality for LGBTQ+, such as loneliness, bullying and abuse via whole school approaches and CYP mental health transformation. These are promising developments, which would be bolstered by greater links between the CYP Mental Health Transformation Programme, Nottinghamshire Healthcare trust and local authority Public Health.

6. Further collaborative work is needed to improve access to support services for Gypsy Roma and Traveller communities. Evidence suggested that roles embedded in the community are best placed to support Gypsy Roma Traveller groups. There is an opportunity to collaborate with existing Community Champions and other community assets.

7. Systems are needed to ensure professionals in community, healthcare, money help and other public-facing roles have up-to-date knowledge and can support access to financial advice and wellbeing and mental health support. This should include knowledge and pathways at a local level. National and local intelligence suggests that financial adversity is a risk factor for suicide.[122] The rising cost of living is likely to add additional risk and requires timely support to be implemented. Feedback from stakeholders acknowledges challenges for both citizens and professionals in identifying what financial support is available and where to access it.

8. Follow-up support is commissioned after first attendance to emergency departments for suicide ideation, and not for later attendances. Intentional self-harm requiring emergency hospital treatment has been found to be present in about 15% of those who take their own life.[123] Effective follow-up care has the potential to help people who self-harm to access the right support and prevent suicide.

9. There is a need to identify effective interventions to address the mental health needs and prevent suicide for people with long term physical health conditions. National data shows that people with long-term and chronic physical illness may be an at-risk group for low mental wellbeing and suicidality. [124] Local intelligence identified cancer diagnosis and chronic pain as the most cited physical health condition within RTSSS data. Some links exist between physical health and mental health services. However, more needs to be done to support and understand patient's needs.

[122] Annual report 2023: UK patient and general population data 2010-2020. March 2023 Available from https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/
[123] McManus S et al. Suicide and self-harm in Britain: researching risk and resilience. NatCen Social Research, 2019 Available from: https://nspa.org.uk/resource/suicide-and-self-harm-in-britain-researching-risk-and-resilience-using-uk-surveys-data-and-analysis/
[124] The association of physical multimorbidity with suicidal ideation and suicide attempts in England: A mediation analysis of influential factors, Smith, L., et al., The International journal of social psychiatry, 2023. 69(3): p. 523-531.

10. Greater links and shared learning between domestic abuse and suicide prevention teams is needed. National data and research highlight that women are disproportionately affected by domestic abuse suicide.[125] [126] This group characteristically have multiple unmet needs with fewer resources to escape and seek help.

11. There is a need to better support the needs of children and young people who are in crisis and present to the emergency department with self-harm or suicidal ideation. Local stakeholders have highlighted inappropriately met or unmet needs of young people who are in crisis or emotionally dysregulated, with some CYP experiencing long waits on physical health wards whilst appropriate provision was sought. Looked after young people and those transitioning from CYP to adult services, were identified as groups of particular need.

12. There is a need to address online safety and suicide-related internet use. In the absence of local data, we look to national data which indicates a general increase in suicide-related internet use since 2011. Evidence of suicide-related internet use was evidenced in 8% of the suicides in people who were in contact with mental health services over the past year.[127]

The following knowledge gaps were identified:

- Evidence is currently limited on the effectiveness of interventions to prevent suicide and self-harm in people using substances.
- Limited understanding of the links between gender, domestic abuse and suicide (particularly sexual violence).
- Effective and appropriate links between RTSSS and Mental Healthcare provider self-harm and suicide data to inform antecedent themes and prevention action.
- Prevalence and means of self-harm, including understanding of self-harm presentations to VSCE organisations and the scale of potentially unmet need.
- Understanding gambling harm local intelligence in relation to suicide risk factors to inform targeted interventions.
- Limited understanding of approaches to reducing suicidality in people in contact with probation and youth justice services.

## What should we do next?

## 10. Recommendations for consideration

[125] The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Annual report 2022. Available from: https://sites.manchester.ac.uk/ncish/reports/annual-report-2022/
[126] Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England Sally McManus et al.June 07, 2022 DOI:https://doi.org/10.1016/S2215-0366(22)00151-1
[127] The National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report: UK patient and general population data, 2010-2020. 2023. University of Manchester. Available from: https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/

The following recommendations have been formulated based on the unmet needs and knowledge gaps identified in section 9 and are aligned to components of the new Suicide Prevention Strategy for England (2023 to 2028):

| | Recommendations | Lead(s) |
|---|---|---|
| | **Improved Data and Evidence** | |
| **1** | Improve data and intelligence sharing between partners including through the local Real Time Suspected Suicide Surveillance (RTSSS) system in order to ensure the quality of the RTSSS data and learning reviews after a suicide death has occurred and to improve the understanding of local need and gaps. | Local authority Public Health teams/ Nottinghamshire Healthcare Trust/ partners in RTSSS working group |
| **2** | Establish protocols for appropriate sharing and analysis of data on self-harm and suicide attempts among key partners working with groups at increased risk of suicidality, including mental health, domestic abuse, drug and alcohol use services to inform preventative actions. | Local authority Public Health teams/ Nottinghamshire Healthcare Trust |
| | **Reducing access to means and high frequency locations** | |
| **3** | Continue to prioritise action on reducing access to means for suicide within public places using intelligence from Real Time Suspected Suicide Surveillance (RTSSS) and through the RTSSS Working Group. | Local authority Public Health teams and partners in RTSSS working group |
| | **Providing tailored and targeted support to target groups.** | |
| **4** | Develop integrated suicide prevention approaches for children and young people (CYP) in school settings via the Whole School Approach and CYP Mental Health Transformation Programme | Local authority Public Health and Education teams/CYP Mental Health Transformation leads |
| **5** | Facilitate the development of services and support, co-produced with men, to address suicide risk factors and promote social connections in informal settings. | Local authority Public Health teams/VSCE sector |
| **6** | Develop targeted suicide prevention communications for men to support engagement in and access to support services. | Local authority Public Health teams/ Nottinghamshire Healthcare Trust |
| **7** | Work with partners (including VSCE and primary care) to better understand where people experiencing self-harm or suicide ideation come into contact with services and what further action is needed to identify and support them, particularly for those whose needs do not meet the threshold for secondary mental healthcare. | All commissioners in Local authority Public Health teams |

| | | |
|---|---|---|
| **8** | Develop communication resources to support people experiencing self-harm to access the right support at the right time. | Local authority Public Health teams |
| **9** | Integrate evidence-based approaches to supporting social connectedness and emotional wellbeing for LGBTQ+ people into school and community-based approaches and services. | Local authority Public Health teams/CYP Mental Health Transformation leads |
| **10** | Partner with community champions and existing organisations to improve access to appropriate support services for people from Gypsy Roma and Traveller communities. | Local authority Public Health teams |
| | **Addressing risk factors** | |
| **11** | Use learning from local pilot projects and listening events to improve access for groups who are at increased risk of not accessing self-harm and suicide prevention support such as:<br>- Gypsy Roma Traveller groups<br>- LGBTQ+ groups<br>- Men<br>- Those who are financially vulnerable, unemployed or people with a gambling problem<br>- People with neurodevelopmental conditions<br>- Young people/adults at risk of self-harm/suicide<br>- People bereaved by suicide | Local authority Public Health teams/CYP Mental Health Transformation leads |
| **12** | Support the community and voluntary sector to support people from at-risk groups who are experiencing self-harm and suicidality such as: men, people with financial difficulty, LGBTQ+ communities, people experiencing loneliness, and people in contact with the criminal justice system. | Local authority Public Health teams/VSCE sector |
| **13** | Work with services providing financial support/advice and wellbeing support to improve the pathways between psychosocial support and money help, promote workforce awareness of financial advice and wellbeing support, and strengthen links between financial support and mental health services. | Local authority Public Health teams |
| **14** | Identify contacts and foster links with commissioners and providers of chronic pain and cancer pathways to explore how to improve access to appropriate support services. | Local authority Public Health teams/ Nottinghamshire Healthcare trust |
| **15** | Develop links with probation, youth justice and community-based services for people in contact with criminal justice system to develop training and involvement with the Suicide Prevention Stakeholder Network and Suicide Prevention Strategic Steering Group. | Local authority Public Health teams |
| **16** | Review mechanisms for sharing learning from Domestic Homicide Reviews relating to suicide with the suicide prevention partnership and consider opportunities for links between Assurance Learning Implementation Groups (ALIG) and the Suicide Prevention Strategic Steering Group. | Local authority Public Health teams |
| | **Effective crisis support** | |

| | | |
|---|---|---|
| **17** | Work with the Integrated Care Board to identify support following Emergency Department attendance for every incident of suicide ideation. | Integrated Care Board |
| **18** | Work with the Integrated Care Board's Children and Young People (CYP) team to identify opportunities to promote the mental health and wellbeing and appropriate crisis support for CYP and looked-after children and ensure pathways for support are aligned to facilitate easy access for CYP. | Integrated Care Board (CYP and looked-after children's team) |
| | **Online safety:** | |
| **19** | Develop an approach to promote online safety, informed by the national online excellence programme. | Local authority Public Health teams, Education and Children's social care teams. |

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**References**

Bookmarked

**Appendix**

None