Care Services Improvement Partnership CSIP

National Institute for
Mental Health in England

National Suicide Prevention Strategy for England

Annual report on progress 2006

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Foreword

In the four years since the national suicide prevention strategy for England was launched, the National Institute for Mental Health in England, part of the Care Services Improvement Partnership (CSIP), has continued to work with its partner agencies to deliver on the extensive programme of work outlined in the strategy.

This is the fourth annual report on progress and sets out what has been achieved in the past 12 months and what further actions still need to be taken in the medium and longer term.

The overall rate of suicide amongst the general population is continuing to fall and is the lowest on record. Following a small rise in the single year rate for 2004, the rate is once again heading in the right direction. I am very encouraged to see a further fall in the suicide rate of young men. There is now clear evidence of a sustained fall in suicide amongst this group. However, the rate still remains high in comparison with the general population. We need to take careful note of the recommendations outlined in the report Reaching Out if we are to ensure this fall continues.

We are also seeing a reduction in the number of suicides amongst mental health in-patients. The third report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, published in December 2006 highlights areas of clinical practice that still need to be strengthened if suicides in mental health care are to be prevented. These include the management of risk in patients discharged from hospital and in-patients who are non-compliant with treatment – there are around 200 patient suicides per year following non-compliance. Good clinical care in this area needs to be backed by legal powers, and the Government is introducing supervised community treatment (SCT) in the Mental Health Bill that is in Parliament now. SCT will ensure that patients in the community, who are at risk of suicide, will receive the treatment they need.

There has also been a further fall in self-inflicted deaths in prison in the past year, a 17% reduction in comparison to the previous year. This is a significant achievement given the prison population contains a high proportion of vulnerable individuals.

We have identified a number of priorities for action in 2007 including reducing incidents of suicide amongst older people and continuing our work in developing effective approaches to engage with young men. We also need to continue to support services in taking forward the recommendations outlined in the NICE Guidelines on Self-harm. Further detailed information on this activity can be found in chapter one of this report.

Although we are seeing encouraging progress towards the target, the rate of decline has slowed and if the current trend continues, the target will not be met. We remain committed to the goals and objectives of the national strategy and will continue to take action at local, regional and national level to help reduce suicides still further in our communities.

Professor Louis Appleby

National Director for Mental Health

CHAPTER**ONE**

PROGRESS IN 2006

Introduction

The national suicide prevention strategy in England was launched in 2002 with the aim of supporting the target to reduce the death rate from suicide and injury (and poisoning) of undetermined intent by at least a fifth by the year 2010. The Public Service Agreement reached between the Department of Health, Treasury and No 10 to reduce the mortality rate from suicide and injury (and poisoning) of undetermined intent by at least 20% by 2010 reflects the Government commitment to improving access to mental health services. This important national target has been retained in *National Standards Local Action: Health and Social Care Standards and Planning Framework for 2005/06 – 2007/08*[1].

The likelihood of a person taking their own life depends on several factors. These include physically disabling or painful illnesses and mental illness; alcohol and drug misuse; and level of support. Stressful life events such as the loss of a job, imprisonment, a death or divorce can also play a part. For many people, it is the combination of factors which is important, rather than any single factor.

There is no single approach to suicide prevention. That is why we developed a broad strategic approach which involves health and social care agencies, Government departments, and voluntary and private sector organisations.

Implementation – progress in year four

The National Institute for Mental Health in England (NIMHE) continues to take implementation of this strategy forward as one of its core programmes of work. We now have:

- the lowest overall rate of suicide amongst the general population on record
- a further encouraging fall in suicide rates amongst young men – continuing the downward trend since the problem of suicides in this group first escalated 25 years ago
- a fall in the number of suicides amongst mental health in-patients, and
- a fall in the rate of self-inflicted deaths in prisons for the third successive year. For the first time the 20 per cent reduction originally set within the national strategy was met.

1 *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06-2007/08 – 2004 http://www.dh.gov.uk/assetRoot/ 04/08/60/58/04086058.pdf*

We have also continued to make progress on a number of specific initiatives. These include:

- publication of *Reaching Out*[2], an evaluation of the three mental health promotion pilots aimed at young men
- expansion of the three centre study of self-harm to a fourth centre at Derby. These centres help provide accurate data and trends and patterns of self-harm, identify any differences between centres, and detect any changes in patterns. A report of the early findings arising out of this initial 18-month can be found at www.nimhe.csip.org.uk
- revised care planning system for at risk prisoners (ACCT) was developed, piloted and evaluated in 2004 with implementation across the estate taking place during 2005-2007
- publication of *Suicide audit in Primary Care Trust localities*[3] – a tool to support PCTs and other bodies carry out population based audit of suicides and open verdicts
- publication of *Help is at Hand*[4] – a resource for people bereaved by suicide and other sudden, traumatic death
- publication of guidance on action to be taken at suicide hotspots[5]
- commissioning of MediaWise to consult with the media about the most useful ways of improving the portrayal of suicide and suicidal behaviour in the media. We will publish the results of this survey, including recommendations for future activity, in the near future, and
- working with mental health services in preventing suicide, and in particular by providing early follow-up to high risk patients who are discharged from hospital.

A comprehensive update on all the strategy's actions – completed, ongoing or planned – will be available from June 2007 on our website *www.nimhe.csip.org.uk*

CSIP, through its eight development centres, works at a local and regional level to help implement the objectives of the strategy. Development centres agree specific work programmes on an annual basis which reflect the ongoing and future work streams outlined in the suicide prevention strategy.

Chapter 3 of this report highlights some of the activity taking place at regional and local level. More detailed information is available from regional suicide prevention leads. Contact details for each development centre are included and further information can be found at *www.nimhe.csip.org.uk*

Where we are now

Suicide rates, whilst fluctuating year on year, show a downward trend since the early 1980s. The Our Healthier Nation (OHN) target is to reduce the death rate from suicide and injury (and poisoning) of undetermined intent by at least a fifth by the year 2010 (from a baseline rate of 9.2 deaths per 100,000 population in 1995/6/7 to 7.3* deaths per 100,000 population in 2009/10/11). Latest available data (for the 3 years 2003/4/5) show a rate of 8.5 deaths per 100,000 population – a reduction of 7.4% from the 1995/6/7 baseline. For a more detailed analysis of the statistical data, see Chapter 2.

** this target was revised from 7.4 following a change in the methodology used by the Office of National Statistics to record the cause of death*

2 *Reaching Out: Evaluation of three mental health promotion pilots to reduce suicide amongst young men (executive summary). CSIP 2006 http://kc.csip.org.uk/viewdocument.php?action=viewdox&pid=0&doc=32542&grp=1*

3 *Suicide audit in Primary Care Trust localities. CSIP 2006 http://www.csip-plus.org.uk/RowanDocs/SuicideAuditTool*

4 *Help is at Hand: A resource for people bereaved by suicide and other sudden, traumatic death. DH 2006 http://www.dh.gov.uk/assetRoot/04/13/90/07/04139007.pdf*

5 *Guidance on action to be taken at suicide hotspots. CSIP 2006 http://www.csip-plus.org.uk/RowanDocs/SuicideHotspots.pdf*

People in contact with mental health services (including in-patients)

Having a severe mental illness is a known risk factor for suicide. Good mental health care and mental health promotion can reduce the risk of suicide among people with a mental illness. We also know that because a significant number of suicides occur during a period of in-patient care or shortly after discharge, managing risk effectively and ensuring good continuity of mental health care are essential.

In mental health services, risk of suicide is highest in the period immediately after hospital discharge. Post-discharge follow-up is one of the key recommendations in '12 Points to a Safer Service' from the National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness (NCI) report *Safety First*[6] which mental health trusts have been asked to adopt. In the guidance to the NHS on targets, covering the period 2005-08, trusts are expected to provide face-to-face or telephone contact within seven days of discharge for people on enhanced Care Programme Approach.

The latest available data shows that the numbers of in-patient suicides in England have fallen from 217 in 1997 to 154 in 2004 (see Chapter 2 for the latest statistical data on in-patient suicides).

In December 2006, the NCI published its third report *Avoidable Deaths*[7]. Whilst the report outlines a number of positive findings, including the fall in in-patient deaths within seven days of admission and suicides by hanging, major problems of safety still remain.

In particular these are:

- in-patients dying by suicide while off the ward without permission
- the large number of suicides that occur during the transition from in-patient to community care – the time of maximum risk is the first week following discharge, and
- the number of patients with severe mental illness and a history of violence or self-harm who are not subject to enhanced care under the Care Programme Approach.

In addition, it is clear that non-compliance with treatment is a frequent antecedent of patient suicide. Avoidable Deaths reported around 200 suicides per year following non-compliance – 14% of all patient suicides. Better compliance with treatment and closer supervision were highlighted by clinicians as the main ways of reducing suicide risk. The Government aims to improve clinical risk management by introducing supervised community treatment (SCT) in the Mental Health Bill, currently in Parliament, and by revising the Care Programme Approach, following a recent consultation. Avoidable Deaths estimated that 56 patient suicides per year could be prevented by SCT.

The Mental Health Bill also addresses risk in patients with personality disorder (PD), removing the "treatability test" that must be applied before PD patients can be admitted for treatment under the Act. Previous research has shown a high risk of suicide in PD. Avoidable Deaths reported over 100 patient suicides per year in whom PD was the primary diagnosis.

6 *Safety First: Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness - 2001*
http://www.medicine.manchester.ac.uk/suicideprevention/nci/SAFETYFIRST2001.pdf

7 *Avoidable Deaths: Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness – December 2006*
http://www.medicine.manchester.ac.uk/suicideprevention/nci/Useful/avoidable_deaths.pdf

Self-Harm

A history of self-harm is associated with an increased risk of suicide. Around 40 per cent of suicides have a history of self-harm and at least one per cent of people who self-harm take their own lives within a year. We have established four centres to study the incidence of self-harm in England – the centres are in Leeds, Oxford, Manchester and Derby – and to provide accurate data on national trends and patterns in self-harm to help inform interventions and detect changing patterns or local variations.

In addition, the National Institute for Health and Clinical Excellence has issued comprehensive guidance on the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. CSIP's eight regional development centres continue to support local services in disseminating these guidelines to acute trusts and A&E departments.

Young Men

There has continued to be an encouraging and sustained fall in the rate of suicide amongst young men under the age of 35. However, the death rate from suicide amongst this high-risk group is still high in comparison with the general population. That is why we developed specific mental health promotion pilots in Camden, Manchester and Bedfordshire to try to encourage young men to seek help earlier and access services or support when in distress. The report of the evaluation of these pilots – Reaching Out – was published in June 2006. We now need to build on the knowledge and experience gained through these pilot projects to help services and other partners develop effective approaches to engage with young men.

Suicide by prisoners

70 apparently self-inflicted deaths occurred in English prisons during 2005/06. This was a reduction of 17% in comparison to the previous financial year, and should be seen in the context of the prison population containing a high proportion of very vulnerable individuals, many of whom have experienced negative life events that increase the likelihood of them harming themselves, e.g. drug/alcohol abuse, social disadvantage or isolation, previous sexual or physical abuse, and mental health problems.

Internal and external researchers continue to examine factors that make prisoners vulnerable to suicide and what interventions may be most effective to reduce suicidal and self-harming behaviours. This research includes a major study of a three-year, £26 million intervention that targeted the vulnerable populations in six local prisons (those that receive prisoners direct from court, often on remand). The study highlighted the importance of a whole-prison approach focusing on reducing distress amongst all prisoners, alongside individual mental health interventions for the most vulnerable. New research will include a study of prisoners who attempted suicide but survived.

Achievements during the past year include a continuation of improved staff skills and knowledge via newly developed training courses, particularly around mental health and around family liaison; and continuing expansion in mental health in-reach services into prison. The revised care-planning system for at-risk prisoners (Assessment, Care in Custody and Teamwork (ACCT)) developed jointly between the Department of Health, the Prison Service and National Offender Management Service (NOMS) has been introduced to a majority of the prison estate. Significant training and resources – supported via CSIP regions – continue to be committed to this initiative, which emphasises individualised care delivered through robust multidisciplinary team working.

NOMS's broad, integrated and evidence-based prisoner suicide prevention strategy takes an holistic approach seeking to reduce the distress of all who live and work in prisons and encompasses, through the decency and other agendas, a wide spectrum of the Prison Service's and the Department of Health's work (around such issues as mental health, drugs, resettlement, leadership and training) whilst not losing sight of those most at risk through interventions such as ACCT care planning, the provision of safer cells and increasing prisoner peer support.

From 1 April 2004, the Prisons and Probation Ombudsman, Stephen Shaw, has been conducting all death in custody investigations and in 2006 an independently chaired Forum for Preventing Deaths in Custody was formally set up to ensure lessons are learnt across custody settings.

Methods of suicide and access to means

Research has indicated that the likelihood of taking one's life will depend to some extent on the ease of access to, and knowledge of, effective means. One reason is that suicidal behaviour is sometimes impulsive so that if a lethal method is not immediately available a suicidal act can be prevented. Findings in this area include reducing access to domestic gas, reducing carbon monoxide emissions from vehicles, reducing the pack size of analgesics and installing barriers at sites that are hotspots for suicide. Chapter 2 provides the latest statistical data on deaths from suicide and injury (and poisoning) of undetermined intent by method and gender.

Measures that have already been taken to reduce the means of suicide include removing potential ligature points in in-patient psychiatric units and regular environmental audits of wards.

Each year in England and Wales alone there have been 300-400 fatalities following deliberate or accidental drug overdose involving Co-proxamol, the prescription only painkiller. Following a review of the risks and benefits of this drug, the Committee on the Safety of Medicines announced its phased withdrawal.

In October 2006, we published *Guidance on action to be taken at suicide hotspots*. Such sites provide either the means or opportunity for suicide, for example by jumping from a particular bridge in the same way that tablets supply the means of suicide by poisoning or overdose. This guidance provides advice to help identify particular hotspots and refers to evidence-based interventions that have proved effective at specific locations.

Primary Care Trust Audits of Suicide

Suicide prevention is a key national priority for all health and social services. Indeed all Primary Care Trusts (PCTs) have a responsibility to carry out suicide audit. There is a variety of suicide audit systems in place across the country. Some PCTs and specialist Mental Health Trusts have established local systems for collecting information whilst others have nothing apart from limited ONS data available to them. Four of the eight CSIP Development Centres collaborated with the Peninsula Medical School in producing a comprehensive population based audit toolkit which aims to support PCTs to establish robust systems to collect relevant information on suicides, which will help inform and improve local, regional and national suicide prevention strategies. The toolkit was piloted in a number of PCTs and was launched nationally in October 2006.

Research activity to establish the risk of suicide amongst black and minority groups and the lesbian, gay and bisexual population

Developing and improving the evidence base about, for example, high-risk groups and successful preventative interventions can only increase the effectiveness of the national suicide prevention strategy. It is difficult to establish the risk of suicide for people of differing sexual orientations or who come from different ethnic groups as these factors are not recorded when the death is registered or at the inquest. NIMHE has therefore commissioned research into the risk of suicide and self-harm amongst lesbian, gay and bisexual people and the risk factors for suicide and suicide attempts in different ethnic minorities. These studies will be completed in 2007 and we will consider how best to incorporate the findings into the work of the suicide prevention strategy.

The use of the Internet and suicide

A new issue that has come to light over recent years is concern about Internet sites and chat rooms that may encourage people to take their own lives by giving detailed information about methods of suicide and allowing those who may be contemplating suicide to communicate with each other. NIMHE has been working across government departments on non-legislative action that we might be able to take to discourage such sites, including:

- raising awareness of the potential dangers of such websites/chat rooms being accessed by vulnerable people, and
- exploring ways of ensuring that search results give prominence to sites offering help and support to people contemplating suicide.

In addition, the Department of Health, the Internet Service Providers Association and the Samaritans are working together to look at ways of supporting vulnerable people who may be accessing these sites, building on practices that are already being adopted by some of the larger and more responsible providers.

Papyrus, a voluntary organisation committed to the prevention of young suicides, has published guidance for parents about the risks of the Internet.

Mental Health and Well-being

Although mental health service users are a high-risk group, 75 per cent of suicides are by people who are not in contact with mental health services. This is why Goal 2 of the national strategy focuses on the need to promote the mental well-being of the **whole** population in line with Standard One of the *National Service Framework for Mental Health*[8].

The National Advisory Group for Mental Health Promotion commissioned *Making it Possible – a good practice guide to improving mental health and well-being*[9]. It identified the ten priority areas for action where there was the best evidence that interventions could be effective, and set out the simple positive actions that everyone could take to maintain their own mental well-being.

In 2006 the latest white paper *Our Health, Our Care, Our Say*[10] contained a commitment to make these health promotion messages more widely known by including mental health in the National Social Marketing Strategy and ensuring that every area has a mental health promotion strategy in line with the best practice set out in Making It Possible.

8 *National Service Framework for Mental Health. DH 1999 http://www.dh.gov.uk/assetRoot/04/07/72/09/04077209.pdf*

9 *Making it possible: Improving Mental Health and Well-being in England. CSIP 2005 http://kc.nimhe.org.uk/upload/making%20it%20possible%20Final%20pdf1.pdf*

10 *Our health, our care, our say: a new direction for community services. DH 2006. http://www.dh.gov.uk/assetRoot/04/ 12/74/59/04127459.pdf*

Over the past year, mental health officials have been fully involved in the development of the social marketing strategy, and action has been taken to ensure that mental health promotion is included in the annual service mapping process for 2007. A framework has been published, based on Making It Possible, to assist Local Implementation Teams to undertake a stocktake of their activity.

A quarterly newsletter has been produced during 2006 to support regional and local health promotion work which is co-ordinated by the CSIP Development Centres through their Standard One networks.

Summary of Priority Activity in 2007

Although we continue to make steady progress in implementing the many actions outlined in the suicide prevention strategy there are areas that we need to give greater prominence to over the next twelve months. These include:

- taking forward the recommendations of the media guidance on ways to improve the way suicides and suicidal behaviour are portrayed in the media
- ensuring that the knowledge and experience gained through the young men's mental health promotion pilots support practitioners and other agencies in developing effective approaches to engaging with young men
- ensuring effective promotion and dissemination of the bereavement pack – Help is at Hand – to ensure those who come into contact with bereaved people are able to offer appropriate support
- further improvements in the care of people in contact with mental health services, including taking steps to incorporate the findings of the latest NCI report into clinical practice. This includes action to reduce absconding from in-patient ward areas. We will also need to consider the findings and conclusions of the review of open doors in acute in-patient wards areas when completed
- further work with people who self-harm
- promoting the mental health of older people. A commitment to working with the Older Persons Mental Health programme to promote the mental well-being of older people with or at risk of mental health problems.
- publishing the findings of the BME suicide research project and taking forward action as part of the Delivering Race Equality programme, and
- The research into the risk of suicide and self-harm amongst lesbian, gay and bisexual people will be published in the summer. We will need to consider the report's conclusions, including recognising LGB people as a group who have special mental health needs under goal 2 of the strategy.

Conclusion

The strategy is an evolving document and will develop over time in the light of progress made, adapting our approach where necessary. It will be subject to regular annual review and evaluation.

CHAPTER**TWO**

STATISTICAL INFORMATION

Introduction

Official suicides are those in which the coroner or official recorder has decided that there is clear evidence that the injury was self-inflicted and the deceased intended to take their own life. Open verdicts or undetermined injuries are those where there may be doubt about the deceased's intentions. Research studies show that most open verdicts are in fact suicides. For the purposes of measuring overall suicides in England, official suicides and open verdicts are combined.

Details are collected when deaths are certified or registered. Most deaths are certified by a medical practitioner; however, suspected suicides must be certified after a coroner's inquest. Statistics on the cause of death are collected by the Office for National Statistics and are passed to the Department of Health on an annual basis.

Suicide numbers and rates

The number of suicide deaths refers to the actual number of people who have died by suicide or injury (and poisoning) of undetermined intent.

The rate of suicide refers to the frequency with which suicide occurs relative to the number of people in a defined population. This age-standardised rate takes account of changes in the size and age structure of the population to provide a comparable trend across time and across different areas.

The suicide prevention target

The target is to reduce the death rate from suicide and injury (and poisoning) of undetermined intent by at least a fifth by the year 2010. The target is measured using three-year pooled rates. Three-year rolling averages are generally used for monitoring purposes, in preference to single year rates, in order to produce a smoothed trend from the data and to avoid drawing undue attention to year-on-year fluctuations instead of the underlying trend.

Current Position

The target is to reduce the death rate from a baseline rate of 9.2 deaths per 100,000 population in 1995/6/7 to 7.3* deaths per 100,000 population in 2009/10/11. Figure 1 shows the latest available data (for the 3 years 2003/4/5) showing a rate of 8.5 deaths per 100,000 population – a reduction of 7.4 per cent from the baseline.

** this target was revised from 7.4 following a change in the methodology used by the Office of National Statistics to record the cause of death*

The three-year average rate rose in the period immediately following the setting of the baseline. The rate has since fallen and progress is now towards the target. Although over the last five years there has been sustained progress towards the target, the rate of decline has slowed, and if the trend of the last five or ten years were to continue, the target would not be met.

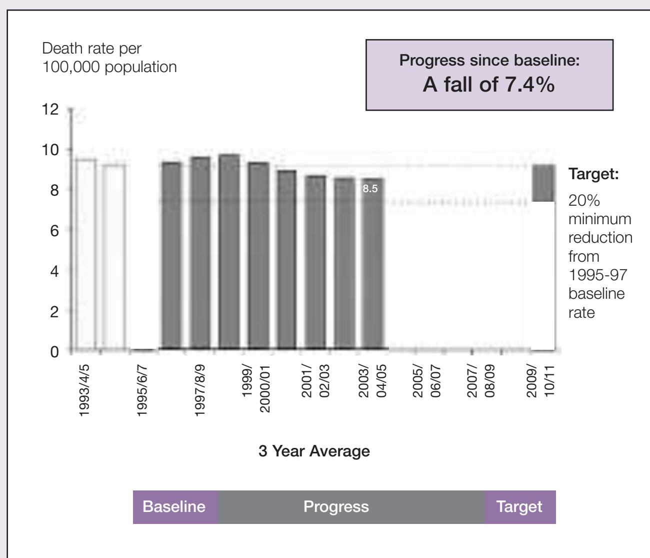

Figure 1: Mental Health PSA Target – *Death rates from Intentional Self-harm and injury of Undetermined Intent excluding 'Verdict Pending' in England 1993-2005 and target for the year 2010, all persons.*

Rates are calculated using the European Standard Population to take account of differences in age structure.

The suicide rate for the year 2005, the most recent available, was the lowest recorded, reversing the slight rise in 2004. The European Age Standardised Rate (EASR) was 8.4 per 100,000 population, however this shows little change since 2002, when the suicide rate was 8.6 (see figure 2).

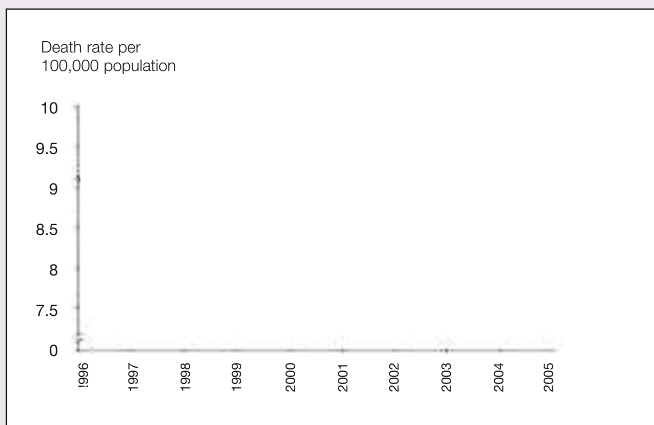

Figure 2: Suicide Mortality – Trend in single year rate – *Death rates from Intentional Self-harm and Injury of Undetermined Intent excluding 'Verdict Pending' in England 1993-2005, all persons.*

Rates are calculated using population estimates based on 2001 census. Rates are calculated using the European Standard Population to take account of differences in age structure.

The majority of suicides continue to occur in young adult males (figure 3 below) – that is those under 40 years. In relation to women of the same age, younger men are more likely to commit suicide. The peak difference is the 30-39 age group where there are 4 male suicides to each female. The average ratio between men and women of all ages is almost three male suicides to each female. Once people pass 50 years of age, the ratio stabilises at around 2.5 male suicides to each female.

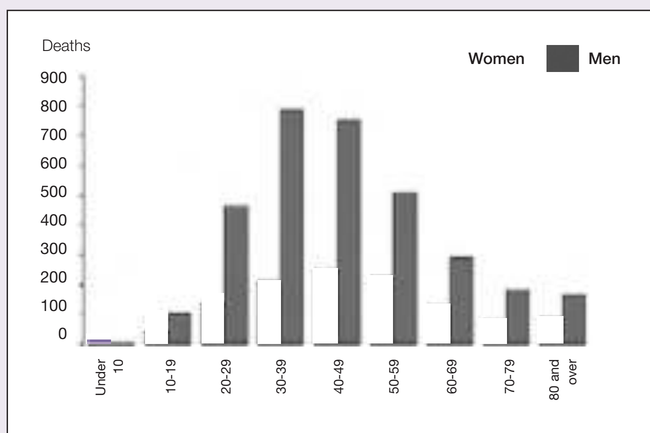

Figure 3: Age pyramid – *Deaths from Intentional Self-harm and Injury of Undetermined Intent by ten year age band and sex, England 2005.*

In the last thirty years of the 20th century, suicide rates had fallen in older men and women but risen in young men. We are now seeing evidence of a sustained fall in suicide among young men in recent years, although the rate remains high in comparison to the general population (see figure 4).

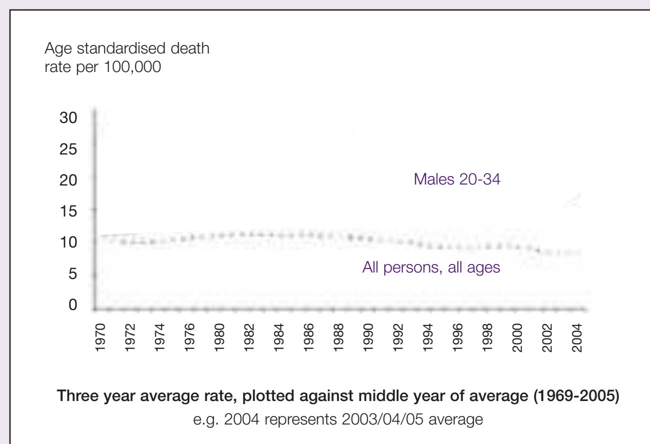

Figure 4: Trend in suicide rate for young men (aged 20-34) – *Death rates from Intentional Self-harm and Injury of Undetermined Intent, England.*

Rates are calculated using population estimates based on 2001 census. Rates are calculated using the European Standard Population to take account of differences in age structure.

The latest data, covering calendar year 2004, show that the number of in-patients taking their own life in England has fallen from 217 in 1997 to 154 in 2004 (see figure 5).

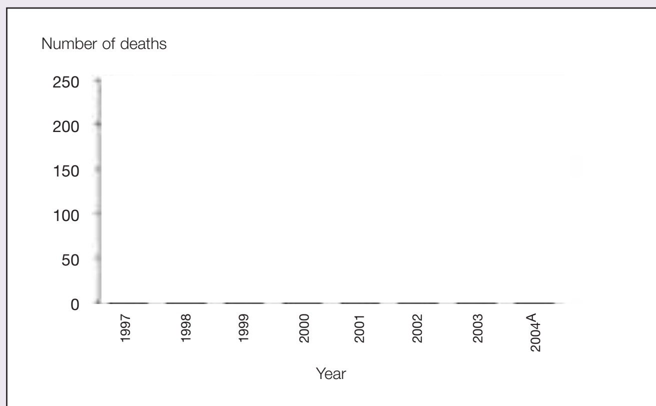

Figure 5: In-patient suicides, persons, England 1997-2004*

* Includes projected figures to account for incomplete data, projected figures are shown to provide the most accurate number of cases expected for the given time period, projected figures may vary annually according to changes in the baseline data.

A **Note:** data for 2004 are 94 percent complete.

Whilst in-patient suicides have shown a welcome fall, suicides by people in contact with mental health services in the year prior to death show an increase in 2004. The projected figure is calculated from the proportion of questionnaires that have been returned on the number of cases identified in 2004 to date. The projected figure for 2004 is an estimate based upon the current 94% questionnaire response rate and will change as questionnaire return improves (see figure 6).

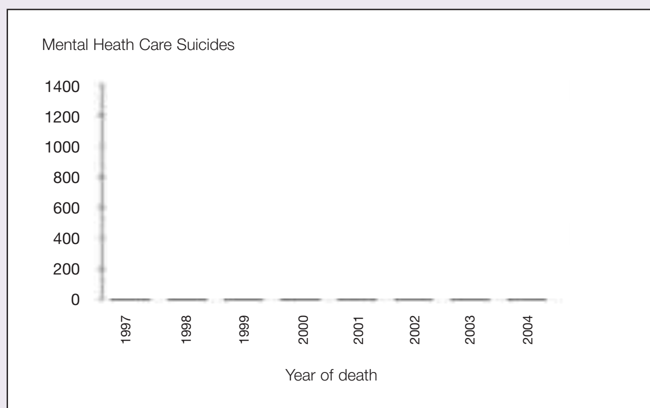

Figure 6: Inquiry suicides, from questionnaires (in 12 months prior to death) – *England 1997-2004*

Projected figures are shown to provide the most accurate number of cases expected for the given time period, projected figures may vary annually according to changes in the baseline data.

Figure 7 shows the number of self-inflicted deaths in prisons for England for the financial years 2000/01 to 2005/06. 70 apparent self-inflicted deaths occurred in English prisons during 2005/06. This was a reduction of 17% in comparison to the previous financial year.

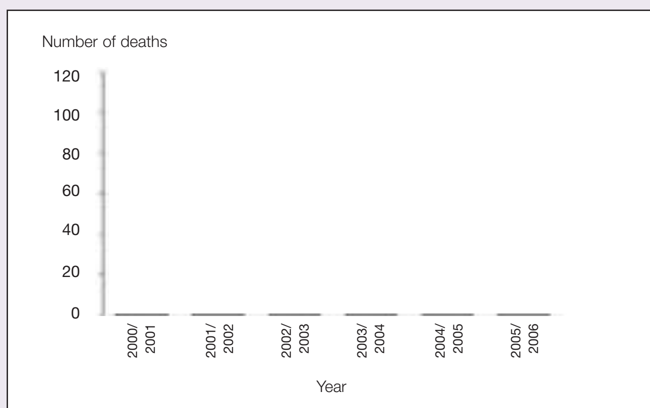

Figure 7: Self-inflicted deaths in prision – *England*

Historic figures are subject to minor changes when inquest verdicts differ from initial classification.

The Prison Service/NOMS statistics are based on deaths categorised as 'self-inflicted deaths.' This differs from the definition of 'suicide' quoted in the introduction. They do not only count the number of deaths that receive a 'suicide' or 'open' verdict at inquest, but any death where it appears that the person may have acted specifically to take his/her own life. The classification used for apparent suicides is therefore much more inclusive than the definition used in community suicide statistics.

Hanging and suffocation is now by far the most common method of suicide for men, accounting for half of all male suicide deaths. The relative importance of drug related or other poisoning (including motor gas poisoning) has decreased accordingly. Among women, drug related poisoning is still the most common method of suicide, accounting for 40% of all female suicide deaths, but hanging and suffocation now account for almost a third of all female suicides and is the second most common method used (see figure 8).

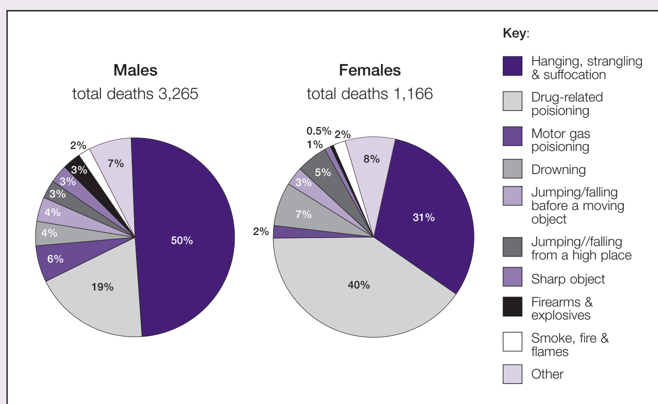

Figure 8: Deaths from Suicide and Undetermined Injury by method and sex – *England 2005*

Figure 9 shows the latest 3 year average rates of suicide by English Strategic Health Authority and by gender.

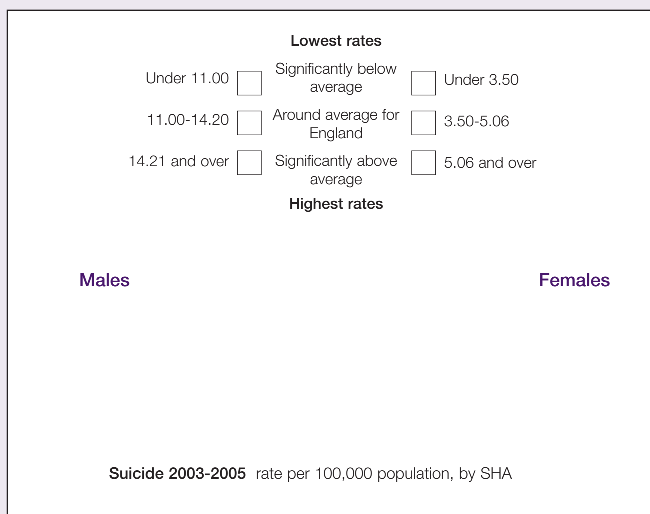

Figure 9: Geographic Distribution of Suicide, 2003-2005 – *Death rates from Intentional Self-harm and Injury of Undetermined Intent excluding 'Verdict Pending' in England (average of three years 2003-2005)*

CHAPTER**THREE**

IMPLEMENTING THE SUICIDE PREVENTION STRATEGY THROUGH DEVELOPMENT CENTRE ACTIVITY

Introduction

CSIP's development centres are key to the delivery of the suicide prevention strategy, providing tailored support to local communities and working in partnership with a range of different stakeholders. They continue to stimulate and encourage innovation and support local communities to implement the strategy priorities in ways that fit local circumstances. This chapter provides a snap shot of some of the activities taking place through development centres to enable us to reduce suicides in our communities. **Contact details for each development centre are included and further information can be found at *www.nimhe.csip.org.uk***

North East, Yorkshire and Humber (North East)

Within the area, a particularly innovative piece of research has recently been completed by a team of professionals in Tees, Esk and Wear Valley NHS Trust. The research was originally undertaken in County Durham and Darlington but the lessons are now being learned across Teesside and eventually the region as a whole. The findings are due to be published in February 2007 and an excerpt is included in the paragraphs that follow.

Understanding the agencies people who take their own lives have contact with prior to suicide is an important part of suicide prevention. Durham & Darlington's Multi-Agency Suicide Prevention Task Force has researched the frequency and nature of contact with a number of agencies.

Of particular note is contact with the Criminal Justice System. It has been found that nearly 25% of people who take their own lives had a registered contact with a police officer within three months of death with an equal mixture reporting crime and being arrested for crime. (Linsley et al British Journal of Psychiatry, in print February 2007). There was a wide spectrum of crimes in each category.

Nationally, only around 25% of people who complete suicide have been involved with mental health services in the year before death. Thus, **as many cases see a police officer within 3 months of suicide as see a mental health professional within 12 months of suicide.**

It should be remembered that the police will see a good deal more people who they do not record contact with; such as 'rescuing' people who are considering jumping, Section 136 cases and informal contacts for incidents not recorded as crime. The figure is thus likely to be greater than 25%.

Liaison with senior officers has identified a willingness to develop information sharing protocols and pathways for the police to seek help/advice for individuals potentially at risk. Exactly how this should operate requires more discussion and it is anticipated that training for police and support from health agencies will be needed to supplement this. **Training and**

communication pathways may help to reduce suicide in this group of vulnerable people.

The facility for the police to be able to communicate with health professionals, we believe, needs to be encouraged and emphasised by the high proportion of these suicides that were found to be simultaneously attending health professional clinics.

We propose these protocols include a number of levels of action **that apply to victims as well as alleged offenders**. For example, previous liaison between Mental Health Services and the criminal justice system has tended to focus on alleged or convicted perpetrators of crime. The levels of action will depend on local support structures and the immediacy of any risk identified.

Of course, other agencies that deal with victims and offenders will also see vulnerable individuals; such as probation, domestic violence, victim support and sexual assault support services. It is likely these groups will benefit from similar training programmes as the police on recognising suicide risk factors.

North East, Yorkshire and Humber (Yorkshire and Humber)

Following a number of incidents around the M1 Junction 37 (Barnsley) in late 2005/early 2006, the Highways Agency commissioned Carrillion WSP to carry out a study into the issue of bridge related suicides on the Area 12 Network. The study was to examine the feasibility of developing an Area 12 strategy to reduce the number of suicidal incidents occurring on the Network, relating primarily to jumping from high places such as bridges.

The study coincided with the preparation of the 'Guidance on Action to be taken at Suicide Hotspots' and it was therefore based on its recommendations.

A stakeholder steering group was formulated and actions taken so far are that Barnsley PCT have provided, in conjunction with the Highways Department and Barnsley Metropolitan Borough Council, Samaritans signage situated on six motorway bridges and one local reservoir.

The study is currently at a stakeholder consultation stage and publication of the final document is imminent.

Further to this, a Public Health Report is being based upon their 5 year Suicide Audit and the PCT is currently in the process of updating and reviewing Barnsley's Mental Health Promotion and Suicide Prevention Strategy. An action plan and additional sub groups to undertake and implement action recommendations are planned.

In Hull and East Riding, a suicide prevention help line card has been developed with supporting flyer and website access for extended information.

50,000 cards have been distributed across Hull and the East Riding – GPs, pharmacies, mental health campaign, voluntary sector, prisons, acute sector, libraries, local authority customer service centres, colleges and university, police custody nurses, minor injury units, mental health services, etc. There has been very positive feedback.

The card and a description of the information on it can be found at *http://www.heros.org.uk/misc_sub.asp?page=195*

They are now developing a card for black & minority ethnic communities in a range of languages, encouraging people experiencing low mood to seek help from doctors, and a directory of mental health information available in other languages. This will be ready by the end of March 2007.

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West Midlands

Throughout the past twelve months, CSIP West Midlands has supported and provided a range of initiatives to maintain a "Combined Approach" to suicide prevention, continuing to reduce suicide among people who were not in contact with mental health services as well as those who were. Significantly increased involvement of Public Health Leads and non-mental health agencies over the past twelve months has resulted in most mental health trusts developing genuinely combined suicide prevention strategies. (See fig.1 below.)

An effective way of raising awareness of the issues that need to be addressed – leading to stronger strategic relationships and wider ownership of suicide prevention plans – has been numerous theatrical performances of "Revolving Door" by the Hearth Theatre Company.

Following every powerful performance the audience has been engaged in discussion about the issues raised and what could have been done to prevent the suicide. There is also the option for the audience to talk with the actors, who remain in character, thus deepening their understanding. In the next twelve months we will go on to modify this performance to address more specific issues such as younger people, bullying and minority ethnic groups.

We have also begun to look at the issue of suicide prevention within rural communities through consultation and meetings jointly facilitated by CSIP West Midlands and the West Midlands Government Office. This has raised the importance of the role of small non-statutory organisations working *as part of their local communities* to promote health and reduce suicide.

These organisations need more appropriate commissioning strategies and developmental support in order to meet the increasing expectations put upon them of working more closely with mainstream services. Work has already begun around working with small agencies, particularly in rural settings, to address this point.

Another area that we have drawn attention to is suicide prevention amongst older adults and our first significant step was to commission Staffordshire University to conduct a literature review outlining the key issues. In addition to the literature review, there are five fact sheets which will be distributed to health and social care teams across primary, secondary and non-statutory organisations. A conference took place in March 2007 with follow-up work planned for 2007-2008.

Attention to the "secondary" elements of the combined approach, that is suicide prevention in relation to people in contact with mental health services, naturally continues. This year we completed the production of the Environmental Audit tool and provided training to suicide prevention leads across the West Midlands.

Building on the importance of gathering audit data, we have begun work with some Public Health Consultants around population wide audits of suicide with the aim of identifying any geographic, demographic or systemic "hotspots" of increased number of suicides that require additional attention.

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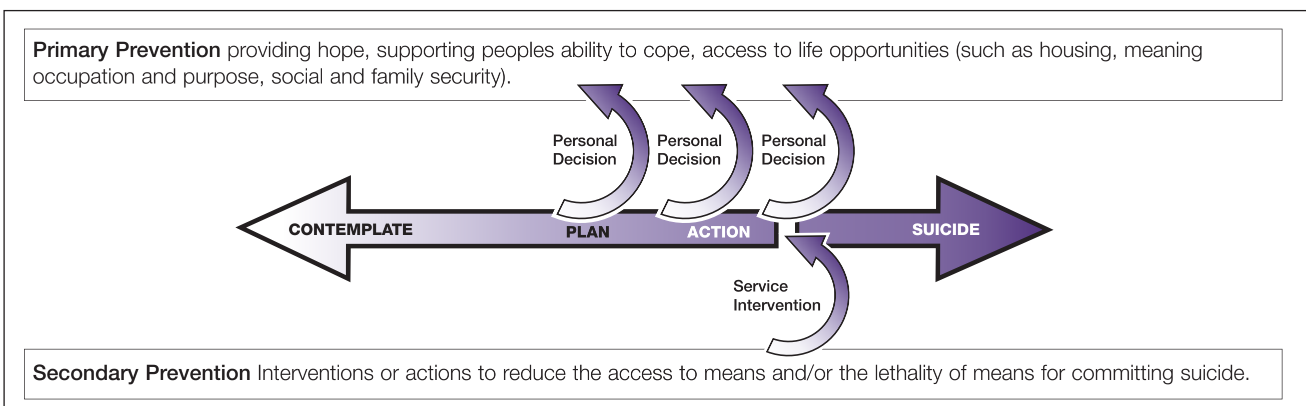

Figure 1: A Combined Approach of 'Primary' and 'Seconary' Suicide Prevention Methods.

London

Whilst the overall rate of suicide amongst the general population in England is at the lowest rate on record, across London, suicide rates continue to vary considerably with the rate in inner London areas being much higher than the England average and in outer areas, much lower. Self-harm has also been identified as a significant issue and whilst there are some limitations in the data concerning suicide hotspots, London does seem to have higher numbers of suicides due to jumping from high places and jumping/falling before moving objects than elsewhere in the country.

In 2006, the London Development Centre (LDC) has implemented a number of activities to support suicide prevention work in the capital. These include the setting up of an advisory group of experts in the field of suicide prevention to support the development centre in disseminating the key messages from the LDC and London Health Observatory 2005 report *Deaths from suicide and undetermined injury in London* (De Ponte, 2005). Group members include representatives from the London Councils, the London Health Observatory, London Underground, several Primary Care Trusts (PCTs) and various university departments engaged in research into suicide and suicide prevention.

The group, which provides an ideal vehicle for developing links with various organisations, from both the voluntary and statutory sectors, is working with the LDC to identify key networks and organisations in London to be targeted in dissemination and training activities. Its expertise will also be drawn on to review the national experience of suicide prevention work and how this may be applied to London.

Already, the group has flagged up a number of groups in the capital that may need focused activity in the future and these include the large student population in further education and university facilities. The Responses and Prevention in Student Suicide (RaPSS) research study by the University of Central Lancashire and PAPYRUS, a national charity working to prevent suicide in young people, has highlighted the particular risks and vulnerability factors which may be present in student suicides, with one of lead researchers from the study being on the LDC advisory group. Findings from RaPSS also indicate that there are considerable gaps in data about this section of the population that undermine the development of effective responses. (For further information about this national study, please see *www.rapss.org.uk*).

Another strand of LDC suicide prevention work in London in 2006 has been to map suicide prevention activity at the local authority or PCT level and to support the sharing of information about local activity and about 'what works' across different London PCTs. This has brought forth mixed results.

London's very diverse and often mobile population poses particular challenges, likewise the heavy demands often placed on in-patient mental health services and the difficulties of recruiting and retaining experienced mental health practitioners including those able to provide psychological therapies. Addressing the heightened risks of suicide amongst young men and those from minority ethnic groups is reflected in some activity reported including the development of new outreach services targeted on specific ethnic groups, the continuation of funding to projects aimed at supporting young men and tackling stigma and work with local community groups to increase local understanding of where people can access help. The training of frontline professionals in cultural awareness has also been noted in a number of London authorities.

The increased risk of suicide occurring in the period following discharge from an in-patient mental health facility has been well documented. This makes the provision of good post-discharge support absolutely essential and it has been heartening to find across the London region a variety of initiatives now underway to address this issue. Activity includes: the implementation and roll out of the Care Programme Approach (CPA); the development of Assertive Outreach Teams to prevent loss of contact with high risk groups and investment in new schemes to provide counselling, other talking therapies and support services for people with mild to moderate mental health needs, particularly those from BME communities.

Another key strand of this activity has centred on improving early identification and risk assessment policies and procedures, also the identification of interagency risk pathways. Work on procedures in Accident & Emergency (A&E) Departments for ensuring follow-up for self-harm presentations who leave without treatment, the development of emergency contact cards for people attending A&E and funding for psychiatric link workers at A&E have been noted, alongside such measures as the implementation of NICE guidance on self-harm and use of the STORM training package. Initiatives focused on children and young people are evident too, with an array of training, support, anti-bullying and awareness-raising activities taking place in the capital's schools.

At the other end of the age range, in several areas of London, plans are noted for GP surgeries to provide information on social support groups and activities for older people to reduce social isolation. There is also quite widespread interest in developing bereavement services and in the promotion of safer prescribing of antidepressants and analgesics, including the development of nurse liaison posts to assist GPs in this area of work.

Finally, improving the range and quality of data available about suicide is evident in many of the plans reported to the DC. This includes work with the coroner's office, the use of audit tools (the centrally produced toolkit being disseminated) and Clinical Governance Team Reviews of the recording of 'unexpected deaths' data.

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Eastern

2006 saw the development of suicide prevention master classes in the region. The events were aimed at bringing primary care; specialist mental health services; community partners for example school nurses and agencies from the third sector and representation from service users and their carers.

The master classes were designed to focus on specific areas of concern for example self-harm among young people. Keynote speakers were invited and workshops were facilitated to consider particular topics.

The aims of the master classes are

- To promote a partnership approach to the issue of preventing suicide
- To create an atmosphere of understanding of the difficulties that the different agencies and their client group face
- To help clarify the role and responsibilities of the differing agencies
- To establish clear and coherent pathways of care
- To give clarity to the recognition of at risk individuals
- To offer an environment which encourages the exchange of ideas and skills
- To promote and consider available research
- To establish evidence based practice utilising the resources of the wider community
- To consider the particular needs of the region, for example access to services and support in rural communities
- To promote networking and establish links
- To establish a database of resources for the region, and
- To enable services to develop an approach to suicide prevention with the direct experience of service users and their carers.

The objectives of the master classes are aimed to promote those of the national strategy and encourage the well-being of the whole community.

The classes will be an ongoing, rolling programme and will continue throughout 2007. The dates and themes for the sessions have already been planned.

Members of the master classes have an input into themes for future events and have highlighted issues such as alcohol and drug misuse and specific rural perspectives.

The master classes also provide a forum to plan for the future in response to regional need, for example the demographic changes in rural communities.

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South East

A major part of the suicide prevention activity in the South East has been the commissioning of local organisations to carry out specific programmes of work as a contribution to achieving the aims of the national suicide prevention strategy. Local projects have included work to improve the provision of self-harm services in Accident and Emergency Departments, spreading the ASIST (Applied Suicide Intervention Skills Training) model of "first aid" suicide prevention training, and work with "hard to reach" groups at high risk of suicide but not in touch with mental health services.

One example of the "hard to reach" projects is the two year project by the West Sussex Public Health Network to combat suicide in men aged over forty. Much attention has been paid recently, and quite rightly, to the high suicide risk in young men, but we must not overlook the fact that suicide risk remains high in men through middle age and into old age. The project has now reached the halfway stage, and a promising start has been made in reaching out to older men through a variety of means. The project has four main aims:

- To develop, implement and evaluate an awareness raising campaign aimed at the target group (men over 40) highlighting the factors that can contribute towards an increased risk of suicide and signposting sources of help
- To develop, implement and evaluate a campaign to raise awareness of the suicide risks in the target group among service providers in both the statutory and voluntary sectors, and develop appropriate pathways of support
- To work with specifically targeted GP practices, to develop strategies to encourage men to attend routine health checks, which would include mental health screening and identification of factors which may contribute towards an increased risk of suicide, and

- To design and provide training sessions for statutory and voluntary health and social care providers and community services to increase awareness of suicide risks, consolidate campaign messages, and increase knowledge of sources of help and advice.

The method chosen for the first aim was to develop a beer mat campaign and use local pubs for its distribution. A multi-agency approach was adopted, involving West Sussex Primary Care Trust, United Response, Chichester District Council, Sussex Police and Pub Watch. Beer mats, credit card sized resources and posters outlining ways to access help during difficult times were distributed throughout nine pubs in Chichester and Bognor during the week of World Mental Health Day, 10th October 2006. The beer mats featured an engaging cartoon of a man trying to lift a heavy weight, accompanied with phrases such as “Are you trying to carry more than you can handle?” and “Can’t do it?”. On the reverse side of the mat “If things are getting too much, you could talk to….” Followed by five suggestions, including GP, West Sussex Mental Health Line (with telephone number), friends and family, Samaritans (with telephone number), and a BBC men’s health website.

The resources were placed in various locations in the pubs, including openly on bars, and discreetly in the toilets. Coverage of the campaign was obtained on various local radio stations during the week. Following the week’s activities, pub managers were interviewed and an evaluation carried out. Feedback varied, and it is impossible to be sure of the effects of the campaign, but it is clear from take up of the resources and several specific comments that the campaign was noticed by the target audience, and in one case definitely acted on. Most of the pub managers felt that the location was ideal to reach men in emotional distress, that there was a strong link between sale of alcohol and emotional distress, and felt the campaign was worth running again.

As part of the fourth aim above, to provide training sessions, a qualified ASIST trainer presented a four-hour suicide awareness workshop to car park attendants from a high-rise car park in West Sussex which has seen 3 fatal suicides and 17 attempted suicides in the past two years. This was the first suicide awareness training that the attendants had received, and their evaluations of the training were very positive. A six-month follow up evaluation is also planned, together with the supply of resources to support interventions and suggest pathways to care.

Another feature of the project has been the provision of a Samaritans listening scheme to selected GP practices in Bognor and Horsham. This initiative allows doctors to organise for a Samaritans volunteer to contact a patient by telephone and provide confidential emotional support as required. Samaritans are keen to emphasise that patients do not have to be actively suicidal to participate or benefit from the help on offer. The service is initially being supplied free of charge and in the majority of cases has resulted in patients requesting further callbacks from the Samaritans. Work to provide meaningful feedback to GPs on the value of the work is ongoing.

Work will continue over the final year of the project, particularly to support the second and third aims, and to find ways to make the encouraging development of local partnerships in suicide prevention work with this important high risk group sustainable in the longer term.

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South West

The South West has had a particular focus on the needs of offenders across a number of the regional development programmes. We have sought to increase the attention on the needs of offenders in the community and promote the scope for improved services.

Research on the help seeking behaviour of prisoners on release which we commissioned from the Peninsula Medical School has reported. It will contribute to the evidence on the factors which inhibit offenders from accessing treatment and support for mental health issues from health and care staff (Professor John Campbell and David Hess). A follow up study is underway with the Probation Service. It is looking at the arrangements currently in place for identifying, assessing and managing mental distress and risk of self-harm and suicide in prisoners on licence and at how probation officers perceive and perform their roles (Dr Christobel Owens).

Our Prison Primary Mental Health Care Development Worker has provided the following;

'By the end of 2006 all prisons in the South West are implementing the ACCT Process. (Assessment, Care in Custody and Teamwork), which has replaced the 20/52 process for those in prison at risk of self-harm or suicide. All those working with prisoners will have had ACCT awareness training. ACCT assessors (may or may not be healthcare staff) have specific training in assessing those at risk including 2 days mental health awareness training. The ACCT process joins up all the various agencies involved with the person at risk including primary and secondary mental healthcare who contribute to the case reviews as necessary.

Working closely with the safer custody lead, mental health awareness training has been delivered to 578 people in South West prisons in the last year and at present the South West is contributing to the further development of this process at a national level. The target is for 20% of all operational staff in prisons to have had mental health awareness training. In addition, mental health awareness training to prisoners who are "Listeners" has commenced and will continue throughout this year. The delivery of mental health awareness training has been a good example of agencies working together to not only recognise mental ill health but to promote mental health within prisons. The recognition of mental ill health is facilitating referral to Primary Care Services at an earlier stage from agencies across the prisons, leading to improved choice for patients and impacting on self-harm and suicide rates.

Developing Primary Mental Health Care provides opportunities to facilitate multi agency and cross sector working and is an integral part of the person's journey through the criminal justice system through custody and after release. Within prison Primary Care services it has been essential to establish links with the patient's community primary care services ahead of release to enable continuity of care upon release and to enable the released prisoner to access services. This also involves making links with agencies such as probation, housing, drugs and alcohol services. As these agencies start to work together in prisons and after release, there should be a positive impact on the number of suicides of those recently released from custody.

Resource Packs giving information on local services have been issued to all prisons in the South West. Resources were not only identified in the prison but also in the local community. This is part of the process to provide better access to services in Primary Care when prisoners are released. Building on this it is planned to include the Probation Service and Bail Hostels in further development. The NACRO report "Mentally Disordered Offenders South West Scoping Survey" highlights the gaps in establishing the health care needs of offenders in the community and makes general suggestions about what arrangements should be in place. It aims to assist CSIP in the promotion and delivery of the South West Health and Social Care in criminal justice programme.

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East Midlands

Department for Environment, Food and Rural Affairs (Defra)/CSIP East Midlands Funded Project

This project was set up and managed by the Suicide Prevention Steering Group for Leicestershire & Rutland. The partners in this project constitute the following:

- Lead – Melton, Rutland & Harborough Primary Care Trust
- Lead – CSIP (East Midlands)
- Rural Stress Support Team
- Safer Custody Group (HM Prison Service)
- Peoples Forum – Leicestershire
- Survivors of Bereavement by Suicide
- Social Services
- Leicestershire Counselling Service
- MIND, and
- Various Mental Health representation from the 5 other PCTs in Leicestershire.

The sole area of work covered by the Steering Group is the prevention of suicidal behaviour through the production of a suicide prevention strategy for Leicestershire and Rutland.

The aim of this Defra/CSIP funded project, set up in September 2005, was to:

- Reduce the level of suicidal behaviour in Leicestershire and Rutland across the farming/agricultural community
- Target areas for training programme that include those people who have contact with persons in high-risk occupational groups such as farming, agricultural workers and vets/veterinary linked occupations
- Provide suicide/self-harm awareness training for groups in contact with members of the farming community associated occupations, and
- Improve access to support both in the voluntary and statutory sectors for those persons at high risk (particularly, those in the farming/agricultural community) of suicidal behaviour throughout Leicestershire and Rutland.

Leicestershire and Rutland comprises a vast farming and agricultural community with many isolated farmers, farm managers, and farm workers. The Suicide Prevention Steering Group (Leicestershire & Rutland) identified a range of 'contact groups, agencies and individuals' for farmers in the local farming community. These included: Citizens Advice Bureau, Cattle Market Managers, Church Groups, clergy, National Farmers Union representatives, bank staff, GPs, vets, teachers, youth workers. These groups were invited to take part in a suicide awareness training programme, which provided a 'take away' toolkit/support package. The training programme and package covered:

- Suicide and suicidal behaviour – risk factors
- Myths about suicide
- Recognising risk factors (mental health problems, social factors etc.)
- Helping (interpersonal), and
- Helping (information and advice).

There were a number of evident reasons why this project was important to the targeted rural area:

1) The counties of Leicestershire and Rutland are traditionally agriculturally focused, though as with all farming areas they are facing the hardships and changes associated with the dairy sector and the CAP Reforms
2) There is a need to make training accessible to relevant groups in the local rural area and increase access to such information
3) Stigma of seeking help in the agricultural industry prevents farmers and farm workers from visiting their GP. Knowledge from RSST indicates that farmers, farm workers and other are more likely to discuss problems with vets or indeed other contact agencies.

Finally, working directly and providing training to those groups identified will help challenge stigmatising attitudes towards mental health problems that may be prevalent in any given community. Taking an educational approach with these groups will mean that such information will be shared among the associated community groups.

Outputs

- 30 (first 6 supported by CSIP start up funding) training sessions delivered during the 2.5 year period throughout Leicestershire and Rutland
- 300+ people trained in Suicide Prevention and Awareness across the 4 rural PCTs of Leicestershire and Rutland on an annual basis, and
- Production of detailed and user-friendly Resource Pack providing all delegates with a source of reference and information to assist them when faced with a person at risk of attempting suicide. This resource pack will be distributed to a myriad of organisations including GP's practices, National Farmers Union and Education departments for dissemination of information amongst their employees, area offices etc.

Outcomes

The ideal result of the training would be a reduction in suicidal behaviour throughout Leicestershire and Rutland; this will be achieved through the outcomes below:

- An increase in the number of people accessing support from both the voluntary and statutory sector relating to mental health needs
- Reduction in the barriers and stigma attached to seeking support relating to mental health and suicide
- Improved mental health amongst high risk occupational groups including farmers and those associated with the industry
- Increase in GP's knowledge of support services and greater numbers of referrals to voluntary sector support services for mental health, and
- Wider understanding of suicide awareness.

Current position

At present, a full pilot has been completed and a set of the first training sessions have been completed. Evaluations of the pilot sessions have been very positive and participants are reporting positive effects of undertaking the training. The group will now set out to implement the rest of the training over the next 2 years.

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North West

S-Kit: Suicide Prevention Local Implementation Framework

Over the last year, CSIP North West has been working with local Suicide Prevention leads to produce and implement the S-Kit – a toolkit for producing and reviewing local suicide prevention strategies. Within the region, there was variability in localities producing strategies and in the comprehensiveness of the documents. The S-Kit was produced alongside delivering a programme of support to localities, e.g. facilitating local multi-agency workshops, co-ordinating a regional practitioners network.

The development work identified 3 critical questions and support needs from Standard 7 Leads tasked with the responsibility of developing local strategic approaches to preventing suicide:

- How do you start developing a strategy for suicide prevention?
- What does a strategic approach to suicide prevention look like?
- How will I know if it has any real impact and how can I measure this?

The S-Kit was developed collaboratively with local leads and the development centre employed one of the local leads, as an associate, to undertake the research, produce the document and test it with peers.

The S-Kit is designed to act as a benchmarking tool. It contains a set of standards for each of the national goals, based on evidence, best practice and policy recommendations. Each standard relates to the actions that could be incorporated into local strategies and is referenced with supporting evidence and a lead organisation is suggested. Partnership working and multi-agency responsibility for suicide prevention is an underpinning recommendation of the S-Kit.

The S-Kit has been disseminated to all localities. Those with existing strategies have used it to review and update their action plans, whilst other areas have used it with partners in identifying the local priorities and key actions. Local leads have valued the S-Kit and its usefulness in producing a robust local strategy.

Improving performance

CSIP North West has been working with the Greater Manchester Mental Health Network (of PCTs) who have prioritised suicide prevention in their current action plan. The network was keen to improve the quality of local strategies and we agreed to use the S-Kit as part of the review. An interactive on-line audit was created for localities to assess their progress against the S-Kit standards. Completing the on-line audit provides each locality with a progress report and gives comparative information and a synopsis of regional progress.

In order to support the performance monitoring of Local Implementation Teams, the Strategic Health Authority have endorsed the use of the S-Kit as part of the Autumn Assessment 2006 and are encouraging each area to complete the on-line audit.

"The S-Kit has given us a focus and tool to implement our Suicide Prevention Strategy"

Mental Health Commissioning Manager

"The S-Kit has been used as a template for our suicide prevention strategy – with local actions for each of the standards. This has enabled us to develop a localised and very comprehensive strategy almost painlessly"

Public Mental Health Co-ordinator

How to use the S-Kit

- 10 Steps to an Effective Suicide Prevention Strategy (p 7) – Offers a simple development process and framework for starting a suicide prevention strategy.
- Encouraging Partnerships (p 8) – Outlines some of the multi-agency partnerships and responsibilities for suicide prevention. This information is also available in a Suicide Prevention Service Matrix which outlines responsibilities (see Appendix 1).
- Suicide Prevention Benchmarking Standards – Identifies a set of benchmarking standards for each objective of the National Suicide Prevention Strategy as well as actions that could be incorporated into local strategies, and
- Interactive Online Audit Tool – Organisations will be able to audit local suicide prevention strategies against the standards laid out in the S-Kit.

Download the S-Kit at
http://www.northwest.csip.org.uk/work/suicide-prevention/skit-suicide-prevention-local-implementation-framework.html

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