

A watercolor painting of a winter landscape. The foreground is a vast, white snowy field with soft, brownish-yellow washes suggesting shadows or patches of snow. In the middle ground, a dark wooden fence runs across the scene, with a small, dark silhouette of a person standing near it. Behind the fence, there are several dark, stylized trees in shades of blue and black. The background is a mix of warm, brown and orange tones, suggesting a sunset or a hazy sky. The overall style is soft and painterly.

Care Services Improvement Partnership **CSIP**

National Institute for
Mental Health in England

National Suicide Prevention Strategy for England

Annual Report 2007

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Description The first national suicide prevention strategy for England was launched in September 2002 to support the target set in the White Paper Saving Lives: Our Healthier Nation to reduce the death rate from suicide and undetermined injury by at least 20% by 2010. This is the fifth annual report outlining progress made in implementing the strategy.

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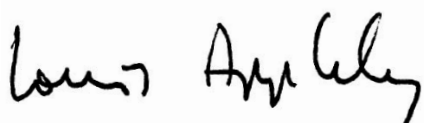
Foreword

This is the fifth annual report of progress 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), is responsible for implementation of the strategy in partnership with a range of agencies and organisations committed to supporting delivery of the strategy goals and objectives.

The overall rate of suicide amongst the general population is continuing to fall and is at the lowest rate on record. We are also seeing a continuing fall in suicides amongst young men under 35. In addition, the number of suicides amongst mental health in-patients continues to fall – a reduction of 70 on the 1997 figure. Whilst these are all encouraging statistics, there remain areas of concern.

Events in Bridgend are a reminder of the potential dangers of insensitive reporting of suicides and the benefits of getting it right. In 2007, we published our report *Sensitive Coverage Saves Lives*, which concluded that, whilst progress has been made, many journalists and editors remain unaware of either general or in-house reporting guidelines. In March 2008, we published a handbook – *What's the Story? Reporting Mental Health and Suicide* – for journalists. This highlights the evidence that careless reporting of suicide may trigger copycat suicides and provides advice to journalists to encourage more sensitive and responsible coverage. It is important now to build on this work in partnership with the media and suicide prevention agencies.

This report sets out what has been achieved in 2007 and highlights what further activity is taking place in 2008.



Professor Louis Appleby
National Director for Mental Health

1 Progress in 2007

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 undetermined injury 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 undetermined injury by at least 20% by 2010 reflects the Government commitment to improving access to mental health services. This important national target originally set out in *Our Healthier Nation* as been retained in the *National Standards Local Action* health and social care standards and planning framework for 2005/06 – 2007/08.

The likelihood of a person committing suicide 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 have developed a broad strategic approach which involves health and social care agencies, Government departments, and the voluntary and private sector organisations.

Implementation – progress in year five

Implementation of the strategy is being taken forward by the National Institute for Mental Health in England (NIMHE) as part of the Wellbeing and Inclusion work stream and in collaboration with a wide range of organisations and individuals. It is an evolving strategy which develops in light of progress made and emerging evidence.

We now have:

- the overall rate of suicide amongst the general population at the lowest rate on record
- a further encouraging fall in suicide rates amongst young
- a fall in the number of suicides amongst mental health in-patients.

Although there has been obvious concern around the number of self inflicted deaths in prison during the calendar year 2007, a marked reduction in deaths towards the end of the financial year has meant that the 20 per cent reduction originally set within the national strategy was again met.

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

- publication of *Sensitive Coverage Saves Lives*, a report compiled by the MediaWise Trust, which involved consultation with the media about the most useful ways of improving the portrayal of suicide and suicidal behaviour in the media.

- publication of a guide for journalists, *What's the Story?: Reporting Mental Health and Suicide*, by the Shift programme which gives practical advice to the media on covering suicide, as well as mental illness in general.
- commissioning of a tool for acute in-patient staff to help reduce the numbers of patients who go missing, some who may be at risk of suicide. This tool will build on the findings of the Review of Open Doors in Acute Inpatient Wards discussion paper.
- publication of Department of Health guidance *Best Practice in Managing Risk* which sets out a framework of principles to underpin best practice across all mental health settings covering self-harm and suicide.
- completion of a review and publication of a discussion paper undertaken by CSIP West Midlands DC and Staffordshire University Centre for Ageing and Mental Health on Older People and Suicide and the development of fact sheets which have been distributed across primary, secondary and non-statutory organisations.
- the phased withdrawal of the commonly prescribed painkiller co-proxamol, its license being withdrawn in December 2007.
- the completion of the research into the risk factors for suicide and suicide attempts in different ethnic groups.
- the completion of a systematic review on the risk of suicide amongst lesbian, gay and bisexual groups. This review was published in February 2008.
- introduction across the prisons estate of the revised care-planning system for prisoners at-risk of suicide or self-harm (ACCT – Assessment, Care in Custody and Teamwork) was completed.
- publication of a revised prisoner suicide prevention and self-harm management strategy.

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. This report highlights some of the activity at regional and local level although more detailed information is available from CSIP Suicide Prevention Regional Leads – see Chapter 3.

Where we are now

The target is to reduce the death rate from a baseline of 9.2 deaths per 100,000 population in 1995/6/7 to 7.3* deaths per 100,000 population in 2009/10/11. The three-year average rate rose in the period immediately following the setting of the baseline. However, the rate has since fallen to 8.3 deaths per 100,000 population and the latest available figures for the period 2004/5/6 show it is now 10.0% below 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 target 'milestone' for this period is for a fall of 12% from the baseline*. Although there has been sustained progress towards the target, the rate of decline has slowed and if this trend were to continue, the target would **not** be met. There are signs, however, that the rate of decline may once again be increasing and an increased rate of decline must be sustained if the target is to be met. For more detailed analysis of the statistical data, see Chapter 2.

In-patient suicides and those in contact with mental health services

Having a severe mental illness is a known risk factor for suicide. Because a significant number of suicides occur during a period of inpatient care or shortly after discharge, managing risk effectively and ensuring good continuity of mental health care are essential.

In-patient suicides have fallen since 1997 by 70. Staff carry out regular audits of ward and ward areas to identify and minimise opportunities for hanging or other means by which patients could harm themselves. Many services have adopted thorough audits of ward areas to identify potential ligatures and ligature points that could be used and all services have removed non-collapsible bed and shower rails, replacing them with collapsible fittings as per the CMO report *Organisation with a Memory*.

Managing risk effectively and ensuring good continuity of mental health care is essential. Implementation of Standards One to Six of the National Service Framework for Mental Health and the recommendations of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness have all contributed to reducing suicides within this high-risk group by promoting;

- better risk assessment and management
- good quality follow up and continuity of care.

In addition, the publication in July 2007 of guidance by the Department of Health – *Best Practice in managing risk: principles and guidance for best practice in the assessment and management of risk to self and others in mental health services* – will also support further improvements in risk assessment and management.

Inpatient psychiatric activity has fallen over time with more care being provided on a community basis, which is well liked by patients allowing them to remain in familiar circumstances at a difficult time for them, and their families. There are now over 700 specialist mental health teams in place to ensure that people with serious mental health problems get the right treatment at the right time. In 2007/08, crisis resolution and home treatment teams alone provided 106,000 episodes of home treatment for people with severe mental illness and helped avoid many hospital admissions.

The latest available data shows that the numbers of in-patient suicides in England have fallen from 215 in 1997 to 145 (projected) in 2005 (see Chapter 2 for the latest statistical data on in-patient suicides).

Young Men/People

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 it is still important for services to develop more effective approaches to engage with young men.

This approach, including using the evidence from the evaluation of the mental health promotion pilots developed in 2006, has, we believe, led to a better recognition of risk by front-line agencies. Research on young male suicide also suggested the need for a broadly based approach, covering alcohol and drug services, access to care in crisis, mental health services and public health approaches.

The Department of Health is working with the Department for Children, Schools and Families (DCSF) to improve the psychological and emotional wellbeing of children and young people and to ensure that those with mental health problems are identified and receive appropriate support at an early stage. DCSF has created the Social and Emotional Aspects of Learning (SEAL) programme to promote the social and emotional skills that underpin effective learning, positive behaviour, regular attendance, staff effectiveness and the emotional health and wellbeing of all who learn and work in schools.

The suicide rate amongst teenagers continue to fall and is below the general population rate. However, events in Bridgend highlight that young people are the most vulnerable and the risk is greater when they have a feeling of identification, whether with celebrities or other young people. We must continue to help support the delivery of improvements in young people's emotional wellbeing and mental health through actions at national, regional and local level.

Self inflicted deaths in prisons

The rise to 90 self-inflicted deaths in English prisons in 2007 followed two years of declining numbers. No conclusions about the increase have been drawn other than there continues to be high numbers of vulnerable individuals coming into prison, many of whom have experienced negative life events that we know increase the likelihood of them harming themselves. Issues that increase risk include drug/alcohol abuse, family background and relationship problems, social disadvantage or isolation, previous sexual or physical abuse, and mental health problems.

There was an increase in 2007 in the numbers of self-inflicted deaths of foreign national prisoners and those with a life/indeterminate sentence. The recent trends are being analysed to see what more can be learnt and to inform preventive policies, and research has been commissioned to look at the 24 foreign national prisoner deaths in 2007 to see what lessons can be learnt. This is in addition to the safer custody research already taking place in partnership with Oxford University's Centre for Suicide Research – two studies of prisoners (one of men and one of women) who were involved in serious suicide attempts.

ACCT (Assessment, Care in Custody and Teamwork – the care-planning system for prisoners at-risk of suicide or self-harm) was introduced across the prisons estate in partnership with the Department of Health during 2005-07 (the last prison completing introduction April 2007). Key benefits of ACCT include a faster first response and the provision of flexible individual, accountable care with useful information which can be shared and includes engagement with the prisoner. It is supported by improved staff training in assessing and understanding at-risk prisoners.

A revised prisoner suicide prevention and self-harm management strategy was published in October 2007 building on several years of learning from the experiences of prisoners, staff, investigators, inspectors and others. This aims to embed improved suicide prevention and self-harm management methods of working in all areas of prison life. The strategy incorporates ACCT, improved cross-agency information flows, and integrated local Safer Custody Teams pursuing a continuous improvement plan in each prison. It also reflects long-standing areas of safer custody work such as Listener and Insider peer supporters, local Suicide Prevention Co-ordinators and working with outside organisations.

In 2007 a review was undertaken – to report in 2008 – on the future of the Forum for Preventing Deaths in Custody. The Forum was set up in 2006 to ensure lessons are learnt across custody settings, and is independently chaired. Since 1 April 2004, the Prisons and Probation Ombudsman, Stephen Shaw, has been conducting all death in custody investigations.

Older Adults

The suicide prevention strategy under Goal 2 (to promote mental wellbeing in the wider population) focuses on a number of groups within society for who additional specific measures should be taken. These are not the groups at high risk of suicide, defined in goal one. They are, however, vulnerable groups of people and the strategy identified older adults as one of these groups. Based on the latest data from ONS it appears that the suicide rate for people aged 75 and over has recently reduced more than the rates for those in middle ages. Chapter 2 provides more statistical information on suicide numbers and ages in different age bands.

CSIP West Midlands Regional Development Centre and the CSIP Older Adults Mental Health Programme in partnership with Staffordshire University Centre for Ageing and Mental Health commissioned a literature review of suicides among older adults.

In 2007 they published a discussion paper and DVD on Older People and Suicide with the aim of assisting health and social care providers and policy makers to engage in primary, secondary and tertiary interventions in response to the risk of suicidal behaviour in the older person. In addition, to wider dissemination of the discussion paper CSIP West Midlands have commissioned the development of simple information sheets designed specifically for front line staff such as GPs and residential home matrons. We need to consider how best to promote the findings of this paper and fact sheets at a national level.

Methods of suicide and access to means

Research has indicated that the likelihood of committing suicide 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 (see Chapter 2 for the latest statistical data on deaths from suicide and undetermined injury by method and gender).

We have already taken some important measures to reduce the means of suicide, including removing potential ligature points in inpatient psychiatric units and regular environmental audits of wards. The phased withdrawal of the prescription only painkiller coproxamol – its license being revoked in December 2007 – will, we hope, lead to a reduction in deliberate or accidental drug overdose deaths.

We continue to promote the guidance issued in 2006 on action to be taken at specific suicide hotspots which is key to support local agencies in identifying and taking action to improve safety and deter acts of suicide at these locations.

Media Reporting of Suicide

There is already compelling evidence, from research conducted in the United Kingdom and elsewhere, that the reporting and portrayal of suicide in the media can lead to copycat suicides, especially amongst young people or those already at risk. That is why the national suicide prevention strategy for England made a commitment to improve the reporting of suicide and suicidal behaviour in the media as one of its six goals. In addition, in 2006 the Press Complaints Commission acknowledged this evidence by adding a sub-clause in the Editor's Code of Practice to discourage the reporting in the media of excessive detail of suicide methods.

In partnership with Shift, the Department of Health funded programme to tackle the stigma and discrimination associated with mental illness, the strategy aims to ensure "...that journalists and editors have effective guidance and support on the reporting of suicides." *Sensitive Coverage Saves Lives*, commissioned by NIMHE, to support improving media portrayal of suicide and suicidal behaviour was published in June 2007.

The report outlines several areas for action in 2008 and beyond that will help sustain improved reporting of suicide and suicidal behaviour in the media. The report also concluded that, whilst progress as been made, many journalists and editors remain unaware of either general or in-house reporting guidelines. A copy of this report is available online at www.nimhe.csip.org.uk, www.shift.org.uk, and www.mediawise.org.uk.

Supplementary update on Priority Activity for 2008 and action already undertaken

Given the late publication of the Annual Report for 2007, it was agreed that it would be helpful to provide a short summary of action already taken or completed in the early months of 2008 and some agreed priority areas for activity in this year.

The following have been completed in 2008:

- publication of the systematic review *Mental disorders, suicide, and deliberate self harm in lesbian, gay and bisexual people* in February 2008. This report is available online at www.csip.nimhe.org.uk. The challenge now is to promote the findings and conclusions of this review and to consider how to take forward. The strategy now includes LGB people as a specific group who have special needs under goal two of the strategy (to promote the mental wellbeing of the wider population).

- in February 2008, Shift published a guide for journalists on how sensitive reporting can help tackle the stigma of mental illness. The handbook, *What's the Story?: Reporting Mental Health and Suicide*, gives practical advice to the media on covering suicide, mental illness and violent crime by psychiatric patients. This handbook highlights the international evidence that careless reporting of suicide may trigger copycat suicides and provides advice to journalists to encourage more sensitive and responsible coverage.
- In January 2008, the Ministry of Justice published a discussion paper on Coroner reports to prevent further deaths: proposed amendments to Rule 43 of the Coroners Rules 1984. We support these proposals.
- in March 2008 the Ministry of Justice published two further documents relating to coroner reform: Coroners Bill – Changes made resulting from consultation and a discussion paper on sensitive reporting in coroners' courts.
- in March 2008 the Department of Health published *Refocusing the Care Programme Approach* a policy and positive practice guide for trusts and commissioners to review local practice to refocus CPA within mental health services.
- on 27 March *Safer Children in a Digital World*, the report of the Byron Review, was published. The review makes a number of recommendations about harmful or inappropriate material, including sites which exist to promote suicide, which will set the framework for future action.

In addition, we have identified the following priority areas for action in 2008:

- improved press coverage of suicide and suicidal behaviour;
- reducing the number of patients that go missing from mental health in-patient units;
- improving mental health care for older people;
- better treatment of depression in primary care through psychological therapies and the Improving Access to Psychological Therapies (IAPT) programme;
- better mental health support for doctors as described in the report *Mental health and ill health in doctors* (DH 2008);
- the new Mental Health Act, in particular supervised community treatment;
- improving safety in prisons.

Conclusion

The strategy is an evolving document and will develop over time in the light of progress made, adapting our approach where necessary. The strategy will continue to be a key programme of activity delivered by CSIP and will be subject to regular annual review and evaluation.

2 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.

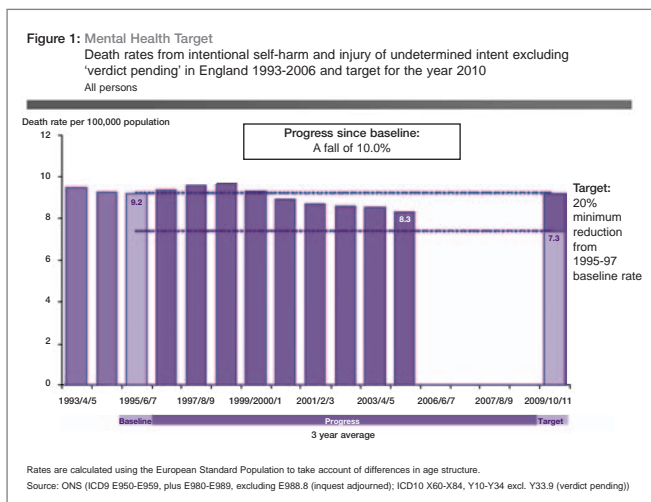
The suicide prevention target

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, starting from a baseline of 1995/6/7. 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

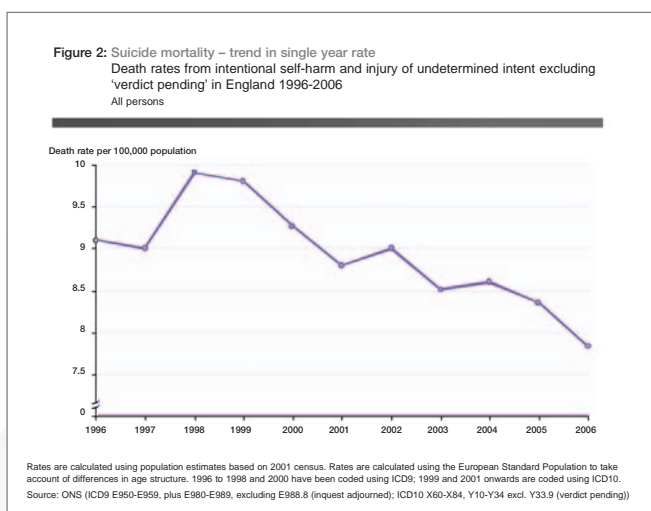
The target is to reduce the death rate from a baseline rate of 9.2 deaths per 100,000 population in 1995/6/7 to 7.3* deaths per 100,000 population in 2009/10/11. Figure 1 shows the latest available data (for the 3 years 2004/5/6) showing a rate of 8.3 deaths per 100,000 population – a reduction of 10.0 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*

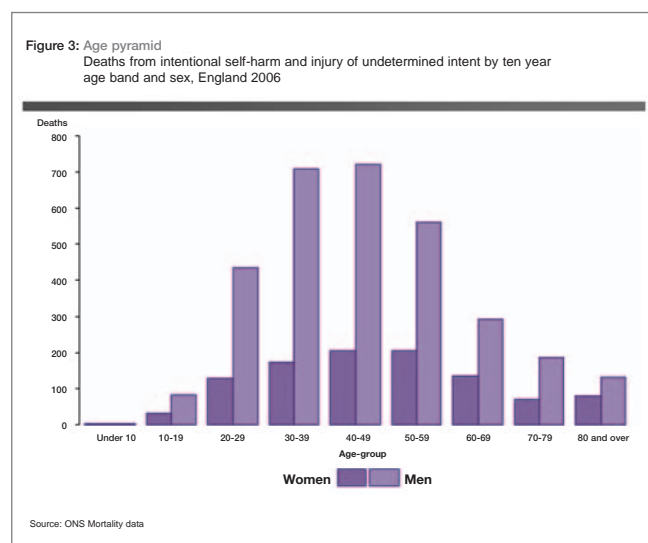


The three-year average rate rose in the period immediately following the setting of the baseline. However, the rate has since fallen and is now 10.0 per cent below the baseline. Although there has been sustained progress towards the target, the rate of decline has slowed, and if this trend were to continue, the target would not be met. There are signs that the rate of decline may once again be increasing; an increased rate of decline must be sustained if the target is to be met.

The suicide rate for the year 2006, the most recent available, was the lowest recorded. The European Age Standardised Rate (EASR) was 7.8 per 100,000 population, following falls in the last 2 years (see figure 2).

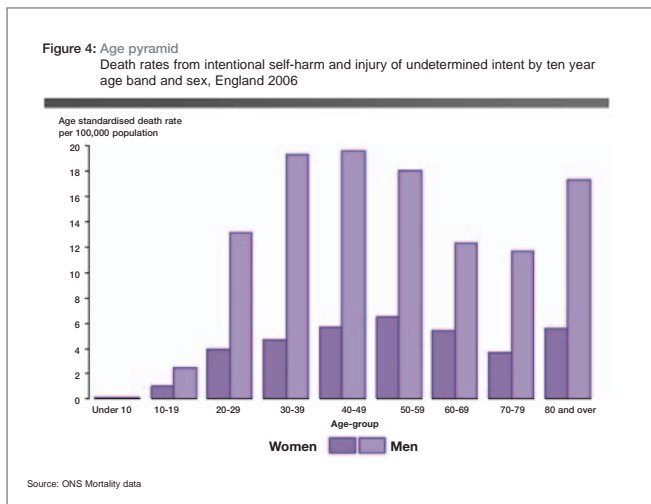


The majority of suicides continue to occur in young adult males (figure 3 below) – that is those under 50 years. In relation to women of the same age, younger men are more likely to take their own lives. The peak difference is the 30-39 age group where there are four male suicides to each female. The 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 gradually reduces, to around 2.1 male suicides to



each female suicide in the 80 and over age group.

In the general population, 4.5% of people are aged 80 or over (around two and a quarter million out of nearly 51 million in England in 2006). 217 people in this age group took their own lives (or had a death from undetermined injury) in 2006, out of a total of 4,180 suicides, representing 5.2% of the total deaths from suicide. So the suicide rate for the 80+ age group is proportionately higher than that for the population as a whole (9.6 vs 7.8). (See figure 4 following).



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 5).

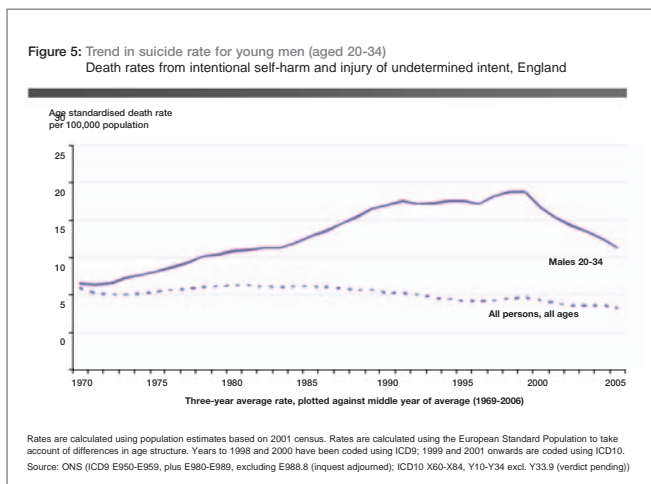
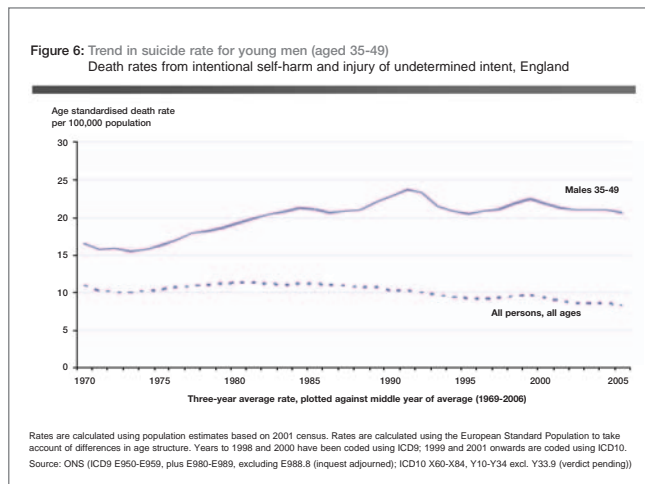
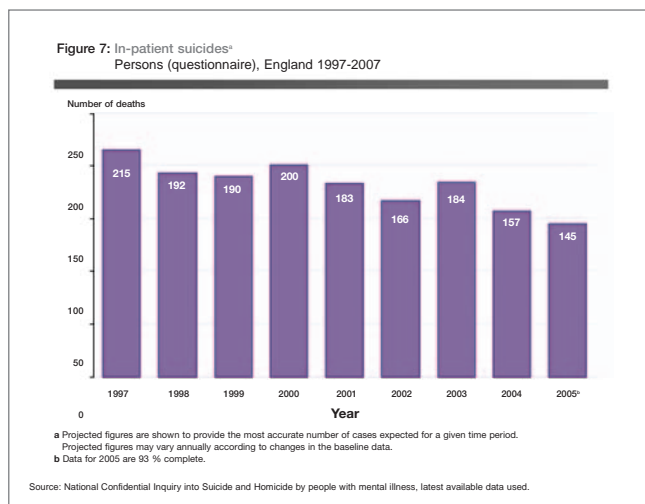


Figure 6. Trend in suicide rate for men aged 35-49. The suicide rate in this group rose gradually over the years 1970 to 1991. In recent years, this rate has levelled off, but is now one of the highest death rates amongst comparable age bands.

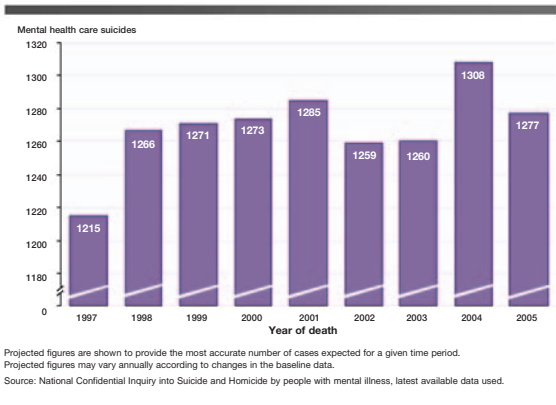


The latest data, covering calendar year 2005, show that the number of in-patients taking their own life in England has fallen from 215 in 1997 to 145 (projected) in 2005 (see figure 7).



Suicides by people in contact with mental health services in the year prior to death show a decrease to 1,277 (projected) in 2005 from a peak of 1,308 in 2004. The projected figure is calculated from the proportion of questionnaires that have been returned on the number of cases identified in 2005 to date. The projected figure for 2005 is an estimate based upon the current 93% questionnaire response rate and will change as the questionnaire returns improve (see figure 8).

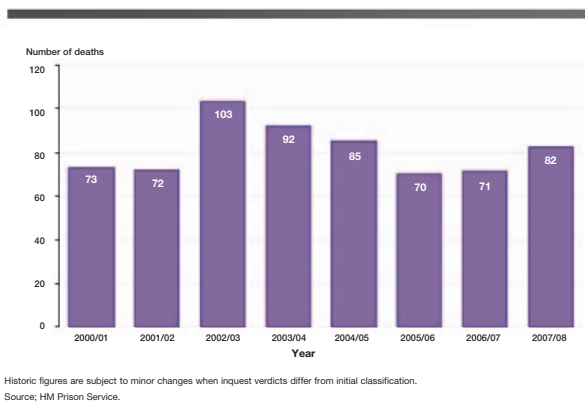
Figure 8: Suicides by people in contact with mental health services (in 12 months prior to death) England 1997-2005



Among the general population, 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 38% of all female suicide deaths, but hanging and suffocation now account for over a third of all female suicides and is the second most common method used (see figure 10).

Figure 9 shows the number of self-inflicted deaths in English prisons for the financial years 2000/01 to 2007/08. Following a period of successive falls, there were 82 apparent self-inflicted deaths in English prisons in 2007/08. This was an increase of 15% on the previous financial year.

Figure 9: Self-inflicted deaths in prison England



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.

Figure 10: Deaths from suicide and undetermined injury by method and sex England 2006

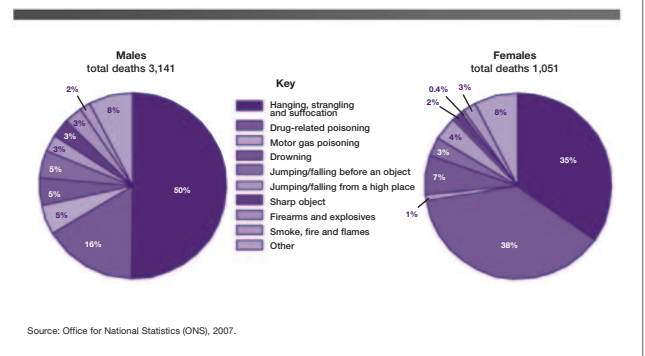
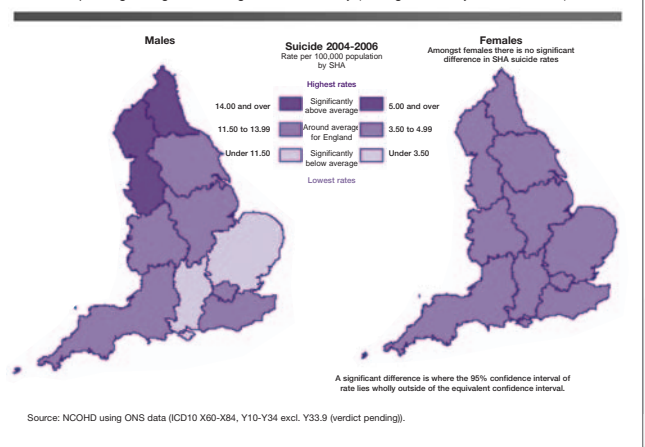


Figure 11 shows the latest 3 year average rates of suicide by English Strategic Health Authority and by gender.

Figure 11: Geographic distribution of suicide, 2004-2006
Death rates from intentional self-harm and injury of undetermined intent excluding verdict pending in England. Strategic Health Authority (average of three years 2004-2006)



3 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 & Humber (North East)

Whilst the overall rate of suicide in England continues to decrease, across the north east suicide rates continue to vary considerably, with some areas having rates approaching double the national rate. As a consequence of this, a regional action plan has been developed, the core concepts of which are outlined below.

- The regional Medicines Management Committee has agreed to introduce a series of initiatives, including:
 - an information campaign highlighting the dangers of paracetamol;
 - the production of safer prescribing guidelines;
 - the regular auditing of tricyclic antidepressants; and
 - the running of 'dump' campaigns to ensure the safe return of unused and unwanted medication.

It is also hoped that there will be agreement to write to all GPs concerning the prescribing of specific tricyclics such as dothiepin and amitriptyline.

- A regional agreement with Network Rail, and eventually National Express, to introduce suicide prevention measures on the regional railway network. This will build on the successes achieved by Samaritans and healthcare partners in Northumberland, Tyne and Wear in placing signage at a number of high profile suicide hotspots.
- The development of a Suicide Prevention and Self-Harm strategy covering asylum seekers, refugees, international students and migrant workers.
- A commitment identified in the regional Health and Wellbeing Strategy to run regional media campaigns to promote the recognition of depression and suicidal risk.
- An agreement by the Strategic Health Authority to improve the coding of incidence of self-harm in Accident and Emergency departments.
- Consideration by two Universities to develop a joint module on suicide prevention.

Further delivery of this plan will be overseen by a regional Suicide Prevention Steering Group. This will have a key role in supporting the work being undertaken across the three sub-regional suicide prevention groups in the north east. Examples of the work of these groups are outlined following:

Northumberland, Tyne & Wear Suicide Prevention Task Group

- The completion of a 10 year retrospective study into self-harm among older adults
- The completion of a research study into self-harm among refugees and asylum seekers in Newcastle, North Tyneside and Northumberland
- The placement of signage at suicide hotspots which has led to a significant reduction in calls to both uniform and Police negotiators. This has led to the legal departments of both the mental health trust and Northumbria Police approving formalised information sharing
- The extension of suicide risk assessment/management training to include the police, probation and voluntary sector. To date, over 3000 people have received the training.

Tees-wide Suicide Prevention Task Force

- The local mental health trust is part of the National Collaborative on Self-Harm
- An Integrated care pathway on self-harm has been extended to cover hospitals in Hartlepool and North Tees
- The development of a training pack for Support, Time and Recovery workers which focuses on positive mental health, the Wellness Recovery Action Plan (WRAP) and what keeps people well

- The production of a series of leaflets which provide advice and helpline numbers concerning common mental health problems such as stress, sleep deprivation and bereavement
- The commissioning of a Mental Health First Aid training programme specifically for Middlesbrough.

County Durham & Darlington Suicide Prevention Task Force

- The development of an information-sharing protocol between specialist mental health services and Criminal Justice agencies to access data on suicides
- The placement of 20 signs at suicide hotspots across the area
- Work between the Mental Health Trust and Area Safer Custody Co-ordinator to support offenders on their release from prison, particularly in relation to employment and accommodation needs.

North East, Yorkshire & Humber (Yorkshire & Humber)

Mental Health First Aid (MHFA)

MHFA originated in Australia through the work of Betty Kitchener and Professor Anthony Jorm. Many countries around the world have adopted the programme, including Scotland, England, Ireland and Wales, each of whom have an international agreement to run the programme outside of Australia.

The aims of MHFA are to:

- preserve life where a person may be a danger to themselves or others
- provide help to prevent the mental health problem developing into a more serious state
- promote the recovery of good mental health
- provide comfort to a person experiencing a mental health problem
- raise awareness of mental health issues in the community
- reduce stigma & discrimination.

Over the past eighteen months, an English version has been developed and there is now a national network of twelve training team members who train new instructors, who then train mental health first aiders.

Since October 2007, in the North East, Yorkshire and Humber, there have been thirty-six instructors and approximately three hundred mental health first aiders trained representing a cross section of society from the general public, staff from statutory and voluntary agencies and service users and carers.

In Hull, initial data from a follow up evaluation around the impact of MHFA training showed the following:

- all respondents felt some confidence in helping with the majority feeling quite or extremely confident
- 92% had contact with someone experiencing a mental health problem
- 92% listened and gave reassurance and information
- 74% advised on self-help strategies and seeking professional help

- type of groups they helped included relatives, friends, work colleagues, faith group members, homeless, general public (not known to helper – eg man in a pub), current mental health service users and council tenants
- confidence levels in helping à slight increase = 51%, great increase = 41%
- 46% reported a moderate to great impact on their own mental well being.

For further details of the Hull evaluation, please contact **Andy Flockton**, Head of Partnerships Hull/ Social Inclusion Lead, email: andy.flockton@humber.nhs.uk

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Applied Suicide Intervention Skills Training (ASIST)

ASIST is about preventing suicide, saving lives, about keeping people safe and communities safer.

Several ASIST Suicide intervention workshops have been held across the North East, Yorkshire and Humber throughout 2007/2008 and over a hundred participants have been trained in ASIST. Designed as a community ‘first aid’ approach to help people at risk of suicide and self-harm, the ASIST model offers an easily understood structured conversation that anyone can be confident to use.

Participants at workshops have included Approved Social Workers, mental health nurses, crisis resolution team members, carers and service users, members of police hostage negotiation teams, Consultant Psychiatrists and Prison Officers.

The model provides a structured conversation, risk assessment and safe plan to help a caregiver keep someone at risk of suicide safe until other resources are available. Each ASIST workshop takes place over two days and provides time to examine attitudes and fears, practice speaking with a person at risk and to build skills and confidence using the ASIST model.

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West Midlands

Over the past 12 months, CSIP West Midlands has continued to provide practical support to Suicide Prevention Leads within provider organisations and primary care trusts with an increased, though not exclusive emphasis, upon further developing population wide strategies and audit processes. The focus on developing population wide audits has encouraged the involvement of a wider range of stakeholders ranging from public health and primary care practitioners through to substance misuse services, accommodation, education and non-statutory organisations.

We have built upon the PCT wide audit tool originally provided by the Peninsula Medical School, by including additional data fields to meet local information needs, local suicide audit groups have also developed information sharing protocols, pro forma, terms of reference and report templates. We anticipate this will lead to even more pro-active and multi agency suicide prevention in the coming year.

We will also look to working with national colleagues to further develop the PCT wide suicide audit tool on the basis of experience gained over the past 12 months. Updates on this will be available via the CSIP West Midlands website.

A cross cutting product that has been developed to support the viability of third sector organisations — by helping them demonstrate cost effectiveness, client outcomes and effective use of resources — has been the development of the Activities and Outcomes Database. The significance of this is that third sector organisations are increasingly expected to work with, or provide, mainstream social care services and recent consultation clearly shows that in order for them to become long-term secure providers of such services, they require more secure funding streams. The Activities and Outcomes Database has been designed with third sector providers over the past 12 months to meet the information needs of commissioners, to support funding applications, providing cost analysis and performance reports that include client outcomes, and management information the small organisations themselves. This database is now available from www.westmidlands.csip.org.uk and has been welcomed by both small provide organisations and commissions.

During 2007 to 2008 further work has also begun around the design of interactive/drama-based training resources to help improve the awareness of suicide risks and potential suicide preventative action (such as local contact details of the services, how to access knowledge and information around suicide prevention etc, all identified through previous consultation events).

This is in response to the need for awareness raising training for community groups and other non mainstream services. We anticipate this interactive/drama-based training will be available in the new financial year with support from CSIP West Midlands.

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Eastern

Throughout 2007, the Eastern region has continued to develop and grow the concept of masterclasses as a method of regional engagement and dissemination of national guidance regarding Suicide Prevention and Self Harm. However, the region has also been keen to “mainstream” the Suicide Prevention programme, ensuring it is not seen as a programme that exists in isolation but cuts across the range of programmes the Regional Development Centre delivers.

This and specific activity is reflected in this report but this is by no means an exhaustive list:

- Improving Access to Psychological Therapies (IAPT) / Primary Care – Through the development of “New Roles” the expectation is that there will be significantly improved accessibility to appropriate services and better signposting for those who do not require direct intervention by mental health services
- CMHT Redesign – In a number of areas, we have worked closely with a range of stakeholders including representatives of Primary Care Trusts, Social Care Commissioners and Practice Based commissioners to redesign CMHTs, with a view to ensuring services are targeted on those who need them most and to improve accessibility

- Department of Health, Risk Assessment and Management guidance – This has been disseminated to all clinical areas and implementation has been monitored through the various regional forums which exist
- Crisis Resolution /Home Treatment – We have held a number of very successful conferences for these teams at which there was an emphasis on these teams providing rigorous assessment for those in a crisis, with a focus on the social context in which the crisis exists. We would expect this to enhance the ability of services to provide effective suicide prevention
- Early Intervention in psychosis teams – CSIP has had a key role in the development of these teams who are working directly with a high risk group. Training and practice development for these teams needs to reflect the suicide prevention agenda
- Dual Diagnosis – This is another high risk group, and efforts have been made to begin the process of increasing the knowledge base, improving the skills and changing attitudes towards this client group. Training has been piloted and will, in the coming year, be rolled out across the region
- Local Implementation Teams (LITS), Local Area Agreements (LAA) and Social Inclusion – CSIP is engaged in all of these areas and is promoting suicide prevention in local health and social care planning bodies
- CSIP Eastern has presented at a range of conferences on this topic, including a recent jointly hosted Strategic Health Authority and National Patient Safety Agency event entitled “Improving Patient Safety”. This enabled dissemination and discussion around the key issues in implementing national policy by a range of senior executives from around the region
- Communications – We have placed articles in our regional publication “East Forward”, again disseminating national policy and stimulating debate. Our website is a key avenue for dissemination and over the next 12 months we will be developing this further.

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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.

In this annual update last year an example was given of one of the “hard to reach” projects – the two year project by the West Sussex Public Health Network to combat suicide in men aged over forty. This year we describe some aspects of a two year project by MindOut, part of Mind in Brighton & Hove, to help prevent suicide in the local lesbian, gay, bisexual and transgender population, and the way in which the outcomes from that project have influenced a follow-on project to target older men generally in the Brighton & Hove area.

Brighton & Hove has the second highest suicide rate in the South East region, after the Isle of Wight, and significantly above the average rate for England. It also has the largest concentration of lesbian, gay, bisexual and transgender (LGBT) people in England outside London. There is accumulating evidence that LGBT people are at significantly higher risk of mental disorder, suicidal ideation, substance misuse, and deliberate self-harm, than heterosexual people (*Mental disorders, suicide, and deliberate self harm in lesbian, gay and bisexual people – a systematic review*, NIMHE Feb 2008).

In 2005, the South East Development Centre (SEDC) agreed to fund MindOut in Brighton & Hove for two years to carry out suicide prevention work in the LGBT population. A project development worker was recruited and a working party formed with representatives from a wide range of local organisations and groups, including Switchboard, Allsorts, ASIST Communities, the Community Safety Team, Rethink, Spectrum, The Gender Trust, Terence Higgins Trust and SEDC.

One aim of the project was to work within the LGBT community to increase people’s awareness of suicide risk, to provide information and advice for people at risk, to encourage people at risk to seek support and to encourage friends and family of those at risk to seek support. One of the themes to emerge in research and in work with people at risk is how isolation can increase people’s feelings of despair, and the project team hoped to convey to people at risk that they are not alone. Links were made with local events such as Brighton Pride and Winter Pride, local music and comedy venues, and magazines, to help with publicity efforts.

Another strand of the project was to develop peer support initiatives. MindOut has been running peer support groups for LGBT people with mental health problems for some years, with very positive feedback from participants, and used this model as a pilot for people who were at risk of suicide. Out Of The Blue is a facilitated peer support group for LGBT people who have experienced or are experiencing suicidal distress. The group runs weekly and currently has several members and one facilitator. As well as using the group for support with current difficulties, time is spent on sharing survival strategies, peer education and peer advocacy. This has developed into a very successful and highly valued service.

The LGBT Suicide Prevention Working Party has contributed to the development of a local LGBT Suicide Prevention Strategy. One of their aims is to see this included in the National Suicide Prevention Strategy and to encourage other local suicide prevention strategies to include it across the country. Advocacy support from the project's Suicide Prevention worker was identified early on as a necessity in developing a good model of LGBT suicide prevention. Many people using the service have attributed advocacy support from an LGBT advocate as helpful in lessening their suicidal distress.

Service users have been involved in all aspects of the project. Two fact sheets on suicide were developed by the project worker and service users, one aimed at people who experience suicidal distress, the second aimed at people who are supporting someone who feels suicidal. A ten week Anger Management course for LGBT people was held, looking at the relationship between anger and suicidal distress.

Helping to develop LGBT affirmative health services is seen as a very important goal for the project, and work is ongoing with the local mental health trust and primary care trust in this area. Perhaps the single most important lesson from this project is how fundamental the involvement of people in distress has been to its development, how much people have valued being listened to, being taken seriously, being supported in the ways they wished to be and being encouraged to take action.

Following the end of the two year project in 2007, the opportunity was taken to build on the learning from the LGBT suicide prevention project, and on the separate project developed in West Sussex, to fund a further one year project in Brighton & Hove, aimed at older men. The objectives include raising awareness for men at risk and signposting to support, developing pathways of support for men at risk of suicide, encouraging GPs and practice staff to screen men over 40 for suicide risk, and consulting with men over 40 to develop peer support for men at risk. Much of this work is building directly on, and expanding, the experience of the previous two years.

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South West

The South West has had a particular focus on 'putting the research into practice' particularly in relation to the Guidance on action to be taken on suicide hotspots and the application of new technologies to reduce the incidence of self-harm amongst young people.

The Guidance on action to be taken at suicide hotspots was first produced in October 2006 by Devon Partnership Trust Research & Development Department in partnership with the Peninsula Medical School. It has been published and disseminated nationally to a wide range of statutory and voluntary sector agencies including NHS trusts, county councils, transport agencies and Samaritans branches.

During the last year, the trust has been contacted to provide advice on the management of suicide risk by the Highways Agency, motorway maintenance contractors, and organisations involved in the design and build of motorway bridges.

Piloting the guidance in Devon has helped to identify a number of potential suicide hotspots within the county. This has led to proactive measures being taken in coordinating action plans to reduce the risk and opportunity for suicide at specific locations. Working collaboratively with the councils and contractors has enabled specific safety features to be incorporated into the design of a new bridge being constructed over the River Taw as part of the Barnstaple Western Bypass scheme.

The Devon Interagency Forum for Self Harm and Suicide Prevention has pulled together the local data on suicide, mapped the high risk locations and convened an expert conference on the subject. This work included survivors of suicide attempts. The work is now progressing using the national guidance on suicide hotspots which involves:

- erecting physical barriers at well known 'jump points'
- placing signs at hotspots urging people to contact the Samaritans or installing telephone help lines
- establishing dedicated 'suicide patrols' of volunteers or paid counsellors to patrol hotspot areas
- training non-health staff to recognise people and situations of possible risk
- working more closely with the media on the reporting of suicides as evidence suggests that media coverage can increase the use of a hotspot.

Self-harm is an area of increasing concern both in the south west as well as across the rest of the country. At the end of 2007, the research team from the Peninsula Medical School and Devon Partnership NHS Trust were successful in being funded by the NIHR to take forward work which will look at how information and support for young people, their families and friends can be more creatively provided. The research team are working to develop a range of online learning opportunities and forums and to research the impact that they have in helping us to tackle the very complex and sensitive issue of self-harm.

A study carried out in UK schools reported that 7% of pupils aged 15-16 had self-harmed and 15% had thought about self-harm during the previous year. Although this may not sound significant, it equates to approximately 75,000 young people aged 15-16 engaging in self-harm and 162,000 thinking about harming themselves each year.

The research will aim to develop and pilot the use of text messaging as a means of delivering psychological support to individuals who engage in self-harm and explore the potential of social software and on line communities to foster engagement. It is hoped that this research will make a major contribution to help those who self-harm and also the way in which we educate others about it.

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East Midlands

Indigo Brave Theatre Group 'Strange Acts' Changing Lives – Developing ways of working with people who self-harm

Indigo Brave is a theatre and arts group based in Nottingham. They have written, produced and developed a theatre piece surrounding the theme of self-harm entitled 'Strange Acts'. CSIP (East Midlands) funded the development of this piece of work to be used in a variety of health promotion and self-harm related events, seminars and workshops. However, the primary purpose of the project is focused around the need to build professional awareness of the:

- a) Key messages within the *NICE Guidelines on Self Harm* (NICE 2004) – specifically service user focused needs
- b) Impact of attitudes and values on people being treated and cared for within a range of healthcare environments (mental health and medical settings).

In the East Midlands, we want to work with A&E staff, paramedics, primary care professionals (GPs, practice nurses etc) to help develop the services provided for people who self-harm. This connects with the on-going activity of *Better Services for People who Self-Harm – Quality Standards for Healthcare Professionals* (Royal College of Psychiatrists 2006).

Strange Acts – Changing Lives – The work of the group

The idea for this project came about following the completion of another mental health project. Many of the clients on the project felt the work had been so beneficial to their mental health that they wanted to continue working in this way.

Self-harm and feelings of suicide was the area chosen to develop further, supporting them to work through their personal issues and to communicate their feelings and thoughts, with the aim of challenging attitudes to this, often taboo area of mental health.

In January 2007, we established a core group of 10 people, who met weekly until the end of October 2007.

During these 10 months, the group tackled a lot of their own personal issues around physical and mental self-harm, drug abuse and suicide attempts. They devised a play, using drama, music, movement and poetry to tell their stories.

During a very challenging time of the year for one of the participants, she acknowledged that she was having suicidal feelings. She went in and out of healthcare services and experienced many different responses. This experience was turned into a very powerful piece of drama.

The theatre piece will be used as part of workshop development day and will help facilitate exploration of working with people who self-harm in different clinical settings. This will cover:

- reasons for self-harm
- the meaning of self-harm for the individual
- influence of attitudes, views and values
- communication with someone who has self-harmed
- physical care of someone who has self-harmed.

Professionals will draw upon 'Strange Acts' to begin to address some of these areas in more detail. Overall, we hope to offer support for professional staff by collaborating with service users. The aim is to work is to develop ways of responding to and helping people who self-harm and who come into contact with healthcare services.

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North West

Analysis and Audit

CSIP NW DC is working with the NW Public Health Observatory (PHO) to conduct an analysis of suicide hotspots in the region. This has involved liaising with external agencies such as railways, police, highways etc. to share data on attempted and actual deaths. A report will be available in the summer.

The PHO are also analysing local PCT suicide audit data. Following the publication of the new audit tool, all localities agreed to use this to collate their suicide data. At the moment, all deaths occurring in 2006 are being audited using the new toolkit and analysed. This will help to build a system to identify regional suicide trends. It is recognised that suicide figures are sometimes too low to provide trends on a locality basis and gaining a picture across the whole region over a three year period will potentially provide some richer information to direct regional and sub-regional resources. Further investment will be needed to develop and maintain this regional analysis system. This work has helped to raise the profile of conducting local suicide audits and it has informed the annual mental health assessment conducted by the Strategic Health Authority.

Localities conducting suicide audit are gaining valuable information to direct the local suicide prevention strategy. For example, over a number of years some areas have seen a growth in suicide amongst older people and are now able to work with similar areas in developing interventions.

Strategic Partnerships

Within the region, multi-agency suicide prevention partnerships have been formed within Greater Manchester and Lancashire & Cumbria in order to develop collective action to preventing and responding to suicide amongst those agencies that have a sub-regional footprint larger than the local authority based groups.

The GM suicide prevention partnership (GMSPP) has joint accountability to the GM public health network and the GM mental health network. It is chaired by the Director of the GM mental health network, and the lead Director of Public Health is Sally Bradley. The partnership meets on a bi-monthly basis. The group seeks to replicate at a GM level the multi-agency and multi-professional representation on local suicide prevention strategies and in so doing:

- a) Support the work of local partnerships
- b) Provide a focal point for GM wide partners
- c) Receive information on suicides and suicide attempts in GM from partners in order to identify hotspots
- d) Provide a sub regional focal point for regional work

The group has the following representation:

- e) Mental Health Network
- f) Lead Director of Public Health
- g) Regional mental health network lead
- h) PCT suicide leads
- i) Representatives from Mental Health Specialist Trusts
- j) Police force lead for coronial issues
- k) Police custody lead
- l) Highways Agency
- m) Office of the Rail Regulator
- n) Manchester University National Confidential Inquiry into suicide
- o) North West Public Health Observatory
- p) British Waterways lead
- q) Lead Coroner
- r) DH NW CSIP/ RPHG
- s) Regional Health Offender Team
- t) Samaritans

The work has initially involved receiving information from all the agencies in order to spot potential trends. One hotspot has been identified as a local motorway bridge running over a waterway. With the support of local planners, the Highways Agency and the Samaritans, Samaritans signs have been put up on pedestrian access to the bridge.

Since this action no suicides have occurred. The signage and process of approval has been confirmed and circulated to all PCT leads for use locally as required.

A number of actions have been taken regarding ensuring new building design reduces opportunity for suicide – including new car parks particularly those within the NHS. The partnership is working with planning leads to take this forward. The partnership is also developing a number of scenarios with which local partnerships can test partners understanding and the robustness of service response e.g. police liaison and referral to mental health services and responses to working with people with mental health problems and suicide ideation.

The regional offender healthcare team continues to roll out best practice in suicide prevention within prison and probation services in the North West. It is recognised that the probation service has more suicides per head than prisons and a number of pilots have been developed within the region.

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London

In 2007, London Development Centre focused their suicide prevention work plan on three key strands of work: use of NIMHE suicide prevention toolkit audit by Primary Care Trusts, coroner's recording systems for collecting ethnicity data in suicide cases and promotion of suicide prevention in Hackney's Turkish community due to a recent spate of deaths.

PCT suicide audit and strategy

In 2006, NIMHE published a Suicide Prevention Audit Toolkit for PCTs. The toolkit set out 9 key actions that PCTs should follow when completing a suicide audit. We contacted each London PCT and asked them to complete a short survey regarding the use of NIMHE's suicide prevention audit toolkit.

Findings include:

The majority of responses stated a strategy was developed based on the findings of a suicide audit, with a supporting steering group established, and on going amendments to the strategy were planned. In one instance, a project manager was employed specifically to conduct an audit and provide recommendations for embedding an audit strategy within the PCT. Consideration was given by PCTs regarding where the suicide audit strategy should be placed within wider trust strategies (e.g. public mental health strategy) and how the toolkit links to other national and local guidance / priorities.

Data from audits was reported to boards / steering groups (e.g. LIT, Suicide Audit Group) and generally used to make recommendations for improvements based on a comparison to previous trends and data collected. Findings were used for a variety of purposes: to amend the suicide prevention strategy, consider suicide hot spots, improve mental health services and identifying unmet training requirements.

The toolkit was disseminated through existing board / networks / groups, in one example with a system to highlight the needs of the audit. Some PCTs reported circulating a copy of the toolkit following a suicide to those who were consulted for the purposes of the suicide audit or specific sections of the toolkit extracted and sent to relevant staff members (e.g. GPs). Clinical governance staff were identified as leading on monitoring whether the toolkit was received by staff. However, it was also suggested that the lack of audit following a suicide would also raise alerts.

In some cases PCTs had not adapted the toolkit for local use or were awaiting the results of a current audit. Where developments had been made they related to collaborative working across PCT boundaries and developing joint action plans. Particular mention was given to coroners, suggesting their valuable role in contributing to suicide audits and partnership working. In one example the toolkit had been developed into a teaching tool for group based training. Finally, the frequency of audits was reported to be reduced (from annual or bi-annually to every three years).

Promotion of suicide prevention in Hackney's Turkish male community

Since July 2007, 9 suicides from young males in Hackney's Kurdish (Turkish speaking) community have been reported. Media reports include suggestions that these suicides are viewed as 'an honourable death' in Turkish communities, challenges were faced when adapting to the English culture, and a clear lack of mental health awareness within the community. (www.timesonline.co.uk/tol/news/uk/article3134100.ece)

Derman (a DRE Community Engagement Project Group) took part in public meetings and was consulted on what can be done on a community level to help prevent further incidents and additionally, conversations with the PCT commissioner led to the creation of a post at Derman of 1 full-time male outreach worker for Hackney's Turkish-speaking males.

CSIP London Development Centre has begun a pilot to deliver Mental Health First Aid training to Hackney's Kurdish community to raise awareness of suicide prevention. The training will include how to recognise men at risk, and increase trained individuals' confidence and comfort in connecting with men they think may need assistance.

The pilot will also teach professionals from the statutory and voluntary sector how to connect with this pilot project group and teach professionals how to connect the men to community resources.

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We help to improve services and achieve better outcomes for children and families, adults and older people including those with mental health problems, physical or learning disabilities or people in the criminal justice system. We work with and are funded by

