Mental Health Network
NHS CONFEDERATION

briefing
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Preventing suicide through community and emergency healthcare

New suicide prevention toolkits for the NHS

Key points

- Over 4,000 suicides occur in the UK each year; 74 per cent of suicide victims are not known to mental health services.
- Around 200,000 cases of self-harm – an indicator of suicide risk – are seen by hospital services each year.
- Community, emergency and general practice staff have an important role in identifying and caring for people at risk of suicide.
- New toolkits can help community and emergency services and general practices understand what can be done to prevent suicide.

The prevention of suicide in inpatient mental health settings has long been a focus for clinicians and managers. Understanding what can be done in community, emergency and general practice settings to reduce the number of suicides has presented more of a challenge.

Although the suicide rate in England has been declining steadily over the last ten years, self-harm – an indicator of suicide risk – continues to rise. Times of economic downturn are known to correspond to a rise in the number of suicides, and 2008 saw the first rise in the suicide rate for some years. Policy-makers and service providers recognise that there is no room to be complacent.

This *Briefing* introduces the National Patient Safety Agency's (NPSA) new suicide prevention toolkits for community, emergency and general practice staff, launched in December 2011, and outlines their benefits for providers, illustrated by the experience of some pilot sites. The Mental Health Network is happy to support the NPSA and the Department of Health to bring the toolkits to the wider NHS.

Background

In 2010, following the success of its mental health toolkit, which is supported by the Care Quality Commission and NHS Estates, the NPSA began developing suicide prevention toolkits for community and emergency services and general practice. The NPSA was aware that the focus on suicide prevention needed to be much wider than inpatient settings. The National Confidential Inquiry into

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Suicide and Homicide found that between 1997 and 2008, 74 per cent of those who had killed themselves were not known to mental health services in the 12 months prior to their deaths. Working in collaboration with the Department of Health's national suicide prevention strategy advisory group, the NPSA led the development of suicide prevention toolkits for:

- ambulance services
- community mental health services
- general practice
- emergency departments.

The toolkits

The toolkits are based on the 2004 National Institute for Health and Clinical Excellence (NICE) guidelines on the management and prevention of self-harm. People who self-harm, either through self-poisoning or self-injury, are at between 50 and 100 times greater risk of suicide than the general population. Although the majority of people who self-harm never go on to take their own life, the behaviour is nonetheless a predictor for suicide risk.

Each toolkit contains an 'audit tool' which requires detailed questions to be answered, under a series of 'standards':

- consent (and capacity to consent) to treatment
- intervention and care
- risk assessment to prevent suicide
- family and carer involvement
- appropriate medication
- discharge, transfer and follow-up care
- post-incident review
- staff training.

The audit tool is intended to be completed annually by clinical, governance or audit staff. It can be completed in less than a day.

The toolkits for community mental health and emergency departments contain a 'mini audit checklist', which can be completed monthly to gauge progress.

Key benefits of the toolkits

The toolkits have a number of key benefits, as reported by pilot sites. These include:

- providing useful management information
- informing practice and supervision
- identifying non-compliance and sharing best practice
- preventing silo working
- addressing training needs.

Providing useful management information

One of the main benefits of the toolkits is their use as a supervisory tool in team management. The audit tools, in particular the mini audit tools, give team leaders a snapshot of areas for improvement, enabling discussion of team performance to be based around objective, tangible evidence.

The audit tools automatically generate performance charts and an action plan. Feedback from boards was that that they valued the plans and performance charts as they clearly identified areas for action and facilitated the creation of business plans.

Identifying non-compliance and sharing best practice

The audit tools enable services to monitor and identify where they are not compliant with the 2004 NICE guidelines on self-harm and help them develop action plans as appropriate. Pilot sites reported that, as a result, risks related to the physical environment, such as the presence of ligature points and the lack of observation bays in emergency departments, were identified.

Areas of good practice were also identified that can be shared across organisations, for example, the use of discharge safety advice cards for patients and carers.

Preventing silo working

The toolkits can identify poor links within and between services, such as poor communication between acute and community mental

New suicide prevention toolkits

New suicide prevention toolkits are available for:

- Ambulance services
- Community mental health services
- General practice
- Emergency departments.

All are available for download at **www.nhsconfed.org/mhn**

Piloting the toolkits

Seven pilot sites worked with the NPSA to trial and develop the toolkits. Feedback was positive and showed a need for suicide prevention resources specific to their field of care. This has enabled further improvements to be made to the toolkits, prior to their roll-out in December 2011.

The pilot sites

Emergency departments:	University College London Hospitals NHS Foundation Trust Yeovil District Hospital NHS Foundation Trust (see case study on page 4)
Ambulance services:	East of England Ambulance Service NHS Trust West Midlands Ambulance Service NHS Trust Yorkshire Ambulance Service NHS Trust
Community mental health teams:	Somerset Partnership NHS Foundation Trust Humber NHS Foundation Trust (see case study on page 5)

health teams. Pilot sites also found variation in risk assessment tools used and the way in which policies were interpreted, with potentially dangerous results. One example given involved different interpretations of what was an unsafe level of discharge medication for patients with a history of overdose.

Addressing training needs

The 2004 NICE guidelines state that clinical and non-clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training to equip them to understand and care for these patients. The audit tools enable managers to identify training needs and leverage support for courses to address those needs. Key training resources include:

- The University of Manchester. Skills-based Training on Risk Management (STORM) – Adult Version 2. Available at: **www.medicine.manchester.ac.uk/storm/packages/**
- WEL mind. Mental Health First Aid. Available at: **www.mhfa.org.uk**
- Freefall – understanding suicide crisis. **www.freefallfilm.co.uk**
- the ‘Recognition of adolescent mental health issues’ free e-learning resource, developed by the NPSA: **http://npsa.ocbgroup.com/course/view/1/login**

Working together to reduce suicide

Suicide prevention requires an integrated approach. No single agency or organisation can be responsible for identifying all those at risk of taking their own life. It is therefore important that all services which come into contact with vulnerable people are confident they have the right skills, processes and procedures in place to identify and appropriately care for someone at risk of suicide. The case for auditing suicide prevention across community and emergency services and in general practice is outlined below.

General practice

People tend to visit their GP more often in the period leading up to suicide – between half and two thirds visit their GP in the month before taking their own life and 10–40 per cent visit their GP in the week before.[1] GPs have a vital role in identifying and supporting people with depression or other mental health problems, assessing suicidal risk and initiating treatment and preventative interventions, including referral to more specialist services.

It is estimated that at least a third of GP consultations are related to mental health issues. However, in a recent survey of over 1,000 people with mental health problems, 30 per cent reported that their GP had a low awareness of the services available to support mental health recovery.[2]

While the number of patients taking their own life is generally low within any given practice, the NPSA’s audit tool for general practice enables practice staff to assess whether they are meeting best practice in respect of safeguarding patients at risk of suicide, and offering appropriate treatment and support for patients, their families and carers.

Ambulance services

Ambulance crews are often the first clinicians to see a patient who has attempted suicide or engaged in serious self-harm. There is a lack of research into the most important factors for ambulance crews to consider when treating these patients, but NICE recommends ambulance staff receive basic training in mental health assessment and enable patients, where they have the capacity, to provide meaningful and informed consent before being treated or taken to hospital or a place of safety.

The audit tool enables ambulance trusts to check that they have a comprehensive set of protocols and pathways in place to link the care they provide to the wider network of urgent, acute and community care.

Emergency departments

Self-harm is one of the most common reasons for emergency care, accounting for around 200,000 visits to hospital each year. Research shows that attendance at an emergency department for self-harm is associated with future suicide and attempted suicide.[3] Despite the important role emergency staff play in identifying people at risk of taking their life by suicide, the Department of Health, in its consultation on preventing suicide in England, highlights that there are still problems with the quality of care and follow-up for people who present after self-harming in some emergency departments. For example, it draws attention to the high proportion of patients not given a psychological assessment, and that treatment and follow-up are not always arranged, particularly for people who repeatedly self-harm.

There is also evidence that attitudes among hospital staff towards people who self-harm is often poor,[4, 5] which demonstrates a lack of understanding about mental illness.

The audit tool enables emergency department staff to assess whether they are taking all appropriate steps to care for patients who may be at risk of suicide. It prompts staff to make a series of checks, such as whether the physical environment for distressed patients is safe and free from ligature points and whether

Case study: Yeovil District Hospital NHS Foundation Trust

Earlier this year, Yeovil District Hospital's emergency department completed the NPSA's suicide prevention toolkit.

Emergency department matron, Janine Valentine, found the audit process useful, although it did generate "a big action plan". A key lesson to come out of the audit was realising how much risk mental health patients still face once they arrive at the hospital: "There is a lot of potential risk in an emergency department; lots of ligature points, lots of separate rooms. It's very busy, and you can't provide one-to-one care at all times."

Following completion of the audit tool, the trust has improved its risk assessment of patients who present with self-harm or have taken an overdose. The trust has piloted the use of a risk assessment in triage and has also developed a mental health proforma to be completed when the patient is seen by the clinician.

Completing the audit tool also highlighted the need to have appropriate policies and documentation to hand: "We may have them, but the important thing is to know how to access them."

The audit lent weight to the argument for additional training in mental health awareness.

The audit results and action plan were shared with a multi-disciplinary team, which included senior medical staff and representatives from the ambulance trust and mental health liaison team, and were incorporated into a wider programme of work to ensure emergency admissions for people with mental health problems are well managed.

Janine Valentine would recommend the toolkit for other departments looking for a practical way to drive improvement for this patient group.

Key learning points

- Emergency departments can be high-risk environments for patients with mental health problems.
- Risk management policies need to be accessible and understood if staff are to feel confident providing care for vulnerable patients.
- Gaining multidisciplinary support for a suicide prevention strategy and action plan can help ensure its effectiveness.

> 'The audit tool enables emergency department staff to assess whether they are taking all appropriate steps to care for patients who may be at risk of suicide'

they are providing correct advice and follow-up care.

Community mental health teams

Patients are referred to community mental health teams (CMHTs) either by their GP or on discharge from hospital for ongoing support and treatment. CMHTs play an important role in suicide prevention, and research suggests that rates of suicide are lower for those under CMHT care as compared to standard inpatient care.[6]

However, it is important to ensure that CMHTs have the right risk assessment processes in place. The National Confidential Inquiry into Suicide and Homicide found that between 1997 and 2008 26 per cent of suicides were 'patient suicides', that is, performed by people who had been discharged from mental health services within the previous 12 months. As such, mental health practitioners have an important role in working with commissioners to ensure that local services implement the right approach to identify and treat vulnerable people, whether they have been in contact with mental health services or not.

As well as helping CMHTs assure themselves that they have established the right risk assessment processes across their services, the audit tool helps teams check they are working well with partner services. Specific audit tools have been developed for child and adolescent mental health services and services for working age adults and older people, in recognition of the differing needs of these service users.

Mental Health Network viewpoint

Suicide prevention, as measured through the suicide rate, is expected to be one of the outcomes agreed within the Public Health Outcomes Framework, to be finalised later this year. It is also linked to commitments within the NHS Outcomes Framework as part of the NHS reforms, such as enhancing the quality of life and experience of healthcare for people with mental illness, and reducing premature death in people with serious mental ill health.

The Government has acknowledged there is a need for

Case study: Humber NHS Foundation Trust

Humber NHS Foundation Trust provides mental health and community services to a population of around 600,000 people.

The trust's team of matrons was impressed with the NPSA's inpatient audit tool and were aware that the right support needed to be in place for community teams.

The trust facilitated a series of workshops with its community practitioners to determine how the inpatient tool could be developed to meet their needs. The importance of ensuring that the right engagement and conversations are occurring between service users and staff and that, where risks were found, these are appropriately followed up, was a key theme that emerged from the workshops.

According to the trust: "If you maintain engagement [with the patient], the risk of suicide becomes less. It is important to know whether staff are talking to service users about mood, their thoughts, whether they are thinking about suicide. It sounds like bread and butter stuff, but these are difficult topics to broach and staff need to be clear about what steps to take if a risk is identified. It's not about checking up on staff, but about ensuring these issues are kept at the forefront of their minds."

Following feedback from the Humber team, the CMHT audit tool now includes 11 questions to help trusts check whether staff are engaging with service users on issues including bereavement and separation, social circumstances and substance misuse, to determine their suicide risk.

Key learning points

- Mental health staff need to be supported in opening conversations about suicide with service users as part of overall risk assessment and management.
- Suicide prevention is as important in community settings as it is for inpatients.

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better data and information on what works in the prevention of suicide. The evidence gathered through these toolkits can help address that need. From April 2013, local health and wellbeing boards will be responsible for developing high-level strategies outlining how they will meet the public health and well-being needs in their areas, for which they will need to gain buy-in from clinical commissioning groups.

The new suicide prevention toolkits, and the gaps they identify, can help to inform local strategies, commissioners and service providers in the task of improving population health and well-being. We are pleased to help the NPSA and the Department of Health introduce the new toolkits for community and emergency services and general practice. They have been rigorously piloted and will undoubtedly improve services and save lives.

The development of the new suicide prevention toolkits was led by Vanessa Gordon, Head of Patient Safety at the NPSA.

References

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Note on data

Unless otherwise attributed, data for this *Briefing* has been taken from The National Confidential Inquiry into Suicide and Homicide by people with Mental illness, July 2011. Data completeness for the inquiry is high overall (over 90 per cent) for those years presented. More recent years of data are less complete. This reflects the period of processing from time of notification of data to the inquiry by the Office for National Statistics, to receipt of clinical data from the trust.

The Mental Health Network

The Mental Health Network was established as part of the NHS Confederation to provide a distinct voice for mental health and learning disability service providers. We aim to improve the system for the public, patients and staff by raising the profile of mental health issues and increasing the influence of mental health and disability providers.

For further details about the work of the Mental Health Network, visit **www.nhsconfed.org/mhn** or email **mentalhealthnetwork@nhsconfed.org**

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