

**KENT AND MEDWAY MULTI-AGENCY SUICIDE
PREVENTION STRATEGY 2010-2015**

April 2010

Acknowledgments

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The framework for this strategy was taken both from the National Suicide Prevention Strategy and has also used some of the work from the Kensington and Chelsea Suicide Prevention Strategy 2009

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1. BACKGROUND AND POLICY CONTEXT

- 1.1 Suicide is a major public health issue. On average, there are approximately 140 deaths from suicide annually in Kent and Medway. Deaths from suicides are in a younger age group than most diseases and therefore account for a much larger number of years of life lost than would be expected for similar numbers of deaths in other disease areas. The National Suicide Prevention Strategy states that many suicides are preventable which gives an added impetus for action
- 1.2 Reducing the death rate from suicide is a government priority. The National Suicide Prevention Strategy which was published in 2002 reinforced the White Paper *Saving Lives, Our Healthier Nation 1999*¹, target of a reduction in the death rate from suicide by at least 20% by 2010. It set out the national strategic priorities and actions for how this was to be achieved. In 2007 and 2008 national progress reports were produced giving updates and reinforcing the national commitment. Standard 7 of the National Service Framework for Mental Health 1999² also reinforced the importance of suicide prevention and gave a framework for action. In 2009 New Horizons was published and restated the Government's commitment to suicide prevention. A refresh of the national suicide prevention strategy is due out in 2010
- 1.3 This strategy seeks to ensure that the PCTs and local partners across Kent and Medway have an up to date strategy with a set of actions likely to impact positively on the suicide rate across the county.
- 1.4 Developing a strategy based just on the characteristics of previous cases of deaths from suicides locally is problematic as there are only a small number of cases. It is unlikely that past cases alone can provide sufficient information on the local population to help focus prevention activity. The local data may identify suicide "hot spots" and indicate target groups, but local suicide data needs to be enhanced with national data and research evidence, plus material from other PCTs, in order to inform local service planning in a meaningful way.
- 1.5 Suicidal behaviour is complex and the contributing factors are many and varied. As suicide often results from an accumulation of risk factors a co-ordinated and collaborative approach is required. Given the nature of suicide, the wide range of services involved in preventing suicides, and the wide range of locations and means used, a multi agency approach is likely to have most impact - this approach is adopted in this strategy. Effective prevention also requires a combination of population level and individual level programmes to reduce the factors associated with suicidal behaviour. The majority of people who die by suicide are not patients of secondary mental health services, so prevention must embrace both primary care and the wide range of other services which are in touch with people at risk of suicide.
- 1.6 Key policy drivers are:
- Saving Lives: Our Healthier Nation White Paper (1999) Department of Health¹
 - National Service Framework for Mental Health (1999) Department of Health²
 - National Suicide Prevention Strategy for England (2002) Department of Health¹³
 - Avoidable Deaths: Five Year Report of the National Confidential Enquiry into suicide and homicide by people with a mental illness 2006³
 - New Horizons (2009) Department of Health⁴

2. EPIDEMIOLOGY OF SUICIDE: NATIONAL AND LOCAL DATA

National Data

- 2.1 The suicide rate has been falling nationally in the past 10 years. However, given the possible link to recession and the rising levels of clinical depression (likely to be the most common illness by 2020), it is possible that the trend in suicide rates will be reversed in the next few years. The suicide rate for England in 2008 showed a sharper increase in any one year than had been the case since 1997. However, it is clearly too early to be able state that this represents any trend.
- 2.2 Researchers have identified factors that place individuals at higher risk of suicide, but very few persons with these risk factors will actually commit suicide. Suicide is a relatively rare event and it is, therefore, difficult to predict which persons, with these risk factors, will ultimately die by suicide. However, the evidence suggests that “rational suicide” is most probably very rare, and most suicides are likely to be associated with a mental disorder or impaired mental functioning. Within mental disorders the strongest association is with depression. People with schizophrenia, bi-polar disorder, borderline personality disorder and addictions to substances are also at heightened risk.
- 2.3 There is a large body of literature on the risk factors associated with suicide as well as the factors likely to protect people from suicide. In 2008 a literature review of risk and protective factors for suicide and suicidal behaviour was published by the Scottish government Social Research Unit.⁵ In summary, the main risk factors are:
- Previous suicide attempt
 - Previous history of intentional self harm
 - Mental illness including depression, bipolar disorders, personality disorders
 - Mental health patients shortly before, or shortly after, discharge from in patient care
 - Poor emotional health in childhood and/or violence and abuse
 - Impaired problem solving skills
 - Being LGBT
 - Substance misuse
 - Social isolation
 - Family member or close friend who has committed suicide
 - Homelessness
 - Imprisonment
 - Loss – relationship break down, sudden death of loved one, unemployment, poor physical health
 - Economic depression, sudden economic change and unemployment
 - Poverty and deprivation

It is common for more than one of these risk factors to be linked and present in people who have died by suicide.

- 2.4 The protective factors are largely a mirror image of the risk factors:
- Family connectedness, good relationships between parents and children, marriage, having children living at home (protective for women).
 - Supportive schools.
 - Personal resilience and problem solving skills.
 - Good physical and mental health.
 - Employment.

- High levels of reasons for living, future orientation and optimism protect against suicide
- Religious participation
- Moral belief that suicide is wrong.
- Social support
- Access to treatment by a health professional may be protective against repeat suicide attempts.

Local Data

2.5 Local data for suicides across Kent and Medway is presented below. This is mainly nationally available information as there is currently no comprehensive suicide audit in place for Kent and Medway. However Kent police carried out an analysis of all suicides taking place between 01/07/08 to 30/06/09. Although numbers are small and therefore meaningful sub group analysis becomes difficult this does provide some useful additional data at a local level.

2.6 Some additional data is available by PCT and can be obtained from the Public Health Directorate but in most cases numbers are not large enough to be meaningful on further detailed sub analysis.

Numbers and rates of suicides in Kent and Medway

2.7 The total average number of suicides in Kent and Medway per year using 2003-2008 data is 136 per year. The table below shows the yearly variation over the last 10 years.

Table 1 : Total number of suicides by year of registration and PCT area 1998-2008

Area	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Kent County	128	111	128	122	117	136	128	125	114	126	88
ECKPCT	71	74	70	69	55	73	70	70	60	68	45
West Kent	57	37	58	53	62	63	58	55	54	58	43
Medway	24	12	18	17	23	13	20	21	23	22	14

Source NCHOD 2009

Rates and trends

National Target:

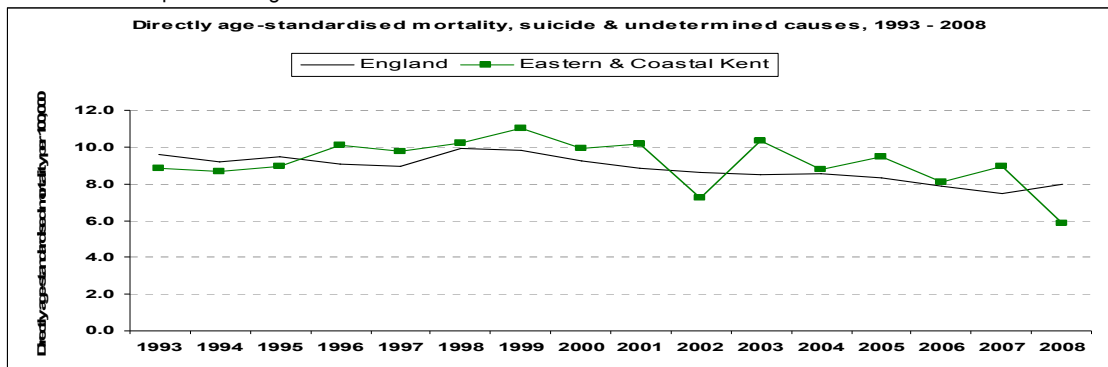
To reduce the rate of suicide and undetermined injury in England by at least 20% by 2010 from a baseline of 1996.

Our Healthier Nation 1999

2.8 Suicide numbers are small so it is difficult to be confident in seeing clear trends at a PCT level. However the figures below set out the best information we have as to rates, trends and future projections by PCT area and for Kent and Medway both from 1993 when data is available and from the 1996 OHN baseline.

For Eastern and Coastal Kent PCT if the baseline is taken as 1993 there is an apparent slight increase in suicide rates up to the present. From 1996 (which is the baseline for the OHN target), when trend lines are fitted it seems that in Eastern and Coastal Kent there is a decrease in suicide rates over this period.(see page 8)

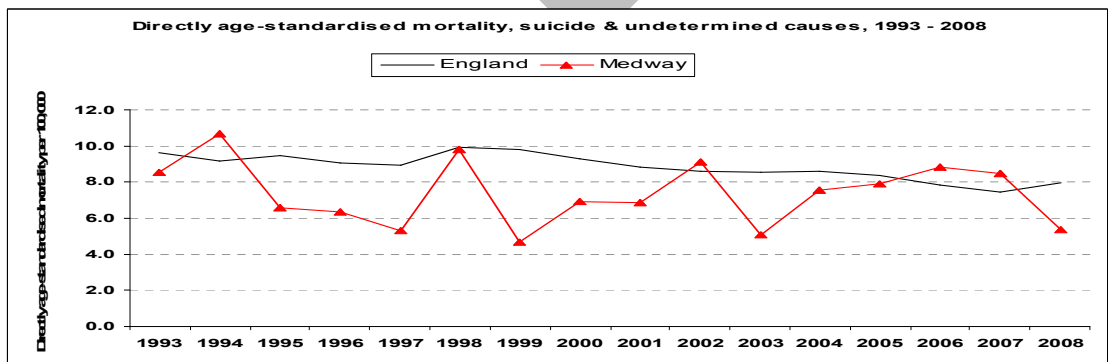
Fig : 1 Directly age-standardised mortality rates for suicide and undetermined causes 1993-2008: NHS Eastern and Coastal Kent compared to England



Source:KMPHO

2.9 For Medway there is an increase in the suicide rates from 1995-97 to the 2006-08 however numbers are very small and so rates tend to fluctuate considerably from year to year. As shown below if the baseline had been taken from 1993 to the present the rate overall may have been similar to that in 1993.

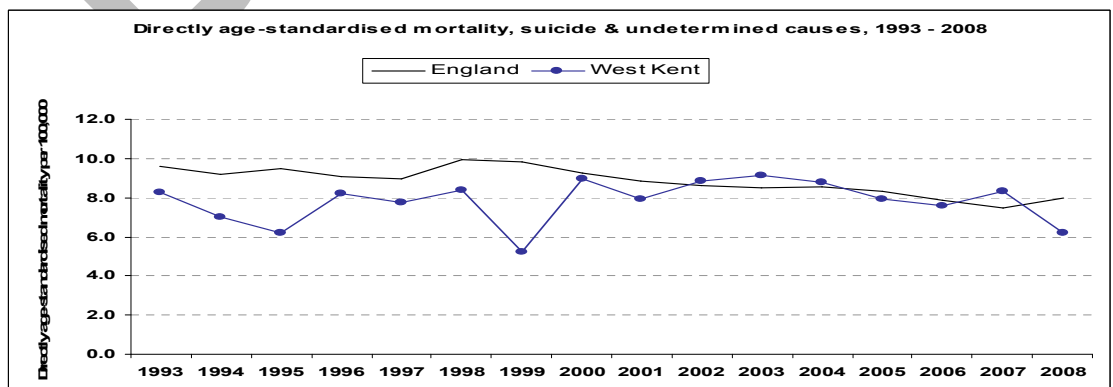
Fig: 2 Directly age-standardised mortality for suicide and undetermined causes 1993-2008: NHS Medway compared to England



Source:KMPHO

2.10 In West Kent from 1995-97 to 2006-8 there has been a slight increase in suicide rates when trend lines are fitted.

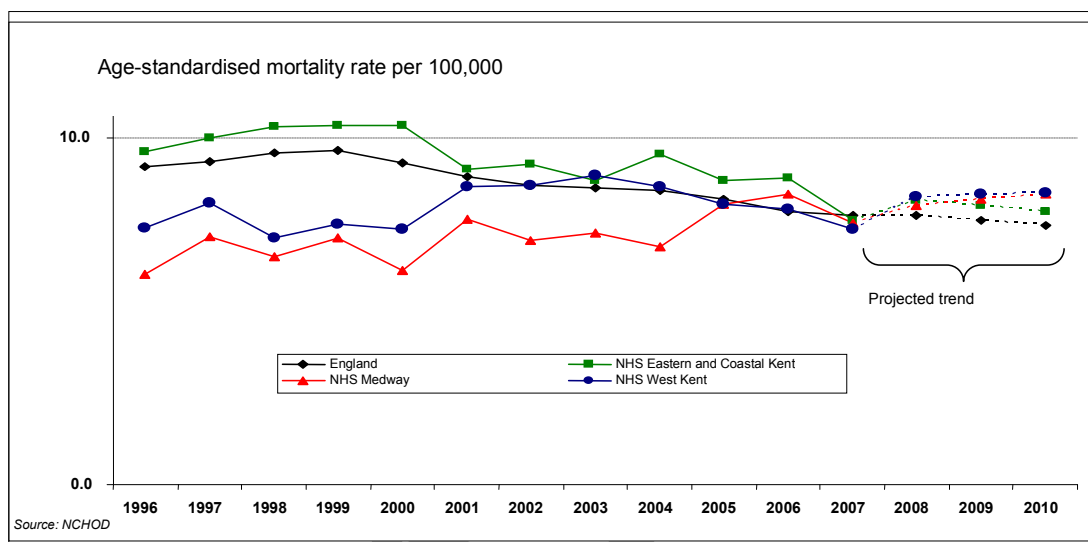
Fig : 3 Directly age-standardised mortality for suicide and undetermined causes 1993-2008: NHS West Kent compared to England



Source KMPHO

2.11 The information below shows the percentage changes in the suicide rates for the different PCT areas from the Our Healthier Nation baseline in 1996 and projected to 2010. This shows that in 2007 (3 year rolling average for 2006-8) Medway had a 25% increase over its baseline. West Kent and Eastern and Coastal Kent areas have respectively a 5% increase and a 28% decrease in suicide rates.

Fig: 4: Age-standardised suicide and undetermined mortality rates: 1996-2007 projected to 2010 for Kent and Medway PCTS and England (3 year rolling averages)



When the trends are projected to 2010 it seems unlikely that any of the Kent PCTs will meet their targets.

Fig: 5 Directly age-standardized mortality rates for suicide and undetermined injury for Kent and Medway PCTs and England from 1995-7 to 2006-8

Area	Period	DASR			% change	% Projected Change 2010
		Male	Female	Total		
England	1995 - 1997	14.1	4.5	9.2	-15	-18.
	2006 - 2008	12.0	3.7	7.8		
Medway	1995 - 1997	10.2	2.1	6.1	+25	+38
	2006 - 2008	12.2	3.0	7.6		
ECK	1995 - 1997	14.2	5.2	9.6	-28	-17.9
	2006 - 2008	11.4	4.1	7.6		
West Kent	1995 - 1997	10.9	4.2	7.4	+5	+14.0
	2006 - 2008	12.1	3.7	7.8		

Source: KMPHO

Compared to England overall in 2006-8 all of the PCTs were close to the England rate but are projected to increase above it to 2010.

Age and sex

2.12 Nationally suicide is the leading cause of death among men aged 15-24 years and the second most common cause of death among people aged less than 35 years. Suicide is three times more common in men than women with approximately 76% of suicides in Kent and Medway being carried out by men.

The age band with the highest number of deaths for men is the 40-49 year age band followed by the 50-59 and the 30-39 age bands.

In women the 50-59 age band has the highest number of deaths but the rate is only slightly higher than the 40-49 and 30-39 age bands.

Fig: 6 Numbers of suicides and undetermined deaths 2006-2008 (pooled by age band in Kent and Medway)

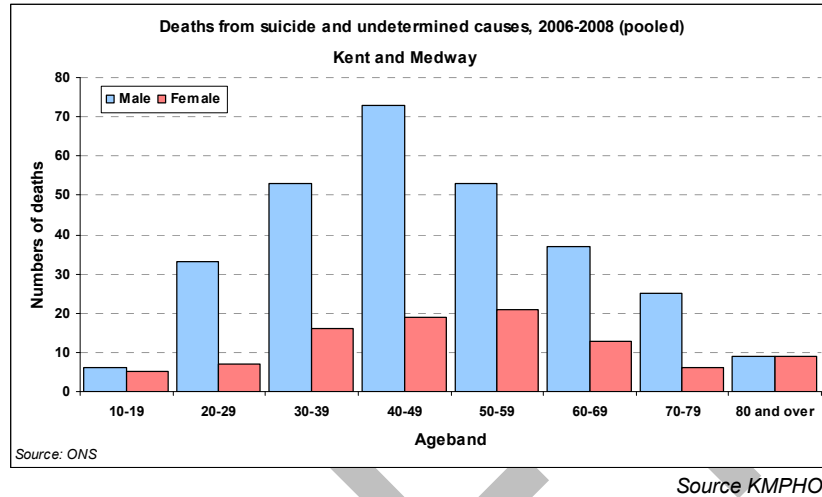
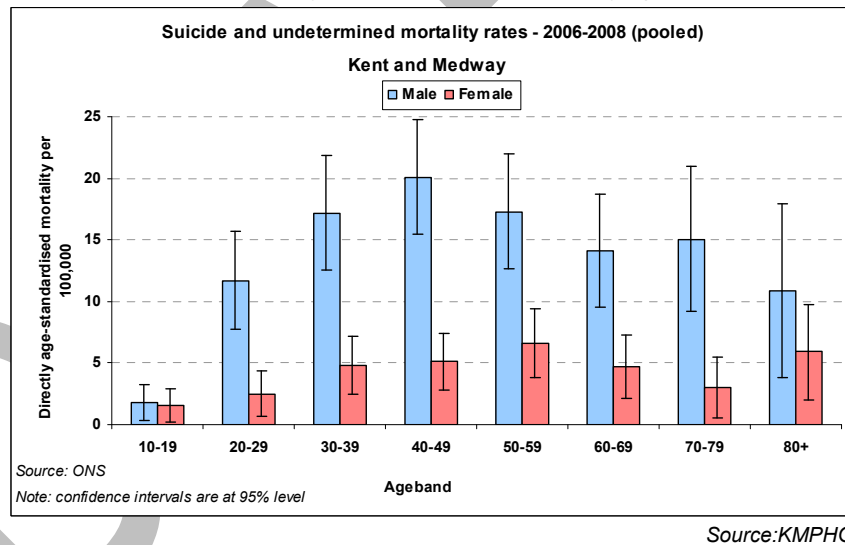


Fig: 7 Suicide and undetermined mortality rates: 2006-2008 (pooled by age band in Kent and Medway)



Interestingly, looking at the suicide rates (as opposed to numbers) by age, the older age groups are proportionately more significant than we might expect from just looking at the numbers. However as confidence intervals are very wide for our local data it is difficult to say with certainty how large these differences are. National data from 2008 shows even higher rates than our local data in the older age groups.

Self harm

2.14 Studies have shown that that people who self harm are 24.7 times more likely to die by suicide compared with those who do not self harm⁶. NICE guidelines on the physical and psychological management and secondary prevention of self-harm in primary and secondary care were produced in 2004.

In the Psychiatric Morbidity Survey in 2007, 5.6 per cent of people said they had attempted suicide at some point in their life and 4.9 per cent said they had engaged in self

harm. These individuals did not necessarily come to the attention of services: less than two thirds of those who attempted suicide had sought help, and only about half of those who self-harmed. However, people diagnosed with mental illness (notably schizophrenia) are more likely to self harm.

Those who survive a medically serious suicide attempt have a poorer outcome in terms of life expectancy.

The NICE guideline on self harm also notes that:

- 80 per cent of A & E attenders with self harm have taken an overdose of prescribed or over the counter medication
- Self injury is more common than self poisoning in the population as a whole
- Association with a physical illness as a precipitating factor
- Two thirds of those attending A& E for self harm meet the criteria for depression at the time, but two thirds of these no longer meet the diagnostic criteria 1 -16 months later
- Half those attending A& E due to self harm will have consumed alcohol
- There are higher rates in young Asian women

The following table taken from the Kent and Medway Mental Health Joint Strategic Needs Assessment applies national prevalence rate to the Kent and Medway population in order to estimate the number of people who reported self harm in the last year or a suicide attempt (ever).

Table 2: Attempted suicide and self harm in Kent and Medway

Disorder	Medway	East	West	K&M
Suicide attempt ever	11,407	33,505	30,414	75,326
Suicide attempt past year	1,833	5,385	4,888	12,106

Source: KMPHO

Method of suicide

2.15 The method of suicide most frequently used in Kent and Medway between 2002-7 (as nationally) is hanging (43%) followed by drugs overdose (23%). Jumping from a height and gas and vapour poisoning are next highest (6% each). The "other" unknown category accounts for 15% of all deaths.

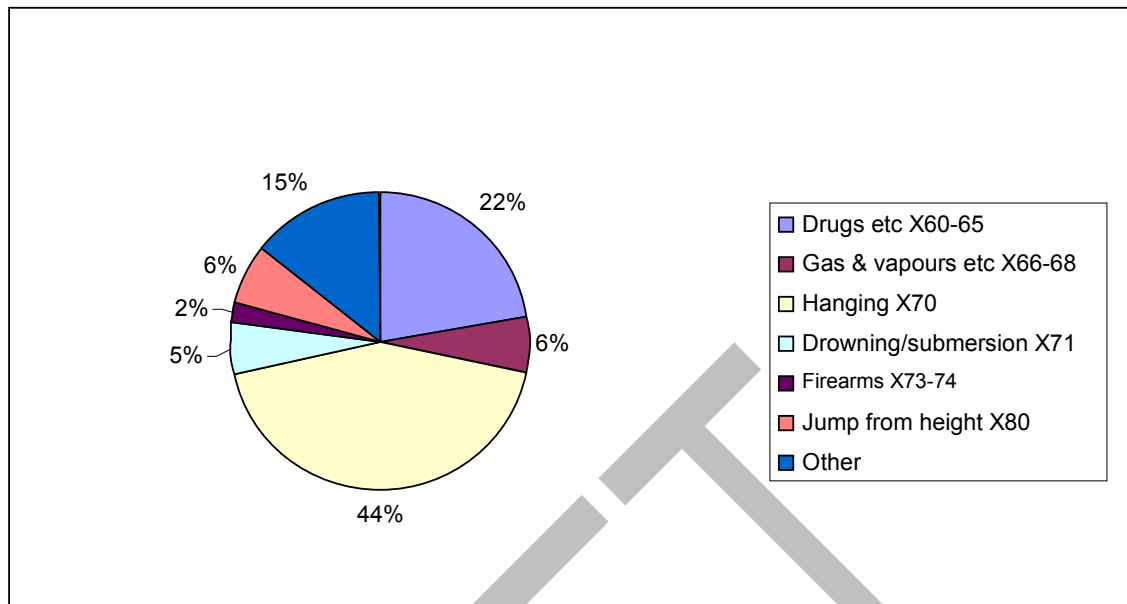
Table 3: Numbers of suicides and undetermined deaths in Kent and Medway 2002-2007 by method of death and PCT

Method	Medway		ECKPCT		WKPCT		K&M	
	No	%	No	%	No	%		%
Drugs etc X60-65	23	19%	97	24%	72	21%	192	22%
Gas & vapours etc X66-68	10	8%	27	7%	17	5%	54	6%
Hanging X70	63	52%	155	39%	155	44%	373	43%
Drowning/submersion X71	8	7%	21	5%	18	5%	47	5%
Firearms X73-74	-	-	-	-	12	3%	20	2%
Jump from height X80	-	-	26	7%	-	-	54	6%
Other	13	11%	64	16%	49	14%	126	15%
Total	121	100%	396	100%	349	100%	866	100%

- is entered whenever a value is under 5 or confidentiality would be breached by inserting the appropriate value

Source NCHOD 2008

Fig: 8 Method of suicide and undetermined injury pooled data 2002-2007 Kent and Medway



Source KMPHO

There are differences between males and females with respect to method of suicide chosen as the table below illustrates. Men are more likely to choose hanging as a preferred method with women being more likely to choose drugs overdose.

Table 4. Numbers and percentages of suicides and undetermined injury by method and sex: Kent and Medway pooled 2002-2007

Method	Male		Female	
	No	%	No	%
Drugs etc X60-65	110	16.8	82	38.9
Gas & vapours etc X66-68	49	7.5	5	2.4
Hanging X70	312	47.6	61	28.9
Drowning/submersion X71	30	4.6	17	8.1
Firearms X73-74	20	3.1	0	0.0
Jump from height X80	39	6.0	15	7.1
Other	95	14.5	31	14.7
Total	655	100.0	211	100.0

Source KMPHO

Additional local police data for one year indicated that deaths from train impact account for approximately 5% of suicides for that year in Kent and Medway with an additional 1% being caused by "Other vehicle impact". These would have been recorded in the "Other" category above. National data indicates that 3% of all suicides annually are due to jumping or lying in front of a moving object.

Occupation

2.16 National research seems to indicate that the highest occupational risk groups are medical professionals and farmers. However in Kent and Medway it appears from the data below that the highest numbers are in the routine and manual occupations, the retired and the unemployed and other category. Further analysis needs to be done to understand whether the national research does apply locally.

Table 5: Number of deaths by suicide and undetermined injury in Kent and Medway by occupation 2002-2007 pooled data:

Occupation	Total
Retired	171
Unknown, unlisted or unemployed	146
Skilled construction & building trades	55
Elementary trades, plant & storage related occupations	53
Transport & mobile machine drivers & operatives	42
Skilled metal & electrical trades	37
Elementary administration & service occupations	33
Administrative occupations	31
Caring personal service occupations	30
Business & public service associate professionals	25
Process, plant & machine operatives	22
Managers & proprietors in agriculture & services	21
Corporate managers	19
Sales occupations	17
Housewife	17
Student	17
Science & technology professionals	14
Science & technology associate professionals	14
Culture, media & sports occupations	14
Leisure & other personal service occupations	14
Textiles, printing & other skilled trades	13
Teaching & research professionals	12
Skilled agricultural trades	12
Health & social welfare associate professionals	9
Secretarial & related occupations	9
Business & public service professionals	8
Health professionals	5
Protective service occupations	5
Customer service occupations	-
	866

Source: Public Health Mortality File

- indicates a value between 0-5

Place of death and identification of hotspots

2.17 The average annual number of deaths and suicide rates by local authority areas are shown below. The highest numbers are in Medway but this is likely to be due to the higher population numbers.

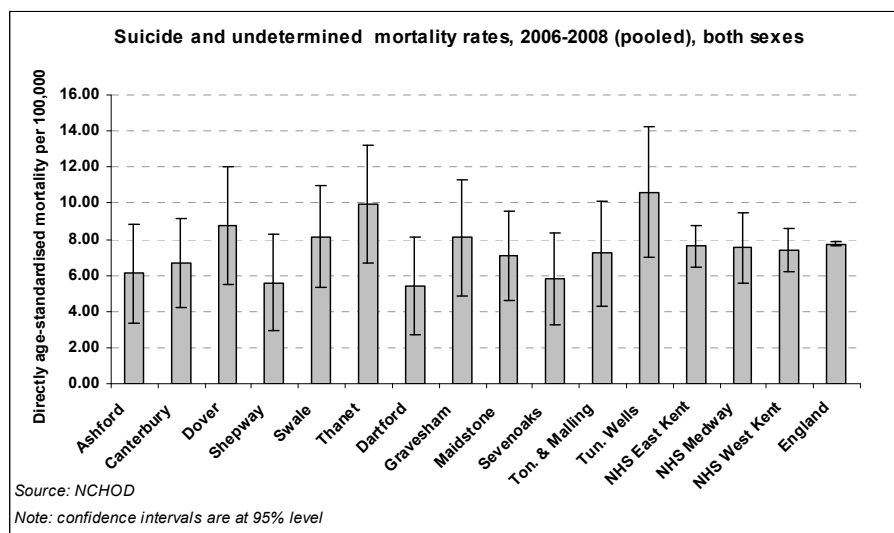
Table 6: Average number of deaths per year by suicide and undetermined injury by Local Authority district in Kent and Medway in 2002-07

Local /unitary authority	Average number of deaths	Local /unitary authority	Average number of deaths
Ashford	9	Sevenoaks	9
Canterbury	13	Shepway	10
Dartford	8	Swale	11
Dover	12	Thanet	13
Gravesham	10	Tonbridge and Malling	8
Maidstone	12	Tunbridge Wells	12
Medway	20	TOTAL	144

Source: KMPHO

Medway has the highest number of suicides but, when rates are calculated, Tunbridge Wells and Thanet appear to have the highest rates. However as can be seen confidence intervals are wide and overlap. This indicates there is no statistically significant difference between the different local authority areas based on these figures.

Fig: 9 Suicide and undetermined mortality rate 2006-2008 (pooled)



2.19 Nationally, available data on place of death in the sense of type of location or institution for Kent and Medway is shown in the table below. This shows that approximately 50% of suicides take place at home. However the data on place of death is difficult to interpret as suicides who are taken to hospital and subsequently die there are recorded as deaths in the hospital even though the initial suicide attempt may have taken place elsewhere.

Table 7: Number of suicides by place of death 2002-2007 for Kent and Medway

Place of death	Year of registration						Total
	2002	2003	2004	2005	2006	2007	
Home	64	76	73	75	70	75	433
Elsewhere	46	43	51	52	47	47	286
Other hospitals etc.(NHS)	28	28	23	18	20	25	142
Other communal establishments	-	-	-	-	-	-	-
Psychiatric (NHS)	-	-	-	-	-	-	-
Hospices	-	-	-	-	-	-	-
Total	139	148	148	146	137	148	866

Source: KMPHO

- indicates that the value is either 0 or under 5

2.20 Probably the most appropriate way of looking at geographical data on place is to look at data on where suicides are initiated and map it to ascertain any possible hotspots or clusters. This gives the most useful information for action. Kent Police have done this using the place where suicide was initiated between 01/07/08 and 30/06/09. In the year of analysis this showed 64% of suicides taking place at the deceased person's home address, a further 5% in prisons where remanded and 2% in hospitals where admitted for mental illness.

- 2.21 This analysis can also be used to help to identify possible hotspots in Kent and Medway. (A hotspot is defined nationally as anywhere where more than one death has occurred in any time period). Within the year covered by the police analysis 3 geographical areas have been identified as having more than one death. In two of these areas the deaths were not linked, in the third area the two people involved were husband and wife.
- 2.22 Further investigation will need to be carried out to ascertain the need for and possibility of appropriate management of these hotspots.

DRAFT

3. A STRATEGIC PARTNERSHIP APPROACH

3.1 In 2007 in Kent and Medway there were 148 suicides and open verdicts recorded in the general population. About 30% of these had been in contact with mental health services⁷. This is similar to the national findings. This means that the majority of suicides are not known to mental health services at the time of their death. This means that no one agency can be responsible for suicide prevention. Indeed, in order to be effective a strategy must involve a wide range of agencies who may have an impact on the behaviour of both high risk groups and the wider population

3.2 It was decided that it would be more effective to have a multi-agency Kent and Medway wide strategy than to have individual PCT strategies. Consequently in November 2009 a Kent and Medway wide multi-agency suicide prevention steering group was formed with the remit of ensuring that a Kent and Medway suicide prevention strategy was developed and implemented.

As part of the strategy development process a number of key stakeholders were interviewed and a Kent and Medway wide consultation event was held which was attended by nearly 60 people from a wide range of different organisations.

A list of key partner agencies who are represented on this steering group and who have been involved in the development of this strategy can be found at Appendices 2 and 3.

3.3 The Kent and Medway suicide prevention steering group will link into the PCTs governance structure via the Mental Health Joint Commissioning Boards. It will also report into the Joint Strategic Mental Health Commissioning Board.

3.4 Other partner agencies will be responsible for ensuring appropriate governance arrangements within their own organisations.

4. STRATEGIC PRIORITIES

4.1 Developing strategic priorities for Kent and Medway needs to take into account both national strategic priorities and local services and information.

4.2 The key national priorities can be used to shape the framework for local action. However an understanding of current local services and local data are essential in ensuring that the strategic priorities and local action plans are robust. The current economic climate will also have an impact on which priorities are selected.

4.3 The 6 national priorities for suicide prevention are:

- To reduce risk in key high risk groups
- To promote wellbeing in the wider population
- To reduce the availability and lethality of suicide methods
- To improve the reporting of suicidal behaviour in the media
- To promote research on suicide and suicide prevention
- To improve monitoring of progress towards Saving Lives: Our Healthier Nation target for reducing suicide.

4.4 The local Information set out in the previous section has been obtained from the Kent and Medway Public Health Observatory and from local partners, particularly Kent Police who have carried out a review of all suicides from 01/07/08 and 30/06/09, and KMPT who carry out a detailed suicide audit on an annual basis of all suicides who are in contact with them at the time of their suicide or up to 12 months previously. In addition, feedback from the stakeholder interviews and the consultation event has been used to shape the national priorities to be appropriate for local use. Local strategic priorities are outlined below.

4.5 **PRIORITY 1: TO REDUCE RISK OF SUICIDE IN KEY HIGH RISK GROUPS**

The national strategy indicates the most appropriate high risk groups to target are:

- People who have currently or recently been in contact with mental health services
- People involved in self harming behaviour in the last year
- Young men
- Prisoners
- High risk occupational groups

In Kent and Medway the available data and discussion with stakeholders would broadly support this prioritisation but with the addition of older people and a change to include young to middle aged men with a focus on those who are unemployed.

So this strategy has prioritised the following high risk groups.

- People who have currently or recently been in contact with mental health services
- People involved in self harming behaviour in the last year
- Young – middle aged men with a focus on those who are unemployed
- Offenders, those in prison, in custody and in the community
- High risk occupational groups
- Older people

Stakeholders felt that it was also important that people suffering relationship difficulties, bereavement or financial difficulties and veterans were considered as a priority for appropriate interventions. These groups will be investigated further and are also included in Priority 2 for action.

4.5.1 Reducing suicide rates for people in contact with mental health services

In 2007 in Kent and Medway 29% of all suicides and open verdicts recorded in the general population had been in contact with local mental health services in the previous 12 months⁷. This is clearly a highly significant risk group.

There is also evidence that the majority of all completed suicides have had a previous diagnosis of at least one mental health disorder. International and national research confirms this. The percentage ranges from 89.7% of American suicides to 78.9% of Australian suicides⁸. Those with adult personality disorder, a psychiatric history, schizophrenia, bipolar disorder, depression or neurosis were 6.1 - 19.7 times more likely to die by suicide than those who were not mentally ill with depression and bipolar disorder located at the higher level of risk⁹.

Kent and Medway NHS and Social Care Partnership Trust (KMPT) currently leads this work across Kent and Medway. A Kent and Medway Suicide and Homicide Prevention Group is in place to oversee suicide prevention work with people in contact with KMPT mental health services. A Kent and Medway wide suicide audit is carried out on an annual basis for all suicides who are in this group. A strategy has been produced specifically for this group of people which has been shaped by information from the audit.

Reducing suicide rates for people in contact with mental health services clearly needs to remain a high priority. Key objectives identified in the KMPT strategy which need to be supported are as follows:

- Improved inpatient safety
- Safer leave and discharge planning
- Improving co-ordination between services including primary care
- Improved training in risk assessment
- Improved application of the Care Programme Approach including quality improvement via audit
- Improved services for patients, families and carers within the CPA
- Continue with and Implement recommendations from the KMPT suicide audit
- Improve services for personality disorder, intentional self harm and dual diagnosis patients
- Improve services for prisoners post release
- Promote R&D in suicide prevention
- Improved services for young and first episode patients
- Improved documentation and communication (particularly with respect to electronic records)

There is representation from KMPT on the multi-agency Kent and Medway Suicide prevention steering group and the yearly audit and progress on these objectives will be reported to the group on a regular basis.

However with the entry of other providers of mental health services across Kent and Medway there is a need to ensure that all providers of mental health services are engaged with this work.

4.5.2 Reducing suicides in people who have self harmed

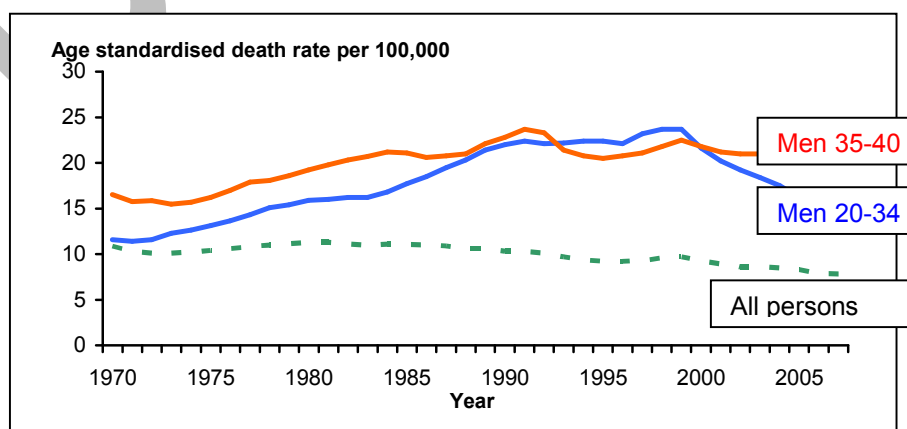
The 2004 NICE guidelines for the short term physical and psychological management and secondary prevention of self-harm in primary and secondary care highlight priority action for a range of agencies in responding to self harm appropriately¹⁰. The key priorities which need to be audited and implemented locally are as follows:

- Respect, understanding and choice. Ensuring that people who have self harmed are treated with the same care, respect and privacy as any patients.
- Staff training: 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 people who have self-harmed.
- Ambulance and emergency department services whose staff may be involved in the care of people who have self-harmed by poisoning should ensure that activated charcoal is immediately available to staff at all times.
- Appropriate triage needs to be available for all people who have self harmed
- Appropriate treatment detailed in the guidance needs to be offered for all people who have self-harmed
- Comprehensive needs assessment: All people who have self-harmed should be assessed for risk: this should include identification of the main clinical and demographic features known to be associated with risk of further self harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent.
- Psychological, psychosocial and pharmacological interventions: Following psychosocial assessment for people who have self-harmed, the decision about referral for further treatment and self help should be based upon a comprehensive psychiatric, psychological and social assessment and not be determined solely on the basis of self harm.

4.5.3 Reducing suicides in young to middle-aged men

With respect to targeting men, data presented in the previous section shows that approximately 76% of all suicides in Kent and Medway are men. The greatest number can be found in the 40-49 age band with the next highest number being in the 50-59 age band.

Fig: 10: Trend in suicide rate for men (aged 35-49) and young men (aged 20-34)
Death rates from Intentional Self-harm and Injury of Undetermined Intent, England



This is in keeping with the national data and it is interesting to note that previous data which indicated higher rates nationally in younger men 20 – 34 from the early 1990s now show that rates in men aged 35-49 are higher.

Both young and middle-aged men still remain a priority as the number of years of life lost in the younger age groups remains high.

National pilots as to appropriate initiatives for working with men have yielded ambivalent findings with recommendations that more successful initiatives will be likely to be those that engage men in activity rather than formal class-room based learning. Given current economic conditions a potential focus for work locally is working with unemployed men and improving awareness amongst employers of mental health issues.

4.5.4 Reducing suicides by offenders and those held in custody

Nationally and locally considerable work has gone on to reduce suicides in prisons. Suicide Prevention and Self Harm Management (Prison Service Order 2700, HM Prison Service) gives guidance to all prisons as to all their roles and responsibilities with respect to suicide prevention. Every prison is required to have a suicide prevention co-ordinator and a suicide prevention team which oversees policy development, monitors statistics and reviews cases. Prisons are also required to have Partnership Boards which include PCT membership which are responsible for oversight of this work.

There are nine prison establishments in Kent (out of 139 in England and Wales). They are shown in the following table, with the prison population as of April 2010

Table: 7 Prison establishments in Kent and Medway

Prison	Type	Population
Blantyre House, Goudhurst	Adult male Category C/D resettlement	122
Canterbury	Foreign national prisoners	303
Cookham Wood, Rochester	Male juveniles	110
East Sutton Park, Maidstone	Female (Adult and Young Offenders)	102
Elmley, Isle of Sheppey	Category B/C	1250
Maidstone	Category C adult male, Foreign nationals	610
Rochester YOI	Males up to 21 years	707
Standford Hill, Isle of Sheppey	Male Category D open	446
Swaleside, Isle of Sheppey	Male Category B (accepts life sentences)	1126

Source:HMPS 2010

In 2009/10 there were 6 self inflicted deaths in prisons who were in contact with mental health services in the prison.

A detailed needs assessment was undertaken by the Kent Forensic Psychiatry Service in 2007. As in a number of national studies, the report showed that mental health problems were more prevalent amongst prisoners than amongst the community as a whole.

The Eastern and Coastal Kent Prison Health Strategy states that 90% of prisoners have substance misuse, and/or mental health problems, personality disorder is common and 9% of the UK prisoner population suffer from severe and enduring mental illness.

However it has been increasingly recognized that suicide risk is increased in those held in police custody and offenders in the community.

As one response which works towards mitigating this risk police custody diversion

services have been set up across Kent and Medway. Community Psychiatric Nurses are attached to all police stations to ensure referral and signposting of people with mental health issues into appropriate services. This service has been made permanent in West Kent with pilots in Eastern and Coastal Kent and Medway in place. This service should be supported across Kent and Medway.

Kent Police have their own suicide prevention strategy which includes the development of appropriate training and risk assessment for all police officers.

4.5.5 Reducing suicide in high risk occupational groups

Research indicates that suicide rates are higher in certain occupations. The highest proportional mortality rates were found in medical and allied professions farmers (males only), nurses, health, education and welfare professionals and allied service workers. This list includes professions which would be compatible with higher social classes which runs contrary to what might be expected. This could be because there are lower mortality rates from other causes and there be greater access to means ¹¹.

Locally in Kent and Medway from the data available the greatest numbers would seem to be in the routine/manual workers occupational groups however further analysis looking at rates is necessary in order to confirm that the highest mortality rates are also within these groups. Numbers are also high in the retired and the unemployed groups.

4.5.6 Reducing suicide rates in older people

The ratio of suicide attempts to completed suicides in older people has been found to be about 4:1. This is much lower than in the general population and means that when an older person attempts suicide this should be taken very seriously as it is a very strong predictor of further completed suicide.

Psychological autopsy studies report that between 71% and 95% of those over 65 completing suicide had a diagnosable mental disorder at time of death, so it is clear that the presence of a psychiatric symptoms is strongly correlated to completed suicides in older people ¹².

The evidence directly linking poor physical health with suicide is mixed. Some physical conditions do appear to be correlated with higher suicide rates and others less so. The underlying physical illness may result in depression which in turn leads to suicide rather than the physical illness leading to suicide directly ¹²

The table below sets out the possible interventions for older people in suicide prevention.

Table 8 Primary, secondary and tertiary interventions for suicide in the older person. Adapted from De Leo, D Scocco, P. Treatment and Prevention of suicidal behaviour in the elderly ¹²

Primary Prevention	Secondary Prevention	Tertiary Prevention
Promotion of economic prosperity Personal Health Promotion Retirement planning	Detection of suicidal ideation Older person help-lines Community support programmes	Crisis Intervention systems Education programmes Individual and group Therapies (especially CBT) Self help groups Re-socialisation groups
Promotion of social participation Building networks of support Reduction in access to means	Access to mental health services Educational programmes Treatment of Depression Treatment of Psychological and Physical consequences of physical illness including pain management	

A priority focus in this area will be to improve the psychological assessment and care of older people particularly those with long-term condition and chronic pain.

4.5.6 Overall as part of the action plan in all these risk groups appropriate actions need to be outlined for all agencies who are in contact with them. People who contemplate suicide, or take their own life if they are not in contact with mental health services, will fall into one of two groups, each requiring a different service response.

- Those in contact with primary care
- Those in contact with other services

Primary care

Primary care has a key role to play in terms of appropriate identification, management and referral of people at high risk of suicide. Appropriate suicide prevention responses include depression screening, suicide screening of those with depression, access to medication, social prescribing and psychological therapies, signposting/referral to secondary care, social care and the voluntary sector. These need to be promoted in primary care in line with the appropriate NICE guidance.

Other services

Other services will include ambulance services, accident and emergency departments, the police, drug and alcohol services, housing and voluntary sector agencies. Appropriate service interventions are likely to include awareness training, appropriate identification, referral and signposting and management of suicide risk for other agencies.

4.6 **PRIORITY 2: TO PROMOTE WELLBEING IN THE WIDER POPULATION**

As the number of completed suicides is so small and in reality can come from a wide range of risk groups, promoting mental health and wellbeing in the wider population and for all risk groups an essential element of improving mental health and wellbeing and preventing suicide. In the Mental Health NSF and in the “New Horizons” mental health strategy, preventative work is a key priority.

Work that contributes to improving mental health across Kent and Medway is carried out by a variety of statutory and voluntary agencies. From a health perspective the following resource is dedicated to mental health promotion work in the PCT areas

- NHS Eastern and Coastal Kent: 3 wte mental health promotion specialists
- NHS West Kent: 1 wte mental health promotion specialist
- NHS Medway: Business case approved for 1 wte mental health promotion specialist.

An overarching Kent and Medway mental health strategy ‘Live It Well’ has been developed which includes a mental health promotion component. In Eastern and Coastal Kent a local mental health promotion strategy has also been developed and a similar process is underway in West Kent. Medway is developing its own mental health promotion framework based on the national strategy. The National Suicide Prevention Strategy¹³ notes that the following groups are of particular concern as needing targeted efforts

- Socially excluded and deprived groups
- BME communities
- People who misuse drugs or alcohol

- Survivors of child and domestic abuse
- Children and young people
- Women during and after pregnancy
- Older people
- Those bereaved by suicide

Of this list, for the purposes of this strategy following discussion with stakeholders 'older people' has been moved to a high risk group under Priority 1.

Although numbers are small the analysis carried out by Kent Police in 2008/9 indicates that with respect to recent significant life events financial problems were present in 14% of suicides with an additional 10% having employment problems. Relationship problems were present in 23% of suicides and 8% had suffered serious illness in the preceding 12 months. Very little information is available locally as to triggers but there is some evidence to suggest that arguing with a partner may be a factor.

In addition, where stated in 26% of suicides had consumed an excessive amount of alcohol with a further 15% consuming moderate amounts. 11% had an illegal drug addiction.

The suicide prevention steering group should ensure that all local mental health promotion strategies should take into account all these risk groups. There should be mental health promotion links from the PCTs to ensure that the development of strategies takes into account the needs of these groups. From discussion with stakeholders and looking at the data, the groups in the above list are all relevant locally but some additional groups have also been identified as of concern.

- bereavement particularly older people losing long term partners
- those leaving care
- veterans.
- LGBT
- dual diagnosis
- those who are having relationship difficulties and breakdown
- those who are experiencing financial and employment difficulties
- students

The groups above have been prioritized locally and should also be included in local mental health promotion work. Further investigation is needed in order to develop appropriate actions for all groups The greatest stakeholder consensus supported by the data was around

- bereavement,
- those who are experiencing relationship breakdown and
- those are experiencing financial and employment difficulties
- people who misuse drugs and alcohol.

Actions to tackle these will be included in the initial action plan for this strategy.

4.7 **PRIORITY 3: TO REDUCE THE AVAILABILITY AND LETHALITY OF SUICIDE METHODS**

There is strong evidence that restricting access to the means for committing suicide is effective in reducing suicides. This is because the level of suicide intent varies over time and deterring suicide when intent is at its highest may deter suicide until the level of intent reduces. Suicidal behaviour can be “impulsive”. Although method substitution does occur, a number of people will not go on to use another method and lives can therefore be saved¹³. Some of the actions to restrict access can only be taken nationally and these are set out in the National Suicide Prevention Strategy.

As stated previously using data from 2002-2007 the method most frequently used in Kent and Medway (as nationally) is hanging (43%), followed by drugs overdose (23%). Jumping from a height and death by inhalation and vapours each account for 6% of suicides.

Local priorities for action are as follows:

4.7.1 Reduce the number of suicides by hanging and suffocation

Hanging and strangulation are particularly associated with mental health wards and prisons¹³ but these are also frequent methods of suicide for men in the community.

Action has been taken as part of KMPT's work on suicide prevention to remove all potential ligature points in psychiatric inpatient wards.

Action has and is continuing to be taken as part of safer custody initiatives by the police and the prison service to re-design cells and windows in order to make the custody environment safer.

4.7.2 Reduce the number of suicides by self poisoning

National action has been taken on this priority to improve safer prescribing. The appropriate and timely use of activated charcoal in preventing fatalities highlighted in the self harm section will also be a priority action here.

Additional local priority actions have been outlined in the attached action plan and could include auditing the safe prescribing of anti-depressants in primary care and mental health services.

4.7.3 Reduce the number of suicides on the railways

The Rail Safety and Standards Board (RSSB) collects its own data on railway suicides. Data on location of death is also collected by the police as part of monitoring suicides across Kent and Medway. This includes railway suicides. The RSSB has taken the problem of railway suicide very seriously. A major report on Suicides and Open Verdicts on the Railway Network (SOVRN) was published in 2003. Following publication of this a national Rail Fatalities Management Group was set up until 2006 which oversaw a series of visits to station operators by RSSB and the Samaritans to agree programmes of suicide prevention.

Potential rail hotspots in Kent and Medway need to be identified and monitored. Appropriate further local action needed should be agreed and implemented with relevant partner agencies.

4.7.4 Reduce the number of suicides as a result of jumping from high places

Locations offering opportunities for suicide by jumping include bridges, viaducts, high-rise hotels, multi-storey car-parks and other tall buildings, cliffs and other topographical features. Suicidal jumps have a high fatality rate⁽¹⁴⁾ are highly traumatic for people living below the jump site⁽¹⁵⁾ and tend to attract copycat suicides. All the world's leading hotspot sites are in fact jumping sites.

Only one year's data is currently available with respect to identification of jumping hotspots in Kent and Medway. This indicates that the only site with more than one suicide in that time period.

Further investigation and ongoing monitoring of geographical place of death is needed to ensure hotspots are appropriately identified.

Where potential hotspots are identified, relevant partners need to decide and agree on appropriate management action. Possible actions include

- Physical barriers
- Signs and telephone hotlines
- Suicide patrols
- Training for staff of non-health agencies working at or near hotspots
- Restrictions on media reporting.

4.8 **PRIORITY 4: TO IMPROVE REPORTING OF SUICIDAL BEHAVIOUR IN THE MEDIA**

The evidence of the impact of media portrayals of suicide on imitative behaviour and therefore copycat suicides was the subject of a systematic review in 2001⁽¹⁶⁾. This included 90 studies from 20 countries and concluded that evidence of a link between coverage and imitative behaviour was significant. A guide for the media has been produced by the national MediaWise Trust which highlights good practice with respect to covering suicide.

As a key objective there is a need to ensure that in Kent and Medway all press and media agencies are aware of the appropriate guidance and implementing it.

There is also a need to ensure that the media is monitored for any inappropriate reporting of suicide and appropriate action taken.

4.9 **PRIORITY 5: TO MONITOR SUICIDE STATISTICS AND PROGRESS TOWARDS NATIONAL TARGETS AND ENSURE APPROPRIATE AUDIT.**

In order to understand how to effectively move forward with suicide prevention it is essential that we continue to collect and analyse data relating to suicide and self harm from across Kent and Medway. We need to monitor trends and any specific local variation from national trends in order to develop effective interventions. We also need to be clear as to our local epidemiology to be sure we are effectively targeting local groups

Combining information from partner agencies will allow for a much clearer picture of the current situation than has been the case previously and using this information appropriately will enable more targeted work to be developed. Key agencies that need to be involved in this are KMPT, Kent Police, PCTs and Acute Trusts. Kent Police have committed to continue to monitor all suicides across Kent and Medway and to analyse and share this information. This will need to be done under appropriate information sharing protocols. Information on suicide rates and trends will be reported to the steering group on an annual basis using national data by the PCTs. Other information such as development

of suicide clusters will be shared for appropriate action as appropriate.

With respect to audits of current practice. This has been highlighted under specific priorities earlier but key audits that needed to be continued or promoted are:

- KMPT retrospective suicide audit carried out annually
- Audit of management and treatment of self harm in A&E
- Significant event audits in primary care

Information from these audits will help to inform the actions taken to prevent suicide across Kent and Medway on an ongoing basis.

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APPENDIX 1:

**CURRENT ORGANISATIONAL MEMBERSHIP OF THE KENT AND MEDWAY
SUICIDE PREVENTION STEERING GROUP**

East Kent Hospitals Foundation Trust

Kent and Medway NHS and Social Care Partnership Trust: A&E liaison service

Kent and Medway NHS and Social Care Partnership Trust: Chair of KMPT Suicide and
Homicide Prevention Steering Group

Kent Drugs and Alcohol Action Team

Medway Drugs and Alcohol Action Team

Kent Police

NHS Medway: Public Health

NHS Medway: Mental Health Commissioning

NHS Medway Medicines Management

NHS Eastern and Coastal Kent: Public Health

NHS West Kent

Rethink

Samaritans

South East Coast Strategic Health Authority

Canterbury Christchurch University

APPENDIX 2: Delegates registered as part of the stakeholder consultation

(some delegates sent alternative representation on their behalf)

NAME	ORGANISATION
Angela Shorter	Acute Care Services Manager, KMPT
Anne Tidmarsh	KCC
April Wiltshire	Assistant Psychologist, Home Treatment Service CHHTOP KMPT
Athene Lane-Martin	Eastern and Coastal Kent
Belinda Wells	Managing Director Organisation Counselling Team Limited
Bonita King	Clinical Nurse Specialist MIMHS Team Kent & Medway NSH and Social Care Trust,
Bose Johnson	Public Health Specialist Practitioner Kent and Medway
Carol Gosal	Rethink Organisation
Caroline Davis	Eastern and Coastal Kent
Chris Allman	Mental Health Recovery Worker
Colette Pinion	Team Leader, CRI Safe Exit
Dave Mottloy	Tenancy Support Officer
Dave Woodward	KCC
David Coldwell	Director - Medway, Gravesham & Swale West Samaritans
Debbie Stock	NHS West Kent
Debra Richards	Community Support worker, KASS
Donna Barker	Team Leader, Casa Support
Dr Ann Andrew	Consultant Psychiatrist
Dr E Lunt	GP Commissioning & IAPT Development
Dr. Joanne Ross	Fit for work pilot Project Manager
Fiona Cave	Community Nurse Learning Disabilities
Gaby Price	Commissioning Manager, Kent Drug & Alcohol Team
Gill Smith	Porchlight
Glenda Ratcliffe	Tenancy Support Officer
Gloria and Malcolm Phyll	Members of East Kent Carers Council
Hana Soliman	Kent and Medway Partnership Trust
Heather Sylvester	Mental Health Recover Worker
Ian Marsh	SUI
Jane Berwick	Senior Occupational Therapist
Jane Wiltshire	Mental Health Commissioning Manager Kent and Medway
Jayne Curran	Eastern and Coastal Kent
Jenny Nuttman	Community Senior KASS mental health team
Jessica Mookherjee	West Kent PCT
Jonathan Sexton	NHS Eastern and Coastal Kent
June Cresswell	Community Support Office, Mental Health
Karen Dorey-Rees	Associate Director - Recovery Services KMPT
Karen Macarthur	Public Health Consultant
Kathy Govett	NHS Eastern and Coastal Kent
Kay Rollinson	NHS Eastern and Coastal Kent
Keith Foster	Suicide Prevention Strategy Implementation Lead National Mental Health Development Unit
Kerry Smith	Operations Manager - KCA
Kevin Molloy	Director of Operations, KCA
Kim Solly	Eastern and Coastal Directorate, Kent and Medway NHS & Social Care Partnership Trust
Laura Bell	Tenancy Support Officer, MOAT HA

NAME	ORGANISATION
Laurence Allen	Acute Care Services Manager, KMPT
Lauretta Kavangh	Director of commissioning for Mental Health Kent and Medway
Lesley Andrews	Kent Gov.
Linda Caldwell	Eastern and Coastal Kent
Linda Meise	PWP
Linda Prickett	West Kent PCT
Lorraine Main	CRI.IDTS HMP Sheppey cluster
Lou Bean	Clinical Audit & Effectiveness Manager KMPT
Louise Parker	Southeast Coast
Lynda Burr	Service Manager, KCA PTP
Malcolm Brown	Clinical Risk Trainer, K&M NHS Trust Learning & Development
Maria Shepperd	Kent PNN Police
Marian Draper,	Locality Service Manager Ashford Community Mental Health Team
Marie Beckett	EKHT
Martin Featherstone	Chief Exec. Medway CVS
Matthew Long	Kent Police
Merryl Chesher	Service Manager Maidstone Mind
Nichola Williams	Immediate Care Team, Folkestone
Paul Absolon	Kent Gov
Paul Burley	Services Manager, Action for Change
Paul Chapman	Samaritans
Peter Konopasek	Tenancy Support Officer, MOAT HA
Phil Kessel	SEVENOAKS AREA mental HEALTH AWARENESS GROUP - MIND
Philip Penders	Samaritans
Professor Hana Soliman	Consultant Psychiatrist
Ray Forrester	Tenancy Support Officer
Raymond Hickton	Rehab home for the NHS
Reena Sooch	Rethink Org
Richard Adkin	Interim Services Manager Mental Health Medway
Richard Adkin	Medway council
Roz Macklin	mental Health Recovery Worker
Sally Castle	CPN, CMHT, NHS
Sally Denley	Eastern and Coastal Kent
Sally Evans	IAPT Clinical Lead, Organisation counselling Team Ltd
Sandra Allen	Senior Practitioners
Sara Moreland	Health Promotion Practitioner Specialist Mental Health - Eastern Coastal Kent
Sean Feeney	Kent and Medway Partnership Trust
Sharon Dennis	IAPT Programme Manager, Mental Health Commissioning
Sharon Rowe	Clinical Nurse Specialist MIMHS Team Kent & Medway NSH and Social Care Trust,
Stephen Deaves	Tenancy Support Officer, MOAT HA
Sue Thomson	mental Health Recovery Worker
Theresa Turle	Eastern and Coastal Kent
Tracey Jones	Development Officer - CVS Medway
Tracey Wightman	MCCH
Tracy Smith-Dance	Head of Services, Sevenoaks Area Mind
Vanessa Fowler	Head of Specialist Mental Health & Secure Services Commissioning For Kent and Medway

**APPENDIX 3:
EFFECTIVE INTERVENTIONS (Kensington and Chelsea Suicide Prevention
Strategy 2009)**

1. INTERVENTIONS WITH EVIDENCE OF EFFECTIVENESS

1.1 INTERVENTIONS AIMED AT THE GENERAL POPULATION

- Depression screening and group activity for elderly people
- Gatekeeper training for those in contact with potentially vulnerable people
- Media training and guidelines to promote responsible reporting
- Family based interventions tackling family risk factors linked to mental health of offspring
- Screening tests for suicide risk
- GP Education on risk factors and what to do

1.2 INTERVENTIONS WITH SUB POPULATIONS

- On line screening for suicidality of university students
- Counselling and support for “at risk” Groups in universities
- Sliding doors and barriers on the underground
- Deep pits under rails on the underground
- Skills based training and social support for “at risk” adolescents
- Behavioural change programmes

1.3 INTERVENTIONS WITH “AT RISK” GROUPS THAT WORK

- Optimal clinical care for people with mental illness
- GP Training in recognising and treating depression in older adults
- Anti-depressant prescribing and SSRI
- Prescribing: Clozapine, Lithium, Depot Flupenthixol
- CMHT's

- Follow up letter after discharge
- Transfer of information to and from prison to ensure continuity of care – especially regarding those considered at risk of suicide
- Counselling for problem drinkers
- Problem solving skills training for at risk adolescents in schools

1.4 INTERVENTIONS WITH THOSE WHO HAVE ATTEMPTED SUICIDE OR SELF HARM

1.4.1 Attempted Suicide

- Training in resuscitation and emergency management for hospital staff
- “Chain of care” – structured collaboration, multi-disciplinary network
- Therapies: problem solving, dialectical behaviour
- “ASIST” interventions and “ASIST” training for staff (Applied Suicide Intervention and Support training)

1.4.2 Self Harm (adults)

- “Green Card” with emergency numbers/contacts
- Mentalisation Based Treatment (MBT)
- Dialectical Behaviour Therapy

1.5 MEANS RESTRICTION

- Educating parents/carers about limiting access to means
- Restriction on sale and prescription of barbiturates
- Barriers at jumping sites
- Analgesics in blister packs
- Media blackout/restrictions
- Restrictions on access to alcohol

- Use of lower toxicity anti-depressants
- Removing ligature points from in patient wards/regular audits
- Reduce amount of paracetamol sold per packet
- Restricting the availability of Coproxamol

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APPENDIX 4: KENT AND MEDWAY SUICIDE PREVENTION IMPLEMENTATION PLAN 2010-2015

	Action needed	Lead agency/contact	Completion date
Priority 1: To reduce risk in key high risk groups			
Reducing suicide rates for those in contact with mental health services	<p>KMPT Suicide Audit to continue on an annual basis to provide appropriate information for action</p> <p>Action plan for KMPT suicide prevention strategy to be implemented (See attached)</p> <p>Liaise with other key providers of mental health services to ensure that appropriate suicide prevention action is in place</p>	<p>Mike Kingham: Kent and Medway NHS and Social Care Partnership</p> <p>Mike Kingham Kent and Medway NHS and Social Care Partnership Trust</p> <p>PCTs Public Health/Mental Health Commissioning</p>	<p>Ongoing</p> <p>As on action plan attached</p>
Reducing suicide rates for those who have self harmed	<p>Promote compliance with NICE guidance on self harm by</p> <ul style="list-style-type: none"> • clinical staff, • primary care, • other relevant agencies substance misuse staff, housing <p>Specifically</p> <ul style="list-style-type: none"> • Carry out an audit of the treatment and management of self harm in A&E departments across Kent and Medway. • Develop and deliver appropriate training for A&E staff in response to this audit • Links between primary care, A&E and secondary care need to be improved. Robust A&E liaison 	<p>Acute Trusts/PCTS/KMPT</p> <p>Lead: Kim Solly A&E liaison</p> <p>Lead: Kim Solly A&E liaison</p> <p>Lead: Kim Solly A&E liaison</p>	<p>Dec 2010</p> <p>June 2011</p> <p>June 2011</p>

	Action needed	Lead agency/contact	Completion date
	<p>services to be in place across Kent and Medway</p> <ul style="list-style-type: none"> • Ensure appropriate training developed and delivered for primary care staff. 	PCTS/MHP specialists	March 2011
Reducing suicide rates in men targeting the unemployed and routine and manual groups	<ul style="list-style-type: none"> • Ensure Credit Crunch Stressline number promoted across Kent and Medway • Liaise with Jobcentre Plus + other agencies working with unemployed men to ensure appropriate training around mental health awareness and suicide prevention training 	Comms PCTS/MHP specialists/Samaritans	August 2010
Reducing suicide rates amongst offenders	<ul style="list-style-type: none"> • Monitor prison health performance indicators around suicide prevention. • Ensure mental health services for prisons are funded appropriately across Kent and Medway • Ensure permanent funding of CPN assessment in custody suite diversion services across Kent and Medway PCT. • Training for all police officers in identification and referral for people with mental health disorders 	<p>Kent and Medway Offender Health Partnership Board</p> <p>Vanessa Fowler/ Mental Health Commissioning</p> <p>Matt Long Kent Police</p>	<p>Ongoing</p> <p>Ongoing</p> <p>Dec 2010</p>
Reducing suicide rates amongst older people	<p>Training for agencies working with older people to include suicide prevention awareness</p> <p>Investigate introducing a psychological aspect to the care plan of someone with a long-term condition</p>	<p>Karen Macarthur PH Lead</p>	tbc
Improving the primary care response to identification and management of suicide risk	<p>Liaise with primary care to ensure 1 significant event audit carried out per PCT per year on a completed patient suicide .</p> <p>Ensure appropriate training for GPs in all PCTs on</p>	Karen Macarthur PH Lead PCTs	tbc

	Action needed	Lead agency/contact	Completion date
	identification and assessment of high risk patients, depression and suicide screening , signposting /referral to secondary care, social care and the voluntary sector , social prescribing and psychological therapies		
Actions for agencies working across all the risk groups	<p>Ensure appropriate mental health awareness/suicide prevention training (e.g ASIST and STORM) in all agencies working with high risk groups.</p> <p>This includes</p> <ul style="list-style-type: none"> • Health and social care staff • Job Centre + staff • Voluntary agencies • Police • Youth workers • Probation staff <p>Specifically training needs analysis across Kent and Medway to be carried out for key agencies.</p>	Bose Johnson: MHP specialist/ Partners	Dec 2010
Priority 2: To promote wellbeing in the wider population			
Population based mental health promotion interventions	<ul style="list-style-type: none"> • To ensure that information as to appropriate information help are widely available. Samaritans, Mental Health Matters information to be publicised more widely. • To support the promotion of the mental health and wellbeing 5 a day message and the Live It Well website on all NHS and provider websites 	Comms PCTs MHP specialists	Dec 2010
Targeted interventions for improving the mental wellbeing of those bereaved particularly by suicide	<ul style="list-style-type: none"> • Circulate copies of “Help is at Hand” suicide bereavement support pack aimed at those who have lost someone through suicide to coroners, registrars, hospitals, police and funeral directors. • Investigate access to bereavement counseling and 	NHS Medway/Samaritans/Comms	Dec 2010 Dec 2010

	Action needed	Lead agency/contact	Completion date
	take steps to improve		
Targeted interventions for those in financial difficulties	<ul style="list-style-type: none"> Support access to debt advice and ensure all health and social care workers are trained in signposting appropriately 	MHP specialists	
Targeted interventions for people who misuse drugs or alcohol	<ul style="list-style-type: none"> Carry out training needs analysis to identify current gaps for drug and alcohol workers with respect to mental health awareness and suicide prevention training. Ensure appropriate training delivered in all providers including signposting to mental wellbeing services. Kent wide suicide prevention review panel set up to review all cases of suicide in contact with alcohol services at the time of death or in the previous 12 months 	KDAAT/MDAAT	Dec 2010 March 2011 Dec 2010
Targeted interventions for those with relationship difficulties	<ul style="list-style-type: none"> Investigate level of current provision across Kent and Medway and identify additional signposting and resource issues 	Karen Macarthur MHP specialists	Dec 2010
Priority 3: To reduce the availability and lethality of suicide methods			
Reduce the numbers of suicides by hanging and suffocation	<ul style="list-style-type: none"> TBC 		
Reduce the numbers of suicides by self-poisoning	<ul style="list-style-type: none"> Investigate use of "Scriptwatch" system to produce "pop-up" boxes listing advised volumes and safer anti depressants Advise prescribers that all patients with a history of self harm in the past 3 months should receive limited supplies of medicine e.g. covering no more than 2 weeks PCT Medicines management teams to support community pharmacies to conduct audit of antipsychotic medication concordance to identify signs that patients are not taking high risk medicines correctly. 	Anne Child Medicines Management NHS Medway	September 2010 September 2010 March 2011

	Action needed	Lead agency/contact	Completion date
	<ul style="list-style-type: none"> Ensure activated charcoal available in all A&E's and ambulances and staff appropriately trained 		
Reduce the numbers of suicides on the railways	<ul style="list-style-type: none"> Liaise with railways to identify appropriate additional actions. 	Karen Macarthur PH Lead	June 2010
Reduce the numbers of suicides by jumping from a high place	<ul style="list-style-type: none"> Using police data <ul style="list-style-type: none"> identify hotspots work with local agencies, the police and the Samaritans in order to manage appropriately with reference to national guidance 	PCTs/Police/Samaritans Matt Long Kent Police	August 2010
Priority 4: To improve the reporting of suicidal behaviour in the media	<ul style="list-style-type: none"> Circulate "<i>What's the story? Reporting Mental Health and Suicide: A resource for journalists and editors</i> to all appropriate news agencies in Kent and Medway. Monitor reporting of suicide coverage in the media and intervene as appropriate 	PCTs/ Communications	September 2010
Priority 5: To ensure appropriate monitoring of suicide statistics and audit of services	<ul style="list-style-type: none"> To work with KMPHO, PCTs, acute Trusts, the police and other partner agencies to ensure detailed information on suicides across Kent and Medway is collected and analysed. To prepare and present updated suicide statistics and trends to the K&M suicide steering group, the Kent and Medway Mental Health Strategic Commissioning Board and the Joint Mental Health Commissioning Boards of the 3 PCTs. To ensure appropriate information sharing protocols are in place and agencies can respond To carry out audits of management of self harm in A&E across all acute Trusts, KMPT audit to continue Significant event audits of suicides in contact with primary care to be carried out Audit of prescribing of anti-psychotic medication in primary care 	KMPHO/ Public Health	Ongoing Annually

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