

Hope from Despair

Suicide Prevention



A Strategy for Doncaster

CONTENTS

Page no.

SECTION 1

1.	The Local Perspective	5
2.	The National Perspective	25
3.	The National Suicide Prevention Strategy	26
4.	Locally developed suicide prevention strategies	29
5.	The Literature	32

SECTION 2

6.	The Doncaster Wide Suicide Strategy	44
7.	Recommendations	48
	7.1 Primary Prevention Strategies	48
	7.2 Secondary Prevention Strategies	52
	7.3 Intervention	56
	7.4 Postvention	57
	7.5 Resources available	60

INTRODUCTION

Death from Suicide is one of the biggest killers of young people in the UK today. It is not, however, confined just to younger men, this study indicates that, within Doncaster, all age ranges, socio economic groups and genders are represented. The aftermath of suicide also affects family members and friends (survivors of suicide). It is estimated that there are at least 3,000 such survivors of suicides in Doncaster. This is based on the fact that Doncaster has more than 20 suicide deaths each year. The lives of families, friends and colleagues are all, in some way and to some degree or other impacted upon by this tragic event.

Assessing suicide is not an exact science and a simplistic review of risk factors only goes a small way towards indicating the potential of an individual to take their own life. Reducing access to the method of suicide and the creation of safe environments is useful within institutional and care settings; limiting access to railways and highways has shown positive results. However, the majority of cases of suicide within Doncaster occurred in the home, or outside of institutional settings, by people not known to the mental health services indicating that a much more fundamental approach be adopted, addressing living conditions, access to services, primary care support and monitoring.

This strategy explores the multi-facted elements relating to addressing suicide within Doncaster. It reviews the socio-economic profile of the area, develops an understanding of the recent deaths by suicide and identifies patterns and risk factors. Alongside this local approach, the strategy makes reference to the large amount of literature and strategies in the wider community and identifies models of good practice which may be adopted within the area. Interviews with staff, families and the voluntary sector have assisted in the development of a strategy which is both personally and locally sensitive. Finally, a set of recommendations and options have been developed, over a number of workshops, which are pragmatic, implementable, locally relevant and cost effective.

This strategy has been developed with the support of Mental Health Strategies and Victor Joseph, public health specialist, working in collaboration with a multi-agency forum with representatives from the voluntary, statutory and personal services.

SECTION 1

1. THE LOCAL PERSPECTIVE

1.1 General Profile of the Doncaster Area

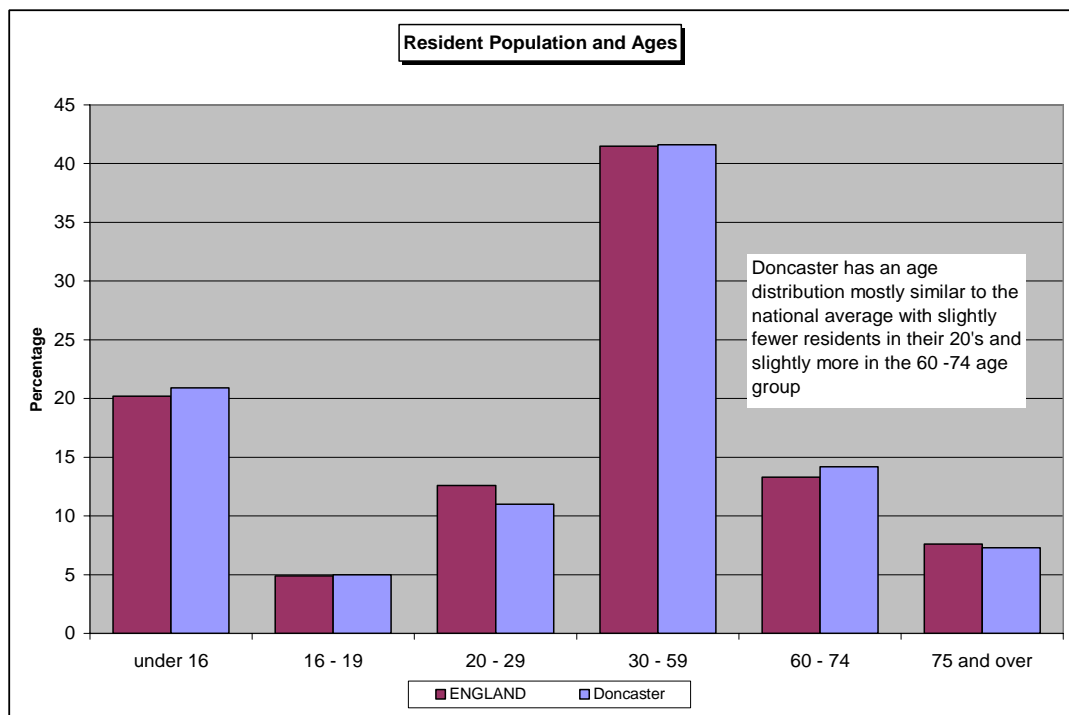
Introduction

This section aims to give general information about the Doncaster area and covers the following general topics:

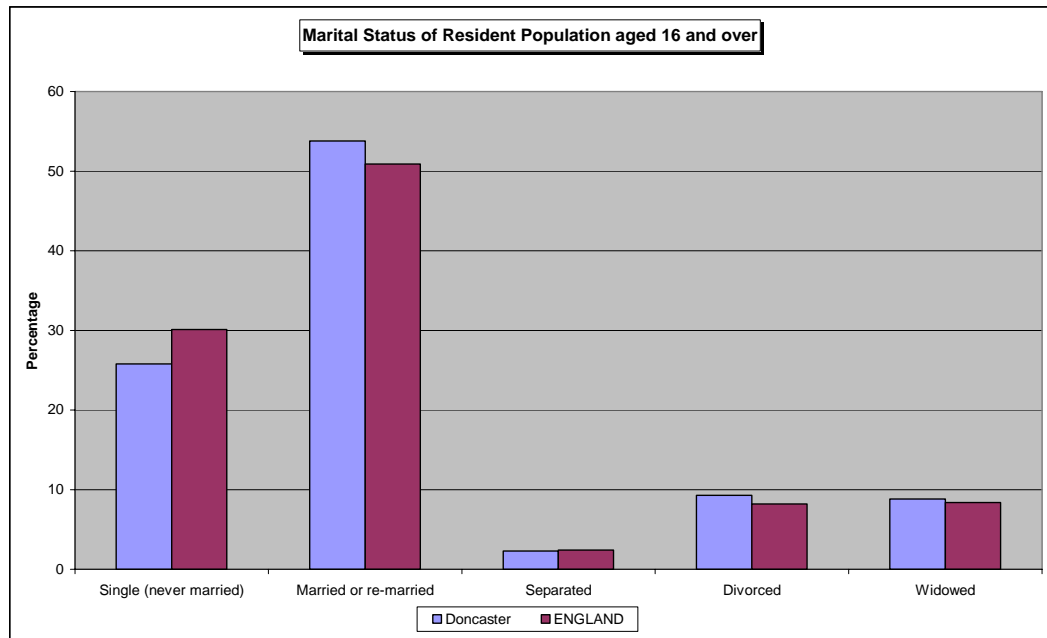
- o resident population and ages
- o marital status
- o ethnic and religion groupings
- o general health and provision of unpaid care
- o economic activity
- o student populations and qualification levels
- o housing and household characteristics
- o crime levels.

The information is provided principally in graphical form, with comparisons to the national average and a table is also shown giving comparison on key figures with the four local authorities most similar to Doncaster - Barnsley, Bassetlaw, Mansfield and Rotherham.

Age Mix, Marital Status, Ethnicity and Religion



The age distribution of the Doncaster area is not unusual, nor does the marital status of its population differ significantly from the national average although the proportion of residents who have been married or divorced is above the national norm.



Doncaster has a smaller ethnic minority population than the national average as tabled below.

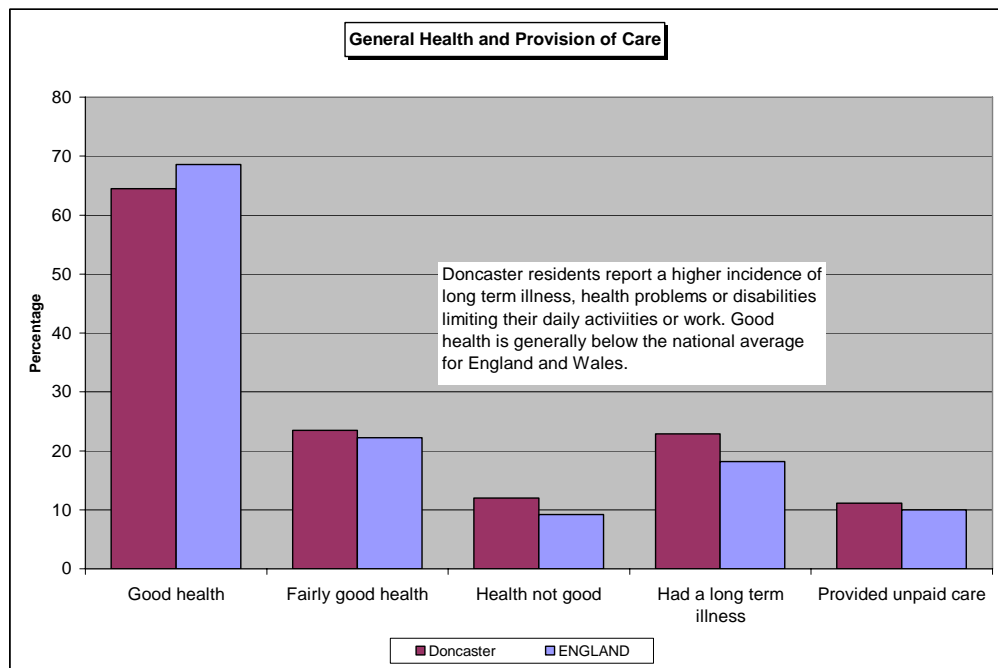
Ethnic Group		
	Doncaster	ENGLAND
White	97.7%	90.9%
Mixed	0.6%	1.3%
Asian or Asian British	1.1%	4.6%
Black or Black British	0.4%	2.1%
Chinese or Other Ethnic group	0.3%	0.9%

Religion		
	Doncaster	ENGLAND
Christian	79.6%	71.8%
Buddhist or Hindhu	0.3%	1.4%
Jewish	0.0%	0.5%
Muslim	0.7%	3.0%
Sikh	0.3%	0.6%
Other religions or religion not stated	7.8%	8.0%
No religion	7.5%	7.7%

Christianity is the predominant stated religion with minority religions broadly in keeping with expected ethnic groups.

General Health of the Population

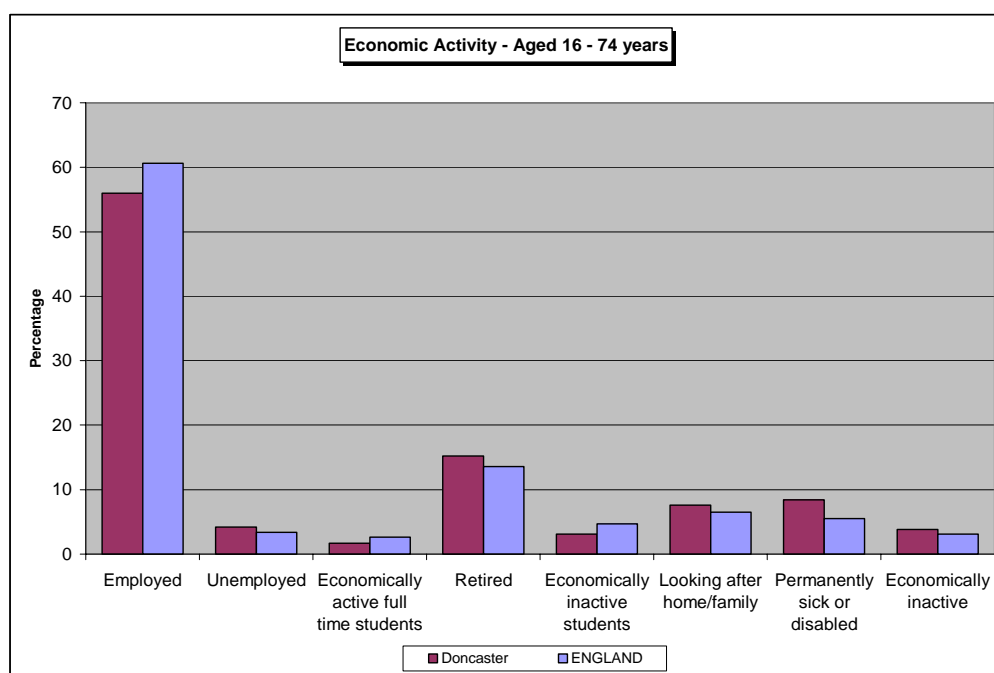
Fewer people in Doncaster reported that their health was good, compared to the national average, and more people suffer from long term illnesses.



More people provide voluntary unpaid care than the national average (11.1% locally compared to 10% for England and Wales). About 9% of the resident population are paid disability or attendance allowances.

Health related benefits paid in Doncaster		
	Number	%
Disability allowance	16,135	6%
Attendance allowance	7,425	3%
Resident population	286,866	

Economic Activity

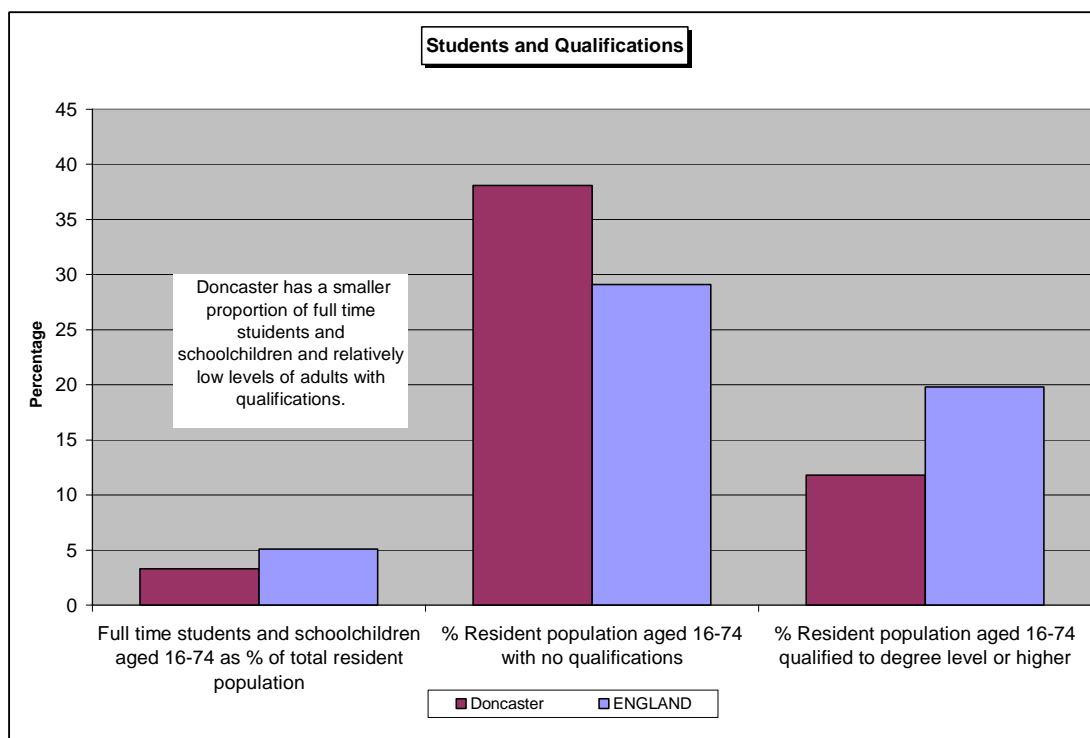


Doncaster has a lower economically active population than the national average, due to a combination of factors such as higher unemployment levels and higher levels of permanently sick or disabled, which has the secondary effect of requiring more people to look after and care for them. 8.4% of the population is permanently sick or disabled.

Economic Activity		
Percentages	Doncaster	ENGLAND
Employed	56.0%	60.6%
Unemployed	4.2%	3.4%
Economically active full time students	1.7%	2.6%
Retired	15.2%	13.6%
Economically inactive students	3.1%	4.7%
Looking after home/family	7.6%	6.5%
Permanently sick or disabled	8.4%	5.5%
Economically inactive	3.8%	3.1%

Student Populations and Qualification Levels

The proportion of residents with qualifications is relatively low as shown in the accompanying chart and table below. Fewer residents have qualifications and fewer people in the area are qualified to degree level or higher.



Students and qualifications

	Doncaster	ENGLAND
Full time students and schoolchildren aged 16-74 as % of total resident population	3.3%	5.1%
% Resident population aged 16-74 with no qualifications	38.1%	29.1%
% Resident population aged 16-74 qualified to degree level or higher	11.8%	19.8%
Total number of full time students aged 16 - 17	5,457	1,014,284
Total number of full time students aged 18 - 74	4,115	1,634,708
Total number of full time students and schoolchildren aged 16 -74	9572	2,648,992

Housing and Household Characteristics

Housing and Households 1

	Doncaster	ENGLAND
One person households	27.6%	30.0%
Pensioners living alone	14.9%	14.4%
Other Pensioner households	31.4%	29.5%
Lone parent households with dependent children	6.8%	6.5%
Average household size (number)	2.4	2.4
Average number of rooms per household	5.4	5.3

Housing and Households 2

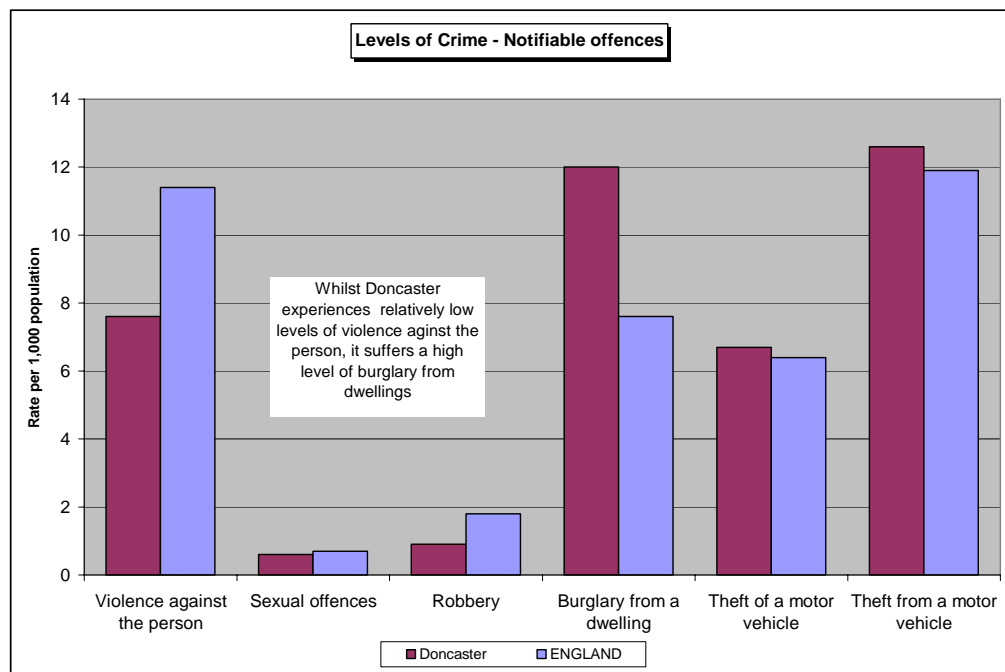
	Doncaster	ENGLAND
Owner occupied	69.6%	68.9%
Rented from Council	19.1%	13.2%
Rented from Others	11.3%	17.9%
Without central heating	6.3%	8.5%
Have no car or van	30.7%	26.8%

Housing Types

	Doncaster	ENGLAND
Detached	22.9%	22.8%
Semi Detached	44.9%	31.5%
Terraced	24.9%	26.0%
Flat	6.6%	19.2%

Crime Levels

Doncaster residents are less likely to suffer crimes of violence against the person but more likely to experience burglary from their dwellings.



Summary - How Doncaster compares with Similar Local Authorities

The table below compares Doncaster with the four most similar local authorities on a range of indicators.

Results are expressed as percentages of resident populations with the exception of household occupancy which are expressed as averages.

	Doncaster	Most Similar Local Authorities			
		Barnsley	Bassetlaw	Mansfield	Rotherham
Age 0 - 4	5.9%	5.7%	5.6%	5.5%	6.1%
Age 5 -14	13.6%	13.3%	13.0%	13.8%	13.6%
Age 25 - 44	28.2%	29.0%	28.3%	28.4%	28.6%
Age 45 - 64	24.4%	24.8%	26.1%	24.5%	24.9%
Indian/ Pakistani/ Bangladeshi	1.1%	0.3%	0.5%	0.6%	2.2%
Black	0.4%	0.1%	0.3%	0.3%	0.2%
Not born in UK	2.9%	1.7%	2.5%	2.7%	2.6%
Population density	5.05	6.63	1.69	12.80	8.66
Separated/ widowed/ divorced	16.9%	16.8%	15.8%	16.7%	16.0%
Single person household	12.7%	13.1%	12.9%	14.1%	12.8%
Single pensioner household	14.9%	14.9%	14.1%	14.3%	14.4%
Lone parent household	6.8%	7.3%	6.3%	7.6%	6.8%
Two adult no children household	18.7%	19.0%	21.1%	19.2%	19.0%
Rent (public)	20.9%	25.7%	19.7%	20.8%	26.4%
Rent (private)	9.5%	10.1%	9.2%	9.3%	8.3%
Terrace	24.9%	25.5%	16.8%	21.1%	20.2%
Detached	22.9%	20.9%	33.0%	27.1%	20.3%
Flats	6.6%	6.6%	6.7%	8.5%	10.4%
No central heating	6.3%	3.5%	4.4%	4.4%	4.2%
Household size	2.4	2.3	2.4	2.3	2.4
People per room	0.44	0.46	0.42	0.45	0.46
HE qualifications	11.8%	11.1%	14.0%	10.0%	11.5%
Professional or managerial	18.8%	17.7%	21.5%	18.3%	19.7%
Routine occupation	27.0%	27.8%	25.7%	27.7%	27.1%
Two car household	24.5%	24.0%	31.3%	25.6%	26.3%
Public transport	11.4%	9.1%	3.9%	8.0%	13.1%
Work from home	7.8%	7.4%	9.3%	7.1%	6.9%
Limiting long-term illness	18.4%	21.1%	17.7%	20.1%	17.4%
Provide unpaid care	11.1%	12.0%	11.5%	11.9%	12.2%
Student	4.8%	4.8%	5.0%	4.8%	4.9%
Unemployment	4.2%	3.9%	4.0%	4.4%	4.0%
Long term unemployment	32.4%	32.5%	31.8%	29.2%	30.8%
Men working part-time	4.0%	2.9%	3.9%	3.3%	3.3%
Women looking after the home	13.7%	13.0%	12.8%	13.4%	13.1%
Women working part time	22.7%	21.5%	23.1%	22.3%	23.3%
Agriculture/ fishing	1.2%	0.9%	2.4%	1.0%	0.8%
Mining/ quarrying/ construction	10.0%	9.9%	9.0%	10.9%	8.8%
Manufacturing	16.5%	20.2%	19.0%	19.0%	20.2%
Hotel & catering	4.6%	4.6%	4.8%	5.1%	4.6%
Health/ social work	11.7%	11.8%	12.7%	12.2%	11.4%
Finance	2.5%	2.4%	2.1%	2.4%	3.7%
Wholesale/ retail	19.5%	18.6%	18.7%	18.6%	18.8%

1.2 Audit of Suicide Deaths in Doncaster: 2003

1.2.1 Introduction

The audit of suicide deaths in Doncaster provides an insight into the local perspective of suicide deaths to inform the process of developing a local suicide prevention strategy

1.2.2 Aims and Objectives of Suicide Audit

The suicide audit aims to assess the effectiveness and efficiency of the local actions to reduce suicide.

Specific objectives of the audit of suicide deaths included:

1. To identify the number of suicide deaths that occurred among the residents of Doncaster during 2003.
2. To identify characteristics (risk factors) associated with suicide deaths in Doncaster.
3. To determine the number of suicide deaths, with mention of mental illness from coroner's record, that were known to mental health services.
4. To determine the trend in mortality from suicide deaths in Doncaster compared with England and Wales.
5. To prototype a method of information gathering for future audit of suicide deaths.

1.2.3 Methods

1.2.3.1 Suicide Data Collection

Coroner's Office

Contact was made with the Coroner's Office in Doncaster through the Director of Public Health for Doncaster West Primary Care Trust in order to obtain information on local suicide deaths in 2003. The information was retrieved from the files of suicide cases (and open verdicts) by a public health professional.

Certified suicide deaths (and open verdicts) by the Coroner for Doncaster's residents were all examined. Those that occurred to residents of another district were excluded. Information was gathered on age, sex, occupation, marital status, methods of suicide, and important factors associated with suicide deaths. Ethnicity was obtained from pathologist description, police record or photographs in the case files.

Public Health Mortality File

The final list of cases obtained from the Coroner's office was checked against data reported to the Doncaster Public Health Intelligence Unit. The ICD-10 codes related to suicide and undetermined injury are; X60-X84, Y10-Y34 not Y33; ICD9 E950-E959 and E980-E989 excluding E988.8). Deaths from injuries undetermined as to whether intentionally or accidentally caused, (ICD-10: Y33; ICD-9: E988.8) - "other specified events" are routinely excluded from suicide statistics.

All the 22 cases were matched against the list generated from the public health mortality file (PHMF). One case on the PHMF was found that was not identified as a Doncaster resident case from the Coroner's list. On closer examination, it was resolved that the case should be included among Doncaster cases since the address of residence was in Doncaster, although the death occurred in Rotherham.

The criteria used for inclusion of cases were:

- o coroner's verdict of suicide death designated as belonging to Doncaster
- o open verdict death occurring in adults designated as belonging to Doncaster. [Deaths with open verdict among babies were excluded].

Community Mental Health Service

Cases of suicide and open verdict deaths identified were checked against the database used by the Mental Health Service in Doncaster to determine if they were known to the service. This database is a secure Department of Health (DH) web-based site that is accessible to designated healthcare staff.

Baseline Information and Mortality Trends

Baseline information, latest mortality figure and trends in suicide deaths were obtained from the Department of Health, Compendium of Clinical and Health Indicators.

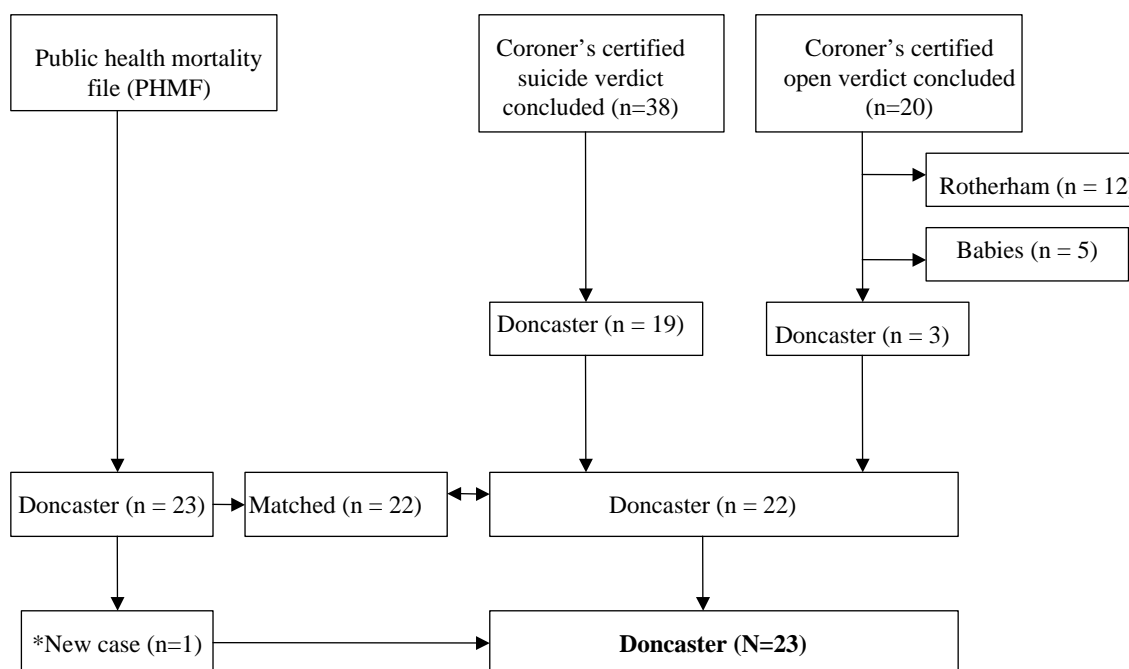
1.2.4 Results

Number of Cases

A total of 23 cases of suicide deaths occurred among residents of Doncaster during 2003. This included 20 suicide verdicts and 3 open verdicts. There were 20 open verdicts that were examined from Doncaster Coroner's record, 12 were outside the Doncaster district.

Of the 8 open verdicts within Doncaster, only 3 (37.5%) were included as they occurred in adults; the rest (5) were excluded because they occurred in babies. Check against public health mortality file enable 1 additional case to be included in the audit. (See figure 1.1)

Figure 1.1: Data collection and verification process of suicide deaths in Doncaster (2003).



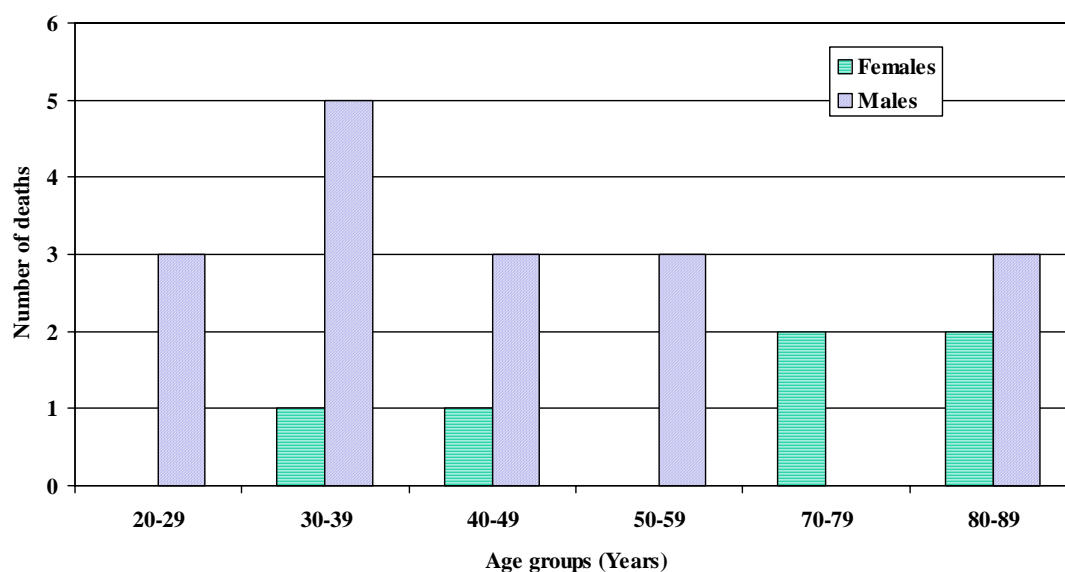
* This case was identified by Coroner's Office as Rotherham case because the death occurred in Rotherham. In PHMF it came as Doncaster case because the address of residence was in Doncaster.

Characteristics of Suicide Deaths

a) Sex and Age

Of the 23 suicide deaths that occurred among Doncaster residents, 17 (73.9%) were in males. Among those under 60 years of age, there were only 2 suicide deaths in females compared to 14 deaths in males. Four of the six suicide deaths in females occurred among those aged 70 years and over. (See figure 1.2)

Figure 1.2: Suicide deaths in Doncaster by age and sex: 2003



b) Marital Status

Of twenty-two cases for whom information on marital status was obtained, 9 (39.1%) were single; 7 (30.4%) married; 3 (13.0%) widowed; and another 3 (13.0%) divorced.

c) Ethnicity

Information was obtained about the ethnicity of 22 suicide victims from pathologists reports, police report or photographic evidence. The ethnicity of two cases was not stated nor was there any photographic form of identification. Of the 20 cases whose ethnicity was established, all of them (100%) were White Caucasians.

d) Occupation

The majority of suicide victims were of low socio-economic backgrounds. Six of these were retired pensioners. There were two students, and one unemployed person.

e) Geographical Areas

There was a wide geographical distribution of suicide deaths within Doncaster during 2003. However, clusters of suicide deaths were observed in the following wards in Doncaster: Balby (4), Edlington (3), Hyde Park (2). These wards are known to be deprived, according to deprivation indices.

f) Methods of Suicide Deaths

The predominant methods of suicide were death by hanging, which comprised more than half (56.5%) of all suicide deaths (n=13). There were two deaths (8.7%) each from drug overdose and drowning. The two deaths from drug overdose involved Co-proxamol tablets in one case, and in another case chlormethiazole, diazepam and nitrazepam tablets

The remaining 6 deaths were distributed singly among the following methods: alcohol related, asphyxia, falls from bridge, railway death, stabbing to the neck, and carbon monoxide poisoning.

g) Location of Deaths

Of the 22 suicide deaths in which the location of deaths was ascertained, sixteen (69.9%) of them occurred at home; two occurred in the woods (Edlington and Rossington). The remaining 4 deaths occurred singly in prison (despite being on 30 minutes watch); railway line; drowning in River Don (Hexthorpe); and Leger Way (footbridge - north of Doncaster Racecourse).

h) Significant Factors Associated with Suicide Deaths in Doncaster: 2003

Important factors associated with suicide deaths that were found from the coroner's records revealed several categories of risk markers. These included the presence of existing medical/mental conditions, previous suicide attempts, involvement with the police, expression of suicidal thoughts, and relationship problems. The risk factors categories and examples of these risk factors are shown in Table 1.1.

Table 1.1: Significant factors associated with suicide in Doncaster

RISK FACTORS* (n)	EXAMPLES OF CASES
1. Involvement with the police (5)	<ul style="list-style-type: none"> • Arrested for drink driving. • Charged with robbery, and released, • Under police investigation, given bail
2. Previous suicide attempts (6)	<ul style="list-style-type: none"> • At least 3 previous suicide attempts, expressed her wish to die. • Attempted suicide in hospital.
3. Work pressure (2)	<ul style="list-style-type: none"> • Can no longer cope with pressure at work • Unsuccessful in one of his re-sit exams at university
4. Expression of suicidal thoughts (5)	<ul style="list-style-type: none"> • Expressed suicide (that she was a burden to husband – because she was ill) • Had been expressing suicidal thoughts; • Spoke of suicide to a friend • Patients had spoke of suicide to family; • Made several threats to commit suicide
5. Loss of close relation (3)	<ul style="list-style-type: none"> • Lost his wife / ex-wife • Death of grandson.
6. Relationship problem (4)	<ul style="list-style-type: none"> • Relationships with 2 girls, both pregnant to the deceased. • Separated; separated for 2 years, • Wife commenced divorce proceedings;
7. Medical / Mental conditions (15)	<ul style="list-style-type: none"> • Was never the same following heart attach • Was upset for giving up of his routine activity due to tremors in hands • “Burden to husband” because of illness (multiple co-morbidity) • Depression / schizophrenia • Subject of Section 3; Section 17 (Mental Health Act)
8. Alcohol Consumption (unusual/abuse): (2)	<ul style="list-style-type: none"> • Drinking on regular basis • Took some alcohol (had never been drinking alcohol before)
9. Request of sleeping pills (1)	<ul style="list-style-type: none"> • Asked for sleeping tablet from hospital after discharge;
10. Refusal of help (1)	<ul style="list-style-type: none"> • Refused help from doctors, thrown medication away

NB: Numbers of risk factors do not add up to the total number of cases because more than one risk factor may be present in a case.

An analysis of 22 cases, based on their known medical conditions, showed that 13 (59.1) of them had mental illness, predominantly depression (11 cases, 50%). Around a third (n=7, 31.8%) did not have any significant previous medical history (see Table 1.2).

Table 1.2: Associated mental health conditions among suicide victims in Doncaster: 2003

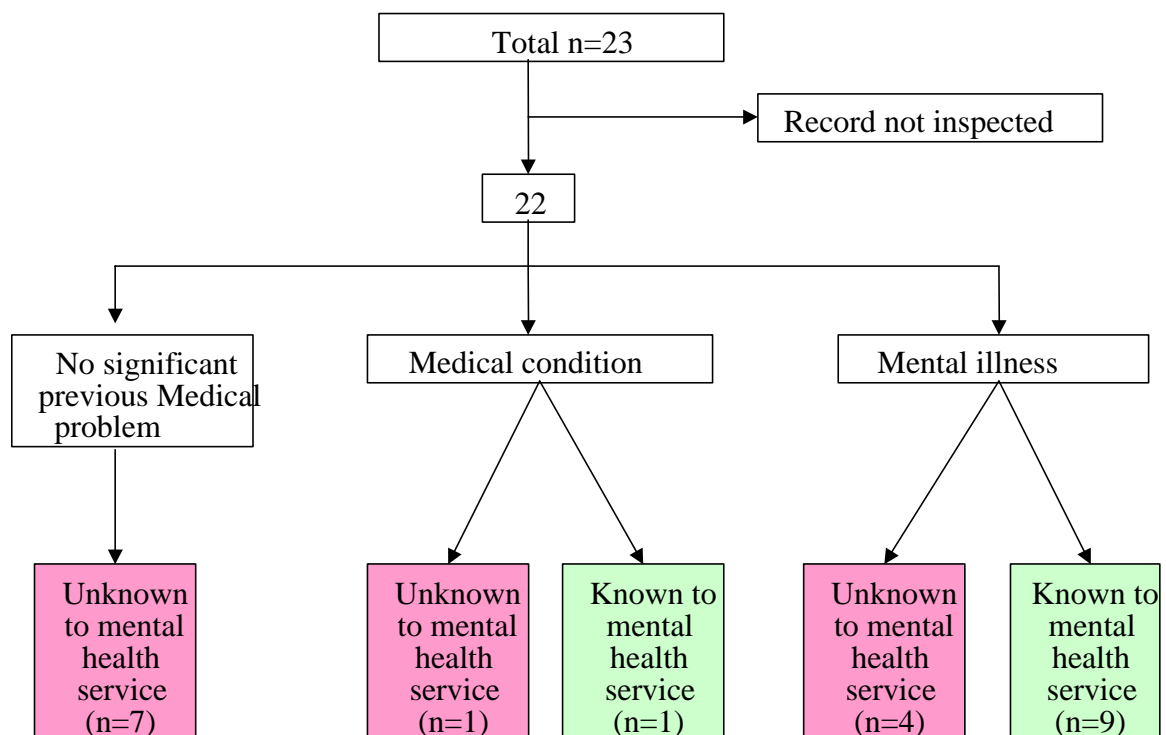
MEDICAL CONDITIONS	Number*	Percent (%)
Mental health illness	13	59.1
• Total with Depression	11	50.0
○ Depression alone	5	22.7
○ Depression with other medical/mental conditions	6	27.3
• Other Mental illness without depression	2	9.1
Other medical condition without mental illness	2	9.1
No significant previous medical problem	7	31.8
TOTAL	22	100.0

*One case whose medical condition could not be ascertained was excluded.

Suicide Deaths and Contacts with Mental Health Service

There were 13 suicide deaths with mention of mental illness from the coroner’s records, 9 (69.2%) were known to mental health services (figure 1.3).

Figure 1.3: Suicide deaths in contact with mental health service in Doncaster 2003



Each death that occurred in the care of mental health service was individually audited to determine lessons learned to inform future practices. A confidential report was produced for each case covering case profile, chronology of events, conclusions, recommendations and action plan. This was shared among key agencies and staff involved in the delivery of care. A sample of such recommendations and actions points is shown below in Table 1.4.

Table 1.4: Action plan following suicide death investigation of Mr. AB

Recommendation	Action	Lead
All staff to be aware that individuals discharged from the acute wards need to be followed up within seven days, be that by their Care Co-ordinator or by medical staff.	<ul style="list-style-type: none"> • Discuss at operational managers meetings • Speak to individual medical staff • Continue discharge follow up monitoring 	<i>Locality Managers</i>
Referrals for home treatment should be made during discharge planning meetings in conjunction with the team, as per operational policy.	<ul style="list-style-type: none"> • Discuss findings with medical staff and Crisis Resolution Service staff 	<i>Locality Managers</i> Crisis Resolution Team Manager
Above recommendations to be shared with other managers.	<ul style="list-style-type: none"> • Discuss at operational managers meeting 	<i>All Team Managers</i>

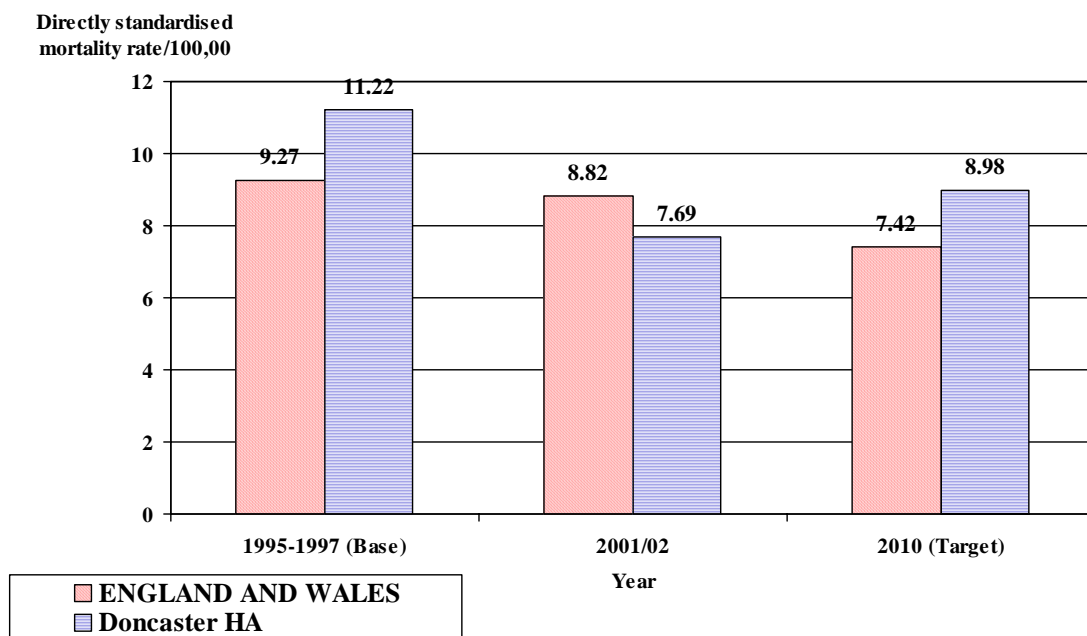
Trends in Suicide Deaths in Doncaster and England and Wales

a) Baseline and Targets of Suicide Mortality

Saving Life, Our Healthier Nation (SLOH) set the goal of reducing suicide deaths by 20% by 2010, from the baseline of 1995-1997. For Doncaster, this means a reduction from 11.22 per 100,000 in 1995-1997 baseline to 8.98 per 100,000 by 2010. Monitoring mortality data for 2001/02 suggests that Doncaster has already achieved mortality rate of 7.69 per 100,000, well below the target for 2010 (Figure 1.4). If the reduction in mortality is sustained, it is likely that the national target will be met for Doncaster. However, because of the small numbers, this rate may fluctuate over time due to random variation.

Figure 1.4: Suicide targets: England & Wales and Doncaster. Mortality from suicide and injuries undetermined (ICD10 X60-X84, Y10-Y34, excluding Y33.9), all ages

Data source: Department of Health, Compendium of Clinical and Health Indicators 2002



b) Pooled Data 2001/02, All Ages, Males and Females for Doncaster and Comparative Areas

Pooled data for 2001/2002 also showed that the age-standardised mortality rate per 100,000 populations from suicide in Doncaster rates (12.34 and 3.62 for males and females respectively) compared favourably to that of England and Wales (13.62 and 4.21 for males and females respectively) (Table 1.5).

Table 1.5: Mortality from suicide and injuries undetermined: Directly standardised rate per 100,000 (95% Confidence Intervals), 2001-02 pooled, all ages

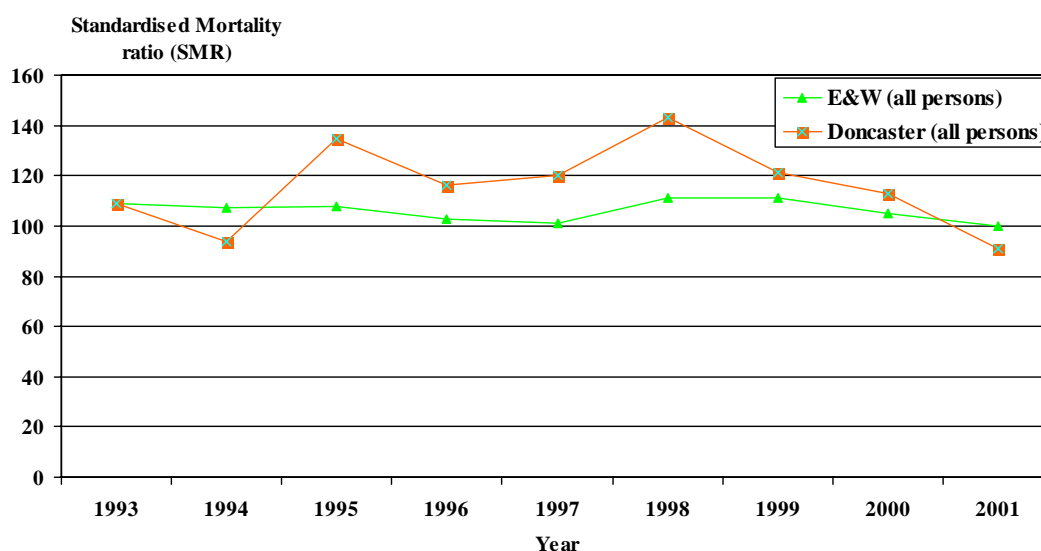
AREA	MALES		FEMALES		PERSONS	
	n	Rate	n	Rate	n	Rate
England & Wales	7201	13.62 (13.30, 13.93)	2419	4.21 (4.03, 4.38)	9620	8.82 (8.64, 9.00)
Yorkshire & Humber	682	13.71 (12.68, 14.75)	215	3.94 (3.40, 4.49)	897	8.71 (8.13, 9.29)
South Yorkshire SHA	160	12.53 (10.57, 14.49)	44	3.27 (2.29, 4.26)	204	7.72 (6.65, 8.80)
Doncaster MCD	36	12.34 (8.25, 16.42)	11	3.62 (1.46, 5.57)	47	7.69 (5.45, 9.93)

Source: Data source: Department of Health, Compendium of Clinical and Health Indicators 2002

c) Standardised Mortality Ratio (SMR) from Suicide Deaths: 1993-2001 for Doncaster and England & Wales.

The suicide mortality trend in Doncaster has shown a steady decline since 1998 (Figure 1.5). This figure may fluctuate from year to year due to the small number of deaths each year.

Figure 1.5: Trends in mortality from suicide and injuries undetermined (ICD10 X60-X84, Y10-Y34 exc. Y33.9; ICD9 E950-E959 and E980-E989 excluding E988.8); ALL AGES; (Standard rates are age-specific mortality rates in 2001)

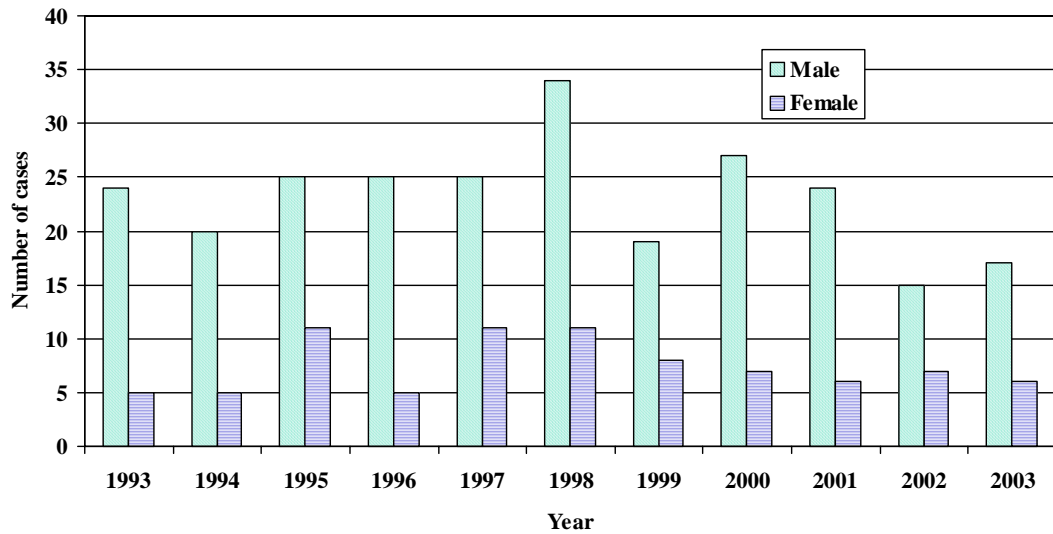


Source: Data source: Department of Health, Compendium of Clinical and Health Indicators.

d) The Incidence of Suicide Deaths in Doncaster: 1993-2003

The pattern of mortality from suicide deaths (1993-2003) in Doncaster shows the incidence of suicide is reducing. However, there is a gender difference in mortality from suicide with males having a higher mortality from suicide than females (figure 1.6).

Figure 1.6: Trends in mortality from suicide and injuries undetermined in Doncaster: 1993-2003 by sex.



Data source: Department of Health, Compendium of Clinical and Health Indicators 2002

1.2.5 Implications of findings

1. Doncaster is making steady progress towards the *Saving Lives Our Healthier Nation* (SLOHN) target of reducing suicide deaths by 20% by 2010.
2. Most of the characteristics of suicide deaths in Doncaster during 2003, such as age, sex, socio-economic distribution, and suicide methods, are consistent with the national pattern.
3. Following the introduction of a Coproxamol policy in Doncaster a few years ago, there was only one death associated with Coproxamol poisoning.
4. Significant factors that were associated with suicide deaths in Doncaster suggest the need for multi-disciplinary and multi-agency collaborative working to address these problems earlier on. Some of these may require counselling services, which are not easily accessible due to long waiting lists.
5. Nearly a third (30.8%) of suicide cases with a record of mental illness were not known to mental health service. This requires consideration of accessibility to mental health service and other support mechanisms.
6. Given the small number of suicide deaths that occur each year, current individual review of suicide cases by the mental health service is recommended.

7. There is a need to consider support mechanism for survivors of bereavement by suicide (SOBS). This group is currently invisible to our local service providers. The cost of ignoring these SOBS is high to society in terms of poor quality of work, sickness absence, increased GP workload, lost income, and increased cost of welfare benefits.

1.3 Interviews with Key Stakeholders

Key local stakeholder involvement, comment and advice is vital in developing a suicide prevention strategy which has local relevance and local commitment. This section highlights the main points derived from interviews with the following groups in relation to strategies to reduce the rate of suicide within the Doncaster area. Groups interviewed were:

- o Local General Practitioners
- o Social Services (planning and review)
- o Senior medical staff, mental health services
- o Doncaster Metropolitan Borough Council - Youth Services
- o Older adults services - Mental Health Trust
- o Crest - Staff support services
- o Accident and Emergency department - DRI
- o Joint Commissioning Managers
- o Mental Health Non statutory Organisations
- o Crisis Resolution Team
- o Doncaster Police
- o Mental Health Services Locality Manager
- o Mental Health In Reach Team - Doncaster Prisons
- o Relatives of Victims of Suicide
- o Survivors of Bereavement by Suicide - registered charity.

Strategies identified include:

- o increasing counselling services and access to such services
- o faster responses from the services
- o improved access to services
- o addressing housing, unemployment, debt and social deprivation issues
- o mental health registers
- o more intensive follow ups of people who substance misuse
- o fast and flexible approaches when dealing with crisis
- o improved interagency working
- o improved case conferences and communication between agencies
- o improved capacity within mental health teams for assessment
- o all agencies within Doncaster signing up to a co-ordinated approach / strategy
- o improved coverage and co-ordination of the care programme approach (CPA)
- o increased resources for assessment, treatment and support

- o improved general practice computer systems (EMIS - depression template)
- o improved prescribing policies (particularly around co-proxamol use)
- o supportive care pathway for bereaved
- o identifying people at risk who are not currently in contact with the services
- o development of the current staff support facilities Critical Incident Response Team (CREST)
- o improved audit of suicides and co-ordination and dissemination of recommendations from Serious Untowards Incidents (SUI)
- o engaging with patients who attempt suicide who present to Accident and Emergency, via the use of literature / credit card type information.

Currently a significant number of patients attend A&E at Doncaster Royal Infirmary who have attempted suicide (usually through overdose and often with alcohol). If a patient is seen, and is conscious in A&E they will be referred to the crisis team. However, two main groups of individuals exist who may not access the crisis team, these are: those who refuse to wait to be seen and those who are unconscious upon admission, are sent to the ward but leave on regaining consciousness before the crisis team have had the opportunity to make contact.

CREST's main aim is to provide support for all grades of staff who have been involved with a critical incident involving more than one member of staff or as a member of a team. The team offers a defusing session if an incident is notified early enough, with subsequent debriefing and follow up. CREST is not a counselling service, however should the debriefers consider it necessary for a member of staff to receive counselling, then the staff member would be encourage to seek referral to another service.

SECTION 1

2. THE NATIONAL PERSPECTIVE

In ***Saving Lives: Our Healthier Nation 1999*** the government set a target to reduce the death rate from suicide by at least 20% by 2010. This target was set in response to the alarming rise in suicide rates, not only in the UK but also throughout the Western world including the United States and Australia.

The **National Service Framework For Mental Health 1999 Standard 7 - Preventing Suicide**, outlines the guidelines by which this 20% reduction should be achieved:

- o promoting mental health for all (NSF Standard One)
- o delivering high quality primary mental health care (NSF standard Two)
- o ensuring that anyone with a mental health problem can contact local services via the primary care team, a helpline or an Accident and Emergency department (NSF Standard Three)
- o ensuring that individuals with severe and enduring mental illness have a care plan which meets their needs, including access to services round the clock (NSF Standard Four)
- o providing safe hospital accommodation for individuals who need it (NSF Standard Five)
- o enabling individuals caring for someone with severe mental illness to receive the support which they need to continue care (NSF Standard Six).

SECTION 1

3. THE NATIONAL SUICIDE PREVENTION STRATEGY

In 2003, a **National Suicide Prevention Strategy** for England was launched, by the Department of Health, to assist achievement of the NSF target. The strategy describes a range of actions to be taken forward both nationally and locally. Responsibility for delivering the national strategy is held by the National Institute for Mental Health in England (NIMHE). Local NIMHE centres will act as support to Primary Care Trusts in developing and delivering their own localized versions of the national document.

The National strategy consists of 6 goals:

- Goal 1: To reduce the risk in key high risk groups
- Goal 2: To promote mental well-being in the wider population
- Goal 3: To reduce the availability and lethality of suicide methods
- Goal 4: To improve the reporting of suicidal behaviour in the media
- Goal 5: To promote research on suicide and suicide prevention
- Goal 6: To improve monitoring of progress towards the *Saving Lives: Our Healthier Nation* target for reducing suicide.

The strategy specifies that interventions should target high-risk groups including:

- o people currently, or who have been recently in contact with Mental Health services
- o those who have deliberately self harmed within the last 12 months
- o young men
- o prisoners
- o high-risk occupational groups (farmers, and agricultural workers, nurses and doctors).

The strategy recognises that vulnerable groups also need to be targeted in a wider campaign to promote mental well-being. These include socially excluded and deprived groups, black and ethnic minority groups including Asian women, people who misuse drugs and alcohol, victims and survivors of abuse, children and young people (under 18), women, during and after pregnancy, older people and those bereaved by suicide.

The strategy also identifies the relatives and carers of those who have committed suicide as an at risk group recognising the high levels of distress that suicide can cause to the relatives.

The National Confidential Enquiry into deaths by suicide has presented a series of recommendations that address policy and practice in mental health. Below is a list of what is considered to be the most important clinical recommendations from these reports, and it is these recommendations that form the basis of the mental health section of the national Suicide Prevention Strategy.

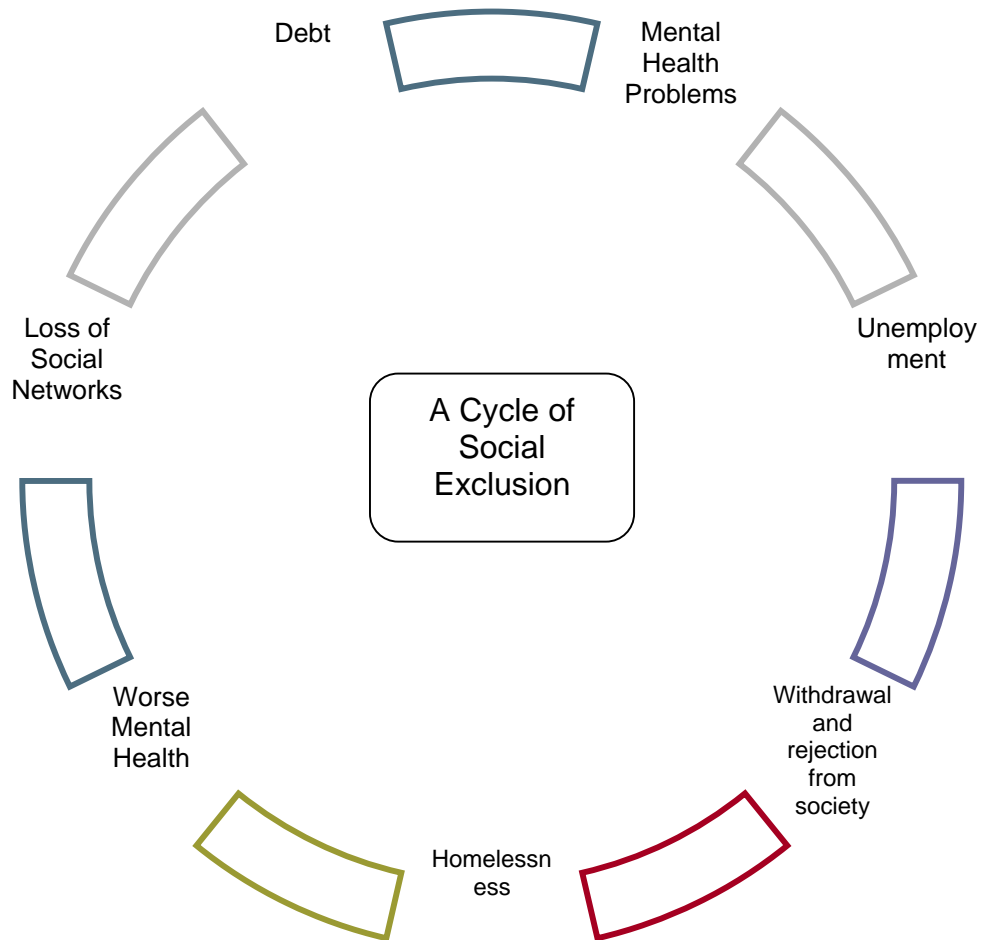
Twelve points to a safer service:

- o staff training in the management of risk - both suicide and violence - every 3 years
- o all patients with severe mental illness and a history of self-harm or violence to receive the most intensive level of care
- o individual care plans to specify action to be taken if patient is non-compliant or fails to attend
- o prompt access to services for people in crisis and for their families
- o assertive outreach teams to prevent loss of contact with vulnerable and high-risk patients
- o atypical anti-psychotic medication to be available for all patients with severe mental illness who are non-compliant with "typical" drugs because of side-effects
- o strategy for dual diagnosis covering training on the management of substance misuse, joint working with substance misuse services, and staff with specific responsibility to develop the local service
- o in-patient wards to remove or cover all likely ligature points, including all non-collapsible curtain rails
- o follow-up within 7 days of discharge from hospital for everyone with severe mental illness or a history of self-harm in the previous 3 months
- o patients with a history of self-harm in the last 3 months to receive supplies of medication covering no more than 2 weeks
- o local arrangements for information-sharing with criminal justice agencies
- o policy ensuring post-incident, multi-disciplinary case review and information to be given to families of involved patients.

In June 2004, the Social Exclusion Unit of the Office of the Deputy Prime Minister produced the report **Mental Health and Social Exclusion**. This report identified that social isolation is an important risk factor for deteriorating mental health and suicide. Two thirds of men under the age of 35 with mental health problems who die by suicide are unemployed.

The report identifies a cycle of exclusion requiring a focus on early intervention, and fulfilling peoples aspirations and potential through work and social participation.

This cycle is represented overleaf.



The paper outlines 27 action points, with the aim of developing a community whereby people with mental health problems have the same opportunities to work and participate in their communities as any other citizen. These action points will have a direct impact upon the way health and social care services are delivered in the future.

It is important to ensure that the suicide prevention strategy does not work in isolation. Specific relationships need to be developed with a wide range of other interrelated policies / services including:

- o National Service Framework for Older People
- o Community Strategy
- o Drug Action Team
- o Child and Adolescent Mental Health Services Strategy
- o Mental health promotion strategy

SECTION 1

4. LOCALLY DEVELOPED SUICIDE PREVENTION STRATEGIES

A search was undertaken for Suicide Prevention Strategy documents from UK and international sources. The findings are summarised below:

Web sites from a range of relevant organisations were searched, including local authorities, railways, highways agency, police authorities, health and safety at work executive... with mixed success.

As part of the development process for the Doncaster suicide prevention strategy a review was carried out of strategies already in place within equivalent demographic and socio-economic areas. A comparison was made between a number of strategies, using the guidelines for the National Suicide Prevention Strategy for England as a measurement and audit tool to assess each strategy and its aim for achieving national goals and objectives, how this was applied at a local level and its ability to meet identified local needs. We also hoped to identify areas of good practice and innovation with a dynamic approach to its delivery.

Overall it appeared the documents were too generic in their approach and although each one highlighted national requirements, it was unclear how they would achieve their goals. In particular, there was a lack of detail about specific prevention strategies. Only one of the strategies reviewed acknowledged specific areas of local need and none of the documents had identified or produced an action plan that was time bound or had any specific individual/group accountability built into it.

Of the non NHS and non local authority agencies, only the railways so far, appear to have developed documents with significant suicide prevention content.

England:

1. UK National Suicide Prevention Strategy for England
2. Railway Group Safety plan 2003-04
3. Railway Safety Research Programme No 12 - Station safety
4. Railway Safety Research Programme No 15 - Suicide
5. Railway Annual Safety Performance Report 2002-03 - Main Report and Summary Report
6. South Yorkshire Policing Plan 2003-04 (highlights need for specialist training)
7. Health and Safety Executive - Statistics of fatal Injuries 2001/.02, and 2002/03
8. Health and Safety Executive - Statistics Highlights 2002/03
9. Health and Safety Executive - Safety in Agriculture (general comments)
10. Barnsley Community Safety Partnership - Shocking Statistics.

Scotland:

11. Choose Life - Scotland's Suicide Strategy document (class.pdf)
12. National Framework for the prevention of Suicide and deliberate self harm in Scotland - Analysis of Written submissions for consultation (nfps.pdf)
13. Identifying Practice examples - Main report and Summary
14. Exploring experience - Discussion process and Summary.

International:

15. Australia - Living is for Everyone (LIFE) : A framework for prevention of suicide and self harm in Australia
16. Australia - Family Health Kit - Suicide Prevention
17. Australia - Reporting Suicide and Mental Illness: A Resource for Media Professionals
18. Australia - Suicide and the Media - A Critical Review
19. Australia - The Media Monitoring Project : A baseline description of how the Australian Media portray Suicide and mental health and illness which sets out to the gaps in knowledge about the way media report
20. USA - US National Strategy for Suicide Prevention - Goals and Objectives for Action
USA - US National Strategy for Suicide Prevention - Summary of Goals and Objectives for Action
21. USA - US National Strategy for Suicide Prevention - Suicide Prevention indicators
22. USA - Developing a Suicide Prevention Plan
23. USA - Nevada Study of Suicide prevention - Recommendations for Inclusion in a proposed suicide prevention programme.

SECTION 1

5. THE LITERATURE

The Effectiveness of Suicide Prevention Strategies, Programmes and Interventions: A Review of the Literature.

5.1 Introduction

The aim of this literature review is to assess the effectiveness of alternative suicide prevention strategies, programmes and interventions. In collecting the literature a broad search strategy was adopted with any strategies, programmes and interventions introduced in the period 1990 to 2004 searched for. Additionally any secondary references to articles of particular interest published in the period before 1990 were also obtained. As with any literature review it was necessary to screen the literature obtained, and identify the papers and articles of most relevance for the purposes of the review.

Whilst in the process of screening the literature, it became evident that the majority of the literature obtained focused on the suicide strategies, programmes and interventions used in certain high-risk groups, namely: young males, adolescents and school children, older people, and prisoners.

An assessment of the local profile of suicides committed in Doncaster in the period from 1st January 1996 to 31st December 2002 (Doncaster NHS Public Health Intelligence Unit, 2003) showed that these were also high-risk populations within the Doncaster area. Moreover, these statistics are also largely reflected at a national level. In fact two of the high-risk groups identified by the National Suicide Prevention Strategy for England and targeted as specific areas for suicide reduction are young males and prisoners (Department of Health, 2002).

With these facts in mind, and given the research evidence available, it was decided to focus the literature review on the suicide prevention strategies, programmes and interventions targeted specifically at these groups. It is hoped that this will provide research evidence that is relevant and informative to the locality of Doncaster.

5.2 Suicide Prevention in Young Males

Within the UK, young men are approximately four times more likely to commit suicide than young women, a gender difference which is consistent throughout Europe. Additionally in the last twenty years the UK, in keeping with other countries, has experienced an increase in suicide rates in males, particularly in the younger age groups. In contrast, however, female suicide rates have been in decline within the same period (Hawton, 2000). Whilst the most recent annual report on the progress of the National Suicide Prevention Strategy (NIMHE, 2004) has shown evidence of a fall in young male suicides, the rate still remains high in comparison to the general population.

This picture is also reflected locally in Doncaster where for the period from January 1996 to December 2002, suicides in men aged under 40 accounted for 38% of all suicides recorded in that period. Furthermore, the ratio of male to female suicides recorded for that age group in Doncaster over the same time period was approximately 5:1. Thus clearly emphasising that at both a national level, in the UK, and at a local level, in Doncaster, suicide in young men remains a significant problem, and one worthy of specific attention in the design of any suicide strategy.

Despite these facts, analysis of the literature on suicide prevention strategies has shown that gender differences are rarely taken into account when developing suicide prevention strategies and programmes. It is widely accepted that young men are reluctant users of primary care and mental health services (Hawton, 2000). However, unless these facts are taken into account the overall effectiveness of any suicide prevention strategy is likely to be limited.

In 2001 the Men's Health Forum, an independent research organisation, undertook an analysis of ten Health Improvement Programme's (HimPs) initiated by different local authorities. The results of the analysis undertaken by the Men's Health Forum (2001) showed that local authorities had largely based their suicide prevention strategies on standard seven of the Mental Health National Service Framework, which outlined a series of recommendations designed to prevent and reduce suicide (DoH, 1999). These included:

- o ensuring high quality primary health care
- o ensuring that everyone with a mental health problem can access local services
- o ensuring that, if required, those with severe mental illness have a care plan and safe hospital accommodation.

Evidently, these recommendations largely depend on the availability of, and access to, primary and secondary care services. Given the reluctance of young men to access such services, the failure to look beyond these services towards other agencies resulted in the development of suicide strategies at a local level that have been largely unsuccessful in reducing suicides in young men.

The one exception to this, however, is Dorset Health Authority. In 1996 Dorset Health Authority initiated a broad and diverse 28-point suicide prevention strategy that remains in operation today, and which specifically aimed to reduce suicide rates in young men. The strategy included: strengthening the delivery of services, planned interventions after a suicide, research and evaluation of services, and the development of local crisis centres and help-lines. In addition the strategy also looked at broader issues such as the reduction of social isolation, work in schools on mental health, drug and alcohol abuse, use of custody training for magistrates, and strategies for dealing with unemployment (Men's Health Forum, 2001). Thus exemplifying a focus on tackling the underlying causes of suicide in young men. Importantly the strategy was also regularly reviewed and monitored in order to ensure that it remained effective.

The success of the strategy is clearly demonstrated through a significant reduction in young male suicides in Dorset. In young males aged 15-24 the suicide rate fell from 18.29 per 100,000 population in 1996, to 9.46 per 100,000 population in 1999.

Based on this evidence the Men's Health Forum (2001) propose that any potentially effective suicide prevention strategy for young men should incorporate each of the following five key elements:

- o a multi-faceted initiative and multi-agency review
- o a needs assessment of local young men 'at risk'
- o specific services targeted at young men, both in terms of mental health and engaging young men in broader-based services
- o the development and acceptance of a broad and coherent strategy
- o a method of monitoring and evaluating each component of the strategy.

5.3 Suicide Prevention in School Children and Adolescents

Suicides committed by school children and adolescents represent a significant problem. McGuire (2001) monitored the suicide rate in England and Wales between 1970 and 1998. He found that whilst there was no significant change in the suicide rate in 10-14 year olds and that the suicide rate for females aged 15-19 fell slightly, the suicide rate for males aged 15-19 increased significantly.

Given the previously outlined high suicide rate in young males aged under 40, it would appear to demonstrate that suicide in school children and adolescents represents a dual problem. Not only is there a high suicide rate in this age group, but people are clearly taking unresolved and ongoing mental health problems into subsequent age groups where they then reach a crisis point.

Within Doncaster there were 12 recorded suicides in people aged under 19 during the period from January 1996 to December 2002, 11 of which were committed by men, and just 1 was committed by a female. The 12 reported suicides represented just over 5% of all recorded suicides for the period from January 1996 to December 2002 (Doncaster NHS Public Health Intelligence Unit, 2003).

A key method of suicide prevention in school children and adolescents are school-based suicide prevention programmes. In 2002 the Alberta Heritage Foundation for Medical Research in Canada undertook a full health technology assessment (HTA) of the effectiveness of school-based suicide prevention programmes (Guo et al, 2002). The results gained from the assessment showed that a range of different school based suicide prevention strategies have been deployed, with vastly different results in terms of their effectiveness.

Given these facts it was concluded within the review that there is insufficient evidence upon which to recommend the implementation of school based suicide prevention strategies. However, evidence from a new school-based suicide prevention strategy (Robert et al, 2004) recently implemented in the USA, and since the Canadian HTA review was undertaken, would appear to provide evidence of a potentially effective new strategy.

The strategy entitled the Signs of Suicide (SOS) prevention programme incorporates two of the key elements of school-based suicide prevention strategies into a single strategy. The SOS strategy combines an educational programme designed to improve understanding and awareness of suicide with a brief screening tool used for the identification and assessment of depression and other risk factors associated with suicide (Robert et al, 2004).

Within the strategy the students are taught to recognise the signs of suicide and depression in themselves and in others, and are then taught a series of action steps in order to enable them to respond to these signs. These action steps are based on the acronym ACT: acknowledge, care and tell. Firstly, the student must acknowledge the signs of suicide displayed by others. Secondly the student must let that person know that they care and want to help, and thirdly the student should tell a responsible adult.

Students are also asked to complete the Columbia Depression Scale (CDS), a screening instrument used for depression, derived from the Diagnostic Interview Schedule for Children. The students complete and score the screening instrument themselves, which in turn helps them to assess and evaluate any depressive symptoms and suicidal thoughts they may have. It is in turn hoped that this may prompt them to seek assistance in dealing with these problems (Robert et al, 2004).

The results gained from the study clearly show the effectiveness of the SOS strategy, with significantly lower rates of suicide reported among students undergoing the programme. Additionally the students also reported significantly improved knowledge of suicide and the risk factors associated with it (Robert et al, 2004).

Within the literature, particularly the US based research, a strong emphasis is placed on the role of school counsellors in tackling the problems of depression and suicide in school children and adolescents. This is important as school counsellors can operate at a range of different levels in suicide prevention (Evans et al, 2002). This may entail not only the co-ordination of an overall prevention strategy, such as the SOS programme outlined previously, but also in establishing external links with community mental health care providers as part of a multi-disciplinary approach. In order for an adolescent suicide prevention strategy to be fully effective it is important to create a broad network of school counsellors, teachers, mental health professionals, other students and family members that adolescents and school children can access (Evans et al, 2002).

Shaffer and Gould (2002) identify that schools offer an excellent setting in which to identify children and adolescents who are at risk for suicide and, when appropriate, provide them with treatment. They also indicate that there is no evidence that a purely educational, or didactic approach effectively leads depressed or suicidal teens to reveal their ideation or seek treatment, neither do they significantly alter the permissive and positive attitudes towards suicide that are held by disturbed youth.

An additional suicide prevention measure targeted specifically at adolescents, and which has proved successful is telephone counselling. In Australia telephone counselling services were introduced under Australia's National Youth Suicide Prevention Strategy. A review of these services undertaken at the University of Queensland in 2003 showed significant decreases in suicidal ideation and in improvement in the mental state of patients in adolescents accessing the service (King et al, 2003).

5.4 Suicide Prevention in Older People

Although suicide prevention in the UK represents a key priority area for the NHS, suicide prevention in the elderly remains a significantly under researched and evaluated subject area. This is surprising given that given that suicide rates in industrialised nations generally increase with age, and that men aged over 75 have the highest rates of suicide in nearly all industrialised countries. The ratio of male to female deaths in elderly patients is approximately 3:1 (Cattell, 2000). Whilst the suicide rate in both elderly males and females has decreased significantly within the UK in recent years, suicide in the elderly still remains a significant problem (Cattell, 2000).

This picture is also reflected in Doncaster where suicides in people aged 60 and over represented 20% of the total recorded suicides for the period from January 1996 to December 2002. Within Doncaster over the same period the ratio of male to female suicides in people aged 60 and over was 1.75:1 (Doncaster NHS Public Health Unit, 2003).

Primary care services play a vital role in the prevention of suicide in elderly people. Within the literature a significant level of contact between elderly people and primary care services was reported in the time prior to suicide. In fact 40-70% of elderly patients who committed suicide were reported to have seen their general practitioner (GP) in the 30 days preceding their death, and between 20- 50% were reported to have seen their GP in the 7 days prior to their death (Cattell, 2000).

This suggests that whilst suicides rates are not related to a low rate of attendance at primary care services in the time prior to death, the training of GPs in understanding and undertaking risk assessment of suicide is of considerable importance. For example in a study undertaken in Gotland in Sweden by Rutz et al (1989) a significant reduction in the suicide rate in the area was recorded in the year after the introduction a suicide risk training and education programme for GPs.

A further potentially effective primary care based strategy for preventing suicide in elderly patients was provided in a randomised controlled trial conducted in the USA between May 1999 and August 2001 by Bruce et al (2004). Within the study, entitled the Prevention of Suicide In Primary Care Elderly Collaborative Trial (PROSPECT), the effectiveness of tailored treatment guidelines and care management programme for patients presenting with depressive symptoms was assessed.

Central to this was the introduction of depression care managers within primary care settings. Working alongside physicians the depression care managers contacted patients by telephone at scheduled intervals, or when clinically necessary, in order to monitor depressive symptoms, medication, and ensure adherence to treatment (Bruce et al, 2004).

The results of the study showed that the intervention was extremely successful. Patients receiving tailored treatment guidelines and the care management programme reported reduced rates of suicidal ideation, and a more favourable course of depression both in terms of the degree and speed of symptom reduction (Bruce et al, 2004).

Despite the fact that, as previously outlined, a high percentage of elderly patients have contact with medical services in the time prior to suicide, it is important to recognise that 30-60% of elderly people committing suicide have no contact with medical services in the time prior to their death. This clearly emphasises the need for community outreach services, particularly given that fact that elderly people are more likely to suffer from social isolation and loneliness (Cattell, 2000).

However, there is a paucity of data on the effectiveness of community outreach programmes specifically targeting the elderly (Cattell, 2000). Regardless of this some interesting initiatives have been introduced abroad. For example within Padua in Italy a TeleHelp-TeleCheck service was introduced for a population of 20,000 over 65 year olds between January 1988 and December 1998. The service was a public health initiative designed to provide help and support to elderly people with psychiatric problems and/or suffering from social isolation (De Leo et al, 2002).

People were referred to TeleHelp-TeleCheck from either GPs or social workers. Referred patients were then provided with an alarm device in order to enable them to trigger a pre-established response network (TeleHelp). Additionally patients received welfare monitoring and emotional support from trained staff through twice weekly telephone calls. Patients were also able to initiate calls themselves 24 hours a day, 7 days a week (TeleCheck) (De Leo et al, 2002).

The results gained from the study clearly show the success of the service, with significantly fewer suicide deaths observed among service users than expected. The service also had a significant impact on the psychosocial functioning of patients, De Leo et al in a preliminary follow-up of findings (1995) found that patients using the services for in excess of 6 months showed statistically significant reductions in home visits by GPs, hospital admissions and scores on Zung's Self-Rating Depression Scale.

A reduction in the availability of the means of suicide as a preventative strategy has proved extremely successful in reducing suicide in elderly people. This is best exemplified by the significant reduction in the elderly suicide rate that followed the detoxification of the domestic gas supply in the 1960s. More recent successful methods of reducing suicide have included the employment of catalytic converters to car exhaust emissions, reduced availability of firearms, and the limitation of over-the-counter paracetamol sales (Cattell, 2000).

5.5 Suicide Prevention in Prisons

A report on suicides in prisons in England and Wales undertaken by Her Majesty's Chief Inspector of Prisons (1999) found that the number of suicides in prisons more than doubled between 1982 and 1998, an increase of approximately 4.5% per annum.

In Doncaster during the period from January 1996 to December 2002 there were 13 prison suicides. Eight were aged under 30, and five were aged between 30 and 49 (Doncaster NHS Public Health Intelligence Unit, 2003).

Despite these statistics the effectiveness of suicide prevention strategies and programmes are difficult to measure. This is because, given their relatively small population size, suicides rates within prisons are too low to be taken as measures of effectiveness unless followed-up over a number of years. Additionally the characteristics of patients differ significantly between prisons, thus making comparisons between prisons problematic (Royal College of Psychiatrists, 2002).

Consequently there is a paucity of data on the effectiveness of alternative prison suicide prevention strategies (Royal College of Psychiatrists, 2002).

Within the literature little data was available on the effectiveness of prison suicide prevention strategies introduced in the UK. However, the Federal Bureau of Prisons Suicide Prevention Programme in the USA would appear to represent an effective strategy/programme. White and Schimmel (1995) report that following its implementation there was a 43% decline in the suicide rate. The programme is a five-point plan, based on each of the following key elements:

- o initial screening of all inmates
- o treatment and housing criteria for suicidal inmates
- o development of standardised record-keeping, follow-up procedures and systematic data collection
- o staff training
- o periodic reviews and audits.

In terms of the of the important factors that determine suicide rates in prisons and more specific strategies arising from this which may reduce the rate of suicide, a central factor would appear to be isolation. The available research evidence suggests that there exists a significant role for prisoners themselves in helping to prevent isolation and recognise suicidal ideation in other inmates (Royal College of Psychiatrists, 2002).

For example in New York a scheme has been set up where inmates are selected and paid by the Board of Corrections to monitor other prisoners for suicidal intentions. The aides are required to patrol the housing area and report unusual behaviour and inmate depression to correctional officers. The selected inmates are trained on how to identify suicidal behaviour and how to communicate with and talk to prisoners who are depressed and suicidal (Royal College of Psychiatrists, 2002).

A further scheme in which other prisoners are used as a means of reducing suicide is the *buddy scheme*, which is already well established at HM Prison Doncaster. Within this scheme prisoners are told on arrival at prison that they can if they wish ask for a buddy. The buddy is a member of the prison population selected and trained in order to provide help, advice and ongoing support to distressed prisoners. Overseeing each buddy is a supervisor, normally a psychologist working as part of a High Risk Assessment Team (Royal College of Psychiatrists, 2002).

An additional option is a listeners' scheme set up by a local Samaritans' group. The listeners are selected from within the prison population and then trained by Samaritans. The listeners provide fully confidential help, advice and support to distressed prisoners who either need or request support (Royal College of Psychiatrists, 2002).

A further option available to tackle the problem of isolation are *Green Cards* providing numbers for prisoners to call for help and support when in crisis. Green Cards have been trialled within HM Prison Manchester, however evidence available from the NHS where the cards were originally initiated suggests that the cards are only useful in people who have no history of self-harm. The current research available would appear to suggest that it is advisable to avoid using Green Cards in those patients who have previously harmed themselves, as these patients may react with an increased propensity to self-harm as a result of receiving the card (Evans et al, 1999)

A further key element in any prison suicide prevention strategy, and one on which quantifiable research evidence is available, are suicide training programmes. Possibly the best evidence of this comes from Canada, where between January 1984 and June 1986 staff were given a series of educative modules, providing advice and information on suicide and suicide prevention. The training programmes proved extremely successful, with an increase in referral rates to psychologists reported and a consequent decline in suicide rates recorded (Lloyd 1990).

The Royal College of Psychiatrists (2002) proposes that each grade of prison staff should receive continuous professional development and sufficient training in order to ensure that each member of staff has a basic understanding of human psychology and psychiatry. Moreover, the College also proposes that the training of doctors and nurses in prisons should include special courses on the recognition and management of suicidal behaviour, depression and substance misuse.

A further key aspect of suicide prevention identified within the literature relates to the transfer of information both within the prison service and from the prison service to the NHS. It is vital that when a prisoner moves from one prison establishment to another that information about their health and their care needs are transferred at the same time. The Royal College of Psychiatrists (2002) propose the implementation of a centralised computer system within the prison service, in order to allow medical data on prisoners to be accessed from more than one site.

In relation to the transfer of information from the NHS to the prison service there is a perceived reluctance amongst health care professionals to transfer information/data into a setting with which they are unfamiliar. Additionally prisoners often refuse permission for data to be transferred. However, the failure to transfer vital health information such as suicide risk from one care service to another is clearly dangerous. Consequently the Royal College of Psychiatrists (2002) propose the full implementation of the Care Programme Approach (CPA) into the prison service. This would also enable effective supervision of prisoners at the end of their prison sentence. All too frequently prisoners are released without the prison staff informing the local mental health team or the substance misuse team of their impending discharge (Royal College of Psychiatrists, 2002).

5.6 Black and Ethnic Minority Groups

Doncaster has 2.3% (6,600) of its population from Ethnic Minority (EM) backgrounds, according to 2001 UK census. The ethnic minority population comprised of 1.1% Asian or Asian British, 0.6% mixed, 0.4% black or black British, and 0.4% Chinese.

A report on ethnic disparities in health and health care by Aspinall and Jacobson (2004) highlighted the following relevant areas, which needs to be considered against Doncaster ethnic minority population structure:

- o self-reported ill health was poor among (EM) than white
- o the rates of Coronary Heart Disease are moderately higher among South Asians than in the general population
- o uptake of breast and cervical screening is low among ethnic minority groups
- o there is high prevalence of undiagnosed non-insulin dependent diabetes among South Asians and Caribbean:
 - mortality from diabetes in this population is three times higher than in the general population
 - there is up to 14 times higher the rate of complications from diabetes in EM compared to general population (diabetic retinopathy, and renal failure)
- o mental health:
 - common mental health disorders are the same among ethnic minorities groups. Research suggests that Black Caribbeans are more likely to suffer from schizophrenia than other population groups

- suicide rates are generally low among EM, except for those born in Scotland, Ireland and among Asian women.

5.7 Conclusion

The aim of this literature review was to assess the effectiveness of alternative health care strategies, programmes and interventions that may be applicable to Doncaster.

In relation to young men the most successful strategy problem would appear to be provided by Dorset Health Authority which recognised the reluctance of males to access mental health services and attempted to tackle the underlying causes of suicide in young men, such as depression, substance abuse, social isolation and unemployment resulting in a significant reduction in male suicide.

In relation to children and young people a range of different school-based suicide prevention strategies were reported within the literature, but without strong evidence of effectiveness. The most successful strategy would appear to be one recently implemented in the USA entitled the Signs of Suicide (SOS) prevention programme which combines both an educational programme designed to enable students to recognise and react to the signs of suicide and depression both in themselves and each other, and a self-completed suicide screening instrument designed to enable students to assess and evaluate any depressive and suicidal thoughts they may have.

In terms of suicide prevention in older people, it was widely reported within the literature that this represents a significantly under researched and evaluated subject area. Surprisingly the research evidence that is available suggests that a high percentage of elderly people who commit suicide are in contact with primary care services in the time immediately prior to their death. Consequently it is proposed within the literature that GPs and other primary care staff should receive special training and education on suicide risk.

Further research evidence suggests a significant role for depression care managers in primary care services. The results of a study undertaken in the USA showed that patients accessing a depression care manager reported reduced rates of suicidal ideation and a more favourable course of depression both in terms of the degree and speed of symptom reduction (Bruce et al, 2004).

The central focus of available research evidence on prison suicide prevention was in the role of prisoners themselves, with a wide acceptance of the role that prisoners can take in recognising and responding to the signs of suicide within other prison inmates. The Royal College of Psychiatrists (2002) in fact praises the use of the *buddy scheme* in HM Prison Doncaster. Within this scheme prisoners are offered the services of a selected inmate (buddy) to provide them with help, advice and ongoing support for any problems that they may encounter.

SECTION 2

Prevention, Intervention and Postvention Strategies

6. THE DONCASTER WIDE SUICIDE STRATEGY

The previous section has illustrated both the focus of need within Doncaster and the current lack of resources assigned to address this need. The literature, interviews and research indicates that the Doncaster Strategy needs to:

- o focus upon the specific needs of the Doncaster Area
- o be multidisciplinary and multi-agency in nature
- o using a public health rather than a specific mental health focus (addressing the underlying causes)
- o specify clear lines of responsibilities and communication
- o address the needs of families, friends, managers and staff
- o move away from the methods of suicide towards the causes of it, and
- o offer creative, locally based solutions rather than high level aspirational statements.

Target Groups within Doncaster

Whilst the Doncaster Suicide Strategy is intended to positively impact upon the lives of all residents of the Doncaster Area, there are specific groups, which are highlighted from both the national strategy, and the local research performed by the strategy development team. Groups identified as warranting specific focus are:

At Risk Groups

These are groups of individuals who, based upon a review of risk factors, specific patterns in data and those identified via research and wider strategies may be of particular risk within the Doncaster locality. Actions originating from the strategy should focus upon developing services and approaches to meet their needs. However, any service development should not be so exclusive as not to offer benefit for the wider community. It is important that, as part of the strategy, regular audit is undertaken to identify any further groups which may need particular intervention (for example, women with children, gay and lesbian communities and minority ethnic groups).

Highlighted at risk groups include:

- o young men (particularly those between 20 – 40)
- o older adults
- o people in prison
- o single people with relationship difficulties

- o individuals who have attempted suicide in the past or have expressed suicidal ideation
- o adolescents and school children
- o people with mental health problems (particularly those treated in primary care, with depression).

Groups Needing Support

The importance of supporting, educating and promoting communication between individuals and organisations directly affected by suicide and its aftermath cannot be underestimated. To that end, the strategy has identified five main groups for which the impact of suicide is of particular relevance. These are:

- o Individuals Bereaved by Suicide

Particular consideration should be given to the families, friends and the suicide victims, ‘significant others’. Survivors of Bereavement by Suicide (SOBS), a national charity in England and Wales, estimates that for each suicide death there are around 6 survivors (relatives and friends). The Charity estimates that each survivor lives a further 25 years. Based on annual deaths of 5000 from suicide, they calculated that there are around 750,000 survivors of suicide deaths in England and Wales. A comparative calculation for Doncaster revealed that there are between 3,000 and 5,000 survivors of suicide who require support (see previous table)

Table 1.4: Estimated number of survivors of bereavement by suicide based on expected number of suicide deaths per year

Expected number of suicide deaths per year	Estimated number of survivors per year	Estimated prevalent number of survivors over a 25-year period
20	120	3,000
25	150	3,750
30	180	4,500
35	210	5,250

Further evidence indicates that survivors themselves may have particular complex needs which need to be addressed and that in a number of cases, a suicide within a family group or community indicates a wider social, economic or mental health need.

- o Staff working with suicide victims

There is a particular need to support staff who work with individuals who commit suicide and families bereaved by suicide. Feelings of personal loss, professional failure, guilt, fear of one's own reputation and anger relating to the disruption caused by the death have all been widely reported. Secondary consequences of such events can be physical sickness, depression, irrational fears, depersonalisation and distancing from clients and deterioration in professional and interpersonal relationships. Such responses are not related to the years of experience or profession.

- o Primary Care Teams

A full time general practitioner may experience a suicide of a patient every 4 to 5 years. Research indicates that adequate preparation and training, improvement in assessment techniques, improved communication between agencies and effective support structures (both interpersonal and professional) not only reduce the level of suicide experienced within general practice, but also improve the ultimate outcome for patients, their families and the primary care team.

- o Service and locality managers

Interviews with service and locality managers indicated the difficult position many are placed in when managing the aftermath of a suicide or attempted suicide. They are often placed in the position of having to support their own staff, mediate with the bereaved, provide information for a number of investigations and enquiries and in some cases instigate disciplinary procedures. Currently within Doncaster, apart from informal support given by senior managers and peers alongside access to CREST services (a service provided by trained volunteers), there exists no formalised support service specifically for managers.

- o Voluntary Services working with individuals at risk

A proportion of individuals who either attempt suicide or commit suicide may already be known to the voluntary services within Doncaster. Discussion with representatives of voluntary agencies suggests that their relationships with clients may differ significantly from the statutory services often being built around a longer term informal relationship, allowing identification of potential suicide indicators through less structured assessments than those employed by the statutory services.

The low predictive power of risk factor analysis (from which many formalised assessment instruments are based) necessitates different methods of assessment, which include building trust, personal engagement within informal environments and monitoring of behaviour, all of which are offered within the voluntary sector.

Hope from Despair: A Suicide Prevention Strategy for Doncaster supports the Government's action plan detailed in the Social Exclusion Unit Report (2004) on Mental Health and Social Exclusion. The Social Exclusion Unit Report proposed actions to tackle underlying determinants of health, which relate to the following:

- o stigma and discrimination: a sustained programme to challenge negative attitudes and promote awareness of people's rights
- o the role of health and social care in tackling social exclusion: implementing evidence-based practice in vocational services and enabling reintegration into the community
- o employment: giving people with mental health problems a real chance of sustained paid work based on their experience and skills
- o supporting families and community participation: enabling people to lead fulfilling lives the way they choose
- o getting the basics right: access to decent homes, finance advice and transport; and
- o making it happen: Partnership working and monitoring.

SECTION 2

7. RECOMMENDATIONS

Specific Recommendations of the strategy include:

- o developing co-ordinated multi agency strategies to address health inequalities
- o developing effective communication strategies relating to older adults, benefit and social support access
- o producing a comprehensive directory of services
- o reviewing the needs of Black and Minority ethnic communities
- o promoting life skills training for children
- o depression and anxiety protocol training for general practitioners
- o training for school counsellors and teachers in relation to the detection and management of suicide
- o ensuring that all staff working with at risk individuals should receive appropriate training relating to assessment, intervention and referral
- o improved assessment and treatment of younger people in the prison estate
- o developing clear referral pathways between the voluntary and private sectors and specialist mental health services
- o proactive engagement with individuals who present to A&E following suicide attempt
- o implementing the '12 steps to a safer service'.
- o agreeing and disseminating information sharing protocols
- o developing a systematic process for the recording of suicides
- o creating a 'log' of recommendations from investigations of Serious Untoward Incidents (SUI)
- o GPs investigating suicides via the significant event recording process
- o offering staff independent support after a suicide or attempted suicide
- o developing a Postvention care pathway for Doncaster Services including effective feedback and information to relatives following significant event analysis.

7.1 Primary Prevention Strategies

Economic Issues and Welfare

The link between suicide and low standard of living, debt, housing issues, unemployment or low paid employment, is well proven. Higher levels of suicide around Doncaster can be seen in particular areas where there are clusters of increased deprivation such as Balby, Edlington and Hyde Park. In addition to this, there is a significant amount of evidence to indicate that older adults are not accessing the supplementary benefits for which they are entitled. It is therefore recommended that the following action be taken.

Recommendation 1:

Health and Social Care Agencies within Doncaster should develop a co-ordinated strategy to identify and address the social welfare needs of the local population, particularly around the 'hot spots' identified.

Recommendation 2:

All agencies within Doncaster should be engaged to develop a communication strategy to ensure that Older Adults access appropriate levels of benefit and social support. This strategy must include the needs of carers.

General Health Care

An overall improvement in the general health care of individuals has been shown to have a significant effect upon the rates of suicide, particularly relating to older adults and chronic pain management. Often mental health promotion and physical health promotion are regarded as mutually exclusive components, this is not the case and an improvement in either component has an impact on each.

An 'holistic' approach to health promotion is regarded as the strategy of choice. Information received from service users and families within Doncaster would suggest that focussing on 'mental health' difficulties and using such labels is unappealing and unlikely to engage certain individuals. Whilst a co-ordinated approach to health promotion should be developed, it has been suggested that integrated information relating to service provision should be available in a single resource.

Recommendation 3:

A 'generic' directory of services and support should be developed for the Doncaster community. This would include information relating to general health, mental health, social care, housing, debt advice, relationship services, recreation and other 'health improving' resources within Doncaster. Reference should also be made to national bodies that may be able to provide support. This directory should be available in paper format, but may also be available electronically.

Black and Minority Ethnic communities

Research indicates that the needs of the BME community in relation to suicide and suicide prevention are not completely understood. Although Doncaster has a lower proportion of people from these communities their needs must be taken into consideration.

Recommendation 4:

Doncaster health and social care community explores the particular needs of the Black and Minority Ethnic communities in relation to suicide prevention.

Social Support Networks

Effective social support networks which reduce social isolation contribute positively to the reduction in suicides amongst all age ranges. Whilst a number of projects are aimed at offering advice and support (such as the Balby Youth Information Project and the Duke Street advice centre), limited facilities exist to develop social networks for adolescents and older people within the area. Where networks do exist, it is important that their availability to the wider community is communicated. The most effective networks exist within families themselves, however, indications are that the majority of people who commit suicide within Doncaster have limited contact with their wider family group.

Local communities are encouraged to develop social support groups aimed at the needs of young people, older adults and people with mental health problems (such as the Out Hand About club). These may be affiliated to schools, youth organisations, church groups, leisure centres, local clubs and organisations, neighbourhood centres or special interest groups. Where there are already groups, their existence should be communicated and publicised within the local area.

Life Skills Training for Adolescents and Children

Equipping young people and children with the skills to deal with distress, communication issues, divorce, bullying and bereavement is an effective way of promoting health.

Recommendation 5:

That Doncaster promotes and examines further strategies aimed at improving the well being and coping skills of children and adolescents and works collaboratively with all agencies to deliver these strategies.

7.2 Secondary Prevention Strategies

Detection of Suicidal Feelings and Interventions

Assessment and detection of suicidal feelings can be problematic. Where suicidal feelings are accurately detected early specialist intervention can be effective. Schools, voluntary organisations, support groups and health and social care professions all have a role to play. Significantly however, most effective detection can come from the individual themselves and their friends.

As the literature identifies, education for individuals in detecting the signs of suicide and distress can be most useful. Within the custodial environment the use of 'buddies' and listeners have been used effectively within HMP Doncaster and HMP Moorland.

A short information leaflet could be produced to indicate the Signs of Suicide and distributed throughout key communities. A younger persons version for schools may be indicated.

Recommendation 6:

General Practitioners within Doncaster receive additional training and information in relation to depression and anxiety protocols including referral pathways.

Recommendation 7:

Teachers and school counsellors within the Doncaster area receive training in relation to detecting the signs of suicide, dealing with queries from students and referring to specialist agencies.

Recommendation 8:

Statutory and non statutory staff working with individuals who are at risk of suicide should receive specific training relating to assessment, intervention and referral. This may take the form of differing 'tiers' of training, either mandatory (including basic awareness) or specialist assessment.

Recommendation 9:

Improve the assessment and treatment of people within the prison estate in Doncaster and improve suicide prevention systems throughout the prison estate within Doncaster.

Recommendation 10:

Clear referral pathways between education, the voluntary sector and primary and secondary care services should be developed and communicated.

Access to Mental Health Services

Many respondents to the information review component of this strategy identified that access to mental health services is an issue in meeting the needs of individuals who may be at risk of committing suicide. A recent service review identified a number of recommendations relating to service delivery and organisation which have been agreed by the organisations senior officers. It is hoped that the adoption of these recommendations would have a positive effect upon to delivery of and access to services.

Treatment of Depression

The study highlighted that a large proportion of individuals who committed suicide were receiving treatment for depression solely within a primary care setting. The use of recently published clinical guidelines, effective communication with their specialist mental health colleagues and continuing professional development all contribute to developing safe, supportive services for patients.

Recommendation 11:

All individuals who present at Doncaster Royal Infirmary Accident and Emergency Unit suspected of attempting suicide are to be given a 'contact' card.

Studies indicate that the use of additional staff to monitor progress and maintain contact with patients during the early stages of treatment are particularly effective in reducing deaths by suicide of that vulnerable group. Depression monitors (individuals who contact patients at home and review their progress using standardised assessment tools) can significantly improve treatment compliance and outcomes.

Recommendation 12:

GP practices within a Doncaster Hotspot (Balby or Edlington), trial the use of depression monitors, with a view to adopting the principle throughout the area.

Developing Safer Services

The National Confidential Enquiry into deaths by suicide has presented a series of recommendations that address policy and practice in mental health. (See part 3)

Recommendation 13:

Ensure that the recommendations of '12 points to a Safer Service' are in place.

Communication Strategies Between Agencies

Communication between treatment agencies and within organisations themselves is highlighted as a key factor in the reduction of suicides within an area. Often misinterpretation of data protection responsibilities, differing languages of care, professional protectionism and incompatible information systems make communication problematic.

Recommendation 14:

Information sharing protocols between key agencies within Doncaster are agreed and disseminated. Existing policies are regularly reviewed to take account of developing legislative and local environments.

Suicide Prevention Toolkit

The national suicide prevention toolkit, developed by NIMHE is an effective tool for auditing the risks of suicide particularly with individuals with mental health difficulties within a mental health residential setting. The recommendations and guidance of the suicide prevention toolkit should continue to be implemented within the Mental Health Services.

7.3 Intervention

Processes, Data Capture and Audit

Information relating to suicides within Doncaster was difficult to obtain, being derived from a wide variety of sources. Hardly any information was available relating to those individuals who had attempted suicide. The team was unable to identify specific policies and procedures regarding the follow-up, additional risk assessment, communication and review of individuals who had attempted suicide, or where at risk of suicide.

Where a serious untoward incident has occurred, it was not clear if the recommendations of the SUI report were effectively shared throughout the agencies concerned with delivering care.

Recommendation 15:

Develop a systematic process for the recording of suicides throughout Doncaster.

Recommendation 16:

Create a 'log' of recommendations arising from SUI reports, disseminate such recommendations and clearly build them into service development and improvement. This log should be available to all agencies and services even if they were not directly involved in the event, via a annual review and report learning event.

Recommendation 17:

The police and ambulance service inform the GP in relation to patient suicides and the GP investigate via the significant event recording process and case conference.

Staff Support (includes training support etc)

Access to staff support immediately after an incident is often approached in an informal manner and left to the discretion of the staff member concerned. Evidence shows that take up of services in such an ad hoc way is limited with the potential arising for problems later. Usually managers or peers offer support for staff, but this may conflict with their own feelings relating to an event or their professional or managerial responsibilities.

Recommendation 18:

Staff are always offered independent support after a suicide or attempted suicide, this includes service managers and locality managers.

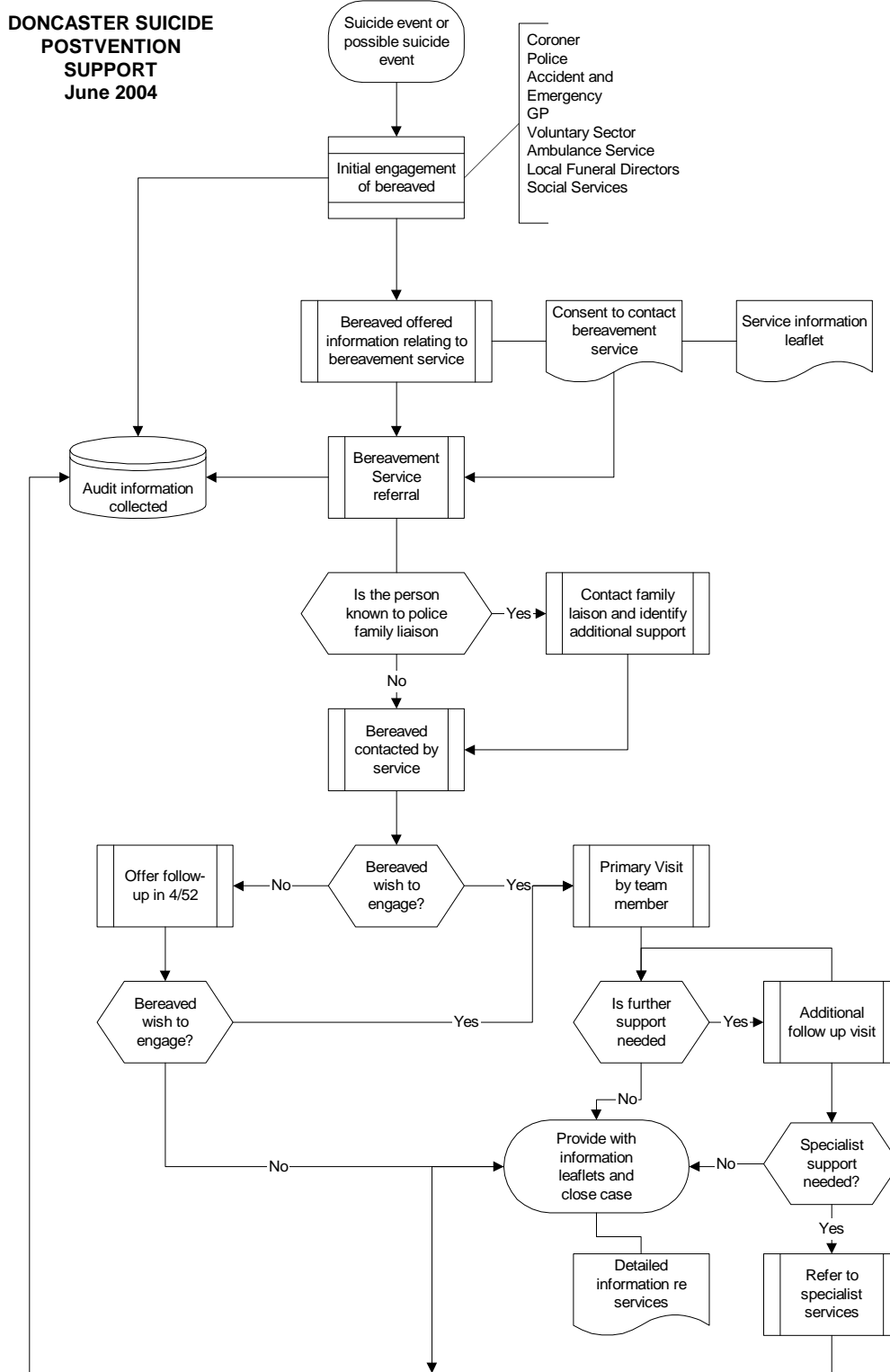
7.4 Postvention

Currently within Doncaster there is no formalised support structure available to survivors of suicide. Examining models of suicide support within the literature and as a result of discussions with SOBS, an effective model of proactive intervention has been developed in Australia (NOOSA). This model obtains information from key, first contact sources post suicide event. Within the Australian model a regional co-ordinator initiates contact and engages the bereaved offering support and contact with appropriate services.

Postvention can be defined as:

"Prevention for the next decade, for the next generation and beyond"

This model has been further developed and adapted by the Suicide Strategy development team and is illustrated below.



The main principle of the process is that the bereaved are given information relating to the bereavement service and other sources of support within the Doncaster area, they are also asked their consent to pass their details onto the service. A service representative will then contact the family and offer them an appointment, should the bereaved not wish to engage with the service at that time they are sent additional information and are contacted again in 4 weeks time. Once engaged a team member would visit the family to offer support and advice as to other services available. Should a referral need to be made to another service then this may be initiated by the team member.

The small number of suicides occurring in Doncaster each year would not support the setting up of a unique service for this function. It would be possible to assign this role to an existing health, voluntary sector or social service team. Doncaster wide co-ordination of the team will be necessary.

This approach has a number of advantages, specifically it will:

- o deliver support to victims of suicide in the immediate and medium term post event
- o reduce the risk of victims presenting to services at a later stage
- o improve communication within services
- o be a ready source of information as to suicide trends within Doncaster
- o offer 'real time' indication as to the effectiveness of suicide interventions
- o provide a necessary service without the need for significant investment.

Recommendation 19:

Develop the Postvention Care pathway for Doncaster Services. Where possible or appropriate, communicate the process following a SUI and the outcomes of the investigation to the relatives of the bereaved as soon as possible. Upon resolution of the event, a full case review, involving all affected parties should take place and the results of the review communicated and built into further strategy and procedure planning

Complaints, Concerns and Communication (including mediation)

Dealing with the immediate aftermath of suicide is traumatic for relatives, friends and services. Clarity relating to immediate postvention procedures is important. Building upon the initial response, the postvention period is important in exploring the reasons surrounding the event, supporting the relatives and staff and formulating the service response to concerns. This period is also significantly confusing and traumatic for all involved and clear procedures, timescales and processes assist to alleviate this. Doncaster should identify the processes and procedures involved in the postvention stage of a suicide, clarify such processes and possibly produce a 'what

happens next' guide for relatives and staff. (this could be used for most serious untoward incidents and not just suicide).

Learning the Lessons

Collection of data relating to the event is most important, to 'learn the lessons' and potentially lessen the risk of a recurrence. Often however, the incident report is completed long before overall resolution of the event for all parties is obtained. The input and experiences of relatives, friends, other agencies and staff members can offer vital insights into how both the incident occurred and the potential for dealing with a similar incident more effectively manner in the future.

7.5 Resources Available

7.5.1 References

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7.5.2 Websites

Partnership for Children

<http://www.partnershipforchildren.org.uk/>

Campaign against living Miserably

<http://www.thecalmzone.net/Home/>

The Samaritans

<http://www.samaritans.org.uk/>

The Rural Stress Information Network

<http://www.ruralnet.org.uk/~rusin/>

Survivors of Bereavement by Suicide

<http://www.uk-sobs.org.uk/about.htm>

Cruse Bereavement Care
<http://www.crusebereavementcare.org.uk/>

Childline
<http://www.childline.org.uk/>

7.5.3 Support groups

Rethink
Unit 12, Stevens Way, Balby, Doncaster DN4 0LT (Tel: 01302 851651)

Doncaster Rape and Sexual Abuse Counselling
PO Box 470, Doncaster, DN1 3XW (Tel: 01302 360421)

Doncaster MIND
27/29 Netherhall Road, Doncaster, DN1 2PG (Tel: 01302 812190)

Doncaster Women's Aid
Tel: 01302 326411

SOBS (Survivors of Bereavement by Suicide)
Tel: 0870 241 3337

Bereaved by Suicide (Doncaster)
Tel: 0870 787 5217
Tel: 01302 366173

CRUSE Bereavement Care
Tel: 0208 939 9530
Tel: 0870 167 1677

Despair after Suicide (DAS)
Tel: 0177 276 0662

Papyrus
(Parents' Association for the Prevention of Young Suicide)
Tel: 0170 621 4449

M25 Housing and Support Group
Tel: 01302 361777

Doncaster Foyer
Tel: 01302 764800

YMCA
Tel: 01302 342148

Doncaster Housing for Young People - DHYP
Tel: 01302 321956 / 321953 / 738198

Women's Aid
Tel: 01302 326411

Appendix

**North East, Yorkshire and Humber Regional development Centre Area, Audit of
Suicides and Undetermined Deaths – Data Collection Form.**

**North East, Yorkshire and Humber Regional Development Centre Area
Audit of Suicides and Undetermined Deaths**

The following information should be collected in relation to all individuals where there is a suicide or undetermined death where suicide is a possibility.

<u>Area of Information</u>	
Post code	<i>First three characters</i>
Gender	Male or Female
Sexual Orientation	Heterosexual / Homosexual / Not Known
Date of Birth	<i>DD/MM/YYYY</i>
Date of Death/ Suicide	DD/MM/YYYY
Ethnicity	Use 2001 Census definitions
<u>Occupation</u>	<p>Choose one from:</p> <ul style="list-style-type: none"> ▪ Employed ▪ Unemployed ▪ Retired ▪ Long term sick <p>Choose one from:</p> <ul style="list-style-type: none"> ▪ Farmers ▪ Nurses ▪ Doctors ▪ Student ▪ Other <p><i>This uses categories in National Suicide Strategy. Individual localities may choose to add to this list</i></p>
<u>Manner of Death/Suicide</u>	<ul style="list-style-type: none"> ▪ Hanging ▪ Poisoning ▪ Motor Gas ▪ Jumping ▪ Railways ▪ Other
<u>Location of suicide act / death</u>	<i>Text description of where the suicide attempt / possible suicide attempt took place, for example a bridge, at home, in a car. This may not be where the individual actually died, for example where someone has died in hospital</i>
<u>Previous history of suicide attempts or self harm</u>	<ul style="list-style-type: none"> ▪ Yes. Within the past 12 months ▪ Yes, but not within the past 12 months ▪ No ▪ Not Known
<u>Current prescribed medication</u>	<p>YES If yes: What type and amount (text)</p> <p>NO</p>
<u>Documented history of drugs and / or alcohol misuse?</u>	<p>YES</p> <ul style="list-style-type: none"> ▪ Drugs ▪ Alcohol ▪ Both <p>NO</p>

	Not Known
Home situation	<ul style="list-style-type: none"> ▪ Living alone ▪ Living with partner ▪ Living with parents ▪ Other shared living arrangements ▪ No fixed abode
Recent Risk Indicator	<ul style="list-style-type: none"> ▪ Relationship problems ▪ Redundancy ▪ Divorce ▪ Homelessness ▪ Illness ▪ Bereavement ▪ Forensic history ▪ Childbirth within the last 12 months ▪ Other
Contact with GP or Primary Care prior to death	<p>Date of last GP or Primary Care appointment: DD/MM/YYYY</p> <p>Length of time before date of death: number of days</p> <p>Reason for contact – choose from:</p> <ul style="list-style-type: none"> ▪ mental health problem ▪ physical health problem ▪ other
Previous contact with specialist mental health services	<ul style="list-style-type: none"> ▪ No known contact ▪ Current at time of death ▪ In contact during the 12 months prior to death ▪ Contact longer than 12 months ago <p>(Each locality will then have its own set of additional audit questions)</p>
Coroner's verdict and date	Text

Notes and typical process established in some areas to obtain the above information:

Weekly: notification of deaths by Coroner to named representatives from mental health services and PCT (can be the same individual if a joint process has been agreed).

Monthly: meeting involving the Coroner's office and representatives from mental health services and PCT (can be the same individual if a joint process has been agreed). This is likely to require approximately 1 hour per month.

At this meeting, the latest preliminary files are shared, giving an initial indication of which cases are likely to be suicides or undetermined deaths. This enables a start to be made to completing the Suicide Information template.

Annually: review of the GP files relating to those cases where there has been a coroner's verdict, in order to complete the Suicide Information template. This is likely to require an average of half an hour per file.

Agreement will be required from the PCT's Caldicott Guardian (or equivalent) before accessing the files.

An annual exercise seems to be a more time effective way to undertake this rather than attempt to review on an ongoing basis.