



The National Confidential Inquiry into Suicide and Safety in Mental Health

Safer services:

A toolkit for specialist mental health services and primary care

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About this toolkit

- > The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) has collected in-depth information on all suicides in the UK since 1996, with the overall aim of improving safety for all mental health patients.
- > We provide crucial evidence to support service and training improvements, and ultimately, to contribute to a reduction in patient suicide rates and an overall decrease in the national suicide rate.
- > Based on our evidence from studies of mental health services, primary care and accident and emergency departments we have developed a list of 10 key elements for safer care for patients. These recommendations have been shown to reduce suicide rates.
- > This toolkit presents the 10 key elements as quality and safety statements about clinical and organisational aspects of care, based on more than 20 years of research into patient safety. It also includes statements about aspects of care in the Emergency Department and in primary care.
- > This resource has been developed by the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH).

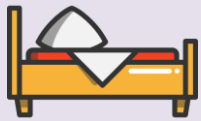
Important note

This toolkit is intended to be used as a basis for self-assessment by mental health care providers and responses should ideally be based on recent local audit data or equivalent evidence. We recommend each element is reviewed annually.

We value your opinion on our research and welcome your feedback on this toolkit, please email: ncish@manchester.ac.uk.



Safer wards



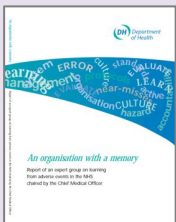
Services should review in-patient safety, and remove ligature points from wards. There should be measures in place to prevent patients from leaving the ward without staff agreement; this might be through better monitoring of ward entry and exit points, and by improving the in-patient experience through recreation, privacy and comfort. Observations policies should recognise that observation is a skilled intervention to be carried out by experienced staff.

Our evidence

Following [NCISH recommendations](#), suicide using non-collapsible ligature points became an NHS 'never event' (a serious incident that is preventable) in 2009. This means that health services are required to monitor their incidence, and are provided with advice to reduce the risk.

Since then suicide by mental health patients continues to fall. However, the large fall in the 4 years after 2006 (31%) has become more modest, e.g. in the 4 years after 2012, the rate fell by 11%. On average, there are still [106](#) suicides by in-patients in the UK per year.

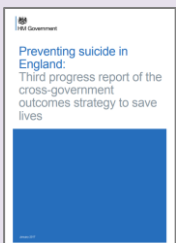
Guidance



This recommendation was originally cited in the Department of Health report [An Organisation with a Memory](#) in 2000.

More recently it is included in:

- > HM Government's [Third Progress Report of the Suicide Prevention Strategy](#)
- > Northern Ireland's [draft suicide prevention strategy](#)
- > The Welsh Government's suicide and self-harm prevention strategy [Talk To Me 2](#)



Safer wards can be achieved by:



Removal of ligature points

	Response		Date next review due	Comments
	Yes	No		
Acute in-patient wards (including PICU, forensic units), have been (re)designed to remove the following: (i) Non-collapsible curtain rails (ii) Low-lying ligature points				
There has been a comprehensive review of in-patient safety.				



Skilled in-patient observation

	Response		Date next review due	Comments
	Yes	No		
Observation policies recognise that observation is a skilled intervention to be carried out by experienced staff of appropriate seniority.				

Safer wards can be achieved by:



Reducing leave from ward without agreement

	Response		Date next review due	Comments
	Yes	No		
Technology is in place to improve monitoring of ward entry and exit points (including CCTV, swipe card access).				
Staffing and observation protocols include information on the monitoring of in-patient ward access and exit points.				
There is a standard response/protocol in place for patients who leave the ward without staff agreement.				
There is acknowledgement in relevant policies that the in-patient experience (e.g. support and recreation, privacy and comfort) can be linked to the risk of leaving the ward without staff agreement.				

Early follow-up on discharge



Patients discharged from psychiatric in-patient care should be followed-up by the service within two to three days of discharge. A care plan should be in place at the time of discharge.

Our evidence

In England, there were 2,220 suicides within three months of discharge from in-patient care between [2006 and 2016](#). 16% of these post-discharge suicides occurred within the first week of leaving hospital, with the highest number occurring on the second (18%) and third (21%) day.

Guidance

Department of Health Mental Health Performance Framework Guidance states that all patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge.

National clinical guidelines have been developed with reference to our findings on suicide following discharge from in-patient care. See the NICE guidance on [transition between in-patient mental health settings and community or care settings](#).



Care planning and early follow-up on discharge from hospital to community

	Response		Date next review due	Comments
	Yes	No		
The discharge policy specifies follow-up of patients discharged from psychiatric in-patient care occurs within 2-3 days in all cases.				
There is a care plan in place for patients discharged from acute care.				

No out-of-area admissions

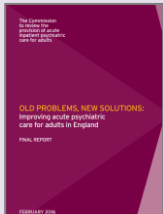


Very ill patients should be accommodated in a local in-patient unit. Being admitted locally means that patients stay close to home and the support of their friends and family, and are less likely to feel isolated or to experience delayed recovery. Local admission should also result in simpler discharge care planning.

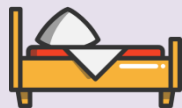
Our evidence

In England, 199 patients (10%) died after being discharged from a non-local in-patient unit. This proportion was similar to those who died within two weeks of discharge (65, 12%). There has been a [downward trend](#) in the number of suicides by patients recently discharged from hospital in England and Scotland. In England, there were 177 post-discharge deaths in 2016 (26 in Scotland), down from 227 in 2011 (49 in Scotland).

Guidance



Both the King’s Fund [Under Pressure](#) report and the [Independent Commission on Acute Adult Psychiatric Care](#) referenced this recommendation in 2015, calling for an end to acute admissions out of area.



No ‘out-of-area’ admissions for acutely ill patients

	Response		Date next review due	Comments
	Yes	No		
There are no acute out-of-area admissions. Where patients are discharged from a non-local in-patient unit, there is a policy in place for close follow-up in the community.				

24-hour crisis resolution/home treatment teams

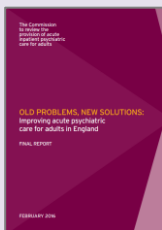


Community mental health services should include a 24-hour crisis resolution/home treatment team (CRHT) with sufficiently experienced staff and staffing levels. CRHTs provide intensive support in the community to patients who are experiencing crisis, as an alternative to in-patient care. CRHT teams should be monitored to ensure that they are being used safely. Contact time with CRHTs should reflect the specialist and intensive nature of that role.

Our evidence

The main setting for suicide prevention is now the crisis team, following a fall in in-patient suicides and a rise in the use of CRHT as an alternative to admission to acute care, [since 2004](#). In England, there are on average [191](#) suicides per year by CRHT patients – over two times as many as under in-patient services. The introduction of a 24-hour CRHT appears to add to the safety of a service overall, with a [reduction in suicide rates](#) in implementing mental health services. In our study of [the assessment of clinical risk in mental health services](#), both patients and carers emphasised the need for clarity about what to do and who to contact in a crisis.

Guidance



Both the King's Fund [Under Pressure](#) report and the [Independent Commission on Acute Adult Psychiatric Care](#) referenced these recommendations in 2015, and emphasised the importance of CRHTs operating efficiently as intensive specialist community-based alternatives to in-patient care, and not simply as generic crisis teams.



24-hour crisis resolution/home treatment teams

	Response		Date next review due	Comments
	Yes	No		
Community mental health services include a 24-hour crisis resolution/home treatment team (CRHT) with satisfactory staffing levels.				
The assessment for CRHT takes into account individual circumstances and clinical need, and recognises that CRHT may not be suitable for some patients; especially patients who are at high risk or who lack other social supports (e.g. live alone).				

Family involvement in ‘learning lessons’



Working more closely with families could improve suicide prevention. Services should consult with families from first contact, throughout the care pathway and when preparing plans for hospital discharge and crisis plans.

Staff should also make it easier for families to pass on concerns about suicide risk, and be prepared to share their own concerns. This could help to ensure there is a better understanding of the patient’s history and what is important to them in terms of their recovery, and may support better compliance with treatment.

There should be a multi-disciplinary review following all suicide deaths, involving input from and sharing information with families.

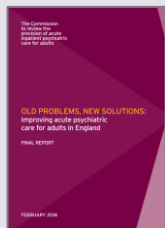
Our evidence

Staff told us that greater involvement of the family by the service would have reduced suicide risk in [17%](#) of patients.

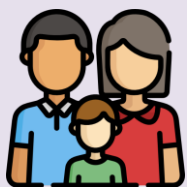
One example of how services can improve contact with families is shown in how services respond when a patient does not attend an appointment. In only [22%](#) of deaths by suicide the service contacted the family when the patient missed the final appointment before the suicide occurred. Policies for multidisciplinary review and information sharing with families were associated with a [24% fall in suicide rates](#) in implementing NHS Trusts, indicating a learning or training effect.

[Patients tell us](#) they want their families to have as much involvement as possible in their assessment of clinical risk, including sharing crisis/safety plans with them.

Guidance



The [Independent Commission on Acute Adult Psychiatric Care](#) cite these recommendations, stating that families and carers are an under-used resource.



Working with families

	Response		Date next review due	Comments
	Yes	No		
There is a specific policy on multi-disciplinary reviews following all suicide deaths, including involving and sharing information with families.				
Protocols for risk management encourage involvement with families and carers as much as possible in the risk assessment process, if wanted by the patient.				
Care plans, for all patients, are devised collaboratively with carers and family members for ongoing safety management, if wanted by the patient.				

Guidance on depression



There should be a local NHS Trust/Health Board policy based on NICE (or equivalent) guidelines for depression and self-harm.

Our evidence

Services that implemented NICE guidance for depression and self-harm guidelines had [significant reductions in suicide rates](#) of 26% and 23% respectively.

Guidance



See the NICE [Quality Standard for the Management of Self-Harm](#).

The NICE [guidelines on depression](#) are currently in development.



Implementing NICE guidance on depression and self-harm

	Response		Date next review due	Comments
	Yes	No		
There are local Trust/Health Board policies based on NICE (or equivalent) guidelines for depression and self-harm.				

Personalised risk management



All patients' management plans should be based on the assessment of individual risk and not on the completion of a checklist. Patients should have the opportunity to discuss with their mental health team the signs that they will need additional support, such as specific stresses in their life. Families and carers should have as much involvement as possible in the assessment process, including the opportunity to express their views on potential risk. Consulting with the patient's GP may also be helpful.

Risk assessment is one part of a whole system approach that should aim to strengthen the standards of care for everyone, ensuring that supervision, delegation and referral pathways are all managed safely.

Evidence

[Most risk assessment tools](#) seek to predict future suicidal behaviour. Clinicians tell us that tools, if they are used, should be simple, accessible, and considered part of a wider assessment process. Treatment decisions should not be determined by a score. Risk tools and scales have a [positive predictive value of less than 5%](#), meaning they are wrong 95% of the time, and miss suicide deaths in the large 'low risk' group. In a sample of patient suicides, the quality of assessment of risks and management was considered by clinicians to be [unsatisfactory in 36%](#).

Risk is often individual, suggesting the management of risk should be should be personal and individualised.

Guidance



NICE guidelines on the [long-term management of self-harm](#) state that risk assessment tools should not be used to predict future suicide or repetition of self-harm, or to determine who should or should not be offered treatment. The guidelines suggest they might be used as prompts or measures of change.



Personalised risk management, without routine checklists

	Response		Date next review due	Comments
	Yes	No		
There is a comprehensive management plan based on an assessment of (changing) personal and individualised risks, and not on the completion of a checklist.				
Protocols for conducting risk assessment should emphasise building relationships and gathering good quality information on: <ul style="list-style-type: none"> (i) The current situation (ii) Past history (iii) Social factors 				
There is specific staff training in place in how to assess, formulate, and manage risk, including training staff in being comfortable asking about suicidal thoughts.				
There is a guide in place on the effective communication of personalised risk management between different agencies, services and professions involved with the patient, including their family and carers and with primary care.				

Outreach teams



Community mental health teams should include an outreach service that provides intensive support to patients who are difficult to engage or who may lose contact with traditional services. This might be patients who don't regularly take their prescribed medication or who are missing their appointments.

Evidence

Implementation of an assertive outreach policy was associated with [lower suicide rates](#) among patients who were non-adherent with medication or who had missed their last appointment with services, and with lower suicide rates overall in implementing Trusts.

Guidance

The [Independent Commission on Acute Adult Psychiatric Care](#) includes recommendations for comprehensive and effective community mental health, including outreach teams.



Community outreach teams to support patients who may lose contact with conventional services

	Response		Date next review due	Comments
	Yes	No		
Community mental health services include an outreach service that provides intensive support to patients who are difficult to engage with conventional services (e.g. community patients who not regularly taking their prescribed medication or who are missing their appointments).				

Low staff turnover



There should be a system in place to monitor and respond to non-medical staff turnover rates. Non-medical staff are all other health staff except doctors.

Evidence

Organisations with low turnover of non-medical staff had [lower suicide rates](#) than organisations where staff changed frequently. In addition, those services with low staff turnover saw a greater reduction in their suicide rates when they implemented NCISH recommendations that services with high staff turnover.

Guidance

The King’s Fund cited this recommendation in their [Under Pressure](#) report in 2015.



Low turnover of non-medical staff

	Response		Date next review due	Comments
	Yes	No		
There is a system in place to monitor and respond to non-medical staff turnover rates (i.e. nurses, qualified allied health professionals and other qualified scientific, therapeutic and technical staff).				

Services for dual diagnosis

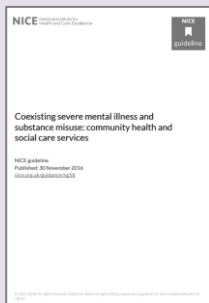


We recommend there are drug and alcohol services available that work closely with mental health services for patients with mental illness and alcohol and drug misuse.

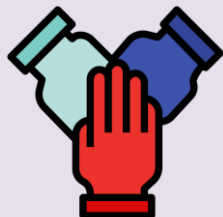
Evidence

Only a minority of patients who died by suicide between [2006 and 2016](#) were in contact with specialist substance misuse services, despite alcohol and drug misuse being a common antecedent of patient suicide in all UK countries. In England, there was a [25% fall in rates of suicide by patients](#) in those NHS Trusts which had put in place a policy on the management of patients with co-morbid alcohol and drug misuse.

Guidance



See the NICE [guidelines on coexisting severe mental illness and substance misuse](#).



Specialised services for patients with mental illness and coexisting alcohol and drug misuse

	Response		Date next review due	Comments
	Yes	No		
Specialist alcohol and drug services are available, with a protocol for the joint working with mental health services (including shared care pathways, referral and staff training).				
There is a specific management protocol or written policy on the agreed management of patients with coexisting alcohol and drug misuse.				
Protocols for managing self-harm patients who are under mental health care should highlight the short term risk of suicide, especially where there is coexisting alcohol and drug misuse.				

Managing self-harm



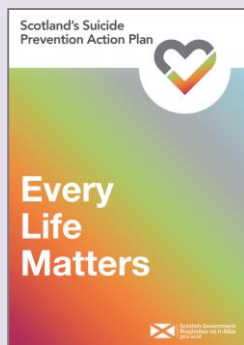
There is evidence that recent self-harm is increasingly common prior to suicide in mental health patients and in people not in contact with mental health services.

Self-harm should be recognised as a suicide warning - presenting an indication of risk and a chance to intervene. We recommend protocols for managing self-harm patients who are under mental health care highlight the short-term risk of future suicidal behaviour.

Evidence

Recent self-harm (in the previous 3 months) [has risen](#) as an antecedent of suicide in mental health patients. In the UK, over a quarter (29%) of patients who died by suicide between [2006 and 2016](#) had recently self-harmed – an average of 434 deaths per year. Self-harm is particularly evident in [younger age-groups](#). Our findings show an episode of self-harm is common as a recent experience in mental health patients who die by suicide but risk can be under-estimated at assessment – [most \(76%\) patients](#) who had recently self-harmed were thought to be at low risk of immediate suicide at their final service contact.

Guidance



NICE [guidelines on the management of self-harm for children and young people and adults](#) describe the importance of an assessment of risks of further self-harm or suicide.

Reducing rates of self-harm as a key indicator of suicide risk is cited in the HM Government's [Third Progress Report of the Suicide Prevention Strategy](#), the Welsh Government's suicide and self-harm prevention strategy [Talk To Me 2](#), Northern Ireland's [draft strategy for suicide prevention](#), and in Scotland's [Suicide Prevention Action Plan](#).



Psychosocial assessment after self-harm

	Response		Date next review due	Comments
	Yes	No		
There is a fully integrated liaison psychiatry service in place offering 24-hour specialist assessment and follow-up for all self-harm patients.				
There is a policy in place for all patients who self-harm to have a skilled psychosocial assessment of risk of future self-harm and suicidal behaviour.				
Protocols for managing self-harm patients who are under mental health care highlight the short term risk of suicidal behaviour.				
Services that respond to self-harm meet NICE quality standards for self-harm care.				

Safer prescribing

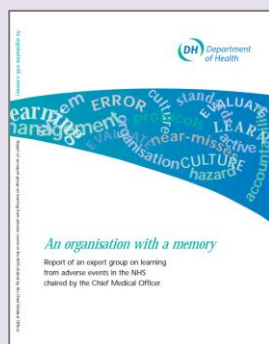


Our evidence indicates a key measure to reduce suicide risk includes the safer prescribing of opiates and psychotropic drugs. These are medications that may have been prescribed for long-term pain, for someone else in the patient's household or bought over the counter in a pharmacy or shop.

Evidence

The main substances taken in fatal overdose are opiates and the main source (where known) is by prescription. In England, opiates and opioids account for [a third \(33%\) of patient suicide deaths](#) by fatal overdose, followed by antidepressants (typically tricyclics and SSRI/SNRIs; 21%), antipsychotic drugs (11%) and non-opiate analgesics (mainly paracetamol, 7%). In Northern Ireland and Scotland fatal overdose by opiates is more common (40% and 48% respectively).

Guidance



NICE [guidelines on borderline personality disorder](#) recommend short-term use of drug treatment may be helpful during a crisis, but that polypharmacy should be avoided. NICE [guidelines on depression in adults with a chronic physical health problem](#) advise limiting the amount that is prescribed if the patient has been assessed to be at risk of suicide.

[General Medical Council guidance](#) highlights that doctors should check whether the treatment provided for a patient is compatible with other treatments they are receiving, including any self-prescribed over-the-counter medicines. Patients should also be encouraged to be open about their use of other medicines during assessment.



Safer prescribing of opiates and antidepressants

	Response		Date next review due	Comments
	Yes	No		
<p>There is a standard procedure in place for safer prescribing of opiate analgesics and tricyclic antidepressants in primary care and accident and emergency departments, which takes into account the toxicity of these drugs in overdose by:</p> <ul style="list-style-type: none"> (i) Considering reduced, short-term supplies; (ii) Asking about supplies of over-the-counter opiate-containing medications kept at home or prescribed to someone else in the household; (iii) Ensuring patients newly prescribed antidepressants are aware of the time taken to work. 				

Monitoring for depression



Good physical healthcare may help reduce suicide risk. Health care professionals working across all medical specialties should be vigilant for signs of mental ill health, especially when treating major physical illnesses including cancer, coronary heart disease, stroke or chronic obstructive pulmonary disease (COPD).

Evidence

[A quarter of patients](#) who die by suicide have a major physical illness and the figure rises to 44% in patients aged 65 and over. Depression is linked to [increased suicide risk](#) among physically ill people, particularly in certain diagnoses such as coronary heart disease, stroke, COPD and cancer. [71% of people](#) who died by suicide and had presented to their GP had a diagnosis of depression.

Guidance



The NICE [guidelines on depression](#) are currently in development.

An integrated mental and physical health approach is a priority action for the NHS cited in [The Five Year Forward View for Mental Health](#).



Diagnosis and treatment of mental health problems especially depression in primary care

	Response		Date next review due	Comments
	Yes	No		
There is a mechanism in place to ensure that patients who present with major physical health issues are assessed and monitored for depression and risk of suicide.				
There is a mechanism in place to ensure that patients with certain markers of risk (i.e. frequent consultations, multiple psychotropic drugs and specific drug combinations) are further assessed and considered for referral to specialist mental health services.				
There is a standard procedure in place for mental health staff to regularly review care with GPs or specialist clinics.				

Additional measures for men

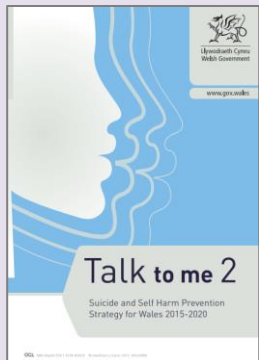


In the last decade there has been an upward trend in suicide in men aged 30-49 years, with particularly high rates in those aged 40-44 years. Suicide risk factors among middle-aged men include a reluctance to seek help, higher rates of substance misuse and isolation, a lack of social supports, and economic pressures such as unemployment.

Evidence

Middle-aged men have the highest suicide rate in the UK but are often not in contact with services. Between [2006-2016](#), in all countries (except Northern Ireland), the highest suicide rates were in men in the middle-aged groups.

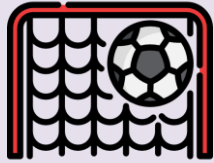
Guidance



The marked rise in suicide in middle-aged men is cited in [The Five Year Forward View for Mental Health](#).

Better targeting of suicide prevention in high risk groups such as middle-aged men is included in:

- > HM Government's [Third Progress Report of the Suicide Prevention Strategy](#)
- > The Welsh Government's suicide and self-harm prevention strategy [Talk To Me 2](#)
- > Scotland's [Suicide Prevention Action Plan](#)
- > Northern Ireland's [draft suicide prevention strategy](#).



Additional measures for men with mental ill-health

	Response		Date next review due	Comments
	Yes	No		
There are specific measures in place to reduce suicide risk in men with mental ill-health, including access to services and interventions that are available online and in non-clinical settings (e.g. sporting communities).				