

Suicide audit in Primary Care Trust localities: A whole systems approach

Supporting Evidence for a National Primary Care Suicide Audit Toolkit

Dr Elaine Church (Consultant in Public Health, Central Liverpool PCT)
and Dr Tony Ryan (Director, Tony Ryan Associates)

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Abbreviations

CHAI – Commission for Healthcare Audit and Inspection

CJS – Criminal Justice Services

CPA – Care Programme Approach

CPN – Community Psychiatric Nurse

CSM – Committee on Safety of Medicines

DSH – Deliberate Self Harm

GMS – General Medical Services

GP – General practitioner

HCC – Healthcare Commission

ICD – International Classification Diseases

LDPR – Local Delivery Plan Review

LIP – Local Implementation Plan

LIT – Local Implementation Team

MHT – Mental Health Team

NCI – National Confidential Inquiry

NIMHE – National Institute Mental Health in England

NIMHE NW – National Institute Mental Health in England North West

NSF – National Service Framework for Mental Health

ONS – Office for National Statistics

PCT – Primary Care Trust

PHCT – Primary Health Care Team

PHM – Public Health Mortality

PM – Post Mortem

QOF – Quality and Outcomes Framework

RR – Relative Risk

SAG – Suicide Audit Group

SEA – Significant Event Analysis

STEIS – Strategic Executive Information System

SUI – Serious Untoward Incident

SPSS – Statistical Package for Social Sciences

Suicide Audit in Primary Care Trusts localities: A Whole Systems Approach

1 Introduction

This document was developed to provide detailed and practical guidance to developing clinical audit of suicides within PCT localities rather than be a systematic review of the literature. It has been designed to inform the development of the National Suicide Audit Tool and supplement the NIMHE toolkit

http://www.nimhe-em.org.uk/suicide_db/index.html

The report aims to provide guidance on how to undertake a whole systems approach to suicide audit within a PCT in order to improve clinical practice by:

- Briefly describing national policy guidance that requires PCTs and Mental Health Trusts to undertake suicide audit
- Exploring the concept of "population" suicide audit and its relation to clinical suicide audit
- Describing the routine and non-routine sources of data for suicide and death by undetermined injury including use of National Confidential Inquiry and local Coroner data
- Review the existing literature to:
 - determine the methodologies that have been used for suicide audit
 - identify which methods are more effective in terms of improving clinical practice
- Describing the difference between adverse incident reviews and clinical audit of suicides

There are many examples of suicide audit across the UK that have been developed at local levels. In the absence of policy guidance to date this report provides the rationale and evidence, where it exists, for the development of the standardised audit tool which should allow for comparative data to be obtained in the future.

2 National policy and initiatives in England

The first *National Suicide Prevention Strategy in England* was published in 2002 (Department of Health, 2002a). The Strategy aimed to support the achievement of the target set in *Saving Lives: Our Healthier Nation* (Department of Health, 1999b) and reinforced within the *National Service Framework for Mental Health* (DoH, 1999a) to reduce the death rate from suicide and undetermined injury by at least a fifth by the year 2010. The Strategy acknowledges there is no single approach to reducing suicides and that a broad strategic inter-agency approach is required. The National Suicide Prevention Strategy for England sets out a programme of activity to reduce suicide based on six goals:

- to reduce risk in key high risk groups
- to promote mental well-being in the wider population
- to reduce the availability and lethality of suicide methods
- to improve reporting of suicidal behaviour in the media
- to promote research on suicide and suicide prevention;
- to improve monitoring of progress towards the *Saving Lives: Our Healthier Nation* (1999) target for reducing suicide

The *National Suicide Prevention Strategy for England Annual Report 2005* indicated some success to date (NIMHE, 2005). The annual report states that “The Public Service Agreement reached between the Department of Health, the Treasury and the Prime Minister’s Office to reduce the mortality rate from suicide and undetermined injury by at least 20% by 2010 reflects the Government commitment to improving access to mental health services”. This important national target has been retained in the National Standards Local Action health and social care standards and planning framework for 2005/06 – 2007/08.

All PCTs are currently required to show trends in suicide rate trajectories and provide action plans for delivery of interventions towards achieving the national target to reduce suicide rates by 20% by 2010. This information needs to be included in PCT Local Delivery Plans. The requirement to undertake suicide audit was included in the CHAI star ratings 2004 and the LIT Autumn Assessment 2005.

PCTs may give differential priority to suicide audit amongst their population as some have very low suicide rates. Therefore, there is a need to support PCTs to select the most appropriate methodology for audit dependent on their local suicide rates, local priorities and level of resources for audit. This decision should be made locally. The audit tool that accompanies this report provides a framework that should enable this whilst standardising the minimum data being collected.

However, suicide audit forms part of the broader public health approaches required beyond that of local NHS service provision. Measures such as those included in the NSF for Mental Health, the NHS Plan (Department of Health, 2000), mental health promotion strategies, alcohol and drug misuse reduction strategies, and media portrayal are all-important approaches to suicide prevention. National initiatives are of fundamental importance in reducing suicide rates. For example, initiatives reducing access to the means of suicide are particularly effective. The Committee on Safety of Medicines (CSM) in the light of its recent review of the risks and benefits of co-proxamol has advised that co-proxamol products should be withdrawn altogether over the next 6-12 months as co-proxamol has increasingly been used by people who have died by suicide. A study by Camidge and colleagues (2003) stated that “the most popular drug used for suicidal overdoses by both young males and females was co-proxamol (37.1%), and notably 37.6% of young suicides had consumed alcohol shortly before their death”. In addition, NIMHE and the Medicines and Health Care Regulatory Agency (MHRA – formerly the Medicines Control Agency) are planning to discuss the possible introduction of a safety warning and helpline number on over-the-counter packs of paracetamol and aspirin.

To work towards reducing suicides on railways, NIMHE are working with the Rail Safety and Standards Board and other key stakeholders to examine the potential for developing safety measures e.g. improving barriers. The NIMHE North East, Yorkshire and Humberside Development Centre have devised a proforma for the collection of data from across the region on suicide hotspots. The National Suicide Prevention Strategy annual report for 2005 provides more information on this aspect of auditing suicides.

Suicide audit should be seen as part of an overarching whole systems approach to suicide prevention. The recommendations from local suicide audit within PCTs (in partnership with other local agencies) and Mental Health Trusts should feed into the LIT, local suicide prevention strategy and mental health promotion strategy.

3 Epidemiology of suicide

Suicide rates whilst fluctuating year on year have shown an overall downward trend since the early 1980s, however most recent statistics show the rate of decline is decreasing. The latest progress report on the Strategy highlights that the suicide rate for young men has fallen to its lowest level for almost 20 years, having dropped almost 30% from its peak in 1998 (NIMHE, 2005). The overall suicide rate in the most recent period (2001-2003) has fallen by 6% from the rate in 1995-7.

However, the majority of suicides continue to occur in young adult men i.e. those under 40 years. In relation to men and women of the same age, the peak difference is the 25-34 age group in which four men die by suicide to each woman. The average ratio between men and women of all ages is just over three male suicides to each female (Department of Health, 2002a).

Suicide rates by people in contact with mental health services in the year prior to death continue to decrease nationally. Having a severe and enduring mental illness is a known risk factor for suicide therefore effective risk management and continuity of care is essential (NIMHE, 2005). The National Patient Safety Agency has identified patient safety in acute mental health settings as a priority (NPSA, 2004).

The variations in risk highlight the need for action at different levels in health and social care. Implementation of Standards 1 to 6 in the NSF will also contribute to reducing suicides as well as implementation of Standard 7, which is specifically concerned with suicide prevention.

The National Confidential Inquiry collects and analyses data on the 25% of suicides that take place in people who have been in contact with secondary care mental health services in the 12 months prior to the suicide event. More information is known on this cohort as a result. Of these, 16% were inpatients at the time of their death and 23% had been discharged from hospital within the previous three months. Many were not compliant with treatment when discharged and the mental health teams themselves regarded 25% of the suicides as preventable. In addition, the majority of Mental Health Trusts are carrying out reviews of adverse incidents that include suicides.

A local whole systems approach to suicide audit by the PCT can supplement this knowledge by adding more detailed information about the local context where risk factors may vary from the national picture. Such an approach would supplement the learning on this group as these would include the 75% of people who die by suicide who are not in contact with mental health services. Not as much information is known about this group though many, but not all, of these people are likely to have been in contact with primary healthcare services.

A GP, or other primary care worker, may be the only health care practitioner in contact with an individual who may be contemplating suicide. Therefore, they will have an important role in detection of risk factors and appropriate management.

According to the National Service Framework for Mental Health (Department of Health, 1999a) 'an average primary care group with a population of 100,000 people would expect 10 suicides each year' therefore individual practices with a list size of 3,500 would only rarely have a suicide within their practice population, perhaps once in 3 years. As a result, suicide audit and prevention may be less of a priority than other areas. In general, suicides are more common in areas of deprivation although this association is complicated by the fact that certain occupations have higher rates of suicide due to easier access to the means of suicide e.g. farmers, doctors, vets and pharmacists (Department of Health, 1999a).

Box 1: Risk factors associated with suicide

High-risk groups include:

- Males (especially young men under the age of 35 years)
- People who have been discharged from inpatient psychiatric services within past 4 weeks
- People with a history of self-harm
- People with alcohol and/or drug problems
- People with a family history of suicide
- Sentenced and remand prisoners and ex-prisoners recently released into the community
- People with serious physical illnesses
- Certain occupational groups – unskilled occupations, doctors, nurses, vets, farmers
- People from ethnic groups – women born in Sri Lanka, India and the East African Commonwealth are approximately 50% more likely to die by suicide than the general population as a whole.
- Divorced people
- Women before and after childbirth
- Older people
- People with mental health problems, especially depression, schizophrenia and personality disorders (many may not be in contact with secondary mental health services, especially people with depression)
- People recently bereaved

Hanging and suffocation are now by far the most common method of suicide for men, accounting for nearly half of all male suicide deaths. The relative importance of drug related or other poisoning (including motor gas poisoning) has decreased accordingly. Among women, drug related poisoning is still the most common method of suicide, accounting for nearly 44% of all female suicide deaths, but hanging and suffocation now account for over a quarter of all female suicides and is the second most common method used (Kelly & Bunting, 1998).

There has been a fall in suicide by car exhaust asphyxiation in all age and gender groups. This change was most marked after 1993. The overall population suicide rate (all methods) also decreased but there was no overall change in suicides by young males or females. Legislation on catalytic converters appears to have contributed to a fall in car exhaust suicides. However, the effect on overall suicide rates in young people has been reduced by method substitution e.g. hanging (Amos et al, 2001).

4 Requirements for suicide audit

The requirement to audit suicides is not new, however the need to do so has been reiterated within the NSF for Mental Health, the National Suicide Prevention Strategy and regulatory high-level performance indicators (see Box 2). New targets for PCTs as part of the annual health check do not include suicide audit as a requirement (Department of Health, 2002b) as it is most PCTs have reported to have a system in place. In the 2004 PCT star ratings, 291 out of 303 PCTs reported having a local system for suicide audit in place. A range of approaches have been developed.

BOX 2: Suicide audit – 2004 Performance Indicator star rating PCT

Local system for suicide audit implemented

Rationale:

The Public Sector Agreement target is, by 2010, to reduce the number of deaths from suicide and undetermined causes by at least 20%, with local services having in place from March 2002:

- systematic suicide audit programmes
- multi-agency protocols for the sharing of information on high risk patients

AND

- staff competent in the assessment of risk of suicide.

75% of all completed suicides involve people who are not in contact with specialist mental health services, therefore to be successful in reducing the suicide rate the development of local systems for suicide audit to learn lessons and take any necessary action is essential.

Data Source and period

LDPR special collection (As at 31st March 2004)

Construction

Do you have a local, population-based system for suicide audit in place in your organisation, or formal arrangements to participate in suicide audit activity undertaken by another local organisation? (LDPR special collection line number S101).

The development and implementation of suicide audit across the country has been piecemeal not least because the former CHAI definition remains vague. The inclusion of “multi-agency sharing of information protocols being in place” and “staff competent in the assessment of risk” within the CHAI definition, is also unclear. Many PCTs have given themselves a “green status” in the Autumn Review 2005 due to the fact that their local Mental Health Trust is reviewing their suicides often as part of the adverse incident review function of the Trust. The removal of suicide audit from the star ratings performance assessment of PCTs will not have helped in encouraging PCTs to undertake comprehensive suicide audit. However, its inclusion within the LIT Autumn Assessment 2005 helped to keep this on the agenda and the monitoring of suicide audit may well be strengthened once a clear definition and agreement for the methodology of audit has been clarified.

The use of the term “population based audit” within the definition is also vague. There is a need for epidemiological monitoring of suicide rates at individual PCT level and across the appropriate Mental Health Trust footprints. However, although analysis of trends is important, it is very different from clinical audit. Clinical audit of suicides measures the care that service users have received against standards of care that they should have received.

In some areas, PCTs are also collecting additional data from the local Coroner’s Office to supplement local routinely available statistics. Hopefully, through NIMHE’s audit tool this will become standardised across England in order to afford comparability.

However, to carry out a thorough programme of audit takes time and resources to implement. Access to resources to support clinical audit within primary care is also variable across PCTs. The current situation is further compounded by the adverse incident review process. The Strategic Executive Information System (STEIS) reporting mechanism requires Mental Health Trusts and PCTs to report all adverse incidents including suicides to the Strategic Health Authority. The subsequent adverse incident review process involves a comprehensive review of these incidents culminating in a report with recommendations and action plans.

Mental Health Trusts may feel that reviewing suicides as part of their adverse incident and STEIS reporting mechanism is sufficient and that to reintroduce suicide audit would lead to duplication of workload when staff resources may be scarce. Nevertheless, there is a need to acknowledge the difference between adverse incident reviews and suicide audit and to ensure appropriate clinical audit of suicides takes place. Mental Health Trusts and PCTs should undertake adverse incident review as part of their risk management processes and suicide audit as part of the clinical governance process.

PCT systems for adverse incident review are often less well developed than within secondary care mental health services in relation to reporting on and reviewing suicides. Within the new GP contract, Quality and Outcomes Framework (QOF) process, GPs are able to undertake significant event audit of adverse incidents as part of the process of accreditation, and this could be used as a vehicle for encouraging GPs to take part in suicide audit. Therefore it is an opportune time to introduce a comprehensive system for clinical audit of suicides in primary care. Please see Issue 5 of “In Safer Hands”, produced by the Royal College of General Practitioners with the support of the National Patient Safety Agency which briefly looks at significant event analysis and how primary health care teams can get the most from the process (at <http://www.rcgp.org.uk/default.aspx?page=3163>).

Research has shown that approximately 25% of people who die by suicide have had contact with a health care professional, usually their GP, during the last week of life (Gunnell & Frankel, 1994). Appleby et al (1996) found that the number of GP visits in people under 35 increased significantly before death and that the recent increase in suicides by young males does not appear to be related to lower rates of GP attendance. There was no sex difference in the rate of GP visits before suicide and both sexes were most likely to attend for psychological reasons. According to a case control study carried out by Haste et al (1998), women at risk of suicide are more likely to have been diagnosed and treated for mental health problems than men. They also concluded that GPs are under-diagnosing and treating men at risk.

Despite the patterns of consultations with GPs of those at risk of suicide, there remains much debate about how much of a reduction in suicide rates can be achieved in primary care by improved detection of those at risk.

There is limited robust research evidence into effective suicide prevention training programmes in mental health. There is some evidence that education for GPs about depression, appropriate treatment and routine risk assessment may help to reduce numbers of suicide (Rutz et al, 1992; Rihmer et al, 1993; Appleby et al, 1996). However, a study in Hampshire failed to ascertain an increase in detection of depression or in patient recovery rates following the use of guidelines and education within a practice based setting in a larger project (Thompson et al, 2000).

The NSF for Mental Health specifies that primary care staff should be able to assess and manage depression and the risk of suicide. The Skills Training on Risk Management (STORM) project is considered an exemplary evidence based training programme (Droughton et al, 2004). This programme can be adapted to professionals working in a range of different settings. It is fundamentally concerned with acquisition of skills, not with learning how to apply checklists or other suicide risk assessment tools. There is a need to improve access to suicide prevention training programmes of this type across a broad range of agencies.

Box 3: Good Practice Guidelines for Training Programmes*

- Consider the involvement of bereaved relatives and people who self harm as trainers in training programmes
- Recognise the impact of media reporting and stereotypes on the attitudes and practice of health care workers and mental health professionals
- Address commonly held myths and anxieties about working with suicidal and self-harming individuals early on in the programme
- Recognise that several occupational groups of public sector workers are at increased risk of suicide
- Encourage organisations hosting training programmes to review how they promote the mental health of staff
- Ensure training courses offer instruction in core practical skills as well as referring to theory and facts
- Courses should include specific culturally appropriate training
- Training courses should be linked to the audit cycle and an implementation plan
- Any training and implementation plan should be owned by the whole organisation
- Training needs to be supported by access to high quality clinical or case supervision.

* Adapted from Droughton, et al (2004)

5 Sources of data to inform suicide audit

Data on suicides in a population can be obtained from various sources including data that is routinely available, non-routine data sources and special surveys:

1. Routine data sources e.g. Office for National Statistics Public Health Mortality files
2. Non-routine data sources e.g.
 - I. National Confidential Inquiry,
 - II. surveys of local Coroner data,
 - III. data from local prisons and probation services,
 - IV. clinical audit and significant event analyses, and
 - V. psychological autopsy research.

Both routine and non-routine data can be used to contribute to a whole system approach local suicide audit.

Data can be obtained at different levels, ranging from demographic information at population level to more detailed information on individual cases. Work undertaken in West Cornwall PCT has examined the rationale for collecting specific items of information at different levels. For each variable, the rationale for inclusion in any data collection process was identified i.e.

- Is it needed for classification?

OR

- Is there evidence for increased risk of suicide?

AND/OR

- Is there evidence for impact of interventions?

5.1 Routine data sources and their strengths and weaknesses

The Office for National Statistics (ONS) produces the locally held Public Health Mortality (PHM) extract which contains details of all residents' deaths regardless of where the person died and all non-resident deaths that occurred in the relevant local area. This dataset provides some useful basic information (see Table 1). However, it is limited in the range of variables recorded; for example, it does not include information on ethnicity or contact with health services before death.

Registration District Code	Date of death	Area of coroner
Administration Area	Age	Registration district name
Registration Number	Gender	Locality
Entry Number	Place of death	Home postcode
First forename	Usual address	HA of residence
Surname	Occupation	HA of occurrence
Date of birth	Name of coroner	Underlying cause of death

Data on the PHM files have other limitations. The data is collected from death certificates that provide information on the primary and co-morbid diagnoses that contributed to the death. Death certificates are sometimes inaccurate and often the true cause of death can only be established by carrying out a post mortem examination. In the case of suspected suicide or suspicious death the coroner has the power to order a post mortem to be performed and therefore it has been found that the details of the precise cause of death is likely to be more accurate in those cases where a PM has been undertaken. (Blackpool, Fylde and Wyre PCTs, 2002).

Suicides are those in which the coroner has decided that there is clear evidence that the injury was self-inflicted and the deceased intended to take their own life. Open verdicts or undetermined injury are those where there may be doubt about the deceased's intentions. Research studies have shown that most open verdicts are in fact suicides (Lindsey et al, 2001). For the purposes of measuring overall suicides in England, official suicides and open verdicts are combined. Details are collected when deaths are certified or registered. Most deaths are certified by a medical practitioner; however, suspected suicides must be certified after a coroner's inquest. Statistics on cause of death are collected by the Office for National Statistics and are passed to the Department of Health on an annual basis.

The *number of suicide deaths* refer to the actual number of people who have died by suicide or undetermined injury. The *rate of suicide* refers to the frequency with which suicide occurs relative to the number of people in a defined population. This age-standardised rate takes account of changes in the size and age structure of the population to provide a comparable trend across time and across different areas.

Currently a coroner can only give a verdict of suicide at an Inquest when there is clear evidence that the victim intended to take their own life. If any doubt exists then a verdict of accidental, misadventure or open verdict i.e. "undetermined" must be given. The latter verdicts are coded as "undetermined". The majority of open verdicts are suicides and it is conventional to include these deaths with suicides as "suicide and injury undetermined" (Lindsey et al, 2001).

Information on "where death occurred" has only been available since 2001; however, caution needs to be taken here. For example, some people who were found and taken to hospital may be recorded as having died within hospital when this may not be the case.

There are also problems when looking at trends over time due to changes in reporting practice and caution needs to be taken when looking at PCT level rates due to the low numbers involved at PCT level. The merger of PCTs to include larger populations will make this issue less of a problem.

When looking at sub-populations e.g. males versus females or particular age groups, the numbers become even smaller and therefore more caution is required in interpretation.

Ideally, confidence intervals¹ should be calculated for rates of suicide and injury undetermined in order to identify differences that are statistically significant. However, when looking at small populations, the confidence intervals are wider and it is more difficult to identify statistically significant differences.

A further technical issue includes the registration date versus date of death. It can sometimes take several months from the date of death and identification of the exact cause of death as a suicide; therefore the date of registration is usually used to identify numbers occurring in one year in order to define a clear endpoint.

¹ Confidence intervals are a statistical range with a specified probability that a given parameter lies within the range.

The National Suicide Prevention Strategy Advisory Group has acknowledged the need to record more detailed information in certain areas and is currently monitoring:

- Suicide following deliberate self harm (DSH) by using cross linked information
- Suicide from different ethnic minority groups and different occupations
- Inequalities in social class rates for suicide

Comparisons should be made between local data and other similar socio-demographic areas and the national/regional picture. Analysis of seasonality, day of death and method may also provide useful information especially when comparing to national rates. Local prison data should be included.

The PHM information on deaths does not provide data on the ethnic group of the person who died by suicide and therefore rates in certain ethnic groups cannot be calculated within a population. The Department of Health has made a commitment to “work towards collecting information on ethnicity by coroners” (Department of Health, 2003).

Research in the field has highlighted seasonal variations in suicides rates, in particular a spring peak in suicide deaths (Chew and McCleary, 1995). Some studies have indicated that suicides using violent methods are more likely to show seasonality, however recent research suggests that seasonal patterns are decreasing, even in an occupational group such as farmers where this might be expected (Simpkin et al, 2003).

Employment is not recorded adequately on the Office for National Statistics’ Public Health Mortality File and so it is difficult to draw any conclusions. Data may be incomplete for several reasons; the coroner may not have recorded employment status, the deceased was unemployed, or was on long-term sick leave or chose not to work.

Suicides and undetermined deaths are classified according to ICD 10 the International Classification of Disease (ICD 10th revision). The codes used are E980-989 (excluding E988.8 and E950-959); ICD 10 X60-84; Y10-Y34 (excluding Y33.9). Deaths in England and Wales have been coded to ICD 10 since January 2001. These changes have not affected the overall number of deaths classified to external causes. The changes to ICD 10 have had no impact on baselines for government targets to reduce deaths from external causes of mortality; however, some of the detail needed to monitor specific interventions has been lost (Griffiths and Rooney, 2003).

Routinely available data does not give detailed information on the circumstances of a suicide or any information about the contact of an individual with services in the period prior to suicide. Information of this type is essential however in order to know the potential for intervention through the various points of contact that suicide victims had with available services.

Consequently, it would therefore be useful to collect more detailed data on suicides within the local population to obtain more locally relevant data on suicides and injury undetermined. This may include additional data kept by Mental Health Trusts and also data obtained from the local Coroner, GP data, A&E, etc.

Table 2: Summary of the strengths and weaknesses of ONS PHM Extract	
Strengths	Weaknesses
Data routinely available and easy to obtain	Data relies on death certificates which may be inaccurate
Able to monitor trends over time	Low numbers at PCT level make comparison difficult
Comparisons able to be made with other PCTs/populations	No data on ethnicity
Information on place of death included 2001	Those people found and taken to hospital are recorded as having “died in hospital”
Various analyses are possible e.g. seasonality, day of death, method	Employment status is often incompletely recorded
Occasional epidemiological reports published by ONS on suicide	No detailed information available on circumstances leading to death or contact with local services

Table 3: Types of analyses that can be obtained from PHM data
<ul style="list-style-type: none"> • Trends in suicides in a region’s PCTs compared to regional and national rates. • Direct age and sex standardised mortality rate per 100,000 population • Graphs to show trends since baseline 1995-1997 to 2010 to show trajectories needed to meet targets • Age and gender variations – (numbers) • Age profile and gender variation by PCT (15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60+) These groupings conform with census population age bands and therefore enable population rates to be calculated more easily. • Method of suicide in a population • Employment status of those who have died by suicide in a population – employed/retired/student/occupation not stated. • Seasonal variations – suicides per month to explore the relationship between seasonality and suicide rate in a population

5.2 Non-routine data sources

5.2.1 The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI)

The NCI has been useful in terms of setting standards for people in contact with mental health services. *Safety First*, the most recent report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, estimates that around 250 suicides could be prevented each year in the UK (Appleby et al, 2001). The report makes some important recommendations (see Table 4).

Table 4: Key recommendations from Safety First

- Minimising suicide risk in all psychiatric in-patient settings
- Use of care and treatment orders in the community to ensure treatment compliance
- The follow-up of all patients with a current history of severe mental illness or deliberate self-harm within seven days of discharge
- The use of national criteria for enhanced care programme approach
- A strategy for the comprehensive care of patients with dual diagnosis
- Anti-stigma campaigns
- Support to meet the needs of black and minority ethnic groups

The NCI request specific information via a questionnaire relating to each suicide where there was contact with mental health services in the 12 months prior to the death. However, in a number of cases information is not available to the NCI and not reported in the questionnaires returned. It is possible that part of the reason for lack of data is the long delay between the suicide and completing the questionnaire for the NCI. In some cases, those involved in the care of a service user may have left the organisation by the time the NCI questionnaire is being completed. Communication with the NCI has indicated that in some cases the NCI were still receiving questionnaires from 2001 in late 2004.

Often it can take many months before the questionnaire reaches the relevant consultant, resulting in less accurate data collection. It would be of benefit to ensure that the questionnaire is completed as soon as possible (preferably prior to any case conference being held) as part of the adverse incident review process. Most Mental Health Trusts have computerised databases to assist in this process.

The data from the NCI questionnaire could be recorded onto an Adverse Incident or Serious Untoward Incident (SUI) database shortly after the incident, thus ensuring the information being sent to the NCI is more accurate and complete and providing local data quicker. The possibility of using an electronic format could also be explored.

Table 5: Strengths and weaknesses of NCI data	
Strengths	Weaknesses
<ul style="list-style-type: none"> • Data provides useful information on people who die by suicide who have been in contact with mental health services in the previous 12 months 	<ul style="list-style-type: none"> • May take months before questionnaire completed by consultant and therefore some rely on case note documentation
<ul style="list-style-type: none"> • Data is provided confidentially and therefore open reporting is encouraged 	<ul style="list-style-type: none"> • One unpublished local review of SUIs in a Mental Health Trust showed that in a number of cases information was not made available to the NCI and relevant information not returned on the questionnaire
<ul style="list-style-type: none"> • Information is used nationally to identify themes and trends from which national standards are developed for suicide prevention 	<ul style="list-style-type: none"> • Contacts with mental health services are defined as those who have a named consultant and casenotes, therefore contacts with CPNs, crisis team etc may not be included.
	<ul style="list-style-type: none"> • NCI has limited usefulness in characterising the psychosocial factors that affect people who go on to die by suicide
	<ul style="list-style-type: none"> • NCI is unable to look at the circumstances surrounding an individual's death in great detail.
	<ul style="list-style-type: none"> • Does not collect data on secondary diagnosis such as personality disorder, substance misuse, serious physical illness, etc.

It is possible to contact the NCI and request aggregated data, which relates to specific Mental Health Trusts (see Table 6). There is, however, a significant time delay in obtaining this of at least 2 years as it takes time for the NCI to send the questionnaires to the Trust, to receive them back from the Trust and then to analyse the data. In requests that cover small samples it may not always be possible to respond to data requests, as individuals may be identifiable.

Table 6: Example of Type of Data available from National Confidential Inquiry (NCI) data relating to a Mental Health Trust or local former Health Authority level.

Sample: e.g. April 1996 – March 2001 based on date of notification of death

Number of suicides and probable suicides	History of deliberate self-harm History of violence History of alcohol misuse History of drug misuse
Number in contact with mental health services within one year prior to death	Last contact with services Within 24 hours prior to death Between 1-7 days before death
Age Min-Max	Period between onset of primary diagnostic disorder and death under 12 months
Sex Male Female	Over 5 previous psychiatric in-patient admissions
In-patient at time of death	Patient requested 'contact' but contact did not take place
Died within 3 months of discharge from in-patient care	Suicide thought to be preventable by patient's mental health team
Non-compliant with drug treatment during the month before death	Regular multi-disciplinary review under CPA
Primary psychiatric diagnosis	

5.2.2 Suicides of people in contact with mental health services (on CPA) in preceding 12 months

Suicides of people in contact with mental health services (on CPA) in preceding 12 months is now recorded routinely as part of the quarterly returns by PCTs and Mental Health Trusts to the Department of Health as part of the performance monitoring information. A key objective of the National Suicide Prevention Strategy is to reduce the number of suicides by people who are currently or have recently been in contact with mental health services.

The National Institute for Mental Health in England published a toolkit for preventing suicides for mental health services in 2003 based on the recommendations of the NCI Report *Safer Services* (Appleby et al, 1999). Most Mental Health Trusts are currently working towards achieving the standards recommended in this guidance and are following comprehensive adverse incident procedures in the event of all patient suicides that have been in contact with mental health services within the last twelve months before death.

For the purposes of the NCI, a “contact” with mental health services is defined as someone who has had a named consultant and who has had a set of casenotes initiated. Many important contacts with mental health services may therefore be excluded e.g. people who have had a CPN assessment following direct GP referral, people who have been in contact with the Crisis Services and who have had one-off assessments in A&E.

A local suicide audit should be able to work to a broader definition of a “contact” to include people who have had CPN assessments or crisis team assessments. Local PCTs may also be able to work closely with the NCI if undertaking audit over the same four year period of data collection as the NCI (currently April 2000 to March 2004) to avoid duplication. All audits should link both the PCT and the Mental Health Trust, also to avoid duplication but as importantly to be able to jointly develop and own the local suicide prevention strategy.

There are two things that local epidemiological analysis and suicide audit can do that the NCI cannot do, which will be relevant locally but of limited relevance elsewhere. Firstly, they can look at local differences from the national picture, and secondly, they can study the circumstances of an individual case in great detail.

5.3 Data from local coroner

Coroners are usually lawyers but in some cases doctors and are independent judicial officers. This means that no one else can direct them as to what they should do but they must follow the laws and regulations which apply. They are all structured a bit differently and have limited resources, so it is essential to develop a good understanding and working relationship with the Coroner’s Office to establish an efficient mechanism for audit.

The purpose of the Coroner’s Inquest is to find out who has died, and how, when and where they died, together with information needed by the Registrar of Deaths to allow the death to be registered. In addition, one of the key purposes of death investigation through the Coroner’s Office is seen to be to contribute along with other public services and agencies to the avoidance of preventable deaths. Following the Coroner’s Inquest, the Coroner sends a form to the Registrar of Deaths to allow the death to be registered. Each PCT has access to the death certification by the Registrar of Deaths in the Registry Office, which can provide a trigger to the audit process.

When the inquest has been completed a person who has a “proper interest” in the Inquiry may apply to see the notes written by the Coroner after the Inquest, or may have a copy of the notes for payment of a fee. Who is deemed to be an “interested person” is set out in Coroner’s guidance by the Coroner’s Society and includes two categories relevant to PCTs. They are:

- any person appointed by a government department to attend the inquest
- anyone else who the coroner may decide also has a proper interest.

Ultimately however, it is for the local Coroner to decide.

Potentially, detailed information on local suicides held at the local Coroner’s Office that could enhance the identification of suicide risk factors as they relate locally and enable broader suicide prevention programmes to be targeted more effectively in a population.

The information properly available is limited and coroners do not have the resources to supply information without a request. The responsibility to negotiate any access rests with the inquirer who must make the initial approach. Nevertheless, Coroners are keen to see the public health benefits of close and careful audit, which is a vital learning tool, and a professional and appropriate inquiry within the framework of an established working relationship is likely to be met with support.

The Department for Constitutional Affairs are currently carrying out a fundamental review of death certification and coroner services.

5.3.1 Types of verdict and related issues

Currently, the purpose of the Coroner's Office is to determine the cause of death or to establish the verdict. The verdicts returned by the Coroner, which are relevant to suicide prevention, are all suicides, all open verdicts and some of the accident or misadventure verdicts. In considering suicide, Jervis on Coroners states:

"Suicide should never be presumed, but must always be based upon some evidence that the deceased intended to take his own life. The test of insufficiency of evidence has been stated to be whether other possible explanations were ruled out" (Matthews, 2004, p.126).

Since 1986, it has been held that the standard proof in suicide cases should be the same as in criminal prosecutions, that is "beyond reasonable doubt". However, there is no crime involved and an inquest is not a criminal trial.

All other definitions (except unlawful killing) operate on the civil standard i.e. the balance of probabilities. This means that if the coroner (or jury) is satisfied on the balance of probabilities that it was suicide, but is not satisfied beyond reasonable doubt, the conclusion must be an open verdict.

No distinction is drawn between *accident* or *misadventure* verdicts although it is implied that "accident" connotes something over which there is no human control, or an unintended act. "Misadventure" however indicates some deliberate (but unlawful) human act, which has unexpectedly taken a turn which leads to death.

In terms of *open* verdicts, these are recorded if there is insufficient evidence to record any of the other suggested conclusions. This includes cases where there is evidence but it fails to reach the required standard of proof.

Hence, not all people who die by suicide will have a verdict of suicide returned. (Squires 2003).

5.3.2 Examining coroner data

When examining data from the Coroner, consideration needs to be given to which verdicts to examine. It is usual to include suicides and open verdicts, however often accidents/misadventure are excluded. A study in North Cheshire found that many people given accident or misadventure verdicts are in fact suicides, however they are suicides that are normally missed in any analysis of routinely collected data (Squires, 2003). The impact of drug and alcohol misuse is particularly apparent in this group and therefore it is important that this group are included within the data collection process where possible for fine-grain analysis to determine whether to include or exclude from final local statistics.

It is important to ensure that efforts are directed at reducing the rate of all unexpected deaths, not just those given a verdict of suicide by the coroner. The inclusion of accident and misadventure deaths when collecting coroner data is time consuming and resource intensive. It requires some clinical judgement being made as to which of these are probable suicides. It is recommended that this be done as a pilot exercise to determine the most appropriate method of analysing and collating this data.

It is important to ensure that the information sought does not duplicate information available elsewhere and provides useful information in terms of prevention, rather than collecting additional data which may not add anything useful.

It also needs to be acknowledged that Coroners' data includes all suicides taking place within their catchment area and therefore would not include those deaths to local residents which took place out of district. The data will however include deaths to people resident outside of the district but who died within the Coroner's area boundaries.

The average time taken to reach Inquest verdicts from the death being reported is variable across the country. For example, within Liverpool, the Coroner service completes most inquests within 4-6 weeks, however this is unusually fast, in other areas it has been known to take up to nine months. Where there is a prompt completion of Inquests, it is possible to use the information from the completed Inquest to feed into the local suicide audit review in a timely manner.

5.3.3 Using Coroner data

The Coroner data can be used in two key ways:

1. To supplement detailed information from the Inquest to inform local suicide audit.
2. To obtain further more detailed demographic information on the local population suicides

- **To supplement local Suicide Audit**

It is particularly helpful to use the data provided by the Coroner's Inquest to inform the local suicide audit process. Information from Coroners' records can be obtained and used alongside further information from a variety of other local sources.

PCTs should seek to develop a good working relationship with local Coroners to ensure the PCT is notified of all suicides that take place. Ideally, the Coroner's Office should have an identified contact within the PCT.

Normally the Coroner will contact the patient's GP following the death in order to request information for the Inquest. The Coroner will then also contact the Mental Health Trust for further information where the deceased has been in contact with local mental health services.

However, because of the nature of Coroners' records, medical and psychiatric histories are only recorded when it is considered directly relevant to the cause of death, or if they throw direct light upon the intent of the individual. Hence, it may be preferable to access GP records, mental health service records or other agency records in order to obtain more detail on health service contacts. Although this is audit work and not research, consideration should be given as to whether or not to seek local ethical approval for this process. Often initial informal contact with the relevant Ethics Committee lead will provide advice on whether or not this is advisable.

The process used to obtain data from the Coroner's Office may vary. For example, in some PCTs a suicide audit project worker or clinical audit project worker may obtain the data directly from the Coroner's Office. Ideally, this data should be input directly onto a computer using Microsoft Access software, SPSS or other statistical packages. In other cases, although much less the case, the Coroner's Office will collect and enter data, sometimes for an administration fee.

The ideal would be for the data collection proforma to be completed following every suicide and to be used to inform significant event audit or other local suicide audit. The forms could then be aggregated and an overall analysis produced on an annual basis, which feeds into the development of the local suicide prevention strategy and the NSF LIT. The local Standard 7 lead should be ideally placed to ensure that this takes place. This requires local agreement between the Coroner's Office and the PCT. The PCT and Mental Health Trust may identify a person to be responsible for visiting the Coroner's office on a regular basis to collect the data or may agree to pay the Coroner's Office a fee for them to collect the data on behalf of the PCT. For example, in Liverpool there is an agreement between the PCT and the Coroner's Office for a suicide audit officer to visit the Coroner's office every month to examine the Inquest verdicts and to collate information using an audit proforma. Should further information be required the project officer is able to access Coroner's records on individual cases.

Other methods may be used to collect data from the Coroner's office e.g. the Coroner may notify a named representative weekly of deaths of patients from mental health services and PCTs. There may be monthly meetings established between the Coroner's Office and representatives from mental health services and PCT. This would allow information to be shared on the preliminary files indicating which are likely to be suicides or undetermined deaths. The relevant Caldicott Guardian would need to be informed.

Squires (2003) study of the Coroner's records in North Cheshire suggests that the details of the individual social circumstances that may lead to suicide provide powerful insights that can be useful to suicide prevention strategies. Within the North Cheshire study, marital breakdown, bereavement or loss of health all played a part in the death. Ideally, there should be links between local mental health and primary care services and Registrars Offices to ensure that suitable information is given out to bereaved people on the support that they could obtain after the death of a friend or relative.

Responses to these issues should be led by the relevant local PCT lead with a view to ensuring access to a range of appropriate services for their population.

- **To provide locally applicable additional demographic information**

For suicides that have not been in contact with mental health services within the last year, data is not available nationally to enable comparison between areas and to understand differences between this group and those who have recently used mental health services.

A by-product of developing a National Suicide Audit Tool is that similar data is more likely to be obtained across the country and improve the opportunities for comparisons and further learning. For the rationale for choosing the variables please see Appendix 3 of the Audit Tool.

An audit undertaken in Manchester (Miller, 2002) examined Coroner data and local GP records for the following range of information:

- Psychiatric diagnoses
- Evidence of follow-up by mental health services within the year prior to death (i.e. NCI cases)
- Substance misuse (alcohol and illicit drugs)
- Overdoses with prescribed medications
- Previous DSH
- Recent significant life events (within last year of life)
- Frequency of GP attendances in the three months prior to death
- Length of time between last seeing GP and death
- Content of last GP consultation
- Assessments of depressive symptoms and risk assessments carried out at last consultation and at any other consultations during last three months of life.

The audit found significant limitations within the data collection process. GP notes were highly variable in quality and most entries were brief and may not actually reflect the depth of the consultation that had taken place. In some cases, the notes were illegible or no entry had been made. Also it was not clear from some of the documentation whether or not the patient was actually present.

Mental health service information was not examined within this audit as it should be included within the NCI. However, as discussed previously, contacts are those who have case records and are allocated a consultant psychiatrist – this therefore may exclude certain relevant contacts e.g. with crisis services, or CPN. The Manchester audit also did not include A&E contacts. A broader definition of what constitutes a contact could be used within a suicide audit with non-health agencies e.g. Local Housing Trusts and Probation services.

There were few copies of computerised records in the notes and it is possible that practices are failing to download information when they send notes off site. This seriously affects the usefulness of the record. Letters from mental health services to GPs also often failed to include a diagnosis. The Manchester audit also showed that frequently Coroners' records did not always include a submission from the GP. This is only requested if it is thought to be helpful in determining the verdict. The inquest notes contain submissions from friends and family, which may be conflicting or even contradict the medical records.

Table 7: Strengths and weaknesses of Coroner's data

Strengths	Weaknesses
<ul style="list-style-type: none">Proposed changes to Coroner system may facilitate data collection via RDPH subject to outcome of recently announced review of coroner system	<ul style="list-style-type: none">Does not include suicides of local residents who die by suicides in other areas under the jurisdiction of another Coroner
<ul style="list-style-type: none">Enables collection of data not routinely available and provides more detailed qualitative information on individual cases	<ul style="list-style-type: none">Time taken to reach verdict is variable and often quite lengthy
<ul style="list-style-type: none">Can be used to support local suicide audit process	<ul style="list-style-type: none">May be time consuming and resource intensive
	<ul style="list-style-type: none">Caution is needed if cases have to be excluded from the audit in terms of the small numbers and inability to generalise findings

5.4 Data from prisons and offender management services

The general population downward trend in suicides has not been mirrored in prisons. However, 2003/04 has seen a reduction from the previous year, although the rate remains higher than in the general population (Paton and Borrill, 2004). PCTs are now required to provide primary care services to prisoners within their local population.

Prisoners are a high risk group for suicide. In 2002, there were 94 self-inflicted deaths in custody equating to a suicide rate of 133/100,000 prisoner population. This is similar to the suicide rate for offenders under community supervision. Ninety four percent of prisoners who die by suicide are male; however this does reflect the large male population in prisons. Women who die by suicide in prisons have a similar suicide rate to men (Paton and Borrill, 2004).

Suicides are significant events within a local prison and all are subject to a comprehensive post incident review. Suicide prevention in prisons in terms of assessing and addressing risk should be treated as importantly as that of the rest of the community. Also, the high rate of suicide in offenders on community supervision orders highlights the need for prisons to be included within PCT suicide audit and associated suicide prevention strategies.

Information obtained from suicide audit in prisons and annual statistics relating to prison suicides should be collated and used to inform the local PCT suicide prevention strategy.

The current Prison Service suicide prevention protocol is under review and its replacement emphasises improved initial assessment, care planning and multidisciplinary team working to reduce risk.

New procedures, to be implemented from 1 October 2005, are being established by the National Offender Management Service (NOMS) to audit the deaths of offenders under supervision of the National Probation Service. An annual report is to be prepared by a designated area Assistant Chief Officer for the National Probation Directorate. The proposed implementation of Custody Plus in the autumn of 2006 (subject to resources) would mean that all offenders being discharged into the community from prison would be supervised by Probation, rather than just those with a sentence of more than 12 months. It is therefore suggested that local discussions regarding opportunities for information sharing take place, as those being discharged from prison into the community are thought to be a very high risk group.

5.5 Psychological autopsy

Psychological autopsy is not a method of specific suicide audit but of research. It has been widely used in suicide research, to reconstruct the lifestyle and personality traits of the person who has committed suicide. Psychological autopsy involves collecting detailed information from a number of different sources, including the relatives of the deceased.

Obtaining information on suicide deaths by interviewing friends and relatives of the deceased requires considerable investment in terms of time and resources and appropriately skilled and trained researchers/investigators. A number of Mental Health Trusts have trained Mental Health Workers in order to be able to interview relatives of the deceased as part of their adverse incident review process.

In 2003 the NCI began conducting a psychological autopsy study of Inquiry cases in the North West. The aims of the study are to identify the level of contact with secondary mental health services in the previous 12 months and to collect more detailed information on the risk factors associated with suicide in those patients. Information is being collected from GPs, relatives, and A&E departments regarding the deceased's contacts prior to suicide.

The NCI and NIMHE NW are undertaking a psychological autopsy in primary care. Information will be collected on each suicide regarding contact with GPs, and Social Services, A&E departments and contact with other services identified from Coroner's records. This is being undertaken to enable more detailed data to be collected on the 75% of cases who die by suicide and have not been in contact with mental health services in the previous 12 months.

Psychological autopsy is a sophisticated methodology requiring the setting up of a specific research project, appropriate funding and ethical approval. However, it is able to provide detailed qualitative information regarding personal characteristics and circumstances leading up to the suicide.

6 Suicide audit

6.1 Suicide audit and confidentiality

It should be stressed that suicide audit is not research. However, many of the concerns that exist in relation to research, the use of information and how confidentiality is maintained are also relevant to suicide audit. Research Ethics Committee approval should not be required for suicide audit however, Suicide Audit Groups may wish to obtain further guidance (including from the Local Research Ethics Committee) on confidentiality and anonymity to reassure themselves and others.

The Department of Health's Code of Practice (2005) on confidentiality and disclosure of information states that in relation to anonymised or aggregated patient information:

"Whenever practicable, patient data disclosed for purposes other than patient's care should be anonymised. Anonymised information is information that does not identify an individual. It requires the removal of name, address, full post code, date of birth, NHS number and local patient identifiable codes, and any other detail or combination of details that might support identification."

It will be an issue for each local Suicide Audit Group (PCT and other partners) to determine locally how they ensure that confidentiality is maintained.

6.2 Suicide audit in PCTs

Clinical audit is a method used to improve practice by measuring current practice against explicit standards, implementing changes and measuring how these have affected practice. Clinical audit:

- identifies and promotes good practice,
- provides training and education opportunities,
- helps to ensure better use of resources, which encourages increased efficiency, and
- can improve working relationships, communication and liaison between staff, service users and agencies.

Suicide audit refers to activities in which the context and activity leading up to suicides are analysed. This can be done individually to identify what could have been done differently, collectively to identify trends or by comparing practice prior to an incident against pre-set standards (Navarro et al, 1997). Suicide audit may be undertaken within the remit of clinical audit.

The National Service Framework for Mental Health suggests that information for auditing be obtained 'from a variety of local sources, including case records, written reports from staff, transcripts of the inquest, summaries of management inquiries, and through discussion with relatives and carers'.

The aim of suicide audit is to learn from positive and negative aspects of care and to improve services, with the ultimate aim of preventing suicides. Local suicide audit has been useful in the past to investigate particular concerns, for example where there have been a higher number of suicides than expected in a particular unit.

A suicide is inevitably a tragic event for all concerned, including health care workers. There is a 'widely held view' amongst mental health staff that they will be 'unfairly blamed' when a serious incident such as a suicide occurs and it is likely that both primary and secondary health care workers will be sensitive to audit in this area (Appleby et al 2001). It is important to stress that suicide audit does not aim to apportion blame but aims to inform health care workers and to improve clinical practice. It will highlight those most at risk and examine whether other interventions may have had a greater role in preventing the suicide. In this way, it will help inform strategies to minimise the chances of another suicide occurring in future.

The use of epidemiology to describe trends and local patterns of suicides within a PCT provides more contextual information on the population which can support suicide audit. It is more useful to specific local areas than generalised to all areas of the country. Often such projects collect data on suicides, usually over a relatively short period of time, broken down by age, sex, employment status, etc. These data rarely provide differing information from national data or research findings and, where they do, the numbers are too small to be particularly useful outside of the PCT area they refer to. In some cases, these projects use the data to identify specific problems and opportunities for improvement in practice in a manner similar to the aim of clinical audit.

The NCI differs from local suicide audit in that it is a form of research where data on suicides and homicides is collected and interpreted in order that recommendations can be made to inform general procedures and practices within the health care system. It draws its data from Mental Health Trusts. Local suicide audit aims to provide information specific to local services in terms of improving local clinical practice and can cover whole service systems not just primary care or secondary mental health care.

When a patient suicide or other patient safety incident occurs, the important question is not "who is to blame?" but "how and why did it occur?" (Woodward et al, 2004).

Retrospective case-note audits have also been undertaken as part of suicide audit and this method is recommended in the NIMHE Toolkit for audit of suicides in secondary care (Duffy et al, 2003).

6.2.1 Standards in suicide prevention

There is currently no toolkit similar to the NIMHE secondary care toolkit for use in the primary care setting. Of the eight standards within the toolkit, it may be possible to adapt a couple of these to make it applicable within the primary care setting. It may also be helpful to use local guidelines and NICE guidelines where relevant to produce standards for suicide audit within the primary care setting, however this requires further consideration.

Possible standards for use in primary care audit may be developed from the following:

- Local standards to be developed based on outcomes of suicide audit analysis held within local PCT
- Standards developed from various NICE guidelines e.g. schizophrenia, post-natal depression, anxiety, obsessive compulsive disorder (OCD), deliberate self harm (DSH) and depression
- Standards developed from enhanced services for depression model of care as part of new GP contract

Suicide is a difficult area for standard clinical audit for two reasons. Firstly, it is unusual for practices to have standards for suicide prevention in place.

Secondly, suicide is not a discrete area but rather is linked to many others including mental health, physical health, social issues, personal relationships, etc. The approach to reducing suicide rates should encompass many areas and therefore audit of 'suicides' alone is less useful than an approach that includes early identification and treatment of depression, coping strategies for people with serious physical illnesses, marital problems or substance misuse problems.

Ideally information should be collected about how primary care teams assess for suicide risk, how potentially suicidal patients are managed, what guidelines are currently in use and a description of post-incident activity. This will help in setting standards for a clinical audit project aimed at ensuring that activity in practices around risk assessment and management, referral and follow up is consistent.

Whatever method is used, clinical audit should ensure that standards are reviewed and recommendations carried out and clinical practice improved.

Epidemiological audit (i.e. data collection and analysis on suicides within the local population) provides a good but general view of the local picture of suicide and allows for significant changes in patterns of suicide to be identified. Its limitations stem from the fact that it provides a general overview and not necessarily enough detail on antecedents and contact with health services on which to base recommendations for changes in practice or audit standards. Similarly, although the data is usually compared to national data, where it differs there is not enough information to determine why.

6.2.2 Significant Event Analysis and Root Cause Analysis

Another method of reviewing suicides is Significant Event Analysis (SEA). The format of structured analysis was developed by Pringle and colleagues in 1995 (Pringle et al, 1995). This is a form of Root Cause Analysis (RCA) used in primary care. Individual episodes with significant consequences, either beneficial or harmful are analysed in a systematic detailed way to ascertain what can be learnt about the overall quality of care. Changes that might lead to future improvements are identified. SEA is a work-based local forum for identifying and analysing incidents as well as celebrating success. It is seen as a positive and proactive approach to incident management (Lewis, 2004).

The National Patient Safety Agency promotes the Root Cause Analysis (RCA) model. It has identified the following factors behind why patient safety incidents occur.

- Active failures
- Latent conditions
- Contributory Factors
- Influencing factors
- Causal factors

RCA is a retrospective review of a patient safety incident, which identifies the above factors and finds out how the incident happened and makes recommendations for change. It is also used for complaints and claims (Woodward et al, 2004).

The stages of RCA are as follows:

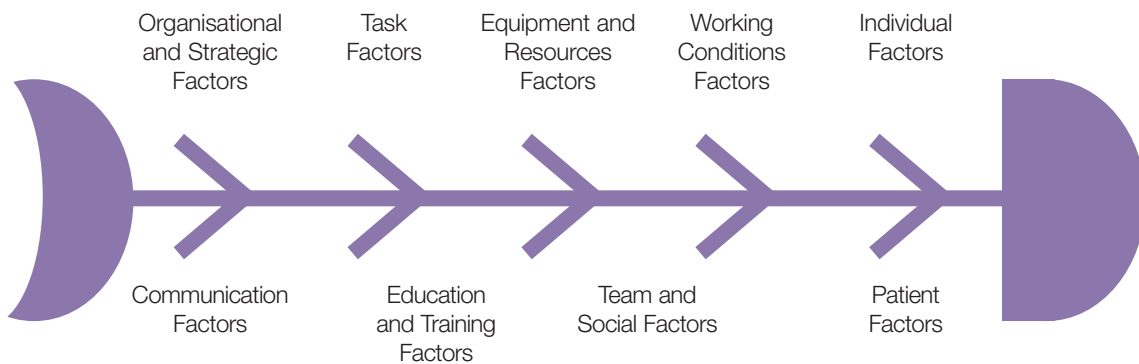
- Stage 1:** Being open
- Stage 2:** Gathering and mapping information
- Stage 3:** Interview process
- Stage 4:** Mapping the information
- Stage 5:** Analysis
- Stage 6:** Barrier analysis
- Stage 7:** Report and recommendations

Within the analysis stage, the fishbone diagram can be used to provide a systematic way of looking at the causes and effects (see Diagram 1).

Gant charts and timelines are also useful within the analytical stage of the process.

This process may be carried out already in some GP practices although not necessarily in a standardised way or recorded and shared across the PCT. Some PCTs have developed a method for conducting significant event analysis including how discussions are facilitated, what, and how, information is provided prior to the discussion, how meetings are recorded and how actions are followed up. In Mental Health Trusts, this function can be considered alongside the serious untoward incident or critical incident investigation process.

Diagram 1: Fishbone diagram²



²Adapted from Woodward et al, 2004

This is not enough, however, to ensure that practice changes. To be a true audit, agreed changes or developments should be reassessed over time to ensure effective change has been achieved. The format for SEA can be modified according to the situation as long as basic prerequisites are honoured (Lewis, 2004). They include:

- All members of PHCT are invited
- A clear initial statement of events and list of all involved is provided
- An opportunity to consider the emotions generated by events is clearly identified in the process
- A set of probing questions are agreed against which analysis, generation of a broad range of ideas and clear plans may be set
- Follow up timescales agreed for review
- Copy of process is held within the practice.

Clinical audit can be used following SEAs to determine whether or not changes have been adopted and whether this has led to improvement. Action plans from SEAs that are demonstrated to improve practice can then form the basis of local standards or protocols. If action plans are sent to and stored by one person or department, progress can be monitored, trends can be identified and these can be fed into Trust wide standards and clinical audit activity.

Appendix 2 describes how SEA can be undertaken within a PCT.

The literature does identify concerns people have about the SEA process itself. In particular, changes in roles and shifting boundaries caused concern for some staff. Some staff felt uncertain about questioning GPs in particular and may be worried about overstepping boundaries (Westcott et al., 2000). Similarly, GPs may be unhappy that junior members of the primary health care team have the opportunity to question their clinical decisions (Hillier, 2002).

Fear of litigation (Hillier, 2002) and recrimination (Harrison et al, 2002) has been cited as a concern for GPs although the confidential and anonymous nature of the process should eliminate this. Time limitations can make staff reluctant to become involved in SEAs, especially where staff are part-time and may not feel that their contribution would be great enough to warrant the time away from other duties (Westcott et al., 2000; Hillier, 2002). At the same time, the short period of time given to SEA discussions could lead to the perception of superficial solutions being adopted (Westcott et al., 2000).

Despite the acknowledgement of concerns, the literature does reflect a generally positive attitude towards SEA. Its usefulness in solving problems, resolving difficult issues, building good team relations and developing trust are highlighted in several papers.

In summary, the evidence base for suicide audit is small and provides little information on effectiveness of different methods of audit. There are also still unanswered questions about the advantages and disadvantages of different ways of conducting SEAs in particular. The research has concentrated on the implementation of suicide audit and SEA rather than follow up of how it has developed and become incorporated into practice and helped staff to improve practice.

6.3 Barriers and levers to implementing suicide audit in primary care

It cannot be assumed that introducing a system of suicide audit will be straightforward or accepted by everyone. Barriers to implementation must be considered and levers identified, some of these are described below.

Barriers may include:

- *Variable priority given by different GPs and practices to suicide audit.* Some practices will not have experienced a suicide for several years and will not see this topic as a particularly high priority.
- *Lack of resources.* Practices participating in SEA will have to set aside time for finding information about the case, contacting the relevant agencies (mental health services, social services, probation, etc.) and attending the SEA meeting itself. It is recommended that each SEA lasts around 30-40 minutes however this is after additional data has been collected and the meeting has been arranged.
- *Perception of 'audit'.* It is common for clinical audit to be one of the less popular activities in the health service partly through being used to identify bad practice and apportion blame. This is not the purpose of audit, which is primarily a quality improvement tool and should provide anonymous results. Some effort will need to be made to reassure staff that the aim of the suicide audit is not to find fault or blame individuals but to identify solutions and to improve practice.
- *Lack of skills in significant event analysis.* Training must be provided for staff, in particular those who will be acting as facilitators. It is by no means a difficult task but it is very important that all teams are undertaking it in the same way and that facilitator's feel confident in their role.
- *Suicide audit removed from star ratings within HCC performance indicators.*

Levers include:

- GMS contract – Quality and Outcomes Framework (QOF). Significant event analysis appears twice in the education and training section of the QOF:
 - Education 2: The practice has undertaken a minimum of six significant event reviews in the past 3 years
 - Education 7: The practice has undertaken a minimum of twelve significant event reviews in the past 3 years which include (if these have occurred):
 - Any death occurring in the practice premises
 - Two new cancer diagnoses
 - Two deaths where terminal care has taken place at home
 - One patient complaint
 - One suicide
 - One section under the Mental Health Act.

Both of these indicators are worth 4 points. The inclusion of significant event reviews in the QOF must be tempered by the fact that these are not requirements and in terms of points are less attractive than providing annual appraisals for all non-clinical team members (3 points) or keeping a record of clinical staff who attend basic life support skills training in the preceding 18 months.

- Revalidation. Significant event analysis is accepted as evidence for GMC revalidation. Good Medical Practice specifies that all doctors must be involved in regular review and audit of standards and performance and deficiencies must be addressed.

The setting up of a SEA should be seen as the beginning of a larger project and should help develop other aspects of the suicide prevention agenda. It must be stressed that the beginning of the project will probably produce more questions and in order to answer them the project will need to be seen as changing and evolving. It is expected that the first review of the direction/remit of the project would take place once the data collection starts. Emerging trends in the data or gaps in knowledge may produce opportunities for further enquiry.

6.4 Review of suicides within mental health services

Currently the majority of Mental Health Trusts are reviewing suicides of patients in contact with mental health services as part of the adverse incident review process and implementation of the national toolkit for mental health services (Duffy et al 2003).

Generally, following a suicide of a service user in contact with mental health services a post-incident review is carried out. There can be confusion regarding whether a post-incident review constitutes suicide audit. The aims of the two processes post-incident review and individual suicide audit are similar. Both processes aim to review the case and establish whether any lessons can be learnt, both positive and negative. Recommendations are generally made and changes should be implemented if appropriate (see Appendix 3 for an example of suicide audit recommendations). Suicide audit is however different from the post-incident review in a number of ways:

- Audit is anonymous – the names of staff are not recorded and this may result in people being more open. The post-incident review process is not anonymous. Copies of the incident review report are made available to managers within the Mental Health Trust, the PCT and the Strategic Health Authority.
- The post-incident reviews identify problems with the system – therefore they often address more managerial issues rather than being a clinical review of the case. A significant event audit or case conference is a clinical review of the case usually involving only clinicians but from a variety of disciplines (multi-disciplinary review).
- Managerial involvement can differ – A study in Bristol looking at suicide audit considered that managers will review any unexpected deaths, but will not expect to attend clinical professional audit (Morgan, 1994). Managers, however, need to be involved in any subsequent discussion particularly where executive action may be necessary to address problems. It was recommended that the key outcomes of the clinical review feed into the post-incident review.
- Suicide audit is separate from adverse incident reviews – ideally, suicide audit should be undertaken within the clinical governance system. It should be seen as separate, but feeding into, the adverse incident review process which is part of the risk management system. It is important to ensure there is minimal duplication between the two processes.

Methods that are used to review suicides in Trusts include Root Cause Analysis (RCA), which enables the organisation to systematically identify and assess the key factors, which contribute towards a patient suicide.

Another method for auditing suicides includes retrospective case-note audit. This should involve auditing key quality standards such as those presented in "Safety First" and "Safer Services" (Appleby et al, 1999; Appleby et al, 2001). The National Institute for Mental Health in England (NIMHE) has produced a toolkit outlining how to go about auditing the 12 standards (Duffy et al, 2003). These standards apply to people who have died by suicide whilst they have been in contact with the Mental Health Trust within the preceding twelve months (See Appendix 1).

Discussion is required within Mental Health Trusts to establish where the most appropriate forum is to consider audit standards and to what extent they could be monitored. This could form part of Mental Health Trusts' audit plans. Ideally, the Mental Health Trust should support PCTs in their development of suicide audit as they have the expertise. Where possible the resources for suicide audit should be shared between PCTs and the Mental Health Trust to enable more efficient use of local resources for suicide audit and to ensure that the two sets of processes are connected.

6.5 Review of suicides within a PCT area not known to primary or secondary care services

A number of suicides take place where people are not known to health services and others who have had minimal recent contact with their GP or who may not be registered with a GP at all. Consequently, there are likely to be some who are not known to either primary or secondary care services. There is a need to ensure a methodology for exploring suicide audit in this area is developed and piloted to include these and to ensure local relevant agencies are involved in the audit.

7 A whole systems approach to suicide audit

The flowchart below (Figure 1) provides a graphical presentation of a whole systems approach to undertaking suicide audit within/across PCTs. Ideally it should consist of:

- Regular epidemiological review of rates of suicide and undetermined injury in different population groups on an annual basis
- Collection of data from Coroner and or other agencies to supplement epidemiology at four yearly intervals preferably to coincide with NCI data collection time period.

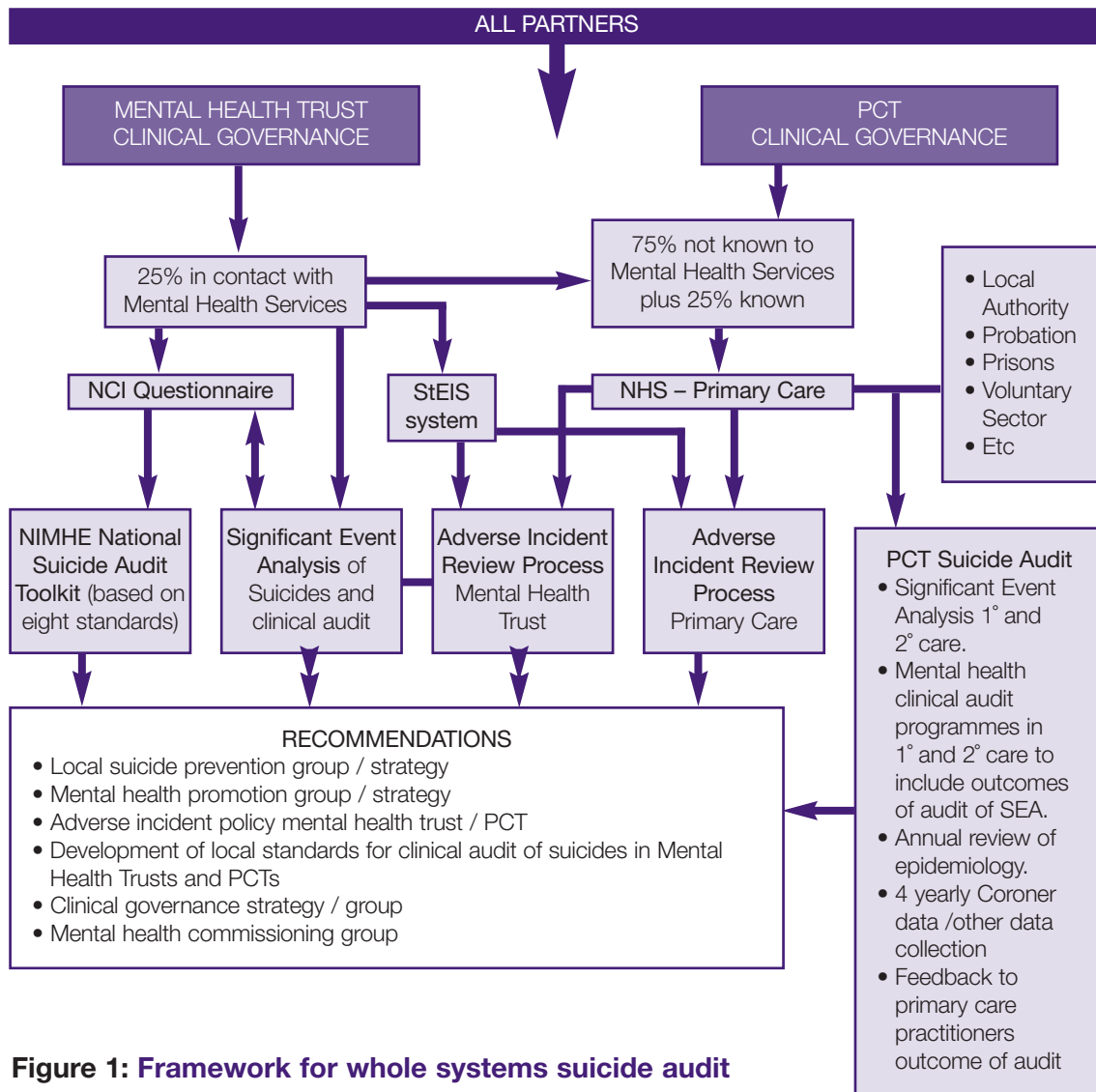


Figure 1: Framework for whole systems suicide audit

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The results of suicide audit and review in primary and secondary care should see implementation of the recommendations monitored and included in relevant local mental health promotion and suicide prevention strategies. The implementation process should:

- Work with local Prisons where appropriate to ensure there is a coordinated approach to suicide audit and suicide prevention across the PCT
- Ensure the development of standards of clinical practice to be developed and clinically audited in primary and secondary care as part of this process.

8 Suggestions for local whole systems to maximise impact

1. Local population based rates of suicide and undetermined injury should be reviewed on an annual basis by the local Department of Public Health and should include the monitoring of trends in suicide and comparisons with national and regional figures. The rates should include confidence intervals where possible. Any disparity between local and national trends should be investigated further within a more substantial suicide audit process. An annual report should be provided to the Local Implementation Teams (LITs) and other strategic groups to inform them of trends and progress towards targets.
2. A more comprehensive suicide audit data collection exercise should be undertaken every 4 years to coincide with the NCI data collection process (currently April 2000 to March 2004). The exact methodology should be determined locally. The recommendations and findings from local suicide audit should feed into the local mental health commissioning group, the local suicide prevention strategy and mental health promotion strategy where appropriate. The action plan developed to implement the suicide prevention strategy should be regularly updated and should include the provision of deadlines for action and named individuals / organisations with responsibility for delivery of each action point. This should be monitored by the LIT and other local strategic groups.
3. General Practices should be encouraged and supported to take part in significant event analysis and clinical audit of suicides in their practice population. The clinical governance leads should ensure recommendations made are acted upon and fed into local annual review of suicides provided to the LIT. Ideally, there should be a local suicide audit group set up across primary and secondary care to explore suicide audit and its findings along with adverse incident reviews and its findings. This may form a subgroup of the LIT or clinical governance group depending on local circumstances.
4. The questionnaires used within the National Confidential Inquiry should be completed proactively for all cases of suicide of people in contact with mental health services in the 12 months prior to suicide and maintained on a local database.
5. The potential for examining further data sources locally by exploring information obtained by agencies e.g. drugs and alcohol services and those outside of the NHS such as prisons, probation services, housing associations, and the voluntary sector should be investigated.
6. Working with local NSF Standard 7 leads, the identification of local hot-spots for suicide should be undertaken and consideration given as to what action might be taken e.g. the use of physical barriers and other prevention measures, along with any other measures as part of the strategy.
7. Ensuring appropriate counselling and support systems are in place within Mental Health Trusts and Primary Care for those who have been bereaved and for staff where appropriate (see Pallin, 2004).
8. Using the NIMHE National Audit Tool will assist with the robustness of local data collection and provide future opportunities for comparisons and aggregation for learning.

9. Conclusions

Historically many PCTs have taken an epidemiological review of suicides in their local population. Several PCTs have also undertaken further data collection from the local Coroner and from primary care services.

The strengths and weaknesses of the data collection process have been identified and described above. Ultimately, there is potential for exploring further data analysis methods locally by examining information obtained by agencies such as drugs and alcohol services, prisons, probation services, housing associations and the voluntary sector. This avenue needs further exploration.

There is also the need in many areas to collect more comprehensive local information on deliberate self harm (DSH) to identify issues that may be of relevance to local service provision.

Pinpointing local hotspots for suicide requires investigation through working with partner agencies to identify them and to take actions to make them safer. The Samaritans and railway authorities have done a significant amount of work in this area.

Ultimately, the evidence of effectiveness for the greatest reduction in suicide rates is achieved through broad public health approaches e.g. reducing access to the means of suicide. The introduction of natural gas and the legislation restricting pack sizes of paracetamol and salicylates in the UK has been demonstrated to have significant impact on mortality and morbidity associated with self-poisoning (Hawton et al, 2001). Attention is now focussed on changing car exhaust design. Catalytic converters were introduced in 1993, however the shape of the exhaust is being examined to see whether changes can be made to ensure hosepipes cannot be attached. Co-proxamol is being withdrawn from use due to its use in overdose. As hanging or asphyxiation is more difficult to effectively prevent as a means to die by suicide, it is essential that a whole systems approach be developed.

APPENDIX 1

Standards from Preventing Suicide: A toolkit for mental health services

Standard one: appropriate level of care

1. Patients at risk are allocated to the enhanced level of the Care Programme Approach (CPA).
2. CPA documentation forms part of case notes and is not maintained separately.
3. These standards are monitored through clinical governance.
4. Patients with schizophrenia with complex needs if convicted of an offence are normally treated in hospital rather than the prison service.

Standard two: in-patient suicide prevention

1. Wards are audited at least annually to identify and minimise opportunities for hanging or other means by which patients could harm themselves.
2. Likely ligature points on in-patient units have been removed or covered.
3. A protocol has been developed to allow potential ligatures to be removed from patients at high risk of suicide.
4. Environmental difficulties in observing patients are made explicit and remedial action is taken as far as possible.
5. Observation policy and practice reflects current evidence about suicide risk.
6. Patients under any form of increased observation are not allowed leave or time off the ward.

Standard three: post discharge prevention of suicide

1. Prior to discharge in-patient and community teams carry out a joint case review.
2. Discharge care plans specify arrangements for promoting compliance / engagement with treatment.
3. Care plans take into account the heightened risk of suicide in the first three months after discharge and make specific reference to the first week.
4. Patients who have been at high risk of suicide during the period of admission are followed up within 48 hours of discharge by an agreed member of the clinical team.
5. Assertive outreach teams have been established to prevent loss of contact with vulnerable and high-risk patients.

Standard four: family / carer contact

1. Families/carers, with patient consent, are given a clear mechanism for making contact with an informed member of the clinical team at all times.
2. Families/carers are given appropriate information promptly following a suicide or homicide.

Standard five: appropriate medication

1. Patients at risk of suicide receive the right medication in the right amounts.

Standard six: co-morbidity/dual diagnosis.

1. A strategy exists for the comprehensive care of people with co-morbidity/dual diagnosis, i.e. people with mental health problems who also engage in alcohol and/or substance misuse.
2. Staff who provide care to people at risk of suicide are given approved training in the clinical management of cases of co-morbidity/dual diagnosis.
3. Statistics for co-morbidity/suicide are collected and used to inform decision making on resources.

Standard seven: post-incident review.

1. Suicides and serious suicide attempts are reviewed in a multi-disciplinary forum, including as far as possible all staff involved in the care of the patient.
2. All staff, patients and families / carers affected by a suicide or serious attempt are given prompt and open information and the opportunity to receive appropriate and effective support as soon as they require it.

Standard eight: training of staff.

1. All care staff in contact with patients at risk of self-harm or suicide receive training in the recognition, assessment and management of risk at intervals of no more than 3 years.
2. The training is approved by the organisation.
3. The training is comprehensive with quality and effectiveness continuously evaluated.

Appendix 2

Example protocol for undertaking significant event analysis in PCTs

What is SEA?

Significant event analysis (SEA) is a method of discussing specific incidents in a structured way, highlighting good and bad areas of practice and agreeing actions designed to improve future practice. It provides a systematic method by which multidisciplinary teams can review their own practice in a non-blaming environment, providing constructive criticism and acknowledgement of good practice. It can be used to review incidents with both good and bad outcomes, as the aim of SEA is to identify good practice and action that will improve practice.

The aim of SEA after incidents of suicide or parasuicide is to learn lessons from previous incidents that can be applied to practice. These lessons may be specific to a single case or common within one GP practice or in many.

How do we do it?

Significant events need to be analysed by as many people involved in the event as possible. In the case of a suicide, members of the primary care team that have had contact with the patient should be involved, as well as representatives from any other services that the person was involved with, e.g. psychiatrist or CMHT member, representative from social services etc.

Teams should consider this when arranging SEA meetings and be aware of time that representatives from secondary care and social services can and cannot make. Information about the event must be circulated to attendees before the meeting; there may be a lengthy gap between contact between the person who committed suicide and primary care services and memories may need to be jogged.

The SEA can take the form of a one-off meeting convened after an adverse incident or as regular meetings. Each meeting needs to be facilitated, either by a regular facilitator taken from the existing group, various members of the team taking the role in turns or by using an external facilitator.

The advantages and disadvantages of each are:

	Advantages	Disadvantages
Team Member	<ul style="list-style-type: none">• Knows existing roles and dynamics• Any follow up of actions by facilitator is easier• Part of existing team and not seen as corporate interference• Process is organised and driven from within the team and less likely to be disrupted.	<ul style="list-style-type: none">• May not have, or be perceived to have, objectivity• Training and support from clinical governance team required• It may be difficult for staff to change roles, for example if a secretary or receptionist acts as facilitator it is possible that they may feel intimidated by clinicians.

<p>External Facilitator (see Robinson et al, 1995)</p>	<ul style="list-style-type: none"> • Leaves everyone in the team free to contribute • Minimises internal personality clashes • Ensures process is kept going • Provides someone on whom to offload distress • Can get peer support more easily from outside the practice 	<ul style="list-style-type: none"> • Could be threatening • Could affect existing team dynamics • Expensive • If external facilitation is interrupted or removed, process may stop completely.
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The local audit group need to agree a facilitator (internal or external).

The role of the facilitator is to:

- maintain the basic ground rules of group discussion
- clarify individual points
- summarise points
- encourage consensus
- encourage participants to accept responsibility for initiating change
- recognise emotion within the discussion, to acknowledge it and to allow appropriate expression within the group
- remain separate from the group and avoid giving unwarranted opinions or colluding with the group

The discussion should begin with the clinician most involved in the case, probably the GP, giving a summary of their recollection of events. It is advisable to describe points of good practice first and then areas of concern. Other group members may add information about the case and make suggestions for improvement. These should form an action plan with timescales and named people responsible for implementing the changes.

When to review?

There is no specific timeframe for SEA to occur. The two options are before or after the coroner inquest results are available. Benefits of holding an SEA before the coroner's verdict include events being fresher in staff's memories. The amount of time between a death and the coroner's verdict can be several months, which allows for events to be forgotten. In Liverpool, this timeframe is usually 4-8 weeks. Not all possible suicides can be considered suicides until the verdict however and so waiting until after the inquest is often the preferred option. This allows time for all relevant information to be collected and should give enough notice for staff to be able to attend. The local audit group need to agree the ideal timeframe for SEA.

Use and storage of information

All information required for SEA must be used and stored according to Caldicott and Data Protection guidelines. This means that information sent to all people attending an SEA must not contain patient-identifiable details and an identifier should be used instead of the patient's name. Ideally, this would be an NHS number however initials or another identifier could be used.

Information about all suicides and open verdicts in a Coroner jurisdiction will be collected by a suicide audit project officer from the coroner's office and held on two databases. One of these will hold names, dates of birth and addresses and a unique identifier code. The second will hold information about the person and their death using their identifier instead of name, address and date of birth. Both databases will be password protected. The Caldicott Guardian will be consulted to ensure that this complies with Caldicott guidelines. The Ethics Committee will also be informed of the project.

Summary information will be sent to relevant practices prior to the significant event analysis. This will include information about:

- any diagnosis (physical or psychiatric),
- method of suicide and cause of death,
- known risk factors,
- prescribed medications,
- last contact with primary care,
- contact with mental health services,
- a summary of events

A standard action plan will be attached to be completed during the discussion.

In some cases, extra information will need to be obtained from practices and/or mental health services.

Reporting and follow-up

Initially, copies of action plans should be sent to the Suicide Audit Project Officer. Actions can then be kept on a database, linked to the suicide databases (see above) and followed up according to the deadlines set at the SEAs. Trends in the action plans will be monitored and problems or improvements that are highlighted in several cases will be given particular attention.

Within primary care, arrangements need to be made to ensure recommendations made from each significant event analysis are collated and fed back to all practices on an annual basis via the PCT clinical governance leads. The precise method of feedback needs to be determined e.g. briefing papers, event days, meetings, presentations.

Recommendations may be practice specific or have general implications for other practices. The implementation of all the recommendations should be monitored by the PCT clinical governance leads as part of their clinical governance review of each practice. An overview of the recommendations should lead towards the development of standards for future audit of suicides in primary care.

Action plans, and trends in particular, will also be useful in helping shape a suicide prevention strategy by ensuring that areas that have previously been a problem are given sufficient attention. They will also feed into the clinical audit process by highlighting areas for audit and in some cases forming audit standards. All action plans should include action to be taken, by whom and the target date for completion. The action plans should be monitored to ensure actions are implemented.

Training

Although SEA is a simple process, it is advisable to train facilitators to ensure that all Practices are carrying out their meetings in a standard way.

TABLE 8: Example of data sheet used within primary care SEA

Identifier	
Marital status	
Age:	
Ethnicity:	
Dependents? (number and ages)	
Diagnosis?	
Method of suicide	
Cause of death	
Known risk factors e.g. alcohol / drugs / self harm / job loss / relationship problems / previous attempts / mental health problems / physical illness	
Medications (drug, dosage and how long prescribed)	
Last contact with primary care (date and who seen)	
Reason for contact	
Risk assessment?	
Contact with mental health services	
CPA status	
Contact with other services	
Summary of events	

Appendix 3

Examples of recommendations from analysed suicide audit reports

Primary care clinical practice

- As part of their accreditation process, GPs should be encouraged to undertake significant event audit of suicides among their registered population, not previously known to mental health services, should such events occur.
- PCTs should foster the development of a culture of shared learning with regard to suicide, in order to establish an organisational memory that will assist in the development of preventive interventions and whole systems solutions.
- As necessary, clinical governance will convene a previously constituted 'suicide group' in the PCT to reflect and review such events for the purposes of shared learning, developing an organisational memory and identifying key elements for potential interventions.
- Identify ways of supporting GPs in their work with traumatic and stressful cases.
- Examine the educational needs of GPs to aid diagnosis of depression.
- Reduce prescribing of potentially toxic preparations such as co-proxamol, dothiepin and amitriptyline.
- GPs should be encouraged to ask general mental health screening questions during their routine consultations with clients. GP case notes should all contain up to date information on the employment status of all patients and the timing of any changes in employment status.
- More information on the prescribing habits of local GPs in relation to antidepressant drugs and anxiolytics is required.

Suicide audit

- A suicide audit should be undertaken each year. Areas of high prevalence should be identified and possible prevention interventions identified and implemented.
- An audit of suicides should be continued within the Clinical Governance framework. Whenever a suicide occurs, the circumstances surrounding the event should be audited and reviewed so that lessons may be learned and practice changed. By creating a database where information regarding each suicide is stored, suicide trends within Stockport can be noticed early and changes made.
- A central contact person could be responsible for collating information on all the suicides in the district and would most usefully be based with one of the psychiatric units but with a remit to work with GPs when a suicide in a practice occurs.

Communication

- To identify areas where communication mechanisms between secondary care and all members of the Primary Care team can be improved.
- Improved multi-agency liaison including Strategic Health Authority, PCT, Social Services, GPs, CPNs, A&E and the voluntary sector.
- There should be increased liaison between local statutory services, local authorities and the Highways Agency to consider suicide hotspots.

- There should be increased awareness between agencies of the suicidal risk associated with homeless people and those from an ethnic minority community.
- Improving the social networks of socially excluded people should be a focal point of the wider suicide prevention, mental health promotion, neighbourhood renewal and social exclusion agenda.
- Intersect oral working with Social Services Departments should be developed.

Secondary care services

- All cases seen by the Psychiatric SHO are discussed with a senior colleague.
- To develop a seamless process whereby a designated team assesses all potential suicides and findings communicated directly to primary care and community workers for ongoing care. Conversely, A&E staff need to understand the risks associated with suicide intent and know how to get hold of members of the Primary Care Team or their representatives out of hours to convey important information about an individual.
- Examine the role of the CPN and ensure that there is a common understanding regarding the role and level of service provided by the community psychiatric service.
- To review and improve existing systems whereby a member of the mental health team reviews patients in 24-48 hours following inpatient discharge as recommended in the NCI. Adequate support mechanisms need to be available and made known to the patient and their relatives and carers should they require help when they return to the community. Action needs to be taken to follow up a patient if he fails to attend for a review meeting, rather than classing them as a 'did not attend' statistic. Risk assessment should be recorded at every meeting.

Risk assessment

- All risk assessments should explicitly reference suicidal risk. Following the identification of suicidal risk, additional sources of support such as help lines or local voluntary organisations are provided to enhance the individual's social support network.
- Specific consideration should be given by GPs to suicidal risk among those patients with chronic physical ailments such as lower back pain or wider musculo-skeletal problems and those with significant hearing impairment.

Strategic Executive Information System (STEIS)

- Proper participation in and use of existing serious incident reporting systems e.g. StEIS, be strengthened for suicides among those not in contact with mental health services, occurring in settings other than traditional NHS premises, e.g. social care or residential settings, community locations. This may or may not be in conjunction with a GP significant event audit.
- Integrated service providers, primary care and other statutory agencies should inform the PCT of serious untoward incidents occurring locally to ensure proper reporting to the StHA.

Local Implementation Team

- Explore methods of supporting those bereaved by suicide.

National Confidential Inquiry

- Local implementation of the national suicide audit toolkit should continue, in association with existing reporting processes such as StEIS, for suicides among those known to be in contact with mental health services.

Coroner data

- Following an unexplained death, Coroner's Officers should have an identified contact within each statutory organisation.

Information

- The Local Implementation Team should work with local coroners, the PCT and other bodies to standard reporting practice.
- Information provided on suicide should include age, gender, place of residence, place of suicide, place of death, place of birth, ethnicity, means of death, previous suicide attempts and contact with healthcare services.
- The PCT should work with the coroners to ensure the PCT is notified of all suicides that take place.

Media

- Media reports of the suicide of local residents should be monitored and any evidence of sensational reporting should prompt a response from the (strategic) health authority to the media.
- The (Strategic) Health Authority should be proactive in highlighting the problem of suicide contagion to the local media, to alert editors to the potential problems associated with suicide reporting.

Education

- Production of an 'At Risk' awareness session, identifying assessment procedures, intervention methods and opening lines of communication between primary care, the police force, social services and the mental health services which will be rolled out to the practices. This will include the promotion of safer prescribing of antidepressants and analgesics.
- To raise awareness of suicide and develop ongoing education programmes for all members of the Primary Care Team. This would involve education on risk factors for suicide, recognition of groups at high risk of suicide, performing and documenting risk assessment and raising awareness of appropriate procedures to follow should someone be suspected of being at high risk of suicide.
- To develop community education programmes on the principles of risk assessment for people who come into contact with potential suicides on a day-to-day basis.
- To develop ongoing education programmes for all A&E staff on the assessment and recognition of risk factors for potential suicide cases and their future management. The programme needs to be run every six months when new casualty officers join the department.
- To raise the profile within the community of voluntary agencies, self help groups, advice lines and the availability of GPs. This would help vulnerable people to know where to go for help. It would also raise public awareness of organisations they can refer to should they be approached by them for help and advice. This could involve distribution

of leaflets in job centres, DSS offices, post offices and libraries as well as other public information exercises (e.g. TV and radio). Information also needs to be available in different languages to enable people from ethnic minorities to seek help should they need to.

- Young males and older females need to be targeted. Health education should be involved and publicity/education and information needs to be in a format relevant to the target groups. With older females, there are often problems of loneliness so other support mechanisms may be needed.
- The prevalence of mental health problems amongst those committing suicide that have been recognised by relatives or friends of the deceased but which have not prompted a referral to their GP or a psychiatrist suggests that the public needs to be made more aware of the importance of mental health and the consequences of mental illness.

Target groups

- Services, which target young people, should be made aware of the risk factors for suicide amongst the young. These could also act as a referral point for young people into the formal psychiatric services.
- The support and development of marriage guidance services and services such as Relate should be encouraged.
- Drug and alcohol misuse needs to be addressed.
- Men's health and the mental health of the unemployed need to be targeted.
- People reporting crimes, especially arson and criminal damage, are at risk of suicide. The local police force should be supported by local PCTs to become aware of potential sources of support and information for victims of such crimes.
- People experiencing their first arrest are at risk of suicide, especially if employed, and those awaiting a court appearance, especially for a drink driving related offence. It is recommended that these factors be incorporated into existing awareness-raising or training programmes.

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Additional useful resources

Websites

Centre for Suicide Research

<http://www.psychiatry.ox.ac.uk/csr/index.html>

Coroners Society

<http://www.coroners.org>

Exeter University

<http://www.projects.ex.ac.uk/sigevent/>

National Institute for Mental Health in England

<http://nimhe.csip.org.uk>

National Patient Safety Agency

<http://npsa.nhs.uk>

Please see Issue 5 of "In Safer Hands", produced by the Royal College of General Practitioners with the support of the National Patient Safety Agency which briefly looks at significant event auditing and how primary care teams can get the most from the process. http://www.rcgp.org.uk/quality_unit/ish.asp

Patient UK

<http://www.patient.co.uk/showdoc/40024612>

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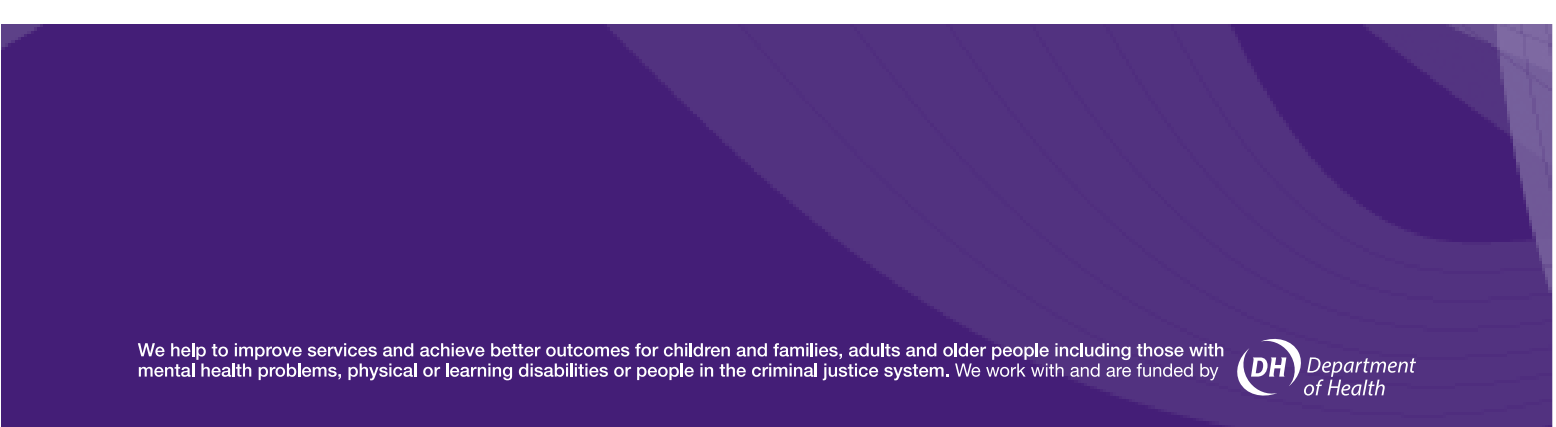
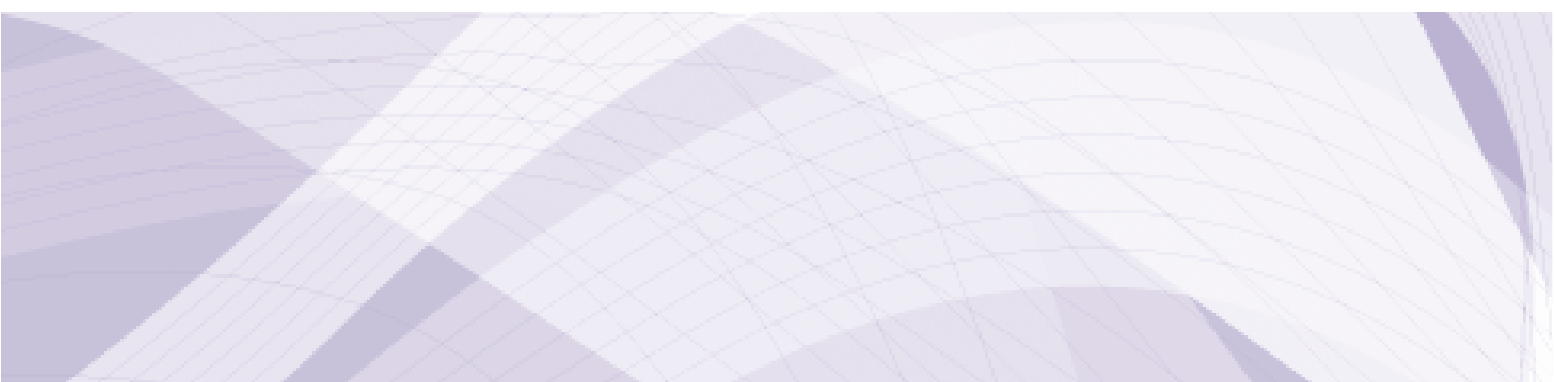
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