



*National Institute for
Mental Health in England*

PREVENTING SUICIDE:

A TOOLKIT FOR MENTAL HEALTH SERVICES

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Performance
Management	IM & T
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Clinical	Partnership Working

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Description	The Audit Toolkit provides a simple way for services to measure existing standards against the recommendations outlined in the report by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. From this baseline measure services will then be able to develop local arrangements, assisted by a list of resources that can support the development of positive practice, to help with implementation.
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Superceded Docs	
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For Recipients Use	

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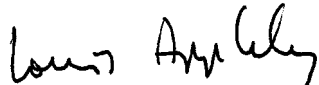
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Preface

Suicide prevention is a key national priority for all health and social services. People with mental health problems are a particularly high-risk group for suicide, and it is vital that mental health services formulate effective local suicide prevention strategies. To this end, *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*¹ offers a number of evidence-based recommendations for service and practice development.

This toolkit provides a simple method for mental health services to measure systematically the extent to which they are addressing Inquiry recommendations, and to develop local arrangements accordingly. It also offers an extensive range of references on good practice in suicide prevention. To assist services the toolkit will be available in both document and electronic format.

I am pleased to commend this NIMHE Toolkit to all mental health services.

A handwritten signature in black ink, appearing to read 'Louis Appleby'.

Professor Louis Appleby
National Director for Mental Health

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Introduction

In recent years important guidance has been published relating to the prevention of suicide by mental health services. Mental health is one of the four national target areas for health improvement and the Department of Health has specified a target of reducing suicide by at least one fifth by 2010. ² *The National Suicide Prevention Strategy for England* ³ sets out a comprehensive evidence-based strategy for achieving this reduction in suicide. Mental health service users are a high risk group for suicide, which is the main cause of premature mortality in this group. Accordingly, *The National Service Framework for Mental Health* ⁴ set prevention of suicide as one of its seven standards for improving mental health care.

This standard is supported by *Safety First*, the most recent report of *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. The Confidential Inquiry analyses reports of all suicides by mental health service users. Examples of its most recent findings include:

- One in four people who subsequently took their lives in England and Wales, around 1,000 people each year, were been found to have been in contact with specialist mental health services in the year before their death
- Of these, 16% were in-patients at the time of their death
- 23% had been discharged from hospital in the previous three months
- Many were not fully compliant with treatment when discharged
- In 85% of cases of suicide, staff assessed the immediate risk of suicide to be low or absent
- Mental health teams in England and Wales regarded 21% of the suicides as preventable
- 25% of suicides with schizophrenia were not subject to enhanced CPA
- Around half the suicides were committed by people with a history of self-harm and either substance misuse or previous admission to hospital.

Building on such findings, the Confidential Inquiry team put forward a large number of recommendations. This audit tool aims to assist mental health services in implementing these recommendations and provides a simple, cost-effective way of measuring existing service standards. It addresses issues of concern along the entire pathway of care from assertive outreach to admission to an in-patient service through to community care. It also covers family/carer involvement, post-incident review and preventive work such as development of a dual diagnosis strategy and liaison with criminal justice agencies.

After carrying out this baseline measure, and assisted by a range of links provided in this document, services will be in a position to develop effective local arrangements and then to confirm progress by re-measuring.

In this tool, the Safety First recommendations have been formulated as eight measurable standards. The standards should be measured by a team of staff, which should include clinicians who are independent of the clinical area, together with one or more staff who have been trained in clinical audit. A pharmacist is needed to help with the audit of Standard Five.

The audit involves the retrospective examination of clinical notes and incident records of people who have been perceived to be at significant risk of suicide. In addition, managers are asked to provide specific data, and training records are to be obtained and examined.

Each standard is followed by a selection of useful resources to inform positive practice with regard to it. There is also a final section that contains useful resources to inform positive practice with regard to all standards. The resources include books, reports, journal articles, organisations and websites. This information is neither exhaustive nor intended to be a 'recommended reading list', but a selective snapshot resulting from work undertaken by the NIMHE North West Knowledge Management Service during August 2003.

An electronic version of this toolkit will be made available via <http://www.nimhe.org.uk>. The e-version contains additional resources with abstracts where possible, and, most usefully, hyperlinks to the source material to enable you to find what you need fast.

It is envisaged that the resources section of the toolkit will grow over time. NIMHE is particularly keen to develop the resources to include local delivery stories – these would be of specific relevance to one of the standards or suicide prevention in a generic sense. If you have a story to tell:

- Complete the pro-forma in [Appendix Two](#) and send it to it to the appropriate development centre detailed in Appendix One or,
- Submit a story on-line at <http://www.nimhe.org.uk/smartsearch/sendstory.asp>.

References

- (1) Department of Health (2001). *Safety first: Five year report of the National Confidential Inquiry into Suicide and homicide by people with mental illness*. London, Department of Health.
<http://www.doh.gov.uk/mentalhealth/safetyfirst/index.htm>
- (2) Department of Health (1999). *Saving Lives: Our Healthier Nation*. London, HMSO.
Executive Summary <http://www.doh.gov.uk/pub/docs/doh/ohnexec.pdf>
- (3) Department of Health (2002). *National Suicide Prevention Strategy for England*. London, Department of Health.
<http://www.doh.gov.uk/mentalhealth/suicideprevention.pdf>
- (4) Department of Health (1999). *National Service Framework for Mental Health. Modern standards and service models*. London, Department of Health.
<http://www.doh.gov.uk/pub/docs/doh/mhmain.pdf>

Acknowledgement

A prototype of this tool was developed by Bolton Salford and Trafford Mental Health NHS Trust, with particular assistance from the Trust's clinical audit team

AUDIT PROCESS

1. Produce a list of admissions to the selected service over a period of time of your choice, e.g. over the preceding year/eighteen months.
2. Select a sample of patients who were judged by the clinical team to have been at high risk of suicide or who have committed suicide (two to three per clinical team). Target patients from different periods over the chosen time frame.
3. Obtain the clinical records for these patients and use them to answer the questions provided in this audit tool.
4. Obtain any training records and examine as directed.
5. Interview the manager of the clinical area and record answers as directed.
6. Present the findings of the audit through a written report, with an oral presentation as agreed with managers/clinicians.
7. Develop timetabled local arrangements with clinical teams to address standards, which have not been fully met.
8. Re-audit the service on the date agreed in the local arrangements.

The standards

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.

Procedure:

1. Check that the care plan records the allocation to enhanced CPA of patients:
 - at risk of suicide or violence *and/or*
 - with schizophrenia *and/or*
 - with a combination of severe mental illness and self-harm or violence *and/or*
 - who are homeless *and/or*
 - who have severe mental illness and are lone parents.
2. Check that the care plan is filed with the case notes.
3. Ask manager what arrangements have been made with the local criminal justice agencies to ensure that patients with schizophrenia with complex needs if convicted of an offence are treated in hospital rather than the prison service.
4. Ask manager to explain how this standard is monitored through clinical governance processes.

Useful resources to inform positive practice with regard to standard one:

Books & reports

- Care Programme Approach Association (CPAA) (2001). *CPA Handbook*. Chesterfield, CPAA.
<http://www.nhsia.nhs.uk/mentalhealth/mh-is/pages/documents/CPA%20Handbook.doc>
- Department of Health (1999). *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach*. London, HMSO.
<http://www.doh.gov.uk/pub/docs/doh/polbook.pdf>
- Department of Health and HM Prison Service (1999). *The Future Organisation of Prison Health Care: A Report by the Joint Prison Service and National Health Service Executive Working Group*. London, Department of Health.
<http://www.doh.gov.uk/prisonhealth/prisonhealthcare.htm>
- Department of Health (2001). *An Audit Pack for Monitoring the Care Programme Approach*. London, HMSO.
<http://www.doh.gov.uk/mentalhealth/auditpack.pdf>
- Department of Health (2002). *Guidance on Developing Prison Health Needs Assessments and Health Improvement Plans*. London, Department of Health.
<http://www.doh.gov.uk/prisonhealth/needsassessment.pdf>
- Department of Health (2002). *Health Promoting Prisons: A Shared Approach*. London, Department of Health.
<http://www.doh.gov.uk/prisonhealth/17042002ahealthpromotingprisons.pdf>
- Department of Health (2002). *Mental Health Policy Implementation Guide - Community Mental Health Teams*. London, Department of Health.
<http://www.nimhe.org.uk/downloads/CMHTguidance.pdf>
- Department of Health (2002). *Prison Health: Health services for prisoners standard*. London, Department of Health.
<http://www.doh.gov.uk/prisonhealth/health-serv-prison-stds.pdf>
- Howard League for Penal Reform (2002). *Suicide and self-harm prevention following release from prison*. London, Howard League for Penal Reform.
- Keating, F. (2002). *Breaking the circles of fear: a review of the relationship between mental health services and African and Caribbean communities*. London, The Sainsbury Centre for Mental Health.
<http://www.scmh.org.uk>
- Pavilion publishers (2001). *Suicide in Prisons: Research, policy and practice*. Brighton, Pavilion.
- Rose, D. (2001). *Users' voices: the perspectives of mental health service users on community and hospital care*. London, Sainsbury Centre for Mental Health.
<http://www.scmh.org.uk/>
- Shaw, J., Appleby, L., et al. (2003). *Safer Prisons Report 1999-00: A national study of prison suicides*. Manchester, National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.
<http://www.doh.gov.uk/prisonhealth/pdf/prison-suicides-report.pdf>

Organisations & websites

- Action for Prisoners Families.
<http://www.prisonersfamilies.org.uk/>
- CJS online.
<http://www.cjsonline.org/>

Department of Health: Prison Health website.

<http://www.doh.gov.uk/prisonhealth/>

HM Prison Service.

<http://www.hmprisonservice.gov.uk/>

Home Office Research Development and Statistics Directorate (RDS).

<http://www.homeoffice.gov.uk/rds/index.htm>

Howard League for Penal Reform.

<http://web.ukonline.co.uk/howard.league/index.htm>

The Institute of Mental Health Act Practitioners (IMHAP).

<http://www.markwalton.net/index.asp>

The Institute of Prison Law.

<http://www.prisonshandbook.co.uk/ipl/home.html>

National Association for the Care and Resettlement of Offenders (NACRO).

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

National Probation Service.

<http://www.probation.homeoffice.gov.uk>

Prison Reform Trust.

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

Women in Prison.

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

Local delivery stories

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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.**

procedure:

1. Ask manager for a copy of an environmental risk assessment for the ward and areas to which patients have access. Check that it:
 - has been undertaken within the last year,
 - identifies likely opportunities for hanging,
 - includes local arrangements for removal of likely ligature points and, if so, that these have been implemented,
 - identifies whether or not there are environmental problems for observation and, if so, that it includes local arrangements for remedial action.
2. Ask manager whether a protocol has been developed in consultation with service users for removal of potential ligatures from high-risk patients.
3. Examine a copy of the current observation policy, check that it: makes reference to periods of increased risk (e.g. evenings and night, reduced levels of observation, gaps in continuous observation, apparent improvement in patient's mood) and specifies actions to take account of these increased risks.
4. Check that care plans refer to increased observation required in periods of increased risk.
5. Check that care plans do not record periods of leave or time off the ward while patient is under increased observation.
6. Obtain records of observation, check that they match prescribed levels and that no inappropriate gaps are recorded.

Useful resources to inform positive practice with regard to standard two:

Books & reports

Department of Health (2002). *Mental Health Policy Implementation Guide - Adult Acute Inpatient Care Provision*. London, Department of Health.

<http://www.doh.gov.uk/mentalhealth/inpatientcp.pdf>

Department of Health (2002). *Mental Health Policy Implementation Guide - National Minimum Standards for Psychiatric Intensive Care Units and Low Secure Environments*. London, Department of Health.

<http://www.doh.gov.uk/mentalhealth/piculsc.pdf>

Mental Health Foundation and Sainsbury Centre for Mental Health (2002). *Being There in a Crisis*. London, Mental Health Foundation.

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

Morgan, S. (2000). *Clinical Risk Management: A Clinical Tool and Practitioner Manual*. London, Sainsbury Centre for Mental Health.

Royal College of Psychiatrists' Research Unit (1998). *Not just bricks and mortar. Report of the Royal College of Psychiatrists Working Party on the size, staffing, structure, siting and security of new acute adult psychiatric inpatient units*. London, Royal College of Psychiatrists.

<http://www.rcpsych.ac.uk/publications/cr/council/cr62.pdf>

Royal College of Psychiatrists' Research Unit (1999). *Guidance on Staffing for Child and Adolescent Inpatient Psychiatry Units*. London, Royal College of Psychiatrists.

<http://www.rcpsych.ac.uk/publications/cr/council/cr76.pdf>

Royal College of Psychiatrists' Research Unit (2002). *Acute in-patient psychiatric care for young people with severe mental illness. Recommendations for commissioners, child and adolescent psychiatrists and general psychiatrists*. London, Royal College of Psychiatrists.

<http://www.rcpsych.ac.uk/publications/cr/council/cr106.pdf>

Sainsbury Centre for Mental Health (1998). *Acute Problems: A survey of the quality of care in acute psychiatric wards*. London, Sainsbury Centre for Mental Health.

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

Sainsbury Centre for Mental Health (2003). *Executive Briefing on Mental Health Policy Implementation Guide - Adult Acute Inpatient Care Provision*. London, Sainsbury Centre for Mental Health.

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

Sainsbury Centre for Mental Health (2003). *The Search for Acute Solutions*. London, Sainsbury Centre for Mental Health.

project outline <http://www.scmh.org.uk/>

project update <http://www.scmh.org.uk/>

Warner, L., Mental Health Commission, et al. (2000). *National visit 2: a visit by the Mental Health Commission to 104 mental health and learning disability units in England and Wales. (Improving care for detained patients from black and minority ethnic communities: preliminary report.)*. London, Sainsbury Centre for Mental Health & University of Central Lancashire, Health and Ethnicity Unit.

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

Mental Health Commission and Sainsbury Centre for Mental Health (1997). *The National Visit. A one-day visit to 309 acute psychiatric wards by the Mental Health Act Commission in collaboration with the Sainsbury Centre for Mental Health*. London, Sainsbury Centre for Mental Health.

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Bowles, N. and Howard, R. (2003). "The refocusing model: a means of realising the national acute inpatient strategy." *The Mental Health Review* **8**(1): 27-31.

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Delord, B. (2003). "The Acute Inpatient Practice Development Network: a change management initiative." *The Mental Health Review* **8**(1): 22-6.

Greenwood, N. and et al. (2000). "Asian in-patient and carer views of mental health care." *Journal of Mental Health* **9**(4): 397-408.

Vardi, K. (2003). "Developing inpatient services for women: challenges and implications." *The Mental Health Review* **8**(1): 32-5.

West, P. (2003). "Improving mental health inpatient care." *The Mental Health Review* **8**(1): 9-16.

Organisations & websites

Hospital In-Patient Data (based on Hospital Episode Statistics).
<http://www.doh.gov.uk/hes/>

Local delivery stories

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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.**

Procedure:

1. Check for record of joint case review (to include in-patient and community staff) in patient notes.
2. Check that joint case review includes risk assessment of patient.
3. Check that the care plan includes actions related to heightened risk in the first three months after discharge.
4. Check records to establish that patient was followed-up within 48 hours of discharge.
5. Check that the discharge care plan indicates whether problems with compliance/engagement are anticipated and what actions are to be taken. For example,
 - *visiting or interviewing the patient,*
 - *adjusting prescribed medication,*
 - *carer/family involvement (except where no permission is granted by the patient),*
 - *psychological interventions.*
6. Check that the care plan documents that family/carers have received information on how to help patients engage with treatment plans.
7. Ask manager if assertive outreach teams have been set up. If not, identify what plans there are to do so.

Useful resources to inform positive practice with regard to standard three:

Books & reports

Burns, T. and Firn, M. (2002). *Assertive outreach in mental health: A manual for practitioners*. London, Pavilion.

Davidson, D. (2002). *Putting Assertive Outreach into Practice: A development tool for team members, leaders and project managers*. Brighton, Pavilion.

Ford, R., Minghella, E., et al. (2001). *Assertive outreach and crisis resolution: The research and development agenda*. London, Sainsbury Centre for Mental Health.
<http://www.scmh.org.uk/>

Graley-Wetherall, R. and Morgan, S. (2001). *Active Outreach: An independent service user evaluation of a model of assertive outreach practice*. London, Sainsbury Centre for Mental Health.

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

Journal articles

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King, E. A., Baldwin, D. S., et al. (2001). "The Wessex Recent In-Patient Suicide Study, 2: Case-control study of 59 in-patient suicides." *British Journal of Psychiatry* **178**(6): 537-542.
<http://intl-bjp.rcpsych.org/cgi/content/full/178/6/537>

Langdon, P. E., Yaguez, L., et al. (2001). "Who walks through the 'revolving-door' of a British psychiatric hospital?" *Journal of Mental Health* **10**(5): 525-533.

Walker, S. A. and Eagles, J. M. (2002). "Discharging psychiatric patients from hospital." *Psychiatric Bulletin* **26**(7): p. 241-242.

Local delivery stories

If you have a story to tell:

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- Submit a story on-line at <http://www.nimhe.org.uk/smartsearch/sendstory.asp>.

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.

Procedure:

1. Check records to establish whether patient gave consent for staff to make contact with family/carers.
2. Check whether care plan documents that family/carers have been given a clear procedure for making contact with an appropriate member of staff at all times (e.g. key worker, care co-ordinator, primary nurse, Responsible Medical Officer).
3. In cases of actual suicide there is written evidence in the clinical records that a member of staff was made responsible for ensuring that the family/carers were promptly informed of actions being taken.

Useful resources to inform positive practice with regard to standard four:

Books & reports

Berry, D. (2001). *Living with Schizophrenia: The Carer's Story*. Brighton: Pavilion.

Department of Health (2000). *Carers National Strategy: Caring for Carers*.
<http://www.doh.gov.uk/pub/docs/doh/care.pdf>

Department of Health and Making Space (2002). *Developing Services for Carers and Families of People with Mental Illness*. London, Department of Health.
<http://www.doh.gov.uk/mentalhealth/devservcarers.pdf>

Kenny, C. (2001). *Suicidal children and adolescents*. Lancaster, Quay Books.

Office of National Statistics (2001). *Informal Carers: Results of an independent study carried out on behalf of the Department of Health as part of the 1995 General Household Survey*. London, The Stationery Office.
<http://www.statistics.gov.uk/>

Journal articles

Wooff, D., Schneider, J., et al. (2003). "Correlates of stress in carers." *Journal of Mental Health* **12**(1): 29-40.

Organisations & websites

American Foundation for Suicide Prevention.
<http://www.afsp.org/index-1.htm>

Anti-Bullying Network.
<http://www.antibullying.net>

At Ease.
<http://www.rethink.org/at-ease/>

Campaign Against Living Miserably (CALM).
<http://www.thecalmzone.net/>

Caring for Carers.
<http://www.carers.gov.uk/>

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

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

Depression Alliance.
<http://www.depressionalliance.org/>

Drug Education and Prevention Information Service (DEPIS) web site.
<http://199.228.212.132/doh/depisusers.nsf/Main?readForm>

Manic Depression Fellowship.
<http://www.mdf.org.uk/>

Mental Health Foundation.
<http://www.mhf.org.uk/>

MIND.

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

PAPYRUS.

<http://www.papyrus-uk.org>

Rethink.

<http://www.rethink.org/>

Samaritans.

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

Survivors of Bereavement by Suicide (SOBS).

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

Young Minds.

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

Local delivery stories

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Standard five: appropriate medication

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

Procedure:

Qualified Pharmacist is involved in checking this standard.

1. Check records to establish that, where the patient was non-compliant with prescribed anti-psychotic medication because of side-effects, atypical medication is prescribed. If older, less safe medication is prescribed, check records to identify whether there is an explanation for this.
2. Check records to establish that, where the patient has a history of self-harm in the previous 3 months, they are prescribed a supply of potentially toxic medication covering no more than 14 days.
3. Check that the care plan and/or discharge letter includes explicit advice to the patient's GP about appropriate prescribing quantities.

Useful resources to inform positive practice with regard to standard five:

Books & reports

Bazire, S. (2001). *Psychotropic Drug Directory*. London, Mark Allen Publishing Ltd.

Department of Health (2002). *Meeting of Minds*. London, Department of Health.
<http://www.nimhe.org.uk/downloads/MeetingOfMinds.pdf>

Journal articles

Bentall, R. P. and Morrison, A. P. (2002). "More harm than good: The case against using antipsychotic drugs to prevent severe mental illness." *Journal of Mental Health* **11**(4): 351-356.

Hughes, I., Hill, B., et al. (1997). "Compliance with antipsychotic medication: From theory to practice." *Journal of Mental Health* **6**(5): 473-489.

Kavanagh, K., Duncan McConnell, D., et al. (2003). "Educating acute inpatients about their medication: Is it worth it? An exploratory study of group education for patients on a psychiatric intensive care unit." *Journal of Mental Health* **12**(1): 71-80.

Organisations & websites

Pharmacy in the future.
<http://www.rpsgb.org.uk/nhsplan/index.html>

UK Psychiatric Pharmacists Group.
<http://www.ukppg.co.uk/>

WeBNF.
<http://bnf.org/>

WHO: Guide to Good Prescribing.
<http://www.med.rug.nl/pharma/who-cc/ggp/homepage.htm>

Local delivery stories

If you have a story to tell:

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- Submit a story on-line at <http://www.nimhe.org.uk/smartsearch/sendstory.asp>.

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.**

Procedure:

1. Ask manager for a copy of the dual diagnosis strategy. Check that it covers:
 - liaison between mental health and substance misuse services, statutory and voluntary agencies,
 - staff training,
 - the appointment of key staff to lead clinical developments.
2. Ask manager whether the organisation approves training programmes in co-morbidity/dual diagnosis
3. Ask manager for training records and identify how many staff have received approved training in co-morbidity/dual diagnosis in the last 3 years.
4. Ask manager whether the organisation collects, analyses and uses data relating to co-morbidity/dual diagnosis, e.g. in contracting, planning services and training.

Useful resources to inform positive practice with regard to standard six:

Books & reports

Abdulrahim, D. (2001). *Substance misuse and mental health co-morbidity (dual diagnosis): Standards for mental health services*. London, Health Advisory Service.

Department of Health (2002). *Mental Health Policy Implementation Guide - Dual Diagnosis Good Practice Guide*. London, Department of Health.

<http://www.doh.gov.uk/mentalhealth/dualdiag.pdf>

Department of Health (2002). *National Alcohol Harm Reduction Strategy*. London, Department of Health.

<http://www.doh.gov.uk/alcohol/pdf/alcoholstrategy.pdf>

Rorstad, P. and Chesinski, K. (1996). *Dual Diagnosis: Facing the Challenge*. Kenley, Wynne Howard Publishing.

Royal College of Psychiatrists' Research Unit (2001). *Role of consultants with responsibility for substance misuse (addiction psychiatrists). Position statement by the Faculty of Substance Misuse*. London, Royal College of Psychiatrists.

<http://www.rcpsych.ac.uk/publications/cr/council/cr97.pdf>

Royal College of Psychiatrists' Research Unit (2001). *Substance Misuse Detainees in Police Custody*. London, Royal College of Psychiatrists.

<http://www.rcpsych.ac.uk/publications/cr/council/cr81.pdf>

Royal College of Psychiatrists' Research Unit (2002). *Advice to commissioners and purchasers of modern substance misuse services*. London, Royal College of Psychiatrists.

<http://www.rcpsych.ac.uk/publications/cr/council/cr100.pdf>

Scott, S. and Anderson, B. (2001). *Get Sorted With Drugs And Alcohol: A training resource pack for professionals working with drug and alcohol users*. Brighton, Pavilion.

Journal articles

Bagient, M., Holme, G., et al. (1995). "Self reports of the interaction between substance abuse and schizophrenia." *Australian and New Zealand Journal of Psychiatry*. **29**: 69-74.

Derricott, J. and McKeown, M. (1996). "Dual Diagnosis; Future Directions in Training." *Association of Nurses in Substance Abuse Journal*. **3**(1): 34-37.

Garnick, D. W., Hendricks, A. M., et al. (1996). "Private sector coverage of people with dual diagnoses." *Journal of Mental Health Administration* **23**(3): 317-328.

Gibbins, J. (1998). "Towards Integrated Care for Patients With Dual Diagnosis. The Dorset Healthcare NHS Trust Experience." *The Mental Health Review*.(December): 20-24.

Gournay, K., Sandford, T., et al. (1997). "Dual diagnosis of severe mental health problems and substance abuse/dependence: a major priority for mental health nursing." *Journal of Psychiatric & Mental Health Nursing* **4**(2): 89-95.

Gournay, K. and Sandford, T. (1996). "Double Bind." *Nursing Times*. **92**(28): 28-29.

Holland, M. A. (1998). "Substance use and mental health problems: meeting the challenge." *British Journal of Nursing*. **7**(15): 896-900.

Holland, M. A. (1999). "How substance use affects people with mental illness." *Nursing Times*. **95**(24): 46-48.

Menezes, P. R., Johnson, S., et al. (1996). "Drug and Alcohol Problems among Individuals with Severe Mental Illnesses in South London." *British Journal of Psychiatry*. **168**: 612-619.

Sibthorpe, B., Drinkwater, J., et al. (1995). "Drug use, binge drinking and attempted suicide among homeless and potentially homeless youth." *Australian & New Zealand Journal of Psychiatry* **29**(2): 248-56.

Swofford, C. D., Scheller-Gilkey, G., et al. (2000). "Double jeopardy: schizophrenia and substance use." *American Journal of Drug & Alcohol Abuse* **26**(3): 343-53.

Watkins, K. E., Shaner, A., et al. (1999). "The role of gender in engaging the dually diagnosed in treatment." *Community Mental Health Journal* **35**(2).

Organisations & websites

Alcohol Concern.

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

Drug Misuse Information: Drug misuse statistics.

<http://www.doh.gov.uk/drugs/stats.htm>

DrugScope.

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

Dual Diagnosis training for services. MSc Dual Diagnosis. Qualification provider: Sainsbury Centre for Mental Health. Awarding Institution: Middlesex University.

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

Lifeline.

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

National Treatment Agency for Substance Misuse (NTA).

<http://www.nta.nhs.uk/>

Turning Point.

<http://www.turning-point.co.uk/>

Local delivery stories

If you have a story to tell:

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- Submit a story on-line at <http://www.nimhe.org.uk/smartsearch/sendstory.asp>.

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.**

Procedure:

1. Ask manager for a list of all service suicides and serious suicide attempts over the past two years. Examine records of post-incident reviews.
2. Check that a multi-disciplinary review was undertaken within two weeks of a suicide or serious suicide attempt.
3. Check whether all staff involved in the patient's care attended the serious incident review.
4. Check that specific local arrangements and recommendations were identified.
5. Check that there is a record of whether a member of staff was made responsible for ensuring that the family/carers were offered support and, with the consent of patients involved in an attempt, were kept informed of any developments.
6. Check that there is a record that family/carers were offered support.
7. Check that a report of the review was produced and that it was shared with the family/carer.
8. Check that there is a record that support for staff was made available, and establish what this consisted of. Ask the manager how its adequacy is ensured.

Useful resources to inform positive practice with regard to standard seven:

Books & reports

Department of Health (2000). *An Organisation with a Memory*. London, The Stationary Office.
<http://www.npsa.nhs.uk/admin/publications/docs/org.pdf>

Department of Health (2001). *Implementing An Organisation With A Memory*. London, Department of Health.
<http://www.npsa.nhs.uk/admin/publications/docs/build.pdf>

Department of Health (2002). *Learning From Past Experiences: A review of serious case reviews*. London, Department of Health.
<http://www.doh.gov.uk/acpc/learningcasereviews.pdf>

Firth-Cozens, J. (2000). Teams, Culture and Managing Risk. in *Clinical Risk Management*. C. Vincent (ed). London, BMJ Books.

Kohn, L., Corrigan, J., et al. (1999). *To Err is Human: Building a Safer Health System*. Washington D.C., Institute of Medicine.

Reason, J. (1997). *Managing the Risks of Organisational Accidents*. Aldershot, Ashgate.

Smith, D. and Elliot, D. (1999). *Moving Beyond Denial: Exploring the Barriers to Learning from Crisis*. Sheffield, Sheffield University.

Toft, B. a. R. S. (1997). *Learning from Disasters, a Management Approach (Second Edition)*. Leicester, Perpetuity Press.

Journal articles

Toft, B. (1998). "Modifying Safety Culture: An Empirical Perspective (Part 2)." *Risk Management Bulletin* 2(6).

Organisations & websites

Agency for Healthcare Quality and Research (AHQR).
<http://www.ahcpr.gov/qual/errorsix.htm>

The Australian Patient Safety Foundation (APSF).
<http://www.apsf.net.au>

Chief Medical Officer.
<http://www.doh.gov.uk/cmo>

ECRI (health services research agency).
<http://www.ecri.org>

Health and Safety Executive.
<http://www.hse.gov.uk/>

The Institute for Healthcare Improvement (IHI).
<http://www.ihl.org>

The Institute for Safe Medication Practices (ISMP).
<http://www.ismp.org>

The Joint Commission on Accreditation of Healthcare (JCAHO).
<http://www.jcaho.org>

Mental Health Act Commission Website.

<http://www.mhac.trent.nhs.uk>

National Patient Safety Agency (NPSA).

<http://www.npsa.nhs.uk/>

National Patient Safety Foundation.

<http://www.npsf.org>

The Patient Safety Research Programme (PSRP).

<http://www.publichealth.bham.ac.uk/psrp/>

QualityHealthcare.org.

<http://www.qualityhealthcare.org>

Local delivery stories

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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 the quality and effectiveness of the training is continuously evaluated.**

Procedure:

1. Ask manager if risk-training courses are formally approved by the organisation.
2. Obtain copies of any training programmes. Check whether the following are covered by the course:
 - indicators of risk,
 - high risk periods,
 - managing non-compliance,
 - managing loss of contact,
 - communication between services, agencies, professionals, users, carers,
 - Mental Health Act.
3. Obtain copies of service/ward training records. If none available, ask manager for information. Then:
 - Identify how many currently employed staff have received training in risk in the last three years. Express as proportion of relevant staff.
 - Ask manager what plans there are to ensure that all care staff are trained every three years.

Useful resources to inform positive practice with regard to standard eight:

Books & reports

Appleby, L. et al (1999). *Safer Services: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. London, Department of Health.

Appleby, L. et al (2001). *Safety first: Five year report of the National Confidential Inquiry into Suicide and homicide by people with mental illness*. London, Department of Health.
<http://www.doh.gov.uk/mentalhealth/safetyfirst/index.htm>

Barz, M. L. (2001). *Assessing suicide hotline volunteers' empathy and motivations*. Florida, University of Florida, US.

Department of Health (2001). *The Mental Health Policy Implementation Guide*. London, Department of Health.
<http://www.doh.gov.uk/mentalhealth/implementationguide.htm>

Department of Health (2002). *National Suicide Prevention Strategy for England*. London, Department of Health.
<http://www.doh.gov.uk/mentalhealth/suicideprevention.pdf>

Department of Health (2003). *Consultation on Healthcare Skills Toolkit*.
Toolkit User Guide <http://www.doh.gov.uk/prisonhealth/consultations/toolkitguide.pdf>
Healthcare skills toolkit (Nursing and Healthcare)
<http://www.doh.gov.uk/prisonhealth/consultations/healthcaretoolkit.pdf>
Healthcare skills toolkit (Prison medical lead)
<http://www.doh.gov.uk/prisonhealth/consultations/prisoncompetencies.pdf>
Healthcare skills toolkit (Doctor providing primary care in prison)
<http://www.doh.gov.uk/prisonhealth/consultations/leaddoc.pdf>

Department of Health (2003). *Fast-Forwarding Primary Care Mental Health: Graduate primary care mental health workers. Best Practice Guidance*. London, Department of Health.
<http://www.doh.gov.uk/mentalhealth/fastforwardguidancejan03.pdf>

Department of Health (2003). *Getting the Right Start, the National Service Framework for children: Emerging Findings*. London, Department of Health.
<http://www.doh.gov.uk/nsf/children/emergingfindings.pdf>

Department of Health (2003). *Mental Health Services: Workforce design and development - Best practice guidance*. London, Department of Health.
<http://www.doh.gov.uk/mentalhealth/workforceplanningrep.pdf>

Department of Health (2003). *Prison Health: Consultation on induction programme for healthcare staff*. London, Department of Health.
Healthcare specific induction matrix: <http://www.doh.gov.uk/prisonhealth/pdf/induction-matrix.pdf>
Core induction matrix: <http://www.doh.gov.uk/prisonhealth/pdf/healthcare-matrix.pdf>

Department of Health, Workforce Action Team. (2001). *Mental health national service framework: (and the NHS Plan): workforce planning, education and training underpinning programme: adult mental health services: final report by the Workforce Action Team: main report: August 2001*. London, Department of Health.
<http://www.doh.gov.uk/mentalhealth/watmainreport.pdf>

Havergal, M. and Edmonstone, J. (2001). *Toolkit for Facilitators: Practical tools for working with teams and groups*. Brighton, Pavilion.

Knapman, J. and Morrison, T. (2001). *Making the Most of Supervision in Health and Social Care : A support manual for supervisees in health and social care*. Brighton, Pavilion.

Marshall, T., Simpson, S., et al. (2000). *Toolkit for health care needs assessment in prisons*. Birmingham, University of Birmingham.
<http://www.doh.gov.uk/pdfs/toolkit.pdf>

Morgan, S. (2001). *Assessing and Managing Risk: A training pack for practitioners and managers of comprehensive mental health services*. Brighton, Pavilion.

National Institute for Mental Health in England (NIMHE) (2003). *Mental Health Occupational Standards Framework*. Leeds, NIMHE.
<http://www.nimhe.org.uk/downloads/Final%20framework%2005.pdf>

National Institute for Mental Health in England (NIMHE) (2003). *National Occupational Standards Implementation Guide*. Leeds, NIMHE.
<http://www.nimhe.org.uk/downloads/nosimplementationguide10.doc>

National Institute for Mental Health in England (NIMHE) (2003). *National Occupational Standards leaflet*. Leeds, NIMHE.
<http://www.nimhe.org.uk/downloads/NOSmailer.pdf>

National Institute for Mental Health in England (NIMHE) and Department of Health (2003). *Expert Briefing: Post-qualifying mental health training*. London, Department of Health.
<http://www.nimhe.org.uk/downloads/training.pdf>

Patients Council, Royal Edinburgh Hospital (2001). *This Could Be You : A video training guide for staff working in hospital with people with mental health problems*. Brighton, Pavilion.

Sainsbury Centre for Mental Health (2001). *The capable practitioner: - a framework and list of the practitioner capabilities required to implement The National Service Framework for Mental Health*. London, Sainsbury Centre for Mental Health.
<http://www.scmh.org.uk/>

Shea Shawn, C. (2002). *The practical art of suicide assessment: a guide for mental health professionals and substance abuse counselors*. New York, Chichester Wiley.

Journal articles

Appleby, L., Morriss, R., et al. (2000). "An educational intervention for front-line health professionals in the assessment and management of suicidal patients (The STORM Project)." *Psychological Medicine* 30(4): 805-812.

Organisations & websites

Centre for Suicide Research, Oxford.
<http://cebmh.warne.ox.ac.uk/csr/mainscreen.html>

Changing Our Minds.
www.changeourminds.org

Cochrane Collaboration.
<http://www.york.ac.uk/inst/crd/sites.htm>

Counselling in Primary Care.
<http://www.cpct.co.uk>

Healthcare Workforce Development Portal.
<http://www.healthcareworkforce.org.uk/>

NHS Modernisation Agency Improvement Leaders' Guides Website.
<http://www.modern.nhs.uk/improvementguides/>

Primary Care Mental Health Education (PriMHE)
<http://www.primhe.org.uk>

Local delivery stories

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- Submit a story on-line at <http://www.nimhe.org.uk/smartsearch/sendstory.asp>.

Useful resources to inform positive practice with regard to all standards:

Books & reports – all standards

- Department of Health (1999). *Saving Lives: Our Healthier Nation*. London, HMSO.
Executive Summary <http://www.doh.gov.uk/pub/docs/doh/ohnexec.pdf>
- Department of Health (1999). *National Service Framework for Mental Health. Modern standards and service models*. London, Department of Health.
<http://www.doh.gov.uk/pub/docs/doh/mhmain.pdf>
- Department of Health (2001). *The Mental Health Policy Implementation Guide*. London, Department of Health.
<http://www.doh.gov.uk/mentalhealth/implementationguide.htm>
- Department of Health (2001). *National Service Framework for Older People*. London, HMSO.
<http://www.doh.gov.uk/nsf/pdfs/nsfolderpeople.pdf>
- Department of Health (2002). *Women's Mental Health: Into the Mainstream Strategic Development of Mental Health Care for Women*. London, Department of Health.
<http://www.doh.gov.uk/mentalhealth/womens-mentalhealth.pdf>
- Duffy, D. and Ryan, T., Eds. (forthcoming). *New Approaches to Preventing Suicide: A Manual for Practitioners*. London, Jessica Kingsley Publishers.
- Hawton, K. and Heeringen, K. V., Eds. (2002). *The International Handbook of Suicide and Attempted Suicide*. London, John Wiley & Sons.
http://www.suicide-parasuicide.rumos.com/en/library/new/book_reviews/internationalhandbooksuicide.htm
- National Institute for Mental Health for England (NIMHE) (2003). *The Cases for Change - Emerging areas of Service Provision*. Leeds, Department of Health.
<http://www.nimhe.org.uk/downloads/10EmergingServiceProvis.pdf>
- National Institute for Mental Health for England (NIMHE) (2003). *The Cases for Change - Hospital Services*. Leeds, Department of Health.
<http://www.nimhe.org.uk/downloads/5HospitalServices.pdf>
- National Institute for Mental Health for England (NIMHE) (2003). *The Cases for Change - User Involvement*. Leeds, Department of Health.
<http://www.nimhe.org.uk/downloads/8UserInvolvement.pdf>
- NHS Modernisation Agency (2002). *Improvement Leaders' Guides: Involving patients and carers*. London, Department of Health.
http://www.modern.nhs.uk/improvementguides/reading/involving_patients.pdf
- NHS Modernisation Agency (2002). *Improvement Leaders' Guides: Measurement for improvement*. London, Department of Health.
<http://www.modern.nhs.uk/improvementguides/measurement/measure4improve2.pdf>
- NHS Modernisation Agency (2002). *Improvement Leaders' Guides: Process mapping, analysis and redesign*. London, Department of Health.
<http://www.modern.nhs.uk/improvementguides/process/processmapping2.pdf>
- NHS Modernisation Agency (2002). *Improvement Leaders' Guides: Spread and sustainability*. London, Department of Health.
<http://www.modern.nhs.uk/improvementguides/reading/sustainability.pdf>
- Scotland Scottish Executive (2002). *Choose life: a national strategy and action plan to prevent suicide in Scotland*. Edinburgh, Scottish Executive.

<http://www.scotland.gov.uk/library5/health/clss.pdf>

Singleton, N., O'Brien, M., et al. (2002). *Mortality statistics general: review of the Registrar General of deaths in England and Wales, 2000*. London, Office for National Statistics.

http://www.statistics.gov.uk/downloads/theme_health/DH1_33/DH1_33.pdf

Organisations & websites - all standards

Australian Commonwealth Department of Health and Aged Care: Suicide Prevention Strategy.

<http://www.mentalhealth.gov.au/sp/>

British Medical Association Library Catalogue.

<http://dynix.bma.org.uk/>

Centre for Evidence Based Mental Health (CEBMH).

<http://cebmh.warne.ox.ac.uk/cebmh/>

Centre for Suicide Prevention.

<http://www.national-confidential-inquiry.ac.uk/>

Database of Abstracts of Reviews of Effectiveness (DARE).

<http://nhscrd.york.ac.uk/welcome.html>

Department of Health: Mental Health section.

www.doh.gov.uk/mentalhealth/index.htm

electronic Library for Social Care (eLSC).

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

Joseph Rowntree Foundation.

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

Health Development Agency (HDA).

<http://www.hda-online.org.uk>

London Development Centre for Mental Health website.

<http://www.londondevelopmentcentre.org>

Mentalhealthdata.org.uk.

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

Mentality.

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

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

<http://www.national-confidential-inquiry.ac.uk/nic/index.htm>

National Electronic Library for Mental Health (NeLMH).

<http://www.nelmh.org>

National Institute for Clinical Excellence (NICE).

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

National Institute for Mental Health for England (NIMHE) website.

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

National Research Register.

<http://www.doh.gov.uk/nrr.htm>

National Suicide Research Foundation (Ireland).

New Zealand Ministry of Youth Affairs: Youth Suicide Prevention Strategy.
<http://www.youthaffairs.govt.nz/sec.cfm?i=21>

NHS Direct.
<http://www.nhsdirect.nhs.uk/>

NHS Economic Evaluations Database.
<http://nhscrd.york.ac.uk/welcome.html>

NHS Health Scotland: Suicide prevention toolkit pages.
<http://www.hebs.com/suicideprevention>

NIMHE North West website.
<http://www.nimhenorthwest.org.uk/>

Northern Centre for Mental Health (NCMH) website.
<http://www.ncmh.org.uk/>

Norwegian Board of Health: National Plan for Suicide Prevention.
<http://www.helsetilsynet.no/trykksak/ik-2539/selmeng.htm>

Office of National Statistics: Suicide datasets.
<http://www.statistics.gov.uk/CCI/SearchRes.asp?term=suicide>

POINT - Department of Health Circulars on the Internet.
<http://www.info.doh.gov.uk/doh/coin4.nsf/Search?openform>

POINT - Department of Health Publications on the Internet.
<http://www.info.doh.gov.uk/doh/point.nsf/NewSearch?openform>

Public Health electronic Library (PHeL).
<http://www.phel.gov.uk/>

PubMed.
<http://www4.ncbi.nlm.nih.gov/PubMed/>

Royal College of Psychiatrists.
<http://www.rcpsych.ac.uk/>

Samaritans: suicide statistics.
<http://www.samaritans.org.uk/know/statistics.shtm>

Scottish suicide prevention strategy.
<http://www.scotland.gov.uk/library5/health/class-00.asp>

Social Care Institute for Excellence (SCIE).
<http://www.scie.org.uk/>

South West Development Centre for Mental Health website.
<http://www.mhsw.org.uk>

Suicide Information & Education Centre (Canada).
<http://www.suicideinfo.ca>

The Suicidology Web: statistics.
<http://www.suicide-parasuicide.rumos.com/en/articles/statistics/stat00001.htm>

Turning Research Into Practice (TRIP) Database.
<http://www.ceres.uwcm.ac.uk/frameset.cfm?section=trip>

US Center for Mental Health Services: National Strategy for Suicide Prevention - Goals and Objectives for Action.

<http://www.mentalhealth.org/publications/allpubs/SMA01-3518/default.asp>

World Health Organization Website: Suicide Prevention Section.

http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/

Local delivery stories

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- Submit a story on-line at <http://www.nimhe.org.uk/smartsearch/sendstory.asp>.

Appendix One: Implementation of this toolkit

This toolkit provides a simple way for services to measure existing standards against the recommendations outlined in the report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Safety First published in 2001. The toolkit should be made available to all healthcare professionals involved in clinical audit and clinical governance. In addition, all Standard Seven Leads involved and represented on Local Implementation Teams should be encouraged to obtain copies of the toolkit. NIMHE, through its network of development centres, should also ensure that it is disseminated to those responsible for and involved in the auditing of suicides and serious untoward incidents. NIMHE development centres will also need to consider what arrangements they need to make to ensure effective dissemination of the toolkit.

The toolkit will be a working document, which will evolve over time to include examples of positive practice, and local delivery stories pertaining to each of the standards outlined. The NIMHE Knowledge Community project, currently in development, will facilitate on-line connectivity to:

- The local delivery stories database so that people can share positive practice and experience;
- The National contacts database to support the growth of a community of practice in suicide prevention work;
- A Suicide Prevention discussion area / weblog to encourage the sharing of ideas and experience and generating positive debate;
- The knowledgebase to support the growth of high quality and relevant literature / resources which can support suicide prevention.

Please refer to existing NIMHE Knowledge Community project documentation at <http://www.headshift.com/nimhekc> for the full context of this project and details of background research undertaken.

NIMHE Contacts

NIMHE CENTRAL TEAM

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Leeds
LS1 4PL

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NORTH EAST, YORKSHIRE & HUMBERSIDE DEVELOPMENT CENTRE

2ND Floor, Blenheim House
West One
Duncombe Street
Leeds, LS1 4PL
Tel: 0113 254 3821
Fax: 0113 254 3828

NORTHERN CENTRE FOR MENTAL HEALTH

(main provider of regions developmental activity)
Operates from two sites, one in York and one in Durham:

Suites 4 & 5, William Robson House
Claypath
Durham
DH1 1SA.
Tel: 0191 370 7760
Fax: 019 383 0109
Email: office@ncmh.co.uk
Website: <http://www.ncmh.co.uk>

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York
YO10 5ZF.
Tel: 01904 717260
Fax: 01904 717269
Email: yorkoffice@ncmh.co.uk
Website: <http://www.ncmh.co.uk>

Melanie Hird Project Manager with lead responsibility for Suicide Prevention
Tel: 01904 717 260
Fax: 01904 717 269
Email: melanie.hird@ncmh.co.uk

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Website: <http://www.nimhe.org.uk/development/eastmidlands/index.asp>

NIMHE EASTERN DEVELOPMENT CENTRE

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THE LONDON DEVELOPMENT CENTRE FOR MENTAL HEALTH

11 - 13 Cavendish Square
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W1G 0AN.
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Janet Davies (Programme Co-ordinator with lead responsibility for Suicide Prevention)
Tel: 020 7307 2431
Fax: 020 7307 2432
Email: janet.davies@londondevelopmentcentre.org

NIMHE SOUTH EAST DEVELOPMENT CENTRE

Parklands Hospital
Aldermaston Road
Basingstoke
Hampshire
RG24 9RH.
Website: <http://www.sedc.org.uk>

Alleyn Wilson Programme Co-ordinator with lead responsibility for Suicide Prevention
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NIMHE SOUTH WEST DEVELOPMENT CENTRE

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TA1 4AR.
Website: <http://www.nimhe.mhsw.org.uk>

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Fax: 01823 272897
Email: Carrie.morgan@mhsw.nhs.uk

NIMHE WEST MIDLANDS DEVELOPMENT CENTRE

Osprey House
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Redditch
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B97 4DE.

Website: <http://www.nimhe.org.uk/development/westmidlands/index.asp>

Nick Adams (lead responsibility for Suicide Prevention)

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NIMHE NORTH WEST DEVELOPMENT CENTRE

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Those with lead responsibility for Suicide Prevention in NW

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Appendix Two: Local delivery stories

NIMHE aims to use the local delivery stories database to help people involved with mental health services to learn from each other what works and also to recognise achievement.

Please use this form to let us know about any work you have been involved with that you would like to share. Alternatively submit a story on-line at <http://www.nimhe.org.uk/smartsearch/sendstory.asp>

Our general criteria are that the piece of work had some clear objectives, that you can explain what has changed and that the improvements are endorsed by staff or service users involved with the service.

It would help us if you can supply brief details using this form. Then select the appropriate NIMHE region and send your details to your local NIMHE development centre. They will contact you about adding it to the local delivery stories database and making it available on the NIMHE web site.

NIMHE DC	(Indicate the appropriate NIMHE region)	
Name		
Title	Mr/Mrs/Miss/Ms/Dr/other	
Job title	(Where applicable)	
Work address	(Or other contact address where applicable)	
		Postcode
Telephone		
Email		Date
Website		
<p>Brief description of the project (or delivery story). Describe your starting point, what was the problem, how you decided what the problem was/is? What actions did you take to change it?</p>		

What difference has this made, and for whom? How can you tell? What measures have you made to decide that a change has taken place?

What are the next steps?

Key words to help people to search for your story on the database (e.g. assertive outreach, training, service users and involvement, etc.)

Do you give your permission for your contact details to be held on the NIMHE Projects and Delivery Stories Database, so that people can contact you if they would like more information or have any questions?

YES [] NO []

If you have answered 'no', is there someone else who will act as the named contact person? (Please provide contact details below).

Have any service users or carers, or your manager or another person associated with your project given their support for this submission?

YES [] NO []

Are there any statements which they would like to make as a 'third party endorsement'? If so, please include them below.