Institution: The University of Manchester

Unit of Assessment: 4 (Psychology, Psychiatry and Neuroscience)

Title of case study: Shaping UK policy and guidelines for suicide prevention

Period when the underpinning research was undertaken: 2011 - 2020

Details of staff conducting the underpinning research from the submitting unit:

Name(s):	Role(s) (e.g. job title):	Period(s) employed by submitting HEI:
Louis Appleby	Professor of Psychiatry and Director, National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)	1996 - date
Nav Kapur	Professor of Psychiatry and Population Health	2002 - date
Jenny Shaw	Clinical Professor and Consultant	1996 - date
Pauline Turnbull	Project Director, NCISH Project Manager, Manchester Self-Harm Project	2015 - date 2013 - 2015
Cathryn Rodway	Programme Manager, NCISH Project Manager, NCISH Research Associate, NCISH	2017 - date 2016 - 2017 2014 - 2016

Period when the claimed impact occurred: August 2013 - December 2020

Is this case study continued from a case study submitted in 2014? N

1. Summary of the impact

Approximately 6,500 suicides are reported annually in the UK, and 28% are patients in contact with mental health services during the year before their death. Research by the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) at the University of Manchester has shown that specific improvements to services significantly reduce suicide rates. NCISH has used this evidence to develop recommendations for improving patient safety in mental health settings. Working with relevant stakeholders, including guideline developers and policymakers, this influential research has directly shaped national suicide prevention policy. NCISH recommendations are incorporated in national policies and clinical guidance in all UK countries.

2. Underpinning research

Background to the research

NCISH at the University of Manchester (UoM) is the UK's leading research programme into suicide prevention in clinical services. The Mental Health Clinical Outcome Review Programme, delivered by NCISH, is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England, NHS Wales, the Health and Social Care Division of the Scottish Government, and the States of Jersey and Guernsey. NCISH's core evidence base is a national register of all suicides occurring in the UK since 1996, recording >144,000 general population suicides. Further detailed demographic, behavioural and clinical information is collected on those people who were in contact with mental health services in the year prior to their death, as many of these suicides may have been preventable. NCISH generates crucial evidence to support service and training improvements and, ultimately, contribute to a reduction in suicide rates. This database underpins publications since 2011, analysing 10-, 15- or 20-years' worth of historical suicide data. An Independent Advisory Group (IAG) provides external oversight of the work of NCISH, which is guided by members of its Project Board. Both the IAG and the Project Board include representation of key stakeholders, including clinicians, service users and carers.

Key research findings:

NCISH research examines the circumstances associated with deaths by suicide of people under current or recent specialist mental health care and identifies factors in patient management and care related to those suicides [1]. Research findings since 2011 include:

- 28% of UK suicides are by people who had been in contact with mental health services in the year before their death [1];
- Between 2007 and 2017 there were >2,000 people who died by suicide in England within three months of discharge from psychiatric in-patient care, with the highest number of deaths occurring on day 3 [1], [2];
- 10% of people who died by suicide within three months of discharge from psychiatric in-patient care were discharged from a non-local in-patient unit [1];
- Between 2007 and 2017 there were >2,000 suicides by patients under the care of crisis teams [1];
- A minority of patients who died by suicide between 2007 and 2017 were in contact with specialist substance misuse services, despite alcohol and drug misuse being a common antecedent of patient suicide in all UK countries [1].

NCISH recommends specific measures to reduce the number of suicides in mental health services and evaluates the effects of these measures. Research has shown that key evidence-based measures are associated with reduced suicide rates. Specific research recommendations since 2011 include:

- There are fewer in-patient deaths following the removal of non-collapsible ligature points, as recommended by NCISH: a 41% fall between 2007 and 2017 [1];
- In England, there was a 25% reduction in suicide rates in health services that had a policy in place on the management of patients with co-morbid substance misuse [3];
- Mental health service staff told UoM researchers that greater involvement of the family would have reduced suicide risk in 18% of deceased patients [1], [3];
- Implementing NCISH safety recommendations in mental health trusts was associated with significant reductions in suicide rates [4]. Suicides were particularly decreased in specific high-risk settings that the recommendations targeted, including ward safety, improved community services, crisis teams [4];
- Service changes based on NCISH recommendations had more effect on reducing suicide rates in services with lower non-medical staff turnover and higher rates of incident reporting [5].

3. References to the research

1. The National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report: England, Northern Ireland, Scotland and Wales. 2019. University of Manchester. https://sites.manchester.ac.uk/ncish/reports/annual-report-2019-england-northern-ireland-scotland-and-wales/
2. Bojanić L, Hunt IM, Baird A, **Kapur N**, **Appleby L, Turnbull P**. Early Post-Discharge Suicide in Mental Health Patients: Findings From a National Clinical Survey. *Frontiers in Psychiatry* 2020; 11, 502. DOI: 10.3389/fpsyt.2020.00502
3. Littlewood DL, Quinlivan L, Graney J, **Appleby L, Turnbull P**, Webb RT, **Kapur N**. Learning from clinicians' views of good quality practice in mental healthcare services in the context of suicide prevention: a qualitative study. *BMC Psychiatry* 2019; 19,346. DOI: 10.1186/s12888-019-2336-8
4. While D, Bickley H, Roscoe A, Windfuhr K, Rahman S, **Shaw J, Appleby L, Kapur N**. Implementation of mental health service recommendations in England and Wales and suicide rates, 1997-2006: A cross-sectional and before-and-after observational study, *The Lancet* 2012; 379, 9820, 1005-1012 DOI:10.1016/S0140-6736(11)61712-1
5. **Kapur N**, Ibrahim S, While D, Baird A, **Rodway C**, Hunt IM, Windfuhr K, Moreton A, **Shaw J, Appleby L**. Mental health service changes, organisational factors, and patient suicide

in England in 1997–2012: a before-and-after study. *The Lancet Psychiatry* 2016; 3, 526-534. DOI:10.1016/S2215-0366(16)00063-8

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4. Details of the impact

Context

Suicide is among the leading contributors to total Potential Years of Life Lost (PYLL) in western countries (Gunnell D, Middleton N. *The Lancet* 2003; 362[9388]: 961-962). Recent NCISH evidence estimates that 28% of suicides are by people under mental health care in the previous year. NCISH research provides evidence and recommendations that directly shape national policy and inform guidelines for effective methods of preventing patient suicides, including the 2016 NHS Five Year Forward View for Mental Health, NICE guidelines on transition from in-patient to community care and the suicide prevention strategies of all four UK nations.

Pathways to Impact - NCISH Recommendations

NCISH research findings and recommendations have been formulated into 10 key elements of a safer service, available to specialist mental health services as a self-audit toolkit (Figure 1), updated annually. The toolkit is a key mechanism for generating impact and has been downloaded >2,900 times since launch in 2012, including 199 times internationally. The 10 core recommendations for safer services, resulting from UoM research, are:

1. Safer wards (ligature point removal, reduced absconding, skilled in-patient observation)
2. Care planning and early follow-up on discharge from hospital to community
3. No 'out of area' admissions for acutely ill patients
4. 24-hour crisis resolution/home treatment teams
5. Outreach teams to support patients who may lose contact with conventional services
6. Specialised services for alcohol and drug misuse and 'dual diagnosis'
7. Multidisciplinary review of patient suicides, with input from the family
8. Implementing NICE guidance on depression and self-harm
9. Personalised risk management, without routine checklists
10. Low turnover of non-medical staff

Figure 1. *The NCISH safer service self-audit toolkit, showing the 10 core recommendations. Services can click through to access research evidence and recommendations.*

The recommendations within the toolkit have been central to informing suicide prevention policies and clinical guidelines across the UK.

Reach and significance of the impact

[i] NHS plan for Mental Health and guidance for commissioners

The 2016 NHS Five Year Forward View for Mental Health [A] highlights suicide prevention and reduction as a key policy and emphasises that NCISH recommendations have impacted practice in order to prevent suicides: *"As part of this [multi-agency suicide prevention and reduction] programme, we are on track to deliver a 10% reduction in suicide rates by 2020/21 … We also now have a dedicated quality improvement programme to implement the findings from [**NCISH**] …. to prevent future suicides".* The plan also focuses on the need to improve discharge planning and implement central NCISH recommendations on 72-hour follow-up. These recommendations are also a key Commissioning for QUality and INnovation (CQUIN) indicator for mental health trusts in England [B]: *"72 hour follow up is a key part of the work to support the Suicide prevention agenda within the Long Term Plan. **NCISH** (2018) found that the highest number of deaths occurred on day 3 post discharge".* As a result of NCISH research and recommendations, NHS England allocated GBP50,000,000 in November 2020 to improve the care of post-discharge patients in England [C].

[ii] UK-wide suicide prevention plans

All UK nations have recently published strategies for improved patient safety, suicide and self-harm prevention. NCISH recommendations are central to England's Cross-Government suicide prevention strategy [D], Scotland's suicide prevention action plan [E], Wales' suicide and self-harm prevention strategy (Talk to me 2 [F]) and Northern Ireland's strategy for preventing suicide and self-harm (Protect Life 2 [G]). For example, England's strategy [D] states "*as part of the £25 million investment in suicide prevention over the next three years, NHS England is leading a national quality improvement programme for improving patient safety and suicide prevention across mental health services*. *The quality improvement programme will be based on the [**NCISH**] model for safer services*" while Wales' strategy [F] states *"**NCISH**… has produced a checklist … which provides key guidance for mental health services for suicide prevention."*

[iii] NICE guidelines

National clinical guidelines on care planning and discharge from acute services have been developed based on influential NCISH recommendations (NICE 2016, [H]). The guidelines highlight the critical period around discharge, especially where people have been admitted out of area, and the critical need for early follow-up after discharge, as recommended by NCISH. *"For people admitted to hospital outside the area in which they live, take into account the higher risk of suicide after discharge at all stages of the planning process (see [**NCISH**])"* [H].

[iv] Reports by national voluntary sector bodies

Reports from influential national bodies have cited NCISH evidence as crucial to support their recommendations. The King's Fund (2015 [I]) reported on pressures in UK Mental Health services and consequent negative outcomes. The report cites NCISH evidence and recommendations, emphasising the need for 24-hour crisis and community outreach teams. Both the King's Fund report and The Independent Commission on Acute Adult Psychiatric Care (2015) [Ji] also cite NCISH evidence in calling for an end to acute admissions out of area in order to prevent suicides. Responding to the latter, the Chief Executive of the national mental health charity Mind commented "*It is essential that when someone has a mental health problem and they are in crisis that they can reach out and always get the support they need as swiftly as possible*." [Jii].

5. Sources to corroborate the impact

A. NHS England 'The Five Year Forward View for Mental Health' (first published February 2016, updated September 2017) report from the independent Mental Health Taskforce to NHS England, proposing a plan for improved mental health services in England and referencing NCISH research and recommendations directly.

B. NHS England and NHS Improvement: Commissioning for Quality and Innovation (CQUIN) Guidance for 2019-2020 (March 2019) cites NCISH recommendation to follow-up patients within 72 hours of discharge from psychiatric in-patient care as a key indicator of mental health trust performance.

C. NHS England and NHS Improvement: Guidance on additional 20201/21 winter funding for post-discharge support for mental health patients (November 2020) cites NCISH research that patients are at highest risk immediately post-discharge.

D-G are the published suicide prevention strategy documents of the four UK nations, all of which reference NCISH research and state the need to implement NCISH recommendations to prevent suicides

D. HM Government's Fourth progress report of the suicide prevention strategy for England (January 2019), the current England strategy.

E. Scotland's Suicide Prevention Action Plan 'Every Life Matters' (August 2018).

F. Welsh Government's suicide and self-harm prevention strategy 2015-2020 ('Talk to me 2') (first published July 2015, updated October 2020).

G. Northern Ireland's strategy for preventing suicide and self-harm, 2019-2024 ('Protect Life 2') (September 2019).

H. The King's Fund 'Mental Health Under Pressure' report (November 2015) provides an overview of mental health services in England and identifies areas for improvement. Directly cites NCISH research and recommendations.

I. NICE guidance on transition between in-patient mental health settings and community or care settings (August 2016) - cites NCISH research and recommendations to reduce suicide immediately after patients leave in-patient settings.

J. Independent review to improve psychiatric in-patient care cites NCISH recommendations calling for an end to acute admissions out of area [Ji]; Mind supports this call for action [Jii].

   i. Independent Commission review 'Improving acute inpatient psychiatric care for adults in England – interim report' (July 2015) calls for action to improve adult mental health services in England, citing NCISH recommendations for preventing suicide.

   ii. Mind responds to independent commission on acute adult psychiatric care report (February 2016). Mind Chief Executive emphasises importance of commission's call for action from service user perspective.