manchester NCISH Self-Audit Toolkit User Manual

User Manual

The National Confidential Inquiry into Suicide and Safety in Mental Health

Safer services:
A toolkit for specialist mental health services and primary care

Introduction

About this toolkit

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

Important note

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

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

10 ways to improve safety

- Safer wards
- Early follow-up on discharge
- No out-of-area admissions
- 24-hour crisis teams
- Family involvement in 'learning lessons'
- Guidance on depression
- Personalised risk management
- Outreach teams
- Low staff turnover
- Reducing alcohol and drug misuse

Safer care in mental health services

Safer wards

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

Our evidence

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

Since then suicide by mental health in-patients has fallen by 46%, although the number of in-patient suicides in 2017-2019 has not fallen; there were 67 suicides by in-patients in the UK (excluding Northern Ireland) in 2019. Between 2009 and 2019, over a third of in-patient suicides took place on the ward. Many of these deaths were by hanging/strangulation from low-lying ligature points. Half of the inpatients who died by suicide were on agreed leave. In our study of clinicians' views of good quality practice in mental healthcare, clinicians emphasized practices that improved safety in a ward environment such as observations conducted by trained staff.

Guidance

This recommendation was originally cited in the Department of Health report An Organisation with a Memory in 2000.
More recently it is included in:
> HM Government's Fifth progress report of the suicide prevention strategy for England
> The Welsh Government's suicide and self-harm prevention strategy Talk To Me 2

HM Government

Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives

Published 27 March 2021

Contents

Safer wards can be achieved by:

Removal of ligature points

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

 Skilled in-patient observation

	Response		Date next review due	Comments
	Yes	No		
Observation policies recognize that observation is a skilled intervention to be carried out by the experienced staff of appropriate seniority.				
Observation policies recognize the increased risk of suicide within the first week of admission.				

Safer wards can be achieved by:

 Reducing leave from ward without agreement

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

Early follow-up on discharge

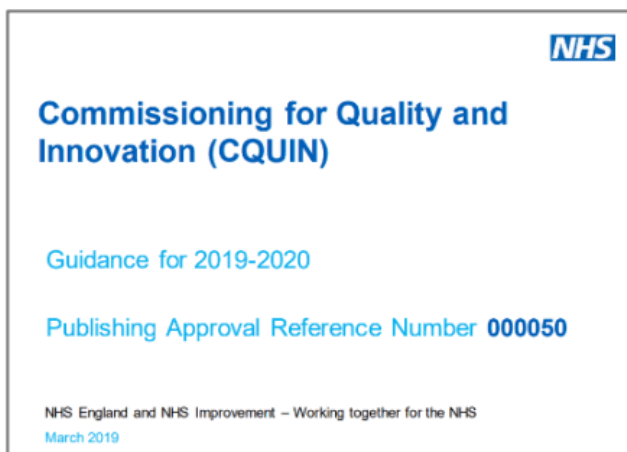| **Early follow-up on discharge**	**Our evidence**
Patients discharged from psychiatric in-patient care should be followed up by the service within 72 hours of discharge. A comprehensive care plan should be in place at the time of discharge and during pre-discharge leave.	In the UK, there were 2,496 suicides within three months of discharge from in-patient care between **2009 and 2019**. 14% of these post-discharge suicides occurred within the first week of leaving the hospital, with the highest number occurring on day 3 after leaving the hospital (day 1 = day of discharge, 21%).

Guidance

We have recommended all patients are **followed up within 72 hours of discharge** from in-patient care. The **NICE guidance** of following up on all discharged patients within 7 days was formally reviewed as part of the **NHS Commissioning for Quality and Innovation (CQUIN) 2019/20 scheme.** Based on our findings, the time frame has since been reduced to 72 hours. NHS England and NHS Improvement have included 72-hour follow-up in the **NHS Standard Contract 2022/23**.

NHS

Commissioning for Quality and Innovation (CQUIN)

Guidance for 2019-2020

Publishing Approval Reference Number **000050**

NHS England and NHS Improvement – Working together for the NHS
March 2019

The 72-hour follow-up standard is also cited in the HM Government's **Fifth progress report of the suicide prevention strategy for England.**

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

In **2021/2022** NHS England will continue the 2020/2021 winter funding program to improve the care of post-discharge patients in England.

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

	Response		Date next review due	Comments
	Yes	No		
The discharge policy specifies follow-up of patients discharged from psychiatric in-patient care occurs within 72 hours of discharge in all cases.				
There is a care plan in place for patients discharged from acute care.				
There is a care plan in place for patients on pre-discharge leave.				

No out-of-area admissions

No out-of-area admissions Very ill patients should be accommodated in a local in-patient unit. Being admitted locally means that patients stay close to home and the support of their friends and family, and are less likely to feel isolated or to experience delayed recovery. Local admission should also result in simpler discharge care planning.	**Our evidence** In the UK, 225 patients (9% of post-discharge deaths) died after being discharged from a non-local in-patient unit. In 2019 there were 13 suicides after discharge from a non-local unit. There has been a **downward trend** in the number of suicides by patients recently discharged from hospitals in the UK. There were an estimated 180 post-discharge deaths in 2019, down from a peak of 299 in 2011.

Guidance
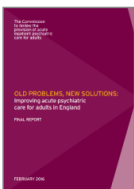
Both the King's Fund **Under Pressure** report and the **Independent Commission on Acute Adult Psychiatric Care** referenced this recommendation in 2015, calling for an end to acute admissions out of the area.

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

No 'out-of-area' admissions for acutely ill patients

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

24-hour crisis teams

**24-hour crisis resolution/home treatment teams**

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

Our evidence
The setting where suicide prevention can have the greatest impact is the crisis team; the main location where patients with acute illness are now seen. In England, there are on average **180** suicides per year by CRHT patients – over two times as many as under in-patient services. The introduction of a 24-hour CRHT appears to add to the safety of service overall, with a **reduction in suicide rates** in implementing mental health services. In our study of **the assessment of clinical risk in mental health services**, both patients and carers emphasized the need for clarity about what to do and who to contact in a crisis.

Guidance
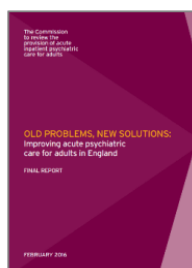
Both the King's Fund **Under Pressure** report and the **Independent Commission on Acute Adult Psychiatric Care** referenced these recommendations in 2015, and emphasized the importance of CRHTs operating efficiently as intensive specialist community-based alternatives to in-patient care, and not simply as generic crisis teams.
This recommendation is included in the HM Government's **Fourth progress report of the suicide prevention strategy for England**. It is noted as an aim in the **Fifth progress report of the suicide prevention strategy for England** that by March 2021, all CRHT services will operate 24/7.

 24-hour crisis resolution/home treatment

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

Family involvement

Family involvement in 'learning lessons'	Our evidence
Working more closely with families could improve suicide prevention. Services should consult with families from first contact, throughout the care pathway, and when preparing plans for hospital discharge and crisis plans. Staff should also make it easier for families to pass on concerns about suicide risk, and be prepared to share their own concerns. This could help to ensure there is a better understanding of the patient's history and what is important to them in terms of their recovery and may support better compliance with treatment. There should be a multi-disciplinary review following all suicide deaths, involving input from and sharing information with families.	Staff told us that greater involvement of the family by the service would have reduced suicide risk in **18%** of patients. One example of how **clinicians think** services can improve contact with families is by informing them when a patient does not attend an appointment. In only **27%** of deaths by suicide, the service contacted the family when the patient missed the final appointment before the suicide occurred. Policies for multidisciplinary review and information sharing with families were associated with a **24% fall in suicide rates** in implementing NHS Trusts, indicating a learning or training effect. **Patients tell us** they want their families to have as much involvement as possible in their assessment of clinical risk, including sharing crisis/safety plans with them. **Clinicians tell us** family involvement is vital to enhancing patient safety in mental health care settings.

Working with families

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

Guidance on depression

Guidance on depression

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

Our evidence
Across the UK, suicide by patients with affective disorders (depression or bipolar depression) rose in **2018-2019** after falling since 2012, with an average of 659 deaths per year between 2009 and 2019. Services that implemented NICE guidance for depression and self-harm guidelines had **significant reductions in suicide rates** of 26% and 23% respectively.

Guidance

 See the NICE **Quality Standard for the Management of Self-Harm**. NICE **guidance on self-harm** is currently being updated and is expected to be published later this year.
See the NICE guidelines on the **identification and management of depression in children and young people** and the NICE guidelines on **depression in adults: treatment and management.**

 Implementing NICE guidance on depression and self-harm

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

Personalized risk management

Personalized risk management

All patients' management plans should be based on the assessment of individual risk and not on the completion of a checklist. Patients should have the opportunity to discuss with their mental health team the signs that they will need additional support, such as specific stresses in their life (e.g. economic adversity, experience or threat of domestic violence), anniversaries, and dates that are important to them and online experience. Families and carers should have as much involvement as possible in the assessment process, including the opportunity to express their views on potential risks. Consulting with the patient's GP may also be helpful. Risk assessment is one part of a whole system approach that should aim to strengthen the standards of care for everyone, ensuring that supervision, delegation and referral pathways are all managed safely.

Our evidence

Most risk assessment tools seek to predict future suicidal behavior. Clinicians tell us that tools if they are used, should be simple, accessible, and considered part of a wider assessment process. Treatment decisions should not be determined by a score. Risk tools and scales have a positive predictive value of less than 5%, meaning they are wrong 95% of the time, and miss suicide deaths in the large 'low risk' group. In a sample of patient suicides, the quality of assessment of risks and management was considered by clinicians to be unsatisfactory in 36%. In our study of suicide risk assessment in UK mental health services, we found risk is often individual, suggesting the management of risk should be personal and individualized.
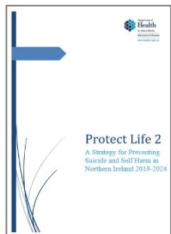
Guidance

NICE guidelines on the long-term management of self-harm state that risk assessment tools should not be used to predict future suicide or repetition of self-harm, or to determine who should or should not be offered treatment. The guidelines suggest they might be used as prompts or measures of change.
The use of risk assessment tools in mental health services has been debated in Parliament.

Personalized risk management, without routine checklists

	Response		Date next review due	Comments
	Yes	No		
There is a comprehensive management plan based on an assessment of (changing) personal and individualized risks, and not on the completion of a checklist.				
Protocols for conducting risk assessment should emphasize building relationships and gathering good quality information on: (i) The current situation (ii) Past history (iii) Social and economic factors (iv) Significant dates and anniversaries (v) Online experience				
There is specific staff training in place on how to assess, formulate, and manage risk, including training staff in being comfortable asking about suicidal thoughts.				
There is a guide in place on the effective communication of personalized risk management between different agencies, services, and professions involved with the patient, including their family and carers and with primary care.				

Outreach teams

Outreach teams Community mental health teams should include an outreach service that provides intensive support to patients who are difficult to engage or who may lose contact with traditional services. These might be patients who don't regularly take their prescribed medication or who are missing their appointments.	**Our evidence** Implementation of an assertive outreach policy was associated with **lower suicide rates** among patients who were non-adherent with medication or who had missed their last appointment with services, and with lower suicide rates overall in implementing Trusts. In our study of **clinicians' views of good quality practice in mental healthcare**, clinicians emphasized dedicated outreach services that provide intensive support to enhance patient engagement.
Guidance The **Independent Commission on Acute Adult Psychiatric Care** includes recommendations for comprehensive and effective community mental health, including outreach teams. The **Northern Ireland strategy for preventing suicide and self-harm** cites this recommendation.	

Outreach teams

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

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

Low staff turnover

Low staff turnover	**Our evidence**
There should be a system in place to monitor and respond to non-medical staff turnover rates. Non-medical staff is all other health staff except doctors.	Organizations with a low turnover of non-medical staff had **lower suicide rates** than organizations where staff changed frequently. In addition, those services with low staff turnover saw a greater reduction in their suicide rates when they implemented NCISH recommendations that services with high staff turnover.
Guidance The King's Fund cited this recommendation in their **Under Pressure** report in 2015.	

Low turnover of non-medical staff

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

Reducing alcohol and drug misuse

	Reducing alcohol and drug misuse

Reducing alcohol and drug misuse

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

Other clinical measures that could reduce suicide risk in this group are alcohol and drug misuse assessment skills in frontline staff and specialist alcohol and drug misuse clinicians within mental health services.

Our evidence

Across all UK countries, alcohol and drug misuse are common among patients who die by suicide (**47% and 37%** of all patient suicides UK-wide, respectively, higher in **Scotland** and **Northern Ireland**). However, only a minority of patients who died by suicide between **2008 and 2018** were in contact with specialist alcohol and drug misuse services.

In England, there was a **25% fall in rates of suicide by patients** in those NHS Trusts which had put in place a policy on the management of patients with co-morbid alcohol and drug misuse.

Guidance

See the NICE **guidelines on coexisting severe mental illness and substance misuse.** Embedding suicide prevention in drug and alcohol policy and services is an action in the **strategy for preventing suicide and self-harm in Northern Ireland.**

Protect Life 2
A Strategy for Preventing
Suicide and Self Harm in
Northern Ireland 2019-2024

Reducing alcohol and drug misuse

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

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

Safer care in the Emergency Department

Managing self-harm

Managing self-harm

There is evidence that recent self-harm is increasingly common prior to suicide in mental health patients and in people not in contact with mental health services. Self-harm should be recognized as a suicide warning – presenting an indication of risk and a chance to intervene. We recommend protocols for managing self-harm patients who are under mental health care and highlight the short-term risk of future suicidal behavior.

Our evidence

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

Guidance
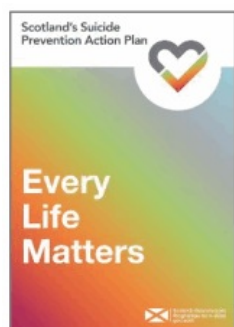
NICE guidelines on the **management of self-harm for children and young people and adults** describe the importance of an assessment of risks of further self-harm or suicide. New NICE guidelines on the **assessment, management and preventing recurrence of self-harm** are currently being drafted. The new guideline will include information for people working in education and criminal justice settings.

Reducing rates of self-harm as a key indicator of suicide risk is cited in the HM Government's **Fifth Progress Report of the Suicide Prevention Strategy** in England, the Welsh Government's suicide and self-harm prevention strategy **Talk To Me 2,** Northern Ireland's **strategy for preventing suicide and self-harm,** and in Scotland's **Suicide Prevention Action Plan.**

A national program of transformation funded by NHS England and NHS Improvement is establishing new and integrated models of **primary and community mental health care across England.** These models will provide improved care for adults and older adults who self-harm in the community, as laid out in the **NHS Long Term Plan.**

Psychosocial assessment after self-harm

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

Safer care in primary care

Safer prescribing

Safer prescribing

Our evidence indicates a key measure to reduce suicide risk includes safer prescribing in primary and secondary care, particularly opiates/opioids prescribed to people with long-term physical illness (especially older patients) and benzodiazepines prescribed to people with anxiety disorders. These are medications that may have been prescribed for long-term pain, for someone else in the patient's household or bought over the counter in a pharmacy or shop.

Our evidence

The main substances taken in fatal overdose are opiates and the main source (where known) is by prescription. In the UK, opiates (including opioid compounds) account for **36% of patient suicide deaths** by fatal overdose, the most common being heroin/morphine (38%), codeine (18%), and tramadol (17%) and methadone (13%). In Scotland, fatal overdose by opiates is more common (**49%**). **38% of patients with a physical health problem** die by self-poisoning, significantly more than patients without a physical co-morbidity (20%). The most common substances taken in this group are opiates/opioids, mostly prescribed.
Management of chronic primary pain in people aged 16 years and over should not include certain medications, such as opioids.

Guidance

NICE **guidelines on borderline personality disorder** recommend short-term use of drug treatment may be helpful during a crisis, but that polypharmacy should be avoided. **NICE** guidelines on depression in adults with a chronic physical health problem advise certain medications (i.e. opioids) should not be prescribed to manage chronic pain in people aged 16 and over.
General Medical Council guidance and **NICE guidelines on anxiety disorder** highlight that doctors should check whether the treatment provided for a patient is compatible with other treatments they are receiving, including any self-prescribed over-the-counter medicines. Patients should also be encouraged to be open about their use of other medicines during the assessment.
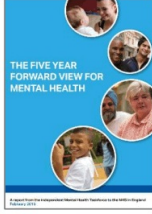Reducing suicide through safer prescribing is cited in Northern Ireland's suicide prevention strategy **Protect Life 2**, and the Welsh Government's suicide and self-harm prevention strategy **Talk To Me 2**.

Safer prescribing

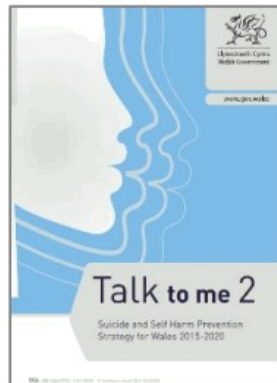|	Response		Date next review due	Comments
	Yes	No		
There is a standard procedure in place for safer prescribing of opiate analgesics and tricyclic antidepressants in primary care and accident and emergency departments, which takes into account the toxicity of these drugs in overdose by: (i) Considering reduced, short-term supplies; (ii) Asking about supplies of over-the-counter opiate-containing medications kept at home or prescribed to someone else in the household; (iii) Ensuring patients newly prescribed antidepressants are aware of the time taken to work.				
Protocols for managing patients with anxiety disorders highlight reduced prescribing of benzodiazepines.				

Monitoring for depression

Monitoring for depression

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

Clinical services should also be aware of the increased risk of fatal overdose, particularly by opiates/opioids in older patients with long-term physical illness.

Our evidence
Physical illness can increase the risk of suicide among mental health patients. In the UK in **2009-2019**, a quarter of patients who died by suicide also had a co-morbid physical health problem and the figure rises to **47% in patients aged 65 and over**.

Depression is linked to **increased suicide risk** among physically ill people, particularly in certain diagnoses such as coronary heart disease, stroke, chronic obstructive pulmonary disease (COPD) and cancer. Often affective disorders have been present for more than 5 years in **patients with a comorbid physical illness** who died by suicide. **71% of people** who died by suicide and had presented to their GP had a diagnosis of depression.

Guidance

See the NICE guidelines on the **identification and management of depression in children and young people** and the NICE guidelines on **depression in adults: treatment and management.**

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

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

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

Additional measures for men

Additional measures for men

Since 2013, men aged 40-54 have had the highest suicide rate in the UK. The suicide rate in middle-aged men in the UK is 3 times higher than women of the same age and 1.5 times greater than men in other age groups. Suicide risk factors among middle-aged men include a reluctance to seek help, higher rates of substance misuse and isolation, a lack of social support, and economic pressures such as unemployment.

Our evidence

Middle-aged men have the highest suicide rate in the UK but are often not in contact with services. Between **2009-2019**, in all countries (except Northern Ireland), the highest suicide rates were in men in the middle-aged groups. **Self-harm in middle-aged men** has also increased, particularly after 2008. In our study of **suicide by middle-aged men** we found high rates of key risk factors in men in mid-life compared to their incidence in the general population, including unemployment, divorce, deprivation, substance misuse, and physical and mental ill-health.

Guidance

The marked rise in suicide in middle-aged men is cited in **The Five Year Forward View for Mental Health**.

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

> HM Government's **Fifth Progress Report of the Suicide Prevention Strategy** in England

> The Welsh Government's suicide and self-harm prevention strategy **Talk To Me 2**

> Scotland's **Suicide Prevention Action Plan**

Reducing the risk of suicide in middle-aged men is an ambition supported by an NHS commitment to provide every area in England with funding for suicide prevention and bereavement services, as laid out in the **NHS Long Term Plan**.

Additional measures for men with mental ill-health

	Response		Date next review due	Comments
	Yes	No		
There are psychological therapies suited to the needs of men in mid-life which can be offered.				
There are measures in place to ensure services are responding to men's needs in a way that helps and engages them. This includes protocols for joint working with primary care, A&E, and the justice system.				
There is a standard procedure in place for men who may be uncomfortable seeking help (i.e. are disengaging) that signposts them to local informal sources of help.				

MANCHESTER 1824
The University of Manchester

HQIP
Healthcare Quality
Improvement Partnership

Safer Services toolkit. Updated: 01/07/2022

Documents / Resources

	manchester NCISH Self-Audit Toolkit [pdf] User Manual NCISH Self-Audit Toolkit, Self-Audit Toolkit, Audit Toolkit

References

- 🌐 **documents.manchester.ac.uk/display.aspx?DocID=37573**
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- Ⓜ **NCISH | Requests for information**
- 🗐 **UK Government Web Archive**
- ◣ **Learning from clinicians' views of good quality practice in mental healthcare services in the context of suicide prevention: a qualitative study**
- ᴮᴹᴶ **Which are the most useful scales for predicting repeat self-harm? A systematic review evaluating**

- risk scales using measures of diagnostic accuracy | BMJ Open
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- NHS England » NHS Long Term Plan
- NHS England » Community mental health services
- NHS England » Full-length NHS Standard Contract 2022/23 (Particulars, Service Conditions, General Conditions)
- Suicide prevention action plan: every life matters - gov.scot
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