Developing a Suicide Prevention Implementation Plan for Older Adults in Kent and Medway

Student Research Internship Project 2014

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Introduction

This document sets out the findings from a ten week student internship project focussing on the development of a suicide prevention implementation plan for older adults in Kent and Medway. The Canterbury Christ Church Student Internship Scheme allows students to work with academic staff on real research projects. Academics can apply for a research intern to work with them on a relevant and clearly defined project, creating capacity to carry out research in areas that are likely to result in tangible outputs. The author of this report is a second year BSc Psychology student at Canterbury Christ Church University who carried out a paid research intern role researching suicide prevention in older adults for the Kent and Medway Suicide Prevention Steering Group over a 10 week period from May to July 2014.

Project Aims

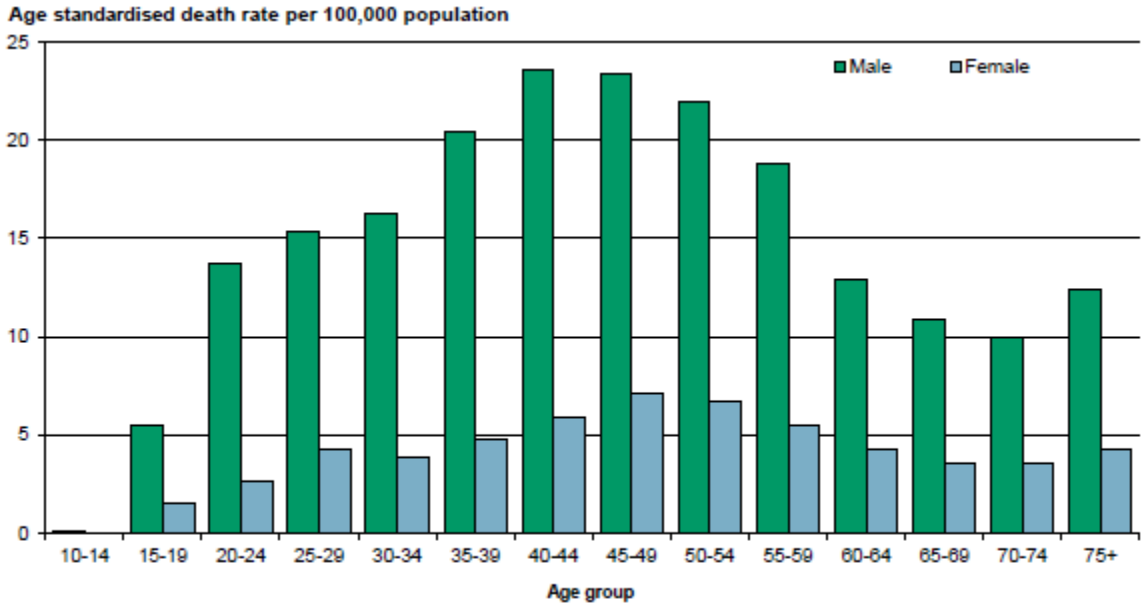
The main aims of the internship project were to:

- Review existing literature around older adults and suicide
- Contact other Suicide Prevention Steering Groups in England to learn about their approaches to preventing suicide in this client group
- Meet with stakeholder groups locally to learn more about existing provisions for older adult suicide prevention in the area
- Work with academic supervisor and Public Health lead to summarise findings from literature review, discussions with Prevention Groups from other areas and local stakeholders
- Operationalize this information into relevant action points for the Kent and Medway Suicide Prevention Group to take forward

Suicide and Older Adults

Suicide nationally

There were 4,513 suicides recorded in England in 2012, with the three-year average rate for 2010-12 being 8.0 suicides per 100,000 general population. The three-year average rate for 2010-12 for males and females was 12.4 and 3.7 per 100,000 population, respectively (ONS, 2014). The figure below shows this data broken down by age group;



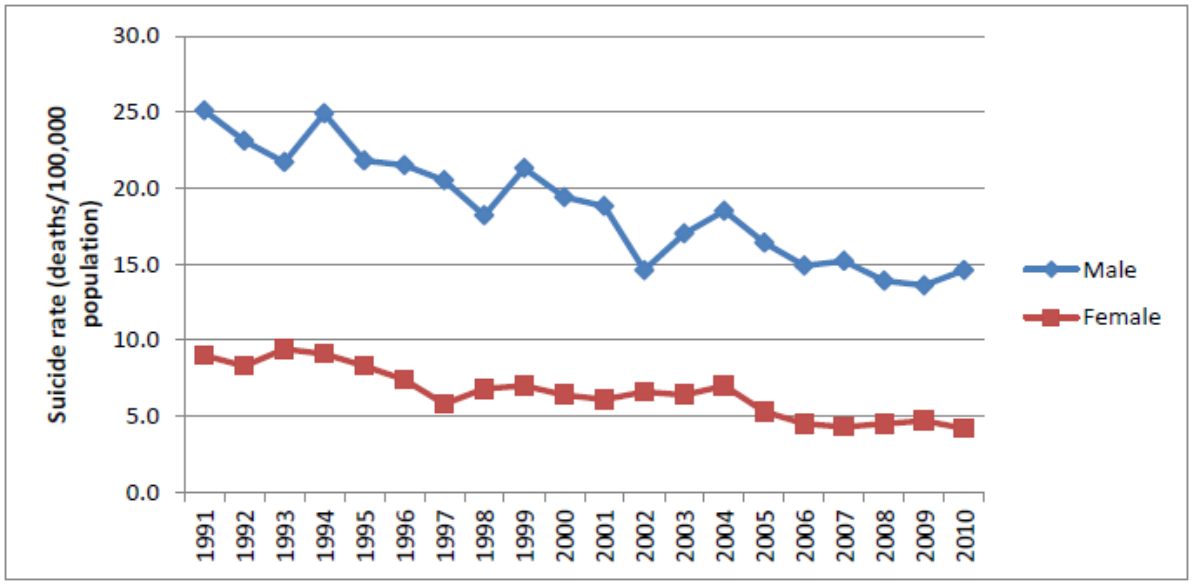
Source: ONS (ICD10 X60-X84, Y10-Y34)

For older adults (65+), the rates (per 100,000) for England for 2012 were;

Age	Overall	Male	Female
65-69	7.1	10.9	3.6
70-74	6.6	10.0	3.6
75-79	6.2	9.7	3.3
80-84	8.1	11.7	5.5
85+	9.0	18.4	4.3

Source: Samaritans Suicide Statistics Report 2014

In terms of trends over time, the figure below gives some indication of rates for older adults (75+) in the UK from 1991-2010:



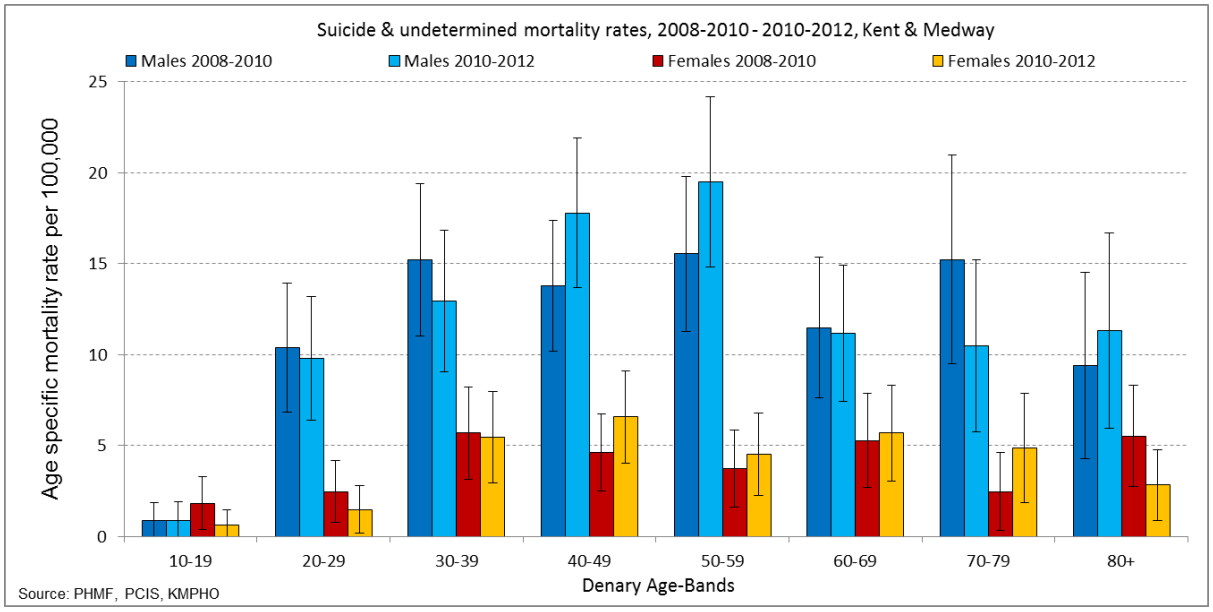
Trend in suicide rate (including undetermined deaths) in the 75+ age group in the United Kingdom

Source: Office for National Statistics (ONS) Public Health Mortality Files / Buckingham (2013)

Suicide in Kent

In Kent for the period 2008-2010 the suicide rate for men was 8.43 per 100,000 people; for women 2.24 per 100,000; and the rate for the population as a whole around 5.24 per 100,000, indicating that the rates of suicide for Kent are slightly lower than the national average (Mookherjee, 2013).

For older adults in Kent the graph below gives some indication of the variation in rates per 100,000 population for different age groups 2008-2010, and 2010-2012.



Literature Relating to Older Adults and Suicide

Overview

Older adults are an especially vulnerable population for many reasons. The increased fatality from suicidal behaviours in older adults could, in part, be due to the greater fragility related to old age (Conwell et al., 1998). Older adults in general tend to have restricted social networks, therefore isolation may act as a big contributory factor which increases the risk of suicide (Turvey et al., 2002). Older adults also tend to be more measured in their suicide attempts which can be seen in their tendency to use more violent methods which are immediately lethal (McIntosh et al., 1994). They are less inclined to show clear warning signs of suicide (Carney et al., 1994), therefore the risk of death is notably higher, and early, aggressive intervention is crucial (Ribeiro et al., 2012). A psychiatric autopsy study conducted by Harwood et al. (2006) in England found that health issues, physical illness, interpersonal problems and bereavement transpired as common factors in suicide completion in older adults. They also found risk factors to revolve around financial difficulties, problems with accommodation, retirement and long-term bereavement issues (Manthorpe & Lliffe, 2011).

The Institute of Medicine suggests that it is possible to think of suicide prevention in terms of Universal, Selective and Indicated measures (Mrazek & Haggerty, 1994). Universal

Prevention targets total populations to reduce cases of suicide using information and skills enhancement. Selective Prevention aims to reduce suicidal risk in groups with raised risk of suicide such as those recently bereaved or those with suicidal traits. Indicated Prevention seeks to reduce risk in individuals with severe suicidal ideation or the survivors of an attempted suicide. It needs to be mentioned that the development of positive aging, coping and resilience are still relatively unexplored areas in suicide prevention and intervention strategies in older adults (Lapierre et al., 2011).

Methodology

Databases searched included: Psycinfo, Medline and Google Scholar.

Primary keywords used in the electronic search were: elderly, suicide, older people.

Additional terms used were; risk factors, prevention, treatment, yale suicidality scale, depression, old age, primary care, family physicians, marital status, interaction effect, bereavement, early-onset depression, inquiry case, late-onset depression, aged, national suicide prevention strategy, attempted suicide, suicidal behaviour, major depression, stress, genetics, epigenetics, suicide ideation, intervention, systematic review, social work, social care, social isolation, alcohol, substance abuse, , injury, fatal, drinking, risk factors.

Inclusion and exclusion criteria: The most current up-to-date literature was used due to the time restraints of this project, covering years 1995 to date. Peer reviewed articles were preferred, but also some 'grey literature' (e.g. Masters projects) was included.

Limitations

This paper represents literature gathered by the author who has interpreted the information relating to suicide prevention in older adults. Due to time restraints, this report cannot be regarded as an all-inclusive search with regards to the literature on this topic. Therefore, it is very possible that relevant data has not been included in this summary report which could result in possible selection bias and the author's interpretation of the evidence covered.

Findings

Having completed a wide literary search and review a thematic analysis was completed and common themes were categorised, found below. A theme matrix is provided in appendix A.

Depression

Depression can be defined as a reduced state of physiological as well as mental functioning which is understood to be associated with feelings of unhappiness (Hayes and Stratton, 2012). Depression is found to play an important role in suicide in older adults. The conclusion therefore, is that the main focus of suicide prevention should be around better detection and treatment and most importantly the correct management of varying mood disorders (Beautrais, 2002). The core focus should be on training for primary, secondary and tertiary caregivers (Beeston, 2006). However, Erlangsen et al., (2011), mention that interventions with a short duration were not seen to have an effect in the prevention of suicide. Innovative strategies should focus on improving resilience and positive ageing (Lapierre et al., 2011), along with early-onset versus late-age onset of depression strategies in coping (Oude Voshaar et al., 2011).

With regards to risk factors for suicide by gender, women are twice as likely as men to meet the criteria for major depression. They are, however, one-fourth less likely than men to commit suicide. Depression in men in later-life is seen as more likely to go unrecognised and therefore, more untreated than in depression in a woman (Szanto, et al., 2001).

Bereavement

Bereavement is the experience of the loss of a relative, friend or acquaintance as a result of their death (Hayes & Stratton, 2012).

There appears to be significant differences between the young, middle aged and older adults. Suicide is typically associated with interpersonal relationships, legal, financial and work related problems in the young and middle aged. In older adults suicide is associated more with physical illness and loss, especially bereavement (Beeston, 2006). In a large study conducted by Guohua (1995) which controlled for behavioural and social variables found

that bereavement was a risk factor for suicide in elderly men only. It also seems that the risk of suicide is as its peak within the first year after bereavement (Guohua, 1995).

Social Isolation

Various types of isolation (geographical and social) appear to be an important factor in increasing suicide risk (Buckingham, 2013).

Using his social intergration theory, the sociologist Emile Durkheim (1951) tried to explain why some countries had higher suicide rates than that of others. He suggested that the total number of suicides can be explained by the degree to which individuals were connected to other people in their society. Therefore, the higher the social integration within a society, the lower the suicide rate. However, Durheim failed to recognise the importance of interactions between environments such as home and life satisfaction. Several studies have compared the risk of suicide within urban and rural areas and there is a general agreement that rural areas have a higher suicide rate. However the greatest risk of suicide has been found of men living in remote rural areas (Singh & Siahpush 2002, Levin & Leyland, 2005, Hirsch, 2006).

Illness

The endurance of physical pain was also seen as putting the individual at risk to suicide ideation / completion. There is a greater risk in individuals with multiple illnesses (Juurlink, et al., 2004).

The decline of physical health has been found to correspond with suicide risk in older adults. In Manchester, in a descriptive study of coroners' records, 65% of suicide victims aged 65 years and over were classed as physically ill, and of these, 23% had been admitted to hospital in the years prior to committing suicide (Cattell & Jolley, 1995). With the use of record linage, many controlled studies have shown significant associations between suicide or suicidal behaviour and varying medical disorders such as congestive heart failure, chronic obstructive pulmonary disease, seizure disorder and urinary incontinence (Juurlink et al., 2004). There appears to be a significant positive correlation between the risk of suicide and the number of illnesses an individual has (Juurlink et al., 2004). Chronic pain has been identified as a recurrent theme in suicides in older adults, however it seems to be a stronger

risk factor in men than in women (Malthorpe & Lliffe, 2010). Perceptions of health and actual health may not always agree, these findings could possibly have influential ramifications on how depressed and anxious patients are managed as well potential prevention strategies (Buckingham, 2013).

Alcohol

The relationship between alcohol use and suicide in older adults is complex and currently vague. Many of the older adults who have alcohol related issues do not meet the alcohol/dependence stipulated standards, therefore the role of this at-risk use of alcohol in older adult suicide could be underrated (Blow et al., 2004).

However, in a population study in USA it was found that drinking increased the risk of suicide in women more than in men, and that a history of drinking in this population was related with an increased risk of fatal injury as a result of a fall, motor vehicle accidents and suicide (Sorock et al., 2007). However, it has been found that in general men who are depressed tend to have a higher prevalence of alcohol and substance abuse than women (Szanto et al., 2001).

Research in Western Australia indicated that the use of alcohol may be predictive of suicidal behaviour in older adults. Furthermore, since this drinking conduct distinctively predicts the risk of suicide, it is possible that standard risk assessment tools are affected by alcohol use in a way that they may operate in a different way to those in alcohol-using populations. However, it seems that no studies have examined if the existing suicide risk assessment screening measures work comparably in those who partake in risky drinking versus those who do not. Furthermore, existing literature around the relationship between alcohol and late-life suicide is sparse (Ribeiro et al., 2012).

The Individual and the Media

Individuals coping strategies needs to be considered and the media have a powerful influence in enlightening the general population about suicide and the prevention thereof. The way a story is reported in the media plays a big role in influencing the public's understanding about who is at risk, warning signs, causes of suicide, behaviours and treatment. They also play a huge role in affecting the wider perception about suicide in the

older adults. The media needs to be aware of how their message is coming across to the public (Beeston, 2006).

Education/Training

It comes across clearly that education and training for GP's and those in various care roles focusing on recognition and screening of depression is something that needs to be done in order to change suicide rates. Buckingham (2013) reports that clear communication between the health service, councils and voluntary groups should take place.

Studies report that almost 50% of those who completed suicide aged 60 and older had visited their GP in the month of their death, 26% had visited their GP in the week before death, and 7% within 1 day before death. However, over half of these consultations were mainly for physical complaints (Szanto etc al., 2001).

With this in mind, physicians, nurses and other health care professionals should be vigilant to the possible threat of suicide in those with chronic illness, especially in those with multiple illnesses. In a study conducted in Canada, the 5 most common diagnoses listed in the week before suicide were; anxiety, unspecified gastrointestinal symptoms, depression, unspecified cardiac symptoms and hypertension (Juurlink et al., 2004).

De Leo et al. (2001) recommended that educational programmes around suicide prevention and training for primary care should consider the importance of:

- Improving incorrect myths which develop around suicidal behaviours
- Supply information about risk factors
- Supply training on how to recognise signs showing suicidal
- Demonstrate local resources to contact when necessary and
- Expand understanding and knowledge on types of self-destructive behaviour

The Approach of Other Suicide Prevention Steering Groups to preventing Suicide in Older Adults

Cornwall and the Isles of Scilly:

The suicide prevention lead for Public Health in Cornwall and Isles of Scilly, Sara Roberts, advised that the suicide rate among older adults in Cornwall is consistently higher than the average and that they recently supported a Masters student, Sarah Buckingham, to research this in more detail. The completed report is attached as appendix C.

Social isolation in older adults is an issue in Cornwall and Isles of Scilly. An email between Sara Roberts, the prevention lead for Public Health in Cornwall and Isles of Scilly, and myself states:

"Lack of social connections is an issue of interest - we are a sparsely populated rural county. We have tried to raise awareness of the risk e.g. through a suicide prevention newsletter for GPs with a focus on older people. There are elements of our strategy that are not specific to older people but that we hope will also reach older people, e.g. ASIST training for around 200 people each year and a suicide liaison service to support people bereaved by suicide".

NHS Scotland:

Correspondence between Alana Atkinson – Programme Manager: Suicide Prevention National Programme NHS Health Scotland and myself:

"I have had a look at what local areas provide in Scotland and there is nothing specific to older adults specifically. Nationally we do not have any specific work, either. Here adult approaches include all ages or are targeted at young people or people aged between 30 and 55, our most at risk populations.

In Scotland we are thinking more about the gender differences and how we may need to change our approaches for men and women. This work is in its early stages.

Work has been done in some other countries. Here is the information we have from a piece of work we did to inform our Suicide prevention in Rural Areas Guide 2011:

Educating rural communities in Japan about depression and reducing stigma amongst elderly populations

Location: Japan

Reference: Sakamoto S et al (2004). Where is help sought for depression or suicidal ideation in an elderly population living in a rural area of Japan? *Psychiatry and clinical Neurosciences.* 58:522–530.

The evaluation found that this intervention served to increase contact between suicidal elderly individuals and health providers in rural areas and reduced overall rates of suicide

mortality.

Tele-Help and Tele-Check service for elderly patients discharged from hospital

Location: Italy

Reference: De Leo D et al (2002). Suicide among the elderly: the long term impact of a telephone support and assessment intervention in northern Italy. *British Journal of Psychiatry.* 181:226–229.

12-week depression treatment using pharmacotherapy

Location: US

Reference: Szanto K et al (2003). Occurrence and course of suicidality during short-term treatment of late-life depression. *Archives of General Psychiatry.*

60:610–617.

After 12 weeks of pharmacotherapy treatment, suicidal ideation had resolved in all treated elderly people. Patients with higher suicide risk needed longer time to respond to treatment (6 weeks) compared with low-suicide risk elders (3 weeks)".

Northumberland, Tyne & Wear NHS Foundation Trust

Jean Robinson, registered psychiatric nurse from the Self Harm and Liaison Team Northumberland wrote;

"Interestingly, in recent years we ourselves raised the issue about lack of clearly defined care pathways for elderly people coming through accident and emergency departments after self harm/overdose. We found that despite this being a high risk group there was no

clear care pathway at that time. We moved to establish these locally with A&E medical staff and community older person's mental health teams. We also included the issue as part of our training on risk assessment which we deliver regularly to the junior medical staff in the general hospital."

This issue was discussed at the Kent and Medway Suicide Prevention Steering Group (09/2014) and it was confirmed that since the beginning of 2013 care pathways for older adults presenting in A&E following self-harm/ overdose have been in place through the KMPT Liaison Psychiatry Service.

Department of Health:

Correspondence between Mary Heaton- Ministerial Correspondence and Public Enquiries, Department of Health and myself:

"Dear Ms Flux,

Thank you for your email of 11 June about suicide prevention. I have been asked to reply.

As you may be aware, the Department of Health's suicide prevention strategy, 'Preventing suicide in England: A cross-government outcomes strategy to save lives', was published on 10 September 2012 to coincide with the International Association for Suicide Prevention's World Suicide Prevention Day. The strategy highlights the importance of targeting people most at risk by providing the right interventions at the right time. The strategy is available on the Government's information and advice website by clicking on the following link:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216928/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf .

The strategy recognises that older men (over 75) have higher rates of death by suicide, which may reflect the impact of depression, social isolation, bereavement or physical illness. Untreated depression is seen as a key issue overall, and for older people in particular. More information on this is available in the section on people with untreated depression, which makes links to the 'Campaign to End Loneliness'.

As part of the Government's plans to improve the public health system, policy responsibility for public health issues, including weight management programmes, was transferred to Public Health England (PHE), an executive agency of the Department of Health, on 1 April 2013. Therefore, you may wish to contact PHE directly, as it may be able to help with other examples. PHE's contact details are:

Public Health England
5th Floor
Wellington House
133-155 Waterloo Road
London SE1 8UG

Tel: 020 7654 8000
Email: pqs@phe.gov.uk

More generally, over the past ten years, good progress has been made in reducing the suicide rate in England and there have been substantial improvements in inpatient services. The most recent National Confidential Inquiry into Suicide and Homicide, which took place in July 2013, shows that the long-term downward trend in patient suicides continues. Since 2000, there has been a 62 per cent fall in the number of inpatients dying by suicide.

Although good progress has been made, ministers are aware that it is important to be vigilant. Around 4,500 people took their own life in 2011 so suicide continues to be a major public health issue, particularly at a time of economic and employment uncertainty. Effective suicide prevention needs a co-ordinated approach with input from a wide range of partner organisations and sectors.

The Department published the first annual report of the suicide prevention strategy for England on 17 January. It summarises the national developments that have taken place for the suicide prevention strategy. It identifies important research studies and their findings, and is accompanied by a report of statistical information on suicides. The report also sets out the actions that local areas can take to prevent suicides, and highlights the importance of responsive and high quality care for people who self-harm. The annual report can also be

accessed on the Government's information and advice website by clicking on the following link:

https://www.gov.uk/government/publications/suicide-prevention-report .

The annual report was prepared with the help of leading experts in the field of suicide prevention, including the members of the National Suicide Prevention Strategy Advisory Group. There is also a joint statement on sharing information appropriately, within the legal framework, to help prevent suicide. This was developed with the Royal Colleges and other professional organisations.

You should note that the majority of suicides continue to occur in adult males under 50 years of age. The biggest difference is in the 30 to 39 year old age group, in which there are more than four male suicides for each female suicide. The highest rate of suicide for men is in the 40 to 49 year age range, although young men under 35 continue to be one of the high risk groups.

I hope this reply is helpful.

Yours sincerely,

Mary Heaton
Ministerial Correspondence and Public Enquiries
Department of Health
26 June 2014"

Consultations with Stakeholder Groups to Learn More about Existing Provisions for Older Adult Suicide Prevention in the Area

It is important to study suicide at a regional as well as national and international level in order to identify relevant local issues and information, and to be able to develop specific, targeted interventions. To this end a number of local stakeholders were contacted to provide information for the project.

Kent Police have recently completed a suicide prevention strategy, comprising a strategy statement, objectives, outcomes and delivery mechanism.

Kent Police Suicide Prevention Strategy.d

Although not geared towards any group specifically, older adults would fall under its remit.

In conversations held with the outreach officer for **Canterbury Samaritans**, as well as with the founder of **Maytree** Suicidal Sanctuary in London, it was apparent that bereavement is seen as an important issue in relation to suicide and older adults, and that bereavement was not just that of a human but could also be that of a well-loved pet and companion to an older adult. Bereavement has a wider effect to the feeling of a sense of loss of control as well as loneliness.

Recommendations

The World Health Organisation (2012) recommends that the development of a suicide prevention strategy should involve the following steps;

1. Identify stakeholders
2. Undertake a situation analysis
3. Assess the requirement and availability of resources

1. Stakeholders

During the course of the project many stakeholders were identified (a list of contacts is provided in appendix B). Given the complexity and the geographical and demographic spread of the issue, though, there will always be a sense that more groups and organisations could be involved. Identifying relevant stakeholders could be considered an ongoing project.

2. Local Situation Analysis

It would be useful to have access to the most up-to-date information with regard to older adults and suicide in the region. The collation of timely information on suicide methods and locations could aid in the development of local preventive strategies with the potential to reduce suicides in this group. It may also help in understanding the risk factors for suicide and sources of stress of this client group within Kent and Medway.

There are issues to contend with in terms of gathering this information (such as delays in coroners' proceedings and the issuing of a suicide verdict; concerns around confidentiality) but steps could possibly be taken to improve the situation. Network Rail, local CCG's, the Coroner's Office, Kent Police and local NHS Trusts might be able to feedback information to the Steering Group which would prove to be useful.

3. The Requirement and Availability of Resources

Existing Initiatives and Preventive Strategies

- **Voluntary groups, charities and counselling services:**
  - Cruse, www.crusebereavementcare.org.uk
  - Age UK, http://www.ageuk.org.uk/

- Helpline Support:
  - The Silver Line: tel: 0800 4 70 80 90. Web: http://www.thesilverline.org.uk/
  - Samaritans, tel: 08457 90 90 90. Web: http://www.samaritans.org/ email support: jo@samaritans.org

- **Support for those bereaved by suicide**
  - Help is at Hand http://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf
  - The Road Ahead… A guide to dealing with the impact of suicide, published by Mental Health Matters. www.mentalhealthmatters.com
  - Healthtalkonline, a website where people can share experiences of ill health and bereavement, including bereavement by suicide. www.healthtalkonline.org
  - Cruse Bereavement Care. www.crusebereavementcare.org.uk
  - Survivors of Bereavement by Suicide, a self-help organisation to meet the needs and break the isolation of those bereaved by the suicide of a close relative or friend. www.uk-sobs.org.uk/

- **Training of healthcare staff**

  A training programme for statutory and non-statutory staff in suicide prevention is being developed through Public Health within the region. KMPT runs its own risk assessment and management training for staff.

- **Media reporting**

  Improved reporting in the media has been identified as an important measure in reducing suicides – 'The media have a significant influence on behaviour and attitudes. There is already compelling evidence that media reporting and portrayals of suicide can lead to copycat behaviour, especially among young people and those already at risk' (DoH, 2012, p43).

  The Editors' Code of Practice: http://www.pcc.org.uk/cop/practice.html

Samaritans Media guidelines for the reporting of suicide:
http://www.samaritans.org/media-centre/media-guidelines-reporting-suicide

- **KCC 10 Point Plan for Wellbeing (see appendix D)**

Possible Future Prevention Strategies for Older People in Kent

The research conducted by Buckingham (2013) into suicide in older adults in Cornwall and Isles of Scilly concluded that preventative measures could 'include reducing access to means (in particular for jumping incidents), earlier detection of depression in the physically ill, bereavement counselling, more social groups and support groups in rural areas, helping people to retain their independence, and a change in societal attitudes towards elderly people' (Buckingham, 2013, p. iv). It would certainly be worth considering the relevance of these to the Kent & Medway area.

Other areas to explore could include;

- **Training**

To include information on risk factors for older adults and suicide in prevention training for GP's; for older adults mental health services (KMPT); for Age UK staff (possibly in conjunction with Samaritans outreach service).

Canterbury Samaritans and Age UK:

The Outreach Team at Canterbury Samaritans have had several meetings with Age UK staff and have arranged two sessions of listening skills training for volunteers and staff to help them recognise and deal with suicidal thoughts and intentions in their client group. These are to be held in the autumn of 2014 and both sessions are fully subscribed, twelve people on each session.

- **Further dissemination of information about helplines and relevant charities in the area**

Discussions with Samaritans' branches as to the feasibility of disseminating more 'age relevant' materials for older people are ongoing. It would be worth exploring further

collaboration between the Samaritans and Age UK in terms of displaying Samaritan's material in their premises.

- **Improved data gathering**

A representative from the coroner's office has been invited to attend the steering group. Their input into a discussion on improving our data gathering would be helpful.

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Appendix A - Literature Review Theme Matrix

DEPRESSION (MOOD DISORDERS/MENTAIL ILLNESS/ANXIETY)					
Appleby, L. et al (University of Manchester)	2014	UK	Suicide in primary care in England	Confidential Inquiry	Study shows the value of CPRD database in investigating factors associated with suicide in patients in primary care.
Beautrais, A.L.	2002	New Zealand	A case control study of suicide and attempted suicide in older adults	Case Control Study	53 adults aged 55 and older who died by suicide versus 269 randomly selected subjects. Findings where that the improved detection, treatement and management of mood disorders should be primary focus of suicide prevention stategies in older adults.
Beeston, D. (Staffordshire University)	2006	UK	Older People and Suicide	Discussion paper	Complex social psychological, biological and spiritual processes. Evidence based discussion to assist health and social care providers and policy makers to engage in primary secondary and tertiary interventions in response to risky suicidal behaviour.
Blow, F.C., Brockmann, L.M., and Barry, K.L.	2004	USA	Role of Alcohol in Late-Life Suicide		The relationship between alcohol use and later-life suicide is complex and currently ill-defined. Majority of older adults who are experiencing problems related to their alcohol use do not meet alcohol/dependence criteria. Therefore the role of at-risk and problem alsochol use in geriatric suicide may be underestimated.

Buckingham, S.A.	2013	UK (Cornwall)	Suicide in adults aged 75 and over in Cornwall: An epidemiological and case study analysis	Masters Thesis	Preventive measure for 75 and over in Cornwall are likely to include reducing access to means or high-risk locations, early detection and treatment of depression, more accessible bereavement counselling, more social and support groups in local areas in order to assist elderly to retain their independence in old age as well as clear communication between health service, councils and voluntary groups
Erlangsen, A et al (Consensus opinions of an expert panel)	2011	UK	Key considerations for preventing suicide in older adults	Consensus Opinions of an expert panel	Set of key considerations is divided into Universal, selective and indicated prevention as well as a section on general considerations. This paper spans a wide range of suggestions and a large scal public health care planning.
Fountoulakis, K.N., Gonda, X., and Rihmer, Z.	2011	Greece	Suicide Prevention programs through community intervention	Review	Very short duration interventions do not seem to have even a slight effect.
Juurlink, D.N., Herrmann, N., Szalai, J.P., Kopp, A., and Redelmeier, D.A.	2004	Canada	Mental illness and the risk of suicide in the elderly	Population Study	Greater risk in individuals with multiple illnesses.
Lapierre, S., Erlangsen, A., Waern, M., De Leo, D., Oyama, H., Scocco, P., Gallo, J., Szanto, K., Conwell, Y., Draper., Quinnett, P., and the International Research Group for Suicide among the Elderly.	2011	USA	A Systematic Review of Elderly Suicide Prevention Programs	Review	Examin results of interventions aimed at suicidal elderly persons and to identify successful strategies and areas needing further exploration. Innovative strategies should improve resilience and positive aging.

Mann, J.J., and Currier, D.M.	2010	USA	Stress, genetics and epigenetic effects on the neurobiology of suicidal behaviour and depression	Review	Alterations in neurobiological systems associated with suicide. Early-life experiences and genetic differences equates to genetic vulnerability.
Manthorpe, J., and Lliffe, S.	2011	UK	Social Work with Older People - Reducing Suicide Risk: A Critical Review of Practice and Prevention	Critical Interpreteti ve Synthesis Review	Discuss three issues: 1) scarcity of research that takes a wide approach to prevention in later life, 2) dearth of evidence regards social work contribution and 3) absence of reference to social work practice in national guidelines for later life.
Oude Voshaar, R.C., Kapur, N., Bickley, H., Williams, A., and Purandare, N.	2011	UK	Suicide in later life: A comparison between cases with early-onset and late-onset depression	Clinical Survey	Early-onset versus late age onset of depression. Support strategies in coping.
Pearson, J.L., and Brown, G.K.	2000	USA	Suicide prevention in late life: Directions for science and practice		Best approach is detecting and treating late-life depression.
Ribeiro, J.D., Braithrwaite, S.R., Pfaff, J.J., and Joiner, T.E.	2012	Weste rn Austra lia	Examining a Breif Suicide Screening Tool in Older Adults Engaging in Risky Alcohol Use	Structural equation modeling examinatio n	Support the viability of the DSI-SS as suicide screeing tool for older adults.
Stoppe, G., Sandholzer, H., Huppertz, Cl, Duwe, H., and Staedt J.	1999	Germa ny	Family physicians and the risk of suicide in the depressed elderly	Representa tive Survey	Education of GP's and those in care roles around recognition and screening of depression as well as in the management as well in order to change suicide rates.

Szanto, K., Prigerson, H.G., and Reynolds III, C.F.	2001	USA	Suicide in the elderly		Aim of this study is to determine if the improved detection of depression, compliance and pharmacotherapy will reduce depressive symptoms
The Scottish Government	2013	UK	Suicide Prevention Strategy 2013 - 2016	Prevention Strategy	Various commitments put into place for Scotland

EDUCATION/TRAINING (GP/PRIMARY CARE/COMMUNITIES/AFTERCARE)					
Appleby, L. et al (University of Manchester)	2014	UK	Suicide in primary care in England	Confidential Inquiry	Study shows the value of CPRD database in investigating factors associated with suicide in patients in primary care.
Erlangsen, A et al (Consensus opinions of an expert panel)	2011	UK	Key considerations for preventing suicide in older adults	Consensus Opinions of an expert panel	Set of key considerations is divided into Universal, selective and indicated prevention as well as a section on general considerations. This paper spans a wide range of suggestions and a large scal public health care planning.
Manthorpe, J., and Lliffe, S.	2011	UK	Social Work with Older People - Reducing Suicide Risk: A Critical Review of Practice and Prevention	Critical Interpretetive Synthesis Review	Discuss three issues: 1) scarcity of research that takes a wide approach to prevention in later life, 2) dearth of evidence regards social work contribution and 3) absence of reference to social work practice in national guidelines for later life.
Pearson, J.L., and Brown, G.K.	2000	USA	Suicide prevention in late life: Directions for science and practice		Best approach is detecting and treating late-life depression.
Ribeiro, J.D., Braithrwaite, S.R., Pfaff, J.J., and Joiner, T.E.	2012	Western Australia	Examining a Breif Suicide Screening Tool in Older Adults Engaging in Risky Alcohol Use	Structural equation modeling examination	Support the viability of the DSI-SS as suicide screeing tool for older adults.

Stoppe, G., Sandholzer, H., Huppertz, Cl, Duwe, H., and Staedt J.	1999	Germany	Family physicians and the risk of suicide in the depressed elderly	Representative Survey	Education of GP's and those in care roles around recognition and screening of depression as well as in the management as well in order to change suicide rates.
The Scottish Government	2013	UK	Suicide Prevention Strategy 2013 – 2016	Prevention Strategy	Various commitments put into place for Scotland

MEDIA					
Beeston, D. (Staffordshire University)	2006	UK	Older People and Suicide	Discussion paper	Complex social psychological, biological and spiritual processes. Evidence based discussion to assist health and social care providers and policy makers to engage in primary secondary and tertiary interventions in response to risky suicidal behaviour.
Erlangsen, A et al (Consensus opinions of an expert panel)	2011	UK	Key considerations for preventing suicide in older adults	Consensus Opinions of an expert panel	Set of key considerations is divided into Universal, selective and indicated prevention as well as a section on general considerations. This paper spans a wide range of suggestions and a large scal public health care planning.

ALCOHOL / SUBSTANCE ABUSE					
Beeston, D. (Staffordshire University)	2006	UK	Older People and Suicide	Discussio n paper	Complex social psychological, biological and spiritual processes. Evidence based discussion to assist health and social care providers and policy makers to engage in primary secondary and tertiary interventions in response to risky suicidal behaviour.
Blow, F.C., Brockmann, L.M., and Barry, K.L.	2004	USA	Role of Alcohol in Late-Life Suicide		The relationship between alcohol use and later-life suicide is complex and currently ill-defined. Majority of older adults who are experiencing problems related to their alcohol use do not meet alcohol/dependence criteria. Therefore the role of at-risk and problem alsochol use in geriatric suicide may be underestimated.
Erlangsen, A et al (Consensus opinions of an expert panel)	2011	UK	Key consideration s for preventing suicide in older adults	Consensu s Opinions of an expert panel	Set of key considerations is divided into Universal, selective and indicated prevention as well as a section on general considerations. This paper spans a wide range of suggestions and a large scal public health care planning.
Fountoulakis, K.N., Gonda, X., and Rihmer, Z.	2011	Gree ce	Suicide Prevention programs through community intervention	Review	Very short duration interventions do not seem to have even a slight effect.
Lapierre, S., Erlangsen, A., Waern, M., De Leo, D., Oyama, H., Scocco, P., Gallo, J., Szanto, K., Conwell, Y., Draper., Quinnett, P., and the International Research Group for Suicide	2011	USA	A Systematic Review of Elderly Suicide Prevention Programs	Review	Examin results of interventions aimed at suicidal elderly persons and to identify successful strategies and areas needing further exploration. Innovative strategies should improve resilience and

among the Elderly.					positive aging.
Ribeiro, J.D., Braithrwaite, S.R., Pfaff, J.J., and Joiner, T.E.	2012	Western Australia	Examining a Breif Suicide Screening Tool in Older Adults Engaging in Risky Alcohol Use	Structural equation modeling examination	Support the viability of the DSI-SS as suicide screeing tool for older adults.
Sorock, G.S., Chen, L., Gonzalo, S.R., and Baker, S.P.	2007	USA	Alcohol-drinking history and fatal injury in older adults	Population Based Study	Drinking increased the risk of suicide more for women than men. A drinking history in older adults is associated about equally with an increased risk of fatal injury from falls, motor crashes and suicides.
Szanto, K., Prigerson, H.G., and Reynolds III, C.F.	2001	USA	Suicide in the elderly		Aim of this study is to determine if the improved detection of depression, compliance and pharmacotherapy will reduce depressive symptoms

BEREAVEMENT (GRIEF/RELATIONSHIP ISSUES/LOSS OF PET/WIDOWED/DIVORCED)					
Beautrais, A.L.	2002	New Zealand	A case control study of suicide and attempted suicide in older adults	Case Control Study	53 adults aged 55 and older who died by suicide versus 269 randomly selected subjects. Findings where that the improved detection, treatement and management of mood disorders should be primary focus of suicide prevention stategies in older adults.
Beeston, D. (Staffordshire University)	2006	UK	Older People and Suicide	Discussion paper	Complex social psychological, biological and spiritual processes. Evidence based discussion to assist health and social care providers and policy makers to engage in primary secondary and tertiary interventions in response to risky suicidal behaviour.
Blow, F.C., Brockmann, L.M., and Barry, K.L.	2004	USA	Role of Alcohol in Late-Life Suicide		The relationship between alcohol use and later-life suicide is complex and currently ill-defined. Majority of older adults who are experiencing problems related to their alcohol use do not meet alcohol/dependence criteria. Therefore the role of at-risk and problem alsochol use in geriatric suicide may be underestimated.

Buckingham, S.A.	2013	UK (Cornwall)	Suicide in adults aged 75 and over in Cornwall: An epidemiological and case study analysis	Masters Thesis	Preventive measure for 75 and over in Cornwall are likely to include reducing access to means or high-risk locations, early detection and treatment of depression, more accessible bereavement counselling, more social and support groups in local areas in order to assist elderly to retain their independence in old age as well as clear communication between health service, councils and voluntary groups
Erlangsen, A et al (Consensus opinions of an expert panel)	2011	UK	Key considerations for preventing suicide in older adults	Consensus Opinions of an expert panel	Set of key considerations is divided into Universal, selective and indicated prevention as well as a section on general considerations. This paper spans a wide range of suggestions and a large scal public health care planning.
Juurlink, D.N., Herrmann, N., Szalai, J.P., Kopp, A., and Redelmeier, D.A.	2004	Canada	Mental illness and the risk of suicide in the elderly	Population Study	Greater risk in individuals with multiple illnesses.
Manthorpe, J., and Lliffe, S.	2011	UK	Social Work with Older People - Reducing Suicide Risk: A Critical Review of Practice and Prevention	Critical Interpretetive Synthesis Review	Discuss three issues: 1) scarcity of research that takes a wide approach to prevention in later life, 2) dearth of evidence regards social work contribution and 3) absence of reference to social work practice in national guidelines for later life.

Pearson, J.L., and Brown, G.K.	2000	USA	Suicide prevention in late life: Directions for science and practice		Best approach is detecting and treating late-life depression.
Szanto, K., Prigerson, H.G., and Reynolds III, C.F.	2001	USA	Suicide in the elderly		Aim of this study is to determine if the improved detection of depression, compliance and pharmacotherapy will reduce depressive symptoms
World Health Organisation	2012	UK	Public Health action for the prevention of suicide	Seminal Document	This document emphasises the need for intersectoral collaoration, multidisciplinary appreaoch and the continued evaluation and review of suicide prevention. Also identifies key elements as a means to increase effectiveness of suicide prevention strategies.

SOCIAL ISOLATION (LOSS OF SOCIAL SUPPORT/BURDEN/LOSS OF CONTROL/SOCIAL EXCLUSION)					
Beautrais, A.L.	2002	New Zealand	A case control study of suicide and attempted suicide in older adults	Case Control Study	53 adults aged 55 and older who died by suicide versus 269 randomly selected subjects. Findings where that the improved detection, treatement and management of mood disorders should be primary focus of suicide prevention stategies in older adults.
Beeston, D. (Staffordshire University)	2006	UK	Older People and Suicide	Discussion paper	Complex social psychological, biological and spiritual processes. Evidence based discussion to assist health and social care providers and policy makers to engage in primary secondary and tertiary interventions in response to risky suicidal behaviour.
Blow, F.C., Brockmann, L.M., and Barry, K.L.	2004	USA	Role of Alcohol in Late-Life Suicide		The relationship between alcohol use and later-life suicide is complex and currently ill-defined. Majority of older adults who are experiencing problems related to their alcohol use do not meet alcohol/dependence criteria. Therefore the role of at-risk and problem alsochol use in geriatric suicide may be underestimated.
Buckingham, S.A.	2013	UK (Cornwall)	Suicide in adults aged 75 and over in Cornwall: An epidemiological and case study analysis	Masters Thesis	Preventive measure for 75 and over in Cornwall are likely to include reducing access to means or high-risk locations, early detection and treatment of depression, more accessible bereavement counselling, more social and support groups in local areas in order to assist elderly to retain their independence in old

					age as well as clear communication between health service, councils and voluntary groups
Juurlink, D.N., Herrmann, N., Szalai, J.P., Kopp, A., and Redelmeier, D.A.	2004	Canada	Mental illness and the risk of suicide in the elderly	Population Study	Greater risk in individuals with multiple illnesses.
Manthorpe, J., and Lliffe, S.	2011	UK	Social Work with Older People - Reducing Suicide Risk: A Critical Review of Practice and Prevention	Critical Interpretetive Synthesis Review	Discuss three issues: 1) scarcity of research that takes a wide approach to prevention in later life, 2) dearth of evidence regards social work contribution and 3) absence of reference to social work practice in national guidelines for later life.
Szanto, K., Prigerson, H.G., and Reynolds III, C.F.	2001	USA	Suicide in the elderly		Aim of this study is to determine if the improved detection of depression, compliance and pharmacotherapy will reduce depressive symptoms
World Health Organisation	2012	UK	Public Health action for the prevention of suicide	Seminal Document	This document emphasises the need for intersectoral collaoration, multidisciplinary appreaoch and the continued evaluation and review of suicide prevention. Also identifies key elements as a means to increase effectiveness of suicide prevention strategies.

ILLNESS (PAIN/PHYSICAL)					
Beeston, D. (Staffordshire University)	2006	UK	Older People and Suicide	Discussion paper	Complex social psychological, biological and spiritual processes. Evidence based discussion to assist health and social care providers and policy makers to engage in primary secondary and tertiary interventions in response to risky suicidal behaviour.
Buckingham, S.A.	2013	UK (Cornwall)	Suicide in adults aged 75 and over in Cornwall: An epidemiological and case study analysis	Masters Thesis	Preventive measure for 75 and over in Cornwall are likely to include reducing access to means or high-risk locations, early detection and treatment of depression, more accessible bereavement counselling, more social and support groups in local areas in order to assist elderly to retain their independence in old age as well as clear communication between health service, councils and voluntary groups
Erlangsen, A et al (Consensus opinions of an expert panel)	2011	UK	Key considerations for preventing suicide in older adults	Consensus Opinions of an expert panel	Set of key considerations is divided into Universal, selective and indicated prevention as well as a section on general considerations. This paper spans a wide range of suggestions and a large scal public health care planning.

Lapierre, S., Erlangsen, A., Waern, M., De Leo, D., Oyama, H., Scocco, P., Gallo, J., Szanto, K., Conwell, Y., Draper., Quinnett, P., and the International Research Group for Suicide among the Elderly.	2011	USA	A Systematic Review of Elderly Suicide Prevention Programs	Review	Examin results of interventions aimed at suicidal elderly persons and to identify successful strategies and areas needing further exploration. Innovative strategies should improve resilience and positive aging.
Manthorpe, J., and Lliffe, S.	2011	UK	Social Work with Older People - Reducing Suicide Risk: A Critical Review of Practice and Prevention	Critical Interpretetive Synthesis Review	Discuss three issues: 1) scarcity of research that takes a wide approach to prevention in later life, 2) dearth of evidence regards social work contribution and 3) absence of reference to social work practice in national guidelines for later life.
Pearson, J.L., and Brown, G.K.	2000	USA	Suicide prevention in late life: Directions for science and practice		Best approach is detecting and treating late-life depression.
Szanto, K., Prigerson, H.G., and Reynolds III, C.F.	2001	USA	Suicide in the elderly		Aim of this study is to determine if the improved detection of depression, compliance and pharmacotherapy will reduce depressive symptoms
The Scottish Government	2013	UK	Suicide Prevention Strategy 2013 - 2016	Prevention Strategy	Various commitments put into place for Scotland

World Health Organisation	2012	UK	Public Health action for the prevention of suicide	Seminal Document	This document emphasises the need for intersectoral collaoration, multidisciplinary appreaoch and the continued evaluation and review of suicide prevention. Also identifies key elements as a means to increase effectiveness of suicide prevention strategies.

Appendix B - Contacts List

CONTACTS						
Organisation Name	**Address**	**Contact No**	**Email**	**Contact Name**	**Title**	**Comments**
Age UK		01227 4263 680		Neil Brown		
Cambridgeshire Constabulary / Cambridgeshire County Council		01223 706 392	kathy.hartley@cambridgeshire.gov.uk	Dr Katharine Hartley	SpR Public Health	Forwarded from Amanda Smith, Crime Business area co-ordinator, Investigating Directorate, Cambridgeshire Constabulary, amanda.smith@cambs.pnn.police.uk. Cambridgeshire and Peterborough have a joint suicide prevention strategy.
Cornwall Council – Adult Care, Health and Well-Being	Cornwall Council, Country Hall, Treyew Road, Truro, TR1 3AY	0300 1234 131.	Sara.Roberts@Cornwall.NHS.UK	Sara Roberts	Suicide prevention lead for Public Health in Cornwall and Isles of Scilly.	Sent Masters Document
Healthcare Quality Improvement Partnership	HQIP, 6th Floor, Tenter House, 45 Moorfields, London, EC2Y 9AE		kirsten.windfuhr@manchester.ac.uk	Dr Kirsten Windfuhr	National Clinical Audit & Patient Outcome Programme	Kirsten is commissioned by HQIP to take care of this programme for them. She will get back to me
Kent County Council	Kent County Council, 3rd Floor Brenchley House, 123-125 Week Street, Maidstone,	0300 333 5685	Yvonne.Phillips@kent.gove.uk	Yvonne Phillips	Safeguarding Adults Quality Assurance & Policy Standard Officer, Adult	Put on agenda for next co-ordinators meeting - July (as busy with Audit at the moment)

	Kent, ME14 1RF				Safeguarding Unit, Social Care, Health & Wellbeing	
KCC Coroner Service			Debbie.large@kent.gov.uk	Debbie Large		
Kent Policed		01622 653 262	jane.hurn@kent.pnn.police	Jane Hurn	PSE, Mental Health Project Team	Suicide Strategy will be posted on the Kent Police Website in the next few weeks.
MayTree Sanctuary for the Suicidal	72 Moray Road, Finsbury Park, London, N4 3LG	0207 263 7070	maytree@maytree.org.uk	Anja Murphy	Operation Coordinator	Do not focus on age differences, although focused approach taken per individual - would like to be kept informed on any developments.
NHS Health Scotland	National Programme for Suicide Prevention, NHS Health Scotland	0131 314 5379	darrenrocks@nhs.net	Darren Rocks	Senior Health Improvement Programme Officer	Focused on Age/Gender. Men 35-54 and deprived areas (most risk). Happy to discuss further)
ReThink Mental Illness		01622 230 718	Roland.Taberer@rethink.org	Roland Taberer		
Samaritans Canterbury Outreach officer	Private	01227 451692	glenislambert@innt.net	Christine		
Scottish Council	NHS Scotland, 2nd Floor, Gyle Square, 1 South Gyle Crescent, Edingurgh,	0131 314 5378	Alana.atkinson@nhs.net	Alana Atkinson	Programme Manager - Suicide Prevention National Programme NHS Health	Nothing specific to older adults. Approach includes all ages and targeted at young people or ages 30 - 55 - most at risk populations. Focused on more gender differences and need to perhaps

	EH12 9EB				Scotland	change approaches for men / women (early stages).
The Alliance of Suicide Prevention Charities	Private	0207 435 1838/ 07809 679 260	Paddybazeley@btinternet.com	Paddy Bazeley	Retired - worked for Samaritans and Founder of Maytree	

Appendix C - Suicide in Adults Aged 75 and Over in Cornwall: An Epidemiological and Case Study Analysis

Sarah Ann Buckingham

SUICIDE IN ADULTS AGED 75 AND OVER I

Abstract

Introduction/Background: Suicide in older people is a historically neglected research area. Local audits had suggested that Cornwall had a higher than average suicide rate, and people aged 75 years and over appeared to be at particularly high risk. Heterogeneity between studies and variations in presenting suicide statistics can make comparison of rates difficult.

Aims: The study aimed to explore in depth the epidemiology of suicide in elderly people in Cornwall, to develop an understanding of the risk factors (including sources of stress), suicide methods, locations, and warnings, and consequently to identify potential preventive strategies.

Methods: A mixed methods approach was taken, combining quantitative epidemiological study of suicide using Office for National Statistics (ONS) Public Health Mortality Files with qualitative retrospective case study analysis using coroner's records and local audit database. All completed suicides (and some systematically selected open verdicts) in people aged 75 years and over occurring in Cornwall between 2006 and 2010 were included. A questionnaire survey of rural community dwelling people aged 75 years and over (n = 49) in a part of Cornwall was also carried out to identify the main sources of stress associated with ageing in the local area.

Results: Some discrepancies in the number of open verdicts reported by the coroner and ONS were noted. Although suicide in the over 75 age group was responsible for only 0.3 % of all-cause mortality in males and 0.1 % in females, the overall suicide rate in this age group in Cornwall was significantly higher than the average for the UK, with a Standardised Mortality Ratio of 172 (95 % CI 123 to 236). Males aged between 75 and 84 years had the highest suicide rate in Cornwall (mean of 25.8 deaths per 100,000 population, 95 % CI 1.1 to 50.5). Jumping from a height and suffocation were the most frequently used methods,

accounting for 8 and 7 of the 34 deaths respectively. 28 of the 34 suicides took place at home. Depressive illness, physical illness and bereavement were the most commonly identified risk factors. Concerns revealed in survey responses were closely related to suicide risk factors, including fear of losing independence, bereavement, physical illness, isolation, and fear of becoming a burden. Warnings included previous self-harm or attempted suicide, suicide ideation or plans, behavioural changes and researching euthanasia.

Discussion: As persons aged 75 and over are at significantly higher risk of suicide in Cornwall than other regions, there is a need to reduce the number of suicides in this group. Possible preventive measures include reducing access to means (in particular for jumping incidents), earlier detection of depression in the physically ill, bereavement counselling, more social groups and support groups in rural areas, helping people to retain their independence, and a change in societal attitudes towards elderly people. There may also be a need to improve the accuracy of suicide statistics.

Conclusion: Health services, councils, voluntary groups and the community as a whole should work together to prevent suicide in older people. Future controlled studies should assess the effectiveness of interventions and focus more on differences between subgroups of elderly people.

Appendix D - Kent Programme for Mental Wellbeing and Preventing Mental Illness

Wellbeing Programme: 10 Point Plan

A 10 point Plan for Wellbeing is in progress in order to tackle Adult Mental Wellbeing in Kent as follows:

1. Large Scale Six Ways to Wellbeing Campaign using social marketing and working with other councils in the south east.

2. Signposting: The Live it Well website www.liveitwell.org.uk is improved and marketed to the whole population and publicised widely.

3. Primary Care Community Link Workers: GP practices have workers commissioned from Porchlight by KCC and the CCG. The Community Link Service will link patients to community programmes and wellbeing services.

4. Community Development and Engagement: Men will be targeted by using an innovative social marketed community engagement programme called KentSheds - www.kentsheds.org.uk . Groundworks South –are leading this for us and will also target ex military. It is a peer support and outdoor activity programme that benefits the whole community. Also working with districts to tackle isolation in older people.

5. Asset Mapping: There are many wellbeing resources that are not funded by KCC or NHS that can be mobilised to improve wellbeing. This research, led by ESRO will work to find these wellbeing resources and map their economic and social impact to support the public and commissioners.

6. Mental Health Inequalities: Conduct large scale mental wellbeing impact assessments (which is an internationally recognised community participation and action planning methodology) to improve outcomes for people in targeted populations.

7. Training: roll out Mental Health First Aid Training (suicide awareness) systematically across Kent

8. Improve Health of People with Mental Health Problems: Health Trainer type role for people in community mental health services

9. Community Resilience Building via **Healthy Living Centres:** Working with Libraries and Pharmacies to turn the community into a wellbeing friendly environment

10. Audit and Evaluation: Continue to provide high quality data and evaluation on our overall performance with this programme as well as suicide and self harm audit and psychological therapy access audit.

(Rudd, 2014: available at *www.kmpho.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=380110*)