Suicide Prevention Joint Strategic Needs Assessment

A review of suicide prevention across Hammersmith and Fulham, Kensington and Chelsea and Westminster

January 2013

This Report

The Suicide Prevention JSNA provides a holistic picture through the gathering of data, evidence and views of service providers and families affected by suicide to contribute to the development of a tri-borough suicide prevention strategy.

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This report would not have been possible without the input from the Inner North West London Suicide Prevention Working Group.

Summary

It is estimated that the average cost per completed suicide for those of working age in England is £1.67m at 2009 prices (Knapp et al, 2011).

Rates of deaths by suicide in Inner North West London are higher than in most London Boroughs. 191 deaths by suicide and undetermined injury occurred between April 2009 – August 2012 (41 months) by individual's resident or GP registered across Hammersmith and Fulham, Kensington and Chelsea and Westminster (the Inner North West London area).

Suicides were most prevalent in men aged 40-49 years old and the majority of all people completing suicide were born in the UK.

Whilst the data available through the Public Health Mortality files provides an overview of suicides in Inner North West London the data available through the coroners could further help shape the service improvements locally. There needs to be improved access to data relative to suicide from coroners.

There is strong evidence for the following interventions to prevent suicides (World Health Organization, 2012)

Universal (general population)	Restricting access to means of suicide Policies to reduce harmful use of alcohol Responsible reporting of suicide in the media
Selective (target at risk groups)	Gatekeeper training Mobilising communities Postvention for suicide survivors
Indicated (individual):	Identification and treatment of mental disorders Management of persons who have attempted suicide or identified as at risk

Evidence suggests that a multi-component approach to suicide prevention, integrating a range of these interventions offers the greatest potential (Beautrais et al, 2007; HSC Research & Development Division Public Health Agency, c2011; van der Feltz-Cornelis et al, 2011).

Feedback from service providers and families of people who have completed suicides indicate that there is an urgent need to:

- Strengthen and co-ordinate postvention for the friends and family bereaved by suicide
- More joined up working between services, including information sharing
- Increased gatekeeper training for family and community members as well as health and social care professionals to help recognise those that might be at risk, question them openly, persuade them to seek help and refer them to appropriate health professionals.
- Improve the knowledge about mental illness and the risk of suicide for family members

Section 1 - Background

Suicide is a common cause of early life years lost, and has a devastating impact on families, communities and other survivors - economically and emotionally.

The suicide rate in England and Wales has fallen in recent years but the 2011 data may indicate that numbers may have reached a plateau. However, suicide is still the most common cause of death in men aged 15–44 years behind accidental death, and suicide rates in Inner North West London are higher than in many London boroughs and is predicted to rise due to the recent economic downturn. Therefore, suicide continues to be a major public health issue, and particularly in those with mental distress.

It is estimated that the average cost per completed suicide for those of working age in England is £1.67m at 2009 prices (Knapp et al, 2011). This includes direct costs (e.g. emergency services, funeral costs) and indirect costs (e.g. lost work output) as well as the less tangible human costs of loss of life and bereavement of family and friends.

The Inner North West London Suicide Prevention Joint Strategic Needs Assessment (JSNA) will inform commissioning by providing a picture of current needs of the local population as well as indicate areas where services need to be commissioned or delivered differently. The JSNA provides a holistic picture through the gathering of data, evidence and views of service providers and families affected by suicide to contribute to the development of a tri-borough suicide prevention strategy.

Section 2 - Methodology

A literature review of effective suicide prevention interventions was undertaken to determine 'what works' according to the available published literature alongside an analysis of the available data. Whilst trends have been described it is important to note the small numbers involved; therefore, any inferences drawn from this local audit should be viewed in association with more robust national data and research. A community wide approach was adopted to gather further insight into Suicide. Families and friends bereaved or affected by suicide and individuals who have attempted suicide were contacted. Meetings and workshops were held with clinical and community providers and families bereaved by suicide.

Section 3 - Policy context

There are two recent key national policy drivers which have provided the impetus for undertaking a Suicide Joint Strategic Needs Assessment (JSNA) in Inner North West London (INWL) (Hammersmith and Fulham, Kensington and Chelsea, and Westminster).

- The Public Health Outcomes Framework will require public health departments within local authorities to report on suicide cases.
- The recent publication of the national suicide prevention strategy *Preventing suicide in England: a cross-government outcomes strategy to save lives* (Department of Health, 2012)

The national suicide prevention strategy *Preventing suicide in England: a cross-government outcomes strategy to save lives* recommended the following areas for action

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

Section 4 - Suicide deaths in INWL

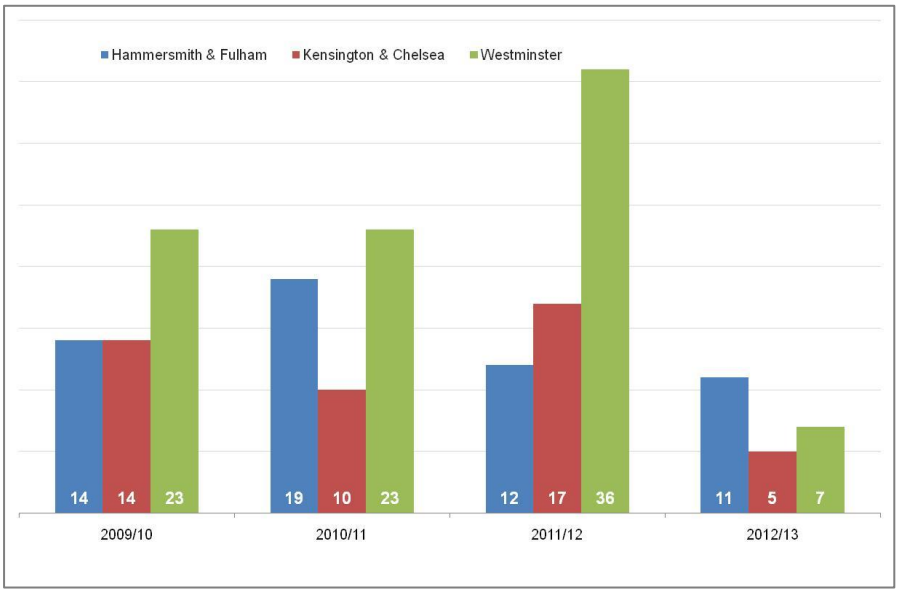
Suicides and undetermined injuries were identified from Public Health Mortality Files using the International Classification of Diseases - Version 10 codes X60-X84 and Y10-Y34, excluding Y33.9.

4.1 - How many suicide deaths occur in INWL?

Between April 2009 and August 2012 (41 months), 191 deaths by suicide and undetermined injury were registered as having occurred amongst individuals who were either resident or registered with a GP in INWL - 125 of these suicides were to people who were both resident and registered with a GP within INWL. The graph below breaks the number of suicides in each borough down by financial year.

The number of suicides across this time period to people who were either resident or registered by borough were - Hammersmith & Fulham - 56; Kensington & Chelsea - 46; Westminster - 89.

It is not possible to provide a rate per population as there is no comparable population numerator. However, it is possible to analyse by resident population and GP registered population.



Number of cases of death by suicide or undetermined injury by borough
April 2009 - August 2012

4.1.1 – Suicide deaths in the resident population

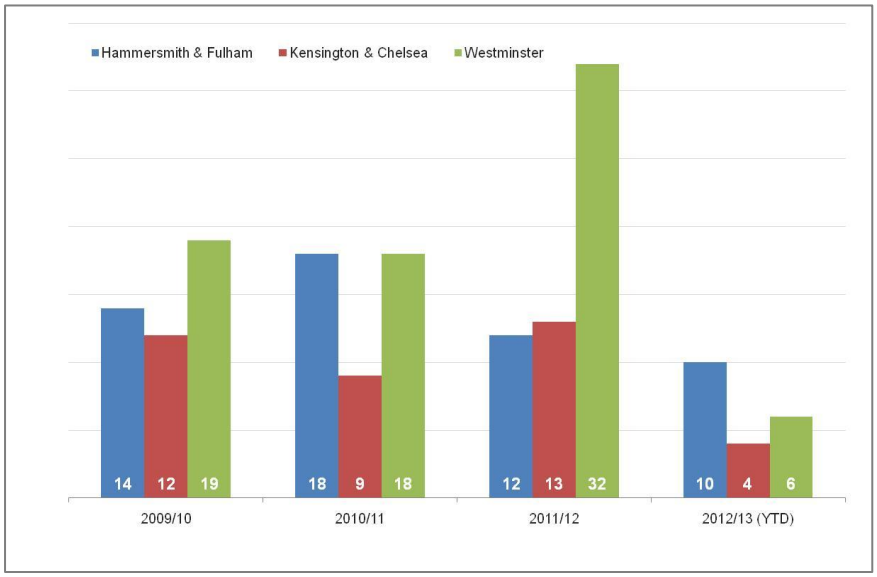
Between April 2009 and August 2012 (41 months), 167 deaths by suicide and undetermined injury were registered as having occurred amongst INWL residents. The graph below breaks this down by financial year and resident borough.

These 167 deaths by suicide and undetermined injury account for 1.75% of all deaths during this time period.

In 2010/11 the suicide rate per 100,000 persons in INWL (age standardised to the European Standard Population) was 10.44 for Males (confidence intervals - 6.68-14.20), and 4.18 for Females (confidence intervals - 1.82-6.54). The London rate for 2010 was 14.0 for Males and 4.4 for Females.

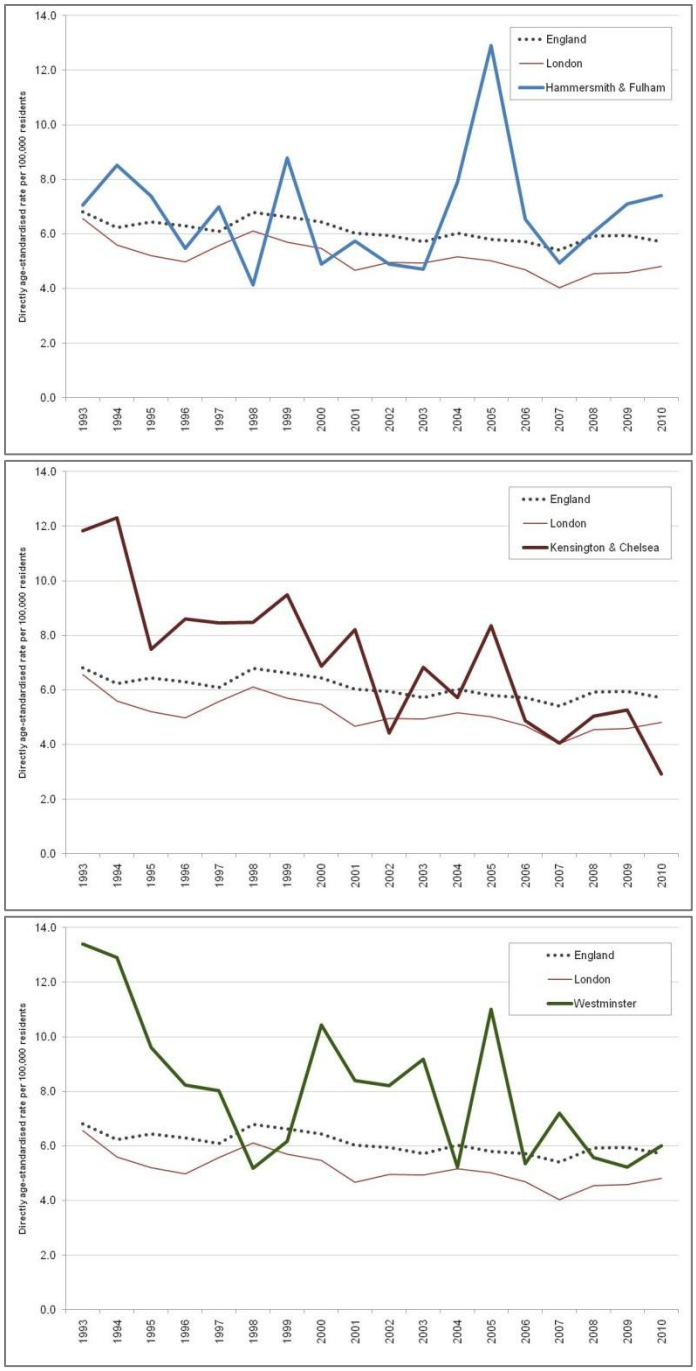
In 2011/12 the suicide rate in INWL was 13.64 for Males (confidence intervals - 9.27-18.01) and 5.68 for Females (confidence intervals - 2.80-8.56). This is an increase on the previous financial year. There is currently no data available for comparator regions.

There have been 20 suicides in 2012/13 to date. If the rate of suicide continues as is throughout the whole of 2012/13, we would expect to see a further 33 suicides.



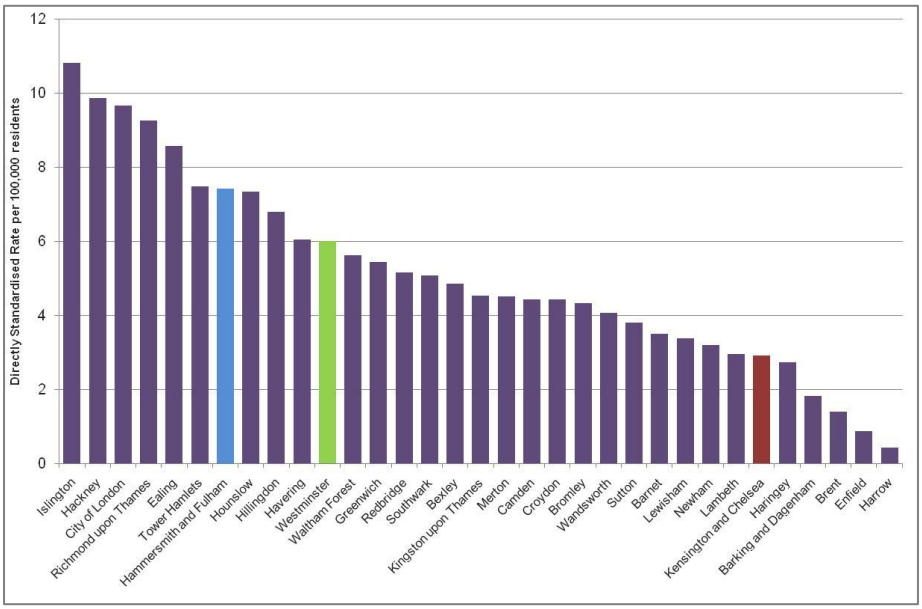
Number of cases of death by suicide or undetermined injury by resident borough
April 2009 - August 2012

The graphs below show the directly standardised rate of suicides per 100,000 resident persons for the INWL boroughs, London and England between 1993 and 2010. Due to the relatively small numbers at borough level the rate fluctuates year on year, however, in the time period shown the rate seems to have fallen in Kensington & Chelsea and Westminster and stayed relatively stable in Hammersmith & Fulham.



Directly Standardised rate of Suicide per 100,000 residents for INWL Boroughs, London and England 1993 - 2010 (Office for National Statistics)

The latest data available to compare against all London boroughs is for the directly standardised rate of suicide per 100,000 resident persons in 2010, shown in the graph below. Locally, Hammersmith & Fulham (7th) and Westminster (11th) were in the top third of boroughs in London. Kensington & Chelsea were in the bottom third (28th). However, with the relative small numbers of suicides per borough, rates are likely to fluctuate year on year.



Directly Standardised rate of Suicide per 100,000 residents for London's 33 boroughs 2010 (Office for National Statistics)

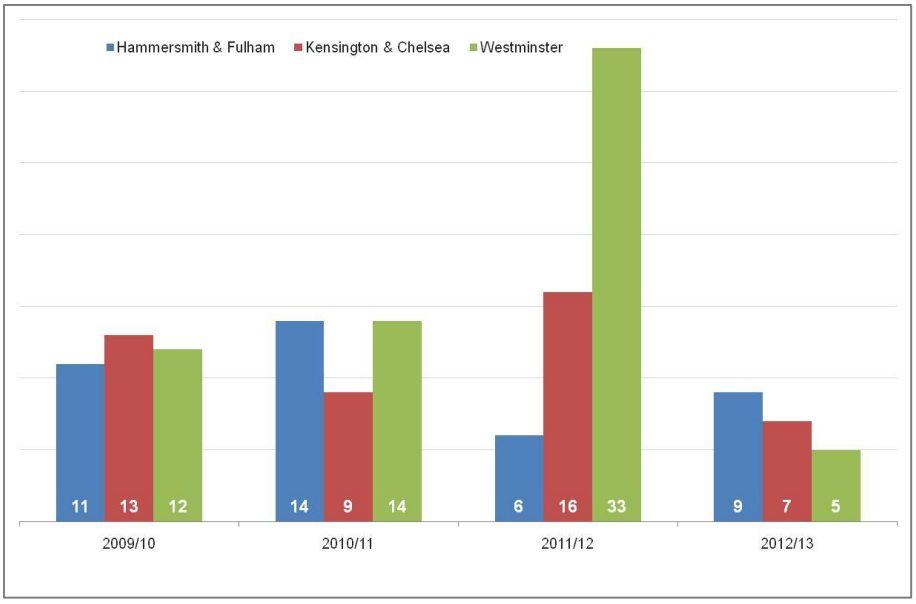
4.1.2 – Suicide deaths in the GP registered population

Between April 2009 and August 2012 (41 months), 149 deaths by suicide and undetermined injury were registered as having occurred amongst those registered with a GP in INWL. The graph below breaks this down by financial year and the borough where the practice is located.

These 149 deaths by suicide and undetermined injury account for 1.60% of all deaths during this time period.

Suicide rates for the GP registered population are very difficult to assess in a standardised way in London because of the highly transitory nature of practice registration over a 3 year period. Also, there is no comparator for London and England.

There have been 21 suicides in 2012/13 to date. If the rate of suicide continues as is throughout the whole of 2012/13, we would expect to see a further 35 suicides.



Number of cases of death by suicide or undetermined injury by PCT of GP registration
April 2009 - August 2012

4.2 Who dies by suicide in INWL?

4.2.1 - Age & Gender in the resident and GP registered population

Between April 2009 and August 2012, there were 122 deaths to males (73%) by suicide or undetermined injury, and 45 deaths to females (27%) who resided in the INWL boroughs. This gender split is similar to that of London and England.

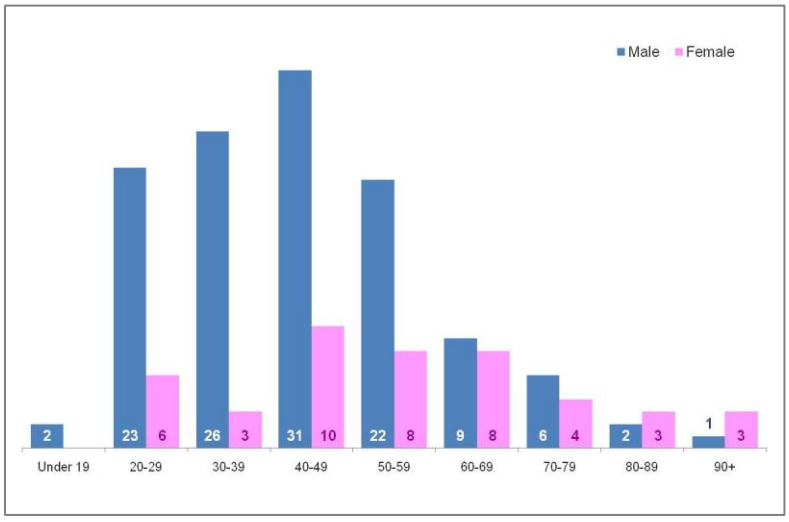
Similarly, between April 2009 and August 2012, there were 98 deaths to males (66%) by suicide or undetermined injury, and 51 deaths to females (34%) who were registered with a GP in the INWL boroughs.

Irrespective of gender, the age group where suicide was most prevalent in both the resident and GP registered populations was 40-49, (41 deaths in resident and 36 in GP registered), with age 50-59 next (30 deaths in resident and 29 in GP registered). There were 29 and 27 deaths to those aged 20-29 in resident and GP registered and 29 and 20 in those aged 30-39 in the resident and GP registered. There were 38 deaths in all other ages in the resident population and 37 in all other ages in the GP registered population.

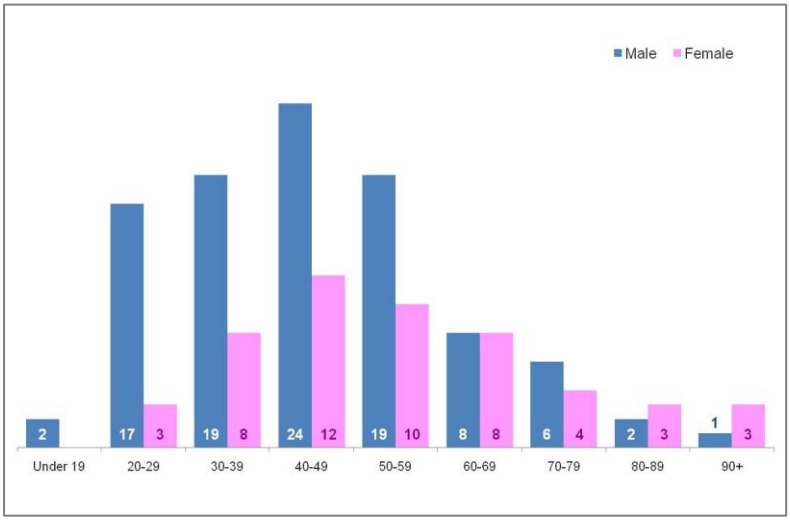
Most male suicide deaths during this period occurred to those typically aged between 20 and 49 (80 deaths) in the resident and aged between 30 and 49 (43 deaths) for the GP registered populations, with the highest number of deaths (31 in resident and 24 in GP registered) in the age group 40-49. However, there were still significant numbers of suicides occurring in males aged between 50 and 79 (37 deaths in resident and 33 in GP registered). This is consistent with the age trends observed nationally.

The age profile of female deaths by suicide or undetermined injury is also consistent with trends observed nationally, being slightly older than that demonstrated for males. While the peak age group for women is also 40-49 in INWL PCTs, the numbers of suicides in 20-39 year old women are distinctly low in contrast. The age groups 80-89 and 90+ are the only groups where the number of female deaths by suicide or undetermined injury is higher than that for males, but the difference is not significant. This is the same for resident and GP registered females.

In 2012/13 to date, of the 20 completed suicides in the resident population and 21 in the GP registered population, 15 residents and 14 GP registered have been Male and 5 residents and 7 GP registered have been Female. Irrespective of gender, the modal age group is 50-59 with 5 suicides by residents and 6 GP registered, followed by those aged 20-29 with 4 suicides in the resident population and 40-49 with 4 suicides for the GP registered population. For Males the youngest suicide death was aged 18, and the oldest 92. For Females the youngest suicide death was aged 40, and the oldest 98.



Number of resident deaths by suicide or undetermined injury across INWL by age and gender April 2009 - August 2012



Number of deaths by suicide or undetermined injury to GP registered patients across INWL by age and gender April 2009 - August 2012

4.2.2 - Place of birth in the resident and GP registered population

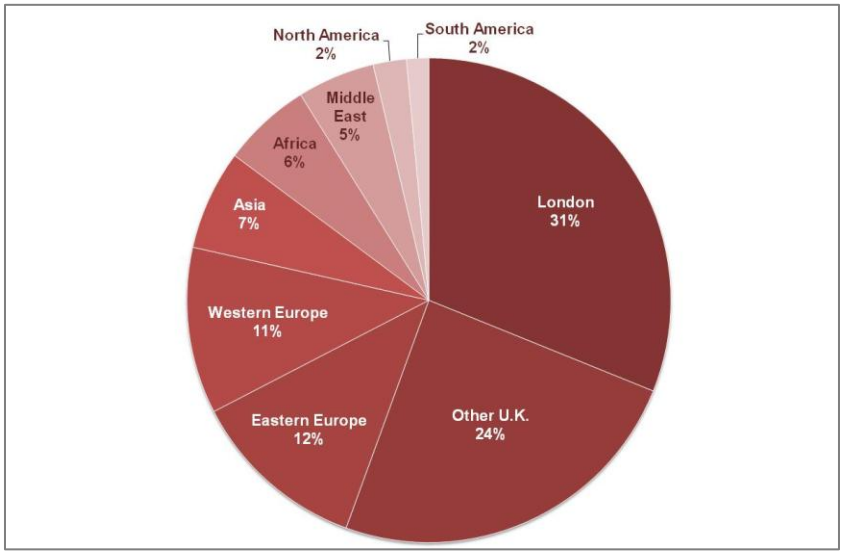
Whilst limited data collected on ethnicity prevents the characterisation of groups more likely to die by suicide by ethnic group, some inferences can be drawn from the place of birth recorded on Public Health Mortality Files.

The largest proportion of suicides occurred in persons born in the U.K. (55% for the resident population and 59% for the GP registered population), the majority of which were born in London (56% of those born in the U.K in the resident and 54% in the GP registered populations). Persons born in Eastern Europe (12% in resident and 9% in GP registered), Western Europe (11% in resident and 9% in GP registered) and Asia (7%) accounted for smaller but significant proportions of suicides and in the GP registered population 7% from Africa.

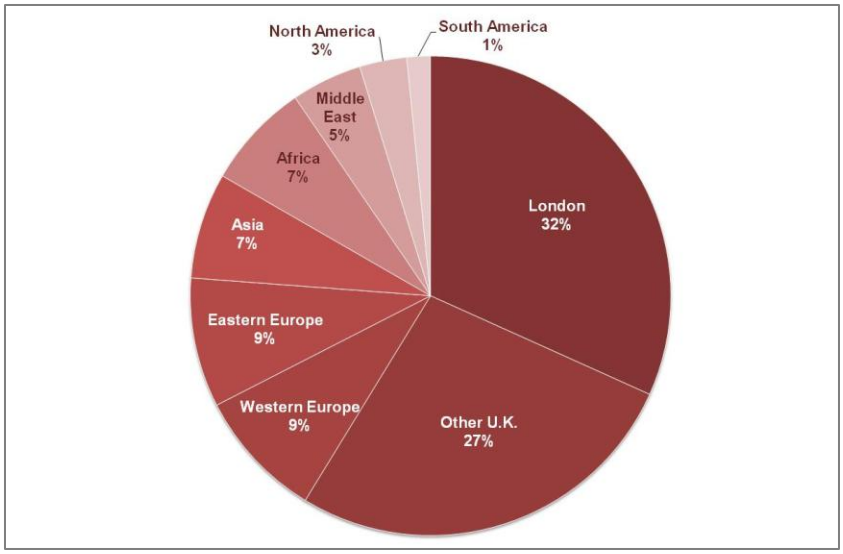
All of those born in Asia who died by suicide in this period were Male, and all those from North America were Female.

Given the most recent estimates of the ethnic make-up of the INWL resident population, the distribution of suicides described above is not entirely unexpected. However, the percentage of suicides amongst Eastern Europeans is notably higher than the percentage in the general population, caution should be taken in interpreting this however, as numbers are still relatively small (21 deaths over 3 years).

Published research suggests that the risk of suicide is affected by ethnicity. For example, the risk of suicide in young Asian men is thought to be lower than in White British men, whereas the risk is higher in Black African and Black Caribbean young men.



Place of Birth of those resident who have died by suicide or undetermined injury across INWL April 2009 - August 2012



**Place of Birth of those GP registered who have died by suicide or undetermined injury across INWL
April 2009 - August 2012**

4.2.3 - Occupation of the resident and GP registered populations

Evidence suggests that certain occupational groups (such as those in professions with easy access to means, including those with medications and chemicals) are more likely to die by suicide, as well as those that are unemployed.

However, there is no indication to significantly back this up from the data available within INWL (over a third of data is missing in the registration records for suicide, and total number are too small to draw significant conclusions). Analyses of coroner reports would help to provide a more accurate picture.

Of the data that is available, Students, Company Directors, Retirees and the Unemployed were the most likely to die by suicide, but numbers are very small.

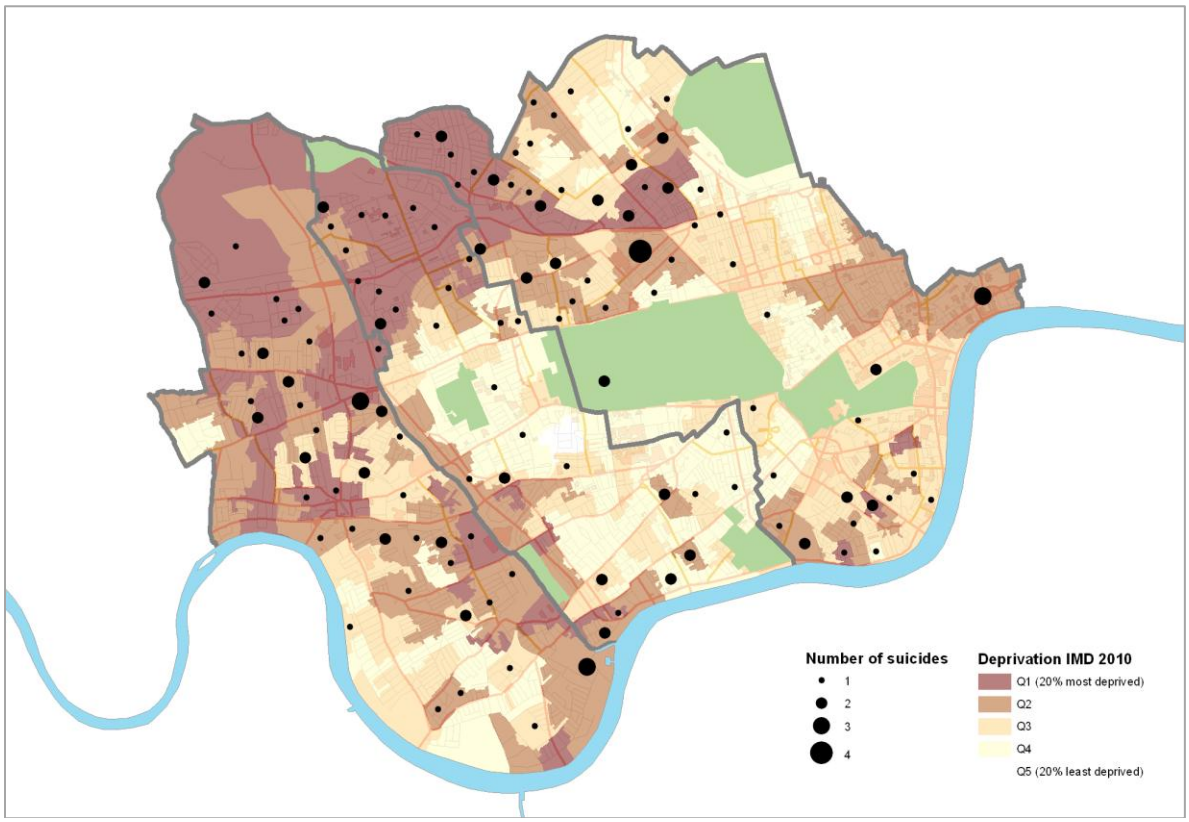
On the whole, those who completed a suicide seem to have been from a number of occupations, from professional jobs (such as Solicitor, Accountant, Journalist, Chemist, Surveyor) to Skilled Labour (Electrician, Plumber, Landscape Gardener), to Low-Paid Work (Labourer, Waiter) and Entertainment (Television, Musician, Artist).

There is no way of knowing if any of the individuals had recently lost employment prior to completing a suicide.

There is no indication to show that the occupation of those GP registered is any different to those who are resident in the borough shown in the analysis previously.

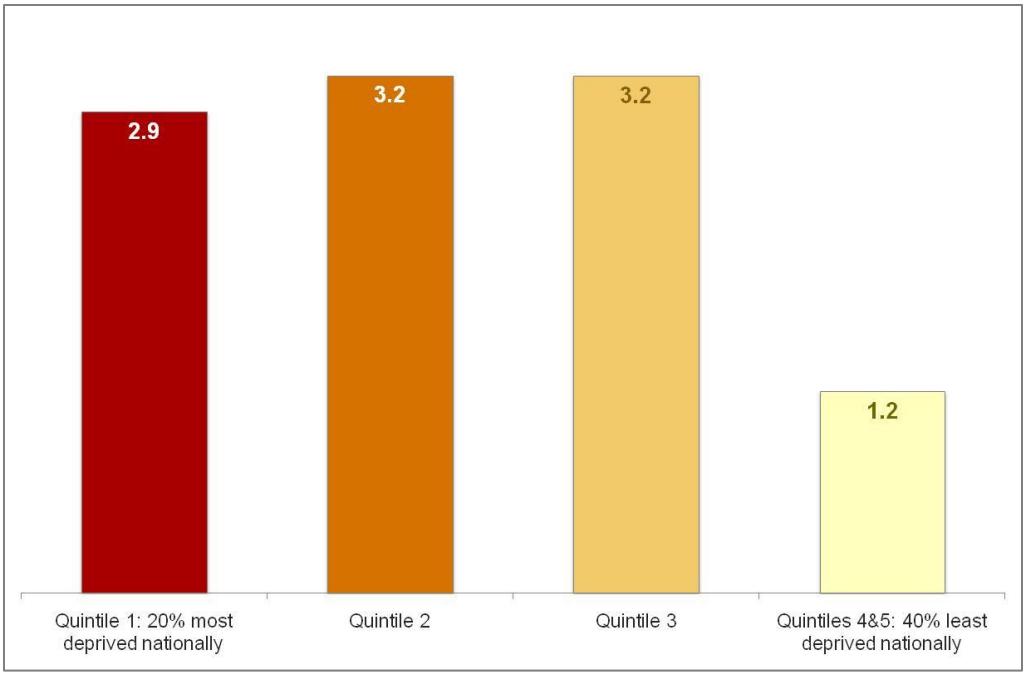
4.2.4 - Location of the usual address of the deceased

The map below shows the Lower Super Output Area (LSOA) of the usual address of the deceased across INWL between April 2009 and August 2012 on a map showing deprivation (IMD 2010).



4.2.5 - Suicide and deprivation

The link between suicide and deprivation locally cannot be significantly proven because of the small numbers involved. However, it is noticeable that the rate of suicide per 10,000 residents is clearly higher in the more deprived areas (quintiles 1-3) than in the more affluent areas (quintiles 4 & 5) suggesting that if investigated at a wider scale you could expect to find a link between relative social deprivation and suicide.



Rate of suicide per 10,000 residents by IMD quintile across INWL
April 2009 - August 2012

4.2.6 - Long Term Conditions

Of those patients whereby it was possible to match to an existing GP records, 15% of those who had completed a suicide were on at least one long term condition register.

Of this cohort approx. 60% of patients were recorded as having Depression. 25% of patients were recorded as having severe and enduring mental health illness.

4.3 - Where do people die by suicide in INWL?

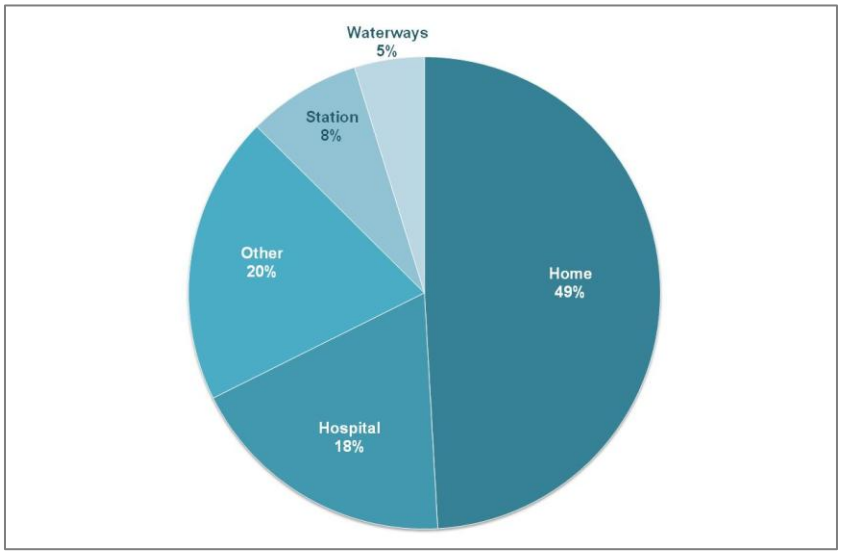
From the data available it is difficult to ascertain where people actually attempt suicide; Public Health Mortality Files refer to where deaths were confirmed, therefore, a relatively large proportion of deaths are classified as hospital deaths rather than the location where the suicide was attempted.

The most common place of death for INWL residents was at home (49% for resident and 47% for GP registered), however, it is likely that in the case of a large proportion of the hospital deaths (the next most common place of death at 18% in residents and 20% in GP registered), the suicidal incident also occurred at the person's home.

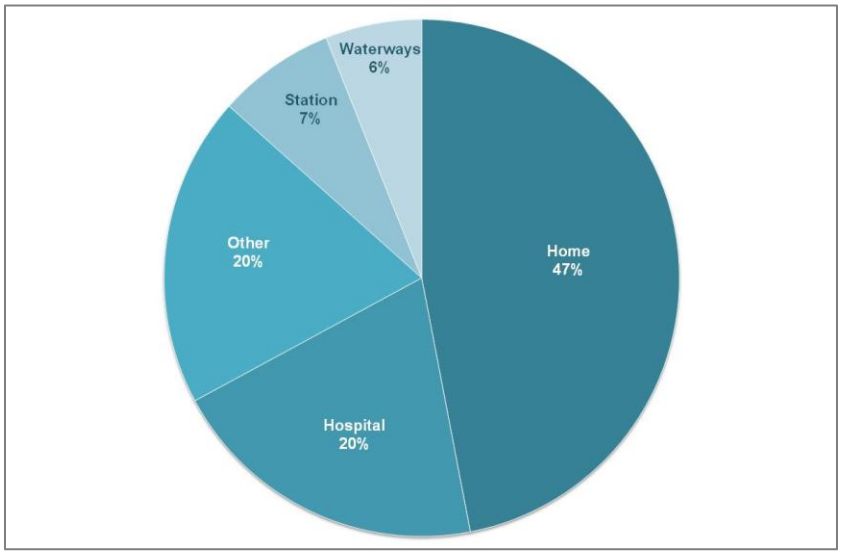
Further places of death recorded for INWL residents included at tube stations or on the overground railway network (8% for resident and 7% for GP registered people), or on the waterways such as the River Thames or Grand Union Canal (5% for resident and 6% for GP registered).

Places of death recorded as 'other' include sites such as other residential addresses, hotel rooms, woodland / natural space, and official institutions (such as prisons, hostels, embassies).

Of the 20 resident and 21 GP registered suicides in 2012/13, 50% resident and 43% GP registered were recorded as being at home, 20% resident and 19% GP registered at hospital, 15% resident and 14% GP registered at stations, 10% resident and 14% GP registered on the waterways, and 5% resident and 10% GP registered in other locations.



Place of Death of those resident who have died by suicide or undetermined injury across INWL April 2009 - August 2012



Place of Death of those resident who have died by suicide or undetermined injury across INWL April 2009 - August 2012

4.4 - How do people die by suicide in INWL?

Generally the method of suicide by the different genders and age groups tend to be quite distinct so the next section splits out cause of death by sex and age. Data presented is for April 2012

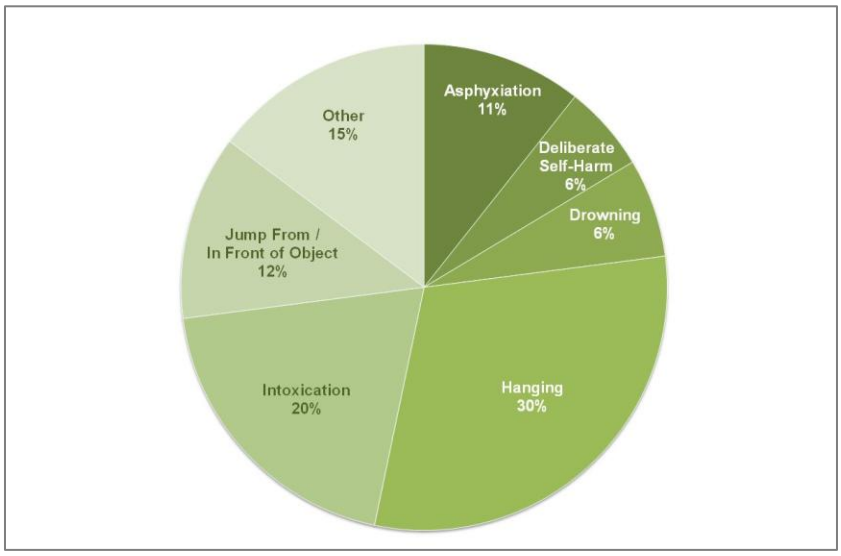
4.4.1 - Males from resident and GP registered populations

Hanging accounted for the largest proportion of male deaths by suicide and undetermined injury to INWL residents at 30% and to GP registered at 24%. This is lower than reported nationally, but it is a method that is proportionally increasing, particularly in young people.

The second most common method of suicide in males was Intoxication (self-poisoning), accounting for 20%. From local audits it is difficult to identify trends in the types of drugs used as the cause of death given the small numbers involved, however, most suicides involved multiple drugs, 48% of all poisonings. National studies suggest that the drugs most frequently used in suicides include co-proxamol (30% of suicides), tricyclic antidepressants (23%) and other analgesics (16%).

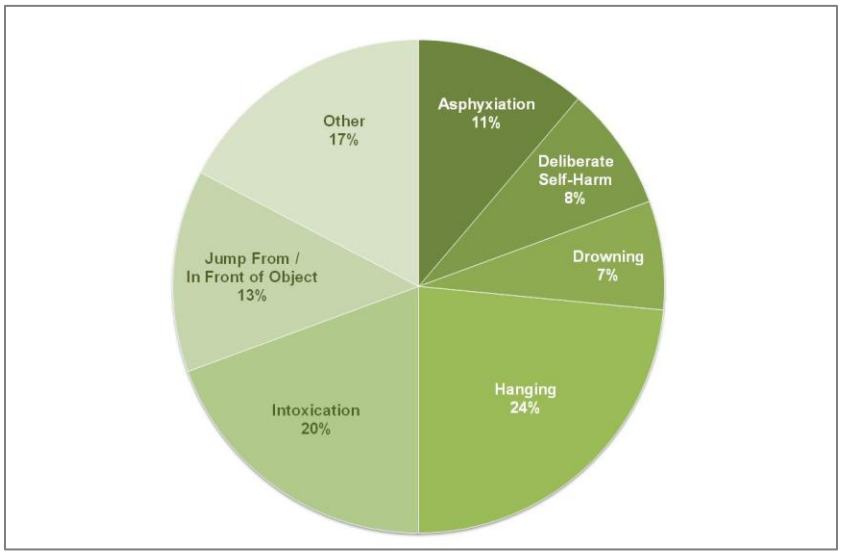
Jumping from a height / jumping in front of a moving object accounts for 12% of resident suicides and 13% of GP registered people. This is significantly lower than recorded in the previous Westminster Suicide JSNA in 2008, however, it is still a serious concern within INWL due to the many people who come into the borough to attempt suicide at local 'hotspots' on the tube network and by the River Thames.

Other forms of Asphyxiation accounted for 11% of deaths in males in this time period, and Drowning accounted for 6% of residents and 7% of GP registered male suicides. Deliberate Self-Harm (e.g. cutting, shooting, self-immolation) accounts for 6% resident and 8% GP registered and 15% of residents and 17% of GP registered were recorded as 'Other' (e.g. Undetermined, Multiple Injuries).



Cause of Death of resident Males who have died by suicide or undetermined injury across INWL

April 2009 - August 2012



Cause of Death of GP registered Males who have died by suicide or undetermined injury across INWL
April 2009 - August 2012

The proportional pattern in terms of method of male suicide doesn't particularly differ between the three boroughs in INWL.

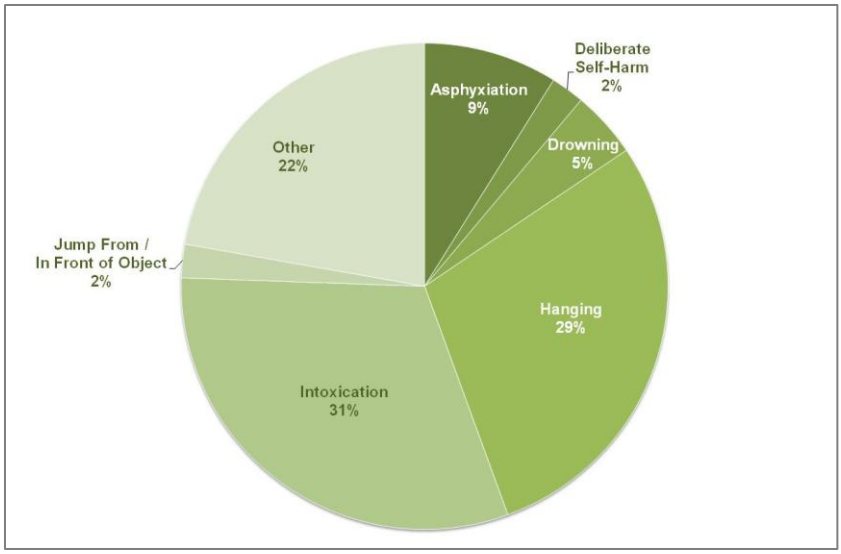
In 2012/13 to date, there is no significant difference to the proportional pattern represented above in the methods used to by males to complete suicide.

4.4.2 – Females from resident and GP registered populations

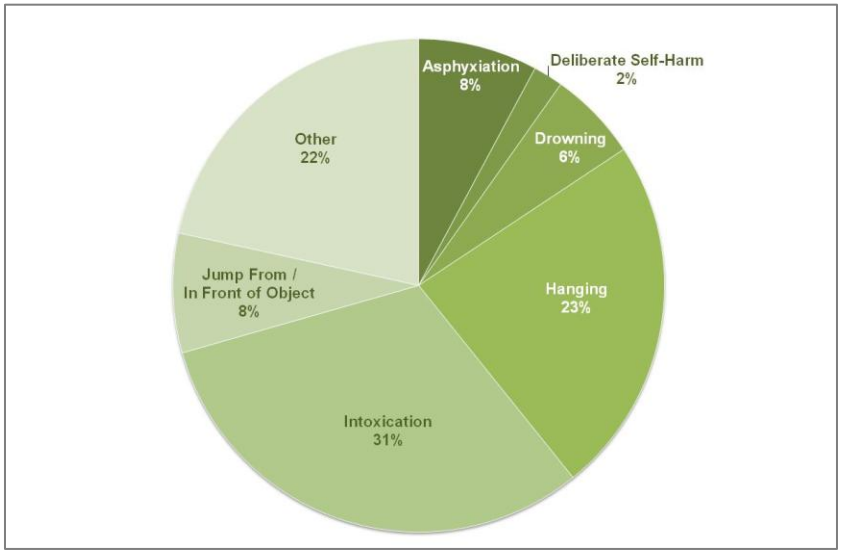
Intoxication accounted for the largest proportion of female deaths by suicide and undetermined injury in INWL residents at 31%.

The second most common means in females is hanging, accounting for 29% in resident and 23% in GP registered populations, a much higher proportion than seen in previous years in INWL.

Jumping from a height / jumping in front of a moving object and other forms of Asphyxiation accounted for 2% and 9% of deaths in resident females and 8% in GP registered females respectively during this time period, and Drowning accounted for 5% of resident females and 6% of GP registered female suicides. Deliberate Self-Harm (e.g. cutting, shooting, self- immolation) accounted for 2%, and 22% were recorded as 'Other' (e.g. Undetermined, Multiple Injuries).



Cause of Death of resident Females who have died by suicide or undetermined injury across INWL
April 2009 - August 2012



Cause of Death of GP registered Females who have died by suicide or undetermined injury across INWL
April 2009 - August 2012

The proportional pattern in terms of method of suicide doesn't particularly differ between the three PCTs in INWL; however, all four deaths by other and asphyxiation occurred in Kensington & Chelsea.

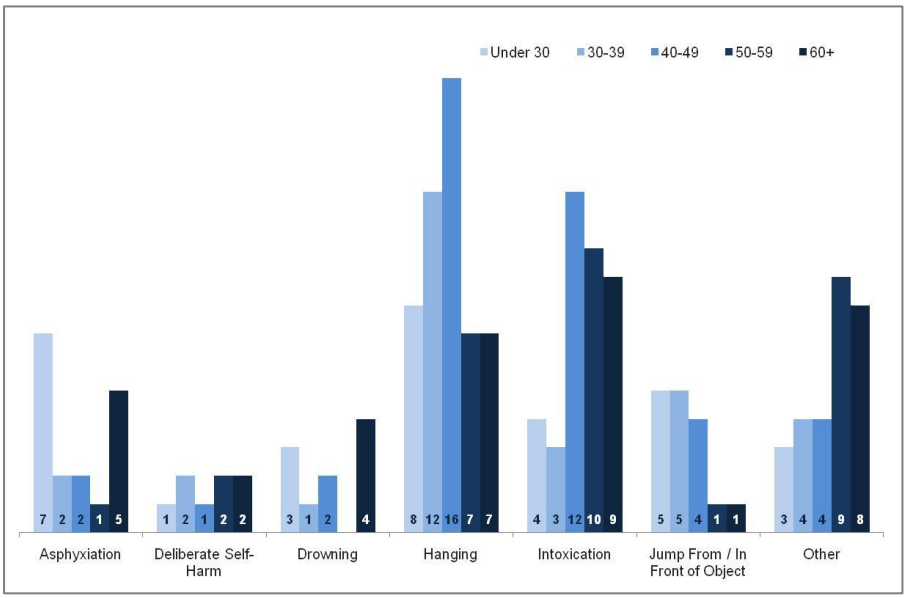
As the number of female deaths by suicide or undetermined injury In 2012/13 is only 5 in the resident and 7 in the GP registered, there can be no significant conclusions made into any changes in the proportional pattern in the methods used to by females to complete suicide. However, it seems that the trend in hanging as a method for females looks set to continue with 3 of the 5 resident suicides and 3 of the 7 GP registered suicides in 2012/13 to date using this method.

4.4.3 - Age of resident and GP registered populations

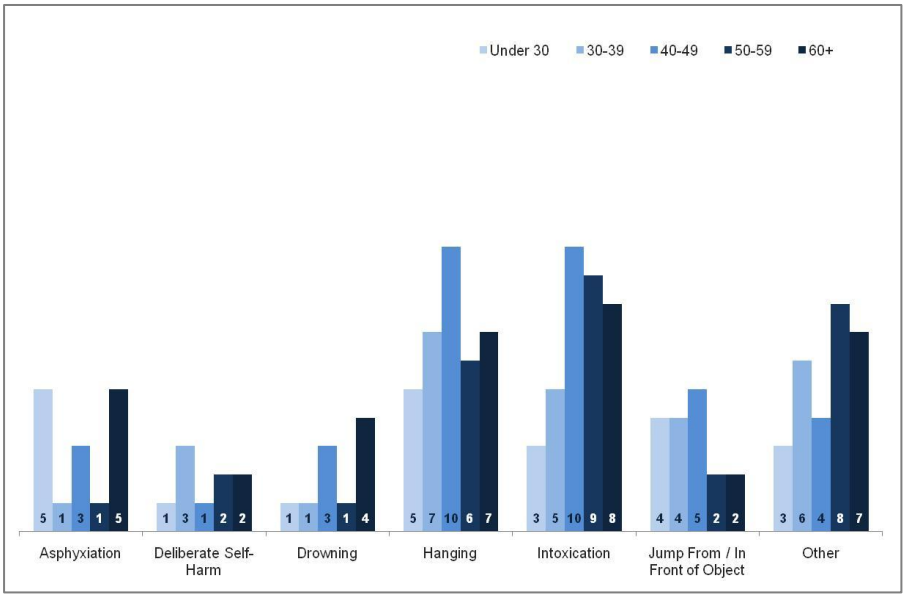
Persons (males and females) aged under 30, and between 30-49 were most likely to complete a suicide by hanging, with Intoxication and jumping off / in-front of an object the next most common. In older age groups, 50-59 and 60+, the most common method of suicide was Intoxication.

This may reflect access to means; for example, younger people are likely to be much more mobile, and older persons may be more likely to be on long-term medication for chronic diseases and thus have increased access to drugs.

There is no distinguishable pattern in the method of suicide by age of the individual in 2012/13 to date.



Number of deaths by suicide or undetermined injury to residents across INWL by age and cause April 2009 - August 2012



Number of deaths by suicide or undetermined injury to GP registered patients across INWL by age and cause April 2009 - August 2012

Section 5 - Evidence review

5.1 - Effective interventions for suicide prevention

There is a lack of good quality studies for suicide prevention interventions. However, from published literature it appears that the *strongest* available evidence is for:

1. Physician/health professional education and awareness in order to improve identification and treatment of suicidal behaviour and mental disorders
2. Gatekeeper training to identify those at risk and facilitate/enable access to care
3. Restricting access to means of suicide e.g. firearm laws, limitations on pack size of certain over the counter drugs, environmental safeguards in prisons, sliding doors on railway platforms to restrict access to track.

There is also evidence that media guidelines and responsible reporting of suicide can reduce suicidal behaviour. This could involve training journalists and media blackouts.

At an individual level there is fairly good evidence that lithium reduces completed and attempted suicide rates.

WHO (2012) recommend the following approaches and interventions for suicide prevention strategies:

Universal (general population)	Restricting access to means of suicide Policies to reduce harmful use of alcohol Responsible reporting of suicide in the media
Selective (target at risk groups)	Gatekeeper training Mobilising communities Postvention for suicide survivors
Indicated (individual):	Identification and treatment of mental disorders Management of persons who have attempted suicide or identified as at risk

Evidence suggests that a multi-component approach to suicide prevention, integrating a range of these interventions offers the greatest potential.

5.1.1 - Media guidelines

There is considerable evidence that media reports and coverage of suicide are linked to an increase in suicide rates (Australian Government Department of Health and Ageing, 2007; Beautrais et al, 2007; Nordentoft, 2011) and that reporting of suicides may particularly affect vulnerable groups. It is asserted that suicide reporting can lead to imitation, copycat or mass cluster suicide (Sisask and Varnik, 2012). Indeed, Beautrais (2007) found that public health messages about suicide and media coverage of suicide issues have a potentially harmful effect.

Consequently, many countries have developed guidelines for responsible media reporting, and there is some promising research that these guidelines demonstrate a reduction in suicide rates. Recent research in Australia has found convincing evidence of an impact on the quality of reporting as well as on reducing suicide related behaviours (Australian Government Department of Health and Ageing, 2007)

In the UK, guidelines produced by the Samaritans (2008) call for caution and sensitivity in order to avoid copycat behaviour and include suggestions for reporting, including the correct phraseology, avoiding explicit details of suicide, avoiding labelling places as suicide hotspots, and encouraging public understanding of the complexity of suicide.

5.1.2 - Postvention

In INWL local families bereaved by suicide feel that currently there is a lack of information on the steps families should go through in dealing with the practical, emotional and psychological issues related to the suicide.

Andriessen (2009) defines postvention as "activities developed by, with, or for suicide survivors, in order to facilitate recovery after suicide, and to prevent adverse outcomes including suicidal behaviour". Postvention policies need to be in place to reduce the likelihood of additional suicides or further suicidal behaviour (Miller et al, 2009).

There is evidence that support or self-help groups may be helpful for the surviving friends or family members (Andriessen, 2009; Manthorpe and Illife, 2010) and that support groups for the

"When services respond to a suicide incident, especially the police, there is a lack of warmth, or ability to deal with the family member in shock. There is no follow-up from services especially when children, girlfriends/boyfriends) are involved" - Family member of someone who committed suicide in INWL

bereaved improve emotional well-being, depression, anxiety, grief, distress, and social activities. Psychotherapy may be helpful for the small group that develops psychological or psychiatric problems (Andriessen, 2009). However, there is little known about what treatments, programmes, and group formats are beneficial for survivors regarding age, gender, kinship, and length of time after suicide.

There is some evidence that a school based crisis management briefing allowed an open discussion preventing the development of misconceptions and provided an opportunity to educate students (Steele and Doey, 2007).

5.1.3 - Limiting access to means of suicide

A number of factors may influence an individual's decision regarding method in a suicide act, but there is substantial evidence to support that easy access influences the choice of method (Sarchiapone, 2011)

There is international evidence that restrictions of access to common means of suicide has led to lower overall suicide rates, particularly regarding suicide by firearms in USA, detoxification of domestic and motor vehicle gas in England and other countries, toxic pesticides in rural areas, barriers at jumping sites and hanging, by introducing "safe rooms" in prisons and hospitals (Sarchiapone, 2011). Furthermore, a decline in the prescription of barbiturates and tricyclic antidepressants (TCAs), as well as limitations on the pack size for paracetamol and salicylate has reduced suicides by overdose.

Restriction to means of suicide may be particularly effective in contexts where the method is common, highly lethal, widely available, and/or not easily substituted by other similar methods. However, since there is some risk of means substitution, restriction of access should be implemented in conjunction with other suicide prevention strategies.

5.1.4 - Interventions for railway networks

Although internationally suicide by collision with a train accounts for 1-12% of all suicides, with up to 94% of all attempts resulting in death, there is limited evidence for effective suicide prevention practices (Krysinska, 2008). Only one review was identified in the literature search.

There is some evidence to support the effectiveness of suicide pits (i.e. deep channels between the rails) and sliding doors on platforms to restrict access to the track. There are also studies that show responsible media reporting of suicide and community media campaigns do help to reduce the numbers of rail suicide. There is also indirect evidence (from the car industry) that points to the effectiveness of airbags and skirts at the front of trains to reduce the severity of injuries.

5.1.5 - Gatekeeper training

Gatekeeper training teaches specific groups of people to identify people at high-risk of suicide and refer those people for treatment, and can be aimed at family and community members as well as health and social care professionals. This training has been identified as a key intervention for suicide prevention (Australian Government Department of Health and Ageing, 2007; Beautrais et al, 2007; Mann et al, 2005; Isaac et al, 2009; van der Feltz-Cornelis et al, 2011; WHO, 2012).

However, there is a need for further research and randomized controlled trials in particular. Most of the evidence for gatekeeper training focuses on suicide prevention programmes where gatekeeper training is one element, which makes it difficult to separate out the effect of the gatekeeper training on its own (Isaac et al, 2009).

5.1.6 - Pharmacology

Safinofsky (2007a) asserts that suicide prevention should begin with adequate case finding, and physicians should aggressively pursue recognition and treatment of depression and suicidality but not put their entire faith in medication. Similarly, Cardish (2007) reported that the first line of treatment for suicidality in personality disorder should be psychological treatments, but that medication may sometimes be complementary and make the treatment more feasible, particularly in times of crisis.

There is fairly good evidence that lithium reduces completed suicide and attempt rates in people with bipolar disorder and recurrent unipolar depression. Antidepressants and psychological treatments may reduce suicidal ideation in depressed patients. However, antidepressant trials do not target suicidality as an outcome, and inferences made are post hoc (Safinoksky, 2007b).

Aguilar and Siris (2007) assessed the effect of antipsychotic medication on suicidality in patients with schizophrenia, and found that it was not possible to draw any significant conclusion.

5.1.7 - Psychotherapy

There is some evidence that therapies such as DBT, CBT and problem-solving may reduce suicide attempts, suicidal behaviour or self-harm (Australian Government Department of Health and Aging, 2007; Daigle, 2011; Tarrier et al, 2008). However, Crawford et al (2007) found no evidence that enhanced psychosocial treatments following self-harm have a marked effect on the likelihood of subsequent suicide.

There is a lack of research on the impact of psychosocial interventions on suicidal behaviour in people with bipolar disorder (Fountoulakis, 2009)

As depression is a significant risk factor for suicide, strategies for prevention may also consider prevention through treatment of mild and moderate depression or sub-threshold depressive symptoms. In a stepped care approach NICE recommends CBT and other therapies, including interpersonal therapy (IPT), behavioural activation, and behavioural couple's therapy. Alternative treatments include short-term psychodynamic psychotherapy and counselling.

5.2 - Limited or no evidence of effective interventions for suicide prevention

5.2.1 - Education and awareness

There is limited scientific evidence that broad public awareness or education campaigns are effective in suicide prevention (Australian Government department of Health and Aging, 2007; Beautrais, 2007), although there is some evidence that they may offer positive outcomes. Although community education programmes are widespread the reporting of their efficacy is limited (Fountoulakis et al, 2011).

5.2.2 - "No suicide" contracts

A "no suicide" contract is a contract that contains an agreement not to commit suicide. It is has been used by some medical professionals dealing with depressive clients. Two reviews (Lewis, 2007; McMyler and Pryjmachuk, 2008) found that the current evidence base does not support the use of contracts to prevent suicide, or as a tool to protect clinicians from malpractice litigation in the event of a client suicide.

5.2.3 - Sports events and physical activity

Lester et al (2010) found that physical activity and sports participation may have a beneficial impact on suicidality, at least in boys and men and in some ethnic groups. However, it is not clear whether physical activity acts directly on suicidality or through a mediating variable such as depression or higher self-esteem.

There is some evidence that sports events can reduce the rates of suicide on the societal level (Andriessen and Krysinska, 2009). However, there is a lack of studies exploring how sports spectatorship might influence levels of suicide risk in individuals and how mediating variables might operate on the individual level.

5.2.4 - Internet and technology

In a review of the role of the internet in suicidality Durkee et al (2011) found significant correlations between pathological internet use and suicidal ideation and non-suicidal self-injury. Pro-suicide websites and online suicide pacts were observed as high-risk factors for facilitating suicidal behaviours, particularly among isolated and susceptible individuals.

However, the evidence also showed that the internet could be an effective tool for suicide prevention, and provides a basis to spread awareness, education and support required to promote mental health and prevent suicidal behaviours.

5.3 - Evidence gaps

The review undertaken for this JSNA identified a particular lack of research evaluating interventions for particular groups, namely Lesbian, Gay, Bisexual and Transgender (LGBT) people, Black and Minority Ethnic (BME) groups, older people, people with a personality disorder, and suicide prevention in a military setting.

In addition, there is a limited good quality evidence base for a range of specific interventions including postvention, psychotherapies, medication for reducing suicide in depressive patients, public awareness, and the role of the internet. The review did not identify any cost-effectiveness research.

5.4 - Risk Groups

Certain factors are known to be associated with increased risk, including drug and alcohol misuse, unemployment, social isolation and family breakdown. People with a diagnosed mental health problem are at particular risk. The highest risks of suicide are among people who are alcohol dependent and those with a diagnosis of clinical depression (both 15%) or schizophrenia (10%). Previous suicide attempts are also an indication of particular risk.

Other risk factors include gender, age, debt, poverty, care received after making a suicide attempt, physical illness and chronic pain, bereavement, discrimination, and imprisonment. Evidence also suggests that adverse drug reactions (ADRs) to a new medication, change of dose or medication, or withdrawal can increase the risk of suicide. The recent cross government strategy (Department of Health, 2012) identifies the following high risk groups to be a priority for prevention:

- Young and middle aged men
- People in the care of mental health services, including inpatients
- People with a history of self-harm
- People in contact with the criminal justice system
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers

Other groups may have a high risk but limited data means that the risk is hard to estimate and there is no way to monitor progress.

There is limited review-level evidence for interventions that work with targeted high risk groups.

Section 6 - Issues identified by services and families across Inner North West London

6.1 - Support to families

Overwhelmingly feedback from the stakeholders identified support for families and friends bereaved by suicide as an issue that is not currently being addressed systematically.

> "After the body was taken away, I was expected to clear the place and never heard from anyone else after that." A girlfriend whose boyfriend had committed suicide.

Immediately following a suicide. When services respond to a suicide incident there were reports from stakeholders that there is a lack of warmth or ability to deal with family members in shock. In addition families and friends were not aware of the processes following a suicide and the practical, emotional and psychological issues that may affect them.

Dealing with bereavement. People cope in different ways to bereavement. There appears to be limited services available to help support families bereaved through suicide.

Follow up for bereaved families. If families do not take up any offer of support immediately following a suicide there is no mechanism to follow up the family in the future when they may be in need of support or more ready to take up support. Also there is no systematic follow-up from the police or other services especially when children are involved. The support offered to families ends after the coroner's inquest (which can be long and complex and tends to end abruptly). This was felt to be inadequate especially where long term support may be needed.

6.2 - Integrated care

Issues of how services work together to provide co-ordinated care for people at risk of suicide was identified as another key issue in INWL.

Care pathways were highlighted as needing to improve, for example if someone has been discharged from hospital and is in recovery but one of the services they have contacted is concerned about them, this service would instinctively inform the GP but this information is not then always passed onto the mental health services who could provide treatment and prevent relapse.

Information sharing was also identified a gap between organisations especially in the notification of a completed suicide. Services do not always know when a patient has gone on to commit suicide. Furthermore, when suicide occurs, there is an expectation of a joint process review with GPs, but this does not always happen. There was a general consensus that there is insufficient sharing between the GPs, primary care and other services like the police to identify suicidality amongst patients who've not been in contact with mental health services.

> *"…an at risk person may be known to one or the other organisation previously but they don't share that information…"*

6.3 - Knowledge of suicide and mental illness

The lack of knowledge about risk of suicide and mental illness in general was identified by respondents. This was expressed in terms of

- individuals not knowing the mental health status of their family member
- services not understanding the suicide risk of their service users
- wider society not understanding the impact that mental health problems have on people

> "If families are not aware that their kin is suicidal, they are not able to offer the support that is required to mitigate suicide" INWL Service provider

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Appendix

Services across INWL

Organization	Referral Method	Description	Contact details
Camden and Islington Shaftesbury Road Project	Community Mental Health Team, GP, Other	Shaftesbury Road Project provides intensive outreach and intensive community rehabilitation support to adults aged 18 to 65 with mental health difficulties.	Tel: 020 7561 5479
London Notting Hill Housing Trust	Community Mental Health Team, GP, Other	The Notting Hill Housing Trust offers a range of services for people with mental health difficulties. It provides accommodation in Kensington and Chelsea as well as practical housing support in this borough and Barnet, Fulham and Hounslow	cst@nhhg.org.uk. Tel: 020 8357 5000
London Seventy4 Foundation	Self-referral	The Seventy4 Foundation offers individual and group counselling for people with drug or alcohol dependency problems, their families and partners. It also provides a dual diagnosis service for men and women who have both mental health and substance misuse problems. Support	Seventy4 Foundation, 18 Dartmouth Street, London, SW1H 9BL Tel: 020 7233 0400

Organization	Referral Method	Description	Contact details
		for eating disorders is also available. This service is available to people who live in London	
Victoria Community Mental Health Team	GP, Self-referral	Victoria Community Mental Health Team provides support and advice for people in Westminster between the ages of 16 and 65 with severe mental health issues. It can refer people to other local organisations where necessary	Victoria Community Mental Health Team, Hopkinson House, 6 Osbert Street, London, SW1P 2QU Tel: 020 8237 2041
South Westminster Victoria Assessment Service	Community Mental Health Team, GP, Other, Self-referral, Social services	The Victoria Assessment Service provides assessments for people with serious mental health problems to help them remain in their homes and live as independently as possible	Victoria Assessment Service, Gordon Hospital, Bloomsburg Street, London, SW1V 2RH Tel: 020 3315 2040
Westminster Joint Homeless Team	Self-referral	The Joint Homeless Team is a mental health service aimed at rough sleepers in Westminster who have no other access to services. Contacts are made by outreach and street work and regular contacts within day centres and other voluntary sector initiatives	Joint Homeless Team, Soho Centre For Health And Care, 1 Frith Street, London, W1D 3HZ Tel: 020 7534 6711
Westminster Drug Project Londonwide	Self-referral	Westminster Drug Project offers counselling and support to people with drug issues	Westminster Drug Project, 103 Kingsway, London, WC2B 6QX

Organization	Referral Method	Description	Contact details
		across	Tel: 020 7421 3100
Marylebone Workshop & Company	GP, Social services	Workshop & Company provides a workshop for rehabilitating people with mental health difficulties. It aims to raise individuals' self-esteem and confidence through practical assignments.	Workshop & Company, 26 Newman Street, Marylebone, London, W1T 1PW Tel: 020 7307 5150
Camden and Islington Kings Cross CMHT	Community Mental Health Team, GP	The Improving Access to Psychological Therapies (IAPT) programme is putting thousands more trained therapists into general practices. The scheme will provide easy access to talking treatment on the NHS to everyone who needs it. For more information on talking therapies and IAPT see our pages on Accessing Therapy. Kings Cross Community Mental Health Team (CMHT) offers specialist assessment, treatment and care to adults with mental health problems in their own homes and the community	Kings Cross CMHT, 1 Tottenham Mews, London, W1T 4AA Tel: 020 3317 6444
Kensington and Chelsea Child and Family Service	Self-referral	The Child and Family Consultation Service are a community-based multidisciplinary child and adolescent	Child And Family Consultation Service, Violet Melchett Clinic, Flood Walk, London,

Organization	Referral Method	Description	Contact details
		mental health team. It offers services to children and families from infancy to adolescence, with an emphasis on early interventions, to families and carers with pre-school infants and primary school age children as well as younger adolescents	SW3 5RR Tel: 020 8237 2837
Camden Psychology Assessment and Treatment Service	GP, Other	Camden Psychology Assessment and Treatment Service offers psychological assessment and treatment to people with mental health issues	Camden Psychology Assessment And Treatment Service, 8 Hunter Street, London, WC1N 1BN Tel: 020 7530 6800
City of London Adults Services	Self-referral	Adults Services at City of London Council offers advice, information, support, counselling and assistance to adult service users and their carers. It provides confidential services to adults on mental health, learning disabilities, physical disabilities or problems associated with caring for someone.	Adults Services, City Of London Council, The Guildhall, Po Box 270, London, EC2P 2EJ Tel: 020 7332 1224
Saint Pancras Holy Cross Centre	GP, Self-referral	The Holy Cross Centre runs drop-in sessions for vulnerable people in the King's Cross area. It has groups for homeless people, people with mental	The Holy Cross Centre, The Crypt, Holy Cross Church, Cromer Street, London, WC1H 8JU Tel: 020 7278 8687l

Organization	Referral Method	Description	Contact details
		health issues, refugees and asylum seekers. There is a session specifically for Italian speakers. It is a dry centre and will not admit people who have had a drink or taken illegal drugs	
South Kensington and Chelsea Assessment Team	GP ,Other, Self-referral, Social services	South Kensington and Chelsea Assessment Team offer assessment of individuals with mental health problems on an emergency basis, and referral to other local teams. This service is available to people aged 18 to 65, living in the South Kensington and Chelsea area	South Kensington And Chelsea Assessment Team, South Kensington And Chelsea Mental Health Centre, Nightingale Place, London, SW10 9NG Tel: 020 3315 5288
South Kensington and Chelsea Crisis Resolution	Community Mental Health, Team, GP, Other, Social services	South Kensington and Chelsea Crisis Resolution Team offers home treatment to people between the ages of 18 and 65 who are experiencing acute mental health difficulties, who might otherwise be admitted to hospital. It also provides home support to people who have been admitted to hospital in order to allow for an earlier discharge. This service is for residents of South Kensington and Chelsea	Crisis Resolution Team South Kensington & Chelsea, South Kensington & Chelsea Mental Health Centre, 1 Nightingale Place, London, SW10 9NG Tel: 020 3315 2711

Organization	Referral Method	Description	Contact details
South Kensington and Chelsea Outpatient Department	Community Mental Health Team, GP	South Kensington and Chelsea Outpatient Department provides outpatient care for adults aged 18 to 65 who are suffering from severe or acute mental health difficulties	Outpatient Department, South Kensington Chelsea Mental Health Centre, Nightingale Place, London, SW10 9NG Tel: 020 8846 6052
Kensington and Chelsea Adult Mental Health Centre	Community Mental Health Team, GP	Kensington and Chelsea Adult Mental Health Centre is a base for the provision of comprehensive mental health services to adults aged 18 to 65 years. It offers psychological therapies including counselling	Kensington And Chelsea Adult Mental Health Centre, 1 Nightingale Place, London, SW10 9NG Tel: 020 8846 6051
Kensington and Chelsea Willow Day Hospital	Community Mental Health Team, GP	Kensington and Chelsea Willow Day Hospital provides a large variety of day services to adults aged 18 to 65 who have any kind of mental health difficulty. It offers classes on relaxation as well as support groups for men and women	Kensington And Chelsea Willow Day Hospital, South Kensington And Chelsea Mental Health Centre, 1 Nightingale Place, London, SW10 9NG Tel: 020 8846 6046
Kensington and Chelsea SMART Social Club	Self-referral	Kensington and Chelsea SMART Social Club provides an open access drop-in for people with mental health needs	Kensington And Chelsea Smart Social Club, The Basement, 15 Gertrude Street, London, SW10 0JN Tel: 020 7376 4668

Organization	Referral Method	Description	Contact details
Camden Clinical Psychology Service	GP, Other	Camden Clinical Psychology Service offers a psychological assessment and treatment service to people in the Camden and Islington areas experiencing mental health problems	Camden Clinical Psychology Service, 211 Kings Cross Road, London, WC1X 9DN Tel: 020 7685 5700
Camden Psychodynamic Psychotherapy Service	Community Mental Health Team, GP, Other	Camden Psychodynamic Psychotherapy Service provides psychodynamic psychotherapy to people in the Camden and Islington areas. Psychodynamic psychotherapy is a form of talking therapy, which aims to help you to understand more about yourself and your relationships	Camden Psychodynamic Psychotherapy Service, 211 Kings Cross Road, London, WC1X 9DN Tel: 020 7685 5703
London Action on Addiction SHARP	Self-referral	SHARP (Self-Help Addiction Recovery Programme) is a structured day programme which offers advice and counselling as well as recovery plans. It also offers a range of alternative therapies. It covers the London area	Sharp, Action On Addiction, 11 Redcliffe Gardens, London, SW10 9BG Tel: 020 7349 5772
Central London Samaritans	Self-referral	Covers Central London boroughs and people can drop in between 9am and 9pm.	Central London Samaritans 46 Marshall Street, London, W1F 9BF www.cls.org.uk Helpline : Tel : 020 7734 2800

Organization	Referral Method	Description	Contact details
Central London Bloomsburg Day Service	Community Mental Health Team	Central London Bloomsburg Day Service provides day support for adults aged 18 to 65 who are registered with a Community Mental Health Team. It offers gym sessions, art classes and one-to-one bridge-building services	Central London Bloomsburg Day Service, 1 St Mary's Terrace, London, W2 1SU Tel: 020 7725 5100
London Look Ahead Housing and Care	Self-referral, Social services	Look Ahead Housing and Care offers specialist and outreach support to vulnerable and isolated people, including homeless people and families, teenage parents, women experiencing domestic violence, people with a history of offending, young care leavers, people with substance misuse issues and people with mental health issues and learning difficulties	Look Ahead Housing And Care, 1 Derry Street, London, W8 5HY Tel: 020 7937 1166
Central Kensington CMHT	GP, Other, Self-referral	Central Kensington CMHT provides a service to people living within the Earls Court and Kensington area who have a severe or enduring mental illness and who are under the care of the South Kensington and Chelsea Mental Health Centre	Community Mental Health Team, 1b Beatrice Place, Marloes Road, London, W8 5LW Tel: 020 7361 7900

Organization	Referral Method	Description	Contact details
Camden Tenancy Support Team South	Community Mental Health Team, GP, Self-referral	The Tenancy Support Team provides support to residents of Camden aged 18 and above who are experiencing enduring mental health problems and who need support to live independently. Help is given across a range of housing, welfare rights, financial, legal, employment, training and health issues	Tenancy Support Team, Crowndale Centre, 218 Eversholt Street, London, NW1 1BD Tel: 020 7974 8888
Sound Minds Wandsworth	Community Mental Health Team, Self-referral	Sound Minds is a user-led independent charity that works with people with severe mental health problems. It offers an arts studio, training in live music, music technology and visual arts, as well as DJing, filmmaking, poetry and drama. This service is available for free to people living in the London borough of Wandsworth, and to people who can access funded referrals from elsewhere in London	Sound Minds, 20-22 York Road, London, SW11 3QA Tel: 020 7207 1786
Kensington and Chelsea Mental Health Befriending	Self-referral	The Kensington and Chelsea Mental Health Befriending Scheme recruits, trains and supervises volunteers to visit isolated people with severe and enduring mental health	Kensington And Chelsea Mental Health Befriending Scheme, 76 Pembroke Road, London, W8 6NX Tel: 020 7938 8295

Organization	Referral Method	Description	Contact details
		problems in Kensington and Chelsea	
Barons Court Day Centre	Self-referral, Social services	Barons Court Day Centre is open to people who are isolated, lonely or homeless, or have had mental health problems. General afternoon drop-in sessions are available and users can take part in different groups and classes. The drop-in covers **Hammersmith and Fulham**	Barons Court Day Centre, Barons Court Project, 69 Talgarth Road, West Kensington, London, W14 9DD Tel: 020 7603 5232
Barons Court Project	Self-referral	Barons Court Project is a day centre for people in West London who are homeless or have mental health problems. It provides CAB benefits advice, tenancy sustainment support, a low cost cafe and laundry and shower facilities. It also runs a black people's group, a mental health group and a women's group	Barons Court Project, 69 Talgarth Road, West Kensington, London, W14 9DD Tel: 020 7603 5232
Hammersmith and Fulham Mind	Self-referral	Hammersmith and Fulham Mind provides information, advice and support for people living with mental health problems	Hammersmith And Fulham Mind, 309 Lillie Road, Hammersmith, London, SW6 7LL Tel: 020 7471 0580
Battersea Haydon House Residential Rehabilitation	Community Mental Health Team, GP, Self-referral	Haydon House Residential Rehabilitation provides residential	Haydon House Residential Rehabilitation, Haydon Way, St

Organization	Referral Method	Description	Contact details
		rehabilitation for men aged 18 to 65 who are suffering from severe or acute mental health difficulties in Battersea	John's Hill, London, SW11 1YG Tel: 020 8874 5609
Hammersmith and Fulham Crisis Assessment Team	Community Mental Health Team, GP	Hammersmith and Fulham Crisis Assessment Team provides assessments and referrals for people over 16 who are experiencing a mental health crisis	Clay brook Centre 37 Clay brook Road London W6 8NF Tel: 020 7386 1113
Hammersmith FIRST	Community Mental Health Team, GP	FIRST (First Incident of psychosis Recovery Support Team) is a community mental health service for people aged 18 to 40 who have experienced their first episode of a psychotic illness. This service offers coordination of care and support to individuals and their families. This service is available to people living in the London borough of Hammersmith and Fulham	First First Floor Clay brook Centre 37 Clay brook Road London W6 8NF Tel: 020 7386 1160
Hammersmith and Fulham Gloucester House CMHT	GP, Self-referral	Hammersmith and Fulham Gloucester House CMHT provide support and advice for people between the ages of 18 and 65 with severe mental health issues. It can refer people to other local organisations	Gloucester House 194 Hammersmith Road London W6 8BS Tel: 020 8250 1900

Organization	Referral Method	Description	Contact details
		where necessary	
Hammersmith and Fulham Crisis Resolution Team	Community Mental Health Team, GP	Hammersmith and Fulham Crisis Resolution Team provide intervention and treatment to residents of Hammersmith and Fulham aged 18 to 65 who experience a mental health crisis. It offers services as an alternative to hospital admission	Hammersmith And Fulham Mental Health Unit Charing Cross Hospital Site Fulham Palace Road London W6 8RF Tel: 020 7386 1146
Hammersmith and Fulham Mental Health Day Unit	Community Mental Health Team, GP	Hammersmith and Fulham Mental Health Day Unit run a variety of group services for adult in patients with severe or acute mental health difficulties. It offers creative activities, talking groups and a variety of therapeutic interventions	Charing Cross Site Fulham Palace Road London W6 8RF Tel: 020 7386 1169
Kensington and Chelsea Grove Resource Centre	GP, Other, Self-referral	Grove Resource Centre (St Mark's Road) is a day centre for adults with mental health issues. It provides group therapy and group activities	Grove Resource Centre 1-9 St Mark's Road London W11 1RG Tel: 020 7313 6830
Westminster Portishead House	GP, Social services	Westminster Portishead House is a residential care home with 14 places for people with mental health issues. The home covers the Westminster area. The home provides continuing care, and aims to facilitate	Westminster Portishead House 5 Portishead House Brunel Estate London W2 5UP Tel: 020 7243 0697

Organization	Referral Method	Description	Contact details
		rehabilitation and recovery	
Kensington and Chelsea Parkside Clinic	GP, Other, Self-referral	Parkside Clinic offers a wide range of mental health support to people living in North Kensington. It provides a specialised family service for Arabic parents, children and young people who may be experiencing emotional, behavioural or psychological problems. It also offers adult psychotherapy as well as individual child psychotherapy, group and individual art therapy and cognitive behavioural therapy	Parkside Clinic 63-65 Lancaster Road London W11 1QG Tel: 020 8383 6123
North Kensington Parkside Clinic Adult Department	GP, Other, Self-referral	The Parkside Clinic is a consultation and therapy centre for people with emotional, behavioural and other mental health problems of all ages and backgrounds in the North Kensington area of West London	Parkside Clinic Adult Department 63-65 Lancaster Road London W11 1QG Tel: 020 8383 6123
Kensington Hestia Community Support Team	Community Mental Health Team, GP, Self-referral, Social services	Kensington Hestia Community Support Team offers housing and support to help homeless people on the streets. It delivers a range of housing, care and support services for	Kensington Hestia Community Support Team 1st Floor, The London Lighthouse 111-117 Lancaster Road London W11 1QT

Organization	Referral Method	Description	Contact details
		homeless people including those with mental health needs	Tel: 020 7313 2950
Wandsworth Oak Lodge Cranstoun Drug Services	Self-referral	Oak Lodge provides services for men and women over 18, who have experienced difficulties with their drug and/or alcohol use and in maintaining abstinence, who want to be drug free	Oak Lodge Cranstoun Drug Services 136 West Hill London SW15 2UE Tel: 020 8788 1648
Kensington and Chelsea Mind	Self-referral	Mind provides information and services supporting and promoting the recovery, growth and wellbeing of people suffering from mental distress to enable them to live full and independent lives	Mind Kensington And Chelsea Office 1 7 Thorpe Close London W10 5XL Tel: 020 8964 1333
Kensington and Chelsea Pepper Pot Day Centre	Self-referral	The Pepper Pot Day Centre offers a range of services for older people (over 60 years old) from the African Caribbean community in Kensington and Chelsea. It offers lunch for a small charge and a home meal service for older people. It also offers information and advice on social and health issues and benefits, recreational and leisure activities and a befriending service for those who live alone or are isolated	Pepper Pot Day Centre 1a Thorpe Close Ladbroke Grove London W10 5XL Tel: 020 8968 6940

Organization	Referral Method	Description	Contact details
Kensington and Chelsea Mind's Service User Network (SUN)	Self-referral	Service User Network provides an advocacy service to minority ethnic mental health service users in Kensington and Chelsea	Service User Network Office 8 7 Thorpe Close London W10 5XL Tel: 020 8964 1333
Westminster Community Outreach Rehabilitation Team	Community Mental Health Team	The Community Outreach Rehabilitation Team (CORT) provides intensive support for people aged 18 to 65 with severe and enduring mental health needs who are difficult to engage in more traditional services	Community Outreach Rehabilitation Team (cort) 7a Woodfield Road London W9 2NW Tel: 020 7266 9620
Westminster Waterview Day Centre	Community Mental Health Team, GP	Westminster Waterview Day Centre provides a community support for adults aged 18 to 65 who have severe or enduring mental health difficulties It also offers psychotherapy.	Westminster Waterview Day Centre 7a Woodfield Road London W9 2NW Tel: 020 7266 9550
London Cyrenians Housing Cambridge Gardens	Other	Cambridge Gardens offers supported housing for people with mental health problems and complex needs in London	Cambridge Gardens 57 Cambridge Gardens London W10 6JD
Kensington Turning Point Linden House	Community Mental Health Team	Turning Point Linden House is a supported housing facility providing long-term accommodation with 24-hour support and supervision for 10 people with severe and enduring mental	Kensington Turning Point Linden House 209 Ladbroke Grove Kensington London W10 6HQ

Organization	Referral Method	Description	Contact details
		illness. It serves the Kensington area	Tel: 020 8964 8411
Kensington and Chelsea Advocate for Mental Health	Self-referral	Kensington and Chelsea Advocate for Mental Health provides advocacy services to people who have mental health needs, helping to improve the provision of mental health services	Advocate For Mental Health 73 St Charles Square London W10 6EU Tel: 020 8969 3000
London Al Hasaniya Moroccan Women's Centre	Self-referral	The Al Hasaniya Moroccan Women's Centre provides support to Moroccan and Arabic speaking women and their families, including refugees and asylum seekers. Services include counselling, benefits advice and help with housing, homelessness, domestic violence, health and mental health	Al Hasaniya Moroccan Women's Centre Bays 4 And 5 Trellick Tower Golborne Road London W10 5PA
Kensington and Chelsea Oremi Centre	GP, Other, Self-referral	The Oremi Centre is a mental health day centre offering outreach, advice and information to African and Caribbean people who are in need of mental health support services	Oremi Centre Unit 3 Trellick Tower 5 Golborne Road London W10 5PA Tel: 020 8964 0033
Kensington Lexham House	GP, Social services	Lexham House provides a therapeutic living environment for 11 people recovering from mental illness	Kensington Lexham House Lexham House 28 St Charles Square North Kensington London W10 6EE

Organization	Referral Method	Description	Contact details
			Tel: 020 8969 8745
Hammersmith and Fulham Ellerslie Road Day Centre	Community Mental Health Team	Hammersmith and Fulham Ellerslie Road Day Centre provides day services to adults aged 18 to 65 who have severe or enduring mental health difficulties. All referrals must come through a Hammersmith and Fulham Community Mental Health Team	Hammersmith And Fulham Ellerslie Road Day Centre 50 Ellerslie Road London W12 7BW Tel: 020 8749 9392
Kensington and Chelsea and Westminster EIP Team	Community Mental Health Team, GP, Other, Self-referral, Social services	Kensington and Chelsea and Westminster Early Intervention in Psychosis Team is a community mental health service for people aged 14 to 35 who are experiencing the first symptoms of psychosis	KSW Early Intervention In Psychosis Team 2nd Floor, The Tower St Charles Hospital Exmoor Street London W10 6DZ Tel: 020 8962 7638
London Action on Addiction SHARP	Self-referral	SHARP (Self-Help Addiction Recovery Programme) is a structured day programme which offers advice and counselling as well as recovery plans	Sharp Action On Addiction 11 Redcliffe Gardens London SW10 9BG Tel: 020 7349 5772
APRIL		APRIL (Adverse Psychiatric Reactions Information Link) is a charity that raises awareness that every day medicines and anaesthetics can induce depression, anxiety, insomnia, agitation, self harm, suicidal thoughts and	APRIL Room 311 Linen Hall 162-168 Regent St London W1B 5TD Tel: 020 7998 1561

Organization	Referral Method	Description	Contact details
		actions, or violence towards others.	
Helpline for: Depression, anxiety, obsession and mental health			
Rethink	Support and advice for people living with mental illness.		Phone: 0300 5000 927
Depression Alliance	Charity for sufferers of depression. Has a network of self-help groups		n/a
CALM	The Campaign against Living Miserably, for men aged 15-35		
MDF: the bipolar organisation	A charity helping people living with manic depression or bipolar disorder		
Samaritans	Confidential support for people experiencing feelings of distress or despair		Phone: 08457 90 90 90
Sane	Charity offering support and carrying out research into mental illness		Phone: 0845 767 8000
Mind	Promotes the views and needs of people with mental health problems.		Phone: 0300 123 3393
The Mental Health Foundation	Provides information and support for everyone with mental health problems or learning disabilities		
Young Minds	Information on child and adolescent mental health. Services for parents and professionals.		0808 802 5544
PAPYRUS	Young suicide prevention society		0800 068 4141

Other useful sites and numbers

CALM's helpline and texting service is aimed at young men who are down or have hit a wall for any reason. However, anyone can ring, so it's there if you need to ring and talk to someone. It's a confidential and anonymous service, currently open from 5pm to midnight on Saturdays, Sundays, Mondays and Tuesdays. Calls won't show on the phone bill.

In London, call 0808 802 5858 (free from landlines within London & mobiles).
Outside London, call 0800 585858 (calls free on 3, Virgin, Orange and Vodafone and landlines).
Or text CALM on 07537 404717, start your first text CALM1.
For text relay dial 18001 + 0808 802 5858 / 0800 585858. Translation facility via interpreter also available.

BEREAVEMENT

Survivors of Bereavement by Suicide (SOBS)
Support, information and local group meetings by those bereaved by the suicide of a close friend or relative.
National Helpline: 0844 561 6855, 9am to 9pm daily.
www.uk-sobs.org.uk

Compassionate Friends
Support for all families bereaved after the death of a child or children.
Phone 0845 123 2304, open 10am-4pm, 7pm-10pm daily.
www.tcf.org.uk

Cruse
Help for anyone experiencing bereavement to understand their grief and cope with their loss, with free and confidential support.
Helpline 0844 477 9400, open Monday to Friday 9.30am to 5pm.
www.crusebereavementcare.org.uk

The Sand Rose Project
Organises breaks for bereaved families.
Office: 0845 607 6357, open Monday and Wednesday, 9am to 3pm.
www.sandrose.org.uk

Widowed and Young (WAY)
Social and support network for widowed men and women under 50.
0300 012 4929
www.wayfoundation.org.uk

BEREAVEMENT & CHILDREN

Cruse RD4U Young People's Helpline
Telephone help for bereaved young people, provided by Cruse.
Helpline: 0808 808 1677, open Monday to Friday 9am to 5pm.
www.rd4u.org.uk

Childhood Bereavement Network
Database of information about sources of support for bereaved children.
Office 0207 843 6309
Childline 0800 1111
www.childhoodbereavementnetwork.org.uk

Childhood Bereavement Trust
Support and advice for bereaved families.
01494 568 900, open Monday to Friday 9am to 5pm
www.childbereavement.org.uk

Grief Encounter
Mission: every bereaved child and their family in the UK get the best possible help, recognition and understanding following their loss.

Monday-Friday 9-5pm 020 8446 7452
www.griefencounter.org.uk

Red Chocolate Elephants, *by Diana Sands.*
This is an Australian educational DVD and book for children and families bereaved by suicide. The DVD is available to order online from Amazon
Winston's Wish
Practical support for bereaved children, young people and their families, publications.
Helpline: 0845 203 0405, open Monday to Friday 9am to 5pm.
www.winstonswish.org.uk

SUPPORT / COUNSELLING

British Association of Counselling and Psychotherapy (BACP)
Find a professionally qualified counsellor in your local area.
NB If you are accessing the BACP website, go to the 'Find a therapist' page.
01455 883316
www.bacp.co.uk
Depression Alliance
Information and support service for people affected by depression.
Information Pack Request: 0845 123 23 20
www.depressionalliance.org
Maytree Respite Centre
Short-term free accommodation and befriending for the suicidal in a confidential and supportive environment.
020 7263 7070
www.maytree.org.uk
Papyrus
Support for anyone concerned about a young person who may be depressed or suicidal, or for those struggling with emotional distress or suicidal feelings themselves. Provides free and confidential helpline.
HOPELineUK0800 068 4141, open Mon to Fri 10am to 5pm and 7pm to 10pm; and weekends 2pm to 5pm
www.papyrus-uk.org
Parent Lifeline
Emotional support and advice to parents under stress of any kind.
Helpline: 0114 272 6575, open 9am to 1pm, 7pm to 11pm, daily.
www.parentlifeline.org.uk
Rethink National Advice Service
Help for people affected by mental illness.
Helpline: 0300 5000 927, open Monday to Friday, 10am to 1pm.
www.rethink.org

The Samaritans
Confidential emotional support for people who are experiencing feelings of distress or despair.
Helpline: 08457 909090 24 hours a day, 7 days a week.
www.samaritans.org.uk

Saneline
Practical information, crisis care and emotional support to anybody affected by mental health problems.
Helpline: 0845 767 8000, open daily from 6pm to 11pm.
www.sane.org.uk

OTHER

Inquest
Advice to bereaved families facing an inquest.
020 7263 1111
www.inquest.org.uk

Sudden Trauma Information Service Helpline
A confidential helpline service for survivors of all kinds of sudden trauma.
0845 367 0998
www.stish.org