NHS
South West London and St George's Mental Health NHS Trust

Suicide Prevention Strategy

2021 - 2024

A 3 year strategy that continues work from the initial strategy, year of year specific annual objectives will be updated added each year* This will be fully reviewed in 2024.

***This strategy will run in conjunction with the Trust Quality Strategy**

Respectful Open Collaborative Compassionate Consistent

Suicide Prevention Strategy

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Every day in England around 13 people take their own lives.

The death of someone by suicide has a devastating effect on families, friends, workplaces, schools and communities. If we want to improve the life chances of future and current generations, we need to address this disturbing reality and do more to prevent suicide.

Every suicide is an individual tragedy and can happen at any age, but suicide is not inevitable and central to any prevention work must be the maintenance of hope and recovery.

South West London & St George's Mental Health NHS Trust (SWLSG) will continue to work in partnership with other agencies to ensure that vulnerable individuals and those at times of crisis are supported and kept safe from preventable harm. We recognise that the prevalence of suicide reflects wider inequalities, as there is a marked difference in suicide rates according to people's social and economic circumstances with those in poorer communities more likely to be affected.

This strategy is based on the key national policy documents and current research on suicide and suicide prevention. Its main focus is upon reducing the risk of suicide in those individuals known to SWLSG services; however, we acknowledge that because suicide is such a complex behaviour with a number of underlying causes, approaches to prevention must be wide-ranging. Therefore, we will continue to work collaboratively with other statutory organisations, third sector providers, service users/patients, their families, friends and carers' and will ensure that the Trust Suicide Prevention Strategy aligns with the wider regional strategy.

The Prime Minister has spoke about the ambition for the Government to tackle burning injustices, including the inequalities caused by poor mental health. Addressing suicide and its prevention is a key part of that ambition, as suicides are more likely to occur in areas of low social and economic prosperity, in under-served communities and among those experiencing a range of challenges to their health, employment, finances, social and personal lives.

Introduction

Data published in 2021 reports that it is estimated that annually 800,000 people across the world die by suicide, with 5,316 people sadly taking their life in England in 2019.

Suicide is multi-factorial and is different for every individual; it is often the combination of factors rather than one single factor. Mental ill health and distress is one of the major factors associated with suicide and is associated with an increased risk of completed suicide. In 2015, 28% of suicides in the UK general population, had been in contact with mental health services in the year before their death and around one third of these suicide deaths occurred in those who had recent inpatients admissions.

SWLSTG continues with its zero-suicide ambition, which carries a foundation belief that deaths of individuals within mental health services are seen as preventable. It presents a bold goal and aspirational challenge, and this strategy continues to build on the progress made since the suicide prevention strategy was first launched in 2018, Suicide is not inevitable and there are many ways in which mental health services can improve clinical practice to reduce suicide among those with mental ill health.

This strategy is aimed at all staff employed by the Trust and all its key stakeholders involved in the work of Suicide Prevention. Service Users and Carers have contributed to the development of the Strategy and will remain involved in its implementation. It builds on the suicide prevention strategies developed at both place-based and system-based levels through the South West London Health and Care Partnership. Progress will be monitored and supported through the work of the Suicide Prevention & Mortality Committee.

Following several years of decline, the number of suicides in England has increased in 2018 and 2019, with the greatest increase seen in people aged 10-24 years, and men aged 45-60 years. It is of the utmost importance that we do all we can to reduce this trend, so that fewer people die by suicide. But it is also of the utmost importance that when, tragically, somebody does end their life by suicide their family, friends and broader community who have been bereaved have whatever support they need in place to manage their loss.

The impact of Covid 19 continues to have a significant effect on people and their lives. We recognize the impact this year has had on some people's mental health and wellbeing. Our voluntary sector partners regularly inform us about the increase in people who have been seeking support. We also recognize the longer-term impacts that the pandemic may have, particularly on the economy and employment, that may act as a driver of mental ill health

Local picture

South West London and St George's Mental Health NHS Trust

The rate of deaths by suicides has remained consistent over the previous three years;

Incident Type	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Suspected Suicide	14	39	47	33	22	25	21

Currently in 2021/22, the Trust is seeing a notable increase (Q2 and Q3) of suicides and if the rate continues the same trajectory, the year-end figure be double the previous year (2020/21). However, 15/16 and 16/17 also saw a notable spike. All deaths by Suicide (or suspected) are subject to a full investigation.

Hanging and overdose remain the most reported means, although there have been more train events in the last two years.

The majority of cases (over 60%) relate to white British persons and nearly 70% are male, with 46-55 being the age range most affected. There has been a notable increase in the number of younger persons affected.

Suicide Prevention Strategy Suicide and Prevention Summit

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The Trust launched its three-year Suicide Prevention Strategy in 2018 which established key initiatives and actions for each that was also dovetailed into the Trust Annual objectives.

The strategy was very successful and helped embed our culture that all suicides are seen as being preventable, plus delivered on a number of specific objectives. The Suicide Prevention Strategy has ben revised and continued from 2021 that builds on current achievements and include a range of new initiates and actions.

The current strategy concluded in 2021 which coincided with the Suicide Prevention Virtual Summit; a series of interactive workshops that explored a range of topics from the perspective of suicide prevention and how this can inform our future work and strategy to help prevent suicide in our communities. The input from a wide range of stakeholders from the SLP, CQC, NHSE, CCG and LA, along with our clinical teams and service user representatives made this submit a great success.

The workshops included

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Suicide Prevention Summit Launch Event – This event set the scene and context which included talks from people with lived experience and looking at regional, national and trust level data. It provided the opportunity to reflect on the many achievements delivered through the 2018 – 2021 Suicide Prevention Strategy and outlined the key workshops that would follow. It also enabled reflection on the challenges around Covid-19 and the implications on mental health.

Zero Suicide: What does it mean for my practice – Explored case studies and the meaning of 'zero suicide'. It looked at the science around errors and learning and how this is core to the design of safety systems and practice. Covered working with individuals who have mental health problems whilst experiencing chronic and suicidality, and how approach treatment, with risk formulation being a critical skill.

Risk Assessment Masterclass – Explored key learning harnessed from incidents and through our risk assessment training (RATE) and how to navigate around difficult areas and interfaces to ensure risks around suicide are properly manged through the lens of risk assessment and how effective and 'interactional' risk assessment is so important.

Dual Diagnosis – Covered research into the interaction of substance misuse and severe mental illness and how this dual diagnosis provides a dangerous mixture and presents a major challenge to mental health services in the future. Focused on national and local ONS data and how 'Co-occurring substance use disorders and mental illness' and the links to increasing risk factors leading to suicide. Considered national guidance and practical application for clinical management and how it links to current trust policy.

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Suicide Prevention in Children and Adolescents – Specific focus on the particular risks faced in children and young people, through case study and how-to best mange risks through multiagency working, noting the increase in such event over recent years. Covered key learning from previous serious events.

Just Culture & the new SI Investigation Framework – a powerful session driven by lived experiences from both staff and families that have been involved in post serious incident processes. The session focused on how to ensure that there is always a culture of fairness and openness to maximise opportunities in learning from mistakes whilst recognising the need for accountability. The session looked at the NHS 'just culture guide' and how the trust could continue to improve with its application and the necessary behaviours, polices and processes needed to ensure this culture is achieved and maintained, whilst exploring how this can be used conjunction with the new national patient safety strategy and Patient Safety Incident Response Framework (PSIRF)

Summit Closing Session - Provided a roundup of all the individual workshops, summarising the key contents and main outcomes from each interactive session. It covered the work of the national Zero Suicide Alliance and our plans for greater participation and the session formally launched the dedicated Suicide Prevention Resource page on our Intranet was developed to provide a central areas and access to a wide range of resources.

The feedback from Summit and individual workshops was fantastic and its clear that a number of resulting reflections, insights and actions with many linked to individual practice and or greater awareness.

Suicide prevention and improving practice standards – Work plan for 2021/22

South West London and St George's Mental Health NHS Trust

2021/22 Key measures of Success/ Outcome:

a) Dual Diagnosis training available for staff
b) Joint working with Network rail and Transport for London
c) Recovery college facilitated 'Zero Suicide' session in place
d) Annual suicide prevention conference delivered

**Includes other objectives reflected from Trust Quality Priorities*

Quarter 1 Milestones/ Deliverables	Quarter 2 Milestones/ Deliverables	Quarter 3 Milestones/ Deliverables	Quarter 4 Milestones/ Deliverables
• **Dual diagnosis policy reviewed** **Lead: Dual Diagnosis Lead**	• Dual diagnosis nurse consultant appointed • Establish a Dual Diagnosis Group to review associated pathways / access to services*	• Input into dual diagnosis SLP complex care workstream to support development of pilot	• Training for dual diagnosis developed (core, generalist and specialist)
• **External stakeholders** **Lead: Deputy Medical Director**	• Meet with network rail to agree focus areas • Continue to forge relationships with local Universities around suicide prevention and awareness*	• Develop suicide prevention and transport infrastructure working group.	• Established process and lines of communication for raising concerns/alerting re patient risks* • Develop safety plans for Barnes hospital • Develop information sharing process between SWLSTG, network rail and TfL
• **Zero Suicide Alliance and Training** **Lead: Dual Diagnosis Lead**	• Raise further awareness of training to staff • Create suicide awareness training for service users and carers as part of the Recovery College training programme*	• Develop facilitated zero suicide alliance training for family/carers	• Launch session at Recovery College and develop schedule • Review of the suicide awareness training for service users and carers as part of the Recovery College training programme *
• **Reviews - outputs and themes from suicide prevention summit** **Lead: Clinical Director – A&UC**	• Develop working group for conference • Undertake a themed review of deaths by suicide within the Home Treatment Teams*	• Date scheduled and programme designed • Review the Ligature Policy, training and induction standards	• Suicide prevention conference delivered • Outcomes from the themed review of deaths by suicide

Suicide Prevention Strategy

AIM

A zero suicide ambition that carries a foundation belief that deaths of individuals within mental health services are seen as preventable. It presents a bold goal and aspirational challenge and this strategy is the first step towards achieving this. Suicide is not inevitable and there are many ways in which mental health services can improve clinical practice to reduce suicide among those with mental ill health.

Key Work Programmes

Trust Quality Strategy focuses on continuous improvement, coproduction and research to ensure fundamental standards of care are delivered –with key themes including - risk assessment, clinical systems, crisis planning, deteriorating patient, non-engagement, discharge planning and third party interface,.

Continued drive to reduce inequalities to support improved access, patient experience and outcomes across South West London and implementation of EMHIP interventions.

Community transformation to deliver the Long Term Plan objectives with the development of a personality disorder care pathway, community rehabilitation service and expanded perinatal provision.

Implement the key recommendations from National Patient Safety Strategy, including training and ensuring 'Just Culture' is embedded throughout SWLSTG to support learning from incidents

7 National Areas

- Reduce risk of suicide in High risk groups
- Tailored approaches to improve mental health in specific groups
- Reduce the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring
- Reduce the rates of self-harm

Key Actions

- Establish Emotionally Unstable Personality Disorder pathway
- Duel Diagnosis Nurse consultant to develop and deliver training programme
- Establish Trust wide Virtual Risk Approach
- Extend the additional provision of CAHMS Paediatric Liaison Services
- Fully imbed Zoning into all settings
- Evaluation of transformed crisis pathway
- Development of improved integration of care through primary care networks

- Work with Schools to help identify high risk YPs and access to CAMHS, plus other signposting to support for teachers and pupils
- Embed domestic violence training through services
- Become a Veteran Accredited Trust
- Continue collaboration with universities
- Reduce inequalities by Improving access, patient experience and outcomes
- Support increased awareness of autism in crisis teams

- Extend the Ligature Assessment Programme (in-patient) to include key areas in community settings and complete the Safer standards assessment
- Through collaborative work with Pharmacy & general practice reduce access to high risk medication, including review of discharge planning
- Joint working group with Transport for London and British Rail

- Improve information and signposting on the Trust Website
- Review the range of support arrangement that are assessable and strengthen signposting to national and local sources of support, including educational, emotional and practical aspects.

- Work with the media promote the responsible reporting & portrayal of suicide & suicidal behaviour, particularly in the wake of a specific patient death
- Ensure that the media and internal team are aware of the latest guidance in regards to promoting responsible reporting & portrayal of suicide and suicidal behaviour
- Promote zero suicide alliance training

- Ensure that the highest levels of compliance with national audit requirements
- Provide data to the regional Suicide Prevention Groups
- In CAMHS sharing research and support on contagion with primary care, including media implications in the event of celebrity suicide /'copycat'
- Deliver Annual suicide prevention conference with thematic review
- Continued review of all relevant NICE Guidance published

- Deliver NICE compliant treatment for self harm in liaison teams
- Evaluation of crisis access through Coral, CAT and MHSL

Implementation of the Strategy

South West London and St George's Mental Health NHS Trust

The Trust suicide prevention objectives remain aligned to the National Suicide Prevention Strategy (NSPS) and aim to reduce the suicide rate in the population of individuals that come into contact with our services and to provide better support for those bereaved or affected by suicide more generally.

We will therefore focus our efforts around the seven areas for action highlighted in the NSPS to deliver these objectives.

The NSPS 7 main action areas are:

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 the 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
7. Reducing the rates of self-harm as a key indicator of suicide risk (added to the NSPS in 2017)

The strategy has been shared with the local boroughs and the leads for suicide prevention and their input will link to annual plans. The strategy has been endorsed by the Medical Director lead who Chairs the Trust Mortality & Suicide Prevention Group.

The strategy will be delivered through the Mortality & Suicide Prevention Action Plan, overseen by the Mortality & Suicide Prevention Group

Action Area 1: Reduce the risk of suicide in key high-risk groups

What do we know?

The National Confidential Inquiry continues to highlight the importance of optimising ward safety, particularly by removing ligature risks on in-patient wards and reducing absconding. Research has also shown that three specific measures, access to crisis care, dual diagnosis policies, and effective reviews after a suicide death, help to prevent suicide.

Suicide rates with people with mental health difficulties remain a key challenge and the highest suicide rates are still found in men in their 40s and 50s and it remains the leading cause of death in young men. At the same time, the suicide rate in women has risen, though the male rate is still three times higher.

27% of people who died by suicide had contact with mental health services in the 12 months before death, although Mental Health in-patient and post discharge deaths continue to fall

We know that, for people who have self-harmed, skilled psychosocial assessment leads to better outcomes; that safer wards and early follow-up on hospital discharge and effective crisis resolution home treatment teams help prevent suicide. We know that supporting young people at risk is a job for primary care, schools, the justice system and third sector as well as mental health services.

A central theme for the national strategy is the need for local suicide prevention plans in every area, put together by the joint working between public health, mental health and the many agencies that support vulnerable and high-risk people which have now been established throughout South West London.

Action Area 1: Reduce the risk of suicide in key higher-risk groups

We will;

- ensure robust risk assessments processes and provide mandatory clinical risk assessment and formulation training (RATE) that focuses on suicide and self-injury to ensure there is early identification of those at high risk.
- use Zoning to help manage clinical risk
- ensure that out of area placements are only ever as a last resort
- provide psycho-social assessments recommended by NICE to provide more comprehensive picture that could be incorporated into care and personal safety management plans.
- ensure accessible services to those at increased risk, by maintaining links with other local services and organisations, ensuring clear pathways into services, for example we will work with local agencies to promote services for males with mental health difficulties.
- for those known to mental health services or referred by their GP as requiring urgent care or who are in crisis, we will work to ensure they experience timely appropriate responses.
- ensure patients who self-injure and present in Emergency Departments we will ensure flagging up at triage, timely assessment, and follow-up by the most appropriate service.
- further reduce the risk of absconding by providing more consistent, comprehensive pre and post leave risk assessments and care plans.
- ensure that there are clear post discharge plans with details of the follow-up arrangements from of transition from in-patient services to the community.
- 48 hour face-to-face follow up of all patients discharged from in-patient to community care (phone follow up for other patients)
- include family and carers in risk assessments and care planning whenever possible
- monitor the risks around 'contagion' in young persons

Action Area 2: Tailor approaches to improve mental health in specific groups

What we know?

The National strategy has highlighted the importance of implementing tailored approaches to improving mental health in a range of groups with specifics needs and characteristics that may expose them to more risk factors for suicide. These include children and young people, the lesbian, gay, bisexual and transgender (LGBT+) community and people from Black and Minority Ethnic (BME) groups, but also people with long-term physical health conditions and people with untreated depression.

South West London and St Georges Mental Health trust recognizes that:

- There is an increasing number of deaths in adolescents aged between 15and 17 years old and female patients.
- People who experience domestic violence have an increased risk of suicidal behaviour
- Personality disorder, eating disorders, drug misuse and self-harm are more common
- Higher rates of unemployment, physical and mental illness increase the risk
- The Risk profiles differs between ethnic groups
- Healthcare professionals have worked through the pandemic and may have experience trauma and burn out
- There is increased focus on the health and wellbeing of Veterans
- People with autism are at increased risk of dying from suicide in adolescence and adulthood

Action Area 2: Tailor approaches to improve mental health in specific groups

We will;

- we will work in partnership with a variety of agencies to identify the best approaches to promote the health and well- being and challenge health inequalities where they exist within the specific characteristics of the population of the region.
- no one will be discharged without a clear discharge plan that gives clarity of who will be providing care in the community and enables positive patient engagement. In addition, care plans will be collaborative with families and carers'
- we will ensure that lessons learnt following incidents of absconding or of patients being absent without leave are disseminated and appropriate strategies put in place to decrease the risk in this area.
- we will improve the physical health management of our service users through support around smoking cessation, weight management, and substance misuse, in addition to integrating physical health into decisions about prescribing and monitoring of medication.
- we will work collaboratively with a variety of agencies to promote our services to those who may feel marginalized
- continue to invest in the Recovery College to provide support to service users
- we will improve the experience of patients who are at points of transition between services.
- we will develop our peer support networks to ensure that those with lived experience are involved in both the design and delivery of our services and can drive recovery focused organisational change
- Work towards gaining Veterans Accreditation
- Train our staff to further develop their understanding of how to support people with autism
- Ensure our staff to identify and support people who experience domestic violence

Action Area 3: Reduce access to the means of suicide

What we know

Restriction of access to lethal means of suicide is one of the most effective strategies for suicide prevention in the general population. People may attempt suicide on impulse, and if the means are not easily available or if they attempt and survive, the suicidal impulse may pass. One of the most effective ways to prevent suicide is to reduce access to means of potential high lethality.

The National Confidential Inquiry reports that the methods most amenable to intervention are removal of potential ligature points in in-patient settings, withdrawal of certain analgesics and limitations in the size of packs that can be purchased, restrictions on the quantities of medications that can be used for self-poisoning being dispensed and reducing the access to areas with easily accessible means of suicide such as multistory car parks and motorway bridges.

Inpatient suicides have reduced since 2004 through stronger risk assessments and better design of fixtures and fittings

Action Area 3: Reduce access to the means of suicide

We will;

- maintain our arrangements for annual review of risk assessments of all in-patient areas, and continue to invest anti-ligature measures both proactivity (EMP) and as a result of risk assessment findings
- work with family and carers' and involve them when appropriate in patients' Personal Safety Plans, to make them aware of potential hazards and to help them work with individuals to identify and reduce access to means at times of crises.
- we will attempt to identify and reduce potential means of suicide by limiting supplies of medication
- we will support patients to reduce stockpiling of medicines
- we will assess access to medicines from other sources (e.g. other household occupants, purchased in retail or online)
- we will carry out medication reviews in line with the NICE guideline on medicines optimisation to reduce unnecessary polypharmacy and use medicines with less risk of harm if taken in excess
- work collaboratively with General Practitioners and Pharmacists to ensure that there is ratification of prescribed medication and effective medicines management strategies identified to highlight non-compliance.
- we will share information when necessary and proportionate with other professionals including General Practitioners, Dispensaries, Criminal Justice Agencies, the Police and the British Transport Police when we are aware of suicidal ideation or plans that involve access to means that can be moderated.
- Use caution when talking and reporting to avoid portraying new high-lethality methods of suicide, that may increase the number of fatal suicide attempts

Action Area 4: Provide better information and support to those bereaved or affected by suicide

What we know

Families and friends bereaved by a suicide are at increased risk of mental and emotional problems and may be at higher risk of suicide themselves. Suicide can also have a profound effect on the local community. Postvention in these circumstances is essential to help survivors cope with their loss.

Close family members and friends are seriously affected by every suicide. We know from studies that, in addition to immediate family and friends, many others will be affected in some way; they include neighbours, school friends and work colleagues, but also people whose work brings them into contact with suicide – emergency and rescue workers, healthcare professionals, teachers, the police, faith leaders and witnesses to the incident.

Effective and timely emotional and practical support for families bereaved or affected by suicide is essential to help the grieving process, prevent further or longer-term emotional distress and support recovery.

Action Area 4: Provide better information and support to those bereaved or affected by suicide

We will;

- continue to invest and develop support and engagement through our Family Liaison Officer (FLO)
- provide information for staff to use when providing support to relatives and carers' (though the carer's group and our collaborative working)
- provide advice for staff in communicating with and supporting those bereaved or affected by suicide so that we can be more sensitive in our language, manner and approach and increase our awareness of the needs of this population.
- work with voluntary and self-help agencies, signposting those affected to local support groups when appropriate and providing links to other agencies via our website.
- participate with partner agencies, and share information and lessons learned about the impact on families and friends bereaved by the suicide so that we can help them to find the most appropriate support.
- keep families informed of actions taken or lessons learnt from their relative's death including any changes as a result of the investigation or inquest.

Action Area 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour

What we know

The media have a significant influence on behaviour and attitudes. There is-compelling evidence that media reporting and portrayals of suicide can lead to copycat behaviour, especially among young people and those already at risk. Promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media.

There is growing concern about the misuse of the internet to promote suicide and suicide methods. The internet also provides an opportunity to reach out to vulnerable individuals who would otherwise be reluctant to seek information, help or support from other agencies. The internet industry being swift to remove content that encourages suicide and provide ready access to suicide prevention services is very important.

As a Trust we must promote the responsible reporting and the portrayal of suicide and suicidal behaviour in the media. It is important that we attend to the language we use in communications. Terms such as 'committed suicide' which have annotations with crime; blame; shame and guilt are not helpful and should be avoided.

Action Area 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour

We will;

- the Communications Team will continue to work with the media to help promote the responsible reporting and portrayal of suicide and suicidal behaviour, particularly in the wake of a specific death involving suicide within services delivered by the Trust.
- ensure that the media and internal team are aware of the latest guidance in regard to promoting responsible reporting and portrayal of suicide and suicidal behaviour in the media and within reports
- we will tackle stigma and discrimination, inspiring a culture where these are actively challenged.
- increase the awareness of staff of the influence of social media.
- improve and develop the Trust's internet site as a source of support and resources for the public and other stakeholders, linking to third party websites where appropriate.
- participate in and promote appropriate national and local campaigns, such as World Suicide Prevention Day, World Mental Health Day and Time to Change.
- Maintain membership of the Zero Suicide Alliance

Action Area 6: Support research, data collection and monitoring

What we know

Reliable, timely and accurate suicide and self-injury / suicide attempt statistics are crucial in order to develop any meaningful suicide prevention Strategy which is of tremendous public health importance. Public Health England is establishing an evidence and intelligence function. This will include gathering information on suicide prevention activities and data on suicide and self-injury in order to publish the data to support the Public Health Outcomes Framework. Research is essential to suicide prevention.

Research studies enhance our understanding of the statistical data provided by the Office for National Statistics (ONS) to inform strategies and interventions; highlight trends and changes in patterns; identify key factors in suicide risk and enhance our understanding of risk groups; evaluate and develop interventions to reflect changing needs and priorities and develop the evidence base on what works in suicide prevention.

Action Area 6: Support research, data collection and monitoring

We will;

- facilitate regular reviews of suicides, subject them to thematic analyses and ensure that lessons learnt are disseminated with a view to constantly improving our services.
- maintain links and work closely with the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.
- complete and return questionnaires and requests for data on Suicide and Homicide promptly.
- we will work to obtain early indications of emerging patterns, such as clusters or particular patterns of suicides, before data are compiled by the ONS.
- support local and national initiatives on research studies on suicide prevention and effective interventions and those that identify and aim to address gaps in current knowledge, particularly Zero Suicide Alliance
- Review all relevant NICE guidance to ensure that services are delivering effective care

Action Area 7: Reducing the rates of self-harm as a key indicator of suicide risk (added to the NSPS in 2017)

What we know

Self-harm is poorly understood in society even among those who in their working lives as school teachers, pastors, social workers, housing officers, police, prison officers and even nurses and doctors encounter people who harm themselves. People who harm themselves are subject to stigma and hostility. In contrast to the trends in completed suicide, the incidence of self-harm has continued to rise in the UK over the past 20 years and, for young people at least, is said to be among the highest in Europe. This high level of self-harm among different age and social groups is a worrying feature of our society

The National Strategy identified those who self-harm as a high-risk group and has including self-harm as a new key area for action.

Self-harm, including attempted suicide, is the single biggest indicator of suicide risk. The UK has high rates of self-harm resulting in over 200,000 hospital attendances per year in England. Approximately 50 per cent of people who have died by suicide have a history of self-harm, and in many cases, there has been an episode of self-harm shortly before someone takes their own life

Action Area 7: Reducing the rates of self-harm as a key indicator of suicide risk (added to the NSPS in 2017)

We will;

- ensure that self-harm remains a key aspect of risk assessment and clinical intervention
- that all incidents are reported and investigated
- ensure all serious incidents will have a thorough RCA investigation
- ensure staff follow the search policy when patients have leave
- Implement the personality disorder pathway through the community transformation programnme

Patient and public involvement

Locally the Trust will develop effective partnerships across all sectors including health, social care, education, housing, employment, the police and criminal justice system, transport and the voluntary sector. We will continue to be represented as an active member of the local Suicide Prevention Partnership and participate in all its activities for reducing suicide locally.

We will use the NICE quality standards, defining high quality care, relevant to both local authorities and Clinical Commissioning Groups (CCGs) in their commissioning roles. Existing quality standards relevant to suicide prevention include alcohol dependence, depression in adults, self-injury in adults and self-injury in vulnerable groups.

The National Suicide Prevention Strategy Advisory Group (NSPSAG) provides leadership and support for suicide prevention initiatives including advice on monitoring and analysing trends in suicide at a national level. The Trust will monitor the intelligence it gathers from this source to update the local suicide prevention Strategy regularly.