



# Suicide Prevention Strategy

## 2018 – 2021

A 3 year strategy that contains specific annual objectives that will be updated each year.



# 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

'Safer Care' Quality Improvement focusing on learning through information gathering and analysis – through interactive workshops and change ideas establishing key themes including - risk assessment, clinical systems, crisis planning, deteriorating patient, non-engagement, discharge planning and third party interface, eg. GPs and Social care.

Improvement plans in these areas are being developed and will play a major part in our strategy to prevent suicide.

The Trust has established Suicide Prevention as a key objective in the 2018/19 Trust Quality Priorities (TQP) with associated actions being monitored.

The following actions have been established through the development of the Strategy in line with the 7 areas in the national plan.

## 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

- Review Emotionally Unstable Personality Disorder pathway
- Assess the Dual Diagnosis Policy against NICE standards
- Update Virtual Risk Approach
- Extend the additional provision of CAHMS Paediatric Liaison Services
- Improve young person's risk assessment process to include elements of knowing someone who has died from suicide and online networks.
- Fully imbed Zoning into all community settings

- Work with Schools to help identify high risk YPs and access to CAMHS, plus other signposting to support for teachers and pupils
- Increase liaison between MASH and CAMHS through a new practitioner

- Extend the Ligature Assessment Programme (in-patient) to include key areas in community settings.
- Through collaborative work with Pharmacy & general practice reduce access to high risk medication, including review of discharge planning

- Improve information and signposting on the Trust Website
- Establish a co-production group to review supporting information
- 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

- 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'

- Undertake a themed & detailed analysis of self-harm incidents over the last two years
- Run a learning event on findings and how to implement improvements
- In CAMHS imbed the new role, MH Nurse for self-harm to improve liaison support Undertake a QI pilot with in a Liaison Team to review the support and follow-up of patients who present to A&E that self-harm

## Suicide Prevention Strategy

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.

In 2017, the Prime Minister 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



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## Introduction

The most recent data available, published in 2017 reports that between 2005-2015 there were 49,545 known deaths in the general population that were registered as suicide or “undetermined”, an average of 4,504 per year. (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2017 (NCISH)).

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, the person had been seen by mental health services in the year before their death. Around one third of these suicide deaths occurred in those who has recent in-patients admissions.

The Trust has a 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 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. This strategy is aimed at staff employed by the Trust and all its key stakeholders involved in the work of Suicide Prevention. Service Users and Carers' have also been invited to contribute in the development of this Suicide Prevention Strategy.

Over recent years there has been a slight decrease in suicide rates in England, However there are still far too many and show the need for continuing vigilance and effort and the Trust is committed to this.



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## Implementation of the Strategy

The Trust suicide prevention objectives are 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 lead suicide prevention lead who sits on 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 has highlighted 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, i.e. access to crisis care, dual diagnosis policies, and effective reviews after a suicide death, help to prevent suicide.

Although the suicide rate in England has fallen slightly, it is too soon to say whether this fall is the beginning of a downward trend. However we shouldn't underestimate the scale of the challenge if we are to meet the national ambition of reducing the suicide rate by 10% by 2020/21.

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.

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. Similarly, a central theme of this year's report on 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



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

### We will continue to;

- embed our risk assessment 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.
- target complacency and de-sensitisation that can occur when working with high risk individuals on an extended basis
- decrease the risk of absconding by providing more consistent, comprehensive pre and post leave risk assessments and care plans.
- work to provide improved monitoring and support post discharge from in-patient services.
- ensure that there are clear post discharge plans with details of the follow-up arrangement and relevant contact numbers as the highest risk of suicide occurs at points of transition from in-patient services to the community.
- fully implement the 48 hour face-to-face follow up of all patients discharged from in-patient to community care (phone follow up for other patients)
- will enhance post discharge support for those who are returning to the area from out of area placements due to potential increased needs in this group.
- include family and carers in risk assessments and care planning whenever possible.
- monitor incidents of DNA / failing to engage to ascertain underlining causes



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## 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 specific 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.



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

### What we will continue to do?

- 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.
- establish a specific group (including service user rep) to develop care plans
- 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 are to be more 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 develop Personal Safety Plans through Care Plans for those identified at risk of suicide or self-injuring, which will incorporate strategies that they can employ, contact numbers and details of their support network to minimize the risk at times of crisis.
- 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, for example we will work closely with Primary Care to facilitate access or services to those in higher risk groups who have mental health difficulties.
- Continue to invest in the Recovery Collage 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 organizational change



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## 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.



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## Action Area 3: Reduce access to the means of suicide

### What we will continue to do

- 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, such as in forensic services
- extend our ligature risk assessment to include community outpatient settings
- we will 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 issued to individuals at times of high risk, and routinely communicating advice about supply to the General Practitioner. We will facilitate removal of excessive medication or return of medications that are not being used.
- we will 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 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.



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## 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. It is estimated that 6 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.



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

### What we will do

- we will continue to invest and develop support and engagement through our Family Liaison Officer (FLO)
- develop an information pack for staff to use when providing support to relatives and carers' (though the carer's group and our collaborative working)
- we will provide training 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.
- we will 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. We will include details of the support after suicide website <http://supportaftersuicide.org.uk/> and the Help is at Hand booklet <http://sprsweb02-v.xswlstg-tr.nhs.uk/cgi-bin/patience.cgi?id=4ae9c6d7-42db-4829-96ce-815cb3e00261> and other bereavement specialist organisations.
- we will 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.
- we will 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.



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## 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 already compelling evidence that media reporting and portrayals of suicide can lead to copycat behaviour, especially among young people and those already at risk.

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. 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

### What we will continue do

- 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 regards 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.



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## 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.



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## Action Area 6: Support research, data collection and monitoring

### What we will continue to do

- facilitate annual 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.



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## 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

The National Strategy in 2012 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<sup>23</sup>, and in many cases there has been an episode of self-harm shortly before someone takes their own life



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

### What we will continue to do

- Ensure that self-harm remains a key aspect of risk assessment and clinical intervention
- All incidents are reported and investigated
- All serious incidents will have a thorough RCA investigation
- Ensure staff follow policy in regards to leave and searching



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## 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.



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# Suicide prevention and improving practice standards

## Measure of Success/ Outcome:

- a) Suicide awareness booklet in place
- b) Improved self-harm safety plans in place
- c) Improved absconding risk assessments in place.
- d) Carers' information available around suicide.

Quarter 1 Milestones/ Deliverables	Quarter 2 Milestones/ Deliverables	Quarter 3 Milestones/ Deliverables	Quarter 4 Milestones/ Deliverables
<ul style="list-style-type: none"> <li>• <b>(From 2017/18) Complete risk assessment re-audit and implement recommendations from these.</b></li> </ul>	<ul style="list-style-type: none"> <li>• Continue with local audits</li> <li>• Ensure themes are included in the Safe Care QI Programme</li> </ul>	<ul style="list-style-type: none"> <li>• Review compliance with 48 hour post discharge follow up</li> <li>• Commence self-harm thematic review</li> <li>• Achieve 95% compliance for RATE training</li> </ul>	<ul style="list-style-type: none"> <li>• Assess Dual Diagnosis Policy</li> <li>• Fully imbed Zoning into community settings</li> <li>• Review EUP Pathway</li> <li>• Reduce access to high risk medication</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Develop communication strategy to support suicide awareness across the Trust and ensure all staff under key risk groups.</b></li> </ul>	<ul style="list-style-type: none"> <li>• Produce suicide awareness materials (including booklet).</li> </ul>	<ul style="list-style-type: none"> <li>• Ensuring ongoing communications around suicide awareness.</li> </ul>	<ul style="list-style-type: none"> <li>• Ensuring ongoing communications around suicide awareness</li> <li>• Provide online Suicide Prevention Training and make accessible via the Trust Website</li> <li>• Conclude on the pilot work in St Georges PLS</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Set up group (including service users) to develop personal safety plans for those at risk of self-harm or suicide</b></li> </ul>	<ul style="list-style-type: none"> <li>• Create personal safety plan.</li> </ul>	<ul style="list-style-type: none"> <li>• Pilot personal safety plan.</li> </ul>	<ul style="list-style-type: none"> <li>• Finalise personal safety plan and implement in all services.</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Review s17 leave policy and ensure fit for purpose; make amendments as defined.</b></li> <li>• <b>Identify current environmental risk assessments and ensure these are up to date and appropriate.</b></li> </ul>	<ul style="list-style-type: none"> <li>• Complete baseline audit around pre- and post- leave assessments.</li> </ul>	<ul style="list-style-type: none"> <li>• Agree approach to improve leave planning and associated care pathways; implement changes.</li> </ul>	<ul style="list-style-type: none"> <li>• Re-audit leave assessments.</li> <li>• Extend ligature risks assessments into community settings</li> </ul>