Avon and Wiltshire Mental Health Partnership NHS Trust

Suicide Prevention Strategy

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Contents

1. Terminology

In-patient suicide:

Death by suicide of a person who was registered as being an inpatient within a mental health ward/unit/hospital at the time of their death, irrespective of the exact location of their death.

Patient suicide:

Death by suicide of a person who had been in contact with mental health services in the 12 months prior to their death, but excluding IAPT and other primary care based mental health services.

Suicide:

The act of deliberately taking one's own life. Excludes other definitions where the word 'suicide' is also used – eg: 'physician-assisted suicide', 'suicide bomber', etc.

Suicide rate:

Refers to the number of suicides which have been adjusted to take into account epidemiological variations in populations (groups of people) such as age, gender, number of people receiving a service, etc. Nationally and internationally the suicide rate is the number of suicides per 100,000 of the population.

2. Introduction

Suicide is a devastating event; family, friends, and the wider community feel its emotional and practical consequences. This strategy outlines the wide range of work being undertaken across AWP that contributes to the prevention of suicide and describes our plans for the next three years (2017-20). As with our previous strategy (2014), it is consistent with the aims and approach of the national strategy – Preventing Suicide in England 2012 and updated in 2017.

Suicide prevention is a complex and challenging task which requires a co-ordinated approach by a number of different agencies. Research indicates that the prevention (minimisation) of suicide, while feasible, involves a whole series of activities, ranging from the provision of the best possible conditions for bringing up our children and young people, through the effective treatment of mental disorders, to the environmental control of risk factors. Therefore prevention strategies should be directed partly at factors which reduce the risk of suicide occurring (eg: availability of dangerous means for suicidal acts, knowledge and attitudes of the population concerning the prevalence, nature and treatability of mental disorders, and media portrayal of self-harming and suicidal behaviour), and partly at recognised high risk groups (eg: people with mental health problems, people in prison, people with an addiction to alcohol and/or drugs).

In general, national suicide rates have risen since the 2008 recession except in Scotland where there has been a sustained fall. The rate in England now appears to be falling. The highest rate is in Northern Ireland. There is variation also within each country, by geographical area. In England this variation is systematic, with higher rates in the north and south-west, and lower rates in London and adjacent south central areas.

There continues to be wide variation in suicide rates in each country by age and gender, with the highest rates in men in middle age. The highest male to female ratio is in Northern Ireland.

The number of suicides by mental health patients in the UK has risen in recent years, mainly as a result of increases in England. This primarily reflects the large rise in the number of people under mental health care in England. During 2004-14, 28% of suicides in the UK general population were by people under mental health care, a total of 18,172 deaths since 1996.

Data relating to suicide, undetermined death and high risk groups has been obtained from the:

- Office of National Statistics (ONS) – 2015 [This is the most recently published data].
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) – 2016.
- Department of Health (England) – Suicide prevention: Third annual report – 2017.

A target of reducing suicide by 10 percent by 2020, from its 2015 baseline, has been set by the Department of Health. Our strategic aim is to follow the Zero Suicide Ambition, aiming to reduce

our total number of suicides to zero. The concept of 'zero suicide' grew out of frustration about the existing approaches to suicide prevention in the US. It challenges to some extent the prevailing wisdom that suicide is inevitable for some people when they hit rock bottom. The idea of 'zero suicide' provokes debate about how much more we might be able to do in the future to avoid such tragedies. It is very hard to look back and think that perhaps something was missed, and the 'zero suicide' approach recognises up front that such ambition has no place at all for blame.

AWP links with public health colleagues who are responsible for suicide prevention in our local general populations, through our six locality suicide prevention groups, and our two STP areas. Each STP will have its own over-arching suicide prevention strategy, with AWP being an active participant in these networks.

3. National trends in suicide

The ONS definition of suicide includes all deaths from intentional self-harm for persons aged 10 and over, and deaths where the intent was undetermined for those aged 15 and over. This definition was revised in January 2016.

According to the ONS the most recent data on suicides can be summarised as:

- In 2015 there were 6,188 suicides in the UK, a small increase from 6,122 deaths in 2014.
- In 2015, the suicide rate in the UK rose slightly to 10.9 deaths per 100,000 of the population, up from 10.8 in 2014. This was made up of a decrease in the male suicide rate from 16.8 to 16.6 deaths per 100,000 of the population and an increase in the female rate from 5.2 to 5.4 deaths per 100,000, the highest female suicide rate since 2005.
- Of the total number of suicides (6,188 deaths) registered in the UK in 2015, three-quarters (75%) were males and one-quarter (25%) were females.
- The most common method of suicide amongst males and females in the UK in 2015 was hanging.

4. National trends in suicide in mental health patients

Mental health patient suicides are referred to as 'patient suicides' by the NCISH, and for the purposes of suicide prevention reporting this group of people is defined as those individuals who were either in contact with mental health services (including statutory drug and alcohol services) at the time of their death, or had been in contact with services at any point in the 12 months prior to their death (NCISH, 2016). This definition does not currently include people who have only been referred to primary care-based mental health services, such as IAPT.

The number of patient suicides in the UK, driven by figures from England, has risen over the past 20 years. However, the *patient suicide rate* – ie: taking into account increases in the number of people under mental health care, has fallen. The calculation is not straightforward, however, being complicated by inconsistent estimates of total patient numbers, re-organisation and re-provision of mental health services (including new models of care delivery), and a changing clinical population.

Suicide by mental health in-patients (ie: people who were registered as being in a mental health unit at the time of their death) continues to fall, most clearly in England where the decrease has been around 60 percent during 2004-14. This fall began with the removal of ligature points to prevent deaths by hanging, but has been seen in suicides on and off the ward and by all methods. Despite this reduction, there were 76 suicides by in-patients in the UK in 2014, including 62 in England.

The trend in individual settings is clearer. The main setting for suicide prevention is now the crisis team, following a substantial fall in in-patient suicides and a rise in the use of CRHT as an alternative to admission in acute care. The fall in suicides after leaving in-patient care has been less substantial and the post-discharge period, especially the first two weeks, continues to be a time of high risk.

The clinical and social characteristics of patients who die by suicide show a number of changes over the last 20 years. Certain risk factors have become more common as precipitants of suicide - these are the factors that services have to address to reduce risk, including:

- Isolation
- Economic adversity
- Alcohol and drug misuse
- Recent self-harm

Non-adherence to medication in the period leading to suicide has become less common; loss of contact is less frequent than 20 years ago but continues to be a common antecedent.

5. Methods of suicide – general population

The most common methods of suicide among the general population are:

- Hanging and strangulation – 47%
- Self-poisoning (overdose) – 21%
- Jumping and multiple injuries – 11%
- Drowning – 4%
- Gas inhalation (including carbon monoxide poisoning) – 3%
- Cutting/stabbing – 3%
- Firearms – 2%

6. Methods of suicide – mental health patients

Between 2004 and 2014, 13,921 deaths (28 percent of general population suicides) were identified as patient suicides – ie: the person had been in contact with mental health services in the 12 months prior to death, but excluding IAPT and other primary care based mental health services.

The number of suicides in male patients has increased since 2006. For females, there has been a 12 percent rise to 2013 since 2006. The rise in male patient suicides since 2006 is 22 per cent, whereas the general population rise in male suicides is less, at 12 percent from 2006 to 2013.

There was an increase in the number of male suicides in those aged under 25, 45-54, 55-64 and 65+. The rise in male patients aged 45-54 and 65+ has been particularly striking since 2005-06. The number of female suicides did not change overall in any age-group.

The most common methods of suicide by mental health patients were:

- Hanging and strangulation – 43%
- Self-poisoning – 25%
- Jumping/multiple injuries – 15%

The most common types of drugs used in suicide were:

- Opiates - 24%
- Tricyclic antidepressants – 12%
- Anti-psychotic drugs – 11%

- Paracetamol/opiate compounds - 9%
- SSRI/SNRIs antidepressants - 9%

7. Local trends in general population suicide

The suicide rate (number of suicides per 100,000 of the population) for each of our respective STP footprint areas is as follows:

- Bristol, North Somerset & South Gloucestershire 10.0
- Bath, Swindon & Wiltshire 8.9

The highest rate of suicide was in Cornwall and the Isles of Scilly, at 13.8, twice the lowest rate, in South West London, at 6.9. In general the highest rates are in the north and south-west, with the lowest rates in London and the south-central areas.

ONS suicide rates mapped to English local authorities can be found at: http://fingertips.phe.org.uk/search/suicide

8. National analysis of suicide trends in AWP

The NCISH provide data[1] for suicide rates in respect of all NHS trusts in England; the rates for 2011-13 and 2012-14 (the most up-to-date figures) show that:

- In 2011-13, we had a suicide rate of 11.4 per 10,000 people under mental health care, compared to the median of 7.65 for the rest of England;
- In 2012-14, we had a suicide rate of 8.6 per 10,000 people under mental health care, compared to the median of 7.13 for the rest of England.

National data analysed by Mazars[2] on behalf of NHS England in 2015 identified that our standardised death rate (all causes, including suicide) is higher than the national (England) average and the average for the South West of England.

These data, whilst recording a significant fall in the rate from 11.4 to 8.6 for the most recent years, nevertheless show AWP with a consistently higher rate than the national average for the rest of English NHS trusts. It is possible that our higher rates are, at least in part, explainable by the fact that total population suicide rates for the South West are higher than the average for the

[1] Summary data in this format have only been supplied by the NCISH since the start of 2016. Given this only covers two whole years, annual fluctuations should be treated with caution as these are not necessarily indicative of particular future trends.

[2] Mazars' data were supplied to AWP (along with other mental health trusts nationally) as a 'one-off' exercise as part of NHS England's (2015) follow-up to the investigation into the failings at Southern Health NHS Foundation Trust.

rest of England. It is important to state that in offering a possible explanation, we are not seeking to justify or accept an inevitably suicide high rate.

9. Suicide prevention within AWP

Our approach to suicide prevention is consistent with the Government's current strategy for England (2012), which was expanded in 2017. Additionally, there is an expectation that we include the principles derived from the 'Zero Suicide Program', which originated in Detroit, USA. This is a health systems-wide approach aimed at eliminating all suicides, and has been adapted for implementation in some parts of the UK. The limited UK evaluations of Zero Suicide (Centre for Mental Health, 2015) have yet to demonstrate either complete adherence to the US model, or the ability to successfully achieve zero suicides in the pilot sites. The contested nature of Zero Suicide means that we have adopted a pragmatic interpretation of the approach, focusing instead on 'zero tolerance' of non-implementation of core patient safety activities across all our clinical services – see Action Area 1, below.

Our strategy addresses seven key areas of suicide prevention activity:

1 Reducing the risk of suicide in high risk groups.

2 Tailoring approaches to improve mental health in specific groups.

3 Reducing access to means of suicide.

4 Providing better information and support to those bereaved or affected by suicide.

5 Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour.

6 Supporting research, data collection and monitoring.

7 Reducing rates of self-harm as a key indicator of suicide risk.

Core suicide prevention activity within AWP will focus on the domains for which we have primary responsibility. Each of the seven domains has been broken down into areas for action (see below), which inform our detailed 'suicide prevention work plan'.

10. ACTION AREA 1: Reduce the risk of suicide in high risk groups

What we know

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) has highlighted the importance of optimizing service user safety across care pathways. Specific aspects of the mental health care pathway where there is potential for suicide prevention includes:

- Removing and minimising fixed ligatures on inpatient wards reduces suicide;
- The majority of inpatient suicides have a history of absconding from, or not returning to inpatient care;
- Half of all inpatient suicide deaths occur in people who are being observed by less experienced or skilled staff;
- On discharge from hospital, the highest number of suicides occurs in the first three days of leaving hospital; and the first three months remains a significantly high risk period;
- Deaths in the first two weeks after discharge are linked to admissions lasting less than seven days, lack of a care plan on discharge, and adverse life events;
- Eleven percent of suicides occur in people who are discharged from out-of-area units (ie: a unit that is not local to them);
- Three times as many suicides occur in people who are in contact with crisis teams than occur in inpatient settings;
- Nearly half of all suicides among people under the care of crisis teams live alone; 40 percent die within two weeks of leaving hospital, and 33 per cent of crisis team patients have been under the service for less than one week;
- For people classed as ‘difficult to engage’, assertive engagement and follow-up practices are associated with lower suicide rates;
- Over 60 percent of suicides among people known to mental health services have an alcohol misuse problem, and more than one third have a drug misuse problem;
- The implementation of a dual diagnosis policy and protocols are associated with up to 25 percent fewer suicides;
- Multi-disciplinary incident review, the implementation of learning, and effective information-sharing with families are associated with significant reductions in suicide deaths;

- Depression and other mood disorders are the most common mental health problems associated with suicide; organisations that implement national clinical guidance (eg: NICE depression and self-harm guidelines) are associated with up to a quarter fewer suicide deaths;
- Person-centred risk assessment and management practice is associated with fewer suicide deaths, when compared to standard 'tick-box' screening and assessment;
- More effective engagement and collaborative care with families can significantly reduce suicide risk;
- There are fewer suicides in organisations who have a lower turn-over of clinical staff (excluding doctors);
- A recent episode of self-harm is a well-recognised antecedent to suicide; over half of all children and young people (under 20 years) had self-harmed in the week before taking their own life;
- The number of people who attend the emergency department for self-harm in the three months prior to suicide continues to increase;
- Opiate-based drugs, followed by tricyclic antidepressants are the most commonly used medications in fatal overdose;
- A quarter of people who die by suicide have a major physical illness (44 percent in people aged over 65-years);
- Major depression is linked to an increased suicide risk in people with diagnoses such as heart disease, stroke, chronic obstructive pulmonary disease and cancer;
- The highest suicide rates are in men in middle age. Suicide rates in men aged 45-54 years have increased by 26 percent since 2006; this appears to be more than twice that of the general population.

A summary of the main characteristics of people in contact with mental health services who die by suicide is provided in Table 1.

Table 1: Mental health patients who die by suicide are most likely to:
Demographics: • Be male • Be unmarried • Live alone • Be unemployed **Priority mental health groups:** • Have been discharged from mental health services within three months • Have missed last mental health contact within one month of death • Have not adhered with psychotropic medication in the month before death **Clinical features:** • Have been diagnosed with a mental illness within 12 months of death • Have had repeated in-patient admissions (>5) • Have had a final in-patient admission that was a *readmission* **Behavioural features:** • Have a history of self-harm • Have a history of alcohol misuse • Have a history of violence • Have a history of drug misuse **Contact with services:** • Have had their last contact with mental health services within 7 days of death • Have had recognised symptoms of mental illness at their final contact

What we will do

Action Area 1 is detailed in 6 sections below. Overall however, this strategy launches our Zero Tolerance approach which focuses on 3 vital areas of clinical practice relating to suicide prevention.

As an organisation we will not tolerate:

- Poor clinical risk assessment
- Poor clinical risk management
- Poor carer engagement in suicide prevention

This zero tolerance will be evidenced through every staff member constantly ensuring that both their own and their colleagues' clinical risk assessment, clinical risk management, and carer engagement in suicide prevention is observable as being of a high standard. Staff members will feel confident in their own practice and in appropriately challenging any examples where they consider this is not of a high standard. The aim is to standardise the culture regarding these domains across the whole organisation.

10.1 Inpatient care

9.1.1 Every inpatient ward will undertake regular (minimum annually) fixed ligature assessments to identify and remove (or manage the associated risks) ligature points.

9.1.2 Develop and implement an anti-absconding toolkit and resources.

9.1.3 Review and revise current observation and engagement policies and practice, utilising the most up-to-date evidence.

9.1.4 Review and revise post-hospital discharge policies and procedures to reflect the most up-to-date evidence.

9.1.5 Develop an 'Inpatient Module' for the Clinical Toolkit, which will include up-to-date information regarding all aspects of inpatient suicide risk assessment and management.

9.1.6 Reduce the total number of admissions to out-of-area beds by 75 percent from its 2017 baseline.

9.1.7 Appoint an 'Out-of-Trust Placements Manager'.

9.1.8 Establish due diligence processes in order to ensure that any non-AWP placement meets CQC quality requirements.

9.1.9 Establish systems which monitor all service users admitted to non-AWP placements.

10.2 Intensive services

9.2.1 Implement the Collaborative Assessment & Management of Suicidality (CAMS) across all intensive teams for people who are acutely suicidal.

9.2.2 Develop and implement the robust use of CAMS measures as a mechanism for assessing and monitoring the appropriateness of home treatment as the preferred service delivery option for people who are at high risk of suicide.

9.2.3 Continue to promote awareness via acute care reviews, service induction, clinical supervision, and professional development (training) of the relative suicide risk for the following:
a) the appropriateness of home treatment as the preferred service delivery option for people who live alone and have little or no social support;
b) the high risk period immediately following discharge from hospital;
c) the relatively high risk period when first taken on for home treatment.

10.3 Improve risk assessment and management processes

9.3.1 Promote an organisational culture regarding the importance of focusing on the following core patient safety domains:
- Comprehensive risk assessment;
- Effective engagement and collaboration with carers and family members regarding risk assessment and risk management;
- Comprehensive risk formulation and risk management plans.

9.3.2 Develop, implement and promote a cross-organisational strategy to promote and reinforce the essential nature of risk assessment, risk formulation and risk management as a core patient safety initiative.

9.3.3 Undertake a review and revision of the 'risk screen' elements of our current electronic patient record (RiO), ensuring that it reflects current evidence-based practice and good practice regarding the assessment and management of risk.

9.3.4 Integrate a 'risk formulation' section within the revised RiO risk screen, as a way of embedding formulation as a core element of risk management practice.

9.3.5 Undertake a review and revision of the clinical guidance on the assessment and management of risk.

9.3.6 As part of the revised Clinical Toolkit, develop and disseminate resources for practitioners which address:
- Adequate assessment and treatment of underlying condition and presenting symptoms;
- Removal and/or reduction in access to means;

- Modification of risk factors;
- Continued and regular assessment of risk.

9.3.7 Establish an operating standard of 100 percent compliance with completed risk assessment, risk formulation and risk management for eligible service users.

9.3.8 Ensure 'suicide prevention and risk assessment' (e-learning) training remains a mandatory requirement for all clinical (including clinical management) staff.

9.3.9 Provide team-based suicide prevention and risk updating for all clinical teams.

10.4 Family and carer involvement in risk assessment and management processes

9.4.1 Develop and implement a trust-wide patient safety initiative, with associated workplan, aimed at reinforcing and demonstrating consistent practice in relation to:
- Family/carer involvement and collaboration in respect of comprehensive risk assessment;
- Effective engagement and collaboration with carers and family members regarding risk management.

9.4.2 Develop and implement a trust-wide patient safety initiative and communication 'campaign' aimed at promoting and reinforcing the changes in culture with regard to family and carer engagement that ensures a consistent focus on:
- Improved risk assessment:
- Effective engagement and collaboration with carers and family members regarding risk assessment and risk management;
- Comprehensive risk formulation and risk management plans.

9.4.3 Revise and update the electronic patient record (RiO) risk screen, ensuring that the core elements of risk assessment, risk formulation and risk management are standardised, all of which provide the necessary administrative structures to prompt and reinforce the requirement to involve carers and family members in risk assessment and management processes.

10.5 Dual diagnosis

9.5.1 Promote the Dual Diagnosis Strategy across all teams and services and as part of training and professional development in suicide prevention.

10.6 Unexpected death review process

Addressed in ACTION AREA 4.

11. ACTION AREA 2: Tailoring approaches to improve mental health in specific groups

What we know

The national suicide prevention strategy identifies that one way to reduce suicide is to address the mental health of the population as a whole – frameworks and approaches to improved mental health are set out in No Health Without Mental Health and Healthy Lives, Healthy People. These are not necessarily discrete groups, and many individuals may fall into more than one of these groups, for example, some black, Asian and minority ethnic (BAME) groups are more likely to have lower incomes or be unemployed. Lesbian, gay, bisexual, transgender and questioning (LGBTQ) individuals are at increased risk of feeling marginalised and stigmatised.

We know that men are three times more likely than women to take their own life, and that middle aged men are at highest risk, particularly those who are socioeconomically disadvantaged. Men also often find it difficult to engage with mental health services.

We know that women with previous or current mental health problems are at increased risk of suicide during pregnancy.

Young people are vulnerable to suicidal thoughts and their risk may be increased when they identify with people who have taken their own life or when such acts are highlighted and promoted through various social media platforms. Self-injury is becoming increasingly common in this group. Older people are also a potentially high risk group – those who have self-harmed have a more significant level of lethality associated with their actions.

What we will do

11.1 Partnership working

10.1.1 Continue to work collegiately with public health leads and commissioners across all areas on the development and implementation of community-wide suicide prevention

plans.

10.1.2 Organise and administer bi-annual meetings with local authority public health/suicide prevention leads and the Bridge Master from Clifton Suspension Bridge.

10.1.3 AWP suicide prevention leads will participate in local suicide prevention strategy/monitoring groups.

10.1.4 AWP suicide prevention leads will participate in the emerging STP-wide footprint for suicide prevention strategies.

10.1.5 AWP will manage the Avon Coroner Suicide Monitoring Project, jointly commissioned by Bath & North East Somerset Council, as a way of monitoring and reviewing local suicide data.

11.2 Children and young people

10.2.1 Engage effectively with young people at risk of suicide.

10.2.2 Develop a plan of work with young people who self-harm.

10.2.3 Develop a plan of work supporting families of young people who self-harm.

10.2.4 Develop a plan of work aimed at promoting resilience in young people.

10.2.5 Develop a primary care training programme aimed at the identification of young people who are high risk of suicide.

10.2.6 Promote CAMHS to LGBTQ groups at increased risk of suicide.

10.2.7 Develop a standardised tool aimed at improving the assessment of suicide risk in young people who present to CAMHS.

11.3 Perinatal mental health

10.3.1 Identify and develop 'Perinatal Mental Health Champions' within each clinical team across AWP.

10.3.2 Implement cross-agency care pathways for pregnant and postnatal women, aimed at facilitating prompt identification, assessment and care planning for women in the perinatal period and ensuring no woman is discharged from mental health services

during and immediately after pregnancy.

10.3.3 Ensure senior psychiatric assessment for all pregnant women under mental health services, with care co-ordination or support by Band 6 qualified staff.

10.3.4 Ensure perinatal risks are identified and recorded as part of standard Safeguarding procedures and risk assessment.

11.4 BAME, LGBTQ, and unemployed individuals

10.4.1 We have not identified any *separate* actions regarding BAME and LGBTQ individuals, or the unemployed, as we envisage that we will address these groups of people via our active involvement with community-wide suicide prevention activities in locality public health services and STP footprints.

12. ACTION AREA 3: Reducing access to means

What we know

Reducing access to lethal or potentially high lethality means is one of the most effective ways of preventing suicide; for example, reducing pack sizes of easily available analgesics has led to a significant reduction in the number of suicide deaths associated with these drugs. Novel or new methods of suicide may occur at any time, for example the inhalation of solvent gas and barbecue fumes. People may attempt to end their life on impulse, and if high lethality means are not readily accessible or easily available, the suicidal impulse may pass.

Learning from previous unexpected death reviews has identified that:

- Many people who take their life have had a history of reluctant compliance or non-compliance with psychiatric medication.
- The risks of prescribing certain psychiatric medications are not always adequately assessed.

The most amenable methods to intervention are removal of potential ligature points in inpatient 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 in overdose being dispensed, and reducing access to areas with easily accessible means of suicide, such as multi-storey car parks and motorway bridges.

What we will do

12.1 Environmental safety monitoring of inpatient areas

11.1.1 Continue to assess, reassess and monitor access to non-collapsible curtain rails, shower rails and cubicle rails in all patient-accessible sites.

11.1.2 Continue with the ligature assessment, monitoring, removal and/or remediation of fixed ligature points such as door ironmongery, window fittings and locks, sanitary ware and bathroom furniture, and bedroom furniture.

11.1.3 Ensure that all inpatient areas undertake an environmental ligature audit using the Manchester Ligature tool on an annual basis, or more frequently if there has been a significant change of use or service redesign.

11.1.4 Implement a ligature monitoring and reduction strategy, informed by regular environmental assessment and review, overseen by the Ligature Reduction Group.

12.2 Supply of medication

11.2.1 Work collaboratively with GPs, community pharmacists and specialist suppliers of medication (eg: HIV medicines) to ensure that there is ratification of prescribed medication (medicines reconciliation) and effective medicines management strategies to highlight non-compliance.

11.2.2 Ensure access to the national Summary Care Record for all clinical staff involved in medicines reconciliation.

11.2.3 Assess the requirement for 'as required' medication and supply accordingly.

11.2.4 We will review, rationalise and ‘de-prescribe’ medications where indicated.

12.3 Proportionate information sharing to reduce the risk of suicide

11.3.1 Share information when necessary with other agencies and professionals – eg: GPs, pharmacists, criminal justice agencies, the police and British Transport Police when we are aware of active suicidal ideation or plans that involve access to means that can be moderated.

12.4 Monitor ‘suicide hot-spots’

11.4.1 Collaborate with public health colleagues to identify geographical ‘hot-spots’, where there have been one or more suicides. This information will be used to inform and intervene in order to improve safety in areas where a high risk area is identified.

13. ACTION AREA 4: Learning from investigations and reviews into unexpected deaths

What we know

The quality and generation of learning from incident reviews – specifically unexpected deaths and suspected suicides – is variable across the NHS, as well as within AWP. Strategies to address this variability have been introduced since 2015, including NHS England’s revised Serious Incident Framework (2015). AWP’s own analysis of suicide deaths among people in contact with mental health services has identified consistent themes of variable risk assessment and management, and overall poor quality of engagement with families and carers in the risk management process.

NHS England's report (2015) into failings at Southern Health recommended that all mental health and learning disability providers review their incident management and investigation processes to ensure that:

- There is a robust system for the investigation of all patient safety incidents;
- A system and framework are in place for the review of selected samples of incidents that do not necessarily meet the criteria for a full investigation.

In common with many other NHS providers (CQC, 2016), the implementation of learning following investigations and reviews continues to be a problem. The CQC identified that "too often, opportunities are being missed to learn from deaths so that action can be taken to stop the same mistakes happening again" (2016).

What we will do

13.1 Incident management

12.1.1 Establish an 'Incident Management Review Group' to ensure all incidents are reviewed and assigned the appropriate level of analysis and/or investigation.

12.1.2 Implement a three-tier investigation/review framework for all incidents (including unexpected deaths and suspected suicides), consisting of:

a. Management review
b. Structured judgement review
c. Root Cause Analysis

13.2 Information sharing and learning

12.2.1 Improve the recording, accessing and sharing of anonymised incident data within local networks – eg: suicide 'hotspot' data, etc.

12.2.2 Establish a 'Mortality Review Group' to ensure the learning from all unexpected deaths is appropriately identified, reviewed and shared in order to inform learning.

12.2.3 Publish internal 'Safety Bulletins' on a monthly basis to share summarised learning from reviews of unexpected deaths, suspected suicides and information identified by the Mortality Review Group.

14. ACTION AREA 5: Support for people bereaved or affected by suicide

What we know

Families and friends bereaved by a suicide are at increased risk of mental health and emotional problems, and may also be at higher risk of suicide themselves. Suicide can also have a

profound effect on the local community. It is estimated that typically, six individuals (family and/or friends) are directly affected by every suicide. In addition to immediate family and friends, many others may be affected in some way; they include neighbours, school friends and work colleagues. People whose work brings them into contact with suicide – emergency and rescue workers, healthcare professionals, teachers, police, etc. are also at risk of being adversely affected.

'Postvention' is essential to help and support those affected to cope with their loss.

What we will do

13.1.1 Provide written information, in accessible formats, for staff to use as an adjunct to support for families and others affected by suicide.

13.1.2 Update the AWP website to include specific information and links to sources of post-suicide support for those affected.

13.1.3 Work with local voluntary agencies and self-help groups to ensure that they are aware of how to access IAPT services for those people who require additional psychological support.

13.1.4 Work with local authority public health colleagues to support the development of dedicated bereavement support for those affected by suicide – eg: SOBS – aiming for a Trust-wide network of specialist postvention support.

13.1.5 Ensure that the importance of postvention and ongoing support for bereaved families/friends is highlighted and emphasised as part of our Incident Management Procedure.

15. ACTION AREA 6: Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour

What we know

The media have a significant influence on potential suicide behaviour and attitudes; there is compelling evidence that certain types of 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 potential misuse of the internet to promote suicide and suicide methods. However, the internet – particularly social media – also provides an opportunity to reach out to vulnerable individuals who might otherwise be reluctant to seek information, help or support.

As a trust we must promote responsible reporting and the portrayal of suicide and suicidal behaviour in the media.

It is important that we pay attention to the language used in all communications – eg: reports, investigations, training events and public meetings. Terms such as 'committed suicide' and 'commit suicide' have annotations with crime, blame, shame and guilt, and should be avoided.

The Samaritans organisation continues to work with the Independent Press Standards Organisation to implement the Editors' Code for reporting matters on suicide responsibly. Public Health England is committed to looking at ways in which it can strengthen the relationship between Samaritans, Public Health England and the Department of Health to support better monitoring of suicide reporting in the media.

What we will do

14.1.1 AWPs Communication Team will liaise with local media groups in promoting the Samaritans' code, and challenge irresponsible reporting. This will be done in collaboration with our Public Health and STP colleagues.

14.1.2 Respond positively to requests from regional and national media outlets regarding the promotion of positive messages about mental health and avoiding portraying suicide as the only option for people in emotional distress or crisis.

14.1.3 Improve and develop both the Trust's internet and intranet sites as sources of support for staff, the public, service users, carers and family members.

14.1.4 Participate in and promote relevant national and local campaigns, such as World Suicide Prevention Day and World Mental Health Day.

14.1.5 Host an annual patient safety learning event.

16. ACTION AREA 7: Supporting research, data collection and monitoring

What we know

The success of the National Strategy is reliant on good quality data at both national and local levels. Improving national data will help to continue monitoring suicide rates and identify emerging trends within high risk groups and new methods of suicide. Improving the quality of local data will be critical in supporting local areas to develop effective multi-agency suicide prevention plans that reflect the issues in their local communities.

Robust data collection and local action plans for suicide prevention should be developed at known 'suicide hotspots' (Public Health England, 2015).

What we will do

15.1.1 Review our use of the Ulysses incident management system and improve both our real-time and retrospective data intelligence.

15.1.2 Continue the local authority public health collaboration of Coroner data collection regarding suicide deaths, which includes sharing appropriately anonymised intelligence – eg: relating to suicide 'hot-spots', etc.

15.1.3 Develop our knowledge and sharing of suicide hotspots intelligence with STP colleagues and include British Transport Police and Network Rail.

15.1.4 Provide financial and other support to regional and national suicide research through continued links with local university academic research units – ie: University of Bristol.

15.1.5 Provide Research Capability Funding to the University of Bristol to develop future suicide research grant applications.

15.1.6 Host any successful future suicide research project bids.

15.1.7 Work with local commissioners to develop 'Self-Harm Registers' across the acute hospital interface within the AWP area.

17. Zero Suicide Ambition

'Zero Suicide' is part of the government's overall suicide prevention strategy, and in late 2018 it became a requirement for all mental health provider organisations to have a 'Zero Suicide Ambition' as part of their overall suicide prevention plans. All of our existing work regarding suicide prevention supports the overall ambition, and a quality standards checklist has been provided to assist organisations with implementing this aspect of their plans.

The concept of zero suicide is inspired by the Henry Ford system in Detroit, which began a programme of screening every patient for risk of suicide, not just those with mental health issues, in 2001 and enjoyed significant results. The suicide rate among its patient population fell by 75% within four years and by 2008, they eliminated all suicides among people in their care.

Some people believe having a similar aim to reach zero suicide within the UK is an over-ambitious objective, but the counterpoint to such a view is, if the target is not zero, what is an acceptable number for deaths by suicide? The Zero Suicide ambition aims to challenge the thinking that simply reducing suicide rates is enough.

The appointment of a dedicated government minister for suicide prevention in October 2018 led to an update to the Suicide Prevention Strategy for England in January 2019, which requires all mental health trusts to have in place plans for a Zero Suicide ambition by the end of 2018/19. NHS England and NHS Improvement have been tasked with monitoring the impact of the Zero Suicide work plans, and the quality standards checklist is summarized below. The checklist addresses four core domains:

1. Purpose, governance and engagement with stakeholders and partners.

2. Safe and effective care and treatment.

3. Competent and skilled workforce.

4. Analysis of data, information, research and innovation.

For ease of reference an addendum to the main suicide prevention work plan has been produced, identifying the actions required to ensure implementation of the Zero Suicide ambition. Where relevant, the main work plan has been cross-referenced.

Our Strategy and the associated Zero Suicide ambition is underpinned by the *10 Ways to Improve Safety* developed by the NCISH (Figure 1).

Figure 1: 10 Ways to Improve Safety in Mental Health Services, NCISH 2018

17.1 Purpose, Governance, and Engagement with Stakeholders and Partners	
a) 'Does the plan clearly outline a co-produced vision and scope for the Trust for the implementation of a zero ambition, showing a clear understanding of the definition of the ambition, its application and "myth-busting" based on the support webinar pack and FAQs? Does it focus on ensuring a culture based on therapeutic care and engagement with every service user?	
b) 'Does the plan evidence a baseline stocktake of what is currently in place across inpatient units for preventing suicide and self-harm, and identify existing foundations to build upon?	
c) 'Does the plan show effective engagement with stakeholders (staff, service users, carers and family members) on the definition and rationale for 'zero ambition' for inpatients, and the subsequent development of the plan? Are continued processes of involvement indicated as the plan is delivered?	
d) 'Are the following partners (at minimum) part of sign off, with roles and duties in continued support to the ambition clearly defined? Board of Directors namely Chief Executive; Chief Operating Officer; Medical Director and associates; Director of Nursing; Executive lead for Corporate Transformation (or equivalent); and Trust chief pharmacist.	
e) 'Is there a communications and implementation plan to ensure Trust wide understanding of the ambition and its aims?	
f) 'Does the plan show clear links to any existing wider plans (eg: STP, ICS) to reduce suicide generally, through the improvement of safety and quality in overall mental health services as per the '10 ways to improve safety' from the National Confidential Inquiry into Suicide and Safety in Mental Health Services?	
g) 'Does the plan evidence alignment to CQC Key Lines of Enquiry for 'Safe, Effective, Caring, Responsive and Well-led'?	
17.2 Safe and effective care and treatment **Does the plan evidence actions to ensure the following:**	
a) 'Clear process to ensure identification and staff support to high risk patients	

(including those with history of intent or self-harm).	
b) 'Personalised safety plans - ensuring existing of collaboratively developed psychologically-informed risk formulations and safety plans as a therapeutic intervention. This should include robust plans for leave.	
c) 'Chief pharmacist leadership for review of systems and processes of medicines optimisation including prescribing, storage and use.	
d) 'Restriction of access to means of suicide - in line with available resources from NHS Improvement estates and patient safety teams (updates sent via the National Mental Health Nurse Directors Forum Network).	
e) 'Beyond inpatient - 48 follow up after discharge via direct contact (phone or face-to-face).	
17.3 Competent and skilled workforce	
a) 'Does the plan evidence actions to develop an organisation-wide learning strategy; competency based suicide prevention training for all staff appropriate for their level and role? Are there systems in place for monitoring levels of attendance/competency? Robust plans should show how these actions are additional to having adequate staff mix for optimum therapeutic environment for inpatient settings; or mitigation to improve therapeutic environment where this is not the case.	
b) 'Is there evidence of the distribution and utilisation of the 'Consensus Statement on Information Sharing and Suicide Prevention'?	
c) 'Has a group of staff members been identified who are responsible for monitoring the highest risk service users ('Safe from Suicide Team' for example as per webinar slides).	
17.4 Analysis of data, information, research and innovation	
a) Does the plan show an understanding of the existing evidence-base and guidance related to suicide prevention and patient safety?	
b) Does the plan evidence a strategy on Serious Incident investigation and Learning from Death mortality reviews for all potential suicides or deaths following self-harm of patients that are in line with those national policies? Does the plan describe how	

those reviews or investigations are undertaken in line with the principles of a Just Culture? Does the plan evidence how patients' families and carers are meaningfully involved from the start of any investigation process and throughout? Does the plan evidence how the findings from investigations and reviews are translated into sustainable and effective change that reduces the risk of any problems occurring again?	

18. Organisation of suicide prevention activities across AWP

Suicide prevention activity is overseen and monitored via the AWP Clinical Effectiveness Group, which meets bi-monthly; suicide prevention is a standing agenda item.

Each local authority public health service has a suicide prevention strategy, supported by an active suicide prevention group. AWP attends each of these groups and regularly participates in joint projects across all of the areas for action identified above.

One of the main ways of sharing information regarding suicide prevention activities and the latest evidence and local intelligence is via the Our Space suicide prevention pages. We aim to publish as widely as possible all relevant information regarding our approach to suicide prevention, as well as information for people at risk of suicide or who have been affected by suicide, on the AWP website.

19. Glossary of abbreviations used in this strategy

AWP	Avon & Wiltshire Mental Health Partnership NHS Trust
BAME	Black, Asian and minority ethnic
CAMS	Collaborative Assessment and Management of Suicidality
CAMHS	Child & Adolescent Mental Health Services
CHRT	Crisis and home treatment team
CIOG	Critical Incident Oversight Group
CQC	Care Quality Commission
IAPT	Improving access to psychological therapies
LGBTQ	Lesbian, gay, bisexual, transgender and questioning
LA	Local authority
NCISH	National Confidential Inquiry into Suicide and Homicide by People With Mental Illness
ONS	Office of National Statistics
SOBS	Survivors of Bereavement by Suicide
STP	Sustainability and transformation partnerships
SNRI	Serotonin-norepinephrine reuptake inhibitors: a group of antidepressant drugs
SSRI	Selective serotonin reuptake inhibitors: a group of antidepressant drugs

20. References

- Department of Health (2012) Preventing suicide in England. London: DH
- Department of Health (2014) Statistical update on suicide: January 2014. London: DH.
- Department of Health (2017) Preventing Suicide in England: Third progress report of the cross-government outcomes strategy to save lives.
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2016) Making Mental Health Care Safer: Annual Report and 20-Year Review.

Version History

Version	Date	Revision description	Editor	Status
1.0				
2.0	17 June 2014	Approved by Q&S	AH	Approved
3.0	19/05/2017	Approved by Q&S as strategy for 3 years	AH	Approved
4.0	28/11/2017	Approved by Q&S	AH	Approved
5.0	20/05/2019	Updated (Zero Suicide Ambition) and approved by Q&S	AH	Approved