Cumbria Partnership NHS
NHS Foundation Trust

Suicide Prevention Plan

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1. INTRODUCTION

This is the first Trust plan for the prevention of suicide. It has been developed following a review of the Trust's approach to the prevention of suicide, commissioned by the Medical Director (Duffy 2012).

The Trust engaged with key clinicians and service user and carer representatives to identify the key themes for the plan. The national suicide prevention strategy, the Cumbria multi-agency strategy and relevant research findings were also taken into account.

2. NATIONAL CONTEXT

Nationally there is evidence that suicide rates dropped from the year 2000 onwards, but there is concern that rates are starting to rise again. (Statistical Update on Suicide 2012 DoH) The Department of Health's national strategy 'Preventing suicide in England' (2012) highlights that suicide remains one of the leading causes of premature death. The national strategy identifies six key areas for action:

1. Reduce the risk of suicide in 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.

National research and policy on people with mental illness who kill themselves or others is led by the National Confidential Inquiry into Suicide and Homicide (NCISH). The NCISH has published findings from analysing suicides and homicides of people with mental illness in England and Wales including both detailed reports (Safer Services 1999, Safety First 2001, Avoidable Death 2006) and annual reports.

Some of the key findings in the most recent report (July 2012) include that:

- there are now more deaths when patients are under the care of Crisis Resolution and Home Treatment (CRHT) teams than when patients are under the care of inpatient wards
- Trusts should now focus on safety in CRHT
- safer prescribing of psychotropic drugs remains an important aspect of suicide prevention.

One of the national reports, 'Avoidable Death', recommends 12 points to a Safer Service to be used as a checklist for local services. The NCISH now produce a **Safer mental health services toolkit** allowing services to be assessed in line with recommendations from the inquiry.

3. CUMBRIA CONTEXT

In January 2009 a wide range of agencies as well as service users and carers were brought together to form the Cumbria Suicide Prevention Reference Group. The group published a comprehensive evidence-based Multi-Agency Suicide Prevention Strategy for Cumbria 2010-2012. This strategy highlighted that Cumbria has a higher suicide rate than national average, with approximately 50 people in the county dying from suicide each year. This is 10-15 more than the national average. There was also variation between the different localities.

An annual clinical reference group meets to support the delivery of the strategy and the strategy is currently being revised to evaluate the work done to date. A number of successful projects have arisen from the multi-agency strategy, including:

- MIND have delivered training on suicide awareness across a number of sectors;
- Samaritans and Network Rail have been working together to target high risk areas;
- Multi-agency support to the Survivors of Bereavement by Suicide (SOBS) Cumbrian Branch which is a self-help group that has grown over the past two years.

The Trust's First Step service aims to help people with common mental health problems including depression, stress and anxiety.

4. TRUST CONTEXT

Most people who die from suicide are not in mental health services at the time of their death. National research has shown that:

- approximately 25-30% of people who commit suicide are in current contact with mental health services
- a third have had contact with mental health services in the past
- a third have never had contact with mental health services.

In the past, as a mental health trust Cumbria Partnership NHS Foundation Trust has focused on preventing suicide in high risk patients (e.g. those with severe mental illness and who have previously self-harmed). We now provide a much wider range of services to a much wider population. For instance, we are in contact with every household in the county where there is a child up to the age of 17. This allows our Trust plan to reduce deaths by suicide by:

- improving the mental and physical wellbeing of the general population (primary prevention)
- early detection and treatment of common mental disorders such as depression (secondary prevention)
- focusing on people at higher risk - those with severe mental illness and who have previously self-harmed (tertiary prevention)

Suicide prevention is everyone's business. The causes of suicide are multi-faceted and link to social, economic, environmental, physical and psychological factors. Effective prevention of suicide can therefore only be achieved by a multi-faceted response to these predisposing and causative factors.

5. DELIVERING THE PLAN

The Trust's Executive lead for suicide prevention is Medical Director Chris Hallewell. The Trust's champion for suicide prevention is Dr Gaetano Dell'Erba, Consultant Psychiatrist.

Action plans will be created for each area (children's health, mental health and physical health) and approved by the Trust's Clinical Governance Committee. Each clinical service group will be responsible for ensuring the actions required are completed within their area and progress will be monitored by the Clinical Governance Committee and reported to the Board on an annual basis.

6. AIMS OF THE SUICIDE PREVENTION PLAN

As the provider of children's, community and mental health care across Cumbria we ensure we are maximising opportunities to prevent suicide in Cumbria through the work of our own organisation and through collaboration and joint working with our partner agencies.

7. CORE PRINCIPLES

This plan is based on the following core principles in suicide prevention:

1. Social, psychological and physical factors will contribute to people becoming suicidal
2. Primary, secondary and tertiary methods of suicide prevention will all need to be used
3. Reducing availability of methods of suicide helps reduce the overall number of suicides
4. The therapeutic relationship with service users and carers is of central importance
5. The importance of learning from near misses and completed suicides
6. Transitions between and within services can be particular risk periods
7. Homicide prevention should be considered with suicide prevention
8. Culture of positive risk management is crucial

1. Social, psychological and physical factors will contribute to people becoming suicidal

People will become suicidal for many different reasons. Research has shown that these centre around:

- Social factors, e.g. social isolation, unemployment, or how suicides are reported in the media and cultural attitudes to suicide
- Psychological factors, e.g. loss of close relationships, childhood trauma
- Biological/physical factors, e.g. chronic pain, tinnitus and intoxication with drugs.

Within the Trust, the suicide prevention plan should become relevant to all staff, not just those working with people with identified mental illness. For instance, a District Nurse visiting an isolated patient in chronic pain may be making a significant contribution to reducing that patient's suicide risk.

2. Primary, secondary and tertiary methods of suicide prevention will all need to be used

Primary prevention: This means improving the health of the general population to avoid disease. In suicide prevention, this means improving the mental well-being of the community. Whilst this is an area primarily led by Public Health Strategy, the Trust contributes to this with many of its services (including community hospitals, day centres and health visitors) which provide benefit to the wider community as well as the identified patient.

Secondary prevention: This means early detection of disease before it causes significant illness. In suicide prevention, this includes screening for post-natal depression by health visitors and the work of the First Step service which helps people with depression.

Tertiary prevention: This means treating patients who are severely unwell to restore function. In suicide prevention this would be focusing on high risk groups, for instance those people who are starting to think about suicide as an option for dealing with their difficulties and those who are acutely suicidal.

The Trusts contributes to primary prevention through services such as health visiting. Training will be provided to help health visitors identify post natal depression.

3. Reducing availability of methods of suicide helps reduce the overall number of suicides

Some people who are suicidal are impulsive and research has shown that restricting the availability of suicide methods (e.g. through safer prescribing) reduces the overall suicide rate. People do not necessarily substitute one method of suicide for another if the first is no longer available. Restricting availability of methods can be applied at primary, secondary and tertiary preventative levels. For instance, safer prescribing would be relevant to most clinical staff whereas the removal of ligature points in psychiatric wards or preventing access to rooftops would apply to those staff involved in tertiary prevention.

4. The therapeutic relationship with service users and carers is of central importance

Most people who are suicidal feel alienated from others by the very nature of these experiences. They will find it difficult to communicate with someone who has all the skills for a good therapeutic relationship, such as a therapist, so it is particularly difficult for them to communicate with other people who might not be as understanding.

If a service user discloses suicidal feelings and they feel unheard or let down, the likelihood is that their risk of suicide will increase and they are less likely to speak up about how they are feeling in the future.

At least 50% of people who kill themselves express suicidal thoughts beforehand, usually to a family member. Family and carers should have an accessible route for raising concerns with relevant staff. Bereavement by suicide is a traumatic experience for family and friends and can increase the risk of suicide of the bereaved. Carers need to be adequately supported following bereavement by suicide.

5. The importance of learning from near misses and completed suicides

Learning needs to occur at all levels and from different sources. The Trust plan is directed by National best practice (NCISH, NICE, Best Practice in Managing Risk) and the wider Cumbria Multi-Agency Suicide Prevention Strategy.

Within the Trust, learning should take place:

- at the individual practitioner level with surface level training (checklists for assessing suicide risk) and deep learning (learning about people's experiences of feeling suicidal - perhaps through anonymous descriptions from service users – so that the importance of the therapeutic relationship is not lost in the training)
- at organisational level with an annual review of all Serious and Untoward Incidents (SUIs) to look at any trends that may be occurring.

6. Transitions between and within services can be particular risk periods

Transition between and within services can be stressful even for those in good mental health as new people and systems need to be adjusted to. It is a particularly difficult time for people with a mental illness. It is also during this time when communication between different teams is most likely to break down. Research has shown that these transitions (for instance, discharge from a psychiatric inpatient unit to a community mental health team) can put some patients at a higher risk of suicide.

7. Homicide prevention should be considered with suicide prevention

There are very rare incidents of individuals killing themselves after having killed others (usually family members) as part of their illness. These are termed homicide-suicides or murder-suicides. Sometimes the perpetrator does not die although that was their intent and whilst the act may legally and statistically be counted as a homicide, the characteristics are of a homicide-suicide. The same core principles of suicide prevention apply to homicide-suicides with the addition that any risk assessment must include an assessment of harm to others as well as harm to self.

8. Culture of positive risk management

Best Practice in Managing Risk (DoH 2007) discusses the importance of positive risk management. Whilst someone's suicidal risk can be reduced by appropriate management it cannot be eliminated.

The risk of suicide should be managed in partnership with the service user, providing they have capacity (and through the Mental Capacity Act and Mental Health Act if they do not). Central to this is the importance of the therapeutic relationship and acknowledging with the service user that transitions may increase risk and that a more secure setting may not be in the patient's best interest.

Best Practice in Managing Risk states *"Over defensive practice is bad practice. Avoiding all possible risks is not good for the service user or society in the long term, and can be counterproductive, creating more problems than it solves."*

8. DELIVERING THE TRUST SUICIDE PREVENTION PLAN

1. All staff employed by Cumbria Partnership NHS Foundation Trust will contribute to the prevention of suicide by having knowledge, skills and competencies relevant to their role
2. Service pathways are designed so that transition reduces risk of harm to self and others
3. Risk management processes are based on current Best Practice in Managing Risk and positive risk management. Assessing suicidal risk includes assessing risk of harm to others
4. We are a learning organisation that works with other learning organisations
5. Carers, as well as patients, are supported
6. We help to reduce the access to means of suicide
7. We contribute to the Cumbria Multi-Agency Suicide Prevention Strategy

1. All staff employed by Cumbria Partnership NHS Foundation Trust will contribute to the prevention of suicide by having knowledge, skills and competencies relevant to their role.

Different levels of competences are required depending on the role of staff. This ranges from a need for basic awareness about suicide prevention (including the ability to recognise risk and refer to the right place) to complex intervention (including prevention and recovery). Specialist groups, including children, elderly, crisis and other acute services, require different skills and competences. Some staff would need to have further specialist capabilities to review individual Serious Untoward Incidents (SUIs) and identify patterns in the Trust as a whole.

Some staff will have sufficient skills to provide training and support to primary care and partner agencies. This will build on work that is already being done, for example through the mental health liaison service to the acute trusts.

Central to this is clarity about information sharing. Staff should have the confidence to know when to share information and with whom and should follow this through in clinical practice in order to protect an individual at risk.

These competencies will be achieved through:

Training

The Trust will provide/commission a range of training which meets the needs of the different staff groups in the organisation, for example:

- suicide and self-harm awareness training for school nurses
- training for health visitors to detect post natal depression
- clinical risk assessment and management for mental health staff
- STORM suicide training

The Trust will look to involve patients and carers as “experts by experience” within this training, as appropriate. Training in assessing and managing suicidal risk must include training in assessing risk of harm to others.

Supervision

Clinical supervision is a key component of high quality professional care. Caring for people who are suicidal is a stressful and demanding role to undertake

School nurses will receive suicide and self-harm awareness training to identify young people who may be at risk.

and staff should receive support for this through both clinical and managerial supervision to enable them to maintain a high standard of care. Supervision is also an important element of support following a near miss or completed suicide. All clinical staff are expected to engage in clinical supervision, and clinical pathway leads are key to determining what should be covered during supervision.

NHS Values

The NHS Values - working together with patients, respect and dignity, commitment to quality of care, compassion, improving lives, and everyone counts - underpin everything the NHS does. These values are central to the therapeutic relationship with patients and carers particularly for people who are suicidal. The NHS values should be emphasised within the training and supervision, induction and culture of the organisation

Debriefing

All staff should be supported following a near miss or completed suicide of someone they have come into contact with. It is important that all staff involved in the care of the patient are involved in this. The aim is to provide immediate support to staff members and to prevent them from developing stress and mental health problems.

2. Service pathways are designed so that transition reduces risk of harm to self and others.

The service pathways (the journeys patients take when accessing and moving between services) will be designed so that transitions between services reduce the risk of harm to self and others.

This would be at different levels, to cover instances such as:

- transitions between staff (for example, if a care coordinator is off work or leaves the Trust)
- transitions between services (for example, between the Community Mental Health Team (CMHT) and the Crisis Resolution and Home Treatment (CRHT) team)
- transitions between Trust services and other organisations (for example, GP practices, acute trusts, other NHS providers, adult social care, housing, police, third sector providers etc.) This is likely to be an increasing challenge as more and more provider organisations become involved in patient care.

This will be achieved through:

NHS key principles

Two of the NHS key principles are particularly relevant (putting patients at the heart of everything it does and working across organisational boundaries and in partnership with other organisations in the interest of the patients, local communities and wider population). Services should be tailored around the needs of patients and should be seamless so that gaps are minimised and there are no disputes as to which service is most appropriate for a patient. The transferring team must continue to support the individual until the new team/ service has started providing care.

Information sharing

Information relevant to the patient's care will be passed on between services if a patient makes a transition. The information will be communicated on the basis of the patient's need rather than hindered by different organisational systems such as governance or IT. Prevention of harm to an individual or others, including safeguarding, is always of primary importance and staff should have the confidence to know when the need to protect overrides the bounds of confidentiality. This includes the ability to pass on relevant risk information.

Addressing the gaps

There are appropriate systems in place between the Trust and partner organisations so that services are seamless. These systems are reviewed so that if gaps are identified they can be addressed.

Involving patients as equal partners

Patients are involved as equal partners as far as possible in ownership of their care. This includes contingency planning, for instance planning what would happen if there is deterioration in health or if the care coordinator is off ill. Ultimately our aim in suicide prevention is to preserve life. There may be cases where this is at odds with the wishes of the individual, which means that the realities of 'equal partner' and 'collaborative care planning' may be compromised. We expect our staff to have the protection of the individual as their primary concern.

3. Risk management processes are based on current Best Practice in Managing Risk and positive risk management. Assessing suicidal risk includes assessing risk of harm to others.

This will be achieved through:

Best Practice in Managing Risk

Decisions about care must be made in partnership with patients and in the patients' best interest with reference to Best Practice in Managing Risk and positive risk management. Treatment plans should clearly state benefits and risks of different treatment options (for instance treatment with CRHT or inpatient admission) and how this has informed the current treatment plan.

National best practice

National best practice, in particular guidance from NICE and NCISH, will be used to decide which risk assessment tools are used by the different services including the need for age and speciality specific tools.

Risk assessment that include risk of harm to others

Assessing suicide risk will always include assessing risk of harm to others.

4. We are a learning organisation that works with other learning organisations

This will be achieved through:

Learning from incidents

This includes near misses and completed suicides or SUIs so that staff and carers are confident that an open, comprehensive, accurate and timely review has taken place where incidents occur when there is an opportunity for learning rather than blame.

Disseminating learning to all staff

A system will be introduced whereby Trust staff are regularly updated on lessons learnt from all parts of the Trust. This will use a range of different methods of communication.

Crossing organisational boundaries

Where SUIs have occurred as a result of transitions between different organisations the learning is conducted in partnership with the other organisation.

Annual review

There will be an annual review of SUIs published which summarises lessons learned and any trends from the year.

National best practice

The learning is driven by national best practice such as NICE and NCISH.

5. Carers as well as patients are supported

The essential role of carers is highlighted in the triangle of care. Carers are often the people most likely to detect deterioration in a patient's mental health and are the people that a patient is most likely to express suicidal thoughts to. Carers can be under considerable stress from caring which can increase the risk of them developing mental health problems. Those bereaved by suicide are also at an increased risk of suicide themselves.

Carers will be supported by:

Carers should be involved in patient care and supported if they do experience bereavement by suicide.

Knowing where they can get help

In all situations carers must know where they can get help and be able to raise their concerns about patients to relevant staff and be confident that their concerns have been listened to.

Being involved

Carers should be involved in patient care/care plans (with the patient's consent) but not so that they are being asked to take responsibility for clinical decisions (for instance being asked to assess the level of suicide risk).

Help with bereavement

If carers do experience bereavement by suicide they should be supported by the Trust. They should be aware of what resources and help are available for them and be able to contribute to and be kept fully informed of any SUI investigations and outcomes. There is also a need for continuity of support (e.g. by a family welfare worker) rather than the carer having to deal with many different members of staff.

6. We help to reduce the access to means to suicide

There are specific areas in which we can reduce the access to means to suicide, including (but not exhaustive):

- Developing safe prescribing policies which provide guidance for staff on the use of medicines where there is a known or potential risk of overdose
- Eliminating ligature points (anything which can be used as a rope) in high risk inpatient settings in accordance with national guidance (NCISH and Never Events).

- Working with carers and families to advise them on how the home environment can be made as safe as possible. Examples include securing or removing access to potential weapons, medicines (including those of other family members), ligature points, alcohol or other substances which can increase risk of suicide.
- Working with the Cumbria multi-agency suicide prevention group to share information and evidence to agree multi-agency responses e.g. identification of suicide hotspots or themes in the local community.

7. We contribute to the Cumbria Multi-Agency Suicide Prevention Strategy

The Trust will continue to have senior representation on the Cumbria multi-agency suicide prevention group, supporting the delivery of the Cumbria multi-agency strategy alongside our partners, including third sector and voluntary organisations.

This is important in recognising that effective suicide prevention goes way beyond the services the Trust offers. However, we also hold a significant amount of skills, expertise, knowledge and data which we must share widely.

A recent example of a Trust initiative was the development of the multi-agency assistance protocol which has been recognised as good practice by the Cumbria suicide prevention leads.

9. EVIDENCING THE SUCCESS OF THE PLAN: KEY OUTCOMES TO BE ACHIEVED

The following are key outcomes to be achieved and evidence that we will monitor. These are Trust wide outcomes and not an exhaustive list. As each pathway develops its response to the strategy it is important that service/speciality specific outcomes are also developed which are meaningful for that service.

1. All staff employed by the Trust will contribute to the prevention of suicide by having knowledge, skills and competencies relevant to their role.

- Trust Mandatory training database and evaluation of training.
- No SUIs identifying staff as not having adequate training and supervision in suicide prevention.
- Service user and carer input into the design of training as experts by experience.
- Examination of supervision notes as part of SUI investigations.
- Review of debrief arrangements following near miss/incidents seeking staff feedback.

2. Services pathways are designed so that transition reduces risk of harm to self and others

- No SUIs occurring due to patients "falling through gap" between services.
- Pathways to care are access to care not obstacles to care.
- Evidence through patient stories.
- No SUIs occurring because the Trust and partner organisations had not reviewed how information sharing would work and because information was lost between organisations.

3. Risk management processes are based on current Best Practice in Managing Risk and positive risk management. Assessing suicidal risk includes assessing risk of harm to others.

- IN all SUIs, care plans should show risks and benefits of different treatment options and summarise how the current care plan was achieved with the involvement of the patient, and if appropriate carer.
- In all SUIs, risk of harm to others was assessed as part of assessing suicidal risk.
- No SUIs occurring because the service has been focusing on risk without considering positive risk management and the best interests of the patient.

4. Regular audit of risk assessments, formulation and risk management plans and communication about risk between primary care and the Trust and between teams within the Trust.

- Learning organisation that works with other learning organisations
- The Trust does not have a national or local never event.
- All SUIs which occur across organisations have joined up learning e.g. Oxford learning events conducted jointly.
- All staff informed of lessons learnt at monthly intervals.
- Annual review of lessons learned from SUIs.

5. Carers as well as patients are supported

- Through SUI investigations and complaints handling, evidencing that carers were able to express their experiences/opinions/concerns and that these were acted on appropriately as part of the clinical decision making for the patients care.
- Risk management plans for patients are clear on where responsibility lies for managing the individual's risks.
- All carers bereaved by suicide are offered appropriate and adequate support.
- The suicide prevention strategy will link in with the development of the Trust's Carer's Strategy.

6. We help to reduce the access to means to suicide

- Safe prescribing policy.
- No suicides occurring due to unsafe dispensation of medication.
- In-patient ligature reduction programme.

7. Cumbria Multi-Agency Strategy

- Evidence of continuous engagement in the Cumbria Multi-Agency Suicide Prevention Group.
- Contribution to multi-agency initiatives arising from the multi-agency plan.

GLOSSARY

CMHT	Community Mental Health Team
CPFT	Cumbria Partnership NHS Foundation Trust
CRHT	Crisis Resolution and Home Treatment Team
STORM	Evidence based training for mental health staff in suicide prevention
NCISH	National Confidential Inquiry into Suicide and Homicide
NICE	National Institute for Clinical Excellence
MCA	Mental Capacity Act
MHA	Mental Health Act
NHS	National Health Service
GP	General Practitioner
DoH/DH	Department of Health
SUIs	Serious and Untoward Incidents

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