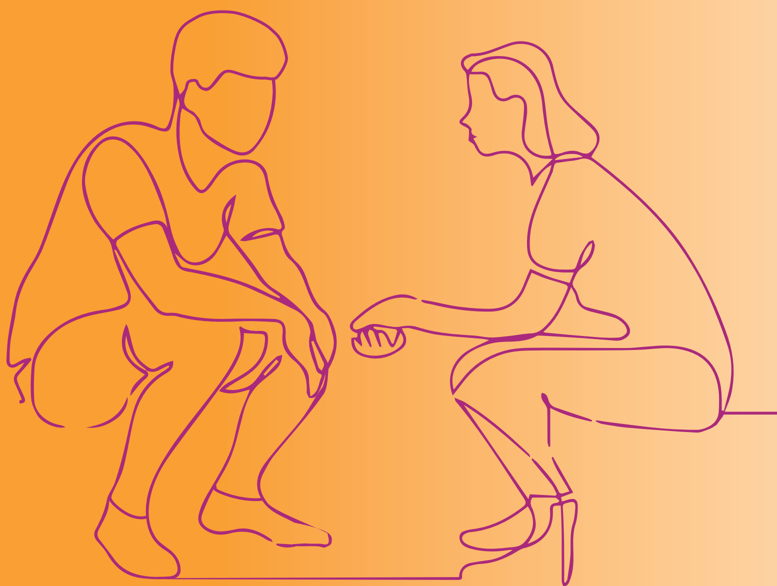
Barnet, Enfield and Haringey **NHS**
Mental Health NHS Trust

A University Teaching Trust

SUICIDE

SUPPORT | LEARNING | PREVENTION



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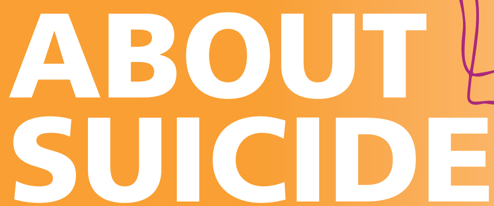

Our Zero Suicide Ambition: Suicide prevention, learning and support strategy

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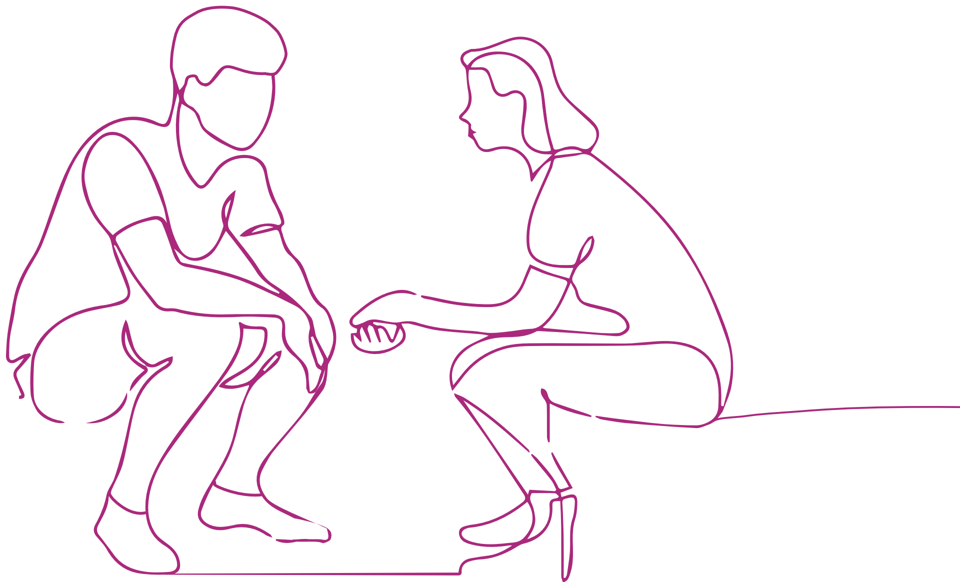
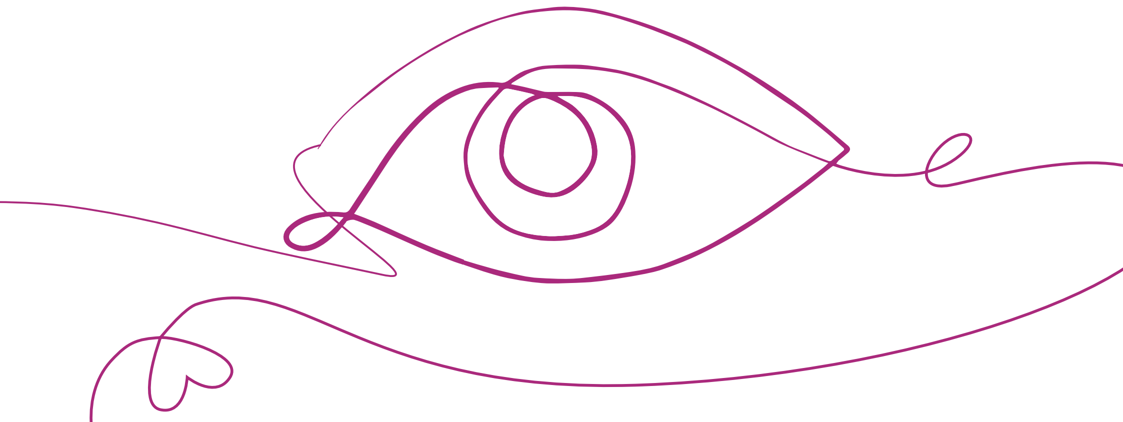


VISION AND OVERARCHING AIM

Our vision is to become a Trust with a just and learning culture where preventing and learning from suicide is at the heart of our work, and where suicide and suicidal feelings are understood as a human response to distress that deserves attention and a compassionate response.

Our ambition is to reduce suicides among people under our care to zero, and to significantly reduce suicide in the broader community. We will do this by providing safer services and by working in partnership with our communities to support joint efforts to minimise suicide across each of the boroughs we serve. We also aim to champion and offer timely, compassionate support to those affected by suicide including families, our staff and our communities.



let's get talking...

STRATEGY PRINCIPLES

1. **Everyone in our Trust has something to contribute to this work – we value the diversity of our shared skills, experience and ideas.**

2. **We respect the unique contribution of the narratives of those lost to suicide and the experience of those affected by suicide and those who live with suicidal thoughts and feelings.**

3. **We recognise that suicide prevention, learning and support are all interconnected and that we will only achieve better outcomes by focussing on learning from suicide and supporting each other.**

4. **Suicide prevention requires safer care for ALL, irrespective of perceived risk.**

5. **Suicide relates to many factors, some of which are outside of our control as an NHS trust. We will work in collaboration with multi-agency partners and communities to make improvements across different systems.**

We will take a collaborative co-production approach based on Quality Improvement methodology and using data intelligence to test ideas and inform the strategy's ongoing development.

This strategy will contribute to our overall Trust strategic aims of:

- Excellence for service users
- Empowerment for staff
- Innovation in services
- Partnerships with others

STRATEGY DEVELOPMENT AND DELIVERY

- This strategy has been co-produced by the Barnet, Enfield and Haringey Mental Health NHS Trust (BEH) Suicide Strategy Working Group. This group includes representatives from clinical and non-clinical staff from across all divisions, voluntary sector and public health partners, alongside bereaved carers and people with lived (personal) experience of suicidality. We agreed that it is vital to create a psychologically safe, transparent culture that supports and respects lived experience, vulnerability and shared thinking.
- The strategy was further developed in consultation with key stakeholders via presentations and workshops. We also cross-referenced our work with national guidance, the National Collaborating Centre for Mental Health Quality Improvement Pilot initiatives in suicide prevention, and evidence-based research.
- To support the successful delivery of the strategy, we carried out a gap analysis of resources, identified process and operational changes needed and created an implementation plan and a training plan.

BACKGROUND

Suicide is a rare and tragic outcome that often leaves a legacy of profound loss for bereaved families and friends and the emotional impact can also cast a long shadow for professionals across their personal and professional lives. As a complex part of the human condition, no socioeconomic group, culture or demographic is safe from suicidality. We know that it is not only our patients who are affected by suicide, many of our staff will be affected by suicide in their personal lives, and healthcare workers are themselves at risk of experiencing suicidal crises and of dying by suicide.

In 2012 the UK launched a National Suicide Prevention Strategy that focussed on support for those bereaved by suicide, risk reduction for high-risk groups, reduction of access to means, and support for research and the media. NHS England took the focus on suicide prevention further in 2016 with the Five Year Forward View which included a commitment to introducing multi-agency suicide prevention plans and launched the aim of reducing suicide by 10% by 2021.

In 2019 a Zero Suicide Ambition was added for mental health inpatients, requiring all NHS trusts to put in place plans towards this ambition. The NHS Long Term Plan identifies suicide prevention as a priority for the NHS and pledges to introduce a new Mental Health Safety Improvement Programme with a focus on suicide reduction especially for mental health inpatients, as well as suicide bereavement support services and personalised care to reduce risk in those with mental illness.

This new BEH strategy not only incorporates the national requirement for a Zero Suicide Ambition for our inpatients but extends this ambition to all patients under our care. As a large NHS provider with mental health expertise, BEH is in a strong position to make a significant contribution to a system-wide approach to suicide prevention across the North Central London Integrated Care System.

NATIONAL PICTURE

The World Health Organization estimates that close to 800,000 people die each year by suicide, which is one person every 40 seconds and represents a global rate of about 11 per 100,000 per year. More people die from suicide than from wars, and in some age groups and countries suicide deaths outnumber those of motor vehicle accidents. In 2018 there were 6,507 suicides in the UK, with the highest rates in middle-aged men aged 45-49. Recent figures suggest a concerning rise in suicide deaths in 2018, with a notable increase in young people under 25.

Although the majority of suicides occur in those not being cared for by mental health services, a significant proportion (28%) are people in contact with mental health services, and these represent an opportunity for prevention. Having a mental illness also carries a much higher risk of suicide. Suicides by mental health inpatients are low and falling, with an average of 110 per year between 2012 and 2016, representing 6% of all patient suicides. 14% of all such suicides happen within three months of discharge, with the highest risk in the first two weeks and the highest number on day three post-discharge. One notable finding is that 57% of suicides in 2017 had a history of alcohol or substance misuse but only a minority had contact with specialist substance misuse services.

The National Confidential Inquiry into Suicides and Safety in Mental Health (NCISH) has analysed suicide data for mental health patients over the last 20 years. Based on this data, they have devised recommendations for 10 main ways mental health organisations can improve safety as pictured on the next page.

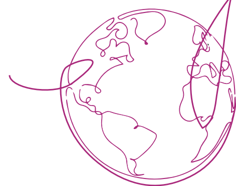


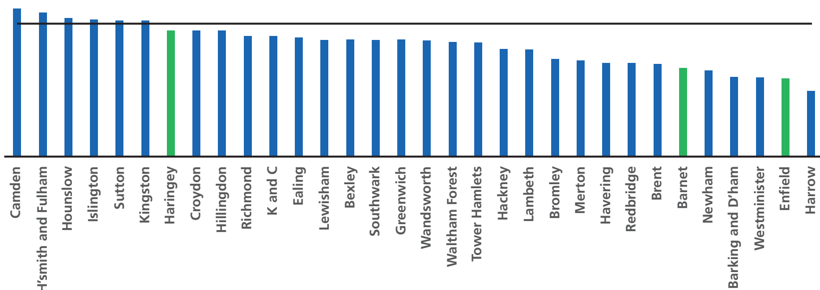
Diagram reproduced from the NCISH publication 'Safer Services: A toolkit for specialist mental health services and primary care'

LOCAL PICTURE

Suicide rates across London, including the boroughs we work with, are lower than for England as a whole according to the latest figures available. Suicide rates between 2017 and 2019 are shown below alongside the data showing the considerable years of life lost due to death by suicide for each borough.

Borough	Standardised Suicide Rate per 100, 000	Years of Life Lost (age standardised rate 15-74 years per 10,000)
England	10.1	33 years
Barnet	6.7	19.9 years
Enfield	5.9	19 years
Haringey	9.6	27.5 years

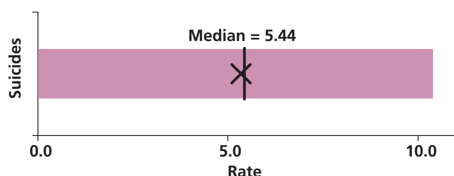
The graph below highlights suicide rates in our three boroughs compared to the rest of London.



WHAT OUR DATA IS TELLING US

We are tracking rates of suspected suicides measuring 'days between suicides' in order to most helpfully capture patterns in the context of relatively rare events. It is worth noting that due to COVID-19 we are not in a steady-state situation so this data will need to be interpreted with caution and in combination with more qualitative narrative data capture to obtain a more rounded picture of patterns of suicide over time.

The latest benchmarking data below from the National Confidential Inquiry into Suicide and Safety in Mental Health shows that the suicide rate for BEH patients is very close to the median for mental health providers across England, at a rate of 5.33 per 10,000 people under mental health care. This is despite having a higher percentage of patients on the Care Programme Approach (a package of care for people with mental health illnesses) than average for the country (13% compared to the national rate of 10%).



Suicide rate

The suicide rate in your Trust was 5.33 (per10,000 people under mental health care) from 2015-2017.

WHAT OUR LIVED EXPERIENCE IS TELLING US

From workshops with BEH staff and from work done nationally, we know that suicide has a profound effect on professionals involved in the person's care. Involved professionals can be left with significant trauma symptoms of guilt, anxiety, shame and grief reactions, often with long-lasting impact on their confidence and relationships with colleagues and patients.

We know that patients with suicidality do not always have positive experiences of our services, and that there is much more we can do to provide continuity and accessible care for those in the midst of a suicidal crisis. Carers tell us they can feel left out of their loved one's care, and uninformed when a crisis arises. Similarly, bereaved carers tell us that the support offered after a suicide is at best variable, and often very scarce.

One family member told us that after his wallet was stolen, the police immediately offered counselling via Victim Support, but in contrast, following the death of his son by suicide, he was given no signposting or any support at all. Families would often like to be more involved in the serious incident investigation and work done to improve care after a death. Those bereaved by suicide (both families and professionals) must endure the coroner's court, and often report this as a very uncertain and highly stressful time where more practical and emotional support is needed.

COVID-19 AND SUICIDE PREVENTION

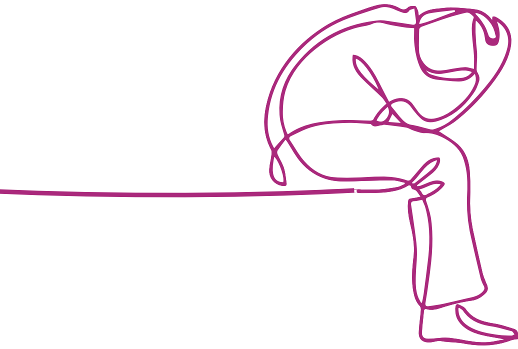
This strategy is being written during the Coronavirus global pandemic. Most recent findings (NCISH 2021) suggest that although the average number of suicides per month have varied, there is no evidence of a significant national rise during the pandemic. However, suicide rates in general are rising and there may be rises in some local areas as the impact of the pandemic has varied across the UK. It is too soon to quantify the impact of economic adversity on mental health and suicide.

We know that the pandemic has caused an increase in stressors such as social isolation, loneliness, entrapment and anxieties about education or employment which may be associated with an increase in suicide risk. There has also been an increase in previously established risk factors for suicide such as financial stress, loss of employment, domestic violence and alcohol consumption

Over the cause of the pandemic, access to NHS services and service configuration changed leading more people to access voluntary services and there was a reduction in the availability of face to face support.

It has been recognised nationally that take an interdisciplinary community approach and applying existing knowledge of effective suicide prevention is likely to be the most effective approach.

In this strategy we have sought to apply existing knowledge on suicide prevention to the pandemic context, and we have also incorporated specific nationally recommended interventions in relation to suicide prevention in the pandemic context and also recent COVID-specific guidance from NHS England/Improvement. These include:



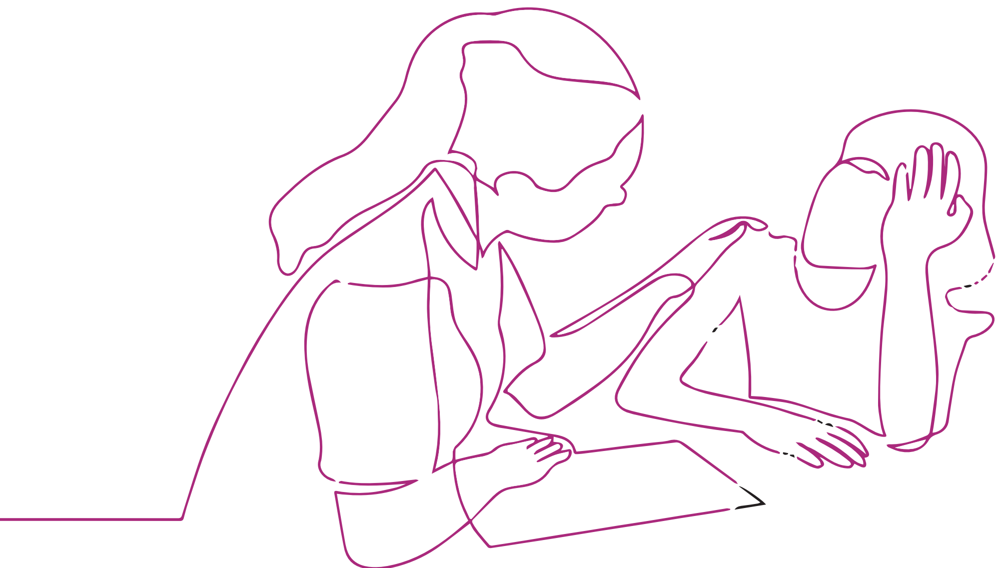
- delivering care in different ways, such as digitally, to reach high risk populations
- developing support for healthcare staff affected by adverse exposures
- making sure frontline staff are adequately supported, given breaks and Personal Protective Equipment, and can access additional support
- developing clear pathways for those experiencing suicidal crisis, including access to remote consultation
- developing our 24/7 crisis helplines
- using digital resources to train our workforce
- continuing to provide talking therapies (known as Improving Access to Psychological Therapies or IAPT) using with digital delivery of evidence-based online interventions and applications
- ensuring accessible help is available for bereaved individuals
- ongoing development of suicide postvention services
- signposting to support for domestic violence and alcohol misuse
- championing safety nets for those in financial difficulties and regular check-ins for colleagues, family and friends, and sensitive media reporting in line with existing guidelines.

As this is a dynamic situation, our approach will be adapted in the light of further local and national intelligence in this area.

BENEFITS AND IMPACT

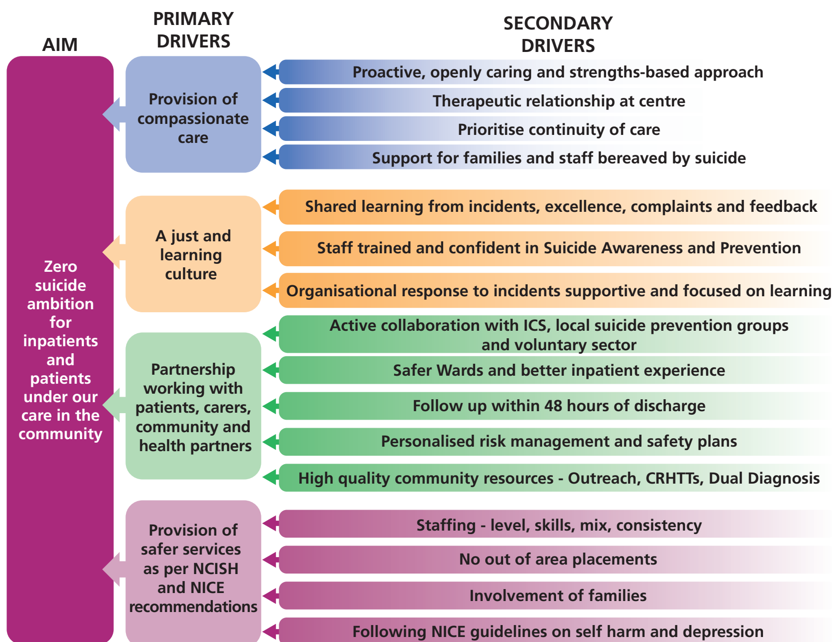
There are benefits to focusing on suicide prevention, both in terms of the individual person and also on those potentially impacted by the death. We know that suicide is not an inevitable outcome, with evidence that many survivors of interrupted suicide attempts feel relief at being saved and go on to lead long and fruitful lives. There is an opportunity, through focus on prevention to celebrate the years gained, and to also prevent the significant impact on others that any individual suicide causes.

Each suicide is thought to impact as many as 135 individuals, with some less affected, many bereaved and a core of individuals who are permanently changed by their loss. The grief caused by suicide is often complex, and bereaved relatives and staff involved may also experience significant secondary trauma symptoms and a much higher risk of suicide themselves. The estimated cost of each suicide is £1.7m (London School of Economics).



STRATEGY FRAMEWORK

We have identified four primary drivers as most likely to lead to success in achieving our aim to maintain zero suicides within inpatient settings and achieve an ongoing reduction in suspected suicides by people living in the community under our care.



Key

CRHTT	Crisis Resolution and Home Treatment Team
ICS	Integrated care system
NCISH	National Confidential Inquiry into Suicides and Safety in Mental Health
NICE	National Institute for Health and Care Excellence

The primary drivers are:

1. Compassionate care
2. A just and learning culture
3. Partnership working with patients and carers and community and health organisations
4. Safer services

1

Compassionate care

Evidence shows that approaches that place the therapeutic relationship at the centre of an intervention and combine a non-judgemental approach, warmth, genuineness, empathy and promoting "connectedness" are important in reducing deaths by suicide. Models using an openly caring approach with strong continuity of care and listening approaches have been effective at reducing deaths elsewhere in the UK.

We know that high caseloads, a focus on risk-management, and the impact of emotionally challenging work can all interfere with being able to provide the continuity and compassion that we know is protective. This can be especially true in our crisis teams where staff are under significant pressure, working with very unwell people, and frequently exposed to the impact of suicide in their patients.

We would like to identify areas for improvement in compassionate care, learn from other trusts and embed this learning into our trust-wide approach to clinical care. We are currently taking part in a national trial of the Open Dialogue approach, which is founded on principles of continuity of care and compassionate listening.

Compassionate care also involves including supporting those bereaved by suicide, including families and staff members. As well as our 'Here for you' critical incident support framework for staff, we plan to create a new system to ensure all families are promptly contacted, supported and signposted to further support following a death of a patient. We are also keen to support the North Central London Suicide Bereavement service.

2

A just and learning culture

A just culture maintains that while individuals remain accountable for following protocols and polices and for their individual practice, there is an organisation-wide emphasis on safety that focusses on system issues that contribute to errors and harm. This culture empowers staff to feel confident to voice concerns about safety and patient care and to actively engage in work towards improvements.

We know that anecdotally, staff often feel a complex mix of feelings in relation to serious incidents and suicides within the trust, including guilt, self-blame, isolation, anxiety and hurt. So it is important that support for staff is integral to any approach which aims to learn from experience and reduce deaths. A quality improvement approach, with the concept of psychological safety as a central feature, lends itself well to this approach and fits well with a whole-trust culture of quality improvement.

We plan to embed shared learning opportunities across the trust and in partnership with the wider community. We have also identified the need to enhance our processes of learning from suicide deaths, by routinely including bereaved carers in our Serious Incident Investigation process and by learning from families' narratives more broadly. We will also work to ensure all staff and multi-agency partners can access this learning.

We have signed up to the Zero Suicide Alliance (ZSA) which is a collaboration of National Health Service trusts, charities, businesses and individuals who are all committed to suicide prevention in the UK and beyond. ZSA have a suite of e-learning tools to support raising awareness and skills training for people supporting those who may be in a suicidal crisis.

Using the Zero Suicide Alliance e-learning, we have included suicide prevention in our mandatory training for all staff, and we will supplement this with a more in-depth bespoke suicide prevention training offer led by clinicians alongside those with lived experience, for those in frontline roles and those with a special interest in this topic. We are also planning to introduce local suicide prevention champions in all divisions to share key messages and learning further across the organisation.

3

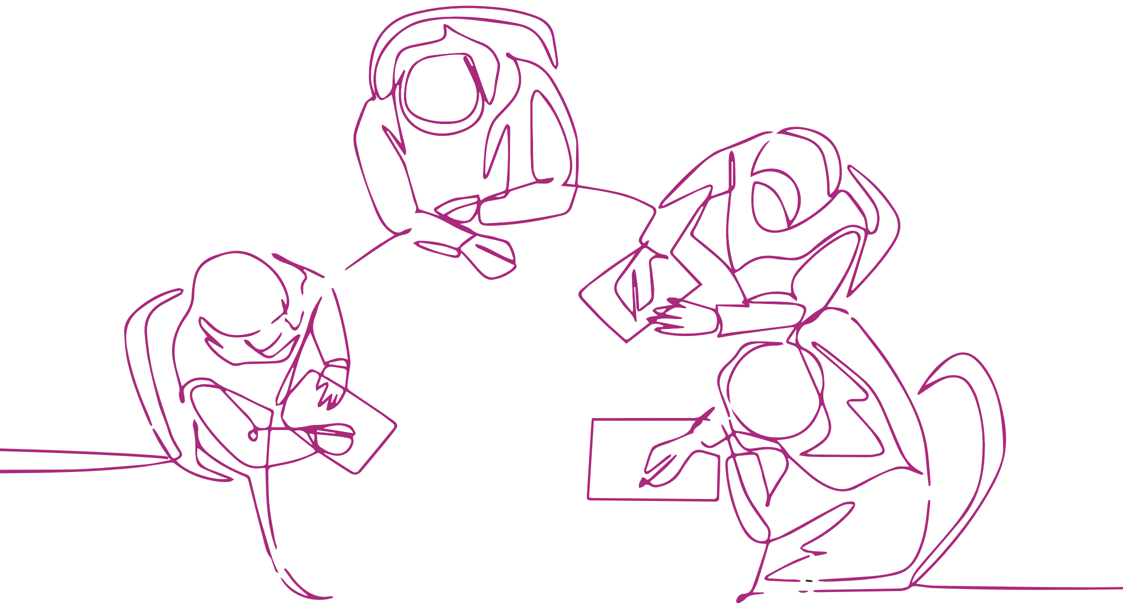
Partnership working with patients and carers and community and health organisations

It is important that our work is part of a broader approach to suicide prevention based on the Cross Governmental Suicide Prevention Work Plan via Local Suicide Prevention Groups and Planning, and as part of the newly formed Pan-London Mental Health Trusts Suicide Prevention Group. We will champion a collaborative process of learning and sharing expertise with other trusts and organisations. We will also continue to champion the development of a North Central London-wide Suicide Prevention Steering Group to oversee work across the sector and ensure that suicide prevention is coordinated and prioritised across the sector.

4

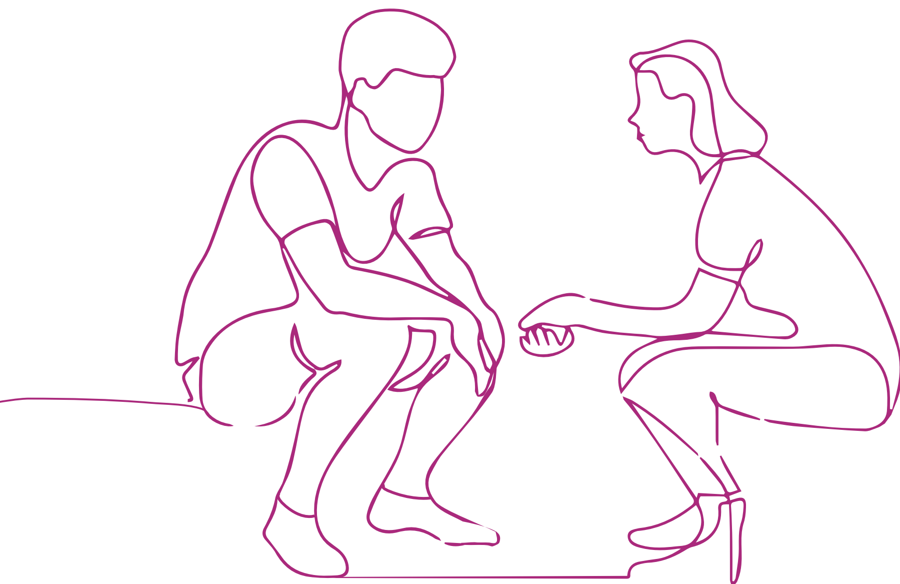
Safer services

As it is impossible to predict which of the individuals under our care will die by suicide over the long term, we aim to provide safer care for all, with a particular focus on areas of care which are known to be important in reducing deaths from suicide. This is in line with the NCISH guidance. We intend to audit all our services using the NCISH Toolkit for Safer Services to identify gaps and then work collaboratively to support improvements in care in these areas. We will also champion the mitigation of risk factors by ensuring that co-produced personalised safety planning is used throughout the Trust.



Leadership and governance of this strategy

Delivery of the strategy will be overseen by the Deputy Medical Director reporting to the Safety, Effectiveness and Experience Group.



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get in touch

If you are interested in learning more about our work on this agenda please visit please visit the intranet page: Working for the Trust > Suicide Awareness, Prevention and Support

We are aware that this topic is a difficult one and can trigger distress. If you or someone close to you needs to talk about suicidality, any time of day or night, you can:

- call the Samaritans free on **116 123**
- text "SHOUT" to **85258** to contact the Shout Crisis Text Line, or text "YM" if you're under 19
- if you're under 19, you can also call **0800 1111** to talk to Childline. The number will not appear on your phone bill.

If you live in Barnet, Enfield or Haringey and you are experiencing a mental health crisis, you can call our 24-hour Crisis Telephone Service on **0800 151 0023**.

Produced by the Communications Department at Barnet, Enfield and Haringey Mental Health NHS Trust