Contents

Executive summary ......................................................................................................................... 3
Introduction ...................................................................................................................................... 4
Implementation of the Strategy ........................................................................................................ 5

Action Area 1: Reduce the risk of suicide in key high-risk groups ................................................. 6
What do we know? .............................................................................................................................. 6
What will we do? ............................................................................................................................... 6

Action Area 2: Tailor approaches to improve mental health in specific groups ............................. 7
What do we know? .............................................................................................................................. 7
What will we do? ................................................................................................................................ 8

Action Area 3: Reduce access to the means of suicide ................................................................... 9
What do we know? .............................................................................................................................. 9
What will we do? .................................................................................................................................. 9

Action Area 4: Provide better information and support to those bereaved or affected by suicide .. 10
What do we know? .............................................................................................................................. 10
What will we do? .................................................................................................................................. 10

Action Area 5:
Support the media in delivering sensitive approaches to suicide and suicidal behaviour .......... 11
What do we know? .............................................................................................................................. 11
What will we do? .................................................................................................................................. 12

Action Area 6: Support research, data collection and monitoring .................................................. 12
What do we know? .............................................................................................................................. 12
What will we do? .................................................................................................................................. 12

Patient and public involvement ........................................................................................................ 13
Suicide Prevention Strategy high level priorities 2016 –2019 ......................................................... 14
Acknowledgements ............................................................................................................................ 18
The Strategy Advisory Group: .......................................................................................................... 18
Executive summary

Every suicide is both an individual tragedy and terrible loss to society. Suicides are not inevitable and central to any prevention work is the maintenance of hope for potentially vulnerable individuals. Lincolnshire Partnership NHS Foundation Trust (LPFT) intends to work in partnership with other agencies to ensure that vulnerable individuals in their care and those at times of crisis are supported and kept safe from preventable harm.

This document is based on the key policy documents and current research on suicide and suicide prevention. This Strategy’s main focus is upon reducing the risk of suicide in those individuals known to LPFT services; however we acknowledge that because suicide is such a complex behaviour with a number of underlying causes, approaches to prevention must be wide-ranging. We are therefore mindful of the need for collaborative working with other statutory organisations, third sector providers, service users/patients and their friends and families and will ensure that the LPFT Suicide Prevention Strategy aligns with the wider Lincolnshire Strategy. This will support a robust county wide interagency approach and prevention structure.
Introduction

The most recent data available and published during 2015 evidences that 4,363 people died by completed suicide in England during 2013 equating to a rate of 15.9 per 100,000 population. (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), July 2015). Suicide is multi-factorial and is different for every individual; it is often the combination of factors rather than one single factor that leads to a poor outcome. Mental ill health and distress is one of the major factors associated with suicide and is associated with an increased risk of completed suicide.

Nationally in 2013 30% of all those who completed suicides had been seen by mental health services in the year before their death. Around one third of these suicide deaths occurred in those who were current or recent in-patients. These people are in the closest proximity to services, which presents opportunities for intervention. (NCISH, 2013). The suicide rate in LPFT was 3.8 (per 10,000 mental health contacts between 2011-13) and in the lowest quintile compared to other mental health providers in England (NCISH).

LPFT have a zero suicide ambition which carries a foundation belief that deaths of individuals within mental health services are preventable. It presents a bold goal and aspirational challenge and this Strategy is the first step towards achieving this. Suicide is not inevitable and there are many ways in which mental health services can improve clinical practice to reduce suicide among those with mental ill health. This Suicide Prevention Strategy is aimed at staff employed by LPFT and all its key stakeholders involved in the work of Suicide Prevention. Service Users and Carers have also been invited to contribute in the development of this Suicide Prevention Strategy. LPFTs Suicide Prevention Group works with LPFTs Serious Incident Review Group and Quality Committee and also with external stakeholders - Public Health, Voluntary Organisations, Local Council and Clinical Commissioning Groups.

Over recent years there has been a slight increase in suicide rates in England, but the rates remain comparatively low especially when viewed in an international context. These changing rates of suicide show the need for continuing vigilance. Evidence is emerging of an impact of the current recession on suicides though suicide risk may not be straightforward and for many people it is a combination of factors. There is a need to develop and support services for people in crisis who have suicidal ideation, but do not meet thresholds for other services (particularly out of hours). There is something about ensuring that those regular attenders to Accident and Emergency Departments, and/or regular
callers to the Police and ambulance services have earlier support so their situation is less likely to escalate into suicide attempts.

It is important to clarify and strengthen referral pathways and integration with community-based services, including third sector organisations particularly for those potential referrals discharged because they have not reached thresholds for secondary or acute care.

Implementation of the Strategy

LPFT’s Strategy objectives are aligned to those of the National Suicide Prevention Strategy (NSPS) and aim to reduce the suicide rate in the population of individuals that come into contact with LPFT services and to provide better support for those bereaved or affected by suicide more generally. We will therefore focus our efforts around the six areas for action highlighted in the NSPS to deliver these objectives.

The NSPS 6 main areas for action are:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring
Action Area 1:
Reduce the risk of suicide in key high-risk groups

What do we know?

The National Confidential Inquiry has highlighted the importance of optimizing ward safety, particularly by removing ligature points on in-patient wards and reducing absconding. Research has shown that 3 specific measures, i.e. access to crisis care, dual diagnosis policies, and routine reviews after suicide deaths, help to prevent suicide. There has been a rise in suicides in males over the last 7 years and this is reflected in male patient population, particularly for young and middle aged men (35-49 years). People who injure, those in contact with the criminal justice service, those who use substances, have chronic physical health problems, are in specific occupations, or individuals bereaved by suicide are some other key high risk groups. Better engagement, management, follow up and support for individuals in these groups could contribute significantly to suicide prevention.

What will we do?

- We will continue to embed our risk assessment processes and provide mandatory clinical risk assessment and formulation training which includes a focus upon suicide and self-injury to ensure there is early identification of those at high risk.

- LPFT will continue to provide psycho-social assessments recommended by NICE to provide a more comprehensive picture that could be incorporated into care and personal safety management plans.

- We will make our services more accessible to those at potentially increased risk by having links with other local services and organizations, ensuring there are clear pathways into services, for example we will work with local agencies to promote services for males with mental health difficulties.

- For those known to mental health services or referred by their GP as requiring urgent care or who are in crisis we will work to ensure they experience timely appropriate responses.

- For patients who self-injure and present in Emergency Departments we will ensure flagging up at triage, timely assessment, and follow-up by the most appropriate service.

- Staff attitudes are important as poor ‘experience of care’ where patients perceive negative attitudes towards them is associated with further self-injury in those prone to this. We aim to reduce the complacency and desensitization that can occur when working with high risk individuals on an extended basis.
• The rate of suicide is elevated during periods of absconding. We aim to decrease the risk of absconding by providing more consistent, comprehensive pre and post leave assessments and care plans.

• We will be working to provide improved monitoring and support post discharge from in-patient services. We will ensure that there are clear post discharge plans with details of the follow-up arrangement and relevant contact numbers as the highest risk of suicide occurs at points of transition from in-patient services to the community.

• There will be enhanced post discharge support for those who are returning to the area from out of area placements due to potential increased needs in this group.

• We will include family and carers in risk assessments and care planning whenever possible.

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

**What do we know?**

The NSPS identifies that the way to reduce suicide is to improve the mental health of the population as a whole as set out in both No Health without Mental Health and Healthy Lives, Healthy People. Some groups may have higher rates of mental health difficulties including self-injury. These are not 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, bi-sexual, transgender and questioning (LGBTQ) individuals are at increased risk of feeling marginalized and stigmatized. We know that men are 3 times more likely than women to die by suicide and that middle age men are people at highest risk, particularly those who are social economically disadvantaged. Men find it difficult to access or take up mental health services available. Young people are vulnerable to suicidal feelings and the risk may be increased when they identify with people who have taken their own life or when acts are highlighted on social media. Self-injury is becoming increasingly common in this group. Older adults also represent a high risk group with higher levels of lethality associated with acts; they require ‘age-appropriate’ treatments and care.
What will we do?

- We will work in partnership with a variety of agencies to identify the best approaches to promote the health and well-being and challenge health inequalities where they exist within the specific characteristics of the population of Lincolnshire.

- We will tackle stigma and discrimination, inspiring a culture where these are actively challenged.

- We will ensure that our Serious Untoward Incident Reviews are robust and that lessons learned will be embedded in clinical practice through the action plans developed from the recommendations.

- We will ensure that lessons learnt following incidents of absconding or of patients being absent without leave are disseminated and appropriate strategies put in place to decrease the risk in this area.

- We will develop Personal Safety Plans for those identified at risk of suicide or self-injuring, which will incorporate strategies that they can employ, contact numbers and details of their support network to minimize the risk at times of crisis.

- People who self-injure are one of the most important high risk groups. The NICE quality standards highlight the importance of high quality assessment and the availability of psychological therapies to this group. LPFT will work with commissioners to ensure these standards are met.

- We will improve the physical health management of our service users through support around smoking cessation, weight management, and substance misuse, in addition to integrating physical health into decisions about prescribing and monitoring of medication.

- We will work collaboratively with a variety of agencies to promote our services to those who may feel marginalized, for example we will work closely with Primary Care to facilitate access for services to those in higher risk groups who have mental health difficulties.

- We will improve the experience of patients who are at points of transition between services.
• We will promote anti-bullying in schools through the Primary Mental Health Teams and support specific training for Safety Champions in schools.

• We will develop our peer support networks to ensure that those with lived experience are involved in both the design and delivery of our services and can drive recovery focused organizational change (ImROC) [www.imroc.org](http://www.imroc.org)

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

**What do we know?**

Restriction of access to lethal means of suicide is one of the most effective strategies for suicide prevention in the general population. People may attempt suicide on impulse, and if the means are not easily available or if they attempt and survive, the suicidal impulse may pass. One of the most effective ways to prevent suicide is to reduce access to means of potential high lethality. The National Confidential Inquiry reports that the methods most amenable to intervention are removal of potential ligature points in in-patient settings, withdrawal of certain analgesics and limitations in the size of packs that can be purchased, restrictions on the quantities of medications that can be used for self-poisoning being dispensed and reducing the access to areas with easily accessible means of suicide such as multistory car parks and motorway bridges.

**What will we do?**

• Continue to audit clinical areas for identification and removal of potential ligature points.

• We will work with family and carers and involve them when appropriate in patients’ Personal Safety Plans, to make them aware of potential hazards and to help them work with individuals to identify and reduce access to means at times of crises.

• We will attempt to identify and reduce potential means of suicide by limiting supplies of medication issued to individuals at times of high risk, and routinely communicating advice about supply to the General Practitioner. We will facilitate removal of excessive medication or return of medications that are not being used.
- We will work collaboratively with General Practitioners and Pharmacists to ensure that there is ratification of prescribed medication and effective medicines management strategies identified to highlight non-compliance.

- Where service users have disclosed they have in their possession the means to complete suicide, such as a recent purchase of rope or tablets and it is apparent that there has been a degree of planning their suicide, staff will make every effort to remove lethal means.

- We will share information when necessary with other professionals including General Practitioners, Dispensaries, Criminal Justice Agencies, the Police and the British Transport Police when we are aware of suicidal ideation or plans that involve access to means that can be moderated.

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

**What do we know?**

Families and friends bereaved by a suicide are at increased risk of mental and emotional problems and may be at higher risk of suicide themselves. Suicide can also have a profound effect on the local community. Postvention in these circumstances is essential to help survivors cope with their loss. It is estimated that 6 close family members and friends are seriously affected by every suicide. We know from studies that, in addition to immediate family and friends, many others will be affected in some way; they include neighbours, school friends and work colleagues, but also people whose work brings them into contact with suicide – emergency and rescue workers, healthcare professionals, teachers, the police, faith leaders and witnesses to the incident.

**What will we do?**

- Prepare an information pack for staff to use when providing support to relatives and carers.

- We will provide training for staff in communicating with and supporting those bereaved or affected by suicide so that we can be more sensitive in our language, manner and approach and increase our awareness of the needs of this population.
• We will provide a pathway into services and timely support for those who require mental health input if necessary.

• We will work with voluntary and self-help agencies, signposting those affected to local support groups when appropriate and providing links to other agencies via our website. We will include details of the support after suicide website (http://supportaftersuicide.org.uk), Help is at Hand http://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf and other bereavement specialist organisations.

• We will participate with partner agencies, and share information and lessons learned about the impact on families and friends bereaved by the suicide so that we can help them to find the most appropriate support.

• We will keep families informed of actions taken or lessons learnt from their relative’s death including any changes as a result of the investigation or inquest.

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

**What do we know?**

The media have a significant influence on behaviour and attitudes. There is already compelling evidence that media reporting and portrayals of suicide can lead to copycat behaviour, especially among young people and those already at risk. There is growing concern about the misuse of the internet to promote suicide and suicide methods. The internet also provides an opportunity to reach out to vulnerable individuals who would otherwise be reluctant to seek information, help or support from other agencies. As a Trust we must promote the responsible reporting and the portrayal of suicide and suicidal behaviour in the media. It is important that we attend to the language we use in communications. Terms such as ‘committed suicide’ which have annotations with crime; blame; shame and guilt are not helpful and should be avoided.
What will we do?

- Ensure local and regional reporters are a key stakeholder group which the organisation engages with.

- Increase the awareness of staff of the influence of social media.

- Improve and develop the Trust’s internet site as a source of support and resources for the public and other stakeholders, linking to third party websites where appropriate.

- Participate in and promote appropriate national and local campaigns, such as World Suicide Prevention Day, World Mental Health Day, Time to Change.

Action Area 6: Support research, data collection and monitoring

What do we know?
Reliable, timely and accurate suicide and self-injury / suicide attempt statistics are crucial in order to develop any meaningful suicide prevention Strategy which is of tremendous public health importance. Public Health England is establishing an evidence and intelligence function. This will include gathering information on suicide prevention activities and data on suicide and self-injury in order to publish the data to support the Public Health Outcomes Framework. Research is essential to suicide prevention. Research studies enhance our understanding of the statistical data provided by the Office for National Statistics (ONS) to inform strategies and interventions; highlight trends and changes in patterns; identify key factors in suicide risk and enhance our understanding of risk groups; evaluate and develop interventions to reflect changing needs and priorities, and develop the evidence base on what works in suicide prevention.
What will we do?

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

Patient and public involvement

Locally LPFT will develop effective partnerships across all sectors including health, social care, education, housing, employment, the police and criminal justice system, transport and the voluntary sector. LPFT will continue to be represented as an active member of the Lincolnshire Suicide Prevention Partnership and participate in all its activities for reducing suicide locally. LPFT will use the NICE quality standards, defining high quality care, relevant to both local authorities and Clinical Commissioning Groups (CCGs) in their commissioning roles. Existing quality standards relevant to suicide prevention include alcohol dependence, depression in adults, self-injury in adults and self-injury in vulnerable groups.

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

In developing this Strategy a full range of patients/service users, carers, family members, Governors, stakeholders and members of the public were provided the opportunity to comment through an open consultation process. On-going involvement will vary by local area to ensure that individuals needs are kept at the heart of service delivery through local provision. Many of the thoughts and comments have been included within the final Strategy and LPFT are grateful for the active participation and valuable knowledge and experience of those who replied.
Suicide Prevention Strategy high level priorities
2016 –2019

The Suicide Prevention Strategy is a three year strategy running as follows:

Year 1: April 1st 2016 to 31st March 2017
Year 2: April 1st 2017 to 31st March 2018
Year 3: April 1st 2018 to 31st March 2019

The priorities for each year have been mapped out below with the view that the overall strategy will be achieved within this three year period. It is not realistic at this stage to operationalise each year as the plan for Year 2 and 3 will be determined by the progress made within the first year.

The Suicide Strategy Group will continue to meet quarterly to check progress against the priorities:

- Quarter 1 meetings of each year will focus on the priorities for that year, operationalising each of the targets. Leads will be identified to take each target forward.

- There will be feedback on progress over Quarter 2 and 3 with identification and troubleshooting of any barriers to implementation.

- Quarter 4 meetings will review progress against the targets and revise goals for the following year where necessary to ensure that unachieved actions are prioritised.

Year 1 of the strategy will concentrate on implementing the changes within the Crisis Teams who will be likely to have frontline involvement with the most vulnerable individuals. It will also prioritise that our clinical areas are safe and that comprehensive risk assessments are completed with all patients to facilitate their developing personal safety plans. We will establish annual divisional reviews of suicides so that lessons learnt can be cascaded and strengthen our post-vention strategies. We will also focus on providing better support for those affected by suicide in the postvention period by signposting national and local sources of support, including educational, emotional and practical aspects.

Year 2 of the strategy will target key high risk groups, such as men, and look at increasing awareness and the accessibility of our services to such groups. We will also focus on the completion of psychosocial formulations to get a more holistic view of difficulties and draw on our service users strengths.
Year 3 will concentrate on establishing clear care pathways for those who self-injure. It will also be used to ensure that collaborative working arrangements are established so that changes implemented by the strategy maintain momentum.

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<th>YEAR 1</th>
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<td>AREA 1</td>
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<tr>
<td>To continue to provide training to staff in the crisis team in completing thorough risk assessments and delivering sensitive support for those at risk of suicide.</td>
<td>Provide psycho-social assessments on all patients as recommended by NICE and incorporate these into care and personal safety management plans.</td>
<td>LPFT will develop care options and a clear care pathway for those who self-injure.</td>
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<tr>
<td>To decrease the risk of absconding by providing more consistent and comprehensive pre and post leave assessments in care plans.</td>
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<td>To continue the audit and active management of potential ligature points in clinical areas.</td>
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<td>To include family and carers in risk assessments and care planning whenever possible.</td>
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AREA 2
LPFT will continue to ensure that serious incident reviews are robust and that lessons learnt are embedded in clinical practice

AREA 2
LPFT will promote access to its services for men and increase awareness of the availability of services to this group.

AREA 2
Work collaboratively with a variety of agencies to promote our services to those who may feel marginalized.
Personal safety plans will be developed in collaboration with service users for those identified at risk of suicide or self-injury, incorporating strategies they can employ, contact numbers and details of support networks.

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<td>We will reduce potential means of suicide by limiting supplies of medication through routinely communicating advice about supply to General Practitioners in clinic letters.</td>
<td>Embed the use of Personal Safety Plans for high risk Groups, in particular males accessing LPFT clinical Services.</td>
<td>Establish/re-inforce cross organisational working with other Professionals including General Practitioners, Dispensaries, Criminal Justice Agencies, the Police and the British Transport Police.</td>
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<td>LPFT will facilitate the removal and disposal of excessive medication.</td>
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<td>To ensure that each team has a clear plan of action on how to manage an incident of suicide.</td>
<td>To cascade postvention training package to teams.</td>
<td>To cascade postvention training package to teams.</td>
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<tr>
<td>To ensure that a support pack is collated including literature and details of local support groups and specialist bereavement agencies are made available to relatives and carers who have been bereaved by suicide.</td>
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### AREA 5
Head of Communications to arrange introductory meetings with local and regional reporters to ensure they are a key stakeholder group with which the organisation engages.

Improve and develop the Trust’s internet site as a source of support and resources for the public and other stakeholders, linking to third party websites where appropriate.

Participate in and promote appropriate national and local campaigns, such as World Suicide Prevention Day, World Mental Health Day, Time to Change.

### AREA 5
Ensure local and regional reporters are a key stakeholder group with which the organisation engages.

Improve and develop the Trust’s internet site as a source of support and resources for the public and other stakeholders.

Increase the awareness of staff of the influence of social media.

Participate in and promote appropriate national and local campaigns, such as World Suicide Prevention Day, World Mental Health Day, Time to Change.

### AREA 6
Facilitate an annual review of suicides in each division, undertaking thematic analyses and ensuring lessons learnt are disseminated.

Establish annual review of suicide practice.

Annual review of suicide practice.
Acknowledgements

The Strategy Advisory Group:

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