Prevention of Suicide Procedure

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Prevention of Suicide Procedure

1 Introduction

The Tavistock and Portman NHS Foundation Trust (the Trust) is a specialist mental health trust based in north London, providing out-patient psychological therapy services for children, young people, families and adults, as well as providing multi-disciplinary training and education. Unlike most other mental health trusts, it has no in-patient beds or psychiatric wards and the majority of patients receiving care at the Trust are at low risk of self-harm or suicidal acts. As a result of the type of care we offer the Trust’s suicide rate has always been low compared to other mental health trusts.

As well as the Trust being committed to reducing the rate of suicide amongst the patients who access its clinical services, it is also committed to contributing to suicide prevention regionally and nationally via its teaching, consultancy and research activities. Since its foundation in 1920, the Trust has been recognised as an international leader in pioneering psychological theories and treatments about emotional and psychological wellbeing, and as such, is well placed to contribute to a national strategy for suicide prevention.

2 Purpose

The Trust has a responsibility to deliver the standards and targets as outlined in national strategies. Suicide prevention is a key national priority for all health and social services. This document outlines the core principles in suicide prevention and sets out the way in which the Trust will seek to meet these principles.

This document should be read in conjunction with the Trust’s Procedure for Clinical Risk Assessment, which provides a framework for a consistent approach to clinical risk assessment of individual patients, including self-harm and suicide, and details the way in which risk assessments are to be recorded and communicated to relevant professionals and others with a legitimate interest.

3 Scope

This procedure is relevant to all clinical staff who are involved in the assessment and/or treatment of patients and to senior managers who are involved both within the Trust and with external colleagues in the planning and developing of services that could have an impact on suicide rate.
4 Definitions

The Trust has adopted the World Health Organisation's definition of suicidal behaviour:

<table>
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<tr>
<th>(i) Suicidal act</th>
<th>The self-infliction of injury with varying degrees of lethal intent and awareness of motive</th>
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<td>(ii) Suicide</td>
<td>A suicidal act with fatal outcome that is deliberately initiated and performed by the person with the knowledge or expectation of its fatal outcome</td>
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<td>(iii) Attempted suicide</td>
<td>A suicidal act with non-fatal outcome</td>
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<td>(iv) Suicidal ideation</td>
<td>The thoughts that a person has about suicide</td>
</tr>
<tr>
<td>(v) Suicide plan</td>
<td>A verbal description of a plan to commit suicide, including timing, availability of method, setting, and actions made towards carrying out the plan. The more detailed and specific the suicide plan, the greater the level of risk.</td>
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5 Core Principles

This procedure is based on the following core principles of effective suicide prevention:

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

Please see Appendix 1 for more details regarding these core principles.
6 Duties and responsibilities

6.1 Medical Director/ Associate Medical Director (Patient Safety and Clinical Risk Lead)

The Medical Director has overall responsibility for this procedure in his role as lead for clinical risk. Working with the Associate Medical Director (Patient Safety and Clinical Risk Lead) he will ensure that: the suicide prevention training provided by the Trust is valid and fit for purpose; to commission and act upon training satisfaction /evaluation processes; to commission an annual audit of suicidal incidents within the Trust and monitor implementation of recommendations; and report to the Management Team of any gaps in the implementation of the procedure.

6.2 CAMHS Director, Director of Quality, Patient Experiences and Adult Services and Associate Clinical Directors

Clinical Directors and Associate Clinical Directors will ensure that suicide prevention training is attended by all appropriate staff in their services; and ensure that this procedure and other relevant policies and clinical guidance are disseminated across services and used to direct practice.

6.3 Qualified Clinical Staff

Clinical staff will follow the principles within this procedure and will:

- Undertake standard suicide prevention assessment with all service users and recognise when more advanced assessments are required
- Seek supervision / guidance when there are any concerns regarding the presentation of service users
- Follow suicide prevention guidelines regarding the best practice
- Develop comprehensive management plans which reflect the service user’s assessed needs in relation to the prevention of suicide
- Document management plans clearly and comprehensively

6.4 Clinical Trainees

Clinical trainees will follow the principles within this procedure and undertake risk assessment of their patients at appropriate intervals during their care at the Trust. Clinical trainees will ensure that risk assessment findings are documented fully and accurately and that where risk factors are identified these are considered in care planning and in communication with relevant others (e.g. GP, referrer, other members of the patient’s care team). Trainees will refer to their supervisor in all circumstances when a risk assessment identifies any suicidal risks.
7 Procedures

7.1 Procedure for management of the individual

7.2 Individual Clinical Management

There should be evidence of a structured risk assessment and management plan for all individuals under the care of the Trust; further clinical guidance is available in the Clinical Risk Assessment Procedure. Individual management is a cycle of:

- Assessment
- Formulation or understanding of risks and problems
- Treatment and management based on formulation
- Evaluation

It is advised that as a minimum risk should be reassessed:

- As part of any initial assessment (first contact within a team or service, even if not first contact with the Trust)
- As part of regular, minimum termly, reviews of a patient’s treatment
- When the service user, carers or staff feel the risk level may have changed
- When there is a change to a service user’s circumstances which research indicates might lead to an elevation of risk (e.g. loss of job, breakdown of a relationship, financial difficulty)
- At thresholds between services or treatment settings
- Prior to discharge
- When there is a marked observed change in service user’s affect (e.g. an apparent abrupt improvement or deterioration in mood, or very high levels of anger)
- When there is consistent insidious low mood

Immediate vs longer term risk management:

- It is recognised that initial risk assessment will be directed at immediate management, often undertaken by an individual rather than a team. It will usually be directed at a newly identified problem and may involve crisis planning.
- Longer term management will more often involve team discussion or multi-disciplinary management, and the assessment and formulation process will be more detailed.

7.3 Assessment

Assessment is not a fixed process, and any risk assessment involves a complex interaction of a number of factors. Suicide risk fluctuates over time. It is important to keep assessing the risk.
Assessment must be based on a sound clinical understanding of risk factors and management strategies for suicidal thoughts, and behaviour (see Trust’s Clinical Risk Assessment Procedure).

Risk of self-harm and suicide is part of the global risk assessment process. Other risks, e.g. to others, to children, neglect need to be considered in conjunction with risks of self-harm.

Sources of information to inform risk assessment include:-

- Accessing, collating and reviewing information already recorded including demographic information.
- Discussion with the patient, carers, significant others and professionals.
- Questionnaires or rating scales where appropriate e.g. CORE, Beck Depression Inventory
- More structured assessment tools for predicting shorter term risk such as the START
- More structured clinical interviews such as the Advanced Suicide Risk Assessment Tool

It is expected that services will carry out assessment which is detailed enough to describe risk, identify factors increasing or decreasing risk of suicide, allow formulation, and inform the next stage of management.

7.4 Risk Formulation

Formulation is an essential outcome of assessment. The aim of a formulation is to bring together the assessment information to develop an understanding of the target behaviour (in this case suicidal behaviour), so as to inform and direct treatment and management plans.

Formulation of risk should seek to establish any clinical reasons behind increased risk, in order for this to be incorporated into treatment plans.

Formulations may be simple or complex, depending on the complexity of the individual service user’s difficulties and situation. For service users with more complex needs, multi-disciplinary team involvement should be considered in constructing the risk formulation.

Service users and carers should be involved in the production of the formulation wherever possible. A risk formulation will include:

- Description of the risk
- Predisposing factors
- Precipitating or trigger factors
- Perpetuating factors
- Protective factors
7.5 Treatment Plan

The identification of suicide risk requires **immediate action**. The risk management plan should:

- Be based on the formulation
- Be developed collaboratively with the patient/service user wherever possible
- Lead to positive identifiable and effective recommendations and actions
- Address underlying problems, identified needs and factors influencing risk of suicide
- Involve family, friends or other agencies as appropriate

Treatment includes consideration of:

- Engagement to engender hope and collaborative working
- Simple psychosocial interventions e.g. information giving, self-help strategies
- Psychological interventions
- Medication; including quantity prescribed and safety in overdose
- Social measures
- Spiritual, religious and pastoral support measures
- Setting for treatment
- Monitoring / supervision of the patient
- Communication of information to relevant parties
- Follow up arrangements

Initial treatment plans may be focused towards keeping the patient safe in the short term. Subsequent plans should be based on a deeper understanding, more detailed formulation and addressing underlying factors for suicidality.

Complex treatment plans will involve individuals from more than one discipline or agency. It is expected that services will maintain an awareness of the options available to them and refer appropriately when needed.

7.6 Special Service User Populations

Service user populations that are known to be at higher risk of suicide include older adults in which physical illness, chronic pain, social isolation and cognitive impairment either on their own or more commonly in combination increase risk of suicide; young people with a history of self-harm; people with substance misuse; people with a diagnosis of depression or schizophrenia; people taking medication.

Although all staff working with patients should be aware of these risk factors, certain services in the Trust will have patients more likely to present with
suicidal thoughts and behaviour, and may therefore be thought of as ‘high risk services’.

These include:

- Adolescent and Young Adult Service
- City and Hackney Primary Care Consultation service
- Complex medical conditions
- Eating disorders service
- Family Drug and Alcohol Service
- Fitzjohn’s unit
- Gender Identity Development Service
- HomeBase
- Looked After Children’s Assessment Service
- MedNet
- Pain service
- Portman Clinic
- Refugee Service
- Trauma service
- Young People’s Drug and Alcohol Service

Although prescribing is infrequent in the Trust, service users at risk of suicide on psychotropic medication should have periodic review to reduce medication if possible. Potential for harm in overdose should be one of the factors involved in the choice of medication. Plans should be put in place to reduce the risk of overdose where the risk is high, e.g. removal of unused medication, prescribing limited quantities, observing administration. GP’s should be aware of appropriate monitoring, prescribing quantities and risks associated with medication.

7.7 **Reflective practice at the level of the individual and post incident reviews**

Suicides and serious suicide attempts must be reported via the Trust incident reporting procedures and will be investigated according to the Trust’s Procedure for Investigation of and Learning from Serious Incidents. All clinical staff involved in the care of a service user will be involved in this process.

All staff, service users and families/carers/partners affected by a suicide or serious attempt will receive prompt and open information and the opportunity to receive appropriate and effective support as soon as they require it by the Service Managers (see below).
7.8 Recording information

The risk assessment and management process should be documented in the case notes. This allows communication between professionals and is the record of decision making and care provided.

Writing the care plan should ideally be a shared process with the service users. Where the service user significantly disagrees with the assessment, including risk assessment, this should be documented in the clinical notes.

7.9 Consent and capacity

The desirability to empower the service user to take responsibility may need to be balanced alongside their capacity to make informed choices, the Trust’s responsibility for the safety of service users and others, staff professional responsibilities and consideration of short and long term consequences of potential management strategies.

Occasionally, treatment will need to be under the Mental Health Act or Mental Capacity Act. As this Trust does not provide in-patient care, any patient assessed and admitted under the Mental Health Act would need to be referred to the patient’s catchment area mental health trust or in-patient facility. In these cases, a consultant psychiatrist should be consulted. For further information see Trust’s Consent to Treatment Procedure and Procedure.

7.10 Supporting service users, family, and friends

It must remembered that caring for a person who has a history of suicide attempts or who is currently experiencing suicidal ideation can be an extremely stressful, worrying and tiring time. Every effort must be made to encourage the service user to allow his family and carers to be actively engaged in the provision of care.

Listening to a service user’s carer is not a breach of confidentiality, and whilst it is good practice to ask/ inform the service user of communications with their family, it is not always appropriate when considering the management of risk.

Post incident reviews following the deaths of a service user by suicide have frequently shown that carers did not feel involved in their loved one’s care. They frequently identify:

- Not being provided with guidance to take if the service user’s mental state deteriorates
- Not being listened to regarding their experiences of living with the service user
- Not being involved in developing a care plan
Families/carers/partners, with service user’s knowledge where possible, will be given a clear mechanism for making contact with services and contributing to care plans; the notes should document this.

Families/carers/partners should be provided with information as regards actions to be taken when deterioration in the service user’s mental state is noted. Where possible, the level of information to be provided to the families/carers/partners should be shared with the service user.

In cases of suicide, the Team Manager will review whether there was written evidence in the clinical notes that a member of staff was made responsible for ensuring that the families/carers/partners were promptly informed of actions being taken, if the Trust held details of those people.

Support services such as Social Care, carers groups and bereavement support should be signposted to families/carers/partners.

7.11 Staff support

‘Providing treatment and care for people who self-injure is emotionally demanding and requires a high level of communication skills and support’ [NICE 2004, Page 8].

Dilemmas and conflicts often occur when working with an individual who hurts themselves or expresses ideas of suicide. Suicidal behaviour can cause anxiety in staff particularly when they feel responsible for the actions of service users or there are conflicting professional approaches. Support is essential for staff and should be actively promoted and facilitated by the Trust. There should be:

- Access to appropriate training on suicide and self-harm
- Regular supervision, with a named supervisor with expertise in this area of work. This should include the possibility of team supervision to help the whole team manage complex service users and issues.
- Post incident support

Suicide is not always preventable and the Trust will seek to support its staff following critical incidents.

8 Training Requirements

Training for suicide prevention will be delivered in the following way:

- Trust induction (all staff) includes an introduction to clinical risk assessment training which includes training in the assessment, management and prevention of suicide and self-harm
• On-going training and support. This will be delivered at directorate level supervision and team meetings.

The aim of training of clinicians is two-fold:

• The primary aim is to impart the system of assessing and managing risk of suicide as outlined in this document and in the Clinical Risk Assessment Procedure.

• Departments with patients at higher risk of suicide (e.g. the Portman Clinic, Family Drug and Alcohol Service, Fitzjohn's Unit) will offer local specific training to support the work of those units. This will take a variety of forms including one to one training, and seminars and multi-professional team meetings when individual patients are discussed

9 Process for monitoring compliance with this procedure

Review of incidents of suicidal behaviour and monitoring compliance with Trust procedures

In the event of an individual SUI the Trust follows its investigation procedure, whilst being open with patients and relatives, and supports staff directly involved. The Trust follows any agreed action plan arising from the investigation of an SUI.

Suicides of service users, or those who have been a recent service user of the Trust, are reviewed or audited together, rather than individually, to look for patterns or trends. This will be monitored by the Patient Safety and Clinical Risk Lead who will report findings to the Clinical Quality, Safety, and Governance Committee.

The annual review will contain a:

• Longitudinal strand, which will identify suicide trends over a ten year period. The aim of this part of the study is to analyse the level of suicides over this time period, and compare changes in suicide rates in relation to the national average. The data for this part of the study will be sourced from the National Confidential Inquiry and from the Office of National Statistics.
• Detailed review all of the suicides of patients of the Trust for the time period being considered. The aim of this detailed suicide audit is to identify any patterns in socio-demographics, assessment and management of completed suicides which may inform service improvement and changes in clinical practice that will contribute to suicide prevention in service users.
A Serious Incident Review Group led by the Trust Patient Safety and Clinical Risk Lead will monitor Trust performance progress against agreed action plans and other activities, and will develop approaches to reduce suicidal behaviours. This group will review this procedure at least biennially and will review suicide audit exercises.

The Trust is a member of the Camden and Islington Suicide Prevention Steering Group, a relatively small (CIFT, CAMHS, MH commissioning, public health and CCG), high-level group, whose purpose is to oversee a pathway review commissioned by Public Health England and to formulate refreshed suicide prevention strategies for each borough, reviewed against best practice.

10 References and further information

- NCISH (2001). Safety First: Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
- Department of Health (2002). The National Suicide Prevention Strategy for England
- NCISH (2006). Avoidable deaths: Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
- Department of Health (2007) Best Practice in Managing Risk
- Royal College of Psychiatrists (2010). Self-Harm, Suicide and Risk Helping People who self-harm
- NCISH (2010). National Confidential Inquiry into Suicide and Homicide by People with Mental illness Annual Report: England and Wales
- Department of Health (2012). Statistical Update on Suicide
- Department of Health (2012). Preventing Suicide in England: a cross-government outcomes strategy to save lives
- NCISH (2014). National Confidential Inquiry into Suicide and Homicide by People with Mental illness Annual Report: England and Wales
11  Associated documents¹

Procedure for clinical risk assessment
Procedure for the management of self-harm
Incident reporting procedure
Procedure for the investigation of serious incidents
Consent to treatment procedure and procedure
Procedure for the prescribing and administration of medicines
Procedure for the rapid transfer of an acutely unwell patient

¹ For the current version of Trust procedures, please refer to the intranet.
**12 Equality Impact Assessment**

1. Does this procedure, function or service development impact on patients, staff and/or the public?

   **YES** *(go to Section 5.)*

2. Is there reason to believe that the procedure, function or service development could have an adverse impact on a particular group or groups?

   **NO**

   It is a document that guides staff based on the clinical presentation/clinical risk of the patient and not on features of equality or diversity.

4. Based on the initial screening process, now rate the level of impact on equality groups of the procedure, function or service development:

   **Negative / Adverse impact: Low**

   *(i.e. minimal risk of having, or does not have negative impact on equality)*

   **Positive impact: Low**

   *(i.e. not likely to promote, or does not promote, equality of opportunity)*

   Date completed 11.2.15

   Name Jane Chapman

   Job Title Governance and Risk Adviser
Appendix 1: National Context

Suicide prevention is a key national priority for all Health and Social Services. People with mental health problems are a particularly high-risk group for committing suicide. Mental health is one of the four target areas in *Saving Lives: Our Healthier Nation* (1999) which set a specific target to reduce the rate of suicide by at least one fifth by 2010. To support the delivery of this target and the continued reduction of suicide rates past that date, a number of important strategic and operational documents have been published:

- Department of Health (1999). *The National Service Framework for Mental Health*
- NCISH (2001). *Safety First: Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*
- Department of Health (2002). *The National Suicide Prevention Strategy for England*
- National Patient Safety Agency (2003; updated 2009) *Preventing Suicide: A Toolkit for Mental Health Services*
- NCISH (2006). *Avoidable deaths: Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*
- Royal College of Psychiatrists (2010). *Self-Harm, Suicide and Risk Helping People who self-harm*
- NCISH (2010). *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report: England and Wales*
- Department of Health (2012). *Statistical Update on Suicide*
- Department of Health (2012). *Preventing Suicide in England: a cross-government outcomes strategy to save lives*
- NCISH (2014). *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report: England and Wales*

National research and procedure 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 and annual reports.

Mental health service users, both inpatients and outpatients are a high risk group for committing suicide, which is why the *National Service Framework for Mental Health* (1999) set prevention of suicide (Standard 7) as one of its standards for improving mental health care. This standard is supported by *Safety First* (2001), the five year report of the NCISH by people with a mental illness which details the 'Twelve Points to a Safer Service’ to underpin the delivery of the national targets and standards, since updated in *Avoidable Deaths* (2006).

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). 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.
Appendix 2 Core Principles Explained

Core Principle 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, social media pressures, 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, drugs/alcohol.

Core Principle 2 Primary, secondary and tertiary methods of suicide prevention are all necessary

- **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 its clinical services (e.g. Family Nurse Partnership), as well as in its teaching and educational activities 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 (e.g. by family nurses in the Family Nurse Partnership) and the treatment of people with depression (e.g. as provided by the different psychological services the Trust provides for adults, adolescents, children and families).

- **Tertiary prevention**: This means treating patients who are severely unwell to restore function. In suicide prevention this means 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. Service user populations that are known to be at higher risk of suicide include older adults in which physical illness, chronic pain, social isolation and cognitive impairment either on their own or more commonly in combination increase risk of suicide; young people with a history of self-harm; people with substance misuse; people taking psychotropic medication; people with a diagnosis of depression or schizophrenia.

Core Principle 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;
the removal of ligature points in psychiatric wards or preventing access to rooftops) 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. Although the Trust has no in-patient beds and low levels of prescribing, nevertheless, consideration of all possible methods of suicide both on site and in the community is essential.

### Core Principle 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. 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 therefore 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. The Trust’s expertise in the provision of psychotherapeutic treatments, as well as its educational and research activities in mental health and social care which emphasize a developmental approach and the centrality of relationships, provide a solid foundation for focusing on the therapeutic relationship with service users and carers in the prevention of suicide.

### Core principle 5 The importance of learning from near misses and completed suicides

Learning needs to occur at all levels and from different sources. This procedure is directed by national best practice (e.g. NCISH, NICE, Best Practice in Managing Risk).

Within the Trust, learning should take place:
- at the individual practitioner level
- at the team or service level
- At the organisational level with an annual review of all Serious and Untoward Incidents (SUIs) to look at any trends that may be occurring.

### Core principle 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 or psychological difficulties. It is also during this time that communication between different teams is most likely to break down. Research has shown that these
transitions can put some patients at a higher risk of suicide. The Trust’s longstanding ethos of promoting a developmental approach to mental health, psychopathology and social care, with particular interest in an individual’s attachment experiences, facilitates the understanding and management of the potential negative impact of such transitions.

**Core Principle 7 Homicide prevention should be considered with suicide prevention**

Homicide-suicides or murder-suicides are very rare incidents of individuals killing themselves after having killed others (usually family members) as part of their illness. 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. Similarly, people who present a risk of violence towards others (e.g. some patients treated at the Portman Clinic), such as those with a diagnosis of antisocial personality disorder, may also be at higher risk of depression and suicide, and harm to self must be assessed in these individuals.

**Core principle 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.