

CR229

Self-harm and suicide in adults

Final report of the Patient Safety Group

July 2020

COLLEGE REPORT

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Introduction

About this report

This report provides new, practice-focused guidance for psychiatrists and other mental health professionals on suicide and self-harm that examines what interaction is now needed between these topics. It considers in detail:

- the national policy context
- prevention of suicide and self-harm
- the commissioning of services
- professional roles
- responsibilities for clinicians and clinical pathways for adults with self-harm.

Best Practice tips and Safety Plans are provided, as well as guidelines for assessment and intervention. Those who use services provide the best insight to support progress and that is why the experiences of patients and those close to them are at the very centre of this guidance. Their contribution has been invaluable.

History

The report evolved as a result of meetings of the Working Group in 2016, 2017 and 2018, with input from faculties of the College as well as from divisions and special interest groups.

It builds on the work done in the previous broadly-based College Report *Self-harm, suicide and risk: helping people who self-harm* (CR158, 2010). This followed a comprehensive review from the RCPsych Patient Safety Expert Working Group which was set up to specifically address the question of why people harm and/or die by suicide and the role that psychiatrists and other mental health professionals should play in their care and treatment. That report provided details of epidemiology and the role that public health should play in managing self-harm. It also reported on a survey which gathered the opinions and experiences of Members of the Royal College of Psychiatrists on the issue of self-harm.

Remit

The scope of this report is suicide in adults, dealing specifically with people over the age of 18 in community and in-patient settings.

It addresses the management of self-harm and suicide across the UK. We are aware that self-harm and suicide are societal issues, subject to government policy, suicide prevention strategies and NICE guidelines on self-harm.

This report seeks to reflect the various challenges presented by different commissioning arrangements across the countries of the UK, and to highlight principles that are common to all of them, regardless of geography. Commissioners hold crucial responsibility in relation to promoting the multi-agency collaboration required for the safe and effective care of someone who has experienced self-harm or attempted suicide. Good care with appropriate level of support for the individual can transform and save lives. In contrast, a patient journey that is disjointed and fragmented, with poor or absent communication between agencies, is itself a risk factor for suicide.

Children and young people are not within the scope of this report. An earlier College Report [Managing self-harm in young people](#) (CR192) has addressed this issue in adolescents.

People in contact with criminal justice services are also not within the scope of this report, however the College is undertaking separate activity on this issue, recognising that the record numbers of prison suicides over recent years, which had risen by 34% to the highest ever level in 2016, are a significant cause for concern. At present there are NICE guidelines on this topic: [Preventing Suicide in Community and Custodial Settings](#) (NICE September 2018).

‘Zero suicides’ ambition

There are currently between 81 and 91 deaths by suicide in NHS in-patient services in England each year. In January 2019 Jeremy Hunt, the Health and Social Care Secretary, announced a ‘zero suicide ambition’ among NHS patients. There is debate about whether this ambition is achievable and what impact it should have on mental healthcare services.

We fully support the attention and resources that the focus on zero-suicide initiatives has brought. However, if they are to avoid unintended negative consequences, it is crucial that they take a Quality Improvement approach rather than one driven by a target number. If every organisation and individual does all that is possible to eliminate the risk of suicide, this will be entirely consistent with a zero-suicide initiative.

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Declaration of interests

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Key messages

- 1 We have noted significant variation in the experience of services by patients and carers. Although some report being treated with respect and compassion, others have felt belittled or ignored.
- 2 The College supports zero-suicide initiatives where the approach taken is a Quality Improvement one, rather than one which is driven by a target number. If every organisation and individual does all that is possible to eliminate the risk of suicide, this will be entirely consistent with a 'zero-suicide' initiative.
- 3 While most cases of completed suicide are linked to mental illness, at-risk patients are not being identified and/or offered the mental health treatment that could have prevented their death.
- 4 Self-harm is one of strongest predictors of suicide, including among older people.
- 5 Suicide occurs more frequently with the coexistence of psychiatric and physical illness.
- 6 It is important that a holistic and person-centred assessment of all patients is undertaken before considering if they are suitable for a crisis resolution and home treatment (CRHT) model of care.
- 7 A significant proportion of self-harm behaviour does not lead to presentation to professionals. Voluntary, peer and community counselling organisations can offer significant help, in addition to family and friends. Informal support can, in some instances, be sufficient to help the individual, and the self-harm may never need to come to the attention of professionals.
- 8 For patients who are at risk of suicide, their care plans will also need to include an immediate Safety Plan, co-produced with the patient. This should make explicit reference to the removal and/or mitigation of the means to harm themselves, list activities and coping strategies, and provide information on how to access social, psychological and emergency support.
- 9 Every acute hospital should provide a timely and comprehensive psycho-social assessment in line with NICE guidelines for all patients presenting with self-harm, and have close liaison with community mental health services for follow-up.
- 10 The long-term treatment of self-harm is affected by the lack of an accurate risk assessment tool to predict which patients will die by suicide following episodes of the behaviour.
- 11 Clinicians, organisations and the media should familiarise themselves with the [*Samaritans Media Guidelines*](#) on reporting suicide. They are clear and simple, and applicable at all levels of interaction when a suicide occurs, covering support for those bereaved, use of social media, and organisational responses.

- 12 Providing better information and support to people bereaved or affected by suicide is one of the overriding objectives of the suicide prevention strategy for England, yet it is rarely implemented in a healthcare setting. This is partly due to a lack of support infrastructure throughout the UK, but also a lack of training of professionals.
- 13 Psychiatric patients bereaved by suicide are a particularly vulnerable group, given that mental illness is itself a risk factor for suicide. Their genetic and social risk factors and their social and family networks increase their likelihood of experiencing the suicide of a relative, friend or a fellow patient, yet they have limited access to specialised support.
- 14 Current research shows that the death of a patient by suicide has a profound effect on the personal and professional life of many psychiatrists and other mental health professionals, and can affect recruitment, retention, quality of professional life, and patient care. This very important area has not been well examined.
- 15 It is critical for professionals to include a person's digital life within their clinical assessments, especially when there are concerns about self-harm.
- 16 The reporting and handling of suicides is important both at the level of emotional and social sensitivity to the bereaved, and as a public health issue. Clinicians, organisations, and the media should familiarise themselves with the media reporting guidelines.
- 17 Suicide is a complex behaviour with multiple aetiological factors, some of which are poorly understood. There is some good evidence for prevention strategies that are population based, and more limited evidence for those targeting high-risk groups.

Executive summary

This summary provides a brief overview of each section and includes key messages that have emerged through the development of this report.

Patients' experience of services

We include in this chapter first-hand accounts of care in relation to self-harm and suicide, from service users, carers and their families. We then highlight the chapters which address these issues.

The issues addressed in this chapter are important in centring our attention on who we are seeking, regardless of whether we are clinicians, providers, commissioners or national policy makers.

Commissioning structures and operating models

We give an overview across the four nations of the UK.

For England, we explain the difference between mental health services commissioned through clinical commissioning groups and those commissioned by NHS England through local area teams.

We also provide information about recent developments that have been introduced to improve commissioning opportunities through a more integrated approach. We recognise that commissioning arrangements will continue to change, and set out the principles that should continue to be met, such as:

- Responsibilities being clear
- Organisations demonstrating that they have effective services in place, and
- Funding allocations reflecting the commitment to parity between physical and mental health

For **Scotland**, we outline a structure that involves 14 NHS regional health boards and 32 local integrated authorities in joint delivery of health and social care. We confirm that the regional health boards have responsibility for the delivery of mental health services.

In relation to self-harm we explain the different types of model that are used to deliver care, but also outline that they need to be consistent with government policy, including the government's mental health and suicide strategies.

We refer also to the Scottish Patient Safety Programme for Mental Health and its focus on reducing self-harm and suicide.

For **Wales**, we explain that commissioning is delivered through seven local health boards. We highlight the coverage and role of specialist liaison teams in relation to people who present to hospital at risk of suicide or following self-harm, as well as the different policies around admission prior to a psychological assessment between adults and children.

For **Northern Ireland**, we acknowledge that future commissioning structures are not currently clear but confirm that whatever is established needs to reflect the findings of the 2015 Donaldson report into Commissioning (Donaldson 2014).

The role of public health in suicide prevention

The 2017 National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH 2017) found that the rate of patient suicide has reduced from 111.5 per 100,000 patients in 2005, to 63.7 per 100,000 patients in 2015. Nearly three quarters of suicides occur in the non-mental-health patient population.

Therefore, the responsibility for suicide prevention needs to lie primarily with public health services to be effective. However, mental health services still have an important role to play as psychiatric patients are one of several high-risk groups.

The chapter covers three distinct areas:

- **Public health – worldwide context**

We describe The World Health Organisation's (WHO) work on this issue, and give an overview of their 2014 report [*Preventing Suicide: A Global Imperative*](#).

- **Public health – UK context**

We discuss the College's role as part of the National Suicide Prevention Alliance; the responsibility that was given to councils to develop local suicide action plans; and Public Health England's (PHE) role in providing resources to help local government deliver their functions in this sphere; the original National Suicide Prevention Strategy (2012); the latest update by the Department of Health (2019); and the findings of the Health Select Committee report into suicide prevention (2017).

- **The cases for and against a zero-suicide approach to suicide prevention**

We reinforce the importance of viewing zero-suicide initiatives as a set of approaches based on Quality Improvement methodologies rather than being driven by a target number; although different models might exist in these initiatives, we highlight the functions that are the primary drivers needed to support this approach.

We also give details on the seven essential elements of suicide care that zero-suicide approaches should seek to embrace:

- Leadership
- Training
- Identification
- Engagement
- Treatment
- Transition
- Improvement

Risk factors, data, and trends

We provide detail under five headings:

- **Suicide rates** – We give the latest data for the numbers of suicides, including a breakdown by gender and age so that those groups most affected are identified; we discuss the demographic factors linked to suicide rates and the social and economic costs of suicides and attempted suicides, with the latest evidence that exists on both.
- **Self-harm** – We present evidence suggesting the UK has one of the highest rates of self-harm in Europe although the data do not reflect the fact that, in most cases, people who self-harm do not present for medical attention; we highlight the disparity between men and women: men are more likely to die by suicide than women, whereas women self-harm more frequently than men.
- **Relationship between self-harm and suicide** – We acknowledge increased recognition of the link between self-harm and subsequent death by suicide; previously, non-suicidal self-injury was not recognised as a risk factor for later dying by suicide; now, active support for people who present with self-harm is recognised as essential in preventing suicide.
- **Relationship between long-term physical conditions, suicide and self-harm** – We discuss the growing interest in investigating this linkage; we detail evidence of increased risk of suicide by patients under primary care with coronary heart disease, stroke, COPD and osteoporosis; we encourage healthcare professionals to be alert to psychological symptoms when treating people with long-term physical conditions.
- **Suicide in CRHT care** – We show that the NCISH has noted that while the number of patients dying by suicide in in-patient units has fallen since 2005, there has been an increase in the number of patients dying by suicide while under CRHT teams (although the overall suicide rate has decreased); we stress the importance of patients being referred for CRHT as a positive decision for their benefit, not because of pressure on in-patient beds.

Presentation of self-harm

We reinforce the point that a large proportion of self-harm incidents are not reported, so are not visible to medical professionals. We emphasise the importance, in these cases, of different types of support, such as family, and voluntary and community organisations.

We acknowledge that when patients do present to services, this can be to a range of professionals. We provide advice on the questions that they should ask and signs that they should specifically look for. GPs and hospital emergency department staff are those most likely to be the first point of contact for people who have self-harmed. We also advise on what it is helpful for them to say or do, and what they should avoid saying or doing.

We stress the importance of effective and timely mental health assessments, as they are the gateway to determine the services to which the individual might need to be referred, and the urgency of that referral.

We describe a range of risk factors and red-flag warning signs under the following themes:

- Demographic and social
- Personal background
- Clinical factors in history and
- Mental state examination and suicidal thoughts

We advise emergency department staff on how to be clear what their role is, and we do the same for the liaison/crisis team, the mental health service, the acute hospital in-patient unit and the general adult and old age community psychiatric services.

To further help clinicians, we identify the most commonly diagnosed mental disorders among those who self-harm, and we advise on assessing risk among those who might be intoxicated at the time of presentation.

Risk assessment and intervention

There is now an increasing awareness of the limitations of risk assessment in regard to suicide risk. We highlight research from Rahman et al. (2013), who showed inadequacies in the mental state assessment, risk formulation, and risk management plan among a proportion of people who had died by suicide within a week of their last assessment. We conclude that the current approach to risk assessment is fundamentally flawed.

We emphasise the importance of health professionals adopting a positive attitude when they engage with the people they are assessing.

We note that increasingly, practitioners working with patients who are at elevated risk of suicide think in terms of mitigating the risk rather than managing it. We link this to the importance of Safety Plans being co-created with the patient, which encourages communication with family and friends. The Royal College of [Psychiatrists](#) [advocates](#) that all health and social care professionals be aware of the [Information sharing and](#)

[suicide prevention consensus statement](#) from the Department of Health, and adapt their practice as necessary to work with family and friends.

The College believes that every person who self-harms and/or has suicidal thoughts should have a Safety Plan, which gives specific personalised advice to care providers on how they can reduce the individual's risk of self-harm and suicide. The components of a Safety Plan are:

- Reasons for living and/or ideas for getting through tough times
- Ways to make your situation safer
- Things to lift or calm mood
- Distractions
- Sources of support, to include anyone you trust

The role of mental health teams in long-term risk management

We refer to the NICE 2011 guideline [Self-harm: longer-term management](#) and reproduce its recommendations, which relate to the following areas:

- General principles of care
- Psychosocial assessment
- Risk assessment
- Care plan
- Risk management plan
- Intervention for self-harm
- Treatment of associated mental health conditions

Despite these guidelines, there is considerable variation in the quality of services provided for people who self-harm. This is the case despite evidence that undertaking a psychosocial assessment, as recommended by NICE, is associated with a 40% reduction in the risk of repeating self-harm (Kapur et al. 2013).

We describe the factors which are specific to the risk of suicide in older people, under the headings:

- Mental and neurocognitive disorders
- Social exclusion, loneliness and bereavement
- Functional disability and physical conditions
- Alcohol and substance misuse

Our section on mental health services refers to the impact that changes in in-patients, CRHT and information sharing policies can have on reducing self-harm and/or suicide.

After suicide: support for family and friends

For this part of the Report we were aided by people who have lost someone through suicide – one of whom has contributed notes on the experience which highlight its impact – as well as by active researchers in the field of suicide bereavement.

There is a need to involve families in the review of patients who have died by suicide, and linked to this is the importance of providing support to families who are so affected, as highlighted by the Health Select Committee [Report on inquiry into suicide prevention strategy, 2017](#).

Largely through the efforts of voluntary organisations, there has been increased recognition of this issue. This has led to PHE publishing a directory of support guidance, [Help is at hand](#). Building on this, forthcoming NICE guidelines on preventing suicide in community and custodial settings are expected to include recommendations on what GPs and prisons need to do to improve their bereavement care following a suicide.

We provide advice and tips across a range of areas, including:

- Routine practice
- After the suicide of a patient
- Training needs
- Auditable standards and
- A list of useful resources

After suicide: support for mental health staff

The effect on mental health staff of one of their patients dying by suicide should not be ignored. Although it has been described in the research for at least 25 years, this has not resulted in any real change in the way mental health services support their staff. Too often these services appear more concerned to avoid criticism in the subsequent inquest than to minimise the damage a death by suicide can cause to a staff member and their wider team.

There is evidence that most psychiatrists have experienced the death of a patient by suicide during their career, a large number of them more than once. Half of them described increased stress in the weeks following the suicide, and a sizeable minority reported a change in their practice, including more referrals to colleagues and requests for admission. The evidence suggests that there is a lack of structured support for psychiatrists and psychiatric trainees following a death by suicide.

We offer ways to improve the situation and best practice advice.

Self-harm/suicide and the internet

The online world, especially social media, has a significant effect on the person at increased risk of suicide. All mental health professionals should recognise this, consider engagement with their patient's digital life, and include it within their clinical assessment, especially where self-harm is identified as a possible factor. Some will find this easier than others.

Though the evidence is limited, it indicates both helpful and harmful aspects of internet and social media use. We outline lines of enquiry of the patient that might be appropriate, suggest specific questions that might be used, and include Best Practice tips for services and clinicians.

The stigma associated with self-harm/suicide

The media are a significant factor in perpetuating this stigma; they include traditional print and broadcast media but also, of increasing significance, online – especially social – media. Although there are clear [guidelines](#) produced by the Samaritans concerning the reporting of death by suicide, it is very difficult to enforce these online. It is important that anyone involved in mental health services understands the effect of their language on family and friends who are bereaved by suicide. Phrases such as ‘committed suicide’ date back to a time when an attempt to take one’s own life was a criminal act.

The evidence base for suicide prevention

The relatively low rate of suicide (around 10–11 per 100,000 in the population), makes it difficult to obtain high quality evidence for suicide prevention. We seek to consolidate what evidence does exist in the UK and internationally that has a level of credibility. This is provided under the following headings:

- Restriction in access to lethal means
- Targeting of high-risk groups

We also detail evidence under the following themes:

- Good evidence for reduction in suicidal ideation and behaviour
- Secondary care interventions with limited evidence of effectiveness in preventing suicide
- Insufficient or no current evidence for preventing suicide

Appendix: Online resources and references

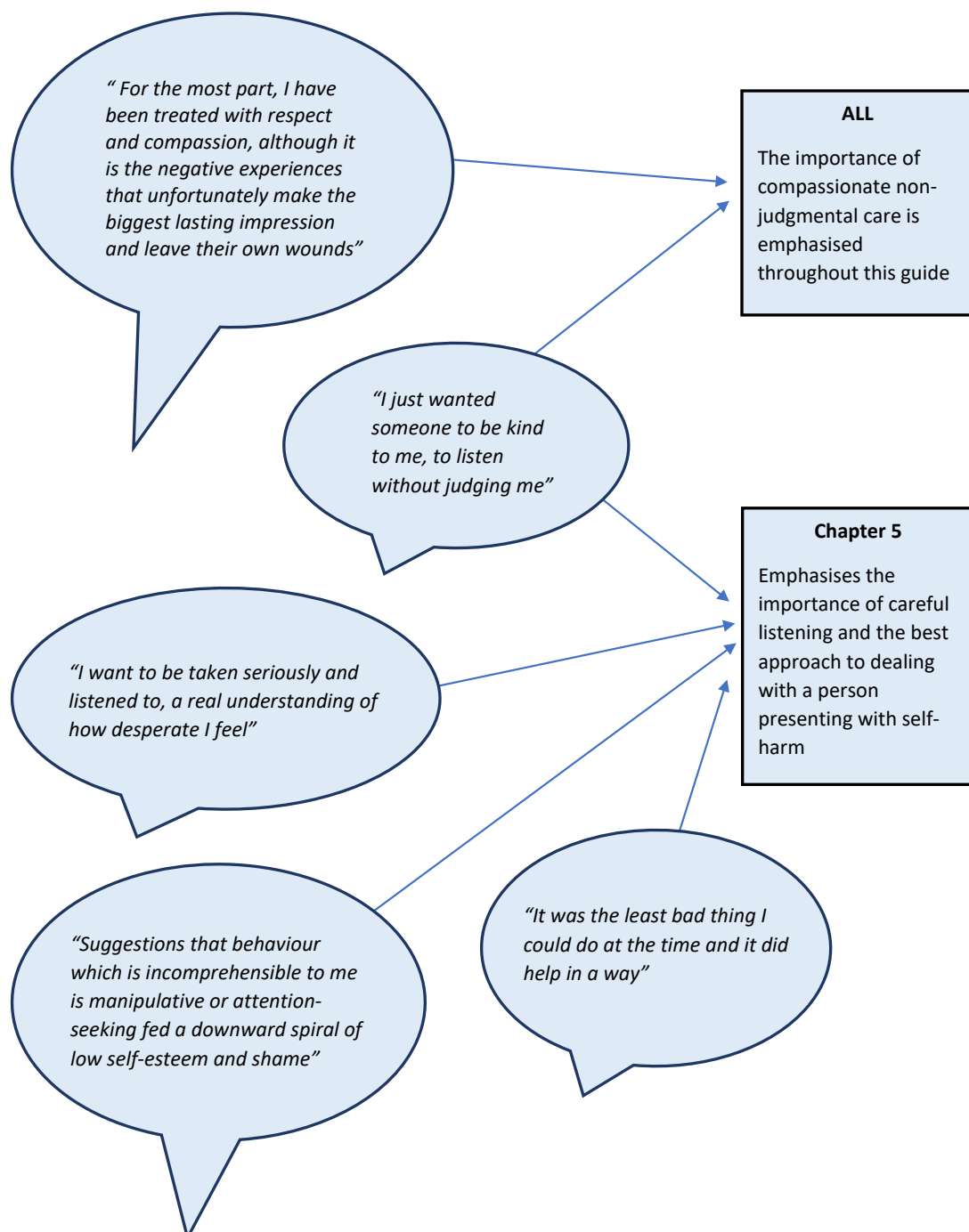
It is crucial that there is access to the most appropriate online resources for all of those who have an interest in reducing and preventing self-harm/suicide. We bring these together in one place.

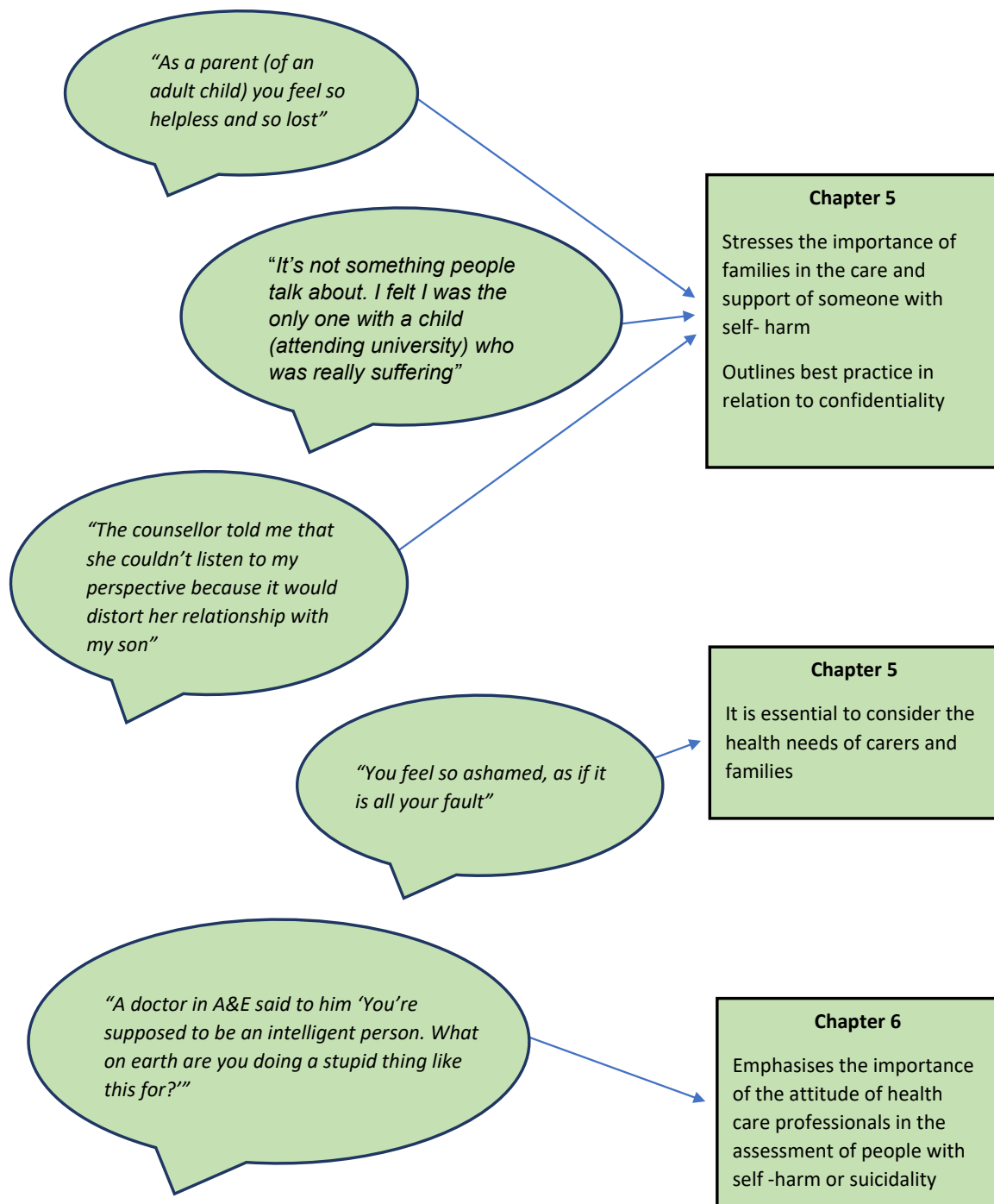
1. Patients' experiences of services

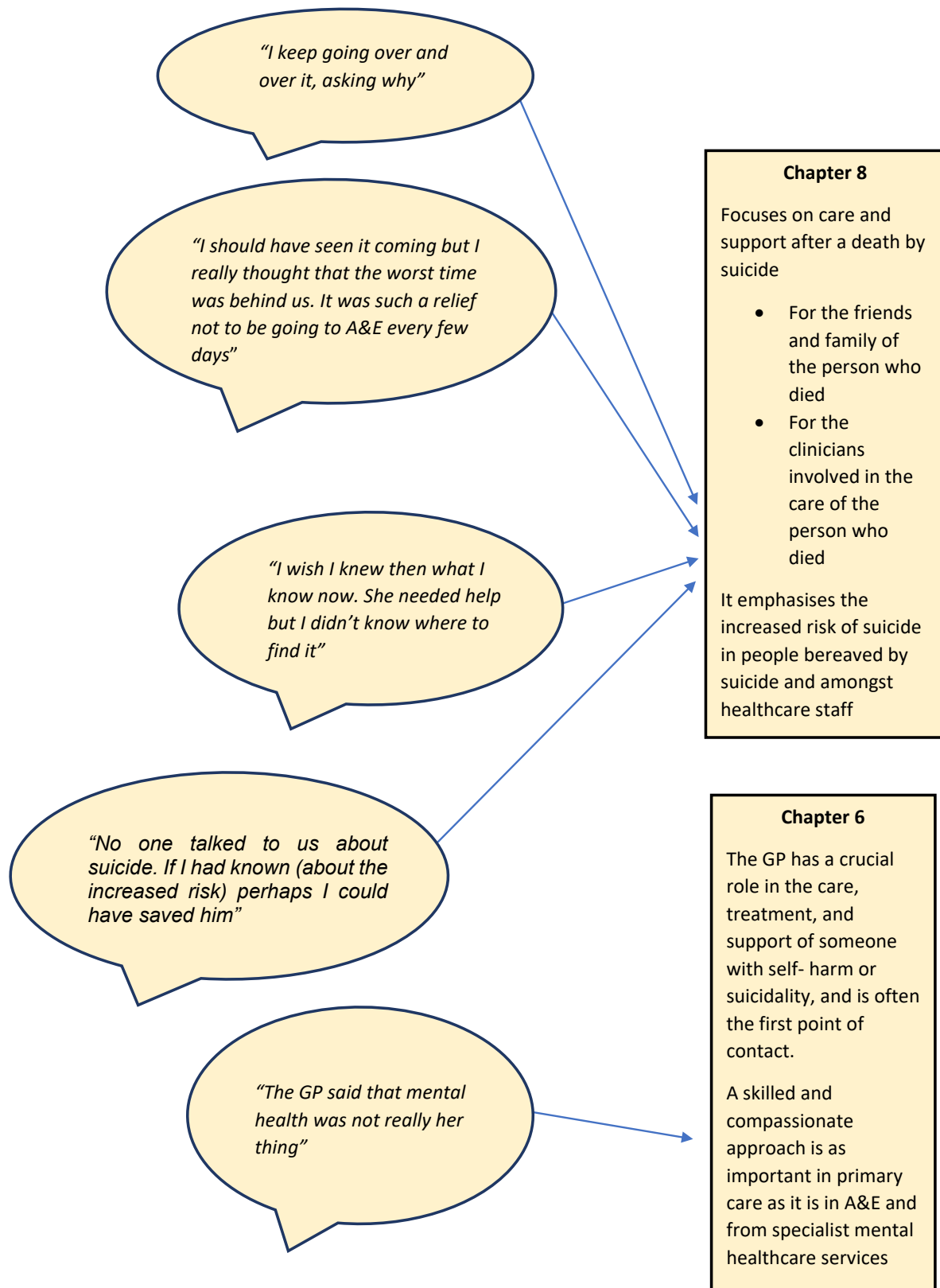
The following are collections of quotes from patients experiencing self-harm themselves, carers of people who self-harm, and people bereaved by the suicide of someone who had suffered from self-harm.

From people experiencing self-harm

Relevant chapters







2. Commissioning structures and operating models

Arrangements across the jurisdiction of the UK

England

Commissioning responsibilities are currently divided between clinical commissioning groups (CCGs) and NHS England. NHS England commissions prescribed services which include a range of specialist provision, including all forensic services, and specialist psychiatric services such as specialist, mood, eating disorders or personality disorder services. All other mental health services, including in-patients, CRHT and community teams, for all age groups, are commissioned by CCGs.

Most of the acute general hospital services are commissioned by the CCGs covering the hospital population. Frequently there is more than one CCG involved in this process. Therefore, there is a matrix of commissioners covering acute hospitals. Psychiatric liaison services are typically commissioned by the acute general hospital.

Local planning is channelled through health and wellbeing boards (HWBs) who typically oversee safeguarding procedures, and increasingly have an influence over commissioning community health services. The local authority to which the hospital belongs is responsible for incidents related to safeguarding arising within the establishment.

In 2015 the introduction of sustainability and transformation plans (STPs) brought NHS providers, CCGs, local authorities and other healthcare services together to form 44 geographical ‘footprints’; this effectively re-integrated the NHS public health function as a key partner with other health and local authority services. STPs have a critical role in delivering the public health and radical prevention aspirations of the NHS England Five Year Forward View, including those for mental health and suicide prevention. STPs are led by NHS and local government staff, including chief executives of NHS trusts, accountable officers of clinical commissioning groups (CCGs), local government senior leaders, and clinicians.

In 2017 eight areas of England were designated as pilot accountable care organisations (ACOs), with the expectation that they will promote genuinely integrated health and care services with demonstrable positive outcomes for populations. In ACOs, commissioners and providers assume responsibility for a budget to deliver integrated services for a defined population. This represents further change for healthcare delivery and suicide prevention: there is a shift away from any division between commissioner and provider,

primary and secondary care, or health and social care services; there is an essential requirement for multi-agency working to meet the needs of any catchment population.

Experience suggests that responsibilities for health promotion, ill-health prevention, and the commissioning arrangements for health and care services will continue to change. It is essential in any structure that responsibilities are clear and that organisations are able to demonstrate effective, comprehensive services, to meet expectations for disease prevention and to provide safe and effective care, with fair allocation of NHS funding following the underlying principle of parity of esteem between physical and mental health services.

The transition from child and adolescent mental health services (CAMHS) to adulthood can be uncomfortable, because of the changes in service as well as in expectations and working practice. In some areas of the UK there are 'all age services' which aim to mitigate the discomfort of transition. In addition, there is both commissioning (Joint Commissioning Panel for Mental Health, 2012) and clinical guidance from NICE (2016) and the Social Care Institute for Excellence (2011), to assist in the journey.

Scotland

Health and social care is a devolved matter which is the responsibility of the Scottish Government. In Scotland, the delivery of health and social services is now integrated: Scotland has 14 regional NHS health boards and 32 local integrated authorities to jointly deliver health and social care. The Regional NHS health boards have been responsible for the protection and improvement of the population's health and for the delivery of frontline healthcare services, including mental health services.

Services currently available to individuals following episodes of self-harm vary across Scotland, from specialist liaison mental health teams to general hospitals. Depending on the health board area the liaison function may be nurse led, provided by crisis assessment and home treatment services, or provided by psychiatry services. The expectation for general mental health services, including those provided for individuals at risk of suicide, are laid out in Government policy, including the Scottish Government Mental Health and Suicide Prevention Strategies. There is a particular focus on helping people in distress who might previously not have fitted well into standard mental health services. Testing of different service models is being carried out in some health board areas.

The work of territorial NHS boards and health and social partnerships is supported by special health boards. These include NHS Education and NHS Health Scotland (whose remit includes public work on suicide prevention) and Healthcare Improvement Scotland, which has a specific Scottish Patient Safety Programme for mental health. This programme has a particular aim to improve safety of services and reduce harm, including self-harm and suicide. It does this through supporting work by the health boards specifically around risk assessment and management, and improved communication and recording of that risk. Healthcare Improvement Scotland also hosts the National Suicide Reporting and Learning System. It has published a discussion framework for teams for reducing suicides.

Information from the NCISH, from the Scottish Public Health Observatory and from the Scottish Suicide Information Database, supports policy development and outcome measurement.

The Scottish Government has supported a number of public health initiatives including 'Choose Life' which has seen a successful reduction in the overall suicide rate in Scotland hosted by mental health through the 'See Me' anti-stigma campaign, and national training on mental health first aid, and explicitly on suicide prevention.

Wales

The seven local health boards (LHBs) are responsible for commissioning primary and secondary healthcare (in close conjunction with their partners in local authority departments), and specialist services, including all Tier 4 services and planning of Tier 3 (multidisciplinary specialist teams) and Tier 2 (uni-disciplinary teams, usually primary mental health teams).

Most areas of Wales have specialist liaison teams although the comprehensiveness of their services varies in terms of both professional mix and hours covered. Not all teams include a consultant liaison psychiatrist. In most areas someone who presents to hospital at risk of suicide or following self-harm will be assessed by a member of the liaison team. In areas that operate a 24-hour liaison service, people are not usually admitted to a medical bed to await a psychosocial assessment unless their medical condition warrants it. However, if a young person presents with self-harm or at risk of suicide out of hours, they are usually admitted to the paediatric ward in the local acute hospital, where telephone advice is available from the on-call consultant child and adolescent psychiatrist. The young person is then assessed by the local CAMHS team on the following working day.

Northern Ireland

The Donaldson report (2014) into health and social care governance concluded that commissioning in Northern Ireland was not as effective as it could be, lacked clarity around accountability, and was an overly complex and bureaucratic system for the size of the population. In a speech in November 2015 Minister Hamilton announced his intention to close down the Health and Social Care Board (HSCB). It is as yet unclear what the structure of future commissioning arrangements will be.

3. The role of public health in suicide prevention

Public health: worldwide context

In May 2013 the 66th World Health Assembly adopted the WHO's [*Comprehensive Mental Health Action Plan \(2013–20\)*](#). Suicide prevention is an integral part of the plan, and one of its targets is to reduce the rate of suicide by 10% by 2020.

The WHO's Mental Health Gap Action Programme, which was launched in 2008, includes suicide as one of the priority conditions and provides evidence-based technical guidance to expand service provision.

In 2014 the WHO published a report on suicide prevention – [*Preventing Suicide: A Global Imperative*](#), which incorporates reviews by international experts of:

- Global epidemiology of suicide and suicide attempts
- Risk and protective factors
- Interventions
- Evidence around suicide prevention

Clarification of key priorities at national levels to support the development of comprehensive responses and strategies for suicide prevention

It identifies five key messages:

- **Suicide is a significant health issue: Over 800,000 people die due to suicide every year.**
 - Suicide is the second leading cause of death worldwide in 15- to 29-year-olds.
 - Evidence indicates that for each adult who died from suicide there may have been more than 20 others attempting it.
 - Suicide is a global phenomenon affecting all countries.
- **Suicides are preventable.**
 - For national responses to be effective, a comprehensive multisectoral suicide prevention strategy is needed, including collaboration between health and non-health sectors at governmental and non-governmental levels.
 - Communities need to be involved in prevention strategies.

- The media has a central role in prevention and needs to be encouraged to report suicide responsibly.
- Improved surveillance, and policies relating to mental health and alcohol, are key to prevention.
- Early prevention should be a core component of any strategy.
- **Restricting access to the means for suicide works:**
 - Effective strategies for preventing suicides and suicide attempts include restricting access to the most common means, including pesticides, firearms and certain medications.
- **Healthcare services need to incorporate suicide prevention as a core component:**
 - Mental disorders and harmful use of alcohol contribute to many suicides around the world.
 - Improved quality of care is the key to reducing suicides that arise as a result of mental and alcohol misuse disorders and other risk factors.
- **Communities play a critical role in suicide prevention and are key to:**
 - Providing social support to vulnerable individuals and supporting follow-up care
 - Fighting stigma and supporting those bereaved by suicide
 - Creating social connectedness which can help protect vulnerable persons from suicide

There are also now international organisations whose primary purpose is to support research and share learning around suicide prevention, such as the International Association for Suicide Prevention (IASP). This provides online resources and supports World Suicide Prevention Day, which has been running annually on 10 September since 2003.

Public health: United Kingdom context

Arrangements for suicide prevention and the commissioning of mental health services have changed significantly since 2012. In England, this has been a more complex and fragmented process due to the transfer of all public health functions to local government in April 2013. This was done with the aim of tackling the wider social and economic determinants of poor health.

The National Suicide Prevention Alliance, a collaborative alliance of organisations including the Royal College of Psychiatrists, was set up in 2013. It evolved out of the 2012 Call to Action for Suicide Prevention in England, which also launched the National

Suicide Prevention Strategy (2012), Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives. Councils were given the responsibility of developing local suicide action plans through their work with health and wellbeing boards (HWBs). Public Health England supported this cross-governmental strategy by creating resources for local authorities and healthcare professionals to understand and prevent suicides in their areas or jurisdictions. Although PHE has responsibility for the development of collaborative multi-agency suicide prevention plans, this is not a mandated responsibility and thus competes for time and funding with responsibilities that public health services must meet by law.

In the third of four updates published by the Department of Health on the National Suicide Prevention Strategy, the Secretary of State for Health set out a commitment to strengthen the National Strategy and drive forward key areas for action to address current suicide prevention priorities, including the risk of suicide in people with self-harm. This accords with the fourth [Suicide prevention: interim report](#) of the House of Commons Health Select Committee (HSC), from 2016, which also had a focus on self-harm. The HSC report also reviewed developments and current challenges at public health level in the United Kingdom. In the light of this, the Department of Health publication [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives](#) identified these priorities:

- Every local area developing a multi-agency suicide prevention plan in 2017
- Better targeting of suicide prevention and help in high risk groups such as middle-aged men and those in places of custody/detention or in contact with the criminal justice system and with mental health services
- Improvements in data at national and local level and how this data is used to help take action and target efforts more accurately
- Improvements in responses to, and support for, bereavement by suicide
- Expansion in the scope of the National Strategy to include self-harm prevention in its own right

In England the independent Mental Health Taskforce also made recommendations in its [Five Year Forward View for Mental Health](#), to set a national ambition to reduce the suicide rate in England by 10% by 2020/21 and for every local area to have in place a multi-agency suicide prevention plan.

To support this, guidance and support for [local suicide prevention planning](#) was published by Public Health England in October 2016.

The National Institute for Health and Care Excellence (NICE) has published guidance: [Preventing suicide in community and custodial settings](#).

In Northern Ireland, a suicide prevention plan and strategy were published in 2006, updated 2012: [Protect Life: A Shared Vision – The Northern Ireland Suicide Prevention Strategy & Action Plan](#) and a revised strategy is currently being developed: [Protect Life 2: a draft strategy for suicide prevention in Northern Ireland](#).

The Scottish Government has also developed a strategy: [Suicide Prevention Strategy 2013–2016](#), Edinburgh, 2013, as has the Welsh Government: [Talk to me 2: Suicide and Self-harm Prevention Strategy for Wales 2015–2020](#).

The cases for and against a ‘zero-suicide’ approach to suicide prevention

‘Zero-suicide’ is an approach to suicide prevention that has been defined as ‘a commitment to suicide prevention in health and behavioural care systems’. A crucial component of its success as a concept is the clear principle that the reference to zero suicides is based on approaches rather than a target number, with the focus being on all individuals and organisations involved in a person’s care doing all they can to minimise the risk of suicide.

It was developed in 2001 in Detroit, USA, by Dr Ed Coffey, then of Henry Ford Behavioral Health Services, initially as part of a ‘perfect depression care’ model. It offers educational and training resources to support its adoption.

Most zero-suicide initiatives are underpinned by Quality Improvement methodology and many follow that approach championed by the Institute of Health Improvement (IHI) in Boston, USA. The first National Suicide Prevention Strategy from 2013 was framed in this way, recognizing that the overall aim of reducing suicide could be met by focusing on 5 main areas (known as ‘primary drivers’ in IHI terms). These are:

- Reducing the risk of suicide in high risk groups
- Tailoring approaches to improving mental health in specific groups
- Reducing access to the means of suicide
- Providing better information and support to those bereaved by suicide
- Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour

The approach has been summarised as ‘a programmatic approach... based on the realisation that suicidal individuals often fall through the cracks in a sometimes fragmented and distracted health care system’, and requiring a ‘systematic approach to quality improvement’ and ‘a system-wide approach to improve outcomes and close gaps’.

Evidence to support the approach is the observation that, in the month before people take their life by suicide, 50% had seen a general practitioner and 30% had seen a mental health professional, and in the 60 days before this 10 per cent had been seen in an emergency department. It is also claimed that the approach can be implemented ‘without additional funding’, but the evidence for this statement is not clear, or the impact of resources being diverted from other areas (Zero Suicide Education and Training Centre, 2015).

It is reported (using data from 2013) that this approach reduced suicide rates from 89 per 100,000 mental health patients in 2001 to 16 per 100,000 in 2013 (Hackman, 2015). In comparison the United States national average was 230 per 100,000 mental health patients, and had varied by less than 5 per 100,000 for over six decades (Claassen et al. 2010).

It has, however, been questioned how representative are the populations where the approach was initially developed, with suggestions that they may be a more affluent group with access to healthcare insurance, as perhaps suggested by the lower previous incidence compared to national figures (Hackman, 2015).

In the United States it was adopted as part of the National Strategy for Suicide Prevention and adopted by the National Action Alliance for Suicide Prevention, which identified seven essential elements of suicide care:

- 1 Lead – Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include survivors of suicide attempts and suicide loss in leadership and planning roles.
- 2 Train – Develop a competent, confident, and caring workforce.
- 3 Identify – Systematically identify and assess suicide risk among people receiving care.
- 4 Engage – Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.
- 5 Treat – Use effective, evidence-based treatments that directly target suicidal thoughts and behaviours.
- 6 Transition – Provide continuous contact and support, especially after acute care.
- 7 Improve – Apply a data-driven Quality Improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

The approach has been introduced in some areas of the United Kingdom and it has had some initial evaluation by the Centre for Mental Health (Moulin, 2015) following a pilot involving four clinical commissioning groups (CCGs) in the East of England.

Themes identified from this were that the approach supported the development of:

- a ‘clear and shared vision’,
- a framework and focus to support a real partnership between community groups, the third sector and statutory sector, capable of unlocking ‘previously unrecognised social capital and local knowledge’, and
- an opportunity to integrate services with web and social media communication, thus potentially making it an approach more accessible to sometimes hard-to-reach groups.

The initiative was not however able to assess the direct impact on the possible reduction of suicides in each site due to a lack of ‘data’.

Some large National Health Service mental health trusts adopted the approach (e.g. Mersey Care NHS Foundation Trust, 2016) and it has received support from NHS England (Fearnley, 2016), and been adopted by a number of different regional collaboratives (e.g. South West Zero Suicide Collaborative, 2016).

It has also received political support (Meikle and Wintour, 2015; Burt, 2015).

There has, however, also been some concern raised that the strength of the claims for 'zero suicide' approaches is not supported by 'strong evidence', and that the potential unintended consequences inherent in any active intervention in healthcare have not been rigorously examined through sufficient research (Coyne, 2016, citing Kutcher et al. 2016).

Bhui (2015) has also raises the issue of policy and practice innovations being implemented before there is good evidence to support them, pointing out that a difficulty in relation to zero-suicide and suicide prevention approaches is the absence of research evidence of risk assessment being predictive of suicide.

The Royal College of Psychiatrists has supported aspects of the approach, including:

- the use of personal Safety Plans before discharge from hospital,
- early follow-up appointments, and
- improved data recording, including recording every suicide which takes place after contact with an NHS Service, and the use of this as one of the headline indicators to judge the performance of the NHS.

This does not address the philosophical aspect of an approach directed at a theoretical impossibility:

"It is critically important to design for zero even when it may not be theoretically possible ... it's about purposefully aiming for a high level of performance."

– Zero Suicide Education and Training Centre (2015),

Also not addressed is how this is consistent with Quality Improvement and management approaches taught to trainees, e.g. SMART (Specific, measurable, achievable, relevant, time-bound) approaches, Doran (1981).

On balance, although the 'zero suicide' approach has generated enthusiasm for radical and system-wide attempts to reduce suicide, and provides a model and framework to engage many different stakeholders, there is not currently sufficient evidence to be confident that it is an effective or sustainable approach, or that there are no potential unintended consequences associated with it. Further research and evaluation are needed in different populations and settings to clarify these issues.

4. Risk factors, data and trends

Suicide rates

In the UK in 2018, 6,507 people died by suicide, an age-standardised rate of 11.2 deaths per 100,000 population. This was significantly higher than in 2017 and represents the first increase since 2013 (ONS, 2018). This total is more than three times higher than the number of deaths from road traffic accidents. Three quarters of those who died by suicide were men, with two peaks in age, 40 to 44 and 90 and over. Suicide is the biggest killer of men under 50 years in the UK, accounting for 1 in 4 deaths in men under 35 years of age. The gender difference in suicide is important and needs to be considered. Non-fatal self-harm (with or without suicidal intent) is one of the most common reasons for presentation to an emergency department (ED) and acute hospital admission. Hawton et al. (2007) estimate that there are more than 200,000 hospital attendances following self-harm in England every year. It is important to remember that suicide is not just about numbers – it is about people in despair who lose the ability to think of solutions, believing, wrongly, that they have no other option but to end their lives.

The most comprehensive study of the factors influencing the increased rate of suicide in people with mental health disorders is the [National Confidential Inquiry into Suicide and Homicide by People with Mental Illness](#) (NCISH 2018). It is however important to remember that three quarters of people who have died by suicide have not been in contact with mental health services at all. The most recent data (NCISH 2018) showed that over the period 2005 to 2015, 28% of deaths from suicide occurred in people who had been treated by mental health services, the most recent years in this period showing a fall in these numbers.

Demographic factors linked to suicide rates

Current suicide risk assessment tools mainly use demographic risk factors (which may be as common in the general population) and have largely been developed without a solid empirical basis. This is the finding of a BMJ ‘state of the art’ review of suicide risk assessment and intervention in people with mental illness (Bolton, Gunnell & Turecki, 2015). The reliance upon risk factor identification fails both clinicians and patients.

Our understanding of which factors differentiate those who will have thoughts of suicide from those who will act upon those thoughts and attempt suicide is still elementary (Klonsky & May 2014; O'Connor & Nock, 2014). Demographic risk factors increase the suicide risk of a whole population across its lifetime, but do not predict suicide in an individual at a single time-point. Furthermore, suicide risk assessment is itself a complex intervention, unpredictable, with the process influenced by practitioner, patient and organisational factors (Cole-King et al. 2013).

While suicide rates vary significantly among different demographic groups, a review of suicide risk assessments in 2015 found that demographic factors are unable to predict suicide risk accurately and should not be relied upon (Bolton, Gunnell & Turecki, 2015). A person may still be at high risk of suicide even though they might not be assessed as a member of a high-risk group.

Conversely, not all members of high-risk groups are equally at risk of suicide. Moreover, suicidal thoughts (and risk) can vary across a relatively short time period. The assessment of suicide risk by the clinician needs to be individually focused and carried out regularly.

The social and economic costs of suicide and attempted suicide

Few studies have focused upon the true economic cost of suicide, however available research indicates that it is huge. Canadian research has estimated that the direct costs (to Health Care, Police and Coroner Services, plus funeral costs) and indirect costs (loss of productivity in terms of employment, family responsibilities, childcare etc.) of each suicide are around £443,000 (Clayton and Barceló, 2000). This figure dramatically increases when intangible social costs such as grief, pain, suffering and lost life experiences for family and friends are included within calculations. Research from New Zealand estimated the cost of each suicide to be around £1.1 million (O'Dea and Tucker, 2005) with similar research based in Ireland putting the estimate higher at £1.4 million (Kennelly et al. 2007). Previous research suggested that about six people are significantly adversely affected by each death of someone by suicide. New research by Cerel and colleagues (2018) suggests that the figure is considerably higher, with far more people being adversely affected, and that bereavement by suicide is itself a risk factor for suicide (Kennelly et al. 2007).

Unfortunately, there are no figures for England and Wales, however research in Scotland placed the estimated cost of each suicide at around £1.1 million (Appleby et al. 2006). If we apply this figure to suicide rates in the UK, the UK annual cost of suicide is approximately £6.5 billion a year.

Self-harm

Self-harm is defined as 'Any act of self-poisoning or self-injury carried out by an individual irrespective of motivation' (NICE 2011). Exact rates are hard to discern as most acts of self harm do not result in presentation for medical attention.

Self-harm is more common in women and 16.7% of females will self-harm at some point in their lives compared to a figure of 4.8% of men. There have been past increases in the number of women who attend hospital following self-harm associated with alcohol and drug misuse (Ness et al. 2015). This is often due to general changes in drinking patterns, which is worrying because people who self harm can be more likely to do so after consuming alcohol.

Many people who manage their distress using self-harm, especially self-cutting, report that their actions do not have suicidal intent. Some report that their self-cutting is a way of preserving their life and ameliorating any suicidal thoughts, ideas or further actions (Nock 2009), (Klonsky 2009). One view is that non-suicidal self-injury (NSSI) (Muehlenkamp 2004) should not be viewed on the continuum of self-harm and suicide. There are debates about whether people who carry out NSSI are a heterogeneous group and whether this is creating a false dichotomy (Kapur et al. 2013).

Relationship between self-harm and suicide

There is strong evidence to show that the risk of suicide among those who have self-harmed is much greater than that of the general population (Chan et al. 2016), as is the risk of premature death (Cooper et al. 2005). Almost half of the general population and over half of young people who end their life by suicide, have previously harmed themselves (Geulayov et al. 2016, Kapur et al. 2013).

Two new studies suggest that scales, or an over-reliance on the identification of risk factors in clinical practice, are unsafe and should no longer be used to predict suicide following self-harm (Chan et al. 2016). Scales can provide false reassurance and should not replace patients receiving a comprehensive psychosocial assessment of their individual situation, risks and needs, as well as their assets and strengths (Steege 2018).

Suicide after non-fatal self-harm is associated with use of several methods of self-harm and with early non-fatal repetition. It is suggested that this combination should be considered a 'red-flag' indicator of suicidal risk (Birtwistle et al. 2018). Early identification and intervention can minimise distress and reduce the likelihood of such a maladaptive coping mechanism becoming well established and entrenched. It is therefore vitally important that anyone who self-harms is supported to draw up a Safety Plan (as described later in this document). Professionals need to be aware of the impact of stigma and negative attitude that, although often unconscious, are detrimental to patients and their carers. Careful use of language around self-harm is particularly important for therapeutic engagement. As an example, the term 'deliberate self-harm' should be avoided. It implies that someone had a conscious choice to engage in their self-harm. It promotes negative and stigmatising attitudes and a preferred term is 'self-harm'.

Self-harm appears to be particularly associated with difficulties in problem solving and coping (Glazebrook et al. 2016) especially when linked to relationships. People who are suicidal are usually in extreme emotional pain and are often ambivalent about dying. Self-harm behaviour, when previously used as a method of managing psychological pain, especially if the person has no other strategies, can, in the context of unbearable distress, escalate and result in death.

The risk of suicide is elevated by between 30 and 100 fold in the year following an episode of self harm, compared to the general population (Chan et al. 2016).

20% of people who attend hospital after self-harming repeat this behaviour within a year, many returning to the same hospital (Kendall et al. 2011).

One in 50 patients who attend hospital after self-harm will die by suicide within one year and one in 15 within nine years (Owens, Horrocks & House, 2002). More than 50% of people who die by suicide have self-harmed, 15% within the previous year (Gairin, House & Owens, 2003). People who self-harm also have a higher all-cause mortality, i.e. not just from suicide (Bergen et al. 2012).

Relationship between long-term physical health conditions, suicide, and self-harm

In recent years there has been heightened interest in investigating the links between physical illness, mental illness, and suicidal behaviour. People with a physical health long term condition (LTC) are more likely to have poor mental health, and vice versa. Suicide occurs more frequently with the coexistence of psychiatric and physical illness.

In primary care patients studies have shown higher suicide risk with coronary heart disease, stroke, COPD, and osteoporosis (Webb et al. 2012). Women with cancer or coronary heart disease have an elevated risk of suicide independent of clinical depression. Risk of suicide is greater in younger, physically ill women and in older women with multimorbidity. Most people who die by suicide late in life have recognised clinical depression. In one Scandinavian study of completed suicides in people aged over 65, visual impairment, neurological disorders, and malignant disease were independently associated with it (Waern 2002).

We know that the risk of self-harm is raised across a wide variety of physical illnesses in both genders, and particularly so in women. Using the General Practice Research Database, Webb and colleagues (2012) found significantly higher risk of self-harm in patients with asthma, back pain, COPD, coronary heart disease, diabetes, epilepsy, hypertension, osteoarthritis and stroke (Webb et al. 2012). Depression explained 57% of the elevated risk among all patients diagnosed with one or more LTCs. Depression raised the risk of self-harm in two thirds of men and half of women. The risk remained elevated in women with asthma, back pain, diabetes, epilepsy or hypertension, even after adjustment for depression.

Healthcare professionals working across all medical specialties should be vigilant for signs of undetected psychological symptoms when providing care and treatment to people with any LTC, and be particularly alert to the risk of suicide in younger physically ill women, especially those with multiple physical health conditions, and in anyone with significant self-harm.

Best practice



- Patients who self-harm should have a psychosocial assessment of need as well as their risk.
- Care and treatment should not be given according to a rating scale but according to a personalised assessment of risks and needs.
- For patients who are at risk of suicide, the care plans will also need to include a Safety Plan, co-produced with the patient. This should have explicit reference to removal and/or mitigation of means to harm themselves, list activities and coping strategies, and contain information on how to access social, psychological and emergency support.

Suicide in crisis resolution and home treatment teams

Crisis resolution and home treatment (CRHT) teams were first introduced in 2000 as part of the National Service Frameworks in the NHS plan (DH 2001). These mandated several specialist community services, with clear service specifications to be followed for 10 years. However, since this ended greater variation has occurred between healthcare providers in the design and type of CRHT service delivery (Johnson 2013). Initially there were clear service specifications for the CRHT model; there needs to be greater clarity about the current model (Wheeler et al. 2015).

Hunt et al. (2016), using data from the NCISH, noted that there had been a 60% reduction in in-patient suicides from 2005–2015, but they suggested that the risk had been transferred to the CRHT teams. This is because CRHT had become the default for acute mental health care because of the pressure on in-patient beds.

An increase in suicide among CRHT patients was first noted in a study covering 2003–2011, when the crude rate was 14.6 per 10,000 CRHT episodes compared with 8.8 suicides per 10,000 admissions for in-patients (Kapur et al. 2016). The higher rate of suicide in CRHT patients is almost certainly due to an increase in the proportion of acutely ill patients being treated by them compared to in-patients. The NCISH found a high prevalence of risk factors among suicides under CRHT, such as adverse life events (49%), living alone (44%), or recent discharge from in-patient care (34%) (Kapur et al. 2016).

Therefore the suitability of home treatment for socially isolated people in suicidal distress, or those with limited perceived social support, needs to be reviewed and considered on a case by case basis. Additionally, home treatment may not be appropriate if the home environment has the potential to exacerbate a mental health crisis. Of those people who died by suicide while under the care of CRHT teams between 2012 and 2013, 37% had been under CRHT for less than a week, which may reflect the acuity and severity of their illness (NCISH 2015).

Changes in service provision, especially the reduction in acute in-patient beds, has resulted in a corresponding increase in the morbidity and acuity of patients who are treated by

CRHT services. In support of this, a controlled study on suicide within 2 weeks of discharge found a link between post-discharge deaths and an admission lasting less than 7 days (Bickley et al. 2015).

Best practice



- It is important that a holistic and person-centred assessment of all patients is undertaken before considering if they are suitable for a CRHT model of care. The referral to CRHT should be a positive decision to benefit the patient and their recovery and not based on a lack of in-patient beds.
- The assessment should take account of the amount of psychological and social support that the patient will require to keep them safe when under the care of the CRHT team.
- For patients who are at risk of suicide, the care plans will need to include a Safety Plan, co-produced with the patient. This should have explicit reference to removal and/or mitigation of means to harm themselves and information on how to access psychological and social support.

5. Presentation of self-harm

Community presentation of self-harm

A significant proportion of self-harm behaviour does not lead to presentation to professionals. In addition to family and friends, voluntary, peer and community counselling organisations can often be of significant help. Not infrequently this informal support can be sufficient to help the individual, and the self-harm may never come to the attention of professionals.

Role of all frontline professionals

People with self-harm present to a range of professionals including counsellors, GPs, emergency departments and mental health staff.

Every individual must be treated in an open minded and compassionate manner, with a non-judgemental and supportive approach. Self-harm is, in essence, a means of communicating distress, and the task of all professionals is to help the person reveal more about the underlying issues.

People who self-harm may feel shame or embarrassment and staff need to validate their distress and assure them that help is available. Asking about self-harm does not increase the likelihood of suicide, and indeed it is much more likely to lead to a reduction in suicidal risk.

It is helpful to:

- take all self-harm seriously and listen carefully, in a calm and compassionate way;
- take a validating and non-judgemental approach;
- help the person to identify their own coping strategies and support network;
- offer information about support services;
- ask permission to talk to family members/friends; and
- offer appropriate support to family and friends as necessary.

Try to avoid:

- reacting with strong or negative emotions;
- becoming irritated with your patient;
- using terms such as 'manipulative' or 'attention seeking';
- becoming frustrated; and
- focussing too much on the self-harm itself, rather than the underlying issues.

If someone has self-harmed by poisoning, attendance at an emergency department is necessary for an evaluation of physical and mental health.

All self-harm needs to be taken seriously. While self-harm by cutting typically does not require attendance at the emergency department, a judgement must be made about referring for an expert mental health assessment. The likelihood of someone who self-harms by cutting going on to die by suicide is greater than that for someone who attends following an overdose. The site of self-injury may be an important determinant of risk of subsequent suicide (Bergen 2011).

All frontline professionals should be able to carry out a basic mental health assessment following self-harm. This will inform the decision to refer to specialist mental health services, and the degree of urgency, and to co-produce an immediate Safety Plan. This initial assessment should ask about any previous self-harm and try to understand the part that it plays in coping. In particular there must be enquiry about suicidal intent and continuing suicidal ideation. Details should be gathered about previous contact with psychiatric services, relevant psychosocial factors, and the level of perceived support. It is essential to assess the severity of depression, hopelessness, and suicidal ideation.

If the frontline professional is concerned about significant continuing risk, they must arrange for a more detailed assessment by a mental health professional.

Patient confidentiality

All clinicians have a fundamental duty to respect patients' wishes for confidentiality. Patients sometimes ask staff not to make contact with family and friends. However, in cases with significant suicidal risk, the right to confidentiality must be balanced against the patient's best interests.

In 2014 the Royal College was one of nine signatories to a [Consensus Statement from the Department of Health \(2014\)](#). This stated: 'if the purpose of the disclosure of information is to prevent a person who lacks capacity from serious harm, there is an expectation that practitioners will disclose relevant confidential information'. The document further indicates that where a person is at 'imminent risk of suicide', this in itself will raise significant doubts about their mental capacity. In such cases the practitioner must record their decision about sharing information and the justification for this decision.

The document further adds that the duty of confidentiality in no way prevents practitioners from listening to the views of family members and friends, who may offer a vital insight into the individual's state of mind, thus aiding care and treatment. Good practice also includes providing families with non-person-specific information such as how to gain access to services in a crisis, as well as support services for carers.

Best practice



- All frontline professionals should be able to carry out a basic mental health assessment of a patient at risk.
- All frontline professionals should be able to co-produce an immediate Safety Plan and signpost patients in distress to appropriate support.
- All frontline professionals should know how to identify and respond to patients at risk of suicide, and when it is appropriate to refer to mental health services.

The role of the general practitioner

Along with emergency department staff the general practitioner is the professional most likely to be the first point of contact for those who have self-harmed or experienced suicidal thinking. Often the GP will have a good knowledge of the patient and their family background. The GP should aim to put the person at their ease, take an initial history and carry out mental state and appropriate physical examinations.

The NCISH (2014) noted that mental illness was often recognised in primary care patients who later died by suicide. Indicators of risk in these patients include frequent consultations and prescription of multiple psychotropic drugs. The self-harm/suicidal ideation may be an indicator of a psychiatric disorder including depression, substance misuse and, less commonly, psychotic illness. In some individuals, the self-harm may be associated with psychological and social factors such as current or past sexual or physical abuse, relationship problems or financial concerns. The GP must also be mindful of the potential risk to children being exposed to adults who self-harm.

If the person presents with self-cutting the GP should establish when this started, its frequency, the parts of the body involved, and the effect of the self-harm on the patient, including its purpose in the control of painful emotions. The GP should ask about specific triggers and whether the self-harm is becoming more frequent or escalating in severity. They should enquire about other self-damaging behaviours such as misusing alcohol or drugs.

The patient should be asked for the key symptoms of depressive illness, including anhedonia, loss of energy, impaired sleep, appetite and concentration, and emerging negative patterns of thinking. The GP should enquire about key relationships, and in particular those in whom the patient can confide. It is often helpful to ask how the person has coped at similar times of distress.

On mental state examination it is important to assess objectively the level of depression, as well as the patient's subjective view of their mood. The GP should check the level of self-esteem, the presence of any guilt and, crucially, hopelessness and suicidal ideation.

The consultation should conclude with an agreed follow up plan. This is likely to include a review by the GP, and advice on how to obtain help, if necessary, before the review. For less severe cases, there may be a referral to counselling within primary care, adult improving access to psychological therapies (IAPT) services or the voluntary sector. The patient may not require referral to mental health services. If there is evidence of specific mental illness, the prescription of medication may be appropriate. However, some patients will be more unwell.

Risk factors and red flag warning signs

A red flag is a risk factor with special significance in that it indicates that a person is at heightened risk of attempting suicide at this particular moment in time. This imminent risk requires an urgent, clinically appropriate and personalised intervention with a Safety Plan.

- **Demographic and social**
 - Perception of lack of social support, living alone, no confidants
 - Males (may not disclose extent of distress or suicidal thoughts)
 - Stressful life events (e.g. recently bereaved, debt/financial worries, loss of attachment/major relationship instability, job loss, moving house)
 - LGBT
 - Ethnic minority group.
- **Personal background**
 - Substance misuse: Alcohol and/or illicit drug misuse especially if precipitated by a recent loss of relationship
 - Feeling close to someone who died by suicide (family or non-kin) or exposure to suicidal behaviour of key others (family, peers, favourite celebrity)
 - Use of suicide-promoting websites or social media
 - Access to lethal means; (If unable to remove lethal means ensure mitigation within a robust Safety Plan).
- **Clinical factors in history**
 - Previous self-harm or suicide attempt(s) (regardless of intent, including cutting)
 - Mental illness, especially recent relapse or discharge from in-patient mental health care
 - Disengagement from mental health services
 - Impulsivity or diagnosis of personality disorder
 - Long-term medical conditions; recent discharge from a general hospital; pain.
- **Mental state examination and suicidal thoughts**
 - High degree of emotional pain and negative thoughts (hopelessness, helplessness, guilt – e.g. ‘I’m a burden’)
 - Sense of being trapped/unable to escape (sense of entrapment) and/or a strong sense of shame
 - Suicidal ideas becoming worse
 - Suicidal ideas with a well-formed plan and/or preparation
 - Psychotic phenomena, especially if distressing; persecutory and nihilistic delusions, command hallucinations perceived as omnipotent (pervasive).

If there are red-flag warning signs/immediate risk of suicidal behaviour, the patient will require:

- Immediate discussion with/referral to mental health services
- A robust Safety Plan (see below)
- Adequate support
- Removal of access to means

Source: Information included with kind permission from
Connecting with People/4Mental Health.

The above definition for the term 'red flag warning signs' is derived from the one used in SAFETool developed by an expert consensus group. The College has consistently recommended that risk assessment should not be reduced to a tick box list of risk factors. However, some risk factors are especially significant in terms of temporal relationship to a potential suicide attempt i.e. the use of the wording of this definition has no ambiguity and includes 'at this particular moment in time'. While other risk factors can still be important, their presence does not often mean that someone is at elevated risk 'at this particular moment in time' compared to at any other time (Cole-King and Platt 2017).

It is important to remember that this list was developed specifically for use in Primary Care; we have to be pragmatic as GPs have a brief time in which to assess a patient (Cole-King and O'Neill 2018). This report clearly states that any patient with suicidal thoughts or following self-harm needs a Safety Plan. No one is ever ineligible for an intervention and Safety Plan.

In many cases of self-harm, family and friends can help to de-escalate the situation. Their own concerns must be recognised, and appropriate support made available. Depending on the urgency of the case, in the period before the patient is seen by mental health services the GP should ideally consult with the family and draw up a Safety Plan with the patient. This may include the removal of knives, tablets and other means of self-harm. The patient and family should be provided with details of how to contact services in an emergency.

Best practice



- Patients who attend their GP after self-harm or with suicidal thoughts need a tailored triage assessment to establish if they need a referral to specialist services.
- Care and treatment should not be given according to a rating scale but according to a personalised assessment of their risks and needs.
- For patients who are at risk of suicide, the care plans will also need to include an immediate Safety Plan, co-produced with the patient. This should have explicit reference to removal and/or mitigation of means to harm themselves, list activities and coping strategies, and contain information on how to access social, psychological and emergency support.

Emergency departments

Patients may present to hospital because they have harmed themselves and require assessment and physical treatment; they may also present with suicidal ideation without actual self-harm.

Emergency department staff, as well as providing physical assessment and treatment, should carry out a basic mental health assessment, including an assessment of risk. While acknowledging the limitations of suicide risk assessments, the risk still needs to be assessed in order that a personalised intervention can be implemented to reduce or mitigate identified risk factors. The ED must have timely access to expert assessment by the mental health service.

The role of the emergency department medical team

- To complete a physical assessment and provide appropriate treatment, ensuring that this is not compromised because of the patient's mental state
- To treat all people with self-harm/suicidal ideation in a respectful and non-stigmatising way
- To gather a detailed history of the self-harm including relevant triggers, any previous history of self-harm, an assessment of mood and the level of continuing suicidal intent
- To gather relevant information about the person's psychiatric history, family, and personal circumstances
- To support the engagement not only of the patient but also, where available, family and friends
- To consult, and refer where necessary to, mental health colleagues.

Best practice



Every acute hospital should be able to provide a timely and comprehensive psycho-social assessment in line with NICE Guidelines for all patients presenting with self-harm, and have close liaison with community mental health services for follow-up.

The role of the liaison/crisis team

Each emergency department must have arrangements for specialist mental health input. This may be provided by a dedicated liaison mental health team, or by a CRHT service or similar team.

The role of the mental health service

- To consult with the ED staff regarding the patient's physical health and mental health
- To carry out a thorough assessment of the self-harm/suicidal ideation including all relevant precipitating factors, the specific circumstances, including how the patient was found and brought to hospital and the patient's attitude towards what has happened
- To determine if underlying mental illness is present
- To explore any previous history of self-harm, engagement with psychiatric services, (including contact with the general practitioner and medications prescribed over the years), any current contact with mental health services and current medication
- To carry out a comprehensive review of the patient's psychosocial background including relevant family history, experiences in childhood, educational, occupational and psychosexual factors, the current social circumstances, the past medical history and forensic history; this should also identify previous successful coping strategies.
- To conduct a full mental state examination, in particular identifying signs of depressive illness as well as other psychiatric conditions, with particular focus upon ideas of hopelessness, guilt and continuing suicidal thinking
- To draw together all of the above information into a diagnostic formulation and draw up a treatment plan including relevant safety factors, in partnership with the patient; this should include all relevant contact numbers and should be shared with family and friends
- To co-produce a Safety Plan (see later in the document)
- To ensure, when the patient requires admission to hospital or home treatment, that this occurs as soon as possible
- To ensure, in the other cases, that arrangements are made for appropriate follow up as soon as is necessary

The role of the acute hospital in-patient unit

A relatively small number of patients who present to the ED with self-harm will be admitted to a medical or surgical ward or occasionally an ICU ward. The ED will provide relevant information about the self-harm. Staff in these wards should be able to carry out a basic psychiatric history and mental state assessment.

Over recent years there has been a gradual enhancement of mental health liaison services in acute hospitals. In some areas the Rapid Assessment, Interface and Discharge model of liaison psychiatry (Tadros et al, 2013) has been instituted. It is important that such services are further developed.

The role of general adult and old age community psychiatric services

Some patients presenting to emergency services with suicidal behaviour or ideation will require admission to acute psychiatric care. However, a much greater number will require follow up by general adult and old age community services. There must be close working relationships between the acute hospital and community mental health services to enable patients to receive care in a reasonable time frame.

The overall number of referrals to mental health services is increasing. However, those who have self-harmed or presented with suicidal ideation to acute hospitals are a particularly vulnerable group and must have rapid access to appropriate follow up care.

Presentation of specific mental disorders

Affective disorders

The most common diagnosis among those who self-harm is of affective disorders. This will range across the spectrum from adjustment disorders to, more rarely, severe depressive disorders with psychotic symptoms. Some patients will have mixed affective disorder and, occasionally, mania. Other patients may have anxiety disorders.

The assessment by the mental health professional should include identifying depressive illness, with particular reference to the key symptoms of low mood, anhedonia, loss of energy, disturbance of sleep, appetite and concentration, and negative patterns of thinking. The mental state examination must assess for objective evidence of low mood in addition to low self-esteem, ideas of guilt, hopelessness, and continuing suicidal ideation. The patient must also be assessed for psychotic symptoms.

In some cases, patients who are significantly depressed and at further risk of self-harm may not disclose the true severity of their illness and may minimise the seriousness of

their suicidal intent. Thus, a very thorough assessment, coupled, where possible, with information from family or friends, is of crucial importance.

Psychotic illnesses

Some patients presenting with self-harm/attempted suicide will have a diagnosis of a psychotic illness. Often the patient will give a clear and detailed history of their diagnosis and engagement with services, past and present. Staff must be able to communicate with the relevant clinical team during working hours, to ensure a proper assessment and help arrange follow up care.

A smaller number of individuals not previously known to services will present with psychotic symptoms for the first time. Some of these presentations may be complicated by past or present substance misuse. It is particularly important to gain as much information as possible from family and friends, and the general practitioner may well have valuable insights. Most patients presenting with symptoms are likely to require admission to an in-patient unit or a home treatment service.

The assessment of these patients should include potential risk to the individual themselves and other people, including staff. Sometimes such patients should be seen by more than one member of staff, in a safe environment, in which help is immediately available should the patient's behaviour become disturbed.

Patients presenting with personality disorder

Many individuals with personality disorder present on multiple occasions to emergency departments following acts of self-harm, including overdoses and self-cutting. It is important to understand that these patients are at high risk of suicide (Doyle et al. 2016).

Assessing and managing these patients can be challenging, particularly when attendances are frequent, and when they are critical of the services trying to provide them with care. Not infrequently the self-harm may occur in the context of intoxication with alcohol or drugs.

Despite these challenges staff must treat every patient with professionalism, courtesy and compassion. Many patients will have had traumatic life experiences. Being mindful of this and maintaining an empathic approach makes it more likely that the therapeutic relationship will be more effective. Even small acts of simple kindness can build trust and make a major difference to the patient's self-esteem. As with all patients presenting with suicidal thoughts/plans it is important for all staff to work with patients to co-produce a Safety Plan to help them have the strategies they will need to help them improve how they deal with distress in the future.

As well as a focus on the immediate reason for the presentation the mental health practitioner needs to be aware of the wider context, other agencies involved and other sources of support. It is important that the patient realises that staff are keen to understand what is troubling them, and what might help, both in the immediate context and, crucially, in the medium to longer term.

All patients are best approached with an attitude of ‘intelligent kindness’ (Ballatt & Campling 2011). This is often acknowledged as helpful by patients. Knowing that professionals will offer a consistent, non-judgemental and calm engagement will, over time, have a lasting positive impact.

Patients presenting with substance use disorders

Suicide and self-harm in the context of drug or alcohol use disorders is highly prevalent and represents a particular challenge. According to the NCISH (2017), over half of the patients who died by suicide had a drug or alcohol use disorder.

The report found that only a small number of those patients had been in contact with specialist substance misuse services. It noted lower suicide rates in patients in contact with ‘dual diagnosis’ services. The Confidential Enquiry recommended that specialist alcohol and drug services should be available, with the ability to manage clinical risk, working closely with mental health services, with agreed arrangements for ‘dual diagnosis’ patients.

The second most common suicide method reported by the NCISH (2017) was self-poisoning. The most common drugs in fatal overdoses are opiates, both prescription and non-prescription. Internationally, opiate misuse and dependence are rising. The Confidential Enquiry recommended that opiate prescriptions should be reviewed carefully. It suggested that they should be subject to ‘safer prescribing’, including reduced use overall and short-term supplies.

Patients with addictions present frequently to emergency departments, and this can cause frustration for staff. Public Health England (2014) reported that in one year, over a million patients were admitted to hospital with alcohol related problems. This figure has more than doubled over the last 15 years. Around 70% of ED attendances between midnight and 5 a.m. on weekend nights are alcohol related.

The provision of specialist addiction liaison services not only benefits patients, but also reduces the length of stay and the number of repeat admissions to general hospitals. Unfortunately, there are too few of these services nationally, due to the current commissioning policy which requires repeated retendering of addiction services. Even when services are available, they may be under resourced, despite evidence that they are clinically and cost effective.

Intoxication and assessing risk

It is often not possible to carry out a comprehensive psychiatric history and examination when someone is intoxicated. Sometimes, asking too many questions may in itself be counterproductive. Intoxicated patients can be unpredictable and on occasion prone to verbal or physical aggression. With such patients, staff must take all appropriate measures to ensure their own safety. It is unwise for an intoxicated patient to be seen by one member of staff alone.

The most important task initially is to deal with any injuries or other physical health problems due to the self-harm. If there is concern about the patient's physical health or level of intoxication, they are best managed in a safe setting in the emergency department with appropriate supervision, until the effects of the substances have worn off.

Once the patient is no longer intoxicated staff can carry out a full mental health assessment. Breath alcohol levels may aid clinical decision making.

Best practice



- Screening and assessment of substance use disorders needs to be integrated in any assessment, risk assessment and in care planning.
- Specialist dual diagnosis services should be commissioned in all areas.
- Ensure safer prescribing of opiate medications and consider reducing their availability over the counter.

Patients presenting with eating disorders

Suicide is thought to account for over 20% of deaths from eating disorders (ED), which themselves have the highest mortality among mental health disorders. Individuals with anorexia nervosa (AN) have a likelihood of death by suicide 18 times higher than gender and age matched individuals; individuals with bulimia nervosa (BN) are seven times more likely to die by suicide (Smith, Zuromski, & Dodd, 2018). Up to a third of people with a diagnosed ED have thought about or attempted suicide. Comorbidity is an important marker of increased suicidal risk.

The association between ED and self-harm/non-suicidal self-injury (NSSI) is especially high; estimates for NSSI in ED range from 25–55%, and occurrence of disordered eating in patients with NSSI 54–61% (Riley, Davis, Combs, Jordan, & Smith, 2016; Svirko & Hawton, 2007). Rates of NSSI differ among the ED subtypes and are related to more severe ED pathology (Singhal, Ross, Seminog, Hawton, & Goldacre, 2014). NSSI is a risk factor for the onset of purging behaviour, a relationship that is mediated by emotional dysregulation (Riley et al. 2016). Both ED and NSSI are most common in females, but men and especially LGBT are also at risk (Duffy, Henkel, & Joiner, 2019). These associations occur across the weight spectrum and are mediated by a range of factors including trauma, interoceptive deficits, pain tolerance and genetic risk (Dodd et al. 2018). The presence of NSSI in ED is a marker of poor prognostic factors, and this is borne out in clinical studies (Olatunji, Cox, Ebesutani, & Wall, 2015).

The clinical implication is that patients presenting with disordered eating across the BMI spectrum should be assessed for self-harm or suicide risk, and the presence of disordered eating (binge eating, purging and episodes of extreme dietary restriction) should be enquired about among individuals presenting with self-harm or suicidal behaviour.

Perinatal mental disorder

Pregnancy and the postnatal period offer no protection against the continuation of existing, or development of new, mental illness. However, the risk of severe mental illness in the days and weeks after childbirth is significantly increased. Early postpartum mental illness may progress rapidly, from non-specific anxiety or mood disturbance to profound disturbance with suicidality, within a matter of hours or days. The life changes around childbirth may also prove destabilising for women with personality difficulties, substance misuse or severe enduring disorders. Although rare, suicide is one of the leading causes of death in pregnant and postnatal women in the UK (National Perinatal Epidemiology Unit 2015).

Acts of self-harm are less common in the perinatal period so, if they do occur, they should be taken very seriously. Specific red flag presentations include:

- thoughts or acts of a violent nature
- rapidly changing mental state, and
- expressions of incompetence as a mother or alienation from the infant.

Any of these presentations, or any acts of self-harm, should trigger detailed risk assessment and referral to specialist perinatal mental health services.

As is the case in assessing all patients at risk of suicide, those doing assessments should avoid over-simplistic categorisation into 'high' or 'low' risk, as this is not effective. They should also avoid describing an act of self-harm as 'impulsive' because this does not, in itself, imply reduced future risk. Indeed, impulsivity may be a pointer to increased risk. For perinatal populations, there should also be caution in descriptions of children as 'protective factors', particularly when there has already been an act of self-harm (Bergen et al. 2011).

6. Assessment and intervention

A thorough assessment, including asking about suicidal plans, is important because suicide risk is not always documented in routine clinical assessments. This was highlighted in research from the Rahman et al. (2013) which found deficits in assessment and management approaches. The case notes of patients known to health services who had died by suicide within a week of their last assessment, showed that:

- 14% had an inadequate mental state assessment (mental state assessments should always include suicide)
- 26% had an inadequate risk formulation
- 38% had an inadequate risk 'Management Plan'.

A review of 70 major studies of suicidal thoughts (McHugh et al. 2019) showed that about 60% of people who died by suicide had denied having suicidal thoughts when asked by a psychiatrist or GP. This highlights the value of a compassionate and therapeutic relationship, so patients feel freer to disclose, and also the need to consider all factors, including an assessment of the degree of emotional pain, a thorough mental state examination, as well as identifying risk factors and/or red flag warning signs. Psychiatrists should not assume that patients experiencing mental distress without reporting suicidal ideas are not at elevated risk of suicide.

The current approach to risk assessment and responding only to those identified as 'high risk' is fundamentally flawed, and the use of terms such as 'low risk' or 'high risk' is unreliable, open to misinterpretation and potentially unsafe (Cole-King & Platt 2016). The absence of risk factors does not mean the absence of any risk of suicide (Cole-King et al. 2013). For a variety of reasons (e.g. stigma, shame, fear, or embarrassment) people may conceal or minimise their suicidal thoughts.

Moreover, suicidal thoughts (and risk) can vary across a relatively short time period. The assessment of suicide risk by the clinician needs to be individually focused and carried out regularly.

Risk factors and ‘red flag’ warning signs

The clinician should be familiar with established risk factors and risk groups (see Chapter 5) for suicide at a population level but should not rely wholly on this knowledge when assessing risk in specific individuals. The absence of risk factors does not mean the absence of any risk of suicide. Thus, a person may be imminently at risk of suicide even though they are not a member of a ‘high-risk’ group. Conversely, not all members of ‘high-risk’ groups are equally vulnerable to suicide. Moreover, suicidal thoughts (and risk) can vary across a relatively short time period.

The presence of red flag warning signs indicates that someone may be particularly at risk of suicide. Neither risk factors nor red flag warning signs can or should, however, be used to predict or rule out an individual suicide attempt (Cole-King, O’Neill 2017, RCPsych book *Mental Health in Primary Care*).

The importance of positive attitude among mental health professionals

Negative attitudes and ‘malignant alienation’ (including therapeutic nihilism of professionals towards challenging patients) may intrude on the therapeutic relationship and actually contribute to a suicide (Watts & Morgan 1994).

Conversely, a more positive and understanding approach helps build a therapeutic alliance between suicidal patients and their therapists, which can be a protective factor against suicide (Collins 2003).

Suicidal patients undergoing constant observation in hospital reported positive feelings towards their observers if they found them friendly and willing to help. Patients reported a reduction in their suicidal thoughts if the observers were perceived as optimistic and gave emotional support. Conversely, the patients’ distress was exacerbated by experiencing a lack of empathy or validation of their feelings.

How mental health professionals can identify suicide risk and mitigate it

Practitioners need to identify ‘risks’ to intervene, and not specifically to predict suicide. This will allow them to fully understand the person’s individual experience, in order to intervene using a bio-psycho-social model, to mitigate or decrease the risks now and in the future. Additionally, the expectation that risk must be controlled, and preferably eliminated, might paradoxically increase suicide risk rather than reduce it, as it might make individuals less likely to disclose their suicidal intent, and cause professionals to be reluctant to identify patients at risk of suicide for fear that they are unable to ‘manage suicide risk’.

The concept of suicide mitigation might be a helpful approach as this considers that all suicidal thoughts need to be taken seriously and met with empathy and understanding. This involves a compassionate and collaborative engagement, assessment and intervention with the co-production of a Safety Plan in addition to the usual treatment and care plan. Increasing hopefulness, resilience, reasons for living and reducing access to the means to attempt suicide, have all been shown to reduce suicide risk.

The importance of Safety Plans

A Safety Plan is an agreed set of activities, strategies, people and organisations to contact for support if someone becomes suicidal or if their suicidal thoughts get worse or if they might self-harm. A Safety Plan also needs to include explicit reference to removal or mitigation of means of suicide or self-harm. There is emerging evidence of the effectiveness of Safety Plans (Zonana et al. 2018).

A Safety Plan should be co-produced with the patient, who will identify most of the elements; if the patient is unable to articulate their wishes, or when their psychological pain and wish to die prevents them from effectively engaging safely, the clinician may have to take a more directive role. The Royal College of Psychiatrists believe that every person who is having suicidal thoughts or who has engaged in self-harm should have a Safety Plan

NICE Guidelines recommend that all patients who present to an acute hospital following an episode of self-harm should receive a psycho-social assessment. This intervention can in itself reduce repetition of self-harm. In the acute hospital, staff can minimise the risk of early self-discharge through compassionate engagement with patients who attend following self-harm. Acute hospital staff need to be able to engage compassionately with people who self-harm, undertake triage assessments and refer as appropriate to secondary mental health care services. They should also be trained to be able to co-produce a basic immediate Safety Plan with the patient.

All care providers should consider the following approach to help patients reduce their risk of self-harm and suicide:

- Promote a shared language, approach and understanding to suicide prevention
- Understand the importance of a thorough and effective clinical assessment
- Be able to safely and effectively assess, triage and refer as appropriate
- The need for a change in culture to one of 'primary prevention' i.e. recognising that not all patients who are at risk of suicide present to services with a presenting complaint of 'feeling suicidal'
- Psychiatrists and MH professionals should have the competences to co-produce a Safety Plan with patients who are experiencing suicidal thoughts or following self-harm

- Psychiatrists and MH professionals should be able to help patients build wellbeing, resilience and resourcefulness
- Promoting appropriate help seeking and self-care
- Need to know when it's appropriate to seek help from statutory and third sector services and how to signpost people to the appropriate service for their needs.

Making a Safety Plan

The following are some of the components of a Safety Plan that clinicians should consider when working with people at risk of self-harm and suicide.

A Safety Plan comprises:

- Individualised strategies/activities to instil hope
- Calming/distracting activities
- Restriction of access to common means of suicide
- Contacts for social and crisis support

[StayingSafe.net](https://staying-safe.net) is an innovative digital solution to equip people to make a Safety Plan. The website includes videos and written guidance and both a downloadable blank safety plan template and an online Safety Plan for electronic completion and storage (phone/mobile device):

- **Reasons for living and/or ideas for getting through tough times**
 - Reminders of positive aspects of life: photos of people, pets or special places
 - Music that boosts mood and makes people feel good
- **Making your situation safer**
 - Remove things that could be used for self-harm or suicide
 - If stopping self-harm is not an option yet consider ways to make self-harm safer
 - If medication is in the home – make it safer or store less
 - Identify and avoid distress triggers, i.e. things that cause distress or make distress worse
- **Things to lift or calm mood – a calming activity is anything relaxing**
 - Meditation, yoga or looking at a photo of a great view or someone you care about
 - Writing down feelings in a diary or a letter
 - Calming thoughts such as about a special place or happy memory
- **Distractions**
 - Anything that 'takes your mind away' from distressing feelings
 - Distracting activities 'keeping you busy' (e.g. exercise, cooking, art, chores, interacting with someone in person, via email or text or on social media)
 - Distracting via thinking 'keeping your mind busy' (e.g. listening to music, cross-words, Sudoku, TV, YouTube, Films)

- **Sources of support – anyone you trust**
 - Day to day support (not necessarily for discussing self-harm or suicide)
 - Agree to talk to someone you trust, including friends, family or people in your community
 - Support if distressed or thinking about self-harm or suicide
 - Agree to talk to one or two close confidants you trust, including friends as well as list any specialist support such as from helplines or mental health professionals
 - Specific suicide and self-harm prevention 24-hour helplines or websites
 - Local healthcare support emergency NHS contact details for out of hours support
 - Acknowledgement: with kind permission from Connecting with People/4Mental Health.

The importance of involving family and friends in suicide prevention plans

Clinicians can gain useful and important information from third parties, such as family, friends or first responders, in addition to any objective evidence, particularly if someone has self-harmed or attempted suicide. Even where a person wishes particular information not to be shared, this does not prevent practitioners from listening to the views of family and friends or prevent them from providing general information such as how to access services in a crisis.

The Royal College of Psychiatrists would strongly advocate all health and social care professionals should be aware of the [Information sharing and suicide prevention Consensus Statement](#) from the Department of Health and adapt their practice as necessary to work with families and friends in the ways this sets out, as there have been cases where this has not been followed.

Best practice



- Although identifying ‘red flag’ warning symptoms during assessments of a patient’s suicide risk is important, evidence suggest that their absence is not necessarily reassurance that someone is not at risk of suicide. An approach of compassion for those expressing suicidal ideation and a holistic psychosocial approach, rather than one which focuses primarily on risk assessment, is likely to be more effective.
- Clinicians who work with patients who are at increased risk of suicide should think in terms of mitigating the risk, rather than managing the risk. Every person who self-harms and/or has suicidal thoughts should have a Safety Plan, co-created with the patient. An essential component of such a Safety Plan is to encourage communication with family and/or friends.
- All health and social care professionals should be aware of the Consensus Statement and adapt their practice as necessary to work with families and/or friends in the ways this sets out.

(Note: ‘Family and friends’ refers to the person(s) with whom the individual has a close emotional relationship).

7. The role of mental health teams in long-term risk management

There is evidence from studies which form part of the NCISH (Kapur et al. 2016) that changes in mental health services can result in a reduction in the number of people dying by suicide within their services. The role of mental health teams in the longer-term management of self-harm and suicide is not always clear. When a patient presents following an episode of self-harm, often at an A&E Department, there are several questions. Firstly, what is the risk that they will subsequently die by suicide? At present there are no risk instruments to accurately assess this risk. This is because suicide is a low-frequency event and as such it is difficult to predict, even after an episode of self-harm. This is despite the fact that self-harm is known to increase the risk of subsequently dying by suicide. The second question is what is the risk of repetition of an episode of self-harm? Although this is a higher frequency event than suicide, many mental health services will be aware of patients who repeatedly present at A&E departments following episodes of self-harm and who clearly have longer term treatment needs. But there is not a clear consensus on how to support these patients in order to reduce their self-harm behaviour.

The NICE Guidelines on the long-term management of self-harm were published in November 2011. Their recommendations included:

- General principles of care – which are common to all interventions for self-harm
- Psychosocial assessment – described as an integrated and comprehensive psychosocial assessment of needs
- Risk assessment – which suggests agreeing with the person who self-harms the specific risks for them, considering a number of specific factors. There is a very clear statement ‘Do not use risk assessment tools and scales to predict future of suicide or repetition of self-harm’
- Care plans – these should be discussed and agreed with the person who self-harms and should document the aims of longer-term treatment
- Risk management plan – this should be a clearly identified part of the care plan to manage the risk of further episodes of self-harm, including a crisis plan about accessing services when self-management strategies fail. There is a statement that the limits of confidentiality should be explained to the person who self-harms and that information may be shared with other professionals
- Interventions for self-harm – it is suggested that 3 to 12 sessions of a psychological intervention, that is specifically structured for people who self-harm, should be offered

- Treating associated mental health conditions – these include treatment for alcohol and/or drug misuse, depression, psychosis, borderline personality disorder or bipolar disorder.

However, the services provided for people who self-harm vary considerably. This is despite the fact that one study (Kapur et al. 2013) of nearly 36,000 individuals who presented with self-harm in 2013 demonstrated that undertaking a psychosocial assessment, such as the one recommended in the NICE Guidelines, was associated with a 40% reduction in the risk of repeating self-harm. This confirmed the findings of an earlier study (Bergen et al, 2010) which showed a 50% reduction in the risk of repetition of self-harm following a psychosocial assessment being undertaken at an acute hospital after an episode of self-harm (Cooper et al. 2013). However, these assessments are still not being undertaken in all hospitals; one study found that they occurred in only 58% of cases in acute hospitals. It is suggested that this may be due to the variability of liaison psychiatry services in acute hospitals (Hawton 2017).

An update of the NICE Guidelines (2013) on the longer-term management of self-harm did not find any studies which would have had an impact on the original Guidelines from 2011. One innovative approach to the management of patients presenting with repeated episodes of self-harm has been to set up a weekly self-harm outpatient clinic in Oxford. The [Brief Intervention in Repeat Self-harm](#) (BIRSH) clinic provides a service to patients who have repeatedly self-harmed and presented to the local A&E Department. Their service is compliant with the recommendations from the NICE Guidelines on the longer-term management of self-harm. Their focus is on improving the patient's problem-solving skills and them managing their own self-harm behaviour (Hawton et al, 2013).

Self-harm is one of strongest predictors of suicide, including in older people who self-harm, who are at greater risk of completed suicide. The main risk factors for death by suicide in older people are:

- **Mental disorders**
Depression, bipolar disorder, anxiety disorders, and psychotic illnesses are all associated with an increased risk of dying by suicide. It is well known that depression is frequently underdiagnosed and undertreated in older adults (Allan et al. 2014). Anxiety disorders, often comorbid with depression, are present in one in six older adults who die by suicide (Harrison et al. 2010).
- **Neurocognitive disorders**
Dementia is a risk factor for suicidal ideation and death by suicide (Serafini 2016). Huntington's disease is also linked to an increased risk of suicide (Haw et al. 2009).
- **Social exclusion, loneliness and bereavement**
These are all important risk factors for self-harm and suicide in older adults. The death of a close relative is a particularly stressful event and is a risk factor for suicide. This risk is highest during the 6 months following the loss of a close relative (McLaren et al. 2015).
- **Functional disability and physical conditions**
A systematic review by Fassberg et al. (2016) on older adults showed that an

increased risk of self-harm and suicide is associated with cancer, neurological disorders, chronic obstructive pulmonary disease (COPD), liver disease, male genital disorders, arthritis/arthrosis, and also pain. Triggers of suicidal attempts included frustration with disability and/or illness and pain, together with loss of: autonomy, a sense of usefulness, dignity, and pleasure in life. Women more often referred to 'not wanting to burden others'. Cancer is increasingly linked with suicide. For example, in a review on suicide risk among patients with genitourinary cancer (specifically prostate, bladder, and kidney cancers, but not testicular cancer), older age represented an increased risk of suicide (M de Lima & Tobias-Machado, 2017).

- **Alcohol and substance misuse**

This is frequently under-recognised as a risk factor for suicide in older adults. Older adults have been found to have the greatest increase in rates of alcohol misuse (RCPsych 2018).

A multi-centre study in three English cities studied self-harm in people aged 60 and over. They found that 1.5% of the study group died by suicide, which suggested a rate 67 times more than the general over-60 population and three times more than the younger adult population who present with self-harm. Men aged 75 and over had the highest suicide rates. Although the rates of self-harm are lower in older adults than in younger adults, the rates of suicide are higher. Self-harm in older adults represents a failed suicide attempt.

Mental health services

There is some evidence from the NCISH that services that have adopted at least 7 of their 9 recommendations regarding in-patients, CRHT, and information sharing policies have shown a reduction in their suicide rates. This was particularly true where 24-hour crisis care was provided. A study from Kapur et al. (2016) developed this further. They found that changes relating to in-patient wards safety, community teams, and training and policy implementation were associated with a reduction in suicides in mental health trusts in England. As this was an observational study, they could not show the specific effects of these changes. One policy change concerned the MDT review following a patient's death by suicide, which should include sharing information with the bereaved family. This further strengthens the importance of implementing the [Consensus Statement](#) on information sharing with families. This study also found that the presence of assertive outreach teams and CRHT teams were associated with a reduction in suicide rates over the study period. This was true even when these specialist functions were merged with community mental health teams.

The key messages from these studies from the NCISH were:

- 1 The health of mental health provider organisations may have an impact on the safety of patients.
- 2 Patient complaints and staff turnover may be markers of patients' suicide risk, and evidence of rising rates for these factors should act as a safety alert to services and commissioners.
- 3 The link between non-medical staff turnover and in-patient suicide could be causal; suicides may be more likely when there is a lack of continuity in care. Services should aim to reduce staff turnover.
- 4 Services are often unsure whether to attach significance to a rise in suicide in a single year. An accompanying rise in safety incident overall should raise concerns.
- 5 Higher rates of complaints and safety incidents are sometimes taken as evidence of an open reporting culture; NCISH findings suggest they may also reflect real safety concerns.

Primary care services are well placed to intervene at an earlier stage in the prevention of suicide in older adults, because often they are the first to have contact with older people with suicidal ideation. This is because of the higher prevalence of physical illness in older adults and its link with self-harm and suicide. As a result, a greater proportion of older adults have contact with the general practitioner rather than with the secondary care psychiatric services prior to an attempt at suicide (Cheung et al. 2015).

Assessing for the presence of the risk factors identified above, especially in older patients facing psychosocial adverse events, will be particularly important in primary care services. More effective longer-term management of vulnerable older people with depression and a history of self-harm, by both mental health services and primary care, will improve the prevention of suicide in this group. This includes recognising the fact that older adults with severe depression respond poorly to all types of antidepressants but could benefit from psychological treatment. Older adults who self-harm should be assessed by old-age psychiatrists or by mental health specialists trained to assess risks and needs in this group of individuals, as they have complex co-morbidities which can have an impact on their treatment.

Conclusion

The long-term treatment of self-harm is affected by the lack of an accurate risk assessment tool to predict which patients will die by suicide following episodes of self-harm. The evidence for the effect of a single psychosocial assessment in reducing risk of repeated episodes of self-harm supports the view by Bolton et al. (2015) that the doctor-patient contact can provide a strong therapeutic effect. This also links with the recommendations to improve the quality of psychosocial assessments (Hawton 2016) and the importance of enquiring about suicide plans in patients who have self-harmed. Finally, the importance of a trusting and understanding approach does help to build a

therapeutic alliance between patients and mental health professionals, which can in turn reduce their risk.

Older adults who have self-harmed are at increased risk of completed suicide, especially those aged 75 or over. The most common risk factors for self-harm and suicide in older adults include: mental illness, neurocognitive disorders including dementia, physical illness and pain, and a poorly integrated social network.

Best practice



- Primary care services should be able to assess the presence of risk factors such as mental and neurocognitive disorders; social exclusion, loneliness and bereavement; functional disability and physical conditions; and alcohol and substance misuse in older patients.
- More effective longer-term management of vulnerable older people with depression and a history of self-harm, by both mental health services and primary care, will improve the prevention of suicide in this group.
- Older adults who self-harm should be assessed by old-age psychiatrists or by mental health specialists trained to assess risks and needs in this group of individuals, as they have complex co-morbidities which can have an impact on their treatment.

8. After suicide: support for family and friends

This chapter has been written with people who have had direct experience of having been bereaved by suicide as well as active researchers in the field of suicide bereavement. The importance of ensuring that there is support available for people bereaved by suicide was highlighted in the House of Commons Health Select Committee report (HSC 2017). This recommended that ‘high-quality support for all those bereaved by suicide should be included in all local authorities’ suicide prevention plans.’ In their third Progress Report on the implementation of the Suicide Prevention Strategy for England, the government noted the severe impact on people bereaved by suicide. This included their own increased risk of dying by suicide.

There is other clinical evidence of the importance of involving families and others bereaved by suicide in the subsequent review undertaken by mental health provider organisations following suicide. A study from 2016 (Kapur et al. 2016) linked to the NCISH showed the interdependence of mental health care, governance and suicide reduction. This study found that mental health services who adopted 16 policies and procedures showed a reduction in their suicide rates. One of these policies was undertaking a case review following a death by suicide in which the family were involved. They saw this as a marker of a learning culture, which suggests that such a culture leads to a reduction in the number of their patients dying by suicide.

However, the experts in this subject are those people who have experienced being bereaved by suicide. The following was written by a family who were bereaved by suicide.

R’s story

“My son R attempted suicide in August 1995 which caused damage to his vocal cords. He was 23 years at the time and at home during the holidays.

After treatment he came to live with us. I was retired then and looked after him.

R made another attempt when we were away from home. After treatment in A&E he came to live with us. He took the family car (when unlicensed and without driving lessons) but came back after some hours.

Was hospitalised several times in acute wards and also in supported accommodation until February 2016 when he took a taxi to a seaside town and took his own life at about midnight.

As far as we were aware there was no psychological intervention. The psychiatrists relied solely on medication with clozapine for the final 8 years.

We were seen by someone from the Mental Health Trust after R's demise last year who enquired into the events, but we had no follow-up from him or anyone else. No counselling or other help has been offered.

As far as we know there has been no psychological input during the 20 odd years that R has been under medical care. No one spoke to us about suicide prevention."

This account was submitted in the hope that it will help in the treatment of patients like R. Carers should be provided with more help on suicide prevention.

Support for people bereaved by suicide

Providing better information and support to people bereaved or affected by suicide is one of two over-riding objectives of the suicide prevention strategy for England (DH 2012), yet is rarely implemented in healthcare settings. This is partly due to a lack of support infrastructure throughout the UK, but also a lack of training of professionals. Such a situation is concerning given that between 60 (Berman 2011) and 135 (Cerel et al. 2018) people are deeply affected by each suicide, and that an estimated 9% of people bereaved by suicide subsequently make a suicide attempt (Pitman et al. 2016). Not only is there robust empirical evidence to support the elevated risk of suicide in people bereaved by the suicide of a child (Qin & Mortensen 2003), partner (Agerbo 2015, Erlangsen et al. 2017), or parent (Garssen et al. 2011) compared to those bereaved by other causes, but also evidence of greater perception of stigma (Pitman et al. 2014). This has help-seeking implications, particularly as those in need of support may not always be next of kin, and the elevated risk of a suicide attempt applies whether a person was related to the deceased or not (Pitman et al. 2016). Indeed, the negative effects of suicide bereavement can affect relatives, friends, partners, and the professionals who cared for that person before their death. Those who are less visible, such as children, ex-partners, and more peripheral friends, are described as the 'hidden bereaved'. They can experience disenfranchised grief that is not socially sanctioned or openly acknowledged, yet they too are in need of support.

Over the last few years there has been growing visibility of provision for people bereaved by suicide, mainly through the efforts of voluntary sector organisations, increasingly in partnership with local authorities. This public health approach includes peer support groups, active outreach after an apparent suicide, telephone helplines, an umbrella organisation (Support After Suicide Partnership) bringing together national voluntary sector support, and a printed directory of support – [Help Is At Hand](#) (Public Health England; National Suicide Prevention Alliance 2015). This latter resource was written by people bereaved by suicide and places emphasis on having access to a range of support, including peer support from those with similar experiences. Forthcoming NICE guidelines on preventing suicide in community and custodial sentences will place

an expectation on GPs and prisons to provide better support for people bereaved by suicide. However, qualitative research shows that GPs do not feel confident supporting parents who have lost a child to suicide, and perceive a need for extra training (Foggin et al. 2016). Given existing pressures on their time, it will be increasingly difficult for them to care for and support people bereaved by suicide, and it is likely that more will be signposted to secondary care.

Psychiatric patients bereaved by suicide are a particularly vulnerable group, given that psychiatric illness is itself a risk factor for suicide. Their genetic and social risk factors, and their social and family networks, increase their likelihood of experiencing the suicide of a relative, friend or a fellow patient, yet they have access to very little specialised support. Findings from the NCISH show that in a third of cases of psychiatric patient suicide between 2003 and 2012 no member of the mental health team contacted the bereaved relatives to offer information or support (Pitman et al. 2016). Specific stigmatizing patient factors (forensic history, unemployment, and primary diagnosis of alcohol or drug dependence or misuse) were associated with a reduced likelihood of staff contacting next of kin after the suicide, suggesting inequitable access to support. Increasing staff awareness of the risk of suicide associated with suicide bereavement, and the resources available to support bereaved relatives and friends, might improve this coverage. Post-suicide reviews that placed more emphasis on offering support to both staff and relatives bereaved by a suicide might also help mitigate this risk.

Best practice



Routine practice:

- When screening for a family history of suicide, also ask about a history of suicide in friends and non-biological relatives.
- If you elicit a positive history of suicide bereavement, respond compassionately by inquiring about its emotional impact.
- Add the patient's history of suicide bereavement to your risk assessment and consider suggesting self-referral for bereavement counselling if indicated.
- Record the date of the bereavement and anticipate successive anniversary reactions, including provision of increased support and greater vigilance over means restriction.

After the suicide of a patient:

- Contact the relatives/carers to offer support and information, including a copy of [Help is at Hand](#).
- Ensure that other patients and any staff who knew the patient are appropriately supported and aware of local voluntary sector support.
- Distribute copies of *Help is at Hand* throughout the team, and to any patients who knew the deceased and who might be affected by it.
- Conduct a reflective and blame-free debrief.

Training needs:

- Train health professionals in how to respond to their patients who experience suicide loss by building their confidence and skills in caring for those bereaved by suicide
- Ensure that all health professionals and first responders are aware of *Help is at Hand*, and how to keep families engaged with services after a suicide
- Disseminate to health and social care professionals, teachers, first responders, and community organisations copies of [Finding the Words](#) – a guide on how to support someone who has been bereaved by suicide.

Auditable standards:

- Ensure that NHS trusts provide support to their staff who have been bereaved by suicide as part of post-suicide reviews, and provide them with a copy of *Help is at Hand*.
- Ensure that NHS trusts have systems by which a named professional responds to a family after a patient's suicide, including providing them with a copy of *Help is at Hand*.
- Ensure that NHS trusts provide support to other patients affected by the suicide of a patient, including providing them with a copy of *Help is at Hand* and considering measures to restrict access to the same means of suicide.

9. After suicide: support for mental health staff

The suicide of a patient can have a profound effect on psychiatrists and other mental health professionals, both personally and professionally (Alexander et al. 2016, Bultema 1994, Campbell and Hale 2017, Castelli-Dransart et al. 2014, Chemtob et al. 1988, Collins 2003, Courtenay & Stephens 2001, Cryan et al. 1995, Deary et al. 1996, Dewar et al. 2000, Foley et al. 2007 and Gitlin 1999)

Gitlin's view (1999) is that a patient suicide may be the most psychologically difficult experience encountered in the life of a psychiatrist, and can result in a combination of post-traumatic stress disorder symptoms, shame, guilt, anger, isolation, and fears of litigation and of retribution from the psychiatric community. Just the risk of patient suicide may have a significant effect on morale, even if a suicidal act does not occur (Cryan et al. 1995). Foley & Kelly (2007) reported on studies that show psychiatrists are more emotionally exhausted and have higher levels of depression than their medical and surgical colleagues.

Incidence

Most psychiatrists experience the suicide of a patient during their career (Alexander et al. 2016, Courtenay and Stephens 2001). In one study 82% of psychiatrists answering a questionnaire reported at least one patient suicide, and 47% experienced a patient suicide within five years of entering psychiatric practice (Cryan 1995). Alexander (2000) found that 66% of consultants had dealt with between 2 and 6 patient suicides, and 13% had experience of between 7 and 15 such deaths.

Emotional effects

Chemtob et al. (1998) found that 53% of psychiatrists reported stress levels in the weeks following a suicide comparable to those reported in studies of people seeking treatment after the death of a parent. This finding was supported by Collins (2003), who found that many mental health professionals had significant grief and bereavement reactions following a death of this nature. Worden (1998) and Seguin et al. (2014) noted multiple types of losses that need grieving in addition to the loss of the patient, including loss of the therapeutic relationship, self-confidence and 'feelings of omnipotence'. There is also the frequently traumatic nature of the event itself that often 'comes out of the blue' (Campbell & Hale 2017).

Dewar (2000) found that 31% of psychiatric trainees reported an adverse effect on their personal lives. Yousaf et al. (2002) found that 52% of the psychiatric trainees in their study who had experienced patient suicide had signs of clinical stress in the aftermath of the event, and 29% remained clinically stressed despite the passage of time. Courtenay and Stephens (2001) found that 51% of their psychiatric trainees reported a moderate emotional impact after a patient suicide and 24% reported a severe impact.

Campbell & Hale (p88–95) (2017) describe how the stress following a patient suicide can be exacerbated by organisational responses, including serious incident enquiries, and the pressure of attending the Coroner's Court.

Seguin et al. (2014) reported enormous variation among mental health professionals in the intensity of stress reactions and noted that although the reasons for this variation were unclear, they may be more intense in those who received insufficient support or felt particularly close to the deceased patient. Chemtob et al. (1988) found that younger, less-experienced clinicians were more affected by a patient's suicide than older clinicians with more experience.

Professional consequences

Changes in a psychiatrist's clinical practice following a patient suicide may include the way suicide risk is assessed, the frequency of referrals to other colleagues, the threshold for hospitalization and other treatment choices, and concerns with legal issues (Alexander et al. 2000, Gitlin 1999).

Alexander et al. (2000) discovered that over 40% of psychiatrists reported a change in professional practice and Dewar et al. (2000) learned that 39% of psychiatric trainees reported an adverse effect on their work.

Alexander et al. (2000) found that 15% of doctors considered taking early retirement and Dewar et al. (2000) reported 9% considered a change of career in the aftermath of a patient suicide.

Support following a suicide

Authors of many studies report on the lack of structured support after a suicide and indicate that both consultant psychiatrists and psychiatric trainees rely on their informal support networks. Courtenay and Stephens (2001) found that 40% of trainees felt their need for help following a patient suicide went ignored. Chemtob et al. (1998) wondered whether this was due to the reluctance of some psychiatrists to deal openly with such a sensitive topic.

Conclusion

Current research shows that the death of a patient by suicide has a profound effect on the personal and professional life of many psychiatrists and other mental health professionals and can affect recruitment, retention, quality of professional life and patient care. This very important area has not been well examined.

Best practice



- 1 Contribute to enhancing a culture of compassion and challenge attitudes of blame and fault. Strategies that decrease the isolation of the clinician and foster perspectives that reduce self-blame may blunt an overdeveloped sense of responsibility and limit fantasies of having ultimate control over patients' lives (Gitlin 1999).
- 2 Promote formalised support for psychiatrists and other mental health professionals after the suicide of a patient (Campbell and Hale 2017).
- 3 Recognise the importance of, and support the development of, regular reflective space for clinicians (e.g. Balint groups, reflective practice groups) as part of everyday clinical work. Then when something like a suicide happens there is already an established and secure setting (Psychotherapy executive).
- 4 Ensure greater attention to suicide in the training of psychiatrists (Alexander et al. 2000).
- 5 Promote local team initiatives to identify potential issues and develop support (Foley & Kelly 2007).

10. Self-harm/suicide and the internet

Professional engagement in digital lives

It is critical for professionals to include a person's digital life within their clinical assessments, especially when there are concerns about self-harm.

When enquiring about this it is important to recognise that it is unlikely that there is a predictable pattern of digital activity and each person's use is different.

Typical lines of enquiry about internet and social media usage could usefully include whether the person:

- Uses social media to access support for self-harm – through peer support or on-line fora, or reading information
- Provides support to other people
- Publicly shares their self-harming behaviour online
- Has many followers on sites they use
- Has been invited by online means to do things they would rather not do
- Has been subjected to negative reactions, threats, bullying or harassment online

While mental state examination is a gold standard for gathering information about a person's mental health, a social media or phone usage profile has not been included in psychiatric evaluation. There would be logic in understanding the content of online interaction, but the desire to protect personal privacy and avoid untoward intrusion tend to stand in the way. However, finding ways of asking for information is a reasonable ambition, and starting with a polite request for sharing of relevant content on the person's phone seems a good way to start.

Asking about internet and social media use

The following questions may help clinicians to assess their patient's use of social media:

- **The purpose of social media use**
 - What makes you use social media, and what do you get out of it?
 - What do you appreciate most about using social media? For example, some people use social media to access support for self-harm, find out what other people do or think, or to find information. What about you?
 - Do you ever find yourself supporting other people on social media?

- **If social media use is related to self-harm**

- If you self-harm, do you ever share this publicly with others online?
- If you do, what do you do? Some people discuss self-harm in general, share information regarding their self-harm, either in writing or using pictures and images. What about you?
- Do you ever use a self-harm related hashtag when you search or post?

- **Experiences**

- Have you had any bad experiences using social media? For example, some people have had negative reactions or threats, or they've experienced bullying or harassment online. What about you?
- Have you ever been invited online to do things you'd rather not do? For example, some people have been asked to send pictures or videos of themselves which makes them feel uncomfortable. Has something like this ever happened to you?
- Has anyone ever complained about your social media activity? If so, can you tell me more? Request details if so.

- **Extent and range of social media use**

- How many different social media sites do you use?
- How much time do you spend on each of these (how often, and how long)?
- How many follow you on the sites you use?
- What is the longest time you can last without using social media or the internet?

- **Internet safety**

- Are you concerned about internet safety?
- What do your two or three closest friends say about the sites and social media platforms you use?
- Do your friends or family know the type of things you read and post online or the sites you visit; do you ever discuss it?
- How much 'chat' do you have with people you have not met in person?

Information available on the internet

See the Online resources section for details of the following. There is an extensive array of websites and other sources of information regarding self-harm and its management on the internet. Much of the information is informative, professionally written and treatment oriented. Examples include the following:

- Information leaflets on the Royal College of Psychiatrists' website.
- Information from NICE, NHS Choices, well known and regarded organisations such as MIND, Papyrus, or Childline which offers advice and a freephone helpline.
- The website 'TheSite', which seems to be recovery orientated with suggestions for support, and information from professionals.

- Selfharm.net which includes a discussion forum, but which is US-based and may not accurately reflect evidence-based treatments and approaches in the UK; the descriptions of what happens during A&E attendance not being particularly encouraging.
- Online counselling and phone support bodies such as the Samaritans which are increasingly common; it is very important to be clear about safety mechanisms employed in these services, particularly when a young person makes risk statements which require an urgent response; this may be out of the control of professionals but is an important area of discussion when considering Safety Plans.

Use of social media

Digital technology is now a central part of peoples' lives, for information, entertainment and communication, particularly social media platforms such as Facebook, Tumblr and Twitter. The use of apps accessed on mobile devices is now a way of life, so people can share, connect and communicate with each other instantly and spontaneously. People use a range of social media platforms and congregate within online forums, which have quickly been gaining popularity due to the easy sharing and anonymity they offer.

While anonymity features can be associated with bullying, these sites also allow people to share and explore difficult issues they are experiencing in their lives, such as anxiety, self-image concerns, and relationships, away from the eyes of others. They may also share thoughts and feelings concerning self-harm and suicide, which may be accompanied by images, videos, or blogs etc.

Update from research

While opinion and fear about the harms of the internet have become commonplace, rigorous research has been evolving gradually, and the field is still in something of its infancy. It is clear that there are both helpful and harmful aspects to making use of the internet.

Accessing self-harm related content is common but not universal. In a general population representative sample (3946 people aged 21) as part of the ALSPAC study, 8.2% reported searching for information about self-harm; 7.5% had searched for information about suicide and 9.1% had used the internet to discuss self-harm or suicidal feelings (Mars et al. 2015).

In another study, 1% of young people reported visiting a website that encouraged self-harm or suicide, so a smaller and more selected subgroup (Mitchell et al. 2015).

In both studies, suicide/self-harm related internet use was particularly prevalent among those who had harmed with suicidal intent and was strongly associated with the presence of suicidal thoughts, suicidal plans, and history of self-harm. Or to put it the other way around, young people who visited such websites were seven times more

likely to say they had thought about taking their own life, and 11 times more likely to think about hurting themselves, even after adjusting for several known risk factors for thoughts of self-harm and thoughts of suicide. Hence there seems to be an association between suicidal ideation/action and accessing relevant content online, particularly for young people. There are some suggestions that it may be associated with more violent methods of self-harm.

Most people (81%) who access harmful sites also access helpful sites (Mars et al. 2015). Young people often find it easier to share online and are less likely to feel judged (Jones et al. 2011). There is a potential risk that accessing self-harm related content will normalise self-harm and potentially discourage disclosure or seeking of professional help (Daine et al. 2015), but there is no empirical evidence for this.

As might be expected, there is caution about the quality of helpful internet sites, with some variation in standards (Lewis et al. 2014), meaning that it would be useful for professionals to have a few suggested sites for people to follow – by way of psychoeducation. A suggested list is included in the online resources listed in the Appendix.

It is important to remember that most harms are more prevalent offline. For example, bullying for young people is 3 or more times as common offline than online. This is not to minimise the importance of online harms, but to remember that internet related risk is usually an old problem in a new format.

One study looked at the mediators of harms and found that depression may mediate the effect of cyber victimisation, but not bullying, particularly in females (Bauman 2013). Aside from raising many questions about mechanisms, it is a reminder of well-known risk factors for self-harm and suicide, namely mental health problems.

Most research has involved younger people – below the age of 25 – which is not surprising given the evolution of technology and the young as earlier adopters. Either way, there is little written about internet-related activity for the general adult population or older people. Hopefully this will emerge with time.

Best practice



Clinicians should enquire about social media use as part of assessments and management of self-harm. Suggested questions are included above.

11. Stigma associated with self-harm/suicide

Media portrayals of suicide

Every suicide is a tragedy and a shock to those close to the person who dies. The reporting and handling of events does seem to be important at the level of emotional and social sensitivity to the bereaved, but also as a public health issue. There is now fairly robust evidence for social contagion – copycat behaviour – occurring in association with a suicide.

Guidance about reporting includes two main documents – the first is the [Samaritans Media Guidelines](#) for reporting suicide (2013), and the second is the [Editors' Code Book](#) (2020). These two documents present similar messages though the first is more comprehensive at 17 pages long in total, and an easy read. The messages are consistent across both and can be summarised as follows: avoid excess detail about events; avoid over simplification of events; avoid glorification; use particular caution if a celebrity takes their life; do be careful about language used; do include information about support. The Samaritans guidance also has a page with advice about digital media.

The *Editors' Code Book* now covers the reporting of suicides as a separate clause (Clause 5) in its publication. Similar to the Samaritans guidance, it outlines the importance of avoiding excessive detail. It also covers the issue of avoiding glamorising or trivialising suicide (such as celebrity deaths or humorous responses, as well as the reporting of inquests). Two related sections include the handling of grief and shock (Clause 4). The overall thrust is that excessive detail should be avoided and that sensitivity to those closely involved in events should be carefully applied.

These guidelines have strong face validity and could usefully be applied to all levels of human response since they aim to deal with the natural emotional response to a shocking event. They could be summarised as 'Contained accuracy and contained compassionate affect'. In other words, accurate information but not too much detail; calm compassionate responses rather than sudden emotion laden concern. These are good maxims in terms at all levels of response – media, organisations, professionals and individuals who survive, off- and online.

Best practice



Clinicians, organisations and the media should familiarise themselves with the media reporting guidance. This is because it is clear and simple, and applicable at all levels of interaction when a suicide occurs, including support for those bereaved, use of social media and organisational response.

Myths and stigma

Self-harm and suicide retain a massive stigma, with multiple myths around motivations that belittle the sufferers, enhancing feelings of shame and thereby ‘feeding the dragon’. Those affected by suicide, whether through having experienced suicidality personally or via the experiences or loss of a loved one, are vulnerable and often stigmatised. Healthcare professionals can be the worst offenders, with automatic references to self-injury as ‘manipulative’ and ‘attention seeking’. Self-harm evokes strong feelings in us all, and the dehumanisation of people who have self-harmed protects us from our own distress, but also hinders us from empathy. This is displayed through the idioms of language and is played out in most hospitals on most days of the week. Suicide was previously construed as sinful and criminal, and although it was decriminalised in the UK in 1961 the use of outdated and unhelpful phrases such as ‘commit suicide’ persists over five decades later.

Stigma can embrace both negative and prejudicial attitudes, also discriminating behaviour towards people who self-harm. Self-stigma is hugely painful and stigmatising language about suicide and self-harm from professionals, which may have connotations of illegality and therefore shamefulness, will exacerbate this (Maple et al. 2010). Stigma should be considered as a life-limiting condition, as the secrecy and shame it propagates prevents people from disclosing and professionals from asking (Reynders et al. 2014).

Psychiatrists and MH practitioners with heightened awareness, and willingness to ask questions around self-harm or suicide, in the context of a compassionate consultation can uncover patients at risk of suicide even if that is not their presenting complaint. Healthcare professionals who are empathetic and compassionate encourage increased disclosure by patients about their concerns, symptoms and behaviour, and are ultimately more effective at delivering care (Larson, 2005). Due to stigma, shame, fear or embarrassment, people may conceal or minimise their self-harm or suicidal thoughts. It is therefore important that, in discussions about suicide, clinicians adopt a non-judgmental stance.

The overall effect is to discourage people from talking of suicidal thoughts and feelings. People at risk of self-harm and suicide are often already marginalised, and challenging stigma remains a constant, but necessary, battle to which we all must contribute.

12. The evidence base for suicide prevention

Suicide is a complex behaviour with multiple aetiological factors, some of which are poorly understood. It has a low base rate in the population at around 10–11 per 100,000 in the UK. This makes high quality evidence for suicide prevention very difficult to obtain. There are few randomised controlled trials (RCTs) and the heterogeneity of strategies and outcome measures limits conclusions. Suicide prevention is however an area of significantly increased interest and evidence over the last 10–15 years, with the first national suicide prevention strategy for England being developed in 2002 (DH 2002). There is some good evidence for prevention strategies that are population based and more limited evidence for those targeting high-risk groups.

The following is a summary of the current evidence for suicide prevention. It includes evidence from the UK and other countries.

Good evidence for prevention of suicide

Restriction in access to lethal means

- **Control of potentially toxic medication:**
 - Smaller packets of analgesics; legislation introduced in September 1998 to restrict pack sizes of paracetamol resulting in 765 fewer deaths over the 11¼ years after the legislation (Zalsman et al. 2016, Mann et al. 2005, Hawton et al. 2011, Hawton et al. 2013, Morgan et al. 2007, Sandilands et al. 2008)
 - Withdrawal of toxic analgesics, especially co-proxamol (Sandilands et al. 2008)
 - Reduction in barbiturates availability and the concentration of caffeine tablets, the detoxification of domestic gas, and the introduction of catalytic converters: all associated with reduced suicide rates (Zalsman et al. 2016, Mann et al. 2005)
- **Restriction of access to frequently used locations for suicide (Pirkis et al. 2013, Perron et al. 2013, Law et al. 2014):**
 - Barriers at sites frequently used for jumping, reducing deaths by jumping by up to 86%, with little evidence of major substitution to other potential jumping sites

- **Prevention of hanging by removing ligature points in secure environments:**
 - Deaths by hanging being considerably reduced on wards, probably partly due to improved safety measures, but a marked increase in suicides while patients are under the care of crisis teams possibly indicating that deaths still occur but later in the treatment pathway (Appleby et al. 2017, Kapur et al. 2013)

Targeting high risk groups

- **Psychiatric disorders: effective pharmacological treatment of depression:**
 - Antidepressant treatment reducing the risk of suicide and not associated with an increased risk of suicide on initiation (Sondergard et al. 2006, Sondergard et al. 2006, Sondergard et al. 2007, Cipriani et al. 2007);
 - Possible increase in thoughts but not actual suicidal behaviour in adolescents (Cipriani et al. 2007)
 - Evidence for prevention of suicidal behaviour being particularly strong in older adults (Zalsman et al. 2016)
 - Use of lithium, both in mood disorders and suicidality; in mood disorders lithium reducing risk of death by 60% when compared to placebo; suicide 2.7 times higher with sodium valproate (Gibbons et al. 2009, Cipriani et al. 2013)
 - Clozapine: one major trial indicating that clozapine might reduce suicidal behaviour in psychosis (Meltzer et al. 2003); recent study indicating that Olanzapine and Risperidone may also have an antisuicidal effect that is comparable to Clozapine (Asenjo Lobos et al. 2010)
- **Harmful Alcohol Use: legislation limiting availability of alcohol significantly reducing suicide rate in men in both Slovenia and Russia (Pridemore et al. 2009, Pridemore et al. 2013)**

Good evidence for reduction in suicidal ideation and behaviour

Note that there is no clear evidence that the following measures have reduced the number of completed suicides:

- **Population strategies**
 - Media guidelines: bidirectional effect established (Zalsman et al. 2016)
 - School-based programmes (Zalsman et al. 2016, Wasserman et al. 2015)
 - Internet and helpline support (Zalsman et al. 2016)

- **High-risk groups (Zalsman et al. 2016)**
 - Pharmacology and ECT in psychiatric disorders: ECT in severe depression with suicidal ideation rapidly reducing suicidal thoughts (Zalsman et al. 2016)
 - Follow up after discharge from psychiatric hospital (Gunnell et al. 2012)
 - Psychological interventions
 - Psychological therapy in depression
 - Psychological therapy in self-harm patients (Hawton et al. 2016)
- **Safety Plans**
 - Six months after ED discharge, fewer patients in the Safety Plan intervention group engaging in suicidal behaviour compared with the usual care group (3.0% vs. 5.3%, respectively), nearly halving the odds of a patient engaging in suicidal behaviour (Zonana et al, 2018).

Secondary care interventions with limited evidence of effectiveness in preventing suicide

- Follow up following a suicide attempt; clear evidence of a link between self-harm and subsequent suicide but no clear evidence that any intervention after self-harm reduces subsequent suicide (Zalsman et al. 2016, While et al. 2012)
- Collaborative care with primary care (Zalsman et al. 2016)
- Crisis teams: some evidence that trusts have lower suicide rates after introduction of crisis teams (While et al. 2012)
- Education and training
 - Primary care physicians (Zalsman et al. 2016, While et al. 2012)

Insufficient or no current evidence for prevention of suicide

- Screening for under-75s in primary care populations: insufficient evidence in general and some evidence to show no effect on suicidality or suicide (Oyama et al. 2008, Oyama et al. 2010)
- Risk assessment tools: no evidence of predicting or preventing suicide (Zalsman et al. 2016)
- General public education: no studies looking at this
- Gatekeeper training: no evidence that affects suicide rate
- Psychiatric admission: no evidence to show suicide reduction.

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Appendices

Appendix A: Online resources

RCPsych resources for patients and their families or carers:

Practical, compassionate advice and links to all main UK crisis support organisations):

Feeling on the edge helping you get through it -- for people in distress attending the emergency department following self-harm or with suicidal thoughts

<http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/feelingontheedge.aspx>

Feeling overwhelmed and staying safe — for anybody struggling to cope when bad things happen in their life; and includes advice on how to make a 'Safety Plan'

<http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/feelingoverwhelmed.aspx>

RCPsych Self-harm leaflet — This information is for anyone who wants to know more about self-harm, particularly anyone who is harming themselves, or feels that they might; we hope it will also be helpful for friends and families

<http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/self-harm.aspx>

U Can Cope – designed to help people develop resilience and cope with any current/future difficulties in their life; just as helpful for adults

<https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/young-people/u-can-cope!-how-to-cope-when-life-is-difficult-for-young-people>

Other resources:

#DearDistressed — inspirational letters from people with lived experience to themselves that would have helped them in their darkest moment to send a clear message that “suicidal thoughts are a sign to change something in your life, not to end your life, and that it IS possible to recover, with the right support.”

<https://www.connectingwithpeople.org/DearDistressed>

American Association of Suicidology — resources for professionals affected by suicide

http://mypage.iu.edu/~jmcintos/therapists_mainpg.htm

Child and Adolescent Mental Health Services — guidance for commissioners; JCPMH (2012)

<https://www.jcpmh.info/good-services/camhs/>

Comprehensive mental health action plan 2013–2020; WHO (2013)

https://www.who.int/mental_health/action_plan_2013/en/

Connecting with People — Mental health & wellbeing programmes; NHS & social care practitioner programmes; 4 Mental Health Ltd

<http://www.connectingwithpeople.org/>

Developing and delivering local bereavement support services; NSPA (2017)

<http://www.nspa.org.uk/wp-content/uploads/2017/01/NSPA-postvention-framework-20.10.16.pdf>

Editors' Code Book — Press code of practice regarding suicide reporting; Regulatory Funding Co (2019) https://www.editorscode.org.uk/the_code_book.php

Evaluating local bereavement support services; NSPA (2017) <http://www.nspa.org.uk/wp-content/uploads/2017/01/NSPA-postvention-evaluation-24.10.16.pdf>

- Finding the Words — How to support someone who has been bereaved and affected by suicide;
Judi Meadows Memorial Fund
<http://judimeadows.com/wp-content/uploads/Finding-the-words-online-version.pdf>
- Help is at Hand — provides people affected by suicide with both emotional and practical support;
Public Health England; NSPA 2015
<https://www.gov.uk/government/news/you-are-not-alone-help-is-at-hand-for-anyone-bereaved-by-suicide>
- Information sharing and suicide prevention consensus statement; DH (2014)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/271792/Consensus_statement_on_information_sharing.pdf
- International Association for Suicide Prevention (IASP)
<https://www.iasp.info/resources/>
- Local suicide prevention planning — a practice resource; Public Health England (2016)
http://www.nspa.org.uk/wp-content/uploads/2016/10/PHE_LA_guidance-NB241016.pdf
- Mental health service transitions for young people — Research Briefing; SCIE (2011)
<https://www.scie.org.uk/publications/briefings/briefing37/>
- Multicentre Study of Self-harm in England — Research programme; DH
<http://cebmbh.warne.ox.ac.uk/csr/mcm/index.html>
- National confidential inquiry into suicide and homicide (NCISH); HQIP (2015)
<https://www.hqip.org.uk/resource/national-confidential-inquiry-into-suicide-and-homicide-ncish-annual-report-2015/#.XdCZYW52tOR>
- National Suicide Prevention Alliance
<http://www.nspa.org.uk>
- National Suicide Prevention Strategy — Call to action; DH (2012)
<https://webarchive.nationalarchives.gov.uk/20120907091554/http://prp.dh.gov.uk/2012/05/22/policy-research-programme-call-for-applications/>
- Preventing Suicide in Community and Custodial Settings; NICE (2018)
<https://www.nice.org.uk/guidance/ng105>
- Preventing suicide in England — A cross-government outcomes strategy to save lives; DH (2012)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf
- Preventing suicide in England — Third progress report of the cross-government outcomes strategy to save lives
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/582117/Suicide_report_2016_A.pdf
- Preventing suicide in England — Third progress report; DH (2017)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/582117/Suicide_report_2016_A.pdf
- Preventing Suicide: A Global Imperative; WHO (2014)
https://www.who.int/mental_health/suicide-prevention/world_report_2014/en/
- Protect Life 2: a draft strategy for suicide prevention in Northern Ireland; DH (2017)
<https://www.health-ni.gov.uk/publications/protect-life-2-draft-strategy-suicide-prevention-north-ireland-consultation-analysis-report>
- Protect Life: A Shared Vision — The Northern Ireland Suicide Prevention Report on inquiry into suicide prevention strategy; NSPA (2017)
<https://www.nspa.org.uk/resources/health-select-committee-report-on-inquiry-into-suicide-prevention-strategy-2017/>
- Samaritans Media Guidelines
<https://www.samaritans.org/about-samaritans/media-guidelines/best-practice-suicide-reporting-tips/>
- Self-harm: longer-term management; NICE (2011)
<https://www.guidelinecentral.com/summaries/self-harm-longer-term-management/#section-society>
- Staying safe — from suicidal thoughts; 4 Mental Health Ltd
<https://staying-safe.net/>

- Strategy & Action Plan; DH (2012)
<https://www.nspa.org.uk/wp-content/uploads/2014/09/Northern-Ireland-Suicide-Prevention-Strategy.pdf>
- Suicide prevention — interim report; HSC (2016)
<https://publications.parliament.uk/pa/cm201617/cmselect/cmhealth/300/300.pdf>
- Support after a suicide — a guide to providing local services; PHE (2017)
<https://www.gov.uk/government/publications/support-after-a-suicide-a-guide-to-providing-local-services>
- The five year forward view for mental health — MH Taskforce Strategy; MHT (2016)
<https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>
- Transition from children's to adults' services for young people using health or social care services; NICE (2016)
<https://www.nice.org.uk/guidance/ng43>
- U Can Cope film (22 minutes long) — inspirational stories of three people for whom life had become unbearable but who found a way through with support
<http://www.connectingwithpeople.org/ucancope>
- Zero Suicide Toolkit; SPRC
<http://zerosuicide.sprc.org/toolkit>

Appendix B: Glossary of abbreviations

ACO	Accountable care organisation
ALSPAC	Avon Longitudinal Study of Parents and Children
AN	Anorexia nervosa
BMI	Body mass index
BMJ	British Medical Journal
BN	Bulimia nervosa
CAMHS	Child and adolescent mental health services
CCG	Clinical Commissioning Group
CMO	Chief Medical Officer
COPD	Chronic obstructive pulmonary disease
CRHT	Crisis resolution and home treatment
DH	Department of Health
ECT	Electroconvulsive therapy
ED	Emergency department; eating disorder
GP	General practitioner
HQIP	Healthcare Quality Improvement Partnership
HSC	House of Commons Health Select Committee
HSCB	Health and social care board
HWB	Health and wellbeing board
IAPT	Adult Improving Access to Psychological Therapies
IASP	International Association for Suicide Prevention
ICU	Intensive Care Unit
IHI	Institute of Health Improvement
JCPMH	Joint Commissioning Panel for Mental Health
LGBT	Lesbian, Gay, Bisexual, Transgender
LHB	Local health board
LTC	Long term condition
MDT	Multidisciplinary team
MH	Mental health
MIND	Mental health charity (not an acronym)
NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NSPA	National Suicide Prevention Alliance
NSSI	Non-suicidal self-injury
PHE	Public Health England
RCT	Randomised controlled trial
SCIE	Social Care Institute for Excellence
SMART	Specific Measurable Achievable Relevant Time-bound
SPRC	Suicide Prevention Resource Center
STP	Sustainability and Transformation Plan
WHO	World Health Organisation