Essex Partnership University
NHS Foundation Trust

CLINICAL GUIDELINES ON THE PREVENTION OF SUICIDE

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CLINICAL GUIDELINE SUMMARY
Evidence-based guidance on the effective detection and management of the risk of suicide. In addition to providing clinical guidance, this document describes the environmental management & monitoring necessary for suicide prevention i.e. ligature inspections, door top alarms.
The Trust monitors the implementation of and compliance with this clinical guideline in the following ways:
Suicide Prevention Group and Care Unit specific meetings Clinical Supervision Record Keeping Audits Datix Learning and Oversight Sub-Committee Care Unit Quality and Safety meetings

Services	Applicable	Comments
Trust-wide	✓	
Essex MH&LD		
CHS		

The Director responsible for monitoring and reviewing this Clinical Guideline is the Executive Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CLINICAL GUIDELINES ON THE PREVENTION OF SUICIDE

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SUICIDE PREVENTION CLINICAL GUIDELINES

1.0 INTRODUCTION

1.1 The purpose of these clinical guidelines is to provide EPUT staff with clear guidance, to enable the effective detection and management of the risk of suicide, with the aim of preventing suicide.

1.2 In England, there were 5219 suicides registered in 2021 (10.5 per 100,000 people). In 2020, 167 people lost their lives to suicide across Greater Essex. There are a number of factors known to increase/mitigate the risk of suicide, which are detailed in sections 4.0 and 7.3.

1.3 All work with people who have self-harmed and/or are suicidal should be undertaken collaboratively. This means developing trusting working relationships from the outset, which enable people to make choices and share decision-making around their care. This way of working is key to empowering individuals and helping them to feel in control of actions related to their care (Self-Harm and Suicide Prevention Competence Framework, NCCMH/HEE, 2018). It is important to remember that there are a number of factors that may affect meaningful and effective collaboration and co-production. These can include differences in: language; communication styles and approaches; cultural experiences and beliefs; learning and coping strategies, and; availability of support networks who understand an individuals' needs. There may be particular adaptions required for people with neurodiversity and learning disabilities, in order for decision and care planning to be meaningful and collaborative.

1.4 In the event of a clinician being concerned about the implementation of these guidelines with a person, advice should always be sought from a senior medical / clinical staff-member.

1.5 EPUT is part of the Zero Suicide Alliance, a collaborative of NHS trusts, businesses and individuals who are committed to suicide prevention. The alliance is concerned with improving support for people contemplating suicide by raising awareness and promoting free suicide prevention training.

1.6 EPUT also has STORM® Skills Training courses available to increase confidence and competence by enhancing the communication skills needed to: engage someone in distress, to work collaboratively, assess vulnerability, plan for safety and prevent suicide.

2.0 DEFINITION

2.1 Suicide is viewed as the intentional act of taking one's own life by someone who is aware of his/her own actions and the probable consequences.

2.2 Attempted suicide is viewed as a deliberate effort to end one's life that may have failed.

2.3 Deliberate self-harm is defined as people who have "carried out an act of self-poisoning or self-injury, irrespective of motivation" (NICE, 2013).

2.4 It is important for all staff to be aware that many people who use our services experience thoughts, feelings and consider plans of suicide.

3.0 SCOPE

3.1 These clinical guidelines provide guidance for staff within all EPUT services, who work with people who present a significant risk of suicide and also those who may hide or not express their suicidal thoughts/plans.

3.2 These guidelines will assist staff who are undertaking assessment and providing treatment for people with the aim of mitigating risk and preventing suicide where possible.

4.0 FACTORS AFFECTING RISK

4.1 There are many factors that may increase risk of suicide; this list is not exhaustive but highlights some of the key factors emphasised in the research. These factors are likely to be intersectional and can be mitigated by various protective factors such as supportive networks, effective coping strategies and interventions.

4.2 In England, 5219 suicides were registered in 2021 (10.5 per 100,000 people) and of these, men were almost three times as likely to die by suicide compared to women (Samaritans, based on data from ONS, 2023). The highest rates in the most recent published data were for men aged 50-54 (22.5 per 100,000). Of the women who died by suicide, those most at risk were aged 45-49 (7.6 per 100,000). There is regional variation in suicide rates. In 2020, 167 people lost their lives to suicide across greater Essex; 83% were male (Let's Talk About Suicide Essex, 2023).

4.3 In addition to gender and age, there are a number of individual and systemic factors that have been found to increase the risk of dying from suicide. The Samaritans report *Dying from Inequality* shows that people living in the most disadvantaged communities, with financial instability and poverty face one of the

highest risks of death through suicide. Lower income and unmanageable debt, unemployment, poor housing conditions and other socio-economic factors all contribute to this increased risk (Samaritans, 2017). There is insufficient data according to ethnicity, but we do know that experiences such as racism and discrimination, inconsistent accessibility of employment opportunities, how people express their experiences differently depending on their background, variability in mental health needs - and the response of services to those needs - may all be important factors to consider in assessing suicide risk (Samaritans, 2023 – Policy position on ethnicity and suicide). Sexual orientation and gender identity may also be factors that increase risk. Many studies have been conducted particularly with younger people, demonstrating rates of suicide attempts within LGBTQ+ youth (under 25 years old) to be 4-7 times those of their heterosexual and cisgender peers. These increased rates are likely to be related to much higher instances of discrimination, bullying, rejection, physical and verbal violence, threats and marginalisation related to their identity (NSPA, 2012**).**

4.4 Intimate Partner violence (IPV), defined as physical violence, sexual, emotional or psychological abuse, and controlling behaviours within an intimate relationship is a risk factor for suicide attempts. Women who experience IPV are nearly 4 times more likely to attempt suicide than women without such experiences. IPV is more likely to be experienced by men than women, however when experienced men the risk of self-harm and suicidal attempts is equal to that of women (McManus et al, 2022). Suicide attempts are a risk predictor of death by suicide.

4.5 A recent report into domestic abuse and suicide found that out of 3500 people who were supported by Refuge 24% of people had felt suicidal at some point. 18% had made plans to end their life and 3.1% had made at least one attempt (Aitkin and Munro, 2018)

4.6 There are well documented links between peoples' experience of mental health difficulties and an increased risk of self-harm and suicide. Research has demonstrated particular links between depression, bipolar disorder, Post Traumatic Stress Disorder, as well as longer term attachment and trauma based experiences that might be given labels such as Complex PTSD and Emotionally Unstable Personality Disorder. The relationships between mental health and suicide is individual and complex. Mental health needs may frequently lead to – and be caused by – social, physical and other emotional difficulties, which increase the intersectional risk of suicide. It may be that the ways people cope with their emotional distress also serve to exacerbate the risks. Factors such as feeling hopeless, helpless or worthless may increase someone's sense that their situation cannot change or they do not deserve to overcome their difficulties, or that loved ones might be better off without them. People with depression are particularly at risk of suicide if there is a lack of protective factors e.g. social support, religious / spiritual beliefs or being responsible for children (Especially young children)**.** If someone is in a heightened state of energy or emotional

dysregulation, they may act in impulsive ways that increase risk of carrying out a suicidal act.

The rate of suicide amongst people with Bi Polar affective disorder is approximately 10–30 times higher than the corresponding rate in the general population. Extant research found that up to 20% of (mostly untreated) people with Bipolar affective disorder end their life by suicide, and 20–60% of people attempt suicide at least one in their lifetime (Dome, Rihmer and Gonda, 2019).

If someone is struggling to cope with the effects of trauma, it may often feel overwhelming and impact on a person's quality of life. Sometimes it may seem that suicide is a preferable alternative to living with intrusive and debilitating PTSD symptoms. Studies have shown that people who have experienced a traumatic event and/or have Post Traumatic Stress Disorder (PTSD or C-PTSD) may be more likely to attempt suicide. Approximately 27% of people who have had a diagnosis of PTSD at some point in their lifetime, have attempted suicide (PTSD UK, 2023).

If people find relationships with others particularly difficult due to past experiences, it may lead to them feeling isolated and abandoned; they may also have struggles with managing emotions and distress because of past trauma. Patients with a diagnosis of personality disorder accounted for 11% of all patient suicides from 2010-2020. The majority were female, women diagnosed with a personality disorder are typically younger, more likely to live alone, be unemployed with a risk of homelessness, evidencing compounding risk. Most men and women given a diagnosis of a personality disorder had a history of self-harm and alcohol and/or drug misuse.

There is approximately a 10-fold increase in risk of suicide for people under mental health care for mental illness (NCISH Annual Report, 2023).

4.7 Neurodivergent can be used to describe someone who has a neurodiverse condition, for example, autism. This means their brain processes information differently. An autistic young person could identify as neurodivergent but so could, for example, someone who has a diagnosis of ADHD or Dyslexia. Neurotypical can be used to describe someone not displaying, or characterised by, autistic or other neurologically atypical patterns of thought or behaviour. Neurodiversity is the idea that the way we think is not always the same. Instead, this term recognises that all variations of human neurology should be respected as just another way of being, and that neurological differences like autism, ADHD and Dyslexia are the result of natural variations in our genes (autismeducationtrust.org.uk).

NICE clinical guidance on suicide prevention (2018) recognises people with autism are amongst those at increased risk of dying by suicide. Research

suggests that up to 11% of people who die by suicide in the UK may be on the Autistic spectrum, despite comprising 1% of the population (Autistica, 2019). Adults with autism who do not have a learning disability are 9 times more likely to die by suicide than people without autism. In children this rate is 28 times more likely (Mayes, 2013). It also appears that women with autism have a proportionally higher risk of suicide compared to women who do not have autism.

People with autism may experience more of the factors such as social isolation, unemployment, trauma, abuse and other circumstances that increase suicide risk, however even with these controlled for, they remain at higher risk of suicide (Autistica, 2019). This may be for a number of reasons. They may camouflage their autistic traits within social situations to fit in, which may negatively affect their mental health, as well as potentially leading to professionals underestimating their level of distress (National Autistic Society, 2021). People with autism might experience more difficulties identifying and explaining their emotions and may not recognise they are in crisis or have the emotional language to explain this to others. Individuals with autism may also find it harder to dismiss repetitive thoughts that relate to suicide if they occur. When someone with Autism is experiencing suicidal ideation, they may struggle to access appropriate support for their mental health or suicidal thoughts (Autistica, 2019).

Research has also shown a link between ADHD and an increased risk of suicidal ideation and death by suicide. This link spans across age groups, gender and culture. The presence of ADHD, as a comorbid condition, conveys an increased risk of suicide for people with other mental health experiences, highlighting that early recognition and treatment of ADHD - either as a comorbid condition or as the primary need - and the co-occurring mental health issues, can play an important role in the secondary prevention of suicide (Balazs & Kereszteny, 2017).

4.8 Research shows that drinking alcohol can increase risk of suicide. This is thought to be related to both the immediate effects of consuming alcohol and the longer term impacts of drinking. Often alcohol can be a way of coping with underlying distress and mental health needs. These underlying issues can sometimes be missed or minimised when someone is using alcohol (Samaritans, 2022). There is an established link between gambling and suicide; people who have gambling problems may on average experience four times higher levels of suicidal ideation and suicide attempts compared to the wider population (Wardle et al 2019). Some studies have even higher prevalence rates, with the suggestion the likelihood of having suicidal thoughts increases in proportion to the severity of gambling problems.

4.9 A long term or severe health condition may also be associated with an increased risk of dying by suicide. This Office of National Statistics (ONS) in 2022 published a new analysis on rates of suicide in patients diagnosed and treated for the following health conditions in England: chronic ischemic heart conditions, low survival cancer, and chronic obstructive pulmonary disease (COPD). Important considerations to note are as follows:

- A diagnosis or first treatment for these health conditions is associated with an elevated rate of death due to suicide when compared with study participants with similar socio-demographic characteristics.
- One year after diagnosis for low survival cancers, the suicide rate for patients (22.2 deaths per 100,000 people) was 2.4 times higher than the suicide rate for the matched individuals (9.1 deaths per 100,000 people).
- One year after diagnosis for COPD, the suicide rate for patients (23.6 deaths per 100,000 people) was 2.4 times higher than the suicide rate for the matched controls (9.7 deaths per 100,000 people).
- One year after diagnosis for chronic ischemic heart conditions, the suicide rate for patients (16.4 deaths per 100,000 people) was nearly two times higher than the suicide rate for the matched controls (8.5 deaths per 100,000 people).

4.10 Evidence suggests that around 50% of people who die by suicide have previously self-harmed. The risk of suicide is particularly heightening the first year after self-harm, especially the first month. It is important to note that the majority of self-harm occurs in the community and does not lead to hospital attendance – skewing the figures set out above. Rates of self-harm in the community have risen since 2000, especially in young people (NCISH, 2023),

4.11 The National confidential Inquiry into Suicide and Safety in Mental Health Annual report (2023) sighted that Suicide-related internet use was present in 8% of all patient suicides between 2010 and 2020. This included obtaining information on suicide method, visiting pro-suicide websites, and communicating suicidal intent online. These patients were most often aged 25-44 years (42%) or aged 45-64 (33%); 18% were aged under 25. Clinicians need to be aware that suicide-related internet use is a feature of suicide by mental health patients of all ages; that it takes several forms, including the promotion of suicide methods; and that enquiry about exposure to internet risks should be a routine part of risk assessment.

5.0 ATTITUDES AND VALUES

5.1 The way professionals conduct themselves during all interactions is key to developing a meaningful therapeutic relationship. The Self-Harm and Suicide Prevention Competence Framework states “this should be the same level of compassion and respect that would be received by, or given to, anyone else, regardless of whether or not they self-harm or have suicidal thoughts” (HEE, 2018).

5.2 The competence framework also outlines that all professionals working in EPUT should be able to:

- Demonstrate an empathic understanding and appreciation of the difficulties that a person is experiencing and recognise that these feelings of distress are very real to them.
- Locate the distress within the broader context of a person's life.
- Demonstrate to a person that their perspective and concerns are respected and being taken seriously.
- Help a person begin to feel in control of their care by establishing and maintaining a collaborative relationship with them, their family, carers or significant others, and involving them in decisions about their care.
- Display awareness of the impact of neurodiversity and learning disabilities, and how these might affect how people present and communicate their distress.

6.0 ASSESSMENT OF NEEDS

6.1 Anyone referred to or already under the care of EPUT services who is expressing suicidal thoughts will have a thorough biopsychosocial assessment. This will cover a broad range of factors, including: details of their suicidal thoughts, intent, plans, personal and systemic factors and a comprehensive mental state examination. It is also important that it assesses individual differences (including neurodiversity and learning needs), other specific risk factors and protective strategies, which are detailed in 4.0 and 7.3.

6.2 It is essential that the risk management plan or safety plan is developed in collaboration with the person and is written in a way that accurately reflects how they are feeling and what interventions have been agreed. It is crucial that risk management conversations and safety plans are discussed and documented in a way that is accessible, understandable and meaningful to individuals and anyone in their system who is supporting them (e.g. families, staff and other professionals). This needs to account for different communication styles and approaches, taking in to consideration people who have additional needs, including neurodiversity and learning disabilities. The compassionate assessment of a person at risk of suicide, with an effective intervention to mitigate their risk, is of significant importance in reducing the likelihood of a completed suicide (Connecting with People, 2017).

6.3 It is important to engage with the person's family/carers if the person is in agreement with this. However, family/carer concerns should be listened to even when there is not permission to share information. This will help to build a collaborative relationship among all those involved in supporting the person. Decisions about the involvement of family/carers should be discussed during the assessment and reviewed regularly in case of change in the persons wishes in line with the Consensus Statement on Information Sharing and Suicide Prevention. (Department of Health, 2014)

6.4 The outcome of the assessment should be shared widely and appropriately to ensure all involved professionals have up to date information relating to risk and the plan of care.

6.5 It is suggested to further prevent suicide in the face of sustained and growing pressures clinicians should focus on common factors associated with suicide including living alone, self-harm and comorbid alcohol and drug misuse (NCISH, 2023)

7.0 RISK ASSESSMENT

7.1 The National Confidential Inquiry into Suicide and Homicide Assessment of Clinical Risk in Mental Health Services (2018) highlights:

- Risk assessment tools should not be seen as a way of predicting future suicidal behaviour.
- Risk is not a number, and risk assessment is not a checklist. Tools, if they are used, need to be simple, accessible and should be considered part of a wider assessment process. Treatment decisions should not be determined by a score.
- In clinical risk assessment the emphasis should be on building relationships; and gathering good quality information on the current situation, past history and social factors, to inform a collaborative approach to managing risk.
- Risk assessment processes are an intrinsic part of mental health care but need to be consistent across mental health services.
- Families and carers should have as much involvement as possible in the assessment process, including the opportunity to express their views on potential risk. The management plan should be collaboratively developed. Communication with primary care may also be useful.
- The management of risk should be personal and individualised but it is one part of a whole system approach that should aim to strengthen the standards of care for everyone, ensuring that supervision, delegation and onward referral are all managed safely.

7.2 Some cases of severe and immediate risk of suicide will be obvious (for example: failed suicide attempt or planning of imminent suicide attempt), whilst for others it will be less clear cut; requiring careful exploratory assessment. Furthermore, whilst the heightened level of risk will be short-lived for some, others will be assessed as presenting a long-term heightened risk of suicide (where the person has made multiple suicide attempts, and would be considered as presenting an elevated risk for a prolonged period). When the risk is immediate and/or recent, a detailed assessment will be completed.

7.3 In formulating the risk assessment and deciding on the risk status of the person, the practitioner should consider individual and systemic factors associated with a heightened risk of self-harm / suicide. *These are described in section 4 of this policy*. Whether or not the person's suicide risk status is considered significant or high will depend upon a number of different factors, including:

- the nature of the suicidal thoughts
- *previous suicidal acts / self-harm*
- the person's perception of the future
- the degree of planning of the suicidal act, including accessing the internet to research methods
- the degree of preparation for the suicidal act
- the person's ability to resist their suicidal thoughts
- the person's level of planning and statement of intent – *which must never be ignored;*
- the persons exposure of internet risks e.g. suicide methods, pro-suicide websites etc.
- the presence and impact of protective factors – e.g. support networks, effective coping strategies, access to meaningful and pleasurable activities – and ability/motivation to engage with those, previous successful experiences of recovery.
- Neurodiversity (including ASD, ADHD, Tourette's)
- Learning disabilities
- Drug and/or alcohol misuse
- Mental health difficulties associated with feelings of hopelessness, helplessness, low self-worth, trauma, emotional instability, impulsiveness and difficulties feeling connected to and cared for by others
- Financial difficulties
- Previous trauma/abuse
- Relationship breakdown
- Social isolation
- Unemployment/Redundancy
- High risk occupations
- Gambling
- Long term health conditions, e.g. chronic pain and acute serious health conditions, especially recent diagnoses
- Social inequalities, discrimination and marginalisation

It is important to remember that although the intersectionality of risk factors may indicate an increased risk, it is not the case that a person with fewer risk factors will always present a lower risk of suicide. In addition some risk factors may convey greater risk depending on the specific circumstances. This is why an individualised and thorough risk assessment is required to understand and formulate a person's risk, including the factors that might mitigate or protect against risk.

7.4 Decisions about the person's assessed suicide risk and management plan should, wherever possible, involve the multi-disciplinary team. For those presenting as high risk out of hours, consideration should be given to discussion with the on-call Consultant re management plan and consideration of input from Home Treatment v. in-patient admission.

7.5 The suicide risk assessment should be clearly documented in the person's care record. A copy of this assessment should be passed to their GP and to any relevant services as soon as possible, to enable effective follow-up care.

7.6 The best risk assessment and risk management plan is one undertaken with the person and their family/carers. The views, observations and reports of others can be a valuable contribution to the understanding of both the risks and the protective factors. However this must be balanced with the right to the confidentiality and privacy of the person.

8.0 TREATMENT AND CARE

8.1 The fundamental principles when working with a suicidal person are:

a. To aim to develop a trusting, supporting and engaging relationship
b. Ensure that people are fully involved in decision making about their treatment and care
c. Maintain continuity of therapeutic relationships wherever possible
d. To ensure suicide prevention through collaborative working and the involvement of any wider community resources that are likely to be helpful for the individual
e. To promote the safety of the care environment, including reducing access to means of harm

When supporting people who present a significant risk of suicide, the practitioner should involve the person in all discussions and decision making about their treatment and care. A care plan will be completed with the person which takes account of their wishes and differences in communication style and approach. The care plan should make reference to individualised coping strategies that work best for that person. Consideration could be given to using a communication passport for people for people with learning disabilities, ASD and ADHD, as well as other adaptions (e.g. see ideas for reasonable adjustments in: How to support neuro-divergent children and young people at risk of suicide and self harm (nspa.org.uk); https://www.autistica.org.uk/downloads/files/Crisis-resource-2020.pdf)

8.2 In accordance with an assessment of risk, consideration should be given to the need for short-term intervention from the appropriate crisis service or admission to an acute mental health ward (NICE CG90, 2018) and particularly for the following:

a. those with depression who are at significant risk of suicide, self-harm or self-neglect
b. following an act of self-harm or those who present a significant risk of self-harm, and particularly if the person presents with significant emotional distress (NICE CG16, 2004 and CG133, 2011)
c. in situations where it has not yet been possible to complete a psychosocial assessment due to the person's presentation
d. those who are likely to return to a harmful / highly stressful environment, which may heighten the risk or precipitate a further suicide attempt

8.3 For those people who present a significant risk of suicide, a specific care plan or safety plan, must be developed covering the immediate and long term risks. The plan should be developed with the person, helping them to consider the difficulties they are experiencing and the resources available to help keep them safe and also therapeutic strategies which may be available and appropriate. This needs to take in to account different communication styles and approaches, with consideration for those people who have additional needs, including neurodiversity and learning disabilities.

The safety plan should include the following core elements:

a. undertaking frequent re-assessment / review of needs and risk status (the frequency of re-assessment / review must be specified within the care plan)
b. communicating the nature and degree of risk to all those involved in the person's care
c. ensuring that the person knows how to access help both within and out of hours, including the Samaritans and the Grassroots "Stay Alive" app
d. agreeing a timetable with carers / friends for providing care and support for person
e. providing information to carers on how best to help the person to engage with their plan of treatment and care and how to contact a team- member both within and out of hours
f. assisting the person to feel safe by providing practical and emotional support
g. mobilising supportive resources (for example: support network, community services, telephone helplines)
h. ensuring positive prescribing practices, such as the prescription of less toxic medicines; the prescription of medications which have a better side-effect profile; limiting the supply of medicines (e.g. no more than 7 days' supply); and, potentially involving a carer in supervising or the safe-keeping of medicines; See EPUT Safe and Secure Handling of Medicines Policy and Procedure for further guidance. Also involving carers in checking the home for excess quantities of medicines and removing medicines that could be

used in a further suicide attempt.

i. ensuring that letters to the person's GP and other involved services include specific and explicit advice on appropriate prescribing patterns, quantities and frequency of supply
j. focusing upon developing and using alternative coping strategies, which build upon the person's strengths and coping resources
k. exploring and reinforcing the advantages of positive actions – for example, viewing self-harm / suicidal thoughts as symptoms of mental illness, promoting hope, exploring and reinforcing reasons for living, generating alternative constructive solutions, exploring ambivalence, the use of distraction methods, structuring time and planning activities;
l. supporting the person in the use of structured problem-solving to address practical problem
m. increasing the frequency of contact with the Care Coordinator / other sources of support / help
n. if a patient refuses to engage or disengages from services, the team should refer to EPUT Guidance for Service Users who Disengage with Mental Health Services. Loss of contact is still common before suicide, and services should actively re-establish care in this situation, involving family members where possible. (NCISH, 2023)

8.4 If a person is assessed as lacking mental capacity, staff have a responsibility to act in that person's best interests. If necessary, this can include taking the person to hospital, and using 'reasonable force' that is necessary and proportionate to allow assessment and treatment in their best interests, against the person's stated wishes. Please note if the person is eligible for detention under the Mental Health Act, which would be the appropriate legal framework to use. It is paramount that the person's rights should not be infringed unnecessarily or excessively and consideration of an authorisation for deprivation of liberty is required.

8.5 Practitioners must be aware of the Consensus Statement on Information Sharing and Suicide Prevention. (Department of Health, 2014) which sets out best practice for the disclosure of information to family/carers.

9.0 CARE REVIEW

9.1 Timely and regular care reviews of the person's care plan must be undertaken by the individual practitioner and multi-disciplinary team, with the risk assessment being regularly updated. This should be completed in accordance with the EPUT policies and practice guidelines in relation to clinical risk assessment, risk management and care planning.

9.2 Where family/carers are involved, their views must be sought except in exceptional circumstances i.e. safeguarding concerns.

9.3 Carers/Families should be offered a Carers Assessment to support them in their ongoing role of support to the client as part of care planning and safety plans.

9.4 It is important to maintain an awareness of misleading improvement and alienation as a consequence of the person's removal from stressful circumstances or the presentation of challenging / difficult behaviours. It is also important to recognise the risks associated with increasing motivation that are often a feature of initial improvement – this may mean that the person is now motivated to carry through their plan for suicide / self-harm and therefore requires careful and detailed re-assessment.

This needs to take in to account different communication styles and approaches, considering those people who have additional needs, including neurodiversity and learning disabilities. For individuals with ASD and ADHD, clinicians need to be aware of people presenting in 'shut down', where they significantly reduce their communication, withdraw, freeze, or respond as expected so that clinicians will leave them alone. This differs from 'masking' and camouflaging (when individuals learn, practice, and perform certain behaviours and suppress others in order to be more like the people around them). These ways of coping are all relevant in considering risk (NPSA, 2019).

10.0 LEAVE/TRANSFER/DISCHARGE PLANNING

10.1 All discharge/transfer of care, including transfer between units, must be informed by an up to date risk assessment. This will include the completion of all relevant documentation including transfer forms. Clinical records must be updated to reflect any identified risks and the risk management plan. Where an individual is being discharged from EPUT and Care Programme Approach is applicable, a review must be undertaken.

10.2 A risk assessment must be carried out and contingency plan agreed with the individual and, where appropriate, family/carer prior to granting leave from an inpatient unit.

10.3 Many individual and systemic factors may modulate risk, particularly at times of transition such as admission, discharge or transfer from a ward admission. These may include factors listed in 4.0 and 7.3. It is important to remember that risk is not static and that the substantial changes in a persons' environment and circumstances - as part of transitions and discharge - may be particularly difficult for some people. For example, people with neurodiversity or learning disabilities may find ward admissions and discharges especially stressful and they may present with greater risk at these times.

10.4 Inpatient admission and recent discharge from hospital continue to be periods of high risk. During 2010-2020, over a quarter (28%) of patients died by suicide in acute care settings, including inpatients, post-discharge care and crisis resolution/ home treatment. The highest number of deaths after discharge from psychiatric in patient care occurred on day 3 post discharge. EPUT has a follow up process for all patients to mitigate this risk. EPUT services prioritise removal of low level ligatures and should ensure pre discharge leave and discharge planning address adverse circumstances the patient may be returning to (NCISH, 2023)

11.0 IMPLEMENTATION, MONITORING & REVIEW

11.1 All clinical directorates and care units are responsible for implementing this clinical guideline and the related procedural guidelines.

11.2 The operational procedures will ensure:

- Any environmental difficulties in effecting formal observation are identified and minimised;
- Medications and special equipment are securely stored;
- Minimum staffing levels and an acceptable skill mix is maintained;
- A staff presence is maintained even during the times of staff meetings and shift handovers.

11.3 In community services, the operational procedures will ensure:

- Bio-psycho-social approaches are applied to discussions of risk through holistic practice
- Risk factors and clinical concerns are communicated within the team
- Staff receive supervision and access training regarding suicide prevention as required

11.4 Suicides and serious suicide attempts must be reviewed by a multi- disciplinary review panel that includes the staff involved in the person's care, with the aims of maximising the safety and well-being of people, promoting learning and service development. Staff, people and carers must be provided with prompt and open information and offered access to effective support.

12.0 TRAINING & SUPERVISION

12.1 All staff will receive training in line with the Trust Induction and Mandatory Policy. Team managers who feel their staff need specific training in relation to clinical risk should contact the Workforce Development Education and Training department

12.2 The Assessment and Management of Clinical Risk training will include the following:

- Principle types of risks
- Indicators of risk
- The process of assessing and managing risk
- Conducting risk assessment through a collaborative approach, involving different sources of information
- Communication between professionals, patients, agencies, and with the carer(s)
- The use of approved risk assessment tools and documentation
- Positive risk taking
- Reference to a series of associated trust clinical policies and procedures.

12.3 All EPUT staff should complete the Zero Suicide Alliance training as a minimum.

12.4 All clinical staff (Mental Health inpatient) to undertake an eLearning ligature risk assessment training.

12.5 All clinical staff should undertake specific training on suicide that specifically covers the experiences of neurodiversity and learning disabilities and relationship to suicide risk. This is the Oliver McGowan training.

12.6 Staff who support people who present a significant risk of suicide are required to access regular supervision with their manager/allocated supervisor and any supplementary clinical / professional supervision.

12.7 Debriefing should be available following incidents of self-harm / injury / suicide in order to ensure that the individual staff-member and / or the whole team are supported, and that any lessons are learned to improve practice.

12.8 The Workforce Development and Training Department will report monthly on compliance levels for mandatory training.

12.9 Managers are responsible for ensuring staff who are approaching update deadlines and those that are out of date take action to undertake training as soon as possible.

13.0 ENVIRONMENT & ESTATES

13.1 A programme of ligature risk assessment inspections will be completed for all wards/units. Every ligature risk assessment inspection will require the attendance and participation of the ward manager (or nominated deputy – Band 6 or above), Risk Management (Band 6 or above) and Estates Team (Band 6 or above).

Further information and guidance can be found in the EPUT Ligature Risk Assessment and Management Procedure (CPG75).

13.2 Door top alarms are designed to raise an alarm within the ward when a door that the system is installed on is used as a ligature point. Please see Appendix 4 for details and testing instructions.

14.0 ASSOCIATED POLICIES & PROCEDURES

14.1 The following policies and procedural guidelines must be read in conjunction with this clinical guideline:

- CG24 – Discharge and Transfer Clinical Guidelines
- CG45 – Managing Leave for Informal Patients Guidelines
- CG71 – Self Harm Clinical Guidelines
- CG77 – Guidance for Service Users who Disengage with Mental Health Services
- CLP8 – Engagement and Supportive Observation Policy
- CLP28 – Clinical Risk Assessment and Safety Management Policy
- CLP30 – CPA Policy
- CLP75 – Search Policy
- CP3 – Adverse Incident Policy
- CP9 – Records Management Policy
- CP36 – Communicating Patient Safety Incidents – Being Open Policy
- CP75 – Ligature Risk Assessment and Management Policy
- HR21 – Induction, Mandatory and Essential Training Policy

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