Notice:

Plymouth Community Healthcare Community Interest Company adopted all Provider policies from NHS Plymouth when it became a new organisation on 1 October 2011.

Please note that policies will be reviewed to reflect the new organisation in line with the reader information sheet, or sooner where this is possible.

Plymouth Teaching Primary Care Trust and
Plymouth City Council

Suicide Prevention Strategy and Action Plan

Version No: 1:12

Notice to staff using a paper copy of this guidance

The policies and procedures page of Healthnet holds the most recent and approved version of this guidance. Staff must ensure they are using the most recent guidance.

Authors/Editor	Suicide Prevention Strategy Steering Group
Access ID Number	PPCTG748

The development of a new suicide and prevention strategy is being led by Plymouth Public Health Department in partnership with Plymouth Guild for the whole of Plymouth. An action plan will also come from this which will address priorities for the whole city. It is hoped that the new strategy will be in place by April 2014 and will supercede this document.

Signatories top the Strategy and Action Plan v1:11

The Signatories to this Strategy and Action Plan are:

- Plymouth Teaching Primary Care Trust
- Plymouth City Council

Certification –

By signing below, the Signatories accept and agree to be bound by the provisions contained in this Strategy and action plan.

on behalf of: Plymouth Teaching Primary Care Trust_____

Signed: _____

Position: _____

Date: _____

By signing below, the Signatories accept and agree to be bound by the provisions contained in this Strategy and action plan.

on behalf of: Plymouth City Council _____

Signed: _____

Position: Joint Director of Strategic Commissioning

_____

Date: 3 April 2008

_____

Reader Information

Type of Formal Paper	Strategy and Action Plan
Category	Corporate
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Document Version Control

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Version 1:1	Updated	13/10/2005	S. Edmunds	Adapted to corporate layout standards
1:2	Updated	31/01/2006	S. Edmunds	Adapted to corporate layout standards
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1:5				
1:6	Updated	06/02/2008	S Edmunds	Corporate compliance standards and sign off arrangements
1:8	Reviewed	26/10/2009	Director of MH Services	Reviewed and extended for 2 year period.
1.9	Reviewed	18/11/2011	Author	Reviewed and extended for 3 months.
1:10	Reviewed	03/02/2012	PRG	Reviewed and extended for 12 months.
1.11	Reviewed	27/3/13	PRG	Sentence added on p.2.
1.12	Extended	6/6/14	PRG	Extended no changes.

Contents

1.0 Executive Summary

This strategy outlines the ways in which Plymouth tPCT aims to work towards a reduction in suicides amongst the population of Plymouth in line with the target of reducing suicide* by 20% by 2010 set in **Saving Lives: Our Healthier Nation.** The strategy is informed by the National Suicide Prevention Strategy for England (DoH 1993).

As the suicide rate is associated with many factors including culture, poverty and adverse social circumstances, physical and mental ill health, life events and access to means, the prevention of suicide necessarily entails significant collaboration between all agencies at a local and national level.

Goal 1. To reduce risk in key high risk groups

Actions to be taken include:

- The use of the **Mental Health Toolkit for the Prevention of Suicide** as an audit tool to ensure best practice within Mental Health Services.

- The implementation of the National Institute for Clinical Excellence (NICE) guidelines on self-harm.

- Continuing to audit suicides, to determine the nature of any local high risk groups (e.g. people with enduring physical health problems or older people).

- Monitoring the impact of Early Intervention Projects (psychosis and personality disorder) on the lives of young men.

Goal 2. To promote mental well being in the wider population

Actions to be taken include:

- Ensuring that all services work to a socially inclusive agenda.

- Work with local agencies to continue to address the range of social issues that affects the lives of vulnerable people e.g. unemployment, finance and housing.

- The development of health promotion initiatives in relation to alcohol/drug misuse.

The term suicide is used to denote deaths from suicide and from undetermined cause.

Goal 3. To reduce the availability and lethality of suicide methods

Actions to be taken include:

- Continue to promote safer prescribing of antidepressants and analgesics.

- To continue to monitor deaths through suicide to identify suicide 'hot spots' (e.g. bridges and the other high places) and to take steps to improve their safety.

Goal 4. To improve the reporting of suicidal behaviour in the media

Actions to be taken include:

- Liaison with local journalists, television broadcasters and editors to encourage the continuation of responsible reporting of suicides and mental health issues based on national guidelines.

Goal 5. To promote research on suicide and suicide prevention

Actions to be taken include:

- To collaborate with researchers across the peninsula in undertaking research on suicide and self-harm.

- To disseminate current evidence on suicide prevention.

Goal 6. To improve monitoring of progress towards the Saving Lives: Our Healthier Nation targets for reducing suicide

Actions to be taken include:

- In collaboration with the National Institute for Mental Health (NIMHE), to regularly monitor suicides by age and gender, by people under mental health care, by different methods and by social class.

2.0 Introduction

2.1 The National Picture

Whilst the rate of suicide in England (8.9/100,000) is below that of many other countries within the European Union, suicide remains a major public health issue with approximately 4500 people taking their own lives every year. There is evidence of a decline in the numbers of people killing themselves in the 2 year period for which most recent data is available.

There has been an overall decline in the suicide rates for older men and women over the past 20 years but men are three times more likely than women to commit suicide and the rate has risen for young men with suicide now the leading cause of death amongst men aged 15 to 24 years.

Many factors have been identified as being associated with suicide and in addition to young men there are a number of other high risk groups:

- The highest rates of suicide occur amongst people in social class five. Poverty, unemployment and poor housing are all correlated with mental ill health.

- People in current contact with Mental Health Services account for approximately 25% of all suicides.

- People in prison.

- Certain occupational groups such as doctors, nurses, pharmacists, vets and farmers are at high risk, partly because of ease of access to the means of suicide.

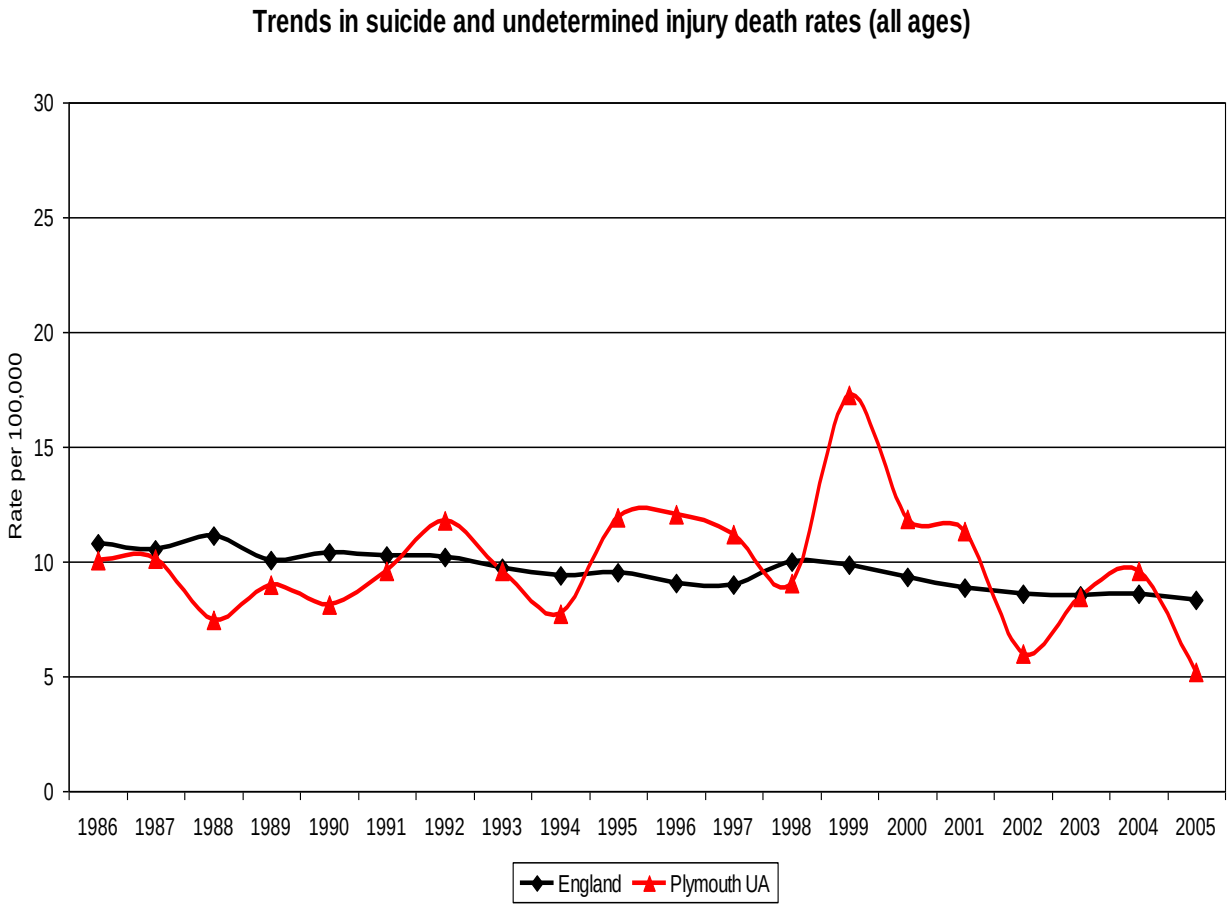
- People who have self harmed have an increased risk of subsequent suicide (approximately 5% over a 10 year period).

- People with histories of childhood sexual abuse or recent adverse life events (bereavement, separation and divorce).

- Isolation, living alone, and alcohol or drug misuse are known risk factors.

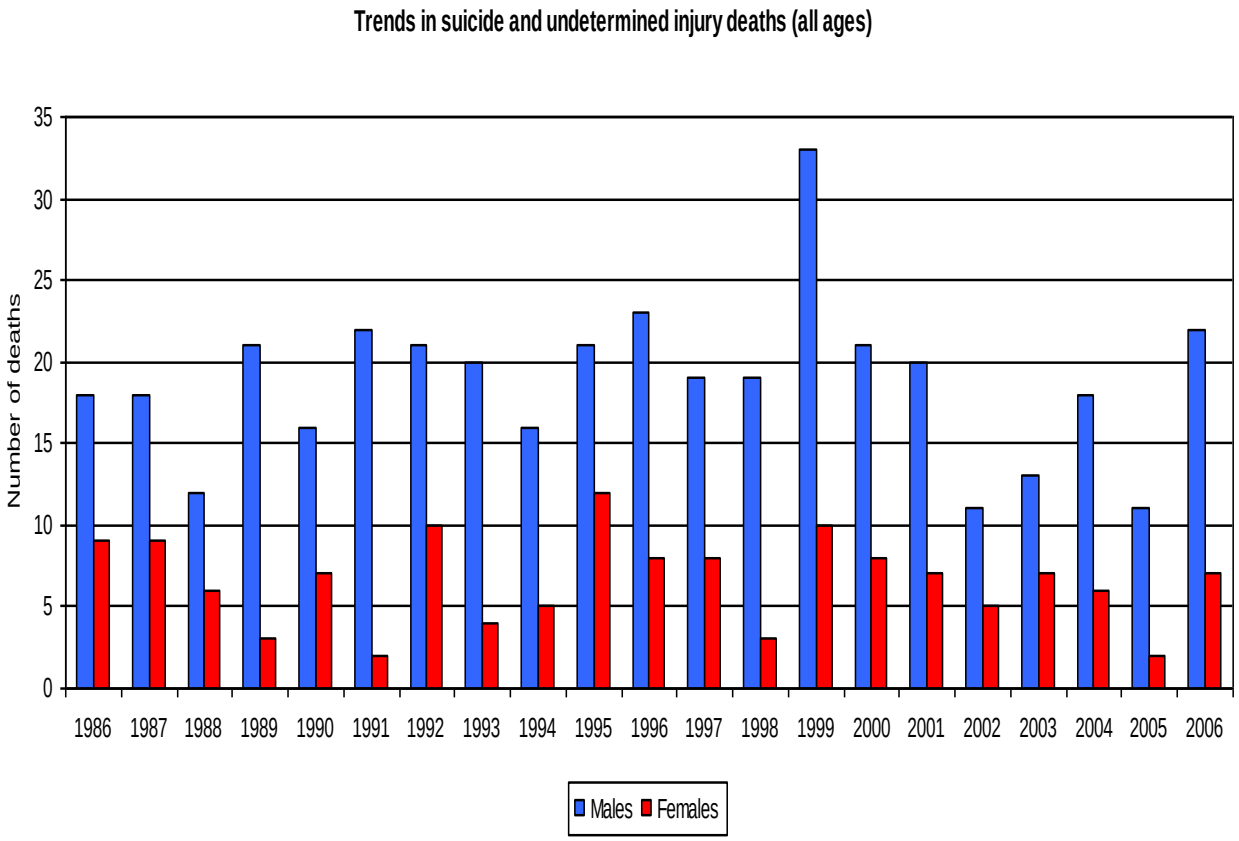
2.2 The Local Picture

The Southwest Peninsula has a rate of suicide higher than for England as a whole and Plymouth has a suicide rate of 11.3 /100,000, which is approximately equivalent to that of the Southwest Peninsula (Figure 1). Due to significantly different demographic characteristics the pathways to suicide will, however, vary.



Over the past 10 years there has been an annual average of 28 suicides per year in Plymouth (males 21. females 7). Though this has ranged from 21-43 per year (Figure 2). Considerable caution should be used in interpreting any changes year by year due to the small numbers. The increase in suicides in 1999 is largely due to an increase in male suicides.

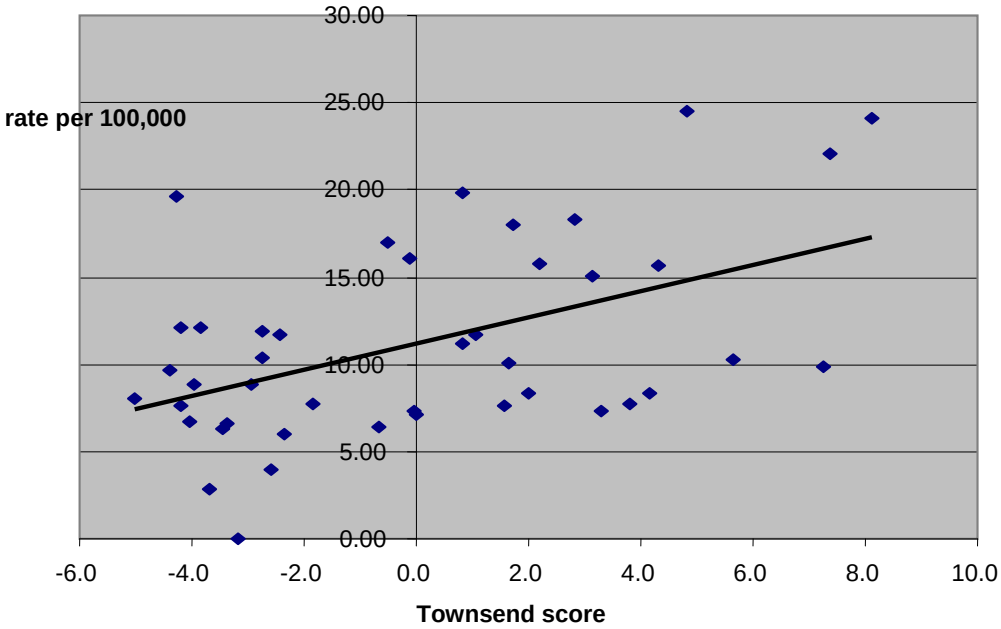
For the 20 year period for which comparable data is available (1986-2006) there is no clear time trend. The data to 1999 suggested an increasing trend particularly in men but this has not continued in the past 6 years.



The highest rates of suicide are found in the most deprived wards, the lowest rates in the least deprived. With regard to the distribution across localities, Waterfront has a suicide rate of 16.4 per 100,000, Riverside, 8.5 per 100,000 and Tamar 8.3 per 100,000.

Figure 3 shows a clear positive correlation between Townsend score and suicide and undetermined injury rates for the neighbourhoods in Plymouth. However there are some interesting outliers to this relationship.

Figure 3. Relationship between Townsend score and rate of suicide and undetermined injury



Whilst this information from national and local sources gives an indication as to areas where continuing preventative efforts should be targeted, further analysis of information about local suicides will contribute to a fuller picture.

The known characteristics of people who do commit suicide clearly indicate that there is no single approach to suicide prevention. The national suicide prevention strategy advocates a broad strategic approach that both targets high risk groups in addition to interventions that improve the well being of the general population and facilitate access to specialist services. This requires co-ordination and collaboration between all public services, the voluntary and private sectors, academic institutions and the concerned individual.

The aim of reducing the rate of suicide by 20% by the year 2010 (Saving Lives: Our Healthier Nation) appears ambitious to many people given that one of the main factors which correlate with rates of suicide are local and national sociodemographic characteristics: these are not readily amenable to short-term, local interventions. This has sometimes led to a focus upon interventions, which can be made by Mental Health Services although 75% of all suicides are not in contact with Mental Health Services at the time of death. Whilst Mental Health Services do have a significant role to play, our local strategy reflects the national strategy in its emphasis upon sustained suicide prevention initiatives being part of a broader approach to public health and welfare.

An expert advisory group through consultation with mental health professionals, researchers, survivors of suicide attempts, the voluntary sector and others formulated the recommendations of the national suicide

prevention strategy. In producing Plymouth's strategy, the local Suicide Prevention Strategy Steering Group has thus used these recommendations as a guide to local initiatives.

In following the National Suicide Prevention Strategy, this document outlines targets (and achievements) within our local area in the six main areas:

1. To reduce risk in key high risk groups.

2. To promote mental well being in the wider population.

3. To reduce the availability and lethality of suicide methods.

4. To improve reporting of suicidal behaviour in the media.

5. To promote research on suicide and suicide prevention.

6. To improve monitoring of progress towards the **Saving Lives: Our Healthier Nation** targets to reduce suicides.

The national strategy document outlines the relative potential benefits of each of these objectives in meeting the target of reducing suicide.

3.0 Goals and Objectives for Action

3.1 Goal 1: To reduce risk in key high risk groups

Objectives

1. Reduce the number of suicides by people who are currently or have recently been in contact with Mental Health Services.

2. Reduce the number of suicides in the year following a deliberate self-harm.

3. Reduce the number of suicides by young men.

4. Reduce the number of suicides by prisoners.

5. Reduce the number of suicides by high-risk occupational groups.

3.2 Goal 2. To promote mental well being at the wider population

A broad approach which aims to improve the health of local communities and neighbourhoods links the suicide prevention strategy with other public health initiatives (i.e. the Plymouth Neighbourhood Renewal Strategy). Standard one of the national service framework for mental health has suggested a similarly broad approach by stating that health and social services should:

- Promote mental health for all, working with individuals and communities.

- Combat discrimination against individuals and groups with mental health problems and promote their social inclusion.

Objectives

1. Promote the mental health of socially excluded and deprived groups.

2. Promote mental health among people from black and ethnic minority groups.

3. Promote the mental health of people who misuse drugs and/or alcohol.

4. Promote the mental health of victims and survivors of abuse, including child sexual abuse (and domestic violence).

5. Promote mental health among children and young people (ages under 18 years).
6. Promote mental health among women during and after pregnancy.

7. Promote mental health among older people.

8. Promote the mental health of those bereaved by suicide.

3.3 Goal 3. To reduce the availability and lethality of suicide methods

One of the most significant interventions to reduce suicide was the phasing out of coal gas as a domestic fuel in the 1950s. Whilst there is unlikely to be any single similar intervention (and method substitution does occur in some cases) the reduction in the availability of lethal methods is likely to contribute to a reduction in suicides particularly amongst those for whom the suicidal act may be impulsive.

Incorporating some of the national objectives into the local strategy has not been thought appropriate. For example, interventions such as the introduction of catalytic converters and the introduction of reduced packet size of paracetamol have required national initiatives. Similarly, a reduction in access to firearms as a means of contributing to a reduction in the suicide within the farming community may not be as relevant in Plymouth as in our neighbouring agricultural communities.

Further analysis of past cases of suicides and the methods used by people in Plymouth will help to inform future objectives within this area.

Objectives

1. Reduce the number of suicides as a result of hanging and strangulation.

2. Reduce the number of suicides as a result of self poisoning.

3. Undertake audit of past cases in order to determine frequency of methods used.

3.4 Goal 4. To improve reporting of suicidal behaviour in the media

There are some indications that the ways in which suicide and self-harm are portrayed within the media can influence the behaviour of some young people already at risk. Once again, the attainment of this goal will largely be due to national intervention but the portrayal of suicide within the load media will make an important contribution.

Objective

1. Continue to promote the responsible representation of suicidal behaviour in the local media.

3.5 Goal 5. To promote research on suicide and suicide prevention

Because suicide is a relatively rare event the majority of research is likely to continue to take place through national R&D initiatives. Currently, evidence suggests that there is no single intervention, which is known to reduce the rate of suicide or self-harm.

Objectives

1. Contribute to national R&D initiatives on suicide prevention.

2. Disseminate existing research evidence on suicide prevention.

3.6 Goal 6. To improve monitoring of progress towards the Saving Lives: Our Healthier Nation targets to reduce suicides

This goal will be largely achieved through the national collection of data.

Objectives

1. Review the data on suicide obtained from national databases on an annual basis.

2. Collate and review data obtained locally.

4.0 Proposed Implementation Plan

Responsibility for the implementation of the national strategy lies with the National Institute for Mental Health in England (NIMHE) and the Plymouth tPCT Suicide Strategy Steering Group will thus liaise closely with NIMHE (SW) with regard to local implementation.

The implementation of the suicide strategy also significantly overlaps with other key areas: the National Service Frameworks (for adults and older people), the NHS plan, the strategy for the development of health care in prisons and the social inclusion strategy.

This section of the strategy sets out for each goal, the actions that are already under way within the tPCT together with actions that are required.

Goal 1. To reduce risk in key high risk groups

1.1 Reduce the number of suicides by people who are currently or who have recently been in contact with mental health services (`recently' defined here as within one year).

Actions under way

- An audit of suicides by inpatients within the Mental Health Directorate and of recently discharged patients is currently under way.

- Assertive outreach, early intervention and home treatment teams have been introduced in order to improve mental health care for people with more severe mental health problems and to improve access to care at times of crisis.

- All significant ligature points have been removed from inpatient facilities within the Mental Health Directorate and this has been followed up with a recent audit.

- The introduction of the **Toolkit for the Prevention of Suicide in Mental Health Services** (see Appendix) has been agreed and leads have been identified to take these areas forward. The Toolkit offers guidelines with regard to the auditing of the **12 Points to a Safer Service** recommendations developed from the work of the National Confidential Enquiry.

- eCPA has now been introduced for all people in contact with specialist Mental Health Services. For those on the enhanced care programme approach. Care plans include the need for employment, housing and welfare benefits.

- Protocols have been developed and made available on the assessment and management of suicide risk. Risk assessment is an integral part of the care programme approach.

- A Severe Untoward Incident (SUI) policy has been agreed which details mechanisms for the review of suicides of people in contact with services. Implementation of the policy (in conjunction with the audit of suicides) will allow the tPCT to be an effective learning organisation.

Actions to be taken

- Continue audit of suicides of people known to mental health services within Plymouth and revise strategy accordingly.

- Ensure regular audit of the agreed standards relating to the prevention of suicides (Toolkit).

- Employment of supervision co-ordinator to ensure effective clinical supervision of staff in order to enhance reflective practice.

1.2 Reduce the number of suicides in the year following deliberate self-harm. Action under way

- Psychiatric liaison teams (for adults of working age and older adults) are in place to work with admissions to Derriford Hospital in cases of attempted suicide and self-harm.

- Leaflets and displays are in place in the A&E department of Derriford Hospital advertising support available from the self-harm project (MIND).

- A review of the most frequent attendees at the A&E department has been undertaken ensuring that these people are in contact with Mental Health Services.

- Multidisciplinary training is available for staff on working with patients who self harm.

Action to be taken

The National Institute for Clinical Excellence (NICE) has recently published guidelines on the management of deliberate self-harm. The Suicide Prevention Strategy Group will assist in the implementation and auditing of these guidelines.

- Admissions to the A&E department for self-harm will be regularly monitored.

- Links between mental health services and the A&E department will be strengthened
- To explore opportunities for improved service for people who self-harm in conjunction with NIMHE (SW).

1.3 Reduce the number of suicides by young men

Action to be taken

National guidelines suggest that some of the common risk factors for suicides amongst young men include deliberate self-harm, unemployment and substance misuse.

- Harbour offers a range of services for young men with substance misuse difficulties.

- The Insight Early Intervention Service is targeted at young people experiencing psychotic ill health and aims to reduce untreated psychosis.

- The DoH funded Personality Disorder pilot project specifically target one young people (18- 25). The latter project specifically targets young people at risk of suicide.

- Open access services are available to young people through the Youth Enquiry Service.

- Links established with the University counselling service for young men at risk. Action to be taken

- Review the outcome of research on CALM (Campaign Against Living Miserably), a crisis helpline for young men. Consider similar local project
- Review the evaluation of the local Personality Disorder pilot project and act on recommendations.

1.4 Reduce the number of suicides by prisoners Action under way

The rate of suicide in prison was 141 per 100,000 in 1999/00. The prison service is acting upon its own suicide prevention strategy.

Key elements include:

- Improved health screening on reception into custody to include risk of suicide/self harm

- The new suicide screening and staged risk management systems

- The introduction of prisoner listeners trained by the Samaritans

In addition, the PCT maintains its link with prisoners through the forensic service through inreach visits and post-discharge follow up (including access to accommodation, education and employment.

1.5 Reduce the number of suicides by high-risk occupational groups

Action underway

Actions initiated by the Department of Health and NIMHE have focused upon the provision of a range of information and support services for farmers and members of the rural community. This is the one occupational group with sufficient numbers of suicides to justify specifically targeted intervention.

There is no single occupational group within Plymouth City that is known to require targeting but occupation will be one variable considered in the audit of suicides currently being undertaken

Goal 2. To promote mental well-being in the wider population

2.1 Promote the mental health of socially excluded and deprived groups

Action underway

- The tPCT's mental health services are based upon the recovery model, working towards the social inclusion of vulnerable adults.

- Working to implement Plymouth's Neighbourhood Renewal Strategy focusing upon combating inequalities.

Action to be taken

- Explore further ways to combat stigma and discrimination across agencies.

2.2 Promote mental health among people from black and ethnic minority groups.

Action underway

- Asylum seekers and refugees team/community development workers are in place to assess the mental health needs of asylum seekers and refugees, to facilitate access to appropriate services and support treatment programmes. This service will extend to wider ethnic groups.

Action to be taken

- At a national level consideration is being given to the recording of ethnicity by coroners.

- To act on advice currently being a sought by the Local Implementation Team from the Racial Equality Council as to how to ensure its providers are racially sensitive in their service delivery.

2.3 Promote the mental health of people who misuse drugs and/or alcohol Action under way

- Local procedures are in place through Harbour to promote mental health in this client group.

Action to be taken

2.4 Promote the mental health of victims and survivors of abuse including childhood sexual abuse

Action under way

- Gender sensitive services are being developed in line with the Women's Mental Health Strategy: Into the Mainstream.

- As part of the implementation of the women's mental health strategy Plymouth has a network of providers who offer a group for women who have experienced childhood sexual abuse (Firebird group).

- There are specific voluntary groups within Plymouth who offer a telephone helpline and counselling to adult victims of childhood sexual abuse.

Action to be taken

- Explore opportunities for additional therapeutic training and support for staff working with survivors of childhood sexual abuse.

- Explore opportunities to develop services for male victims of childhood sexual abuse and establish training to highlight their needs.

2.5 Promote mental health among children and young people (aged under 18 years)

Action under way

- Open access services for young people at Youth Enquiry Service (YES)

- Formation of new multidisciplinary team addressing mental health needs of young care leavers.

Action to be taken

- Work with Public Health Department to ensure that children's education centres will develop more robust mental health promotion strategies in schools.

- Further developments of Sure Start initiatives in line with universal models of care for children and families.

2.6 Promote mental health among women during and after pregnancy.

Action under way

- Recent protocols for the assessment and treatment of perinatal depression have been introduced.

- All health visitors are now trained in undertaking listening visits for mothers identified as suffering from perinatal depression.

- Surestart projects offer a range of support to mothers. Action to be taken

- Monitoring of services and auditing of protocols.

2.7 Promote mental health among older people

The recently introduced National service framework for older people is being implemented. This seeks to promote good mental health for older people through ensuring access to integrated mental health services and the provision of effective treatments and through a range of support services for older people and their carers.

Action under way

- Introduction of Community Mental Health Teams for Older People ensuring a multidisciplinary, joint-agency approach to specialist assessment, treatment, therapy and support.

- Introduction of an Older Persons Psychiatric Liaison Team based within Local General Hospital.

- Clinical audit of all referrals to the Older Persons Psychiatrist Liaison Team. Audit to include analysis of co-existing physical illness and method/type of suicide attempt.

- Services in place to monitor depression in patients with early onset dementia.

- Development of Outreach Services for those patients with Huntington's disease at potential risk of suicide.

Action to be taken

- Audit of in-patient admissions and CMHT referrals for patterns/type.

- Education and support to General Hospital staff on recognition of depression within elderly patient group.

2.8 Promote the mental health of those bereaved by suicide

Action to be taken

- Review of support to families of patients' known to mental health services who commit suicide.

- Review of Mental Health protocol for supporting families bereaved through suicide.

- Prepare information leaflet for families bereaved through suicide

Goal 3. To reduce the availability and lethality of suicide methods.

3.1 Reduce the number of suicides as a result of hanging and strangulation

Action under way

- A risk assessment has been carried out on all inpatient wards and significant ligature points removed.

- The prison service strategy includes the requirement for appropriate environmental redesign to reduce ligature points.

Action to be taken

- Regular environmental audit of inpatient wards.

3.2 Reduce the number of suicides as a result of self poisoning.

Action under way

- Nationally, overdose death using the paracetamol and aspirin appears to have fallen following the introduction of reduced pack sizes.

Action to be taken

- The promotion of safer prescribing of antidepressants and analgesics.

3.3 Reduce the number of suicides as a result of motor exhaust gas

Action under way

- Nationally, the introduction of catalytic converters and motor vehicles for environmental reasons has led to a reduction in the number of suicides by this method.

3.4 Reduce the number of suicides as a result of jumping from high places

Action to be taken

- Act on recommendations of suicide at audit regarding any 'hotspots'.

Goal 4. To improve reporting of suicidal behaviour in the media

Action to be taken

- Liaise with local media to encourage continuing the responsible reporting of suicides (including avoidance of reference to means of suicide and avoidance of sensationalism).

- To continue to encourage responsible reporting with regard to mental health issues, avoiding stigma and discriminatory attitudes.

Goal 5. To promote research on suicide and suicide prevention

Action to be taken

- To collaborate with researchers across the Peninsula in undertaking research on suicide and self-harm.

- To disseminate current evidence on suicide prevention.

- To support local audit and evaluation relating to suicide prevention.

Goal 6. To improve monitoring the progress towards the Saving Lives, Our Healthier Nation targets to reduce suicides.

Action under way

- In collaboration with the National Institute for Mental Health (SW), to contribute to the design of common systems of audit across the Peninsula subsequent to recent scoping exercise.

- To regularly monitor suicides by age and gender, by people under mental health care, by different methods and social class.

5.0 Members of the suicide prevention strategy steering group

Consultant Clinical Psychologist/Psychotherapist
Clinical Facilitator
Director of Public Health
Public Health Information Specialist
Head of Clinical Psychology
Consultant Psychiatrist
Risk Manager
Performance Manager
Mental Health Commissioner
Operational Manager (Forensic Services)
Clinical Risk Advisor
Provider Service Manager (Learning Disability Services)
Deputy Director and Head of Adult Mental Health Services
Community Care Associate Director in Mental Health

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Appendix 1: - A Toolkit for Mental Health Services

Standard One: Appropriate Level of Care

1. Patients at risk are allocated to the enhanced level of CPA

2. CPA documentation forms part of case notes and is not maintained separately.

3. These standards are monitored through clinical governance.

4. Patients with schizophrenia with complex needs if convicted of an offence are normally treated in hospital rather than the prison service.

Standard Two: In-patient Suicide Prevention

1. Wards audited at least annually to identify and minimise opportunities for hanging or other means by which patients could harm themselves.

2. Likely ligature points on in-patient units have been removed or covered.

3. A protocol has been developed to allow potential ligatures to be removed from patients at high risk of suicide.

4. Environmental difficulties in observing patients are made explicit a remedial action is taken as far as possible.

5. Observation policy and practice reflects current evidence about suicide risk.

6. Patients under any form of increased observation are not allowed leave or time off the ward.

Standard Three: Post Discharge Prevention of Suicide

1. Before discharge in-patient and community teams carry out joint case review.

2. Discharge care plans specify arrangements for promoting compliance/ engagement with treatment.

3. Care plans take into account the heightened risk of suicide in the first three months after discharge and make specific reference to the first week.

4. An agreed member of the clinical team follows up patient who have been at high risk of suicide during the period of admission within 48 hours of discharge.

5. Assertive outreach teams have been established to prevent loss of contact with vulnerable and high-risk patients.

Standard Four: Family/ Carer Contact

1. Families/ carers, with patient consent, are given a clear mechanism for making contact with an informed member of the clinical team at all times.

2. Families/ carers are given appropriate information promptly following a suicide or homicide.

Standard Five: Appropriate Medication

Patients at risk of suicide receive the right medication in the right amounts.

Standard Six: Co-morbidity/ Dual Diagnosis

1. A strategy exists for the comprehensive care of people with co-morbidity/ dual diagnosis, i.e. people with mental health problems who also engage in alcohol and/ or substance misuse.

2. Staff who provide care to people at risk of suicide are given approved training in the clinical management of cases of co-morbidity/ dual diagnosis.

3. Statistics for co-morbidity/ suicide are collected and used to inform decision-making on resources.

Standard Seven: Post-incident Review

1. Suicides and serious suicide attempts are reviewed in a multi-disciplinary forum, including as far as possible all staff involved in the care of the patient.

2. All staff, patients and families/ carers affected by a suicide attempt are given prompt open information and the opportunity to receive appropriate and effective support as soon as they require it.

Standard Eight: Training of Staff

1. All care staff in contact with patients at risk of self-harm or suicide receive training in the recognition, assessment and management of risk at intervals of no more than 3 years.

2. The training is approved by the organisation.

3. The training is comprehensive the quality and effectiveness of the training is continuously evaluated.