Safeguarding Partnership Board - Adults

Learning Brief from a Serious Case Review

A Thematic Review into Suicide

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The Review

Jersey Safeguarding Partnership Board commissioned a thematic review of suicide to understand how effectively agencies work together where adults are at risk of suicide. The aim of the review was to identify areas that needed to be strengthened as well as good practice, and to use the learning to make improvements across the partnership.

The review explored the circumstances of five men who sadly died by suicide during 2018-2019. It examined multi-agency working with each of those men and drew together the themes relevant to all five. To protect the identity of the men and their families, pseudonyms have been used in the Learning Brief.

The Thematic Review concluded in February 2020 but the report could not be finalised until inquests had been completed. This learning brief summarises progress made on the recommendations in the interim.

Background of the Five Men

'Scott' had lifelong psychological trauma. He had multiple physical health needs and had lost his job and then his home. Scott had limited support networks and had become dependent on alcohol. He had made previous attempts at suicide and had a recent incident of deliberate, significant over-dose. Scott may have benefitted from long term psychological therapies, but this was not available to him. There were multiple agencies involved with Scott in the last two years of his life. However, agencies did not recognise the significant risk factors, there was poor communication between them and an absence of a coordinated, holistic response.

'David' had a history of work-related stress and anxiety. He received treatment for anxiety but would have benefitted from psychological therapies. His mental health distress spiralled in the last year of his life with David carrying out multiple high risk suicidal behaviours. Hospital admissions did little to help his recovery. David received a high level of support within the community but there was an over reliance on police providing welfare checks and a need to improve multi-agency risk assessment and safety planning.

'John' had alcohol dependency, poor physical health and was socially isolated. He lived in a flat and was due to be re-housed. John had periods of depression and a history of suicidality. He had previous hospital admissions, but his suicide risk appeared to be overshadowed by the focus on problematic alcohol use. Agencies had some knowledge of John's risks and vulnerabilities, but this was not brought together in a shared risk assessment and care plan. Housing was not aware of John's suicide risks. There was insufficient involvement from professions such as Social Work, Occupational Therapy and Psychology, to address John's psycho-social needs.

'Brian' had a long-term diagnosis of schizophrenia. Sadly, his illness was treatment resistive, and he had had multiple admissions to hospital. Brian's circumstances were worsened by problematic alcohol use. He lived alone, was unemployed and socially isolated. Though Brian had extensive support from mental health services and his parents, there was increasingly a reactive response to his crisis that relied on the police. There was a need for more proactive, holistic response to prevent crisis that coordinated support from agencies and involved Brian and his parents. Brian's mental health led him to self-neglect. His parents believed Brian became overwhelmed by the poor condition of his home and that this added to his risk of suicide. This was not effectively addressed through a multi-agency response.

‘Thomas’ had experienced multiple losses in his life and was struggling to come to terms with his bereavements. He had been known to mental health services for many years. Thomas had obsessive compulsive disorder with hoarding behaviours. He had also had past admissions to hospital due to depression and suicide behaviours. Thomas was on leave from hospital when he took his own life. The review highlighted the need to improve the shared care approach between GPs and mental health services and the access to psychological therapies. The review also reinforced the need to target interventions to reduce suicide risk, including developing safety plans for periods of leave and involving carers in this.

Learning Themes and Key Messages

The review highlighted recurring vulnerabilities and risk factors associated with risk of suicide:

Mental illness/distress	Problematic alcohol use	Physical illness	History self-harm, suicide attempts
Demographics - age & gender	Loneliness, loss, bereavement	Unemployment	Insecure accommodation - risk of homelessness

Key Messages to Front Line Practitioners

1. Develop awareness of vulnerability and stress factors that heighten risks of suicide and be alert to these. Remember risks may be constantly changing so assessments need to be dynamic.
2. Recognise the heightened risk of suicide where people are self-neglecting.
3. Don’t shy away from talking to people about their risk of suicide.
4. If someone has thoughts or feelings about suicide, it's important to take them seriously.
5. Listen to and involve carers, friends, and family where possible and appropriate.
6. Don’t work in isolation –multi-agency working broadens understanding of risk and enables a coordinated support plan to reduce risks of deliberate self-harm and suicide.
7. The co-existence of mental illness, alcohol/substances, increases the risk of suicide – don’t compartmentalise these needs. Seek to understand the underlying causes and address needs holistically.
8. Access training to help you make a difference in suicide prevention.

Key Messages for Management and Strategic Development

Years of underfunding in mental health services had left gaps in provision. There was insufficient psychological therapies and resources within the community for crisis prevention. Challenges are heightened in Jersey by workforce pressures, insufficient housing and paying for Primary Care.

Response to suicide prevention needs to be more than mental health service – it requires commitment across Government Departments, across communities and agencies. The review flagged the need to reinvigorate Jersey’s Suicide Prevention strategy, to re-look at priorities and develop strong leadership to progress the improvement plans.

What's Changed?

The review concluded in 2020 and made a series of recommendations to improve the strategic response to suicide prevention, as well as direct practice by individual practitioners and the multi-agency partnerships.

Since the report, Health and Community Services have responded to the recommendations through the following measures:

- Undertaken a service redesign which ensures timely access to those in crisis.
- Invested in and delivered evidence-based training for front line mental health practitioners.
- Provided suicide prevention training to the general hospital and other organisations.
- Undertaken a government wide suicide awareness training programme which over 1000 staff have completed.
- Conducted ongoing monitoring of groups at increased risk of self-injury and suicide.
- Introduced screening for suicidality in certain at-risk populations.
- Offered and provided support for families and friends following a sudden and unexpected death thought to be suicide.

Health and Community Services are working in partnership with the wider community to develop a new suicide prevention strategy.