Identifying and responding to suicide clusters and contagion
A practice resource
About Public Health England

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Foreword

Louis Appleby, chair of the National Suicide Prevention Advisory Group

A cluster of suicides is a rare event, but when it happens it can affect more than families and friendship groups. The impact can be widespread. Any suicide is shattering, but a suicide cluster can cause distress in whole communities. Anxiety may well be exacerbated by unhelpful media attention.

No single agency is likely to have the resources or experience to manage an evolving suicide cluster. This document is intended to support local authorities to put advance plans in place to analyse the situation quickly, and prepare a coherent, measured and co-ordinated response. It should be read alongside Public Health England’s guidance for developing a local suicide action plan.

This is a complex and under-researched area, but this guide should also help prevention groups recognise both a local problem, bounded by geography, and those clusters that are linked in other ways. With modern communications, a potential cluster may not simply be people who live near each other or go to the same school or college: other connections, for example, via social media, may be more important.

Preparation is key. Agencies may be faced with several pressing priorities: dealing with the devastating aftermath of a suicide, protecting vulnerable or impressionable individuals and trying to prevent a cluster from expanding. In the early stages of the response possible opportunities for prevention may be missed as community leaders search for answers.

So this is a practical toolkit, based on our understanding of suicide clusters, however incomplete. It provides a framework for action, together with some step-by-steps, that we hope local authorities will adapt to their own particular needs, resources, and strengths.
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Executive summary

This document is for people with responsibility for suicide prevention in local authorities and their partner agencies.

Suicide clusters understandably cause great concern and may lead to hasty responses. It is important that plans for such occurrences are prepared in advance, to ensure a measured and effective response. Authorities need to remain vigilant for the sorts of suicidal behaviour that might lead to contagion, and put strategies in place to forestall this.

This has been developed as a contribution to the National Suicide Prevention Strategy for England. It should be read alongside the guidance on developing local suicide action plans. (www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan)

The document includes: the meaning of the term ‘suicide clusters’, their identification, suggestions for who may be at risk of suicidal acts due to the influence of other people’s suicidal behaviour, the mechanisms involved, and the effects of suicide (including suicide clusters) on other individuals.

The steps that need to be taken at local level to prepare for a suicide cluster are described. This necessitates the development of a community action plan (CAP), including suicide surveillance group (SSG) to review local occurrence of suicides and self-harm, together with a suicide response team (SRT) to deliver the plan. If all this is already in place, you may wish to move on to page 22, ‘Identification of a possible suicide cluster.’

It is important to balance rapidity of response with careful thinking, which is why a series of checklists are included at the back of this report, to aid analysis. The need for close collaboration between children’s safeguarding agencies and the SRT is highlighted.

Identifying possible suicide clusters can be difficult. Early indicators are described, together with the need to carefully establish the facts and avoid premature and possibly unhelpful responses.

This document suggests responses to possible suicide clusters, especially preventing unhelpful media reporting, identification of individuals and groups who may be particularly vulnerable and practical interventions to reduce the risk of a spread of suicidal behaviour. It also covers help for those directly affected by suicide.
In a group vulnerable to imitation it is crucial to take prevention measures after an initial suicide. Particular attention is paid to addressing suicides and their potential spread in mental health services and schools.

In this age of instant information sharing it is possible for a cluster to be geographically dispersed. Local groups will need to alert other local authorities if this looks possible. The issue of when and how to wind down a response to a suicide cluster is also outlined, with emphasis on the fact that localities which have had clusters may be at heightened risk of further clusters.

Finally, best practice is provided on evaluation of responses to a cluster and using the experience to improve further suicide prevention measures.
Figure 1: Steps in intervening: an overview

1. Preparation
   Multi-Agency Suicide Prevention Group – with named Public Health Lead
   • Development of Community Action Plan
   • Surveillance
   • Agree pathway for reporting concerns
   • Agree key contact person
   • Training

2. Identification of possible cluster/contagion
   Surveillance Group
   • Response to multiple suicides
   • Response to suicides that cause particular concern

3. Responding
   Suicide Response Team
   • Linking with Child Death Overview Panel Rapid Response Team in case of deaths of under-18 year olds

4. Stepping Down the Response

5. Evaluation and Modification of Response
What is a suicide cluster?

The term ”suicide cluster” describes a situation in which more suicides than expected occur in terms of time, place, or both. A suicide cluster usually includes three or more deaths; however, two suicides occurring in a specific community or setting and time period should also be taken very seriously in terms of possible links (or contagion – see below), particularly in the case of young people. It is important to establish at a very early stage if there are connections between them.

Most attention has focused until recently on a greater than expected number of suicides in specific locations and time periods (”point clusters”), such as the cluster of suicides that occurred in the Bridgend area of Wales in 2007-08. However, with suicidal behaviour increasingly spreading via the internet and social media, a greater number of suicides than expected may well occur in a specific time period, and be spread out geographically (so called ‘mass clusters’). Local groups may need to alert other authorities to the possibility of contagion early on. It is worth emphasising the importance of taking prevention measures after even a single suicide in a group vulnerable to imitation.

The updated definition of a suicide cluster blurs the boundary between the two types of clusters (see box 1).

**Box 1. Updated definition of a suicide cluster** (adapted from Larkin and Beautrais)

A series of three or more closely grouped deaths…which are linked by space or social relationships. In the absence of transparent social connectedness, evidence of space and time linkages are required to define a cluster. In the presence of a strong demonstrated social connection, only temporal significance is required.

While the focus of this guide is mainly on suicides, it is essential to recognise that self-harm can also occur in clusters, as can mixed clusters of suicide and self-harm; indeed, linked episodes of self-harm may precede a suicide cluster. While we use the term ‘suicide cluster’ throughout most of this guide, much of what is covered could apply equally to self-harm.

It is difficult to ascertain how many suicides occur in clusters and the extent to which clusters contribute to overall suicide rates. An early study estimated that approximately
1% of suicides in young people occur in the context of point clusters.\textsuperscript{8} This figure is now likely to be considerably higher. Approximately 5% of all suicides in New Zealand appeared to occur in point clusters.\textsuperscript{1} Data from England and Wales suggests that possibly as many as 10% of suicide deaths in people who are in contact with mental health services in the year prior to their death may be related in time and setting.\textsuperscript{9}

Estimation of such figures is approximate. It is not known how many suicides occur in mass clusters because accurate identification of those affected may be impossible as they tend to be geographically remote and sometimes occur in different countries.

Identification of suicide clusters can be difficult in practice (go to ‘Identification of a possible cluster’). For the purposes of establishing a community response it is best based on local impressions, although this needs to be done with caution.

Areas which have suffered a suicide cluster are at increased risk of it happening again (so-called ‘echo clusters’).\textsuperscript{5} This may be related to particular characteristics of the area/population which increase vulnerability (for example, high levels of socio-economic deprivation).

The term ‘multiple suicides’ is often used to describe a situation where more than one suicide occurs in close temporal and geographical proximity, although this may not be viewed as amounting to a cluster. Establishing any connections between such deaths can be important and will help to minimise the chances of suicide contagion (see ‘Mechanisms involved in suicide clusters’, below).

Certain locations may be frequently used for suicide (for example, particular bridges, cliffs, remote areas). Separate PHE best practice on taking action to prevent suicide in public places will also be available shortly.

Individuals who may be involved in suicide clusters

Some population groups are particularly vulnerable to suicide clusters, including young people,\textsuperscript{10} people with mental health problems,\textsuperscript{11} and prisoners.\textsuperscript{4} Relatedly, clusters of suicidal behaviour are more common in certain settings, including schools,\textsuperscript{4} psychiatric facilities,\textsuperscript{11} prisons,\textsuperscript{4,12} and workplaces.\textsuperscript{13} People who share similar characteristics or identify psychologically with individuals who have taken their lives may be vulnerable to the contagious effects of suicide, which may contribute to the development of clusters.\textsuperscript{14}

Mechanisms involved in suicide clusters

Suicide clusters may result from ‘contagion’, whereby one or more than one person’s suicide influences another person to engage in suicidal behaviour (see box 2). The
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people involved are likely to already be vulnerable, perhaps because of existing mental illness and thoughts of suicide, or factors such as severe family discord. However, it is also possible that exposure to suicidal behaviour may make a person contemplate a suicidal act for the first time; it can also provide a model of the method to use.

Box 2. Suicide contagion is more likely to occur where:

- a suicide involves a person with similar characteristics (eg, gender, age, social circumstances) to other people who have died (so-called ‘horizontal transmission’). Such deaths may have occurred within an individual’s social network or in people they became aware of through media or other influences
- new methods of suicide are publicised
- there is a death of a celebrity by suicide (or other cause). This is known as ‘vertical transmission’

There are often several complex issues at play in individual suicides, it is important to note that not all suicides that occur in clusters are the result of contagion (for example, when shared environmental stressors, such as job loss, occur).

The role of media

Probably the most important influence prompting clusters to develop is the spread of news about suicides via the media. This includes traditional media such as print, newspapers and television, as well as electronic media, the internet and social networks. The way suicides are reported can be very important in determining whether contagion will occur. A US study of newspaper reports associated with suicide clusters in 13-20 year-olds showed that reports of suicides which were followed by clusters differed from isolated (single) suicides in terms of:

- news appearing more frequently
- being more often on the front page
- having headlines which included the word ‘suicide’ or a description of the method used for suicide
- providing more detailed descriptions of the individuals and their suicide acts

The wider impact of suicide and suicide clusters

Suicide is devastating for families, friends, workmates and others and any suicide usually affects a large number of people. These will not just be close family or friends (see figure 1).

People respond to shock and loss in very different ways and have varying levels of resilience. A “one size fits all” approach to support those bereaved or affected by suicide may be detrimental rather than helpful. Responses to single, multiple or cluster
suicides must be flexible enough to meet individual needs. Responders should be mindful that not everyone will want to directly engage with available support.

**Figure 2. The range of individuals who may be affected by suicide** (modified with permission)

After any suicide some form of intervention is required, especially supporting those who are bereaved. However, if an emerging suicide cluster is suspected, it is important that a community suicide response plan is not actioned prematurely. This can itself lead to harm (eg, through increasing publicity about suicides, panic in a community, etc). Nevertheless, there has to be some sort of response, even if the situation is unclear (eg, when concerns are raised about the possible effects of a single suicide in a school). The occurrence of suicide clusters may be particularly distressing because of the ongoing trauma and the media attention that is likely to occur. This was vividly illustrated by the dramatic, detailed and insensitive media reports associated with the deaths in the Bridgend area of Wales in 2007-08. Distress to the bereaved may be reawakened over time by the media revisiting the event.
Preparing for a suicide cluster

Methodology

It should be noted that while this document is based on the best available evidence, this is an emerging field and all of the recommendations are based on best practice, informed by expert opinion and those with practical experience in this area. Further detail on the methodology for developing this practice resource is on page 64.

Process

Each local authority area should have an established multi-agency suicide prevention group (MSPG), headed by the public health suicide prevention lead or their equivalent and overseen by the local health and wellbeing board. PHE has issued guidance on setting up such groups:


MSPGs are responsible for developing suicide prevention action plans, which should include a CAP for responding to possible suicide clusters.

There are already processes in place for reviewing and responding to any sudden death, including suspected suicides, of young people under the age of 18 years (local child death overview panel rapid response team) (RRT) and these should be tied in with the CAP. Suicide contagion is not confined by age boundaries. It is essential that the MSPG establishes links with local bodies responsible for safeguarding children (in England these are local safeguarding children boards) and the local child death overview panel, and is familiar with the guidance for working together to safeguard children: www.gov.uk/government/publications/working-together-to-safeguard-children.

A CAP supports those affected by suicide and to prevent further suicides by:

- providing and obtaining ongoing and accurate information
- managing media reporting
- identifying individuals, groups and areas at greater risk
- responding to immediate support needs and mitigating risk
- facilitating access to psychiatric/psychological treatment and other support for those who need it
- ensuring that further deaths by suicide are responded to appropriately
- ensuring that front-line responders delivering the CAP have access where necessary to psychological support and supervision
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- deciding when to step down the response and ensure relevant agencies are aware of how to direct future concerns

Developing a CAP

Responses to suicides and suicide clusters must be multi-agency. The following bodies and individuals may be required to contribute to a CAP, although not all of these parties will have responsibility for direct delivery:

- public health consultant responsible for suicide prevention (lead)
- adult and children’s safeguarding boards, including a representative from the child death overview panel
- NHS and local authority commissioners
- police
- coroner’s service
- healthcare (primary care, mental health services, acute general hospitals, substance misuse services)
- local expert in reviewing mortality data (including, if possible, suicide deaths)
- schools, colleges and universities
- media communications lead, who should be a consistent communications representative from either the local authority or police
- local non-statutory agencies (e.g., counselling agencies, bereavement charities, Samaritans and other suicide prevention charities)

When developing a CAP the MSPG will need to consider:

- consulting widely with stakeholders including those who may be involved in implementing the CAP
- establishing how and to whom community concerns about suicide contagion should be directed
- agreeing procedure and governance for information sharing and managing confidentiality
- identifying local agencies needed to implement the CAP
- identifying likely training and support needs for first responders and later response agencies (see box 3 for recommended training)
- agreeing the process by which the CAP should be activated, monitored and reviewed
- identifying an SSG. This group should meet regularly to review real-time data regarding local suicides and self-harm as part of overall local suicide prevention activity. The group should be small and include the public health suicide prevention lead, mental health trust suicide prevention lead, police suicide prevention lead and a local expert in reviewing mortality data. This should include reviewing data collected through the NHS England serious incident reporting system
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- one member of the group might take responsibility for a regular review of data. The group should ideally link with comparable groups in neighbouring counties to allow a regional overview. This will enable early identification of possible increased numbers of suicides and ensure that CAPs are activated quickly and appropriately. Initiatives to establish regular real-time monitoring of suspected suicides could help to facilitate the remit of the SSG.

**Box 3. Training that may be helpful for those who respond to suicides and suicide clusters**

- suicide awareness
- ability to identify warning signs of suicidal behaviour and those at risk
- suicide risk reduction strategies
- suicide contagion and clusters and eliciting risk (this should ideally be incorporated into professional and mandatory risk training of healthcare professionals)
- identifying and supporting those bereaved or affected by suicide
- the psychological impact of finding a suicide (eg, family/friend/public) and being a first responder (eg, police, paramedic)
- awareness of normal and abnormal responses to trauma and early signs of post-traumatic stress disorder
- signposting to and provision of psychological support
- safeguarding
- data protection

Implementing CAPs

CAPs should involve several different agencies which can form an SRT (box 4). Many of these agencies and individuals will already be represented on the MSPG and will therefore be involved in the design of the CAP. Effective co-ordination and monitoring of this team by the relevant public health consultant will be essential to ensure that the process is seamless and consistent with the agreed plan. The most effective CAPs will involve the statutory and voluntary sectors. Membership of teams is likely to vary depending on the circumstances of individual suicides and resources available within the local community. It is crucial to recognise that suicide clusters may not be confined to local authority areas. Therefore there usually needs to be close collaboration with other affected areas.
Key tasks of the SRT are to:

- work with the SSG to establish the facts surrounding suicides and determine the risk or evidence of contagion
- maintain close links with the child death overview panel and associated RRT for under-18s
- ensure support is offered to those directly bereaved or affected by suicide, including first responders and professionals involved in the deceased’s care or education
- identify vulnerable individuals and groups who may be at risk from contagion and ensure support, information and signposting is offered

Box 4. SRTs might include:

- mental health, acute care and community health NHS Trusts
- drug and alcohol services
- clinical commissioning groups
- primary care
- adult and childrens’ social care (including emergency duty team) and child protection
- police
- probation service and youth offending team
- coroners officers
- schools, colleges and universities
- safeguarding board representatives (children and adults) with close links to the child death overview panel
- representatives of workplaces
- bereavement services and charities including those specialised in supporting people bereaved by suicide
- Samaritans and other suicide prevention charities
- street pastors
- the clergy and faith groups
- carer support agencies
- counselling agencies
- the community safety partnership (made up of local authority, police, fire and rescue, probation and health representatives) may be required to participate in cluster response plans if there are concerns around means and location (eg, frequently used areas)
- a media communications lead who is identified as the single named point of contact for all media liaison will be an essential member of both the MSPG and the SRT to ensure a consistent approach across stakeholders
• ensure a stepped up level of vigilance for contagion, including any increase in self-harming behaviour (which may precede suicides)
• ensure over-responding (ie, duplicated efforts to support families and vulnerable groups) is avoided
• agree and co-ordinate media liaison through the identified media communications leads.
• provide support, information and signposting to any community groups concerned (ie, school, youth groups, faith groups, etc)
• promote suicide awareness and help-seeking within the community
• identify any environmental or operational changes that might be necessary at particular locations (eg, public places where suicides occur and where safety might be improved)
• report to the MSPG through the public health lead
• plan for longer-term follow-up at significant dates (eg, coroner inquests, publication of serious case reviews, birthdays, first Christmas) and the anniversary of deaths
• monitor the implementation of the CAP
• agree and plan strategies for stepping down the response

**Figure 3** overpage illustrates the interplay between the MSPG, the SSG, SRT and the child death overview panel process.

**Confidentiality**

Confidentiality must be considered when planning and implementing suicide cluster responses. Although it is important for multiple agencies to work together and share information, it is also crucial that confidentiality and data protection are considered at all stages. This should be overseen by the public health suicide prevention lead. Organisations will need to be guided by their own confidentiality and data sharing policies.
Figure 3. Interplay between the agencies involved in suicide response

Multi-Agency Suicide Prevention Group
*Headed by Public Health Suicide Prevention Lead*

Suicide Surveillance Group

INCIDENT

Suicide Response Team

Rapid Response Team

Child Death Overview Panel

For children under 18 years
Identification of a possible suicide cluster

Determination of whether or not a death is officially a suicide depends upon a coroner’s inquest. Unfortunately inquests usually occur a considerable time, often months, after deaths. Response to possible suicide clusters must occur rapidly in order to prevent further deaths, and therefore identification of possible suicides must take place at the earliest possible stage.

Initial awareness of possible suicide contagion usually comes through concerns raised within the community, by for example, police, schools, healthcare services, community-based services and the media. Agencies should be made aware that they may contact the public health lead for suicide prevention at any time with their concerns. In the case of under-18s, deaths by suicide will be picked up by the child death overview panel. Whatever the source, the facts around the concerns must be established as soon as possible. It is important that possible clustering of self-harm episodes is also considered. Concerns about possible clusters of self-harming behaviour might be raised by primary care, general hospital emergency department staff, schools, tertiary education, community and youth organisations.

When should communities be concerned about the possibility of suicide clusters?

Vigilance should be heightened after all suicides; however, a full CAP is not necessary after every suicide. It is very important to avoid premature declaration of a suicide cluster as this may lead to unnecessary panic and cause additional problems.

Activation of CAPs should always be considered in the event of:

- early identification of contagion/possible emerging suicide clusters through real-time data surveillance by public health teams and/or the SSG
- suspected suicide of children and young people (see schools/colleges)
- suspected suicide of mental health service users who are part of a mental health community such as an inpatient ward, therapy group or day hospital (see mental health services)
- reported suicide of celebrities or local prominent individuals
- increases in suicides in specific populations (eg, ethnic or religious groups, or known vulnerable groups, such as lesbian, gay, bisexual and transgender populations)
- non-suicide external events that may trigger risk of suicide within the affected community. Examples include the sudden death of celebrities, sudden traumatic death of school children, and high profile events involving vulnerable young people such as child sexual exploitation cases
Establishing the facts

Several potential sources of information may be used, including:

- police reports
- coroners’ reports and communication
- rapid response reports
- healthcare initial incident reports
- schools and colleges
- hospital emergency departments
- primary care services
- local self-harm data (where available)
- local community leaders

To make a judgement about whether there is a risk of a cluster occurring the SSG should review available data, and establish a timeline of events surrounding suicides where possible risk of contagion has been identified. Timelines can incorporate factors such as geography, police and healthcare data, coroner’s information and anniversaries of previous suicides.

Tools and methods

Plotting suicides and self-harm episodes and also connections (both geographical and social) between them on a map, is a valuable method for identifying possible links or contagion. There are proprietary geo-spatial mapping and link analysis software tools available, which are often used by police and other public agencies to graphically present data on a map and to illustrate the links that exist between people, places and events. These tools may already be available to one or more of the partners involved in the suicide surveillance and response groups and could help to facilitate this activity.

A fictitious scenario

Figure 4 below provides a fictitious example of such an exercise based on the following scenario:

The small town of Dorborough was rocked by a number of tragic deaths. In February, Lee, a popular teacher at Bluewald school, died by suicide in his home. In March, an 18 year-old woman, Keeley, was found dead by suicide in another part of town. Keeley died by an unusual method of suicide. She was very active on social media and had a YouTube channel showcasing her reviews of recent films. Because of Keeley’s age, her family’s media connections and her social media presence, Keeley’s death was widely reported in the media. This included some local reporting of her method of suicide.
In July, Mike, a troubled 21-year-old man, died by suicide using a similar method to Keeley. Mike was in a band that was well-known locally. He had been struggling with mental health problems. In October, Mike’s young cousin Scarlette also died by suicide. She was a pupil at Bluewald and knew Keeley through her older sister. She had been struggling to cope with her schoolwork and her cousin’s death. Shortly thereafter, Mike’s friend and bandmate, James, survived a serious self-harm episode involving a different method. James, now working, had been a pupil at Bluewald several years beforehand.

Figure 4. Hypothetical map showing geographical and social connections between suicides and self-harm episodes
Responding to a possible suicide cluster

Cluster response should include:

- media liaison
- provision of information to relevant agencies in the community
- provision of support for those directly affected
- identifying additional vulnerable individuals and targeting supportive interventions
- ongoing monitoring of suicidal behaviour by the SSG

Media liaison

It is essential that potentially damaging media reporting of suspected suicides is addressed as early as possible. The SRT should carefully consider its media communication strategy, including making statements to the media. This should be informed by best practice guidelines (www.samaritans.org/media-centre/media-guidelines-reporting-suicide). It is essential that there is a single point of media contact and this should be the media communications lead of the suicide prevention group and SRT. If necessary this individual can get in touch with the Independent Press Standards Organisation (IPSO) to issue a ‘desist notice’ to prevent the media from using images of those who have died. Box 5 provides some key points for media reporting. IPSO can be contacted by email at inquiries@ipso.co.uk, and has a 24-hour emergency advice line: 07659 152656.
### Box 5. Key points for media reporting (from Samaritans)

Media should:

- avoid re-running details of each death in every report, re-reporting previous stories and making links to other suicides
- not give undue prominence to a story, such as front cover splash and dramatic headlines and use of photographs and memorials of people who have died – specifically repeated use of image galleries should be avoided
- play a positive role by publishing articles and feature pieces which include messages of hope, such as a case study of a person who has lived through a difficult period in their life because they were able to reach out for help
- avoid speculation about the ‘trigger’ for a suicide – ensure that the devastation left behind for families and communities is sensitively represented
- be wary of over-emphasising community expressions of grief. Avoid dramatic headlines and terms such as ‘suicide epidemic’ and ‘hot spot’, and sensationalist pictures or video
- remember that people bereaved by suicide are often vulnerable and communities can also be impacted following a death, particularly if there has been more than one incident of suicide
- avoid the use of witness comments, such as ‘heaven has gained another angel’ and ‘jumped holding hands’. Refrain from including content from a suicide note
- bear in mind that coverage is sometimes generated by campaigning groups/bereaved families, with the aim of raising awareness of the issues (eg campaigning to get safety measures installed, such as nets on a bridge). However, this type of campaigning in the media can inadvertently highlight a suicide method/location
- include sources of support, such as Samaritans’ helpline, 08457 90 90 90 in all articles
- and supplementary factsheets, to avoid the risk of encouraging copycat behaviour
- Samaritans’ national press team is available to give advice on reporting suicide. Contact details are: Tel: +44 (0)20 8394 8300, out-of-hours: +44 (0)7943 809 162 and email: press@samaritans.org.
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Informing agencies in the community

Relevant community agencies should be given factual, non-sensationalised information about suicides, in order to keep people informed and stop inaccurate rumours developing.

If there are clear concerns that a suicide cluster may be underway, information should be shared across relevant professional groups, subject to appropriate confidentiality. It is important that families are consulted, and advised with sensitivity, so they understand what information is to be shared and why. There may be certain facts families do not want to be shared, and this should be respected as much as possible.

Support for those affected by suicide

People bereaved by suicide should be given information about available support at the earliest opportunity. Ideally this should be provided by the police who attend the scene of a possible suicide. Information should include contact details for local and national bereavement support agencies, Samaritans and other relevant local voluntary organisations. In Gloucestershire a process has been developed by the police, the NHS and Survivors of Bereavement by Suicide whereby an information leaflet is given by police to relatives when they attend a possible suicide which provides sign-posting to relevant support agencies. This model is being replicated in several places throughout England. Copies of the leaflet Help is at Hand: A Resource for those Bereaved by Suicide or other Sudden Traumatic Death (www.nmhdu.org.uk/silo/files/help-is-at-hand.pdf) should be given to all bereaved relatives as soon as possible. This document provides detailed advice on practical aspects of dealing with the aftermath of suicide as well as information on its emotional and psychological impact, along with sources of help and support.

Additional resources for people bereaved or affected by suicide are listed in box 6 below.
**Box 6. Supporting the bereaved**

Households with children should be given contact information for local child bereavement services or charities. These agencies have skilled staff who are experienced in supporting families and schools. They can also help parents to explain the nature of their loved one’s death to siblings and other children. In the absence of local services, the following operate nationally:

Child Bereavement UK [www.childbereavementuk.org](http://www.childbereavementuk.org)

Winston’s Wish [www.winstonswish.org.uk](http://www.winstonswish.org.uk)

Survivors of Bereavement by Suicide (SOBS) provide a telephone helpline, email support and peer support groups in some areas. [http://uk-sobs.org.uk](http://uk-sobs.org.uk)

PAPYRUS (Preventing Youth Suicide) provides support via its HOPELINE to people bereaved by suicide of young people [www.papyrus.uk.org](http://www.papyrus.uk.org)

Relatives should be made aware of the healthtalkonline module on experiencing suicide bereavement:
[www.healthtalkonline.org/Living_with_dying/Bereavement_due_to_suicide](http://www.healthtalkonline.org/Living_with_dying/Bereavement_due_to_suicide)

During the early stages of loss, bereaved relatives should be advised to see their GP regularly, so that they have the opportunity to talk about how they are coping and to give the GP an opportunity to assess them for traumatic grief reactions and depression.

A member of the SRT should be identified to offer support and be available for the bereaved while the community response plan is live. Wherever possible this should be someone from an agency with the appropriate experience, for example, a bereavement service or charity.

**Identifying additional vulnerable people**

The Circles of Vulnerability Model (figures 5 and 6 below) can help to identify people who are most at risk of suicide contagion. The model is based on the idea that every suicide is like a stone cast into a pool of water – ripples spread out across the pool all the way to the edge, but the effects are larger closer to the point of impact. Vulnerability can be thought of in terms of concentric circles (figure 5) and, more specifically, in terms of interlocking circles representing three axes: geographical proximity (the physical closeness or distance to the incident), social proximity (the social closeness or distance to the person who has died by suicide) and psychological proximity (how close or distant someone relates psychologically to the person who has
died by suicide) (figure 6). Box 7 provides more detailed information about these types of proximity.

**Figure 5. Concentric circles of vulnerability.** The central red circle (D) represents the person who has died by suicide. The darker the circle the greater the possible vulnerability to suicide contagion.

![Concentric circles of vulnerability](image)

**Box 7. Types of proximity**

| Geographic proximity | The physical distance between a person and the incident. For example, people discovering the body of someone who has died by suicide or exposed to the immediate aftermath may be more at risk. Extensive or sensationalised news or social media coverage may extend the geographic boundaries of people who may be vulnerable.  
Social proximity | The social closeness to the person who has died by suicide. |
Identifying and responding to suicide clusters and contagion

<table>
<thead>
<tr>
<th>Family members and close friends, including boyfriends and girlfriends, are likely to be particularly vulnerable. It is also important to consider individuals in communities such as schools, faith groups and wider friendship groups (including those in contact via social media).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychological proximity</strong></td>
</tr>
<tr>
<td><em>The psychological closeness a person feels to the individual who has died by suicide.</em> Some people may identify with the deceased more than others – for example, individuals of a similar age or sexual orientation, or those who have cultural or religious connections. People who were seen as role models may have a wider circle of individuals or groups who identify closely with them psychologically. There is often a larger risk of contagion in people who were not the closest friends of the deceased, but who knew them socially.</td>
</tr>
</tbody>
</table>

In practical terms, social and psychological factors can be combined into *psychosocial proximity*, referring to people who either are socially connected or identify closely with the person who died by suicide, as these groups often overlap.

**Figure 6. Varying vulnerability according to closeness to the deceased (D) in terms of geographical and psychological and social proximity**
A **vulnerability matrix approach** can be used to identify and prioritise at-risk individuals and groups and identify appropriate interventions and support (figure 7). These matrices can be populated by the SRT to help map and record interventions. This can help to avoid missing people or duplicating responses and also to identify gaps and ongoing need. The vulnerability matrix should be seen as a live document which can provide real-time information about the SRT activity at a glance.

It is important to identify and support community resilience and protective factors, such as informal social support networks; these can also be highlighted using vulnerability matrices.

Examples of completed vulnerability matrices can be seen below and box 8 provides a checklist to guide the SRT through the process. Blank vulnerability matrices for ready use can be found in **appendix 1**.

**Figure 7 (i-iii) Examples of vulnerability matrices**

**i) Geographic proximity**

<table>
<thead>
<tr>
<th>Circles of Vulnerability: Individuals or Groups</th>
<th>Description of risk</th>
<th>What has been done to help this person?</th>
<th>What remains to be done?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual(s) discovering the body</td>
<td>Psychological trauma, mental health, grief/loss, contagion</td>
<td>Information about: responses to trauma, Help is at Hand and bereavement services (where individuals were known to deceased) Signposting to suicide prevention charities GP advised</td>
<td>Follow up wellbeing checks. Consider fast tracking to psychological services</td>
</tr>
<tr>
<td>Professionals on the scene</td>
<td>Psychological trauma, mental health</td>
<td>Wellbeing checks Information about responses to trauma Signposting or referral to psychological services/in-house counselling</td>
<td>Follow up wellbeing check</td>
</tr>
<tr>
<td>Neighbours</td>
<td>Exposure, loss, mental health</td>
<td>Given brief bereavement leaflet at scene Signposting to community talks and clinics</td>
<td>Follow up wellbeing check</td>
</tr>
<tr>
<td>Members of household</td>
<td>Psychological trauma, grief/loss, mental health</td>
<td>Bereavement services including child bereavement Help is at Hand GP advised</td>
<td>Follow up. Consider fast track to psychological or mental health services where indicated</td>
</tr>
<tr>
<td>Local population (through media reporting)</td>
<td>Potential to broaden exposure in community, contagion</td>
<td>Liaison with media to encourage sensitive reporting Signposting to suicide prevention charities</td>
<td>Distribution of leaflets, posters beer mats etc.</td>
</tr>
</tbody>
</table>
### ii) Social proximity

<table>
<thead>
<tr>
<th>Circles of Vulnerability: Individuals or Groups</th>
<th>Description of risk</th>
<th>What has been done to help this person?</th>
<th>What remains to be done?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children within family or local friendship group</td>
<td>Grief/loss, psychological trauma, mental health</td>
<td>Child bereavement services for child and family support</td>
<td>Follow up. CAMHS if indicated</td>
</tr>
<tr>
<td>Close friends and family</td>
<td>Grief/loss, psychological trauma, mental health</td>
<td>Bereavement support Help is at Hand</td>
<td>Follow up. Referral to psychological services if indicated</td>
</tr>
<tr>
<td>Workmates or college peers</td>
<td>Grief/loss, contagion</td>
<td>Facilitated psychological support sessions Signposting to supportive literature and community talks/clinics</td>
<td>Follow up</td>
</tr>
<tr>
<td>Pupils at same school</td>
<td>Grief/loss, psychological trauma, mental health contagion</td>
<td>Schools guidance followed Samaritan Step by Step services CAMHS presence</td>
<td>Continuation</td>
</tr>
<tr>
<td>Club or group members</td>
<td>Loss, contagion</td>
<td>Community talks Signposting to clinics Awareness posters, leaflets, beer mats</td>
<td>Promotion of community awareness and help seeking</td>
</tr>
<tr>
<td>Social media connections</td>
<td>Contagion</td>
<td>Media liaison lead to post suicide prevention and bereavement charity information on memorial posts Police to monitor Facebook</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Individuals who were in recent contact (text messages, social visits that day)</td>
<td>Psychological trauma, loss</td>
<td>Wellbeing checks Signposting to counselling and community talks/clinics and bereavement services</td>
<td>Promotion of community awareness and help seeking</td>
</tr>
</tbody>
</table>
### iii) Psychological proximity

<table>
<thead>
<tr>
<th>Circles of Vulnerability: Individuals or Groups</th>
<th>Description of risk</th>
<th>What has been done to help this person?</th>
<th>What remains to be done?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse or partner, ex-partners, children</td>
<td>Psychological trauma, grief/loss, mental health, contagion</td>
<td>Bereavement support including Help is at Hand Signposting to bereavement services for adults and children</td>
<td>Follow up. Consider fast track to psychological or mental health services if indicated</td>
</tr>
<tr>
<td>Peer Group</td>
<td>Loss, grief, mental health, contagion</td>
<td>Distribution of supportive signposting literature with helpline numbers Signposting to community talks and drop in clinics Step by Step for schools Schools guidance followed</td>
<td>Letter to parents of affected children. Support and awareness posters and literature to be distributed</td>
</tr>
<tr>
<td>Professional staff who had contact</td>
<td>Psychological trauma, loss, stress, mental health</td>
<td>Workplace support Signposting to ongoing support and supportive literature</td>
<td>Support and awareness posters. Offer of follow up support</td>
</tr>
<tr>
<td>Social media connections</td>
<td>Contagion</td>
<td>Media liaison lead to post suicide prevention and bereavement charity information on memorial posts. Police to monitor Facebook</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

### Box 8. Checklist of key steps when responding to a possible suicide cluster

- convene meeting of the SRT
- generate a list of those most vulnerable to contagion due to geographical, social or psychological proximity to the person who died by suicide, starting with those closest and directly bereaved but also including those more distantly connected (see figures 5 and 6). Describe how each individual or group is at risk
- agree upon and describe interventions for each individual or group, as well as which person or agency is responsible for providing the intervention
- identify completed actions and ongoing needs and allocate tasks to SRT members
- ensure that the vulnerability matrix is communicated to all involved agencies and groups with attention to confidentiality
- update the vulnerability matrix at every subsequent meeting of the SRT
- ensure the SRT members are adequately supported and supervised
- SSG to continue to monitor and report suicidal behaviour beyond concerns about suicide clusters
Ongoing monitoring of suicidal behaviour by the suicide surveillance group

Local information on suicides and self-harm will of course need to be continuously monitored by the SSG. Another aspect of surveillance is possible monitoring of communications in electronic social media to identify messages indicating individuals or groups at risk. This responsibility is probably best placed with the police. This could help identify opportunities for interventions to prevent suicide.
Interventions

Interventions provided by the SRT will vary depending on the nature of the suicides concerned and related cultural, faith and circumstantial issues. Approaches will also be influenced by the agencies involved, in that certain suicide prevention charities may have particular styles of outreach work. For example ‘Feet on the Street’ is a proactive initiative developed by Samaritans in 2007, in response to suicides in Bridgend. Volunteers approach members of the public in busy town centres on a Friday or Saturday night to talk about emotional wellbeing and offer access to confidential and non-judgemental support.

To ensure needs of all identified vulnerable groups are met it might be useful to consider the following three tiers of intervention:

1. Whole population approaches
Whole population approaches should aim to raise community suicide awareness and help-seeking behaviour. This might involve initiatives such as ‘Feet on the Street’, distribution of posters, leaflets, cards and beer mats to pubs, clubs, sports/leisure centres, workplaces, GP surgeries, community centres, churches and faith meeting centres etc. It may be appropriate to consider positive use of the media through articles on depression with examples of people who have sought help and come through difficult periods in their lives. There is a strong role for civic leadership in a whole population approach, through various community groups and organisations (eg, talks at youth clubs, sports clubs), and interventions that are non-health specific may be particularly helpful in reaching and engaging vulnerable people.

2. Targeted approaches
Targeted interventions should focus on specific groups identified as being vulnerable – eg, those from particular residential areas, schools, workplaces, health centres, faith, minority or community groups. These interventions may include talks, drop-in clinics, provision of counsellors and more specific literature on the emotional and psychological impact of suicide and depression.

3. Individual approaches
Individuals who are recognised as being at risk of contagion should be approached and offered time to talk about their thoughts and feelings. Where necessary they should be referred for more formal psychological or clinical support. Psycho-education regarding grief and trauma responses might be provided in both verbal and written form. It may be helpful to establish rapid referral pathways to mental health services, including community psychological treatment agencies (such as Increasing Access to Psychological Therapies (IAPT)). Those bereaved should be supported as discussed above (Support for those bereaved by suicide) and availability of support for those
bereaved or affected by suicide should be communicated sensitively across the community.

**Examples of interventions**
Box 9 provides an example of tiered interventions delivered in response to a suicide cluster in Nottingham and box 10 outlines an approach called “Kitchen Table Talks” that has been used in the Netherlands.

**Box 9. The Nottingham Experience of delivering tiered interventions**
Harmless is a Nottingham-based organisation that provides support, information, training and consultancy around the issue of self harm and suicide prevention [www.harmless.org.uk/](http://www.harmless.org.uk/). In 2013 Harmless developed the Tomorrow Project [www.tomorrowproject.org.uk/](http://www.tomorrowproject.org.uk/) in response to a local suicide cluster. Named by its local community, the Tomorrow Project includes a three-tier model:

1. Relevant and accessible information resources, designed to be wide reaching across all strands of the community. These include posters, beer mats, and leaflets. The beer mats have been the most popular resource.

2. A range of community meetings to inform different groups about the risk of suicide, the signs, how to respond and where to go for help, facilitated in conjunction with community leaders to ensure uptake. This includes contributing to personal, social and health education (PHSE) within the local school, where appropriate, and offering information sessions with GPs, healthcare providers, teachers, community members, families and faith groups.

3. Professional direct access clinical support (delivered by therapists), commencing as soon as possible after local suicides and based on cognitive behavioural therapy guidance and risk assessment principles.

Community feedback following the 2013 suicide cluster response indicated that the Tomorrow Project significantly raised local awareness of suicide and helped to tackle stigma. The clinical support component was delivered to a varied client group with respect to age and gender who predominantly accessed the service through self referral. Self-report evaluation indicated that clinical support reduced suicidal planning and suicidal thinking and that satisfaction with the intervention was high.

Harmless has collaborated with local health, social care and non statutory agencies in delivering the Tomorrow Project and carrying out local self-report evaluation, including reviewing relevant provision from all sectors across the community, with a view to improving local suicide prevention and response to suicide clusters.
Box 10. Kitchen Table Talks – an approach to reaching and supporting peers after a young person’s suicide

A project in Westfriesland, an area in the North West Netherlands, offered “Kitchen Table Talks” with young people after they had experienced the suicide of a friend. The aim of these talks was to validate distress and strengthen solidarity, empathy and empowerment within the friendship group. The sessions were facilitated by mental health nurses, but were not therapy, and they were held at a location the friends chose for themselves.

The KitchenTable Talks helped the young people share their experiences. Three key questions facilitated this:
• how did you hear about it? What did you do when you heard that your friend had died?
• how are you getting on now? (can you sleep, eat, go to school?)
• what are your future plans?

Young people reported that after the talks they felt a sense of relief that they had been able to talk and not feel judged. The friends said they felt closer to each other and more confident that they were all there for each other.

Knowledge of the value of the Kitchen Table Talks has spread and now schools and sports centres have requested them following suicides of their members. This work has not yet been formally evaluated but are an example of how emotional resilience among friendship groups can be boosted. See: www.loketgezondleven.nl/i-database/interventies/l/1401491/

Use of social media

One way to reach vulnerable people is via social media. This can include communities such as Facebook, Twitter, LinkedIn, YouTube, Tumblr and blogs. When online posts that cause concern are identified (eg reference to suicidal ideation, excessive online discussion or glamorisation of a recent suicide, establishment of tribute sites), an SRT member could be assigned to post resources or positive comments to the discussion. These resources should be available nationally, as social media connections may extend far beyond immediate geographic boundaries. A sample response to posts that cause concern might read as per box 11.
Box 11. Sample response to social media posts that cause concern
If you or someone you know is feeling desperate help is always available. The best way to honour [person’s name] is to seek help if you or someone you know is struggling. If you’re feeling lost, desperate or alone, please get in touch.

Samaritans 08457 90 90 90
Papyrus www.papyrus-uk.org Hopeline tel: 0800 068 41 41 text 07786 209 697
email pat@papyrus-uk.org
Childline 08001111
Young Minds www.youngminds.org.uk Parents helpline: 0808 802 5544
CALM www.thecalmzone.net 0800 58 58 58
Harmless www.harmless.org.uk
Mental health services

All mental health services should have a policy for the prevention and management of suicide and self-harm which aligns with local public health strategy and the MSPG and includes the necessity of being vigilant for suicide clusters and suicide contagion, both within the mental health service user population and beyond. An experienced clinician should be identified as mental health self-harm and suicide prevention lead. Their role is to oversee the organisation’s response to suicides, keeping close links with all services within the organisation and relevant external agencies. This role would involve:

- participating in the local MSPG and the SSG
- advising senior management and executive teams on service issues relevant to suicide risk management
- ensuring appropriate staff training is available and up to date and contributing to delivery and governance of training
- providing advice and support to staff following a suicide
- linking with the internal communications team, the Suicide Prevention Group/CAP media communications lead and the SSG, where there is media interest following a suicide
- monitoring internal and local trends in suicide and self-harm through the SSG to ensure early identification of possible suicide clusters (e.g. within community mental health teams, day hospitals, therapy groups or inpatient services)
- supporting local information sharing with police and other public agencies regarding patients in the community thought to be at acute risk of suicide, in line with relevant local and national guidance.

Response following the suicide of a patient

All mental health organisations should have a written policy regarding action in the event of a suicide (or sudden unexplained death) of a patient under their care, which includes being vigilant about contagion.

Information giving

All involved staff should be informed of any suicide. Ideally this should be done via face-to-face contact. Provision for staff who are working shift patterns may be required.

In instances where the family of the deceased are not already aware of the death a senior member of the clinical team should contact them as soon as possible.

If a death occurs in the context of an inpatient ward, day hospital or therapy group, a community meeting should be attended by both staff and patients. Details of the method of suicide should be kept to a minimum and staff should discuss what information they need to convey in advance.
Identification of those at risk

Clinical teams should consider those at risk of suicide or self-harm, taking account of the circles of vulnerability (see above). These will include:

- geographical proximity – those who were closely involved in the suicide(s) (eg those who witnessed the event)
- psychological proximity – patients who are identified with the deceased (eg in the same therapy group, on the same ward, sharing similar problems)
- social proximity – close friends and family of the deceased. Patients who were close to the deceased, those who present with existing suicide risk and others who may be particularly vulnerable will need increased monitoring and support after patient suicides. Heightened risk management plans should be fully documented and implemented

Support for staff

- all staff should be provided with general support. Some may require additional clinical support, particularly if they are dealing with other suicidal patients. Ongoing support should be provided by someone outside their clinical team or through occupational health where possible
- all staff involved in the care of the patient should be invited to take part in an initial support session as soon as is practicable, followed by a more structured psychological support session one to two weeks later. The purpose of such sessions is for staff to talk about how they feel and share any initial responses they might have
- all clinical staff should be invited to attend periodic serious incident review meetings at which recent suicides and near misses are discussed. Ideally these meetings should involve professionals from various teams and specialties from within and, where appropriate, outside the organisation to facilitate greater breadth of learning. A supportive collegial environment will help to identify and share learning and spot any underlying systems failures. Outcomes and recommendations for improvement can be fed back to senior management. Services introducing such meetings have been found to have reduced levels of patient suicides

Support for family members and others

- a senior member of the clinical team should contact the patient’s family to offer them support and the chance to meet and ask any questions they might have. The family should have a single point of contact within the service to whom they can turn for support or information. Support might be offered to other individuals who were close to the patient (eg, partners, close friends, room-mates)
- this is also an opportunity to provide families with information about independent organisations that support those bereaved by suicide and to identify any
immediate psychological support needs (see box 6, page 24, on bereavement support)

- further meetings should be offered as necessary and family members and others affected by the death should be advised to see their GPs regularly for monitoring of their health and wellbeing.
Schools/colleges

Following the sudden death of a young person under the age of 18 years there is a nationally agreed process in England. It is overseen by a county-wide local safeguarding board and its child death overview panel. The immediate response is coordinated by a RRT, whose role is to gather information, support the family, identify those at risk and aim to prevent future child deaths.

After every sudden death the designated professional identified as the single point of contact with responsibility for coordinating the RRT is contacted immediately. This person ensures rapid communication to all agencies and professionals involved with the child. The head teacher of the child’s school needs to be informed as soon as possible. A meeting of the RRT should be convened within 72 hours.

In the case of multiple suicides, a strategy meeting should be set up urgently, involving the RRT and the heads of all relevant agencies – social care, education, the police and mental health services – to share information and plan appropriate preventive action.

Schools should have a pre-prepared written policy regarding action in the event of a suicide – or probable suicide – of a student. The policy should record which staff are in the coordinating group for that school, and their emergency contact details. When information regarding a suicide is passed to the school this group should be alerted. It would then coordinate an immediate response, in conjunction with the RRT.

Links with other agencies

The school should maintain a close link with the RRT, which will coordinate communication with the family and the response across agencies. Establishing rapid links with relevant services such as primary care, Child and Adolescent Mental Health Services (CAMHS), educational psychologists, social care, Samaritans and local bereavement services will be essential. Samaritans have developed a Step by Step Programme (www.samaritans.org/your-community/supporting-schools/step-step), which provides advice and practical guidance to help schools respond effectively, recover as a community and prevent the formation of a suicide cluster following the suicide of a student.

Information giving

The school needs to liaise closely with the RRT which will be coordinating involvement with the family. Any information sharing will need prior agreement with the family. Minimal information should be shared about the cause of death, particularly as a coroner’s verdict of suicide may not be confirmed immediately.
Within the school, teachers and other staff should be informed first. Students close to the deceased should be identified and informed by a familiar member of staff. Other students should be informed in classroom groups rather than a large assembly (a script for the teacher should be prepared; details of suicide method/s should not be shared).

Information for students should include:
- Pertinent facts about the death (not the details) – as agreed with the family
- Normalisation of the emotions experienced in response to the death
- Encouraging caring for each other and letting staff know if anyone has concerns about other students
- Encouraging positive ways of managing distress/stress
- Letting students know that support is available
- Sharing useful resources with the students

Following agreement with relevant agencies and the RRT, letters should be sent out to parents giving information and details of contacts and agencies for support (see box 11, page 51, for recommended content). As mentioned earlier, the school must check with family of the deceased first before sending out any details about the death.

Details on how to access support should also be posted on the school website.

**Identification of those at risk**

Pastoral heads of each year should consider who might be at risk for suicide or self-harm, taking account of the circles of vulnerability. These will include:

**Geographical proximity**
- Those who were closely involved in the suicide(s), (eg witnessed the event or its aftermath, or discovered the body). Extensive media coverage can exacerbate this

**Psychological proximity**
- Students who identified with the deceased (eg same class, similar interests, same clubs or sports team; or those who perceived that they were similar to the victim in some way)

**Social proximity**
- Close friends of the deceased
- Current or recent partner(s) of the deceased
- Relatives of the deceased
Identifying and responding to suicide clusters and contagion

Individual students who may be at increased risk include those who:

- suffer from depression or other mental illness, substance abuse or who have a sense of hopelessness
- engage in self-harming behaviour
- feel responsible for the death, or who may be subject to allegations as a result of the death
- already have experience of suicide or self-harm in family or friends
- lack family or social support
- have a history of adverse childhood events

All students should be offered specific opportunities for counselling/individual support.

Support for teachers and other staff

Staff should be given the opportunity to meet in groups for information sharing and review. Staff should be offered the support and resources of specialist bereavement services or access to the RRT.

Staff should also be given information regarding risk factors and warning signs for suicidal behaviour.

Support for students

Staff should be aware of students’ need to talk about the event(s) and express feelings. External agencies could help facilitate gathered acts of reflection and remembrance. Specialist advice for different cultural and religious groups may need to be sought.

- forums should be set up to provide opportunity for students to talk in a group led by a facilitator (eg, a child bereavement counsellor, mental health nurse), such as through a Kitchen Table Talk approach (See box 10, page 42)
- drop-in sessions/hotlines/information leaflets/support room should be made available
- individual/group counselling should be provided to those at risk or considered vulnerable either by school counsellors or local child bereavement counsellors
- referrals may be made to local CAMHS where appropriate
- every effort should be made to continue school routines as usual

Facebook pages or groups

Where possible the activity of any Facebook page of the deceased or set up by students following the suicide should be monitored, being aware of the potential for increasing risk in other students. The RRT and the school coordinating group should
decide who is responsible for monitoring this site (usually the police). If comments are posted which indicate risk in any other young people, their family and relevant professionals should be contacted with some urgency, although diplomacy and sensitive use of language is required.

**Longer-term support**

School staff should be aware of longer-term issues that may arise for those at risk (eg development of depression, anxiety or self-harm). The anniversary of the young person’s death may be a particularly difficult time for some students.

Schools should promote a caring and supportive school environment, facilitating appropriate discussion and help-seeking.

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**Box 12. Suggested essential content of letter for parents following the suicide of a student**

- brief pertinent information about the death(s) including what year the student was in
- confirmation of when and what the students were told
- encouragement to the parents to let their son/daughter know that the letter has been received and that they (parents) will listen to concerns
- acknowledge any parental concerns about son/daughter’s reaction to the news, and normalise grief reactions
- guidance on how to talk to the young person
- encouragement to parents to discuss positive strategies to cope
- advice to keep connected to the young person and support them in a general sense
- advice to contact their GP if they or their child would like further support
- information on how the school is responding and supporting students, including provision of drop-in support and specific counselling to those that need it
- details of staff member to contact if there are any specific concerns/questions
- acknowledgement that the school will be carrying on their normal routines as far as possible
- add link to relevant website for parents and young people (eg, PAPYRUS)
Stepping down the response

CAPs should remain in place while concern about suicide contagion or a suicide cluster is current. Public health suicide prevention leads will need to meet regularly with the SRT and the SSG to review evidence and the risk of ongoing contagion. When it is agreed that there is no longer evidence of continuing contagion and risk has been satisfactorily mitigated by the cluster response team a stepping-down strategy should be agreed. This should include:

- informing bereaved or affected individuals and groups of the winding down of the plan and reinforcing the availability of support agencies
- ensuring that where necessary, agencies continue to work together to support those affected
- planning support for significant dates and anniversaries
- ensuring community agencies (ie, police, schools, healthcare teams etc.) are aware of how to communicate future concern
- providing the SRT with an opportunity for reflection and documenting that learning
- ongoing surveillance of suicide and self-harm in the area, especially as geographical areas that experience a suicide cluster may be at risk of further (‘echo’) clusters in the future. It might also be advisable for the SSG to ensure vigilance around anniversaries of suicide clusters
Evaluation and future planning

Assessment of the impact of interventions to address or prevent suicide clusters should be an ongoing process. It should include assessment of real-time local data on suicides and, where possible, self-harm. Media reporting of local suicides should also be closely monitored.

To ensure readiness to respond promptly to concerns about suicide contagion or clusters, the MSPG should regularly review CAPs, whether or not there has been suicide contagion or not.

The following points are relevant to retrospective evaluation of the impact of interventions:

- focus on both what was done well and where improvements can be made
- where possible, feedback should be sought from the bereaved and others involved
- feedback should be obtained from all local agencies involved in response initiatives
- external peer review from neighbouring regions is recommended
- given that clusters are rare occurrences, evaluation may be more informative when conducted at a regional level
- CAPs and any associated training should be updated accordingly
Resources to inform and support CAPs

- **National Suicide Prevention Strategy (2012)**
  Sets out national plans for reducing suicide rates and supporting people affected by suicide with annual reports reporting progress.

- **National Suicide Prevention Alliance (NSPA)**
  A cross-sector, England wide coalition committed to reducing the number of suicides in England and improving support for those bereaved or affected by suicide.

- **Guidance for developing a local suicide prevention action plan: information for public health staff in local authorities**

- **Preventing Suicide in Public Places**
  www.sprc.org/sites/sprc.org/files/library/SuicideHotspotsGuidance%20PDF.pdf
  A best practice guide developed for the National Institute for Mental Health by the University of Exeter to support effective multi-agency collaboration in identifying locations that are ‘hotspots’ for suicide and take appropriate steps to improve safety and deter acts of suicide at these locations.

- **Suicide Prevention Fingertips Tool**
  http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide
  This has been produced to help develop understanding at a local level and support an intelligence driven approach to suicide prevention. It collates and presents a range of publically available data on suicide, associated prevalence, risk factors and service contact among groups at increased risk.

- **Media reporting guidance**
  www.samaritans.org/media-centre/media-guidelines-reporting-suicide
  Developed and regularly updated by the Samaritans (most recent version 2013) to promote sensitive reporting of suicides in order to protect families and bereaved and limit suicide contagion.

**Independent Press Standards Organisation**
www.ipso.co.uk/IPSO/index.html

**Ofcom**
• **Information sharing and suicide prevention: consensus statement**
  Designed to promote greater sharing of information within the context of the relevant law, and to clarify that this is a matter of professional judgement for an individual practitioner providing care to an individual person.

• **National Suicide Bereavement Support Partnership**
  The Suicide Bereavement Support Partnership (SBSP) is the hub for those organisations and individuals working across the UK to support people, who have been bereaved by suicide.
Resources for people vulnerable to suicide and those bereaved or affected by suicide

- **Help is at hand: a resource for those bereaved by suicide or other sudden traumatic death**
  
  www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf
  
  Provides detailed advice on practical aspects of dealing with the aftermath of suicide and traumatic death, as well as information on the emotional and psychological impact of suicide and sources of help and support.

- **NHS Choices**
  
  www.nhs.uk
  
  Information from the National Health Service on conditions, treatments, local services and healthy living which includes signposting to support for people who are feeling suicidal or are affected by suicide.

- **Child Bereavement UK**
  
  www.childbereavementuk.org
  
  Grief support app for young people (11-25) who have been bereaved of someone close to them www.childbereavementuk.org/support/our-app/
  
  Telephone support and publications
  
  E-learning for schools – supporting bereaved pupils www.elearningschools.co.uk

- **Winston’s Wish**
  
  www.winstonswish.org.uk
  
  Offers support and guidance to bereaved children, families and professionals, with a specific service for children affected by suicide

- **Samaritans**
  
  www.samaritans.org
  
  24 hour telephone support, text messaging and email service and time limited drop in facilities available in branches.
  
  **Step by Step programme** for helping schools respond to suicides
  
  www.samaritans.org/your-community/supporting-schools/step-step

- **PAPYRUS: Prevention of Young Suicide** www.papyrus-uk.org/
  
  Helpline, text and email support for young people and parents
  
  Suicide prevention training
  
  Suicide bereavement support for those who have been affected by a young person’s suicide

- **Survivors of Bereavement by Suicide** http://uk-sobs.org.uk/
Self-help support groups and support line facilitated by people who have themselves been bereaved by suicide

- **Healthtalk.org** [www.healthtalk.org/](http://www.healthtalk.org/)
  Information on a range of illnesses and other health-related issues from seeing and hearing people’s real life experiences including:
  **People bereaved by suicide**
  [www.healthtalk.org/peoples-experiences/dying-bereavement/bereavement-due-suicide/topics](http://www.healthtalk.org/peoples-experiences/dying-bereavement/bereavement-due-suicide/topics)
  **Depression, self harm and suicidal feelings**
  **Parents and carers of young people who self harm**
  [www.healthtalk.org/peoples-experiences/mental-health/self-harm-parents-experiences/topics](http://www.healthtalk.org/peoples-experiences/mental-health/self-harm-parents-experiences/topics)

- **Cruse Bereavement Support**
  [www.cruse.org.uk/home](http://www.cruse.org.uk/home)
  Face to face, group, telephone and email support to support people who are bereaved

- **The Compassionate Friends**
  [www.tcf.org.uk/](http://www.tcf.org.uk/) 08451 232304
  Provides support and friendship to parents and families after the death of their son or daughter, at any age and from any cause.

- **The Way Foundation (Widowed & Young)**
  [www.widowedandyoung.org.uk/](http://www.widowedandyoung.org.uk/) 0300 012 4929
  Aims to support young widowed men and women as they adjust to life after the death of their partner – whether that was a month, a year, or ten years ago.

- **If U Care Share Foundation**
  [www.ifucareshare.co.uk/](http://www.ifucareshare.co.uk/) 0191 387 5661
  Promotes emotional wellbeing in young people and support families bereaved by suicide (in North East England)

- **CALM (Campaign Against Living Miserably)**
  [www.thecalmzone.net/](http://www.thecalmzone.net/) 0800 585858
  Helping to prevent male suicide in the UK.
Glossary

**Child death overview panel**
Statutory panel in England (under the Health and Care Act 2012) made up of representatives of local safeguarding children board, public health and child health, with responsibility for undertaking reviews of each death of a child normally resident in the local safeguarding children board’s area.

**Child death overview panel rapid response team (RRT)**
A core group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child.

**Community action plan (CAP)**
A local plan developed by the MSPG in conjunction with relevant stakeholders to guide a community response to suicide clusters with the aim of supporting those affected by suicides and preventing further suicides.

**Community safety partnerships**
These are groups made up of local authority, police, fire and rescue, probation and health representatives who have responsibility to protect their local communities from crime and help people feel safer.

**Health and wellbeing board**
Statutory body in England that all top-tier and unitary local authorities must have in place, to enable joint working to improve the health and wellbeing of the local population and reduce health inequalities.

**Independent Press Standards Organisation**
The independent regulator for the newspaper and magazine industry in the UK (see Ofcom below).

**Local safeguarding boards**
Statutory arrangements in England by which organisations come together to agree on how they will cooperate with one another to safeguard and promote the welfare of children and adults in their area and protect them from neglect and abuse. Local authority areas will usually have separate safeguarding children and safeguarding adults boards.

**Multi-agency suicide prevention group (MSPG)**
Local group headed by the public health suicide prevention lead responsible for developing and overseeing local suicide prevention strategy.
Ofcom
The regulator for broadcast media in relation to reporting and portrayal of suicide.

Public health suicide prevention lead
The public health consultant within the local authority who is identified as having responsibility for local suicide prevention strategy.

Suicide surveillance group (SSG)
Subgroup of the multi-agency suicide prevention group, overseen by the public health suicide prevention lead, with responsibility for monitoring local real-time suicide data.

Suicide response team (SRT)
Team, comprising statutory and voluntary services, identified by the multi-agency suicide prevention group to respond to concerns about suicide contagion or suicide clusters.
Appendix 1. Blank vulnerability matrices templates

<table>
<thead>
<tr>
<th>Circles of Vulnerability: Individuals or Groups</th>
<th>Description of risk</th>
<th>What has been done to help this person?</th>
<th>What remains to be done?</th>
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Identifying and responding to suicide clusters and contagion

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SOCIAL PROXIMITY
Identification with, relationship to or connection to the person who died
## PSYCHOLOGICAL PROXIMITY
Identification with, relationship to or connection to the person who died

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<th>Circles of Vulnerability: Individuals or Groups</th>
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Appendix 2. Methodology

This practice resource document has been developed by Professor Keith Hawton, director of University of Oxford Centre for Suicide Research, Karen Lascelles, suicide prevention lead nurse, Oxford Health NHS Foundation Trust and Anne Ferrey, research co-ordinator, University of Oxford Centre for Suicide Research. They were supported by an expert development team, listed on page 66.

It has been developed in five stages, including a feedback loop to ensure that the views of relevant experts were incorporated. The five stages were:

**Stage 1. Assembling evidence from reviews of the literature and existing guidance**
The authors reviewed policies included in guidance from other countries and organisations. They had already conducted recent systematic reviews on the nature of suicide clusters and their mechanisms (Haw et al, 2013; Niedzwiedz, 2014). They updated this search of the literature to ensure that the latest information was included, consulted a recent review on responding to clusters (Cox et al 2012) and again updated the relevant literature research.

**Stage 2. Stakeholder consultations**
The authors particularly drew on the experiences of communities and organisations in the UK, Ireland and Australia which have experienced suicide clusters and/or have acted to contain a cluster. In addition, they consulted agencies involved in early responses to suicides, in particular the police. These consultations focussed on both content (eg, how to recognise a cluster, key steps to be taken to prevent or contain a cluster, the roles of organisations and authorities, and examples of previous strategies to manage clusters) and application of this advice (ie, how to ensure it would be most practical and useful for communities which may need to develop a local plan/respond to an apparent cluster).

**Stage 3. Developing the draft resource**
A draft guide was developed with contributions from all members of the development team on the basis of the information gathered in stages 1 and 2 and also through further consultation of relevant literature.

**Stage 4. Seeking feedback on the draft resource**
The draft guide was then distributed to advisors and to other organisations and individuals identified through stage 2. This included several consultants in public health in England and Wales. They also consulted some individuals who have been bereaved by suicide. They sought feedback on the usefulness of the guide, especially the need to
ensure that it is as practical as possible and in keeping with current practises. This process was repeated twice.

Stage 5. Finalising the guide
The guide was modified on the basis of the feedback which was received. It should be noted that while this document is based on the best available evidence, this is an emerging field and all of the recommendations are based on best practice, informed by expert opinion and those with practical experience in this area.
Appendix 3. The practice resource development team

Co-ordinators:
Professor Keith Hawton, director, Oxford University Centre for Suicide Research, and consultant psychiatrist, Oxford Health NHS Foundation Trust.
Karen Lascelles, suicide prevention lead nurse, Oxford Health NHS Foundation Trust; suicide intervention and prevention network lead, Thames Valley.
Dr Anne Ferrey, research coordinator, Oxford University Centre for Suicide Research.

Other members of the team:
Dr Anne Stewart, consultant in Child and Adolescent Psychiatry, Oxford Health NHS Foundation Trust.
Dr Ann John, clinical, associate professor in public mental health, Swansea University. Honorary consultant in public health, Public Health Wales. Chair of the National Advisory Group to Welsh Government on Suicide Prevention.
Dr Jane Mathieson, Consultant in public health, Cumbria County Council.
Professor Camilla Haw, professor in mental health care, Northampton University; Oxford University Centre for Suicide Research; consultant psychiatrist, St Andrew’s Hospital, Northampton.
Dr Kate Saunders, clinical lecturer, University of Oxford, and honorary consultant psychiatrist, Oxford Health NHS Foundation Trust.

Advisors
Professor Jane Pirkis, director of the Centre for Health Policy, Programs and Economics, University of Melbourne, Australia. Was lead for the development of the Australian guideline, Developing a Community Plan for Preventing and Responding to Suicide Clusters (2012).
Professor Ella Arensman, director of research, National Suicide Research Foundation and Department of Epidemiology and Public Health, University of Cork, Ireland. President, International Association for Suicide Prevention.
Caroline Harroe, CEO and founder of Harmless and The Tomorrow Project.
Hamish Elvidge, Matthew Elvidge Trust; Co-Chair, National Suicide Prevention Alliance and The Alliance of Suicide Prevention Charities; Chair, Suicide Bereavement Support Partnership.
Acknowledgements

The guide development group and advisors are listed at the back of this document. The assistance of the following individuals is gratefully acknowledged: Dr Olusola Aruna (consultant in public health medicine, Gloucestershire County Council), Gordon Benson (assistant director of governance and compliance, 2gether NHS Foundation Trust, Gloucestershire), Fiona Brand (research nurse, Oxford Health NHS Foundation Trust), Rachel Brown (public health intelligence analyst, Liverpool John Moores University), Sal Culmer (public health improvement practitioner, Public Health Team, Oxfordshire County Council), Julieann Exley (safeguarding services manager, Oxfordshire Clinical Commissioning Group), Lorna Fraser (acting press and PR manager, Samaritans), Marianne Frieling (community psychiatric nurse, Westfriesland, The Netherlands), Stephen Habgood (chairman, PAPYRUS), Rebecca Kelly (learning from incidents lead, Oxford Health NHS Foundation Trust), Julie Kerry (assistant director of nursing, Thames Valley Area Team, NHS England), Rutuja Kulkarni (head of public health, Royal Borough of Windsor and Maidenhead), Helen McKinnon (director, SeeSaw Child Bereavement Charity, Oxford), Katie Simpson (GP mental health commissioner, Berkshire), Mark Smith (head of suicide prevention and mental health, Central Operations Department, British Transport Police), Matt Williams (suicide prevention project facilitator, Thames Valley Suicide Prevention and Intervention Network), Mary Zacaroli (bereaved by suicide, Oxford).

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