

# Suicide prevention: example of enhancing education and care delivery

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# Suicide Benchmarking Project 2012/13 – 5 NHS Trusts: Thames Valley & Wessex

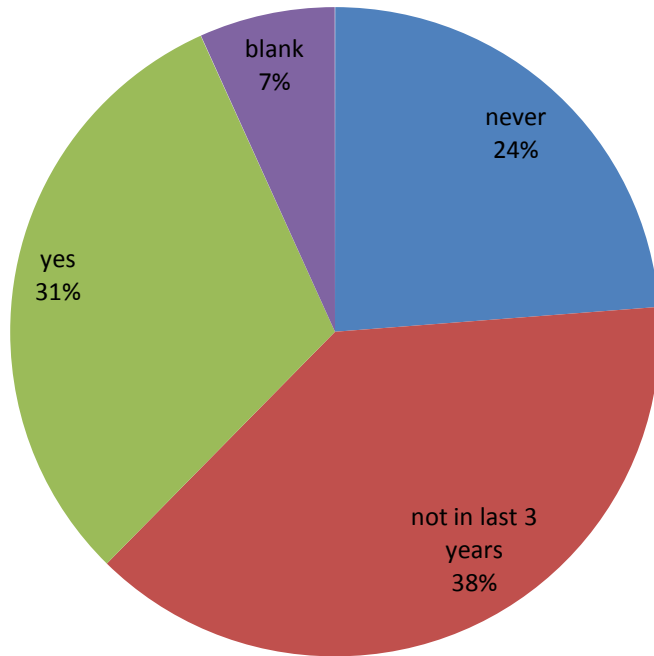
Analysis of Serious incident reports  
and large scale staff survey

# Key findings

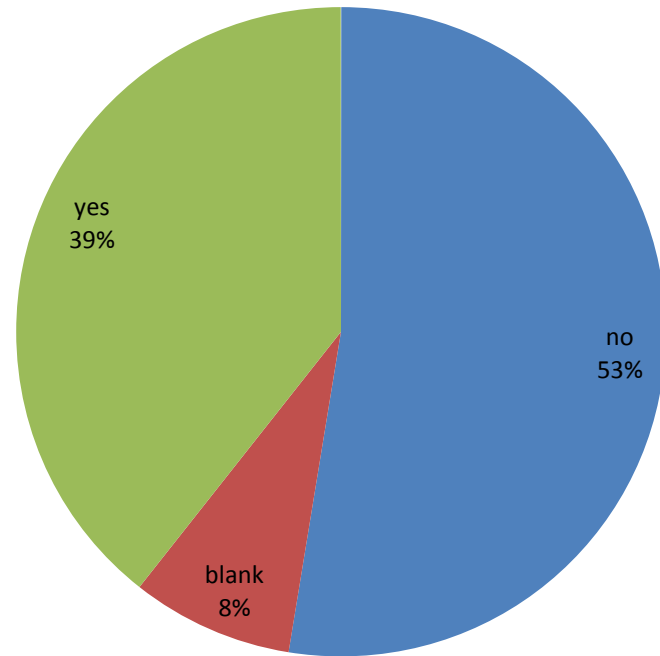
- **Low risk Paradox**
- **Nebulous risk formulations**
- **Not revisiting risk**
- **Over-reliance on self report**
- **Lack of depth of clinical conversations**
- **Superficial documentation**
- **Lack of carer involvement**
- **Interface issues**
- **Lack of theoretical understanding of suicide**
- **Whose protective factors are they....?**

# Training & knowledge

### Have you received training ?



### Familiarity with theories

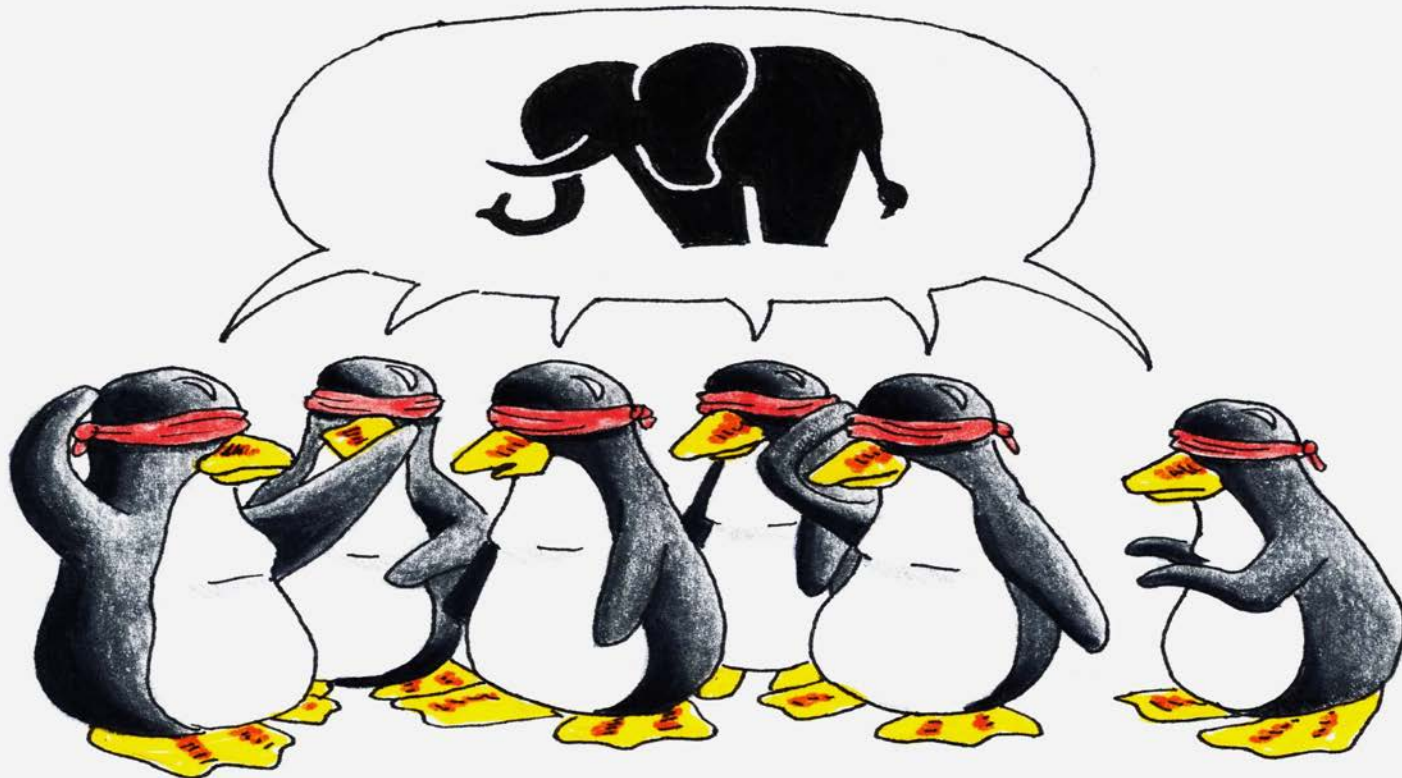


# Dissonance



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# Developing a shared understanding









# Content

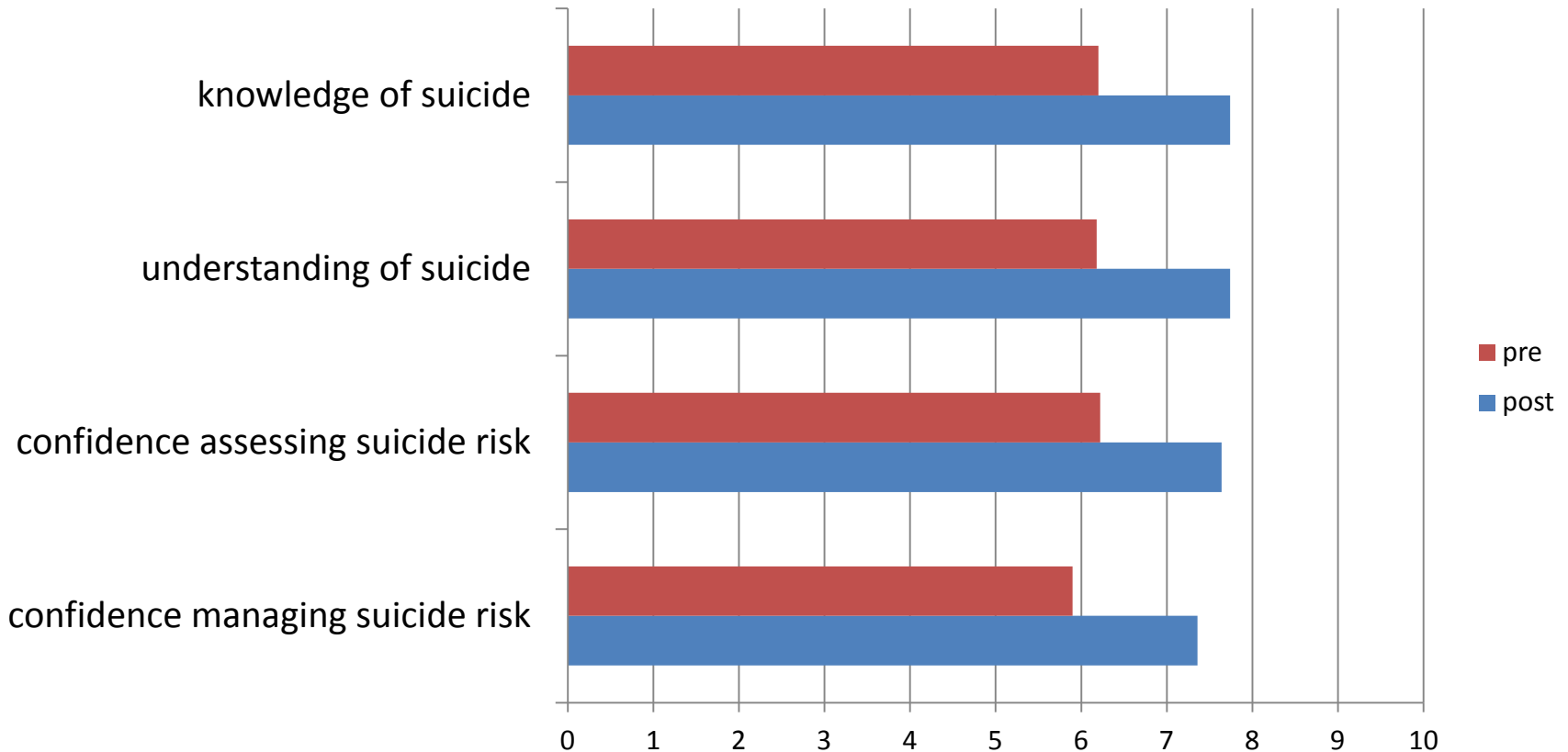
- Epidemiology
- Theoretical frameworks
- Lived experience
- Assessment
- Intervention
- Management
- Contagion
- Policy
- Reduction
- Prevention
- Postvention
- Resources

- Training and reflective practice using the interpersonal theory of suicide (Joiner 2009) as a central framework
- Team based
- Flexible re timing and content (core content always delivered)
- Includes lived experience wherever possible
- Dialogue central to the learning process

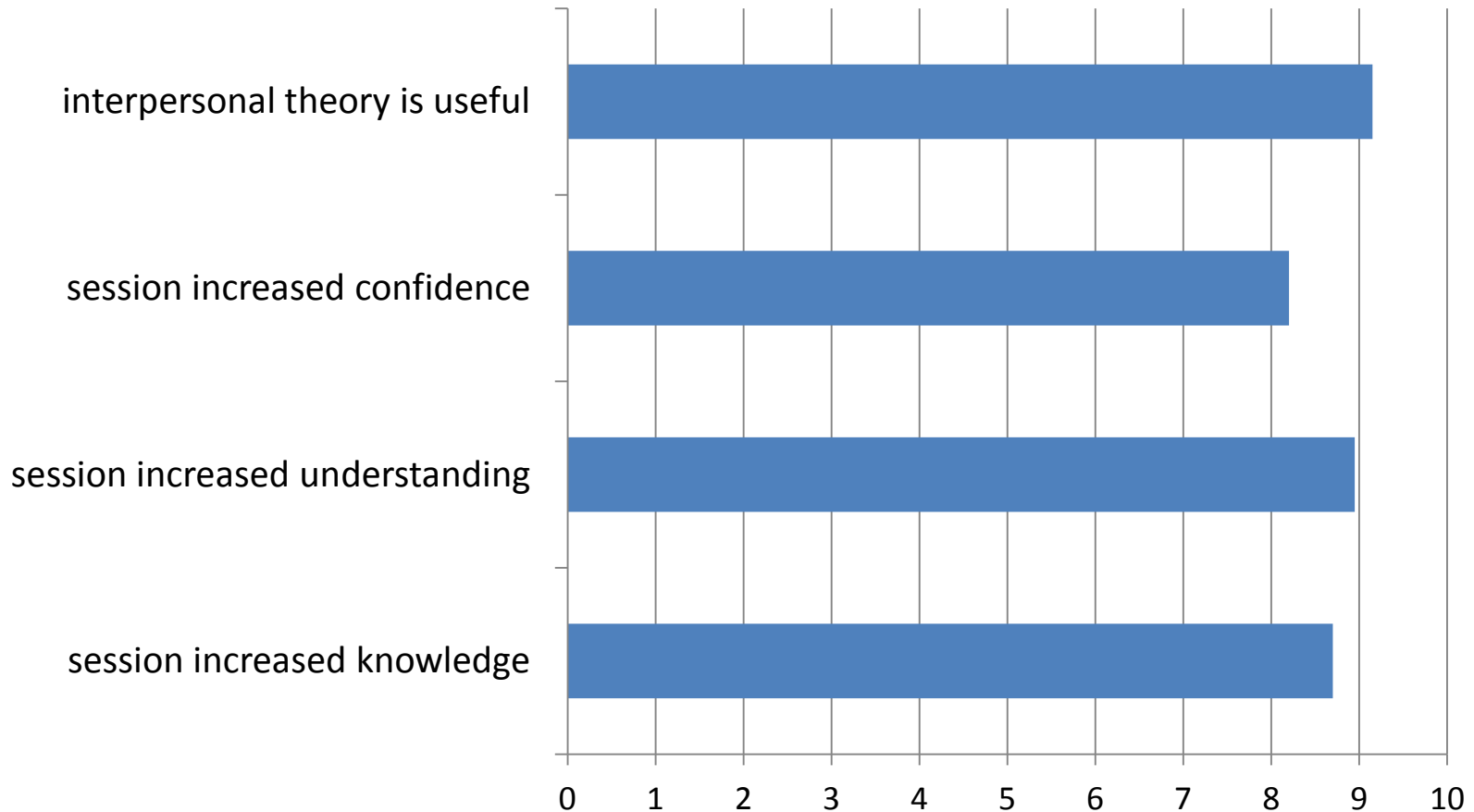
# Who trained (mental health)?

- Wards
- Community – adult, older adult, CAMHS
- ED liaison
- IAPT (Tiers 2,3)
- Psychological services (Tier 4)
- Senior managers
- HCA/STR workshops
- Student nurses

# Pre & post training self report ratings (mental health staff n=133)



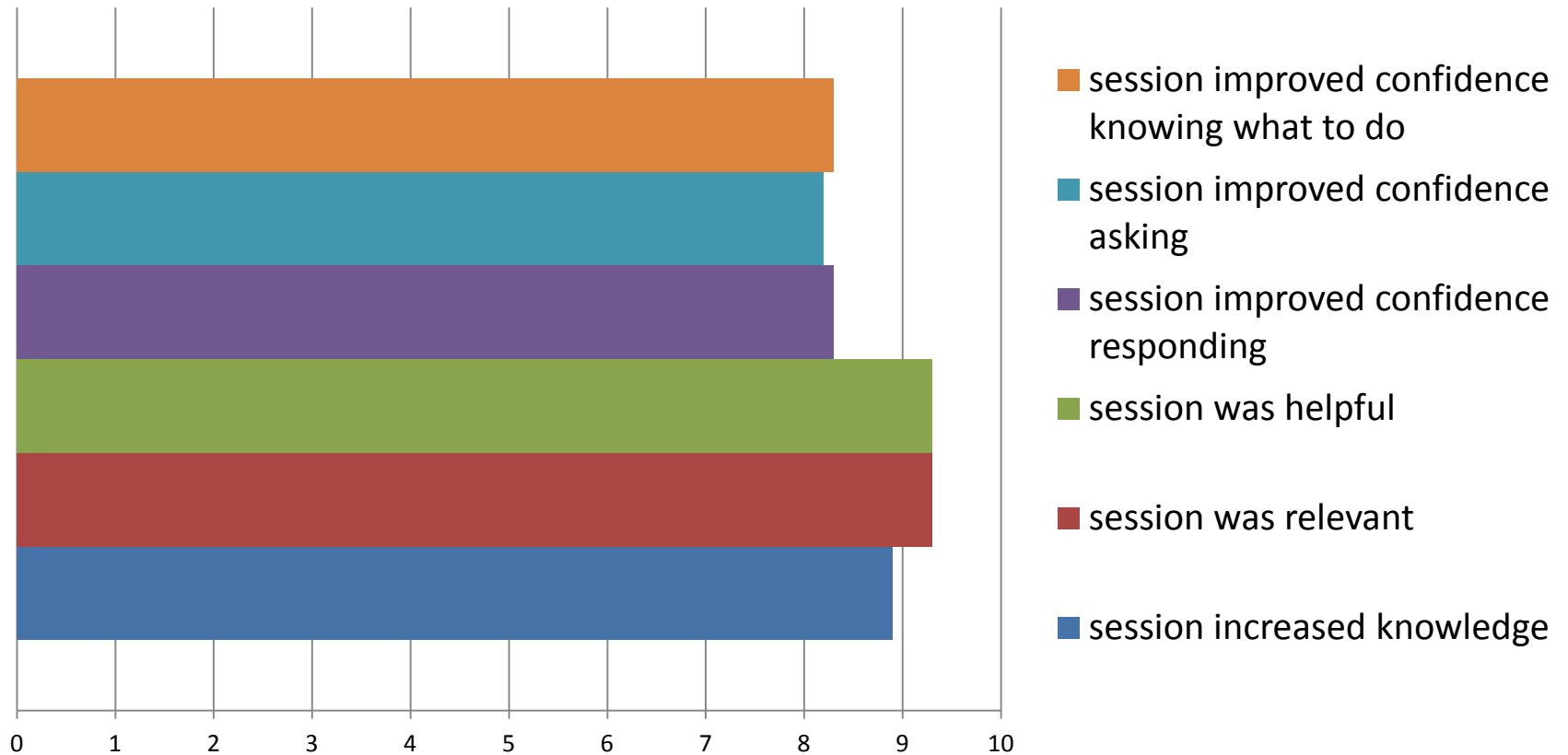
# Self report following single sessions (mental health staff n=147)



# Who trained – non mental health?

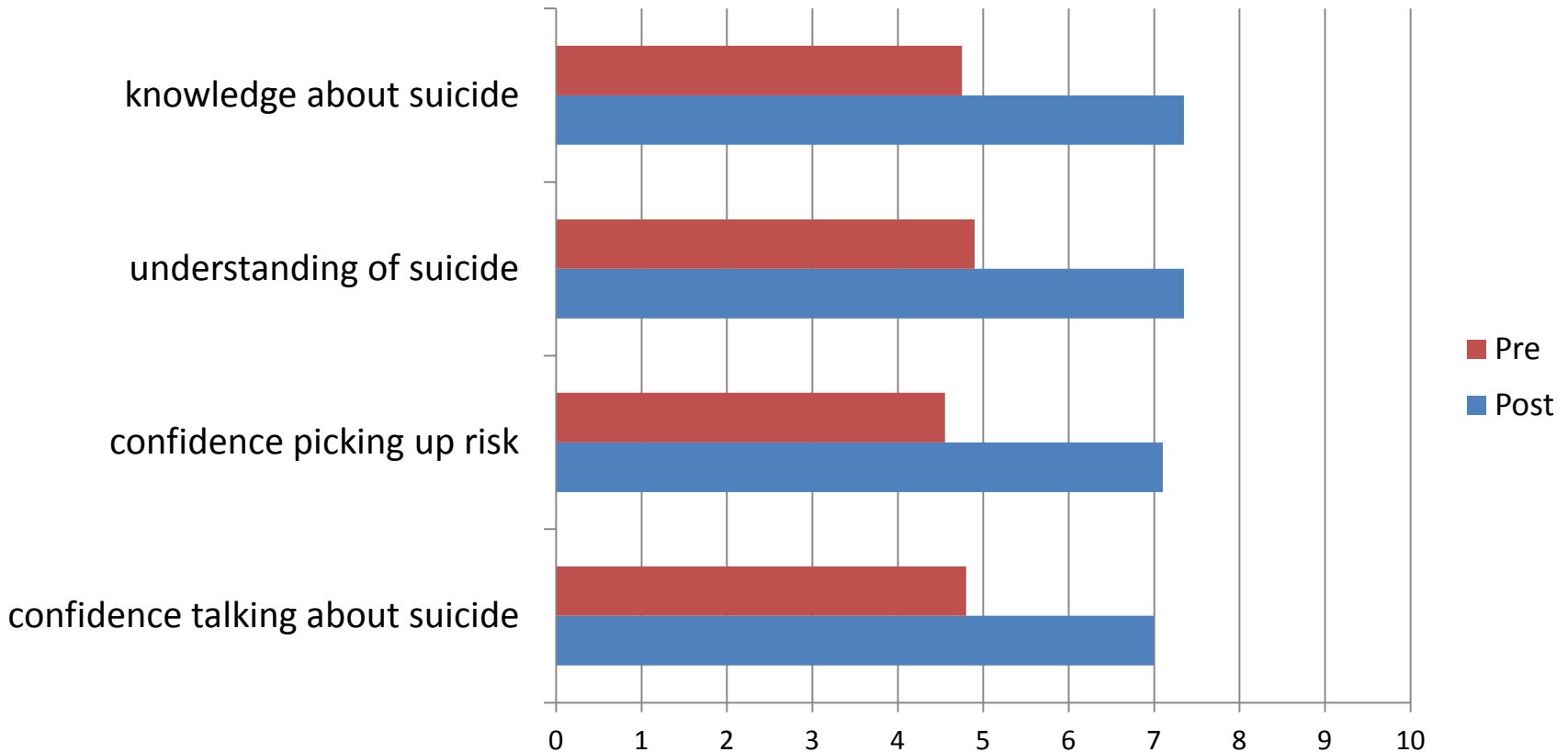
- Physiotherapists
- Out of Hours staff
- Minor
- Injuries/Emergency Nurse Practitioners students (includes paramedics)
- Troubled families teams
- University pastoral care staff
- Social care staff

# Physio post session self report (n=21)



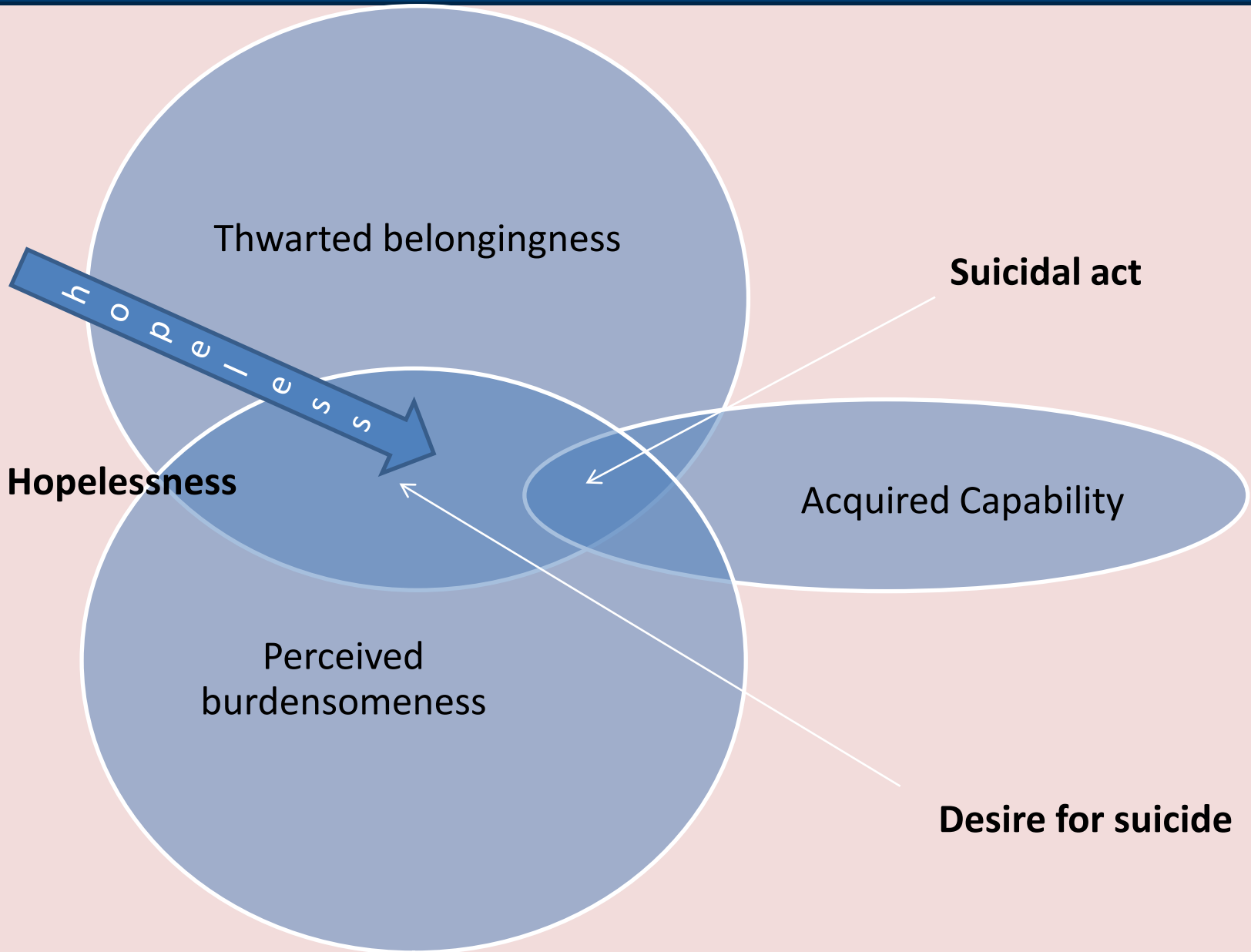


# Pre & post training self-report ratings (non mental health n = 42)



# What do people like best?

- Lived experience
- Time to reflect & ambiance of openness, honesty
- Contemporary knowledge of prevalence, incidence, methods and insight into changes over time
- Signposting to Third Sector resources and provision



- **Static risk factor:**
  - fixed and historical e.g.: past abuse, family history of suicide, hx self harm
- **Stable risk factor:**
  - long term but not fixed e.g. diagnosis of personality disorder, substances
- **Dynamic risk factor:**
  - present for an uncertain amount of time e.g. unemployment, relationship issues, illness, substances
- **Future risk factor:**
  - anticipated e.g. anniversary, discharge from hospital, access to means

# Success Criteria

- Credible trainer – **current practice essential**
- **Credible theory**
- Not lumped in with generic risk training
- **Lived experience involvement**
- Has a focus on practitioners responses/experiential learning
- Informality & flexibility
- **Time for team discussion**
- Focus on realistic improvement
- Sophistication nestled within simplicity

# Reference

- Joiner, T. (2009). *Why people die by suicide*. Harvard University Press.