Suicide prevention: example of enhancing education and care delivery

Karen.lascelles@oxfordhealth.nhs.uk
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?

- Yes: 31%
- No: 53%
- Never: 24%
- Not in last 3 years: 38%
- Blank: 7%

Familiarity with theories

- Yes: 39%
- No: 53%
- Blank: 8%
Dissonance
Developing a shared understanding
Caring, safe and excellent
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)

- Knowledge of suicide
- Understanding of suicide
- Confidence assessing suicide risk
- Confidence managing suicide risk

0 1 2 3 4 5 6 7 8 9 10
Self report following single sessions (mental health staff n=147)

- Interpersonal theory is useful
- Session increased confidence
- Session increased understanding
- Session increased knowledge
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)

- Session improved confidence knowing what to do
- Session improved confidence asking
- Session improved confidence responding
- Session was helpful
- Session was relevant
- Session increased knowledge
Pre & post training self-report ratings (non mental health n = 42)

- Knowledge about suicide
- Understanding of suicide
- Confidence picking up risk
- Confidence talking about suicide

0 1 2 3 4 5 6 7 8 9 10

- Pre
- Post
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
Caring, safe and excellent

Thwarted belongingness

Hopelessness

Perceived burdensomeness

Acquired Capability

Suicidal act

Desire for suicide
**Risk factors**

- **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