Derbyshire Healthcare NHS
NHS Foundation Trust

SUICIDE PREVENTION STRATEGY

April 2016

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Better together

Contents

Foreword	Page 3
Executive summary	Page 6
Introduction	Page 7
Strategic priorities	Page 10
Authors of this strategy	Page 30
Glossary	Page 31

Foreword

As a medical practitioner, psychiatrist and more recently medical director it has been my privilege over the last 30 or so years to learn how individuals come to terms with their own mortality and how families and others close to the deceased cope with the struggle of living without somebody they loved.

The dilemmas and conflicted emotions involved are intensely magnified when we are trying to help those who are feeling suicidal or are trying to support the families who have been bereaved in this way. The truth is we will never know in most cases why a particular individual took their own life and crucially what could have made a difference to their terminal actions. It seems that psychiatry, psychology, nursing and all the other professions who are trying to help will not have anywhere near all the answers and in this way suicide prevention is everybody's business.

We also know that none of us are immune to intense emotional distress given a certain set of adverse circumstances and so preventative work cannot be divorced from our own life experiences and we need to break the taboo that still surrounds the discussion of matters directly relating to suicidal intent. There has been a useful discussion around avoiding terms such as "commit" or "complete" suicide for this reason.

Nationally, the debate has oscillated from one pole concerning the right for people to die, having access to assisted suicide, and the other pole of zero tolerance for any deaths due to suicide. It is my view that as compassionate human beings (who may also be highly skilled professionals) the key is for us to see life as far as possible through the patient's eyes and then to help them find hope and a way forward in a world they may see as only offering them extreme choices.

For all these reasons I think this strategy needs to be owned by every one of us and not seen as an action plan that can be broken down and delegated. It represents the essential stuff of human existence.

John R Sykes

Dr John Sykes

Consultant Psychiatrist, Medical Director
Derbyshire Healthcare NHS Foundation Trust (DHCFT)

"The impact of suicide is far-reaching and our increasing suicide rates in Derbyshire are of great concern. As a representative for mental health service receivers in the county I welcome the long awaited Suicide Prevention Strategy by Derbyshire Healthcare NHS Foundation Trust.

The strategy has been heavily influenced by people with lived experience and this brings a unique perspective and depth for professionals to utilise. I hope that there will be a full implementation of the areas identified for action and a true commitment to supporting those whose lives are affected by suicide."

Catherine Ingram
Chief Executive
Derbyshire Voice

"When someone takes their own life, the effect on their family and friends is devastating. Many others involved in providing support and care will also feel the impact.

The national suicide prevention strategy for England, revised and published in 2012, has built on the progress of its predecessor. The national suicide rate reached an all-time low in 2006-7 but worldwide economic pressures then took their toll on the mental health of the population. The new strategy was designed to reflect the changing pattern of suicide, such as the rising rate in middle-aged men and the emergence of new suicide methods. In particular it highlighted the need to support bereaved families and those worried about a suicidal person in their household.

Every one of the 4,800 lives lost to suicide each year in England is a tragedy. The causes are complex and often individual - some people are known to be at risk for many years, for others a sudden crisis proves impossible to bear. Prevention too can be complex, with the potential for helping someone shared between services, communities, families and friends. The message of this strategy is clear: no suicide is inevitable.

For some suicidal people, it is hard to ask for help because of the shame and embarrassment that can accompany mental ill-health. Stigma can kill and overcoming it is literally vital. It is a job for all of us - service users, professionals, the media, society as a whole - not just through campaigns but through everyday attitudes and actions.

The recent mental health task force report set the aim of a 10% reduction in suicide by 2020 and every local area will have to play its part if this is to be achieved. The Derbyshire Healthcare Foundation Trust strategy has been designed to translate the national strategy into a local initiative. It sets out what contribution the trust can make to prevention - the actions it can take locally, the role it can play in the wider community. It is an approach that other parts of the country, whether their rates are high or low, can adopt.

Professor Louis Appleby

Chair, National Suicide Prevention Strategy Advisory Group

Executive summary

The Derbyshire Healthcare Suicide Prevention Strategy, written in consultation with key stakeholders, sets out our aims for reducing the incidence of suicide across the Trust. Using the National Suicide Prevention Strategy as our anchor, and through reference to the countywide Derbyshire Suicide Prevention Partnership Strategy, this document describes key strategic aims, and ways to achieve them.

Whilst reducing suicides in those who use our services sits at the heart of our strategy, we are mindful of the need to promote engagement with those outside our service, and our approach must be suitably wide-ranging; a strategy that does not consider how we can work collaboratively with statutory, third sector, and other key groups cannot hope to address this complex issue in its entirety.

The document sets out seven key strategic priorities. For each priority, we have sought to illustrate why it is important, both in terms of how it relates to the wider national picture and suicide prevention research, and also how it relates to the individual experiences of service receivers.

The seven strategic priorities are:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring
7. Build the resilience of local communities to prevent and respond to suicides

Within each strategic priority, the document identifies important outcomes, and sets out ways in which we can not only achieve them, but also measure the extent to which they have been achieved. Through the incorporation of our DHCFT values and Core Care Standards, we intend the strategy to be truly accessible to every stakeholder. As such, the key message of the DHCFT Suicide Prevention Strategy is that we all have a part to play; suicide is everyone's business.

Introduction

At that particular time in my life, all I could think of, was ending it - I just couldn't go on. I couldn't exist anymore; I was so sad and desperate, I felt like a burden to everyone and that the world would be a better place if I were not in it.

I made a plan. I was an inpatient at this time, and was allowed weekend leave.

That weekend, my housemates were all meant to be away at that time. I had spoken to a nurse before leaving, saying that I felt quite suicidal. It was not taken seriously and I went home and took my medication.

To cut a long story short, unexpectedly, one of my friends came back and he found me - still alive, but not really there. Hence, I ended up in Accident and Emergency. The staff were quite horrid to me, one even saying that I deserved to have a tube thrust down my throat as I lay there sobbing. Their attitudes did not get any better.

Things were done to me, but, I wasn't spoken to. A few days later, I was, again, back on the acute ward. The staff did not really speak to me. I felt ignored and helpless. I felt that they had not understood me at all - I was alone.

On reflection, if a suicide prevention strategy was in place, and staff had had training within the realms of 'suicide', they would perhaps have acted differently. If I just had someone to talk to, I may have acted differently also. It may have prevented me from trying to kill myself.

TS

March 2016

Suicide is a major public health issue across the globe. When each and every suicide is a personal tragedy for the person, their family and the community, it sometimes seems inappropriate to speak of numbers. Despite this, the figures paint a picture of both a global problem and a worrying trend.

The World Health Organisation estimates that there are at least 800,000 suicides per year, though many countries do not collect good data and the stigma of suicide ensures that this is highly likely to be an underestimate.

One person in the world dies by suicide every 40 seconds, according to a comprehensive report from the World Health Organisation, which talks of a massive toll of tragic and preventable deaths.

In Derbyshire itself the most recent figures show an alarming 87% increase in deaths by suicide within one year in Derbyshire county, with the Derby city figure showing a 25% increase (Deaths from Suicide and undetermined injury in Derby and Derbyshire. 2015, Public Health Intelligence and Knowledge Services).

Suicide is the act of intentionally causing one's own death. Suicide is often carried out as a result of despair. Although the cause is frequently attributed to a mental disorder such as depression, bipolar disorder, schizophrenia, borderline personality disorder or substance use, around 75% of those who die by suicide were not in contact with mental health services at the time of their death. A range of other factors such as financial difficulties, interpersonal relationships, and bullying can play an important role.

Suicide prevention efforts include reducing access to means of suicide such as medications, treating high-risk groups with mental illness, alcohol or substance use, and providing better information to those bereaved by suicide. This requires a coordinated response from all health, social care and third sector groups. Truly, suicide is everyone’s business. Our Trust has a vital role to play in suicide prevention working in partnership with other agencies.

The DHCFT strategy, written after extensive consultation with stakeholders, is influenced by both the National and Regional Strategy developed with Public Health Derbyshire. Our seven key strategic priorities have been developed, reviewed and rewritten on the basis of feedback gained and shared locally, nationally and internationally.

Our strategy also benefits from local Derbyshire expertise particularly in the fields of self harm and compassionate care. We have been influenced by our Trust values and core care standards.

Our Trust values

Our core care standards

People who use the services of the Trust have the right and expectation to the following core care standards:

- **Assessment** We will find out with you what your needs are
- **Care planning** You will have a clear care plan
- **Review** We will check that things are working for you
- **Co-ordination** Your care will be co-ordinated
- **Discharge & transfer** We will make sure your transfer or discharge works well
- **Families and carers** We will work with families and carers
- **Involvement and choice** You will be involved as much as you want and are able to be
- **Keeping yourself and others safe** We will help you and others to be as safe as you can be.

Our expectation is that DHCFT's operational and clinical leadership use this strategy document to guide the development of future suicide prevention work. No suicide is inevitable. There are numerous ways in which services can improve practice to reduce suicides. Healthcare services have a particular role in preventing suicides in high-risk groups and those people presenting in distress or in crisis.

Our DHCFT suicide prevention strategy sets out not only what we must do to reduce suicides but also how, when, why and who will help us get there.

Dr Allan Johnston

Consultant Psychiatrist
Chair of the DHCFT Suicide Prevention Strategy Group

Strategic priorities

Strategic priority 1:
Reduce the risk of suicide in key high-risk groups

It is important to point out that suicide often occurs, not necessarily because that person wants to die, but because they cannot tolerate the suffering with which they have endured. It is at such times of desperation when one's depression is so overwhelming that suicide appears as the only realistic and permanent means of ending that person's pain.

It is difficult to argue that there is any issue more important in mental health than that of suicide prevention. After all, it is literally a matter of life and death.

Service user RW
March 2016

A number of population groups have been identified as being at increased risk of suicide compared to the general population. Limitations on the data available means that the groups identified within the national strategy are not an exhaustive list. The national strategy identifies the following groups as being at increased risk of suicide:

- Young and middle-aged men
- People in the care of mental health services, including in-patients
- People with a history of self-harm
- People in contact with the criminal justice system
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

In addition, within Derbyshire County, the highest rate of suicide in 2013 was observed amongst older adults.

Identified strategic outcomes	Actions or objectives
Support frontline workers that have contact with individuals in higher risk groups to have the skills and confidence to identify and respond to individuals at risk of suicide	1. Training – all clinical staff will be trained by September 2017 receiving the nationally validated suicide awareness and response training 2. Supervision – all staff to receive supervision as per DHCFT Supervision Policy 2016 3. Supporting staff – Resilience and coping through post incident debrief/ support 4. All clinical staff to have the opportunity to discuss complex cases within a multi-disciplinary team environment
Ensure that known trigger factors for suicide are explored in groups at increased risk of suicide	1. Training to promote the use of risk mitigation when working with individuals 2. Team approach to safety plans – all clinical staff trained and using safety plans. Known triggers for the individual will be identified and, working collaboratively with the person, plans will be developed to mitigate the risks 3. Care Programme Approach (CPA)— which supports an individual approach to timely assessment and review of care and interventions 4. Consider the use of standardised evidence based assessments to assist staff, for example Becks scales, where licences are available

Build evidence for partnership working and information sharing between organisations in contact with individuals	1. Information Technology/Electronic Patient Records will be used to ensure effective and timely communication for example emailed letters 2. Information Sharing agreements e.g. Information Sharing and Suicide Prevention: Consensus statement (RCPsych, 2014) 3. Suicide Prevention Partnership Forum meetings e.g. Representatives of DHCFT to attend the Derbyshire Suicide Prevention Partnership Forum (DSPPF) and support the annual conference. Quarterly meetings and monthly data group 4. Use of Varm (Vulnerable Adults Risk Management) meetings and other inter-agency clinical meetings to robustly manage risk across inter-agency boundaries
Develop a strategic approach to self-harm and guidance to support people who self-harm. Provide professionals with the skills to talk to with people who self-harm	1. Trust approach to NICE guidance for self harm 2. Derbyshire Healthcare Suicide Prevention Strategy Group (DHCFT SPSG) to identify lead for the development of a DHCFT approach 3. Co produce information / literature for people who self harm
Ensure access to mental health services, especially for those experiencing imminent suicide risk including out of hours	1. Audits to measure access to services, both quantitative and qualitative 2. Service specifications describe issues relating to accessing services 3. Review operational policies for access e.g. for CRHT, front door presentations (FDPs), MHLT

Offer suicide prevention safety planning and means restriction to individuals experiencing suicidal thoughts	1. Audit patient ‘Safety Plans’ 2. Audit CPA care plans 3. All clinical staff will receive suicide awareness and response training which promotes risk mitigation. Keeping people safe and managing access to means of suicide is central to this 4. Review ligature points as per ligature review policy; as a minimum annually or more regularly on new information or new risks identified 5. Review of safety planning and suicide means restriction within the investigation of serious untoward incidents 6. Consider the development of co-produced training in suicide prevention safety planning and means restriction as a recovery college course

Strategic priority 2:
Tailor approaches to improve mental health in specific groups

As a child I had been physically and sexually abused but unfortunately I never felt safe or trusting enough to talk to anyone in mental health services, especially in the first few years of becoming ill when I was hospitalised quite regularly.

Service user RW
March 2016

Many people who receive mental health services have experienced trauma and thus are at an increased risk of suicide. DHCFT has committed to the cultivation of a trauma-informed culture that is evident within strategy, policy, practice and education at every level of the organisation.

Trauma-informed services start with a trauma-informed workforce and we have prioritised the concept of 'Do no Harm' in our services, whereby the potential for the healthcare setting and care interventions to re-traumatise people is understood by all staff and informs care and treatment.

Samantha Kelly
Consultant Nurse

The national strategy highlights the importance of adopting a population approach to improving mental health to reduce suicides. As well as improving the mental health of the whole population, there are certain groups that may require a tailored approach to address their vulnerabilities or known problems with access to services. The groups identified in the national strategy that require a tailored approach are:

- Children and young people such as looked after children, care leavers, and young people in the youth justice system
- Survivors of all types of trauma, abuse or violence, including sexual abuse
- Veterans of armed forces
- People who misuse drugs, alcohol or Novel Psychoactive Substances ("legal highs")

- Lesbian, gay, bisexual and transgender people
- Black, Asian and minority ethnic groups, including asylum seekers
- Addressing the needs of people following child sexual exploitation.

Identified Strategic outcomes	Actions or Objectives
Early identification of children and young people with emotional and mental health needs in a variety of settings, and referral processes for them to receive appropriate support	1. DHCFT Children's services e.g. Health Visitors, Paediatricians, school nurses, Children and Adolescents Mental Health Services (CAMHS) – work collaboratively with external agencies e.g. Social Care, General Hospitals, voluntary sector 2. Staff working for DHCFT will receive training with regard to Safeguarding and children 3. DHCFT staff will follow and contribute fully to the agreed Derbyshire wide Safeguarding Policies and Procedures 4. Safeguarding supervision 5. Access to support (e.g. age ranges of services) 6. Think Family information to be given to all carers as appropriate
Develop the potential to provide young people with skills to enable them to develop emotional resilience to promote positive mental health throughout their life	1. Explore with public health commissioners as part of the contract including investment and capacity issues 2. DHCFT Children's services e.g. health visitors (HVs), paediatricians, school nurses, CAMHS 3. Think Family

Increase identification of and relationship between physical health conditions amongst individuals with depression and other long-term mental health needs	1. DHCFT Children's Services awareness of this need e.g. HVs, paediatricians, school nurses, CAMHS 2. Audit care plans for physical health 3. Training in physical healthcare for mental health staff 4. Physical Care Committee policy
Identify and support those at increased risk of isolation, vulnerability or stigma	1. Training e.g. anti-stigma, equality and diversity 2. Use of Voluntary Sector Single point of Access (vSPA) services
Family, carers and friends of people being cared for by mental health services to be given information on how to access services promptly and at all times if they have a concern that someone is feeling suicidal	1. Care plans audit 2. Use of contact cards 3. Friends and Family Test 4. Review outward-facing internet presence for easy access to information on crisis services
Increased awareness and understanding of the relationship between trauma, health and wellbeing	1. Development of trauma training by 2016 2. Suicide awareness and response training – all clinical staff to be trained by September 2017 3. Compassion Focussed Therapy (CFT) training 4. Supervision 5. Shared educational resources 6. Services avoiding re-traumatisation

Strategic priority 3: Reduce access to the means of suicide

> **I think that suicide prevention could be greatly improved by having experienced individuals involved in talking to suicidal people in order to support them at times of crisis and even when this is an emergency. We know exactly how it feels to want to die and can use this knowledge to help others to want to live.**
>
> **It is no surprise that doctors and farmers have a disproportionate rate of suicide because they have such ease of access to the means. The international example of suicide in the USA shows a high prevalence of suicide by firearms because of the prevalence of guns. The job of suicide prevention strategies is to look at the most used means and try to ameliorate the rate.**
>
> **Service user RW**
> March 2016

Suicide can arise out of an impulsive action in response to a sudden crisis or extremely difficult circumstances. If the means for completing suicide are not easily available or made more difficult to access then the impulse may pass. Reducing access to means is therefore an effective way of preventing suicide. The national strategy highlights that the suicide methods most amenable to intervention are:

- Those that occur at high-risk locations
- Those on the rail network
- Self-poisoning
- Hanging and strangulation.

Identified areas for action	Actions or Objectives
Exchange information about high-risk locations in Derbyshire with DSPPF and wider groups. Work in partnership to mitigate this risk	1. Adherence to Public Health England 'cluster and contagion' guidance document, working with Derbyshire Suicide Prevention Partnership Forum (DSPPF) 2. DSPPF strategy to share information via monthly Data Group

	3. Serious Incident Group (SIG) of DHCFT actions shared with DHCFT SPSG when relevant
Exchange information about high-risk methods in Derbyshire with Suicide Prevention Forum and wider groups. Work in partnership to mitigate this risk	1. DSPPF strategy to share information 2. DHCFT SIG actions shared with DHCFT SPSG when relevant
Proactively review Trust data for methods of suicide and devise ways to respond locally and share information	1. SIG group annual report - internal and external data reviewed and shared with DHCFT SPSG 2. Collaborate with other DHCFT groups, for example Quality Leadership Teams, to implement action plans and disseminate information
Reduce access to means in healthcare and other settings, especially opportunities for hanging and strangulation	1. Review ligature points as per ligature review policy; as a minimum annually or more regularly on new information or new risks identified 2. DHCFT clinicians/prescribers to limit the number of prescribed medications to individuals at risk of suicide/self harm and consider prescribing medications which are less toxic if taken in overdose 3. Individualised safety care plans considering access to means 4. At times when individuals are inpatients and at high risk, staff to follow the DHCFT observation and search policy

Strategic priority 4:
Provide better information and support to those bereaved or affected by suicide

A friend of mine was in bereavement following his partner's suicide. A few months later he tried to take his own life.

Thankfully he did survive, although this has left him severely scarred. In his experience his psychiatrist had made him worse by how he chose to speak to and "treat" him.

It was a surgeon at Nottingham Queens Medical Centre who performed his skin grafts that he found compassionate and helped him to feel some sense of future purpose. Help is At Hand is a very good document.

Service user RW
March 2016

Those bereaved by a suicide are at increased risk of mental health and emotional concerns, and may also be at increased risk of suicide themselves. This effect can be lifelong. Provision of timely and effective support and information is therefore important to help the grieving process and prevent longer-term distress. Suicides can also have a profound effect on local communities, including friends, work colleagues and neighbours, but also teachers, healthcare professionals, witnesses to the incident and emergency service workers.

Within Derbyshire Healthcare NHS FT we need to ensure that there is:

- Effective and timely support provided to those affected by suicide - to both relatives of patients who have died by suicide and patients whose relatives have died by suicide
- An effective local response is in place in the aftermath of a suicide
- Information and support are provided to families, friends and colleagues who are concerned about someone who may be at risk of suicide (e.g. Think Family).

Identified areas for action	Actions or Objectives
Promote staff education and awareness of importance of supporting those bereaved by suicide	1. Suicide awareness and response training – all clinical staff to be trained by September 2017 2. Serious Incident (SI) process including supporting the bereaved
Engage with those bereaved by suicide to determine their immediate and longer-term needs in the aftermath of a suicide. These needs can reoccur at any time	1. Family Liaison workers and named clinical service leads in partnership to provide first contact 2. Awareness of and ability to access information for the bereaved e.g. "help is at hand" 3. Links between Family Liaison workers and groups engaged in supporting those bereaved by suicide e.g. Papyrus and Survivors of Bereaved by Suicide (SOBS) 4. Recognition and exploration of potential long-term needs e.g. anniversary of bereavement
Ensure DHCFT supports the needs of our staff affected by suicide	1. Serious Incident process 2. Schwartz Rounds – occur regularly in the north and south of the county 3. Develop a clinically accountable culture and change the experience of staff who fear a blame culture 4. Training and support for staff affected by suicide themselves

5. Organisational awareness of effects of trauma on staff

6. DHCFT provides psychological support to all staff and groups of staff who have experienced distress following suicide

7. Make available up-to-date managers guidance for supporting staff through a Serious Incident investigation and the Coroners' process, in line with Morecambe Bay guidance reissued by NHS Improvement in May 2016 ('Duties relating to coroner requests') and any subsequent publications process

Strategic priority 5:
Support the media in delivering sensitive approaches to suicide and suicidal behaviour

"It's only through my work for the Trust that I've started to realise the importance and power of language when it comes to communicating about issues of self-harm and suicide.

I'm now much more aware of our responsibility to educate those outside the Trust, so we find a common way to discuss these issues that is open and honest without ever being graphic or sensational."

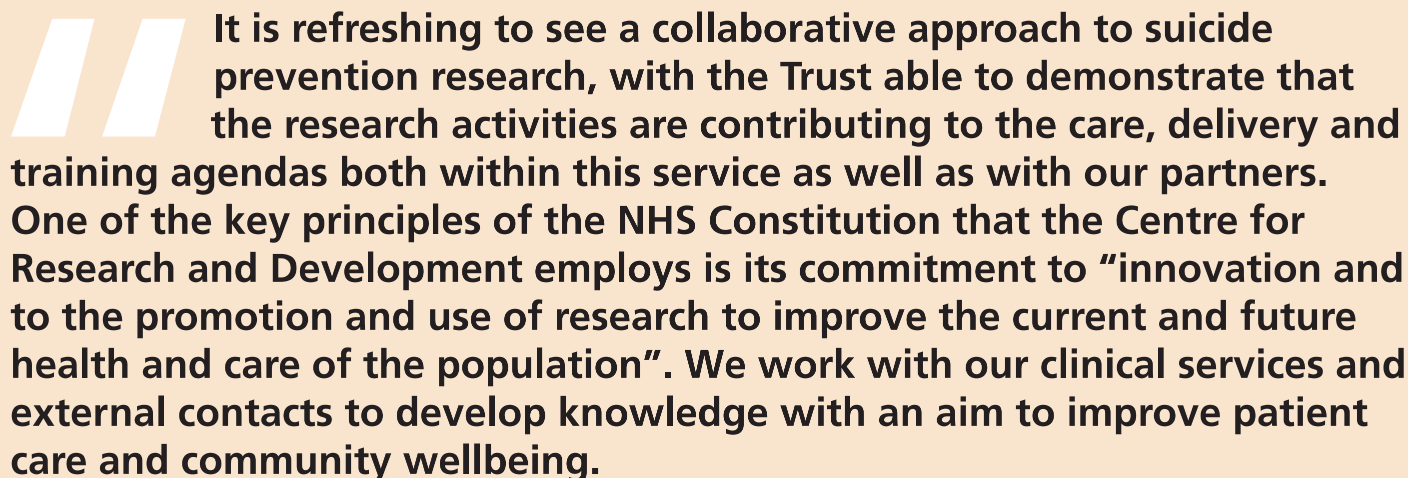
Richard Eaton
Communications Manager

The media has a significant influence on behaviours and attitudes towards suicide. Encouraging responsible reporting and portrayal of suicide can reduce the risk of so-called "copycat" suicides but also provides an opportunity to promote support and information.

Social media and the internet are often associated with negative aspects of suicide, such as the availability of sites that promote and encourage suicide and e-bullying amongst young people. However, there are also opportunities to harness the positive effects both can have in supporting those in distress.

Identified areas for action	Actions or Objectives
Review DHCFT communications and reporting of suicides and suicidal behaviour by local media	1. Provide advice for staff e.g. Samaritans Media Guidelines. Communications within DHCFT to provide advice for all staff who speak to the media regarding suicide
Media enquiries relating to suicide are directed towards Suicide Prevention Strategy Group via the Chair of DHCFT SPSG	1. Communications department within the Trust have a list of DHCFT SPSG members and contact details for current chair
Use communications approaches to promote support available to those in distress and those concerned about an individual	1. Social media (e.g. Twitter) 2. World Suicide Prevention Day annual event to be actively supported by Trust staff 3. DSPPF attendance by DHCFT SPSG members
Derbyshire Healthcare NHS Foundation Trust website to have supportive information or links to helpful websites	E.g. Samaritans, Relate, Citizens Advice Bureau (CAB), 111 - the NHS non-emergency telephone triage service

Strategic priority 6:
Support research, data collection and monitoring



It is refreshing to see a collaborative approach to suicide prevention research, with the Trust able to demonstrate that the research activities are contributing to the care, delivery and training agendas both within this service as well as with our partners. One of the key principles of the NHS Constitution that the Centre for Research and Development employs is its commitment to “innovation and to the promotion and use of research to improve the current and future health and care of the population”. We work with our clinical services and external contacts to develop knowledge with an aim to improve patient care and community wellbeing.

The strength of the Trust’s approach is linking everyday clinical activity and recording, into a research approach (for example our partnership in the Multicentre Study of Self-harm in England), whilst also helping to inform services and clinical colleagues of research findings. The work of the Centre for Research and Development delivers against the Trust strategy and its vision and values, as well as the NHS Constitution pledges on research.

Keith Waters

Director of Centre for Self Harm and Suicide Prevention

Local information will form the foundation of suicide prevention work in DHCFT. This information will allow the DHCFT SPSG to continually develop a strategic direction for suicide prevention work through the identification of trends and changes in the pattern of suicide. This will allow local work to adapt, and enable the development and evaluation of interventions that reflect changes in need. In order to build a comprehensive picture of local needs, reliable, accurate and timely data will be collated from a variety of sources, and will not be reliant solely on official sources of data on completed suicides that are published over a year in arrears. Developing metrics will also allow for monitoring of the impact of local suicide prevention work to be undertaken.

As well as local data, national and international research can be used to assess the effectiveness of interventions to reduce suicides, including near misses, as well as enhance the understanding of suicide risk in population groups.

Identified areas for action	Actions or Objectives
Be an active member of the DSPPF to develop a meaningful picture of local suicide prevention needs, that is reported	1. Reporting of suicides to public health at DSPPF via monthly Data Group 2. Bring and exchange quantitative and qualitative information to DSPPG 3. Timely response in Reporting to National Confidential Inquiry into Suicides and Homicides (NCISH) by responsible clinician/lead clinician
Contribute to the local suicide data to help inform the planned available online summary	1. DSPPF meetings attended by DHCFT SPSG staff 2. Data analysis with public health
Exchange information across DHCFT and with partners to raise awareness of local suicide needs and influence the work of other groups including service receivers and third sector groups. Individuals and teams to evaluate local intelligence and share this within the Trust	1. Suicide awareness and response training 2. Service receiver information comes to DHCFT SPSG 3. Third sector and voluntary groups 4. Other public services e.g. East Midlands Ambulance Service NHS Trust 5. Disseminate information regarding the importance of local data e.g. teams identifying patterns, information on DHCFT intranet site

To be a part of the process of disseminating recommendations and information from reviews of suicide deaths	1. Individuals and teams to evaluate local intelligence and share this within DHCFT 2. DHCFT SPSG to lead on dissemination of information from sources e.g. NICE, SIG, Coroners' verdicts 3. DHCFT SIG to consult DHCFT SPSG regarding recommendations when relevant 4. Complete analysis of findings from National Confidential Inquiry into Suicide and Homicides reports and disseminate through Serious Incident group and DHCFT clinical and management structures
Support the work of the research department and input into multi-centre monitoring of self harm	1. Trust commitment to research

Strategic priority 7: Building the resilience of local communities to prevent and respond to suicides

Some years ago a man jumped from a roof. I would like to have a couple of people with mental health and suicide 'experience' who are available to 'talk down' the person in such a situation. I believe this could be pioneering and progressive towards reducing suicide rates.

However, the worst thing about the day referred to above, and what proved to be a cause of his eventual jumping, was that a huge crowd had gathered on the pavements and road below who continually shouted insensitive comments up at him. Some of these comments were shamefully encouraging him to jump. Why had the crowd not been cleared from the street? How could we seriously expect to prevent such a suicide when faced with an obstacle like that one on that day?

Service user RW
March 2016

There is always an opportunity, as well as a responsibility, to learn from difficult events and for change to occur. Following the above incident, we were able to provide training and support for car park staff, individuals responsible for the management and design of the car park and engage with police negotiators across the East Midlands.

By undertaking in this collaborative work, we have been able to increase awareness of suicide and help guide and support those who may work with distressed individuals at risk of suicide.

The local suicide prevention strategy groups identified approaches that could help both in terms of identifying potential locations where people in distress may go to but also in raising awareness. People working in these locations are able to seek guidance and support on prevention methods.

Nationally the work of Network Rail, which includes the construction of barriers at potential locations and the use of signage to encourage help seeking, has been an example of learning from difficult events.

In addition to this, the work of chaplains and street triage at known locations, and the recent document from Public Health England "Preventing suicides in public places: a practice resource", are also able to show that measures have been put in place to learn from suicides and prevent them.

On a closing note, the 'Find Mike' campaign, where Jonny Benjamin was reunited with the stranger who talked him down from a bridge, demonstrates the importance of making contact with those in distress and the power of lay people's awareness and involvement in prevention approaches - and thus the importance of training, support and guidance for people working at all levels.

Keith Waters
Director of Centre for Self Harm and Suicide Prevention
Clinical Advisor - Suicide Prevention, East Midlands Health Science Network

Suicide Prevention is everyone's business. We are all responsible for building local networks of support that have the potential to help those who are in distress and may feel that they have nowhere else to turn. An important part of this will be the need to raise awareness of suicide within local communities and building people's confidence to support and provide comfort for those in distress. It will also serve to reduce the stigma around suicide.

Identified areas for action	Actions or Objectives
Promote mental health anti-stigma campaigns, such as Time to Change, amongst local organisations to dispel myths about mental health and suicide that persist amongst professionals and the general public	1. Training for Acute Hospital care staff e.g. Emergency Department staff 2. Schwartz rounds 3. DHCFT Human Resource processes to build community resilience including with staff
Use opportunities like World Suicide Prevention Day to build community resilience	1. World Suicide Prevention Day annual event to be actively supported by Trust staff 2. Media promotion of the event
Use our membership of the Derby Suicide Prevention Partnership Forum to influence other agencies' approach to suicide and mental health stigma	1. Attendance at DSPPF 2. Accountability to DSPPF strategy 3. DHCFT SPSG members to work alongside DSPPF to develop training and support for primary care staff
Staff stigma – staff to feel able and supported to be open about their own mental health and wellbeing	1. Staff survey analysis
Develop links with local communities to build resilience	1. Partnership working with a wide range of groups e.g. sports club, faith groups

Authors of this strategy

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Abbreviations and Glossary

111 Telephone Service:
111 is the free NHS non-emergency number. Call 111 and speak to a highly trained adviser, supported by healthcare professionals. They will ask you a series of questions to assess your symptoms and immediately direct you to the best medical care for you. NHS 111 is available 24 hours a day, 365 days a year. Calls are free from landlines and mobile phones.

Care Programme Approach:
The Care Programme Approach (CPA) is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. You might be offered CPA support if you: are diagnosed as having a severe mental disorder

Children and Adolescent Family Therapy Services (CAMHS)
CAMHS is a specialist NHS service. In Derby and the south of Derbyshire it is run by DHCFT. It offers assessment and treatment for children and young people have emotional, behavioural or mental health difficulties.

Citizens Advice Bureau (CAB):
Provides the advice people need for the problems they face and improves the policies and practices that affect people's lives.
CAB provides free, independent, confidential and impartial advice to everyone on their rights and responsibilities. They value diversity, promote equality and challenge discrimination.

Compassion focused therapy (CFT):
A form of psychotherapy developed that integrates techniques from cognitive behavioural therapy with concepts from evolutionary psychology, social psychology, developmental psychology, Buddhist psychology and neuroscience. The central therapeutic technique of CFT is compassionate mind training, which is used to help people develop and work with experiences of inner warmth, safeness and soothing, via compassion and self-compassion. Compassionate mind training helps transform problematic patterns of cognition and emotion.

Crisis Resolution and Hone Treatment Team (CRHT):
Crisis Resolution and Home Treatment teams provide crisis assessment and intensive home treatment to individuals with mental health problems who present in a 'crisis'.

Derbyshire Healthcare NHS Foundation Trust (DHCFT):
We are a leading provider of mental health, learning disabilities and substance misuse services in Derby city and Derbyshire county. We also provide a wide range of children's services. We employ over 2,400 staff based in 100 locations. Across the county and the city, we serve a combined population of approximately one million people.

Derbyshire Suicide Prevention and Partnership Forum (DSPPF):
The Derbyshire Suicide Prevention Partnership Forum allows representatives from a number of different organisations to work together on achieving the common goal of reducing the number of people who die from suicide in Derby City and Derbyshire County. All members of the group have committed to champion suicide prevention work within their organisations and networks.

Derbyshire Voice:
A user led organisation and a registered charity and company who have played an important part in developing this strategy and generally working to improve mental health services. As of April 2016 our service receiver representation is provided by Derbyshire Mental Health Alliance.

DHCFT Serious Incident Group:
An internal DHCFT group of senior clinicians and managers who meet weekly to review all serious incidents. Investigations will be commissioned and reviewed. Immediate action will be taken as required.
DHCFT Suicide Prevention Strategy Group (SPSG)
DHCFT internal group linking to the wider Derbyshire group attended by clinicians from DHCFT and service users.

DHCFT Family Liaison Workers
Derbyshire Healthcare employs workers who provide support and help to families including those bereaved by suicide.

Front Door Presentations (FDP):
These are individuals who present to the either the Radbourne Unit, Derby or the Hartington Unit, Chesterfield who have not been formally referred but are requesting an assessment.

Help is at Hand:
A booklet for people who have been unexpectedly bereaved by suicide and other sudden and traumatic deaths. Called 'Help is at hand', it includes advice on coping with emotions, practical matters and how friends and family can help. It also provides information to help healthcare and other professionals understand the impact of suicide and how they can provide support

Mental Health Liaison Team:
Our Psychiatric Liaison Teams provide comprehensive advice, support and a signposting service to patients over the age of 17, where potential mental health and/or drug and alcohol issues are identified. Following referral from a health professional in Accident and Emergency or an inpatient ward within the general hospital, the team will offer a high-quality intervention, assessment and discharge process that covers all aspects of mental health - including drug and alcohol use and self-harming.

The team has been established by integrating the former Mental Health Liaison & Self Harm Team with the Older Adults Mental Health Liaison Team and the Hospital Alcohol and Drugs Liaison Team to create a 24/7 single point of access service at the Royal Derby Hospital and Chesterfield Royal Hospital.

Research shows that untreated mental health issues can lead to people spending longer in hospital and to poorer physical health outcomes. By working with other clinical colleagues, the Liaison Team is making sure that patients get the right help, at the right time, in the right place. They also provide a vital educational resource to staff throughout the hospital - to raise awareness and understanding of mental health needs and recognising the signs and symptoms.

The National Institute for Health and Care Excellence (NICE): publishes guidelines in four areas: the use of health technologies within the NHS (such as the use of new and existing medicines, treatments and procedures); clinical practice (guidance on the appropriate treatment

and care of people with specific diseases and conditions); guidance for public sector workers on health promotion and ill-health avoidance; and guidance for social care services and users.

National Confidential Inquiry into Suicide and Homicide:
Research into suicide and homicide by mental health patients across the UK and the sudden unexplained death of psychiatric in-patients. As the UK's leading research programme in this field, the Inquiry produces a wide range of national reports, projects and papers – providing health professionals, policymakers, and service managers with the evidence and practical suggestions they need to effectively implement change

Papyrus:
PAPYRUS is the UK charity dedicated to the prevention of young suicide.

Relate:
An organisation that help people (including providing therapy) make the most of their relationships, past, present or future. They can help you even if people are not currently in a relationship.

Schwartz Rounds:
A forum for clinical and non-clinical staff from all backgrounds and levels of an organisation to come together once a month and explore the impact that their job has on their feelings and emotions. A team/individual who have/has cared for a patient tell their story and this is followed by discussion, open to all, exploring issues that have arisen. It is not about problem solving – rather it is a dedicated time for reflection and a safe place to voice feelings not often shared, such as frustration, anger, guilt, sadness, joy, gratitude and pride.

Suicide awareness and response training:
This is evidence-based training in suicide and self harm prevention. It aims to increase empathy, reduce stigma and enhance participants' ability to compassionately respond to someone who has suicidal thoughts or following self harm. Such training supports the development of a common language, promoting a more integrated response across statutory services, third sector providers and communities.

Survivors of Bereaved by Suicide (SOBS):
Survivors of Bereavement by Suicide exist to meet the needs and break the isolation experienced by those bereaved by suicide. They are a self-help organisation and aim to provide a safe, confidential environment in which bereaved people can share their experiences and feelings, so giving and gaining support from each other. They also strive to improve public awareness and maintain contacts with many other statutory and voluntary organisations. They offer a unique and distinct service for bereaved adults across the UK, run by the bereaved for the bereaved.

Think Family:
Think Family' strategies promotes co-ordinated thinking and delivery of services to safeguard children, young people, adults and their families/ carers. Neither children, young people nor adults exist or operate in isolation. This presents a unique and positive opportunity to adopt a 'Think Family' approach to the planning and enabling of the delivery of services which are safe, effective and of high quality.

Trauma:
"The physical, cognitive, emotional and behavioural response someone has to an event or experience he or she perceives as traumatic"

Voluntary Sector Single Point Of Access (vSPA):
The service links local people at most risk of hospital admissions to the extensive range of support services that exist across the Voluntary Care Sector (VCS).

Individuals can be referred to vSPA by any health or social care professional, including GPs, community support teams, hospital discharge teams and staff working in social care. VCS organisations will also be able to refer their clients to the vSPA service for even more support.

Vulnerable Adult Risk Management (VARM): is a multi-agency risk management process to enable professionals to come together to develop creative and assertive plans to support Adults at Risk who have mental capacity and who are at risk of serious harm or death through self-neglect, risk taking behaviour or by refusing previous offers of support from services.

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